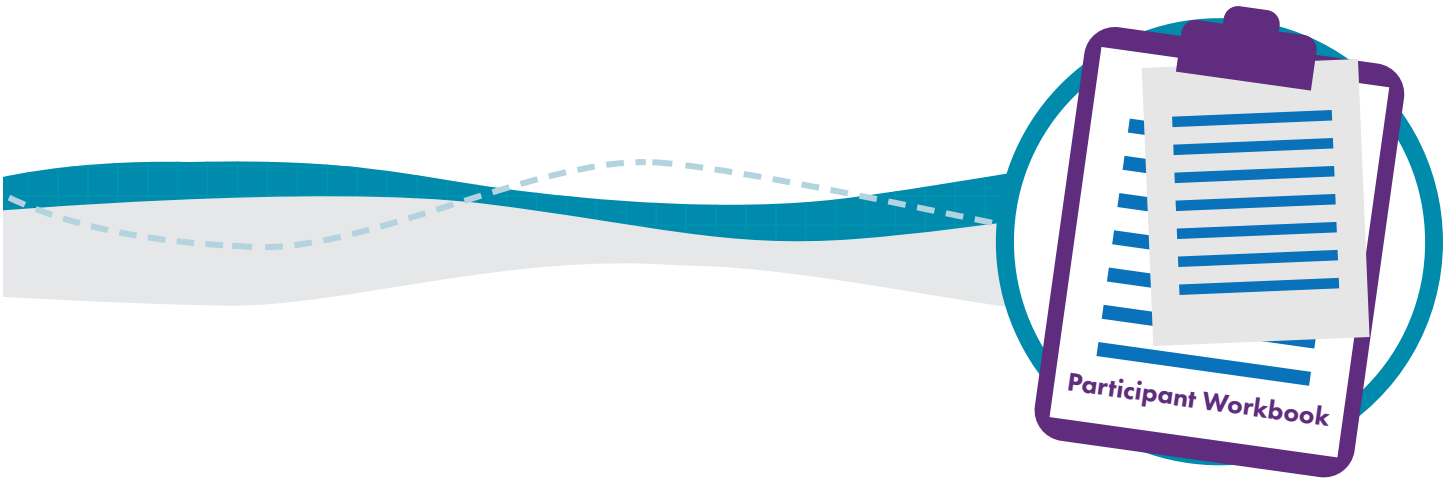

TeamSTEPPS® for Diagnosis Improvement

Participant Workbook

Agency for Healthcare Research and Quality

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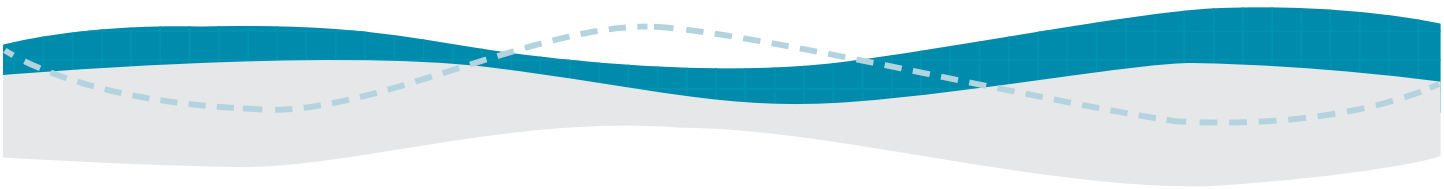
Contents



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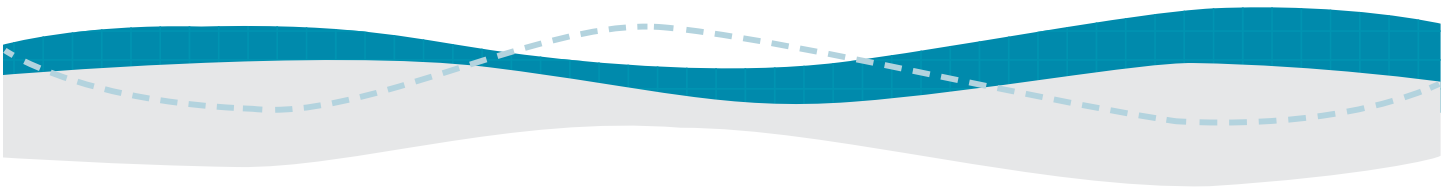

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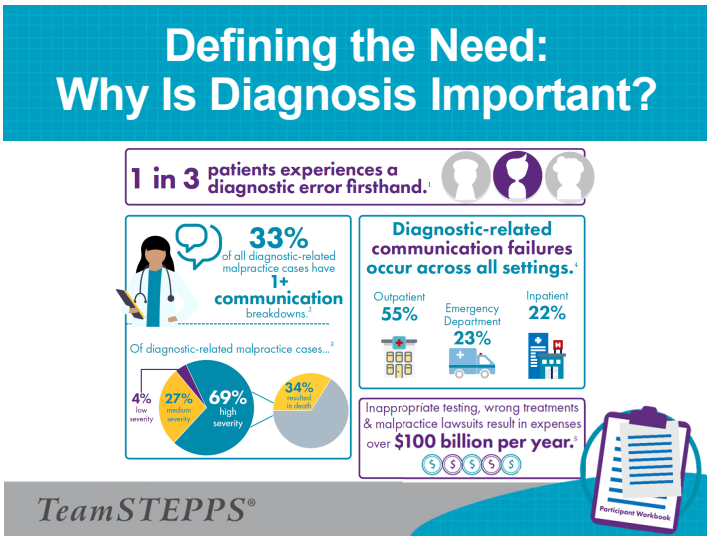
Introduction: TeamSTEPPS for Diagnosis Improvement

The TeamSTEPPS® for Diagnosis Improvement Course applies the TeamSTEPPS program principles to the specific problem of diagnostic error. When implementing TeamSTEPPS for Diagnosis Improvement, teams will learn about the four competency areas and how improved communication among all members of the care team can lead to a safe, accurate, and timely diagnosis in all healthcare settings.

The course consists of seven PowerPoint training modules that are customizable to the needs of the local team and course facilitator and can be delivered virtually, in a classroom setting, or as individual self-paced learning modules. This Participant Workbook is the primary tool for learners to complete the course activities, such as exercises, case-based scenarios, and reflective practices.

Slide 5: Defining the Need: Why Is Diagnosis Important?



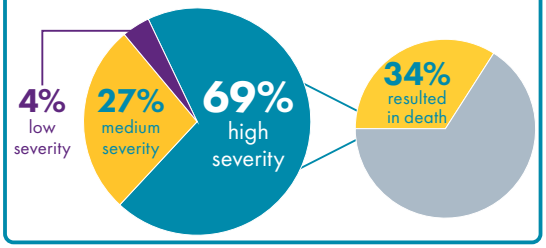
On the following page is an infographic that underscores how frequently errors occur during the diagnostic process.

Did you know...

1 in 3 patients experiences a diagnostic error firsthand.[1]

33% of all diagnostic-related malpractice cases have **1+ communication** breakdowns.[2]

Of diagnostic-related malpractice cases...[3]



Diagnostic-related communication failures occur across all settings.[4]

Outpatient **55%**

Emergency Department **23%**

Inpatient **22%**

Inappropriate testing, wrong treatments & malpractice lawsuits result in expenses over **$100 billion per year.**[5]

Improve Communication and Teamwork Among Providers by Using the TeamSTEPPS® for Diagnosis Improvement Course

Module 1: Introduction

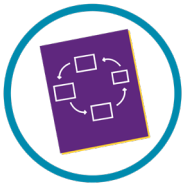
Module 2: Diagnostic Team Structure

Module 3: Communications

Module 4: Leadership

Module 5: Situation Monitoring

Module 6: Mutual Support



Module 7: Putting It All Together

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2. Hanscom R, Small M, Lambrecht A. A Dose of Insight: Diagnostic Accuracy: Room for Improvement. Boston, MA: Coverys; March 2018. https://coverys.com/PDFs/Coverys_Diagnostic_Accuracy_Report.aspx. Accessed January 5, 2022.
3. Hoffman J, Raman S. Communication Factors in Malpractice Cases. Cambridge, MA: CRICO; 2012. https://www.rmf.harvard.edu/-/media/Files/_Global/KC/PDFs/Insight_Comm_2012.pdf. Accessed January 5, 2022.
4. Malpractice Risks in Communication Failures: 2015 Annual Benchmarking Report. Boston, MA: CRICO Strategies; 2015. https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/Risks-in-Communication-Failures. Accessed January 5, 2022.
5. Newman-Toker DE. Diagnostic value: the economics of high-quality diagnosis and a value-based perspective on diagnostic innovation. Modern Healthcare Annual Patient Safety & Quality Virtual Conference; June 17, 2015.

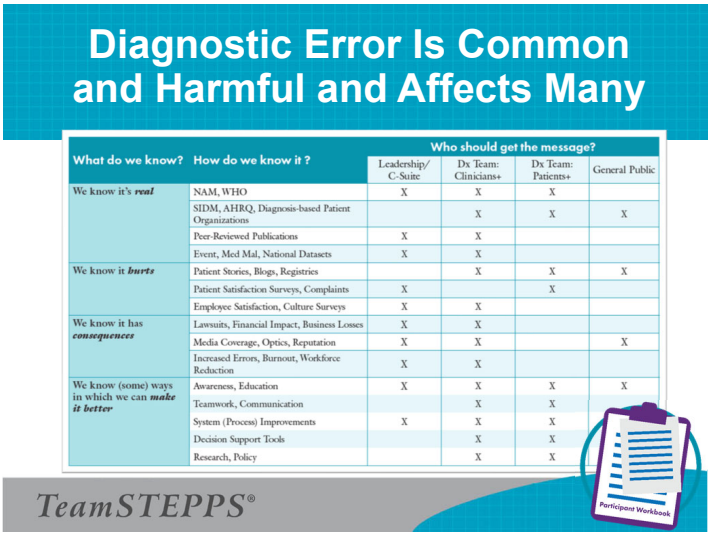
AHRQ Agency for Healthcare Research and Quality

TeamSTEPPS® for Diagnosis Improvement

AHRQ Publication No. 22-0015

February 2022

Slide 11: Diagnostic Error Is Common and Harmful and Affects Many



What do we know?	How do we know it ?	Who should get the message?			
		Leadership/ C-Suite	Dx Team: Clinicians+	Dx Team: Patients+	General Public
We know it's *real*	NAM, WHO	X	X	X	
	SIDM, AHRQ, Diagnosis-based Patient Organizations		X	X	X
	Peer-Reviewed Publications	X	X		
	Event, Med Mal, National Datasets	X	X		
We know it *hurts*	Patient Stories, Blogs, Registries		X	X	X
	Patient Satisfaction Surveys, Complaints	X		X	
	Employee Satisfaction, Culture Surveys	X	X		
We know it has *consequences*	Lawsuits, Financial Impact, Business Losses	X	X		
	Media Coverage, Optics, Reputation	X	X		X
	Increased Errors, Burnout, Workforce Reduction	X	X		
We know (some) ways in which we can *make it better*	Awareness, Education	X	X	X	X
	Teamwork, Communication		X	X	
	System (Process) Improvements	X	X	X	
	Decision Support Tools		X	X	
	Research, Policy		X	X	

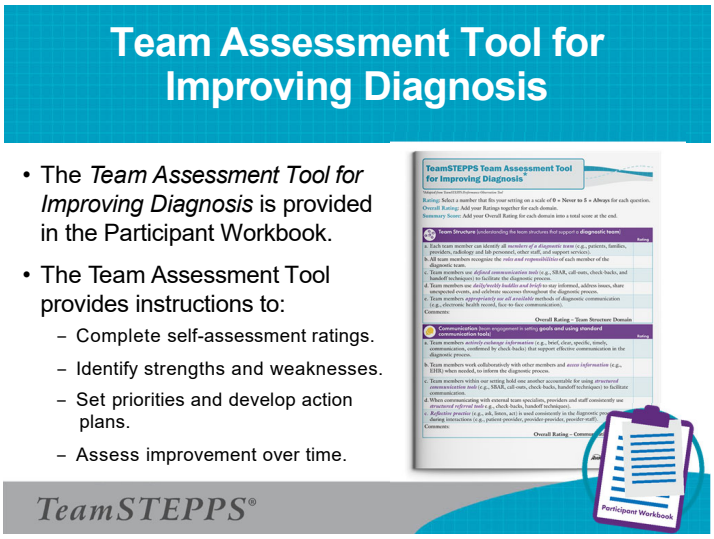
Diagnosis is not the sole responsibility of clinical providers or providers and patients. **Appropriate communication can mitigate diagnostic errors**, so it is important to tailor the communication about the diagnostic process and diagnostic errors to various stakeholders across the delivery system.

The following tool serves as an example of how to tailor messages for the greatest potential impact. It is important to know your audience when soliciting champions to support improvement efforts.

The Challenge of Diagnostic Breakdowns

What do we know?	How do we know it ?	Who should get the message?			
		Leadership/ C-Suite	Dx Team: Clinicians+	Dx Team: Patients+	General Public
We know it's ***real***	NAM, WHO	X	X	X	
	SIDM, AHRQ, Diagnosis-based Patient Organizations		X	X	X
	Peer-Reviewed Publications	X	X		
	Event, Med Mal, National Data Sets	X	X		
We know it ***hurts***	Patient Stories, Blogs, Registries		X	X	X
	Patient Satisfaction Surveys, Complaints	X		X	
	Employee Satisfaction, Culture Surveys	X	X		
We know it has ***consequences***	Lawsuits, Financial Impact, Business Losses	X	X		
	Media Coverage, Optics, Reputation	X	X		X
	Increased Errors, Burnout, Workforce Reduction	X	X		
We know (some) ways in which we can ***make it better***	Awareness, Education	X	X	X	X
	Teamwork, Communication		X	X	
	System (Process) Improvements	X	X	X	
	Decision Support Tools		X	X	
	Research, Policy		X	X	

Slide 21: Team Assessment Tool for Improving Diagnosis



This tool assesses the maturity level of your healthcare setting in five critical teamwork domains: Team Structure, Communication, Leadership, Situation Monitoring, and Mutual Support. It can help identify strengths and opportunities to increase teamwork, set priorities, develop action plans, and enhance communication for diagnostic improvement.

This tool should be **completed individually by all members in your setting after Module 1**: Introduction of TeamSTEPPS for Diagnosis Improvement Course. The survey should be administered **anonymously** and can be done via paper-based or electronic administration.

1. **All *individual* team members will complete the self-assessment ratings.**
   a. **Step 1: Rate each question**. For each question, select a number that best describes how often the behavior occurs in your setting. Each question has a point range of 0 to 5 (0 points = Never and 5 points = Always).
   b. **Step 2: Add your ratings**. Add your Overall Ratings into a Summary Score at the end of the assessment; the range is from 0 to 125 points.

2. **The *course facilitators* will identify strengths and opportunities to improve.**
   a. **Create an average Summary Score.** From the results of all the assessments completed in your setting, calculate the average Summary Score by adding the Overall Rating of each domain. (Detailed instructions are on Page 9 below).
   b. **Set priorities.** Using the results of all domains, select specific areas on which to focus your setting's improvement efforts.
   c. **Assess your improvement over time.** Readminister this assessment periodically to prioritize and guide initiatives in the five critical teamwork domains, with safer diagnoses as an overarching objective.

TeamSTEPPS Team Assessment Tool for Improving Diagnosis*

**Adapted from TeamSTEPPS Performance Observation Tool*

Rating: Select a number that fits your setting on a scale of **0 = Never to 5 = Always** for each question.

Overall Rating: Add your Ratings together for each domain.

Summary Score: Add your Overall Rating for each domain into a total score at the end.

Team Structure (understanding the team structures that support a **diagnostic team**)	Rating
a. Each team member can identify all ***members of a diagnostic team*** (e.g., patients, families, providers, radiology and lab personnel, other staff, and support services).	
b. All team members recognize the ***roles and responsibilities*** of each member of the diagnostic team.	
c. Team members use ***defined communication tools*** (e.g., SBAR, call-outs, check-backs, and handoff techniques) to facilitate the diagnostic process.	
d. Team members use ***daily/weekly huddles and briefs*** to stay informed, address issues, share unexpected events, and celebrate successes throughout the diagnostic process.	
e. Team members ***appropriately use all available*** methods of diagnostic communication (e.g., electronic health record, face-to-face communication).	
Comments: **Overall Rating – Team Structure Domain**	

Communication (team engagement in setting **goals and using standard communication tools**)	Rating
a. Team members ***actively exchange information*** (e.g., brief, clear, specific, timely, communication, confirmed by check-backs) that supports effective communication in the diagnostic process.	
b. Team members work collaboratively with other members and ***access information*** (e.g., EHR) when needed, to inform the diagnostic process.	
c. Team members within our setting hold one another accountable for using ***structured communication tools*** (e.g., SBAR, call-outs, check-backs, handoff techniques) to facilitate communication.	
d. When communicating with external team specialists, providers and staff consistently use ***structured referral tools*** e.g., check-backs, handoff techniques).	
e. ***Reflective practice*** (e.g., ask, listen, act) is used consistently in the diagnostic process during interactions (e.g., patient-provider, provider-provider, provider-staff).	
Comments: **Overall Rating – Communication Domain**	

Leadership (role of leadership in supporting **effective team communication**)	Rating
a. Leaders ***ensure all team members understand the goals and vision*** for effective communication in the diagnostic process (e.g., patient goals, shared model for plan of care) and hold each other accountable (e.g., use metrics for tracking improvement, debriefs, huddles).	
b. Leaders ***provide resources*** for the diagnostic team to effectively facilitate communication both internally and externally.	
c. Leaders support ***balances workload*** within the team and delegate tasks consistent with roles and responsibilities of team members.	
d. Leaders ***act as a liaisons*** for resolving team issues, system issues, and any breakdown in communication.	
e. Leaders ***set expectations for participation*** in effective communication practices (e.g., briefs, huddles, debriefs) in the diagnostic process.	
f. Leaders reinforce good practices by ***celebrating diagnostic team successes.***	
g. Leaders ***models*** teamwork behaviors.	
Comments: **Overall Rating – Leadership Domain**	

Situation Monitoring (the team's ability for **self-assessment** to improve communication processes)	Rating
a. Team members ***routinely assess*** communication practices to identify opportunities for improvement (e.g., this survey tool, debriefing events, safety culture surveys).	
b. Team members regularly ***review systems*** intended to support the diagnostic process (e.g., scheduling, test results, consultations) for gaps and improvement opportunities.	
c. Team members have a systematic process in place to capture and ***learn from near-misses and no-harm adverse events*** that occur because of communication gaps.	
d. Team members ***establish goals, share*** with diagnostic team, and implement ***action plans*** after assessments.	
Comments: **Overall Rating – Situation Monitoring Domain**	

Mutual Support (**supporting each other's efforts and resolving challenges** and conflict)	Rating
a. Team members are held accountable for ***proactively assisting*** each other in the diagnostic process (e.g., catching and correcting communication failures, providing task assistance).	
b. Team members freely ***provide timely and constructive feedback*** to each other to improve the diagnostic process.	
c. Team members feel ***safe raising issues***, sharing concerns, and advocating for patient needs.	
d. Team members attempt to ***resolve conflicts*** using structured communication tools (e.g., Assertive Statements, Two-Challenge Rule, DESC Script).	
Comments: **Overall Rating – Mutual Support Domain**	

Summary Score	

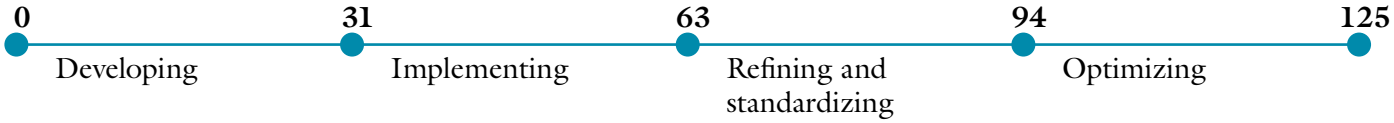
TeamSTEPPS® Team Assessment Tool for Improving Diagnosis – *Using the Results*

How to interpret and use the results from this Team Assessment Tool

a. **Create a setting-average Summary Score**. From the results of all assessments completed in your setting, calculate the average Summary Score for your setting. First, for each assessment completed, add each of the Overall Ratings domains (Team Structure, Communication, Leadership, Situation Monitoring, and Mutual Support) together to generate a Summary Score (A). Secondy, add the Summary Scores (A) from all the assessments completed together, and divide that number by the total count of assessments completed (B), which will determine the diagnostic maturity level of your setting (A/B =Maturity Level).

Based on your setting-average Summary Score, your team will fall on a probability scale range of 0 to 125 points: **0-31 = Developing Level, 32-63 = Implementing Level, 64-94 = Refining and Standardizing Level, 95-125 = Optimizing Level.** This scale provides an approximate sense of where your setting lies on the journey of maturing teamwork capabilities to support safe diagnosis.

On this probability scale, determine the maturity level of your setting:



b. **Set priorities. Identify strengths and opportunities to improve** teamwork by looking at the highest and lowest scores across individual domains, use this information to set priorities, and develop action plans to improve your diagnostic maturity. What are the highest scoring domains? Lowest scoring domains? What are the highest and lowest scoring questions within each domain? Do team members in your setting have consistent or inconsistent ratings in these domains?

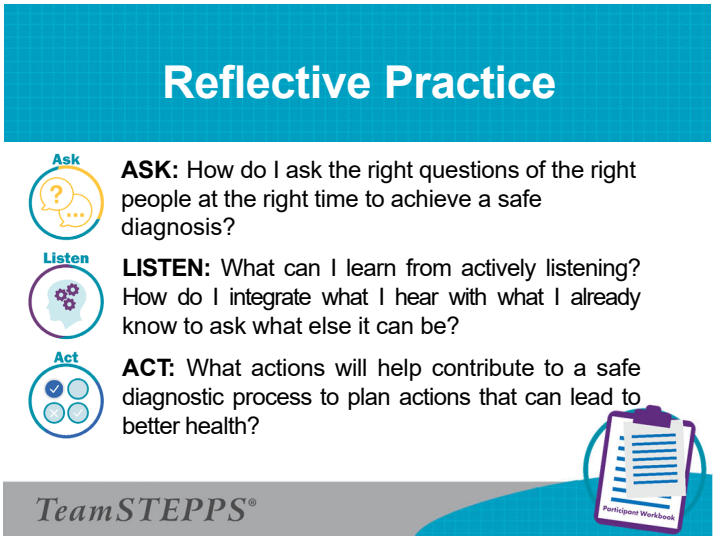
Share the results across your setting and invite discussion to decide where you have the strongest teamwork during diagnosis, and where you have the most room to improve.

Decide on specific items on which to focus your improvement efforts with your diagnostic team.

Each of the five critical teamwork domains of Team Structure, Communication, Leadership, Situation Monitoring, and Mutual Support of this Team Assessment Tool links directly to a TeamSTEPPS for Diagnosis Improvement module. You can find practical communication approaches, teamwork tools, and strategies for improving the diagnostic process in each area in the modules. Implement your action plan guided by the modules.

c. **Assess your improvement over time. Revisit this tool** (e.g., quarterly, semiannually, yearly) to guide your improvement in each teamwork for diagnosis improvement domain over time and set new goals with safer diagnoses as a long-term objective. Repeat the steps above. Reflect with your team: Are your strengths consistent? Are you making progress on your improvement opportunities? Has your average Summary Score improved in the diagnostic teamwork area on which you have focused? Do you have a long-term plan to ensure all five critical diagnostic teamwork domains are completed and scored?

Slide 23: Reflective Practice



The diagnostic process and reflection have similar goals as both derive from a spirit of inquiry. Throughout the course, we will use a three-word prompt to remind us of the reflective process. The words are **Ask, Listen**, and **Act** and are described on the following page

TeamSTEPPS® for Diagnosis Improvement

Reflective Practice Tool: The Spirit of Inquiry

ASK

Questions are the path to discovery and questions convey value. How do I ask the right questions of the right people at the right time to achieve a safe diagnosis?

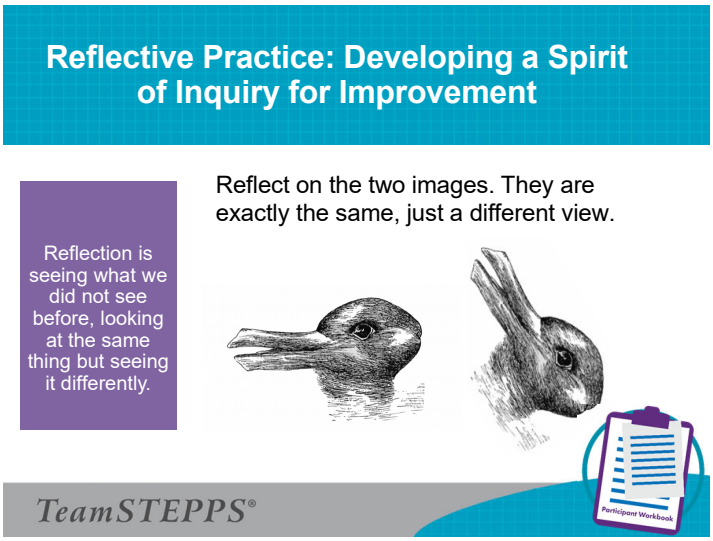
LISTEN

Questions are only meaningful if I listen actively through mindful engagement to the responses. What can I learn from actively listening? How do I integrate what I hear with what I already know to ask what else it can be?

ACT

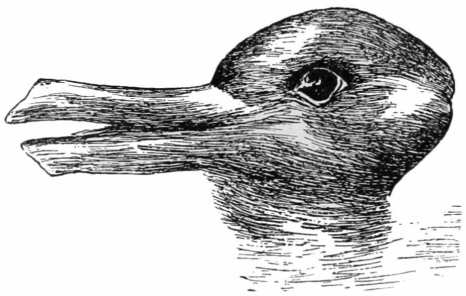
Asking and listening are followed by thoughtful action and a plan that includes patient perspectives. What actions will help contribute to a safe diagnostic process to plan actions that can lead to better health?

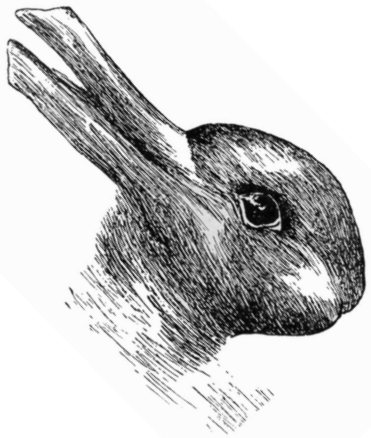
Slide 24: Reflective Practice: Developing a Spirit of Inquiry for Improvement



The practice of reflection is part of the improvement process. The most useful reflection involves the conscious consideration and analysis of beliefs and actions for the purpose of learning. Reflection is seeing what we did not see before, looking at the same thing but seeing it differently.

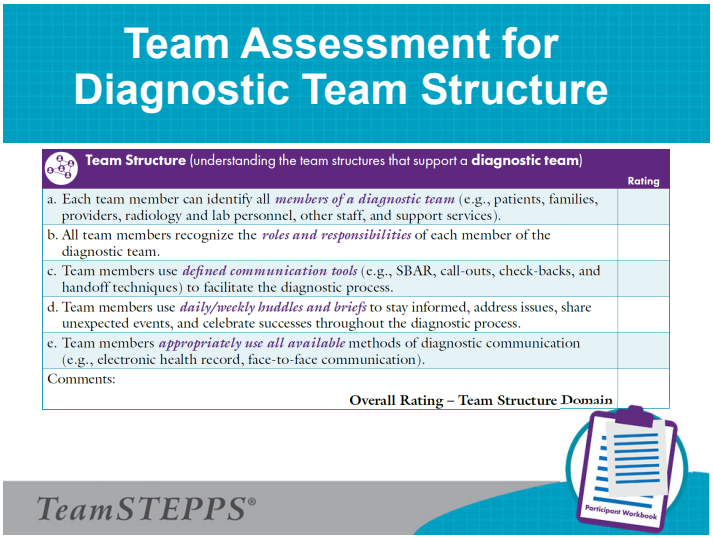
Look at the two images below:





1. **What do you see most clearly?**
2. **Do you see a duck and a rabbit?**
3. **Did your perspective change once you read that the two images are the same, just presented in a different view?**
4. **Can you see two ducks? Two rabbits?**
5. **What does this exercise suggest in terms of our ability to see things differently after reflection?**

Slide 4: Team Assessment for Diagnostic Team Structure

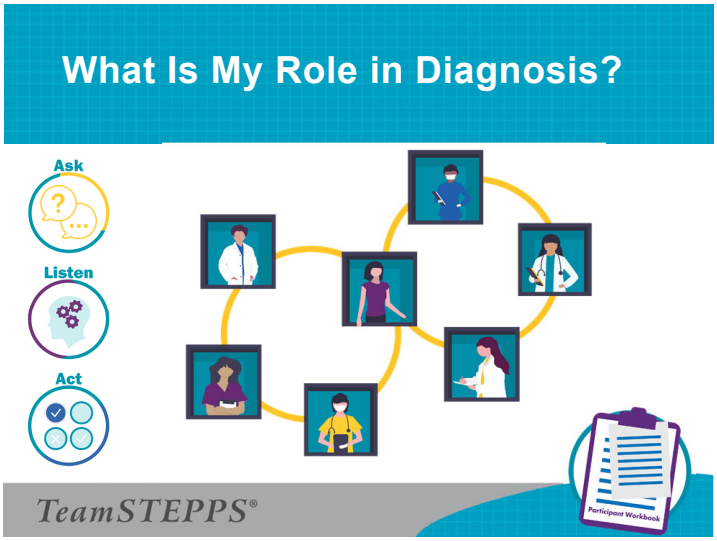


By now you should have completed the **Team Assessment Tool for Improving Diagnosis**. Refer to your responses relevant to **Team Structure**. Discuss with your team:

1. **How does the average Summary Score on Team Structure compare with the other TeamSTEPPS Dimensions (Communication, Leadership, Situation Monitoring, and Mutual Support)?**
2. **What are the highest scoring Team Structure characteristics?**
3. **What are the lowest scoring Team Structure characteristics?**
4. **How do team members at your site rate these characteristics?**

After discussing the scores, ask participants to identify together where the site has the most effective Team Structure methods to support improved diagnosis and where the site has opportunities to improve.

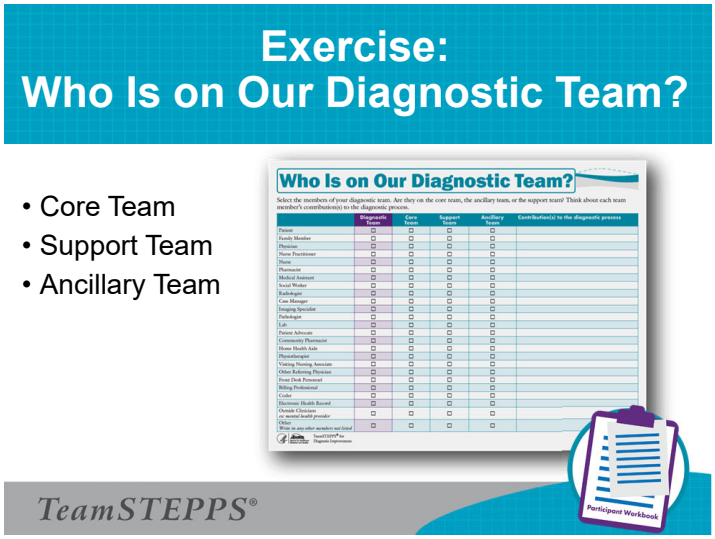
Slide 7: What is My Role in Diagnosis?



Using the Reflective Practice tool, let's discuss what your role is as part of the diagnostic team.

- **ASK** – What are MY contributions to the diagnostic team? How and where do I interact and exchange information? How does my communication affect diagnosis?
- **LISTEN** – How do your teammates describe their roles and contributions to the diagnostic team? Reflect on how you work together.
- **ACT** – How might your understanding of your role within the diagnostic team now change your actions? What might you do individually to contribute to safe diagnostic communication?

Slide 9: Exercise: Who is on our Diagnostic Team?



Now that you have reflected on your own roles on your diagnostic team, take a moment to reflect on who all the members of your diagnostic team are, as a whole.

Use the checklist on the following page to check all members of your diagnostic team and the role each one plays in the diagnostic process.

The purpose of this exercise is to take a pause to reflect on your team's definition of the diagnostic team. Each organization is different and some positions in the checklist might not be in your organization, or some positions missing from this list might be vital to your organization's diagnostic team.

The checklist has common members of the diagnostic team, such as clinicians, nurses, and medical assistants, who play a clear role in a patient's diagnostic journey. Some nontraditional team members on the diagnostic team include an interpreter, insurance staff, community health worker, and caregiver.

Each organization is different, and each member of the diagnostic team can fall into core, support, or ancillary team. A description of these teams is included in the Module 2 presenter notes for this slide. Talk with your team about the role each member plays on the team

Remember the Reflective Practice Tool as you discuss with the team:

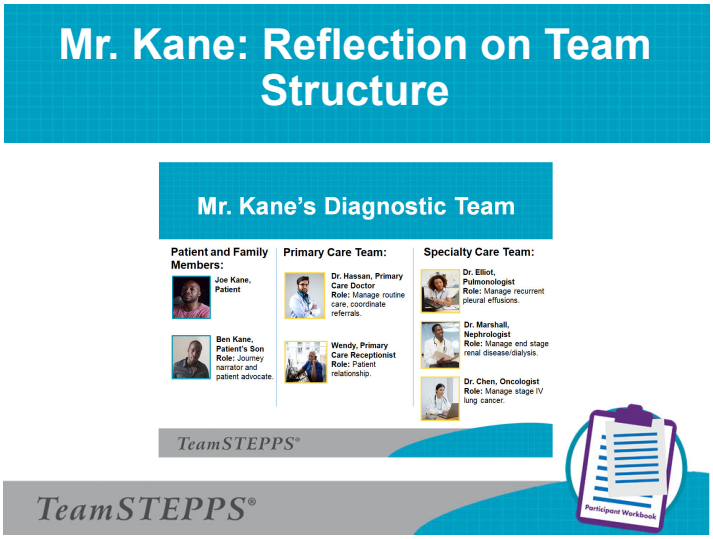
- **ASK** – What does the team look like? How and where does the team interact and exchange information? How does your communication affect diagnosis? Who is missing from the diagnostic team that we should add?
- **LISTEN** – How do your teammates describe the structure and their contributions to the diagnostic team? Reflect on how you work together.
- **ACT** – How might your new understanding of the diagnostic team structure change your actions? What might you do individually to contribute to safe diagnostic communication?

Who is on Our Diagnostic Team?

Select the members of your diagnostic team. Are they on the core team, coordinating team, or the ancillary services and support team? Think about each team member's contributions to the diagnostic process.

	Diagnostic Team	Core Team	Support Team	Ancillary Team	Contribution(s) to the diagnostic process
Patient	☐	☐	☐	☐	
Family Member	☐	☐	☐	☐	
Physician	☐	☐	☐	☐	
Nurse Practitioner	☐	☐	☐	☐	
Nurse	☐	☐	☐	☐	
Pharmacist	☐	☐	☐	☐	
Medical Assistant	☐	☐	☐	☐	
Social Worker	☐	☐	☐	☐	
Radiologist	☐	☐	☐	☐	
Case Manager	☐	☐	☐	☐	
Imaging Specialist	☐	☐	☐	☐	
Pathologist	☐	☐	☐	☐	
Lab	☐	☐	☐	☐	
Patient Advocate	☐	☐	☐	☐	
Community Pharmacist	☐	☐	☐	☐	
Home Health Aide	☐	☐	☐	☐	
Physiotherapist	☐	☐	☐	☐	
Visiting Nursing Associate	☐	☐	☐	☐	
Other Referring Physician	☐	☐	☐	☐	
Front Desk Personnel	☐	☐	☐	☐	
Billing Professional	☐	☐	☐	☐	
Coder	☐	☐	☐	☐	
Electronic Health Record	☐	☐	☐	☐	
Outside Clinicians *ex: mental health provider*	☐	☐	☐	☐	
Other *Write in any other members not listed*	☐	☐	☐	☐	

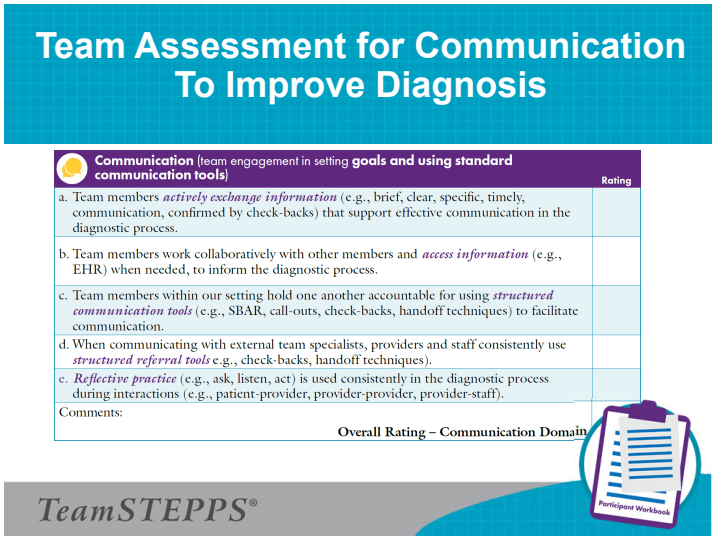
Slide 11: Mr. Kane Case: Reflection on Team Structure



Individually or in small groups, review the case of Mr. Kane's Diagnostic Journey. Discuss the following questions:

1. **What elements of Mr. Kane's journey showed good team behavior?**
2. **Did you see opportunities for better ways the team could support diagnosis? If yes, what were they?**
3. **How might those methods become common practice?**
4. **What tools might be useful to achieve improved support?**
5. **What type of biases may have affected Mr. Kane's diagnostic journey?**
6. **Describe ways to overcome those biases.**

Slide 4: Team Assessment for Communication To Improve Diagnosis

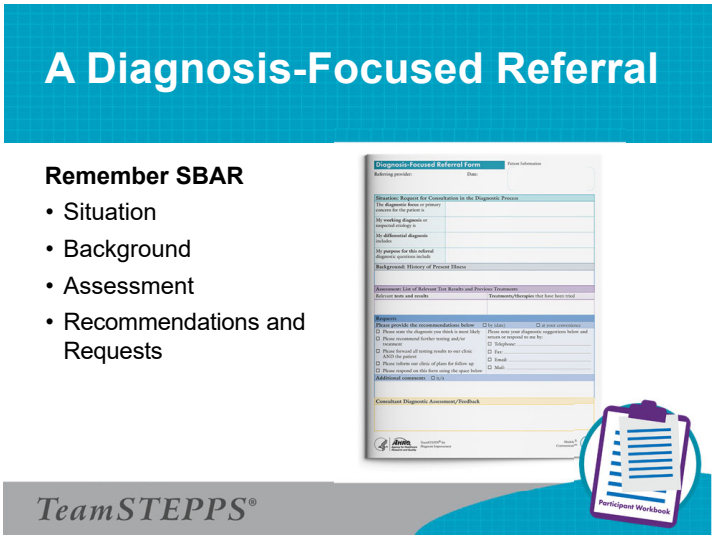


By now you should have completed the **Team Assessment Tool for Improving Diagnosis**. Refer to your responses on page 2 relevant to **Communication**. Discuss with your practice team:

1. **How does the average Summary Score on Communication compare with the average Summary Score on other TeamSTEPPS dimensions (Team Structure, Leadership, Situation Monitoring, and Mutual Support)?**
2. **What are the highest scoring Communication characteristics?**
3. **What are the lowest scoring Communication characteristics?**
4. **How do team members at your site rate these characteristics?**

After discussing the scores, ask participants to identify together where the site has the most effective Communication methods to support improved diagnosis and where the site has opportunities to improve.

Slide 10: A Diagnosis-Focused Referral



Review as a group or individually the Diagnosis-Focused Referral form samples on the following pages and discuss the following questions:

1. **When and how could we implement or integrate this referral process, tool, or approach into our workflow?**
2. **When would it be most helpful and for what patients should we use this process?**
3. **How might we use the form to address breakdowns in the diagnostic referral process?**
4. **Can you provide an example of when use of the diagnosis-focused referral process would be a challenge or problem?**
    - How might the challenge be mitigated by using the four TeamSTEPPS principles?
        1. Team Structure
        2. Communication
        3. Leadership
        4. Situation Monitoring

Diagnosis-Focused Referral Form

Patient Information

Referring provider:
J. Jackson, MD
Example Health Clinic

Date:
03-05-2019

Maria Rodriguez
DOB: 05/05/1963

Situation: Request for Consultation in the Diagnostic Process	
The **diagnostic focus** or primary concern for the patient is	Breast lump; redness; family hx of breast CA
My **working diagnosis** or suspected etiology is	r/o breast CA
My **differential diagnosis** includes	None
My **purpose for this referral**/ diagnostic questions include	Breast biopsy

Background: History of Present Illness

55F presented w/ lump on left breast; no previous mammogram

Assessment: List of Relevant Test Results and Previous Treatments

Relevant **tests and results**	**Treatments/therapies** that have been tried
none	none

Requests

Please provide the recommendations below ☐ by (date) ☒ at your convenience

- ☒ Please state the diagnosis you think is most likely
- ☐ Please recommend further testing and/or treatment
- ☒ Please forward all testing results to our clinic AND the patient
- ☐ Please inform our clinic of plans for follow up
- ☒ Please respond on this form using the space below

Please note your diagnostic suggestions below and return or respond to me by:

- ☐ Telephone: _____
- ☐ Fax: _____
- ☒ Email: sample@email.com
- ☐ Mail: _____

Additional comments ☒ n/a

Consultant Diagnostic Assessment/Feedback

Diagnosis-Focused Referral Form

Referring provider:

Dr. Ann Smith
Example Practice

Date: 01/11/2020

Patient Information

Patient Name: Brown, James
DOB: 01/01/1972
Contact Phone: 555-555-5555

Situation: Request for Consultation in the Diagnostic Process	
The **diagnostic focus** or primary concern for the patient is	Repeated episodes of SOB on exertion with no positive cardiac findings
My **working diagnosis** or suspected etiology is	COPD
My **differential diagnosis** includes	Lung CA? Asthma?
My **purpose for this referral/** diagnostic questions include	What is etiology of the SOB?

Background: History of Present Illness

48M reports daily SOB episodes on exertion; Pt works in construction

Assessment: List of Relevant Test Results and Previous Treatments

Relevant **tests and results**	**Treatments/therapies** that have been tried
EKG and CXR normal	Little relief with albuterol

Requests

Please provide the recommendations below ☐ by (date) ☒ at your convenience

- ☒ Please state the diagnosis you think is most likely
- ☐ Please recommend further testing and/or treatment
- ☒ Please forward all testing results to our clinic AND the patient
- ☒ Please inform our clinic of plans for follow up
- ☒ Please respond on this form using the space below

Please note your diagnostic suggestions below and return or respond to me by:

- ☐ Telephone: _____
- ☒ Fax: 000-000-0000
- ☐ Email: _____
- ☐ Mail: _____

Additional comments ☐ n/a

Please also offer smoking cessation counselling.

Consultant Diagnostic Assessment/Feedback

Chest CT scan revealed lung damage likely caused by emphysema. Recommended Dx is COPD. Smoking cessation counseling provided/test results faxed to your clinic on XX/XXXX (date). Our clinic notified patient of testing results and will follow up with continued counseling.

Diagnosis-Focused Referral Form

Referring provider: Date:

Patient Information

Situation: Request for Consultation in the Diagnostic Process	
The **diagnostic focus** or primary concern for the patient is	
My **working diagnosis** or suspected etiology is	
My **differential diagnosis** includes	
My **purpose for this referral/** diagnostic questions include	

Background: History of Present Illness

Assessment: List of Relevant Test Results and Previous Treatments

Relevant **tests and results**	**Treatments/therapies** that have been tried

Requests

Please provide the recommendations below ☐ by (date) ☐ at your convenience

- ☐ Please state the diagnosis you think is most likely
- ☐ Please recommend further testing and/or treatment
- ☐ Please forward all testing results to our clinic AND the patient
- ☐ Please inform our clinic of plans for follow up
- ☐ Please respond on this form using the space below

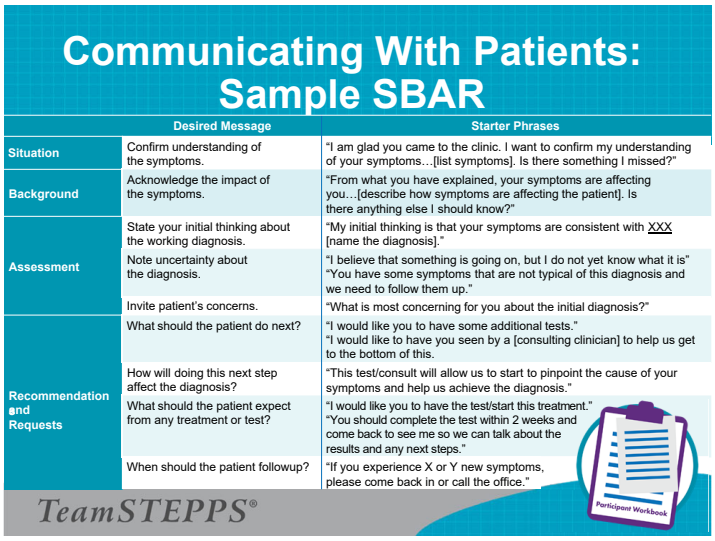
Please note your diagnostic suggestions below and return or respond to me by:

- ☐ Telephone: _____
- ☐ Fax: _____
- ☐ Email: _____
- ☐ Mail: _____

Additional comments ☐ n/a

Consultant Diagnostic Assessment/Feedback

Slide 12: Communication With Patients: Sample SBAR

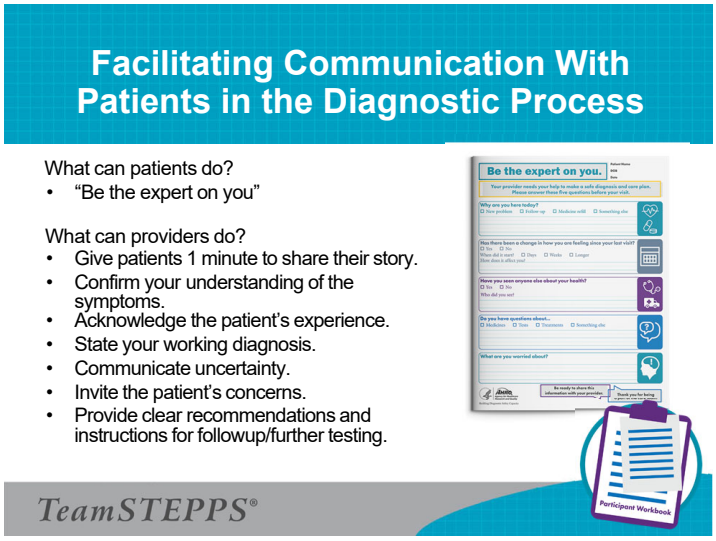


Review as a group or individually the following SBAR example. Notice that all questions are open ended and acknowledge the patient's experience.

Communication With Patients: Sample SBAR

	Desired Message	Starter Phrases
Situation	Confirming understanding of the symptoms	"I am glad you came to the clinic. I want to confirm my understanding of your symptoms…[list symptoms]. Is there something I missed?
Background	Acknowledge the impact of the symptoms	"From what you have explained, your symptoms are impacting you… [describe how symptoms are impacting the patient]. Is there anything else I should know?"
Assessment	State your initial thinking about the working diagnosis	"My initial thinking is that your symptoms are consistent with XXX" [name the diagnosis]."
	Uncertainty about the Diagnosis	"I believe that something is going on, but I do not yet know what it is." "You have some symptoms that are not typical of this diagnosis and we need to follow them up."
	Invite patient's concerns	"What is most concerning for you about the initial diagnosis?"
Recommendations and Requests	What should the patient do next?	"I would like you to have some additional tests." "I would like to have you seen by a [consulting clinician] to help us get to the bottom of this."
	How will doing this next step impact the diagnosis?	"This test/consult will allow us to start to pinpoint the cause of you symptoms and help us achieve the diagnosis."
	What should the patient expect from any treatment or test?	"I would like you to have the test/ start this treatment." "You should complete the test within two weeks and come back to see me so we can talk about the results and any next steps."
	When should the patient follow up?	"If you experience X or Y new symptoms, please come back in or call the office."

Slide 15: Facilitating Communication With Patients in the Diagnostic Process



On the following page is the "Be the Expert on You" patient note sheet (English version, Spanish version) created by The Agency for Healthcare Research and Quality.[1] The goal of the patient note sheet is to facilitate communication in the diagnostic process by helping patients share their story and helping clinicians receive the full story of the patient's health problem.

The tool encourages patients to prepare for their appointments by writing down their symptoms, when those symptoms started, treatments that have been tried, and anything that is worrying them. While patients are sharing their story, providers can use skills in reflective practice to help integrate the patients' health information into their working diagnosis and to promote diagnostic thinking.

1. Toolkit for Engaging Patients To Improve Diagnostic Safety. Rockville, MD: Agency for Healthcare Research and Quality. Content last reviewed August 2021. https://www.ahrq.gov/patient-safety/resources/diagnostic-safety/toolkit.html. Accessed February 4, 2022.

Be the expert on you.

Patient Name

DOB

Date

Your provider needs your help to make a safe diagnosis and care plan. Please answer these five questions before your visit.

Why are you here today?

☐ New problem ☐ Follow-up ☐ Medicine refill ☐ Something else

Has there been a change in how you are feeling since your last visit?

☐ Yes ☐ No

When did it start? ☐ Days ☐ Weeks ☐ Longer

How does it affect you?

Have you seen anyone else about your health?

☐ Yes ☐ No

Who did you see?

Do you have questions about...

☐ Medicines ☐ Tests ☐ Treatments ☐ Something else

What are you worried about?

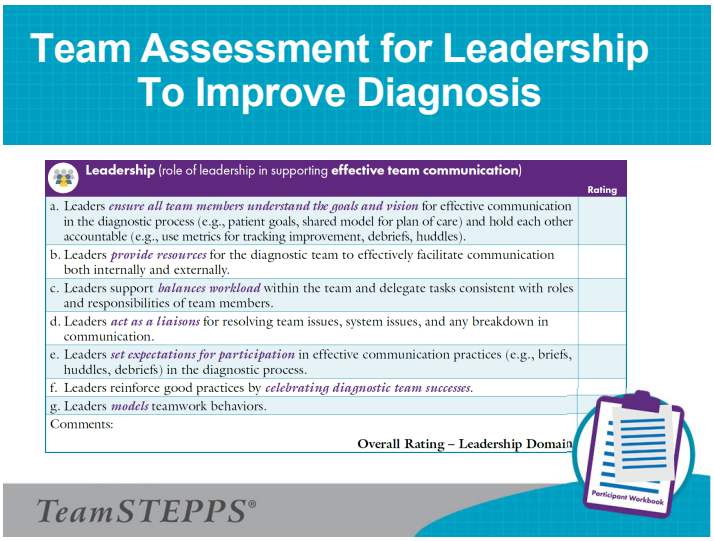
AHRQ Agency for Healthcare Research and Quality

Building Diagnostic Safety Capacity

Be ready to share this information with your provider.

Thank you for being a part of the care team!

Slide 4: Team Assessment for Leadership

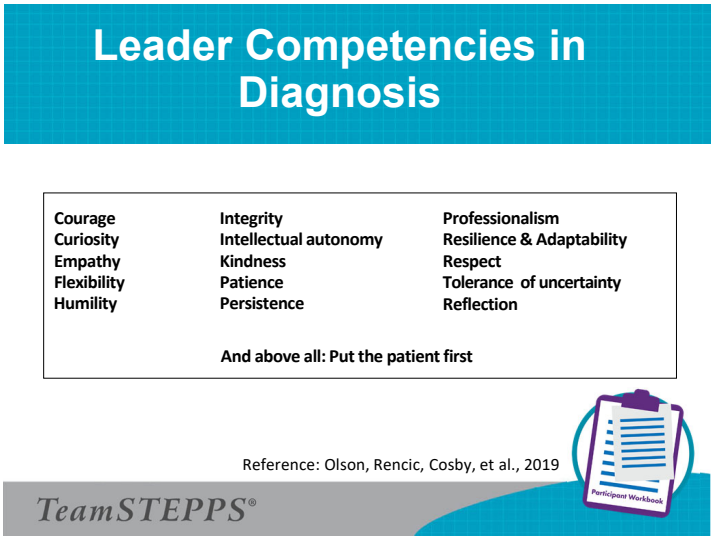


By now you should have completed the **Team Assessment Tool for Improving Diagnosis**. Refer to your responses relevant to **Leadership**. Discuss with your team:

1. **How does the average Summary Score on Leadership compare with the average Summary Score on other TeamSTEPPS dimensions (Team Structure, Communication, Situation Monitoring, and Mutual Support)?**
2. **What are the highest scoring Leadership characteristics?**
3. **What are the lowest scoring Leadership characteristics?**
4. **How do team members at your site rate these characteristics?**

After discussing the scores, ask participants to identify together where your site has the strongest Leadership to support improved diagnosis and where opportunities exist to enhance Leadership practices.

Slide 5: Leader Competencies in Diagnosis



The leader of the diagnostic team needs to have and model the values and attitudes that would support optimal diagnosis. These competencies influence not only diagnosis but also diagnostic improvement strategies and tactics, as well as the overarching patient safety climate.

In a recent study,[2] an interprofessional group reviewed existing competency expectations for multiple health professionals and conducted a search that explored quality, safety, and competency in diagnosis. The group used an iterative series of group discussions and concept prioritization to derive a final set of competencies for all healthcare providers.

Characteristics and Attitudes for Diagnosis

- **Courage**: Being able to recognize, acknowledge, and appropriately handle mistakes. The courage to voice dissent or stay with your beliefs when others doubt your conclusions.
- **Curiosity**: Maintaining a natural inquisitive state that propels one further in search of answers or explanations.
- **Empathy**: Being able to see illness from the perspective of the patient, to listen well enough to understand their description of illness.
- **Flexibility**: Being able to re-evaluate and reframe diagnostic possibilities and incorporate new information, maintain an open mind toward new ideas, and be aware of our assumptions and biases. Open-minded inquiry is not dogmatic; rather, it is open to questioning and rethinking one's assumptions.
- **Humility**: Being able to recognize the strength and weakness of one's opinion and judgments and of other ideas. From Criticalthinking.org: intellectual humility is "having a consciousness of the limits of one's knowledge, including a sensitivity to circumstances in which one's native egocentrism is likely to function self-deceptively." It also includes sensitivity to bias, prejudice, and limitations of one's viewpoint.
- **Integrity, Veracity**: Being honest with ourselves and others.
- **Intellectual autonomy** (from Criticalthinking.org): "Having rational control of one's beliefs, values, and inferences." Critical thinking involves thinking for oneself and gaining command over one's thought processes. Critical thinkers are committed to analyzing

and evaluating beliefs based on reason and evidence. Criticalthinking.org also notes that critical thinkers know how "to question when it is rational to question, to believe when it is rational to believe, and to conform when it is rational to conform." The critical mind lacks gullibility (is not prone to false claims and spurious unproven ideas).

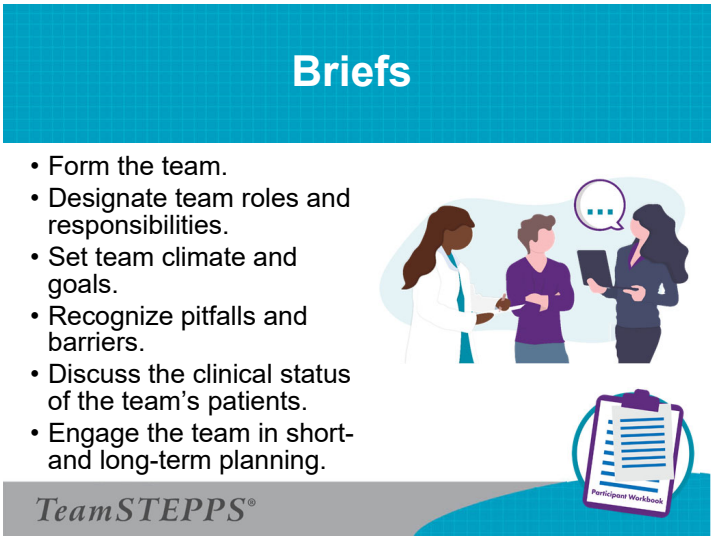
- **Kindness**: Helping patients in whatever ways we can.
- **Patience**: Knowing when to slow down and tease through a difficult problem. Letting patients tell their story; tolerating a period of watchful waiting to see how symptoms evolve.
- **Persistence**: Being able to put effort toward a difficult task, to avoid accepting a shallow explanation when there is a poor fit.
- **Professionalism**: Being able to command one's resources to interact in a nonjudgmental way; respecting patients and peers.
- **Resilience**: Being able to withstand criticism, evaluate one's performance with integrity, learn from mistakes, and recover from loss.
- **Adaptability**: "Being aware of the inhibitors and facilitators of rationality; pursuing the standards of critical thinking; developing a comprehensive awareness of cognitive and affective biases and how to mitigate them…."[3] Adaptability involves understanding logic and logical fallacies and engaging in cognitive processes such as reflection and mindfulness. It also involves approaches that embrace creativity and innovation.
- **Respect**: Respecting the input and collaboration of other healthcare professionals who have contact with the patient; incorporating their input and opinions into medical decision making.
- **Tolerance of uncertainty**: Believing that nothing is constant and nothing is certain. Lack of certainty requires tolerance of ambiguity—the ability to commit to action while accepting the provisional nature of our conclusions.[4,5]
- **Reflection**: Consciously considering and analyzing beliefs and actions for the purpose of learning.

Put the Patient First: Understand patients' values and preferences. Act in their best interests and advocate for them. Help them navigate the healthcare system and the diagnostic process. Make the patient a member of the diagnostic team.[6]

With your team, think about The Diagnostic Journey of Mr. Kane and discuss which leadership competencies influenced the trajectory of his care.

2. Olson A, Rencic J, Cosby K, Rusz D, Papa F, Croskerry P, Zierler B, Harkless G, Giuliano MA, Schoenbaum S, Colford C, Cahill M, Gerstner L, Grice GR, Graber ML. Competencies for improving diagnosis: an interprofessional framework for education and training in health care. Diagnosis (Berl). 2019 Nov 26;6(4):335-41. https://doi.org/10.1515/dx-2018-0107. Accessed February 3, 2022.
3. Croskerry P. Adaptive expertise in medical decision making. Med Teach. 2018 Aug 40(8):803-8. https://doi.org/10.1080/0142159X.2018.1484898. Accessed February 4, 2022.
4. Simpkin A, Schwartzstein R. Tolerating uncertainty - the next medical revolution? N Engl J Med.375(18):1713-5. https://doi.org/10.1056/NEJMp1606402. Accessed February 3, 2022.
5. Attard K. Uncertainty for the reflective practitioner: a blessing in disguise. Reflective Practice. 2008;9(3):307-17.https://doi.org/10.1080/14623940802207188. Accessed February 3, 2022.
6. McDonald K, Bryce C, Graber M. The Patient is in: patient involvement strategies for diagnostic error mitigation. BMJ Quality and Safety. 2013;22, Part 2:30-6. https://doi.org/10.1136/bmjqs-2012-001623. Accessed February 3, 2022.

Slide 10: Briefs

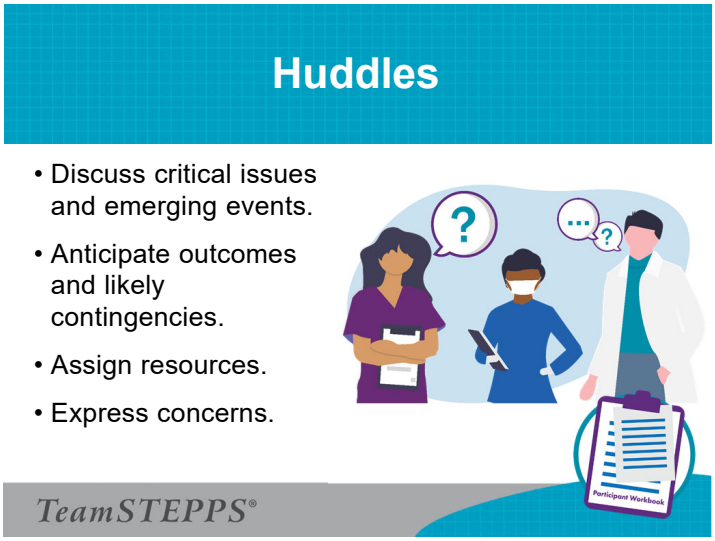


Briefs are held for planning purposes and can be used for multiple reasons. For example, a complex case might require the establishment of a very specific coordinated team to address a diagnostic safety concern. In this case, a brief would clarify who would lead the team, open lines of communication, prepare the team for the patient's clinic visit, and increase the team's understanding of what was expected.

Review the following questions and think about how briefs are incorporated into your setting.

1. **When and where does clinic/site-level quality improvement planning occur now?**
2. **Who attends? Clinical or operations staff? Or both?**
3. **Who should attend?**

Slide 11: Huddles

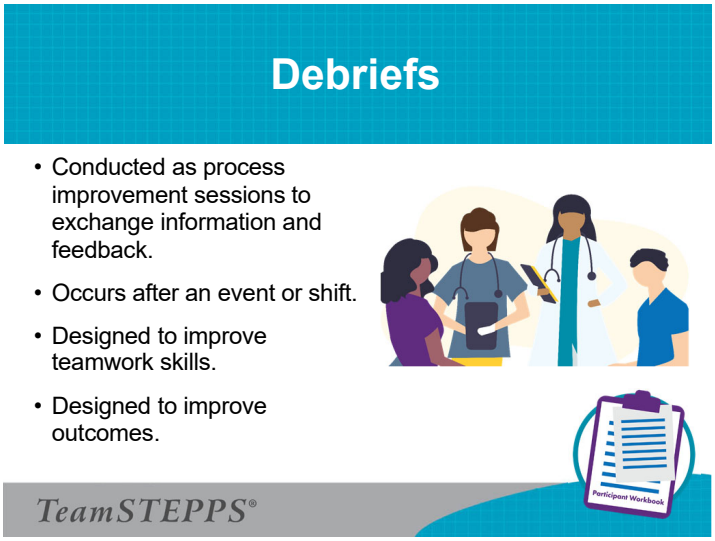


Huddles are held for problem-solving purposes. For example, a huddle could be used to gather more information from other members of the diagnostic team (e.g., front desk staff, nurse) on a patient with a complex case in order to better strategize on their care plan.

Review the following questions and think about how huddles are incorporated into your setting.

1. **Think about a situation in your office in which the team leader could have called a diagnosis improvement/communication-related huddle but did not. What were the results?**
2. **List a few examples of when a huddle should be used to improve diagnosis. These examples can be from actual experience or situations that you imagine could happen.**
3. **What members of the diagnostic team should feel empowered to call a huddle?**
4. **Do you think issues discussed during huddles should be tracked over time?**
    - Why or why not?
    - How could that happen in your setting?
    - What would you want to learn if you decide to track issues?

Slide 12: Debriefs

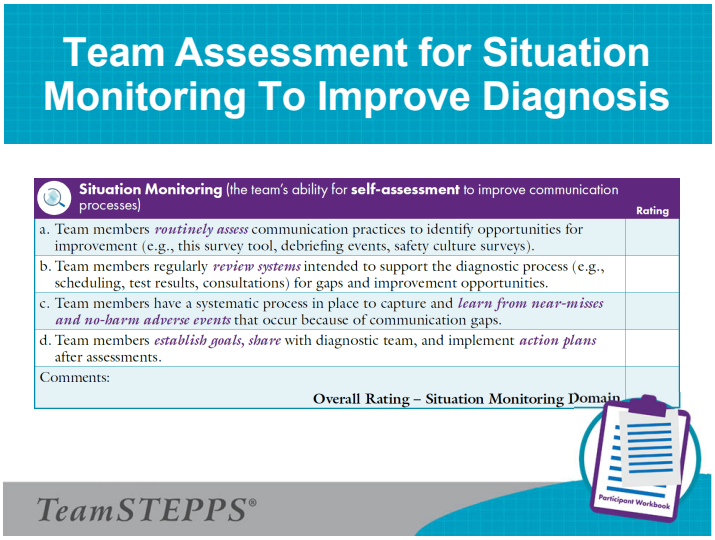


Debriefs are short, informal information exchanges used for process improvement. For example, after dealing with a complex diagnostic situation, the team leader may conduct a debrief. This debrief would recap the established plan and key events that occurred and ask questions related to team performance.

Review the following questions and think about how debriefs are incorporated into your setting.

1. **Have you ever participated in a debrief? If so, what debrief questions were used?**
2. **Think about a diagnostic-related situation in your office in which the team leader should have called a debrief but did not. What were the results?**
3. **List a few examples of when a debrief should be used. These examples can be from actual experience or situations that you imagine could happen.**

Slide 4: Team Assessment for Situation Monitoring

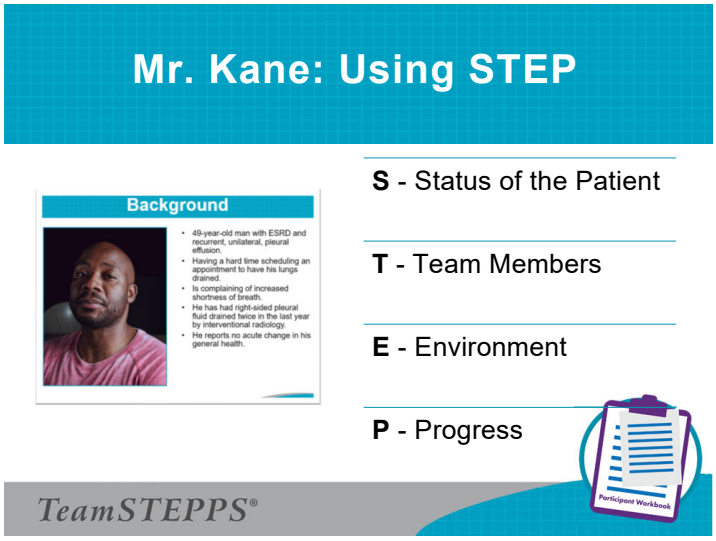


By now you should have completed the **Team Assessment Tool for Improving Diagnosis**. Refer to your responses relevant to **Situation Monitoring**. Discuss with your team:

1. **How does the average Summary Score on Situation Monitoring compare with the other TeamSTEPPS dimensions (Team Structure, Communication, Leadership, and Mutual Support)?**
2. **What are the highest scoring Situation Monitoring characteristics?**
3. **What are the lowest scoring Situation Monitoring characteristics?**
4. **How do team members at your site rate these characteristics?**

After discussing the scores, ask participants to identify together where the site has the most effective Situation Monitoring methods to support improved diagnosis and where the site has opportunities to improve.

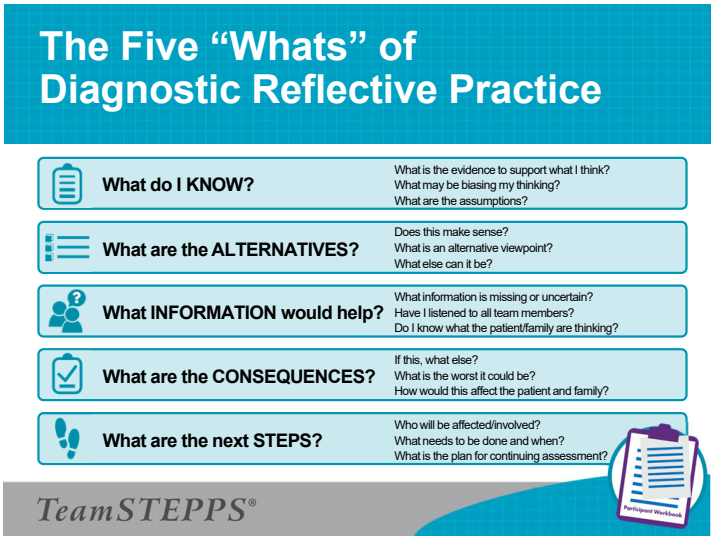
Slide 10: Mr. Kane Case: Using STEP



With your teams, review the presentation on Mr. Kane's case and discuss the following questions:

1. **What was the presenting status of the patient at each of his clinic visits?**
   - As perceived by the patient, Mr. Kane?
   - As perceived by his son?
   - As perceived by his primary care provider?
   - As perceived by his pulmonologist?
   - As perceived by his nephrologist?
2. **Who were the members of the diagnostic team?**
   - Did they see themselves as members of the same team?
   - If not, how might that have been addressed?
3. **Did environmental factors play a role in Mr. Kane's treatment?**
   - If so, what were they?
   - Were they adequately addressed?
   - If not, what might have been done differently?
4. **How was Mr. Kane's clinical progress measured and understood?**
   - By the patient?
   - By his son?
   - By his primary care provider
   - By his pulmonologist?
   - By his nephrologist?
5. **Discuss: What actions might have improved Mr. Kane's diagnostic journey?**

Slide 11: The Five "Whats" of Diagnostic Reflective Practice

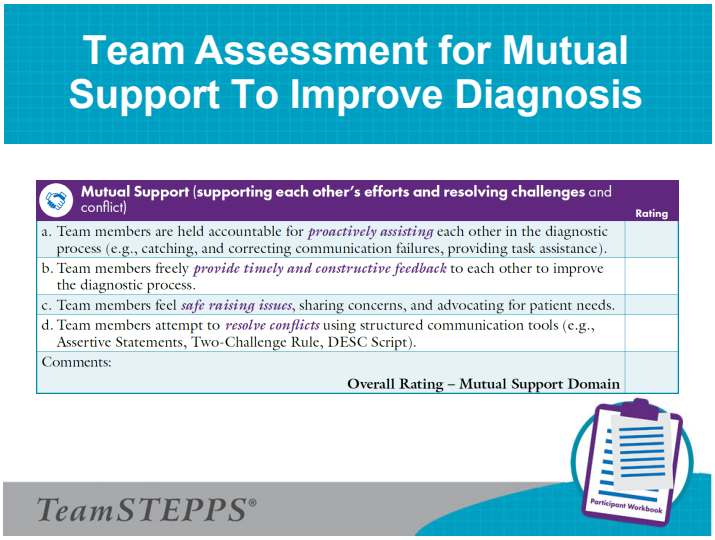


On the following page is an example of how the five-question KAICS mnemonic can be applied to a clinical diagnostic case.

The Five Whats of Diagnostic Reflective Practice

What do I know?	▪ This patient has a cough, tachycardia, hypoxia, and shortness of breath. ▪ I've documented that this could be pneumonia, but I know they have a history of congestive heart failure (potential bias). ▪ They do not give a history of missing Rx or increasing fluid intake (assumption to trust them).
What are the alternatives?	▪ It makes sense that an infection could be present (e.g., would explain everything). ▪ Alternatively, symptoms could also be explained by congestive heart failure, pulmonary embolism, spontaneous pneumothorax, undiagnosed obstructive lung disease, or metabolic acidosis from a nonpulmonary cause.
What information would help?	▪ Lab data (culture data, respiratory viral panel, COVID testing, beta natriuretic peptide, D-dimer, complete blood count). ▪ Additional exam/imaging (e.g., chest x ray, Wells score, point of care ultrasound, peak flow assessment). ▪ Additional or confirmatory patient history from family members (e.g., medication adherence, sick contacts, lifestyle changes/fluid intake, duration of symptoms).
What are the consequences?	▪ If this is an infection, the patient will qualify as having "sepsis" and early interventions with antibiotics, fluid administration, and assessments can reduce the risk of mortality. ▪ If this is heart failure, additional fluids may be counterproductive. ▪ Anchoring on a single diagnosis may miss life-threatening conditions.
What are the next steps?	▪ Expeditiously obtain additional information (additional history for fever, sick contacts, muscle aches, loss of taste/smell, other history to place at risk). ▪ Expand physical exam (thorough pulmonary exam, including percussion, egophony, multipoint auscultation, assessment for unilateral/single-limb vs. bilateral/sacral edema, other sources of infection). ▪ Calculate validated scores to aid in pretest probability calculations (e.g., Wells score). ▪ Obtain simple, inexpensive, easily obtainable testing (chest x ray, D-dimer, complete blood count, point of care ultrasound). ▪ Commit to a "most likely" diagnosis and initiate empiric treatment while awaiting additional results (e.g., antibiotics while awaiting culture results). ▪ Weigh risks and benefits for initiating testing or therapy for dangerous alternative diagnoses (e.g., anticoagulation, diuretics, CT imaging). ▪ Document the results of that risk/benefit assessment to aid in care across multiple healthcare professionals.

Slide 4: Team Assessment for Mutual Support

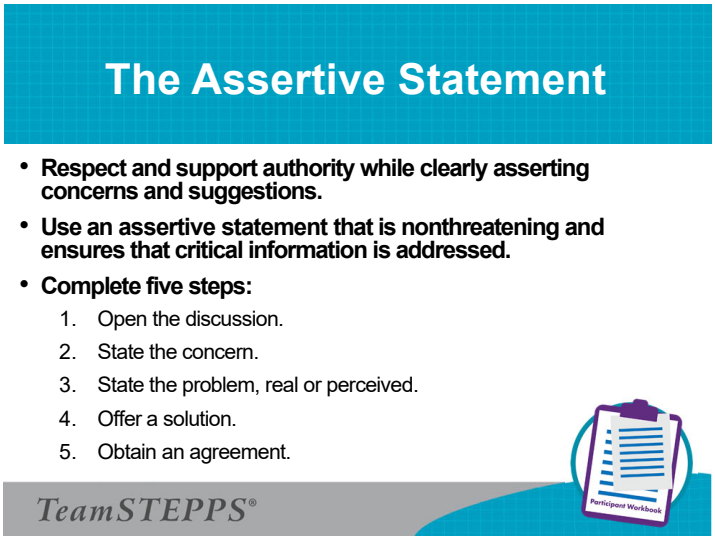


By now you should have completed the **Team Assessment Tool for Improving Diagnosis**. Refer to your responses relevant to **Mutual Support**. Discuss with your team:

1. **How does the average Summary Score on Mutual Support compare with the other TeamSTEPPS dimensions (Team Structure, Communication, Leadership, and Situation Monitoring)?**
2. **What are the highest scoring Mutual Support characteristics?**
3. **What are the lowest scoring Mutual Support characteristics?**
4. **How do other team members at your site rate these characteristics?**

After discussing the scores, ask participants to identify together where your site has the most effective Mutual Support methods to support improved diagnosis and where the site has opportunities to improve

Slide 13: The Assertive Statement

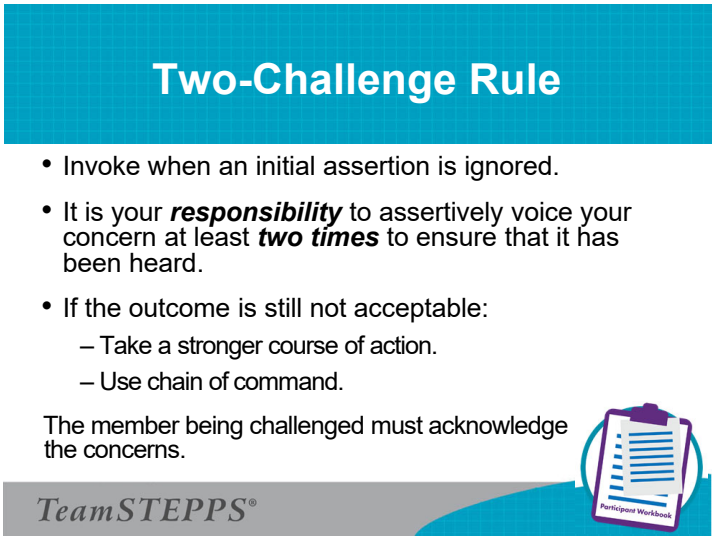


Consider a scenario in which a nurse sees a physician treating a receptionist rudely in front of a patient. The nurse waits until after the incident and takes the physician aside.

Individually or in small groups, pretend you are the nurse in this scenario. Following the Five Steps and prompts below, build an assertive statement that you could use with the doctor.

- **Open the discussion: "I'd like to share my thoughts on _____. "**
- **State the concern: "I am concerned that _____. "**
- **State the problem, real or perceived: "This is a problem because _____. "**
- **Offer a solution: "In the future _____. "**
- **Obtain an agreement: "Can we agree that _____? "**

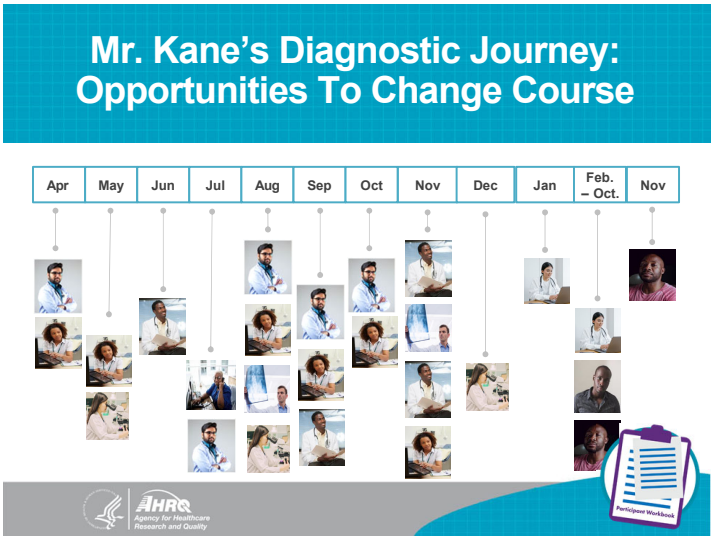
Slide 15: Two-Challenge Rule



Discuss with your team the following questions:

1. **Have you ever spoken up regarding diagnosis-related issues? Examples: missing lab results, orders that seem inconsistent with the care plan, concerns or questions raised by patients that are not being addressed.**
   - What did you consider before speaking up?
   - How did you decide to whom you should speak?
   - How did it feel to raise your concern?
   - Was the outcome what you hoped?
     - If the outcome was not what you anticipated, what did you do or what could you have done?
2. **Has anyone ever raised a concern about diagnosis-related issues TO you?**
   - What did you consider before responding?
   - Might your response have been different if the person raising the concern was a:
     - Colleague?
     - Support staff?
     - Manager?
     - Physician provider?
3. **"Stopping the line" in healthcare refers to the ability of any individual to speak up immediately if they see a risk to patient safety, including diagnostic safety.**
   - Are team members able/encouraged to "stop the line" for diagnostic safety? Can you share any examples?
   - Are patients and family members encouraged to "stop the line" for diagnostic safety? Can you share any examples?

Slide 16: Mr. Kane's Diagnostic Journey: Opportunities To Change Course



Considering when, where, and how the use of the TeamSTEPPS tools and lessons from this course could have resulted in a different outcome is a key teaching strategy. Although the options and opportunities are too numerous to review comprehensively and the impact on outcomes is hypothetical, it is easy to imagine how things might have gone differently.

TeamSTEPPS® for Diagnosis Improvement
Knowledge Assessment

This knowledge assessment tests the participants' knowledge of the teamwork principles demonstrated in the TeamSTEPPS for Diagnosis Improvement course.

1. TeamSTEPPS provides resources to optimize team performance across organizations. Several defining properties make it unique among teamwork and performance improvement programs. TeamSTEPPS is:
   a. Evidence based, comprehensive, and customizable.
   b. Evidence based, practical, and effective if you follow training exactly.
   c. Evidence based, low cost, and has master trainers available in every state.
   d. Evidence based, available in multiple languages, geared toward nurses and ancillary staff.

2. TeamSTEPPS is composed of four teachable-learnable skills. These four skills include.
   a. Mutual support, coaching, communication, problem solving.
   b. Leadership, SBAR, situation monitoring, handoffs.
   c. Leadership, situation monitoring, mutual support, communication.
   d. Team structure, coaching, leadership, situation monitoring.
   e. Coaching, leadership, communication, mutual support.

3. Which of the following statements best describes briefs, huddles, and debriefs?
   a. They are situation monitoring strategies used to create situational awareness.
   b. They are leadership strategies that structure team events for planning and learning.
   c. They are mutual support strategies used to resolve information conflict.
   d. They are communication strategies used to structure information exchange.
   e. They are team strategies used by situational leaders.

4. SBAR provides a structured framework for communication among team members and stands for:
   a. Situation, Background, Action, Recommendation.
   b. Status, Background, Action, Recommendation.
   c. Situation, Background, Assessment, Recommendation.
   d. Setting, Background, Action, Results.
   e. Situation, Behavior, Assessment, Results.

5. All of the following statements about conflict resolution to improve diagnosis are true EXCEPT:
   a. It is important to reprimand those involved in diagnosis-related communication conflicts.
   b. Personal conflicts can affect patient care.
   c. Advocating for the patient can result in conflict.
   d. The Two Challenge Rule or CUS can be used to resolve information conflicts.
   e. Resolving conflict can prevent harm to patients.

6. A medical assistant corrects a lab value misstatement made by the physician to a patient, but the physician ignores the correction. What should the MA do in this situation?
    a. Dismiss the incident because the physician is in charge.
    b. Voice his or her concern a second time, more forcefully, to ensure the correction is heard.
    c. Write up the physician using the online reporting system.
    d. Arrange a meeting with their supervisor to report the incident.
    e. Quit and go to work somewhere else where their voice is respected.

7. TeamSTEPPS To Improve Diagnosis uses the National Academy of Medicine definition of diagnostic error: "the failure to establish an accurate and timely explanation of the patient's health problem(s) or communicate that explanation to the patient." Using this definition, which of the following may be considered a diagnostic error?
    a. Two days after an emergency department visit due to a bicycle accident, a patient receives a call that says to contact an orthopedic physician; a wrist fracture was just discovered on an x ray taken when they presented at the ER.
    b. Mrs. Jones goes in for her annual mammogram and is asked if she followed up on the exam from last year, which showed a small suspicious mass. Mrs. Jones says she was never notified about the suspicious mass and it was not mentioned by her primary physician.
    c. Mr. Godfrey, 58 years old and a former construction worker, has a long history of intermittent back pain that has been attributed to arthritis and treated with anti-inflammatory medications by his primary care provider. One Saturday morning, Mr. Godfrey drops dead as he is getting ready for the day's activities. Autopsy confirms Mr. Godfrey died from a ruptured abdominal aortic aneurysm.
    d. All of the above.
    e. None of the above.

8. The _____ is always at the center of the diagnostic team.
    a. Primary care physician
    b. Nurse/nurse practitioner
    c. Patient
    d. Administrator/manager
    e. Surgeon

9. Causes of diagnostic error may include:
    a. Poor clinical reasoning.
    b. Lack of reliable test results.
    c. Incomplete communication between patients, families, and clinicians.
    d. All of the above.
    e. None of the above.

10. Diagnostic error is:
    a. Common, harmful.
    b. Costly and often preventable.
    c. A problem in hospitals but rare in outpatient settings.
    d. A & B.
    e. All of the above.

11. Leader attributes for diagnosis include:
    a. Humility.
    b. Clinical skill.
    c. Experience.
    d. Flexibility.
    e. A. & D.

12. Reflective practice:
    a. Is a tool designed for individuals who have made a diagnostic error.
    a. Is part of the improvement process.
    b. Involves conscious consideration and analysis of beliefs and actions for the purpose of learning.
    c. B. & C.
    d. A. & B.

13. Inappropriate testing, wrong treatments, and diagnosis-related malpractice lawsuits result in expenses of over:
    a. $200 billion per year.
    b. $ 75 billion per year.
    c. $100 billion per year.
    d. $ 100 million per year.
    e. None of the above.

14. What do we know about diagnostic process breakdowns?
    a. They are real and common.
    b. They are sometimes harmful.
    c. Consequences may include lawsuits, business losses, and adverse media coverage.
    d. They often result in provider burnout, increased errors, and workforce reduction.
    e. All of the above.

15. Ask, Listen, and Act are components of:
    a. Huddles.
    b. Reflective Practice.
    c. Briefs.
    d. Mutual Support.
    e. Situation Monitoring.

16. Several types of teams participate in the diagnostic process. Which of the following is true about the diagnostic "core team"?
    a. The diagnostic core team consists of team leaders and team members who are involved in the direct care of the patient.
    b. The diagnostic core team is clinicians who are responsible for day-to-day diagnostic management and coordination functions.
    c. The diagnostic core team leadership is dynamic; leaders are required to take on different roles at various points in the plan of care.
    d. A. & C.
    e. All of the above.

17. SBAR is a communication tool that can be used:
    a. To communicate with patients.
    b. To communicate among providers in a practice or care unit.
    c. To communicate with referring providers.
    d. None of the above.
    e. All of the above.

18. The five "Whats" of diagnostic reflective practice include:
    a. What do I know, what are the alternatives, what information would help, what are the consequences, what are the next steps.
    b. What is the problem, what are solutions, what has already been tried, what am I concerned about, what are the next steps.
    c. What am I concerned about, what do I know, what information do I need, what has already been tried, what are the next steps.
    d. What do I know, what information is missing, what can I do to obtain missing information, what has already been tried, what are the next steps.
    e. What is the problem, what are the consequences, what help do I need, what has been tried, what are next steps.

19. Mutual support in the diagnostic process may include:
    a. Use of assertive statements to raise concerns and suggestions to authority.
    b. Use of the Two Challenge Rule to ensure that your concern has been heard.
    c. Use of chain of command when concerns are not responded to acceptably.
    d. All of the above.
    e. None of the above.

20. The Diagnostic Team Assessment Tool is completed by each course participant after the course introduction in order to:
    a. Identify who should lead the diagnostic team.
    b. Assess knowledge and skill of individual team members.
    c. Assess maturity phase in your practice setting and identify strengths and opportunities to increase teamwork, set priorities, and develop action plans to enhance communication for diagnostic improvement.
    d. Clarify what your diagnostic team structure should be.
    e. Recognize units with the highest diagnostic team skills so they can role model and mentor other units.

TeamSTEPPS for Diagnosis Improvement
Additional Resources

Module 1: Introduction

TeamSTEPPS Pocket Guide

A quick-reference tool for the TeamSTEPPS communication framework.

Description	Link
Pocket Guide: TeamSTEPPS 2.0 Handout	https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.pdf
TeamSTEPPS Pocket Guide App	Apple Store: https://itunes.apple.com/us/app/teamstepps/id1239893278?mt=8 Google Play Store: https://play.google.com/store/apps/details?id=gov.ahrq.teamstepps&hl=en

Additional Diagnostic Safety Cases

Cases or examples of diagnostic safety events.

Description	Link
Improving Diagnosis in Health Care Appendix D: Examples of Diagnostic Error	https://www.ncbi.nlm.nih.gov/books/NBK338598/
WebM&M Case Studies	https://psnet.ahrq.gov/webmm-case-studies
PSNET Diagnostic Errors Examples	https://psnet.ahrq.gov/primer/diagnostic-errors

Interactive Diagnostic Process

An interactive view of the National Academy of Medicine conceptualization of the diagnostic process.

Description	Link
Interactive Diagnostic Process	https://www.improvediagnosis.org/processes/the-diagnostic-process/

Reflective Practice Exercises

Additional exercises that might be relevant to the team based on discussion and feedback.

Description	Link
The Illusions Index	https://www.illusionsindex.org/illusions

SBAR

Standardized framework for members of the healthcare team to communicate about a patient's condition.

Acronym: **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation.

Description	Link
DoD SBAR Toolkit	https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/Toolkits/SBAR-Toolkit
AHRQ SBAR Video	https://www.ahrq.gov/teamstepps/instructor/videos/ts_SBAR_NurseToPhysician/SBAR_NurseToPhysician-400-300.html

Call-Out

Tactic used to communicate critical information during an emergent event.

Description	Link
AHRQ Call-Out Slide and Video	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module3/slcommunication.html#sl13

Check-Back

A closed-loop communication strategy used to verify and validate information exchanged.

Description	Link
AHRQ Check-Back Slide and Video	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module3/slcommunication.html#sl14

Handoff

Transfer of information (along with authority and responsibility) during transitions in patient care.

Description	Link
AHRQ Handoff Slide and Video	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module3/slcommunication.html#sl16
Handoff Communications Targeted Solutions Tool	https://www.centerfortransforminghealthcare.org/what-we-offer/targeted-solutions-tool/hand-off-communications-tst
I PASS the BATON	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module3/igcommunication.html#ipassbaton
Handoffs and Signouts	https://psnet.ahrq.gov/primer/handoffs-and-signouts

Description	Link
I PASS	http://www.ipasshandoffstudy.com
SHARQ	https://www.accc-cancer.org/docs/documents/oncology-issues/articles/ma11/ma11-john-b-amos-cancer-center-the-medical-center-inc.pdf
HAND-IT	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540511

Toolkit for Engaging Patients To Improve Diagnostic Safety

Toolkit designed to help patients, families, and health professionals work together as partners to improve diagnostic safety.

Description	Link
AHRQ Toolkit	https://www.ahrq.gov/patient-safety/resources/diagnostic-safety/toolkit.html
Be the Expert on You Note Sheet	English: https://www.ahrq.gov/sites/default/files/wysiwyg/patient-safety/resources/diagnostic-toolkit/10-diagnostic-safety-tool-patient-note-sheet.pdf Spanish: https://www.ahrq.gov/sites/default/files/wysiwyg/patient-safety/resources/diagnostic-toolkit/10-diagnostic-safety-tool-patient-note-sheet-spanish.pdf

Module 4: Leadership

Brief

A team briefing is an effective strategy for sharing the plan. Briefs should help form the team, designate team roles and responsibilities, establish climate and goals, and engage the team in short- and long-term planning.

Description	Link
DoD Briefs and Huddles Toolkit	https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/Toolkits/Briefs-and-Huddles-Toolkit
AHRQ Brief Checklist	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module4/slleadership.html#im11

Huddle

Huddle is a tool for communicating adjustments to a care plan that is already in place. When a plan changes as a result of changes in the patient or team membership, or aspects of the current plan are not working, a huddle should be convened by either the designated or situational leader.

Description	Link
DoD Briefs and Huddles Toolkit	https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/Toolkits/Briefs-and-Huddles-Toolkit
AHRQ HAI Daily Huddle Component Kit	https://www.ahrq.gov/hai/tools/ambulatory-surgery/sections/sustainability/management/huddles-comp-kit.html
AHRQ Huddle Slides	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module4/slleadership.html#im13

Debrief

TeamSTEPPS advocates that after-action reviews occur and that, as new trainers, you try to include opportunities to debrief critical team events. These events are excellent learning opportunities for team members.

Description	Link
DoD Debriefs Toolkit	https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/Toolkits/Debriefs-Toolkit
AHRQ CUSP Debrief on Accountability Video	https://www.ahrq.gov/hai/cusp/videos/07c-debrief/index.html
AHRQ Debrief Checklist	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module4/slleadership.html#im15

Module 5: Situation Monitoring

STEP

STEP is a mnemonic tool that can help you monitor critical elements of the situation and the overall environment.

Acronym: **S**tatus of the Patient, **T**eam members, **E**nvironment, **P**rogress toward the goal.

Description	Link
AHRQ STEP Slide and Video	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module5/slsitmonitor.html#sl6

I'M SAFE

A checklist to assess your own condition, as well as the condition of your team members. Determines your ability to perform safely.

Description	Link
AHRQ I'M SAFE Checklist	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module5/slsitmonitor.html#sl9

Module 6: Mutual Support

Task Assistance

This strategy includes both asking for assistance when needed and offering assistance to team members when the opportunity arises. Task assistance is guided by situation monitoring, because situation monitoring helps team members to effectively identify when they or other team members need assistance.

Description	Link
AHRQ Task Assistance Description	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module6/igmutualsupp.html#task

Feedback

Feedback is information provided for the purpose of improving team performance. The ability to communicate self-improvement information in a useful way is an important skill in the team improvement process.

Description	Link
AHRQ Feedback Description	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module6/igmutualsupp.html#feedback
AHRQ Feedback Video	https://www.ahrq.gov/teamstepps/instructor/videos/ts_FeedbackDocToMedTech/feedbackDocToMedtech.html

Assertive Statement

The Assertive Statement is one tool used to facilitate speaking up when there is concern for patient safety.

Description	Link
AHRQ Assertive Statement Description	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module6/igmutualsupp.html#statement

Two-Challenge Rule

This tool is used to facilitate team members' speaking up. In the clinical environment, team members should challenge colleagues if they have requested clarification but the response or confirmation does not alleviate the concern regarding potential harm to a patient.

Description	Link
AHRQ Two-Challenge Rule Description	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module6/igmutualsupp.html#two

CUS

In verbal communication, "CUS" and other signal phrases catch one's attention. If all team members have a shared mental model and are on the same page, when these words are spoken, all team members will clearly understand the issue and its magnitude.

Acronym: **C**oncerned, **U**ncomfortable, **S**afety issue.

Description	Link
AHRQ CUS Description	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module6/igmutualsupp.html#cus
AHRQ CUS Video	https://www.ahrq.gov/teamstepps/instructor/videos/ts_CUS_LandD/CUS_LandD.html

DESC Script

Used to communicate effectively during all types of conflict and is most effective in resolving interpersonal conflict.

Acronym: **D**escribe the specific situation, **E**xpress your concerns about the action, **S**uggest other alternatives, **C**onsequences should be stated

Description	Link
AHRQ DESC Description	https://www.ahrq.gov/teamstepps/instructor/fundamentals/module6/igmutualsupp.html#descscript
AHRQ DESC Video	https://www.ahrq.gov/teamstepps/longtermcare/video/12descscript_ltc/index.html