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The Time to ACT for Better Diagnosis™ is Now

Each year, an estimated 40,000 to 80,000 deaths in U.S. hospitals can be attributed to an inaccurate or delayed diagnosis. That’s about the same number of people who die annually from breast cancer or diabetes, which we rightly hear a lot about. But no one talks about deaths from inaccurate or delayed diagnosis.

We aim to change that.

This year, we launched ACT for Better Diagnosis, an initiative to make diagnosis more Accurate, Communicated and Timely by engaging stakeholders through research, education, policy and quality improvement. The effort goes to the heart of our current mission and our vision for the future: That everyone has a role to play in improving diagnosis.

Established seven years ago, the Society to Improve Diagnosis in Medicine (SIDM) remains the only organization of its kind focused solely on the problem of diagnostic quality and safety. We’re successfully bringing others to the table to enhance our thinking about this vexing problem, expanding our understanding of what will help address it and spreading our message to others.

That’s why more than 40 of the country’s most prominent organizations in health care and patient advocacy joined us in launching ACT for Better Diagnosis—representing hundreds of thousands of healthcare clinicians and patients, as well as the leading organizations and government agencies involved in ensuring safe and quality patient care. Both their numbers and interest continue to grow.

While this initiative has been at the forefront of our work this year, it is not the sum of our efforts. We are also piloting diagnostic quality improvement initiatives across the country, designing new curriculum and tools to support clinical reasoning skills, supporting the development of patient leaders in diagnostic research, preparing to hold the 11th annual and largest-ever Diagnostic Error in Medicine International Conference and more.

Thanks to the generosity of our funders, supporters and professionals who volunteer as members of our board and committees, we’ve made great strides. Now we must maintain momentum and catalyze still more action.

Improving diagnosis will require disciplined and sustained work over many years. It will require engaging diverse stakeholders in even larger numbers, representing every sector in health care—more physicians, nurses, physician assistants, patient and family advocates, hospitals and health systems, medical educators, imaging professionals, clinical laboratory scientists, health information technology (IT) experts, insurers, government agencies and others. It will require increased funding and government-supported research on what causes, and what can help prevent inaccurate and delayed diagnoses.

As we look to the future, we ask ourselves—and you—what’s the next action to take? How will you and your organization help increase the quality and safety of patient care by improving diagnosis? Where will you make your mark? Because if we don’t push forward together and make improved diagnosis a shared priority, we won’t make meaningful, sustainable improvements.

The time to ACT for Better Diagnosis is now.
VISION, MISSION, STRATEGIC PRIORITIES

SIDM works every day to ACT for Better Diagnosis. Our efforts are guided by our vision, mission and strategic priorities. For every action we take—we ask, ‘will it serve these guideposts?’

VISION
Creating a world where no patients are harmed by diagnostic error.

MISSION
SIDM catalyzes and leads change to improve diagnosis and eliminate harm from diagnostic error, in partnership with patients, their families, the healthcare community and every interested stakeholder.
STRATEGIC PRIORITIES

Awareness and Engagement

Make improving diagnosis a priority for health care

- Raise awareness of the magnitude and impact of the diagnostic quality and safety problem, and SIDM’s unique role in addressing the problem.
- Engage healthcare organizations in a coordinated effort to improve diagnosis.
- Engage regulators, payers, liability insurers, policymakers, healthcare professionals and the patient community in policy initiatives that will drive improved diagnostic performance.

Research

Increase research on diagnosis and focus on diagnostic outcomes that matter to patients

- Seek increased public and private sector funding for diagnostic quality research.
- Catalyze the development of data sources and measures of diagnostic quality and safety.
- Expand the community of researchers studying diagnostic quality and safety.
- Facilitate diagnostic research collaboration across disciplines, institutions and sectors.

Education

Transform education of health professionals to improve diagnosis and develop new leaders in diagnostic quality and safety

- Promote the development and assessment of diagnostic competencies in the education of health professionals with a focus on diagnostic reasoning and health IT.
- Identify, develop and promote educational tools that improve diagnostic abilities among practicing healthcare professionals.
- Develop leaders in diagnostic quality and safety among educators and promote diagnostic quality as its own field.

Practice Improvement

Engage patients, clinicians and healthcare systems to improve current diagnostic performance and reduce harm from diagnostic error

- Drive the development of innovative interventions including patient and technology-enabled tools.
- Catalyze the development of measures used to evaluate interventions and monitor the diagnostic process and its outcomes.
- Disseminate and promote utilization of effective interventions, including IT tools.
- Expand diagnostic quality improvement collaborations among practitioners.

Patient Engagement

Integrate patients and their families in all diagnostic improvement efforts

- Develop a skilled, diverse national and international community of patient thought leaders knowledgeable about diagnostic quality and safety.
- Engage the patient community in SIDM research, policy, practice improvement and education efforts to drive focus on outcomes that matter to patients.
- Promote SIDM’s patient engagement efforts and disseminate SIDM’s resources and materials broadly.

“Without an accurate and timely diagnosis, time is lost in starting effective treatments, and the underlying disease worsens.”
– Paul Epner
CEO and Co-Founder, SIDM
Dear Friends—

All of us share a sense of urgency about improving the accuracy, communication and timeliness of a medical diagnosis, but one among us has made it his life’s work to pursue better diagnosis. The renowned career of Mark L. Graber, MD, FACP, has spanned clinical care, medical education and health services research, all in service of reducing patient harm by improving diagnostic safety and quality.

As a senior fellow at RTI International, Professor Emeritus of Medicine at the State University of New York at Stony Brook, and distinguished quality advocate and researcher with more than 80 peer-reviewed publications, Mark wears many hats. Almost lost among them, due to his personal humility, but of significant international importance, is his foresight in starting the Diagnostic Error in Medicine meeting in 2008 and founding SIDM in 2011. Today SIDM remains the only organization focused solely on improving the quality and safety of medical diagnoses.

Mark’s work to elevate the issue of diagnostic error in the national healthcare conversation is unparalleled. During Mark’s seven-year tenure as president, SIDM achieved many important milestones:

> Expanding the annual Diagnostic Error in Medicine conference, which now brings together more than 300 researchers, educators, physicians, clinical team members and patients to discuss ways to improve the diagnostic process in pursuit of better patient outcomes;

> Launching Diagnosis in 2014, as SIDM’s official peer-reviewed journal with Mark also serving as the journal’s co-editor in chief;

> Establishing the Coalition to Improve Diagnosis, a collaboration of now more than 40 leading healthcare organizations representing diverse stakeholder groups and focused on ensuring that diagnoses are accurate, communicated and timely;

> Catalyzing the 2015 publication of the Institute of Medicine (now the National Academy of Medicine) report, Improving Diagnosis in Health Care; and

> Attracting the recurring, generous support of nationally recognized funders including the Josiah Macy Jr. Foundation, the Gordon and Betty Moore Foundation, The Mont Fund and others.

Mark is a respected national leader in the field of patient safety, originating the first-ever Patient Safety Awareness Week in 2003, an event which is now internationally recognized. He is a pioneer of myriad efforts to address diagnostic error, with his research in this area supported by the National Patient Safety Foundation, the Agency for Healthcare Research and Quality and others.

In recognition of his seminal contributions to understanding diagnostic error and bringing diagnostic quality and safety to the forefront of the patient safety movement, in 2014 he received the prestigious John M. Eisenberg Patient Safety and Quality Award from the National Quality Forum and The Joint Commission. This award recognizes major achievements by individuals to improve patient safety and healthcare quality.

As the incoming president of SIDM, I am proud and humbled to assume the mantle of leadership from him. Mark has made—and will continue to make—an impact on countless patients and their families by preventing harm from misdiagnosis. He has bravely challenged clinicians, educators and researchers to improve diagnostic tools and training. He has shaped and championed the field of diagnostic medicine.

Mark has set the bar very high, while providing a solid foundation to catapult SIDM forward.

I know you will join me in expressing our deep respect and personal and professional gratitude to him.

David E. Newman-Toker, MD, PhD
President-Elect, SIDM Board of Directors
In 2018, we continued efforts to expand membership, especially in the areas of patient-facing organizations, laboratory science and hospitals and health systems. Over the last few months we’ve added many organizations that include representation from these constituencies, increasing membership to more than 40 premier national healthcare and patient advocacy organizations. Together, they’re bringing much-needed attention, action and awareness to the issue of misdiagnosis as an essential first step in improving the quality of care that patients receive.

All of the Coalition organizations have publicly agreed that:

1. A timely, accurate and efficient diagnosis is appropriately the expectation of every patient.
2. Diagnosis, which by its very nature involves uncertainty, is one of the most difficult and complex tasks in health care, involving both human and systematic elements, and is made more difficult by an explosive growth in knowledge and tools that are both helpful and problematic.
3. The overwhelming majority of diagnoses are accurate, but the burden to patients, families, healthcare professionals and society associated with diagnostic error, is significant.
4. Every participant in health care, from providers and the extended team of healthcare professionals, to patients and families, and to others who are key to the success of our healthcare system including the industry, payers, researchers, educators and more, has a role to play in reducing the burden.
5. They must and will, individually and collectively, take action to help solve this problem.

Coalition members include:

(*New Coalition members as of October 4, 2018)

ABIM Foundation
Academy for Academic Internal Medicine
American Academy of Family Physicians
American Academy of Pediatrics
American Association for Clinical Chemistry*
American Association of Nurse Practitioners
American Board of Internal Medicine
American Board of Medical Specialties
American Cancer Society Cancer Action Network*
American College of Emergency Physicians
American College of Physicians
American Health Quality Association*
American Heart Association*
American Society for Healthcare Risk Management
Association of American Medical Colleges
Association of Clinical Scientists
Children’s Hospital of Philadelphia*
Consumers Advancing Patient Safety
Council of Medical Specialty Societies*
ECRI Institute*
Geisinger*
Institute for Healthcare Improvement
Intermountain Healthcare
Johns Hopkins Medicine
The Joint Commission*
The Leapfrog Group
Maryland Patient Safety Center
Massachusetts Coalition for the Prevention of Medical Errors
Medical Professional Liability Association*
MedStar Health
Midwest Alliance for Patient Safety
National Association of EMS Physicians*
National Association of Pediatric Nurse Practitioners
National Quality Forum
Northwell Health*
Patient-Centered Primary Care Collaborative*
Penn State Health (Hershey Medical Center)
Pennsylvania Patient Safety Authority
The Permanente Federation, Kaiser Permanente
Society of Bedside Medicine*
Society of Hospital Medicine
Society to Improve Diagnosis in Medicine
WomenHeart*

Also participating in the Coalition are federal liaisons, including the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS) and Veterans Health Administration.
In September 2018, the Coalition to Improve Diagnosis, convened by SIDM, launched ACT for Better Diagnosis, a targeted effort to improve the Accuracy, Communication and Timeliness of diagnosis to a standing-room-only crowd of stakeholders, representing every sector of health care, and select media. The initiative aims to improve the diagnostic process by identifying and spreading practical steps that everyone throughout the healthcare system—patients, physicians, nurses, health system leaders, laboratory scientists and others—can take to improve diagnosis.
Working collaboratively over several months, the more than 40 leading healthcare and patient advocacy organizations behind ACT for Better Diagnosis identified several obstacles they believe impede diagnostic accuracy, including:

- **Incomplete communication during care transitions**—When patients are transferred between facilities, physicians or departments, there is potential for important information to slip through the cracks.
- **Lack of measures and feedback**—Unlike many other patient safety issues, there are no standardized measures for hospitals, health systems or physicians to understand their performance in the diagnostic process, to guide improvement efforts, or to report diagnostic errors. Providers rarely get feedback if a diagnosis was incorrect or changed.
- **Limited support to help with clinical reasoning**—With hundreds of potential explanations for any one particular symptom, clinicians need timely, efficient access to tools and resources to assist in making diagnoses.
- **Limited time**—Patients and their care providers overwhelmingly report feeling rushed by limited appointment times, which poses real risks to gathering a complete history that is essential to formulating a working diagnosis and allows scant opportunity to thoroughly discuss any further steps in the diagnostic process and set appropriate expectations.
- **The diagnostic process is complicated**—There is limited information available to patients about the questions to ask, whom to notify when changes in their condition occur, or what constitutes serious symptoms. It’s also unclear who is responsible for closing the loop on test results and referrals, and how to communicate follow-up.
- **Lack of funding for research**—The impact of inaccurate or delayed diagnoses on health care costs and patient harm has not been clearly articulated, and there is a limited amount of published evidence to identify what improves the diagnostic process.

The Coalition and the ACT for Better Diagnosis initiative are made possible through the generous support of the Gordon and Betty Moore Foundation and The Mont Fund.
SIDM is committed to engaging and integrating patients and family members in all of our diagnostic improvement efforts. As part of these efforts, SIDM and Project Patient Care are collaborating with and learning from patients and family members, many from key patient advocacy organizations, as learners and co-designers of the Patients Improving Research In Diagnosis program, or PAIRED Project. Together, our Patient Partners are working with expert researchers to co-design a novel curriculum to train patients and family members to participate as partners in the planning, conduction and dissemination of research to improve diagnosis.

Patient Organizations
Key patient organizations and healthcare systems that identified Patient Partners to participate in the PAIRED program:

- American Diabetes Association
- American Heart Association
- Arthritis Foundation
- Crohn’s & Colitis Foundation
- Full Ability
- Kaiser Permanente
- LymeDisease.org
- MedStar Health
- Metro Breast Cancer Consortium
- National Kidney Foundation
- Sepsis Alliance
- WomenHeart

Funded by a Eugene Washington Engagement Award from the Patient-Centered Outcomes Research Institute, we facilitated learning sessions, both virtual and in-person, acquainting Patient Partners with the fundamentals of research, the role of patients throughout the research process, as well as the National Academy of Medicine’s (NAM) diagnostic process framework. Examples of session topics included:

- Diagnosis research topics, such as uncertainty and biases related to age, race and gender;
- Effective storytelling methods to identify patient-generated research questions;
- The use of Patient-Reported Outcomes for symptom tracking in research;
- Fundamentals of Patient-Centered Outcomes Research and Comparative Effectiveness Research processes; and
- Important emerging issues, such as the proportionally higher occurrence of misdiagnosis in women.

The highlight of 2018 activities was a face-to-face meeting in Chicago, bringing together the cohort of Patient Partners with Research Mentors and mapping their personal or family experience of missed, wrong or delayed diagnosis onto NAM’s Diagnostic Process Framework. The exercise resulted in Patient Partners translating their personal stories of misdiagnosis into potential research topics and questions (“What ifs”).

The PAIRED Project, overseen by a national expert Advisory Council, will be featured at the 2018 Annual International Diagnostic Error in Medicine (DEM) Conference and Patient Summit. The project’s end result, which will be finalized in 2019, will be a curriculum co-designed by patients for patients. SIDM plans to use these learnings to develop a blueprint for a Patient Academy to better prepare patients, family members and other stakeholders for participating as partners and co-designers in all diagnostic improvement efforts.
In 2018, a top priority for SIDM and the Coalition has been to highlight the need for greater federal investment in diagnostic quality and safety research, including through new Centers of Diagnostic Excellence. Despite the health impact of billions of dollars, current research funding levels total roughly $7 million per year, making diagnostic quality the most under recognized and underfunded patient safety issue in health care. Our leaders and volunteers met with dozens of policymakers from both parties to educate them on this topic and share the SIDM RoadMap for Research: Policy Action, which lays out the case for increased research funding devoted to improving diagnosis and highlights specific actions that policymakers and others can take now.

Head to the Hill
In June, SIDM hosted a briefing on Capitol Hill to highlight very directly the human and financial toll of diagnostic error and opportunities to improve diagnostic safety and quality. Staffers from more than 50 congressional offices heard from SIDM experts, clinicians and family members who have lost loved ones or experienced significant harm due to diagnostic error. Sponsored by two highly respected leaders and long-time champions of healthcare quality and safety, Senators Orrin Hatch (R-UT) and Sheldon Whitehouse (D-RI), the event featured compelling stories of diagnostic process failures and explored the steps needed to drive improvement. The event, moderated by Lisa Sanders, MD, author of The New York Times column Diagnosis, captured the hearts and minds of congressional staff, many of whom were surprised by the scope and scale of the problem, but heartened to learn it is an actionable problem—good indicators for our work ahead. Already, lawmakers are taking important steps to respond. Fiscal year 2019 funding for AHRQ includes $2 million in new funding to support grants to address diagnostic errors and explore the process of establishing Centers of Diagnostic Excellence. While the funding amount is modest, it is a significant start and will be an important catalyst to develop specific approaches to reducing harm caused from diagnostic error and improve diagnostic quality and safety.

Prioritizing and Promoting Measure Development
Actionable measures of diagnostic quality and safety are a fundamental gap for diagnostic quality movement, and closing that gap is a critical step to moving the field forward, whether in policy, research, practice or quality improvement. The National Quality Forum (NQF)—a Coalition member—published a measures framework to improve diagnosis last fall, and key journal publications by SIDM members are spotlighting additional measure concepts that are important to diagnosis and supported by research. SIDM is working to bring resources to develop these concepts into evidence-based measures that can be used across the field to improve diagnostic quality and safety. In addition, NQF recently announced a multi-stakeholder committee to explore concepts, data sources and approaches to standardizing nomenclature about emergency department patients’ symptoms or “chief complaints,” another foundational step for the field.

Broadening and Deepening Relationships
This year, we took concerted steps to raise the visibility of SIDM and its mission to key federal healthcare agencies, including CDC, CMS and the vast network of federally supported safety and quality improvement organizations. We worked to help them recognize that accurate diagnosis is foundational to high-value care, and the need to integrate diagnostic quality and safety improvement into their funding and technical assistance programs. As a result of this outreach, SIDM is responding to a growing number of welcome requests for presentations, tools and technical assistance, including from the CMS Hospital Innovation and Improvement Networks and the clinical Quality Improvement Organizations.

SIDM’s Consensus Statement on the need to increase and coordinate federal research spending on diagnosis has been signed by 27 members of the growing Coalition to Improve Diagnosis.
DRIVING QUALITY IMPROVEMENT EFFORTS

The NAM’s landmark 2015 report, *Improving Diagnosis in Health Care*, identified diagnostic error as a major, unaddressed patient safety issue, noting that “most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences.” The report called on organizations to “develop and deploy approaches to identify, learn from and reduce diagnostic errors and near misses in clinical practice.”

**SIDM has been at the forefront of quality improvement (QI) in diagnosis.**

INCUBATING DIAGNOSTIC QI ACROSS THE COUNTRY

Working with the Institute for Healthcare Improvement (IHI), SIDM developed a collaborative engaging six healthcare institutions across the country. These six organizations tested real-world interventions to improve the diagnostic process in their institutions. Using the unique “IHI Breakthrough Series Model” approach, the participating organizations worked together to share problems, insights and lessons to continually improve the QI projects they completed. Lessons from the program will serve to support the development of future quality improvement activities focused on improving the diagnostic process.

Diagnostic Error Change Package

Working in collaboration with the American Hospital Association’s Health Research & Educational Trust, SIDM helped develop a Change Package to support hospitals and health systems in their efforts to improve the diagnostic process.

A Change Package seeks to achieve better patient outcomes through quality improvement focused on specific care processes or healthcare features—in this case, the diagnostic process.
QI COLLABORATIVES

University of Michigan, Department of Emergency Medicine
Testing the use of innovative technology to accurately interpret unstructured provider notes—specifically, the medical decision-making portion of the electronic health records—this project seeks to obtain insight into the cognitive aspects of the diagnostic process. The team hopes to then validate them to screen large numbers of electronic health records to investigate the epidemiology and derive interventions to mitigate diagnostic errors in the context of acute care.

Northwell Health
Northwell is working to reduce diagnostic errors within the Ambulatory (Community/Faculty Practices), Emergency Department (Long Island Jewish Medical Center) and Inpatient (Lenox Hill Hospital-Adult/Cohen Children’s-Pediatrics) clinical settings. By focusing on the roles of the patient, family and caregiver, they are enhancing patient communication, using a scripted “Teach-Back” intervention. Providers are asked to explain a given diagnosis/diagnoses to a patient and have the patient repeat back what they understood about their diagnosis/diagnoses at the end of the encounter.

Nationwide Children’s Hospital
During this prototyping collaborative, the team introduced a framework for diagnostic deliberation, the “diagnostic time-out,” in efforts to circumvent cognitive biases that may interfere with medical decision-making. They are examining if fostering an environment to support active discussion regarding diagnosis will improve the differential diagnosis.

University of California, San Francisco Medical Center
Members of the hospital medicine program identified cases using seven-day hospital readmissions, autopsy, inpatient mortality and self-report as triggers. These cases were reviewed by two hospital medicine physicians using the SaferDX tool to classify as either diagnostic error or no diagnostic error. All diagnostic error cases were reviewed using a diagnostic error fishbone analysis grid to identify root causes and contributing factors. Feedback regarding the cases and trends was given to the hospital medicine physician group as well as primary care physicians.

Tufts Medical Center (TMC)
Understanding that test results that return after discharge increase the risk of diagnostic errors, TMC has developed a tool that collects results that are returned after discharge, and transmits that information via email to the responsible discharging attending. Post-discharge results may include radiology, microbiology, pathology, chemistry and “send-out” tests that are performed at regional or national reference labs.

MedStar Health
This project sought to improve utilization of “the VTE advisor,” a mandatory clinical decision support tool embedded in the electronic medical record designed to help physicians stratify patients’ risk of venous thromboembolism (VTE) and guide VTE prophylaxis recommendations.
SIDM is committed to supporting the next generation of clinicians, teams and medical education programs to ensure they are integrating diagnostic improvement into their training. SIDM is spearheading initiatives to ensure the diagnostic process is a fundamental component in medical education and training. In addition, we are working with organizations to develop and support continuing medical education focused on improving diagnostic skills for clinicians in practice.

**Inter-Professional Consensus Curriculum on Diagnosis and Diagnostic Error**

While healthcare professionals learn the basics and clinical reasoning in school, most medical schools do not offer training on diagnosis or how to avoid diagnostic error.

With support from the Josiah Macy Jr. Foundation, a multi-disciplinary Consensus Committee with representatives from a wide range of stakeholders (including patients, clinicians and educators from internal medicine, pediatrics, emergency medicine, nursing, pharmacy, laboratory sciences and radiology) came together to look at how training could support the diagnostic team. The committee determined existing training programs may not provide adequate education regarding diagnostic quality and safety, and that there is a clear mandate to improve diagnostic safety training in health professions education.

Programs at the University of Minnesota; Texas College of Osteopathic Medicine; Dell School of Medicine, University of Texas at Austin and the University of North Carolina have agreed to pilot the curriculum.

**Clinical Reasoning Toolkit**

Diagnostic reasoning is a fundamental skill for any clinician. The Clinical Reasoning Toolkit presents a collection of go-to resources for clinicians endeavoring to develop their clinical reasoning skills. It also includes a special section for those teaching the next generation of physicians and other members of the clinical team.

**Assessment of Reasoning Tool**

Errors in clinical reasoning are central factors in many diagnostic errors. The Assessment of Reasoning Tool (ART) is a user-friendly tool intended to support educators in assessing a learner’s clinical reasoning skills during patient presentations. The ART guides feedback conversation with learners and can serve as formative feedback. The ART can also help programs fulfill Liaison Committee on Medical Education and/or Accreditation Council for Graduate Medical Education requirements for assessing diagnostic and clinical reasoning skills.

**SIDM Fellowship in Diagnostic Excellence**

SIDM offers an annual fellowship for healthcare professionals with an interest in improving diagnostic quality and safety. SIDM matches young researchers with experienced mentors who are recognized leaders in the fields of diagnostic error education, research or practice improvement. This year, with the support of the Gordon and Betty Moore Foundation, we are able to offer a funded Fellowship position at the University of Pennsylvania that will provide a stipend for work done as part of an institutional degree program. This program will be expanded next year to include the University of Pennsylvania, Johns Hopkins University and an additional institution.
2018 SIDM FELLOWSHIP IN DIAGNOSTIC EXCELLENCE

Caitlin Clancy, MD, Pulmonary and Critical Care Fellow at the Center for Healthcare Improvement and Patient Safety (CHIPS) at the Perelman School of Medicine at the University of Pennsylvania, will be working to better understand and assess clinical reasoning skills. Dr. Clancy will be mentored by Jennifer Myers, MD, Professor of Clinical Medicine and Director of CHIPS, Director of Quality and Safety Education in the Department of Medicine at the University of Pennsylvania; and Joseph Rencic, MD, Associate Program Director of the Internal Medicine Residency program and Associate Professor at Tufts University. This is a funded fellowship through the Gordon and Betty Moore Foundation.

Alexa Miller, MA, will be focusing on how to use art to better inform clinicians about uncertainty in clinical reasoning. Miller is a Founder and Consultant in Arts and Clinical Learning at Arts Practica, a medical education consultancy. Her research mentor is Leslie H. Fall, MD, Adjunct Professor of Pediatrics at the Geisel School of Medicine. Dr. Fall is also the founder of Aquifer, an e-learning system based on a library of patient cases, as well as a leading expert in medical education.

Kelly Gleason, PhD, RN, Assistant Professor at Johns Hopkins University School of Nursing, will be studying how to engage patients to better understand diagnosis. Her mentors are patient advocates Dan Berg and Welcome Jerde.

Vinita Parkash, MBBS, Associate Professor of Pathology at Yale School of Medicine, will be working to develop a better classification and taxonomy for diagnostic errors in pathology. She will be mentored by Mark Graber, MD, FACP, President and Founder of SIDM.

2017 Fellows

Paul Bergl, MD, is an Assistant Professor in General Internal Medicine and a Critical Care Fellow in the Division of Pulmonary, Critical Care & Sleep Medicine at the Medical College of Wisconsin. Dr. Bergl is investigating the role and impact of potentially preventable diagnostic errors in admissions to critical care units. His mentor is Robert El-Kareh, MD, Hospitalist and Associate Professor of Medicine at the University of California, San Diego.

Najlla Nassery, MD, is an Assistant Professor of Medicine at Johns Hopkins University School of Medicine. Her project is looking at how to use large databases to develop measures for diagnostic safety, quality and efficiency. Her mentor is Mark Graber, MD, FACP, President and Founder of SIDM.

Thilan Wijesekera, MD, is a Clinical Instructor and Fellow in Medical Education in the Department of Internal Medicine at Yale School of Medicine. His project examined designing and implementing diagnostic educational curricula. His mentor is Andrew Olson, MD, Assistant Professor of Medicine at the University of Minnesota.

We need to build the next generation of scholars focused on improving diagnosis.”

—Karen Cosby, MD
Chair of the SIDM Fellowship Committee
With nearly 400 attendees, the 10th Annual International Conference on Diagnostic Error in Medicine was SIDM’s largest conference ever. Focused on Improving Diagnosis: It Takes a Team, conference participants represented a wide range of experts and stakeholders, including patients, clinicians, nurses, medical administrators, researchers, risk and liability managers and educators to focus on how to utilize more effective teamwork as a means to improve diagnostic quality and safety.

A really outstanding mix of research and application.”

—Attendee of the 10th Annual International Conference on Diagnostic Error in Medicine
While we’re proud of last year’s success, the 2018 Diagnostic Error in Medicine 11th Annual International Conference is set to become our largest-ever.

“A wonderful combination of inspiration and practical tools and ideas for bringing change and improvement to our own organizations.”

– Attendee of the 10th Annual International Conference on Diagnostic Error in Medicine
The fact that some diagnoses are incorrect, delayed or not communicated is a significant problem. Not all diagnostic errors are significant—sometimes the patient still gets better. The problem is those cases that do result in harm, and you multiply that by the millions of diagnoses being made every day in our country, that’s where the harm adds up.”

—Mark Graber, MD
President and Founder, SIDM
Diagnosis

Our peer-reviewed journal shares the latest evidence and emerging best practices on how to increase the accuracy of diagnosis. Published by DeGruyter, Diagnosis focuses on how diagnosis can be advanced, how it is taught, and how and why it can fail, leading to diagnostic errors. The journal welcomes both fundamental and applied works, improvement initiatives, opinions and debates to encourage new thinking on improving this critical aspect of healthcare quality. This year SIDM was proud to announce that Diagnosis is now indexed on PubMed—a great accomplishment for such a young journal. SIDM members receive free access to Diagnosis.

Journal Club

This year researchers from across the globe shared insights about their studies and engaged in discussions with other academics in the field. Scholars from Emory University, the Larner College of Medicine at The University of Vermont, Harvard Medical School and University of São Paulo discussed their latest published research. Those discussions are available on SIDM’s YouTube Channel.

Join the Discussion

SIDM’s active listserv has more than 800 subscribers. Listserv participants touch on topics such as patient engagement, checklists and disparities in diagnosis. They raise important issues, discuss solutions and sometimes work through disagreements.

Follow us on:

Twitter: @ImproveDx
Facebook: @ImproveDx
LinkedIn: Society to Improve Diagnosis in Medicine

SIDM seeks to engage and expand the community of those working to improve the diagnostic process. We use a number of vehicles to share the latest in research and quality improvement, and important stories about efforts to reduce harm caused by diagnostic error.
## Fiscal Year Ends June 30

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<tr>
<td><strong>Total Net Assets</strong></td>
<td>$742,335</td>
<td>$1,763,693</td>
<td>$2,999,276</td>
</tr>
</tbody>
</table>

Sources of Revenue**

<table>
<thead>
<tr>
<th></th>
<th>FY2016</th>
<th>FY2017</th>
<th>FY2018*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Giving</strong></td>
<td>$42,955</td>
<td>$79,819</td>
<td>$100,398</td>
</tr>
<tr>
<td><strong>Organizational Giving</strong></td>
<td>$32,500</td>
<td>$107,500</td>
<td>$369,600</td>
</tr>
<tr>
<td><strong>Grants &amp; Foundations</strong></td>
<td>$401,862</td>
<td>$1,611,000</td>
<td>$3,250,735</td>
</tr>
<tr>
<td><strong>Contract Services</strong></td>
<td>$0</td>
<td>$0</td>
<td>$42,350</td>
</tr>
<tr>
<td><strong>DEM Conferences</strong></td>
<td>$228,770</td>
<td>$348,683**</td>
<td>$285,691</td>
</tr>
</tbody>
</table>

* Unaudited Results
** Excludes Investment Income
***FY2017 includes U.S. and Global Conferences

### REVENUE/EXPENSES

<table>
<thead>
<tr>
<th></th>
<th>FY2016</th>
<th>FY2017</th>
<th>FY2018*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td>$705,934</td>
<td>$2,150,033</td>
<td>$4,072,695</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td>$630,575</td>
<td>$1,082,433</td>
<td>$2,786,835</td>
</tr>
<tr>
<td><strong>Net</strong></td>
<td>$75,359</td>
<td>$1,067,600</td>
<td>$1,285,860</td>
</tr>
</tbody>
</table>

### RESTRICTED VS. UNRESTRICTED ASSETS

<table>
<thead>
<tr>
<th></th>
<th>FY2016</th>
<th>FY2017</th>
<th>FY2018*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unrestricted Net Assets</strong></td>
<td>$303,629</td>
<td>$1,513,087</td>
<td>$2,725,752</td>
</tr>
<tr>
<td><strong>Restricted Net Assets</strong></td>
<td>$438,706</td>
<td>$250,606</td>
<td>$273,524</td>
</tr>
</tbody>
</table>

### FY2018* SOURCES OF REVENUE**

- Grants & Foundations
- DEM Conferences
- Individual Giving
- Organizational Giving
- Contract Services

*Unaudited  **Excludes Investment Income
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