FREQUENTLY ASKED QUESTIONS (FAQ)

ELIGIBILITY

Who can apply?
Applicants are limited to care delivery organizations. These include, but are not limited to, office-based primary and specialty care, clinics (urgent and acute), other ambulatory centers (surgical and imaging), community hospital, academic medical center, psychiatric hospital, rehab facility and VA & military centers.

Can for-profit corporations or not-for-profit organizations including hospital associations, patient safety organizations, professional societies, etc. apply?
Organizations that do not provide direct care are not eligible to apply as the lead on a DxQI project, but may partner with an eligible organization, not as the applicant, nor as a project lead, but as part of the team.

Can international locations apply?
Yes, international locations can apply, however the focus is on identifying interventions that will improve the US healthcare system. Therefore, international applicants MUST convincingly address the importance of the problem and the applicability of the intervention to the U.S. healthcare system.

Can multiple teams from the same institution apply?
Yes, we will accept multiple proposals from the same institution as long as each application a) names a different project lead and b) focuses on a different problem/intervention combination. Please note that while we will accept multiple proposals from the same institution, we are unlikely to fund more than one.

Do you accept applications that involve IRB approval?
QI projects typically do not require IRB approval. If you anticipate you'll need IRB approval or an IRB-issued waiver and you are selected, we will make a contingent award. Once you submit proof of IRB approval, we will award you the grant. You will have up to 90 days to submit proof of approval.

APPLICANT CONSIDERATIONS AND PROCESS

What do I need to submit?
For your application to be considered "complete", please make sure you've submitted the following:

- Response to all online application questions
- A Letter of Support from an executive sponsor that demonstrates organizational support for the project and the project team (see Letter of Support details in the RFP)

What are the grantee expectations?
The grantees will be expected to:

- Designate appropriate team members to be part of the QI Team
- Attend a kick-off webinar
- Submit bi-monthly status reports describing:
  - What barriers/challenges have you faced?
  - What unanticipated consequences did you encounter with this month's tests?
  - How did you overcome those?
- Submit formal 6-month mid-project and year-end final report
- Participate in quarterly calls
- Participate in the online Community
- Attend two designated QI Summits at future Diagnostic Errors in Medicine National Conferences
- Confirm no additional external funding is available to do this work
- Ensure the IRB is aware of the proposed project and appropriate authorization will be obtained prior to the start of the project.

Why should I seek a SIDM DxQI grant?
If awarded, the grantee will:

- Receive up to $50,000 to identify, develop and test interventions aimed at achieving diagnostic excellence and reducing the harm from diagnostic error
- Bring visibility to the topic of diagnostic quality and safety in their own institutions
- Participate in an online community fostering peer-to-peer learning with other grantees
- Attend quarterly virtual meetings to share challenges and review progress with the entire cohort or with topically similar subgroups
- Have support to submit manuscripts to SIDM's peer-reviewed journal, *Diagnosis*
- Present project and findings at annual DEM QI Summit
- Become a member of the rapidly growing community focused on the number one patient safety problem in healthcare.

THE APPLICATION

I have never done a grant proposal. Is there any assistance available?
Many professional organizations are members of the Coalition to Improve Diagnosis and some of them have offered to provide assistance to their members. Check with your professional society to see if they are one of them. We will also be hosting a Q&A webinar for prospective applications on Friday, February 21st at 12pm EST.

Where can I get guidance on completing specific parts of the application.
The DxQI website contains downloadable question-by-question instructions.

What are the critical elements of the proposal?
We will score your application on the following elements: the AIM (SMART AIM), prior QI experience of the project lead, appropriateness and experience of the team, applicability to one of the priority categories and diagnostic quality, the strategy for measuring effectiveness, appropriate patient engagement, access to necessary resources such as data infrastructure, and a comprehensive project plan outlining measures, data collection and risk mitigation strategies. The proposed intervention must be described by one of the four categories below:

- A well-defined problem and discovery period followed by adequate time for a to-be defined intervention that will be tested and improved
- A well-defined intervention that will be tested and improved
- An implemented, but unevaluated intervention with a well-defined evaluation plan and an opportunity to improve
- An implemented, evaluated intervention that will be tested and improved in a novel setting

For additional guidance, visit the DxQI website where you can review a summary of the scoring criteria our reviewers will use during the application review phase.

Is there guidance about the size of the QI team?
We do not have a minimum or a maximum number, but we expect an appropriately sized and skilled team for the proposal, although we would typically expect to see three to five on the CORE team in addition to the project lead.

What is a SMART Aim?
SMART is an acronym for Specific, Measurable, Attainable, Realistic, Timely. Your project aim should succinctly incorporate each of these elements.
Below are some examples of SMART Aims:

- Reduce adverse drug events (ADEs) in critical care by 75 percent within 1 year.
- Reduce waiting time to see a physician to less than 15 minutes within 9 months.
- Reduce incidence of ventilator-associated pneumonia by 25 percent.
- Increase the number of surgical cases between cases with a surgical site infection by 50 percent within 1 year.
- Reduce waiting time to see a urologist by 50 percent within 9 months.
- Reduce the average length of stay for Medical ICU patients by 50 percent within 9 months.

For additional guidance, you can refer to the Science of Improvement: Setting Aims page on the Institute for Healthcare Improvement (IHI) website. (http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementSettingAims.aspx)

Is there anything you won't fund?
We are looking for interventions to reduce diagnostic error that might include (but are not limited to) cognitive interventions in patient care settings such as checklists, decision support or the provision of feedback on diagnostic outcomes; systems interventions to change diagnostic processes or workflow in practice; or educational interventions where the targeted outcomes of the study are practice change in diagnosis, either on the part of the patient or the healthcare team.
We are NOT looking for studies that measure the burden or causes of diagnostic error without an intervention; the development of new interventions in a "lab" setting without testing them for patient care outcomes; or that involve purely studying new diagnostic biomarkers or imaging modalities without an emphasis on testing and improving an intervention designed to improve diagnostic quality.

Will the specific interventions proposed, and the other information contained in the proposal, be kept confidential?
Individual interventions and proposal narratives will remain the property of the submitters and be kept confidential. Reviewers will be required to sign a confidentiality agreement with SIDM. Aggregated information from a cohort might be used to provide general analysis of the submission pool.

Where can I find ideas about what to improve?
If you are interested in identifying opportunities for improvement, the figure below, extracted from the supplemental online information associated with the Newman-Toker publication, may offer some great places to start as it lists top specific contributing factors in each of the Big Three disease categories. You can find all of the supplemental material at the bottom of the study publication webpage.

TOP 5 CONTRIBUTING FACTORS WITHIN EACH OF THE TOP 3 CAUSE CATEGORIES (each case may have had more than one causal factor [mean 3.8 per case])	VASCULAR (% of total high-harm cases in this disease category)	INFECTION	CANCER	OTHER	% of 26,506 identified causes (not counting 186 with no cause identified)
Failure or delay in ordering a diagnostic test	10.7%	10.3%	11.9%	9.2%	**10.7%**
Failure to establish a differential diagnosis	9.2%	10.0%	5.5%	8.7%	**7.9%**
Failure to appreciate relevant symptom, signs, or test results	8.2%	8.1%	7.3%	7.9%	**7.8%**
Failure or delay in obtaining consultation or referral	7.2%	6.5%	6.5%	7.2%	**6.9%**
Misinterpretation of diagnostic studies (imaging, pathology, etc.)	4.2%	2.3%	9.1%	4.7%	**5.8%**
Other clinical judgment failure	24.7%	25.5%	16.3%	23.8%	**21.7%**
SUBTOTAL CLINICAL JUDGMENT	***64.3%***	***62.7%***	***56.5%***	***61.6%***	***60.6%***
Failure in provider-provider communication about patient's condition	5.2%	5.4%	4.4%	5.9%	**5.1%**
Failure in provider-provider communication (failure to read medical record)	0.8%	0.8%	1.8%	1.0%	**1.2%**
Other patient-provider communication failure	0.8%	1.2%	1.6%	0.9%	**1.2%**
Failure to communicate follow-up instructions	0.7%	0.6%	2.1%	0.5%	**1.1%**
Poor rapport with patient	0.4%	0.5%	0.4%	0.7%	**0.5%**
Other communication failure	1.0%	1.2%	0.7%	1.2%	**1.0%**
SUBTOTAL COMMUNICATION	***8.9%***	***9.7%***	***10.9%***	***10.3%***	***10.1%***
Patient did not receive results—no report or wrong report	0.4%	1.0%	3.1%	0.5%	**1.4%**
Failure to follow up a new finding	0.7%	1.0%	2.8%	0.5%	**1.4%**
Failure or delay in completing recommended diagnostic test	1.6%	1.0%	1.0%	1.3%	**1.2%**
Clinician did not receive test results (other)	0.5%	0.7%	1.2%	0.5%	**0.8%**
Failure to identify provider coordinating care	0.4%	0.6%	1.0%	0.7%	**0.7%**
Other clinical systems failure	0.6%	0.6%	1.4%	0.6%	**0.9%**
SUBTOTAL CLINICAL SYSTEMS	***4.3%***	***4.9%***	***10.5%***	***4.1%***	***6.5%***
Top 5 Specific Causes in Top 3 Cause Categories TOTAL	***77.5%***	***77.3%***	***78.0%***	***75.9%***	***77.2%***
All Others TOTAL	***22.5%***	***22.7%***	***22.0%***	***24.1%***	***22.8%***
GRAND TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

David Newman-Toker, et al. Serious misdiagnosis-related harms in malpractice claims: The "Big Three" – vascular events, infections, and cancers. Diagnosis 2019; 6(3): 227–240

Is there a limit on indirects?
Indirects are not a required component of the budget request, but if you include them in your budget, they must be limited to 12.5% of your direct budget. In no case will more than $50,000 be awarded.

GRANT DECISIONS AND NOTIFICATION

When will we find out whether we are selected?
We expect to complete the selection process by June 5th,2020.

Can I apply again if I did not get awarded in the first year? Will we receive feedback on the proposal?
Each applicant will receive notification regarding the status of their submission after review. Those applications that make it beyond the initial review process will also receive additional information about the strengths and weaknesses of the proposal. Using this feedback, we encourage you to revise your application and submit again in future application periods.

Who can I contact for additional information?
For additional information, please visit our Seed Grant Program site, or e-mail us at dxqiseedgrant@ImproveDiagnosis.org.