DxQI Seed Grant Program
An initiative of the Society to Improve Diagnosis in Medicine

FREQUENTLY ASKED QUESTIONS (FAQ)

ELIGIBILITY

Who can apply?
Applicants are limited to healthcare organizations that deliver direct patient care. These include, but are not limited to, office-based primary and specialty care, clinics (urgent and acute), other ambulatory centers (surgical and imaging), community hospitals, academic medical centers, psychiatric hospitals, rehab facilities and VA & military centers.

Can for-profit corporations or not-for-profit organizations including medical schools, hospital associations, patient safety organizations, professional societies, medical equipment companies, IT vendors, etc. apply?
Organizations that do not provide direct patient care are NOT eligible to apply as the lead for a DxQI project grant, but may partner with an eligible organization, not as the applicant or project lead but as a third-party member of the team. If a third party is involved, a letter of support from that entity will need to be included with the application.

Can international locations apply?
Yes, international locations can apply, however the focus is on identifying interventions that will improve the U.S. 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?
The seed grants are designed to fund quality improvement (QI) projects, not scientific research. Quality improvement projects typically do not require IRB approval. If you anticipate you will 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 have 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 by addressing all seven required elements as specified in the RFP
- A letter of support from a 3rd party partner if one is involved
- A bibliography of relevant citations that support the project rationale and intervention plan

THE APPLICATION

I have never done a grant proposal. Is there any assistance available?
Interested applicants are encouraged to participate in a webinar on Wednesday, February 24, 2021 at noon EST. Questions submitted by noon EST on February 22nd will be given priority on the call. All questions received by February 26th will be posted with answers on the DxQI site by March 2, 2021.

- Register for webinar
- Submit a question for webinar

Information on the webinar and additional resources on characteristics of a good application will also be made available. Check the DxQI website periodically for updates.

Where can I get guidance on completing specific parts of the application?
The DxQI website contains a downloadable step-by-step application guide.

How will the proposal be scored?
We will score your application on the following elements:

- Aims statements (i.e., SMART Aims);
- Importance of problem selection to the diagnostic process and its local and national applicability;
- Proposed QI intervention and rationale;
- Prior QI experience of the project lead, appropriateness, and experience of the team;
- Applicability to one of the "Areas for Improvement" in diagnostic quality specified in the RFP;
- Strategy and measures of effectiveness;
- Appropriate patient and family engagement;
- Access to necessary organizational resources such as IT, data infrastructure, or other operational support;
- Project plan and timing for planning, implementing (or testing), evaluating, and improving the intervention; and
- Potential risks and mitigation strategies.

What are some examples of patient and family engagement in quality improvement interventions?

Patient and family engagement can be a confusing concept because it has been defined in multiple ways and in various contexts. For the purposes of the Seed Grant program, there are two types of patient and family engagement for you to keep in mind. The first, which is most well-known, is the idea that patients, who are empowered and supported to be active partners in their own care, tend to do better and feel better (James J, 2013). Therefore, patients and families should be looked to as key members of the care (and diagnostic) team and involved in decision-making and goal setting. The other type of engagement focuses not on a given patient's own clinical management, but rather on drawing from the lived experience of patients and families to improve and design the healthcare system that serves them (Sheridan S, et al., 2017 and Carman KL, et al., 2013). In QI, this means partnering with patients and families in the planning, development, and evaluation of QI interventions whenever possible.

How do I describe patient and family engagement in my proposal?

It is important to include enough details to provide a clear picture of how patients and families will be involved in the use or facilitation of the intervention and in the planning, development, and/or evaluation of the intervention—or why this involvement is not possible or not believed to be beneficial. An example is provided in Figure 1.

Sample Patient and Family Engagement Plan

This project is centered on communication of [the issue] with the patient and family. Because the project is focused on pediatric patients, involvement of the patient and the family is essential to this project. A core outcome of the project will be the assessment of how communication of [the issue] is received and understood by the family. A primary objective is to increase the involvement of the family in the diagnostic process from the very beginning and throughout. In addition, patient and family members who have dealt with [the issue] will be involved in the process and development of all tools, interventions, and [the issue] curriculum intended for all level clinicians. Feedback from the family is vital to the planned process improvement and education development and will be critical for the PDSA cycles. In terms of measuring [the issue] and its impacts on the patient and family, the interaction with families and their reaction will be measured through a survey methodology. Data obtained will inform future iterations and change ideas.

Is there guidance about the size of the QI team?

We do not stipulate a minimum or a maximum number. The core team should be interdisciplinary and include meaningful stakeholders with the skills, competencies, and authority to execute the project plan. The team should also include members who have appropriate training and/or experience in quality improvement and/or change management. Projects involving IT should include a representative core team member.

Figure 1

Example 1 - A project seeks to create a tool to identify missed or delayed diagnoses of rheumatoid arthritis (RA) by reviewing EMR and patient portal data to find commonly missed symptomology.

Without Engagement	The research team uses "pain" and "swelling" as search terms.	The findings identify instances of the words "pain" and "swelling," not capturing the terminology patients themselves might use.
With Engagement	Patient partners with RA offer additional search terms often used by people in their community such as discomfort, "cranky" or "angry" joints, irritated, sore, vs. pain, or puffy, fat, lumpy, vs. swelling.	The findings identify a more robust collection of data, inclusive of terminology patients use.

Example 2 - A project seeks to improve the problem of "drop-off" in imaging follow-up once an abnormality is found during exam and malignancy is expected.

Without Engagement	The research team compiles their perceptions of the drop-off; the imaging order is written, but the patient never shows up for the imaging appointment.	The solutions crafted include reminders to the patient, and follow-ups to ensure the imaging was done.
With Engagement	Patient and family members who have navigated cancer diagnoses share the multiple potential barriers for follow-up including insurance denial, getting on the imaging center schedule during non-working hours, transportation to the imaging center	Solutions crafted include assistance with insurance denials, referrals to imaging centers with after-hours scheduling, referral to imaging centers near public transportation routes.

We wish to qualify as an entrant focused on diagnostic quality disparities. Where can we find information and what are some ways we can enhance our application?
A bibliography on disparities in diagnosis can be found on the SIDM webpage "Foundational Readings – Disparities in Diagnosis." Proposals to improve diagnostic outcomes related to health disparities explicitly identify one or more vulnerable populations where the quality improvement will be demonstrated, i.e. populations differentiated by age, race/ethnicity, gender and/or other social determinants of health. Ideally, there will be quantitative evidence of disparate outcomes that will be described in the background and be used as a basis for measuring improvement. Alternatively, an applicant can focus on a setting that primarily serves vulnerable populations, e.g. Federally Qualified Health Centers or Safety Net hospitals. Proposals that meet the criteria for both disparities and "Big 3" would maximize your chances assuming a high-quality proposal.

What is are some examples of SMART Aims?
SMART is an acronym for **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, **T**imely. Your project Aim should succinctly incorporate each of these elements. Below are some examples:

- 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 Institute for Healthcare Improvement's "Science of Improvement: Setting Aims" webpage.

Will the specific interventions proposed, and the other information contained in the proposal, be kept confidential?
Peer Reviewers sign a confidentiality non-disclosure agreement with SIDM. They will also be instructed to explicitly identify conflicts of interest and recuse themselves from scoring an application where conflict of interest exists.

Is there anything you won't fund?
We are NOT looking for studies that:

- Measure the burden or causes of diagnostic error without an intervention;
- Develop new interventions in a "lab" setting without testing them for patient care outcomes;
- Focus on new diagnostic tests without a QI intervention that emphasizes reduction in diagnostic error;
- Are retrospective case studies with no planned QI Intervention;
- Evaluate the efficacy of a medical treatment or modality; or
- Are primarily scientific research with no direct impact on patient outcomes.

Where can I find ideas about what to improve?
Check the DxQI website for information on currently funded grant projects and organizations. Additionally, Newman-Toker D, et al. (2019) identifies several contributing and causal factors in each of the Big Three disease categories that are opportunities for improvement (see table on next page). Literature reviews on system-related and cognitive interventions to reduce diagnostic errors by Singh H, et al. (2012) and Graber et al. (2012), respectively, offer further guidance.

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	INFECTION	CANCER	OTHER	% of 26,506 identified causes (not counting 186 w/ no cause id'd)
	(% of total high-harm cases in this category) (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%***

BUDGET JUSTIFICATION

What won't the grant fund?
Grant funding will not be appropriated for major capital expenses (such as medical equipment, supplies, or IT infrastructure), sub-grants, or travel to other conferences.

Is there a limit on indirect expenses?
Indirect expenses 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.

The Budget requires $2000 for travel expenses and $1000 for registration (non-editable) to be included in the grant budget. What if your organization is willing to cover the registration and travel expenses?
If your organization will pay for the travel and registration expenses from other funding sources, enter $0.00 in the TRAVEL expense section. Then in the OTHER expense section enter a negative amount for the registration costs to offset the non-editable number, along with a short explanation.

In addition, have the Executive Sponsor include language in the Letter of Support which states that the organization commits to funding the registration and travel expenses (transportation, lodging, and meals for 3 nights) to the SIDM conferences.

Due to the uncertainties that still exist around COVID-19, what happens if travel restrictions are still in place at the time the SIDM summit and/or conference are scheduled to be held?
In 2021, the QI Summit and the SIDM conference will be convened virtually due to the ongoing COVID-19 pandemic so no travel funds are necessary. The 2022 Conference is planned for Minneapolis, MN. Refer to the SIDM website and FAQs for updates to conference plans.

GRANT DECISIONS AND NOTIFICATION

When will we find out whether we are selected?
We will notify awardees in June 2021.

Can I apply again if I did not get awarded in the 1st year?
Each applicant that applied in the 1st year received notification regarding the status of their submission after review. Those applications that make it beyond the initial review process received additional information about the strengths and weaknesses of the proposal. Using this feedback, you are encouraged to revise your application and submit again in future application periods.

Who can I contact for additional information?
We will update our FAQs to reflect answers to questions raised during our February webinar as well as those received via email. In fairness to all applicants, we will not answer new content questions about the program or application. If you have technical issues or questions, please reach out to our IT support team via email at help-sidm@getopenwater.com for assistance.