

NATIONAL QUALITY FORUM

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IMPROVING DIAGNOSTIC QUALITY AND SAFETY
IN-PERSON MEETING

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WEDNESDAY
JANUARY 11, 2017

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Missy Danforth and Mark Graber, Co-Chairs, presiding.

PRESENT:

MISSY DANFORTH, Vice President, Hospital Ratings, The Leapfrog Group, Co-Chair
MARK GRABER, MD, FACP, President, Society to Improve Diagnosis in Medicine, RTI International, Co-Chair
JENNIFER CAMPISANO, JD, Attorney and Patient Advocate, Booby and the Beast Blog
MICHAEL DUNNE, PhD, Vice President, Research and Development North America, bioMerieux, Inc.
DAVID GRENACHE, PhD, Professor of Pathology/Laboratory Medical Director, University of Utah
HELEN HASKELL, MA, President, Mothers Against Medical Error
CARLOS HIGUERA-RUEDA, MD, Vice Chair of Quality and Patient Safety, Orthopaedic and Rheumatologic Institute; Assistant Professor of Surgery, Cleveland Clinic
MARILYN HRAVNAK, RN, PhD, ACNP-BC, FCCM, FAAN, Professor of Nursing, University of Pittsburgh

MIRA IRONS, MD, Senior Vice President, Academic Affairs, American Board of Medical Specialties

NICHOLAS KUZMA, MD, Attending Physician, Section of Hospital Medicine; Assistant Professor, St. Christopher's Hospital for Children

PRASHANT MAHAJAN, MD, MPH, MBA, Vice-Chair, Department of Emergency Medicine, Section Chief, Pediatric Emergency Medicine, University of Michigan

KATHRYN MCDONALD, PhD, Senior Scholar and Executive Director, Center for Health Policy and Center for Primary Care and Outcomes Research

LAVINIA MIDDLETON, MD, Deputy Chief Medical Officer and Professor, Department of Pathology, The University of Texas MD Anderson Cancer Center

DAVID E. NEWMAN-TOKER, MD, PhD, Professor of Neurology; Director, Armstrong Institute Center for Diagnostic Excellence, Johns Hopkins University School of Medicine

MARTHA RADFORD, MD, MA, Chief Quality Officer, NYU Langone Medical Center

DAVID SEIDENWURM, MD, Quality & Safety Director, Sutter Health

THOMAS SEQUIST, MD, Chief Quality and Safety Officer, Partners Healthcare System (via telephone)

HARDEEP SINGH, MD, MPH, Physician Researcher, Veterans Affairs Center of Innovation and Baylor College of Medicine

NQF STAFF:

JOHN BERNOT, MD, Senior Director

HELEN BURSTIN, MD, MPH, Chief Scientific Officer

ANDREW LYZENGA, MPP, Senior Director

VANESSA MOY, MPH, Project Analyst

CHRISTY SKIPPER, MS, Project Manager

ALSO PRESENT:

PAUL EPNER, MBA, MEd, Society to Improve

Diagnosis in Medicine

KERM HENRIKSEN, PhD, Agency for Healthcare

Research and Quality

DAVID HUNT, MD, Department of Health and Human

Services

JEFFREY JOPLING, MD, Gordon and Betty Moore

Foundation

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1 P-R-O-C-E-E-D-I-N-G-S

2 8:59 a.m.

3 CHAIR GRABER: Good morning,
4 everybody. Welcome back to Day 2. I think
5 everybody's here. We are going to start a minute
6 or two early, and our job today is very simple
7 and it's going to be a lot of fun.

8 We are supposed to come up with as
9 many measure concepts as we can for the NQF about
10 how to approach this problem of diagnostic error
11 and improving diagnosis.

12 Yesterday was kind of the background
13 that you need to start developing measure
14 concepts and to think about them in a
15 comprehensive way.

16 So what we were planning to do right
17 now is kind of review what we went over yesterday
18 and get you in the mood to start developing
19 measure concepts, see if there is any questions
20 or things you want to expand on that we went over
21 yesterday and get going for the majority of the
22 day on working in small groups to come up with as

1 many concepts as we can.

2 It's very much a brainstorming kind of
3 activity so don't spend a lot of time criticizing
4 other people's concepts. Better to say that's
5 great, that's great, and just get as many as you
6 can on the table.

7 There will be plenty of time to
8 critique these over the next couple months and by
9 the time we are done with all this at our next
10 face to face meeting they will all look much
11 better organized and refined and some of the weak
12 ones will have been weeded out.

13 But our job today is just to get as
14 many as we can on the table. Yeah, can we go to
15 the next slide? Okay. Okay.

16 Good. So I just want to review what
17 we went over yesterday so it will be fresh in
18 your mind.

19 We talked about that diagnosis is a
20 process, and the framework that we were going to
21 work from was this one from the National Academy
22 report that laid out all the steps of the process

1 starting with patient engagement, the big circle
2 where all the - most of the action is in terms of
3 doing a history and physical and thinking about
4 what the possibilities might be, coming up with
5 some initial diagnostic possibilities, maybe
6 ordering some tests, maybe getting some consults.

7 And then some period of time goes by.
8 I put that in red. You know, in the initial
9 diagram you could barely see that time dimension.
10 But it's so important because diagnosis plays out
11 over time no matter what diagnosis you're talking
12 about.

13 And then eventually you come up with
14 some plan of action and you do something and you
15 find out hopefully whether it was a good thing or
16 a bad thing and you learn from it and you may
17 readjust the diagnosis. But it's part of a
18 learning process that plays out over time.

19 I think everybody's pretty confident
20 with working with that at this point. Next.

21 And we emphasize that the process has
22 outcomes. So when you're thinking about outcome

1 measures, keep this slide in mind, and there are
2 patient outcomes - the patient either gets better
3 or they don't - they respond or they don't - they
4 are happy or they are unhappy - they benefit or
5 they are harmed.

6 There are different degrees of harm.
7 There is minor harm, there is temporary harm,
8 there is permanent harm, there is death. So
9 these are all patient outcomes that are relevant
10 and psychological harm should certainly be part
11 of what we are thinking about and there are
12 system outcomes.

13 This process has got a certain
14 efficiency. A certain fraction of patients are
15 diagnosed in a timely fashion or they are not. A
16 certain fraction of patients are diagnosed
17 accurately or they are not.

18 Laboratories have a performance
19 characteristic. They have a certain percentage
20 of tests that are completed on the right
21 turnaround time or within a certain specification
22 of accuracy. So there are system characteristics

1 and system outcomes that we would also like you
2 to keep in mind and would be very appropriate for
3 measure concept development.

4 And for sure don't forget about the
5 learning aspect. Right now, there is no learning
6 or very little learning about diagnostic errors.
7 Health care organizations aren't finding these.
8 They are not hearing about them except if there
9 is a malpractice suit. We would like to have
10 much better ways, more ways, more effective ways,
11 of finding and capturing these diagnostic errors,
12 learning from them and having that learning
13 process be fed back somehow to improve the
14 process so that they won't happen with such
15 frequency going forward.

16 So that learning process is really key
17 and hopefully we will have a lot of measures that
18 focus on that learning and the process
19 improvement.

20 Kathy reminded us that this all takes
21 place in an organization that has certain
22 characteristics. It has certain people with

1 certain skills. The physical environment is
2 important to diagnosis - how many distractions
3 you get per hour. The people that you work with
4 - how many of them are available to help you do
5 things?

6 Can they help you with documentation?
7 Can they help you with researching clinical
8 questions that come up? Are the tools you need
9 available -- the diagnostic tests?

10 Can I get a CAT scan today if I need
11 it, or an MRI? Can I get a consultant on the
12 phone in ten minutes if I need to to consult
13 about a case?

14 So the work system critically
15 determines how successful we are in diagnosis.
16 Definitely keep that in mind, too.

17 And the team members -- so it starts
18 off with that dyad. It's, you know,
19 traditionally the doctor and the patient.
20 They're supposed to be a team, and how do -- how
21 do we get that to happen?

22 Right now, it's usually the

1 paternalistic model of medicine where the
2 physician speaks down to the patient and expects
3 them to just kind of obey blindly.

4 That's not what we want going forward.
5 We want a partnership where the patients are
6 actively engaged in diagnosis, participate in it
7 to the extent that they want to and that they
8 can, and we want to somehow bring the other team
9 members back in to be part of a functioning team.
10 They have, like - they have, like, dissipated.
11 The radiologists are in a room somewhere.

12 We never talk to them. The clinical
13 laboratory staff would be so valuable in helping
14 us understand the best testing algorithm to use
15 or how to interpret a test or to know the next
16 best test to order, and yet we rarely talk to
17 them.

18 We need to bring all these team
19 members back in to much closer collaboration so
20 that they can work for the betterment of the
21 patient.

22 We want to focus on things that

1 matter. So this is a diagram that David
2 emphasized. There is little subparts to that.
3 Can you kind of click through them? Yeah.

4 So we want to focus on that shape in
5 the middle, the football -- preventable
6 diagnostic error.

7 So we want to focus on things that
8 matter -- things that are breakdowns in the
9 diagnostic process somewhere but that affect the
10 outcome and lead to a diagnosis that's delayed or
11 wrong or missed. Those would be the key
12 opportunities there.

13 And we want to focus on things that
14 lead to harm. So this is from Hardeep's
15 presentation that emphasizes, again, that concept
16 of looking at preventable diagnostic harm but
17 harm for sure. That's the target. We want to
18 reduce harm to the extent that we can.

19 And this is, again, from Hardeep's
20 presentation. We want measures that are
21 actionable so that an organization to build them
22 in to their quality improvement program.

1 They could use them for learning, that
2 they would be available for research. We need so
3 much research. You know, there is all these
4 interventions out there.

5 We have no idea which ones work.
6 Having a measurement framework and having measure
7 concepts that would give us some data for
8 research would just be terrific and would be
9 really an essential next step to help improve
10 what we are doing in this domain and we need
11 measures that engage the audience.

12 And who is our audience for these
13 measures? Well, it's a large group for sure.
14 It's the providers, the doctors, the nurses, all
15 the professional staff. The measures have to
16 make sense to them.

17 They have to be able to look at it and
18 say oh, yeah, you know, if we did a good job on
19 that measure that would improve diagnosis in my
20 practice.

21 So they have to have face validity, I
22 think. For sure they have to be recognizable and

1 understandable by patients and actionable by our
2 health care organizations.

3 So, you know, I don't know what the
4 characteristics of an ideal measure are but it
5 would certainly include those elements for sure.

6 All right. So, you know, we want you
7 to focus on all the steps of the diagnostic
8 process but there is other things that we hope
9 you'll keep in mind as you're developing measure
10 concepts.

11 So here is my little list. For sure
12 the six dimensions of quality. So should be
13 safe, efficient, timely, equitable, patient
14 centered, and gold star to whoever can remember
15 the sixth one. Effective. Thank you. That's
16 it.

17 You know, keep in mind that there are
18 certain conditions where diagnostic errors are
19 more prominent and from malpractice claim studies
20 these are the ones that rise to the top of the
21 heap -- cancer, cardiovascular conditions,
22 infections, fractures, trauma.

1 So keep in mind the common things.
2 Try and keep in mind the root causes of
3 diagnostic errors so we are concerned about all
4 the system-related flaws that contribute, all the
5 cognitive shortcomings that we know about and the
6 human factors perspective -- the human factors
7 engineering principles that tie these together.

8 Kerm is like our expert in that and
9 has reminded us that, you know, our performance
10 is just so intricately related to the system we
11 are working in and how well all that works and
12 how it facilitates us or gets in our way. So the
13 root causes are important.

14 And there are some things that aren't
15 in that IOM process diagram that we talked about
16 that we want to include. So screening wasn't
17 really dealt with in that process diagram but
18 it's an important -- certainly a very important
19 item and breakdowns in screening lead to lots of
20 harm from diagnostic error.

21 I mentioned yesterday that failure to
22 get your cancer screening is just way too common

1 a cause of severe harm and, certainly, highly
2 preventable. So please think about measures
3 related to screening but at the same time we
4 don't want inappropriate testing. We want
5 diagnosis to be efficient and there is way too
6 much inappropriate testing at the present time.

7 I have a strong bias against using
8 that over diagnosis term. I don't like it. I
9 don't think it's specific and I don't think it's
10 within our domain.

11 But what is within our domain is
12 inappropriate testing, which is part of the over
13 diagnosis problem. So when I talk about this I
14 think it's great to have measures that address
15 inappropriate testing.

16 I would be much less interested in all
17 the other aspects of over diagnosis. I think
18 that's out of range. At least, that's my
19 perspective.

20 And definitely think about the
21 electronic medical record. It is right in the
22 middle of everything that we do these days. It

1 helps us in a thousand ways and it - you know
2 it's a problem in 2,000 ways.

3 So, hopefully, in 50 years it'll all
4 be figured about but right now we need measures
5 that will help us understand those elements that
6 are beneficial and those elements that are
7 detrimental and how we can optimize the process
8 by taking best advantage of all the resources
9 electronic health records allow us.

10 And please also think about the
11 patient. We also mentioned that that's really
12 not prominently emphasized in that IOM diagram
13 that we started off with.

14 Yeah, they are there. They are there
15 at the start when they engage with the health
16 care system and they are there at the end when
17 they receive the diagnosis.

18 And where are they in the middle
19 there? You don't really get a feel for that from
20 the diagram. But they are there at every step of
21 the process, and as we discussed yesterday, it's
22 appropriate and will be helpful and beneficial to

1 think about that and to involve them to the
2 extent that we can and to the extent that they
3 are willing in every step of the diagnostic
4 process.

5 Particularly, we'd like them to give
6 us better feedback about how we are doing - did
7 we get it right, did we get it wrong, how was
8 your experience in the diagnostic pathway.

9 For sure we'd like them to help us
10 identify diagnostic errors because we are not
11 finding them now and they are in an ideal
12 position to know whether diagnosis worked for
13 them or it didn't.

14 And for sure we'd like them to
15 participate in performance improvement - that
16 learning process that we have been talking about.

17 So those are some of the major places.
18 But definitely they think about every single way
19 that they can be involved.

20 So how can we use measurement to
21 improve patient engagement, but also take into
22 account that some patients will be able or be

1 more willing or more aggressive in participating
2 in their care and some will not.

3 So we have to appreciate where they
4 are at and their level of understanding and their
5 desire to work with us.

6 We do not want to get to the point
7 today of discussion measures per se so we are
8 going to stop at the measurement concept level.
9 So you don't need to worry about well, what is
10 going to be the numerator and what's going to be
11 the denominator and how are we going to figure
12 those things out.

13 That is a topic for another day and
14 probably for other groups. So today we are just
15 going to talk about concepts, not specific
16 measures per se. And I don't think you have to
17 worry too much about filling up every - all those
18 buckets and cubbyholes that we talked about
19 yesterday. The NQF staff will sort all that out
20 when we are gone. If you just focus on what are
21 the good outcome measures, process measures,
22 structure measures, those are the three big

1 buckets that we want you to fill up and we will
2 sort them out into the little buckets over the
3 next few weeks and months.

4 Okay. So let me just pause there.
5 Did that make sense? Do you have comments,
6 questions, concerns about where we are coming
7 from and what we would like to do?

8 MR. LYZENGA: I would also encourage
9 you if you're having - if there is something that
10 you think ought to be measured, you're having a
11 hard time kind of conceptualizing it as a measure
12 or a measure concept, throw it up there anyway
13 even if it's just a question - I think we should
14 measure this, how do we measure that, broad
15 areas. You know, if you're having a hard time
16 sort of making it into a concept or a measure
17 concept put it up there anyway and we can kind of
18 work through it later as well.

19 CHAIR GRABER: Yes, please.

20 MEMBER HRAVNAK: I was just wondering
21 - in some of the conceptual models, as I am
22 looking at them, I keep looking for caseload

1 somewhere and I am wondering are you assuming
2 that it's under one of those other headings and I
3 am just missing it or is it important enough to
4 be called out somewhere specifically?

5 Because we know that it is a very
6 powerful component with error. And I guess the
7 other thing is that's also a very important
8 mitigator for the time continuum because when
9 people say, I don't have enough time, or we are
10 looking at timeliness it's relative to the time I
11 have in distribution across the caseload. So --

12 CHAIR GRABER: Yeah. Thanks for
13 bringing that up. So that's usually talked about
14 in the environment of care. So, you know, what
15 is your workload and your pressure of production.

16 So it does -- you know, that's one
17 place where it comes up. But, you know, we have
18 got time that goes throughout the whole process
19 and workload, you know, plays out at more than
20 one step for sure.

21 So very important. There is a lot of
22 physicians that would say that's the number-one

1 thing that would help with diagnosis. They just
2 don't have enough time to do it, to think, and it
3 takes time to think.

4 So yeah, key area to think about.

5 DR. BURSTIN: Maybe just to broaden
6 that a bit. I mean, I think it's certainly on
7 the physician side and the diagnosis in practice
8 but also, I mean, a fair amount of evidence on
9 nurse staffing and safety and so not forgetting
10 the in-patient side and, obviously, it's not just
11 the docs either.

12 MEMBER HRAVNAK: I was just wondering
13 if it -- if we think it's important enough to
14 actually spell it out somewhere.

15 CHAIR GRABER: Yeah.

16 MEMBER HRAVNAK: Should be a concept.

17 CHAIR GRABER: Okay. Everybody's
18 happy? All right. So here's our -- here's our
19 task for the next two hours. We'd like you to
20 come up with as many concepts as you can in these
21 three buckets - structure, process and outcome.

22 So our recommendation for dividing up

1 your time is that you appoint somebody to be the
2 timekeeper and you spend 30 minutes on each of
3 them.

4 Maybe at the end of the day there is
5 many more concepts in one bucket or the other but
6 at the present time we don't know. So try and
7 spend equal time on those three things.

8 The fun part is the last 30 minutes or
9 maybe you want to work it in somehow in some
10 other fashion. You're welcome to reconfigure.

11 We'd like you to think about one
12 specific disease -- concept measures that would
13 be applicable to a specific disease. And you can
14 pick the disease, but here's how we'd like to
15 divide them up.

16 So in group one - I am in that group -
17 we will pick some disease that's, like, subacute
18 in nature like anemia or asthma or I'm not sure
19 what. We will find something.

20 And group two is Hardeep's group.
21 Hardeep, can you, like, pick some cancer problem
22 to focus on?

1 And the third group - David's in that
2 one - some emergency diagnosis. Something that's
3 got to be diagnosed, like, right now or something
4 really bad will happen.

5 And maybe - I don't know if it's best
6 to do that maybe first because it would help you
7 come up with general things or do it last because
8 you'll have the general things in mind. I don't
9 know. You can work that out internally. But 30
10 minutes devoted to that will be also very much
11 appreciated.

12 When we are done we will get back
13 together. We will take a look at what
14 everybody's come up with and we will try and get
15 your reactions to them and start to prioritize
16 which concepts we think are most important to
17 move forward.

18 So is it clear? Any questions?

19 MEMBER SINGH: So Mark, this is
20 already a nice sort of list here. Do you want to
21 talk about how we --

22 CHAIR GRABER: Yeah. What do -- what

1 do we have available for people?

2 MR. LYZENGA: So we have got that list
3 of some preliminary concepts, which also includes
4 the domains, if that helps, you know, sort of
5 focus your thinking. But as Mark said, don't
6 worry too much about that.

7 We have also, I think, printed out the
8 Safer Dx categories if -- again, if that helps
9 stimulate thoughts or help focus your ideas, and
10 then the diagram of the IOM framework, all just
11 things to sort of get your minds stimulated and
12 help you sort of focus your thinking.

13 But don't worry about fitting things
14 into any of those categories. That's just to
15 give you ideas.

16 MEMBER SINGH: So as a group should we
17 look at these and say hey, this one looks really
18 good -- let's consider that, put it in our bucket
19 --

20 MR. LYZENGA: Sure.

21 MEMBER SINGH: -- or this one will not
22 work.

1 MR. LYZENGA: Sure, or if you have
2 like a tweak that - tweak you want to make or
3 something that's --

4 MEMBER SINGH: A tweak or something
5 that's based on this? Okay.

6 MR. LYZENGA: Yeah, really a measure
7 -- an additional one or anything that.

8 CHAIR GRABER: There will be a member
9 of the NQF staff with each of the groups to help
10 take notes. So that's taken care of. And where
11 should we go?

12 MR. LYZENGA: Here is a list of the
13 groups. We kind of assigned people out, if
14 that's all right. I think we could probably just
15 congregate in kind of corners of the room. Maybe
16 we could put one group over here, say, group one
17 over here, group two and then somewhere toward
18 the back of the room over there, group three.
19 Oh, back there? Is that better? All right.
20 Group three back there. So yeah, here, there --
21 group one, group two, group three.

22 CHAIR GRABER: Okay.

1 MR. LYZENGA: Does that all make
2 sense?

3 DR. BERNOT: Just one thing, Andrew.
4 For David and Kerm, you're not on these but feel
5 free to join the group. I know, for example,
6 group three's down a person without Tom. So,
7 certainly, if one of you can join that. But it
8 would be good to get your input. Oh, okay.
9 Perfect. That works also.

10 (Whereupon, the above-entitled matter
11 went off the record at 9:20 a.m. and resumed at
12 11:46 a.m.)

13 CHAIR GRABER: So the general plan is
14 to have lunch in about a half hour and to show
15 you the results from group one before lunch and
16 do the other two groups after lunch.

17 We need just a few minutes to organize
18 all the ideas that came out of our group. Any
19 initial reactions to how your group went or how
20 this process went or how we could do it better?

21 Was it helpful to consider a specific
22 disease or was that -- did that get in the way?

1 That's good?

2 MEMBER MCDONALD: It was kind of fun.

3 CHAIR GRABER: Kind of fun?

4 MEMBER MCDONALD: Yes.

5 CHAIR GRABER: Good. As opposed to
6 really fun, right? Okay. Well, let me just get
7 started a little bit with our group.

8 We were the group that was -- that
9 were supposed to pick a disease entity that was
10 neither an emergency nor cancer. We settled on
11 child abuse because Prashant was in our group and
12 it's a big problem in pediatric emergency rooms,
13 and it raised some interesting concept questions
14 for us as we were trying to think through what
15 might be relevant to that specific disease or
16 that kind of disease.

17 The first thing that came up was often
18 in diagnosis you try and generate a general story
19 -- a general history from all the people there.
20 So you'll talk to the patient and the family, and
21 you try and synthesize everything into one
22 coherent history.

1 But in cases of child abuse, it's very
2 important to get independent histories from the
3 different players and it just --- I don't know if
4 that's unique or how unique it is, but it's
5 certainly different, and I don't know if it
6 generates a concept or not, but it's relevant to
7 the quality of diagnosis that in that particular
8 case you have to talk to everybody and do it
9 independently so that things don't blend
10 together.

11 Another thing that came out of that
12 discussion was the problem of uncertainty in
13 diagnosis. Right now we don't have a good way
14 of designating uncertainty.

15 Oftentimes, clinicians will just check
16 a box == ICD code, whatever it is -- and that's
17 what you're forced to do because the clinical
18 rules require that you bill for that care that
19 you provided. But that labels a patient
20 prematurely before you know with any certainty
21 what they have, in some cases, and that that
22 would be particularly inappropriate in cases of

1 child abuse because the consequences of labeling
2 a family as one that's where child abuse is a
3 problem are severe and you have to take
4 definitive action and remove the child from that
5 situation.

6 So we were hungering for a way to
7 designate uncertainty and a concept around that,
8 but we didn't quite succeed.

9 Does anything come to mind in terms of
10 a concept for how it would improve diagnosis to
11 be able to capture uncertainty or to designate
12 uncertainty?

13 MEMBER NEWMAN-TOKER: Sure. I mean,
14 you could have a structural measure that says
15 whether there is a structured data field in your
16 electronic health record that allows you to code
17 the stage of the diagnostic process like, you
18 know, is this differential diagnosis, tentative
19 diagnosis, working diagnosis or final diagnosis.

20 CHAIR GRABER: So that would be the
21 structure thing and then the process thing where
22 do people use it --

1 MEMBER NEWMAN-TOKER: Do people use
2 it, yeah.

3 CHAIR GRABER: - and for what
4 situations is it most appropriate?

5 MEMBER NEWMAN-TOKER: Yeah.

6 CHAIR GRABER: Yeah. Thank you.
7 Good.

8 DR. BURSTIN: This might be a good
9 place for David to make a comment as well --
10 David Hunt, the other David -- just because I
11 think some of these may not really be measures,
12 but they could wind up being standards for EHRs.

13 And so David thought that was fair
14 game. So some of these elements, again, you
15 wouldn't want to necessarily create new measures
16 on things that are basically structural elements
17 in the EHR. So I just want to at least put that
18 on the table.

19 MEMBER SINGH: So we actually
20 discussed it in our session in our group as well.
21 There is a couple of things. So one is there is
22 no ICD-9 code or ICD-10 code for uncertainty.

1 I think we need to sort of influence
2 the field in which to capture uncertainty at
3 billing and coding levels so that you can
4 actually get reimbursed for a visit where you
5 talk to the patient about a lot of things and the
6 diagnosis was still uncertain. I mean, we are
7 labeling people with a diagnosis they don't have
8 because you don't know what to put, for instance,
9 in a requisition form for an imaging test.

10 MEMBER RADFORD: Canada has diagnosis
11 not yet made.

12 MEMBER SINGH: Yeah. Yeah.

13 MEMBER RADFORD: It's there but it's
14 not - yeah.

15 MEMBER SINGH: Yeah, exactly. So -

16 MEMBER RADFORD: So, you know, we can
17 - we can learn from Canada.

18 MEMBER SINGH: Yeah. So that's one
19 sort of major policy implication and we sort of
20 put that and recaptured that.

21 Second thing was we actually just
22 finished a narrative review, which is still under

1 review, but I can sort of send a confirmation
2 copy to you all.

3 But essentially the measurement
4 methods around uncertainty are very under
5 developed, and what we found was there is ways to
6 get to it.

7 For instance, you can look at a
8 medical record and look for ways such as maybe,
9 probably, likely, could be -- you know, all of
10 those narrative terms that capture, and there
11 could be electronic methods to do a linguistic
12 analysis of the note to capture uncertainty
13 within the note, and we talked about that for
14 radiology and pathology as well.

15 And then another measure could be what
16 we call sort of this shotgun testing. Somebody
17 comes in with a new symptom or a new complaint
18 and you just order a whole lot of tests, like
19 more than five types of different lab tests along
20 with an imaging test or, you know, and that could
21 be another measure of potential uncertainty.

22 A fourth one would be potential

1 differential diagnosis documentation. So we have
2 got a nice differential diagnosis documentation
3 that also expresses uncertainty, which is also
4 maybe a good thing that you're thinking about it.
5 So those are the four that, I think, we discussed
6 and --

7 MEMBER KUZMA: Oh, Nicolas. Yes. I
8 was just going to -- that jogged my memory.
9 Actually for child abuse on the ICD-10 codes,
10 it's a spectator-confirmed child abuse is what
11 you enter in for them. So you do have that level
12 of I am suspicious of this or this is definitive.
13 There is two separate codes that you bill for
14 that. So that's one rare situation where that's
15 kind of built into the ICD-10 code already.

16 CHAIR GRABER: We generated over a
17 hundred discrete ideas, which is way too many to
18 show you. There were some that, you know, people
19 said oh, that's good -- let's -- that should lead
20 to a concept.

21 So we are just going to show you that
22 group and it's about, I don't know, eight or nine

1 and we'd like to get your reactions. What I'd
2 like to ask you to do as you -- as we go through
3 this for each of the groups is to jot down a
4 concept that you really like so that at the end
5 of the day I would like everybody to, you know,
6 have an idea -- here's one or two things that I
7 really thought were terrific and should be headed
8 towards a concept. And not everything we are
9 going to show you is going to meet that bar, but
10 maybe some of them will.

11 So we are going to be reviewing the
12 ones that are in purple, if we can figure out a
13 way to see them. Okay.

14 Can people see that? Okay. So one
15 concept was that the electronic record should
16 support the diagnostic process, which is, I guess
17 really at a very general level.

18 I am guessing each of the groups help
19 refine that a little bit. Yeah?

20 PARTICIPANT: Well, we didn't talk
21 about that one much.

22 CHAIR GRABER: I find that hard to

1 believe. Okay. So let's leave that for other
2 groups. You spent some time on that I am
3 guessing, right, Hardeep?

4 MEMBER SINGH: No, not that --
5 seriously not that much. We were just sort of
6 talking about other stuff. But it looks like a
7 nice concept. I think it's way too high level to
8 be any useful -- anything useful in the future
9 unless we fix it now --

10 CHAIR GRABER: Yeah.

11 MEMBER SINGH: -- in terms of what is
12 it we are trying to get at.

13 CHAIR GRABER: Right. So let's spend
14 a minute on that. What specific ways could the
15 electronic record support the diagnostic process
16 better than it does now?

17 MEMBER SINGH: So we did do that. We
18 did review some measure concepts around
19 documentation such as, you know, copy-paste,
20 excessive use of templates and we even went to
21 the extent of proposing sort of measurement
22 concepts around OpenNotes where patients could

1 actually report -- there was just a recent study
2 where a patient could actually report
3 documentation-related diagnostic issues with the
4 notes based on OpenNotes. So I think we need to
5 get down to a little bit of specificity as to
6 what part of the diagnostic process -- is it --

7 CHAIR GRABER: Those are all good.

8 MEMBER SINGH: - interruption? Is it
9 communication of test results? Is it
10 communication of referrals? What is it that we
11 are trying to support? We can't do - this is
12 like saying we need technology to improve
13 diagnosis.

14 MR. HENRIKSEN: Yeah. It could be
15 navigational ease of pulling up diagnostic
16 information. I mean --

17 CHAIR GRABER: Right. And
18 interoperability comes in there. You really
19 need the information from everywhere to be
20 effective at diagnosis.

21 MEMBER NEWMAN-TOKER: So just one
22 comment on this. I agree with Hardeep that this -

1 - at this some level this feels like it's just
2 way too high altitude. Although one could
3 imagine a measure that was sort of a general
4 survey type measure of employees at a health
5 system or hospital saying, does your electronic
6 health record support the diagnostic process and
7 getting a percentage or a score or something like
8 that.

9 Well, it would give you an indicator
10 of whether people thought that it was
11 facilitating -- I mean, you would -- you could --
12 you'd have to phrase the question differently.
13 You'd say, you know, does it help you prevent
14 diagnostic error and improve diagnostic
15 performance, and that might give you something.
16 I don't know. I am just --

17 MEMBER SINGH: I think most clinicians
18 would say no, that it doesn't help.

19 MEMBER NEWMAN-TOKER: Yeah. But the
20 other thing is --

21 MEMBER SINGH: We know that already
22 though.

1 MEMBER MCDONALD: Actually, there is
2 a --- there is a good measure, like, for office
3 chaos, like calm versus chaos. It's one scaled
4 measure. It's possible that there is something
5 kind of analogous here where it's -- you know,
6 does the -- does your electronic health care --
7 health care record kind of create more, you know,
8 like an easier way of doing diagnosis or harder
9 and it's just, you know, a scale of easier to
10 harder, and it's possible people could answer
11 that. That could be tested.

12 MEMBER SINGH: So I have one
13 suggestion in this -- I have one suggestion in
14 this area. So AHRQ is developing health IT
15 safety supplement questions to their patient
16 safety culture survey, and I am wondering what
17 those questions are, and if there are a few
18 questions that could influence still -- I don't
19 know what stage the project is at. You know,
20 there could be one around diagnosis-related
21 safety culture or related issues, you know.

22 MR. HENRIKSEN: That's under

1 consideration, yes.

2 MEMBER SINGH: You have something on
3 the way then hopefully.

4 CHAIR GRABER: David.

5 MR. HUNT: It's under consideration.

6 MEMBER SEIDENWURM: So the -- so the
7 electronic record can support the diagnostic
8 process either by facilitating it or by not
9 standing in the way of it. And so I think that
10 we need to address this really, you know,
11 vigorously in a two-pronged fashion.

12 The ways in which the electronic
13 medical records as they are currently constituted
14 impede the diagnostic process is by producing an
15 enormous cognitive burden on clinicians who are
16 trying to make very complex decisions. So while
17 they are toggling between and among screening and
18 while they are toggling between and among the
19 different cognitive domains, they are also trying
20 to, you know, think very complex thoughts and
21 just as they tell us, you know, not to use flash
22 photography at Cirque du Soleil because it might

1 distract the performers, I think that we are
2 doing the equivalent to physicians and subjecting
3 them to flash photography as they are, you know,
4 attempting to, you know, perform the triple flip
5 on the high wire. Okay. So I think that's the
6 first thing, and so we need to have screens that
7 do not present us with a blizzard of information.
8 We need to have things that are appropriate in
9 physical and conceptual scale to the task at
10 hand. We need not -- we need to have to not go
11 between verbal memory and visual spatial memory,
12 you know, a million times a second. So I think
13 that's the first thing is we need to have systems
14 that don't impede us as we do these things.

15 The second thing we need, I think, are
16 systems that facilitate diagnosis. So, you know,
17 when we want toast, you know, we put the bread in
18 the slot and we push down the lever because there
19 is a device that captures our need.

20 And so in the same way when we want to
21 make a diagnosis, if -- you know, cough -- then
22 something should come up with cough and, you

1 know, the chest -- any other chest x-ray reports
2 that the patient -- I mean, I don't know, you
3 know, what it would be.

4 Any cultures the patient has had, any,
5 you know, are there risk factors, whatever it is,
6 you know, should come up in a way that's
7 presented in a -- in a soundly designed fashion,
8 and we are not getting that.

9 So we need -- we need systems that
10 don't prevent us from thinking, and we need
11 systems that help us think. And industry knows
12 how to do this, right? I mean, we all -- we all
13 have such objects in our pocket. Why can't we
14 have them in our hospitals?

15 CHAIR GRABER: Martha, and then Helen.
16 Martha, go ahead.

17 MEMBER RADFORD: I just wanted to
18 comment that this came up when it -- you know,
19 basically as kind of an observation that the EHRs
20 are set up for billing and not for care and, you
21 know, I think that David's workflow suggestions
22 are most excellent.

1 MEMBER HASKELL: Okay. I just wanted
2 to reiterate my point that patient input is
3 critical. I think technology is the key way that
4 you can get patient input into diagnosis. So
5 people can put in -- correct misperceptions, put
6 in changing symptoms. They can add in a lot.

7 And then the other thing, we -- and
8 this is me speaking from a totally naive
9 perspective -- but we had a discussion of red
10 flags and why the electronic medical record
11 couldn't flag things that need attention.

12 It seems to me that wouldn't be so
13 hard to do. I think Google, as you pointed out,
14 already does it in other areas. But so you say
15 great weight loss between appointments or
16 symptoms that taken together could be troubling.
17 I don't see why that couldn't be -- electronic
18 medical record couldn't just flag that.

19 CHAIR GRABER: Those are two good
20 ones. EMR should highlight red flag conditions,
21 and it should allow patients to contribute.
22 Thank you. Marilyn.

1 MEMBER HRAVNAK: So I was just
2 thinking that maybe process is just too broad of
3 a word. Maybe because, you know, it helps the
4 availability of information, but I think it
5 doesn't always facilitate clinical decision
6 making.

7 So maybe the electronic record
8 supports diagnostic decision making or
9 facilitates diagnostic decision making might get
10 a little bit closer to what we mean.

11 CHAIR GRABER: Good. Thank you.
12 Mira.

13 MEMBER IRONS: Yeah, I am just
14 thinking in terms of I agree that process may be
15 too broad. But I wonder if there could be
16 language that talks about the electronic records
17 supports communication between the patient and
18 other members of the team that actually allows
19 for focusing of the encounters that occur. There
20 are two communities now -- cystic fibrosis and
21 inflammatory bowel disease -- that have disease
22 specific EHR portals, where patients actually put

1 in information prior to a visit that allows the
2 doctor to then just focus on the problems that
3 they've identified and not go through everything
4 else that we have to do for compliance reasons
5 that ends up optimizing that visit and the EHR
6 actually facilitates that by allowing input from
7 the patient, the doctor, other clinic staff.

8 CHAIR GRABER: Good. Thanks. Martha,
9 did you have something else?

10 MEMBER RADFORD: No.

11 CHAIR GRABER: No problem. Okay. So
12 let's move on. The second item there is
13 appropriate staffing ratios and mix, and our
14 concept there was when a patient comes in with a
15 problem, institutions need to have thought about
16 how that patient's going to be triaged and
17 whether they have the appropriate mix of staff
18 and the appropriate number of staff in the
19 particular areas to handle that. And, of course,
20 that's going to vary tremendously from small
21 hospitals to big hospitals and private settings.
22 But thought needs to be given to how you're going

1 to handle different diagnostic problems and
2 whether you have on site or available appropriate
3 staff to take care of that problem. Prashant.

4 MEMBER MAHAJAN: Mark, if I can just
5 add. So where this came up was this concept of
6 which from the pediatric world that is the sole
7 concept of pediatric readiness for emergencies
8 and what they found out when they did a national
9 survey of all the hospitals across the country,
10 it came up that close to 70 or 80 percent of the
11 institutions are just not ready to handle
12 pediatric patients. By that, not only was the
13 training not adequate but the equipment -- like
14 pediatric-sized equipment.

15 So that was one approach, sort of a
16 pediatric readiness. So an extrapolation would
17 be an institutional readiness for seeing patients
18 that they are expected to see. So, for instance,
19 if they are seeing pediatric patients, geriatric
20 patients, then the institution is geared in all
21 concepts -- training, equipment, et cetera, from
22 that. So that's how we became after that.

1 CHAIR GRABER: Any other comments on
2 that one? Hardeep.

3 MEMBER SINGH: So I, again, would
4 suggest focusing this a bit better on diagnosis
5 and risk like we discussed yesterday. So what's
6 sort of the risk here? Why do we want this?

7 We want to -- I am guessing --- I am
8 just giving, for example, if I am a patient, I
9 started having some new problem today, I want to
10 try to get in to see somebody.

11 So I am not sure whether you can just
12 have such a measure for all types of care which,
13 you know, include chronic care and, you know,
14 multiple other types of things. But I would say
15 you need to have some capacity to see patients on
16 an urgent care basis if they have new problems
17 and most institutions or many institutions will
18 not have as much capacity as they think they do
19 when patients often have to wait, you know, five
20 days, six days to see a patient. So I don't
21 know, can you sort of modify that a little bit
22 for, you know, urgent conditions?

1 CHAIR GRABER: Yeah. Sure, it needs
2 more thought. It came up in our group
3 particularly in regard to child abuse because you
4 need some specialty expertise. You need
5 pediatricians who know that syndrome. You need
6 expertise in the medical conditions that mimic
7 child abuse. You need social work services. So,
8 you know, have institutions thought that through
9 to the extent that they'd be able to
10 appropriately triage and handle those kinds of
11 cases.

12 MEMBER SINGH: So would --

13 MEMBER RADFORD: It also came up in
14 discussing that it takes time to make diagnoses.
15 It takes thought. It takes all those things and
16 that, you know, one of the things came up was
17 that -- not related to child abuse but other
18 diagnoses on the -- in the outpatient setting
19 that if a provider is expected to see 80 patients
20 in a day, then their ability to make diagnosis is
21 very clearly compromised so that that kind of
22 staffing needs to be more explicit perhaps.

1 MEMBER SINGH: So just to have a more
2 explicit measurement concept around time or --

3 CHAIR GRABER: Yeah. Yeah.

4 MEMBER SINGH: -- number of patients
5 per day or caseload, or something else?

6 CHAIR GRABER: Yeah, we talked about
7 capacity yesterday. You need capacity. You need
8 time to think, and that's worthy of a measure or
9 concept, although we didn't quite capture it
10 here.

11 Okay. Let's move on. We are going to
12 skip the next one because I don't recall what we
13 said about that. But let's talk about feeding
14 things up to the board, which I think is an
15 important thing. There needs to be -- our idea
16 here was that there needs to be some way for
17 diagnostic quality and safety to become something
18 that the board hears about and the leadership of
19 the organization knows about and considers and
20 addresses. Any reactions to that one? Martha.
21 No? No? Okay. No problems.

22 MEMBER MCDONALD: We had -- we had one

1 that was a little similar. We were talking about
2 kind of how hospital boards or other
3 organizations' boards might be, you know, having
4 agenda items and being - responding to, you know,
5 peer review issues, malpractice issues. So we
6 were - we were trying to think about that one. I
7 would just endorse that another group is
8 interested.

9 MEMBER SINGH: Yeah, and I -- yeah, we
10 would just say what kind of diagnostic
11 performance data. So when we thought about what
12 kinds, like, now it was the things that are
13 readily available at the institution such as peer
14 reviews, patient complaints, malpractice claims.

15 So just involving the board in
16 diagnostic performance itself is a good
17 measurement and concept but what safety data do
18 you want to show them and that's when we came up
19 with some specifics.

20 MR. LYZENGA: We also just said: does
21 the organization have a recurring board agenda
22 item for diagnosis?

1 CHAIR GRABER: All right. So the
2 members of my group are going to have to help me
3 with this one. Evidence-based interview tool to
4 record medical ailments -- I am not recalling the
5 thought there.

6 MEMBER RADFORD: Well, this had to do
7 with the fact that to make a diagnosis that --
8 taking, obviously, a history and doing a physical
9 is key, and that we felt that interview
10 techniques may need some support because they may
11 not be optimal -- you know, where there is a lot
12 of examples of failure to take a good history or,
13 you know, that kind of thing and just put -- just
14 sort of put that in.

15 CHAIR GRABER: Yeah. So thank you,
16 Martha. It's coming back to me. So I think we
17 talked about, for example, if you come in to an
18 ER with chest pain, most hospitals have a nice
19 algorithm -- a pathway that you go through -- and
20 that that helps standardize the process and
21 reduce variability and reduce diagnostic errors.

22 So shouldn't there be more of those

1 for more conditions? Is that kind of where we
2 were headed?

3 MEMBER RADFORD: Well, also just
4 interview techniques, more generally. I mean, we
5 were talking also at dinner last night around
6 taking a good medication history and there is
7 been these techniques that have come up about how
8 to do that more better than we're doing now and,
9 you know, it just was something to think about as
10 a structure measure, is that in place in an
11 organization?

12 CHAIR DANFORTH: I think it's a way to
13 really validate the importance of the information
14 that you can get from the patient, which is
15 something we have talked a lot about yesterday
16 and in our group today, right.

17 And so when we say getting correct
18 information from the patient is really important
19 then using evidence-based ways to get that
20 information, you know, to have the support.

21 MEMBER SINGH: So just to clarify, how
22 is that a sort of a -- how do you operationalize

1 that into a measurement concept?

2 CHAIR GRABER: You could say pathways
3 exist for the top 10 complaints that you see in
4 your setting, you know, the diagnostic --

5 MEMBER RADFORD: Or you could say
6 staff received or staff and medical staff -
7 including medical staff received instruction on
8 interviewing techniques. I mean, anything is
9 possible.

10 CHAIR GRABER: Yeah, Carlos.

11 MEMBER HIGUERA RUEDA: You can -- some
12 hospitals have different needs and you just can
13 let them decide what are those needs, but the
14 measurement is to be sure that they facilitate it
15 and they put that system in place to have the
16 providers to get together and say that we need to
17 be aware of A, B and C. So they have a protocol
18 for the most common conditions. I mean, they
19 will know what are the things that they need to
20 take care of.

21 CHAIR GRABER: Yeah. Thanks. David.

22 MEMBER GRENACHE: Our group touched on

1 this briefly, too, but in the -- in the realm of
2 competency. You know, this might be more of a
3 process, but what is used by health care systems
4 to demonstrate that care providers are competent
5 to perform specific skills as it relates to
6 diagnosis.

7 CHAIR GRABER: Good. The next one was
8 a discussion that -- I think this was structure -
9 - that our electronic records systems should be
10 able to capture the chief complaint, should
11 capture key points along the diagnostic process
12 and the final diagnosis so that you could use
13 those things to study timeliness and accuracy and
14 -- yeah, the next line is separate. So the
15 concept there is to better capture those key
16 things. Comments on that?

17 MEMBER NEWMAN-TOKER: I think that's
18 a really important thing for us to be monitoring.
19 I don't know whether it ends up as standards for
20 the EHR or whether it ends up as a measure. But
21 I think this idea, and I think it has to be
22 capture and retains because the -- the chief

1 complaint or symptoms -- and it has to be in a
2 standardized format like ICD-coded symptoms or
3 the CDC's reason for visit-coded symptoms, so
4 that it's not a disaster to compare across
5 settings and providers because right now if you
6 have a chief complaint pick list in Epic, it's
7 sort of configured for all your local or
8 departmental or whatever specific desires and
9 then it's not comparable across the institution.

10 MEMBER HASKELL: What do you mean by
11 patient diagnosis on here?

12 CHAIR GRABER: Yeah. David -- David
13 Hunt.

14 MEMBER RADFORD: Sorry. There is --
15 a chief complaint -- there is a working
16 diagnosis. There is a differential diagnosis and
17 eventually there is a final diagnosis -- all of
18 those.

19 MEMBER HASKELL: And the outcome?

20 MEMBER RADFORD: Well, outcome is a
21 different issue. This is documentation about the
22 diagnoses. The outcome of the diagnoses -- I

1 mean, maybe the final diagnosis is an outcome of
2 the diagnostic process. But, you know -- yeah.

3 CHAIR GRABER: David, and then
4 Hardeep.

5 MR. HUNT: What I am hearing again and
6 again as far as the EHR is issues around
7 usability of the EHR -- that there is got to be
8 support along the interface for -- but also
9 cognitive support. So two different areas.
10 That's just the theme that I am hearing.

11 MEMBER SINGH: Again, I would sort of
12 just build on that. This is -- I was thinking --
13 I think making this a bit more sort of specific
14 because if you look at this, I think the EHRs are
15 trying to do this already.

16 So what's sort of new here? I wasn't
17 there. I mean, most -- I mean, EHRs capture -- I
18 mean, you either write a free text or you click a
19 checkbox about what the chief complaint is.
20 Already we do that, and what do you mean the
21 whole process of diagnosis is when you mean tests
22 and procedures? Well, EHRs are supposed to have

1 that data anyway. I mean, there is a whole
2 policy around it.

3 CHAIR GRABER: I think there is a lot
4 of variability.

5 MEMBER SINGH: So there may be a way
6 So if you want to just capture chief complaint
7 they can, but I know Epic does this. VA, you can
8 just write chief complaint in a text. I mean,
9 what's the -- you either have a box or you have
10 text. You can do one or the other in most EHRs.

11 MEMBER NEWMAN-TOKER: Well, so it's
12 the standardization piece that is really key to
13 being able to actually track these issues in and
14 around your institution and across institutions.
15 So I think what we need is not only the ability
16 for somebody to free text their way into a chief
17 complaint field, which is fine, but they also
18 need to be able to provide in some kind of
19 structured data format what it is and then they
20 just save that. It can't just be something that,
21 you know, people have to divine from the records.

22 MEMBER SINGH: So if you want to say

1 EHRs capture chief complaint in structured
2 fashion, that's different from saying what it is
3 now. But I might say -- I still then would not
4 be sure what whole process of diagnosis and
5 patient diagnosis is. I mean, I am -- sorry, I
6 am being a little bit of a, you know, challenge
7 here. But I don't understand this, and I study
8 this area so --

9 MEMBER MAHAJAN: So Hardeep, actually
10 the point is I -- you know, I was also trying to
11 think about how do we eventually do this. So
12 where it struck me was, like, a forcible
13 function. Not necessarily standardization of the
14 wording but if force function -- and maybe I've
15 being naive here -- but somehow that before you
16 move on to ordering a test -- say, for instance
17 -- you have to put a list of differential
18 diagnosis, like a force function.

19 So what the - the discussion was that
20 if there is a way to capture the thought process
21 on how it is documented in the EHR -- like what
22 were the differentials, why were the tests

1 ordered -- then this would be one way to capture
2 that. And maybe this may not be the right thing
3 but I am ---

4 MEMBER SINGH: So maybe - I think what
5 you're getting to is some EHRs there is too much
6 of structured data collection. It's checkbox,
7 checkbox, checkbox, and maybe we will want to say
8 that it should be a balance between narrative
9 text of thinking reflection on what the
10 clinician's thinking or a reflection on what the
11 clinician is thinking, versus some structured
12 data entry for some critical elements such as
13 chief complaint. That would be a lot more sort of
14 logical than -- you know, and that could be
15 measurable because you could see how much
16 structure in there if data exists in a note or in
17 an EHR.

18 MEMBER MAHAJAN: So at this time,
19 should we then think of a balancing -- or this is
20 not the right time -- but a balancing measure to
21 this one in a sense because it could be that
22 there could be a medical legal implication of

1 certain documentation. So should we be thinking
2 of that now or not, or put it in the parking lot?
3 Because some of this may have a flip.

4 CHAIR GRABER: Mike, and then David.

5 MEMBER DUNNE: Yeah. Central to what
6 this form wants to do is the ability to define a
7 missed or inappropriate diagnosis, and if you
8 cannot track the process from start to finish, if
9 the working diagnosis displaces the initial
10 diagnosis, or the final diagnosis displaces or
11 modifies the working diagnosis, you never have a
12 -- you never have a paper trail of how things
13 went, what the logic of the thinking was along
14 the entire process.

15 So if you want to take the final
16 diagnosis for review and say where might this
17 have gone in the wrong direction, you need to log
18 and retain each of those steps and then be able
19 to review it.

20 That also filters back in through what
21 we call a feedback improvement loop because now
22 you can involve the entire team when there was a

1 deviant diagnosis and say where did the process
2 go wrong.

3 And unless you maintain that and force
4 that step, you know, force a log on these
5 different phases, you're never going to capture
6 it.

7 MEMBER SEIDENWURM: I am just sort of
8 digesting what Mike said. That's correct. A lot
9 of times the EHR goes back and retrospectively
10 changes things, you know, that were not
11 reflective of information at the time and maybe
12 that gets to something that was said earlier
13 about, you know, potential med-legal
14 implications.

15 But the point that I was going to
16 make, which I think is a great deal less
17 important than the two other points that were
18 made in between, is that although the EHR is
19 supposed to have this information available to
20 the clinician it does not present it in an
21 affirmative fashion. The clinician has to search
22 for it and I think that there are enough sort of

1 known patterns of clinical reasoning and clinical
2 problem solving that perhaps these could be more
3 - I don't know if it's deeply or superficially
4 embedded in the system so that they, you know,
5 would present the relevant information or the
6 relevant questions or the relevant appliance for
7 that person.

8 CHAIR GRABER: Yes, organize it better
9 and facilitate the process. Good. Let's move
10 on. We talked about updating the board. What
11 else do we have?

12 Okay. There needs to be
13 interoperability and available past records -
14 kind of obvious. We talked about uncertainty.

15 So this is about appropriate
16 screening. We were saying that we haven't been
17 talking much about behavioral health disorders
18 the last couple days. So appropriate screening
19 for this and for many other instances where
20 appropriate screening should be done would be, I
21 think, a very good concept. I am guessing the
22 other groups talked a little bit about screening.

1 David.

2 MEMBER NEWMAN-TOKER: I just think at
3 this level of granularity or abstraction the - in
4 terms of the measurement concepts I think we
5 should stay away from calling out specific
6 diseases or conditions.

7 I think the idea of having a measure
8 of compliance with appropriate screening across
9 important conditions, recognizing that child
10 abuse may be important, depression may be
11 important and cancer may be important, whatever,
12 but that it - the measurement concept is
13 essentially compliance with appropriate
14 screening.

15 CHAIR GRABER: Yes. Back it up a
16 little. Good. David, and then Prashant.

17 MEMBER SEIDENWURM: So in our group we
18 did talk about the issue of appropriate mental
19 health diagnoses along with physical, if you want
20 to call it that, diagnoses and the role that the
21 appropriate diagnosis of mental health conditions
22 can alter the feasibility of certain treatment

1 algorithms or diagnostic algorithms in particular
2 patients and then, conversely, the false positive
3 diagnosis of mental illness can also result in
4 impediments to the diagnostic process and they
5 are both, I think, way too common and they are
6 both unhelpful to the patient. So I think that,
7 you know, I agree with what Dave said about, you
8 know, not being too disease-specific but, I mean,
9 we are not saying - we didn't say depression or
10 schizophrenia. You know, we just want to make
11 sure that the patient - and this gets to the
12 whole idea of patient communication, patient
13 understanding, patient's ability to act on the
14 diagnostic information. So we thought that was
15 important. Yes.

16 CHAIR GRABER: Good. David, did you
17 have more comments? Okay. So our last one -
18 it's not purple. But we talked about the value
19 of being able to find triggers that would
20 facilitate learning about diagnostic error.

21 So, for example, we need better ways
22 to screen readmissions to detect possible

1 misdiagnosis from the prior admission. So this
2 is, perhaps over specified but the general
3 concept is kind of endorsement of the idea of
4 using triggers to facilitate learning about
5 diagnostic errors.

6 So I am guessing, Hardeep, you're in
7 favor of that one. David?

8 MEMBER SEIDENWURM: Yes. Yes, we came
9 up with a bunch of examples of this that, you
10 know, readmission would be a great one. We
11 talked about, you know, a cancer being discovered
12 at surgery. We talked about, you know, 17 office
13 visits before an asthma diagnosis and, you know,
14 there are problems with the individual ones we
15 talked about - you know, multiple imaging studies
16 before a cancer diagnosis. We talked about a lot
17 - you know, there - you know, we have to learn
18 more about the exact, you know, predictive value
19 of these various administratively determined
20 indicators. But yes, we - I think our group
21 spent a fair amount of time trying to be creative
22 on this topic.

1 MR. LYZENGA: There were also a couple
2 from our group on things like poly pharmacy as an
3 indicator - potential indicator of misdiagnosis
4 or similar things to that.

5 CHAIR GRABER: David, and then
6 Hardeep.

7 MEMBER NEWMAN-TOKER: So I guess - I
8 think it's absolutely critical that institutions
9 need to be able to use these kind of - revisit
10 readmission, changing status of care kind of
11 measures to inform their understanding of
12 diagnosing performance.

13 The question is what are - what is the
14 measurement concept there that it's a disease-
15 specific rate of unplanned revisits or
16 readmissions? Is that the measurement concept?

17 CHAIR GRABER: Well, just speaking for
18 the group, I think we were thinking more about
19 how valuable it would be to start using
20 administrative data of facilitate learning.

21 MEMBER NEWMAN-TOKER: Well, I think
22 that that's critical. I think how that gets

1 turned into a measure is sort of an interesting
2 idea. But I think at some - and there are lots of
3 different ways you could do it, right? You could
4 say as a structural level is this available at
5 your institution to be able to do this. It's a
6 process level - do you actually do this for the
7 top 10 - because these are the complaints. And
8 as an outcome measure, you know, you could do
9 kind of the deeper analytic dives.

10 I think here the main thing that we
11 should try to do is avoid tying ourselves too
12 much to the nuances of the metric. Like, so I
13 think, you know, triggers is one way - that is,
14 to look for things that prompt chart review but
15 that direct analysis of data is another way. So
16 I think that there is - there are multiple ways
17 you can get to this issue of using readily
18 available administrative data to track diagnostic
19 errors.

20 MEMBER RADFORD: Yes, and specifically
21 our group was - I mean, my personally - I am
22 lateraling this right back to CMS, who has access

1 to everything about Medicare patients and I wish
2 I could hear from them when someone shows up at,
3 you know, another hospital with a new diagnosis
4 so that I can then investigate what happened and
5 make sure. So payers, too. I mean, I guess -
6 what is it, the payers are starting to do this as
7 well.

8 MEMBER NEWMAN-TOKER: So on that
9 point, our group did bring up specifically this
10 issue of regionalized feedback and the critical
11 nature of that sort of closing the loop when
12 people leave your health system and that in and
13 of itself is probably a market of diagnostic
14 quality if you're actually able to track what
15 happens to your patient when they leave your
16 health system.

17 CHAIR GRABER: Good point. And David.

18 MEMBER SEIDENWURM: So we talked about
19 information sharing among economically unrelated
20 entities because I think there is pretty good,
21 you know, sort of vertical information silos but
22 there is pretty bad, you know, horizontal sharing

1 of information when it doesn't fit the business
2 model and I am looking over at our colleague from
3 the, you know, ONC because I think that, you
4 know, the purpose of regulation I think is to
5 help when the business model doesn't
6 independently support it. So I would say that,
7 you know, maybe that's something that we can
8 suggest that would facilitate appropriate
9 diagnosis.

10 CHAIR GRABER: Great. So just think
11 back over the last 20, 30 minutes and if there
12 were any of these concepts that you really like -
13 one or two - just make note of that and we will
14 do lunch and reconvene at what time?

15 MR. EPNER: Can we have a public
16 comment? It's on the agenda.

17 CHAIR GRABER: Yes, sure. Okay. We
18 need to open the line and see if there is any
19 public comment.

20 OPERATOR: Okay. At this time, if you
21 would like to make a comment please press star,
22 then the number one. And there are no public

1 comments at this time.

2 MR. EPNER: I have one.

3 CHAIR GRABER: Did you want to make a
4 comment, Paul?

5 MR. EPNER: Yes, I have one, and this
6 goes back to David - thank you - it goes back to
7 David's comment about usability and - versus
8 capability. I think we are talking now about
9 things that may be - should be in standards but
10 also we need to be thinking ahead about what the
11 measure might come afterwards.

12 So, again, if we think of how Fed Ex
13 deals with a package, they have a very defined
14 process with computer alerts and time stamps and
15 things like that.

16 And the diagnostic process, whether
17 it's the safer Dx model or the NAM model, it's a
18 process and we need to be thinking about how do
19 we build the data structures including time
20 stamps that will later enable us to do the alerts
21 and the things where the process isn't working in
22 a timely fashion. And I just hope that should be

1 thought about. Thank you.

2 CHAIR GRABER: Good. So thanks,
3 everybody. Great morning, and come back at 1:00
4 o'clock. David.

5 MR. HUNT: I just wanted to highlight,
6 because I've heard a number of times where we
7 want to have the capacity and I want to remind
8 the group of the old adage that culture eats
9 standards for lunch, and that is to say having
10 the capacity and oh, gosh, we have learned this
11 the very hard way - having the capacity to do
12 something in a technology or in a tool is a
13 wholly different consideration as to whether or
14 not it's used and having the culture that
15 supports and nurtures the use of a specific
16 method of process I think is almost as important
17 if not more important.

18 MEMBER SINGH: And just to follow that
19 up with a concrete example, EHR has a lot of meta
20 data already that actually tracks a lot of the
21 things that are going on and when lawyers get
22 their records to look at anything what they are

1 getting is a whole lot of paper that they then
2 sort of have to sift through to figure out and
3 they can't make head or tail out of it and they
4 call these experts who have said, I can't
5 understand the medical record. So just FYI.

6 CHAIR GRABER: We'll all have a little
7 indigestion but enjoy your lunch.

8 (Whereupon, the above-entitled matter
9 went off the record at 12:32 p.m. and resumed at
10 1:03 p.m.)

11 CHAIR GRABER: We're going to hear
12 from group two and group three. They will each
13 have a half hour to present their
14 recommendations.

15 After that, we are going to go around
16 the room and everybody I would like you to tell
17 us the two concept measures that you like the
18 best.

19 So keep working on that list of the
20 ones you really like and we'd like to hear your
21 top two. We will then hear what the next steps
22 are from the NQF staff and that'll be it.

1 So group two.

2 MR. LYZENGA: I'll ask my group
3 members to help me out and correct me, chime in.
4 Not sure how to - we didn't actually highlight
5 any as particularly worthy of discussion or
6 important. We actually started out with our
7 disease specific, just to sort of get our
8 thoughts oriented and get us going. So we have -
9 and we didn't order these into structure process
10 outcomes so just a number of sort of concepts or
11 ideas related to cancer care or diagnosis. Did
12 you follow a specific diagnostic pathway. Oh, I
13 am sorry. Sorry. From my member - like, group
14 members any of these that you would highlight
15 here? A number related to time to diagnosis or
16 this notion came up a number of times of when are
17 you certain enough - when do you achieve a degree
18 of certainty where you have, you know a
19 reasonable diagnosis and you don't have to keep
20 doing testing. Let's see - a couple of more
21 concepts like - oh, sorry. Go ahead.

22 MEMBER MCDONALD: Yes. I was going to

1 say one thing. As we are sort of looking at this
2 the - we did discuss was how sometimes you'd want
3 to think about pairing concepts because you're
4 trying to deal with the - so as we were talking
5 about cancer it was this idea of that concern
6 about too much testing versus too little testing
7 and how to have measures that would help you see
8 if you're in trouble on one side or the other,
9 whether it's population level measures or whether
10 it's more, like, process measures at a - at a -
11 the level of a particular delivery system. So as
12 we look at these people can know that we were
13 thinking about that.

14 MR. LYZENGA: So then in a little bit
15 more in the line of sort of a measure concept
16 there is some things like - sorry, percent of -
17 percent of cancers with a delayed diagnosis.
18 You'd probably want to pick some particular ones
19 where you have an idea of what a delayed
20 diagnosis might mean. Occults blood in stool and
21 did not get a colonoscopy - that's a fairly
22 specific measure, I think. Time to follow an

1 abnormal screen - I can't remember what that was
2 about. Is that time follow-up on an abnormal
3 screen? Is that the idea? Okay.

4 MEMBER SINGH: Somebody has a fecal
5 occult blood test that's positive, follow up on
6 that. Or a mammogram abnormal, follow up on
7 that.

8 CHAIR GRABER: These all look
9 important to me. The one that I would like to
10 maybe emphasize is the timeliness issue. The VA
11 embarked on a program a couple years ago to track
12 timeliness of colon cancer diagnosis. So how
13 long did it take between the red flag and your
14 colonoscopy and they set a goal. So they defined
15 timeliness for that one condition and it forced
16 everybody to really think about that and it
17 changed organizational performance nationwide.
18 So I think that's a very powerful concept idea is
19 to start divining - defining what timeliness
20 means for specific conditions.

21 MEMBER MCDONALD: Yes. I guess the
22 countervailing thought to that where we started

1 in this discussion was the idea of kind of
2 chasing - David, you were the one who were saying
3 chasing a diagnosis for a long, long time, trying
4 to get more and more certainty when maybe more
5 and more certainty isn't all that beneficial for
6 the vast, vast, vast majority of cases. So if
7 you could pair what the VA did with that concern
8 about over chasing then you'd have a nice
9 balanced set of measures.

10 MEMBER SINGH: And we also thought -
11 and I think maybe you have it below, Andrew - to
12 look at the U.K. so the cancer early detection
13 programs where we - where they've actually come
14 up with pathways for two weeks and four weeks
15 and they measure this very sort of bell. They've
16 been doing this for many years now. Within four
17 weeks - if you're a new suspected cancer you need
18 to have the evaluation done within four weeks and
19 what proportion of patients meet that criteria.

20 MR. LYZENGA: I think I just made a
21 note to look up those concepts.

22 MEMBER SINGH: Yes, so we will just

1 look at those benchmarks.

2 MR. LYZENGA: Somebody - I think
3 another group talked about this a little bit -
4 discrepancy rate of pathological interpretations.
5 This one - I thought it was kind of interesting -
6 clinically significant amendment to original
7 pathology or radiology report for inpatients
8 subsequently diagnosed with cancer I guess
9 intended to be an indicator of a misdiagnosis.
10 Is that right? From our group.

11 MEMBER MCDONALD: Yes. I don't - I
12 don't think it was just inpatient actually,
13 right? I mean, it could be in any setting. But
14 just the idea that this would be a proxy for -
15 something's going on here and kind of maybe it's
16 more of a quality improvement type of concept.

17 MEMBER SEIDENWURM: Yes, we were
18 trying to get at the idea that, you know, of a
19 diagnostic change and what might be triggers to
20 go looking for those.

21 I mean, you know, a lot of amendments
22 to pathology reports might be special testing

1 coming in, right, and that wouldn't be the same
2 thing or radiology reports might be, you know, I
3 called the ICU and told them. You know, but
4 maybe we thought this was an enriched supply of -
5 an enriched source of these types of things.

6 CHAIR GRABER: Lavinia, you're a long
7 way away.

8 MEMBER MIDDLETON: And I would just
9 add to that, the next acknowledgment of that in
10 the - in the record or acknowledgment to the
11 patient or actionable item to complete the loop
12 because, unfortunately, sometimes these things
13 happen and if there is not a critical result
14 policy or a red flag result policy that you're
15 measuring what happens in the report in the lab
16 but not the impact on the patient or the patient
17 care.

18 MR. LYZENGA: So this next one here is
19 not really a concept as much as sort of idea of -
20 that may be worth pursuing is sort of a system
21 outcome.

22 Jen mentioned the sort of phenomenon

1 of somebody getting an improper diagnosis and
2 improper treatment, which leads to the subsequent
3 inability to participate in clinical trials -
4 sort of a down side for the system. Do you have
5 tumor boards at your organization and is there
6 patient involvement, engagement or presence at
7 those boards, particularly for difficult to
8 diagnose cancers or diagnostic dilemmas?

9 MEMBER MCDONALD: The interval pace
10 was interesting. You might want to -

11 MR. LYZENGA: Yes. Do you want to
12 talk about that for a minute?

13 MEMBER MCDONALD: Yes. Some of my -
14 some of our clinical colleagues might talk about
15 it better but it actually came - Jen, it started
16 out with you. It's just the idea of more of a -
17 more of a focus on that interval between being
18 seen and it's kind of like - I think it's a look
19 back in terms of maybe a red flag having been
20 missed.

21 So we were, I think, talking about
22 that this might be a sign of, you know, if a

1 cancer shows up after an interval when there was
2 a previous image that cleared the patient of any
3 concern you can look back and see if was that
4 clearing really appropriate or not would be a way
5 to get at problems. You have to look at them
6 retrospectively.

7 MEMBER SEIDENWURM: And we wanted this
8 to be something to be considered in either
9 screening types of modalities like colonoscopy
10 for example. You know, cancer shows up a year
11 after a colonoscopy - you know, what does that
12 tell you and is there a proportion. We know in
13 mammography, for example, there is a known
14 proportion of times that that'll happen but you
15 deviate from that so in the opportunistic
16 detection - what we were talking about before.

17 MEMBER SINGH: The goal being if
18 you've had a normal colonoscopy that's in the
19 last one year and you just got diagnosed with
20 colon cancer, those are the people who you want
21 to look at.

22 So somehow we were getting to that

1 kind of concept. Maybe - I think maybe we are
2 clarifying some of the language on that.

3 MR. LYZENGA: We had a few like this
4 that were, like, more - again, indicators of a -
5 of a potential missed diagnosis or lack of
6 diagnosis, more than five androgen tests within
7 the past year or three or more consultations or
8 an inefficient diagnosis, rather. Sort of the -
9 you know, possibly indicating more, reflecting
10 that. Some patient reported experience of their
11 experience in navigating the diagnostic process
12 or understanding it - their understanding of the
13 diagnosis, whether it's been communicated to them
14 effectively - did they get a care plan - was it
15 explained - were the effects of treatments and
16 expected outcomes explained. We talked a little
17 bit about system outcomes as - patient confidence
18 as a system outcomes, you know, would be hard to
19 specify maybe as a measure concept but just that
20 issue that was raised about the public debate and
21 sort of controversy about breast cancer screening
22 kind of lowering patient confidence in the system

1 to some degree.

2 We talked a little bit about some
3 population level measures, looking at the
4 percentage where - or rate of things like early
5 stage diagnosis, late stage diagnosis, even maybe
6 mortality or something like that or other metrics
7 at a population level that might be reflecting
8 some inadequacy in the diagnostic process or
9 approach. Anything else to add to that from our
10 group members? Were these the okay ones? Okay.

11 MEMBER SEIDENWURM: So we talked - so
12 we got off the idea of cancer a little bit when
13 we added PE but the arithmetic's the same. The
14 idea would be trying to look at the rate of
15 diagnosis of the condition compared to changes of
16 its - in its mortality or morbidity rates to look
17 for over diagnosis and then you could also look
18 at, you know, percentage of negative studies, you
19 know, in the PE area. You know, we know that
20 that's kind of a problem depending upon which
21 diagnostic algorithms were employed - you know,
22 whether they do DDIME or Wells testing and there

1 are similar, you know, analogous circumstances in
2 cancer and other diagnoses.

3 DR. BURSTIN: Just as an example, NQF
4 hasn't endorsed state-level measure that looks at
5 percent of late presentation of HIV. It's
6 another way of looking at that that might be a
7 nice analogy to take a peek at.

8 MR. LYZENGA: We talked a little bit
9 about, again, patient-reported harms related to
10 the diagnostic process and even provider-reported
11 peer to peer reporting of harms related to the
12 diagnostic process and extracting something from
13 that. Another patient-reported outcome,
14 something like was getting a diagnosis worth it
15 in the end. That was sort of a little bit vague
16 but something like the amount or level of
17 radiation exposure, you know, prior to your
18 diagnosis, just trying to get at, you know,
19 again, that over testing question.

20 So yes, measures trying to identify
21 where organizations are sort of outliers in
22 certain domains such as malpractice claims for

1 the same problem - are they way above normal or
2 do they have above - more than normal patient
3 complaints maybe for a particular problem in a
4 certain time frame where most clinicians that are
5 consistently being poorly scored in peer review.

6 CHAIR GRABER: Could I put in a vote
7 of support for the peer to peer reporting?

8 MR. LYZENGA: Uh-huh.

9 CHAIR GRABER: You know, it went by
10 kind of quickly. But in terms of finding
11 diagnostic errors, I think talking to patients is
12 a gold mine.

13 But getting reports from providers is
14 the other main way to find diagnostic errors
15 effectively. And what we have seen over the
16 years is that providers just don't bother or they
17 are reluctant to report through the usual
18 pathways - I am not sure why - but that they are
19 more comfortable reporting to a peer. So I think
20 that's a really nice concept that you capture
21 there that we should try to encourage and then
22 work on.

1 MEMBER SINGH: Yes, and we discussed
2 that and we may have put it in a separate
3 structure box but essentially health care
4 organizations need to support the process of
5 providers discussing either errors in M&M -
6 morbidity mortality - conferences or getting
7 feedback or facilitating some kind of a reporting
8 system where you can learn from errors and so
9 giving examples of what happened in Maine where,
10 you know, somebody led a project on reporting and
11 learning from reporting.

12 MR. LYZENGA: Let me know, again,
13 group members if you want me to highlight any
14 particular ones here. Here's an interesting one,
15 I thought - does the second opinion match the
16 first diagnosis or some measure of discrepancies
17 between first and second opinions or we also
18 talked about, I think, maybe in the structure
19 section or process does - did you get a second
20 opinion or does the organization recommend
21 getting a second opinion, particularly for some
22 conditions that are - that would be appropriate -

1 particularly appropriate for. Again, another
2 population level, late stage diagnosis rate. I
3 think these are maybe duplicates. Resolution and
4 discordant pathology or other discordant findings
5 - maybe something like a patient or a - primary
6 care provider reported assessment was the lab or
7 radiology or other testing report clear, just
8 some way of getting at the sort of adequacy and
9 communication of testing findings and the other
10 group has some of these things like poly pharmacy
11 as a marker or indicator of misdiagnosis. If
12 somebody's on over seven medications maybe
13 they've -

14 DR. BURSTIN: As a primary care doctor
15 that's my entire practice.

16 MEMBER MCDONALD: Right. But the -
17 but the idea would be if you are actually
18 assessing patients who have poly pharmacy and
19 worrying about whether they have side effects or
20 interactions from their poly pharmacy that's good
21 diagnostic practice.

22 MR. LYZENGA: Yes, that's not exactly -

1 MEMBER MCDONALD: Well, this is the
2 idea that if somebody has poly pharmacy and those
3 interactions aren't being assessed then it would
4 be a way to sort of drill into potential outcomes
5 that are harm - the harm outcomes.

6 MR. LYZENGA: Can we work that one a
7 little -

8 MEMBER MCDONALD: Yes, it needs more.

9 MEMBER SEIDENWURM: But this might be
10 a trigger or, you know, a source of an enriched
11 population for which to look for diagnostic
12 difficulties.

13 MEMBER MCDONALD: Ultimately want it
14 to be harms from poly pharmacy, not being
15 evaluated appropriately. Yes.

16 MR. LYZENGA: Again, similarly, poly
17 testing as an indicator of excessive work up.
18 Let's see - number of complaints per year
19 similar to the, I presume, the receiving
20 clinician - you know, making a complaint about an
21 unclear or inadequate report from the lab or
22 radiology. Got into a little bit of some EHR

1 issues like percent of cut and paste. Some
2 people raised some ways you can actually measure
3 that using keystroke analysis and things like
4 that.

5 Same with did you consult the prior
6 lab results. I think a previous group talked
7 about percentage of prior studies available and
8 timeliness of work up.

9 PARTICIPANT: Talking about cancer?

10 MR. LYZENGA: No. Now we are into the
11 cross cutting. We went through some outcomes.
12 Now we are in process. Sorry, that wasn't clear.
13 That's more of a structure outcome. Do you have
14 a patient portal at your organization.

15 Talked a little bit about the clarity
16 and the communicate of test results to patients -
17 for example, through patient portals. Some
18 disagreement about whether it's possible to
19 communicate some certain test results,
20 particularly things like radiology results to
21 patients in - at something like an eighth grade
22 level. But maybe there can be some sort of index

1 or other tool analyzing the level of - at which,
2 you know, test results or other information is
3 presented to patients. Did you have something?

4 MEMBER NEWMAN-TOKER: Just a comment
5 on the stroke example. Here's another example of
6 where - that you just had - just appeared on the
7 screen there - it's another example of where we
8 have to be clear about what we want to measure
9 for process.

10 I think all the process measures -
11 when we think about them as being disease
12 specific we actually have to think of them as
13 being symptom specific because the problem isn't
14 what happens when the patient comes with a TIA
15 and whether they get an appropriate work up for
16 stroke. Once somebody knows it's a TIA or a
17 minor stroke then they almost invariably get the
18 right treatment.

19 The problem is in detecting that in
20 the first place. So the TIA is actually a
21 diagnosis there. It's not a symptom. So you
22 have to - you know, you can say in patients with

1 transient or illogical symptoms or patients with
2 dizziness or patients with numbness or whatever,
3 but I think we are going to see this all over
4 again. Once we get to the point where we are
5 actually talking about symptom-specific - symptom
6 specific measures it really has to - it has to be
7 clear that that's - that the process points to a
8 symptom, not a disease.

9 CHAIR GRABER: David.

10 MEMBER SEIDENWURM: Yes, I totally
11 agree about the symptom idea but I think there is
12 still enormous gaps in care in a guideline-
13 specified evaluation of common diagnostic
14 problems in that. So I think that this was just
15 meant to be an index case of that where,
16 particularly with respect to timeliness and
17 certainly, you know, in too many places. Just to
18 use the example of TIA again, oh, he's all better
19 - you know, we have got plenty of time when, you
20 know, we know that that's not the case. So I
21 think - and there are other examples of that
22 sort. But your point is exactly correct that

1 it's really the symptom rather than the
2 diagnosis.

3 MEMBER SINGH: And I wanted to add
4 that I think we just followed the instruction of
5 just discuss anything and everything possible in
6 terms of concepts without sort of clearing
7 through the language and the measure and the
8 measure concept, et cetera. I think a lot of
9 this needs to be fleshed out and I particularly
10 am saying this because you only came up, I think
11 with eight or nine and maybe that's because you
12 discussed those more and you focused on those.

13 But here we just captured the entire
14 conversation about anything and everything
15 possible, which is sort of what understood and I
16 think Kathy and I kind of had a little discussion
17 there. We are not sure exactly but we just
18 captured everything.

19 CHAIR GRABER: Please use -

20 MEMBER SINGH: I may not have said
21 that.

22 CHAIR GRABER: Please use your

1 microphones.

2 MR. LYZENGA: Similar to the clarity
3 of communication some sort of assessment about
4 what a patient needs to know about their
5 diagnosis and is that being communicated in a way
6 that corresponds to their health literacy, which
7 would need to be associated, presumably, with are
8 you assessing the health literacy of your
9 patients is the next one. OpenNotes - does the
10 organization collect information about diagnosis-
11 related problems and solicit feedback from
12 patients through their OpenNotes and through
13 patient portals. That's, again, probably a
14 structure measure. Maybe not. Again, were mental
15 health problems considered.

16 Patient and family-centered grounds
17 with all necessary parties involved - again,
18 maybe structure. Some measure concepts related
19 to over utilization, whether imaging is being
20 done in the last weeks of life or other
21 diagnostic tests in the last weeks of life
22 because that's really necessary. Communication

1 about with patient not just about, you know -
2 again a sort of static diagnosis but about their
3 disease progression continuing through, you know,
4 their encounters with the - with the clinician
5 about their disease progression and the evolving
6 treatments approach. We thought that as sort of
7 part of the communication about the diagnosis.

8 Periodic reassessment and confirmation
9 of diagnosis and that would probably need to be
10 disease specific. Let's see - any other ones our
11 group would want to highlight here?

12 MEMBER SINGH: Yes. So the one about
13 the asthma came from - you know, there is certain
14 papers already of how much time or length of - or
15 times somebody has to visit before we made the
16 diagnosis. I think for asthma it was seven.

17 CHAIR GRABER: Asthma was seven. Iron
18 deficiency - anemia was two years.

19 MEMBER SINGH: Two years. And so we
20 thought that we could have certain measures
21 around where the evidence already existed there
22 are, you know, certain delays and identify.

1 And then the pairing of medication
2 with known side effects came from yesterday's
3 discussion. I think Helen - you know, Helen
4 asked or you mentioned this is a common problem.
5 So we thought electronic health records could
6 enable us to figure out, you know, who are the
7 patients who are taking ace inhibitors, for
8 instance, and had cough where the ace inhibitor
9 was discontinued and it was because of the cough,
10 and certain medication in pairs could lead to
11 detection of, you know, known problems.

12 CHAIR GRABER: I'd just like to
13 mention that in Gordy Schiff's work in the top
14 ten reasons for diagnostic errors are medication
15 side effects that were misinterpreted. So that's
16 a very rich area.

17 MEMBER SINGH: And actually that was
18 number two, yes, and we did a similar survey in
19 pediatrics and pediatricians said the number two
20 misdiagnosis in children was missed medication
21 side effects.

22 MR. LYZENGA: This is another one

1 about sort of patient communication, whether the
2 patient is understanding. A clear distinction is
3 being made between what's a consultation and a
4 handoff of care was raised that there may be some
5 confusion sometimes and the patient thinks that a
6 consultation is them being handed off to somebody
7 who's going to be providing their care, moving
8 forward. Were consultations completed if they
9 were ordered -

10 CHAIR GRABER: That's extremely
11 important. I think - Hardeep, weren't you
12 involved with a VA policy that required
13 clarification of who owns a test result?

14 MEMBER SINGH: Yes. Right. Yes. And
15 we didn't sort of discuss that explicitly but
16 essentially sort of the ownership of who's
17 responsible for follow-up is a big issue that has
18 come up in several, you know, related studies and
19 that could be for test results where we picked it
20 up but it could be for other stuff as well.

21 There is always everybody pointing
22 fingers at each other - I am not the one

1 responsible.

2 MR. LYZENGA: Similarly, was it
3 specified testing regimen completed, was the
4 follow-up algorithm completed. Not sure what
5 algorithm refers to here.

6 Again, timeliness of diagnosis and
7 testing and consultation. Something trying to
8 get at whether - at under work-ups. Is there
9 some standard set of assessments or criteria -
10 diagnostic criteria that are being completed when
11 they should be. I assume that would, again, be
12 disease specific or condition specific.

13 MEMBER SEIDENWURM: Yes. So to
14 clarify, the melanoma one was kind of about
15 timeliness but it was also about the adequacy of
16 the evaluation, right, because if the tumor shows
17 up, you know, at a short interval following an
18 evaluation designed to detect that tumor, for
19 example, then perhaps the tumor was especially
20 fast growing or the evaluation was especially
21 poor.

22 MR. LYZENGA: Inadequate history -

1 these would need to be definitely worked into
2 some kind of concept. It's a little bit under
3 specified. Detection of medication side effects
4 errors - I think that's kind of a duplicate.
5 When it is sort of a quality improvement issue is
6 when there is a misdiagnosis is there a process
7 in place to follow up and learn from the
8 experience.

9 MEMBER MCDONALD: I'd go back to the
10 medication side effect pairing just to make sure
11 people understand that one. There we were
12 talking about the - there are specific - there
13 are specific medications where you know that
14 there could be a side effect and if those
15 diagnoses are being missed for the medications
16 that are paired with those side effects that
17 would be something that could be searched and
18 monitored and would be helpful in diagnostic work
19 that relates to missing side effect diagnoses
20 because those get missed. We hear that
21 frequently from patients.

22 CHAIR GRABER: David.

1 MEMBER SEIDENWURM: So just on this
2 inadequate history and inadequate exam, I just
3 want to make sure that we don't forget that the
4 majority of diagnostic errors happened at the
5 bedside and the kind of interaction between the
6 provider and the patient and although it's easier
7 to find information on when test results are lost
8 to follow-up, et cetera, we can't ignore the fact
9 that that bedside piece is a piece that's hard to
10 track but really central to actually improving
11 diagnosis at the bedside.

12 Our group had a couple of discussions
13 around this issue of kind of how you can move
14 that towards measurement and I think it's really
15 through this idea of process mismatches either
16 between the diagnosis process done and the
17 symptom - presenting symptom or the diagnostic
18 process mismatches with the disease that ends up
19 being diagnosed.

20 So, for instance, just to give a
21 concrete example, if a patient with benign
22 positional vertigo leaves with a diagnosis of

1 benign positional vertigo, got neuro imaging,
2 that's a process mismatch because there are two
3 guidelines that say that you should diagnose
4 benign positional vertigo at the bedside and not
5 through neuro imaging.

6 So that's a clear indication that the
7 diagnostic process at the bedside and the test
8 ordering and the rationalization of everything
9 just doesn't make any sense.

10 And if there is no mention, for
11 instance, of nystagmus, that one word alone as a
12 key word search in the electronic health record,
13 if that's never mentioned and a patient, given a
14 vestibulous disorders diagnosis, clearly,
15 something is wrong, right, at the bedside. So I
16 think we should be identifying the symptoms
17 specifically as a process mismatch.

18 CHAIR GRABER: Yes, I agree, and
19 thanks for emphasizing that. I think this is a
20 perfect place for patient reporting. Patients
21 with OpenNotes are seeing examinations where the
22 physician looked at 90 things when the patient

1 knows that the physician didn't touch them. We
2 have heard that several times.

3 MEMBER SINGH: We had a - we had a
4 discussion on a similar measure. We didn't put
5 it on the -

6 CHAIR GRABER: Right. So we need to
7 start looking at that and the patients are in a
8 perfect position to tell you what was done and
9 what wasn't done.

10 MEMBER SEIDENWURM: So we had to
11 search for, you know, search for patient
12 complaints. I mean, I think you read a lot on
13 your social media sites about, you know, I got
14 this bill for all this stuff I didn't get. So
15 maybe a structural one could be do you monitor.

16 MEMBER MAHAJAN: So Mark, what - one
17 comment.

18 CHAIR GRABER: Yes, Prashant. Sorry.

19 MEMBER MAHAJAN: So, you know, just
20 going up to the melanoma one, it just struck me
21 that if we are going by condition specific, so
22 one of your - like the group starts with that if

1 it is a high risk condition like stroke or cancer
2 then it needs to come in there.

3 My point is that we do end up in that
4 way I just hope that we are not missing other
5 conditions which require more timely diagnosis
6 but just our group doesn't end up bringing that
7 up. You know, it could be some other
8 subspecialty related measures.

9 CHAIR GRABER: We're about at the end
10 of our half hour. How are we doing on your list?

11
12 MEMBER SEIDENWURM: Let me just scroll
13 down and see if there are any structure measures
14 worth - a lot of these are not really concepts
15 but just sort of ideas.

16 MEMBER MCDONALD: Actually in the
17 spirit of that last comment though too we - I
18 think while we were talking about structures we
19 ended up talking about how we - you need to be
20 sort of condition specific and you need to be
21 setting specific to some extent when you're
22 thinking about what structural measures would be

1 appropriate and how they, you know, how you'd
2 think about their causal path.

3 MR. LYZENGA: We talked about a number
4 of sort of indicators of culture - you know, the
5 appropriate diagnostic culture, whether a system
6 exists for nonpunitive reporting of diagnostic
7 errors or problems, leader of protected time to
8 consider diagnostic issues, whether there is a
9 policy disclosure program, thought about whether
10 some of these things could be done through a -
11 some sort of a culture survey related - with
12 elements related to openness to reporting and
13 learning from diagnostic problems, again, whether
14 patient portals, OpenNotes were two consultant
15 product that was the - that was sort of a
16 facetious one but some indicator of when too many
17 consultants are involved I think David raised
18 this as they multiply the number of tubes in the
19 patient with the number of consultants and you
20 get an indicator of whether there is -

21 MEMBER SEIDENWURM: The point is that
22 was in - yes, when we were interns that was an

1 indicator of, shall we say, case complexity.

2 And so we were trying to think of an
3 indicator that could be derived from
4 administrative data that might indicate complex
5 cases where there was diagnostic uncertainty.
6 And so I had, you know - to internship.

7 MR. LYZENGA: I don't think I was
8 supposed to write that one either. Again, does
9 the - does the organization have a standardized
10 process for hand-offs, do they have a recording
11 board agenda, does the organization perform, has
12 the - have they performed at least one RCA for a
13 diagnostic problem within the past year. You
14 have to think that there has been at least one
15 and if they are not doing that there is probably
16 some inadequacy there. Again, standardized
17 process tool for hand-offs. Let's see -

18 MEMBER NEWMAN-TOKER: Just a minor
19 comment on that point. You know, so there are a
20 lot of these measures where you can make them
21 yes/nos or graded or whatever. I mean, something
22 like that probably - rather than say have you

1 performed at least one, you know, it should be
2 how many have you performed in the last year so
3 that you can get a more robust set of answers out
4 of the data.

5 MR. LYZENGA: I think maybe Hardeep
6 mentioned this earlier. Sorry, go ahead.

7 MEMBER IRONS: Just to comment - you
8 know, a few times I've seen this come up about is
9 this on the board agenda, you know, and is this a
10 priority for a board, and I wonder whether having
11 been on a hospital - several hospital boards it
12 may - it might make sense - should the question
13 be should this be on the organizational
14 dashboard, you know, rather than just having
15 board reports every so often, have specific
16 metrics on the organizational dashboard because
17 that's something they'd buy into.

18 MEMBER SINGH: Yes, but I think the
19 problem is we don't know what to put on that
20 dashboard. So we - I think - you're totally on
21 the spot. We definitely need boards to see this
22 data. I think we need the CEO, the CFO and the C

1 whatever to look at this data. But what?

2 MEMBER IRONS: So you could start
3 small. I mean, one could be - how many root
4 cause analyses have we done for a diagnostic
5 error in the last year.

6 MEMBER SINGH: For diagnosis we
7 actually talked - yes.

8 MEMBER IRONS: You know, and then once
9 you tackle that one, you know, if the numbers are
10 going up or the numbers are going down then you
11 graduate to higher things.

12 MEMBER SINGH: Yes.

13 MEMBER IRONS: But I'd get something
14 on there rather than wait for the perfect - you
15 don't want grade to be the enemy of good here -

16 MEMBER SINGH: Yes. Yes.

17 MEMBER IRONS: - if you can get on the
18 dashboard.

19 MEMBER SINGH: So I think that's where
20 we put that RCA, patient complaints, peer review
21 data, malpractice claim data - all four - as
22 diagnostic performance data that was potentially

1 more ready right now to be shown to somebody in
2 the leadership level.

3 MEMBER IRONS: Protected time some
4 folks to work on this issue.

5 CHAIR GRABER: Microphones, please.

6 MEMBER IRONS: I'm sorry.

7 CHAIR GRABER: Okay. We need to move
8 on. We are going to hear about one more.

9 MR. LYZENGA: One more - one more
10 analysis that we talked very, you know, briefly
11 about this issue of certainty of diagnosis that
12 sometimes coding - codes are applied when they
13 are not appropriate just because something needs
14 to be put in and whether there is a need for
15 symptom-based coding to sort of more
16 appropriately reflect the diagnostic process and
17 what was done there unless, Mira, any more
18 comments.

19 CHAIR GRABER: Great. Thanks very
20 much. Good job. Group two. Group three.

21 MEMBER MIDDLETON: A quick comment,
22 just very quickly.

1 CHAIR GRABER: Yes. Lavinia.

2 MEMBER MIDDLETON: RCAs - number of
3 RCAs and whether or not an RCA has been used to
4 drive institutional improvement.

5 MEMBER SINGH: Excellent point. There
6 was a whole paper on problem with RCAs recently
7 in BMJ quality and safety and that's one of the
8 biggest problems they are saying. A lot of the
9 RCAs don't lead to actionable improvements.

10 CHAIR GRABER: Another problem is that
11 they don't include a cognitive analysis, which is
12 so often involved in diagnostic errors.

13 Even in new RCA 2 tool from the MPSF
14 doesn't focus on diagnostic errors at all.
15 Definitely need to do some work there.

16 MEMBER NEWMAN-TOKER: So I am going to
17 represent for group three and if my colleagues
18 will permit I am going to take a little poetic
19 license and focus our attention on a few specific
20 things that I don't think have been discussed
21 thus far.

22 And one of them is patient engagement

1 and measures associated with that and the other
2 is a few of the specific things where, you know,
3 we can start getting towards the actual - move in
4 the direction of measures, you know, thinking
5 about percentages and fractions and numbers,
6 numerators and denominators.

7 So on the side of - on the structure
8 piece we had a fair amount of talk about the
9 patient engagement and the diagnostic process
10 through electronic tools.

11 So somehow the issue of either - being
12 able to get whether the system allows the patient
13 to amend their diagnoses or put notes or get
14 feedback on whether the diagnoses were accurate
15 or inaccurate that somehow there could be a
16 measure that was developed around that - the
17 concept of having structures in place for
18 patients to be able to engage in the diagnostic
19 process.

20 The second in this sort of structural
21 one was the idea of space, sort of patient-
22 centered space. So, for instance, there is a -

1 there is an innovative health clinic that - I
2 don't know for those who've followed the
3 internet, it was founded by ZDoggMD - and they
4 show - I saw them give a talk and they showed how
5 they kind of reconstructed the space to have a
6 more patient-centered experience just by how they
7 aligned the patient and the computer and the
8 physician or the provider so that it was like a -
9 they had, like, this sort of, like, a half circle
10 table and they were both sitting kind of next to
11 each other looking together at the computer
12 screen and the space facilitated kind of better
13 communication with the patient. So I think
14 that's another potential place to sort of look
15 for the extent to which we are engaging patients
16 in the - in the diagnostic process through a
17 structural measure.

18 Under outcomes, obviously, we all
19 have, you know, the issues about outcomes in
20 terms of diagnostic accuracy, et cetera, and we
21 talked at length about how we might be able to
22 use patients as a source of information.

1 But I think we haven't talked a lot
2 today about measures of psychological harm. So I
3 think it's one thing to measure patient
4 satisfaction with their care process but I
5 actually think we have to go beyond that. We
6 talked about how the psychological harms of a
7 misdiagnosis are an important outcome to capture
8 and one that really kind of falls off the radar
9 screen. And even when you talk about sort of
10 morbidity/mortality, in people's minds that
11 doesn't include the psychological morbidity
12 associated with getting a wrong diagnosis, and as
13 we have heard, Jenny testified the other day
14 that, you know, that was kind of like the big
15 player in this story.

16 So somehow measuring the psychological
17 harm associated with misdiagnosis I think is the
18 potential measure space.

19 On the process side, there was
20 definitely some discussion about this idea of
21 patients being able to communicate directly and
22 succinctly with the providers that they need to

1 and there are lots of measures that you could
2 think of around that space - you know, number of
3 - you know, total time from initial patient
4 attempt to reach the team about the diagnostic
5 process to actually getting their needs met or a
6 number of encounters or steps that they have to
7 take in the process in order to get to a relevant
8 provider who can provide them the answers that
9 they need related to their diagnosis, et cetera.

10 And in terms of this idea of having
11 methods in place to assess from patients, not
12 just whether they were satisfied but whether they
13 were explicitly engaged in shared decision making
14 as part of the diagnostic process where their
15 values and preferences were accounted for and
16 taken into account as part of the diagnostic
17 discussion since what tends to happen nowadays is
18 that physicians or other providers may just
19 substitute their own sort of judgments of the
20 evidence without weighing and factoring in the
21 patient's preferences and values into that
22 discussion. And then in particular, making sure

1 that patients actually understand and are
2 communicated the diagnosis but not just
3 communicated the diagnosis but that they were
4 given the kind of appropriate intelligible and
5 actionable post-discharge instructions that
6 facilitated their recognizing if a diagnostic
7 error had occurred and reentering the system so
8 that they could be part of the proactive process
9 of early capture of diagnostic failures.

10 Right now, the post-discharge
11 instructions are a little too vague and too, sort
12 of, general, like, if you get worse, you know,
13 call your doctor kind of thing rather than these
14 are the three things for this - you know, the
15 thing we are worried about in you - if you came
16 in dizzy and we think it's an ear problem but
17 this is what's going to happen to you if it's
18 not. You know, here are the five symptoms you
19 need to be monitoring yourself for, I think, is
20 another way to let - have the patients be more
21 proactively engaged in that process.

22 So those are the kind of patient-

1 centered one. Maybe I'll stop there if people
2 have any comment. Yeah, go ahead, Helen.

3 DR. BURSTIN: I think a lot of those
4 are great. I was really just thinking there we
5 have been bringing in measures recently of
6 decision quality that are patient surveys
7 essentially where they reflect on what they've
8 done. We will likely be bringing in Collaborate,
9 which is a nice example of just a very simple
10 three-item tool in the current year developed by
11 Glyn Elwyn at Dartmouth, and I think I told a
12 couple of you yesterday what's really exciting
13 about tools like this is they have, first of all,
14 three items - sort of refreshing - as opposed to
15 pages and pages and pages. But, you know, as Dr.
16 Elwyn - Glyn Elwyn's the developer of it - and if
17 you ask him and the Likert scale goes one to
18 nine, which is kind of unusual, like, why nine,
19 and his response is very simple. There are nine
20 buttons on a cell phone and this survey was
21 developed with the intent that patients could
22 just complete it on their phones as they are

1 walking out of an office visit. So just as an
2 example, the three questions were things like how
3 much effort was made to help you understand your
4 health issue, how much effort was made to listen
5 to the things that matter to you most about your
6 health issue and how much effort was made to
7 include matters most to you in choosing what to
8 do next. You could easily see how even though it
9 wasn't necessarily developed I think with the
10 idea of diagnosis in mind it might be very
11 applicable or even potentially could be tweaked
12 into something that could be more aligned with
13 the diagnostic realm. But it just seems like a
14 really easy kind of potential early opportunity
15 to get a measure out there that's very patient
16 centered that I think everyone should be curious
17 about - Jen or Helen's perspective on something
18 like that being something that would be of value
19 through your journey.

20 CHAIR GRABER: Could you send that
21 around?

22 DR. BURSTIN: Yes.

1 CHAIR GRABER: That would be great.

2 Thanks.

3 MEMBER NEWMAN-TOKER: So on that
4 point, we actually had - on the issue of tweaking
5 these instruments we certainly shouldn't reinvent
6 the wheel where we don't need to. But one of the
7 things that came up in our conversation was
8 about, for instance, the current culture survey.
9 If you actually read the detailed questions
10 almost none of them apply to kind of whether the
11 place is safe with respect to diagnosis. They
12 are all - almost all related to kind of treatment
13 application and so it's not clear that the
14 concept of safety culture as it replies to
15 treatment necessarily generalizes to diagnosis.

16 MEMBER SINGH: I'm not sure if that's
17 true because teamwork and communication is part
18 of it so -

19 MEMBER NEWMAN-TOKER: It's not a
20 question of whether the team -

21 MEMBER SINGH: And I am pretty sure
22 there is several other elements that address to

1 the structural and process elements of making a
2 diagnosis.

3 MEMBER NEWMAN-TOKER: So we should
4 look at that offline. But I actually think that
5 when people -

6 MEMBER SINGH: Run diagnostic -
7 diagnosis specific but it addresses several
8 related elements, which is communication and
9 teamwork and speaking up and other things.

10 MEMBER NEWMAN-TOKER: Yeah. The
11 problem - the problem there is whether people are
12 answering the culture survey with diagnosis in
13 mind when they are answering those questions.

14 And from having spoken to people who
15 fill out the culture surveys they've said no.

16 MR. HENRIKSEN: At our - in our center
17 we recently just a couple months ago went through
18 a similar process where we were trying to come up
19 with ideas in the different patient safety areas
20 and diagnostic safety was certainly a major
21 component of that.

22 In terms of culture survey we called

1 it diagnostic readiness but it was essentially a
2 culture survey, and the - and we had a sort of
3 debate on what your - the two points of view that
4 both, you know, Hardeep and David are sort of
5 discussing and one was do we just sort of prepare
6 sort of a supplement for the standard medical
7 office culture survey and append it to that
8 because if you had a separate total survey on
9 culture or on diagnostic safety alone then now
10 you have two culture surveys for the medical
11 office and are we giving them too many surveys.

12 And then the other option is no. The
13 other argument is that diagnostic safety needs -
14 is so unique that it needs its own culture
15 survey, a full-blown very well psychometric
16 survey that can speak to the diagnostic safety
17 issue.

18 And so we haven't really resolved that
19 debate but I was sort of favoring the latter in
20 my own way of thinking. But we haven't really
21 resolved it and that would be for our 2018 budget
22 year.

1 MEMBER SINGH: So Kerm, do we know - I
2 know you kind of talked to us about the health IT
3 safety supplement items. How many, roughly,
4 items were you thinking of adding, let's say, for
5 heath IT safety, roughly?

6 MR. HENRIKSEN: Well, we would want it
7 to be multidimensional. You need two to four
8 questions to flesh out a dimension and so you're
9 talking about, you know, like 28 items - between
10 28, 30, 32 items depending upon - and these are
11 things that are fairly clearly stated. They are
12 - all the questions are vetted and, you know, you
13 establish the psychometrics for reliability and
14 validity and so there are very - it takes time to
15 develop those and it's not a quick measure. But
16 in terms of the how much - how many surveys and
17 how many toolkits can medical offices and
18 different settings of care actually implement and
19 not be confused. But once we received an
20 application because someone thought that there
21 are so many tools out there that we need a tool
22 to - for organizations to decide among all the

1 tools out there which ones to choose. And, I
2 mean, it's really gotten to that point.

3 MEMBER SINGH: So and that's a perfect
4 example of bringing - so there is actually - you
5 know this but I am going to mention for the sake
6 of this group, there is actually an AHRQ testing
7 process toolkit which has questions on the
8 testing process in the office and includes safety
9 items around diagnostic, you know, safety and
10 culture.

11 And so, you know, here is where we are
12 going to reinvent another tool to put into place.
13 I am just thinking is there ways to leverage, and
14 I know that the uptake of that tool is not a lot,
15 you know, based on some other things but -

16 MR. HENRIKSEN: Yeah, and that's the
17 Mickey Eider toolkit and RTI, in conjunction with
18 Paul also developed a testing - you know, a risk
19 assessment toolkit for a send-out testing and I
20 remember talking with Paul after. Art did not do
21 much with that in terms of putting it out there.
22 It was an actual contract and I thought SIDEM was

1 going to put it on its website, and was there any
2 traction on that or -

3 MR. EPNER: No, we did not post it
4 anywhere that I know. There was a publication
5 that came out. That's all.

6 MR. HENRIKSEN: Okay. Yeah, there
7 was.

8 MEMBER SINGH: Helen?

9 DR. BURSTIN: We only had three. Was
10 the culture - the culture of safety sort of is at
11 a facility level, right? It's still at the
12 hospital, for example.

13 MR. HENRIKSEN: Well, there is H
14 shops. There is a hospital -

15 DR. BURSTIN: Right.

16 MR. HENRIKSEN: - level. There is
17 hospital level. There is hospital, medical
18 office, long-term care.

19 DR. BURSTIN: Great. Okay. No, that
20 would be really useful to them.

21 CHAIR DANFORTH: I just want to put in
22 a huge plug to integrate additional questions in

1 the current survey instruments. One of the only
2 national organizations that I can name that's
3 been asking hospitals to do these culture safety
4 surveys going on now. Sixteen years - it's
5 becoming increasingly difficult to get hospitals
6 and other health care organizations to do these
7 surveys in their entirety and what they are doing
8 is they are going to your website, they are
9 taking your survey, they are picking five
10 questions and they are sticking it on the back of
11 a Press Ganey employee engagement survey and they
12 are completely undoing all of the psychometric
13 properties that you've tested for and developed.
14 And we have had to do so much work - two years'
15 worth of work - with a national expert panel to
16 get them to basically stand behind us and tell
17 organizations you can't do this - it won't count
18 as doing a safety culture survey. So doing
19 something separate on diagnostic safety, I think,
20 one, there is going to be a problem with uptakes.
21 They are going to take two questions from it or
22 one question from it. They are not going to use

1 it the way you intended to use it. But two is I
2 think that it - diagnostic safety needs to be
3 seen from an organizational standpoint as a
4 critical part of overall quality and safety. I
5 mean, going back to the conversation we had
6 yesterday, they are not necessarily separate or
7 different. It's an aspect of patient safety.
8 The things like being able to speak up.

9 When you do speak up, you feel like
10 people are responding to - you know what I mean -
11 to your suggestions. All of those things are
12 similar. Those are maybe some unique things.
13 But - and I am happy to talk to you more offline.
14 But you can put out a 28-question survey that's
15 got the best psychometric testing results you've
16 ever seen. They are going to take one or two
17 questions from it and stick it on the back of an
18 employee engagement survey.

19 MEMBER SINGH: And I think this would
20 also be an opportunity to sort of go back and
21 look at all the questions that we developed, I
22 don't know, what, a decade or more ago, right?

1 I mean, see what is now our national
2 priority and maybe change things over time. Take
3 some out for the next five years. Take stuff out
4 on things that have been relatively better
5 addressed and things that are new. Add some
6 supplemental questions on diagnosis, which are
7 not being covered elsewhere.

8 MEMBER NEWMAN-TOKER: Yeah. I think
9 the key for me out of this conversation is that
10 it's critical that we have some specific
11 questions that relate to diagnosis and I think,
12 you know, finding ways to find - to compress the
13 instruments either by throwing out old stuff that
14 isn't really necessary anymore or by doing
15 something clever like the NIH PROMIS system which
16 is an adaptive computer-based, you know, approach
17 to sort of reduce the number of questions yet
18 still psychometrically valid.

19 You know, there are ways to decrease
20 the respondent burden but it doesn't change the
21 fact that right now there isn't enough focus on
22 the culture of diagnostic safety and somehow we

1 have to get that into the mix and have it be
2 measurable as its own at least somewhat discrete
3 entity so that we can say okay, look, you know,
4 the diagnostic safety culture at this place looks
5 not so good and it's improving now or it's
6 falling off the map or whatever.

7 MR. HENRIKSEN: Do you think five or
8 six items as a supplement to an existing culture
9 survey would be sufficiently -

10 MEMBER NEWMAN-TOKER: It's better than
11 nothing.

12 MR. HENRIKSEN: - impact - okay.

13 MEMBER SINGH: I'm actually thinking -
14 I mean - I mean, we have the AHRQ testing process
15 toolkit - has a bunch of questions in there. We
16 know testing process is a problem in the
17 outpatient setting. We can start with one thing
18 - you know, maybe start with that or take some
19 questions just from there.

20 MEMBER NEWMAN-TOKER: Well, I mean, so
21 I sit in the - I've been in the patient safety
22 board of - we have a patient safety board at

1 Hopkins and that's sort of like a subset of the
2 board of trustees. And they really pay attention
3 to these results of these culture surveys
4 whenever they are being tracked at each of our
5 hospitals, so on and so forth, and I think just
6 nowhere in this discussion is, you know, whether
7 we are actually paying attention to the issue of
8 diagnosis coming up at all.

9 So somehow I think it needs to make it
10 to that, you know, kind of boardroom discussion
11 and if the way to do that is to append five or
12 six questions maybe that's the way.

13 So almost done with the time. Just -
14 John asked me if I would sort of point to a
15 couple of specific measures so maybe we will do
16 that. Our group did stroke and the - I think the
17 key issue - I think when you start drilling down
18 into specific conditions, especially where you
19 know what the diagnostic error problems are, you
20 can actually get concrete about which measures
21 are relevant and which ones aren't. And I think
22 for this particular one the issue of the - you

1 know, the percentage of patients presenting with
2 a particular complaint like dizziness who did not
3 receive a timely diagnosis of stroke and then
4 looking at the percentage of patients who are
5 harmed including the severity of that harm.

6 There is some additional sort of
7 secondary issues about management, about the
8 patients requiring surgical decompression, is a -
9 is a specific measure that relates to the
10 lateness of presentation. So the same way we
11 heard earlier from Helen about the, you know, the
12 late HIV presentations, right. Like, did you get
13 to that point that it was that severe kind of
14 idea and the percentage of patients who receive
15 appropriate preventive - secondary prevention
16 stroke therapy.

17 There were some suggestions. Mira has
18 left but she said, for instance, you know, even
19 just looking to see whether stroke was on the
20 differential diagnosis in patients with
21 neurological complaints in and of itself could be
22 a measure concept.

1 And what I - what I said was in this
2 particular case for the sort of - for the average
3 dizzy patient who's older, stroke is always on
4 the differential diagnosis and the problem is
5 that the right information for how to
6 differentiate it from your problems is not
7 gathered.

8 But it is true that in younger
9 patients in whom the risk of misdiagnosis is much
10 higher that is actually an issue - that it just
11 doesn't even come on to anybody's radar screen.
12 So there are some potential measures in that
13 space.

14 And I think on the structure side the
15 availability of appropriate specialists to deal
16 with this kind of problem, whether that's, you
17 know, a stroke neurologist or vestibular
18 specialist or other people, and I think the
19 access to those individuals such as via
20 telemedical services to be able to consult in a
21 timely way so that those diagnoses can be made
22 when they need to be made in frontline health

1 care settings. So those are the, I think, the
2 key things that we came up with.

3 This sheet that you guys have now as a
4 printout is just a summary work that Mark and
5 Hardeep and I and other people did as part of the
6 diagnostic error in medicine research summit in
7 2015 and what we were trying to do is kind of
8 come up with a short list of metrics in this sort
9 of structure process outcomes framework that
10 might be used in monitoring or measuring
11 performance at kind of a leadership or a safety
12 officer kind of level. And we tried to focus on
13 things that were actually measurable with today's
14 data, or pretty close, and so, you know, to the
15 extent that this is helpful and informs the
16 process we brought up several of these and sort
17 of put them in our list as a group. But to the
18 extent that this is of use to the broader
19 initiative, happy to share the PDF with anybody,
20 or Christy has it and she can send it around, so
21 on and so forth.

22 CHAIR GRABER: Can you send it around,

1 David, or -

2 MEMBER NEWMAN-TOKER: Christy will.

3 Thanks.

4 CHAIR GRABER: Great.

5 MEMBER SINGH: And I was going to say
6 just as a source of original data to think about
7 measurement related concepts, something we had
8 mentioned earlier is actually safer guides that
9 we developed with ONC's sponsorship which has two
10 guides that are relevant for discussion to this
11 group. One is on test results reporting and the
12 second one is on communication of - communication
13 in general through the electronic health record.
14 That would be useful.

15 The other source of data to sort of
16 just think about the measurement concepts is a
17 recent paper review by Alcare - I think Edna
18 Shenwee is the first author - where they looked
19 at the review of the triggers to find diagnostic
20 errors and sort of the methodology that they use
21 of categorizing things might be also used for,
22 like, escalation of care, discordance and, you

1 know, changing the exchange in that. It's a nice
2 taxonomy that you might want to look at.

3 MEMBER NEWMAN-TOKER: Yeah, and you'll
4 note that some of those are also on the work that
5 we did back in 2015 under outcome metrics.

6 CHAIR GRABER: Fantastic. Well, a
7 huge thanks to everybody's participation in the
8 groups. Lots of ideas came out of this. As we
9 identify other resources it'll be helpful -
10 please share them around. I think everybody
11 would enjoy and benefit from seeing those.

12 We'd like to spend just a few minutes
13 hearing what you think are the cream of the crop.
14 So we'd like to hear from everybody are top two
15 things - what two things did you like the best in
16 terms of measure concepts. Jeff. Or you can
17 pass.

18 MR. JOPLING: So I was busy looking up
19 some stuff. Can I comment on the cultural
20 surveys and things like that? It's kind of to
21 echo what people have already said. But - and
22 Dave may end up being able to speak to this

1 better than I can.

2 Really quick - looking at the work
3 that Peter Pronovost did with CLABSIs, you know,
4 spread stuff across a hundred ICUs in Michigan
5 with the checklist invitation coupled with the
6 cusp cultural transformation package.

7 They gave this - the 65 questions -
8 safety attitudes questionnaire to all the ICUs
9 before and afterwards and at the end of the study
10 ran a regression - sophisticated regression
11 against which of these 65 statements, you know,
12 the agreement against those affected or
13 correlated strongly with improvement in CLABSIs.
14 And so there is actually only two - fortunately,
15 two - things that fell out. Item 10 and item 41
16 - so item 10 was hospital administration supports
17 my daily efforts and item 41 was I am frequently
18 unable to express disagreement with staff
19 physicians/intensivists in this ICU. So those
20 two components out of 65 questions were
21 correlated with a difference. And so there is -
22 there have to be research and testing done and

1 maybe actual pilot studies of improving
2 diagnosis. But we - I think there is hope to
3 distill things down to just a question or two.

4 CHAIR GRABER: Great. You'll send
5 that around too?

6 MR. JOPLING: Yeah.

7 CHAIR GRABER: That would be great.
8 Did you want to nominate two concepts that you
9 liked? Paul.

10 MR. EPNER: Can I just throw in
11 another comment or two then and not have - use
12 the public comment period later - just do it all
13 now?

14 Yeah, that's what I am saying. I'll
15 package it all up quickly. So first thing, I
16 think similar to research dollars there is a lot
17 more research on the treatment side than there is
18 on the diagnostic side. We have to fix that, and
19 I think we worry about survey questions and we
20 worry about other work that's already being done
21 and the proliferation of tools. I think the
22 relationship between the diagnostic side and the

1 treatment side is out of balance and so I
2 wouldn't - I'd say we have to figure out that
3 problem.

4 So what I really would suggest from a
5 measures standpoint is the notion that treatment
6 and diagnosis are distinct domains and that
7 because something exists in the treatment world
8 that's generalized to make it look like it fits
9 every situation.

10 We have to figure out a diagnostic-
11 specific way to address it and make sure that
12 they don't answer on one side and just say yeah,
13 we have answered that question already.

14 So that's - I don't know if that was
15 in there specifically. I didn't see in there but
16 the notion of different kinds of measures such as
17 - I mean, I didn't hear us talk about things like
18 Saul Reiner's work in standard patients and so
19 other approaches to measuring that are different
20 from the normal.

21 So, you know, I would hope that we
22 would think about innovative approaches to

1 measurement that could be built into this
2 framework. But I didn't hear anything about
3 secret Santas, shoppers or any of that stuff.

4 Two other quick comments - clinical
5 context. So we are still in a world where the MR
6 has to talk to the lab information system and the
7 radiology information system and there is still
8 IT people who focus on keeping the interface
9 light and not letting a lot of information go
10 across the interface. And so there is all kinds
11 of diagnostic errors associated with - if, you
12 know, Paul Tang at one of our meetings who's a
13 radiologist talked about the notion that he can
14 get an order for an abdominal image and he has 35
15 ways of implementing that and without knowing
16 what the suspicions are and the differential he
17 can't decide.

18 In the laboratory - the clinical
19 laboratory physicians I don't think really have
20 an appreciation for how much they are unaware of
21 the imprecision of laboratory tests. The notion
22 that patients are taking a lot of Vitamin B and

1 the biotin and all that is influencing the
2 chemistries of the tests and leading to
3 misdiagnosis of thyroid disease - the notion that
4 cross reactivities with drugs and poly pharmacy
5 is throwing off lab results. So a structural
6 measure around the notion of what kind of
7 clinical context is passed on to the supporting
8 organizations who are being - who really have to
9 look out for the ordering physician and advise
10 them when there is a risk of a wrong answer
11 because of mitigating factors. That's not
12 happening. So I would think about that.

13 And then my final comment - final
14 comment, truthfully - is that the Coalition to
15 Improve Diagnosis of which 32 organizations are
16 members including NQF is embarking on a tools
17 environmental scan for diagnosis.

18 So it's been coming up today. If
19 there is something we can build into this
20 environmental scan both literature search and
21 survey to figure out what's out there. If there
22 is something that would be useful to this NQF

1 committee we should have you involved to some
2 degree in the planning stage. I just need to
3 know if there is something to build into that.
4 We are really starting to get going on that.
5 Thank you for the opportunity.

6 CHAIR GRABER: Would this be the right
7 time to get public comment? Yeah. Is there
8 anybody online who wanted to comment?

9 OPERATOR: At this time if you would
10 like to make a comment please press star and then
11 the number one. There are no public comments at
12 this time.

13 CHAIR GRABER: Thank you. David, your
14 two favorite concepts.

15 MEMBER NEWMAN-TOKER: Yeah. So just
16 to reflect momentarily on Paul's comment. It
17 does give Kerm an alternative strategy to the
18 ones he mentioned, which is they have two columns
19 - one for with respect to treatment and one for
20 with respect to diagnosis and they ask the exact
21 same questions.

22 For me, the - I think the two that

1 rise to the top of the list are revisit tracking
2 for diagnostic errors in a symptom-disease
3 framework so the percentage of patients with, you
4 know, symptom X or discharge diagnosis X who
5 return with diagnosis Y that's linked and
6 measuring those is the top and most important
7 thing because I think that needs to ultimately be
8 in dashboard work for CEOs and executives.

9 And the second is process mismatched
10 tracking at the bedside. So where we - the
11 percentage of encounters with symptom X or
12 problem X where we fail to document critical
13 pieces of information or perform diagnostic tests
14 that were totally inappropriate to that problem
15 or that condition or diagnosis. We put in a half
16 plug for having a diagnostic safety officer named
17 at your institution.

18 CHAIR GRABER: Thank you. David.

19 MEMBER SEIDENWURM: One quick comment
20 and my two choices - the interface concept is
21 extremely important. Most hospital information
22 structures are run like spy rings. You know, the

1 agent in Madrid doesn't know the identity of the
2 agent in Paris and the - you know, the
3 information transfer is lost and so I think
4 that's a really important point.

5 I guess my two concepts that I'd like
6 to put towards the top of the list would be the
7 sort of calibration of diagnostic certainty and,
8 you know, when you're allowed to stop doing the
9 work up and, you know, how sure do you need to
10 be. I mean, those are the things - if we could
11 get at ways of measuring that or defining that
12 better that would be great.

13 And then I like the idea of using
14 administrative data to search for possible cases
15 of diagnostic error - you know, I really like
16 that as sort of screens. We had the interval
17 cancer ideas and we had the, you know, five ER
18 visits ideas and we had, you know, lots of ideas
19 around that. And so I think that whole area is
20 potentially a rich vein of ore to mine. Thanks.

21 CHAIR GRABER: Carlos.

22 MEMBER HIGUERA RUEDA: The first

1 concept is the one that relates to the time and
2 observer relationship with misdiagnosis. So I
3 think that something around staff support or time
4 ratio for encounter that would be probably number
5 one. And number two will be correlated with the
6 process with appropriate history and physical.
7 So be sure that we have some sort of - not a code
8 or anything like that but just like one or two
9 lines with a rationale with the main points.
10 Rationale for the diagnosis work-up and the main
11 points of the physical exam.

12 CHAIR GRABER: Hardeep.

13 MEMBER SINGH: So the two that I would
14 favor, one of them would be something around the
15 timeliness of diagnosis and of a high-risk
16 condition and so I would, you know, put cancer to
17 start but mostly focusing on specific problems
18 such as follow-up with abnormal test results, you
19 know, to fix. So I think that would be one
20 measurement concept I would propose forward.

21 And the second one would be something
22 at the organizational level. So does the

1 organization have the capacity to do measurement
2 related to diagnostic safety. So are they
3 looking at it from the organizational perspective
4 and having infrastructure to do that would be the
5 measurement concept that I would support because
6 that'll actually pull everything up because once
7 they have the collective mindfulness about what
8 they are finding they will fix stuff
9 automatically. Thanks.

10 CHAIR GRABER: Jen.

11 MEMBER CAMPISANO: I would say that
12 two that rise to the top for me, one would be
13 having a culture where it is okay to report
14 problems and to learn from them, and in an
15 environment at the hospital level or at the
16 clinical level where doctors feel comfortable,
17 you know, saying oh, I made a mistake, and so I
18 guess that would be sort of a systemic notion.

19 And then the other would be
20 communication of the diagnosis with the patient
21 and making sure that that is clear and well
22 understood and not just initially but throughout

1 the treatment process.

2 CHAIR GRABER: Missy. You're going to
3 miss?

4 MR. JOPLING: Sorry, I had a second,
5 yeah.

6 CHAIR GRABER: Okay.

7 MR. JOPLING: So I am thinking action
8 oriented. So one of the concepts I really liked
9 was having some type of tie to the board whether
10 it's - you shouldn't have let me go - you can
11 further specify because it can be, like, from
12 what Lavinia said to have, you know, the three
13 pieces of the RCA from doing it to actually
14 acting on it to having some type of measure on
15 their dashboard - just something so that the
16 board is actually paying attention to it.

17 The second thing, I think, is
18 actionable from the front line would be the
19 document - the recognition of and documentation
20 of the red flag symptoms. I think that's a
21 massive part that's missing from both the
22 research perspective. It's missing from the

1 daily clinical activities if that's actually
2 recorded that can help team members from the
3 start to finish of the diagnostic process,
4 actually see what the - those reflections were as
5 they - as they were there.

6 CHAIR GRABER: Thanks. Would you mind
7 turning off the microphone next to you? Great.

8 CHAIR DANFORTH: Okay. So board
9 engagement related to diagnostic quality, for two
10 reasons. One is because I think it's important
11 for the board to recognize problems that will
12 need resources and then allocating those
13 resources, and two, just from an accountability
14 standpoint there has been a lot of work to move
15 accountability for patient safety events away
16 from not just front line care givers but up to
17 administrators and ultimately the board. And so
18 I think this is a good opportunity to do that.

19 The second one are - the second
20 concept, any kinds of measures that measure
21 effectiveness of communication with patients not
22 only in gathering their history and communicating

1 them - communicating with them throughout the
2 diagnostic process but also involving them in
3 resolving diagnostic errors including
4 interviewing them for root cause analyses.

5 CHAIR GRABER: Well, these are like my
6 children. I love them all. I would really like
7 to see organizations finally learn from
8 diagnostic errors and I'd like to see that
9 diagnosis includes differential diagnosis
10 somewhere along the process. Those are my top
11 two. Kathy.

12 MEMBER MCDONALD: I'd like to just
13 ditto Missy's but I'll be different. So
14 electronic health records support diagnostic
15 process and decision making, the first one of
16 group one and the way that it was further
17 articulated is really important in my view.

18 And the other really important one in
19 my view is the patient-reported outcomes - you
20 know, whether the goals are met, delays in
21 diagnosis occurred - you know, kind of all the
22 questions that could be asked to patients about

1 their experience of diagnosis.

2 CHAIR GRABER: Martha.

3 MEMBER RADFORD: My two favorites are,
4 one, does the organization have a robust way to
5 learn from the diagnostic issues. That's a
6 structure measure. And two, mining our
7 administrative data more thoroughly and more
8 insightfully to pick up diagnostic issues and we
9 had several strategies for that around
10 readmissions, appearance of rare diagnosis -
11 appearance of new diagnoses over time, et cetera,
12 that I think we need to take advantage of, and
13 the reasons for these are, you know, I am a CQO
14 and I want things I can use.

15 CHAIR GRABER: Thank you. And Helen.

16 MEMBER HASKELL: So I am echoing Kathy
17 in that I like the idea of capturing and
18 retaining the whole diagnostic process in the EHR
19 with the patient input as part of that so all
20 along including patient outcome. So I am rolling
21 many things into one so that I can get two. And
22 then my second one is the idea of pharmacy side

1 effects so checking for pairing of drugs with
2 side effects and also red flagging poly pharmacy
3 and checking that people are not having
4 interactions and side effects that are
5 undiagnosed.

6 CHAIR GRABER: Nicholas.

7 MEMBER KUZMA: I think the first one
8 is the institution trying to create some sort of
9 system to identify diagnostic errors and then
10 when they identify them do they have a system in
11 place to learn from them and change processes.

12 And then the second one would be
13 something with communication with the patients
14 and families. Do they - are they involved in
15 creating the diagnosis - do they understand what
16 the - the follow-up and all of that.

17 CHAIR GRABER: Thank you. David.

18 MR. HUNT: It is hard to choose but I
19 do like the late stage first presentation be it
20 cancer or any other condition - a late stage
21 diagnosis for a population. One of the reasons I
22 like that, I mentioned - one topic that I hadn't

1 heard come up earlier is that that would also be
2 a very good measure when you split by race,
3 ethnicity, social economic status for looking for
4 disparities.

5 And the second one that I like is the
6 - any board or governance activity, looking
7 specifically at the accuracy of diagnoses. And
8 the only thing I'll ask is I am sure we are going
9 to but those who have left we will solicit them
10 for their two answers also. Thank you.

11 CHAIR GRABER: Thanks. Kerm.

12 MR. HENRIKSEN: First of all, thanks
13 for the - just confirmatory feedback on the
14 extent to which we want to use culture surveys in
15 terms of the issue of a few items for
16 supplemental modifications versus the full-blown
17 new instrument in and of itself. So that's very
18 useful information to carry back. And I think
19 that is probably the direction that we have the
20 capability and the funding mechanisms for the
21 contract mechanisms to actually implement in a
22 sooner - quicker order. But in terms of the

1 measures that folks have been talking about, they
2 may have been discussed but I don't think it was
3 discussed to any great extent and that was
4 measures to identify disparities with regard to
5 the nature of the extent of the diagnostic work-
6 up, given the same underlying condition whether
7 it's a - and so there is - there is some emerging
8 evidence to show that those are really evidence-
9 based disparities that need to be addressed. And
10 so I don't know if it was on the list. I heard
11 discussion of it in a sidebar conversation. So
12 it's just something that really needs to be put
13 on the list.

14 The measures of uncertainty has been
15 brought up several times and - but it still seems
16 to be a challenge, and maybe it's the peer to
17 peer discussions that folks have mentioned as
18 being, you know, clinicians talking to
19 clinicians, physicians to physicians and that may
20 be indeed one way of capturing some of that.

21 The other issue that sort of resonated
22 with me when Paul was speaking about let's not

1 lose sight of the distinctiveness of diagnostic
2 safety by trying to overgeneralize things that
3 are going on in patient safety to cover - to say
4 that we are addressing the diagnostic side of the
5 coin, I think this group needs to really think
6 about how to raise the distinctiveness of
7 diagnostic safety separate from treatment,
8 separate from patient safety.

9 And so there are various ways of doing
10 that - perhaps the dashboards that were -
11 organizational dashboards were recommended. I
12 know there is - you know, all sorts of
13 possibilities of increasing the distinctiveness
14 of diagnostic safety as its own entity. And so
15 that probably deserves some more brainstorming.

16 CHAIR GRABER: Thank you, Kerm.
17 Prashant.

18 MEMBER MAHAJAN: So Lavinia actually
19 gave me her two so is it okay to read hers?
20 Okay. So first we had feedback mechanism for
21 improvement to RC advocacy and the second was
22 communication of diagnosis to patient with

1 acknowledgment of understanding from the patient.

2 And my two were I was trying to look
3 at the clinical reasoning skills and how to do
4 measures and more of a structure measure. So
5 forcing the EHR to have the clinicians document
6 what you mentioned - differential diagnosis in
7 the thought process so hoping to capture that.

8 And second was patient involvement but
9 more from shared diagnosis model rather than
10 shared decision making, point being that at every
11 time of uncertainty that they are involved and
12 they are aware of the thought process and some
13 way to capture that in the EHR.

14 DR. BURSTIN: We have some from Tom,
15 who's - Tom, are you with us? Do you want to
16 just report out yourself or we could read it for
17 you? He's feeling a little better today. I'll
18 just read it for him.

19 He said some concept around follow-up
20 of abnormal findings or results like a metric of
21 time to diagnosis from important conditions - a
22 subset of that one - and then some concept around

1 identifying, tracking potential diagnostic
2 miscues, something along the lines of a trigger
3 tool.

4 He said board engagement is important.
5 It's a big part of his own day jobs, since he's
6 head of a quality and safety partners health
7 system. But I am not sure it's a metric to
8 follow in this space that would be directly
9 actionable enough.

10 CHAIR GRABER: Great. Our work is
11 done. Thank you all. Great ideas. Thanks for
12 everybody's interest and participation. We are
13 going to turn it over to the NQF staff to tell us
14 how this all becomes sausage.

15 DR. BERNOT: All right. I'll be brief
16 just to wrap this up. But what we will plan to
17 do is from our staff we will try to make some
18 sense of this, especially with the high points
19 and digest this down to where we - there is going
20 to be somewhere we think are already listed at a
21 measure concept level and other ones that are
22 more the themes and ideas we may pass back for

1 essentially a homework assignment to have people
2 help us get those down to what they might get
3 closer to measure or at least measure concepts
4 from those themes.

5 So we have - I'll let Christy - I'll
6 turn it over to Christy to give the details but
7 we have a meeting coming up in just one week. So
8 in this process - in the course of this next week
9 is we will have the instructions on what we are
10 going to do and then we will present it all
11 there. So it's a real nice follow-up time frame,
12 I think, for this.

13 MS. SKIPPER: Yes. So thank you, John,
14 you just covered what I was going to say about
15 web meeting to we will still be - we will be in
16 touch with you about what's going to occur on
17 that call. But following the second web meeting
18 we will have updated the draft framework and we
19 will post it for a 30-day member and public
20 commenting period just to get other feedback from
21 members and the public and then we will reconvene
22 for a web meeting on March 16th to have the

1 committee respond and adjudicate the comments
2 received and revisit our measure inventory and
3 other items that may need to come up and be
4 addressed on that call. And this meeting will
5 also be a precursor to the next in-person meeting
6 which takes place April 12th and 13th.

7 MR. LYZENGA: I just want to quick
8 emphasize on the - on the 30-day comment period
9 on the draft framework and I want to, again,
10 emphasize that this is - this is a draft
11 framework. We have some work to do on that,
12 clearly, I think, in sort of refining some of the
13 domains or categories. But given the short time
14 turnaround before we have to get this out for
15 comment we may do something pretty similar to
16 what we presented to you here even though we may,
17 again, have further development of that as we
18 move forward in the project. But if you see this
19 pop up on a new website and you say oh, we - we
20 are going to change that and then, you know,
21 don't worry about it, we still may, and it's just
22 something we need to put out for comment. So

1 more work to come.

2 MEMBER SINGH: Are you putting in just
3 the draft framework without any of the
4 measurement concepts that were discussed in the
5 last two days?

6 MR. LYZENGA: Yeah. Probably not the
7 concepts that have been discussed in the last two
8 days, just -

9 MEMBER SINGH: So what would actually
10 go out?

11 MR. LYZENGA: So it - well, that's yet
12 to be decided. Some context around it but the
13 domains and subdomains, some explanation of what
14 those are, what the thinking was behind it.
15 Possibly some examples of measures associated
16 with that -

17 MEMBER SINGH: For instance, would you
18 put some of these -

19 MR. LYZENGA: - similar to that.

20 MEMBER SINGH: - right sided things
21 out, especially some from today or -

22 MR. LYZENGA: We have to - we can

1 welcome -

2 DR. BURSTIN: Again, it's just public
3 comment. It's always just an opportunity for
4 input. So that's part of I think what we will
5 talk with you about on the 17th, yeah.

6 MR. LYZENGA: Right. We are open to
7 input from anyone at what should be included in
8 that.

9 MEMBER RADFORD: Strongly for some
10 context.

11 MEMBER SINGH: Absolutely. I am very
12 concerned that your people will misunderstand
13 what we are doing here and we will get comments
14 that are probably very tangential.

15 I think this is all - it's a very,
16 very large body of knowledge and I think if we
17 put the whole thing out there it would probably
18 send some kind of a mixed message or - and I
19 would - if you want to put some stuff out there.

20 The other thing I was going to say is
21 I think you were asked okay, what are the top
22 two. I mean, that also has to be contextualized.

1 Top two things to do now versus top two things to
2 focus on in the next 10 years or five years. The
3 science in this area, as I mentioned yesterday,
4 is so poor and so under developed we can tell
5 about the two things that organizations can do
6 now. But then with saying that, you know, for
7 instance, Kerm mentioned uncertainty. That came
8 up again and again - calibration. Those are
9 concepts for the future. The things that we can
10 do now are the practical things like making -
11 getting organizations involved and trying to sort
12 of do something about this and maybe
13 communication of results. But I think if we
14 advocate for a lot of things at the same time
15 without saying this is for the future, this is
16 for now, I think it sort of might be taken very
17 well by the general public.

18 DR. BURSTIN: Yeah, and we will put
19 that in context. I do think that we want to put
20 out at least even if it's early just to say
21 here's - with context linking back to the
22 framework some potential concepts that might link

1 back to the framework just to make it more alive.
2 But I think the idea of having a measure concept
3 is something somebody could develop into a
4 measure in the next three to - you know, the next
5 three years or so. So we can frame it that way.
6 But there is, obviously, going to be a lot of
7 research and background work that would get you
8 to the next level. But I still want to make sure
9 we keep this moving forward, that it isn't all
10 about this -

11 MEMBER SINGH: So - yeah, so maybe
12 important concepts that would inform further
13 measure development or measure concept. So, I
14 mean, just clarifying the language itself will
15 help without calling them measurement or measure
16 related things because people think there is a
17 measure now on, like, 300 things. So -

18 CHAIR GRABER: Thanks, everyone.

19 (Whereupon, the above-entitled matter
20 went off the record at 2:31 p.m.)
21
22

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C E R T I F I C A T E

This is to certify that the foregoing transcript

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and Safety In-Person Meeting

Before: NQF

Date: 01-11-17

Place: Washington, DC

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