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 test 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, an 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

In the matter of: Improving Diagnostic Quality
                  and Safety In-Person Meeting

Before: NQF

Date: 01-11-17

Place: Washington, DC

was duly recorded and accurately transcribed under
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_____
Court Reporter