National Quality Forum

Moderator: Patient Safety
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OPERATOR: This is Conference # 99811910.

Christy Skipper: Good afternoon, everyone, and welcome to the second webinar for the ambulatory care patient safety project. Before we begin today, I just want to make sure that you all need to be logged in on the computer to follow along with our slide set.

So, I'm just going to go over the agenda really briefly. We are going to review our approach to the environmental scan and then take you all through a review of the measure inventory, have a discussion around that. And then also, we have questions related to priorities, barriers, and challenges for ambulatory care patient safety.

We'll close out with public and member comments. And so, my name is Christy Skipper. I'm the project manager for this work. And I'll turn it over to my colleagues to introduce themselves.

(Vanessa Moyen): Hi, everyone. My name is (Vanessa Moyen). I'm the project analyst on this project.

Andrew Lyzenga: Hi, Andrew Lyzenga, a senior director at NQF.

Andrew Anderson: Hi, everyone. This is Andrew Anderson, also a senior director in quality measurement here at NQF.

(Vanessa Moyen): Thank you. OK. And then I'll do a roll call for this advisory group. Is (Peter Brower) here by any chance?

(Peter Brower): Yes, I am here.

(Vanessa Moyen): OK. Thank you.

How about (Sonali Desai)?

(Sonali Desai): Yes. I'm here as well.

(Vanessa Moyen): OK. Thank you.

And (Richard Roberts)? OK.

How about (Urmimala Sarkar)?

(Urmimala Sarkar): Yes. This is (Urmimala Sarkar).

(Vanessa Moyen): OK. Thank you.

(Kevin Shehan)?

(Kevin Shehan): I'm here.

(Vanessa Moyen): Well, thank you. And (Saul Weingart)?

(Saul Weingart): Yes.

(Vanessa Moyen): And just to make sure, is (Brandon Lorhan and Barbara Bartman) here?

(Brandon Lorhan): Yes.

(Vanessa Moyen): OK. Thank you.

I'll turn it over to Christy to do the overview of the ambulatory care and patient safety.

Christy Skipper: All right. Thank you, (Vanessa).

So, just as a review, the purpose of this project was to conduct a scan of measures and measure concepts related to ambulatory care patient safety in the non-elderly population. The final deliverable for this report will include

the measure inventory of measures and measure concepts that we identified and you all prioritize. And it will help address measure development in the area of patient safety.

So just following our call today, we'll be taking the committee's discussion and any comments that we receive from members of the public to incorporate in a draft report which I explained that will basically lay the foundation for informing future measure development.

The draft report will be posted for a 30-day comment period beginning on February 16th. And then we'll bring the committee back for a third webinar on March 29th to review any comments on the draft report and just make any final recommendations on measurement gaps and priority areas, and then final report will be published on April 13th.

All right. So, next slide. So some of this is a review from the last call, but again we'll be looking for measures and measure concepts, gaps in measurement, and seeing some challenges related to measure development.

We search databases like PubMed, Academic Search Complete, and also searched the Grey literature. Most of the measures that we did find came from our own inventory, National Quality Forum, ARC, measures from CMS and PQA.

So these are our primary research questions that will be guiding – that we use to guide the environmental scan. So again, we were looking at what the gaps were, what are emerging topics and themes.

And this slide just shows you the search terms that were used they were combined with terms like measure, survey, and scale just to make sure we didn't miss anything. So what's new from the last call is that we did conduct key informant interviews just to supplement what we found in the literature and what learned from you all during that first orientation call.

So we conducted hour-long interviews with two individuals. We spoke with a registered nurse who directs the quality program at Cedar-Sinai. And we also spoke with an associate professor and director of quality informatics at UCSF.

So in addition to understanding their duties as it relates to patient safety, we also ask for their opinions on which measures best capture ambulatory care patient safety, data sources that can be leveraged to assist in measurement. And we also asked them to provide any insight on measurement gaps, any challenges and best practices.

So I'm just going to summarize some of the key takeaways. So when we asked them what current measures they thought were important for patient safety, antibiotics, overuse measures, measures around hand hygiene, and opioid prescription patterns were the key measures that popped up.

They also felt like measures around safety culture would be important. They also did, a checklist and tools were useful and helpful in addressing safety issues. We heard several challenges around the data, so for one, we all know that data are not uniformly collected.

They're not in standardized fields. For example, some information that can be used for patient safety such as falls, other events taking place in the medical office, lab-related events or serious adverse reactions to medications are noted in progress notes.

And so, they felt like there is a need for creating discrete fields to collect information from the progress note. On the other hand, one person shared that structured information can only get us so far and that organization noted that they were able to use a natural language processing to pull information from the progress notes.

On the other hand, the infrastructure to run a natural language processing algorithm is huge and expensive. Another obvious challenge is that data are in silos, which can make it hard to collect and control the data, standardize, clean and aggregate it.

OK. Interviewees also mentioned that staff resources, skill mix and infrastructure were also issues for patient safety measurement. One person

noted that there is a lack of funding and expertise to do work around measure development and also in ECQM development.

OK. Another challenge given was difficulty with developing metrics that use the appropriate denominator. So going back to this example of falls, within hospitals, the number of hospital days can be used for the denominator. But in an outpatient setting, for instance, if the volume of patients was used as a denominator, was that really accurate, was that helpful. And I guess, the bigger question was what denominator would be meaningful in that particular example.

Moving on to measurement gaps, we didn't get a lot of information on exact measurement gaps around this topic, but they – one person noted that they struggled with what structural measures that identified staffing levels.

Another person added that their needs to be an investment in the fundamental research to identify gaps in care that will drive meaningful measures that are feasible for implementation, so it was almost like we were putting the cart before the horse. That we can't just start with identifying gaps, there needs to be that foundation, research and discovery and then begin to identify gaps.

Just a couple of future directions or things that we pull from those key informant interviews and I've already touched on additional research and funding is needed, but hand-in-hand with that was the feeling that there is too much of focus on existing measures and implementing those in national programs, but again, that research and discovery is needed around patient safety instead of focusing on the measures that currently exist.

Another key takeaway, and I'm paraphrasing, is that in ambulatory care patient safety health plans drive measurement. One person noted that their organization give higher priority to pay-per-performance. And they felt like providers shouldn't be the only stakeholders. The attention should be given to the role that health plans play in patient safety measurement.

Another key takeaway was to use multiple data sources. The individual noted that combining EMR records along with claims data would paint a robust

picture of patient safety, so the more layered the data you have, the fuller picture that you could have on patient safety.

And then the last takeaway when we asked about databases that can be leveraged for patient safety, one person noted that their in-house safety event database captures such information on patient complaints, risk, legal claims against providers, accreditation and audit findings that again, can be looked at and leveraged for patient safety.

That's just a brief, I think, brief overview of what we talked to the informants about. Does anyone have any questions or reflections on what I've presented so far?

(Urmimala Sarkar): This is (Urmimala Sarkar). I'm wondering if in the course of your environmental scan, I had mentioned last time that the Medicaid program in California, their federal waiver includes some measures of patient safety in outpatient settings, I'm wondering if you pulled that and included it because it is beyond what you called out as specific issues.

Christy Skipper: We had not got our hands on that at this point and you – will you say that again, the Medicaid federal waiver…

(Urmimala Sarkar): Yes. So several states have Medicaid waivers, right, so that's sort of a pay-for-performance approach to Medicaid programs that the states create themselves, California one publicly available. It includes an optional study on ambulatory patient safety.

I believe I mentioned this at the last call, but that's project 1.4 of the California PRIME Medicaid waiver. In addition there are other required metrics within the waiver which are things that all the safety net hospitals that provide Medicaid in California, all the health systems have to provide this data to the state.

And it includes things like closing the loop on some specialty referrals and includes things like following up on abnormal cancer screening results that are highly relevant patient safety measures.

And that to me is, this is the only, actually operationalization – I can't talk this morning, sorry, of these patient safety measures that I'm aware of. But there are 21 public health care systems in California who are reporting these measures and they've already reported for two years.

So, I would suggest that you get those. I'm also happy to resend you the information that's all publicly available.

Christy Skipper: That would be very helpful to us. And as we learn more from you on this call or hear other comments, we will be able to incorporate those additional findings or measure concepts into the inventory that we sent around, so thank you. And it would be…

(Urmimala Sarkar): Some of them are NQF measures like NQF measure, I believe it's 555 with anti-coagulation follow up. People are actually measuring that across the state here.

Christy Skipper: OK. Thank you. Anyone else? OK.

(Peter Brower): I have more of a comment on – with regard to the natural language processing. I don't think the comment that it is laborious – I don't know the exact words. Highly expensive, labor intensive, I think I'll add a few other buzzwords out there, but with machine learning and artificial intelligence really at our fingertips now, I think NLP five years ago, you need really costly tools like Humedica or Optum, it's called now.

I think that natural language processing or the ability to mine free text for meaningful information is at our fingertips. And if we're not doing that, we're missing out. So, I don't think that commentary was precise.

Christy Skipper: OK. Thank you.

(Vanessa Moyen): May I ask who was that speaking?

(Peter Brower): That's (Peter Brower).

(Vanessa Moyen): Oh, OK. Thank you.

(Peter Brower): Thanks.

(Urmimala Sarkar): This is (Urmimala Sarkar), sorry, I thought of one other thing. So, I've been talking a lot with the Patient Safety Organization that we have here in California, which is called the (CALHPSO). And I don't know, it seems like neither of your key informants mentioned that as a place to look for ambulatory patient safety incidents. But there are many, many, many incidents reported to Patient Safety Organization.

(Peter Brower): Yes.

(Urmimala Sarkar): And you should definitely be including that as the data source.

(Peter Brower): Yes. This is (Peter Brower). I definitely, (Visiant) is the one that we used. I think it's the largest PSO. I think that's a great point.

Christy Skipper: Thank you both. So, now we'll just turn it over to a review of our measure inventory and have a discussion around that.

Andrew?

Andrew Lyzenga: As you know, yes, we are aware of the common formats generally. We're planning on sort of discussing that a little bit. We don't typically consider them measures exactly.

It's a reporting system made of, of reporting patient safety data, but typically you don't – as I understand it have things like a numerator, a denominator able to sort of calculate rates out of that data, although we'd be very interested to hear if anybody is trying to do that or, sort of, capable of doing measurement derived from data pulled from the common format reporting.

So just sort of briefly talk upfront. Based on what we've been finding in our search and what we have kind of been reading in the literature, we set out a few broad conceptual domains for measurement in ambulatory care of patient safety issues.

We're sort of using as our kind of main ways to categorize the measures that we're finding and likely to do some gap analysis once we sort of finalize the scan a little bit more. And we'll return to this and talk to you guys about what you think of these conceptual domains in just a few minutes. But I just wanted to sort of set that out upfront because it sort of performs a framework of how I'm walking through this as well.

You can go to the next slide. And this summary here is of what we've identified as – well, what we're calling measures, and what that means is measures that have been specified with at least a numerator and a denominator.

We typically prefer even a little bit more information than that, something like a data source level of analysis, or at least a target population and that sort of thing. And many of the measures do have that, but some do not, but just in the, sort of, interest of pulling in what we could, we took in a lot of those measures that had merely a numerator and denominator.

In addition to that, we have a list of concepts that we found which don't even have a numerator and denominator, although in some cases if you can sort of extract the numerator and denominator just by looking at the description, but they haven't specified that.

And those are a little bit – most of them tend to be just a brief description of what the measure might address or look like. We found those a little bit less useful. We're still going to do some further analysis of those to see if we can sort of parse out some more information from them and do some analysis on them.

But for this call, we thought we would focus mostly on the actual measures we've identified and use your feedback on these to sort of help guide how we handle those concepts subsequently. So, with that said, we found a total of 146 measures that could potentially be considered ambulatory care patient safety measures.

We sort of went through and gave each of these measures a yes, maybe, or no on whether it is, in fact, related to ambulatory care of patient safety as we're

defining it and found that of those 146, around 38 we thought were fairly likely to be considered ambulatory care of patient safety measures that got a yes, a larger number of maybes that are – that make up the remainder of those 146.

And a large part of this call is sort of getting your thoughts on some of those general categories of the maybes and seeing what you think about whether we ought to consider those patient safety measures if they are truly addressing safety issues, if they are important to ambulatory care safety and whether we ought to include measures like that in our inventory.

So, and to sort of break down those 146 measures a little bit we sort of got counts by domain. The biggest grouping of the measures were around medication management and safety. Second was in the area of care coordination. A pretty good number in diagnostic safety, although there is a good deal of overlap there between care coordination and diagnostic safety in many instances. It's another thing we're hoping to get some thoughts from you on.

Some measures that we're calling prevention of adverse events. A group of measures related to admissions and readmissions, again, a category, as a whole we're wondering if we should truly consider it to be measures that are directly related to patient safety in the ambulatory care environment.

So we'll ask you about that. HIT safety, sort of an emerging issue. There is a few that we thought could be considered HIT safety measures. Some measures related to patient self-management.

Again, in our sort of reading and preparation for this project recognized that one of the potential issues for safety in the ambulatory care environment is – because there are sort of fewer touch points with patients, you don't have them in your hospital in a sort of inpatient environment, and able to monitor and track what's happening and manage their care there.

There is a lot more importance of having patients able to manage their own care when they're in their homes or wherever else and sort of preparing them for that and ensuring that they're able to and doing it appropriately.

Again, sort of something of an open question about that whether this truly is safety issue for our purposes or not. And then a few measures also that we called related to safety culture, sort of, broadly construed.

In terms of the data sources that these measures are drawing from, a lot of them are based on claims data, either claims only or claims and other data, and that could include pharmacy data, laboratory data, other kinds of sort of electronic or clinical or other data.

A chunk of measures that are based on data extracted from the EHR. And by that we don't typically mean eCQMs or eMeasures, but measures that are based on review of the electronic health record and some of those also with other data sources in addition.

Some measures were based on patient reported data, a few that are registry based and then a good number of the measures we found did not have a data source available.

In terms of measure type, as you might expect, the bulk of the measures are processed measures. We did find 33 outcome measures, although again, we may find that many of those in that category may not truly be safety related sort of strictly speaking. We have a few structure measures and then a chunk of patient engagement/patient experience measures that we included for discussion as well.

In terms of the level of analysis, this is sort of an important category base, and one of the ways we were trying to look at whether these measures were in fact applicable to the ambulatory environment. We were including measures obviously that are applicable to individual clinicians or to clinician group practices.

But in addition, I thought that we should include measures that are analyzed at the health plan level, thought that those could certainly be applicable to the

ambulatory care environment. There are a number of measures that are sort of intended for the population level measurement. But we do know that some of those have recently been sort of – there's been discussion of applying those to the level of a clinician or a group practice. So, we thought we'd include some of those for discussion again.

Integrated delivery systems, and by that, we're actually having some discussion at NQF right now as to what exactly that means. Typically think of some of those larger integrated delivery systems like Geisinger or Intermountain Healthcare and Kaiser Permanente that include lots of different settings of care and manage patients across those settings.

But also our thinking that that may include things like Accountable Care Organizations or sort of groups that are called patient-centered, medical homes, again, groups that are taking accountability for patients across the settings of care and across episodes of care. Thought that would be important to incorporate into sort of look at measurement in the ambulatory care environment.

These levels of analysis, these counts here are actually overlapping because many of the measures we found are applicable to multiple levels of analysis. You could do that at one or the other. So this obviously doesn't total up to 146. But some of these measures did also include measurement at the facility or agency level, which I think at the outset we were not really looking for, but some of the measures are applicable at that level.

And then some that were applicable at the multisite or corporate chain level, some that could be applied to quality improvement organizations. And then a good number that just sort of set other or not available. And we weren't immediately to, sort of, find what the exact level of analysis was for those.

Maybe I'll just pause there for a moment and see if there are thoughts or questions on that kind of summary.

(Urmimala Sarkar): This is (Urmimala). It would help me to understand a bit maybe if you have a working definition of each domain. I've been asking myself about

things like inadequate translation services for patients with limited English proficiency. Where would you put that on this list?

Andrew Lyzenga: Yes. It's a good question. I'm not sure if we would – potentially in the area of patient self-management or preparation for sort of patient self-management, but I'm not sure if that quite fits there either. Possibly care coordination, possibly diagnostic safety. We have a…

(Urmimala Sarkar): Yes. I mean it begs the question of whether a communication domain is needed that, obviously there is some overlap between care coordination and communication, management and communication.

Andrew Lyzenga: Yes. Yes.

(Urmimala Sarkar): But the question – I just feel like I need to understand better what the definition of each domain is to know if there's anything missing.

Andrew Lyzenga: All right. We'll try to put a little bit more definition around that and send that out to you guys and take a look. I think we tended a group measures related to communication in care coordination, sometimes in diagnostic safety. That was, again, one of the questions I had here and there's, again, some overlap. But you're right that we should, sort of, try to define those a little bit more strictly, and so we have a better sense of what those terms mean.

Maybe we can go on. So for these next slides, oh here, so these are some of the themes that were within those domains, the sort of broader domains, medication management and safety measures related to MedRec, appropriateness of prescribing, monitoring of medications, antibiotic stewardship and opioid safety, again, in care coordination, communication between providers.

Some measures related to follow-up after hospitalization. And then a good group of measures around patient experience with and of care coordination and some sort of interesting set of measures. Looking at how patients have experienced their care and how their care is being managed, that kind of thing.

Diagnostic safety, so yes, these and some of these, just particularly the closed loop referral and follow-up issues could certainly be included in care coordination as well and sort of weren't sure whether we should put them in one or the other, but I know we had a project recently focused on diagnostic quality and safety.

And this was a major issue of follow-up on referrals and closing the loop on referrals and follow-up on test results was a major point of interest there, so at least for the time being had categorized many of those measures in this category.

With respect to HIT safety, most of those were really related to whether providers were using HIT in certain ways, sort of structural measures of that type. Prevention of adverse events, a number of measures related to prevention of falls and pressure ulcers, but then some measures that are of sort of potentially avoidable complications.

And these were some measures that were submitted to NQF recently or have been over the years. A good chunk of them recently had their endorsement removed, but we still thought it was important to include those in here, we're including both endorsed to non-endorsed measures.

And those look at a wide range of complications usually focusing on patients with particular conditions or having undergone particular procedure that then have complications in I think the 30-days window afterwards.

In terms of admissions and readmissions, again, these sort of population level admissions measures many of these from ARC, what they call their prevention quality indicators which have – I know have been proposed for some of the federal programs related to clinician measurement as potentially being applicable to either the clinician level or to Accountable Care Organizations.

So, I thought we would include those here. And then, again, ED admissions focused on particular conditions, usually I think high risk conditions and whether those have been avoided through appropriate outpatient or ambulatory care.

So having said that, we wanted to kind of look through some examples of some of these categories and talk through with you guys a little bit or at least sort of get these in your mind and maybe get some feedback from you, if not on this call, afterwards, whether be or similar measures ought to be considered for our purpose to be ambulatory care, patient safety measures and ought to be included in our inventory.

And go to the next slide, so starting with medication management and safety, we had a number of measures related to adherence. I've seen these adherence considered as safety issue before. I think some others don't.

Here are a couple of examples of the measures, many of these use a medication possession ratio to measure what other patients are adhering to their medications or at least whether they're filling their prescriptions and sort of able to adhere to the medications.

Does this seem like a safety issue to you? If you were gathering measures of safety in the ambulatory care environment, would you consider adherence to be in that category?

(Urmimala Sarkar): I'm sure you guys looked at the report that HRQ put out about ambulatory safety.

Andrew Lyzenga: We have.

(Urmimala Sarkar): And I worked on that report and we specifically talked about adherence, I don’t know how much of that, with our key informants. I don’t know how much of that made its way into the final report.

But the bottom line is that really neither experts nor frontline clinicians consistently agree. You will hear some people say non-adherence is dangerous, people have preventable complications, it is a safety issue, but that is a minority perspective and I think people generally feel like it's a bit of overreaching to call non-adherence a safety issue.

Andrew Lyzenga: That's helpful. Others agree or any other thoughts on that?

(Saul Weingart): This is (Saul). I think adherence is a huge part of patient safety in the ambulatory setting and would really support trying to expand the set of metrics that we have to help us understand and improve it.

Andrew Lyzenga: Maybe we can…

(Urmimala Sarkar): And there you hear the controversy.

Andrew Lyzenga: You're right. Maybe the sort of thing where maybe we could not necessarily include those measures in our inventory, but discuss sort of in a little bit more of the narrative that adherence can be an important issue and can be a potential source of harm to patients.

And that maybe there's a need to develop measures that are sort of focused on adherence from a safety standpoint and see if they could be sort of more tailored to avoidance of harm, is that a reasonable way to approach this?

(Barbara Bartman): I think it depends on how you scope the project. I mean, is adherence a critical issue when it comes to patient safety and ambulatory care? Of course, it is because we co-create safety with patients and their families and caregivers and in the ambulatory space.

So it's sort of essential to thinking about safety. But if you scope the project so it's mostly about what caregivers are doing, what clinicians are doing then that would turn it into more of a footnote than the first chapter.

(Urmimala Sarkar): I absolutely agree with that characterization of the issue.

Andrew Lyzenga: OK. All right. Well, we can return and get more thoughts on that. We don't have too much time on this call, so we may at some point try to reach out to some of you and talk with you a little bit more informally on an individual basis just to sort of draw some thoughts out for me because, again, we don't have a ton of time on these calls and we found some of the key informants interviews helpful in that way just to talk a little bit with somebody on a one-on-one basis, and then we can share those results with the groups as well.

But moving on to the next – also a group of measures related to antibiotics stewardship. Again, can be seen as a patient safety issue or more of a sort of appropriate use issue I guess. Do you guys have opinions or thoughts on whether this ought to be considered for our purposes a safety issue and whether we should include measures related to this topic?

(Barbara Bartman): This is (Barbara Bartman from ARC. I wonder if some people could comment on if this is a safety issue or if these measures are more measures of quality.

Andrew Lyzenga: Right. That's also …

(Kevin Shehan): Yes. Yes. This is (Kevin) (inaudible) I would agree with that.

Andrew Lyzenga: More…

(Kevin Shehan): … more of equality.

Andrew Lyzenga: Equality.

(Kevin Shehan): Yes. Not necessarily strictly a safety measure.

(Urmimala Sarkar): Or effectiveness would be the domain.

Andrew Lyzenga: OK, that's helpful. Thank you.

(Barbara Bartman): It's always easy to – I mean, it's difficult to always stay in one domain, quality of safety. So people frequently slip into the other domains, so I just wanted to bring that up.

(Urmimala Sarkar): Because that's what people say about adherence as well to be clear.

(Barbara Bartman): Yes.

Andrew Lyzenga: All right. So the next group we were kind of curious about were measures related to monitoring patients who are on certain medications. For example, doing potassium and creatinine checks for (inaudible) annual monitoring for patients on persistent medications.

I could see a sort of stronger argument being made for some of these over others. You could say that some of these are, again, more treatment quality issues, but some measures seem to be focused on avoiding adverse effects of medications that have been prescribed and that seemed a little closer to a safety issue to us. Curious as to what's your thoughts.

(Urmimala Sarkar): So most of these are being measured across California right now for anyone participating in the Medicaid waiver, they are both part of the optional Project 1.4. Every health system has to choose a certain number of projects. I think eight or ten of them have chosen Project 1.4 which this is part of.

Andrew Lyzenga: OK. Any other…

(Urmimala Sarkar): Although, I will tell you that they have chosen to eliminate digoxin, and the reason that they have done that is because it's used so seldom that it doesn't feel very meaningful to the participating health system and the state has agreed to that.

Andrew Lyzenga: OK.

Christy Skipper: I see that (Richard Roberts) has his hand raised in the chat. Would you like to make a comment? (Richard)? OK.

Andrew Lyzenga: Operator, does (Richard Roberts) have an open line? And if not, could we get him one? We'll see if we can get that resolved and we can move to the next group.

So some, a group of measures that are related to we're saying appropriateness of prescribing some of these, again, are a little more close to safety than others you might say, and we included some of these measures of avoidance of medications in the elderly even though I think strictly speaking we're looking at safety in the nonelderly environment.

So we may cut these out based on feedback from our colleagues at ARC and the panel. But just generally some of these were related to the appropriateness of prescribing medications that may for example have adverse interactions or in maybe high-risk populations and those sorts of things. Use of, things like

use of multiple concurrent antipsychotics in children and adolescents, I was a little unsure, more unsure whether those would be safety related or more, again, treatment quality-type issues.

(Kevin Shehan): Yes. Again, that falls in the treatment quality domain.

(Barbara Bartman): I think it's probably good to maybe review the definitions of – or the differences in safety and quality that were defined by the – at that time the Institute of Medicine in its Crossing the Quality Chasm report.

(Urmimala Sarkar): This is clearly in the bailiwick of safety in a way that the field is conceptualized as far as I know.

(Barbara Bartman): I think too.

(Urmimala Sarkar): Like prescribing medicines that are contraindicated, that's a safety issue.

(Barbara Bartman): Yes, right. Because it can produce harm as opposed to quality which is dealing more with efficiency, effectiveness, purposeful care, it gets the job done, and does the right thing. But I just think that going forward in the future to use that framework, so we could be somewhat consistent.

Andrew Lyzenga: Yes.

(Barbara Bartman): Safety for avoiding bad events, safety makes it less likely that mistakes will happen, while the quality focuses on doing things well. I mean, if you look back at that, I think it's a good…

Andrew Lyzenga: That's kind of the…

(Barbara Bartman): Sometimes I go back and refer to that.

Andrew Lyzenga: That's kind of the framing we were, sort of had in mind, avoidance of harm or avoidance of adverse events, versus making treatment better but there's – even with that kind of sort of distinction, you have a lot of blurred lines at least in my opinion.

(Barbara Bartman): Yes, right.

Andrew Lyzenga: Gray areas. So that's the sort of things we wanted to kind of work out with this group a little bit. I think we can move to the next.

So in the area of care coordination, again, not always considered a safety issue but obviously sort of a little – particularly relevant in the ambulatory environment. We don't, for example, at NQF put care coordination typically in our safety projects. We have a separate group that deals with care coordination measures. But it does seem like for our purposes many care coordination measures would be relevant.

So just sort of looking to you guys, if you have any kind of rules of thumb on where we might want to draw a line between safety and not – again, some of these sort of types of measures related to communication between providers, we put in the diagnostic safety bucket, the things related to follow-up on referrals and follow-up on lab results and I think those are a little more clearly safety-related.

But things like communication with the physician or other clinician managing ongoing post care, post fracture for men and women aged 50 and older could be in that gray area. It could have safety implications, but maybe it's more of a treatment quality type of issue, any thoughts on that from the group?

(Urmimala Sarkar): The last one is something that has really been written about and talked about as a safety issue, timely transmission of transition records. So there's a lot of literature about that that's in the safety space. I think people think of that as a safety issue. Documenting a treatment plan for melanoma, that doesn't feel like a safety issue to me.

Andrew Lyzenga: Right.

Male: I agree with that. And I think – there are lots of oncology literature about treatment plans but it's not typically about safety, it's about – again, effectiveness and standardization.

Andrew Lyzenga: OK. Again, helpful. Somewhat similar group I have here, follow-up after hospitalization, these were some measures that, again, were specified not

really for the clinician or group practice level but more for sort of the health plans and integrated delivery systems.

And looking to make sure that patients who are discharged are, particularly for specific conditions are followed up on within a certain timeframe. Any thoughts on whether we might want to consider these safety or are these more, again, sort of more treatment quality or even more of an inpatient-focused issue that the discharging hospital ought to be responsible for doing this kind of thing?

Male: Sort of access issues, don't they?

Andrew Lyzenga: Access issues.

(Urmimala Sarkar): I mean, these have very much been conceptualized as hospital. I know that heart failure, people think – some people would argue it's a safety issue, definitely a quality issue. The people I see talking about this are more in the acute care setting rather than in the ambulatory setting.

I don't think that's necessarily where it needs to sit, but in practice, that's where I've seen the literature and the discussion.

Andrew Lyzenga: OK. Next slide. So these are some of those measures that I mentioned a little bit earlier. There's a whole sort of sweetness of measures both from the cap survey and then there's this survey of the family experiences with coordination of care and obviously not all of these are related certainly to patient safety and not even to care coordination in many instances.

But there are some care coordination elements and these, again, probably we wouldn't at NQF for measure evaluation purposes, we wouldn't put these in our safety committee, we would probably put them in our patient and family-centered care committees.

But as we were thinking about care and safety in the ambulatory environment and thinking about care coordination, we sort of thought it could be useful to get the patient experience of what that coordination looks like and get insight into potential safety issues for measurement in this area.

So just curious to if you have any thoughts about that generally, about measurement of patient experience with the care coordination that is something worth pursuing, if we should sort of recommend measures be developed to focus more on safety related issues that incorporate patient reporting or patient experience or if this is sort of off the table for our purposes.

(Richard Roberts): This is (Rich Roberts), I'll chime in on that if I might. I hope you can hear me. And I've been able to hear the entire conference, we're just having some technology issues at my end that I couldn't get through with voice.

I was shouting as loud as I could but it couldn't hear me past Michigan. Yes, I would view this one as not necessarily a safety measure, but kind of a patient satisfier measurement. In fact, when you look at patient satisfaction, it's often inversely related to quality and outcomes.

So that's a tricky one and I don't know that as another safety measure goes, this would be one that I'd add.

Andrew Lyzenga: I should note that some of them are less – I would call less patient satisfaction and more maybe patient reported process measures almost sort of asking whether the patient – asking the patient whether they got this service or was their care coordination adequate from their perspective, that kind of thing.

(Richard Roberts): In fact, if I might add, (Andrew) onto that, I think a couple of the bigger issues for me at least in the primary care world that we aren't really touching on with any of these measures thus far, at least none that I've read in the materials and which I think is part of the meltdown in primary care that we're seeing now as two kinds of measures.

One looking at continuity measures, how often is the patient handed off across a primary care team or in the ambulatory setting across the care team and outside that setting to other care teams, because I think that is a function of – or a determinant of safety. I mean, if we – more than half the errors that we encounter in healthcare are communication errors and so the more people that we bring in the chain of communication, the increased probability there.

And then the other one is burnout and that – turnover as a measure maybe an important metric as a systems level for safety, because the staff that's left behind is going to be increasingly stretched and you're always having to get to know the next patient, there's very little sense of who they were before.

So those are the two that I'd drop there as you begin to add these up and they seem like this is the first chance I got to throw those out.

Andrew Lyzenga: OK. Any other thoughts on maybe not these specific measures but on patient reports as a source of data, the safety of care coordination or quality of care coordination? If that should be something that of interest to the ambulatory care, patient safety field?

Well, hearing none, we can move on to the next group, I think. So getting into diagnostic safety here, so pulled a few examples here. These – you could call – I think are trying to get at misdiagnosis or sort of whether you've diagnosed appropriately but…

(Urmimala Sarkar): Yes. There's more like this that are in use. Like what proportion of bi-rad zero which means that you don't know if it's abnormal or not. Actually get a repeat mammogram, that's another one that's in use.

There's also kind of an intermediate for this, so bi-rad four or five, is this what you got here? Is the ones that result in cancer, what's actually being measured right now in California is a proportion that have a biopsy because if people don't have a biopsy, it doesn't really matter what proportion have cancer, what matters is what proportion get the definitive diagnostic intervention.

So there's a variation on that. There's a similar one around colonoscopy. So the proportion of people who have an abnormal fecal immunochemical test that subsequently have colonoscopy within the recommended interval. So this is definitely right in the sweet spot and I think you guys just need to augment it maybe with the ones that are actually in use.

Andrew Lyzenga: OK. We'll reach out to you again about that.

(Urmimala Sarkar): Yes. I resent it to the ambulatory safety email address.

Andrew Lyzenga: OK, perfect.

(Urmimala Sarkar): And I'm certainly happy to talk.

Andrew Lyzenga: And then are there sort of question about this is, we had some guidance too that sort of procedural, the outpatient procedural environment was out of scope but, again, there's some gray area here about whether sort of the area of referrals to get testing done or response of the sort of managing clinician to testing results which we thought was relevant. I don't know if others agree.

(Urmimala Sarkar): I mean, I think that's fine, right? That's within the – you can't get to a timely and accurate diagnosis if you don't have adequate notification and follow-up practices around test results and that's well accepted. So I don't think that's controversial.

Andrew Lyzenga: OK. And we did…

(Urmimala Sarkar): Headache measure is perplexing to me. I don't really under – I mean if somebody – the first time they show up with a migraine in the emergency department, I don't see why that's a safety issue.

Andrew Lyzenga: Yes, that was a little confusing to me too, it's one of the reasons I included this here because I wasn't quite sure what to make of these…

(Saul Weingart): I think that was more of the utilization measure. Maybe ambulatory sensitive condition where they have been on appropriate prophylaxis, kind of like asthma, that they wouldn't have shown up but, again, I think that's more effectiveness.

(Urmimala Sarkar): Yes. And (Saul), don't you think – I can completely imagine that maybe – I mean kids only see the doctor once a year. What if the first time they get a migraine…

(Saul Weingart): Yes.

(Urmimala Sarkar): It just doesn't really seem like a safety measure to me.

(Saul Weingart): I agree.

(Urmimala Sarkar): Whereas the last one really, you can imagine that really does represent a delay diagnosis stroke, right? Because if somebody had shown up within 24 hours of going to the ER with a stroke, with a TIA symptom, that's a delayed diagnosis of stroke because if I saw them in clinic, I really should have sent them right then to the ER.

Andrew Lyzenga: OK, that's helpful. Maybe we go to the next. So some measures related to, I guess, we would say use of the appropriate diagnostic tool or diagnostic assessment, again, maybe a little bit removed from patient safety in some sense, but could be considered related to timeliness or accuracy of diagnosis and be related to safety issues in that sense. Any thoughts from the group on these?

And then the other one on the slide is really this documentation of diagnostic information. I guess, which again came up in our diagnostic quality and safety project, the importance of recording diagnostic information in the record, so that helps with sort of care transitions again and making sure the appropriate follow-up occurs, but weren't sure if…

Male: I mean, characterizing the type of retinopathy and specific findings performed by the ophthalmologists is a little bit out of the scope of the PCP I think.

Andrew Lyzenga: Yes.

(Urmimala Sarkar): This really feels to me like that if you're a hammer, everything looks like a nail. Like this to me is not within the purview of making a timely and accurate diagnosis. So, I don't feel like these are safety measures.

Andrew Lyzenga: OK.

(Sonali Desai): This is (Sonali), I agree with that as well. You could have this for really any chronic disease. There's a set of things that need to be done to measure all different diseases and this doesn't seem – I don't know why we would call these out as supposed to any others.

Andrew Lyzenga: OK. Thank you. So admissions and readmissions is sort of a broad category that we wanted to get your feedback on whether it was reasonable to include measures like this in an inventory of ambulatory care, patient safety measures.

Some of them are specifically sort of called ambulatory care, sensitive conditions, say for example, where appropriate ambulatory care prevents or reduces the need for admission if so if you could still consider that a treatment quality issue, with pretty broad measures in many cases.

The PQIs in particular are – and I think these others are – were developed to be applied at a population level to look at a region or state or community to try to sort see what the adequacy of preventive care is generally – but, again, I know there has been some interest in trying to apply these to the clinician or ECO level to sort of identify preventable admissions and readmissions.

And, again, the plan all cause readmissions we included, we didn't include those that were focused on the inpatient environment but thought that maybe the all cause readmissions at the plan level could again be possibly considered a measure of – and sort of outcome of sorts of the safety of ambulatory care. So any general thoughts from the group on that, whether these are, reasonably be called safety measures?

(Saul Weingart): This is (Saul), the readmissions measures are really fraught and quite controversial with respect to whether there are actually measures of quality or measures of – I think that are utilization. So I would argue in favor of not including these as under the rubric of safety. I think they're just not ready for primetime and if anything the pendulum is swinging the other way.

(Urmimala Sarkar): I agree.

Female: I agree too.

Male: I would agree too. Yes.

Andrew Lyzenga: OK. That's helpful. Thank you.

(Saul Weingart): I'd find it very validating, thank you.

Andrew Lyzenga: Yes. All right. So the next group are – so prevention of adverse events and there's one example here of sort of proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.

These are measures that look at particular – patients with particular conditions and they have a whole lift of complications that they have identified as being potentially avoidable and there are some issues sort of validity and reliability for endorsement purposes, the committee that reviewed these measures did not think they were ready for accountability purposes and public reporting and that kind of thing.

But did assess them as being pretty valuable for internal quality improvement purposes and I don't think we are limiting the scope of this project to only measures that would be put into accountability programs. So, we thought that those were probably warranted being included as measures of safety in the ambulatory environment.

There's also these measures related to sort of screening and assessment and prevention of falls and pressure ulcers, sort of again maybe a bit of a grey area because there's to some extent not much you can do as a clinician maybe or a primary care physician to prevent somebody from having a fall in their home or developing a pressure ulcer, but there maybe there are some preventive steps and educational and screening and assessment and putting a plan of care in place that can avoid those things.

Do you think these are worth including in a scan of ambulatory safety measures?

(Urmimala Sarkar): I can tell you that a lot of the ambulatory events that are reported to the PSO in California are falls. So, on the frontline, people do conceptualize falls in ambulatory settings as safety events.

Andrew Lyzenga: OK. Any other thoughts, any objection to including these potentially avoidable complication measures?

(Urmimala Sarkar): I don't know. I feel like that's a – it's hard to say that if one of my patients who has COPD is admitted with an exacerbation that that's a patient safety event or...

Andrew Lyzenga: Right.

(Urmimala Sarkar): ...that feels to me like that is going to be hard for frontline clinicians to accept, right? If someone has hypertensive urgency because they don't take their meds or they have a big dietary indiscretion and get admitted with a heart failure, of course, that's unsafe for them.

Should we consider that to be – I mean, I would consider, first of all, this feels more like a system of patient health management to me than prevention of adverse events.

Andrew Lyzenga: OK.

(Urmimala Sarkar): But then, I can see how getting good primary care could prevent these. I just feel like not all of them are preventable.

Andrew Lyzenga: Yes.

(Urmimala Sarkar): So, it's hard to think about that being acceptable when I try to pitch that to my colleagues in primary care.

Andrew Lyzenga: Yes, alright. Well, we'll give that some more thought and take that into consideration. Go ahead.

(Richard Roberts): Well, this is Rich. And I guess building on her comments looking at the next one on pressure ulcers, I mean, the problem I had with a lot of these disease specific measures is it's built by people who basically focus on disease specific problems and that ain't it in primary care.

We focus on people. We have sometimes have problems. And so, whether it's my local cheesehead falling off the bar stool at the tavern, I mean, he had a fall. Is that a patient safety issue? I don't know. But in the case of pressure ulcers, if it had a comprehensive assessment. I would challenge the cause and

effect that that kind of a write up in a primary care record is somehow going to lead to a better outcome. It's certainly dotting I's and crossing T's.

I guess for many of these very just kind of disease specific measurements and that was raised earlier by the group, I just have a lot of hesitancy about getting into them too much, because it sort of misses the point. You're trying to create a safe environment in the primary care setting.

You're trying to make sure that the information gets to who needs it to in a timely way. You're trying to make sure that patients are well informed and educated and I guess running down rabbit holes, I'm not sure it's going to get us anywhere.

Andrew Lyzenga: All right, again, helpful. All right, then, we can go to the next.

All right, so, this is a group of what we were calling kind of patient self management issues. This first one here, medication adherence looked actually like less like an adherence measure to me than sort of – it's a patient reported measure related to how confident they were in managing their medication or whether they'd increase their level of confidence between in the initial assessment after three months in case management.

Again, it seems like it could plausibly be considered a measure of how – keeping your patients safe even when they're not in your direct care.

And then, the next one is related to patient activations scores, whether they're increasing. Again, probably less, maybe a little less directly related to safety as such, but could provide insight into whether patients are being helped to manage their care themselves and maintain their own safety in their homes and other settings.

But again, I'm not sure if it quite falls in the pocket of this project. So, any thoughts you have on that would be welcome.

(Urmimala Sarkar): It sounds like safety measures to me.

Andrew Lyzenga: Yes. Any agreement or disagreement from the rest of the group? OK. Probably call those no's. All right, so those were some of the sort of major issues we were sort of struggling with in terms of categorization and whether we ought to consider things safety related or not. In terms of the domains overall, as you see on the slide, a few questions here – do you think these are the right domains?

We've already gotten some feedback that we ought to define these more carefully and that's certainly a point well taken and that care coordination may not – may be a little bit too broad. Maybe we should look at communication as a separate issue.

Any other thoughts or reflections or questions about these domains and whether they would be useful for, again, identifying gaps in measurement or if there are other kinds of – a different kind of lens that you might suggest for identifying gaps?

(Saul Weingart): This is (Saul). I was wondering about the HIT safety category and whether that might impact (inaudible) attributed to some of the other domains. So, when I look at the items in the grid, it looks like several of them maybe belong with medication safety.

Andrew Lyzenga: Yes.

(Saul Weingart): And another one might belong with test safety. So, I wonder if that's actually kind of an instrument that maybe belongs more disaggregated or distributed. So, that's one suggestion.

The other one I had was I wondered if there needed to be a domain around infection and I can't exactly remember why I thought that was a good idea. But, when you think about the in-patient setting, management of preventable infections is really big area. So, I wasn't sure if there was some literature that we might want to add.

Andrew Lyzenga: Yes. We can look take a look to see if there's any literature on infection in the ambulatory care setting.

(Sonali Desai): This is (Sonali). Another suggestion and I may have missed it, so I apologize. But, I was looking for a measurement on medication error rates in the ambulatory setting under the medication management and safety. And I don't know that I saw one, but if there is one, I apologize.

Andrew Lyzenga: Yes. We didn't find any sort of adverse event measures and we – that's sort of identified in the past is a major gap in medication safety generally. Even in the inpatient environment, there aren't as many outcome measures related to adverse medication events or adverse drug events and it's something we've sort of sought from the community for a long time.

But we didn't find any that certainly that were in this sort of outpatient environment. And if you're aware of any, we'd love to hear about them.

(Sonali Desai): No. But I've been interested in developing some, and I just wonder if it is going back to our other conversation about the use of machine learning, AI, or NLP or just thinking about other more creative ways to measure medication errors for certain high risk medication categories.

Andrew Lyzenga: Right, right. That's an interesting thought. We can pursue that. Any other thoughts on...

(Urmimala Sarkar): I mean, I think that unless – there's a couple of things. One thing that's in HIT safety is that an important concept is errors introduced by electronic health records.

Andrew Lyzenga: Right.

(Urmimala Sarkar): And I don't think there are good measures of that per se, but that's an important concept for which we – and we know it happens. We just don't have a good way of measuring it currently, but I think that's a point that needs to come out of whatever product that there is.

I would also say that we should think carefully about communication and whether you feel like the domains that are up there cover the communication concerns that have been shown to be safety risks in outpatient settings. And maybe they're in there in care coordination and diagnostic, safety, and patient

health management, but I'm not seeing them clearly. So, I think that's worth exploring.

Andrew Lyzenga: What are the major sort of issues related to communication and ambulatory care that you would...

(Urmimala Sarkar): Well, I thought of them as two major domains, one is clinician-to-clinician communication, right, and the point about discharge summaries getting into outpatient physicians' hands is a really important part of that clinician-to-clinician communication, closing the referral loop which every system in California is measuring because it's a required measure for the Medicaid waiver. That's an important clinician-to-clinician communication measure.

And those, you could both consider to be part of care coordination, but they're not really reflected in the current care coordination measures. Then, there's patient-physician communication. So, then, you could look at issues of medication communication.

Does it happen? Is it literacy and language appropriate? And it's really important I think in the area of self-management to look at symptom recognition. There's abundant literature to suggest that that's a problem and I don't know of any good measure concepts in that area.

But again, in order for safe care to be delivered, just as the (inaudible) for the diagnostic safety report that you have to make a diagnosis and the patient, you have to communicate it to the patient. That is the piece that we want to make sure that at some point starts to get measured. Is that clear?

Andrew Lyzenga: Yes, absolutely. Yes. It's something that we again look at in our diagnostic quality and safety project but weren't really able to identify any measures around. We did have, as part of that project sort of brainstorm some potential concepts or ideas for measure concepts.

Those were again very not well specked out by any means really, just some preliminary ideas. But we may pull those into our concept inventory just as a – just so people know that they're there.

I think we'll probably take admissions and readmissions out. It sounds like the group is in agreement that those are not really a reflection of what we want to be measuring in this area.

Did somebody have another comment? And if not, maybe we can sort of talk through some – through again some broader issues about what the major gaps are. Obviously there are a lot especially given we're probably going to remove a lot of measures after this and even the measure that we had identified we probably didn't address many of the gaps that you might identify.

But if you have any thoughts on what the major gaps in measurement in ambulatory safety are, what kinds of measures might more meaningfully address safety and sort of generally what's the most important or highest priority safety issues are in ambulatory care, any thoughts you have on that would be very welcome.

Again, we'll probably reach out to you to talk a little bit offline and get some feedback from you on these sorts of things. But anything you can give us right now would be very helpful.

(Saul Weingart): Yes. This is (Saul). I mean, I think there's a lot of opportunity around patient reported safety metrics and not a lot that's been created. So, this might be an area that we identify as an opportunity. Clearly, patients and families are astute observers and can potentially identify and escalate events.

So, I think that's a real opportunity. There've been a bunch of pilots and we just don't know how to do it well. So, that was one. I mean, I think in ambulatory, the real issues are missed and delayed diagnoses, med related events and then issues around transitions.

Those are really the ones that come up over and over again, and it feels to me that we need to get a little bit more granular with initiatives categories about kind of what are the measures, how good are they, how accessible are they and that will help us give you some more advice about where we see opportunities.

Andrew Lyzenga: OK. That's really helpful. So, we can maybe sort of, yes, get a little bit more granular in those particular areas and show you a little more specifically what we found in some of those areas and get some more specific feedback from you on that.

(Urmimala Sarkar): I agree with those measures in general. Although, I have been working increasingly on the second victim phenomenon and I think it may – those three domains when I talk about outpatient safety are those are the ones I talk about: transitions, diagnostic safety, and medication related events.

I completely agree that we need to have some better patient reported event metrics. I would also say that it's probably time to think about how we're measuring the impacts of patient adverse events on clinicians in outpatient settings. I agree that's a major cause of burnout and something that should be prioritized.

(Saul Weingart): Makes sense. And thinking also, population based metrics are going to be increasingly important as we move to accountable care organizations. So, both clinical level measures but also measures across these managed care groups is going to be important, not just at the level of the insurer, but the level of the ACO.

Andrew Lyzenga: OK. Again, do you find those TQI measures as promising in that area or do you think there's – it needs to be something much more focused on safety related issues or somehow otherwise sort of refined to meet the needs that you just mentioned?

(Saul Weingart): Well, there's a lot of kind of "finding the keys under the lamp post". We have a lot of those metrics that we use because we can pull them out of claims data.

Andrew Lyzenga: Yes.

(Saul Weingart): So, I think moving to EMR data and figuring out how to use tools to search text to do computer aided coding and so forth I think will really be helpful. It's just really challenging.

Andrew Lyzenga: One of the concerns we heard from our key informants was not just the sort of infrastructure for things like data natural language processing, but the burden of gathering data and then the expertise needed to sort of analyze the data and that sort of thing.

You don't always need that I guess in the clinician office when you're doing measurement, but it was a concern we heard raised, that some people just don't have the sort of expertise or knowledge to help implement these kinds of measures. Any thoughts on that?

(Saul Weingart): I think that's fair, although a lot of the work done in Kaiser Permanente around doing data mining, looking for patients with abnormal lab tests who haven't had a follow up in a certain period of time or patients prescribed to certain medication that needs monitoring or haven't had it certain period of time, those are all I think pretty interesting.

You have an abnormal PSA and there's not an evidence that anybody's ever seen urologist or had a biopsy or repeated the test, that kind of thing. But PSA is the best example.

(Sonali Desai): I agree. This is (Sonali). But I do think that there ends up being a fair amount of chart review in those – even with those metrics, even though it seems like they're a little bit more simple. But I think that they do a fair amount of chart review to actually validate some of that and to get it up and running.

So, I think that they do have a pretty robust infrastructure in place to be able to carry out all of those (inaudible). And so, I think there's a balance between developing measures that are actually meaningful and are measuring the concepts that we'd like to measure, but then actually being to practically do them with the resources at your fingertips.

Andrew Lyzenga: That's fair.

Male: Yes. And the frustration that I have is that we continue to focus primarily on process measures and not our outcome measures of patients. I mean, PSA is a very good example when you look at PIVOT and (PLECO) and other trials. I mean, do you really want to close the loop and have them show up at the

urologist and have the biopsy that two out of 100 times lands them in a hospital with bleeding or infection only to say "We're not going to treat you anyway." I mean, sometimes leave well enough alone.

So, I would encourage us as we think about measures to think about the outcomes that matter to patients, not the process measures that we can measure. We get so hyped up on the low hanging fruit. And I would ask us to kind of step back and look at the practice at a sort of a macro level rather than very granular disease by disease.

Part of it is just going to be the reporting – the data collection reporting burden and part of it is primary care practices right now are overwhelmed ticking checklists. And if we throw more boxes at them, it's got to blow up. I mean, that's part of the burnout that we're all talking about. Unfortunately, measures are almost always additive and rarely substitutive or reduced. That's just the nature of the beast.

Andrew Lyzenga: Do you have any thoughts on what kinds of outcomes you would like to see or what are...

Male: How about death? Death matters a lot.

Male: Yes.

Male: I mean, wouldn't it be great if we could all agree we'd measure dead?

Male: Yes.

Male: That's a good starting point. And as I said, I think from a primary care perspective, I can't speak for other disciplines, but certainly in my world, the more times you hand somebody off to the outside world, the greater the chance for harm because the ball gets dropped, things get done. I mean, one-third of the procedures we do currently are felt to be inappropriate by those very specialties' own criteria.

I will say to our residences, if you don't want to have a bad outcome in the hospital, then, don't admit them. If you don't want to have a bad surgical

outcome, then, don't send them to the surgeon. And that's our job of primary care is try to prevent those problems and keep them from having to take on that risky next step.

But that's what I'd like to see as measure is how much can you get done in your setting if that's your job is to take care of the bulk of the problems because that's – high functioning primary care systems around the world. That's what they do. 85 percent to 95 percent of all encounters happen in those settings. So, to me, comprehensiveness, continuity, those are really important measures for safety.

Male: OK.

Male: Now, I realize with a bunch of internists around the phone, you guys are going to be a little uncomfortable with that, but I'm just trying to call it like I can see it.

Andrew Lyzenga: Any responses or thoughts and comments from the rest of the group?

Female: The internists like primary care.

Male: Now, I know you like primary care, but you like referring a hell a lot more than we do in family medicine.

(Urmimala Sarkar): Yes. I mean, I don't know. I'm an internist who does primary care. And I say I agree with you that, yes, I cannot disagree that mortality is important. So, I think we're on the same page there. But, I also think that we have a lot – the kind of causal link between what we do and what happens to patients is not as clear as when they're under 24/7 observation in the hospital.

And I think it's much easier when you're doing measure creep and measuring more and more things. I think it's much easier to be really clear that these are things we're asking you to do to get there with this measure on the path toward getting to – so, I view these process measures as a step on the way to getting to those meaningful outcomes that we all care about.

And to me, it makes sense to move forward in that fashion because if we can all agree that people who have a bi rad 5 or 4 mammogram really need to get that biopsy within seven days, then that's a step and what really needs to happen is that people who have breast cancer need to get into treatment quickly.

But obviously, it feels things feel very undoable to people in the frontline and primary care at least in the safety net where I practice. So, I don't mind doing it incrementally.

Male: Well, sometimes we have to use process measures because we don't have the outcomes measures or at least none that have been identified yet. But the bi rad 4 or 5s are probably a good example and again we can debate whether they need to have their biopsy done in seven days. I think they should but some don't.

But let's say that we all believe that. Do you really want to have the primary care safety measure that they got in for the biopsy when in fact there may be a communication failure that does not get the mammography report back to the primary care folks within the seven days, because not all systems turn that around very efficiently.

I mean, most of us practice in large groups that are using Epic or similar integrated system software packages, but that's not true for all the clinicians out there.

Maybe you put that burden in the ambulatory setting on the mammographer to make sure the biopsy happens. That's part of what I'm saying here though is the sense of who should be responsible in terms of who's the locus of decision making ultimately in terms of what needs to happen next.

And as we all know as referring docs, but the radiologist says "Do this test," 99 times out of 100, you're going to do it because you feel like you have to, so put the burden on them.

(Urmimala Sarkar): Maybe. I think it's sort of, to me, there's a blend of setting specific versus general issues and what you just said (inaudible).

Andrew Lyzenga: Any other thoughts on generally about what the most important or high priority issues we might want to focus in on there or identify?

Male: The one thing I might add to this conversation, (Andrew), is a lot of what – and I think all the people that are on the phone have sort of touched on this is that all the measures historically that we've used in the safely world in the United States have been centered in the hospital setting where it's been easier to get the data and often easier to do system interventions.

But there's a wealth of data in other countries. I mean, the United Kingdom, some of their (QAF) measures and they've been at it for 15 years are safety measures, and I would urge us to look outside of our own shores. We unfortunately tend to be very parochial as Americans in that regard when it comes to safety issues or actually any healthcare issues.

Andrew Lyzenga: Yes. We've tried to do that a little bit. It's a little hard to sort of find the information, at least detailed information on some of these programs overseas, but we're looking into that.

Male: And I'd certainly be happy to help.

Andrew Lyzenga: Yes, if you have any suggestions or...

Male: Yes. I do. I'll get you hooked with people you need to know at least in the U.K.

Andrew Lyzenga: Great, great. Other thoughts or questions, concerns? If not, we'll open up I think for a quick public comment to see if anybody has thoughts they'd like to share with us in the group.

Operator: At this time, if you would like to make a comment, please press star then the number one on your telephone keypad. We'll pause for just a moment.

And there are no public comments at this time.

Female: OK. Thank you, operator.

So, thank you all for your feedback. So, I'll to talk a little bit about the next steps for this project, Christine mentioned it in a couple of slides, the next steps is on February 14th, we'll be submitting a draft, environmental scan report to CMS and (ARC).

We'll just gather all your feedback from today and all our findings on environmental scans and we'll incorporate it into the draft report and you'll be hearing from us very soon about that.

And just a little bit more information about the project contact information, if you want to get ahold of us, you have some suggestions or other measures or contact that you want us for key informants, you can email us at our project mailbox which is shown on the slide and also our phone number. And we continuously update all the project materials on the project page and you can also access it through your SharePoint committee site as well.

And I'll just briefly stop and pause if you have any additional comments or questions for us.

OK. Well, then, that ends our meeting and thank you so much for all your feedback.

Andrew Lyzenga: Yes. We'll be in touch shortly. I think we'll have a few more certain discrete questions and things we want to get specific feedback from you on. This was sort of to get us started on that and hone in on what we needed to get more from everyone.

So, we will be following up and we'll be in touch soon. Thanks everybody for taking your time to talk with us today.

Male: Great. Thank you.

Male: Thanks everyone.

Female: Thank you.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END