

Welcome

- Laptops and cell phones
 - ▣ *Wi-Fi network*
 - User name “guest”
 - Password “NQFguest”



NATIONAL
QUALITY FORUM

Improving Diagnostic Accuracy 2016-2017

In-Person Meeting #1

January 10-11, 2017

Welcome, Introductions, and Overview of Meeting Objectives

NQF Project Staff

- Helen Burstin, MD, MPH, Chief Scientific Officer
- John Bernot, MD, Senior Director
- Tracy Lustig, DPM, MPH, Senior Director
- Andrew Lyzenga, MPP, Senior Director
- Christy Skipper, MS, Project Manager
- Vanessa Moy, MPH, Project Analyst

Disclosures of Interest

Committee Panel

- *Mark Graber, MD, FACP, Co-Chair*
- *Missy Danforth, Co-Chair*
- Jennifer Campisano, JD
- Michael Dunne, PhD
- Mark Grenache, PhD
- Helen Haskell, MA
- Carlos Higuera-Rueda, MD
- Marilyn Hravnak, RN, PhD, ACNP-BC, FCCM, FAAN
- Mira Irons, MD
- Nicholas Kuzma, MD
- Kathryn McDonald, PhD
- Prashant Mahajan, MD, MPH, MBA
- Lavinia Middleton, MD
- David Newman-Toker, MD, PhD
- Martha Radford, MD
- David Seidenwurm, MD
- Thomas Sequist, MD
- Susan Sheridan, MIM, MBA, DHL
- Hardeep Singh, MD, MPH

Federal Liaisons (Non-Voting Committee Representatives)

- Centers for Medicare & Medicaid Services
 - *Marsha R. Smith, MD, MPH, FAAP*
- Agency for Healthcare Research and Quality
 - *Rear Admiral Jeff Brady, MD, MPH*
 - *Kerm Henriksen, PhD*

Opening Remarks

Project Objectives

- Develop a conceptual framework for measuring healthcare organization structures, processes, and outcomes that address the improvement of diagnostic accuracy
- Identify any existing measures or measure concepts consistent with the conceptual framework that could be used to measure baseline status and improvement of healthcare organizational efforts to improve diagnostic accuracy
- Use National Academies of Sciences, Engineering, and Medicine's (NASEM) *Improving Diagnosis in Health Care* report as a guide

In this Project we will:

- Build on the NASEM report on diagnostic error to identify a **measurement framework**
- Identify measures in development, testing, and in use
- Identify measure concepts
- Identify significant measure gaps
- Set measurement priorities
- We will not:
 - *Develop a new conceptual framework*
 - *Develop measures*
 - *Endorse measures*

Meeting Objectives

Day One:

- ▣ *Refine and prioritize domains and subdomains of diagnostic accuracy measurement framework*

Day Two:

- ▣ *Group discussion on measures, measure concepts, and domains*
- ▣ *Identify gaps in measures and recommendations to address gaps*

Meeting Ground Rules

- Acknowledge that you would like to speak by placing your name card in the vertical position
- Always use your microphone for the benefit of remote participants and transcript
- Openly share and respect differing views
- Avoid dominating a discussion and allow others to contribute

Overview & Historical Perspective of the NASEM Diagnostic Accuracy Framework

Where Failures in the Diagnostic Process Occur

Failure of Engagement

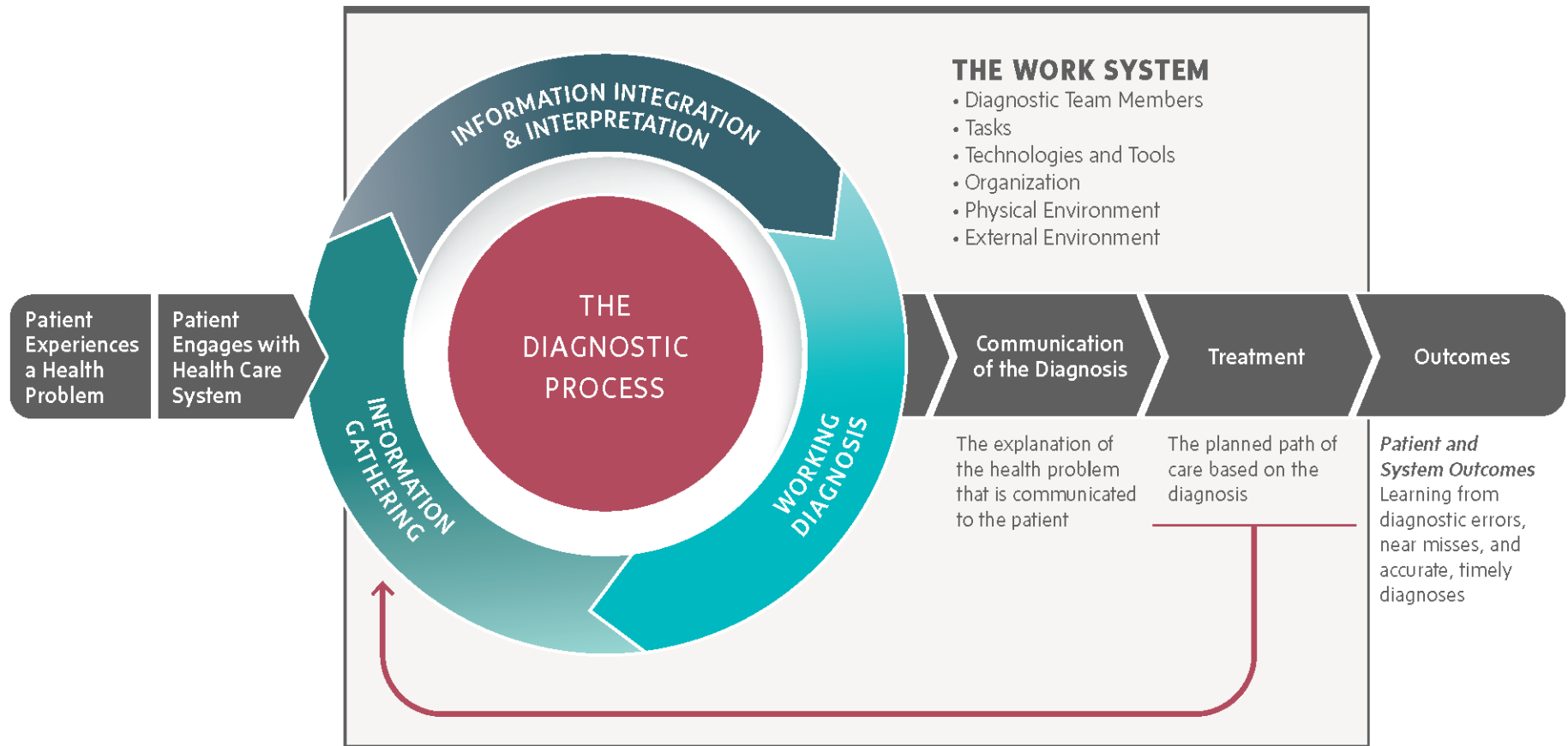
Failure in Information Gathering

Failure in Information Integration

Failure in Information Interpretation

Failure to Establish an Explanation for the Health Problem

Failure to Communicate the Explanation



Committee's Conceptual Model

- Definition of Diagnostic Error
- Overview of the Diagnostic Process
- Work System Factors that Influence the Process
- Outcomes from the Diagnostic Process

Definition of Diagnostic Error

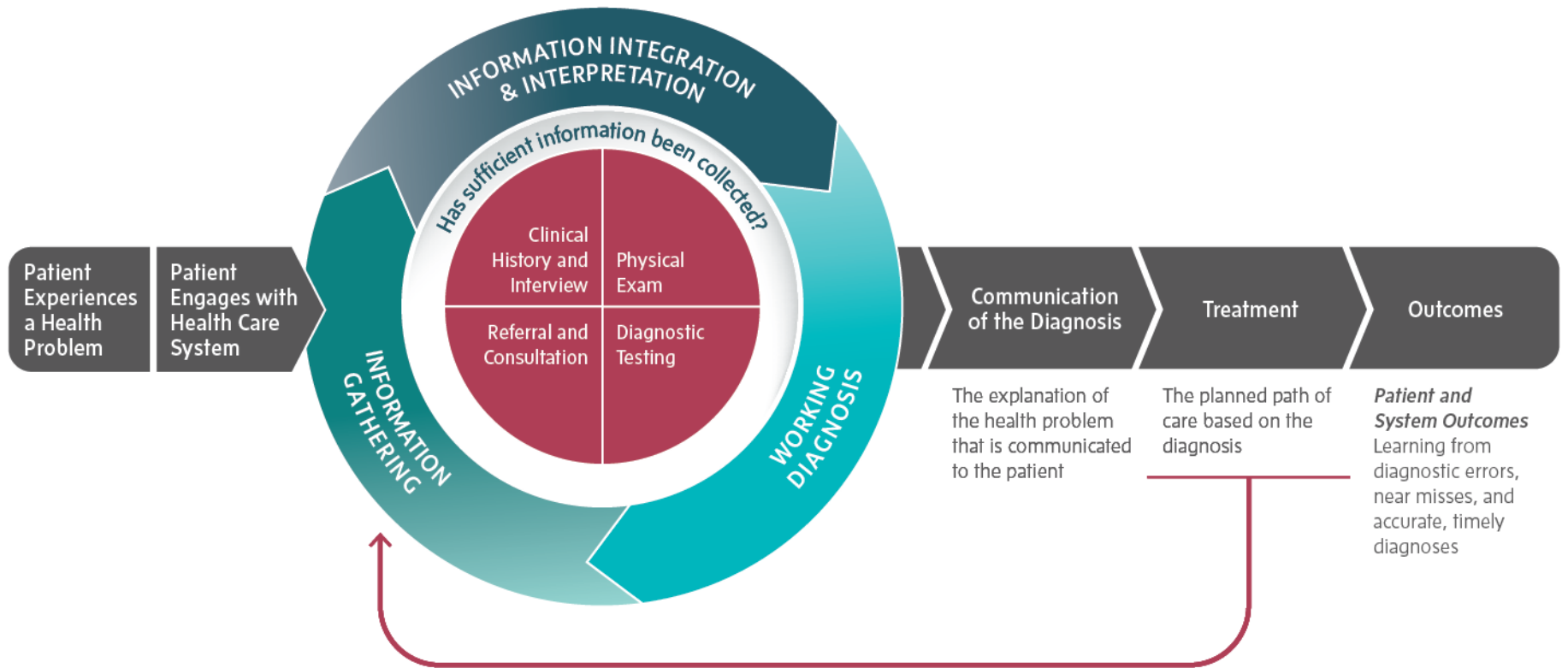
The failure to:

(a) establish an **accurate** and **timely** explanation of the patient's health problem(s)

or

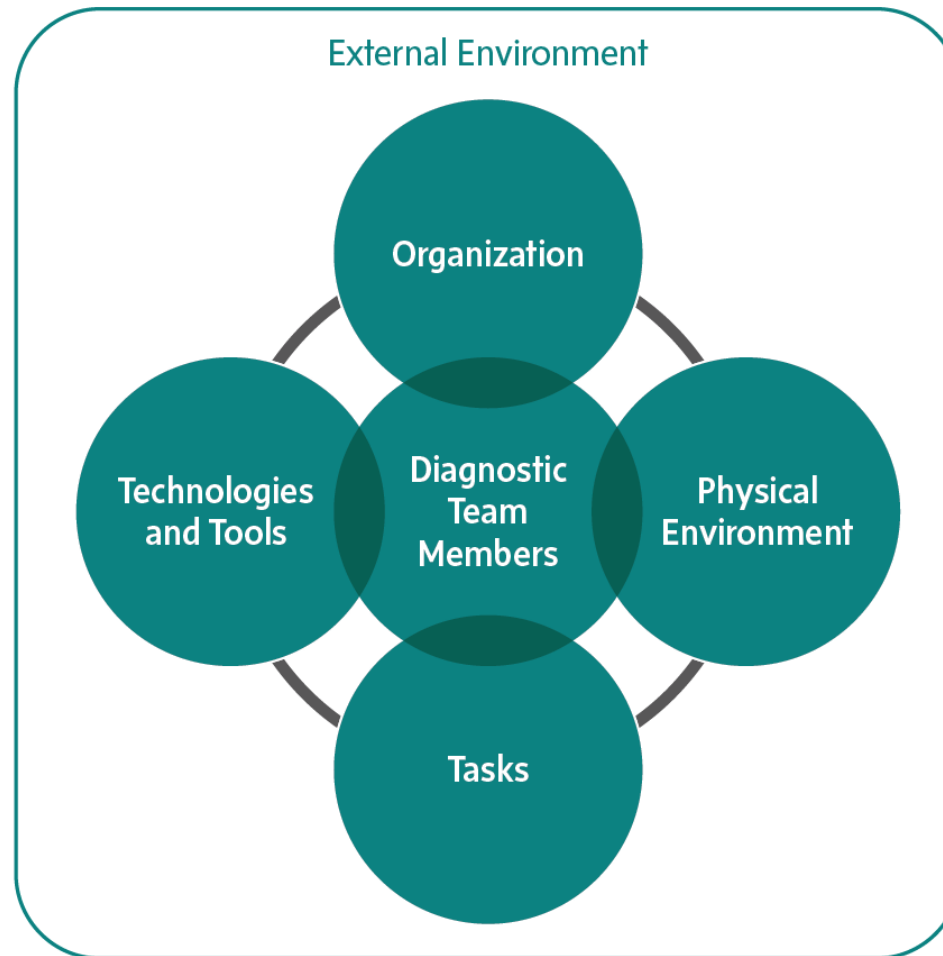
(b) **communicate** that explanation to the patient

The Diagnostic Process



TIME →

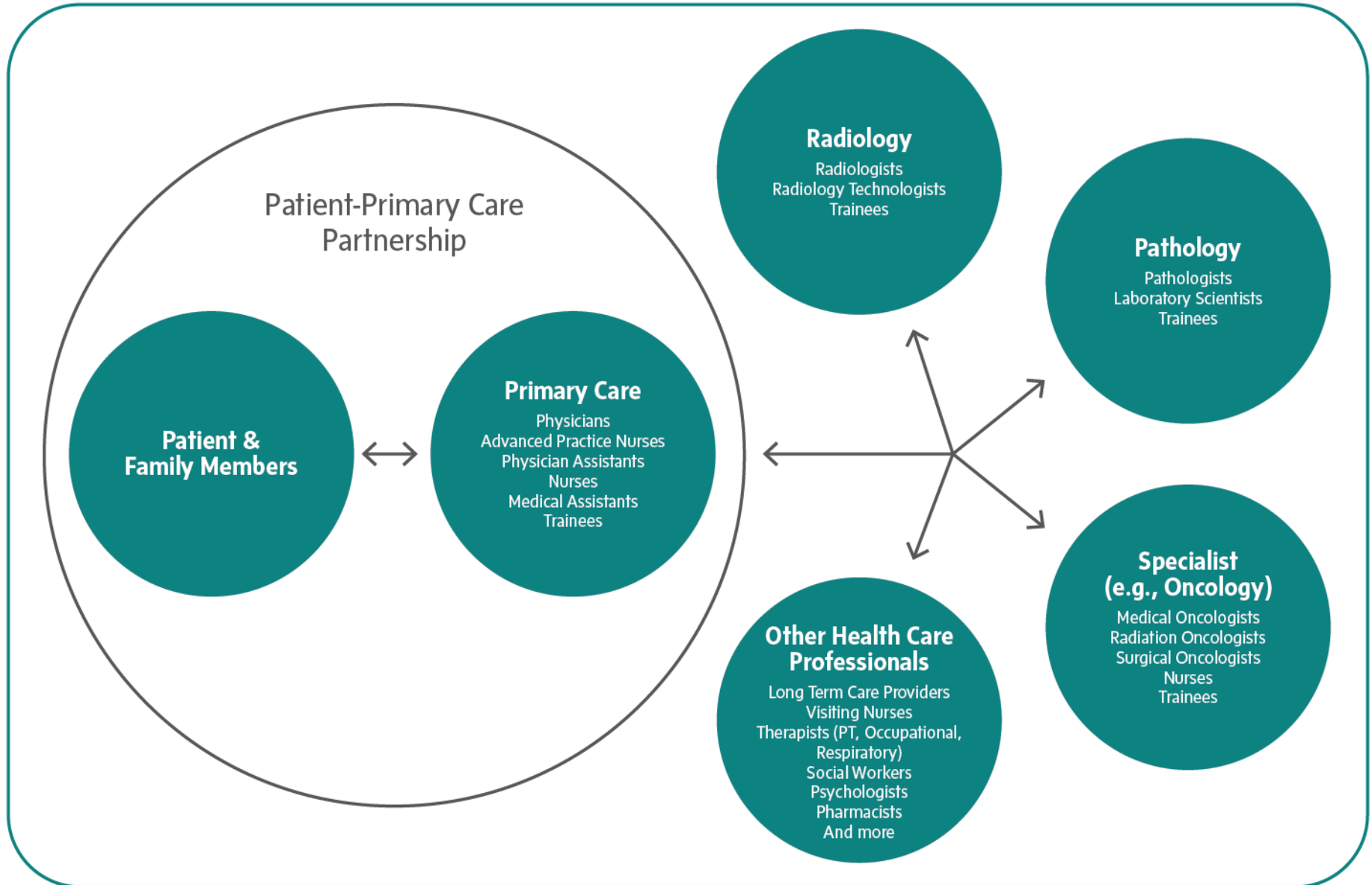
The Work System



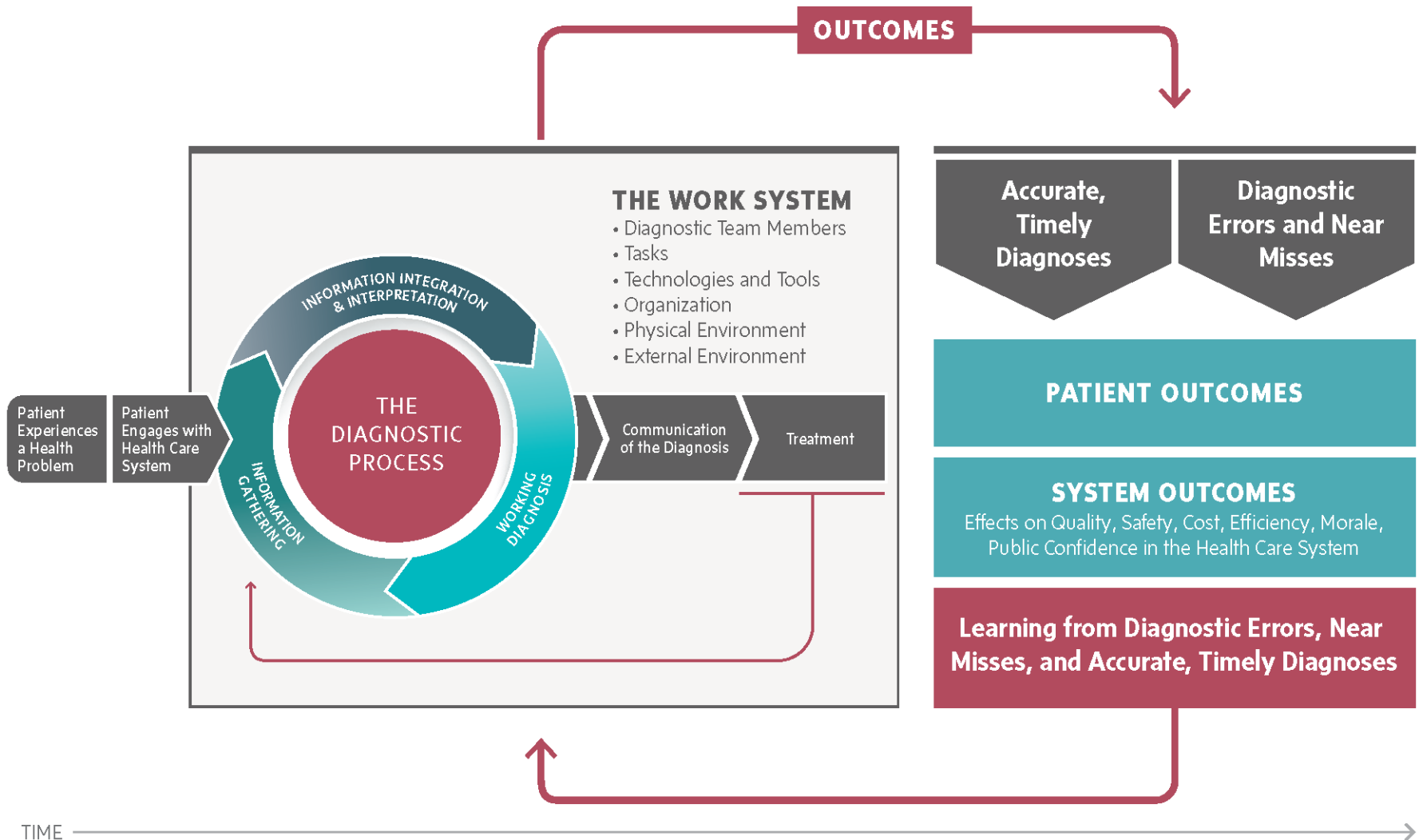
Diagnostic Team Members



Diagnostic Team Members



The Outcomes from the Diagnostic Process



Where Failures in the Diagnostic Process Occur

Failure of Engagement

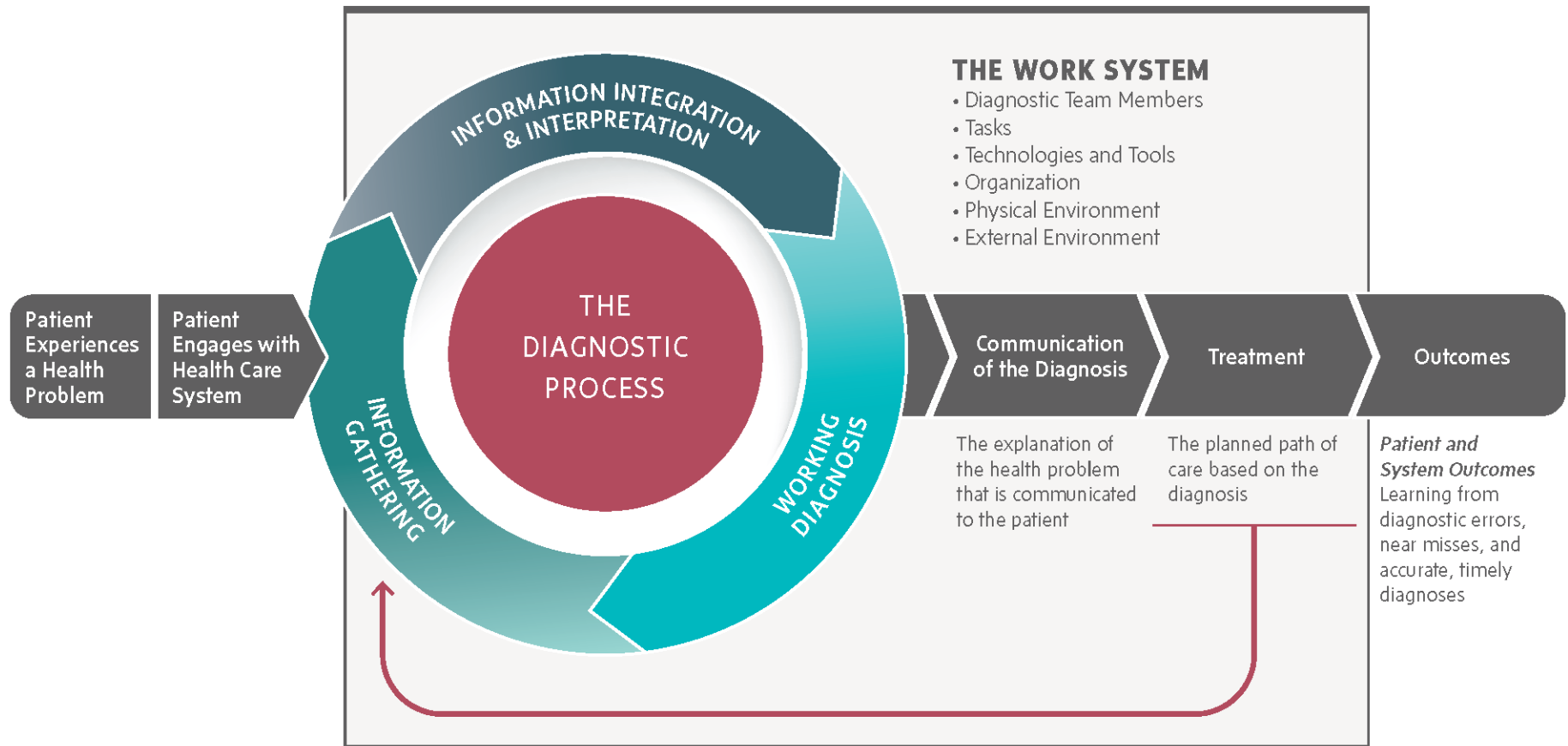
Failure in Information Gathering

Failure in Information Integration

Failure in Information Interpretation

Failure to Establish an Explanation for the Health Problem

Failure to Communicate the Explanation



TIME →

Excerpts, NAM Chapter 3

...committee's dual focus on improving the diagnostic process and reducing diagnostic errors.

Characterization of diagnostic errors requires understanding

- (1) which aspects in the diagnostic process are susceptible to failures and
- (2) what the contributing factors to these failures are.

The committee used its conceptual model and input from other frameworks to provide a context for the measurement of the causes and risks of diagnostic error. Measurement can focus on diagnostic process steps, the work system components, or both in order to identify causes and risks of diagnostic error.

TABLE 3-2 Methods for Detecting Failures Across *the Diagnostic Process*

- **Where in the Diagnostic Process the Failure Occurred**

- Failure to engage in the health care system or in the diagnostic process

- **Nature of Failure**

- Delay in patient presenting

- Patient unable to access care

- **Methods for Detecting Failures**

- Analysis of emergency department, urgent care, and other high-risk cohorts

- Surveys to determine why and what could be done differently

TABLE 3-1 Methods for Estimating the *Incidence of Diagnostic Errors*

- **Data Source**

- Medical records

- **Key Features of the Data Source**

- Rely on documentation (what was recorded, such as clinical history and interview, physical exam, and diagnostic testing)

- **Method(s) for Selecting Cases for Review (Denominator)**

- Pre-specified criteria (e.g., trigger tool)

- Random sample

- **Method for Determining if Error Occurred (Numerator)**

- Implicit review/expert assessment

- Explicit criteria

Related Frameworks

THE SAFER DX FRAMEWORK FOR MEASUREMENT AND IMPROVEMENT OF DIAGNOSTIC SAFETY

HARDEEP SINGH, MD, MPH

HOUSTON VA CENTER FOR INNOVATIONS IN QUALITY,
EFFECTIVENESS & SAFETY

MICHAEL E. DEBAKEY VA MEDICAL CENTER

BAYLOR COLLEGE OF MEDICINE

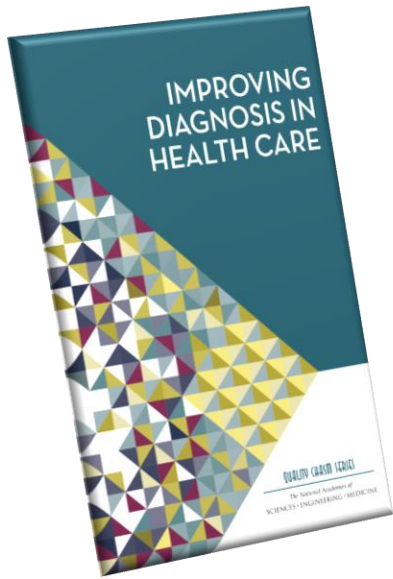
Twitter: [@HardeepSinghMD](https://twitter.com/HardeepSinghMD)



VA
HEALTH
CARE | Defining
EXCELLENCE
in the 21st Century

Why Little Progress in Measurement

- “Basic Science” at the confluence of cognitive science, informatics, human factors, social science, & the ‘art’ of medicine
- Experts still debating definition of “diagnosis”
 - ▣ Lack of standards for most “diagnosis” concepts
 - ▣ Confusion with screening; quality issues
- Operational definitions of diagnostic error harder & especially with evolving diagnosis
 - ▣ Uncertainty at play; not always black & white



Comments from frontline docs

“A "diagnosis" is not a static, fixed conclusion; it is a fluid, evolving conclusion based on serial observation and hypothesis building”

“One moves from less certainty to more certainty more or less quickly depending on a number of factors”

“Many of the complications introduced by both medicolegal and quality improvement efforts come from treating diagnosis as a black and white situation”

Safety Begins with Measurement

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Hard to improve if we cannot measure;

And....

*Harder to measure if we cannot define the
problem we are trying to solve!*

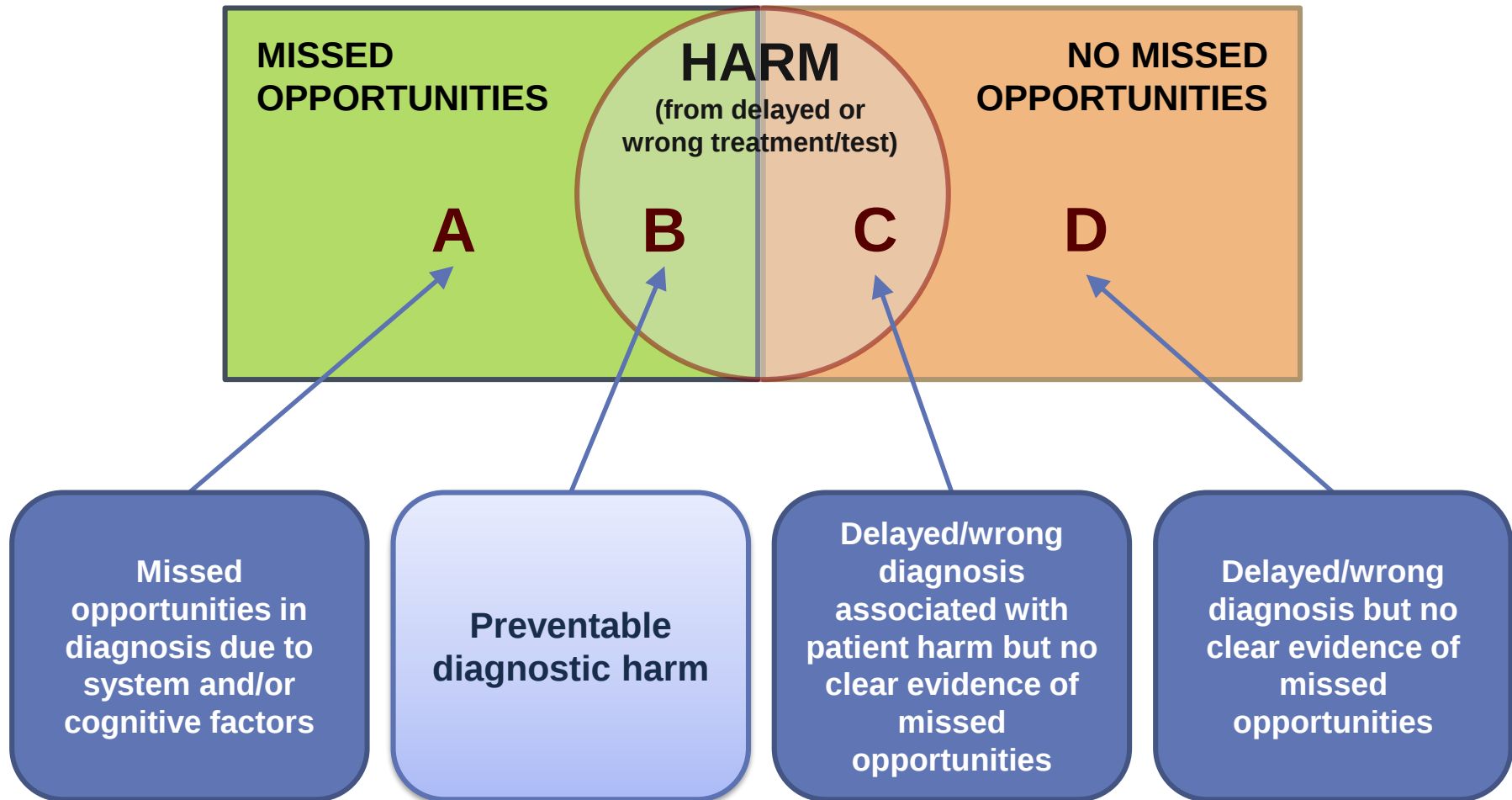
Operational Definition of Diagnostic Error

31

- Case analysis reveals unequivocal evidence of a missed opportunity to make a correct or timely diagnosis (do something different?)
- Missed opportunity is framed within the context of an “evolving” diagnostic process
- The opportunity could be missed by the provider, care team, system, and/or patient

Measuring Preventable Harm

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Foundation for Rigorous Measurement

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- Few valid and reliable data sources
- Must reflect real-world practice
 - ▣ more than just what's in “the doctors head”
 - ▣ systems, team members, and patients, all inevitably influence clinicians' thought processes
- Diagnostic performance = individual + system performance so need both provider-centric and system-centric approaches
- Shared accountability beyond clinician/s

Singh *BMJQS* 2013

Singh & Graber *NEJM* 2015

Singh & Zwaan *Annals of Internal Medicine* 2016

Foundation for Rigorous Measurement

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- “Structure”- complex adaptive sociotechnical system - technological and non-technological dimensions
- “Process”- diagnosis evolves in distributed dimensions beyond the provider visit
- “Outcomes”- safe (correct and timely) diagnosis vs. missed/delayed/wrong/over diagnosis; but should also account for patient and care outcomes

Meyer et al *JAMA Intern Med* 2013

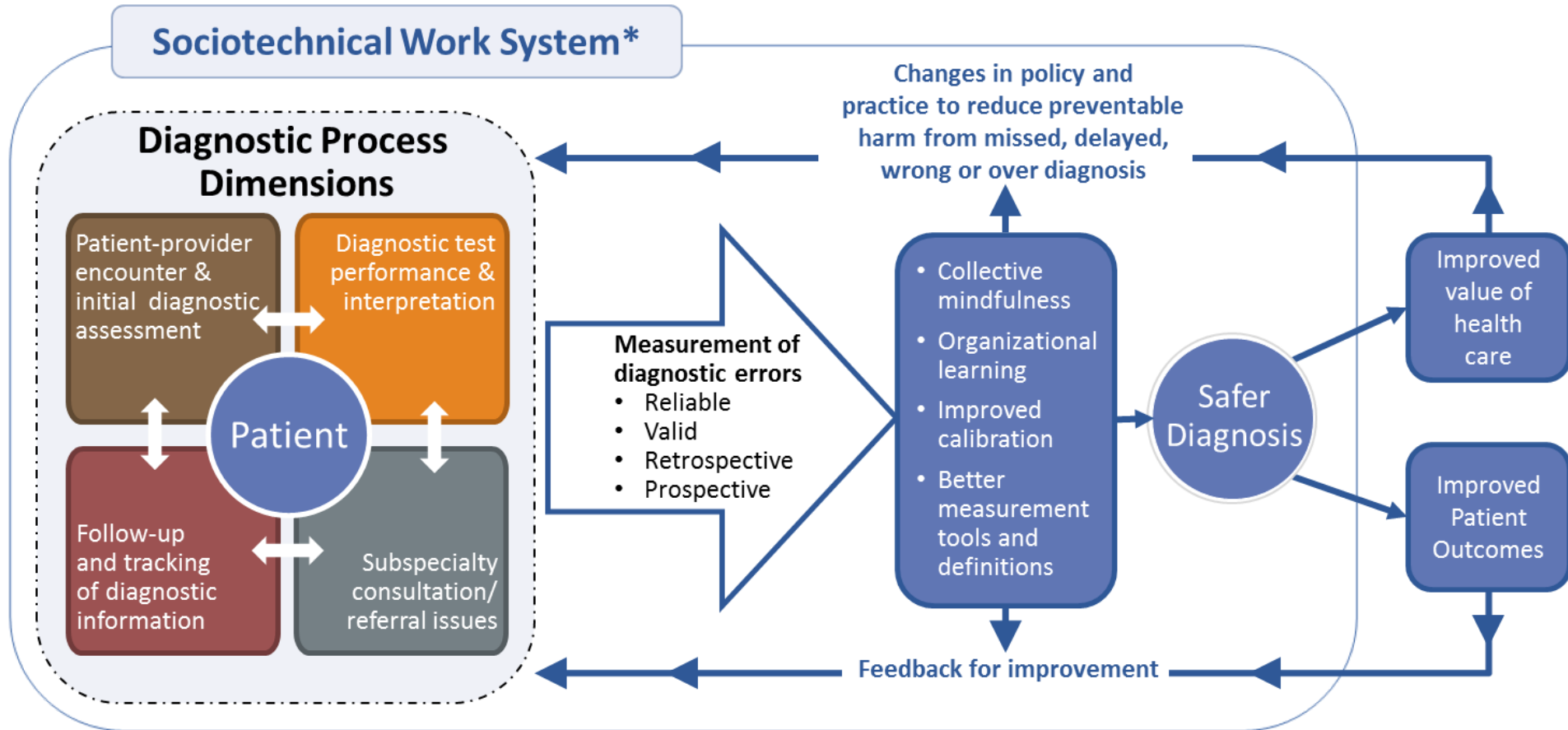
Singh & Sittig *J Gen Intern Med* 2014

[Singh et al *JAMIA* 2012](#)

Singh & Graber *JAMA* 2011

Safer Dx Measurement Framework

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* Includes 8 technological and non-technological dimensions

What Did We Learn After a Decade

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- Common diseases missed despite clear evidence to suggest diagnosis (or need to pursue diagnostic evaluation)
- Failure to elicit or act upon key history/exam finding or ‘red flags’, incl. abnormal results
- Poor calibration is key:
 - We struggle between under-diagnosis and over-zealous diagnostic pursuits

Time Ripe for Retrospective Measurements

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- Signals from administrative data are weaker
 - ▣ If validated, could provide clues on possible missed opportunities that warrant additional clinical evaluation
- Stronger signals to bolster error measurement
 - ▣ Review high-risk cohorts (cancer $\sim$ 1/3rd delays)
 - ▣ Triggered record reviews (e.g. unexpected hospitalization post PCP/ED visit; missed results)
 - ▣ Reports from providers or patients ?

Accuracy of the Safer Dx Instrument to Identify Diagnostic Errors in Primary Care

Aymer Al-Mutairi, MD^{1,2}, Ashley N. D. Meyer, PhD¹, Eric J. Thomas, MD, MPH^{3,4}, Jason M. Etchegaray, PhD^{4,5}, Kevin M. Roy, MD⁶, Maria Caridad Davalos, MD⁶, Shazia Sheikh, MD⁷, and Hardeep Singh, MD, MPH¹

¹Houston Veterans Affairs Center for Innovations in Quality, Effectiveness and Safety, Michael E. DeBakey Veterans Affairs Medical Center and Baylor College of Medicine, Houston, TX, USA; ²Department of Family & Community Medicine, Baylor College of Medicine, Houston, TX, USA; ³Department of Internal Medicine, University of Texas Medical School at Houston, Houston, TX, USA; ⁴The University of Texas at Houston-Memorial Hermann Center for Healthcare Quality and Safety, Houston, TX, USA; ⁵RAND Corporation, Santa Monica, CA, USA; ⁶Department of Pediatrics, Section of Critical Care Medicine, Baylor College of Medicine and Texas Children's Hospital, Houston, TX, USA; ⁷Department of Medicine, Baylor College of Medicine and Ben Taub Hospital - Harris Health System, Houston, TX, USA.

IMPORTANCE: Diagnostic errors are common and harmful, but difficult to define and measure. Measurement of diagnostic errors often depends on retrospective medical record reviews, frequently resulting in reviewer disagreement.

OBJECTIVES: We aimed to test the accuracy of an instrument to help detect presence or absence of diagnostic error through record reviews.

DESIGN: We gathered questions from several previously used instruments for diagnostic error measurement, then developed and refined our instrument. We tested the accuracy of the instrument against a sample of patient records ($n = 389$), with and without previously identified diagnostic errors ($n = 129$ and $n = 260$, respectively).

RESULTS: The final version of our instrument (titled Safer

CONCLUSIONS: The Safer Dx Instrument helps quantify the likelihood of diagnostic error in primary care visits, achieving a high degree of accuracy for measuring their presence or absence. This instrument could be useful to identify high-risk cases for further study and quality improvement.

KEY WORDS: diagnostic error; measurement; patient safety; diagnostic safety; primary care; quality improvement.

J Gen Intern Med 31(6):602–8

DOI: 10.1007/s11606-016-3601-x

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Approach Diagnostic “Error” as Diagnostic “Safety”

ORIGINAL ARTICLE

OPEN

Measures to Improve Diagnostic Safety in Clinical Practice

Hardeep Singh, MD, MPH,* Mark L. Graber, MD,†‡§ and Timothy P. Hofer, MD, MSc||¶

Abstract: Timely and accurate diagnosis is foundational to good clinical practice and an essential first step to achieving optimal patient outcomes.

infections, and medication errors. The dearth of valid measurement approaches is a major barrier in efforts to study and ultimately improve diagnosis.^{9,10}

TABLE 1. Candidate Set of Measurement Concepts to Consider for Evaluation of Diagnostic Safety

Measurement Concept	Rationale
Structure	
Web-based decision support tools and online reference materials are available to all providers to aid differential diagnosis.	80% of diagnostic errors in one study had no documented differential diagnosis. ²⁶
Process	
Proportion of laboratory test results or diagnostic imaging not performed within the expected turnaround time	Delays in diagnostic testing lead to delays in diagnosis and increase chances for iatrogenic injury in the interim. ⁴¹
Outcomes	
Proportion of patients with newly diagnosed colorectal cancer diagnosed within 60 days of first presentation of known red-flags	Nearly a third of patients with colorectal cancer have missed opportunities for an earlier diagnosis. ^{48,51–53}

To create a foundation for further discussion on evidence for measures for diagnostic safety, 6 questions should be considered:

- What are the appropriate time intervals to diagnose specific conditions of interest that are frequently associated with diagnostic error?
- How can we measure competency in clinical reasoning in real-world practice settings?
- What measurable physician or team behaviors characterize ideal versus suboptimal diagnostic performance?
- What system properties translate into safe diagnostic performance, and how can we measure those?
- How do we leverage information technology, including electronic health records (EHRs), to help measure and improve diagnostic safety?
- How do we leverage patient experiences and reports to measure and improve diagnostic safety?

“Actionable Measurement”

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- Measurement of diagnostic error ready for QI, learning & research purposes
 - ▣ Translate into feedback & learning
- Not ready for public reporting, performance measurement or penalties
- Engage providers, patients & organizations
- Generate evidence to measure diagnostic ‘harm’, ‘safety’, ‘reliability’, ‘uncertainty’

Lets Only Measure If....

Actionable For Safety

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- For sharp-end outcome measures for missed opportunities, more 'basic science' needed
- For blunt-end measures for system diagnostic performance, need standards and operational definitions (e.g. VA policy on test results)
- Must evaluate measurement burdens and unintended consequences
- A “measured” approach (JPS paper; Safer Dx) essential to inform good measures and solutions

Thank you and Acknowledgements

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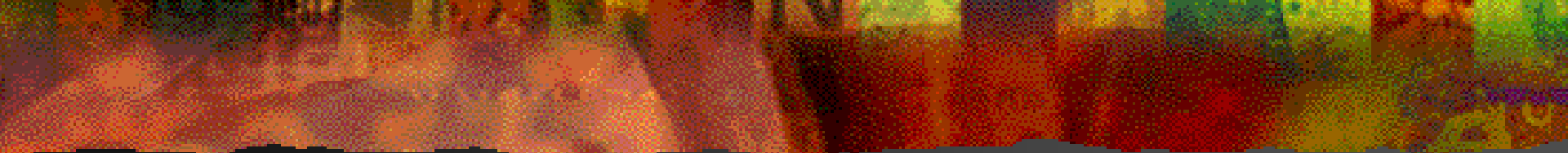
- Funding Agencies:
 - ▣ Department of Veterans Affairs
 - ▣ Agency for Healthcare Research & Quality
 - ▣ National Institute of Health
- Multidisciplinary team at VA Health Services Research Center for Innovation

Papers: https://www.researchgate.net/profile/Hardeep_Singh

Email: Hardeeps@bcm.edu

Web: <http://www.houston.hsrdr.research.va.gov/bios/singh.asp>

Twitter: [@HardeepSinghMD](https://twitter.com/HardeepSinghMD)



NQF Measurement Framework Meeting, January, 2017

Unified Conceptual Model for Diagnostic Errors

David E. Newman-Toker, MD PhD

Director, Armstrong Institute Center for Diagnostic Excellence
Professor of Neurology, Otolaryngology, & Emergency Medicine

*Johns Hopkins University School of Medicine
Johns Hopkins Bloomberg School of Public Health*

DISCLOSURES

1. Grant support

- ▶ NIH U01 DC013778-01A1 (NIDCD), 5U01NS080824, (NINDS), U24TR001609-01 (NCATS), AHRQ (pending)
- ▶ Siemens/SIDM, Brainscope, Kaiser Permanente

2. Research VOG devices loaned by

- ▶ GN Otometrics
- ▶ Autronics-Interacoustics

3. Founding Board Member SIDM (unpaid)

4. 'Diagnosis' career focus (academic COI)

Investigational Use – None

Diagnostic Errors

NAM DEFINITION

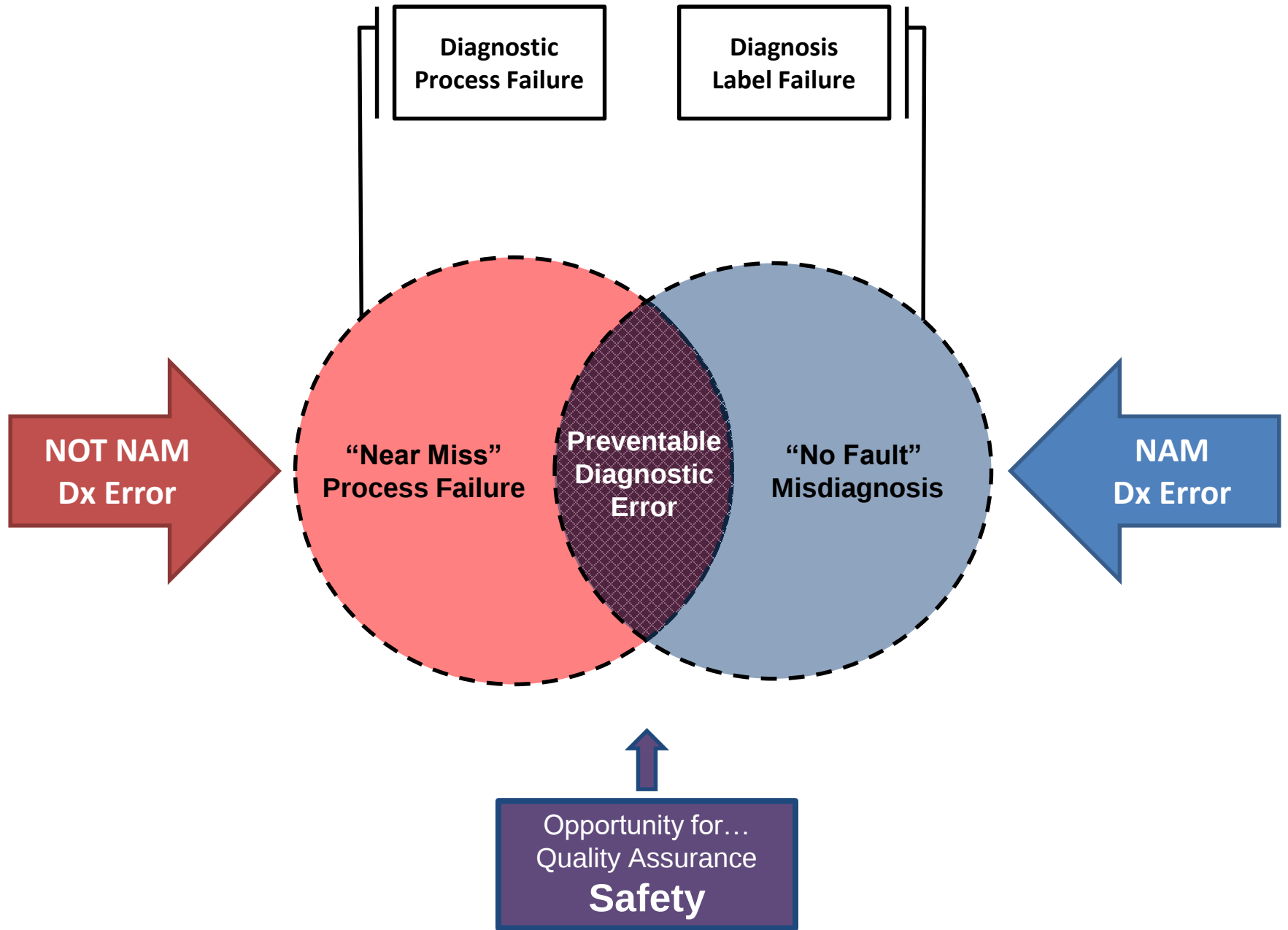
NAM Definition of Diagnostic Error

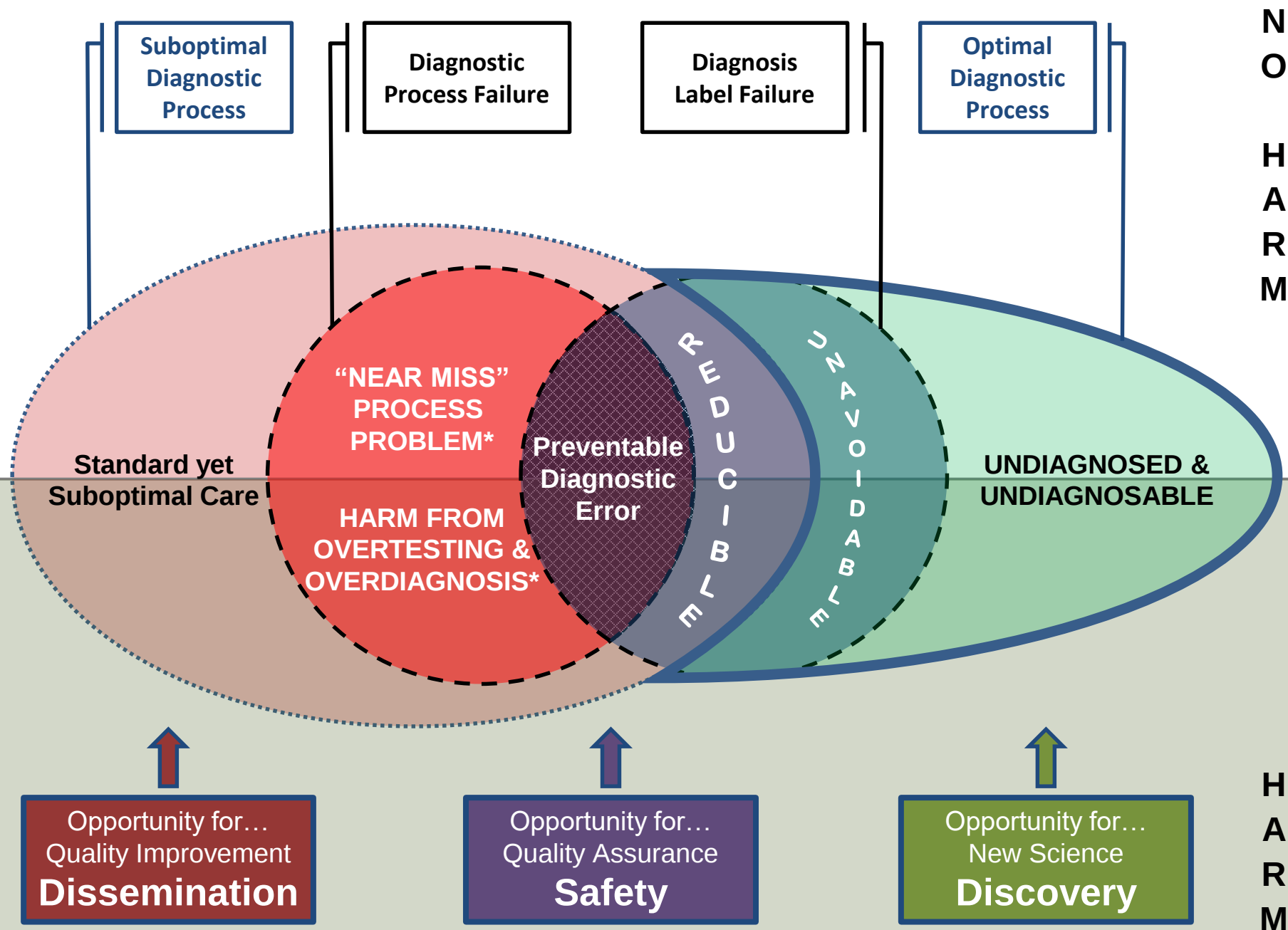
DIAGNOSTIC ERROR is the failure to...

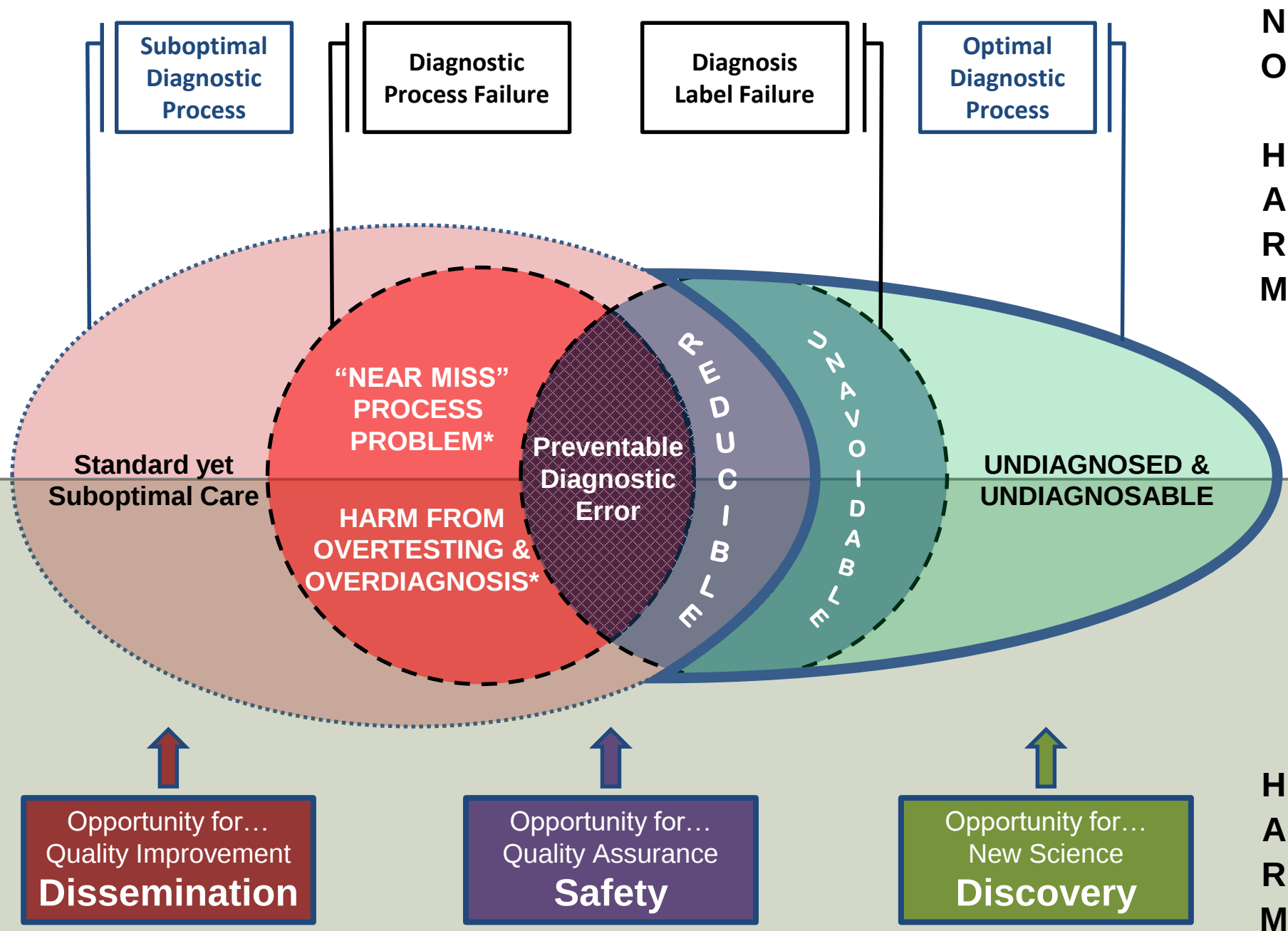
- (a) establish an accurate and timely explanation of the patient's health problem(s) or
- (b) communicate that explanation to the patient

Diagnostic Errors

UNIFIED MODEL

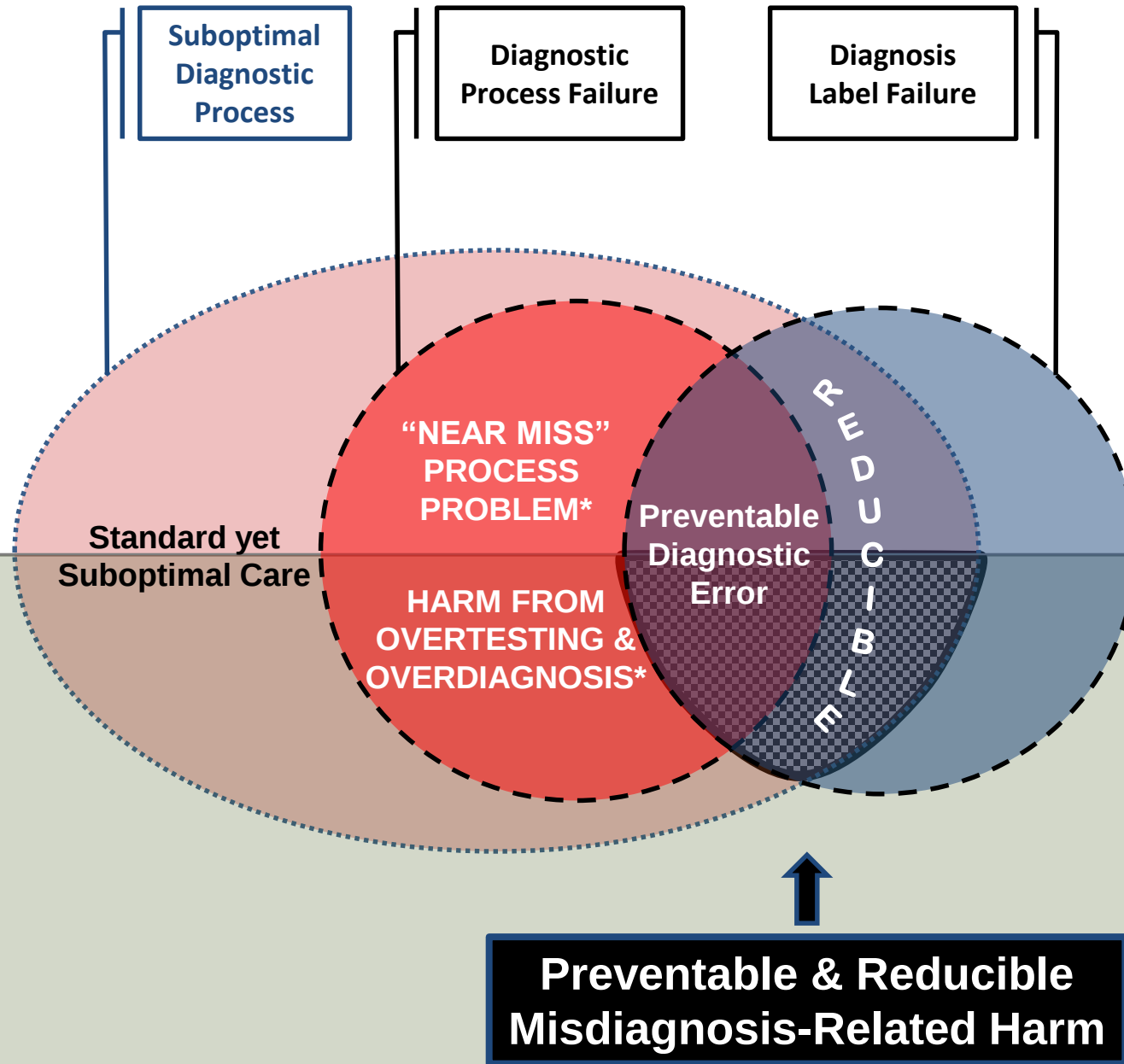






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Diagnostic Errors

MEASUREMENT

IMPLICATIONS

IMPLICATIONS FOR MEASUREMENT

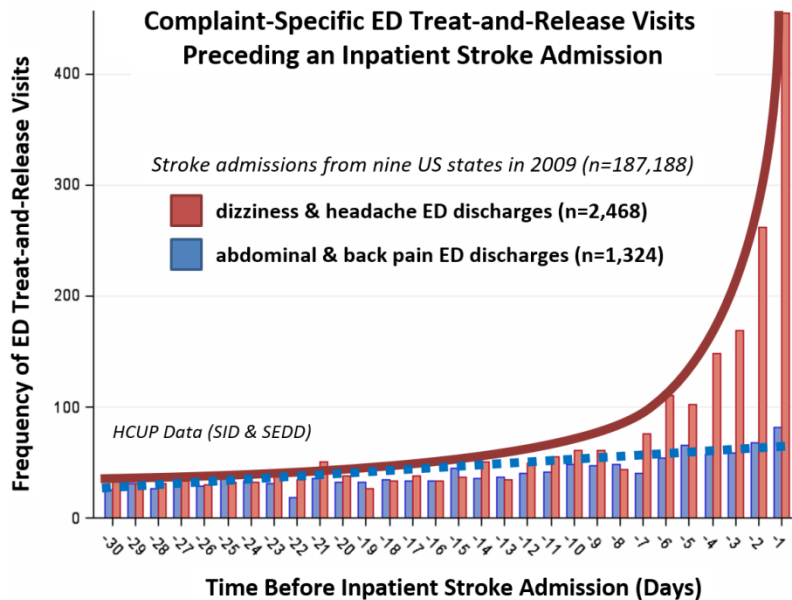
1. Process defect not required for dx error
2. Process defect alone is a 'near miss'
3. 'Suboptimal' is similar to 'failed' process
4. Overdiagnosis & overtesting may harm
5. Harm is a key parameter to measure

BIG DATA FOR NAM-DEFINED DX ERROR & HARMS

PROCESS NOT NEEDED TO DEFINE DX ERROR

Look Back Approach:

Stroke patients more likely to have been discharged from ED with “benign” dizziness prior ~14 days (N = ~180,000 strokes)

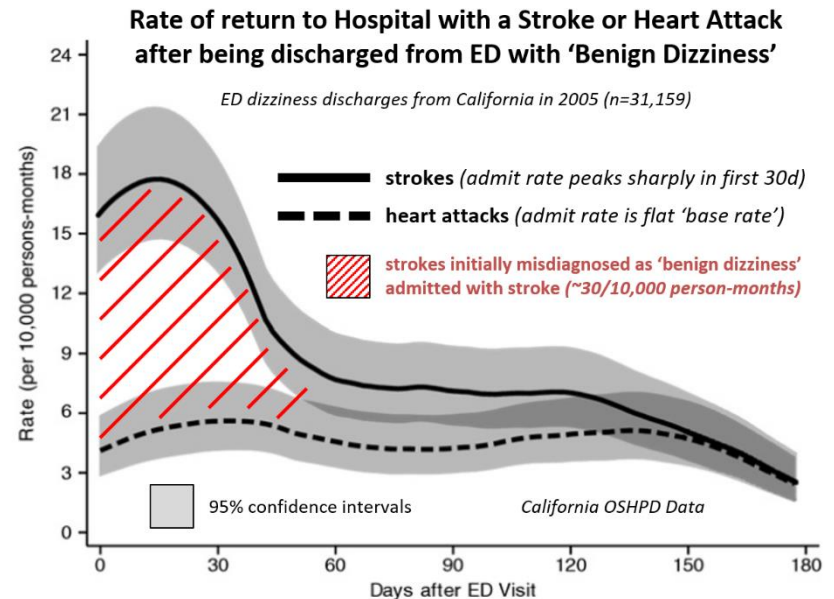


A

Adapted from Newman-Toker et al., Diagnosis 2014

Look Forward Approach:

‘Benign’ dizziness sent home from ED more likely to return with a stroke within ~30 days, but not heart attack (N = ~30,000 ED dizzy discharges)



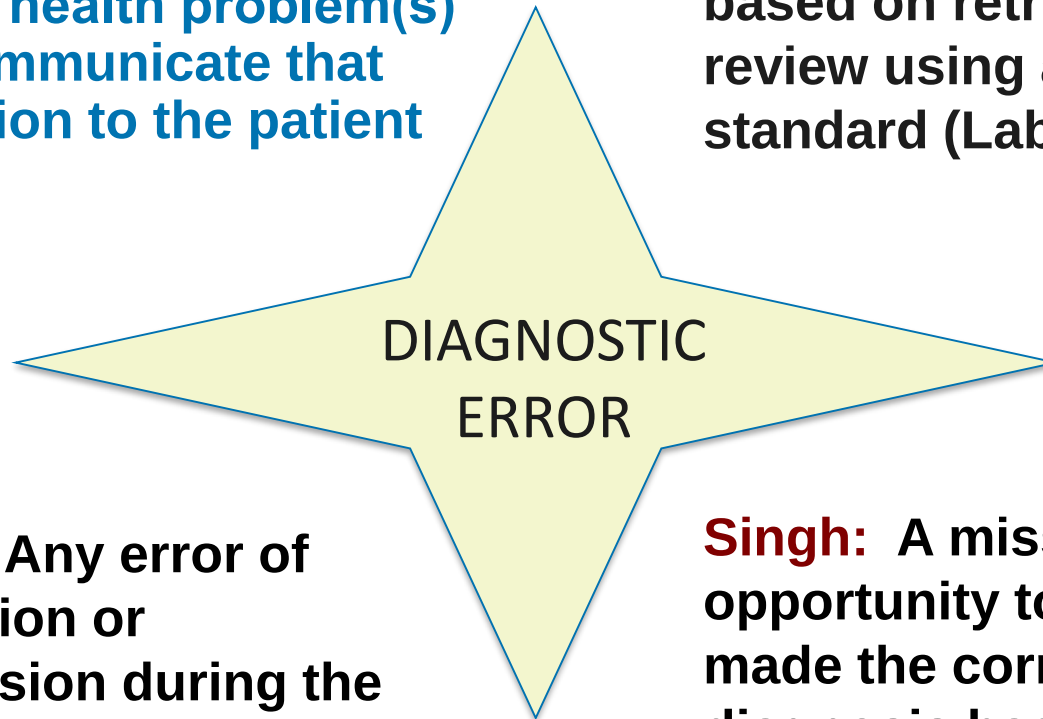
B

Adapted from Kim et al., Annals of Emergency Medicine 2010

Committee Discussion – Terminology and Definitions

IOM: The failure to:
establish an accurate and
timely explanation of the
patient's health problem(s)
or (b) communicate that
explanation to the patient

Graber: A diagnosis
that is wrong, missed,
or egregiously delayed,
based on retrospective
review using a gold
standard (Label failure)



Schiff: Any error of
ommission or
commission during the
diagnostic process
(Process failure)

Singh: A missed
opportunity to have
made the correct
diagnosis based on
retrospective review
(Process failure)

Terminology and Definitions

- Diagnostic Error and Diagnostic Accuracy
- Move to a focus on *quality*?
 - ▢ *Diagnostic Quality*
 - ▢ *Quality of Diagnosis*
 - ▢ *Quality of the Diagnostic Process*
- Do we need to call out “Safety” or rely on IOM definition of quality (and incorporate it into definition)?
 - Safe
 - Timely
 - Patient-Centered
 - Efficient
 - Effective
 - Equitable

Potential Definitions for Diagnostic Quality

- *The degree to which an accurate and timely explanation of a patient's health problems has been (1) established and (2) communicated to the patient.*
- *The degree to which the healthcare system can be relied upon to establish an accurate and timely explanation of a patient's health problem and to communicate that explanation to the patient.*
- *The degree to which diagnosis-related systems, processes, and behaviors increase the likelihood of desired health outcomes and are consistent with current professional knowledge.*

Definition should also recognize that diagnostic quality can be evaluated across the IOM's six dimensions of quality:

- **Safe**
- **Effective**
- **Patient-centered**
- **Timely**
- **Efficient**
- **Equitable**

Opportunity for Public and Member Comment

Lunch

Review of Proposed Framework for Measuring Diagnostic Quality

Proposed Framework for Measurement of Diagnostic Quality

- Purpose:

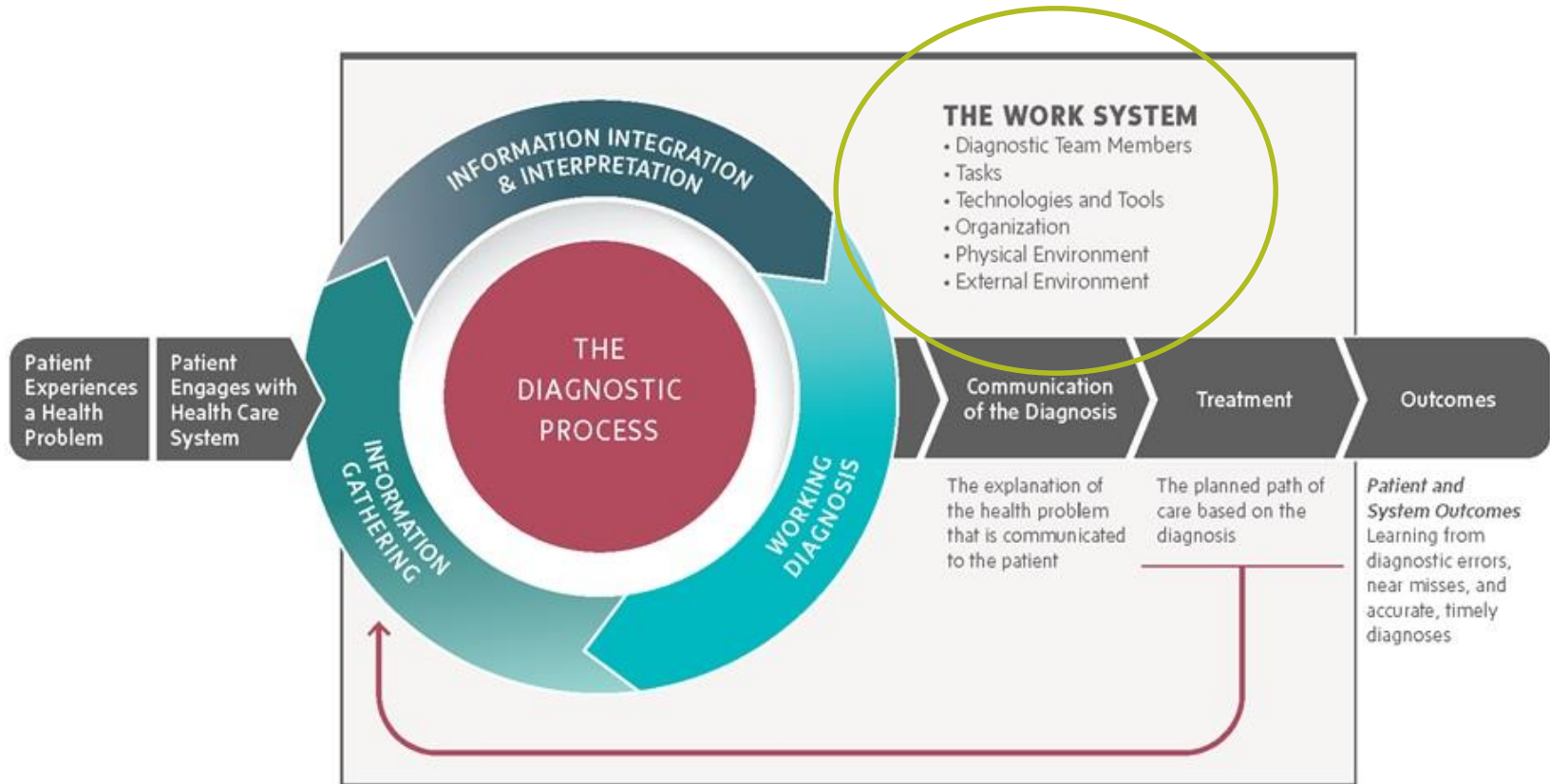
- *To provide an organizational scheme for identifying and categorizing diagnosis-related measures*
- *To facilitate systematic identification of measure gaps*
- *To facilitate systematic prioritization of measures and/or measurement areas*
- *To serve as a conceptual framework and guidance for future development of diagnosis-related measures*

Proposed Framework for Measurement of Diagnostic Quality

- Three high-level domains:
 - **Structure**
 - » Aspects or attributes of the work system in which diagnosis occurs
 - **Process**
 - » Actions or processes supporting accurate and timely diagnosis
 - **Outcome**
 - » Outcomes associated with diagnosis or diagnostic performance

Within the structure-process-outcome model, elements of the NASEM framework serve as subdomains

Structure Domain

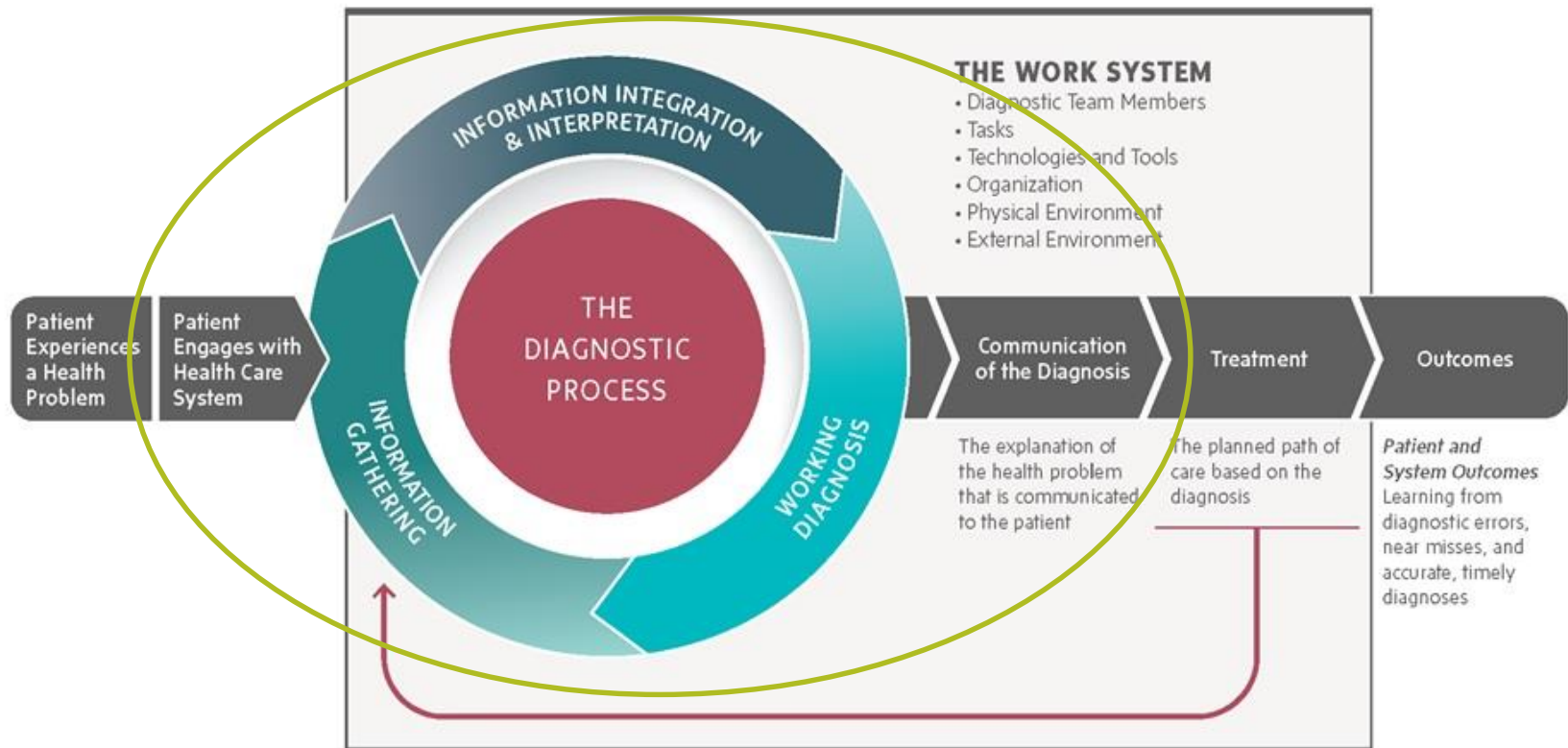


Structure Domain

Subdomains:

- People (“Diagnostic Team Members” in NASEM report)
- Tasks
- Technologies and Tools
- Organizational Characteristics
- Physical Environment
- External Environment

Process Domain

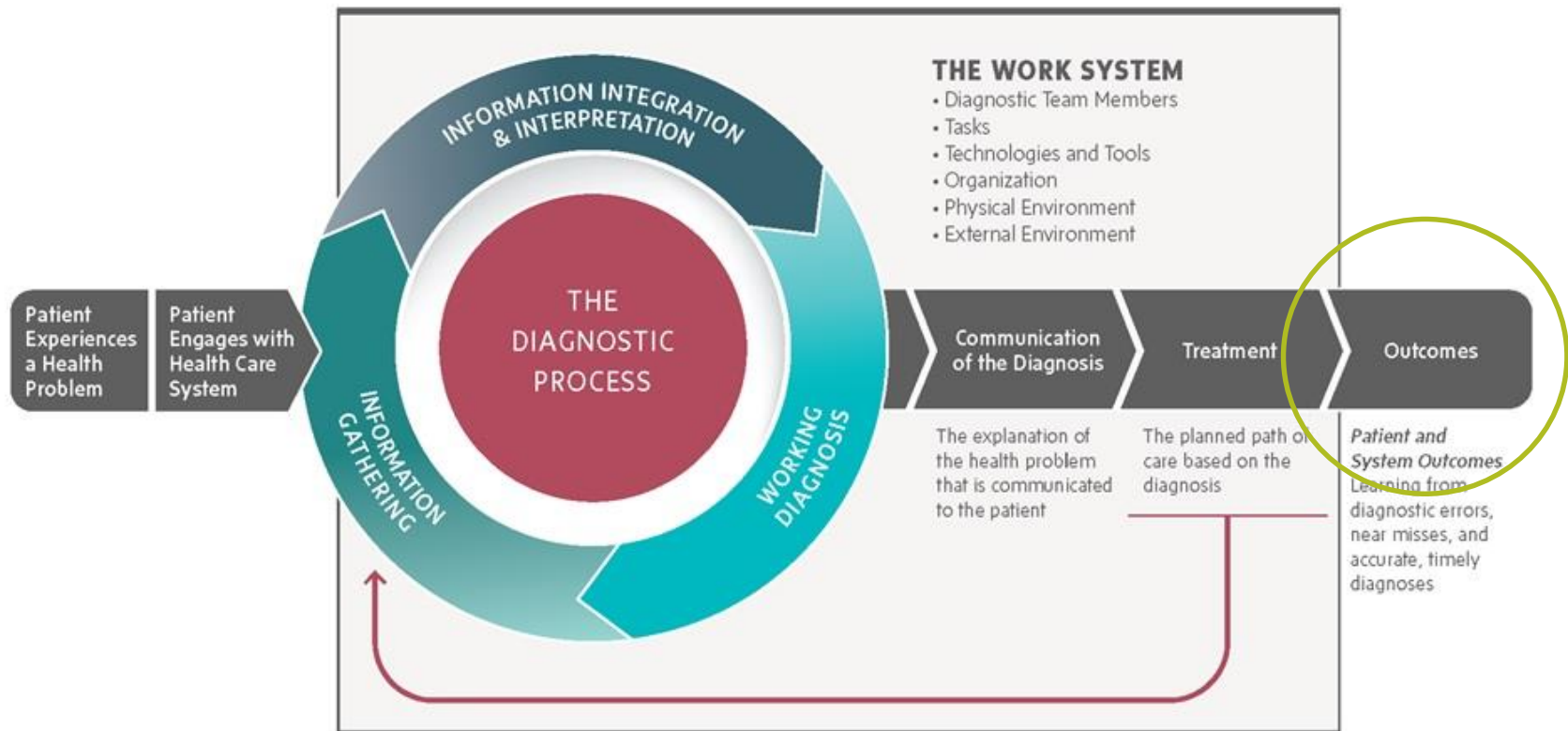


Process Domain

Subdomains:

- Patient Engagement
- Information Gathering/Diagnostic Evaluation
- Information Interpretation/Hypothesis Generation
- Information Integration/Hypothesis Confirmation & Revision
- Communication of the Diagnosis to the Patient
- Quality Improvement and Learning Activities

Outcome Domain



Outcome Domain

Subdomains:

- Intermediate Outcomes
- Patient/Clinical Outcomes
- Patient Experience
- System Outcomes

Questions?

Environmental Scan

Environmental Scan Overview

- To identify measures of diagnostic error and other approaches to assess or monitor the accuracy of diagnosis
- Research Questions:
 - What evidence-based metrics exist for evaluating diagnostic accuracy?
 - What are the current approaches to identifying, learning from, and reducing or avoiding diagnostic errors?
 - What conceptual and measurement gaps exist with respect to diagnostic accuracy?
 - What outcomes might be associated with errors in diagnosis?
 - What are organizations doing to establish a work system that supports the diagnostic process? How are organizations facilitating more effective teamwork and communication among health professionals, patients, and families?

Literature Review

- Identify existing structure, process, and outcome measures, including those that are in testing, development, or in use to improve diagnostic accuracy
- Information Sources
 - *PubMed*
 - *Grey Literature (i.e., academic or policy literature that is not commercially published)*
 - » *Government publications (e.g., federal or state agency reports, rules and regulations, etc.)*
 - » *Reports or publications from foundations, associations, or non-profit groups*
 - » *Conference papers, abstracts, or proceedings*
 - » *Key informant interviews*
 - *Measures Inventory*

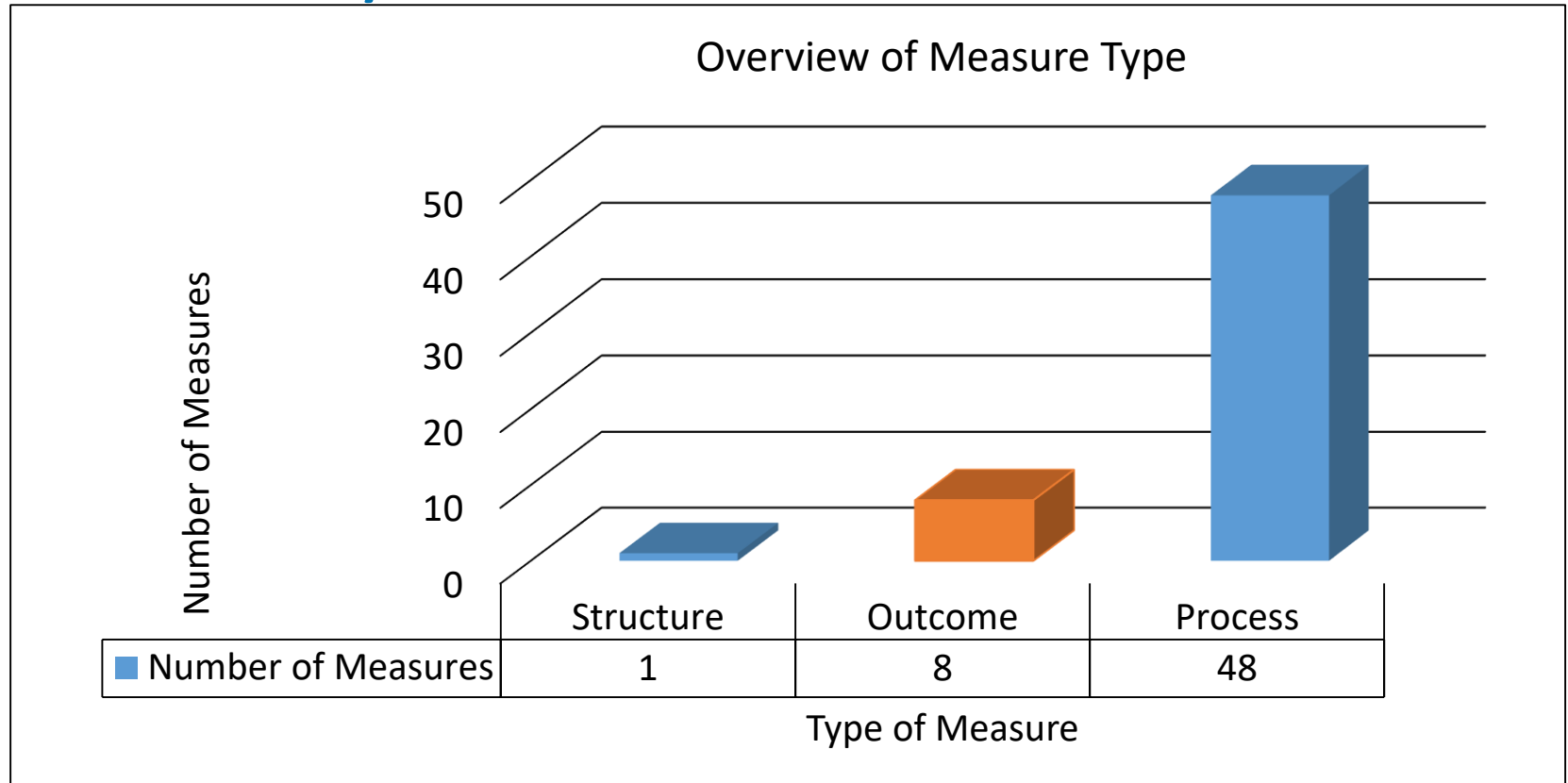
Measures Inventory

- AHRQ National Quality Measures Clearinghouse and National Guidelines Clearinghouse
- Health Indicators Warehouse
- CMS Measures Inventory
- NQF Endorsed Measures

Keywords

- Diagnostic errors
- Diagnosis errors
- Diagnostic process
- Diagnostic performance
- Diagnostic uncertainty
- Diagnostic accuracy
- Diagnostic safety
- Medical error
- Latent error
- Near misses
- Adverse event
- Misdiagnosis
- Missed diagnosis
- Safety Culture
- Diagnostic failure
- Diagnostic testing
- Diagnostic bias
- Diagnostic delays
- Timely/timeliness

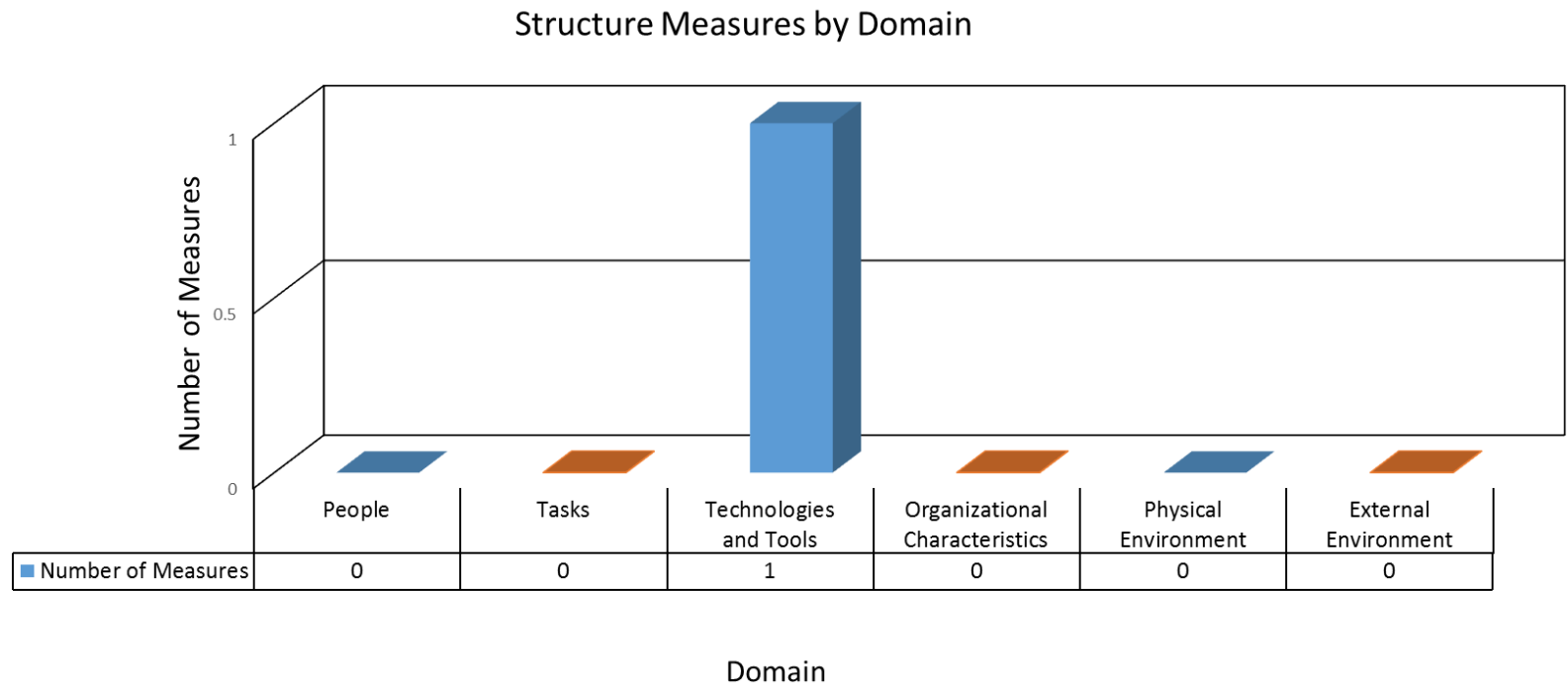
Results of Environmental Scan: Summary



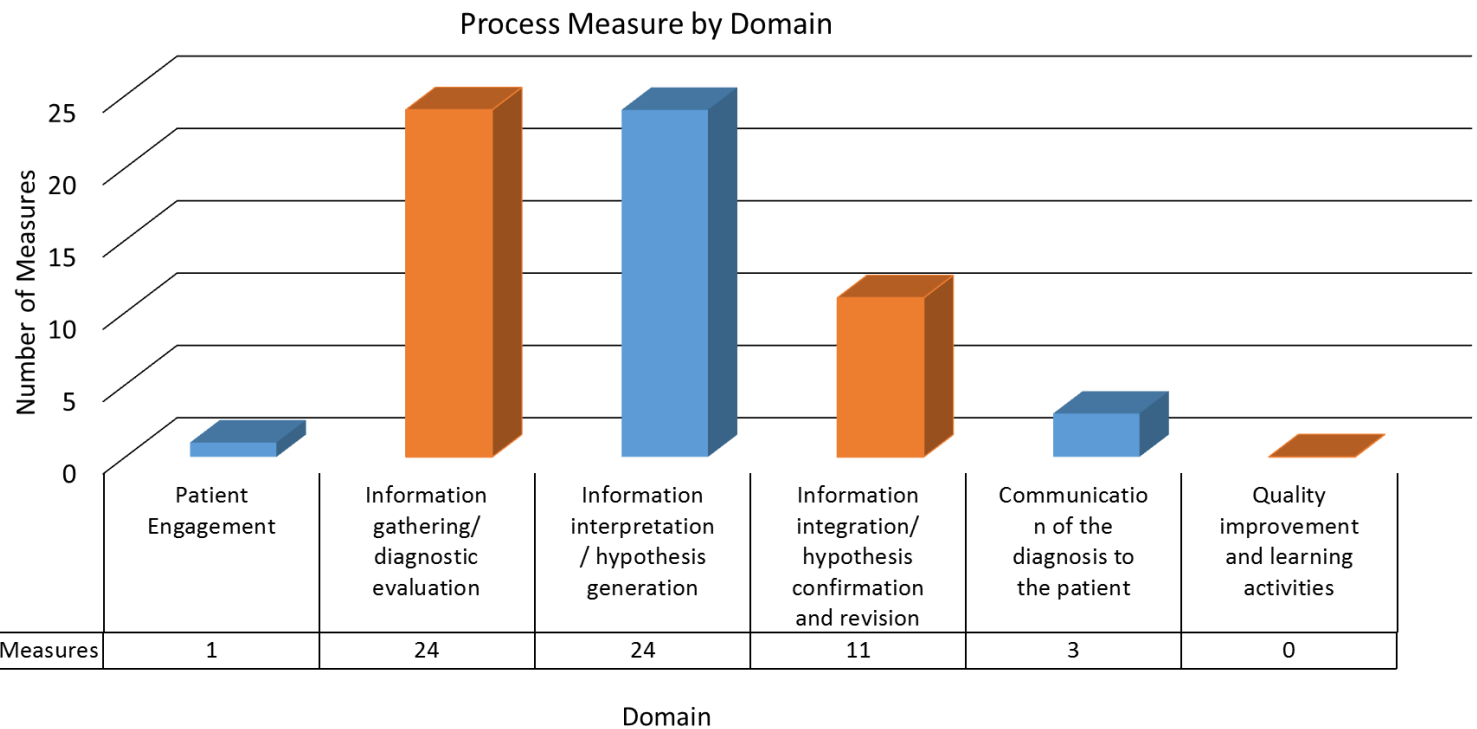
- 54 Measures found

See handouts

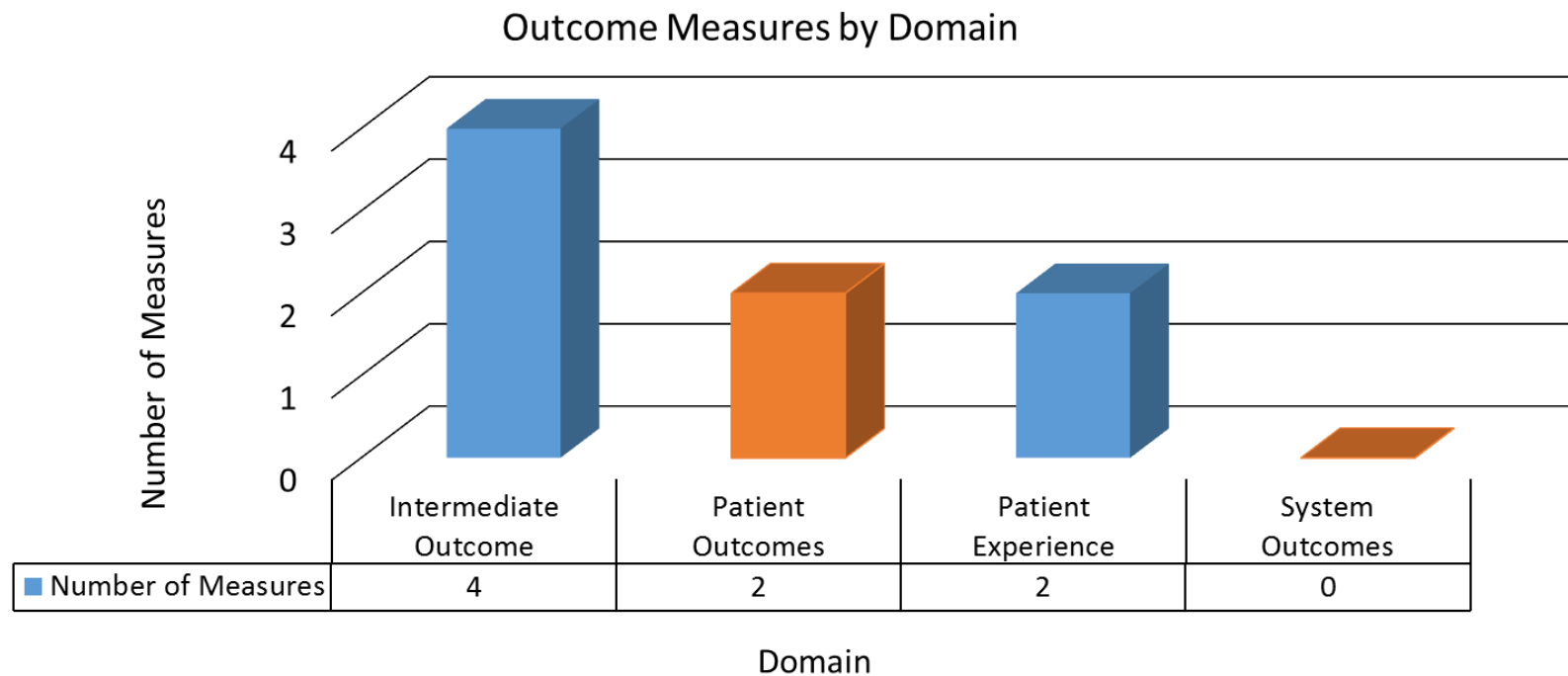
Results of Environmental Scan: Structural Measures



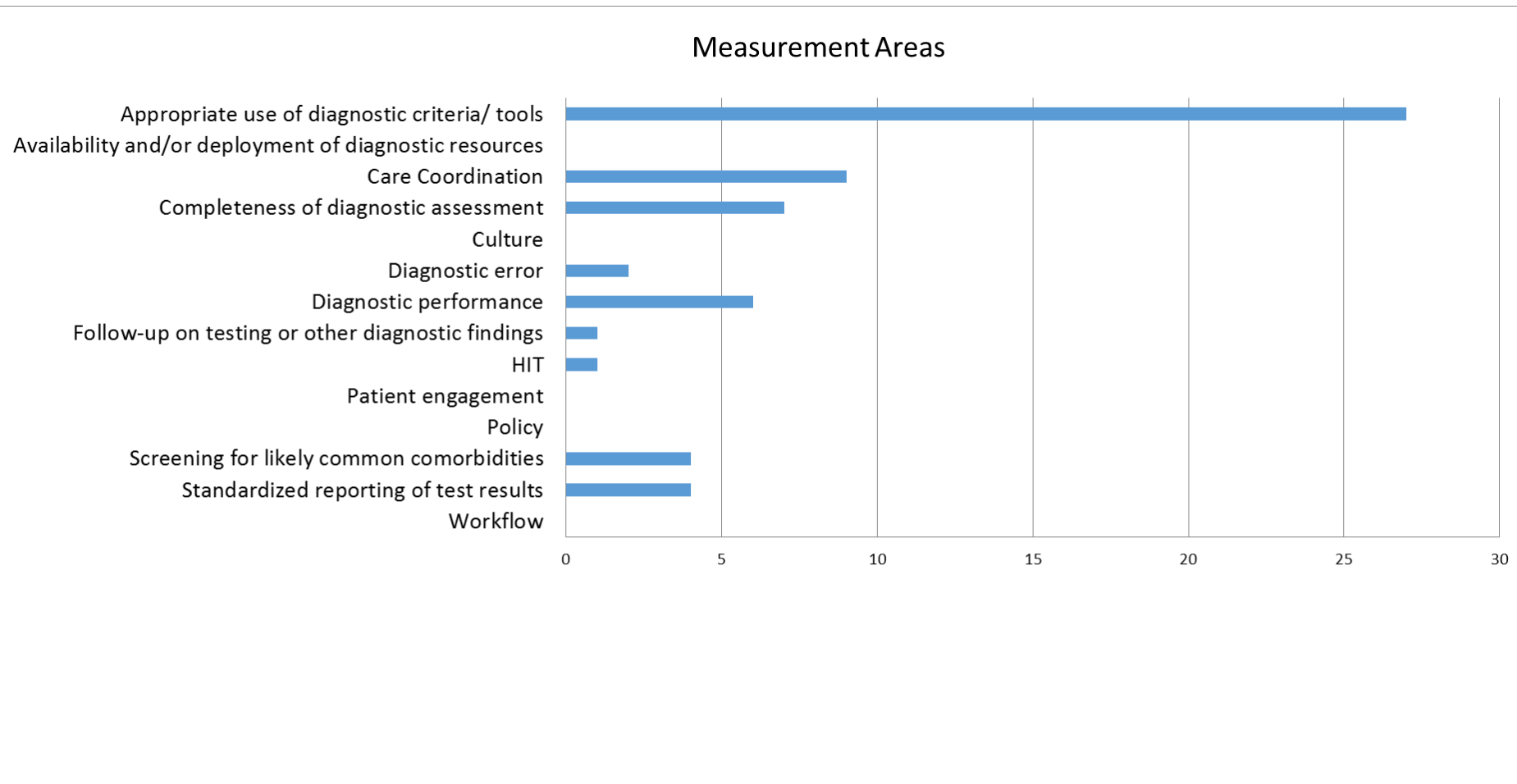
Results of Environmental Scan: Process Measures



Results of Environmental Scan: Outcome Measures

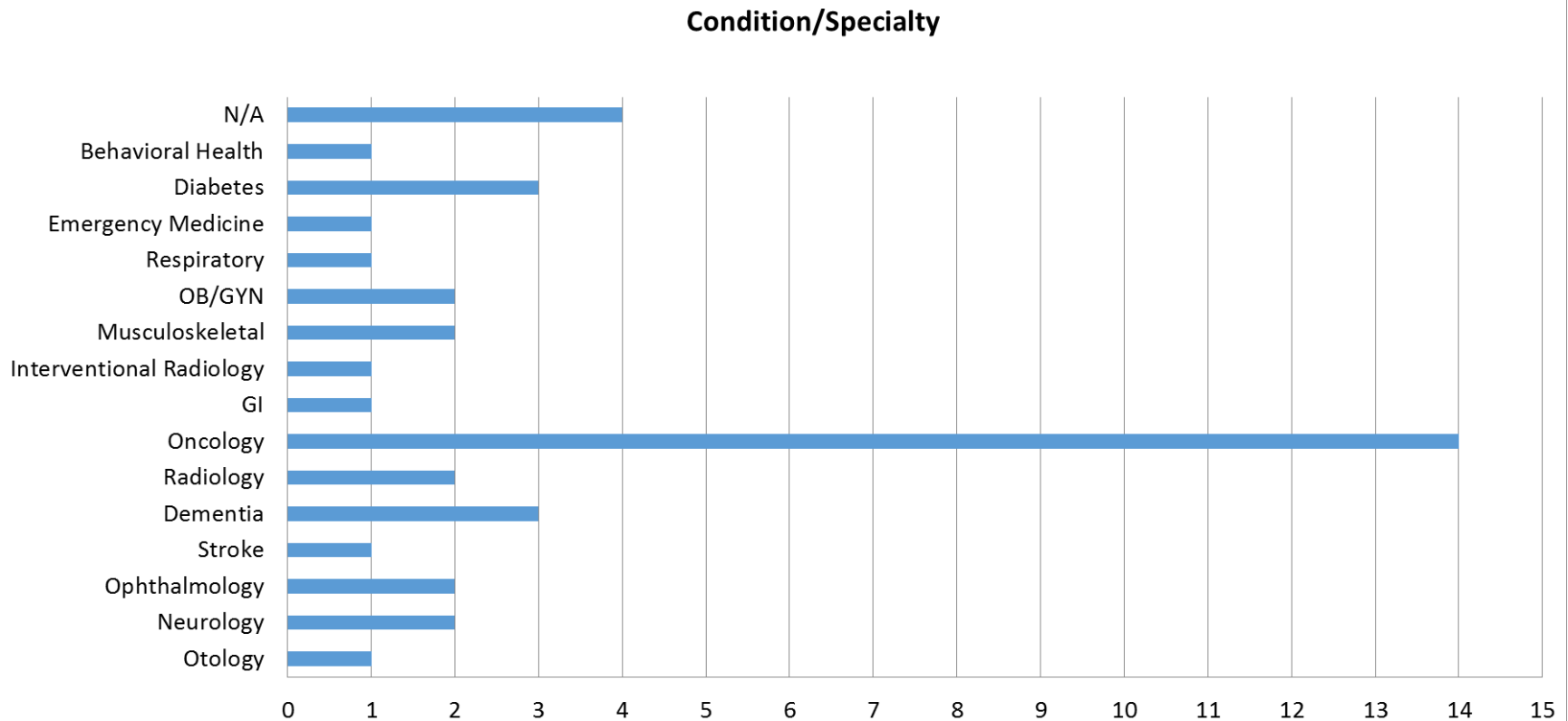


Qualitative Analytics: Measurement Areas



Qualitative Analytics:

Topic Area (Condition/Specialty)



Committee Discussion – Feedback on Framework and Environmental Scan

Questions

■ Framework:

- *Does this framework address all aspects of diagnosis that could be subject to measurement?*
- *Are there elements missing?*
- *Should any elements be modified or added?*
- *Will this framework be useful for categorizing and prioritizing measures of diagnostic quality?*

■ Environmental Scan:

- *Are there any measures that should be included?*
- *Are there any measures that should be excluded? Why?*

Opportunity for Public and Member Comment

Committee Dinner

P.J. Clarke's

1600 K St. NW

6pm – Reservation under NQF

Walking Directions from NQF:

Head south on 15th St. NW toward K St.

Turn right onto K St. and the destination is on your left

Walking Directions from Residence Inn:

Head south on 14th St. NW toward L St. NW

Turn right onto L St. NW

Turn Left toward K St. NW, turn right onto K St. NW and the destination is on your left

Adjourn.



NATIONAL
QUALITY FORUM

Welcome and Day One Recap

January 11, 2017

Meeting Objectives

- ▣ Group discussion on measures and domains
- ▣ Identify gaps in measures and recommendations to address gaps

Brainstorming Exercise – Potential Measures of Diagnostic Quality

Groups

Group 1

- Mark Graber
- Michael Dunne
- Missy Danforth
- Carlos Higuera-Rueda
- Prashant Mahajan
- Martha Radford

Group 2

- Helen Haskell
- Marilyn Hravnak
- Lavinia Middleton
- Mira Irons
- Thomas Sequist
- David Newman-Toker

Group 3

- Jennifer Campisano
- Mark Grenache
- Nicholas Kuzma
- Kathryn McDonald
- David Seidenwurm
- Hardeep Singh

Discussion Questions

- What are the most important aspects of diagnosis that should be measured?
- What are things that can be measured now?
- What else is important?

Review of Breakout Group Discussions

Lunch

Committee Discussion: Revisiting the Framework for Measuring Diagnostic Quality

Opportunity for Public and Member Comment

Break

Next Steps

- Web Meeting #2: Post Meeting Follow-up
 - *January 17, 2017 2-4 PM ET*
- 30-Day Comment period on Draft Framework:
 - *January 31-March 1, 2017*
- Web Meeting #3: Respond and Adjudicate Comments; Revisit Measure Inventory
 - *March 16, 2017 1-3 PM ET*