NATIONAL QUALITY FORUM

Moderator: Improving Diagnostic Accuracy
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OPERATOR: This is Conference #: 81224997.

Operator: Welcome everyone. The webcast is about to begin. Please note today's call is being recorded. Please standby.

Christy Skipper: Good afternoon and welcome to the third webinar for the Improving Diagnostic Quality and Safety Project. The purpose of our call this afternoon is to review the comments submitted on the draft to measurement framework.

Next slide, please.

Following introductions and roll call, we will review the comments received then move on to suggestions for the measure prioritization criteria. We'll then open for member and public comment and then close out with the next steps.

My name is Christy Skipper, Project Manager, and I'll turn it over to my colleagues to introduce themselves.

Andrew Lyzenga: Hi. This is Andrew Lyzenga, Senior Director on the project.

Tracy Lustig: Hi, Tracy Lustig, also a Senior Director.

Vanessa Moy: And I'm Vanessa Moy. I'm the Project Analyst.

John Bernot: And I'm John Bernot. I'm the Senior Director on the project.

Christy Skipper: OK, now we'll move in to roll call when you hear your name just please say here.

Vanessa Moy: I know Mark Gaber can't make it. Is Missy Danforth here?

Missy Danforth: Yes. Hi everyone.

Vanessa Moy: We'll thank you. Jennifer Campisano?

Jennifer Campisano: Yes, I'm here.

Vanessa Moy: Michael Dunne?

Michael Dunne: Here.

Vanessa Moy: David Grenache?

David Grenache: Yes here.

Vanessa Moy: Helen Haskell?

Helen Haskell: Yes I'm here after all. I know I said I wouldn't be.

Vanessa Moy: Thank you. Carlos Higuera-Rueda? How about Marilyn Hravnak? Mira Irons? Nicholas Kuzma?

Nicholas Kuzma: Yes I'm here.

Vanessa Moy: OK, thank you. Kathryn McDonald?

Kathryn McDonald: Here, here.

Vanessa Moy: Prashant Mahajan?

Prashant Mahajan: Yes, I'm here.

Vanessa Moy: Lavinia Middleton? David Newman-Toker? Martha Radford?

Martha Radford: I'm here. Thank you.

Vanessa Moy: OK, thank you. David Seidenwurm?

David Seidenwurm: Here.

Vanessa Moy: Thomas Sequist?

Thomas Sequist: Here.

Vanessa Moy: And Hardeep Singh?

Hardeep Singh: Yes, I'm here. I'm in a car. And if I lose you, I'll call back. Thanks.

Vanessa Moy: OK, thank you. Is there anyone else that I missed or just joined in to this webinar?

Christy Skipper: OK, thank you. Before we get started, I just want to remind everyone that you need to be dialed in and logged on via the computer to hear and follow along with our slides today. And also if you are following along on your computer, to please mute your computers to reduce any feedback or echo.

All right, so the last we met via webinar, we reviewed the draft the measurement framework for this project and it was then posted for a 30-day member and pubic commenting period beginning on January 31st and closed on March 1st. During that time, 21 comments were received. Most of which were very supportive of the framework and the work done so far.

Several comments offer new measure concepts or requested that the committee expand on to some measure concepts. We will review all the measure comments submitted by the public and the ones you all submitted at – excuse me, we will review the measure comments or the measure concepts that were submitted by the commenters and the measure concept you all submitted at our in-person meeting next month. The purpose of this call today is to respond to the members and public comments. And those comments require your response and that's what we'll do today. And we'll use your feedback to help refine the framework and add some more detail to the final report.

So, right now, appearing on your screen is our – the comment table that was sent out to you and we sent that out last week. And I'll just give a moment to pop up.

So we sent out an Excel files numbering the comments received in column A. And in column B, we just let you know what the comment was directed to, whether it was directed to the framework overall or a specific domain. We also listed who submitted the comment and we also drafted a preliminary response there in column F. And we'll come back to that a little bit later on. But I just wanted to remind you all about the comments that we did send out.

Next slide.

So the first comment, comment I.D. 002 was submitted on the subdomain technologies and tools within the overall structure domain. I won't read it word for word but it just has a question here is, what does the committee mean by the term advanced and what are reasonable expectations with regard to laboratory capabilities. And I'll just leave it up there just for a second for you all to take a look at it and then we'll go right into the discussion.

Andrew Lyzenga: And just for Hardeep or anybody else who hasn't been able to join the webinar, this was the response to measure concept, that I think had been suggested in our initial meeting which says, it's a structural measure as Christy said it's advanced and the concept is advanced imaging and laboratory diagnostics are available, so basically the health care organization.

There are – well, the question is, what do we mean by advanced imaging and laboratory diagnostics and does that – and I think the commenter also is sort of wanted to know if that applied to – advanced applied to laboratories as well as imaging. And again, if we could just clarify what we mean by that, and also to clarify whether the commenter raised that some hospitals may not be able to have the most advanced sort of tools on site but may have it available offsite somewhere with some organization have, maybe a contracting relationship with her or something like that and wanting to know if that would also be acceptable under the measure. So, shall we open it up?

Christy Skipper: Yes.

Andrew Lyzenga: So any comments on that from our committee members what we mean by advanced imaging and diagnostic or advanced imaging and laboratory diagnostics?

David Seidenwurm: So, David Seidenwurm here. Advanced imaging typically refers to MRI and spiral C.T., I would think. You might want to include ultrasound in that because I think there's a lot of advantages especially in pediatric populations and obstetric populations in having timely access to ultrasound as well. So, generally we would say ultrasound, C.T. and MRI.

Andrew Lyzenga: OK, that's helpful.

Hardeep Singh: Yes, this is Hardeep. So, Andrew, the way – I don't recall where this measure came from but I think what – maybe we need think about is do we really need all the hospitals and health care organization to have these advanced modalities. I think the point here if you're a rural facility, you need to have the essential, you know, modalities to diagnose the routine problems that come to you, which is different from being a tertiary medical center in the middle of Houston or, you know, Atlanta where your own definition of advanced and what you can diagnose is totally different.

So, I don't whether we should reword the measure and call it, make it a little more contextual depending on the practice setting. The necessary means to diagnose the most, you know, commonly theme conditions or, you know, something like that. You know, you don't expect to have PET scanner in the middle of rural sector.

(Crosstalk)

Missy Danforth: Right. Yes, this is Missy. I agree with Hardeep, and I don't think we want to encourage, right, every health care facility to have that equipment either. So I agree with rewording this to be more specific about having, you know, imaging and laboratory diagnostic technology, something appropriate to the

most common types of, you know, care delivered or, you know, something to get Hardeep's point.

(Crosstalk)

Kathryn McDonald: This is Kathy. It might be worth doing something a little bit like what happens in emergency preparedness where there's kind of a hazard assessments. In other words, what would be the types of diagnostic capabilities that should be available given like what you're saying the most common or the most, you know, the most likely hazards in the context and then having – basically having a process where that's done and that the organization, the delivery system knows that it has enough access to, you know, enough timely access to the right set of diagnostic capabilities and it has an ability to show that that's the case.

Martha Radford: You know – this is Martha. There are seems to be two capacities here and I really like the idea of timely access to advanced imaging as the concept that we're trying to get at here as opposed to have everything on site.

But there's also this issue of knowing when to get advanced imaging, which is part of the diagnostic process that perhaps smaller organizations maybe more challenged and – or not. So, you know, I think the timely – just adding timely access too would help with this – making this concept applicable broadly.

Male: It seems if that that's a great focus and timely access is I think the issue, and if you were going to raise one issue of timely access for which there is I believe a gap in care that's been documented it would be pediatric and obstetric ultrasound after hours.

Martha Radford: Yes, and I think – I mean we're dealing with measure concepts here so, you know, whether we want it to get – how specific we want to get it about exactly what it is. I mean that can be certainly for an example. Yes.

Michael Dunne: Hi. This is Mike. I wouldn't get too specific because, you know, supplies, the laboratories and the availability of esoteric testing from reference laboratories, and is there a routine in place where request for esoteric testing or the labs already know where those samples have to be forwarded and how long the

turnaround time is, you know, whether it's through ARUP or Mayo or some of the other larger reference labs that do the esoteric testing.

But I think that the point here is that there's access and they know where to get the appropriate testing performed if it's necessary.

Andrew Lyzenga: All right. Thanks, everybody. That's helpful. We can try to …

Male: One other quick point.

Andrew Lyzenga: Go ahead.

Male: We should take the suggestion and add PET to the list of advanced imaging if we're going to enumerate advanced imaging techniques.

Andrew Lyzenga: OK. So we'll kind of play around with that a little bit and maybe wordsmith a little on that and present it back to the committee. And this is the sort of thing I think that we could, you know, maybe propose a somewhat vague concept and then add a little bit of narrative around it to just sort of provide guidance on what the committee was thinking and what sort of possible options might – there might be for future measure development.

As somebody said we're not, you know, actually developing the measure here or really proposing the measure itself just sort of a concept that could be pursued in the future and we can kind of flush out a little bit of guidance and what the kind of committee's mindset was when they read this and your comments that you just provided here. And, you know, allow measure developers to kind of work out the real details as they see fit and as they – as their, you know, measure development studies sort of take them and lead them in that direction.

Prashant Mahajan: This is Prashant. I just wanted to add, you know, I think we should not use the word advanced. I would suggest that we use access tool imaging and laboratory diagnostics, maybe – and in the narrative, we mentioned probably appropriate to the population that that institution is likely to see or something like that, you know. Because the advanced imaging, that term advanced gives

a different connotation as compared to access to appropriate imaging and lab diagnostics.

Andrew Lyzenga: OK.

Christy Skipper: Thank you. Next slide.

OK. So the second part of this comment was focused on the measure concept organizational characteristics and the concepts, original concept read organization measures diagnostic performance, labs, et cetera.

The commenter wanted the committee to define diagnostic performance and they also offered a revision to the measure concept, which reads, we recommend that the measure concepts be written as organization measures diagnostic performance and utilization of laboratory testing.

Andrew Lyzenga: And it sounds like they wanted some clarification on whether with the term diagnostic performance we meant laboratory utilization, specifically or something else like as they said compliance with clinical guidelines.

My own interpretation of that had been that we meant diagnostic performance and the sort of very broad sense of kind of what this project is all about in the sense that we are trying to come up with measures of diagnostic quality and safety and to determine those sort of diagnostic performance measures of some sort.

My impression had been that the idea was that we wanted to just have them propose the measured concept that got at whether an organization was basically measuring the quality and safety of their diagnostic care in general that they had a program in place where they were, you know, actively measuring their ability to give good and accurate diagnosis and communicated, et cetera. All the sort of the dimensions of diagnostic quality that we've discussed.

But I wanted to make sure that that was in fact the practice of intent, not something we can narrow like laboratory …

(Off-Mic)

Andrew Lyzenga: … so if there are any comments on that?

(Crosstalk)

Female: It's really hard to hear you. There's some weird background noise. I don't know if anybody else was able to hear you but I wasn't.

Andrew Lyzenga: Sorry about that. I guess this is – is that Hardeep. I think you might be in the car. I just want to …

Hardeep Singh: Yes. No, Andrew, can you hear me?

Andrew Lyzenga: Yes, you got a bit little background noise but go ahead.

Hardeep Singh: Yes. Yes, I'm certainly keeping myself on mute, but I agree with you. Basically, I think we should remove the word diagnostic performance and leave this quality and safety language that you have in there and just say that the organization has the, you know, the infrastructure to do this that we're proposing.

Michael Dunne: Except that takes out appropriate laboratory orders, you know. So, there has to be some kind of a feedback loop that evaluates appropriate test requisitions from physicians, from ordering physicians.

One of the sources of diagnostic error is requesting the wrong test and getting a false positive or a false negative result. So, I think there has to be a component of appropriate laboratory utilization that's reviewed on a periodic basis and also the amount of reference testing that's sent out. I mean that's something that should be the purview of the head of the – of laboratory medicine. And maybe I'm not stating that appropriately so I'd ask David to chime in on that.

David Grenache: Yes, sure, Mike, I agree. I think that the measure lacks specificity because you can see the folks at ACLS interpret it in a variety of ways. And so, I think what our intention – I don't think we really clarified what our intention was

when we made – came up with the measure. But I think it has to do with all those things, right? Diagnostic performance not so much in how the test performs clinically, but is the laboratory offering tools and resources to help guide test selection and utilization, things along that line.

Michael Dunne: That's exactly what I wanted to say.

Andrew Lyzenga: And we could also have that as a separate concept maybe as a little bit more specific measure that we proposed, that the laboratory staff is providing guidance and assistance in appropriate test ordering and utilization.

I would see that as slightly different than a structural measure trying to get at whether the organization as a whole is – has sort of a quality measurement program in place with regard to diagnosis. Whereas what you guys are describing I think is a little bit more narrow trying to get a specific aspect of sort of the quality of laboratory services and their interaction with the broader health system. Am I interpreting that correctly?

Michael Dunne: Yes.

David Grenache: Yes.

Andrew Lyzenga: Is that Mike Dunne?

Michael Dunne: Yes, it is. And David.

David Grenache: It's Mike and David.

Andrew Lyzenga: Mike and David, OK. I'll reach out to you guys maybe separately and we can maybe insert another concept into our list along those lines.

David Grenache: OK.

Andrew Lyzenga: That sounds good. Thank you.

John Bernot: Andrew, this is John. I also wanted to just say going forward first of all I think this is really good feedback. And just to echo what Andrew just said, this may end up that this discussion question helps us get to two or three other

concepts and we're also going to be taking this information with all of the information we got from the Google documents. So it may fit in very nicely with that. So, please keep this rich discussion going, I think it's very helpful.

Female: All right, next question?

Christy Skipper: OK. So the next comment, we'll discuss this comment 15 and this comment stated that references to provider could be misinterpreted. The commenter suggested that the committee might need to clarify what the word provider mean in order to align with the NAM report which highlight the importance of effective teamwork in the diagnostic process, among health care professionals, patients, and families.

Kathryn McDonald: This is Kathy. I was really glad to see this comment. I thought that was important and that we should try to be responsive to it.

Christy Skipper: OK. So, agreed and we've listed some alternative here or we're asking you how do we want to provide our design provider.

Andrew Lyzenga: And sort of the question here is, are we using provider to mean health professionals or something like that, or as more of an umbrella term which I'll just sort of say that was kind of my interpretation of it. Again, that it was kind of applying to health professionals and sort of allied help, you know, clinicians, physicians. And then also applying to health care organizations as the whole hospitals or physician offices, or ambulatory care facilities or whatever kind of settings we want to apply measurement to provider being sort of, again, umbrella term to include all of those different types of health care providers.

And then we could potentially specify if we do intent it to mean for some particular measure concept, specific health professionals or individual clinicians or something like that. But that provider meant any individual or health care organization involved in the delivery of health care.

That does make sense to folks or do you have a different way you would like to phrase things or define provider? Or do you want to use some other word maybe?

Kathryn McDonald: This is Kathy again. I mean I think something along those lines is about right. I think the other thing that's commented too is, it's not always just one person. So even apart from – the comment didn't state this but made me think apart from just the idea of it is a doctors and nurse practitioners, is it, you know, an allied professional et cetera. But also it is just one person, not necessarily.

Andrew Lyzenga: Yes, and I think – and that's sort of what a number of the concepts particularly in the structural domain are likely to apply more to an organization. Again the one we just talked to is the health care organizations have a program in measured quality or something. It's not really intended to apply to an individual clinicians but to the organization more broadly. And certainly, as you know, we don't want to downplay the importance of teamwork and focus really just on individuals.

Sorry, go ahead.

Jennifer Campisano: Yes. Sorry, this is Jen Campisano. I just wanted to say that I think that makes – to make an umbrella term that's sort of all encompassing. And then as needed maybe defining it more specifically like you mentioned from a patient perspective, I mean that makes the most sense because there are so many different components that come into diagnosis, at least from, you know – when I speak of a provider, I'm not necessarily only talking about my oncologist and we might also talking about the nurses or about the hospital where I go to get my imaging. So I think that umbrella definition makes the most sense.

Hardeep Singh: So Andrew, this is Hardeep. Is there any other reference resource we can look at where this could have been done before so we don't have to reinvent the wheel? Because we are talking about different concepts here that the people who actually diagnosed or front-line caregivers, which would be positioned than nurse practitioners, you know, subspecialist. So, you know, various types including surgeons. Then there are nurses and there are physical therapists, then there are patients, then there are diagnostic providers too which is labs and radiology.

So think maybe rather than instead of copy their own terms, I'm wondering if we could do a little bit of search into maybe one of the other reports either from them or somebody else have used these provider-based term consistently so we don't have to reinvent the wheel.

Female: Yes.

Hardeep Singh: We could have broad term like health care professional as well.

Female: But the diagnostic, you know, (perfect) diagnostic – diagnosis report, it does have some of the language that might be if you could just grab.

Andrew Lyzenga: OK. We can look at that. And Tracy did point out that NAM report uses health professional sort of most frequently. Although we did one want to also ensure that we were including, you know, again health care organizations because presumably many of these measures will apply to health care organizations more broadly rather than just the individual health care professionals.

Female: The report does that too. The report kind of creates those two different concepts.

Andrew Lyzenga: Got you. All right.

Female: The health care professional concept and the health care organizations concept.

Andrew Lyzenga: OK, we'll look back at that and see if we can incorporate some of that language and clarify. Any other thoughts on that for the group?

Martha Radford: This is Martha. I mean it does get to the kind of what is the unit of analysis here. Is it the organization? Is it the, you know, again – but it think the concept that provider or providers/provider team kind of covers I think a little bit of this what the inclusiveness that you like to see for this particular unit of analysis.

Andrew Lyzenga: And that will sort of the unit of analysis will vary by measure, our measure concept. And we'd expect that some would apply to …

Martha Radford: Right. We've just discussed a couple where the unit of analysis is clearly the organization. Whereas, you know, the implication of this one is that the unit of analysis is really in a way the provider team, or whatever that is. And then we probably should define what that is a little bit but we can leave that for another conversation.

Andrew Lyzenga: And again as we get into the sort of specific measure concepts, we can kind of define that as applicable in any instance. But – and maybe is a little bit more relevant for how we – have presented out framework and we'll get into that I think a little bit in the next comment actually, because there were some proposals for – I think Marc Graber in fact had earlier on proposed having under our processed domain sort of the two subdomains, potentially being kind of the provider patient interaction and then sort of intra provider, or either provider interactions there. You know, our language might be more important to clarify what we mean in that instance, if that is the direction in fact that we go and maybe we could actually just move on to the next comment to get into that discussion.

Christy Skipper: OK, thank you. So the next comment, comment I.D. 016, is on the subdomain within the overall process domain. The comment noted that the separate subdomain for patient engagement might present a separation between the patient and the health care professional, and then suggest three dyads, so clinician patients, non-clinicians, health care professionals to the patient and clinician, non-clinician health care professionals.

Andrew Lyzenga: And just to remind everybody this was one of the things that we are hoping to get some comment on. We had kind of going back and forth a bit and had a fairly rich discussion on how we would break out the process domain.

What we had sort of presented as a preliminary approach in the framework report was two subdomains, one being patient engagement and the second being the diagnostic process, presumably that being more of a sort of internal

process for the AMA provider and not as much on the patient provider interaction side.

So it's a sort of analogous to that patient provider versus provider-provider distinction. And Paul Epner, who submitted this comment proposed a different way of framing it, sort of what's kind of three dyads as he put it. Those being – as Christy just said, the clinician to the patient, the non-clinician health care professionals to the patient, and then clinician to non-health care professionals. And I think by non-clinician health care professionals, he's talking about I think laboratory staff, lab techs and that type of thing, or other non-clinician health care professionals.

Tracy on our team also raised a good point that sometimes that phrasing of something like non-clinician, health care professionals can come off or be construed as in a negative light that you're sort of proposing a non-clinician to a non-clinician or something like that, like it can be a little bit of touchy subject.

Christy Skipper: I also think that those three don't necessarily capture all the relationships we're interested in because there's also – if you were to use this terminology, there are clinician to clinician interaction that are important as well.

I think really what we're trying to get at is between the health care workforce and the patient and then among the health care workforce. Again …

Female: Yes …

Christy Skipper: … this is just what terminology we're using.

Kathryn McDonald: So, (Herman Mollas) like her – one of her articles that I think we've shared – this is Kathy McDonald speaking, has, you know, a framework and she talks about the three types of interaction. So there's the patient to the professional, there's the professional to the professional and then there's the professional to the system, meaning like a bigger, you know, a bigger group.

And so that would be like your alternative to consider that you've got patient provider, providers was defined as the health care professional, that health

care professionals to health care professional, and then you got also health care professionals to kind of the broader team or the organization.

Prashant Mahajan: This is Prashant. I actually like that position a lot because, you know, if you look at the slide, it doesn't include or address the health system issue. You know, the way I look at this slide is how where we could measure process breakdown.

So, the suggestion that was just mentioned, you know, about the provider to the health care system. Or it could also the patient with the health care system would capture that portion.

Kathryn McDonald: Yes, I noted that the patient to the system is not included in her breakdown. (Herman Mollas)' breakdown and her article is based on having interviewed, you know, focus groups with health care professionals. So seeing what type of interactions they had and where there were breakdowns. But your point is absolutely right. There also would be a patient to the system.

And Helen, this is your – one of the things you always bring up which is that patient doesn't necessarily know kind of who's in charge, you know, how to escalate the problem, and so that's just kind of illusive system to the patients as a failure point because the system isn't telling the patients, like who's who and how to get something done.

Helen Haskell: Yes. Well, the relationship of the patient to the system is the central one, isn't it?

Kathryn McDonald: Yes. And it's one that's hard for the patient to understand how to navigate.

Helen Haskell: Right. But it's not in this …

Kathryn McDonald: It's not in this one, yes.

Michael Dunne: I think here we're creating kind of a new paradigm. And actually I think it ought to be a triad as supposed to be dyad. In my career as a laboratory scientist and professional, we've never communicated directly with patients.

It's only between the attending physician or residents or conveying the information or being asked questions.

So, this is something new where you bring in other health care professionals to actually converse with patient to describe the results for testing.

David Seidenwurm: Hey Mike, this is David. It's true that we don't traditionally interface directly with patients and certainly not from sort of a diagnostic perspective. But patients do call the lab especially now that they can get test results directly from the lab by passing the physician.

And so I feel that many questions from patients, who ask me a lot of questions but I have to be very careful and measured in my responses, because I'm not a licensed physician, I'm not going to provide medical information. But I do address technical questions about laboratory testing.

Michael Dunne: Yes, and that might be somewhat unique to ARUP as oppose to medical-centered laboratories.

David Seidenwurm: So I think …

Michael Dunne: Go ahead.

David Seidenwurm: I think more and more our patients have access to their results and I've gotten numerous calls about radiology results. So, there is the laboratory professional, radiologist comes as a lab does play a role. And I wonder if the pathologists are experiencing this as well.

Michael Dunne: I'm not saying it should happen. I think it should because otherwise you're playing telephone game. You're explaining results and one person is trying to explain it to another. And it would be nice to be able to discuss the results with the physician and the patient ideally at the same time but, yes, I'm not opposed to having laboratory professionals discussing diagnostic results. I'm just saying that in my experience over the years, it's not in a primary function.

David Seidenwurm: I agree with that and I'm not sure that it's a good trend but it is a trend.

Helen Haskell: Well, I'm not sure, is it an actually an issue in this proposal. I'm not – when you're talking about interacting with the system, I mean you're not necessarily saying who they should be talking to, right? I mean I'm not sure we're actually creating a new paradigm here, I think.

Michael Dunne: Well if you look at point – bullet point number – sub-bullet point number two, you got clinician patient and then non-clinician health care professional patient. That's the one that I haven't seen often. But David is getting consults from patients reviewing results and want a little bit more understanding about what it means. So, it does happen …

Helen Haskell: Well, I'm a little troubled that the restrictiveness of these three categories, I think it leaves out a lot of things and maybe that one is served unduly highlighted.

Andrew Lyzenga: And I think – actually – and I've heard another proposal here from Kathy and others who sort of modified that we could maybe have sort of four bullets here instead, which would be something like patient to health professional, health professional to health professional, health professional to the system, and then patient to system.

Helen Haskell: I think that's better.

Andrew Lyzenga: OK.

Helen Haskell: And then, you know, I mean also the main people that hospital patients interact with are technicians, non-professional – are you calling them professionals?

Andrew Lyzenga: I think – I'm not sure if we want to use the, sort of the – yes, I guess we would maybe call those health professionals. Any thoughts on that? And maybe I think Paul Epner is on the phone. Maybe we could open up his line, operator, to get some clarification on what he had meant by non-clinician health care professionals and where – what his thoughts on that were.

Operator: And Paul's line is open.

Andrew Lyzenga: Paul, are you there?

Paul Epner: Can you hear me?

Male: Yes.

Paul Epner: Can you hear me?

Andrew Lyzenga: Yes.

Paul Epner: So, first thing, thank you for giving us the time. I think I wasn't trying to be – I was trying to broaden which in – and to broaden further to include system. I think it's appropriate to health system.

But I was thinking not only at lab who in many cases are having more discussions with patients directly but physical therapist who do an evaluation, and there are many other people involved in various elements. And I would just again concerned as I was in the previous comment, that provider tend to signal – maybe inappropriately but too many people as the doctor or the doctor and the nurse.

So, what you all describing I think it's what my intent was. I didn't know what the right answer is. I did want to see it broaden out to recognize that the patient is not in a siloed domain but it's part of the ecosystem and that there are many different interactions.

Does that clarify or I have not done a good job there?

Male: I think that's helpful.

Hardeep Singh: This is Hardeep. I think this is discussed in the lab section. I think we're going on in circles now because we just have a conversation about the provider and all the other terms that we're going to go and look in the NAM report, and that includes patients …

(Off-Mic)

Hardeep Singh: … as well.

Andrew Lyzenga: So we can on our end, sort of again go back and work around with this a little bit and present something updated for the committees' considerations and we don't, I think – and we can get more feedback at that time. So, yes, we don't have to keep going around in circles, but I think we've got some good ideas here and some good feedback from the committee that we can, again, review and try to incorporate all of your thoughts into this.

Paul Epner: And Andrew, I can certainly just go offline with you one on one. As you've regionally – in the last few minutes expanded the notion of what provider means, that too helps to resolve some of the issues.

Andrew Lyzenga: OK, great. Thanks, Paul.

Christy Skipper: OK. Moving on to the last two comments are – in regard to the structure domain. And this comment here focuses on the people subdomain and the measure concept that, that staff should operate to the top of their license to free up cognitive load of the M.D. The commenter asked the committee if it would consider extending the concept to recognize certifications or staff are not licensed and to include clinical lab professionals.

So, the question here is, does the committee agree to expand this measure concept and we've proposed a couple of alternative. The first one there is staff operates as their top of their license or training, or staff operates at the top of their license or certification. Is there any feedback on that one?

Hardeep Singh: Sounds good to me. So they're trying to expand some provider staff, right?

Andrew Lyzenga: And also from – to expand beyond the concept of licensure to also certification, it sounds like it was something …

(Crosstalk)

Hardeep Singh: Yes, absolutely. Sure.

Andrew Lyzenga: Fair enough.

Hardeep Singh: Yes. Sounds good to me though.

Christy Skipper: I think the main question is do we want to go with training or certification because there are some professions that don't even have certification. But what I think the – what the concept we're trying to get at is that everyone should be working to the – what they've been trained to do, but that sort of a nuance.

Hardeep Singh: Yes. You can put an or between those. So you can say some (patient) or training or something, you know, I mean the deal – our goal is to give a concept not an exact measure, right? So you're communicating that these are the broad concepts we're thinking about.

David Grenache: Yes, I think it's important – this is David Grenache. I think it's important to include not only license and training but certifications or probably all three.

Female: OK.

Male: OK.

Helen Haskell: So, my concern about this, this is Helen, is I always cringe a little when I hear the term top of the license because I feel it's sort of putting the (Peter) principle into action, which is that everyone rises to their level of incompetence.

You know, I – you know, I know that this is really fashionable but I feel as though there should be some leeway there that if you're maxing everybody out the system is very strained. If you got everybody doing the very top of what they're supposed to be have been trained for and sort of assuming that their training has been good.

You know, that's my concern with the concept and I realized that I am, you know, I'm sort of an outlier on that. But I feel as though it leaves no wiggle room in the system. And that it, you know, creates more potential for errors.

David Grenache: Helen, this is David Grenache again. I hear your words. I understand what you're saying. I guess I'm interpreting it differently when it says top of their – operate at the top of your license. I thought I interpreted as not so much, you know, maximizing your workload but, you know, operating or functioning in the capacity for which you are appropriately trained.

You know, you want to maximize the potential of any individual in any system. And so you want both, say who are nurses doing things nurses do and not doing things that respiratory therapist do.

David Seidenwurm: So I thought that was magnificently put and the reference to the Peter principle was great, and really, you know, profound.

I will say though that I think we do have to allow that as the MAC – work into the limited of the licenses in terms of our – that people understand, to mean that people work to the level of their license but also to the level of their clinical competence. I mean I'm technically speaking license to perform brain surgery but I don't do it because, you know, I don't feel comfortable doing it and a hospital wouldn't give me privileges to do it. And they would quickly remove them if I did one, because the results speak for themselves.

So I think that we have to understand the concept as people use it which is that we give people an opportunity within their comfort zone to perform at the level of their maximum licensing.

Missy Danforth: This is Missy Danforth from Leapfrog. You know, we have measure on our annual hospital survey that actually sort of gets to this around prescribing medications in hospitals and who can prescribe.

I can just tell you from a very practical point of view. It's a little bit tricky to use the word training because sometimes, you know, different staff in hospitals might be trained by the hospitals to do something that they're not necessarily licensed or certified to do. And that maybe they're not even legally allowed to do under their license or certification in that particular state.

So, I would be more comfortable using the terms licensed or, you know, licensed or their certifications and actually not using the term training because

I actually think that could be potentially problematic. And I know we're just talking about measure concepts here but I still think we should limit it to licenses and certification.

Hardeep Singh: This is Hardeep. So I think the point here is to be more inclusive for health care professionals who haven't (fitted) in diagnosis or diagnostic activities, or maybe diagnostic safety activities.

I'll give an example. I mean, we've tried to get nurses to help us track test results, normal, abnormal. And there' a fair bit amount of resistance at least in many of the sort of the circles I've tried this in where the nurses say, well this is not a proper job. And we, you know, I mean we also get some conflicting opinions from doctors who would say, "Well, I don't want my nurse to do this because this is too complicated for her to track any test results for me."

So, I mean, if we are going to talk about diagnostic teams we're going to have to raise some of the bar in terms of some of their activities that people are doing to become part of the team. So I don't know whether that should include training but I think it should. But if you want to leave training out that would be fine. But I think the point is we want to be – trying to get other members of the team to try to come up to a level that we can talk about diagnostic safety as a team.

Andrew Lyzenga: OK. We'll go back and – and again, take a look at that but this discussion was helpful and we'll make some changes as needed, and again, present to the committee. Yes.

Christy Skipper: OK. Next slide. OK. So the last comment, comment I.D. 21, asked that the technologies and tools subdomain include mention of laboratory information systems, noting that interoperability between the electronic health record and the laboratory information system is critical.

And so, pretty straightforward, I think, does the committee agree that the technologies and tools subdomain should include mention of interoperability between EHRs and laboratory information system.

Hardeep Singh: Yes. This is Hardeep. It's absolutely (true) and in fact we should go back to the last NQF report on health I.D. safety which also expanded on it.

Andrew Lyzenga: OK. That should be an easy one …

Jennifer Campisano: And this is Jen Campisano. I would just say absolutely yes.

Christy Skipper: All righty. And just before – so we've discussed all of the comments that NQF felt like we should queue up for the committee. Were there any other comments within the table that the committee wanted to discuss or even as result of your discussions this afternoon, did anything else bubble up that we should address or that we're not thinking of?

Prashant Mahajan: This is Prashant. I just wanted to follow up on Hardeep's comment. You know, I agree with that but should we also add radiology systems? Are there any other systems that we are overlooking that could also need to have interoperability, or should we just limit it to those two?

Christy Skipper: Anyone have thoughts on that?

Hardeep Singh: I don't have obviously things in front of me, but do we have something in which we talked about electronic communication in general like between referring physicians and subspecialist? I mean because you need – you need connections to all the diagnostic data, right? The diagnostic data would come from either subspecialist, lab, imaging, pathology. That's the only other group that I can sort of think of.

I mean, in generally (interoperability) in total, so I'm not sure. Andrew, I'm almost certain that there were some interoperability-related measure that we could directly import out of the other report.

Andrew Lyzenga: Yes. We're currently …

Hardeep Singh: I don't know which one.

Andrew Lyzenga: Yes. We can pull some things in, and again, kind of work through this in a narrative to talk about the importance of just electronic communications in

general. As you said, and the need for interoperability across systems wherever there are, you know, diagnostics important – information important to the diagnoses being communicated, that it's important to have the capability there and interoperability, kind of flesh that out a bit in our discussion.

Prashant Mahajan: Right. Because and then, what this does is it keeps it broader and allows us to, you know, add other newer forms of communication if they were to develop, you know. So, I think that's better rather than just limiting it to two of those.

Andrew Lyzenga: OK.

Christy Skipper: OK. If there are no other comments you all would like to discuss or any – then we'll turn it over to Andrew for the measure prioritization criteria. Thank you.

Andrew Lyzenga: Thanks. Thanks, Christy. So we wanted to float some ideas for what we may use as our criteria for prioritizing the measure concepts that we come up with. Again, we're still sort of refining that list, getting input from you all and other sources. But as we move forward we're going to want to go through some exercises where we actually do, you know, take that list, that sort of raw list of concepts that we proposed, and try to give some guidance to the field and to readers on which ones the committee feels are sort of the highest priority ones relatively speaking, where the sort of focus of measure development should be in the area of diagnostic quality and safety.

So this will be important for us to try to nail down as much as we can to a sort of systematic way of doing that to identify what the committee's priorities are. And so we're floating some proposed criteria to do that, to give us something sort of solid to pin that to. These are kind of analogous to NQF criteria for evaluating fully specified measures. But those criteria are not fully applicable to these, because again we're really just talking about pretty vague concepts here. And you can't really apply some of the criteria that we used to evaluate full measures to a very vague concept. It just sort of doesn't make sense. You don't have the testing information, you don't have the specifications to be able to say, well, this is or it's not reliably, you know, to implement and practice.

But we can maybe, you know, we pulled some concepts from those criteria to see if we could get at some criteria that you could use to evaluate the concept in terms of identifying which ones are, again, higher priority and which are lower priority. So we'll kind of walk through those here at a high level to sort of main criteria here we're proposing are important, safe validity, feasibility and usability.

We would maybe rate those – rate its concept against each of those criteria on something like a high, moderate, low scale. And then use those results to kind of get, you know, sort through what we have and identify which the highest priority concepts are and which are a little bit lower in priority. So this will be important for our work moving forward to, again make sure we have some sort of systematic way of doing this and some ground to stand on when we say some of these are higher priority than others.

So, maybe you can just quickly try to walk through these in a little bit more detail. So, starting with the first one of importance, again some of this is sort of conceptuality pulled from our measure evaluation criteria for the endorsement process.

So again the overall rating would be on what – how important is this measure concept, high moderate, high medium, or low. And then sort of the questions that would feed into that are, is there evidence supporting the focus of the measure concept? That one again is maybe a little bit down the line. It's hard to say that there would be evidence necessarily supporting a fairly vague measure concept in some of these cases. But in general, is there evidence that supporting measurement in this area? Is there – maybe evidence supporting, you know, best practices for a given measure that's focused on a process or structure? So, you know, we would welcome some input on that.

And then the second part of that is the impact, to what extent does the measure of concept address an issue that affects a large number of patients or has a substantial impact on patients. Or is it leading cause of morbidity or mortality or contributes to inappropriate resource use. Again sort of just getting to the –

whether the measure concept is addressing an issue that is high impact on patients.

Maybe we can pause there and see if anybody has any thoughts on that criteria.

Hardeep Singh: So Andrew, I apologize again for not having in front of me. Do you have an impact something about preventable harm or something that gets close to preventable harm?

Andrew Lyzenga: It's a good question. We don't have anything about that explicitly. I'm trying to …

Hardeep Singh: Because, you know, as I mentioned with my United example, I mean we could just get lost with lots of things that could potentially impact patients but we really need to try to focus on preventable diagnostic harm. And I would, again, encourage us to sort of think about how do we, you know, make sure that these concepts are addressing, you know, high priorities, safety issues where patients are being harmed unnecessarily versus broader quality issue. That's again my plea. Thank you.

Martha Radford: Yes, I would …

Andrew Lyzenga: OK.

Martha Radford: This is Martha. I would kind of agree with that and really focus it on (harmness) due to diagnostic errors here, that we need to be kind of very focused on where are the, you know, where have this – is there evidence that there's a diagnostic accuracy gap specifically.

Andrew Lyzenga: OK. That, to me, that sort of gets to this – the next criterion actually a little bit the face validity one. Maybe I'll hold off on that actually for a moment. It's actually a little hard to sort of parse out what the difference between those are, you know, thinking about it. And when we do our, again, evaluation for endorsement, we have some fairly clean separation between those two concepts, where the importance, again, it's just sort of looking at the concept broadly because it's an important thing to measure around, is it having an

impact on patients? And then getting more into this specific measure with the concept of validity, saying, you know, does this measure specifically measures something, you know, is it measuring what it's supposed to measure and is getting at quality, the issue of quality?

But I say I take your point and I think that is important to reflect in this importance criteria as well. So, we'll try to incorporate something about that, whether it is, you know, the concept is focused on an issue that – or harm that is due to diagnostic error or whether it leads to preventable harm. We'll kind of work on that a little bit and see if we can incorporate something along those lines if others agree.

In general, does the concept of importance as a criteria makes sense to everybody? As it sort of stated here, maybe incorporating something like that what was just suggested?

Missy Danforth: Yes. This is Missy. I think it does.

Andrew Lyzenga: OK. And we don't have to sit on this. We can – we'll welcome your feedback after this and maybe we'll send you some reminders to get some feedback online – offline about this but we do want get nail down in fairly short order so that we can have it ready for our next meeting that is coming up soon.

So, maybe I'll move on to – so that was the first criterion important. The next one would be phase validity. And just sort of generally the question here is, does the concept have phase validity as a measure of diagnostic performance?

If we were evaluating fully specified measures, you know, we would look at whether the data source, you know, is accurately reflecting what you're trying to get at, whether your measure is specified clearly and fully enough to be implemented consistently and all kinds of, you know, whether it needs to be risk adjusted and all kinds of issues of that sort, but we really can't get into at the level we are which is again, just fairly vague concepts.

But we thought, and this was on a suggestion actually of your co-chair Mark Graber, that maybe we could get at something like, you know, just general phase validity. Does the concept, if you were to, you know, theoretically

develop a measure, you know, based on this concept, could you use, would it be a valid measure of a clinician or a hospital's performance with respect to diagnosis? Any thoughts on that?

Nicholas Kuzma: This is Nick Kuzma. I guess this one is little confusing or vague to me. I guess, I'm wondering if, you know, we can think something has validity but without having evidence that you know, it's really just our opinion and that could be right or wrong. So, I don't know, I guess, with this one, I feel like we're just kind of guessing at something. And without evidence behind it we don't really know. So I don't know how helpful that is in the big picture.

Andrew Lyzenga: Yes. That is true and it's a point is well-taken. To some extent we are kind of just guessing at this point. Again, because we're working with fairly vague concepts that you can't really evaluate fully. You just, and I think to a large extent we are just kind of getting your opinion as experts here in the field. Whether, you know, at a very high level conceptually does this measure concept on its phase have validity as a measure of diagnostic performance? But again, your point is well-taken. Any other thoughts about that? Or about the criterion in general?

Martha Radford: Yes. This is Martha. I agree with the comment so far. And it's sort of a placeholder for all of the other validity issues that will come up once they're specified. So I mean I don't have any problem with it. It's kind of like motherhood and apple pie in a way.

Andrew Lyzenga: Right. Right. I mean, you could – again, it could maybe be of some help, again, sort of distinguishing between, you know, the concepts that we have on the table in front of us which are, you know, relatively speaking, which have higher phase validity, you know, than others. But, we'll think that through a little bit more. It sounds like there's a little bit of uncertainty as to whether this would be easily interpretable when applying, you know, to a measure concept. So, we'll give that a little bit more thought and discussion. Any other thoughts on that one?

Maybe we can kind of – maybe we can merge this together with the importance somehow. They're all kind of getting – it's all kind of getting up

something similar. So again, we'll think that through a little bit more and would love to get more feedback from you after this call. So we'll reach out to you about that. So I guess, let's move on to the next. So we've done important phase validity.

The next one would be feasibility. Again, you know, hard to say, you know, when you're talking about a fairly vague concept. But, in general, if you, you know, taking a concept, if you were to sort of spec it out and implement it, would it be – is it something that you could, I guess the question is, is this something that you could, you would be likely to, you know, specify out into a full measure and implement consistently? And so some of the questions related to that might be, you know, is their data available and easily capturable that would allow you to collect the information to calculate this measure, theoretically again because we see you're speaking about a fairly vague measure concepts. But, in general, is this something that, that might be measurable in practice?

Another aspect of that would be how ready are organizations to tackle this problem? This is something I kind of pulled from our HIT safety projects. They wanted to get at whether this was something that organizations could really maybe do something about. Some of that issue in HIT safety were still a little bit in the future and maybe organizations were not quite ready to do some of these things – or some more were less ready. So, just generally, whether organizations are ready to tackle the underlying problems in question.

And then we wanted to add something about the burden question. So, as part of that feasibility consideration, would measuring this concept add significantly to the measurement burden for providers? Any thoughts on that? The feasibility criterion?

Nicholas Kuzma: This is Nick Kuzma again. How about adding something about like how much time it would take to do it and the cost, so as kind of additional factors about how feasible something is.

Andrew Lyzenga: OK.

Missy Danford: Yes. This is Missy. Without, you know, at the measure concept level, I just think feasibility is kind of tricky.

Andrew Lyzenga: Yes.

Missy Danford: I think it's hard and, you know, a concept can seem complicated but a fairly straight forward process measure could come out of a concept, right, that would actually be very feasible to collect. So, I would just want to be careful about using this as a criterion to eliminate concepts at this point because again, sometimes the actual measures specifications that come from a concept can be very different. So I would want to, just make sure that we weren't taking concepts that …

Martha Radford: This is Martha …

Missy Danford: … otherwise they had priority joining me like off the table because of this particular criterion.

Martha Radford: Yes, this is Martha. I want to agree with Missy on this one, this is my least favorite measure criterion. Partly because it implies that a certain status quo, I mean, in the current status quo, is it really, can you really measure this? Is what it says. And in fact, we need to, I think, release ourselves from that shackle because in the future we might be able to measure different stuff. And we're talking about concepts here that can be present or future. So, I would, you know, downgrade this as a criterion (at all).

Andrew Lyzenga: OK.

Martha Radford: But I think the concept from a measure concept is, are there many data sources out there that might be sources that would be appropriate? I mean that kind of feasibility.

Hardeep Singh: So this is Hardeep. I think what we could do is, I think it stay there but we could modify it as, is it something that could be done immediately like a short-term thing or a long-term thing? I mean, you know, that could be something really important and it could be feasible but not just yet. It could be feasible another five years or whatever and we should consider that. So I

would firstly would – sort of keeping like this or maybe dividing it up into immediate or later one.

The other thing I was going to ask is, I know you mentioned burden. Is burden a part of this assessment or is it a separate, like a fourth or fifth concept that we needed to be thinking about?

Andrew Lyzenga: I guess I could open that up to the committee. We had initially here proposed that as part of the feasibility criterion. Something you would sort of taken to consideration when assessing whether giving concept to as feasible, would part of that sort of consideration would be, would it add to the burden for providers but we could certainly separate it out into its own separate criterion if you guys think that it's important enough to do so.

Thomas Sequist: This is Tom. I just feel like that's a different question than feasibility of like how can you collect the data? How much does it cost to collect the data? Because that question is more a global question about in your health care setting, you know, what are you measuring now, what are the other things you're measuring? And it's still like that's going to be really hard. It's just mixing two different concepts.

Andrew Lyzenga: Yes. Yes.

Michael Dunne: I was going to say you could break this down into ease of implementation and ability to do some kind of metric analysis on it. Because I think those are the two issues that are involved in this, right?

Andrew Lyzenga: Potentially, yes. All right. Yes. And that's helpful. Any other thoughts on this? Again, we'll kind of revisit. Rethink a little bit. Come back to you. But any other thoughts on this? See the issue of feasibility.

All right. The next one is usability. And this one is a little, you know, uncertain too. I think what we're trying to get out here are a couple of things. Basically, the importance or usefulness of the resulting information for measure users that those being potentially patients who are looking up performance information in making decisions, providers for doing quality

improvement activities. Other users of the measure information like payers, purchasers and others.

Basically, how useful will the resulting measure information be and then the question of sort of actionability or the likelihood that measuring this concept will drive changes in organizational behavior. And these get – add a little bit to some of the earlier questions as well. And I'm sort of thinking that we can do some consolidation here potentially but, first of all, I'll open it up to the group again to see what you think about this criterion of usability.

Male: Well this is what determines uptake. So it's important.

Andrew Lyzenga: Yes.

(Crosstalk)

Michael Dunne: I'm thinking about something about something about potential benefits.

Andrew Lyzenga: Yes.

Michael Dunne: As opposed to …

Andrew Lyzenga: And again, there's some crossover there to earlier importance criterion and the question of impact, you know, whether it has an impact on, or is it impacting, you know, large numbers of patients or severity of illness or that sort of thing. And I guess that's in some sense similar to this. Is that what you're suggesting or something else?

Michael Dunne: Yes, I (would give that) usability.

Andrew Lyzenga: OK.

Martha Radford: I can – this is Martha. I tend to sort of think of this particular criterion as actionability. I mean would, can action be taken based on this measure? Just my own bias. I think it's an important criterion.

Kathryn McDonald: This is Kathy. And I keep thinking on all of these like what's different about diagnosis. I mean these are all kinds of criteria that matter for any

measurement activity. So, you know, I know earlier in the discussion, Hardeep is saying a preventable harm, you know, that's obviously important in diagnosis so it will be use, usability, usefulness.

I've read that, we like you connecting it, how would this activate folks on the health care delivery side as well as maybe what patients can do to, you know, incentivize better diagnosis and better diagnostic safety. But, it's a big stretch to figure out what would be unique about diagnosis? These are the – how you would have criteria for measurements. I'm not coming up with a lot. I just want to throw that out there, that it seems like the usual way of approaching measurement which is what you're laying out here is some – is useful.

Hardeep Singh: This is Hardeep. And so – Andrew, were you're thinking of trying to merge some this and then ask everybody for their ranking or wording or whatever?

Andrew Lyzenga: Yes. I think so. I think we can revisit this a little bit. I mean maybe we could just have some discussion and a little bit, you know, in light of these proposed criteria and anything else you can think of. How – what is the best way you guys can think of to, or criteria, or what are the considerations you want to take into, you know, keep in mind as you're evaluating the measure concepts once we have list put in front of you to prioritize those.

Would it be something like this? Are there other things you wound want to be thinking about? What would be the best way to do that prioritization? Kind of what criteria would you want to use to say these are the most, sort of important, high priority measures we think we want to really signal to the field that should be pursued. And these other ones are maybe a little less important or maybe not less important, but less, you know, urgent or whatever, or maybe less feasible.

Again, you know, these are the kinds of things you might be wanting to think about. What – how do you want to make those decisions in terms of prioritizing the listed measures? Would it be something like this? Are there other ideas you have that you would suggest?

Hardeep Singh: So I think …

Kathryn McDonald: Andrew, this is Kathy again. So you just said something I want to kind of underscore for us, which is this is really about our prioritization work on the measure concepts.

Andrew Lyzenga: Yes.

Kathryn McDonald: As opposed to, once there are measures, how NQF would prioritize among measures.

Andrew Lyzenga: Yes, exactly. This is, you know, about sort of our work in the coming months as, you know, to sort of help us make our recommendations in this report because we want to again, give some signal to the field, sort of these concepts or these group of concepts for measurement areas are what we deemed to be most important and how, you know, how do we want to move that (question).

Kathryn McDonald: Right. OK. So I think it's important. I think we don't have a criteria here about whether we think that it's highly likely or highly unlikely if the measures could be created for a particular concept.

Andrew Lyzenga: So that, I think, we are trying to get at that with the feasibility. Again, that being sort of the question of this data available, is it something you would implement. I think that needs some refinement. But I think that was the idea we were sort of trying to get at. Is this something essentially that is measurable? Is it something that we, you know, you could see a measure realistically be created around.

Kathryn McDonald: Yes, the realistic part is the, I guess that's the dimension I'm wondering about. Should we just have a criteria about …

Andrew Lyzenga: Yes.

Kathryn McDonald: … you know, kind of how realistic is it that there could be measures that would meet this other criteria. That they, once they were establish these measures they would, that one, they could establish these measures, and two they would meet the usual criteria of measures. How realistic is that for any particular concept area. If there's a will, there's a way, but, you know, can take quite a bit of resources to get there which makes it less realistic.

Hardeep Singh: So this is Hardeep. I was thinking does burden include unintended consequences? Potential unintended consequences of measurement off of that critical concept?

Andrew Lyzenga: It could or – but we could also keep, you know, add that as a separate criterion or incorporate it into another. Typically, again, I sort of am thinking and I'm keeping our usual NQF measure evaluation criteria in mind and we typically put that in as part of usability. I don't know if that's entirely intuitive, but as part of usability is we usually have a section on whether there would be unintended consequences. But maybe we could pull that out separately if you think that's important.

Hardeep Singh: I think as long as that's addressed somewhere it probably doesn't matter but I can clearly see at least three different sorts of themes emerging. I think we're on the right territory, maybe with some refinement of language. So one is impact/importance which is sort of preventable harm thing that we talked about earlier.

The second was this burden/unintended consequences. And the third was feasibility in terms of short-term, long-term feasibility. I think those three to me seem to be encompassing most of the conversation that just happened. I could be, maybe I missed another concept, but to me those three will include everything.

Andrew Lyzenga: OK.

Female: Yes, this is – I just want to make a comment about burden, I mean, I kind of feel a little burdened at the concept level the same way I feel about feasibility, which is that it's really hard to know. And I think we want to be careful that we don't lose some this really important measure concepts because of perceived, you know, issues with, you know, burden or feasibility when there's actually, you know, no specified proposed measures yet that might relate to those concepts.

I think we also might want to capture, maybe this is something we can do under usability, kind of the importance of having the, you know, the measures

that come from the concepts actually show variation among providers, sort of the individual providers or hospitals or systems or other kinds of health care centers. I think, you know, really encouraging measures that show variation, will be most usable for our patients and providers and purchasers and everyone.

I think sometimes, you know, we see measure developers take out a lot of time and effort in developing measures that don't go over well when they get to the standing committee because these are really low-level kinds of measures and, you know, the panel just get – that the committees get consent and they're really not going to show any kind of meaningful variation among providers, sort of everyone is doing the same.

And so, you know, one thing I hope we can do is sort of communicate or signal to potential measure developers. You know, what kinds of other properties about, you know, we'd like to see. And I think showing variation is one really important one.

Andrew Lyzenga: OK. And again that is, you know, to a large degree and, you know, the speculative based on a vague measure concept, but it's something that we kind of have to speculate a little bit about. And take a fairly big concept and try to, you know, foresee, you know, whether were – or judge whether in general there is, you know, variation and performance in this area. Because we can't, you know, take the measure and see, you know, get data and, you know, testing results to see if there is in fact variation in performance, but it's something we have to kind of speculate about.

Female: Right. I'm just wondering if there's a way to communicate sort of only come up with that …

Andrew Lyzenga: Yes.

Female: … list of concepts that have been prioritized, if there's sort of a opportunity to communicate, you know, properties that we'd like to see measure developers take into consideration when they're getting taking …

Andrew Lyzenga: OK.

Female: … the concepts and turning them into measures.

Andrew Lyzenga: OK, yes that's a good …

Female: You know, I mean I sat around a table with some really disappointed measure developers. And it seem like they just weren't getting the kind of feedback on the front-end they needed. You know, before investing a lot of time and energy.

And I think this is such an area where there's such a lack of measures and such a need for measure. So it would just be good to communicate as much as those of – of those expectations at the beginning is possible.

Kathryn McDonald: I think this gets – this is Kathy again. I mean this gets – as somebody who's been involved in measure development a lot. This gets at the – I think the point I was maybe not making very well, which is, just having a straight prioritization at the end of the day, I don't think it's as useful as having these concepts prioritize along with different dimensions.

So, for me to know that it's more realistic to be able to develop a measure that is of moderate importance and moderate, you know, usability and – then that might be a better choice than to tackle it really, really realistic but not important measure or a – or to – you know, what I mean, it's like – I think us saying here's the most important concept down to here's the least important concept to cross a multi-attribute space is less useful to those who might get involved in measure development in this area and ultimately the success running through NQF processes or other, you know, measures aren't only use within the NQF endorsements, you know, context.

Andrew Lyzenga: Yes, that's – your point is well-taken, and maybe we could do something like that where, you know, we wouldn't necessarily have a sort of rank ordered list of concepts just, you know, all things considered necessarily, which we can talk this through a little more maybe, but as you said, sort of have rate, you know, and again we would anticipate having maybe something like ratings on each of these dimensions, so that, you know, you could potentially see.

So which of these are, you know, sort of the most realistic concepts, you know, that in the committee's opinion and then, you know, which ones are potentially the most high impact. And which ones are kind of strike a balance there and that kind of thing and try to get that across.

But this …

Kathryn McDonald: Yes, exactly. Thank you. Yes, and I think, you know, it is – is that matter of like high impact is (social), it's important and there's enough variation. So that – and that there's actually belief that improvements could happen, you know, the variation is not a variation, it's just intrinsic to some system that can never be changed. So, I like that, I like the impact and the realism. (Two main) overarching dimensions that developers might need to think about.

Andrew Lyzenga: Yes. I do kind of want to get back to this sort of question of face validity. I would consider that at least somewhat important, again, to kind of bring us back to the, what our underlying question here is, you know, about diagnosis and the quality or safety of diagnosis.

You know, some of the – sort of going through the list of concepts. You know, some of these concepts are in a good measure – measurement concepts, but are only in some sense maybe tangentially related to the issue of diagnostic quality or safety. I'm just try to, you know, see if we can get that question of, you know, for a given concept, if you as a clinician or as in hospital or, you know, again a provider generally, scored well on this measure or scored poorly on this measure, would it be fair to say that that's meant you were doing better or worst at diagnosis?

I'm sort of trying to get at something like that. Is that a reasonable question to ask about these concepts and is there …

Kathryn McDonald: Yes, that's really well put. That's excellently put. That should be the face validity we're looking for.

Andrew Lyzenga: Yes, and so we can try to rephrase that a little bit. Any other thoughts on that?

Any other just general questions or comments, reflections about the criteria and about how we move forward with this prioritization? Suggestions? Again we'll follow up later with you as well, but any thoughts here?

Kathryn McDonald: I guess the other thing is, if this is something that we're going to be doing. You know, we should be sort of individually and getting back to you, thinking about kind of how doable it is for us to go through all the concepts.

Andrew Lyzenga: Yes.

Kathryn McDonald: And kind of keep enough, you know, I feel that there's some concepts that I could, you know, assess pretty well and there's some concepts that I can't assess at all. So that the mechanism by which we extract this information from ourselves in a way that's, you know, reasonable as a task and also reliable in terms of it reflecting a knowledge-base that I for example have, is something I would want for us.

Andrew Lyzenga: Well we would welcome your feedback on that question too.

Kathryn McDonald: Yes.

(Off-Mic)

(Crosstalk)

Kathryn McDonald: Maybe different for different people. And maybe – and that's something that we should – I'm suggesting that for like – all of us, as a committee as a whole, that this is an important thing for us to think about how we can contribute effectively in our separate ways, even though the task can maybe provided to lessen some, you know, like uniform approach.

Jennifer Campisano: This is Jen. Kathy I really appreciate you saying that, just I mean, specially from the patient perspective there are so many of these that I don't feel – that I have (extra piece on at all), whereas, you know, others I might be able to contribute more, but definitely not across the board.

Anyway, thank you.

Andrew Lyzenga: Thank you.

David Seidenwurm: Hi, this is David.

Michael Dunne: So …

David Seidenwurm: Oh. Oh I'm sorry, didn't mean to cut all …

Michael Dunne: No, that's …

David Seidenwurm: … go right ahead.

Michael Dunne: That's OK. As I understand this, we're going to propose different concepts to reduce diagnostic error. And we want to know how important we think that concept is. How feasible it is to implement, whether or not we can actually measure an outcome with it. And then with that outcome can we promote change? Is that kind of where we're going with this?

Andrew Lyzenga: Yes, that's I think roughly what we're trying to get at and again for each concept there, we'll sort of have to ask, also the question is, it realistic to get through everyone of this concepts, or do we want to kind of move things up a level potentially and look at maybe measurement areas that we prioritize or something like that. But …

Michael Dunne: OK …

Andrew Lyzenga: … that's not what we're trying to get at.

Michael Dunne: And then you're trying to get a score that would place these things in a hierarchy, you know, if the importance in ranking, right?

Andrew Lyzenga: Yes, basically. And again we can talk a little bit about how the best way to do that and whether it would be appropriate to give just an overall hierarchy or whether we want to do that along, you know, some dimensions like these different criteria or something, so that we – because as Kathy I think pointed out maybe not necessarily appropriate to give that sort of rank order just overall but, you know, maybe some of these again are unbalanced, you know, more feasible but slightly less impact and, you know, some of them are more

impactful but a little less feasible and, you know, we welcome your feedback on exactly how we work that out. And – sorry go ahead.

Michael Dunne: Well eventually these are going to end up in a quadrant that says high impact, low feasibility or low …

Andrew Lyzenga: Right.

Michael Dunne: … low impact, high feasibility, you know …

Andrew Lyzenga: Right.

Michael Dunne: … it's going to place these things in the separate domains that will tell you whether or not it's possible to even do this.

Andrew Lyzenga: Right.

Michael Dunne: OK. That's what I thought.

Hardeep Singh: So Andrew, this is Hardeep again. I'm wondering – now we've got a lot of measure concept, can you tell us a little bit of what are the final like list looks like, there's 100, over 100, 150. What's the general …

Andrew Lyzenga: Yes, I mean we're kind of still working through that and getting suggestions and pulling some concepts in from different courses. That is a good question and I think we need to …

Hardeep Singh: Well …

Andrew Lyzenga: … talk a bit more …

Hardeep Singh: Yes. I'm thinking there should be – I was thinking there should be two levels. One is, you know, a very high-level of what do you want to exclude. I mean there's some things that, you know, we should be able to exclude as a committee, as a group of by wording or whatever else you want to do. It should literally be like keep for discussion or leave out of the list. Literally two categories.

And then once we get to that shorter list of whatever that might be 30, 40, 50, I'm not sure what it's going to be. Then we will have a broader discussion on each of these individual dimension, feasibility, burden, unintended consequences, important or whatever you want to call that.

That's what I thought, you know, because the list is way too unwieldy for trying to go through the entire process.

Andrew Lyzenga: OK, so maybe sort of a first order, have first to identify those that we really do want to evaluate and then evaluate that short list against the criteria.

Hardeep Singh: And I think that I would for the – so I'm not sure whether what – if you structured two days have a meeting in April, how are you going to do those. Is that decided how we're going to use those two days in some type of a …

(Crosstalk)

Andrew Lyzenga: Not entirely but – yes, that's something along lines that you're just talking about, you know, some sort of exercise to get through this list and at least get a first pass (at the) prioritization of the concepts. Well that is the idea.

Hardeep Singh: OK.

Andrew Lyzenga: And we welcome again your feedback on that. If you want to reach out to us individually and give us any thoughts on how you think would be best to approach that, if you (inaudible).

Hardeep Singh: All right, sounds good. OK, thanks I'll do that, thank you.

Andrew Lyzenga: David, did you have a comment or?

David Seidenwurm: Oh, yes, no I was just going to really thank everyone for the deep consideration and the thoughtfulness with which they're addressing this part of it, I was mentioning to Andrew and the team.

Yesterday that out of the all the things we value at HHS, this prioritization piece of the work is by far of the greatest value, because measures come and

go and you can tweak, you know, numerators and denominators, but to have a good sense of what the committee thinks are the most important areas at least to address or think about in a given domain or topic. It is by far the most valuable thing that you can do.

Andrew Lyzenga: Thanks, David.

John Bernot: Hey Andrew, this is John. And just to get – to give Hardeep a little bit more information. Just to – and the whole committee, we've – we went through the list on the Google Document, we had just over 100 concepts on there and we have a couple of the e-mails that we're incorporating also. So I think the list will probably get up to about 120.

And really just reiterating again what Andrew said is we will be taking some steps. There are some that are – are not actually concepts, some that are very related and other ones where we have some groupings of ones that might automatically be considered a lower priority very binary, some of the structure measures that we can present probably to the committee.

So, more to come on this and I wish I had the details. But I just want to give you an idea of where things really were. Again, it came in at about 120, and I think we get a pair of that down, or at least prioritize certainly a third of half of those and I think another half or two-thirds will fall into a bucket and the committee team could more easily give a thumbs or thumbs down too.

Hardeep Singh: Yes, sounds good, John, thanks a lot.

Kathryn McDonald: Yes, that's very helpful, and I think – this is Kathy again. In terms of like what I think of some of those that might be groups, then when I think about the importance of, like think of all your missed opportunities, Hardeep, if we have like all of the missed opportunities, you know, measures for each type of missed opportunity, sure it would be important.

If we have only measures for one, you know, for the – you know, missed colonoscopies, when there was a red flag, that's important ...

(Off-Mic)

Kathryn McDonald: ... as it were all the missed opportunities. And I think we as a committee, when we're going through our prioritization process we'll also have to have some instructions about whether we're thinking about kind of the fullest measurement of a concept or a more restrictive measure of a construct, and of course it's more realistic to do a more restricted measure, and less impactful, you know, and vice versa.

So, again just to sort – you're thinking about collapsing the list, great that sounds really good and yet it will create a need for us to know what to think about when we're thinking about importance and realism.

Andrew Lyzenga: Absolutely. And I think that's where we're headed, we're not obviously going to take anything off the list ourselves, but as we're going through the list and stuff, hopefully we can do some of this heavy lifting to exactly what you're saying.

Whereas some, one might be very finite and one might be very broad. We can actually potentially give some suggestion how to broaden our concept or narrow one down to make it what would be more of a feasible measure.

(Off-Mic)

Andrew Lyzenga: But more of an easier and interpretable measure concept. So we are working on that, I just want to let you know so that hopefully by the time the list is in front of you, it's cleaned up with potentially even some suggestion as to how that concept might fit better at the same level of granularity as the rest of them.

Kathryn McDonald: And I know that's hard work to do, we thank you.

Hardeep Singh: Yes, and this is Hardeep again. And 'm just thinking, you know, we had good discussion on the concepts that might be used to rate measures, all measure concepts along those dimensions. I'm actually wondering, just to sort of save time, because you simplified a lot of the committee discussion right now, would it be a good idea to send a new list of the three or four or whatever

consolidated concepts that we sort of, you know, discussed. So that – and you can get feedback on those before we meet in April.

So that we have a good idea that if we do a two-step process then on the second step these are the four things we're going to be thinking about. Otherwise we might have a four-hour discussion just to hand those four things.

Andrew Lyzenga: Yes, that's – again point well-taken. So we'll see what we can do to make that meeting most efficient and I agree maybe circulate certainly something in advance so you can take a look and have a bit of time before the meeting to give it some thought, and maybe provide some input back to us.

Christy Skipper: All right, thank you everyone for your input this afternoon. Now we want to ask the operator to please open the line for public and member comment.

Operator: At this time, if you like to make a comment, please press star one on your telephone keypad.

Paul Epner: Am I still open?

Andrew Lyzenga: We can hear you, Paul.

Paul Epner: OK, under the public comment period, I just wanted to add one quick comment on, relative to training and licensure and that sort of stuff. You should know that for laboratory professionals, there are only 13 states last I heard, could be off by one or two, but 13 states are required certification or licensure for laboratory professionals.

So, please take that into – I think that's why someone interjected the word training, and not to reduce say burden but rather to just recognize that 37 states don't require certification or licensure for laboratory professionals.

Andrew Lyzenga: Thank you.

Operator: And we have no public comments at this time.

Andrew Lyzenga: OK, thank you.

Christy Skipper: So, now we'll hear from Vanessa on next steps.

Vanessa Moy: OK, so thank you for all your input and feedback we appreciate it. So for our next steps, as many of you know we have in-person meeting, the second one that's coming up on April 12th to 13th, you'll be getting emails for meetings in a couple of weeks about it, how to register, and on on-board registration for it.

And also after that in-person meeting, we have another committee, web meeting on April 18th, it will be held from 2:00 p.m. to 4:00 p.m. Eastern Time and then we'll also be drafting our framework report, which would be out for a public comment here it from May 16th through June 14th. And we'll have one last committee web meeting on June 27th from 1:00 p.m. to 3:00 p.m. Eastern time.

Christy Skipper: Thank you, Vanessa. And again, this – here is our contact information if you need to reach any of us directly. And we've heard what you've said about possibly getting some of these materials in advance so that we can have the most sufficient in-person meeting and we will be working to get those to you.

And so if there are no other comments from the group, we will adjourn the call here.

Kathryn McDonald: All right, thank you, everyone.

Male: Thank you, thank you.

Hardeep Singh: Thank you.

Female: Bye.

END