

NATIONAL QUALITY FORUM

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IMPROVING DIAGNOSTIC ACCURACY 2016-2017

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WEDNESDAY
APRIL 12, 2017

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

PRESENT:

MARK GRABER, MD, FACP, Co-Chair; Society to Improve Diagnosis in Medicine, RTI International Plymouth
KATHRYN MCDONALD, PhD, Co-Chair; Center for Health Policy and Center for Primary Care and Outcomes Research
JENNIFER CAMPISANO, JD, Booby and the Beast Blog Phoenix
MICHAEL DUNNE, PhD, bioMerieux, Inc.
DAVID GRENACHE, PhD, University of Utah
MARILYN HRAVNAK, RN, PhD, ACNP-BC, FCCM, FAAN, University of Pittsburgh
NICHOLAS KUZMA, MD, St. Christopher's Hospital for Children
PRASHANT MAHAJAN, MD, MPH, MBA, University of Michigan
LAVINIA MIDDLETON, MD, The University of Texas MD Anderson Cancer Center
DAVID E. NEWMAN-TOKER, MD, PhD, Johns Hopkins University School of Medicine
MARTHA RADFORD, MD, MA, NYU Langone Medical Center

DAVID SEIDENWURM, MD, Sutter Health
THOMAS SEQUIST, MD, Partners Healthcare System
SUSAN SHERIDAN, MIM, MBA, DHL, Patient-Centered
Outcomes Research Institute
HARDEEP SINGH, MD, MPH, Veterans Affairs Center
of Innovation and Baylor College of
Medicine

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
MARCIA WILSON, PhD, MBA, Senior Vice President,
Quality Measurement
JOHN BERNOT, MD, Senior Director
TRACY LUSTIG, DPM, MPH, Senior Director
ANDREW LYZENGA, Senior Director
VANESSA MOY, Project Manager
CHRISTY SKIPPER, Project Manager

ALSO PRESENT:

PAUL EPNER, Executive Vice President, Society to
Improve Diagnosis in Medicine

KERM HENRIKSEN, Patient Safety Program Officer,
Agency for Healthcare Research and Quality
(AHRQ)

DIVVY UPADHYAY, Senior Research Associate, Social
& Scientific Systems

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

2 (9:04 a.m.)

3 MR. LYZENGA: All right. I think
4 we're going to get started. Thanks, everybody,
5 for coming out for this meeting. We really
6 appreciate your attendance, taking the time.

7 We've got a busy couple of days ahead
8 of us, I think. We hope to make this a working
9 meeting, sort of dig into the long list of
10 concepts we have. And work through them
11 gradually, and in a sort of iterative process.
12 And come up with a smaller list of prioritized
13 measures. We think we've come up with a pretty
14 good approach for doing that.

15 I should maybe start out with an
16 apology of sorts. We had, you know, certainly
17 anticipated, and hoped to get you materials to
18 review much earlier, and in advance of this
19 meeting.

20 Sort of had a plan worked out. And
21 then ended up going back to the drawing board a
22 little bit, late in the game, and rethinking our

1 approach and the materials we would need.

2 So, just wanted to acknowledge that we
3 sort of did you a disservice by not giving you
4 more time to review these things in advance. But
5 that said, I think we'll have time to work
6 through these things today and tomorrow. And we
7 look forward to a productive meeting.

8 Mark, did you have any welcoming
9 remarks, or anything like that you wanted to --

10 CO-CHAIR GARBER: Good morning,
11 everybody. Thanks so much for being here again.
12 So, I always knew that the NQF did miraculous
13 things. And there's evidence right here today.

14 We left with I think 40 measures. And
15 we've come back and there are like 200. So, it's
16 like the miracle of the loaves, or the oil, or
17 something.

18 So, as you all know, I think, the
19 chairs do almost nothing. It's the NQF staff who
20 really do all the heavy lifting behind the
21 scenes. So, huge thanks to Andrew and John, and
22 everybody at the NQF, for somehow massaging all

1 this, and getting it to the point where we can
2 discuss it today.

3 Missy Danforth had a minor emergency
4 at Leapfrog, and wasn't able to be with us. So,
5 huge thanks to Kathy for pinch hitting as co-
6 chair of the meeting. And I'll turn it over to
7 her for comments, if she'd like to make some.

8 CO-CHAIR MCDONALD: Yes. So, put up
9 with me basically. Yes. Looking forward to a
10 good couple of days with everybody, and lots of
11 participation that's, you know, pretty much baked
12 into this.

13 We're not going to be able to get away
14 without really engaging. And I think it will be
15 very useful for all of us to do that. So, good
16 to be here. And now, I think we do
17 introductions. Is that right?

18 MR. LYZENGA: Maybe we could just do
19 another quick round of re-introductions for
20 everybody in the room. Go this way? Just a
21 quick introduction.

22 MEMBER SHERIDAN: Good morning. I'm

1 Sue Sheriden. I'm the Patient Family Advisor at
2 CMS.

3 MEMBER SINGH: Hi. Hardeep Singh,
4 Patient Safety Researcher at Baylor College of
5 Medicine and Houston VA.

6 MEMBER KUZMA: Nick Kuzma. I'm a
7 pediatrician in Philadelphia.

8 MEMBER HRAVNAK: Marilyn Hravnak. I'm
9 a nursing faculty at the University of
10 Pittsburgh. I lead our PhD program. But I'm
11 also a nurse practitioner in the ICU.

12 MEMBER RADFORD: Martha Radford. I'm
13 Chief Quality Officer at NYU Langone Medical
14 Center in New York City.

15 MEMBER NEWMAN-TOKER: David Newman-
16 Toker, Johns Hopkins Health Services Researcher
17 on Diagnostic Safety and Quality.

18 MEMBER MIDDLETON: Lavinia Middleton,
19 MD Anderson Cancer Center. Director of Quality
20 Operations and Deputy Chief Medical Officer.

21 MEMBER SEQUIST: Morning. I'm Tom
22 Sequist. I'm the Chief Quality and Safety

1 Officer at Partners Healthcare.

2 MR. HENRIKSEN: Kerm Henriksen,
3 Patient Safety Program Officer at AHRQ.

4 MEMBER DUNNE: Mike Dunne, Senior
5 Fellow, bioMerieux Clinical Microbiologies.

6 MEMBER GRENACHE: I'm David Grenache,
7 Professor of Pathology at the University of Utah,
8 and Medical Director of a clinical chemistry lab
9 at ARUP Laboratories.

10 MEMBER MAHAJAN: Prashant Mahajan,
11 Vice Chair of Emergency Medicine, and a pediatric
12 emergency physician at University of Michigan Ann
13 Arbor.

14 MEMBER HUNT: I'm David Hunt. I'm the
15 third David so far. I'm a medical officer, and
16 Medical Director for Patient Safety at the Office
17 of the National Coordinator.

18 MEMBER SEIDENWURM: David Seidenwurm,
19 fourth and final David. And I'm the chair of the
20 Quality Committee at Sutter Medical Group, and a
21 neuroradiologist.

22 MEMBER CAMPISANO: I'm Jen Campisano.

1 I'm a patient advocate.

2 MS. LUSTIG: I'm Tracy Lustig. I'm
3 part of the NQF staff.

4 DR. BURSTIN: Good morning, everybody.
5 Welcome back. Helen Burstin, Chief Scientific
6 Officer. And especially pleased to work through
7 the CMS issues, and able to join us today.

8 DR. BERNOT: John Bernot, also part
9 of the NQF staff here.

10 MR. LYZENGA: Andrew Lyzenga, part of
11 the NQF staff.

12 MS. SKIPPER: Good morning. Welcome
13 back everyone. Christy Skipper, project manager.

14 MS. MOY: Good morning, everyone. My
15 name's Vanessa Moy. I'm also an NQF staff.

16 CO-CHAIR MCDONALD: Do we have any
17 committee members on the phone?

18 (Off microphone comment.)

19 CO-CHAIR MCDONALD: Oh. Any committee
20 members on the phone? No? No committee members
21 on the phone? Okay. And then, guests? Paul.
22 Yes.

1 MR. EPNER: Paul Epner, Executive Vice
2 President, Society to Improve Diagnosis in
3 Medicine.

4 CO-CHAIR MCDONALD: Divvy? Yes.

5 (Off microphone comment.)

6 MR. UPADHYAY: Morning. I am Divvy
7 Upadhyay. I'm a Senior Research Associate at
8 Social and Scientific Systems. Thank you.

9 MS. SKIPPER: And I'm sorry. And this
10 is Marcia Wilson, also part of the NQF staff.

11 CO-CHAIR MCDONALD: Okay. Welcome,
12 everybody.

13 MR. LYZENGA: So, I think maybe we can
14 just jump in. John, you want to talk a little
15 bit about some, sort of thoughts and potential
16 revisions we've, maybe proposing to our
17 measurement framework here?

18 DR. BERNOT: Yes. Yes. Thank you
19 very much. And again, welcome, everyone. Thank
20 you so much. As Mark said, it's absolutely
21 amazing the involvement that we've had, both from
22 public comments, to participation in between

1 sessions. I don't think any of us expected that
2 we would crest 200 measure concepts here in a
3 short period of time.

4 So, we did have the pleasure of going
5 through all of these concepts. And trying to put
6 this into something that made sense, in a way
7 that we can now analyze it, and hopefully come
8 out of today with some priorities. And maybe
9 even some ratings in different categories as to
10 where the measures stand. And we'll talk about
11 that. Can you go to the next slide? Maybe the
12 next one after that then.

13 Okay. So, this is how we left it at
14 the meeting last time. We said we had, we came
15 up with three domains, structure, process and
16 outcome domains. And within those a number of
17 sub-domains that we'll talk about in just a few
18 moments here.

19 And as we went through these different
20 concepts we came up, and they really clustered
21 into three pretty big concept areas. Not
22 surprisingly, not totally different. But around

1 the organization, around the diagnostic process,
2 and around the patients and the caregiver.

3 And the reason I point this out is for
4 a few reasons. One, within those though there
5 was a lot of crosscutting of measure types. So,
6 within the organization we're seeing structure
7 and process measures. Within the patient and
8 caregiver we're seeing structure, or process and
9 outcome measures.

10 So, it got us to thinking, do we
11 really have things laid out the right way? Or
12 are we maybe looking at it from the other side?
13 And the other things is, as we were talking
14 internally, when we come up with a framework it's
15 our feeling that we should have the domains as
16 something important.

17 We're saying, this is a project. Is
18 it really important that we have a structure
19 measure? Maybe, maybe not. But is it really
20 important we have an organizational measure?
21 Absolutely. Is it important that we have a
22 patient measure? Absolutely.

1 So, when we saw this large volume of
2 data it clustered a little bit differently. And,
3 Vanessa, can you go to the next slide?

4 So, what we were thinking of doing is
5 actually moving the domains over, the structure
6 process outcome, and actually making it more of a
7 measure type. And you can go to the next slide
8 on here.

9 And really moving those over and
10 saying, rather than those being the domains, they
11 became a type of measure within the sub-domains.
12 And actually then moving the concepts over to,
13 the concept areas over, and let those become the
14 domain. So, flip flopping these two things on
15 the side of the sub-domain. You can go to the
16 next slide.

17 And then, this is what it would look
18 like. And this is by no means us trying to
19 change the committee's wishes. I think this is
20 how the data clustered. And we definitely want
21 to give this as a proposal.

22 By no means is this a directive that

1 this is the way it should be. But just as we had
2 a lot of time, many, many hours going through
3 this information, it actually seemed to cluster a
4 little better this way, and maybe make a little
5 more sense.

6 In the process of this also, the sub-
7 domains would need to be tweaked. But largely,
8 the sub-domains still held up. And I'm going to
9 show you how that would look if we did go through
10 with this proposal.

11 So, just a couple of more slides, and
12 then we'll open it wide open for questions. So,
13 if we did this, we would have three domains,
14 organization, the diagnostic process, the patient
15 and the caregiver, with the sub-domains.

16 And I will take the time to read them,
17 just because I think it's important. So, in the
18 organization, the external environment,
19 organizations diagnostic, QI activities, patient
20 access, and workforce.

21 Also, I'm going to show you next now
22 these match back to the old sub-domains. So, you

1 don't have to try to figure that out in your
2 head.

3 Diagnostic process, as you can see,
4 very much going in line with the National Academy
5 report, the info gathering, the integration,
6 interpretation, and some other things on
7 efficiency, errors or accuracy, and follow-up.

8 And lastly, the patient and caregiver,
9 patient engagement and patient experience. So,
10 okay, you can go to the next slide. And this is
11 how they compare. And this will be the last
12 slide. I know I'm throwing a lot of information
13 quickly at you.

14 But no change in the external
15 environment. Where we saw the organizational
16 features we broke that up into a couple of
17 different components that had clear, clear
18 delineations in the amount of concepts that came
19 in.

20 Technology and tools was one of these
21 ones that got us thinking about this whole thing.
22 We were seeing technology and tools more so than

1 just in the structure. And that's where we
2 originally had it.

3 Technology and tools was being found
4 in different areas, how it interacts with a
5 patient, how it interacted with the process, and
6 things. Does this really fit the way it is?
7 Work, people and workforce, essentially the same
8 thing.

9 So, no real change in the diagnostic
10 process, except for the expansion. Really, we
11 took that one, and really opened it up into a lot
12 of different ones. And it was truly because of
13 the volume, and the clear separation of the types
14 of concepts that were coming in. In our mind
15 there's a clear separation.

16 No change to patient engagement. No
17 change to patient experience. And again, the
18 outcomes, sub-domains would be moved in as
19 measure types, into the domains.

20 So, that is a lot. It is lot. And,
21 can you go to the next slide? Actually, let's go
22 back to, just so people can see. Keep going

1 back. We can just stop here, so this is
2 available for everyone to see.

3 And I want to turn it over to the
4 committee, just to get your gut reaction, if this
5 makes sense, or if we want to revert back.
6 Again, everything's fluid, and nothing is set in
7 stone for us whatsoever. I'll turn it over to
8 the chairs.

9 CO-CHAIR GARBER: Comments from
10 anybody? Please.

11 MEMBER NEWMAN-TOKER: Yes, I'd like
12 to. The one thing that I found myself tripping
13 over a little bit was the patient and caregiver,
14 and then the sub-domains. Both being about
15 patient engagement and patient experience.

16 I don't know if there's a provider
17 experience piece of this story that exists out
18 there. But if, I would either, if we don't care
19 about other provider fields, might make that a
20 patient domain, the patient and the caregiver
21 domain.

22 Oh, did you mean caregiver? You

1 didn't mean the providers? You meant the
2 patient's family? That was confusing to me. So,
3 I would see, think if there's some way patient
4 and family, or something slightly different. I
5 don't know.

6 DR. BERNOT: Absolutely.

7 MEMBER NEWMAN-TOKER: Patient family
8 and caregivers. Or something that would make it
9 more, clearer to me anyway. It wasn't --

10 DR. BERNOT: That makes sense.

11 MEMBER NEWMAN-TOKER: -- You didn't
12 mean physicians and nurses?

13 DR. BERNOT: I did want to comment on
14 the first, about the clinician provider
15 experience in the, we put that in the workforce
16 part. And there actually was some concepts on
17 burnout that people had proposed here.

18 MEMBER HRAVNAK: I like it. I only
19 had one question, which is that when we came up
20 with those original domains, we must have had a
21 reason for why those seem to be the one to go
22 with.

1 And is that reason okay to give up?
2 I mean, was that based on how NQF does other
3 things? Or was it based on something nationally?
4 Or is there anything to lose by giving up the
5 original, I guess was my only question.

6 DR. BERNOT: I'll briefly, but I think
7 I'd rather have the committee make that decision.
8 But there was nothing that we felt that we lost
9 in the process.

10 We did come up with those as we were
11 looking at the report from the National Academy,
12 and just the way that they had laid out some of
13 their things. So, it, I don't want to say it was
14 arbitrary that we picked those to start. But it
15 was the starting point based on that.

16 I don't think there was anything more
17 to it, in my recollection. But I really would
18 like to make sure that I'm not missing something.

19 MR. LYZENGA: I should note that some
20 of those ideas were pulled from our colleague,
21 Hardeep's diagnostic, what's the framework? The
22 diagnostic safety, Safer Dx Framework, which had

1 sort of broken things down into structure,
2 process, and outcome categories. And that kind
3 of made sense to us, and aligned very well with
4 many of the categories that were in the National
5 Academy's report.

6 But again, as we reviewed the measure,
7 concepts that would see, it seemed like we were
8 having many of these categories, things like
9 information gathering and documentation, that
10 were cutting across structure, process, and
11 outcome, you had measures reflecting each of
12 those things.

13 And it kind of started to feel like a
14 bit of an artificial distinction to say that
15 information gathering and documentation was only
16 related to process measures.

17 But that, you know, you could also
18 have structure measures representing those
19 elements within that, and outcomes related to
20 them. So, that was kind of the thinking.

21 CO-CHAIR MCDONALD: Hardeep?

22 MEMBER SINGH: Yes. So, I think

1 conceptually speaking this is fine. I was
2 thinking, are we missing anything? So, I tried
3 to sort of in my mind do the, you know, when I
4 think of diagnostic errors and how to study the
5 topic.

6 In general three things come up,
7 system issues, provider/team issues, and patient
8 issues. And I think you've got those covered.
9 You just have titled them differently, which is,
10 you know, works.

11 You know, a couple of things I'll say.
12 Okay. So, if you -- you mentioned provider
13 burnout a second ago. Where would that go? I
14 think you can still put that in the
15 organizational workforce issues, because a lot of
16 those problems are organizational. And so, I
17 think it is covered.

18 The other way I was trying to break it
19 down to see have you missed anything. If you
20 sort of go away from the structure process
21 outcome, you know, model that we were using, I
22 think we're still okay.

1 Because a lot of the structural things
2 are under the organization. A lot of the process
3 things are already covered. And a lot of the
4 outcomes that we're interested in are patient
5 outcomes.

6 And are we missing anything, like
7 provider outcomes? Maybe not. Because then, as
8 I said, they may be under workforce. So, I think
9 this is okay. No matter what titles we use, I
10 think we've covered it broadly. So, I'm fine
11 with it.

12 CO-CHAIR MCDONALD: Thank you.

13 Martha?

14 MEMBER RADFORD: Again, I like it.
15 There was a fair amount of misassignment around
16 structure process outcome in the original list.
17 So, we probably need to kind of tighten that up a
18 little bit.

19 CO-CHAIR MCDONALD: And the thought
20 was that you'd still do structure, process, and
21 outcome. But sub-domains, so that will still --

22 MEMBER RADFORD: Matter, right.

1 (Simultaneous speaking.)

2 CO-CHAIR MCDONALD: David?

3 MEMBER HUNT: I feel like a very old
4 dog, just recounting the history of the
5 Donabedian structure, process, outcome. I don't
6 think, you know, and I can share. I always keep
7 a copy of his original, that article on
8 structure, process and outcome, from the
9 Millstone Quarterly.

10 (Off microphone comment.)

11 MEMBER HUNT: Huh?

12 DR. BURSTIN: It's on my desk.

13 MEMBER HUNT: Oh, okay. But just to
14 speak to it. If we read that and look at this, I
15 think this is wholly concordant with the basic
16 tenets of what he was trying to forward, as far
17 as this is concerned. And I feel like this still
18 has a tremendous amount of rigor and elegance.
19 And I don't think we're losing anything with
20 this.

21 CO-CHAIR MCDONALD: Thank you. And I
22 actually have to add too here that I think it

1 nicely reflects the National Academy's model.
2 Because that's got the patients sort of
3 throughout. It's got the process, and the kind
4 of main part within the work system, which is
5 sort of the organization. So, if you had to
6 parse it into three subcategories, this would be
7 aligned with that. Prashant?

8 MEMBER MAHAJAN: So, to me honestly it
9 didn't make much of a difference, in the sense it
10 was what I thought that the structure, process,
11 outcomes would have captured all these. I think
12 it just reassigned them. But eventually we are
13 doing the same thing.

14 I mean, what I am anticipating, at
15 least coming out under organization, under the
16 sub-domains, we will eventually have measures
17 related to structure, process, outcome. Maybe
18 not everyone will have everything.

19 But the only thing I would add is
20 probably try to balance it in such a way that we
21 just shouldn't end up having too many of the
22 process measures or the outcome measures. But

1 check off each of them a little bit.

2 CO-CHAIR GARBER: Yes. So, one thing
3 is missing that is in the IoM report, is the
4 impact of the external world. So, these are all
5 measures that are perfect I think for healthcare
6 organizations. But don't take into account the
7 external factors. So, I guess, is it an
8 assumption that we're --

9 MEMBER SINGH: This is the --

10 CO-CHAIR GARBER: -- just developing?

11 MEMBER SINGH: It's the external
12 environment. I checked off for it, and it's
13 there. So it will, it's under organization,
14 which is sort of a little artificial. But it
15 affects the organization.

16 So, if there's a change in Medicare
17 policy or reimbursement structure, you are
18 mediating this with the organization. So, I
19 think it's okay. I don't know if it deserves a
20 separate category. I thought about that also
21 before I --

22 (Off microphone comment.)

1 MEMBER SINGH: The organization as a
2 mediator.

3 CO-CHAIR GARBER: Is that, John and
4 Andrew, is that where you're thinking external
5 means?

6 (Off microphone comment.)

7 CO-CHAIR GARBER: Models?

8 MR. LYZENGA: Yes, yes.

9 CO-CHAIR GARBER: Liability reform?
10 Those things? Okay.

11 MEMBER SINGH: Well, I mean, if you
12 want to be precise you could just, you know,
13 retitle the organization as something else, you
14 know, organizational and policy issues, or
15 external environment issues, or something of the
16 like. If you want to like really be crystal
17 clear, you could do --

18 MR. LYZENGA: I don't think we're
19 necessarily tied to these names, by any means.
20 If you have a better way of describing things --

21 MEMBER SINGH: So, the other thing we
22 could do is, as we create the measures, or

1 measure concepts, see what new things we have,
2 and change the --

3 MR. LYZENGA: Yes.

4 MEMBER SINGH: Yes. And change the
5 names accordingly.

6 MR. LYZENGA: Yes. That's absolutely
7 the idea. Both the domains, and then the sub-
8 domains as we're going through them, consider as
9 we're working through them, are these the right
10 sort of, you know, names for the sub-domains? Or
11 should they be tweaked or modified at all? Are
12 we getting the appropriate buckets, again, to
13 capture the measures and the conceptual areas
14 they're trying to cover?

15 CO-CHAIR MCDONALD: Is anybody else
16 wanting to comment? David?

17 MEMBER NEWMAN-TOKER: Just the, so the
18 question of whether the patient access piece, it
19 is something that the organization has obviously
20 a direct impact on. But so does the patient
21 experience. It's directly impacted by the
22 organization.

1 I wonder whether it belongs in the
2 patient bucket, rather than the organization
3 bucket, the sort of, you know, access,
4 engagement, and experience? Almost feel like
5 they're, that they belong together.

6 CO-CHAIR MCDONALD: So, I was looking
7 at that too, wondering about that. And then I
8 made an argument for why it should be in
9 organization. But I want to hear what the
10 argument was that was yours.

11 DR. BERNOT: Yes. So, first of all,
12 this one is one that Andrew and I at the last
13 minute were going back and forth. So, I
14 definitely, I could definitely see that going
15 either way.

16 The one thing I did with, at the risk
17 of turning everyone's attention away from the
18 discussion, I did want to point out, we put a
19 pretty thorough definition list of exactly what
20 we think fits into each of these.

21 For example, just based on Mark's
22 question. Not, then again, all this can be

1 changed. But what we thought external
2 environment, we said policy costs, legal issues
3 around diagnostic quality.

4 So, you at least, if you look at this,
5 it's the proposed new domains and sub-domains
6 sheet. It really at least lets you have an
7 insight into our thinking. Again, all of that
8 can be changed. But just, so for clarification
9 purposes.

10 We also tried to include, based on
11 some of those really rich discussions on the last
12 webinar, about where the different communications
13 occur, provider/provider, provider/patient,
14 system/patient. We had a lot of discussion.

15 And we wanted to make sure that we at
16 least addressed that in our definitions. So, I
17 think I've said enough. But I just wanted to
18 make sure that you had that in front of you.

19 MR. LYZENGA: I should add, we, just
20 again, much of this emerged from our going
21 through the list many time, of the concepts. And
22 those patient access measures seemed to us

1 largely to be related to organizational
2 activities, and sort of characteristic, things
3 like ease of getting an appointment, geographic
4 access, you know, that patients receiving
5 sufficient long appointments.

6 Most of them seemed to kind of be
7 those things that were in the organization's
8 control. So, that was again, and we sort of, you
9 know, speaks to the process by which we did this.

10 It was a sort of inductively
11 reasoning, I think that's the right word, from
12 the concept list to our sub-domains in some
13 sense, with some input or, you know, considering
14 other things as well. But that was the reason
15 behind it.

16 MEMBER SINGH: And we're not looking
17 for perfect, you know, mutually exclusive
18 categories, correct? I mean, there could be a
19 little bit of, there's never going to be a
20 perfectly mutually exclusive --

21 The other thing I was thinking is, for
22 some organizations patient access is huge. I

1 mean, for VA, probably even Kaiser, and some of
2 the other organizations, it's a huge issue. And
3 it's an organizational issue.

4 The other thing I was thinking was,
5 which I think maybe David's also referring to is,
6 access that means, I, you know, didn't go and see
7 the doctor for a month, or a year, or six months,
8 and my diagnosis got delayed. And some of those
9 issues could be patient engagement related. So,
10 I think maybe that's okay as a balance.

11 MEMBER NEWMAN-TOKER: I think, you
12 know, just now reading your definitions here for
13 patient access to care, includes timely
14 availability of human and diagnostic resources.

15 I almost think you might want to think
16 about changing it from patient access to care, to
17 some access to diagnostic services, or something
18 like that.

19 Just because the implication here is
20 that, you know, you've got on call radiology for
21 24/7, you know, like you've got, organizationally
22 and institutionally you have the capacity to

1 provide diagnostic services.

2 Some of those things aren't really
3 patient access, per se. They're more like
4 internal workings of access to care, you know, at
5 off hours, and this, and that, and the next
6 thing. So, I think probably the better resolve
7 is to move access to patients, but to remove the
8 word patient from access.

9 CO-CHAIR MCDONALD: Are there any
10 comments on the patient and caregiver block
11 there? I know from the last time that we had
12 discussions about patient engagement, sort of
13 patient partnership, patient activation.

14 There's, you know, kind of all these
15 ways of thinking about kind of what the role of
16 the patient is, and where the vulnerabilities
17 might be. Is having sort of two buckets
18 appropriate? And are those the right
19 buckets? Put that out there.

20 MEMBER CAMPISANO: I think that makes
21 sense. And, you know, I think that the way that
22 these domains and sub-domains are laid out makes,

1 in general makes a lot more sense than how it was
2 previously, just from a lay person's perspective.

3 CO-CHAIR MCDONALD: I think it being
4 pretty accessible to the patient community is
5 important. And I think this does a better job at
6 that. It doesn't seem as sort of technical.

7 MEMBER SHERIDAN: I'm nodding my head,
8 because although I'm with, I'm representing CMS,
9 I'm also a patient advocate. So, I'm agreeing
10 with Jen, that I think this is understandable,
11 and easy to digest as a lay person.

12 CO-CHAIR MCDONALD: Well, it sounds
13 like everybody's liking this. Anyone having sort
14 of remaining concerns, or questions?

15 MR. LYZENGA: And again, we'll, as
16 we're working through --

17 CO-CHAIR MCDONALD: Yes.

18 MR. LYZENGA: -- these activities,
19 just kind of keep it in the back of your head.
20 If you think something's kind of off, you know,
21 raise that during our discussions, and we'll see
22 if we can rework it.

1 CO-CHAIR MCDONALD: Thank you.

2 DR. BERNOT: Just to summarize the two
3 things I have so far, that we'll work towards.
4 And that is, if there's something adding patient
5 family caregiver, to make sure we clarify that.

6 And then the other one is getting rid
7 of the patient part, and maybe something along
8 the lines of access to diagnostic services or
9 resources. Something in those, to clarify those
10 two sub-domains.

11 And if anything else comes up, just
12 let us know and we'll get something out to the
13 rest of the Committee, either tomorrow or as
14 follow-up.

15 DR. BURSTIN: Just as an aside to
16 that, just having done way too many of these over
17 the last ten years. The other thing is, once you
18 actually go through the concepts, it's very often
19 that you then go backwards. And then it becomes
20 more clear what the domains and sub-domains are.

21 So, I wouldn't get too hung up on
22 structure, not to go back to Donabedian. But I

1 think you've probably done enough for structure.
2 And it's probably fine to just kind of let it
3 flow, and come back to it as needed.

4 CO-CHAIR MCDONALD: Okay. I think,
5 no, Martha, you're not trying to -- Okay. Okay.
6 That's fine. You get to continuously go for it.
7 No problem. Okay. So, should we move on to --

8 MR. LYZENGA: Yes.

9 CO-CHAIR MCDONALD: -- the next item?

10 MR. LYZENGA: Yes. So, yes, I guess
11 we can kind of jump right into our work here.
12 We're running slightly early, which is great.
13 So, just to give an overview of kind of what, the
14 process we're following here.

15 We're going to sort of do this
16 iteratively. And we're going to do this a few
17 times. First, what we're going to ask you to do
18 is sort of sit down by yourselves, take your
19 laptop, and work through the measure list fairly
20 quickly, kind of gut instinct.

21 What are your top five to ten
22 measures? We've actually asked for you to give

1 us a specific number in each sub-domain. Which
2 are your top measures in each sub-domain?

3 We've got a spreadsheet we'll ask you
4 to work in, and just put an X next to the ones
5 that you feel are the top measures, the most
6 important the highest priority, whatever sort of
7 criteria you would like to apply at this stage.

8 Tomorrow we'll be sort of applying our
9 more standard criteria. But in terms of this
10 first cut, we just want you to give again sort of
11 more of a gut feel. Which ones of these are the
12 most important? Which do you think should be
13 pulled out for further discussion and
14 prioritization?

15 Those will then go to, you'll break
16 out in small groups. They'll essentially do the
17 same exercise, sort of taking fresh eyes,
18 discussing amongst themselves. Do we have the
19 right sub-group of measures pulled out of each
20 sub-domain to then review and rate.

21 Those groups will report back to the
22 full Committee, which again will kind of go

1 through the same exercise, asking the question,
2 do we have the right concepts here pulled out of
3 each of these sub-domains? Getting different
4 perspectives who weren't in the sub-groups.

5 And after that we'll have sort of our
6 subset of measures that will then be more fully
7 reviewed and rated. We'll do the same kind of
8 exercise in terms of gaps. We'll take out the
9 individual part.

10 But we'll go into small group
11 discussions, and assess gaps within each of these
12 sub-domains. Those small groups will then bring
13 back to the Committee, who will kind of go
14 through the same exercise, look at gaps, review
15 the small group work, bring their other
16 perspectives.

17 And then finally, and we'll get into
18 this tomorrow, we'll do the small group again.
19 And they'll do those ratings against our criteria
20 for each of those, that sub-group of concepts
21 that has emerged from today's work.

22 And then we'll bring back to the full

1 Committee for a check, and to finalize the
2 ratings against the criteria. So, sort of at a
3 high level, that's our approach here.

4 We'll kind of be doing the same thing
5 a few times, but in different groups as sort of
6 an iterative process. Each kind of doing a check
7 on the next, and providing different perspectives
8 at each stage.

9 So again, the first part of this is
10 that we're going to ask you to sit down and work
11 through the concept list yourself, and pick out
12 your top concepts from each sub-domain.

13 Hopefully all of you do have a laptop.
14 I know, Martha, you didn't. But you kind of
15 worked it out on paper, which is great. And
16 we'll incorporate that into the spreadsheet. If
17 anybody else has any issues accessing the
18 spreadsheet, let us know, and we can work out
19 something else.

20 I think we've got a good bit of time
21 here, until I think 10:30 a.m. is when we had
22 scheduled. So, we can sort of make this into a

1 break/working session for you guys to just run
2 through the list.

3 If you get through it quickly, feel
4 free to take a break, look through some of the
5 materials. And sort of think about what we're
6 going to be doing subsequently. But we'll give
7 you, try to give you enough time to get through
8 that list.

9 We had done it ourselves, a few of us
10 and some other staff, and generally found it to
11 take about 30 to 40 minutes to work through the
12 list and give out top measures. So, hopefully
13 that will be consistent with your experience.

14 DR. BERNOT: And, Andrew, I don't want
15 to put Vanessa on the spot. But is it possible,
16 since we have a couple of minutes, to actually
17 bring up the, to do a demonstration of the Google
18 doc for the group? So everybody knows what we're
19 looking to do. Sorry to put you on the spot.

20 MEMBER RADFORD: While you're doing
21 that, can I just ask a question?

22 CO-CHAIR MCDONALD: Sure.

1 MEMBER RADFORD: So, have you resorted
2 these measures according to the new -- Okay.

3 MR. LYZENGA: We have.

4 MEMBER RADFORD: So, and you're going
5 to send that to us? Okay.

6 MR. LYZENGA: Yes. We sent it out.
7 And these are in our new sub-domains. And so,
8 I'm glad you guys like them.

9 CO-CHAIR MCDONALD: Marilyn, did you
10 have -- Yes.

11 MEMBER HRAVNAK: On the asterisked
12 things. So, are we not to rate those? Are they
13 already accepted? Or --

14 MR. LYZENGA: No. You should consider
15 those in the same way. Rank them if you think
16 they're important. We just thought it might be
17 worth marking those.

18 Those are actually fully developed and
19 specified measures that we identified through our
20 environmental scan. That may be something you
21 want to take into consideration as you're doing
22 your rating.

1 The others are just sort of these
2 concepts that we came up with in the last
3 meeting, and since then with Committee members
4 entering things into that working document. So,
5 those measure concepts are pretty vague in
6 general.

7 The fully specified measures are a
8 little bit more fleshed out, and have, in some
9 instances, been implemented in programs. So,
10 something you may want to consider.

11 Many of those, I should note, are very
12 narrowly focused on specific sort of conditions
13 or topic areas. So, that's another thing to take
14 into consideration.

15 I don't think you should feel like you
16 have to prioritize those over the concepts, if
17 you think there's a concept that better reflects,
18 you know, the sub-domain, or some important
19 aspect of diagnostic quality. Just something we
20 thought you should know.

21 CO-CHAIR MCDONALD: Yes. It does seem
22 like that's useful for when we get to the rating

1 stage. So, at this stage, where we're just
2 trying to think through from our own vantage
3 points, which concepts seem more, something that
4 matters to us, that we haven't kind of created a
5 rating around them.

6 Then, it's about, okay, just, you'll
7 each have your own reason for why you think a set
8 of concepts are more important than another set
9 of concepts in any domain. And that's perfectly
10 valid. Because that's the point of doing things
11 independently to start out with.

12 CO-CHAIR GARBER: Any other questions?

13 CO-CHAIR MCDONALD: Vanessa, is this
14 a good time for you to show us?

15 MS. MOY: So, yes. So in this Google
16 doc there are 12 different tabs. And in each tab
17 there's your name on it for your column. And on
18 the very left hand corner it tells you how many
19 concepts to take out of those total concepts.

20 Let's say there's 25 out of this tab
21 for diagnostic efficiency, for instance. So,
22 you'll select your top five measure concepts that

1 you think should belong for this sub-domain.

2 And then you can mark it by, there's
3 a drop down list. And if you think that's a, one
4 of your top ones, you just mark it. And if it's
5 not your top, you can just leave it blank.

6 And that's what you do for the rest of
7 them. And for the rest of the tabs, on the upper
8 left corner it will say, like how many measure
9 concepts to select.

10 And the ones with the asterisks are
11 the ones that were existing measures, as we
12 mentioned previously before. So, yes. Just let
13 me know if you have any questions, and how we can
14 help you.

15 (Off microphone comment.)

16 MS. MOY: On the Google doc link.

17 (Off microphone comment.)

18 CO-CHAIR MCDONALD: The asterisk means
19 that it's not just a concept --

20 (Off microphone comment.)

21 CO-CHAIR MCDONALD: It's a measure.

22 Oh, where would you see it?

1 (Off microphone comments.)

2 MS. MOY: So, yes. If you scroll down
3 to --

4 MR. LYZENGA: It's the first character
5 in the cell.

6 MS. MOY: Right there.

7 CO-CHAIR MCDONALD: Yes. So --

8 MS. MOY: Yes, sorry. So, if you
9 scroll down there's like a little asterisk on one
10 of the measure concepts. So, that would mean
11 that it's like an existing measure before.

12 MEMBER NEWMAN-TOKER: So, you want us
13 to each fill in our named column for ourselves?
14 The question is, do you care whether we hide or
15 delete the other columns? Do you, how are you
16 going to be reintegrating them.

17 MS. SKIPPER: Please don't hide or
18 delete any --

19 MEMBER NEWMAN-TOKER: Okay.

20 MS. SKIPPER: -- other columns.

21 MEMBER NEWMAN-TOKER: Okay.

22 MS. SKIPPER: We did freeze the screen

1 so that your name should appear in that top row
2 regardless of how far you scroll down.

3 MR. LYZENGA: Or, if you scroll across
4 it should keep those domains on the left, I
5 believe. So, you can kind of move it over.

6 MS. MOY: Yes. So --

7 MR. LYZENGA: Well, almost.

8 MS. MOY: So, you can locate your name
9 by like scrolling to the right or left.

10 MR. LYZENGA: It depends on whether
11 they're the last people in the list.

12 MS. MOY: And you can scroll --

13 (Off microphone comment.)

14 MS. MOY: Yes. So, the rows are
15 frozen.

16 MR. LYZENGA: Already frozen. So, you
17 can just scroll just scroll over to where your
18 name is, and work down.

19 CO-CHAIR MCDONALD: Basically it's
20 kind of an honor system. It's beneficial to do
21 it on your own. So, go ahead and just look at
22 the items and the concepts, and --

1 MR. LYZENGA: And again, this is --

2 CO-CHAIR MCDONALD: -- consider them.

3 And then mark your X.

4 MR. LYZENGA: Yes.

5 CO-CHAIR MCDONALD: Because my
6 understanding is that it's not that you're going
7 to kind of use these initial rankings in any way.
8 It's --

9 DR. BERNOT: Right. This is an
10 informal --

11 CO-CHAIR MCDONALD: This is for our
12 own process to be able to record and remember
13 what we were thinking. And then we'll use that
14 when we get into the small groups.

15 MR. LYZENGA: First cut, group
16 exercise will do the same sort of thing, and
17 review what comes out of this. And then the full
18 Committee will kind of review that.

19 (Off microphone comment.)

20 MEMBER SINGH: On the second, there's
21 a second column next to, choose a number of top
22 measure concepts, on the instruction sheet.

1 What's that?

2 CO-CHAIR MCDONALD: So, Hardeep and
3 everybody, see up at the top, it shows -- No, go
4 back to one of the tabs though. Yes. So, see
5 how at the top it says, please select five
6 concepts from this sub-domain?

7 MEMBER SINGH: Yes.

8 CO-CHAIR MCDONALD: So, always look at
9 that. Because sometimes it will be five,
10 sometimes it will be a different number.

11 MEMBER SINGH: Right, right. But
12 what's the other --

13 MR. LYZENGA: He was just talking
14 about Column C --

15 MEMBER SINGH: I'm talking about, go
16 back to the instructions.

17 MR. LYZENGA: -- on the instructions
18 page.

19 MEMBER SINGH: What is the 4123 on the
20 right side?

21 CO-CHAIR MCDONALD: Oh.

22 MR. LYZENGA: Digital detritus? Or is

1 that not anything?

2 MS. SKIPPER: So you all can ignore
3 that last column. Sorry about that.

4 MEMBER SINGH: Just want to make sure
5 we're following instruction, that's all.

6 CO-CHAIR MCDONALD: Okay. So, do
7 people feel ready to, I saw a couple of people
8 maybe had already done their homework.

9 MEMBER NEWMAN-TOKER: Just one --

10 CO-CHAIR MCDONALD: But most haven't
11 had a chance.

12 MEMBER NEWMAN-TOKER: One particular
13 question.

14 CO-CHAIR MCDONALD: Okay.

15 MEMBER NEWMAN-TOKER: So, the total
16 number of, just give us an approximate for how
17 much time we have for each of these things.
18 We've got about 45 minutes total, and there are
19 how many tabs?

20 MR. LYZENGA: Twelve tabs. So, you
21 know --

22 MEMBER NEWMAN-TOKER: So, we got two

1 or three minutes for --

2 MR. LYZENGA: Yes. And five to eight
3 minutes I would guess for each one.

4 MEMBER NEWMAN-TOKER: All right.
5 Okay.

6 CO-CHAIR MCDONALD: We'll have to
7 move.

8 MR. LYZENGA: Yes, got it.

9 CO-CHAIR MCDONALD: But they tell us
10 we can do it in this amount of time. So, we can.
11 David.

12 (Off microphone comment.)

13 CO-CHAIR MCDONALD: Okay. Yes. Raise
14 your hand if you're having any challenges, and
15 the --

16 (Off microphone comment.)

17 CO-CHAIR MCDONALD: -- staff will
18 help.

19 (Off microphone comments.)

20 CO-CHAIR MCDONALD: Okay. Have at it.
21 Yes. And if you have any questions,
22 we'll just have folks helping.

1 MS. SKIPPER: And I'll resend the link
2 with the Google docs in just a moment.

3 CO-CHAIR MCDONALD: Oh, yes.

4 MS. SKIPPER: For those of you who
5 don't have it.

6 MS. MOY: Yes. I would like to add
7 also, if you need to have a laptop, we can also
8 loan out some laptops for you if you need one.

9 MEMBER SINGH: And it saves
10 automatically, right?

11 (Whereupon, the above-entitled matter
12 went off the record at 9:43 a.m. and resumed at
13 10:51 a.m.)

14 CO-CHAIR GARBER: This is complicated,
15 and hard to tackle. But thank you all for going
16 through that exercise. I'm going to turn it over
17 to Andrew, who will give us instructions on where
18 we're going from here.

19 MR. LYZENGA: Yes. So, yes, I'll
20 reiterate. Thank you for sticking through that,
21 and toughing it out. That, we did anticipate
22 would be sort of the rockiest part of this. And

1 lose a little bit of momentum maybe in the
2 beginning. But we think we'll gain it back in
3 the group stage.

4 So, again, we just went through an
5 individual exercise to pull out, to select what
6 we think are the top measures or measure concepts
7 in each sub-domain.

8 We'll now break into some groups.
9 Each group will be assigned a few sub-domains,
10 and will essentially go through that same kind of
11 exercise.

12 We'll review what the individual
13 results were, which measures or measure concepts
14 rose to the top. And we'll ask you to sort of
15 consider these questions on the slide there.

16 There's a little bit more detail and
17 guidance in the discussion guide, if you have
18 that. But basically, have the correct concepts
19 risen to the top and selected from each sub-
20 domain. Discuss that amongst your group.

21 Among those concepts, can any of them
22 be further specified or better described? Some

1 of them, again, are very vague, and just sort of,
2 you know, a general idea of measurement. Can we
3 get a little bit more flesh around those sort of
4 bones of those concepts? We'll try to do that in
5 other sessions as well.

6 Should any of the concepts be re-
7 categorized? Did you find in your review,
8 individual review or in your group review, that
9 any of the concepts should be in another sub-
10 domain? That they're not in the right sub-
11 domain?

12 And then, are the sub-domains
13 themselves appropriate? Do they need to be
14 modified, amended, renamed, rethought?

15 But the sort of main thing we want you
16 to do is to review which, that set of the most
17 important or top concepts, and make sure that you
18 agree amongst yourselves in the group that those
19 are the right concepts to pull out for further
20 rating. Does that make sense to everybody?
21 Questions?

22 MEMBER NEWMAN-TOKER: Yes. I'm going

1 to, having struggled with this myself, let me
2 make a plug for really thinking hard in the sub-
3 groups about, when you're talking about a given
4 measure concept, that you're adjusting the level
5 of granularity to the right level.

6 Because I think there are some good
7 measure concepts that are buried in some of the
8 individual measures. But the measures themselves
9 seem too specific to be part of the conversation.
10 And I think we should be abstracting those to the
11 level of generalization.

12 But there are also others where it's
13 the other way. Where, you know, it's like, you
14 know, mom and apple pie. Like, we want, you
15 know, everything to be nice, but there's no way
16 to measure it. And those need to be brought
17 down.

18 And I think maybe if we could agree
19 that any disease specific one, the sort of base
20 assumption should be that it's, you know, disease
21 X, you know, of a certain class, like, you know,
22 dangerous disease, or whatever.

1 And only if we specifically think it
2 needs to be a specific disease, or a specific
3 disease class, like cancer, or whatever, that we
4 call it out.

5 Like, that we be clear in the
6 discussions whether we're talking about a class
7 of, you know, all diseases, this is a
8 representative measure. Or no, we mean
9 specifically breast cancer. And that needs to be
10 a measure. That at least we're clear about that
11 when we're talking to each other.

12 MR. LYZENGA: Absolutely. Totally
13 agree. So that is definitely something you
14 should be thinking about and talking about in
15 these group discussions. And we'll do that a few
16 times again as we move through this process.

17 I also just, I forgot to mention, we
18 noticed that in these documents, and in the
19 spreadsheets, it must have happened in an import
20 into the Google Documents, or in the sorting.
21 But all of the measure types, the outcomes,
22 structure, process are completely mislabeled.

1 MEMBER NEWMAN-TOKER: Oh, thank God.

2 (Simultaneous speaking.)

3 MEMBER NEWMAN-TOKER: I'm like, you
4 guys need to give us better definitions of what
5 structure, process and outcome is.

6 MR. LYZENGA: Yes, yes.

7 MEMBER NEWMAN-TOKER: Because I'm
8 lost.

9 MR. LYZENGA: That was a technical
10 glitch I think they got an import or in the sort
11 of the columns. So, Martha actually kindly went
12 through and reassigned all of them. And we'll do
13 that again on the back end. Maybe we can get it
14 for our next round, get those corrected.

15 But, any more questions or
16 clarifications on the group work? Or should we
17 break out and start our work?

18 CO-CHAIR MCDONALD: Just, oh, sorry.
19 Just a comment --

20 MEMBER NEWMAN-TOKER: Can I just do
21 one --

22 CO-CHAIR MCDONALD: -- on David's

1 comment though first. And then you can comment
2 some more. I think there's a little bit of a
3 picture of kind of how the group work can kind of
4 sort of move through this process might be
5 helpful.

6 Because it's a little hard to know,
7 are we going to have like all these separate
8 group discussion, like you just had with us as a
9 big group? And not profit from the big group
10 kind of calibration, cross calibration?

11 MR. LYZENGA: We will do that after.
12 We'll have the groups do their work on this, sort
13 of these questions. And then we'll get back.
14 The groups will report out their findings, and
15 their discussion.

16 And then we'll pretty much address the
17 exact same questions again in the full Committee,
18 to have the full Committee sort of check what the
19 group's thoughts and decisions were, add their
20 own perspectives, make sure we're getting it all
21 right.

22 And out of that we'll have sort of

1 that final Committee decision on which are the
2 subset of concepts from each domain. Does that
3 make sense?

4 CO-CHAIR MCDONALD: Yes, that does.
5 And, I mean, I think it's helpful for us to know
6 that as we go into our groups. That we get to
7 come back and say, here's where we sort of
8 wrestled. We could go this way.

9 Like, you know, worry about
10 granularity, or do groupings, like you said. And
11 that we're coming back to the bigger discussion,
12 knowing that we may in our groups have found
13 things that would translate to other groups. And
14 we may all bump --

15 MR. LYZENGA: Right.

16 CO-CHAIR MCDONALD: -- into the same
17 stuff, and resolve it in the same ways. But we
18 may also bump into slightly different stuff, or
19 resolve things in slightly different ways.

20 So, I wanted to make sure we all
21 understand that we get to sort of step through
22 this, you know, in our sub-groups, but then

1 together. Go ahead, David.

2 MEMBER NEWMAN-TOKER: Can I just ask
3 a question about the target numbers of things
4 that we're shooting for? So, we've obviously had
5 this big expansion, you know, to 200 things. We,
6 maybe we had gotten it going down. And now it's
7 blown up, and we're coning it down again, which
8 is all good.

9 But it seems like you guys picked the
10 numbers, you know, five these and eight of these,
11 almost as sort of like a proportionality of the
12 number of measures that were there.

13 I'm not sure that that's necessarily
14 fair or right. Like, there may be some places
15 where, you know, for the patient experience, or
16 whatever, there might be fewer.

17 Because there aren't that many
18 different ideas to deal with there. But it
19 doesn't mean that three or four of them shouldn't
20 end up in the, kind of the final version, even
21 though there were only eight to start with, or
22 whatever.

1 So, can you clarify for us what each
2 group is supposed to do in terms of target
3 numbers? Are we sticking with the numbers you
4 gave us? Are we trying to get the total package
5 down to 20? Or, you know, what are we trying to
6 do?

7 MR. LYZENGA: I don't think we have a
8 target number. We're just hoping to get it down
9 to a more manageable number for, again, the full
10 rating exercise. You know, we're hoping to get
11 it down to maybe 50 or 60 to do that rating.

12 But I think that's a totally fair
13 point. And I think we're comfortable with, if
14 you, you know, if you're, if we've asked you to
15 take out two or three measures from some sub-
16 domain, and you really think we should get three,
17 five more, pick them out. We'll discuss it at
18 the full Committee level. And we can take those
19 in and, we want to be flexible about this.

20 CO-CHAIR GARBER: And one more
21 question that we need some NQF expertise about.
22 Just, David brought it up. But some of the

1 concepts are really general, but very
2 appropriate, but probably not actionable.

3 Do you want us to work on making them
4 actionable, or just note that this is relevant,
5 and you guys will reword it to make it
6 actionable?

7 MR. LYZENGA: We would certainly
8 prefer that you reword them to make them
9 actionable. If you have ways that you think that
10 could happen, that should definitely be part of
11 your discussion.

12 Take a concept and see if you can kind
13 of, you know, reword it, describe it, flesh it
14 out a little bit to be more actionable. That
15 would be fantastic.

16 And again, we can do that at the full
17 Committee level again too. And we can do that as
18 part of our gaps discussion. We'll be looking
19 at, you know, are there things missing?

20 And as part of that, you know, we can
21 also look at the concepts that are there and say,
22 do they need to be still tweaked a little bit, or

1 refined?

2 MEMBER SINGH: So, following that on.
3 So, I think bullets 3, second third and fourth,
4 can should and are, those are fine. The first
5 one is have. And I think that's the most
6 important one. Have the correct concepts been
7 selected. So, I think Mark is sort of trying to
8 get to it, actionable.

9 I think we need to just be careful
10 about, we're not developing measures. We're
11 talking about measurement concepts that can be
12 further studied, evaluated rigorously and, you
13 know, made into measures in the future. So, I
14 think that's one important thing that all the
15 groups need to realize.

16 The second issue is, what are the
17 prioritization discussions going to be like?
18 What are they going to be based on? So, one is
19 actionability. Mark mentioned that.

20 But, you know, it's okay for feasible
21 action, important. But I think this came up last
22 time as well. And my comment on United Airlines

1 is probably even more relevant now.

2 But essentially, are we going to be
3 focusing on just things that are preventable
4 harm? Or are we sort of looking at it broadly?
5 Should that be under the discussion?

6 MR. LYZENGA: That, so we would expect
7 you to sort of incorporate that. We'll talk
8 about our criteria a little bit tomorrow. Or
9 maybe if we have time, later today.

10 We've pared it down to initially two
11 sort of axis of importance and feasibility. And
12 part of that importance, importance sort of
13 includes a number of different dimensions.

14 Among those could be, I mean, you
15 could interpret the importance to be how relevant
16 is it to avoiding patient harm, among other
17 considerations.

18 We actually added another dimension or
19 criteria on, with the input of Dr. Graber, to
20 think about which measures or measured concepts
21 may contribute to cost savings. Because, the
22 idea of that being that that's a very important

1 area and consideration for decision makers. And
2 may help sort of highlight the importance of
3 these measures as we --

4 MEMBER SINGH: Can you qualify that?
5 Do you mean cost savings for the organizations?

6 MR. LYZENGA: Yes.

7 MEMBER SINGH: Or cost savings in
8 terms of diagnostic testing and --

9 MR. LYZENGA: I think the idea --

10 MEMBER SINGH: -- resource
11 utilization?

12 MR. LYZENGA: -- is sort of, I think
13 this, it actually needs to be fleshed out a
14 little bit more, I think, in --

15 MEMBER SINGH: Because I don't think
16 any of these measures is going to save anybody
17 any money --

18 MR. LYZENGA: That's right.

19 MEMBER SINGH: -- anytime soon.

20 MR. LYZENGA: Overall, we're sort of
21 thinking overall system costs. Whether it would
22 help to sort of drive down costs for the

1 organization across the healthcare system. Not
2 necessarily for patients. But maybe that would
3 be applicable.

4 That, maybe we should discuss that
5 tomorrow as we're talking about the criteria.
6 Because we added that on a little bit late. And
7 it's worth talking through.

8 CO-CHAIR MCDONALD: Okay. And,
9 Martha? Yes.

10 MEMBER RADFORD: Also, I just noticed
11 after going through this list twice, for various
12 reasons. A lot of them kind of overlap. And I
13 think it's worth the Committee, the sub-groups
14 calling that out. And maybe summarizing three
15 measures in one that would get to all of those
16 concepts, if you will.

17 MR. LYZENGA: Right.

18 MEMBER NEWMAN-TOKER: And one other
19 thing, just in terms of thinking about the future
20 use of some of these measures. So, there were
21 some things where at face value they sort of
22 sounded like a good idea. Like the number of

1 diagnostic errors reported by physicians and
2 patients, or something like that.

3 And it seems like a thing that was
4 easy to measure, and that was relevant. But when
5 I think about ones like that, where the result of
6 having a higher or lower number could be both,
7 either a positive thing or a negative thing, in
8 terms of the quantification. That those are
9 probably not great measures.

10 So, like you could be increasing the
11 number of diagnostic errors reported, because
12 you're doing a great job of beating the bushes,
13 and encouraging culture in reporting.

14 Or, and your diagnostic error rate,
15 reported rate could go, you know, your total
16 number could go up. So, it's a numerator only
17 measure. Or if you're really amazing at your
18 job, right, the number's going to go down in
19 terms of fixing it.

20 And I think we have to be careful
21 about using, recommending a direction towards
22 measures that both up and down could be a good

1 sign.

2 MR. LYZENGA: Thank you. And please
3 do. You know, those are exactly the kind of
4 thoughts we want to sort of have come out of
5 this. We'll be, you know, we're recording this
6 all. We're going to be reviewing the transcript.

7 And those are the sorts of things that
8 we can try to incorporate into the report. And
9 sort of add to the richness of the discussion
10 around these measures. And say, these are the
11 considerations to take in mind, you know, just
12 the sort of thing --

13 MEMBER NEWMAN-TOKER: It's basically
14 especially risky with numerator only measures,
15 where you just don't have a denominator, and
16 you're just dealing with, you know, unsystematic
17 reporting where you just don't know whether
18 you're doing a better job or a worse job.

19 CO-CHAIR MCDONALD: And, Prashant?

20 MEMBER MAHAJAN: So, just to clarify
21 my understanding. We are looking at the
22 conceptual area? Like, so for instance, patient

1 involvement in diagnostic understanding of the
2 process.

3 To me that is a conceptual area, which
4 we could say, yes, it's important, no it's not
5 important. And that's what we are doing, rather
6 than percentage of patients who understood their
7 diagnostic process, you know.

8 See, because that is a measurable
9 event. But what I think you were alluding to,
10 Hardeep, is that we are looking more at the
11 conceptual approach. Whether it's important for
12 us to think whether patient involvement and
13 understanding of the diagnostic process is
14 important or not. Yes, or no. And then the
15 actual measure, right? I'm not sure.

16 MR. LYZENGA: Yes. I think that's
17 fair. And I think we can, you know, we would
18 like to get down to specific sort of concepts or
19 measure approaches if we can.

20 But if you, you know, that is
21 perfectly reasonable, to say we think this is an
22 important sort of concept to measure. And then

1 we can sort of say, here's one way you might do
2 that, you know, this X percentage or, you know,
3 the numerator or denominator. There may be other
4 approaches. But we think that in general is a
5 very important concept that we want to measure.

6 MEMBER RADFORD: I would go further
7 than that. I would say, if we think the concept
8 that's listed is not important to the diagnostic
9 process, we go no further. And we only kind of
10 think hard about those that we think are
11 important.

12 And then, you know, if they need
13 tweaking, or they need specification, or if they
14 need a little more clarity around even just the
15 concept, well then, let's work on that.

16 MEMBER SINGH: I think that's where --

17 CO-CHAIR MCDONALD: Yes. So, I mean,
18 it seems that we probably should get into our
19 small groups, try this out. This kind of
20 conversation is what we'll have in our small
21 groups.

22 And the idea is that whatever we're

1 discussing about how we're thinking about this,
2 is part of the process that you need. But we can
3 do it in our smaller groups, with these smaller
4 lists, instead of the list of 200.

5 And at the end of the time we'll have
6 some, you know, answers to some of these
7 questions from each small group. And if we have
8 questions, we'll be able to ask them in our small
9 groups. Because we'll have a NQF staffer with
10 us. But I'll just take the last series. Kerm?

11 MR. HENRIKSEN: Is there any interest
12 in distinguishing between quality and safety
13 measures, where there's a harm involved? Going
14 back to Hardeep's earlier comment that some of
15 these are very broad based, and seem to be
16 quality.

17 MR. LYZENGA: If the Committee thinks
18 that would be valuable, maybe we could something
19 like, you know, tagging measures. This is sort
20 of related to quality. Or, you know, this one is
21 related to safety, or is a sort of safety
22 sensitive measure, or something like that. And,

1 I don't know if that's, or some other approach.

2 MEMBER SINGH: So, I have another sort
3 of suggestion, and maybe take on quality. I
4 think there are several areas which are
5 important. They're clearly important. I mean,
6 one that, I'm not going to pick on anyone, but
7 health literacy one came to mind.

8 Yes. It's really important to do
9 that. But is it measurable immediately? Can we
10 do something about it, or not? And I think
11 that's number one. So, that, is it quality, yes,
12 for sure?

13 And the second is, has that been
14 associated with preventable harm? That's sort of
15 getting into safety. And I think we need to have
16 that kind of discussion when you go into the
17 small groups.

18 Because that's going to lead to some
19 kind of prioritization better, if you ask the
20 questions. And then, maybe we can mark the ones
21 that came out be under lots of scrutiny because
22 they were important.

1 If people felt this was a really
2 important area, but was not measurable. Or it
3 was a really important area, it was not directly
4 related to quality, to safety. But it goes under
5 some other quality domain.

6 And maybe we could just sort of re-
7 market those measures and give it to you. I
8 mean, I'm sure there are other workforces
9 addressing this issue too.

10 CO-CHAIR MCDONALD: Ready to divide
11 this up?

12 (Off microphone comment.)

13 CO-CHAIR MCDONALD: I mean, I think
14 this is, I think we're just having kind of little
15 talks that will be the same talks we have to
16 have. And that the focus is, that you'll put
17 those questions back, and our groups will --

18 MR. LYZENGA: Yes.

19 CO-CHAIR MCDONALD: -- have to sort of
20 organize ourselves to move through those
21 questions --

22 MR. LYZENGA: Yes, exactly.

1 CO-CHAIR MCDONALD: -- and come back.

2 MR. LYZENGA: Again, we'll kind of --

3 CO-CHAIR MCDONALD: Yes.

4 MR. LYZENGA: -- iterate on this --

5 CO-CHAIR MCDONALD: Yes.

6 MR. LYZENGA: -- sort of at the group

7 level --

8 CO-CHAIR MCDONALD: Yes.

9 MR. LYZENGA: -- and at the Committee

10 level.

11 CO-CHAIR MCDONALD: Yes.

12 (Off microphone comment.)

13 MR. LYZENGA: No, no. We split those

14 out across, say that your group will be assigned

15 a few of the sub-domains.

16 MS. SKIPPER: All right.

17 MR. LYZENGA: So, do we have our

18 materials ready for the groups?

19 MS. SKIPPER: Yes.

20 MR. LYZENGA: We do? All right.

21 MS. SKIPPER: Okay. So, we'll split

22 up. Group 1 is me. I guess we can gather here

1 by Nicholas and Marilyn. Group 2 will be with
2 Vanessa. Just, you all can gather down there by
3 Thomas. Group 3, Andrew and Tracy, over in the
4 corner by Kerm. And then Group 4 I guess can go
5 here.

6 And then, members of the audience,
7 please feel free to join any group, and sort of
8 float around. So, we can break into groups, 1,
9 2, 3, and 4.

10 (Whereupon, the above-entitled matter
11 went off the record at 11:11 a.m. and resumed at
12 12:19 p.m.)

13 CO-CHAIR MCDONALD: We have a chance
14 for public comment at this point. And I think
15 we're going to go to the phones. Is anybody on
16 the phone ready to give public comment?

17 OPERATOR: If some of you would like
18 to make a public comment, please press *, then
19 your number 1. There are no public comments at
20 this time.

21 CO-CHAIR MCDONALD: Okay. Thank you.
22 And are there public comments in the room? Paul

1 Epner?

2 MR. EPNER: Paul Epner, Society to
3 Improve Diagnosis in Medicine. Love the domains
4 and sub-domains. You have external environment
5 under organization, which is sort of a catch all.

6 I would, but I think there's some
7 issues that are both, that are in there, and
8 maybe overlap with access to care, that might
9 need to be called out in your definition or
10 example. So, one, employer issues such as being
11 allowed to have time off to go get tests, or go
12 have doctor's visits, or whatever.

13 And payer issues, where they can put
14 patients through a tremendous tech review cycle.
15 They can deny, and you have to go through appeal
16 process. And you have payers in here, or cost
17 issues. You don't have payers, per se.

18 But then can insert a tremendous delay
19 if a physician asks for a certain diagnostic
20 procedure, and they don't agree. That process
21 could cause a big delay.

22 So, just again, I think you've got the

1 right categories. But you may want to add some
2 rich examples, to make sure it gets outside of
3 the health system walls.

4 CO-CHAIR MCDONALD: Thank you. Any
5 other public comments here? Okay.

6 (Off microphone comment.)

7 CO-CHAIR MCDONALD: So, we've done
8 public comments. What next?

9 MS. SKIPPER: And so, we'll break for
10 lunch. And we'll resume at 12:45 p.m., so that
11 groups that need additional time to go through
12 their measure concepts can do so.

13 CO-CHAIR MCDONALD: I was hoping we
14 were going to hear that. Lunch time. Thanks.

15 MS. SKIPPER: Thank you.

16 (Whereupon, the above-entitled matter
17 went off the record at 12:21 p.m. and resumed at
18 1:36 p.m.)

19 CO-CHAIR GARBER: Okay, thanks for
20 coming back. I hope everybody enjoyed lunch. I
21 will do the reporting or share the reporting
22 responsibilities for Group 1 with Tom.

1 The approach we used was to first hear
2 what items on our list were highly rated to make
3 sure that, indeed, we thought they were
4 appropriate to include. We then went over the
5 items on our list that got zero or very low
6 scores to see if there were any that we thought
7 had been overlooked.

8 We then went through and tried to
9 decide whether there was any overlap or measure
10 concepts that could be combined or needed to be
11 reworded. And basically, we ignored the several
12 very specific measures that were included in our
13 group, because they seemed to specific and
14 already very well developed.

15 Although, you'll see one example where
16 we went backwards and took a measure that was
17 very specific and translated it into one that was
18 more general.

19 So we are reviewing the topic called
20 Information Gathering and Documentation. And
21 these are the measure concepts that we thought
22 should be included. It was Number 5, that the

1 problem list is accurate and up-to-date. And
2 people thought that was an important enough
3 concept that it should stand on its own.

4 I'll just go through them all? Yes?
5 Number 6 had to do with the percent of cut and
6 paste in notes. And we combined that with
7 several others into a measure concept that speaks
8 to the adequacy and accuracy of documentation in
9 general.

10 So our suggested revision is that
11 clinical documentation should support quality in
12 the diagnostic process. It should be clear,
13 complete, and accurate. It should discourage
14 inappropriate use of copy/paste, it should
15 include the rationale for making a diagnosis, and
16 it should include a differential diagnosis for
17 new complaints and an accurate problem list that
18 is reconciled with the patient and at transitions
19 of care.

20 There's a little typo in the bottom
21 there. We want an accurate problem list, not an
22 inaccurate one. Yes.

1 (Off microphone comments.)

2 CO-CHAIR GARBER: Let's go through
3 them all and then we'll just go back and make
4 comments. So I think those were -- we definitely
5 want EMRs to be able to capture the chief
6 complaint and the reason for the visit.

7 Next? And we combined 11, 12, 13, and
8 14, so our suggested revision is down at the
9 bottom there. It says that EMR should not
10 require documenting a diagnosis before it is
11 appropriate to do so. It should allow
12 designating patients as being not yet diagnosed.

13 It should allow providers to assign a
14 probability of a diagnosis being correct. And it
15 should allow for ways to distinguish an initial
16 or an admitting diagnosis from a working
17 diagnosis, from a final diagnosis.

18 I think that's our last -- okay. And
19 about communication, we combined several. So our
20 suggested revision is down at the bottom on the
21 left. Communication to patients and their
22 families should be documented, and patients

1 should be aware of their diagnoses.

2 And 38, 38 is an example of an
3 existing measure that was very specific, that
4 within 60 minutes, if you're being transferred to
5 another healthcare facility, you should have
6 complete documentation.

7 So we're suggesting a more general
8 concept, and that is that complete information
9 about diagnoses may, during an in-patient stay,
10 including tests pending at discharge, should be
11 available in a timely manner to the clinical care
12 team who will be seeing the patient subsequently.

13 I think that's it. Okay, so those are
14 our recommendations for the measure concepts for
15 information gathering. David?

16 MEMBER NEWMAN-TOKAR: Just a quick
17 comment about granularity. Can you go back a
18 couple of slides there to, yes, stop, this one?
19 So you have -- so there, clearly the percent of
20 cut and paste in notes is either all the way down
21 at the measure level or a measure concept,
22 certainly.

1 We called this higher level thing that
2 you've got here aggregated as 19, the adequacy of
3 documenting initial findings, the clarity and
4 accuracy of documentation, a measurement theme.
5 We found that we were missing that kind of one
6 rung between sub-domain and measure concept.

7 Because underneath it, your bullet
8 points are all measure concepts, in some sense,
9 right. Like, you could talk about, under copy
10 and paste, your measured concept could be the
11 percentage of cut and paste in notes. Or it
12 could be the measure concept underneath the
13 measurement theme of adequacy of documenting the
14 initial findings.

15 So in case that helps as we sort of
16 struggle with keeping things at kind of the same
17 levels, I think maybe we need an intermediate
18 between sub-domains and measure concepts, just to
19 lump things in a sensible way.

20 Because clearly what you were saying
21 was we need to find some way to make sure that
22 people are getting clear and accurate

1 documentation in the EHR.

2 CO-CHAIR GARBER: Right. I think as
3 we see how each group did it differently, we'll
4 get some feel for those different levels. Thank
5 you, good suggestion.

6 CO-CHAIR MCDONALD: I have a question
7 for your group. In terms of when I look at the
8 list versus what you've pulled, I was wondering
9 about all these things that are actually quite
10 clinically narrow and specific, whether there was
11 any discussion of batching those in some way.

12 So, you know, this was the list that
13 had a lot of measures that already exist,
14 percentage of patients with esophageal biopsy
15 reports for Barrett's esophagus that contain a
16 statement about dysplasia and if present the
17 grade of dysplasia.

18 So it had a lot of these, like, very,
19 very specific things. And I just wondered if
20 there was any thought about, like, grouping those
21 as a concept, that when there is a specific thing
22 that could be looked at that it would be on a

1 list of measures to --

2 MEMBER NEWMAN-TOKAR: Yes. We didn't
3 have time to go through each one of those and see
4 whether there was some more general concept that
5 needed to be spelled out except for this one
6 example we had on the last slide. But I think
7 you're right, I think that we should do that, go
8 back and do that.

9 MEMBER SINGH: Do you have more, or
10 just that information?

11 CO-CHAIR GARBER: That's it from
12 information gathering.

13 MEMBER SINGH: But you've got more
14 other concepts to go through?

15 CO-CHAIR GARBER: We have one more
16 concept.

17 MEMBER SINGH: Oh, okay. Okay, so I
18 just wanted to sort of just reflect on a couple
19 of things. So we're still -- some of the intent,
20 I'm getting confused. So some of them, the
21 language -- or maybe that could get cleaned up --
22 is more about this is what you should be doing as

1 a good practice.

2 It's just a good clinical practice to
3 have, you know, good notes and not do copy and
4 paste versus actually a measurable concept or a
5 measure concept. So I think we need to get a
6 little more defined.

7 And if you look at your slide, the one
8 that you just showed, not your actual last slide,
9 the timely one, you know, somebody started with
10 60 minutes. Fine, you could have X-minutes. But
11 I think we should think about having some defined
12 parameters.

13 What is timely? What is accurate? We
14 don't know. I mean, problem list, how do you
15 know it's complete and accurate? How would we
16 ever know if it's complete and accurate?

17 So I think we need to sort of think
18 about what we are proposing. Is it just a good
19 clinical practice, which is a good thing, or is
20 it something like a measurement concept that we
21 can actually do something about.

22 So I think that kind of distinction

1 we're going to have to think about doing. So I
2 was getting confused between, yes, this is all
3 great stuff, but Helen's going to --

4 DR. BURSTIN: I actually think it's a
5 really good thought. And I think some of this
6 gets at this question of what's a really
7 interesting idea, broad concept, and what becomes
8 a performance measure? Are they really talking
9 about here a measurement concept, meaning what's
10 the target focus, what's the population you're
11 most interested in?

12 I mean, this is a great topic. And
13 it's really important to this. But I guess the
14 question is how would you actually get to a level
15 of detail more granular? For example, where I
16 practice, none of my residents have any idea how
17 to take a problem off the problem list. There's
18 no dating, there's no time, there's no -- I mean,
19 I'm very serious.

20 So the question is are there elements
21 of this where you create what are the things you
22 would measure with a bit more specificity of what

1 is, in fact, an accurate and timely problem list?
2 Because otherwise, just simply stating it isn't a
3 concept, it's just a nice idea.

4 MEMBER SINGH: And, you know, that's
5 exactly what I was getting to. I think Helen put
6 it much more nicely than I was trying to get to.
7 But the point is, you know, like, differential
8 diagnoses you've got on there. Absolutely.
9 We've got -- we've seen patients who are
10 completely misdiagnosed, no differential
11 diagnosis, right? I mean, you quote that study
12 as well.

13 Can we try to make it some type of a
14 measurement concept around differential
15 diagnosis? I mean, just start. More than half
16 of the records seen on a, you know, triggered
17 patient list, I mean, just make up something to
18 make it more measurable. That's what I'm getting
19 to, rather than having a way documentation is
20 related.

21 CO-CHAIR GARBER: But is there a
22 measure? It sounds more like a measure than a

1 measure concept?

2 MEMBER SINGH: We could make it a
3 measure concept. I'm just thinking. I think
4 we're going to have to narrow down --

5 CO-CHAIR GARBER: Well, let's take an
6 example and see if we could do that. Because I'm
7 really struggling with the difference between a
8 concept, and a measure, and what's in between.

9 DR. BURSTIN: Why don't we stay on
10 that example. If you want to, I'll try it. So
11 for example, it said that you had a, where was
12 it, a complete and accurate problem list. Is
13 that still on this slide somewhere? It's the one
14 -- but can you go back one, wherever that is?
15 Okay, here we go.

16 So for example, problem list is
17 accurate and up to date is really, I think, the
18 goal of what you're trying to achieve in the
19 measure.

20 You could do something like percent of
21 problem lists that include time stamps, you know,
22 something that allows you to actually qualify

1 what that is among all those using electronic
2 health records that include a problem list. So
3 something that specifies exactly what it means
4 to, in fact, be accurate and up to date.

5 MEMBER SINGH: Can you go a little bit
6 more extreme and think about something like
7 number of diagnoses found inaccurate on a review
8 of a hundred problem lists? I mean, that would
9 be a measure, but --

10 DR. BURSTIN: How would you know
11 what's inaccurate among --

12 MEMBER SINGH: Well, that's what I'm
13 saying. You will have to get to a review, which
14 is exactly the point. How are we going to
15 operationalize any of these areas?

16 CO-CHAIR MCDONALD: Okay, we have a
17 lot of signs up so make a list.

18 MEMBER HUNT: I was going to say, one
19 way you could do this is by having the patient or
20 family compare the problem list to what the
21 doctors have and make sure there's agreement.
22 And that would be one way that you measure this

1 pretty easily, I think.

2 CO-CHAIR MCDONALD: And, David?

3 MEMBER SINGH: There's already a
4 measure on that.

5 CO-CHAIR MCDONALD: Oh, what, David?
6 This one, and then -- I'm going back and forth.

7 (Off microphone comments)

8 MEMBER SEIDENWURM: So we use just
9 reconciled at each visit.

10 CO-CHAIR MCDONALD: You said --

11 MEMBER SEIDENWURM: The problem list,
12 we use, in our place, reconciled at each visit.
13 There's a million ways you can operationalize
14 this.

15 MEMBER SINGH: Well, then it becomes
16 one of those medication reconciliation things
17 that we could never, ever do for the last decade.

18 CO-CHAIR MCDONALD: David, it's David
19 Hunt?

20 MEMBER HUNT: Yes. No, I was going to
21 say that so many of us in practice know the
22 problem list is a cesspool. It's just something

1 --

2 (Laughter.)

3 MEMBER HUNT: It's just something
4 that's just continually added to. But some
5 things are never taken off. And who is
6 ultimately responsible for the problem list?
7 Traditionally, it should be the primary care
8 physician, I would say. Because they're the
9 coordinator of everything.

10 I would like to also offer up support
11 for a concept of the differential diagnosis. In
12 many EHRs, there's not a place to really put it
13 in a structured format. And to be really useful
14 and manipulatable, and that's not even a word,
15 but it would have to have a structural place in
16 the EHR.

17 And so I would advance the ability to
18 have -- at least to record what is your
19 differential. Because my residents nowadays,
20 they don't even list the differential, usually,
21 in their records. Because, you know, well, where
22 am I going to put it and that type --

1 CO-CHAIR MCDONALD: Okay, Marilyn?

2 MEMBER HRAVNAK: So in defense of Team
3 1, I think that what we were trying to do was --
4 I thought that our first assignment was to try to
5 separate the wheat from the chaff a little bit.
6 So to take this -- and we had two very big areas
7 to take out and just kind of pull out those
8 concepts that we thought were thought were the
9 most important versus those that were lower on
10 the list.

11 I don't think that we -- you know,
12 that was sort of like the first pass. And then I
13 think the actual measurement concepts under them,
14 it could be that some of them might be very
15 generic for that particular concept and would
16 apply to all settings and all populations.

17 Whereas some of them might be more
18 specific, you know, some of the ones we were
19 looking at specific to a cancer diagnosis or a,
20 you know, a heart disease diagnosis.

21 So I think that's why we kind of had
22 to step back, just sort of looking at what are

1 concepts that we should be -- that should rise to
2 the top of this list to begin the winnowing
3 process, was my view of what we were doing.

4 CO-CHAIR MCDONALD: Reasonable,
5 Lavinia, you had yours up. Okay, no. Okay,
6 David?

7 MEMBER NEWMAN-TOKAR: So I think
8 there're actually, as a dimension, several
9 different ways that one could operationalize
10 this, including some that haven't been mentioned.

11 So, for instance, you could say, okay,
12 I'm going to take five or ten diseases where I
13 have, you know, common diseases, where I have a
14 known gold standard of some kind.

15 Like, you know, most of the cancer
16 diagnoses have pathology reports somewhere in
17 your EHR that say lung cancer, or breast cancer,
18 whatever. And your stroke patients have, you
19 know, stroke written on their MRI report, or
20 whatever.

21 You can electronically compare how
22 often patients with, you know, Disease X, as

1 confirmed by such and such testing that everybody
2 can agree on is a gold standard, in the cases
3 where we have gold standard -- we don't have a
4 gold standard for everything, but we have gold
5 standards for a bunch of things -- and you could
6 say, okay, how often, when there's a gold
7 standard diagnosis of Disease X, does it show up
8 in the problem list? And how often does it show
9 up in the problem list without a gold standard
10 diagnosis of Disease X?

11 So you wouldn't get an all-
12 encompassing view of whether the problem list was
13 perfect, but you could still measure whether, you
14 know, where you were at, like, if you were at 50
15 percent sensitivity and 50 percent specificity
16 for the top ten, you know, things that you had
17 gold standards for. That would be telling you
18 something.

19 MEMBER SINGH: Yes. Actually, I think
20 Adam Wright from -- and, Tom, you may want to add
21 to this, Adam Wright from Harvard has done some
22 work in the area.

1 So you're looking at patients who have
2 definite diabetes, because they've got hemoglobin
3 A1c showing up on your EHR measurement as over
4 ten, or they take oral hypoglycemic, but diabetes
5 is not on their problem list.

6 So we could come up with a bit more
7 specific measure, saying definite presence of
8 disease by other criteria, but absent on problem
9 list, as a little bit more specific measure
10 concept that we could push forward.

11 MEMBER NEWMAN-TOKAR: And just one
12 more issue on that granularity. Like, I would
13 take what Hardeep said and say, okay, look, the
14 measure concept is, you know, Disease X diagnosed
15 by gold standard test, present or absent on --
16 you know, percent present or absent on problem
17 list.

18 The individual measures are one for
19 diabetes, and one for stroke, and one for cancer,
20 whatever, and this is a measurement theme. This
21 idea is I want the problem list to be accurate
22 and up to date. How am I going to operationalize

1 that as a measure concept and then individual
2 measures?

3 CO-CHAIR GARBER: Yes. That's very
4 helpful. Could we go ahead then, Tom, with your
5 section?

6 CO-CHAIR MCDONALD: Put your
7 microphone on too, Tom.

8 MEMBER SEQUIST: Okay. So this is the
9 section on information integration. I think it's
10 the next one. Yes, okay. So our top seven
11 choices for information integration, so I guess
12 in this section we did a little bit more of this.
13 We kind of changed the wording of some of the --
14 how it was actually displayed in the Google doc.

15 And we had a little bit of -- took a
16 little bit of liberty with trying to reinterpret
17 what was being meant. So this one, medical
18 record sharing among non-economically related
19 entities, we sort of re-translated that as
20 participation in health information exchange
21 across institutions that support diagnostic
22 quality, such as transmitting test results and

1 disease diagnoses. So that was, again, that was
2 sort of our interpretation of what it meant to
3 medical record share across non-economically
4 related institutions.

5 I'll just keep going, and then we can
6 do comments and at the end. The next one was
7 proportion of diagnostic evaluations with
8 appropriate team involvement. So we had a lot of
9 discussion about what this meant and what it was
10 to have team involvement.

11 How we rephrased this was, proportion
12 of diagnostic evaluations with appropriate
13 patient and inter-professional team involvement,
14 such as nurses, physicians, pharmacists, and
15 everyone in the medical neighborhood.

16 So the next slide, yes, all right.
17 So, proportion of patients diagnosed with a
18 specified targeted disease of interest who
19 received a second opinion. So this probably had
20 the most debate in our group about whether this -
21 - basically, I think a lot of the debate was
22 about whether this was separate from what I just

1 described on the prior concept which was around
2 appropriate involvement of all members of the
3 team.

4 And I think that the debate surrounded
5 this concept of what does second opinion mean.
6 Because I think you could take that as a very
7 broad generic, kind of asking anyone, asking the
8 nurse who works with you, or the pharmacist.

9 But what people are -- my concern and
10 some others, the concern was the term second
11 opinion is, to many people, going to mean you
12 asked another physician specialist, like you
13 referred them. You placed a referral.

14 And we weren't entirely sure that that
15 was a good measure of diagnostic quality, simply
16 the act of involving more physician specialists.
17 So there was a lot of debate on that one.

18 But we thought we would just put it
19 out here and get group discussion. Because there
20 is this other important concept that it is good
21 to get second opinions in general, to get advice
22 from other people, like, even within your primary

1 care practice, let's say.

2 If you're struggling with, you know,
3 a person comes in with a rash on their foot, and
4 is it cellulitis, is it contact dermatitis, and
5 getting to somebody else to say, hey, what do you
6 think that is? And so trying to capture that
7 spirit without saying that I'm asking you to
8 always refer patients to specialists was the sort
9 of debate here.

10 So the next one, Number 10, we lumped
11 a bunch in this area of information integration.
12 We thought Concept 10, 13, and 19 were all
13 related to each other. Ten and 13 were almost
14 exactly the same thing. One was can you track
15 closed-loop referrals, and the other one was your
16 performance on that, the percentage that are
17 closed loop.

18 But Number 19 used the standardized
19 communication techniques between consultants. We
20 thought it was sort of included in this concept
21 of how well are our referrals being managed from
22 sort of soup to nuts, from the placement of the

1 referral, to the occurrence of the visit, to the
2 communication of the treatment plan, and any
3 results back to the referring providers.

4 So we came up with the wording of,
5 close-loop referral to specialists, including
6 completion of visits and communication of test
7 results, and treatment plans, or treatment
8 recommendations back to the referring team.
9 That's sort of encompassing 10, 13, and 91
10 together.

11 The next slide. So Number 12: use of
12 structured hand-off programs in the hospital. We
13 left that one as is and thought that was an
14 important concept.

15 Number 15, so there was -- all this
16 said was diagnostic reconciliation. So several
17 of us in the group didn't know what that meant or
18 hadn't heard that term in particular before.

19 So we sort of thought about what it
20 might mean and, actually we were all just talking
21 about this a couple of minutes ago, are we going
22 back and confirming diagnoses? And is the

1 problem list actually accurately listing what
2 the, you know, what conditions the patient
3 actually has?

4 Similar to Med Rec, and again like the
5 group was just saying before, it comes with all
6 the same problems as Med Rec, good concept,
7 nearly impossible to measure in any, you know,
8 meaningful way.

9 So, again, we liked the concept of
10 saying, you know, revisiting, making sure if
11 you're saying someone has COPD that they actually
12 have COPD. If you're saying somebody has, you
13 know, X, Y, or Z disease that they actually have
14 that disease.

15 Although our sort of caveat with that
16 is it does -- and then we put it on here, Med
17 Rec, it does sort of lead you down that same
18 pathway as medication reconciliation.

19 Number 23, so this said, correlation
20 of histology and molecular findings. So, we
21 weren't necessarily supporting that particular
22 measure, but it got us into the conversation

1 around the general concept of are you looking at
2 all the sources of information that you have in
3 the record and making sure that they all lead you
4 to a concordant diagnosis.

5 And really, we got into this
6 discussion of saying, okay, well, do we have any
7 concepts in here around information integration
8 that helped counter our heuristic biases?

9 So if I have a confirmation bias --
10 and I'm just, like, I think the patient has X
11 disease, and any information that gets presented
12 to me that supports it, I'm going to use it, and
13 any information that gets presented to me that
14 doesn't support that, I ignore it -- do we have a
15 process where you are sort of forced to reconcile
16 outlier information?

17 Again sort of, we thought, an
18 important concept, didn't get to the point of how
19 would you operationalize that, you know, and
20 maybe start to feel a little bit more like Med
21 Rec again.

22 But we just felt, like, in the

1 information integration there wasn't anything in
2 here that addressed our biases that we bring into
3 the diagnostic process as part of integrating
4 information. So that's why we had that one in
5 there, again, open for discussion.

6 And then the, let's see, the last one
7 was more general. So I just talked about the
8 first bullet on the last slide around biases.
9 And then this is all actually relating to that
10 last concept. I think I covered it all, but --

11 (Simultaneous speaking.)

12 CO-CHAIR GARBER: No, good job,
13 absolutely. So we definitely need some input
14 from the group on whether there needs to be a
15 measure concept related to getting second
16 opinions. Do people feel that's something that's
17 valuable and we should include or not?

18 MEMBER SEIDENWURM: We know that in
19 the radiology field, and I believe this is also
20 documented in pathology as well, that there are
21 improved outcomes, for example, in mammography.
22 It's been well documented.

1 CT for oncology follow-up, I think, is
2 also documented in certain pathological
3 circumstances as well, I think, in the lymphomas
4 and in the distinctions among the different
5 grades of breast cancer, where second opinions
6 are valuable.

7 The problem is, they're expensive.
8 And they're difficult to administer, especially
9 in areas where there might be only one competent
10 specialist available or expert in that particular
11 area. So it would be great if we could do it,
12 but the other impediment is that there's often
13 not -- it's not a chargeable event either.

14 CO-CHAIR GARBER: Hardeep and then
15 David.

16 MEMBER SINGH: You know, I was going
17 to say, I think we're going to need to do
18 something about second opinions, especially
19 because I think it's an important concept.

20 What we need to do is debatable.
21 Because my view on this would be oftentimes it's
22 the fact that, I know it's hindsight, but a lot

1 of times people should have got a second opinion
2 or, you know, we should have got a second opinion
3 for them, depending on what side you are, but it
4 was not done.

5 So I think we may have proposed
6 something like this similar before. But
7 something like -- there are known diagnostic
8 dilemmas, you know. Celiac disease comes to
9 mind. There is, you know, ankylosing
10 spondylitis. There are certain conditions for
11 which it is almost essential that you need to get
12 second opinions for or specialists to refer them.
13 Oftentimes you just can't tell which one is
14 which.

15 And if you've got a condition such as
16 celiac disease which took ten years to get
17 diagnosed, where a second opinion just happened
18 one year prior, and for nine years somebody never
19 got a second opinion, or their physicians never
20 got a second opinion for them, that's a problem.

21 So I'm just wondering if we can re-
22 frame our measurement or measurement concept in

1 some way. Or, for acute disease, make it about,
2 I mean, we had this paper, spinal epidural
3 abscess. People came in recurrently to the
4 emergency room with multiple red flags, and they
5 were sent back.

6 So if you've got a patient who just
7 got diagnosed with spinal epidural abscess but
8 had to have seven emergency room visits in the
9 last, you know, two months, or three weeks,
10 whatever it might be, that becomes a measurable
11 or measure concept. So either do it in absence
12 of or too much, you know, depending on what
13 encounter you're referring to.

14 MEMBER NEWMAN-TOKAR: So I agree with
15 Hardeep that you probably need to get a little
16 bit more specific. Because if you have a too
17 blunt tool in this situation, you're going to end
18 up with the is it better if I had more or better
19 if I had fewer kind of problem.

20 I think Hardeep's onto something
21 there, if I could paraphrase. He's saying in
22 situations where we know the diagnostic failures

1 are common or, you know, sort of a potential
2 pitfall, we could pick those situations the same
3 way in the last scenario.

4 We could say what are the diseases
5 with a gold standard diagnosis where we could
6 reference where the problem was. What are the
7 situations where we know these diagnostic errors
8 and delays are happening, and can we reference
9 how frequently those people are being sent for
10 second opinions or how early they're being sent
11 for second opinions?

12 So I think if you narrowed the focus
13 and didn't just say, you know, what is the total
14 percentage of our population that gets a second
15 opinion, which I think is not going to tell you
16 very much, I think if you start getting specific
17 into situations where there's diagnostic
18 uncertainty and known pitfalls, I think that's
19 the right idea.

20 CO-CHAIR GARBER: There was one
21 concept that was raised by, I'm not sure who,
22 that it would be nice, for example, in a group of

1 primary care providers if there were somebody who
2 raised their hand and said I'd be happy to
3 provide second opinions. So that's a kind of a
4 structure measure. Is there a person who is
5 available to provide second opinions for patients
6 who would like one.

7 MEMBER NEWMAN-TOKAR: One other thing
8 is I would just make sure that we distinguish
9 between second opinions and the sort of quality
10 improvement that hopefully we'll talk about
11 activities where you deliberately do second
12 reviews of some sample of, you know, like, you
13 double-read ten percent of the pathology slides,
14 or the radiology, or check clinic charts, or
15 whatever.

16 Like, that's a little different
17 though. You're talking about second opinions,
18 like, I don't really know what's going on and,
19 you know, I need somebody else to help me rather
20 than just test, retest.

21 CO-CHAIR MCDONALD: So on this one
22 there is sort of the patient-facing side, and

1 there's kind of the payer-facing side where
2 sometimes second opinions are, you know, we often
3 think of second opinions with treatment.

4 But for these types of situations
5 where the diagnosis is going then produce, you
6 know, maybe a high cost treatment, a second
7 opinion could be used to verify the diagnosis,
8 and it would find some that were missed.

9 If we think about the payer side,
10 maybe payers would get involved in figuring out
11 where it's appropriate to have second opinions
12 around specific diagnoses.

13 And then if you think about the
14 patient side, patient's being able to get second
15 opinions when they feel like they're not getting
16 a diagnosis that matches or comports with what,
17 you know, the explanation has not turned out to
18 resolve anything, perhaps because they have been
19 misdiagnosed.

20 MEMBER HUNT: I mean, the payer
21 getting involved is a little chilling to me. But
22 that's my own issue.

1 One thing I would like to see
2 supported in the second opinion is some
3 institutional activities that may be included as
4 a second opinion, but it's not a formal one.

5 And I'm thinking of Tumor Board. I
6 have gotten a tremendous amount of feedback when
7 cases are presented at Tumor Board. Because you
8 have a group of your peers that really weighs in,
9 similar to almost Mortality and Morbidity
10 Conference also. In some way or another being
11 able, if the measure concept or if the measure
12 could include that type of activity, I think it
13 might be good.

14 CO-CHAIR GARBER: Tom?

15 MEMBER SEQUIST: So I think that was
16 the spirit of what we were talking about. It was
17 less about can we measure referrals to
18 specialists, but does the environment in which
19 you're practicing sort of enable you or
20 facilitate you getting additional input on what
21 you're doing?

22 And we've given the example in my

1 clinic, or our clinic I was in a while ago,
2 actually someone had started a sort of an online,
3 although within our firewall, blog where primary
4 care doctors, among 20 or 30 primary care doctors
5 could all say, you know, hey, I saw this patient
6 today who had X, Y, and Z. Has anyone else seen
7 that? I did this. What would you do?

8 And then, like, the 20 of us could
9 write back and say I would have done this, or
10 that's what I would have done.

11 I'm not saying we have a measure
12 around who's got blogs in their clinics. But
13 it's more, like, the spirit was, like, is there a
14 way that it's being enabled that you don't
15 practice in a silo, that you are somehow able to
16 get -- now I worry about that being too -- I was
17 going to say touchy-feely, not touchy-feely,
18 well, maybe I should be worried about it being
19 touchy-feely. But it's to, like, yes, squishy
20 maybe. I don't know, but very hard to turn that
21 into a measure.

22 But it's something really tangible,

1 right, that a practicing clinician feels, right,
2 that even though I'm surrounded by 3,000 doctors
3 in my hospital, I'm basically practicing medicine
4 alone.

5 (Off microphone comments.)

6 MEMBER SEQUIST: Sure, yes. So if you
7 use, like, the arc, you know, sort of model of --

8 (Simultaneous speaking.)

9 CO-CHAIR GARBER: Last call for
10 comments on this section. So Prashant, David,
11 and then Hardeep.

12 MEMBER MAHAJA: So my only question is
13 after this comes out it does appear that the
14 second opinion is getting some traction. I'm
15 just wondering that should we also be looking at
16 the downside effects of the decisions that come
17 out of this committee?

18 For instance, I'm just looking at
19 this, like, the second opinion were to be given
20 more importance. And depending upon how it is
21 received, it has implications on excessive
22 investigation, or more diagnosis now in a

1 different cost, and psychological impacts. So
2 I'm just going to throw that out. Do we need to
3 think about it at this time or not?

4 CO-CHAIR GARBER: Hardeep?

5 MEMBER SINGH: I was going to say I
6 found, you know, that I was scared. Because
7 David said just the opposite. When Kathy was
8 onto something about payers, and David said no,
9 no, no, keep them off -- sort of --

10 MEMBER HUNT: It just chills --

11 MEMBER SINGH: Yes, chills. Yes. We
12 don't have a payer representative here, right?
13 We don't have anybody from there. But they have
14 a lot of the data. And they know what the final
15 diagnosis is, because then they are paying for
16 treatment. Well, hopefully it's correct.

17 But if you've got a patient with,
18 let's say, multiple sclerosis, and you're paying
19 for that diagnosis, you can go back and look how
20 their, you know, utilization was and how many
21 second opinions they got, or how many
22 neurologists they went to, and how many primary

1 care visits were for, you know, for a totally
2 unrelated neurological condition before they got
3 diagnosed with MS. So they could be a source of
4 rich data that you want to consider some
5 utilization metrics on.

6 CO-CHAIR GARBER: Great. Thanks,
7 everybody. Let's move on to Section 2, Group 2.

8 MEMBER NEWMAN-TOKAR: So Group 2 used
9 a very similar process, the ones that were
10 described earlier that Mark articulated, the top
11 ones, and then we looked at the other ones that
12 didn't make the top, made sure there wasn't
13 anything. And then we tried to consolidate.

14 And we sort of went with this kind of
15 intermediate kind of measurement theme idea
16 underneath the sub-domain. Because we could all
17 quickly agree that the theme was either important
18 or unimportant. And then we sat around and
19 argued about what the measurement concepts would
20 be within that theme.

21 So the first thing we agreed on pretty
22 easily under the diagnostic efficiency sub-domain

1 was the timeliness of the diagnosis of priority
2 Disease X. And we said priority just meaning,
3 you know, whether you're believing that that's
4 diseases that kill people, like cancer, and
5 sepsis, and whatever, or whether priorities are
6 public health oriented things, like, you know, a
7 lot of patients with asthma, or diabetes, or
8 whatever.

9 So people could kind of define that
10 the way that they wanted to. But then we wanted
11 to get something about timeliness. So we then
12 broke that up into two domains that would get us
13 to kind of a measure concept here, sorry, domain
14 is not the right word, two sub-themes or two
15 measurement concepts within this theme.

16 And one was the timeliness of initial
17 diagnosis, that is from essentially the symptoms
18 to the explanation.

19 And the second sort of phase of that,
20 the timeliness of from the explanation to
21 management, recognizing that the group felt that
22 there was, even though some of this is a

1 continuum, that there was kind of this difference
2 between measuring whether you had, you know,
3 gotten to the point of a lung cancer diagnosis,
4 as opposed to getting all the subsequent staging,
5 and testing, and whatever else, to get to the
6 point where they actually knew which chemo to get
7 you after they did the molecular diagnostic
8 tests, and so on, and so forth.

9 And we've actually seen at Hopkins
10 some of this. You know, our lung cancer folks
11 have done a great job of squishing down the time
12 from biopsy proven lung cancer to the point of
13 actually chemo infusion. By bundling all the
14 diagnostic tests up and happening quickly, they
15 cut out a month-worth of wasted time.

16 But that's a little different than
17 that time to first get to the point where you've
18 got the cancer diagnosis in the first place. So
19 it was enough feeling that those were discreet
20 that we should have two separate measure concepts
21 there.

22 Obviously, the timeliness concept, as

1 everybody said before, is really around -- is
2 really disease-specific. And we didn't want to
3 get too hung up and particular about what would
4 be considered acceptably timely.

5 But I think that, obviously, it's
6 going to be different for subarachnoid hemorrhage
7 than it is going to be lung cancer, than it is
8 going to be celiac disease, or whatever,
9 conceptually. And some of that's just going to
10 have to be worked out with the science of
11 measurements or figuring out.

12 And there are nice epidemiologic
13 studies showing, you know, sort of looking at the
14 relationship between how long a diagnosis took
15 and the likelihood that there was kind of a
16 missed opportunity. So that's those two.

17 And then we moved to the next sub-
18 group which was really around -- this theme was
19 around value in the diagnostic process.

20 So there was really a concern
21 expressed in the group that we needed to make
22 sure we didn't just deal with the under-

1 diagnosis, if you will, or missed diagnosis type
2 problem. That we also thought about the issue of
3 over-testing, and over-diagnosis, and that there
4 needed to be somewhere in there, some kind of
5 measures that sort of dealt with the specificity
6 problem, not just the sensitivity problems, so to
7 speak, if you want to put it in diagnostic test
8 terms.

9 So here we had one of the sub-themes
10 was related to over-testing, the other to over-
11 diagnosis. And then we had three measure
12 concepts in the over-testing.

13 One was that whether there was a
14 policy in place at the organizational level or
15 standard operating procedures for some kind of
16 gatekeeper function for tests that are known to
17 be overused.

18 So if there were specific things where
19 it was just known that it was being done too
20 much, molecular diagnostics for cancer, or
21 whatever it was, that there was some mechanism
22 for tamping down on that.

1 The percentage of patients with
2 Symptom A, or Disease X, who are tested
3 inappropriately, and we gave you a couple of
4 examples there, that actually is -- there's an
5 extra bullet there that's not there. There are
6 only two concepts there. I think it's just --
7 that's a mess up on my part. I hit an accidental
8 character return there. Yes, there you go.

9 So, like Lyme disease serology ordered
10 in a patient with non-specific rash in a Lyme
11 endemic area, you can subtract stuff like that.

12 Now, on the over-diagnosis side, we
13 have these two bullets here as sort of measure
14 concepts, disease-specific. And these are
15 really, they're kind of the standard ones that
16 are kind of out there in the over-diagnosis
17 space.

18 One is essentially measuring whether
19 you're diagnosing this stuff a lot more
20 frequently than everybody else who's got a
21 similar patient base to you.

22 So the idea would be sort of case-mix

1 adjusted peer organizational comparisons, like a
2 health system might have a -- they might be
3 diagnosing prostate cancer, you know, at a
4 population prevalence of five percent. And
5 everybody else is doing it at one percent. And
6 then they'd be an outlier in the percentiles.
7 They'd be in the 90th, you know, or 99th
8 percentile for the prevalence of prostate cancer.

9 And as long as you had sort of roughly
10 comparable groups or case mix adjustment, which
11 everybody already does all the time in all these
12 institutions around payments, you could have a
13 similar kind of measure there.

14 And it could include sort of, you
15 know, the disease/illness spectrum of severity if
16 we were concerned that it wasn't just the total
17 but that it was a shift to everything being
18 diagnosed. And it was sort of early stage or not
19 really, you know, not really breast cancer or
20 whatever, that same kind of deal.

21 And then finally, the last one there,
22 looking at the relationship between incidents and

1 total morbidity and mortality, again, another
2 sort of over-diagnosis metric that, if you're
3 making a lot of excess diagnoses without benefit,
4 it shows up in the form of unchanged morbidity
5 and mortality but an increase in disease
6 incident. So again, relative to peer
7 organizations having some kind of percentile
8 rank, just to see if you are way far an outlier,
9 essentially.

10 All right, next group. So then we had
11 diagnostic error. We lumped this into a couple
12 of big themes for ways that one would think about
13 identifying possible or likely diagnostic error-
14 type scenarios.

15 One is around this unanticipated
16 change in level of care. You can see that there
17 are several measures that are all the sort of
18 same thing. But it's, you know, one set's from
19 primary care to the emergency department, one
20 set's from emergency department to ward, another
21 one says from ward to ICU.

22 They're all the same, in my view, and

1 I think the group's view, the same measurement
2 concept, which is that if you got bumped to the
3 level of care, and at the same time you had a
4 change in diagnosis that for the sort of same
5 symptom presentation or problem, that that was
6 potentially a sign that not only had there been a
7 diagnostic error, but potentially that there was
8 some harm associated with it, especially if there
9 was a care escalation.

10 So this would be the measure concept
11 percent of patients with discharge diagnosis X,
12 where X is benign, subsequently diagnosed with,
13 you know, Disease Y, where Y is dangerous for the
14 same index symptom sign or test result example.

15 You know, some of the stuff we've
16 done, for instance, with the discharge from the
17 Emergency Department within nine days in a
18 history of men with stroke. But you can do the
19 same thing with any other similar kind of
20 pairing.

21 And then the percentage of patients
22 harmed by the diagnostic delay is defined above,

1 just so you get a sense for sort of the magnitude
2 of the harms. And obviously, that would be
3 potentially a little bit harder to measure. And
4 you'd have to, you know, have people
5 systematically looking into that.

6 But we thought that at least trying to
7 get some sense of whether people were harmed or
8 not from these kinds of problems would be
9 significant.

10 And the group also wanted to make sure
11 that we covered the reverse, the sort of de-
12 escalation idea that, like, oops, you know, we
13 admitted the patient to the ICU as an MI, and
14 then they were de-escalated to a esophageal spasm
15 within 12 hours. And they went to the ward, and
16 then they went home that afternoon or the next
17 morning. Again, balancing both sides of the
18 coin, you know, we missed important stuff or we
19 over-called stuff that wasn't important.

20 The second bin here, so the second
21 measurement theme was this idea that an outcome
22 that happened to the patient, either a lost to

1 follow-up, or adverse events, or explained
2 deaths, might be a marker of misdiagnosis.

3 And here we tried to get the concept
4 of -- we had these two concepts of percentage of
5 patients with, you know, Symptom A, lost to
6 follow-up prior to a confirmed diagnosis.

7 So basically, if somebody's sort of,
8 you know, they go to their pediatric clinic,
9 they've got a headache. They get neuroimaging
10 ordered, because somebody's worried. They never
11 follow-up, or it never happens that they're sort
12 of lost to follow-up. You could have, you know,
13 sort of the fraction of those kinds of headache
14 neuroimaging ordered that never followed up or
15 disappeared.

16 That would be potentially a sign that
17 there were -- that, at the very least, you
18 weren't closing the loop, and at the worst that
19 patients were suffering some adverse
20 consequences.

21 And the same for the second one, same
22 basic idea, Symptom A, suffering major health

1 event or death prior to a confirmed diagnosis.
2 And then in particular, obviously, if you have
3 patients who, you know, have then a known cause
4 of death or the adverse event that you can link
5 back to that, we never closed the loop or
6 finished the diagnostic process.

7 Next one, so the last tab that we were
8 asked to deal with was information
9 interpretation. I think some of this actually
10 harkens back to one of the other discussions
11 about information integration, this issue of sort
12 of reconciliation of conflicting results. There
13 may be someplace to harmonize there.

14 But the general theme here was there
15 ought to be some way that one is sort of
16 monitoring and managing when Report A says you
17 have cancer, and Report B says you don't have
18 cancer, or whatever, you know, whatever diseases
19 are things those are.

20 And we wanted both kind of a policy
21 and a procedure in place for identifying and
22 reconciling those discordant interpretations or

1 findings. You know, like, the radiology
2 diagnosis of brain tumor, and a pathology
3 diagnosis of the biopsy of the lesion as a
4 demyelinating lesion, that there's some way of
5 actually tracking that, and sort of feeding back
6 into the system, and reconciling them, and
7 learning from them.

8 And then the other two measure
9 concepts there were the sort of fraction of
10 discordant diagnoses that might be resolved
11 through those type of SOPs and a percentage of
12 patients where there was a discordant result of
13 some kind associated with -- where it didn't
14 match their clinical outcome. So, like, percent
15 of patients with clinical normal colonoscopy
16 diagnosed with colon cancer in a short timeframe,
17 or something like that.

18 The second theme in the information
19 interpretation section was use of decision
20 support. So we suggested two concepts. One is
21 availability of sort of an EHR-integrated,
22 evidence-based decision support pathways for

1 diagnosis of common symptoms.

2 The second was the percentage of
3 encounters in which decision aids, those or
4 otherwise, are used. And we suggested three
5 potential ways that that could monitored or
6 measured, either with click tracking on the EHR
7 or using administrative data.

8 Seeing whether, you know, if
9 somebody's scheduled to be on Pathway X for chest
10 pain that they're always supposed to get an EKG,
11 or troponin, or whatever, looking at the
12 percentage of cases where that actually happened,
13 or surveying people and seeing whether they're
14 following the pathways.

15 And then finally, the EHR supports
16 high quality diagnosis. And really here the
17 demand was that we go above and beyond the simple
18 idea of kind of meets the minimum standard.
19 Like, there was some goal that it actually worked
20 rather than it met specs.

21 And I think you'd ultimately need to
22 measure things like that by surveying providers

1 who use the EHR and things like that. I think
2 you could do it that way. And say, look, does
3 this actually work? You know, do you actually
4 feel like -- And, you know, you think about
5 historically that's been done in some places,
6 like, the people at the Brigham who really had
7 their electronic health record up, you know,
8 pretty much first and had a really nice one.

9 Were unbelievably upset, you know, and
10 had to go to Epic. And, you know, they felt the
11 loss. So there is clearly the ability for people
12 to discern between, you know, not so good and
13 good in terms of this.

14 So those were our main things. We did
15 have a couple of things at the bottom that we
16 thought -- that sort of came up in our
17 discussion, that seemed like they fit in some of
18 the other buckets, that we needed something in
19 there about systematic second review of
20 diagnoses, whether it's radiology, pathology, ten
21 percent, second reads, or whatever. But also the
22 clinic records, the same kind of thing, making

1 sure that we have the same kind of comparison to
2 a reference standard, not just inter-rater
3 reliability but to some gold standard or
4 whatever, and then making sure that people are
5 available, consultants or diagnostics, you know,
6 radiologists, pathologists, to interpret the
7 results. I think that would show up in some of
8 the other groups.

9 (Off microphone comments.)

10 CO-CHAIR MCDONALD: Microphone.

11 MEMBER NEWMAN-TOKAR: For which one?
12 Tell Vanessa which one to switch.

13 MEMBER MAHAJA: The first one, go to
14 the top one. And the ones that we use, the IOM
15 definition for including diagnosis. So we use
16 explanation of the patient's problem and then do
17 so that they stayed consistent with that.

18 CO-CHAIR GARBER: And, David, you had
19 something on specificity here. But it seems that
20 you dropped the sensitivity measure in regard to
21 screening. Did your group not want to include
22 recommendations on screening tests for cancers,

1 for example?

2 MEMBER NEWMAN-TOKAR: Which tab was
3 that in?

4 CO-CHAIR GARBER: Efficiency.

5 MEMBER NEWMAN-TOKAR: So the question
6 is, yes, I don't think we were entirely -- it
7 wasn't one of the ones that made the adequacy of
8 screening procedures. It wasn't one of the ones
9 that made the group top list. It was actually
10 one of the lower ones. So I don't know if it's
11 an efficiency issue. It's more, to me, I guess
12 it's closer to --

13 CO-CHAIR GARBER: Yes, I'm not sure
14 where it goes, because I don't think it's
15 mentioned in any of the other tabs.

16 MEMBER NEWMAN-TOKAR: If it's not
17 mentioned in any of the other tabs --

18 CO-CHAIR GARBER: So if cancer is the
19 number one condition that's misdiagnosed,
20 shouldn't we have something about trying to
21 address that through appropriate screening?

22 MEMBER NEWMAN-TOKAR: I do think that

1 the adequacy of screening for whatever diseases
2 are relevant to the screening issue -- I mean,
3 there are a lot of screening topics, right,
4 there's cancer, there's, you know, neonatal
5 hearing loss screening, there's screening for
6 diabetes, and so on, and so forth. But there are
7 -- yes, I think that the adequacy of screening is
8 something that's worth doing. I just don't know
9 where it fits.

10 CO-CHAIR GARBER: Please use the
11 microphones.

12 MEMBER DUNNE: We kind of address that
13 in population-specific testing that takes into
14 account prevalence, disease prevalence, and so
15 forth. So buried within there, I think, are the
16 specifics that are necessary for any kind of
17 screening test. It's just not specifically
18 addressed.

19 (Off microphone comments.)

20 MEMBER DUNNE: Well, right under over-
21 diagnosis. I mean, we discussed this in terms
22 of, for example, testing for Lyme, using

1 screening testing or testing that's appropriate
2 for populations, looking at diagnosis or
3 particular diseases within your particular
4 population relative to others.

5 CO-CHAIR MCDONALD: So are you saying
6 that maybe the label shouldn't be over-diagnosis,
7 but it should be under and over-diagnosis?
8 Because those kinds of --

9 MEMBER DUNNE: Sure, yes.

10 CO-CHAIR MCDONALD: -- assessments
11 could see either side of it.

12 MEMBER DUNNE: And there was another
13 part too. Let's see. Go down a little bit.

14 MEMBER NEWMAN-TOKAR: So I think it
15 needs to be there. Like, I mean, I don't know
16 whether it needs to be on this tab or on a
17 different tab. But I do think it needs to be
18 there. There needs to be some issue of, you
19 know, how well we're adhering to guidelines for
20 screening for cancer and other diseases that are
21 --

22 CO-CHAIR GARBER: Or we could present

1 the counter argument.

2 MEMBER SINGH: I strongly recommend
3 that we do not put screening related stuff in
4 this diagnosis related report. It is a different
5 animal, if you will. It is a different concept.

6 We can't even get diagnosis right when
7 we have obvious signs, and symptoms, and tests of
8 patients who are being misdiagnosed at an
9 alarmingly high rate. Why would we go for
10 asymptomatic populations where the evidence is
11 much weaker about what we're going to do right
12 and what we're going to do wrong?

13 I mean, look at the controversies
14 around any cancer about screening. There's just
15 very few cancers where the evidence is very
16 strong and the harms from screening are pretty,
17 you know, it's coming out --- And I would
18 encourage you to just look at the recent
19 literature. Some of it has been forwarded to
20 Mark for his consideration. But I don't think
21 the evidence is strong that we should be
22 including in our group. That's what my

1 suggestion would be.

2 CO-CHAIR GARBER: David?

3 MEMBER SEIDENWURM: So I think that
4 there's about a billion metrics out there for
5 uptake of screening. So I don't think that we
6 need to go there.

7 I think that that there're -- and I am
8 sympathetic to the argument that's just been made
9 regarding the harms of screening, but there is
10 one area that I do think that we should address
11 with respect to screening, or two areas,
12 actually.

13 One is inadvertent screening which is
14 the phenomenon of incidentaloma. You know, for
15 example, if you do a MRI targeted to the lumbar
16 spine, and you see a lump on the adrenal glands,
17 that's essentially screening for adrenal
18 carcinoma, which no one would advocate as a
19 stand-alone procedure, yet we do it
20 inadvertently.

21 So I do believe that we should
22 address, you know, incidentaloma/inadvertent

1 screening. And we should clearly define that as
2 a concept, you know, in this report.

3 The second thing that I would like to
4 address is, and I do believe that this is one
5 area of screening that should be part of this
6 report, and that is when a screening test is,
7 we'll say, mandated even, right, because, for
8 example, mammography is an ACO metric, you know,
9 a mammography uptake is an ACO metric, we should
10 also have corresponding metrics for the quality
11 of that service.

12 If colon cancer screening is, I think
13 that's also an ACO metric, then we should have
14 corresponding quality metrics for all of the
15 various modalities that are employed for that
16 purpose, you know, both the optical colonoscopy
17 procedures, the CT, the various fecal tests, and
18 so forth. So I think that -- and I think also
19 with respect to the follow-up pathways for
20 cervical cancer screening.

21 And I do believe that that should part
22 of our agreement here. So inadvertent screening

1 and then the adequacy of the screening procedures
2 themselves but not, as Hardeep said, you know,
3 whether someone should be screened for a
4 particular diagnosis. So that's well covered.

5 MEMBER SINGH: Yes. And I want to
6 qualify it. Abnormal screens needing follow-up
7 is a totally different ball game, because it
8 comes under diagnosis. Because then there is
9 signal to go forward to do something. The person
10 is not asymptomatic anymore which is sort of the
11 whole argument about doing this. My other sort
12 of --

13 MEMBER SEIDENWURM: Yes, I totally
14 agree.

15 MEMBER SINGH: Yes. My other sort of
16 comment was has a lot of the language been
17 changed in some of the concepts? Because this is
18 -- a lot of this is new language. And it's -- I
19 don't know, I mean, I was just sort of -- it was
20 hard for me to keep at it and sort of try to
21 understand where things were falling, having done
22 the, you know, the things.

1 So I'm not sure what we lost and what
2 we gained. A couple of the things I was going to
3 mention, so the EHR one, for instance, and then
4 there was something about over-testing and over-
5 diagnosis. I mean, there's over-diagnosis stuff
6 right here. I don't know how you would measure
7 that, to tell you the truth.

8 But something you could, you know, do,
9 something which is more measurable, I mean, there
10 is decision support engines to cut down
11 unnecessary testing, for instance, or lab tests
12 was mentioned. So we over-use, you know, and we
13 do want to see lab testing.

14 Well, there is now additional support
15 that works to prevent that. So can we combine
16 things like over-diagnosis or over-testing in one
17 area and, you know, we know we want better EHRs
18 and sort of combine the clinical decision support
19 and make that more of a measurement concept.
20 Because some of this still appears a little
21 loosey-goosey to me.

22 MEMBER HUNT: I keep going back and

1 forth and ping ponging as far as the screening.
2 But I'm persuaded by what Hardeep says. If we
3 think about diagnostic accuracy as the timely
4 explanation of the patient's health problems,
5 then that obviously precludes screening, because
6 they didn't have a -- this speaks diagnostic
7 tests for something, for a problem rather than
8 screening.

9 MEMBER SHERIDAN: Yes. Just looking
10 at this through a patient perspective, first of
11 all, I don't know how to define over-testing.
12 And then as I was reading this and hearing you,
13 David, I was thinking about -- I reached over to
14 Kathy, and I said what about under-testing. And
15 under-testing of things that are, you know, the
16 standard of care now or embedded in guidelines
17 that still aren't getting done.

18 And I'm thinking of the jaundice, you
19 know, testing and screening where there is, you
20 know, the whole population, children in the 90's
21 that emerge with kernicterus because of the acts
22 of omissions of necessary tests. So I was

1 wondering where that fit in here.

2 MEMBER NEWMAN-TOKAR: Yes. I think
3 that's a good question. So if we just scroll up
4 a little bit to the timeliness, so you can break
5 down the issue of appropriateness of diagnosis in
6 any number of ways.

7 What we were actually trying to do was
8 keep it simple in the sense that the thing that
9 people ultimately care most about is whether they
10 got a timely, accurate diagnosis, right.

11 So what we're saying here is that if
12 you didn't get a timely or accurate diagnosis, we
13 don't necessarily care whether it was because the
14 tests were underused, or what percentage of them
15 were underused, or whatever, right. Like, we're
16 just saying the outcome is what matters. The
17 outcome is whether you got a timely diagnosis.

18 We weren't asking to measure all of
19 the steps along the way. You could, and we
20 mention it there, like, the timeliness of the
21 first key test. Like, did you get to that, you
22 know, first, I guess, in a symptomatic patient

1 with a potential, you know, with a headache and a
2 potential brain aneurysm. Did you get to that CT
3 scan within such and so many hours, or whatever,
4 or not do it at all, right?

5 But we have the notion of correct
6 diagnosis and under-diagnosis, if you will, to
7 sort of use a loose term that it counters the
8 over-diagnosis term. It's all in this idea of
9 whether you've had a timely diagnosis of your
10 disease. It's not, as opposed to breaking it out
11 and saying did you get this test, did you not get
12 this test?

13 Now, you could do all those things
14 too. There's no reason why they can't be
15 measurement concepts. And I'm not averse to
16 including them. But it wasn't that we didn't
17 consider under-diagnosis. We just wrapped it up
18 as you need -- what percentage of the time are
19 you getting a timely, accurate diagnosis? That
20 was the roll-up of getting the right diagnosis.

21 And the other piece was just to make
22 sure that in the process of encouraging people to

1 get timely, accurate diagnoses, we didn't just
2 willy-nilly encourage them to, in a profligate
3 way, over use tests and end up with, you know,
4 bad results as a result of over-testing.

5 That was the logic. It may not
6 resonate, it may feel like we need something that
7 feels a little more analogous to the over-
8 testing. But this is where it is.

9 MEMBER SHERIDAN: This, in the body of
10 this information here, is there -- and again,
11 from a really simplistic patient point of view,
12 you know, patients, we tend to believe that
13 guidelines are followed and that that's going to
14 keep us, you know, evidence-based guidelines, and
15 that's going to keep us safe and from harm. And
16 we know that a lot of guidelines are not
17 followed.

18 And is there any such measure of the
19 percentage of clinical guidelines that are
20 followed for certain things that are, you know,
21 misdiagnosed? I mean, something as simple as
22 that.

1 You know, hospitals do, in their
2 bylaws, I mean, say they, you know, follow the
3 American Academy of Pediatrics guidelines. But
4 do they really? Is there a percentage of that,
5 any measurement that would be something that the
6 lay audience would understand?

7 MEMBER NEWMAN-TOKAR: You mean is
8 there a measure on this page of that? Yes. So
9 if we scroll down, I don't know if it's something
10 the lay audience would understand or not
11 understand, but we have here, excuse me, where's
12 the -- if we go all the way down to the bottom
13 one, the interpretation, I think, one, so what I
14 guess we don't have adherence to guidelines
15 specifically in there. We have --

16 (Off microphone comments.)

17 MEMBER NEWMAN-TOKAR: Well, we have,
18 you know, we have the availability of pathways,
19 we have the percentage of encounters where some
20 kind of decision support was used. But we don't
21 have the percent adherence to guidelines in
22 diagnosis. And I think we could -- that's easy

1 enough to add. I think we should.

2 CO-CHAIR GARBER: David, there were a
3 couple other things that seemed important that
4 were missing.

5 MEMBER NEWMAN-TOKAR: It's very
6 similar to the timeliness idea. But it's
7 different. It's a process measure rather than an
8 outcome measure. Yes?

9 CO-CHAIR GARBER: A couple other
10 things that seem to be missing, one was in the
11 diagnostic error bucket were measures relating to
12 asking patients and physicians about reporting
13 diagnostic errors. I didn't see anything on
14 that.

15 And under information interpretation,
16 there seemed to be a lot of value in the kind of
17 trigger tools that are being used by Michael
18 Cantor. I didn't see a measure concept being
19 advanced in regard to that.

20 MEMBER NEWMAN-TOKAR: So there's no
21 measure concept that specifically has the word
22 trigger tool in it. But that's what all of these

1 things are.

2 MEMBER SINGH: Well, I thought there
3 was a trigger one. Where did it go? It was down
4 here?

5 MEMBER NEWMAN-TOKAR: No, no, no.
6 There is one on the list, but there wasn't one
7 that rose to the level of making it to the
8 document.

9 CO-CHAIR GARBER: Well, you're not
10 opposed to that concept?

11 MEMBER NEWMAN-TOKAR: No, I'm not
12 opposed to concept of trigger tools. These are
13 all trigger-based ideas.

14 MEMBER SINGH: You know, I was just
15 going to emphasize, I think, Sue, what you're
16 referring to is, well, we would imagine that
17 there would be guidelines to make sure that we
18 diagnose patients with colorectal cancer with
19 some timeliness, such as 60 days, or 90 days, or
20 even 180 days.

21 But oftentimes for diagnosis issues,
22 there's no clear cut guideline as to what to do

1 next. Because it's all a lot of gray, a lot of
2 gray zones.

3 So there are a lot of screening
4 related guidelines. But if you look at the
5 guidelines for diagnostic issues, algorithms,
6 protocols, pathways, they are probably just less
7 in number. And they're more, you know, because
8 every patient is different.

9 So the one patient with abdominal
10 pain, you're going to go this way, but the next
11 patient with abdominal pain, you might go a
12 totally different way. So it all sort of
13 depends.

14 People are coming up with more. I
15 know there's somebody working on, like, an
16 abdominal pain guideline in the ER. But it's not
17 easy, and they're not a whole lot of them
18 available, sort of my take is.

19 CO-CHAIR GARBNER: We need to move on
20 to Group 3. I'm sorry. Yes, we could talk about
21 this one for a lot longer. We're suggesting that
22 we do Group 3, and then take a break. All right

1 with people? Okay. Group 3?

2 (Off microphone comments.)

3 MEMBER SINGH: Our approach was fairly
4 similar to what Mark was describing. So we
5 looked at all the measures, you know, even the
6 ones that had zeros in it. And then we
7 integrated and consolidated concepts.

8 Basically, we were trying to look for
9 areas of overlap, and synergy, and we changed a
10 few things. So I'm just going to quickly go
11 through and you can read the rest.

12 Also the first one was key activities,
13 the diagnosis of the key activities that an
14 organization could do. So we changed the
15 language, and we combined.

16 So if you'll look, each of these sub-
17 bullets was a different measure. And we ended up
18 combining it to one, or whatever, measure
19 concept. And we made one out of these five or
20 six. So we thought we were being efficient.

21 So that then becomes examples of the
22 types of things that the organization can do to

1 measure diagnostic performance. So they need to
2 have an EHR data analytic infrastructure to
3 measure diagnostic performance. So we thought we
4 got all -- we gained a lot of ground without
5 losing anything, keeping all the concepts
6 together and then merging it into a high level
7 measurement concept.

8 The second measure concept here is,
9 organization has established mechanics of
10 providing feedback. Each of the feedback ones
11 got three or four each. But when you combine
12 them, that's what it became. And it became,
13 like, seven out of -- you know, so it was pretty
14 high. And so we combined that. So that's the
15 second one that, again, was prioritized a lot.

16 Next one. So then we had a big
17 discussion about, well, you can have all of these
18 infrastructures in place, but unless you're
19 learning from all of this measurement we're not
20 going to gain any ground.

21 So we thought that the learning part
22 itself deserved a separate measurement concept

1 away from sort of the, you know, the measurement
2 part earlier and the infrastructure around it.

3 So this is the one around learning.
4 And then we put language about RCAs, autopsies,
5 someone brought up, very rightly, number of
6 autopsies performed per number of deaths. It's a
7 great measure, but unless you learn from it,
8 there is no value to it at all. And so a similar
9 concept applies to M&M conferences.

10 Next one. So we had one that gained,
11 I think, three or four words. I can't remember.
12 But it was important enough for us to consider
13 for a later time. And I think somebody else is
14 doing patient access, correct, mixing it?

15 And so this was important. And
16 actually, it has already come up in the previous
17 discussion. On the recent study for Open Notes,
18 20 percent of patients actually discovered errors
19 in their own documentation and reported it to the
20 organization.

21 So building on that concept, I thought
22 that was an important concept. We all thought

1 that it should be kept. It just wasn't in our
2 area. And we wanted to hand it off to somebody.
3 So whoever is doing patient stuff, should take
4 note for this one.

5 CO-CHAIR MCDONALD: So, Hardeep,
6 actually, before you go on, maybe we should do
7 one tab at a time. I was noticing last time when
8 we did three tabs and then we had to get
9 comments, it was hard.

10 MEMBER SINGH: Oh, sure, sure. I can
11 stop.

12 CO-CHAIR MCDONALD: So maybe, like,
13 stop --

14 MEMBER SINGH: Yes, yes.

15 CO-CHAIR MCDONALD: -- stop here, get
16 a few comments, and then do the next tab.

17 MEMBER NEWMAN-TOKAR: Is leadership
18 engagement anywhere there?

19 (Off microphone comments.)

20 MEMBER SINGH: So we had the thought
21 of involving, I think it was actually in a
22 separate one. There was a separate leadership

1 measure that probably got disconnected. But I
2 thought we actually put it back.

3 MEMBER RADFORD: Oh, this was part of
4 it. I mean, having the Board get these measures,
5 et cetera. We thought all of that was important.
6 But it was sort of wrapped into organization-wide
7 measurement.

8 MEMBER NEWMAN-TOKAR: Yes. I think
9 just adding, making sure that leadership is
10 bought it where -- because almost all of the kind
11 of culture, behavior change stuff, ultimately if
12 you don't get leadership buy-in, it doesn't work.

13 CO-CHAIR MCDONALD: David Hunt?

14 MEMBER HUNT: Typically I'm going to
15 say the same thing, that this really rolls up to
16 the question of does your organization support a
17 culture of diagnostic performance quality.

18 CO-CHAIR MCDONALD: Culture and
19 leadership. Mike? Are you -- no, okay. David?

20 MEMBER SINGH: So I don't know if
21 anybody's taking notes, but I would just say, you
22 know, make sure that we address leadership and

1 culture amongst one of those bullets in there --

2 MEMBER SEIDENWURM: There were several
3 things in there in the list of proposed concepts
4 about imaging autopsy. I'm not sure that we want
5 to go too heavy on that. I think that
6 literature, I think those ideas were ahead of the
7 literature.

8 MEMBER SINGH: Yes, we left them out.
9 They didn't even come to high enough.

10 (Off microphone comments.)

11 MEMBER SINGH: Just number of
12 autopsies in general.

13 MEMBER SEIDENWURM: Sure.

14 MEMBER SINGH: Yes. Just to make sure
15 that people are still doing them.

16 CO-CHAIR MCDONALD: And then what
17 about -- so on the RCAs, I know there was one in
18 here that said RCAs, like, with patients
19 involved. And there's the organization, like,
20 learning and getting feedback.

21 I don't think it's patient engagement.
22 Like, the patient engagement tab to me, or that

1 thing is more about patients and their own
2 individual care. This QI activity would be more
3 about what the organization's doing. So a
4 handshake with having patients involved in
5 something here seems like it's a missing piece.

6 MEMBER SINGH: Yes, you could just say
7 something like the organization expert needs to
8 conduct a comprehensive RCA in cases involving
9 diagnostic errors. And these RCAs involve
10 patients when appropriate.

11 MEMBER SHERIDAN: Hardeep, on that
12 bottom bullet: The organization has an
13 established mechanism providing feedback when
14 there's a significant change in diagnosis.
15 Feedback to whom?

16 MEMBER SINGH: Well, you know, I think
17 the spirit was supposed to be care teams.

18 MEMBER SHERIDAN: Yes.

19 MEMBER SINGH: Providers and care
20 teams. There was a separate one for disclosure
21 to patients that we didn't really go into. It
22 didn't even get enough of a priority. Because

1 people already have disclosure programs. And we
2 didn't think -- and it was post-error, and we
3 didn't want to sort of mess with that.

4 MEMBER SHERIDAN: So it's post-error.
5 Okay.

6 MEMBER SINGH: Yes. This is mostly
7 for care teams and providers. That's what we
8 understood. And that's why --

9 MEMBER SHERIDAN: So it's not like
10 it's during active care, like, when there's a
11 change in diagnosis or a change in a pathology,
12 that there is a mechanism to change the -- to
13 inform the care team and the patient?

14 MEMBER SINGH: Yes, yes. Yes, that
15 would be included. Yes. That should be
16 included. If there's a change anywhere, I think
17 -- we didn't think this would specify a real time
18 or, you know, post-one-year feedback. It was
19 just anytime, anytime there's an opportunity for
20 feedback and learning. That's probably what the
21 intent was.

22 MEMBER SHERIDAN: Okay.

1 MEMBER SINGH: I mean, we didn't
2 discuss exactly what you're getting to.

3 MEMBER SHERIDAN: Yes.

4 MEMBER SINGH: I think I know what
5 you're getting to, yes. But it's included
6 though. It's sort of encompassed in this.

7 Okay, so two stood out from the
8 external environment very strongly. We changed
9 the language for the second one. The first one
10 you might be familiar with. I don't think we
11 changed the language for the first one. But in
12 the second one, we changed -- we combined the two
13 that stood out.

14 And we basically said payment
15 incentives should be aligned to promote timely
16 and correct diagnosis. And that basically was
17 trying to get to the external environment piece
18 of it. There was a measure concept already in
19 there. And we just changed the language a little
20 bit.

21 In access, we changed some language.
22 This wait time was already there, stratified by

1 specialists. It stood out quite, I think it was
2 actually the number one.

3 The second two is what we talked about
4 a lot in our discussions. We changed this a
5 bunch. Availability of rapid or point of care
6 testing for critical diagnostic decision making.
7 It was in a way that was not phrased correctly.
8 And we had people in our team -- and feel free to
9 jump in, everybody from our group, to give your
10 input as well.

11 And then there was one about having
12 advanced imaging and lab available. And we
13 changed to access to appropriate testing for the
14 most common conditions. And in fact, some of you
15 who may have been on the call in March, this was
16 discussed on the call quite a bit as well.

17 The measure concept, at that time,
18 said there should be access to advanced imaging
19 and lab. And we didn't know that meant. So we
20 changed it to access to appropriate testing for
21 the most common conditions that you see that are
22 most relevant to you.

1 MEMBER MAHAJA: I just think, you
2 know, just from the ER perspective, I keep on
3 looking at it, patient-reported communication
4 isn't getting calls back. Like, from the patient
5 perspective, would that make any --

6 MEMBER SINGH: Was that there? Did it
7 reach up to --

8 MEMBER MAHAJA: Patient access, right
9 under patient access. Like, from the patient's
10 perspective, the ease of --

11 MEMBER SINGH: Yes. I think it didn't
12 raise up to the --

13 MEMBER MAHAJA: It didn't --

14 MEMBER SINGH: Can you read it,
15 because I think it probably didn't raise up to
16 the --

17 MEMBER MAHAJA: So I think it's Number
18 7: patient-reported communication ease in getting
19 called back by medical team when reporting
20 concern.

21 MEMBER SINGH: Yes. Actually, I think
22 this was an important one that -- I actually

1 ranked it. But it didn't reach up. But if you
2 think it's --

3 CO-CHAIR MCDONALD: I had that ranked
4 too and --

5 MEMBER SINGH: -- one to include,
6 lets' just add it.

7 (Simultaneous speaking.)

8 CO-CHAIR MCDONALD: Yes, you can add
9 in.

10 MEMBER SINGH: Let's just add it.

11 CO-CHAIR MCDONALD: Yes.

12 MEMBER SINGH: It's the number --

13 MEMBER MAHAJA: Number 7.

14 MEMBER SINGH: Number 7. We should
15 include it. Anybody from our group feel
16 differently?

17 (No audible response.)

18 MEMBER SINGH: I think it just didn't
19 get enough. Because, you know, it got one,
20 because I know I gave it a one.

21 CO-CHAIR MCDONALD: And I know I had
22 marked it, but I didn't get mine all the way

1 through. I didn't get --

2 CO-CHAIR GARBER: Could we all --

3 CO-CHAIR MCDONALD: I knew you had
4 one. You have more votes for it.

5 MEMBER SINGH: Oh, we had more votes
6 than we think? Oh, okay, that makes sense.

7 (Off microphone comments.)

8 CO-CHAIR GARBER: Could we also talk
9 about Number 10, that patients have a long enough
10 appointment if you're a new patient? A lot of
11 doctors say that's the number one problem. They
12 just don't have enough time.

13 MEMBER SINGH: Long enough for the new
14 patients?

15 Yes. We were asked to, you know, keep
16 it to three. I mean, we're going to make it to
17 five. Is that okay with the NQF team?

18 CO-CHAIR MCDONALD: Five's okay, I
19 think, from our vote and this conversation, yes,
20 that --

21 (Simultaneous speaking.)

22 MEMBER SINGH: No, I think I marked

1 that one too, actually. It was a good one.

2 CO-CHAIR MCDONALD: Yes. Let's add
3 those two. I mean, the comment was that each of
4 these tabs, you know, just because there's only a
5 few doesn't mean they're not -- they should --

6 MEMBER SINGH: Yes.

7 CO-CHAIR MCDONALD: Yes.

8 MEMBER SINGH: Okay?

9 MEMBER SHERIDAN: Can I just ask a
10 question about the payment model slide? Can we
11 go back to that, payment? So, payment incentives
12 should be aligned to promote timely and correct
13 diagnosis. Physician payment form must recognize
14 the importance of frontline diagnosis --

15 MEMBER SINGH: It's quite high level.

16 CO-CHAIR MCDONALD: Yes. It's very
17 high level. But I'm wondering if we should add a
18 word, like something that -- a collaborative or
19 something. Because, you know, it's something
20 that -- I've been engaged in this dialogue about
21 ensuring that pathologists and ordering
22 physicians get reimbursed for the time talking to

1 each other. And right now, that's not in payment
2 bundles.

3 So I don't know if it gets embedded in
4 that, some type of payments that should be
5 aligned to promote collaborative, timely, and
6 correct diagnosis, or something to -- it's not
7 really a second opinion when you --

8 MEMBER SINGH: So team-based? You
9 know what I'm saying?

10 CO-CHAIR MCDONALD: Yes, team-team.

11 MEMBER SINGH: Team-based, timely, and
12 correct diagnosis?

13 CO-CHAIR MCDONALD: Yes.

14 MEMBER SINGH: Yes. I think we have
15 another one that talks about teams. I don't know
16 whether --

17 CO-CHAIR MCDONALD: In the payment --
18 yes.

19 MEMBER SINGH: Okay, yes. That's
20 good.

21 CO-CHAIR MCDONALD: Yes. And that's
22 part of the IOM report, if that was, like, you

1 know, the --

2 MEMBER SINGH: Okay.

3 MEMBER NEWMAN-TOKAR: So could I just
4 ask on this slide, these are obviously important
5 topics, a little like mom and apple pie, but what
6 did you envision as the actual measures for
7 something like, payment incentives should be
8 aligned to promote timely and correct diagnosis?

9 MEMBER SINGH: So I think it's also
10 sort of reflected on maybe another -- the
11 workforce one. You know, right now we're
12 rewarding quantity and not quality. So we didn't
13 actually come with a specific measurement or
14 measure area.

15 This was one of the ones that's
16 bordering on something that needs to be done, but
17 exactly what we're not sure. And so when we
18 started having a little bit of discussion, Andrew
19 said keep that discussion for the sort of the
20 next stage rather than, you know, hashing it out
21 right now.

22 MEMBER NEWMAN-TOKAR: I do think this

1 is one where you could potentially get -- you
2 could survey providers. I mean, providers might
3 be able to answer these two questions, and it
4 might be a valid way of approaching the issue of
5 whether they feel, in a generic sense, they're
6 being supported both legally and payment-wise.

7 Could I just see the one more slide
8 forward. Oh, that's what it was. It was just
9 brought up, this issue of the length of the
10 appointment. And that's one I would just make
11 sure we're careful about.

12 I think everybody agrees that it's
13 impossible to provide high quality diagnostic
14 care unless you have a sufficient amount of time
15 to spend with the patient. And it's certainly an
16 important complaint.

17 There's a lot that's been written
18 about visit lengths. And over the last three
19 decades, the visit lengths have actually
20 increased by about one minute on average in
21 primary care clinics. But the face time has
22 dropped by 50 percent or whatever it is.

1 So we have to make sure that, when we
2 go there, that we've gone there in a way that's
3 sensible. If people are, you know, if the way
4 people are doing better diagnosis is by changing
5 the care delivery model, and then happens to
6 shorten the apparent visit length but it
7 increases the face time, or whatever, we have to
8 be careful about not incentivizing against
9 creative care approaches that actually improve
10 diagnosis and maybe even improve the time with
11 patients but don't look that way when you do the
12 math.

13 That's a very dangerous measure, in my
14 mind. It's not that it's not important. It is.
15 But I think we have to be really careful when we
16 go there.

17 MEMBER SINGH: So I think we have --
18 if you look at the next one, people are going to
19 get a little --

20 CO-CHAIR MCDONALD: Actually, so wait,
21 though, before you go there. Because we've got
22 Lavinia, and Tom, and Martha. And then we'll

1 just have you go on. So, Lavinia?

2 MEMBER MIDDLETON: Just on the next
3 slide, I think the word we were looking for
4 perhaps is integrated diagnosis. Because that's
5 initially what the IOM report states and, I
6 think, is best care integrating the pathology,
7 the radiology, any other complex molecular tests
8 that are there, or clinical symptoms brought in
9 from the patient.

10 So integrating all of the available
11 information in order to create the diagnosis and
12 having time to do that, either with the patient
13 or outside the patient room is, I think, where
14 we're trying to go.

15 CO-CHAIR MCDONALD: Tom?

16 MEMBER SEQUIST: So I just wanted to,
17 I guess, second what you were saying about the
18 visit times. We used to measure that, sort of
19 using EHR data. And it's really fascinating
20 data, but at the end of the day, we weren't
21 really sure what to do with it after a while.

22 I mean, we'd see things, I would see

1 patterns, like, not to pick on specialties, but
2 you would see, like, dermatology office visit
3 lengths. And you would look at it, and I would
4 say that can't be safe for some people who were
5 outliers. But I don't know to -- I didn't know
6 that. I just sort of was, like, about --

7 PARTICIPANT: They were 30 seconds.

8 MEMBER SEQUIST: Yes. When you're
9 less than 10 seconds, it couldn't have been a
10 good full exam. But it never felt right, it
11 never worked as a way to assess whether the
12 diagnostic quality was good. So we sort of
13 abandoned it for -- and I just wanted to sort of
14 second. I agree that I don't know about that
15 particular one.

16 CO-CHAIR MCDONALD: Martha?

17 MEMBER RADFORD: Yes, just a couple of
18 things. First, on that last comment, we were
19 most concerned about, you know, two mills.

20 (Off microphone comments.)

21 MEMBER RADFORD: Mills. You know, and
22 trying to figure out the outlier physicians who

1 were seeing, you like, 100 patients a day or
2 something that you can't possibly make the right
3 diagnoses in that period of time.

4 And we also acknowledged that this is
5 specialty-specific, so things like dermatology
6 might have a different profile. So I think that
7 that's the concept we were trying to attack
8 first.

9 I just want to also say something
10 about somebody said, well, how would you measure,
11 you know, the payment for making -- the teamwork
12 payment for making a diagnosis. And I'd say you
13 make it a measure of the health plan. Does the
14 health plan reimburse for it? And that's, you
15 know, fairly simple. You just look at their
16 reimbursement rules and figure it out. So that's
17 how I would address that.

18 CO-CHAIR MCDONALD: Okay, now there's
19 a few more cards. But, Hardeep, why don't you go
20 on and do the rest of your assignment so --

21 MEMBER SINGH: Yes, because a lot of
22 what you're talking about is actually addressed

1 in the workforce slide, which some of you might
2 like, some of you may not like. So let's -- have
3 we finished patient access? We have, right?
4 Okay.

5 So workforce one, we spent a lot of
6 time on this one, especially on the ones that are
7 red. So the first one was we were trying to make
8 this more actionable, this, providers operate at
9 the top of their license.

10 It did get a lot of votes, by the way,
11 you know, sort of at the top, to free up
12 cognitive liability. We thought it was
13 important. This is where the team stuff that you
14 all were talking about, is where what we
15 discussed. You know, how do you make sure that
16 the teamwork principles, and there's, whatever,
17 eight or nine them, are integrated.

18 And so this is where I think we're
19 going to have to think more about this. And we,
20 obviously, in the short time we had, we didn't do
21 that. But I think this is really, really
22 important. How do leverage teams? How do you

1 leverage a nurse? How do you leverage the other
2 specialties, other patients? So this is one of
3 the ones that needs some development.

4 The second one is, I think we're
5 getting close to what you were talking about. Do
6 we have adequate time to gather, integrate,
7 interpret all the data that we need? And you
8 could say providers are care teams, for that
9 matter.

10 And this is where the face to face
11 time and the non-face to face time came up as
12 well. We spend a lot of time taking care of
13 patients through the EHR, you know. So it's just
14 not the visit length. I agree with Tom, I'm not
15 sure if it's just the visit length.

16 But then there's one that we -- I want
17 to just highlight, because it's related. If you
18 look at the bottom one, we did think it's not
19 safe. If you're an internist, and if you're
20 seeing more than 50 patients a day, there's
21 something wrong.

22 MEMBER SEQUIST: That's back to that

1 one that I was talking about. It definitely
2 feels wrong.

3 MEMBER SINGH: And so we didn't know
4 what we would do, but we wanted to put it out
5 there. Because we discussed this a lot. And
6 that's why we said, okay, you know, it could be
7 specialty-specific.

8 And what we wanted to do was to change
9 the thinking that we don't want to award
10 quantity. We want to think of something else.
11 Because that's what's rewarding quantity. The
12 reason they're seeing 100 patients or 75 patients
13 a day is because that's how they make money.

14 And we want to change that thinking.
15 I thought some area of measurement in that sort
16 of thematic area would be really important.

17 So this is what we best came up with
18 in the 30 minutes we had. Identification of
19 potential outliers related to the number of
20 patients encounter per day.

21 Let me finish, and then we can take
22 more questions. We thought burnout was important

1 -- no, no, no, I didn't finish. That's why I
2 dropped down. If you look at Number 3, rate of
3 burnout, there's measures to do that. There are
4 surveys, everything, so people are already doing
5 it. The radiologists have already stood out. We
6 talked about that.

7 Here's the next new one that we came
8 up with: diagnostic performance is included in
9 professional practice evaluation for
10 credentialing and re-credentialing of clinical
11 providers.

12 We wanted to see if we could get to --
13 you know, frankly, some physicians who may not be
14 ready to practice anymore, or may be close to
15 retirement, or something close to that, and we
16 were, like, how do we identify these people? And
17 so that's the best, most diplomatic way we
18 thought we could do that.

19 The last one is, I think, maybe just
20 an additional Number 8. If you go to the next
21 slide. Oh, yes. David, do you want to talk
22 about vacancy rate? Because this is the best lab

1 and primary care thing we came up.

2 MEMBER GRENACHE: Right. So I was the
3 only one in my group that advocated to have this
4 on here. But I seemed to convince the others.
5 So this started because one of the proposed
6 measures was vacancy rate in clinical lab
7 personnel.

8 So, you know, the laboratory's a
9 source of quite a bit of diagnostic data. Many
10 people in healthcare outside of pathology are
11 unaware that there's a shortage of clinical lab
12 personnel, up to projections of 40 percent
13 vacancy rates in the coming five years. Yes,
14 yes. So tremendous job growth, you know. And I
15 want us to go into it. But it's going to be a
16 problem.

17 And so addressing that is important.
18 But then we ended up talking about, well okay,
19 it's an easy thing to measure. But how does it
20 improve diagnosis, right? How does it make
21 things more accurate?

22 So one of the concepts here was that

1 awareness could raise -- could be addressed by,
2 oh, you know, healthcare systems recognize, hey,
3 we don't have enough people working in our lab.
4 We should put incentives in place to assure
5 adequate staffing. And then it expanded beyond
6 just a focus on labs to talk about other
7 specialties and primary care physicians.

8 MEMBER SHERIDAN: Dave, I noticed that
9 Number 3: attending staff are onsite to supervise
10 trainees 24/7, didn't make it. And I'm going to
11 channel Helen Haskell here, because I think she
12 would probably bring this up.

13 And I'm also bringing it up, also in
14 light of the ACGME going back to the 16-hour
15 resident hours, or going back up to 28 hours from
16 16. I'm just wondering if this is something that
17 we should consider?

18 MEMBER SINGH: WE talked about it
19 briefly. Martha, you can help me here a little
20 bit. I mean, one of this is -- this is the game.
21 All the second is, you know, oftentimes it's not
22 just the attending is not there, but it's the

1 resident never bothered to call the attending and
2 doesn't that they need an attending.

3 It's unbelievable to see the
4 calibration of -- sorry, I have to sort of put my
5 personal views up here -- but some of the
6 residents that are coming out are very confident.
7 They don't think they need the attendings.

8 And so I don't know if having that is
9 useful or not. You could debate. We did discuss
10 it. And we thought it was useful, but then we
11 decided, Martha, you --

12 MEMBER RADFORD: Yes. This is kind of
13 an important area. But I don't think that's a
14 good measure of it or for it. It's really a
15 process measure.

16 Honestly, I think it needs to be --
17 we're really focused on a lot of process measures
18 here if you look at it, and structure. The
19 outcome is, you know, timely and accurate
20 diagnosis or lack thereof, for the safety aspect
21 of it.

22 And we addressed this actually in our

1 health system through looking at the number of
2 codes outside the ICU that were not preceded by a
3 response team call, for example.

4 I mean, so that's looking at the
5 potential failure to diagnose because of this
6 failure to interact with the senior people on the
7 team. We're a teaching hospital. So I
8 personally don't like anything having to do with
9 duty hours. I think that they're terrible
10 measures of anything. And I'd like to look at
11 the outcomes myself.

12 CO-CHAIR MCDONALD: We have more --
13 so, Lavinia, did you have something? Or that's
14 up, okay. David, I've seen you put that up for a
15 while.

16 MEMBER SEIDENWURM: I wanted to get to
17 the idea of too many patients per day. I think
18 that that's something that we have to be very
19 careful about. Severity adjusting or something.

20 Because if someone said, if an intern
21 sees 50 patients in day --

22 PARTICIPANT: I did.

1 MEMBER SEIDENWURM: Okay.

2 PARTICIPANT: Huge responsibility.

3 MEMBER SEIDENWURM: Right. So it
4 depends on what they're seeing them for.

5 You know, if they are very simple one
6 problem quick things or if a radiologist is
7 looking at a 100-lymphoma follow-up, CT abdomen,
8 chest abdomen, pelvis CTs in a day, that's too
9 many. But if they're looking at a hundred ankle
10 films in a day, we'd fire them. You know what I
11 mean?

12 For underperformance. So you have to
13 be very careful.

14 CO-CHAIR MCDONALD: Yes.

15 MEMBER SINGH: I think we could make
16 it easily 60 a day. Or 70 a day. Pick a number.

17 But I think we're going to have to,
18 and you can adjust based on the type of visit.
19 If you have 9921, is it 99213 still or whatever,
20 the middle one? If you're having, because it's
21 supposed to be for, I think a 15 to 20-minute
22 visit, and you can say -- you can tie this to

1 other stuff too. So, the other thing we
2 discussed is, some of these measures were, this
3 looks important, but it looks important if
4 something else is also not going right.

5 And so, if you've got lots of patient
6 complaints, and if you're one of those more than
7 50 patients a day kind of guy, we'll, we got to
8 look at you. Just to see what you're doing.

9 So that sort of was the intent. Or
10 you didn't pass your OPPE for instance. Which is
11 the evaluation.

12 MEMBER NEWMAN-TOKER: So a few
13 comments on this, and the other things we've been
14 discussing.

15 So, I'd be careful about putting too
16 many numbers on exactly the number of visits, the
17 number of people seen.

18 I do think that it's right to talk
19 about looking at whether people who are
20 underperforming on outcomes, like they're getting
21 the diagnosis wrong, the diagnoses are delayed,
22 to ask the question, what is the distribution of

1 their number of visits and how much time are they
2 spending with patients? That's a great question
3 to ask as a causal factor in predicting, is that
4 the reason why they're getting the diagnoses
5 wrong?

6 But I think it's really treacherous to
7 just looking in an unadorned way at the number of
8 visits or the time of the visit. If people are
9 getting it right and doing it in two seconds,
10 because they're retina specialists who are just
11 looking at choroidal melanomas all day and
12 whatever it is, that they're just really, really
13 good at it, they should be encouraged to get it
14 right in a very short amount of time.

15 At some level, we shouldn't be
16 discouraging them from moving quickly. If
17 they're getting it right consistently.

18 What we really need to be measuring is
19 whether they're getting it right or not. And
20 then we can argue about whether they're
21 overworking or seeing patients too quickly or not
22 spending enough time.

1 Second thing is, on a couple of these
2 things, I think it would be helpful if we made a
3 measure concept that was a less specific. Like
4 the radiologists are available 24/7 to read stat
5 diagnostic imaging studies in real time, seems
6 like a good measure, but it seems like there are
7 others in that measurement concept umbrella.

8 Like you ought to be able to get a
9 stat CBC read in your lab or whatever else you
10 might need. Like, the idea that you have stat
11 access to diagnostic services that are ordered
12 that way I think is important --

13 MEMBER SINGH: We have that too, by
14 the way. It's in a previous slide.

15 MEMBER NEWMAN-TOKER: Okay. So, and
16 the other thing I would suggest is, around the
17 burnout, another potential measure there, other
18 than the survey-based measures, which I think are
19 good, would be actually to look at turnover
20 numbers. Which would be another surrogate for
21 that same concept, but that's very easily
22 operationalized and one that is probably the

1 strongest indicator of how bad things are.

2 MEMBER SINGH: Yes, we could change it
3 to rate a physician -- or other measures of
4 turnover. Just for the record.

5 CO-CHAIR MCDONALD: Okay then,
6 Prashant and then Tom.

7 MEMBER MAHAJAN: So I just want to
8 nuance the last point. You know, from the 50
9 patients. And I agree, specialty-specific.

10 But the way I was interpreting that is
11 when -- we should have some measure where we
12 should be able to put a hard stop where the
13 provider is not further exposed to more workload.
14 Like cognitive workload.

15 So again, going back to my specialty,
16 you just keep on seeing a lot of patients. And
17 you see by the end of your shift, you are either
18 overtesting, or the patients staying there for a
19 longer time; you're not giving a proper
20 explanation. So I looked at it from a different
21 perspective.

22 And they have that for the floor,

1 right? They have a cap for inpatients. So that
2 is how I was looking at it. So I think there is
3 a value in having a hard stop.

4 MEMBER SEQUIST: So I had, recognizing
5 I had initially said the number of visits worried
6 me, it didn't worry me because I think it was
7 dangerous. It worried me because I wasn't sure
8 where to draw the line. Seventy-five patients
9 for an internist is too many patients.

10 Even, I can't imagine any internist
11 who is seeing patients at an acuity level low
12 enough that it's okay to see 75 patients.

13 I just want to sort of clarify two
14 things in my mind. So one is, we're not talking
15 about comparing ophthalmologist to internist. I
16 mean, ophthalmologists would all be compared to
17 themselves, and I recognize that dermatologist
18 can do visits faster than an internist because
19 they're doing something different.

20 So you're comparing dermatologists to
21 dermatologists. Which inherently controls for a
22 lot of the confounding we've been talking about.

1 But the other thing that, that it's
2 not to me, the reason why we were looking at the
3 number of visits was not just about the amount of
4 diagnostic time during the encounter; it's really
5 interesting to look at the diagnostic pitfalls
6 that occur downstream of having high volume.

7 So the providers who see lots of
8 patients, not surprisingly, generate twofold more
9 lab test results that need follow-up. And we
10 know, not in the workforce section, but the
11 follow-up of lab tests is a giant diagnostic
12 error problem. And you just can't manage that
13 information flow.

14 So it's not just about the time in the
15 office with the patient and whether or not you're
16 spending enough time to get the diagnosis. It's
17 just the high volume.

18 If we have providers who are on
19 average reviewing 85 test results per session or,
20 not per session, oh my gosh, but let's say per
21 week, with a result being a whole panel of labs,
22 right, that it just, it creates all these other

1 downstream problems.

2 So I guess I just want -- so I'm not
3 saying that I am against the concept in general.
4 I don't know how to implement it. But I believe
5 that the concept is measuring something real.
6 That it's not safe to see high outlier volumes of
7 patients over time.

8 And just like you said, that is why we
9 have inpatient teams where we cap you at 15
10 patients or 18 patients. Not because we just
11 sort of like want to be real nice in the hospital
12 to the hospitalists. It's because it's not safe
13 ultimately.

14 MEMBER HUNT: Well first, I always, my
15 dermatologists always said they see so many because
16 they are so much smarter than I am. That's what
17 they always tell me.

18 MEMBER HUNT: So much richer, too.

19 MEMBER SEQUIST: They made the smart
20 choice in medical school.

21 MEMBER HUNT: That is true. But I do
22 want to put out a couple of things. It's sounds

1 as though we're revolving around the concept of
2 like the batting average. It's not just how many
3 times you're up to bat, but how many times that
4 you actually get a hit.

5 So if you're seeing a large volume and
6 your diagnostic accuracy rate is relatively low,
7 then that combined. So it's a bit of a composite
8 measure I think that we want to begin to think
9 about.

10 But finally, I don't want to
11 completely dismiss the idea of total time,
12 because there are other fields, gastroenterology,
13 colonoscopy, time, that is actually a measure.
14 How quickly or how long it's taking you to do
15 that colonoscopy.

16 MEMBER SEQUIST: Yes, I wasn't saying,
17 it's not just about the time --

18 MEMBER HUNT: yes.

19 MEMBER SEQUIST: -- you have a
20 downstream implication of seeing high volume.

21 MEMBER HUNT: Exactly.

22 CO-CHAIR MCDONALD: So we're about

1 ready for a break, but go ahead.

2 MEMBER NEWMAN-TOKER: One small point
3 on this issue of specialty-specific. So, an
4 ophthalmologist is not an ophthalmologist is not
5 an ophthalmologist. And a retina specialist
6 isn't a retina specialist is not a retina
7 specialist.

8 So it has to do with scope of practice
9 more than it has to do with what the name is on
10 your discipline. Because if you're a retina
11 person, we had a guy who all he saw was retinal
12 choroidal melanomas questions. It was either it
13 was a nevus or it was a melanoma, and that was
14 all he did, all day, all the time. It's a very
15 different life in terms of diagnosis than an
16 ophthalmologist or even another retina specialist
17 who is dealing with medical retina, and they're
18 trying to figure out whether the patient has
19 central serous retinopathy and all this other,
20 you've got a list of a thousand things it might
21 be.

22 So I think, even within the specialty-

1 specific idea we have to be a little bit nuanced
2 about the notion of, what's too much volume. I
3 mean, obviously, there is some point at which it
4 is impossible to see the patients. And you could
5 drive the number up as high as you want, and
6 eventually you'll get to a place where everyone
7 agrees it's too many.

8 But I do think it's harder than it
9 looks to just do that on a specialty by a
10 specialty basis.

11 MEMBER SINGH: Well I know. And
12 again, none of this is easy, and a lot of this
13 has never been done before, but the point is, the
14 key word out there is potential outliers.

15 You've got to be an outlier. So you
16 could be in the 5th percentile, 95th, whatever
17 you want to call it.

18 And all that means is somebody needs
19 to look at these people in context of other
20 things. Rather it's a downstream lab testing or
21 lab follow-up or patient complaints or some other
22 measure. And I think that's the point, the

1 spirit behind the measure concept.

2 CO-CHAIR MCDONALD: Okay, so we have
3 one group left, but we're going to take a break
4 first. I think we have to figure out how much of
5 a break.

6 Ten minutes? Ten minutes. Run
7 outside, get warm, run back.

8 (Whereupon, the above-entitled matter
9 went off the record at 3:17 p.m. and resumed at
10 3:35 p.m.)

11 CO-CHAIR MCDONALD: Come on back. And
12 we're going to be having Group 4 report back.
13 Jen is going to report back for our group. There
14 is our group. And you can take it away, Jen.

15 CO-CHAIR GRABER: And the goal is to
16 be done by 4:00.

17 CO-CHAIR MCDONALD: Yes. So we have
18 25 minutes.

19 MEMBER CAMPISANO: I think I can do
20 that. Okay, so the first tab that we tackled was
21 patient engagement.

22 We decided to keep three measure

1 concepts. Number 2: patients understand actions
2 they can take to improve diagnostic performance.
3 Number 6: information on red flags provided to
4 patient. For example, included in after visit
5 summaries, discharge summaries. Number 10:
6 whether the organization has a documentation
7 system that captures informal caregivers' roles
8 for each patient, and do they reconcile it with
9 the patient and their caregivers, at some
10 interval or every encounter or on any regular
11 basis.

12 And then we came up with a couple of
13 new consolidated concepts. So we took some of
14 the proposed measurements that were on there and
15 combined them and maybe tweaked them a little
16 bit.

17 So the first one was timely patient
18 access to medical record, including test results,
19 in and out of hospital, and available to the
20 patient electronically or otherwise. And then
21 process to assure that diagnosis and diagnostic
22 information is communicated in an understandable

1 manner to the patient. So without jargon.

2 Do you guys want to talk about this
3 tab before I move on to the next one, or are
4 those pretty clear? Okay.

5 CO-CHAIR MCDONALD: Yes.

6 MEMBER CAMPISANO: Oh.

7 MEMBER NEWMAN-TOKER: Just quickly. I
8 think Number 6 is really important. I think we
9 need to sort of improve the wording of it --

10 MEMBER CAMPISANO: Sure.

11 MEMBER NEWMAN-TOKER: -- so it
12 clarifies. It was sort of like the same thing as
13 the Number 5: percentage of patients with
14 presumed benign condition given explicit
15 instructions for how to recognize dangerous
16 symptoms should their condition evolve or
17 something.

18 Like, I think we need more meat on the
19 bone there, but I think that's a really important
20 thing.

21 They basically need to know what to
22 expect and know that if things go off script, it

1 may be not because their treatment isn't right,
2 but because their diagnosis isn't right. And
3 that's such a critical thing that I think most
4 patients don't leave with.

5 MEMBER CAMPISANO: A clear
6 understanding of.

7 CO-CHAIR MCDONALD: I'll just add to
8 that. That was one that didn't receive that many
9 votes in the broad group, but we talked about it
10 and wanted it. So yes.

11 MEMBER CAMPISANO: Yes. Okay.

12 MEMBER HRAVNAK: I had a question
13 about the health literacy stuff. Because there
14 were a few health literacy things originally, and
15 it looks like they fell off. Or are you
16 consolidating them under something else?

17 MEMBER CAMPISANO: I believe that they
18 were consolidated. And if we can go to the next
19 slide?

20 MEMBER HRAVNAK: Understandable.

21 MEMBER CAMPISANO: In understandable
22 manner. So this process to assure that this

1 information is communicated in an understandable
2 manner to the patient, with jargon-free
3 communication.

4 We wanted to take, one of the things
5 that we discussed was taking the onus of literacy
6 off of the patient, because there can be very
7 health-literate patients who still don't
8 understand medical language, per se. And that
9 they want -- that we wanted to ensure that
10 basically this information is being communicated
11 in a way that is understandable to an average
12 patient.

13 MEMBER HRAVNAK: I don't disagree with
14 that, but I just worry about us losing the health
15 literacy. I mean, it's just so well-established
16 in the evidence-based literature. There are
17 measures, actually, to measure it. And it's
18 pretty finite.

19 CO-CHAIR MCDONALD: Do you think it's
20 been linked with the diagnostic side of medicine
21 very well?

22 MEMBER HRAVNAK: I don't know about

1 the diagnostic side as much as like follow-up and
2 people being able to follow their post-discharge
3 instructions and things like that. But, I think
4 that it could be, but I just don't think it's
5 been looked at.

6 If people -- the level of health
7 literacy. And you can explain something crystal
8 clear and free of jargon at an 8th grade level of
9 printed material and so on, and yet, just based
10 on people's health literacy and experience, they
11 still won't get it.

12 So I just think, if you say that it's
13 jargon-free or understandable, it still doesn't
14 get to that piece of that own patient's
15 individual level.

16 CO-CHAIR MCDONALD: I mean, my thought
17 on that is that there's a little tension here.
18 Because even health literacy is almost a jargony
19 thing. So from a patient-, sort of, facing
20 perspective, the jargon-free is more helpful.

21 I think you're right though, from the
22 perspective that there's a stream of research,

1 there's a stream of activities in the healthcare
2 delivery system that try to pay attention to
3 health literacy, it probably makes sense for us
4 to sort of incorporate that in some way. As a
5 sort of supplementary piece of this, but not take
6 away understandable, the understandable piece.

7 MEMBER HRAVNAK: I'm pretty sure it's
8 like a mesh term. And if you search on that in
9 PubMed, or whatever, you will get a body of
10 literature surrounding that.

11 MEMBER CAMPISANO: Yes, I don't
12 personally have a problem including it in some
13 way. I just, I think what Sue and I were getting
14 at was, again, taking the burden off of the
15 patient. For having to be the one to learn, to
16 come up to speed to learn the certain terms to
17 decipher their own diagnosis.

18 CO-CHAIR MCDONALD: I would just add
19 to that, too, that in some ways a person can be
20 fairly health-literate in one domain, based on
21 having had a lot of activity, and then they like
22 move to different domain where there's this new

1 diagnostic journey.

2 And I just don't know if the research
3 is there that says how it can be different when
4 an individual -- is it a static health literacy
5 ability? So we should look at that a little. I
6 mean, it should be looked at some more from a
7 diagnostic lens.

8 MEMBER HRAVNAK: If we're losing
9 something by leaving it off the table.

10 MR. EPNER: Just as part of the group,
11 so I'll intrude for a second if you will let me.
12 I think the concern was that, if you switch the
13 discuss too aggressively to health literacy, you
14 have to write at the 5th grade level or
15 something, it becomes, you check a box, and you
16 don't know if the patient understands.

17 So we were at a very high-level trying
18 to, recognizing that the measures people will
19 have to operationalize it later, but trying to
20 make sure that the issue is understanding, rather
21 than hitting a certain level of literacy.

22 CO-CHAIR GRABER: So, several of us

1 have written about the Rory Staunton case. So
2 this was a 12 year old boy who was seen in the
3 ER, told he had a benign gastroenteritis, but
4 really was septic.

5 And part of the problem was, his
6 parents realized he was deteriorating at home,
7 but didn't know how to get back into the
8 healthcare system. So I'm wondering if we need
9 some concept measure that would deal with
10 ensuring that follow-up is facilitated and that
11 you can get back in to the healthcare system if
12 things aren't going well.

13 And it may be related to the patient
14 access domain, which we already talked about, or
15 maybe it could be here. But I don't see it in
16 either place.

17 CO-CHAIR MCDONALD: Tom, are you
18 waiting?

19 MEMBER SEQUIST: Yes. So I had a
20 comment on the first bullet, but I had a comment
21 on both bullets. You didn't go over the first
22 bullet yet, did you?

1 CO-CHAIR MCDONALD: I read it.

2 MEMBER SEQUIST: Oh, okay. So two
3 comments. One quickly is maybe the wording is
4 around -- so the health literacy one in the
5 second bullet, I worry a little bit about us
6 setting too high of a bar, I can't believe I'm
7 going to say this, but setting too high of a bar
8 in the evidence base. Because there is -- just
9 this space in general of diagnostic error is hard
10 to study. And health literacy is clearly linked
11 to so many health outcomes.

12 But so I wonder if what we're looking
13 for is that you somehow confirmed an
14 understanding on the part of your patient.
15 Regardless of their health literacy or any other
16 communication barriers that may have.

17 But to me it's sort of, what's lacking
18 in that statement is that we have confirmation
19 that they get it.

20 The first bullet, I guess I wanted to
21 put -- get folks input on, obviously, the patient
22 should have access to the medical record. It's

1 their record.

2 You emphasize test results, which I
3 think are somewhat important and the diagnostic
4 process. I think they should have access to the
5 note.

6 And so these initiatives around note
7 transparency, which everyone has access to, but
8 you just have to go to your medical records
9 office and make a request.

10 If I were to emphasize something in
11 that statement, I would like to emphasize access
12 to the note. Because that's where the physician
13 is thinking out loud, right? And that would be,
14 I think, helpful in the diagnostic process.

15 Test results are important, and you
16 want to know if you have a lung nodule on a chest
17 x-ray.

18 But I would like for us, thinking
19 forward, to emphasize that people should be
20 reading their notes. Because then they're
21 reading the mind of their, not in a weird way,
22 but reading the mind of their physician, that

1 that's --

2 CO-CHAIR MCDONALD: That's a good
3 point. We actually did want it to be expanded.
4 It was just we didn't want to limit it to test
5 results, so that's why we said including. It was
6 coming off of the concept that was on the list.
7 But the notes, really good call out too.

8 On the understandable, this one gets
9 at the provision of something that's
10 understandable. We have in the next batch I
11 think, or maybe we had it in our gap, the receipt
12 in the -- but it was actually -- it arrived and
13 was understood. So we parsed that. I think it's
14 coming in another tab.

15 I think we have to kind of keep moving
16 to keep to the 4:00.

17 MEMBER CAMPISANO: Sue, do you want to
18 take over or do you want to --

19 MEMBER SHERIDAN: Oh, you're already
20 there.

21 MEMBER CAMPISANO: Yes.

22 MEMBER SHERIDAN: Yes. Great. Sorry

1 about my absence here, but ironically, I was out
2 in the hall talking to CMS about the importance
3 of Open Notes. And so I walked in the room and
4 you made the comment about notes.

5 And I don't know if there is evidence
6 to show that having access to notes reduces
7 diagnostic errors, but if any of you have it,
8 please sent it my way.

9 MEMBER SEQUIST: There was an article
10 that was published in the, I think it was either
11 in the Joint Commission Journal for Patient
12 Safety or in the Journal for Patient Safety,
13 where it was a qualitative study by folks at the,
14 I think the BI guys in Harborview. Where they
15 present a lot of great case examples of it.

16 MEMBER SHERIDAN: Yes.

17 MEMBER SEQUIST: But there's not been
18 a quantitative study of it.

19 MEMBER SHERIDAN: We could talk later.
20 And any kind of evidence would be great.

21 Okay, so we're talking about, now,
22 patient experience. These are two measure

1 concepts that -- patient-reported experience of
2 diagnostic care, were problems explained, et
3 cetera. And patient-reported understanding of
4 diagnoses.

5 What's our, are we just going through
6 all the slides now? Continue?

7 Okay. So the new consolidated
8 concepts, and I think this is, I'm refreshing my
9 memory, but I think this is where we collapse
10 several of the proposed recommendations. You
11 know, package them all together.

12 That patient satisfaction within the
13 diagnostic process, including the decision of the
14 diagnoses, e.g. patient had the opportunity to
15 give input to the process.

16 We had quite a bit of dialogue,
17 actually, around this. In that we wanted to make
18 sure that if patients were questioning the
19 diagnoses, that they had the opportunity to give
20 input, give additional information.

21 We can go to the next slide. Are we
22 asking for comments after each slide?

1 CO-CHAIR MCDONALD: After each batch.

2 MEMBER SHERIDAN: Yes.

3 CO-CHAIR MCDONALD: So this is one of
4 our domains --

5 MEMBER SHERIDAN: Yes.

6 CO-CHAIR MCDONALD: -- so go ahead on
7 this one. If people have --

8 MEMBER SHERIDAN: Any comments on
9 that?

10 CO-CHAIR MCDONALD: And our last one
11 is follow-up, which is a little different.

12 MEMBER DUNNE: I can wait until we're
13 finished.

14 CO-CHAIR MCDONALD: No, go ahead.

15 MEMBER DUNNE: All right. My question
16 regards bias in terms of patient reporting
17 satisfaction or happiness with the whole process.

18 There are going to be a number
19 patients who don't feel enabled to criticize the
20 healthcare system and/or a physician. And
21 there's no way of knowing whether they're being
22 silent, and they're unhappy with the process or

1 whether they were just pleased as punch.

2 So there is inherent bias into that
3 system, and I don't know you can get rid of that.

4 MR. HENRIKSEN: One thought, looking
5 at the wording, regarding the decision of the
6 diagnosis, if a patient, you know, the process
7 could be quite satisfactory. But if the decision
8 is related to the outcome, and if the outcome is
9 terminal disease, I'm not sure one can be very
10 satisfied with the decision. And so just the
11 wording, how that gets worded, would probably
12 need to be adjusted.

13 CO-CHAIR MCDONALD: Good points. I
14 guess, any other comments on those? Yes, David.
15 Sorry.

16 MEMBER SEIDENWURM: Well, two things.
17 I mean patients with serious diagnoses are often
18 the most satisfied with their care, so I'm not
19 sure that would necessarily be a problem. And
20 Fenton, I think, was the author of a paper about
21 that a couple of years ago.

22 Was this where you, did you guys

1 address the measure concept around, was the juice
2 worth the squeeze? Was the diagnostic process
3 worth the effort? Is that where this concept was
4 dealt with?

5 CO-CHAIR MCDONALD: It was on the list
6 of like the cost of the diagnosis. It was on
7 this list.

8 MEMBER SEIDENWURM: And time to
9 diagnoses, I mean, is that where this is?

10 CO-CHAIR MCDONALD: It was on this
11 list, but we didn't --

12 MEMBER HRAVNAK: It didn't get much
13 attention.

14 MEMBER SEIDENWURM: Oh.

15 CO-CHAIR MCDONALD: Yes. It hadn't
16 got a lot of attention from the group nor had any
17 of us put -- so would you like to make a plug for
18 it?

19 MEMBER SEIDENWURM: I think it's
20 interesting.

21 CO-CHAIR MCDONALD: Like more of a
22 plug for it?

1 MEMBER SEIDENWURM: I think that one
2 of the things that we see is the diagnostic
3 cascade or the diagnostic vortex. And we see
4 patients get sort of sucked into these kinds of
5 processes only to emerge at the end.

6 Now, some of them are paradoxically
7 quite satisfied with this. They think that their
8 doctors were very concerned and effective
9 individuals who have done a good job for them.

10 I mean, I remember one time, I made a
11 mistake on a film and then I got a call back from
12 the, you know. We followed it up, and it was
13 nothing, of course, but it shouldn't have been
14 called back to begin with, and the patient was
15 happy.

16 The doctor called me back to tell me
17 what a wonderful radiologist I was. And I looked
18 at the pictures again, and I had completely
19 screwed up. So there is that side of it.

20 And then there's the other side where
21 the patient has gone through a valid diagnostic
22 process and sometimes isn't satisfied with it.

1 But more is down the middle where we see a
2 patient with some incidental finding, and they go
3 into a two-year process, a follow-up, for
4 something that's a one in a thousand, one in two
5 thousand event.

6 And so I think that if we can get at
7 some of that, from the patient's point of view,
8 not the least of which we could probably bankrupt
9 them, it would be of interest, I think, to our
10 constituents in this process.

11 MEMBER HRAVNAK: I just had a
12 question. I was curious about the HCAHPS
13 information, because I didn't see that it was
14 reiterated here. And I was just wondering what
15 the conversation was.

16 MEMBER SHERIDAN: Yes. If you really
17 read through the HCAHPS it doesn't really
18 address. You can have a wrong diagnosis and die
19 from it, and the HCAHPS doesn't capture that kind
20 of information. So we thought that that wasn't
21 really the right tool to capture diagnostic, the
22 experience in the diagnostic process.

1 MEMBER HRAVNAK: Okay.

2 CO-CHAIR MCDONALD: Okay. Well, let's
3 do follow-up. And just --

4 MEMBER SEQUIST: Can I just make one
5 comment?

6 CO-CHAIR MCDONALD: Oh, sorry, go
7 ahead. Yes, Tom, sorry.

8 MEMBER SEQUIST: I think this is a
9 really great space to get into. Can we use the
10 word patient experience with the diagnostic
11 process?

12 Satisfaction implies ratings, in the
13 CAHPS world. So it would seem less helpful for
14 patients to rate their diagnostic experience from
15 one to ten.

16 Like rate your hospital, rate your
17 doctor one to ten. Because that's very
18 subjective, and we don't know what's leading to
19 that reading.

20 If we use the word experience, then it
21 implies that what we're really looking for from
22 them is, do you think too much money was spent on

1 your evaluation? It becomes much more objective.

2 I know that's like nitpicky, but in
3 the CAHPS world, like it means a lot to say
4 satisfactory --

5 CO-CHAIR MCDONALD: Yes, that's
6 actually quite, I mean I'm interested in the rest
7 of the group, but that's probably a pretty good
8 idea. Because that would broaden this, which is
9 the idea; it's a consolidated concept

10 Because when it's consolidated, it
11 means we wanted to cover a few of the measure
12 ideas. So that's another, I mean, we've had a
13 couple of ideas right here that are in line with,
14 I think, our desire to broaden it.

15 So it would be patient-reported
16 experience with the diagnostic process. And that
17 could then have sub-measure concepts. David.

18 MEMBER NEWMAN-TOKER: One of the
19 things that you have to think about, a little
20 bit, is whether we're going to advocate for
21 patients to be inquired on this issue
22 systematically or in the sampling schema or

1 whatever.

2 Because at the moment, for instance,
3 most of these follow-up calls that are done are
4 done for just like a 10 percent sample or
5 whatever. And depending on how you plan to use
6 these, right, that may not be enough for
7 identifying diagnostic errors in subgroups of
8 patients or with particular providers or anything
9 else.

10 So there's also, in addition to kind
11 of honing the wording, there is also the sort of
12 honing the sampling frame.

13 And I think what Mark said earlier,
14 about asking the patients whether they got the
15 right diagnosis or not I think is an important
16 source. It should probably go under the tab that
17 we had, the diagnostic error tab. But I think
18 you could kind of combine some of these ideas
19 together.

20 MEMBER KUZMA: I can't remember if the
21 slide before did this, but I think in addition to
22 satisfaction or experience, we should have

1 patient understanding of the diagnostic process.
2 With a teach-back or something like that.

3 CO-CHAIR MCDONALD: Right. We didn't
4 have it here, but yes, there it is.

5 MEMBER KUZMA: Okay.

6 MEMBER GRENACHE: That reaches into
7 the health literacy issue that we were just
8 talking about earlier. So I'm half guessing
9 that.

10 CO-CHAIR MCDONALD: Meaning here
11 again, we should probably make sure we're keeping
12 the link to health literacy, to the extent --

13 MEMBER GRENACHE: Yes.

14 CO-CHAIR MCDONALD: -- that it is
15 applicable in the diagnostic space in some way.
16 Yes. But that should be examined.

17 MEMBER GRENACHE: Yes.

18 CO-CHAIR MCDONALD: Okay. Can we do
19 the next tab?

20 MEMBER SHERIDAN: Sure. Okay, this is
21 follow-up. This is the fun topic.

22 Okay, so we've got the -- again, we

1 consolidated. There were many concepts that were
2 similar, so we consolidated several of them.

3 And then we have the percentage of
4 tests that were pending during a transition of
5 care. Yes, we really thought about transitions
6 of care, home or to another location.

7 Gosh, I'm having a hard time reading
8 it from this angle. Why don't you read it,
9 Kathy. Go ahead.

10 CO-CHAIR MCDONALD: Sure. Yes, so
11 percentage of tests that were pending during a
12 transition of care, so it had been hospital-only,
13 are documented, and have adequate and appropriate
14 hand-offs.

15 So pending results includes awaiting
16 final read or final interpretations. So we just
17 wanted to make that clear.

18 The second one is rate of critical
19 test results that are acted on in a timely
20 manner. And then the rate of noncritical,
21 actionable test results that are acted on in a
22 timely manner.

1 So we kind of divided up the test
2 space into three main categories. There is
3 critical test results, which are, they're on some
4 list. Joint Commission's, or they're defined as
5 critical.

6 Then there is noncritical but
7 actionable. In other words, test results that
8 clinicians would be interested in seeing and care
9 about.

10 And then there might be other tests
11 that nobody is really trying to act upon once
12 they've gotten a quick look at them. So those
13 are the three.

14 So we ended up with six actually in
15 follow-up.

16 So this one is that there are sort of
17 processes in place, standard operating processes
18 that are in place, to ensure closed loop
19 communication of actionable test results to the
20 patient. So this would be both critical and the
21 non-critical.

22 The same thing, standard operating

1 procedures are in place to ensure monitoring of
2 abnormal findings, broadly construed. Standard
3 operating procedures are in place to ensure that
4 results are communicated to the responsible
5 communicator.

6 For example, the primary care doctor
7 or other responsible, sort of organizing
8 physician if a patient's care is mostly being
9 coordinated by another physician.

10 And those were our six that were
11 pulled in from what we had --

12 MEMBER GRENACHE: Can you go back to
13 the previous slide?

14 CO-CHAIR MCDONALD: Yes. Okay. Yes,
15 go ahead, David.

16 MEMBER GRENACHE: So you mentioned,
17 for the critical test list, use something that
18 might be well-adopted as these are critical
19 tests. Is it up to us to define that, or are we
20 going to defer --

21 CO-CHAIR MCDONALD: Yes, so our
22 understanding is that there are lab tests out

1 there that are already called critical test
2 results.

3 MEMBER GRENACHE: There are --

4 CO-CHAIR MCDONALD: Okay.

5 MEMBER GRENACHE: -- but they're not
6 standardized.

7 CO-CHAIR MCDONALD: Okay.

8 MEMBER GRENACHE: And I think I'm
9 going to agree that potassium, troponin and
10 things, certain things are critical. But then it
11 quickly expands beyond, things that I would say
12 aren't critical but are often considered to be
13 critical.

14 Which brings me to my next point, the
15 bullet point number 3. Is it, again, up to us to
16 define what an actionable test result is, or --

17 CO-CHAIR MCDONALD: Yes.

18 MEMBER GRENACHE: So there's ambiguity
19 there that --

20 CO-CHAIR MCDONALD: Definitely there's
21 ambiguity there. And so the idea was just that
22 there is, the thought was, what we were hearing

1 from folks in our group was, that there is such a
2 thing that critical test results that labs
3 already say are critical and that have to be
4 communicated within a very confined time window.
5 And that those should have their own category.

6 Because they've been blessed by
7 someone somewhere. At the Joint Commission and
8 perhaps others. We didn't know if there was any
9 further extension.

10 And the other category is tests that
11 clinicians would feel are, it's good to have them
12 be acted upon in some timely manner, both --

13 MEMBER GRENACHE: Right. Okay, so --

14 CO-CHAIR MCDONALD: -- which would
15 need to be defined. Yes.

16 MEMBER GRENACHE: Right. It could be
17 left up to the healthcare system.

18 CO-CHAIR MCDONALD: Yes.

19 MEMBER GRENACHE: You know, this is
20 our medical review board's decision on what a
21 critical test or an actionable test --

22 CO-CHAIR MCDONALD: Yes. Hardeep.

1 MEMBER SINGH: So there are current
2 recommendations that CLIAC, which is a CDC-based
3 Committee, Federal Advisory Committee, passed on
4 to CMS, which we're hoping that they would
5 respond to in the near future, about
6 standardizing exactly some of the things that you
7 brought up, in terms of what tasks are actionable
8 or not and what to do with them in terms of
9 communication and sort of follow-up procedures.
10 And closed loop reporting.

11 The results of that will not be out by
12 the time NQF has to produce this report. So we
13 can look at other types of recommendations that
14 have come up, by other governmental agencies,
15 including ONC and the VA.

16 So within the CDC recommendations,
17 both of those documents, one was ONC SAFER
18 Guides, that David can talk to a little bit more,
19 that we helped develop. Which addressed
20 communication of test results.

21 And in fact, I think John, there is
22 some measures that we discussed briefly in email,

1 that get exactly to that. So rather than
2 proposing things that would come up with debate
3 or action, can we just point to some of the SAFER
4 measure concepts that are in the SAFER Guides
5 already?

6 And David, the new SAFER Guides have
7 some of these measures that we could just say
8 that, to adopt. And then also reflect on some of
9 the VA's work on communication of test results.
10 And using some of the measures that were
11 proposed. As an example. It doesn't have to be
12 --

13 That's what CLIAC did. They just give
14 examples, and they said, VA and SAFER Guides are
15 examples of the types of things that this
16 workgroup ought to be working on, which should
17 come out of CMS. I don't know what the CMS
18 action on that's going to be though.

19 CO-CHAIR MCDONALD: Okay, Mike.

20 MEMBER DUNNE: Yes, once again, as we
21 get into this area, it's like peeling an onion.

22 So positive blood cultures are a

1 critical result and need to be communicated
2 directly to the responsible physician.
3 Antimicrobial results, susceptibility testing, or
4 the organism that's recovered from the blood, is
5 not.

6 To me, it's just as important as the
7 organism. But there have been studies, there are
8 passive results. They go right into the LIS and
9 the HIS. But physicians need to retrieve the
10 results themselves.

11 But there have been interesting
12 studies that have shown that all of the
13 antimicrobial activity, in terms of therapy,
14 occurs after the blood culture is reported
15 positive. And very little happens after the
16 antimicrobial susceptibility results are entered
17 into the LIS.

18 So there's a sense there that there
19 probably are critical results that need to be
20 called, but it would be impossible to comply with
21 that.

22 CO-CHAIR MCDONALD: Interesting.

1 David. And then David and then Sue. Oh, Sue,
2 did you want to reply to any of that because --

3 MEMBER SHERIDAN: No.

4 CO-CHAIR MCDONALD: Okay.

5 MEMBER SHERIDAN: No, it's an
6 additional comment.

7 CO-CHAIR MCDONALD: Okay. Okay.

8 MEMBER SEIDENWURM: So this idea, this
9 whole concept of closing the loop, is extremely
10 important. And I think that one of the main
11 areas, and I think this would be great if we
12 could address this, is a patient comes into the
13 emergency room, for example, has a big work-up,
14 and there's stuff that needs to be dealt with
15 that isn't necessarily germane to their acute
16 event. And then two weeks later, they're
17 discharged, and that information has been kind of
18 lost in the sands of time.

19 So if there could be a dedicated EHR
20 functionality for following some of these
21 problems that was actually kind of user-friendly
22 and so forth, that would be great.

1 The other thing that would be great,
2 and we've tried to implement this in our system
3 and have had a great deal of difficulty
4 integrating this into our EHR system, is just the
5 whole mechanism of loop closing and making it a
6 humane process and not something that depends
7 upon people's memories and looking back through
8 the chart when the patient comes back.

9 And then just to say that radiologists
10 are, we own part of this problem, because we
11 don't give useful information sometimes, so we
12 are putting in place a -- well, we're proposing a
13 performance measure now through our process of
14 specifying the time interval for follow-up and
15 the specific modality of follow-up, to the extent
16 that we can.

17 And so I think that each other, some
18 of the other specialties perhaps could do some of
19 the same things. And specifying exactly what
20 that would be. And that would somehow be
21 integrated into these EHR functions that would
22 actually make it more likely that these processes

1 occur.

2 Because right now, even though the
3 vendors purport to have these functions, they're
4 oftentimes difficult to use.

5 DR. BERNOT: David, could I just
6 respond to the very first thing? Can you go to
7 the next slide, Vanessa?

8 We actually were hitting that exact
9 same thing on the abnormal findings in the second
10 bullet point over here. We may need to clarify
11 the language, but that's what we had intended to
12 do.

13 You go to the emergency department;
14 something strange comes up. How does that get
15 followed up? Some abnormal finding. So we'll
16 clarify the language.

17 CO-CHAIR MCDONALD: Okay. And then,
18 we'll just go, Lavinia.

19 MEMBER MIDDLETON: Just a quick
20 comment to you. We could perhaps use a decision
21 support tool that either the clinician who put in
22 the positive -- put in the antibiotics for the

1 positive blood culture would be notified, that
2 very clinician or the pharmacy, once the
3 susceptibility comes out.

4 And either taking the clinician out of
5 the ordering loop or notifying the clinician and
6 the pharmacy that the susceptibility of whatever
7 the positive blood culture is. I mean, I think
8 that's the type of closed loop and decision
9 support that we need, in order to improve patient
10 care.

11 And to assume that the pathologist and
12 the laboratory will be able to identify the
13 appropriate person for both the positive blood
14 cultures and the susceptibilities is less likely
15 to happen. But to have a decision support where
16 it's either automatically updated or
17 automatically contacted and updated is, I think,
18 where we want to go.

19 CO-CHAIR MCDONALD: Yes.

20 MEMBER DUNNE: Well yes, I can foresee
21 a time where a pharmacist is available 24 hours a
22 day and is looking at results coming off on a

1 tickertape like Wall Street. And when something
2 is incompatible with a drug that the patient is
3 receiving, then it would flag that result.

4 A lot of this stuff has to be
5 automated. You know, it just can't be done
6 manually.

7 CO-CHAIR MCDONALD: That's cool.

8 MEMBER NEWMAN-TOKER: So if we go back
9 one slide. Just one comment and then sort of a
10 comment/question.

11 I would make sure that we're a little
12 bit specific about what we mean by test results.
13 So, like it's easy enough to think about lab
14 tests and then people start talking about, well,
15 does that include radiology. Okay, probably it
16 does, but then what about other tests.

17 What if you get an EEG, and it shows
18 that you're in status epilepticus. Is that a
19 critical, just make sure that we kind of clarify
20 the spectrum of what is included in that
21 umbrella.

22 And on the last slide, one more down.

1 Forward, whatever you want to call it.

2 Is there a reason why, I mean, because
3 we struggled with this a little bit, too, like,
4 when do you say our measure is whether standard
5 procedures are in place, as opposed to just
6 measuring whether we're doing it?

7 CO-CHAIR MCDONALD: Yes. Yes, we've
8 actually said we're not sure that it's the
9 standard procedures exactly that should be
10 measured. So the stuff to the right is more the
11 critical piece, and whether it's some measure
12 around standard procedures or whether it's some
13 other measures, that's still to be determined.

14 MEMBER NEWMAN-TOKER: I think part,
15 for me anyway, the sort of threshold is, if I
16 can't think of any way to actually measure
17 whether they're doing it --

18 CO-CHAIR MCDONALD: Yes. Then you do
19 this.

20 MEMBER NEWMAN-TOKER: -- then I resort
21 to a standard operating procedure.

22 CO-CHAIR MCDONALD: Yes.

1 MEMBER NEWMAN-TOKER: But I almost
2 don't care about the standard operating procedure
3 if I can find a way to measure the actual thing.

4 CO-CHAIR MCDONALD: Yes.

5 MEMBER NEWMAN-TOKER: Whether they're
6 doing the behavior.

7 CO-CHAIR MCDONALD: Yes. Yes. Do we
8 have to be wrapping up? Okay, we have to be
9 wrapping up. So maybe quick last comments.
10 Hardeep, Susan.

11 MEMBER SINGH: I was just going to
12 add, and I think it's sort of implied, but it
13 probably needs to be --

14 One of the single most important
15 breakdown points, why results are not getting --
16 at least the sub-critical ones, and I think those
17 are the ones that are even more vulnerable to
18 follow-up, not the potassium, is an institution
19 coming up with who is the responsible person for
20 our follow-up.

21 And working with so many institutions
22 now, just sort of trying to come up, everybody

1 has their own thinking, and I'm wondering if we
2 should actually call that out as somewhat sort of
3 measurable.

4 We can put it as a separate SOP, but
5 that assigning who's the reasonable clinician in
6 your institution is one of the hardest things for
7 anybody to do.

8 CO-CHAIR MCDONALD: Yes. Hard for the
9 patient to know, too. Okay, so we're at the
10 point where we are going to break into our small
11 groups again, and I think we have instructions.
12 Who's giving us the instructions?

13 MS. SKIPPER: Yes. Yes, so we'll
14 break back into the same small groups we had this
15 morning and review any measurement gaps.

16 And I believe we have a slide that
17 will sort of guide through some of the discussion
18 questions for this breakout. But we will come
19 back at 4:45 and then go to public and member
20 comment. And then we'll let you all report out
21 notes on gaps first thing tomorrow morning.

22 So we are going to --

1 CO-CHAIR MCDONALD: Yes. So go sit in
2 your groups again, see if there's any gaps that
3 you feel that your area might need to cover
4 because it wasn't covered somewhere else. And it
5 seems to be related to your area, or you just
6 want to expand your area because you've heard
7 from people, and write those down.

8 And we will be reporting back on those
9 tomorrow. We're not going to report back on
10 those today. Since we'll come back and have the
11 public comment and be done for the day.

12 MEMBER SINGH: Kathy, are these
13 slides, all of the slides going to be available
14 as we discuss, to just recap and say, hey, what
15 are they saying about that measure and that one.

16 CO-CHAIR MCDONALD: Yes, that would be
17 helpful, wouldn't it.

18 MEMBER SINGH: That's number one. And
19 number two, do we have any sense of, you know, we
20 started off with more than 200, do you know how
21 many we have come down to?

22 Because we know, in our group for

1 instance, and we were down to, what, 17 right?
2 So we're down to 17 in our group.

3 CO-CHAIR MCDONALD: It looked like
4 everybody had like four to six on average for the
5 12 tabs. So we must be, roughly, at 60. Which
6 was the goal.

7 (Off microphone comment.)

8 CO-CHAIR MCDONALD: Yes.

9 MEMBER SINGH: If we could count them,
10 it would be really useful. Please. I mean, just
11 seeing how much more we need to weed out.

12 CO-CHAIR MCDONALD: Yes, I think we've
13 made good progress.

14 (Whereupon, the above-entitled matter
15 went off the record at 4:11 p.m. and resumed at
16 4:53 p.m.)

17 MS. SKIPPER: Okay, everyone, if we
18 could make our way back to the large group, we'll
19 open up for public and member comment and just a
20 couple of announcements.

21 Operator, could you open the line for
22 any public and member comments?

1 OPERATOR: If you would like to make a
2 public or member comment, please press * 1. And
3 there are no public comments at this time.

4 MS. SKIPPER: Thank you. Comments in
5 the room?

6 MR. EPNER: Paul Epner. It's tough to
7 make member comments four hours after the comment
8 was made that you're responding to, but I have
9 just a few.

10 There was a notion this morning on
11 the, or earlier this afternoon, on capturing the
12 initial diagnosis, the working diagnosis, and the
13 final diagnosis. All of which are really
14 important points.

15 I think that I would just ask the
16 committee to keep in mind that, especially in
17 primary care, sometimes the first visit is a
18 diagnosis sort of, and then the patient never
19 comes back, and you don't know if it was the
20 right diagnosis or if it went away or anything.
21 So does everything get coded as an initial? When
22 does it become a final? What's a working?

1 It's always a snapshot in time, and
2 how it would get decided, I don't know.

3 I think the most important thing of
4 the notion is the audit trail. Being able to
5 know when it moves so you can look at why it
6 shifted and who changed it and things.

7 So my comment there was, think about a
8 structural requirement to have an audit trail as
9 things move from initial to working to final.

10 The second opinion statement, I think
11 a possible measure concept is around second
12 opinions that match the first opinion as focusing
13 on the positive there. Because getting the
14 second opinion that is discordant doesn't mean
15 the second opinion is right any more than the
16 first opinion was right, unless there's an
17 adjudication process and that's documented. It's
18 still just overall knowing your rate of
19 confirmation from second opinions. But also,
20 it's just sort of a little of the reverse.

21 Something we've probably beat to
22 death, the notion of overtesting and

1 overdiagnosis. I think on the issue of
2 overtesting, there is no question; there's a ton
3 of overtesting.

4 But as was pointed out, there is
5 undertesting. A1c among diabetics, people on
6 drugs that have liver toxicity that aren't
7 getting their liver tested. You know, live
8 enzymes.

9 So there's lots of examples. And so
10 to put influence on, more emphasis on one more
11 than the other in the absence of evidence, which
12 I haven't seen that one is more important than
13 the other, I think I would recommend against
14 that.

15 And again, when we talk about
16 overdiagnosis, there may be diagnoses that we
17 want to put in that category, but I think ever
18 misdiagnosis is an overdiagnosis of something
19 because it's clicked up one more in the diagnosis
20 that shouldn't have been there.

21 So again, being careful of what are we
22 adding in the measures world, that doesn't mean

1 people in the drug world or people in the policy
2 world don't want to keep using overdiagnosis, but
3 in the measures of safety and quality, what are
4 we adding from this world overdiagnosis that
5 misdiagnosis or overtreatment isn't capturing?
6 So just something to think about.

7 We talked a lot about pathways and
8 guidelines and measuring compliance with them,
9 and which ones are the ones we're going to
10 measure compliance with. A structural measure
11 might be, have health systems adapted, adapted a
12 certain set of pathways.

13 However they define what's acceptable,
14 but that they said, this is how we wish to
15 practice medicine. And then measuring compliance
16 with that.

17 Whether it's some specialty
18 organization that did a systematic review and
19 made a recommendation. The onus should be on the
20 system to say which ones are we going to live by.
21 And then measuring compliance with that.

22 And then, I don't know if that came up

1 in gaps or whatever, the comment this morning
2 from me about delays due to payers forcing
3 patients to a denial or a petitioning cycle. So
4 again, whether it's access or whatever, just that
5 notion that picking up those other aspects I
6 think is important.

7 And I think those are my comments.

8 Thank you.

9 MS. SKIPPER: Thank you. So just a
10 couple of announcements. We will be taking your
11 discussions from this last breakout group and
12 having those ready for you to review and report
13 back out first thing tomorrow morning.

14 We'll also be cleaning up the measure
15 concept lists based on your discussions today to
16 have a clean slate to sort of work from.

17 And then also, I just want to note
18 that we do have a reservation for dinner tonight
19 at Siroc. You can see the instructions for the
20 address on the slide here.

21 The reservation is under NQF. And we
22 just ask you to please keep your receipt for

1 reimbursement following the meeting.

2 MR. LYZENGA: I forgot to mention that
3 last time. We're not allowed to pay for you for
4 dinner. We reimburse you, but we can't pay
5 directly. So pay for it, get your receipt, bring
6 it back to us, and we'll reimburse you.

7 And apparently, you're only allowed to
8 have one alcoholic drink per the federal
9 government rules. Or we're only allowed to pay
10 for one.

11 MEMBER MAHAJAN: Is the size of the
12 alcoholic drink --

13 (Laughter.)

14 MR. LYZENGA: No. You may have found
15 a loophole.

16 (Laughter.)

17 MEMBER RADFORD: So those of us that
18 are at the hotel now have a dead hour and a
19 quarter, essentially, if we're going to go eat.
20 So many can we start a little sooner maybe?

21 MS. SKIPPER: Do what?

22 MEMBER RADFORD: Could we start eating

1 a little sooner, because usually restaurants
2 don't care if you show up early.

3 MS. SKIPPER: Yes, I'm sure we could
4 reach out and arrange that. So I guess maybe
5 push it to, what, 5:30?

6 MEMBER RADFORD: Yes, something like
7 that.

8 MS. SKIPPER: Get out of here and
9 maybe --

10 MEMBER RADFORD: Yes.

11 MS. SKIPPER: -- go back to your rooms
12 and set your stuff down and come back or --

13 MEMBER RADFORD: We can't.

14 MEMBER NEWMAN-TOKER: The hotel is too
15 far away.

16 MEMBER RADFORD: The hotel is too far
17 away.

18 MS. SKIPPER: Okay.

19 MEMBER RADFORD: That's the thing.

20 MS. SKIPPER: Oh.

21 MEMBER NEWMAN-TOKER: It will take us
22 15 or 20 minutes just to get back to the hotel.

1 MS. SKIPPER: Okay.

2 MEMBER NEWMAN-TOKER: So it's just a
3 little bit easier to just move on.

4 MEMBER RADFORD: Yes.

5 MS. SKIPPER: Okay.

6 MEMBER RADFORD: Just go right to the
7 restaurant. Let's eat, and then we get back to
8 the hotel.

9 MS. SKIPPER: Okay. We will take care
10 of that. And just to note, we are starting
11 tomorrow, 8:30, breakfast; 9:00 a.m., the meeting
12 will begin again.

13 And we'll let you know, I'm sure the
14 reservation will be find, so we'll see you there.

15 (Whereupon, the above-entitled matter
16 went off the record at 5:01 p.m.)

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