

NATIONAL QUALITY FORUM

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IMPROVING DIAGNOSTIC ACCURACY 2016-2017

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THURSDAY  
APRIL 13, 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

HELEN HASKELL, MA, Mothers Against Medical Error

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  
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, Senior Vice President,  
Quality Measurement

JOHN BERNOT, MD, Senior Director

TRACY LUSTIG, 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)

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

2 9:04 a.m.

3 CO-CHAIR GRABER: Good morning,  
4 everybody and welcome back. I talked about the  
5 miracles that NQF is capable of and it's happened  
6 again. We've left them with this big mess when  
7 we were done yesterday. And they transformed it  
8 into a gorgeous document that summarizes all our  
9 concepts that we were happy with. At the back  
10 are the areas that need more discussion, the  
11 areas where there are still gaps or there is  
12 still more refinement needed.

13 So the plan for this morning is to  
14 start off with the gaps which are at the back of  
15 the handout that you have. We will go through it  
16 group by group. Each group will talk about the  
17 gaps that they discussed individually in their  
18 groups yesterday. The rest of us will have an  
19 opportunity to point out any other gaps that we  
20 identified then or now and would like to see  
21 included.

22 After that, we will get to the main

1 part of the document which is the concepts that  
2 we all like and agree upon and we will rank those  
3 according to their importance, their feasibility  
4 and their potential for cost-savings.

5 That is the plan. Christy will tell  
6 us more about the paper and the process.

7 MS. SKIPPER: Yes. Thank you, Mark,  
8 and good morning, everyone. Everyone should have  
9 in front of them this concept rating sheet which  
10 pairs down all of the measures that you all  
11 pointed out as important and to move onto the  
12 next level to move onto today for review.

13 We have around 70-72 measures concepts  
14 down from over 230 yesterday. So we organized  
15 this sheet so that you can see the measures per  
16 subdomain that were categorized.

17 I just want to note that I didn't  
18 finish all of my homework. So Groups 2, 3, and 4  
19 do have their gaps in the presentation slides  
20 that we are going to show you this morning.  
21 Group 1 as I said their measurement gaps or ideas  
22 for measures that need refinement are toward the

1 end of that document. I'm sorry that I didn't  
2 make that more clear, Mark.

3 As Mark said, we will review the  
4 measure prioritization criteria with you this  
5 morning after we do the presentation of gaps.  
6 And you will use this paper document to begin to  
7 do your individual prioritization or your  
8 individual ratings of each concept according to  
9 the criteria, importance, feasibility and cost  
10 savings. We'll go over this again once we get to  
11 that activity.

12 But for now, we'll start out with the  
13 group report backs starting with Group 1 on any  
14 measurement gaps or as we call it concepts or  
15 ideas that we have for measure concepts and they  
16 need further refinement.

17 For Group 1, if you could hit this  
18 document here and turn to the second to the last  
19 page. You should see it up on your screen in  
20 front of you. Measure concept ideas that need  
21 further refinement. I'll turn it over to Mark to  
22 run through those.

1 CO-CHAIR GRABER: Is everybody on the  
2 next to last page? It says Measure Concept Ideas  
3 that need refinement. These are some things that  
4 we talked about in our group that didn't make it  
5 into the list of measures that we all agreed  
6 would be great. But they had something in them  
7 that seemed like it needed a little bit more  
8 discussion or fleshing out.

9 For example, the first thing there is  
10 about discussion support in the medical record to  
11 make diagnosis easier. And we have one in our  
12 medical record in the VA. If you're seeing a  
13 patient with diabetes, it pulled in all the  
14 information that you want to know for that clinic  
15 visit. It saved you from having to tab around  
16 and find the 20 things that had been aggregated  
17 for you.

18 We were wondering if that kind of  
19 thing might be helpful for diagnosis. If so, it  
20 would be great to have a measure that encouraged  
21 it.

22 Are we just mentioning these, Christy

1 or?

2 MS. SKIPPER: Yes.

3 CO-CHAIR GRABER: Vote on them? Get  
4 a group reaction?

5 MS. SKIPPER: Group reactions.  
6 Reporting out the concepts from Group 1. So we  
7 had those listed in one through eight were the  
8 concepts or ideas that you all discussed  
9 yesterday. Have you ran through them all?

10 CO-CHAIR GRABER: Maybe just thumbs  
11 up/thumbs down. I don't think we have time to  
12 discuss each one in detail.

13 MS. SKIPPER: Just general impressions  
14 or.

15 CO-CHAIR GRABER: Okay. Just maybe  
16 one minute on each. Thoughts on that? Ways to  
17 make diagnosis easier using decision support.

18 MEMBER SINGH: There's already  
19 something in there.

20 CO-CHAIR GRABER: The only thing in  
21 there now is decision support with differential  
22 diagnosis. So it would be like a data aggregator.



1                   MEMBER NEWMAN-TOKER: I think we have  
2 to be careful about getting too far down the road  
3 of trying to legislate every aspect of the  
4 specifications of what's in the EHR. I actually  
5 think using an approach where the measurement is  
6 a little bit more details agnostic. Asking the  
7 physicians and the other providers does the  
8 electronic health record, how well does it  
9 support your delivering accurate, high quality  
10 diagnoses as an aggregated just Likert scale or  
11 whatever.

12                   CO-CHAIR GRABER: Yes.

13                   MEMBER NEWMAN-TOKER: We can give them  
14 some examples in that question. Does it provide  
15 decision support pathways? Does it aggregate  
16 data properly as a good data visualizations?

17                   I'm just a little worried about  
18 creating 20 measures that say does your EHR do  
19 this, does your EHR do that, does your EHR do the  
20 next thing. I'm not sure that's really where we  
21 want to go.

22                   CO-CHAIR GRABER: Hardeep.

1                   MEMBER SINGH: So I think we need to  
2 first think about we can't have good clinical  
3 decision support or any decision support without  
4 good structured data. Now we don't structure  
5 some key data elements including, for instance,  
6 family history on patients who have family  
7 history of colon cancer and we miss them.

8                   I think maybe we need to just think  
9 from the point of diagnosis the key would be the  
10 EHR should be able to capture some key critical  
11 structured data whatever that might be, chief  
12 complaint or family history or whatever other  
13 data elements rather than being at that high  
14 level.

15                  CO-CHAIR GRABER: Thanks. It sounds  
16 like this one is a little premature. The second  
17 one was about education. Shouldn't there be --

18                  DR. BURSTIN: Mark, I'm sorry. I  
19 actually had a comment. I just wanted to maybe  
20 ask David a question.

21                  Some of these feel like they may in  
22 fact really be -- I'm sorry. There are so many

1 Davids. David Hunt. It just seems like some of  
2 these really could wind up being certification  
3 elements for EHRs. Not everything has to be a  
4 performance measure just because we're talking  
5 about nails and hammers here. Not every one of  
6 these is a nail. I guess the question would be  
7 would some of these really be things better  
8 suited towards certification requirements for  
9 EHRs.

10 CO-CHAIR GRABER: I definitely think  
11 that's true and when you get down to the EHR  
12 level, we really need to be more granular in  
13 terms of the concepts. Taken very, very broadly,  
14 an EHR with clinical decision support that really  
15 supports diagnostic accuracy is Watson. And  
16 that's just not.

17 I think the thing that I'm hearing  
18 more and more from our colleagues is they really  
19 need good cognitive support such that data is  
20 aggregated and that you get all of the data.

21 So its inoperability is absolutely  
22 key. That test, that scan, the other information

1 that was done last week is in front of me now so  
2 I can make an appropriate decision. I think the  
3 data aggregation and collation functions are  
4 probably key.

5 And strictly speaking it already  
6 should be baked in there when we look at what  
7 we've asked to have done just isn't done very  
8 well. So a long way of saying, I think to some  
9 extent some of this fits into what we call the  
10 category of usability more so than actual new  
11 functionality.

12 MEMBER RADFORD: I'd just like to  
13 iterate a focus that I have in this group which  
14 we are developing measures that will be reported  
15 nationally. Some of the measures' suggestions  
16 predispose the interventions that need to be  
17 made. This is one of them.

18 And I really think it's very premature  
19 to put these as measures. These are potential  
20 ways to improve diagnosis that some providers  
21 will experiment with, trial. And after they  
22 become more common, maybe they can become

1 measures perhaps via certification. I like that  
2 idea. But I personally would not put this on the  
3 short list today.

4 CO-CHAIR GRABER: Anything else on  
5 that one?

6 The second one was about education.  
7 We don't have a measure that says maybe there  
8 should be some education about diagnostic error  
9 either in medical school or for people in actual  
10 practice. Should there be a measure related to  
11 providing some education about diagnostic error?

12 MEMBER SHERIDAN: Yes, I was thinking  
13 about this last night just thinking about the  
14 measures that we spoke about yesterday and  
15 wearing my patient advocate hat, thinking about  
16 the errors that took place in our family. Would  
17 these measures reflect that or prevent some of  
18 the harm that happened in my family?

19 And you brought up the education.  
20 Something that we learned in my son's case who  
21 suffered brain damage from his newborn jaundice  
22 that the nurses had not -- They looked back for

1 13 years in the records of the education of the  
2 nurses and they could not find any evidence of  
3 the nurses being educated about the dangers of  
4 jaundice.

5 When I testified in AHRQ in 2000,  
6 that's one of the things I asked to be  
7 researched. How could nursing staff not know in  
8 the newborn section about the dangers of jaundice  
9 going back 13 years? There was no indication of  
10 education.

11 That's a very specific in a very  
12 specific area. But I think that if there's some  
13 way to communicate that we need to know that  
14 there is adequate education in certain areas  
15 where there is a high risk of misdiagnoses.

16 MEMBER HASKELL: Well, I would agree,  
17 although I don't know how specific it necessarily  
18 needs to be. But it needs to be a big part of  
19 medical education since it's obviously a big part  
20 of what young doctors do. They often are not  
21 aware of what they don't know.

22 And the other issue that Sue just

1 brought up is education for nurses which I think  
2 is something that's an aspect of diagnosis that  
3 we need to really develop some guidelines for of  
4 how do nurses intervene in diagnosis. What do  
5 they do? Maybe there are guidelines that I don't  
6 know about. But I think that's an important  
7 issue.

8 MEMBER DUNNE: Is this limited to  
9 medical school? Nursing school and medical  
10 technology school, radiology/technology school,  
11 this is all part of health care. I mean if we're  
12 going to cover it we've got to cover it as part  
13 of the education for every health care related  
14 field, pharmacy. Don't limit it to medical  
15 school.

16 CO-CHAIR GRABER: I guess it's a  
17 question for the NQF staff. Are we allowed to  
18 make measures that address education needs?

19 DR. BURSTIN: It's a really  
20 interesting question. Obviously, there aren't  
21 accountability measures per se for that sector  
22 which is why again -- back to my hammer and nail

1        thing -- not everything has to be a performance  
2        measure. It could be this is a recommendation of  
3        this committee that you would like to recommend.  
4        These get incorporated, for example, into ACGME  
5        and whatever the equivalents for the other  
6        broader health professional schools.

7                    But I don't see it as a performance  
8        measure per se. But I don't want to lose Sue and  
9        Helen's point. This is really important and it  
10       could be important recommendation of this  
11       committee. I don't know whether IoM already did  
12       that as well as part of theirs.

13                   MEMBER SINGH: This was sort of  
14       touched up already by IoM. And we're going  
15       beyond a little bit of what we're supposed to do  
16       here.

17                   If you want to try to say here's a  
18       measurement area that there is a gap and you want  
19       to do something about it, then we need to make it  
20       more specific and say "I hear that you have a  
21       Macy Foundation grant to develop a curriculum."  
22       Andrea Olsen has been developing curriculum.



1 Maybe we could say something specific. Curricula  
2 such as X, Y and Z is the recommendation of the  
3 Committee, should be incorporated and somewhat  
4 measured and trainees should be measured on his  
5 performance in the future as a gap area that we  
6 need to address and could be addressed in the  
7 future. But it has to be a lot more specific  
8 than right now.

9 MEMBER HRAVNAK: I was just also going  
10 to say that we could probably put the word  
11 interprofessional in here. I think that that  
12 would help to broaden it and maybe something  
13 about both preparatory and continuing education.

14 MEMBER NEWMAN-TOKER: I think the  
15 other thing is that we could potentially wrap  
16 some of this is into the notion of the learning  
17 health system rather than couching it in terms of  
18 what's taught in medical school and what's taught  
19 in nursing school. We should be thinking about  
20 it as part of what the institutions are doing  
21 when they're learning from diagnostic error and  
22 then retraining and educating people around the

1 errors that are found. Then we could be  
2 essentially closing the loop on the educational  
3 front as well.

4 CO-CHAIR GRABER: The next one is  
5 about differential diagnosis and we already had a  
6 measure that we had agreed upon. It was number  
7 five back on the very first page. It says allow  
8 the clinician to document the differential  
9 diagnosis.

10 And we had some discomfort I guess  
11 about that. Did it effectively address not only  
12 structure but process? We felt like we didn't  
13 quite nail it.

14 Is it enough to say that your EMR  
15 should allow you to do it? Or should there be a  
16 measure that says we'd like to see one on every  
17 new patient that's got a new complaint?

18 MEMBER SINGH: This one doesn't say  
19 EMR, the one we have here. It just says allow  
20 for the clinician to document. It doesn't say  
21 the EMR should, does it?

22 MEMBER NEWMAN-TOKER: No, it's under

1 specified, implied, but obviously we would need  
2 to state it. But in this situation again for any  
3 given idea or theme you could have a structure, a  
4 process and an outcome measure. And part of the  
5 goal of the non-proliferation of measures is to  
6 try to pick the level at which you can get there.

7 I think if you have a measure that  
8 says what percentage of the cases have a  
9 differential diagnosis documented effectively  
10 you've covered the structure measure of are you  
11 able to document in your EMR a differential  
12 diagnosis. And it's a better measure of whether  
13 they're actually doing it rather than whether  
14 they have the potential opportunity to do it. So  
15 I would just switch that from a structure measure  
16 to a process measure and move on.

17 MR. LYZENGA: And actually we have a  
18 structure measure that's in the list already to  
19 allow for the clinician to document.

20 MEMBER NEWMAN-TOKER: Number five.  
21 I'm saying take number five and just make it  
22 percentage of clinicians who are able to document

1       their differential diagnosis or do document their  
2       differential diagnosis in the electronic medical  
3       record. And you'd kill two birds with one stone.

4               MEMBER SINGH: If you're going to go  
5       down that route, we have to make it a gain more  
6       specific. You don't need to put a differential  
7       diagnosis for every single patient who comes in  
8       for a routine medical visit. You would do that  
9       if they're coming with a new symptom that you're  
10      uncertain about. So I think we're going to need  
11      to put some parameters if you're going to make  
12      some recommendations that aren't something that  
13      broad.

14             MEMBER MAHAJAN: Just as a part as a  
15      clinician who would see a patient as part of that  
16      evaluation it would be a part of the differential  
17      diagnosis. And I'm just looking at the EHR world  
18      and the feasibility of initiating a new step in  
19      the EMR which is mandated versus requiring the  
20      clinicians to document differential diagnosis as  
21      a part of their known. I don't know how feasible  
22      that is but I'm just saying from that

1 perspective. So because One is changing the EHR,  
2 which may be a harder battle, versus forcing the  
3 clinicians because we need the portion of the  
4 clinician, not the fact that they can document.

5 CO-CHAIR GRABER: Kerm.

6 MR. HENRIKSEN: Just an observation.  
7 Many medical offices are starting to use medical  
8 scribes for documentation purposes. And this is  
9 a growing industry it looks like. And it frees  
10 up the clinician in terms of the problems they  
11 have with the EHR to begin with.

12 But at the same time, there's  
13 opportunity to introduce new forms of error as a  
14 result of someone not as well trained perhaps as  
15 a medical scribe into the system. So it's not  
16 just the clinician that may be doing the  
17 documentation. It's the medical scribe. And  
18 that's still something that needs to be evaluated  
19 I guess in terms of the long-term outlook for  
20 that. As long as EHRs are not very useable, this  
21 is likely to be a growing industry.

22 CO-CHAIR GRABER: The next one is

1 about whether there should be a measure that  
2 addresses quality monitoring and laboratory and  
3 radiology services. So many health care  
4 institutions, they have a policy that a certain  
5 fraction of the x-rays are re-read as a peer  
6 review process and a quality monitoring process  
7 or certain fraction of the biopsy gets a second  
8 reading. And we don't yet have a measure that  
9 says that that's a good idea. Should we?

10 MEMBER DUNNE: There are accreditation  
11 agencies for both of these specialties. And it's  
12 pretty rigorous. So if the CAP certifies the  
13 laboratory as being accredited on a routine  
14 basis, then it's not something that we have to  
15 redo.

16 CO-CHAIR GRABER: Does the CAP have  
17 criteria that says a certain fraction should be  
18 re-read?

19 MEMBER DUNNE: You can develop your  
20 own quality improvement markers and so forth so  
21 that they allow for a variety of different. For  
22 example, in microbiology, what's the percentage

1 of contamination of blood cultures? How many  
2 identifications don't correspond with the correct  
3 antibiogram and so on.

4 MEMBER NEWMAN-TOKER: We filled that  
5 gap in the revision after the discussion. So  
6 it's on the list.

7 MEMBER RADFORD: I would just like to  
8 point out that there's a lot of cardiology  
9 testing that needs to have the same type of  
10 concern, EKGs, ECHOs, nuclear, blah, blah, blah.

11 CO-CHAIR GRABER: Looking at number  
12 six, I'm not recalling our discussion on number  
13 six. Anybody from Group 1 remember the issue  
14 about OPPE and FPPE?

15 MEMBER SINGH: We addressed it in  
16 ours, but it wasn't anything like this. I'm not  
17 sure what this means. I mean you've got to talk  
18 to patients and providers. I think that's so  
19 broad.

20 CO-CHAIR GRABER: And I'm having a  
21 similar problem with seven. I don't remember the  
22 issue there.

1 MS. SKIPPER: And I think measure  
2 concept seven that was one that Thomas had come  
3 up with and he is not here to perhaps provide  
4 more clarity today.

5 CO-CHAIR GRABER: Okay. And number  
6 eight --

7 MEMBER KUZMA: I think it was just the  
8 idea that when there's data that doesn't support  
9 the diagnosis are you documenting that there's a  
10 conflict that exists for this work-up or  
11 something like that.

12 CO-CHAIR GRABER: That's right. Yeah,  
13 wouldn't it be nice to have a Watson like process  
14 running in the background to say your diagnosis  
15 is not consistent with this lab finding over here  
16 or something like that.

17 MEMBER NEWMAN-TOKER: At the very  
18 least we have some in ours that talk about in  
19 reference to Gold Standard.

20 CO-CHAIR GRABER: Okay. And the last  
21 one was about I think in each of our groups we  
22 had some very specific, disease specific measures



1 that had already been developed and approved  
2 elsewhere. And we were looking at those and we  
3 just had the comment that it would be nice if  
4 every professional subspecialty came up with  
5 measures that are very specific for their  
6 diseases like the ones that we all had examples  
7 of.

8 The thought that the work on  
9 developing measures shouldn't stop with this  
10 group, we should ask some subspecialist and their  
11 societies to go through a similar process to come  
12 up with measures that would target their specific  
13 areas of expertise.

14 David and then Prashant and then  
15 David, David.

16 MEMBER SEIDENWURM: With respect to  
17 number eight, I think that's really an important  
18 one, particularly in areas where there are clear  
19 criteria for the work-up to stop. And I think in  
20 radiology we see endless follow-up. I think if  
21 there are clear criteria that define benign  
22 positional vertigo rather than an infarc, if

1       there are clear criteria that define a benign  
2       adrenal lesion rather than a rare adrenal  
3       cortical carcinoma, these should be defined and  
4       everyone should be given permission to declare  
5       victory and go home.

6               MEMBER NEWMAN-TOKER:   And this would  
7       be a recommendation.   You're not proposing, Mark,  
8       that eight would be a measure or even a measure  
9       comment.   You're just saying, right, it would be  
10      one of the recommendations made in the report.

11             CO-CHAIR GRABER:   Yes.

12             MEMBER SINGH:   I think the  
13      recommendations could be very strong in this area  
14      because there are areas that need potential  
15      measures and some of which already exist.   So  
16      United Kingdom, they have very strong measures  
17      around timeliness of cancer diagnosis.   They  
18      don't exist in this country.   They have two week,  
19      four week.   They're very strict about it.   They  
20      have lots of papers about it.

21             I think it would be good to outline  
22      some high risk areas and get the specialty

1 societies to do some work around it.

2 CO-CHAIR MCDONALD: I think actually  
3 there is a measure concept here though in the  
4 generic thematic level. So I think the concept  
5 is that there's sequences of testing that are  
6 understood by each profession to be appropriate  
7 under particular conditions. And there should be  
8 measure that fit that concept. We're not saying  
9 what they are. We're saying that it's  
10 appropriate for the specialty societies to look  
11 through what they have and then create measures  
12 around that.

13 MEMBER NEWMAN-TOKER: I think we have  
14 that measure concept in ours in the  
15 appropriateness section.

16 CO-CHAIR MCDONALD: Okay.

17 MEMBER NEWMAN-TOKER: So I think we  
18 have the --

19 CO-CHAIR MCDONALD: The sequence of  
20 testing and the idea that you didn't know the  
21 sequence of testing to say that we're benign.

22 MEMBER NEWMAN-TOKER: You may not like

1 the individual measures that we've suggested that  
2 might be associated with that measure concept.  
3 But we have the concept.

4 CO-CHAIR MCDONALD: Okay. Good.

5 CO-CHAIR GRABER: Does anybody have  
6 any other gaps or things that they think are  
7 missing from the Group 1 areas which were  
8 information gathering and documentation and  
9 information integration?

10 And, Christy, if we think of things as  
11 we go along or after we leave, will there be an  
12 opportunity to say I just thought of this one  
13 that we missed?

14 MS. SKIPPER: Yes, there will  
15 definitely be time for that.

16 CO-CHAIR GRABER: Okay. So we don't  
17 have to necessarily identify every gap right now.  
18 But it would be nice. Okay. Group 2.

19 MEMBER NEWMAN-TOKER: We took to heart  
20 all the suggestions that were made by the large  
21 group which I think were great. And we buffed up,  
22 changed, filled in gaps. The main thing we

1 changed just so you can find it is under  
2 diagnostic efficiency.

3 So we really completely refrained the  
4 issue we heard, Sue's concern and others concern,  
5 that we missed the boat on the under/over issue.  
6 We were over weighting or over concerned about  
7 over diagnosis and over testing and under  
8 concerned about under diagnosis and under  
9 testing.

10 What we did was -- I think this was a  
11 really, really strong point, Sue, that got us to  
12 a better place in terms of the measurement  
13 concept which really is around appropriate  
14 diagnosis and appropriate testing, essentially,  
15 the measure being linked to being an outlier  
16 whether you're a high outlier or a low outlier  
17 around your performance in this space.

18 And that gets us really where we want  
19 to be which is if everybody's under diagnosing,  
20 we want them brought up. And if everybody is at  
21 the other end we want to bring them back down.  
22 But we can get that in one measure that's linked

1 basically to your percentile ranking. I think  
2 that was a great suggestion.

3 We also took Mark's concerns and  
4 brought up a couple of things. I don't know if  
5 it made it onto this page. We put some text in  
6 there about trigger methods. And really trigger  
7 isn't a measure. It's a way of getting to a  
8 measure. It's a method for getting to a measure.  
9 And we put that in there predominantly as an  
10 appropriate strategy for getting to the  
11 measurement.

12 And then we added things/gaps that  
13 were either brought up in our group or by others  
14 including this diagnostic reliability thing which  
15 could easily go in the diagnostic QI subdomain.  
16 But it also could go in the diagnostic air  
17 subdomain if you wanted to, this whole idea of  
18 second reads and whether it's radiology,  
19 pathology, clinical charts, EKGs, or anything  
20 else. The idea that you might sample a certain  
21 percentage of these and have a systematic way of  
22 making sure that you're at least getting

1 consistency, if not, accuracy. We buffed up the  
2 ones on accuracy that are related to diseases  
3 where there's a Gold Standard for comparison  
4 there.

5 Anything else that we filled in gaps  
6 on, guys, that I'm missing? I think that's all  
7 we have to report that's different from the first  
8 time you saw it. I'll just make sure.

9 Oh, patient reporting, sorry. There  
10 was one other.

11 CO-CHAIR MCDONALD: Tell us where you  
12 are.

13 MEMBER NEWMAN-TOKER: Sorry. I'm not  
14 sure where I am. Here it is. I'm under  
15 diagnostic errors number 13. This is one that  
16 there may be worth some discussion. The first  
17 thing we did was put a structure measure in  
18 there. Mark, you were concerned that we didn't  
19 have anything in there about patient's reporting  
20 diagnostic errors which I think was an important  
21 oversight.

22 We have a structure measure that says

1       there's a way for people to actually report the  
2       stuff. Clearly, I don't know if it will make the  
3       top ten list, but it's clearly something that  
4       would be relatively easy to do and sensible in  
5       terms of making sure there's a portal for that to  
6       happen.

7               Then what we also added was the idea  
8       that you might actually want to try to get a rate  
9       of diagnostic error out of the contact with the  
10      patient. Essentially, the frequency of  
11      diagnostic error is hard to measure across a  
12      broad range of conditions. But probably the  
13      single, best source of information on whether a  
14      diagnostic error has occurred is probably the  
15      patient.

16             Although it's fraught with lots of  
17      problems -- people don't have the health literacy  
18      and they don't know whether their prior problem  
19      was related to their current problem and there's  
20      confusion about causality and relationships and  
21      they don't know enough about the details to be  
22      sure -- we talked about how it might still



1       nonetheless be valid for individual institution.  
2       If they were systematically testing or  
3       robocalling their patients at 30 days and saying,  
4       "You were seen on such and such a date with this  
5       symptom and we gave you this diagnosis. Is that  
6       still to the best of your knowledge the right  
7       diagnosis, just get a yes or no. Then you could  
8       follow up the nos with a human call and get a  
9       little bit more meat on the bone as a potential  
10      way of tracking your total diagnostic error rate.  
11      That would be otherwise very difficult to  
12      aggregate.

13               We put all that in there because you  
14      expressed that concern. I think it was a very  
15      legitimate one.

16               CO-CHAIR GRABER: Any gaps in David's  
17      areas? So, David, your areas were efficiency and  
18      diagnostic error.

19               MEMBER NEWMAN-TOKER: And one more.  
20      Information interpretation.

21               CO-CHAIR GRABER: Maybe we could just  
22      take a minute to look over it. That's a lot of

1 material. Can we give people a minute to just  
2 look through that and see if there's any gaps?

3 (Pause.)

4 CO-CHAIR MCDONALD: Go ahead, Martha.

5 MEMBER RADFORD: Is that working?

6 CO-CHAIR MCDONALD: Yes.

7 MEMBER RADFORD: Sorry. Okay. So I'm  
8 seeing a lot of overlap with the last three and  
9 maybe the last four on our discussion before  
10 about the fact that we need to have differential  
11 diagnosis. And very likely there are health  
12 systems that will use the EHR and decision  
13 support to do that. Are we focusing a little bit  
14 too much on the solution rather than quantifying  
15 the issue?

16 You know these all may be very fine.  
17 But I really see there down the road they're not  
18 the first set.

19 MEMBER SINGH: Are we going to have a  
20 later discussion on ranking these?

21 CO-CHAIR MCDONALD: Yes.

22 MEMBER SINGH: I just want to make

1       sure.

2                   CO-CHAIR MCDONALD:  There's going to  
3       be a whole priority thing along different  
4       criteria.  So that's where some of this will sort  
5       out.

6                   MEMBER SINGH:  This is just a gap  
7       session, right?

8                   CO-CHAIR MCDONALD:  This is the gap  
9       session, yes.  Are there extra gaps?  Comments  
10      though about thinking about any of these are  
11      helpful in terms of priming whether things are of  
12      priority or that we're missing something that we  
13      haven't gotten to.

14                  CO-CHAIR GRABER:  Are we ready for  
15      Group 3?

16                  CO-CHAIR MCDONALD:  But there were no  
17      more comments on this group's three tabs.  No  
18      more gaps.

19                  CO-CHAIR GRABER:  So for Group 3,  
20      could you tell us your areas and any gaps that  
21      you would like to discuss?

22                  MR. LYZENGA:  Let me see.  They may be

1 down at the bottom. I can't remember if we -- It  
2 may actually be best to pull up those slides and  
3 talk through them that way. I'm not sure if any  
4 of those actually warrant being pulled into the  
5 ratings sheet at this point. Many of them were  
6 just raising issues. Let's take a look.

7 MEMBER SINGH: We have built all the  
8 language around the comments that we received.

9 MR. LYZENGA: Yeah, we updated some of  
10 the concepts. Keep going. It's just like a  
11 couple of notes on external environment. It's  
12 difficult to measure but important. We're not  
13 sure.

14 Similar to what we were talking about  
15 with education. Who do you hold accountable for  
16 having policies that facilitate good diagnoses,  
17 payment policies and things like that? These are  
18 difficult to apply to any given entity or body.

19 MEMBER SINGH: I think the point was  
20 a lot of these are HCO health care organization  
21 centric measures. And some of them were so  
22 beyond what the organization could do. I mean

1       who would be accountable? Would some of these  
2       like CMS and other policy making bodies be  
3       accountable for some of these measures? ACGME?  
4       Whoever? So that was a big problem especially  
5       for leadership and cultural issues.

6               MR. LYZENGA: Skip forward a little  
7       bit. Somebody mentioned why didn't we see the  
8       length of time seeing the patient come up and we  
9       just noted that that was addressed in the work  
10      force section. Skip forward. One more. One  
11      more after that.

12             Again, we had some. I don't know if  
13      you want to talk to it, Hardeep or anybody else.  
14      We had a measure related to incorporating  
15      measures of diagnostic performance and to  
16      credentialing and re-credentialing processes.  
17      These were just some questions about how do you  
18      go about doing that basically and how do you link  
19      them to internal dashboards and link them to  
20      learning. Anything else to add on that?

21             MEMBER SINGH: Lavinia, do you want to  
22      add to that?

1                   MEMBER MIDDLETON: I think that there  
2                   is a push to put a lot of the assessment measures  
3                   from the specialty societies in both the ongoing  
4                   professional practice evaluation and the focus  
5                   practice evaluation. I think there's an  
6                   opportunity to use some of the six competency  
7                   areas recommended by The Joint Commission which  
8                   include diagnostic knowledge and either refer or  
9                   use that vehicle that's already in place and  
10                  recommended by The Joint Commission to look at  
11                  individual providers' ability to make appropriate  
12                  diagnoses and to document when that ability falls  
13                  short. It's also to link that with credentialing  
14                  and privileging and making sure that we're  
15                  privileging people based on not assumption of  
16                  knowledge. But it's also documentation that they  
17                  are able to diagnose correctly. I think it's  
18                  another opportunity to pull in information that's  
19                  also being collected. That was a recommendation.

20                 CO-CHAIR GRABER: I'd like to make one  
21                 comment on that. As much as I would love to have  
22                 that happen, we don't have really any way now to

1 know who's good at diagnosis and who isn't or  
2 even to assess how good they are of clinical  
3 reasoning. I would love to see some tools  
4 developed over the next decade to be able to say  
5 that somebody is competent at this.

6 MEMBER MIDDLETON: What we use is our  
7 rate, rule and roll metrics. And basically we're  
8 comparing each provider to their peers based on  
9 predetermined and a lot of times society-specific  
10 measures.

11 Actually, I did a little homework last  
12 night and we were talking about it. I do have a  
13 list of many of the specialty societies. There  
14 are URLs websites that we could perhaps share as  
15 other reference points to look at where this  
16 information is being collected or recommended to  
17 be collected.

18 MEMBER SINGH: One of the examples we  
19 measured was the colonoscopy withdraw time that  
20 gastroenterology has as a quality measure which  
21 already exists. Just an example of how the  
22 specialty society stuff could be operated.

1                   MEMBER RADFORD: Right. And the point  
2 here is that this group is going to be  
3 recommending some measures that are going to be  
4 appropriate for national presentation somewhere,  
5 national display reporting eventually. Some of  
6 those will be in this sphere of control of the  
7 physician and could be drilled down upon by  
8 physician and then reported in their  
9 credentialing process as would the subspecialty  
10 measures as well.

11                   So it's a recommendation that those  
12 things start to appear in credentialing and that  
13 be used in OPPE and FPPE and also that it's a way  
14 to use the measures at a local and a national  
15 level. But is there is a measure here? Well,  
16 maybe it's yes. You use these measures as much  
17 as possible in your credentialing process which  
18 is a structure measure. But another way to work  
19 this is to say "Joint Commission, you should have  
20 this in your standards."

21                   MEMBER MAHAJAN: Also this is giving  
22 the concepts. I think we could recommend that at



1 the minimum there should be one measure or one  
2 aspect in the OPPE and FPPE that is linked to  
3 diagnostic accuracy or diagnostic performance. I  
4 mean we could come out with that statement as a  
5 strong statement.

6 CO-CHAIR GRABER: Sounds like a great  
7 way to word it. Anything else for Group 3?

8 MEMBER HRAVNAK: Be sure to include  
9 the interprofessionalism here, particularly for  
10 credentialing and privileging. Remember that  
11 it's not physicians. I think The Joint  
12 Commission language has other licensed,  
13 independent providers. So they changed the  
14 wording a little bit to reflect that.

15 CO-CHAIR GRABER: Anything else for  
16 Group 3?

17 MEMBER SINGH: I'm going to just bring  
18 that up. So that's come up before. So is it  
19 going to be okay when we do that if some of the  
20 nursing community feel that they don't make the  
21 diagnosis. So why are they going to be made  
22 accountable for something?

1 (Off microphone comment.)

2 MEMBER SINGH: Yeah, but are there any  
3 diagnosis that affects things or any of the team-  
4 based things that we could include?

5 MEMBER MIDDLETON: Absolutely. And  
6 following up and communicating results -- I'm  
7 sorry to speak, but absolutely. And these are  
8 metrics that can be evaluated. And they're part  
9 of the diagnostic team. We talked about that the  
10 first time we were together in the whole  
11 diagnostic continuum. And they certainly play an  
12 important role that can be measured and reported.

13 MEMBER SINGH: So I think we should  
14 make a determination or at least some distinction  
15 that we're not saying they're going to make the  
16 diagnosis in maybe some of the nursing community,  
17 but things like follow-up. That came out in our  
18 discussion.

19 That is so important that if the  
20 nursing community can assist with follow-up of  
21 test results. It's such a huge step up.

22 MEMBER HRAVNAK: So there are probably

1 two roles here which is their participation in  
2 maybe the final medical diagnosis. But there are  
3 also independent nursing diagnosis that are made.  
4 For example, we would stay within the scope of  
5 nurses to diagnose pain and then to apply.

6 That's where we got with the HCAP  
7 thing yesterday. That's why I was asking that  
8 question. There is usually a standing order for  
9 pain medication, but it's up to the nurse to  
10 really assess the patient for pain, diagnose that  
11 they're having pain and then apply the  
12 intervention. If they don't make that diagnosis  
13 correctly, then patients aren't satisfied with  
14 their pain.

15 MEMBER SINGH: I think these are great  
16 examples and it will avoid some of the pushback  
17 that I've received about we're not the person  
18 making the final clinical diagnosis. So I really  
19 think we should give specific, concrete examples  
20 just the way you guys have listed. Anytime you  
21 mention specific things like including them for  
22 certification related things.

1                   MEMBER NEWMAN-TOKER: We've had good  
2 success at Hopkins engaging nurses. They started  
3 out feeling like they had nothing to do with  
4 medical diagnosis And now I've got roomfuls of  
5 hundreds of nurses raising their hands saying  
6 that they think that diagnosis is part of their  
7 shtick.

8                   We've just written a manuscript and  
9 submitted it, but the three areas are one of them  
10 is a measure that Hardeep mentioned, this idea of  
11 improving and closing the loop in the follow-up  
12 of test results.

13                  The other two areas are around medical  
14 diagnosis in addition to nursing diagnosis that  
15 Marilyn mentioned, one is around the notion of  
16 what we call diagnostic triage. Triage is a very  
17 comfortable idea for nurses. They involved in  
18 the diagnostic process all the time. The medical  
19 diagnosis process, all the time.

20                  They decide post-op patient whether  
21 they're just going to give them meds off the list  
22 or they're going to call the doc because this

1 patient has a swollen leg or whatever it is.  
2 They're involved in the initial process all the  
3 time and the dichotomy between saying you're  
4 never to make a medical diagnosis and then trying  
5 to tell them that they're also part of the  
6 medical diagnostic team is causing trouble. So  
7 we have to just get rid of the old logic and move  
8 to the new.

9 And the other place they can really  
10 help with in patient education around diagnosis.  
11 We talked about whether the patient understands  
12 their diagnosis. That's another critical domain.

13 CO-CHAIR GRABER: Helen.

14 MEMBER HASKELL: Along these lines, I  
15 just want to reiterate some of the things I had  
16 said on the phone earlier about the idea of  
17 working to the top of your license. I think it  
18 does go against that. And I see what you have  
19 here, the idea of replacing it with the idea of  
20 teamwork principles which I think is a much  
21 better concept.

22 I think that promotes hierarchy and it

1 goes against the idea of teamwork so that you  
2 have the nurse, for example, saying I can't do  
3 diagnosis. It puts people into slots.

4 CO-CHAIR GRABER: Great segue to our  
5 last group which is Group 4.

6 MR. LYZENGA: Just maybe Hardeep or  
7 Martha or somebody could talk. Some of these  
8 were just little notes. But a few, maybe those  
9 last four or five bullets there were possible  
10 measure concepts.

11 MEMBER RADFORD: These were more  
12 specific measure concepts that organizations  
13 might want to consider. That's basically it to  
14 add to the OPPE business, yeah. They weren't  
15 really necessarily measures for this group,  
16 although I suppose they could be.

17 MEMBER NEWMAN-TOKER: On this list,  
18 the last one, unexpected transfer to the ICU is  
19 covered in our section very specifically. And I  
20 do think it's worth talking about failure to  
21 rescue since it's an existing measure that's  
22 reported by a lot of people. It incorporates

1 more than just diagnosis, but it's the closest  
2 thing we have to a diagnosis-oriented measure  
3 that's actually widely used in clinical practice.  
4 What do people think about that?

5 CO-CHAIR GRABER: But it looks like  
6 you had a measure on that, David, in this revised  
7 list somewhere.

8 MEMBER HASKELL: There is PSI 4 is  
9 what you're talking about, right?

10 CO-CHAIR MCDONALD: There's two  
11 versions. There's PSI 4 and there's Silver's  
12 version.

13 DR. BURSTIN: PSI 4 was just withdraw  
14 from AHRQ.

15 CO-CHAIR MCDONALD: Because of --

16 MEMBER HASKELL: Why was it withdrawn?

17 CO-CHAIR MCDONALD: Because of the  
18 amount of work that it would have taken to put it  
19 back through. I think it was a resource  
20 decision.

21 MEMBER HASKELL: And there is a new  
22 failure to rescue measure that was approved by

1 the Patient Safety Committee.

2 DR. BURSTIN: There is the existing  
3 measure that's Jeff Silver's. And there was also  
4 I think a version of Jeff Silver's measure for  
5 pediatrics just brought through the Pediatrics  
6 Committee.

7 MEMBER HRAVNAK: I would just  
8 reiterate. I think we strongly need to support  
9 the existing failure to rescue measures and  
10 metrics. And it is viewed as a nurse-sensitive  
11 measure as well.

12 MEMBER RADFORD: There are issues with  
13 the current measure. It is not specific enough  
14 in my view. In fact, for national reported  
15 measures, we really need to err on the side of  
16 specificity relative to sensitivity. I'd better  
17 write a paper about that because it's all there  
18 is.

19 MEMBER RADFORD: It could be improved,  
20 but it's all there is.

21 MEMBER HRAVNAK: I know.

22 MEMBER SINGH: And I'm not sure how



1 much of that is related to a diagnostic related  
2 issue. We could say some of these failure to  
3 rescue measures should be developed to evaluate  
4 for diagnostic-related issues rather than what  
5 they might be looking at right now.

6 MR. LYZENGA: Do we have any guidance  
7 on how you can focus these diagnostic issues?

8 CO-CHAIR MCDONALD: One possibility  
9 would be to just say failure to rescue  
10 reconfigured with more of a focus on diagnostic  
11 sensitivity. You have to think about the  
12 timeliness of where would there be more  
13 preventability. Because if diagnoses were more  
14 delayed rather versus less delayed and it's  
15 possible to have it less delayed, then you would  
16 want to be looking for failure to rescue for  
17 those situations. And you'd want to give them  
18 primacy over situations where it's much, much  
19 harder to expect that there could have been a  
20 diagnosis in time to then rescue.

21 MEMBER SINGH: I think the point of  
22 this is this is a gap area. There are a lot of

1 unknowns about it. The same thing when we were  
2 talking about readmissions yesterday, so many of  
3 these are nothing related to diagnosis. I think  
4 this is just a gap area. That's how we should  
5 couch it.

6 DR. BURSTIN: Just one comment. It  
7 may be that rather than keeping to use. The term  
8 failure to rescue at least the AHRQ measure for  
9 example is surgical. It's very specific. And  
10 maybe it's really an opportunity to think about a  
11 broader framing of this.

12 Is this really the idea of getting  
13 towards a trigger measure that would make you  
14 look areas where there may be potential for  
15 diagnostic issues? Then you could list that what  
16 some of those could be. And those could be good  
17 fodder for developers.

18 MEMBER SINGH: Actually we just did a  
19 study in the pediatric ICU transfers where RRT's  
20 failure to rescue when the patient went to the  
21 ICU and then deteriorated subsequently in 24  
22 hours was better than just looking at autopsies

1 or patients who had a visit previously before  
2 they came to the ICU. So it has actually some  
3 fertile ground, but it needs to be looked at much  
4 more.

5 MEMBER NEWMAN-TOKER: Just in that  
6 vein then, Helen, that's a great suggestion. If  
7 so, we could make the argument in the diagnostic  
8 error section where we talk about death, adverse  
9 event or loss to follow-up as a means for  
10 essentially investigating or triggering a search  
11 for diagnostic error is in there in that sense.  
12 And maybe we could allude to the fact that it's a  
13 refinement of the failure to rescue so people  
14 don't think we just ignored it.

15 CO-CHAIR MCDONALD: There are new  
16 opportunities with ICD 10, too, that didn't exist  
17 with ICD 9. That's why there was the surgical  
18 restriction in the last round of coding  
19 availability.

20 CO-CHAIR GRABER: Anything else with  
21 Group 3?

22 (No response.)

1 CO-CHAIR GRABER: Okay. Group 4.

2 CO-CHAIR MCDONALD: I have that. So  
3 go to the follow-up session. In that we have on  
4 concept two we've just elaborated a little bit  
5 more. We went back and talked about this idea of  
6 the two different types of tests we talked about  
7 before, critical and non-critical, and didn't  
8 like where we can come down. So we did some  
9 massaging there.

10 The idea would be that the definition  
11 for critical results are those that fall  
12 significantly outside the normal range and may  
13 suggest a life-threatening situation. That's  
14 what The Joint Commission calls critical test  
15 results.

16 The idea for critical test results is  
17 that definition that's been legitimized by a  
18 national body. I think there was some discussion  
19 of VA having critical tests. Perhaps other  
20 national bodies have something they call critical  
21 tests. This concept relates to those situations  
22 where there's a national body that has a

1 definition for critical test and there's sort of  
2 a standardized process for what the follow-up  
3 time frame should be.

4 Then we took our rate of actionable  
5 tests. So instead of saying rate of non-critical  
6 actionable test, now it's just rate of actionable  
7 tests as the other area. This is one where  
8 probably specialty societies and other groups  
9 would need to work pretty hard on developing the  
10 right lists of tests and findings that would be  
11 appropriate to be measuring and assuring that the  
12 rates of getting those test results to be acted  
13 upon are what would be expected. So, that was  
14 sort of a refinement.

15 Then down at the bottom, the gap was  
16 to have a process in place to identify the  
17 responsible clinician -- that gray area, seven -  
18 -- a process in place to identify the responsible  
19 physician for tests. And we had a lot of  
20 discussion about this and how difficult it really  
21 is to know who the responsible physician is.  
22 Yet, ultimately without having a responsible

1       clinician responsible for whatever the next step  
2       in the diagnosis is, responding to the tests,  
3       etc., that's a big crack where there could be  
4       many failures.

5                   It's not a fully developed idea. We  
6       kept it at a pretty high level. We had a lot of  
7       discussion on that. I just wanted to know if  
8       there were any comments on that one as a gap.  
9       Paul.

10                   MR. EPNER: And just to expand on your  
11       definition, we looked especially at pre-op  
12       testing where a primary care physician may order  
13       a battery of tests for the surgeon, not really  
14       for themselves. But the surgeon isn't the  
15       ordering physician. That's an example of where  
16       knowing who needs the results may not always be  
17       the ordering physician as opportunities for  
18       things to fall through cracks.

19                   CO-CHAIR MCDONALD: Marilyn.

20                   MEMBER HRAVNAK: I was going to say  
21       the same thing. I think it needs to not be  
22       physician-limited. And maybe we need a multi-

1 layer system as well. If you're going to send it  
2 just to the physician who is in the operating  
3 room, it will be hours before anything will  
4 happen. Frequently this is placed in the hands  
5 of nurses to track people down, but it's not fail  
6 safe. So I think multilayer.

7 CO-CHAIR MCDONALD: Thank you. That's  
8 great. I know a lot of us are thinking about in  
9 situations that we've seen go awry for family  
10 members and such which measure concepts cover.  
11 And I've certainly seen this a lot where all  
12 sorts of other clinical professionals are  
13 involved in the care and don't necessarily have  
14 the results when they need them or know that they  
15 have access to them and so forth. Good.

16 And then moving down to --

17 MEMBER HASKELL: Wait one second. And  
18 one thing I would add to that, Kathy. The  
19 patient knows which clinician is in charge of the  
20 tests. That's sort of a failsafe measure.

21 CO-CHAIR MCDONALD: Right. Yes.  
22 Thank you for adding that. We should include

1       that. That's even more aspirational, right, if  
2       the clinical team doesn't have an ability or a  
3       strategy to know where the assignment is except  
4       for norms and assumptions, then it's going to be  
5       even harder for the patient to know. Good point.

6               Sue, go ahead.

7               MEMBER SHERIDAN: Again, a midnight  
8       reflection about our conversation yesterday and  
9       just being a patient advocate you learn to just  
10      use what's in your heart. You have to say it.  
11      And sometimes it doesn't fit in.

12              But I really thought about our  
13      conversations yesterday and my role as an  
14      advocate -- not CMS, I'm taking my CMS hat off -  
15      - and thinking about the communication of  
16      critical test results. That's really been kicked  
17      around for almost 20 years. Who's defining what  
18      and is it critical or is it not? Is it  
19      actionable? Is it subcritical?

20              Quite frankly, it's unacceptable.  
21      People are still dying today from malignant  
22      pathologies that do not get communicated. They



1 fall through the cracks. And it's chilling to  
2 know that our health care system has not stepped  
3 up and done something really major and robust to  
4 stop this from happening.

5 Quite frankly, if somebody in my  
6 family gets cancer or if I get cancer, I'm going  
7 to go to a hospital and say, "What is the  
8 percentage of malignant pathologies that get  
9 communicated to your patients?" That's the  
10 measure I want to see. I want to go to a  
11 hospital and say "Do 100 percent of your patients  
12 know when they have malignant cancer?"

13 I would like to challenge us to be a  
14 little more specific about let's step in and  
15 propose some concepts and measures that's really  
16 going to stop some of these diagnostic errors  
17 that are happening. It's very clear in the  
18 diagnostic process that we can step in and do  
19 something that's really meaningful. Quite  
20 frankly, nothing has happened in 20 years since  
21 this happened to my husband.

22 DR. BURSTIN: I was going to say

1 something almost identical to Sue actually. I  
2 think in many ways we're actually way beyond the  
3 idea you would figure out who the responsible doc  
4 is anymore. Frankly, every pre-op test I order  
5 is my responsibility. I don't care. It's my  
6 name on it. I need to check it.

7 But the bigger issue I think is is it  
8 time for a measure that simply says all test  
9 results are available to a patient within seven  
10 days. Hard stop. It's what the VA has done. It  
11 is part of their process now. You don't have to  
12 figure out what's critical and not critical.

13 The patients get every lab result,  
14 every result available to them within seven days.  
15 And if you talk to people at the VA -- several of  
16 you are here like Hardeep and others -- there was  
17 a lot of consternation early on on the part of  
18 clinicians like oh no. What if I haven't seen it  
19 first? Do you know what happened? Clinicians  
20 made sure they saw it first and it worked.

21 I would very much like to be in Sue's  
22 camp. In some ways, I think it will push us

1 where health care needs to even if it's not where  
2 it is now. And I don't want to get into who is  
3 responsible. It just creates a quagmire and it  
4 will never get the job done. My personal  
5 feelings.

6 MEMBER SINGH: Can I answer this?  
7 Being someone who actually wrote the VA national  
8 policy on communicating test results, I really  
9 think Sue's on the spot. We've had enough of  
10 this. We also wrote ONC SAFER Guides in addition  
11 that have been out about three plus years which  
12 very few health care organizations around the  
13 country are using even though almost everything  
14 you have here is in the SAFER Guides.

15 So rather than reinventing the wheel  
16 over and over again, why don't we just have some  
17 kind of measure where organizations are doing  
18 test results reporting and communication of SAFER  
19 Guides. We actually did the SAFER Guides.

20 We updated them. The first SAFER  
21 Guide did not have a recommendation on patient  
22 notification of test results because of some very

1 convoluted reasons. But there is one now, 3.3,  
2 if I remember correctly.

3 So I think it's time for us to endorse  
4 something like the VA policy on communicating  
5 test results which actually is seven days for  
6 actionable and 14 days if it's not just to give  
7 clinicians adequate time. There was a lot of  
8 pushback as Helen mentioned, but it's the right  
9 thing to do.

10 There are two big resources. I have  
11 no idea when CMS will actually take it up to come  
12 up with a task force which will have some  
13 national recommendations on communicating test  
14 results. But we have two very good existing  
15 resources we need to be building upon. So I  
16 think a measure around just those two things will  
17 be good enough.

18 MEMBER RADFORD: I'd just like to  
19 share. I would like to agree very strongly with  
20 the last three speakers and just tell you that we  
21 have a standard at NYU that all test results are  
22 reported to patients within 72 hours. And we

1       measure that.

2                   We're living through the doctor  
3       pushback about I have to know first and all that.  
4       We're living through that and you're right. They  
5       just go in and check. I think it's a very good  
6       thing to do.

7                   MEMBER CAMPISANO: Just speaking from  
8       a five year cancer patient perspective, I know a  
9       number of patients whose doctors just give them  
10      access so that 24 hours after their test they can  
11      go in and check their results whether they've  
12      talked to their doctor or not. Especially in the  
13      metastatic setting where women and men, but in  
14      metastatic breast cancer, it's primarily women.  
15      But they're living with this and going in for  
16      scans every three months.

17                   They know the process at this point.  
18      They know what to look for on their scan reports.  
19      So they are able to go in the next day and read  
20      them themselves whether they've had the chance to  
21      talk to their doctor or not.

22                   MEMBER SEIDENWURM: There are some

1 state rules with regard to disclosure of cancer  
2 diagnoses. California has some rules about that.  
3 I don't know if they're statutes or  
4 administration. They're not to be disclosed in  
5 this automated fashion. The idea being that they  
6 should be presented in some face-to-face manner.  
7 So there are embargos on some test results in  
8 that regard.

9 MEMBER SINGH: Yes, and I think most  
10 of the stuff that we've written via policies as  
11 well as ONC SAFER Guides don't say that sensitive  
12 test results such as HIV and cancer should be  
13 immediately communicated either. I mean there  
14 needs to be some kind of institutional hold on  
15 some of the results that need face-to-face  
16 discussion. All that can be built in.

17 So rather than again coming up with  
18 these nuances, this is a very complex areas. It  
19 seems very simple. In fact, we used to be called  
20 the Low-Hanging Fruit of Diagnostic Error. It is  
21 not low-hanging. It is really a hard and complex  
22 area.

1 CO-CHAIR MCDONALD: Lavinia.

2 MEMBER MIDDLETON: Just to share at  
3 M.D. Anderson. We first started with a seven day  
4 rule to release results. We've decreased that  
5 now to immediate release of results. And the  
6 patients can access them real time in their  
7 electronic medical record. I think it helps  
8 everybody.

9 CO-CHAIR MCDONALD: Paul.

10 MR. EPNER: And I think it's just  
11 important that we explicit about whether we mean  
12 make available or confirm receipt because not all  
13 patients have easy access to IT tools and things.  
14 It doesn't reduce our obligation.

15 CO-CHAIR MCDONALD: And that's number  
16 four, right? We have rate of close of  
17 communication actionable results to the patient.

18 MR. EPNER: But in this discussion.

19 CO-CHAIR MCDONALD: That was right  
20 there. Yeah, number four. An important point.  
21 Okay. Others? Did I miss anybody else who  
22 wanted to comment on that? Helen.

1                   MEMBER HASKELL: I would say it would  
2 still be helpful for the patient to know who the  
3 relevant clinician is.

4                   CO-CHAIR MCDONALD: Yes, that should  
5 be in addition. So process in place to identify  
6 the responsible clinician for tests and have the  
7 patient know who the responsible clinician is.

8                   MEMBER NEWMAN-TOKER: If you're got  
9 that information in the EHR, then it ought to be  
10 available in the portal. Yes.

11                  CO-CHAIR MCDONALD: Yes, people are  
12 taking notes.

13                  Then our next category was patient  
14 engagement. And on that one, we just have added  
15 based on the conversation yesterday to number  
16 five. We had said that we wanted diagnostic  
17 information and the diagnosis communicated in  
18 understandable manner to the patient. We added  
19 while recognizing the impact of health literacy.  
20 We added that based on the discussion yesterday.

21                  For that one, we hadn't identified  
22 gaps. I'll go on to patient experience and then



1 we'll open it up to see if we've missed other  
2 gaps. In patient experience, the gap that we  
3 noted and added, it's number four in the gray.  
4 That's patient experience with a diagnostic  
5 process.

6 We have patient satisfaction with a  
7 diagnostic process. And now we've added patient  
8 experience with a diagnostic process which  
9 included: Was it worth the effort? Did the  
10 patient feel like they didn't incur a lot of  
11 extra expenses that weren't appropriate after the  
12 whole diagnostic process was experienced? I think  
13 that was your point, David. But there would be  
14 other subdomains of this possible as well.

15 MEMBER SINGH: Kathy, I thought we  
16 were going away from the word satisfaction.

17 CO-CHAIR MCDONALD: Some people were  
18 not liking it and some people were liking it. So  
19 we left it on there for right now to go through  
20 the prioritization process.

21 MEMBER HASKELL: I would really say  
22 something more along the lines of assessment,

1 the patient's perspective on the diagnostic  
2 process that they went through.

3 CO-CHAIR MCDONALD: So as a separate  
4 theme or under one of these?

5 MEMBER HASKELL: When you're talking  
6 about the word satisfaction, I agree that that's  
7 not a good word because it has so many  
8 implications. For a bland word, it's pretty  
9 freighted. So I would say something like  
10 perspective, which gives a little more weight as  
11 well to the patient's opinion.

12 CO-CHAIR MCDONALD: So maybe it would  
13 be that this could be in the structural process  
14 about was the patient's experience of the  
15 diagnostic process invited and checked on and  
16 known.

17 MEMBER HASKELL: I interpret this --  
18 and maybe I'm misunderstanding because it's just  
19 a few words -- to mean did the patient feel it  
20 went well. They were diagnosed in a timely and  
21 efficient way. Or was it a mumbling process that  
22 they weren't happy about?

1 CO-CHAIR MCDONALD: Yes.

2 MR. LYZENGA: Just to remind us that  
3 we have a few like the measure concept above this  
4 of similar patient experience with the diagnostic  
5 process or different aspects of it.

6 MEMBER HASKELL: Yes, I think they can  
7 fruitfully be combined.

8 MR. LYZENGA: I don't know if we want  
9 to bundle this together.

10 MEMBER HASKELL: Yes.

11 MR. LYZENGA: A sort of composite of  
12 patient reported experience survey that includes  
13 these elements and others or something like that.

14 CO-CHAIR MCDONALD: Yes, this one  
15 seems like it really needs more work. I don't  
16 know what the process should be by which it gets  
17 the extra work it needs.

18 MEMBER SINGH: I'm just going to add.  
19 I think this is a very under researched area that  
20 I'm not sure that we could claim. I mean all of  
21 these are nice things. But I'm not sure they are  
22 getting to the point of trying to create even a

1 measurement concept.

2 What does it mean? If I have cold, I  
3 go to the doctor. My head hurts or whatever. I  
4 get a steroid shot. I come back and I feel  
5 great. My diagnostic experience was so good. I  
6 feel beautiful the next day.

7 Was that good? Is that what we're  
8 trying to catch? I don't know. I mean I just  
9 think we could say for high risk conditions  
10 maybe, for certain aspects of breast cancer,  
11 colorectal cancer, something to make it more  
12 specific. I just don't know if we know enough  
13 about this area.

14 The other thing we should think about  
15 is -- and maybe this is in the next session --  
16 are some of these things just good concepts that  
17 need to be put in further for development and  
18 measurement. But they are good ideas. But we  
19 just can't call them measurement concepts yet.  
20 And we should put them separately as a little  
21 addition section or not. Can we do that?

22 MEMBER SHERIDAN: I'm circling with

1       this as well because also what is the timing of  
2       this. Do we ask them right after an office  
3       visit? Do we ask them six months later? I would  
4       have been very pleased with the diagnostic  
5       experience with both my husband and my son. But  
6       six months later, I learned that they were  
7       harmed.

8                   I think this is challenging. But I'm  
9       wondering if there's a -- I don't know if this is  
10      a measurement either -- but can we recommend that  
11      a question be framed for something to go into  
12      CAHPS or something to go into another patient  
13      satisfaction survey that can capture some of  
14      this. I don't know what tool will capture this  
15      and when.

16                   CO-CHAIR MCDONALD: David.,

17                   MEMBER NEWMAN-TOKER: I do think that  
18      these are measurement concepts in the sense that  
19      there's something measured. You could measure  
20      patient satisfaction. That's not that far from  
21      an actual measure.

22                   But I think that the concern expressed

1 over whether -- again the same issue I alluded to  
2 yesterday -- you don't know whether it's a good  
3 thing if the number is up or down. In some sense  
4 whether the patient is feeling good about where  
5 they're at with their treatment or whatever it is  
6 may not be an indication as Hardeep said that  
7 they got the right diagnosis.

8 I think if we specify some of these  
9 things more and give more meat on the bone in the  
10 questions that we ask the patients maybe there's  
11 a better space there, closer to what Helen was  
12 getting at which is were the tests adequately  
13 explained to you, did you feel as if you  
14 understood the diagnostic reasoning that the  
15 provider was giving and so on and so forth. That  
16 may be better than just a generic were you  
17 satisfied with your diagnosis or comfortable with  
18 your diagnosis.

19 CO-CHAIR MCDONALD: Helen and then  
20 Helen.

21 MEMBER HASKELL: I think we're talking  
22 about some kind of a survey in that respect. And

1 I'm also going back to the -- I'm not sure which  
2 group it is, but under diagnostic error talking  
3 about reporting diagnostic errors. I do think  
4 that's critical to have patient-reported  
5 outcomes, not necessarily just errors. Because  
6 they may not know it's an error.

7 In fact, I think a large part of the  
8 time they don't. But if they're reporting the  
9 outcome someone else might recognize that there  
10 was an error. So I think to me the challenge is  
11 how you would divide these things. We need a lot  
12 more patient reporting on all aspects of the  
13 diagnostic process. But how exactly you'd  
14 structure it and how you divide outcomes  
15 reporting from error reporting from a survey on  
16 the whole process I think is the issue.

17 CO-CHAIR MCDONALD: Helen, could you  
18 give an example when you say an outcome could be  
19 reported that the patient doesn't know was an  
20 error, but it might be figured out later? Do you  
21 have one?

22 MEMBER HASKELL: I'll say the ones

1       that I've seen reported for example reactions to  
2       medications which are typically under reported by  
3       physicians. And the patient might not  
4       necessarily know that it was a reaction to a  
5       medication.

6               And this is a little bit off  
7       diagnosis, but not entirely. So they wouldn't  
8       know why something happened, but they know that  
9       something happened. And in a broader assessment,  
10      a clinician might be able to connect the dots.

11              CO-CHAIR MCDONALD: Okay. Helen.

12              DR. BURSTIN: I was going to say I  
13      don't think every measure can solve all of this.  
14      So I think we have to think about how they come  
15      together. Patients get results. We just talked  
16      about it. Something about patient experience I  
17      think is critical here and I really want to make  
18      sure something patient-focused/patient-voiced  
19      comes out as being at the top.

20              Just as an example, I think I may have  
21      mentioned at the last meeting that there was a  
22      tool developed by Glyn Elwyn at Dartmouth called



1 CollaboRATE. Again, it's three questions. And I  
2 think it can be something where you could take  
3 something like that and try to adapt it.

4 I think I read this last time. But  
5 just very briefly, these three items are how much  
6 effort was made to help you understand your  
7 health issues, how much effort was made to listen  
8 to the things that mattered to you most about  
9 your health issue and how much effort was made to  
10 include what matters to you in choosing what to  
11 do next.

12 There's a simplicity to that that I  
13 think the way Glyn's been using it is to say  
14 thinking about the recent appointment or thinking  
15 about your recent process. I mean just something  
16 rather than saying you have to start from  
17 scratch. There's an amazing body of work now on  
18 shared decision making that I think it won't  
19 solve everything, but I think it's a real  
20 opportunity to think about it.

21 I know Glyn is going to be submitting  
22 it to us as soon as we have an opportunity in the

1 fall. It has gotten remarkable pickup, and I  
2 think I mentioned this to you last time, it was  
3 developed with a nine point Likert scale with the  
4 intent that it would be done on a cell phone.

5 When you ask Glyn why it's in one to  
6 nine Likert Scale, he said because there are nine  
7 buttons on a cell phone. It's time to move to  
8 things you can do in real time in real practice  
9 and have that dialogue going.

10 MEMBER SINGH: Helen, exactly this is  
11 the point. How long did it take for him to do  
12 this work and was it done under some kind of  
13 research in Wyoming? Did he actually validate  
14 some of these things?

15 CO-CHAIR MCDONALD: Yes, it takes time  
16 to develop.

17 MEMBER SINGH: Right.

18 CO-CHAIR MCDONALD: But all of these  
19 concepts have some sort of measurement work.

20 MEMBER SINGH: Yes, that's what my  
21 point was.

22 DR. BURSTIN: I think my point is not

1 everything has to be a de novo effort of a data  
2 collection that will take five years. There is a  
3 phenomenal amount of work done to see what's out  
4 there that could potentially be used now to try  
5 to get some of these issues addressed.

6 CO-CHAIR MCDONALD: I think on that  
7 last package of the patient experience ones it's  
8 still worth keeping the four that we have for the  
9 rest of the process. And the idea is that -- go  
10 all the way down -- they could be fiddled with.  
11 But if you look at them as a set, there's  
12 something related to the experience of diagnostic  
13 care. So problems explained.

14 Each one of these can be drilled down  
15 on, patient reported and understanding the  
16 diagnosis. So each of these it's important that  
17 those two things they tie into the definition.  
18 Patient satisfaction, patient experience of the  
19 diagnostic process, this is the idea that there  
20 could be some things that relate a little bit  
21 more to satisfaction with steps in the diagnostic  
22 process. Some steps would be appropriate to ask

1 about that. Some steps might not be appropriate  
2 to ask.

3 Patient experience with the diagnostic  
4 process, actually the idea of how it was  
5 experienced. That's a little bit more like the  
6 Glyn Elwyn type of measure.

7 That's the idea here is that there's  
8 a lot of room to develop actual measures within  
9 each of these. And some may tackle different  
10 pieces of the diagnostic process and different  
11 failure points differently. Okay, Helen.

12 MEMBER HASKELL: And one more thing,  
13 I do think it's worth having patient reporting on  
14 specific parts of the diagnostic process. Care  
15 coordination for example which is the bugaboo of  
16 course of patients. If that is reported by  
17 patients, you might get a very different report  
18 from what you're getting from the people on the  
19 other side of it who think they're doing great.

20 CO-CHAIR MCDONALD: Exactly. And so  
21 each one of these from the group what people do  
22 need to know is the idea is that each one of

1       these you could go into the nuance of where it's  
2       worth trying to measure. That would take a whole  
3       process with a group of people, but not such a  
4       process that it couldn't happen. It's very  
5       doable.

6               Having looked at everything, were  
7       there any gaps that we missed that are vitally  
8       important? Okay, Mike. You can say something.  
9       Go ahead.

10              MEMBER DUNNE: On patient engagement  
11       number five, you don't specify who will provide  
12       the diagnostic information. And we spoke briefly  
13       about medical scribes and how they have to be  
14       somewhat certified to do this. So who is left  
15       with the responsibility? Do you have someone  
16       who's trained in this? Or should it be the  
17       primary clinician?

18              But you just can't say someone has to  
19       do it because it could end up being a health care  
20       provider who's not thoroughly versed in the  
21       diagnostic process.

22              CO-CHAIR MCDONALD: That's a good

1 point for us to add here in terms of just on the  
2 side note part that you need to have not only  
3 communicated in an understandable manner but in a  
4 manner that has fidelity to the knowledge base  
5 that could be transmitted from a knowledgeable  
6 person who could transmit that knowledge.

7 And it's right now put as a structure  
8 measure. So the process to assure that the  
9 diagnosis and the diagnostic information is  
10 communicated in an understandable manner by a  
11 person who is appropriately trained to do so.

12 Great. I think we've covered the gap  
13 section.

14 MS. SKIPPER: I just want to note that  
15 our next step would be to move into the measure  
16 prioritization criteria. We can either keep  
17 moving right into that, or do people want to take  
18 a quick ten minute break?

19 CO-CHAIR MCDONALD: We were going to  
20 explain how that process was going to work, and  
21 then people were going to individually do it.

22 MR. LYZENGA: I think that was the

1 idea that we were going to do another individual  
2 exercise. Talking to people yesterday after the  
3 meeting, it seemed like people found that  
4 valuable to dig into the measures.

5 CO-CHAIR MCDONALD: I think it would  
6 be good to explain what the process is then and  
7 then let people take a break and then come back  
8 with any questions and then start to do the  
9 process that way. If it's clear enough and  
10 people want to spend a little bit more and use  
11 the break time, they can. But they don't have  
12 to.

13 MR. LYZENGA: And we do also want to  
14 talk about the criteria a little bit because we  
15 had a few modifications to that and a late  
16 addition in that additional criteria.

17 CO-CHAIR MCDONALD: Are you guys game  
18 to go a little bit more so you know what the  
19 independent work will be before taking a break?  
20 Okay. Good.

21 MR. LYZENGA: I don't know if you guys  
22 have your handouts. There's actually a new

1 version. Yeah, the handouts from yesterday.

2 We talked about this a few times  
3 including on our most recent conference call.  
4 And then we had some further discussions about it  
5 internally. We talked a little bit about it with  
6 our Co-Chairs. We've landed on the two main  
7 overarching criteria of importance and  
8 feasibility, those being the two main axes  
9 behind which we would look at these measures.

10 I think somebody suggested which I  
11 think would be helpful is that we could end up  
12 being able to have a 4X4 box or something like  
13 that where we could see where the most important  
14 and highest feasibility measures are and those  
15 that are high importance but low feasibility  
16 maybe, or high feasibility and low importance.

17 Depending on what your interest is as  
18 a measure developer or a policy maker, you could  
19 look to see which are the higher feasibility ones  
20 and which are the most important ones and areas  
21 where those line up. Depending on what you're  
22 looking for you can find that.



1                   We did add up another third criterion  
2                   which is cost. Maybe I should first say that  
3                   there's a lot of stuff jammed in here in  
4                   importance. This is intending to keep it at  
5                   least relatively simple for us in terms and low  
6                   burden in terms of doing our actual ratings.  
7                   Didn't want to have to go through each of these  
8                   subcriteria you could call them.

9                   But these are really in that second  
10                  column considerations to take in mind, questions  
11                  you might want to ask yourself when you're  
12                  thinking about whether a given concept is  
13                  important. How relevant is it to diagnostic  
14                  quality or safety? Is this more of a general  
15                  quality or safety area? is this really specific  
16                  in capturing something about diagnosis?

17                  There's this element about high  
18                  priority. This is actually drawn from some work  
19                  that we're doing around prioritizing measures  
20                  generally at NQF. And these are three goals for  
21                  measurement that we're trying to focus on as part  
22                  of that process.

1                   We have a focus on outcomes. Outcome  
2 measures are obviously higher priority. They're  
3 meaningful to the patient and that they support a  
4 systemic or integrated view of care. Just some  
5 things to keep in mind as you're considering  
6 whether this is an important measure concept.

7                   Impact is another aspect of that.  
8 Basically, is this going to have an impact on  
9 patient health? If a provider is performing well  
10 on this, is it likely that they're going to have  
11 better outcomes essentially if it's a process or  
12 structure measure. And as part of that, you  
13 could think of it through Hardeep's lens, and to  
14 what extent is it reducing diagnostic error  
15 specifically.

16                   And then finally actionability or the  
17 likelihood that measuring this issue will drive  
18 changes in organizational behavior and the  
19 results of the measure will drive improvement.  
20 Any questions on that? Does it make sense? Go  
21 ahead, David.

22                   MEMBER NEWMAN-TOKER: So it's golf,

1 right? The lowest score is the best.

2 MR. LYZENGA: Yes. Actually, we're  
3 thinking that is what's here. But now I'm  
4 reconsidering that.

5 MEMBER NEWMAN-TOKER: Yes.

6 MR. LYZENGA: As I'm thinking about  
7 how we're going to tally these up, maybe we  
8 should flip that and say three is the highest  
9 importance and one is the lowest importance.  
10 We're going to have to tally these and get a --

11 MEMBER NEWMAN-TOKER: The only other  
12 thing is, could you just clarify for us on the  
13 time period of what's short-term? Can you scroll  
14 down a little bit?

15 MR. LYZENGA: Yes, the feasibility.  
16 We haven't scrolled down to that yet.

17 MEMBER NEWMAN-TOKER: Is short-term  
18 like a few months? A year? Two years?

19 MR. LYZENGA: I don't know if anybody  
20 has any input or thoughts on that. We could  
21 leave it to your discretion.

22 MEMBER NEWMAN-TOKER: Could we just

1 pick something arbitrary within here?

2 MR. LYZENGA: Anybody have any  
3 thoughts on what short-term, medium-term, long-  
4 term means to them? We have some of those fully  
5 developed measures that we think could pretty  
6 feasibly be implemented immediately or in the  
7 very short term. And I don't know.

8 To some extent you can use your  
9 judgment and discretion in saying this is a much  
10 more aspirational goal. I'm going to give this a  
11 three. The two, maybe there's a lot of wiggle  
12 room in there. But I'd welcome any thoughts from  
13 the Committee on how we might further define  
14 those.

15 MR. HENRIKSEN: Wouldn't it depend on  
16 the concept under review and the disease entity  
17 in terms of what's long-term or short-term?

18 MR. LYZENGA: Probably would.

19 MEMBER NEWMAN-TOKER: Yes, that's a  
20 good point, too. So the measure concept may  
21 already have some measures that are well  
22 established. But others that need a longer term

1 development, so that does even make it messier.  
2 Thanks for pointing that out, Kerm.

3 CO-CHAIR MCDONALD: Preshant.

4 MEMBER MAHAJAN: The way I would look  
5 at it is: How impactful are we anticipating the  
6 report from NQF to be? Say, for instance, we  
7 anticipate to help move the policy in this  
8 direction. Then the measure in the OPPE to me is  
9 a broad reaching measure which could impact to  
10 say it should happen, something like that, that  
11 we could prioritize. That would be one way to  
12 approach it.

13 Or someone did mention about oncology  
14 which is like the most commonly missed illness  
15 than some measures related to transmission of  
16 results specifically for oncology should then be  
17 more sharp than what you're able to measure  
18 comparative. That is one way to look at it.

19 CO-CHAIR MCDONALD: Martha.

20 MEMBER RADFORD: To me this question  
21 is all about data sources. Are they available  
22 now? Could they be developed quickly? Will it

1 take a relatively longer time to develop the data  
2 sources for this measure? For example, we do  
3 have some that are available now. And that's how  
4 I'm going to rate it.

5 CO-CHAIR MCDONALD: The other factor  
6 I think of, too, is just measure development. I  
7 mean to develop a decent measure does take some  
8 time. One way to think about this would be to  
9 think in terms of as you're looking at the group  
10 for each tab and you're having to indicate the  
11 feasibility. You could do it comparatively,  
12 right, of which ones among these have the data.  
13 So now it's really more of measurement time  
14 cycle.

15 Or they already have a measurement.  
16 So if there's data or there's already a measure  
17 that's already decent, then obviously it's short-  
18 term. But if there's not, then it's relatively  
19 medium-term. And if there's a bunch of other  
20 barriers in the way, then it's long-term.

21 MEMBER NEWMAN-TOKER: And I think  
22 Martha's point is probably spot-on that the

1       availability of data is what's going to determine  
2       the immediacy with which people can start to take  
3       action towards the measure and the fewer  
4       political hurdles there are.

5               We did our stroke measure at Kaiser in  
6       three weeks. They just -- they have all the  
7       data.

8               CO-CHAIR MCDONALD: But they might  
9       still have to say -- The other piece of this is  
10      whether something is possible to do at the  
11      national level. Being able to proof of concept  
12      of the measure within the Kaiser system or at NYU  
13      is different than being able to have a measure  
14      that could go through an endorsement process  
15      here.

16              Are we thinking about just feasibility  
17      of being able to get to the point of having a  
18      measure somewhere of this? Or are we thinking of  
19      a measure that could go through an NQF process?

20              DR. BURSTIN: I'll just make a brief  
21      comment. I think we are increasingly trying to  
22      think about these graduated approaches to

1 measurement. I think part of what we've seen is  
2 when measures go directly straight into  
3 accountability with any effort in the field to  
4 use them, see them, test them is not ideal.

5 So I would just put forward whatever  
6 the best measure is and if it's something that's  
7 developed and initially used for improvement and  
8 benchmarking and eventually tested and eventually  
9 brought into NQF, that's fine. But I don't want  
10 to hold up the field while waiting for the  
11 perfect measure when in fact we're just kind of  
12 nowhere on this field yet in terms of building it  
13 into anything we do in terms of clinical  
14 practice.

15 CO-CHAIR MCDONALD: Lavinia.

16 MEMBER MIDDLETON: Another way to look  
17 at the data is to look at the existing data on  
18 diagnostic errors that we have. I remind the  
19 group to the first meeting again that we had  
20 together with the continuum of where the  
21 diagnostic errors occur. And maybe we should  
22 develop the priority of the measures to make sure



1       that at each step of the continuum where we know  
2       that errors occur that we at least propose a  
3       measure that impacts that area.

4               CO-CHAIR MCDONALD:   David, were you  
5       wanting to add?

6               PARTICIPANT:   No, it was said a lot  
7       better than I could have.

8               CO-CHAIR MCDONALD:   Okay.   Martha.

9               MEMBER RADFORD:   Just about this issue  
10       of data availability, we have a number of  
11       suggestions for structure measures which are  
12       basically by attestation which is actually a  
13       pretty fast way to get data in theory.   And just  
14       to make that point.

15               CO-CHAIR MCDONALD:   And now on our  
16       list I saw it looks like process and structure  
17       and our immediate process and all of that are  
18       right on our concept list.

19               MR. LYZENGA:   It should hopefully be  
20       correct now, yeah.

21               CO-CHAIR MCDONALD:   It's a good point.  
22       Structure ones are faster by definition usually.

1                   MR. LYZENGA: And then on the other  
2 side of the coin --

3                   MEMBER RADFORD: They are reasonably  
4 good first steps toward getting more nuanced  
5 measures in the future.

6                   MR. LYZENGA: And then on the flip  
7 side you might expect outcome measures and  
8 intermediate outcomes to be higher importance  
9 generally. I was just saying in general we might  
10 expect also as a corollary of that outcome  
11 measures to be higher importance. I don't know  
12 what the implications are for feasibility, but  
13 it's just something to keep in mind.

14                  MEMBER NEWMAN-TOKER: But when we're  
15 talking about feasibility, we're talking about  
16 the feasibility of moving the measurement ball  
17 forward for a particular measure concept in the  
18 immediate short term as opposed to the political  
19 correctness of including it in a pay-for-  
20 performance framework.

21                  CO-CHAIR MCDONALD: Yes, I'd like to  
22 underscore. I mean, Helen, when you said

1 graduated and quality improvement given where the  
2 stage of this area is I think it's really  
3 important to take into consideration.

4 MEMBER NEWMAN-TOKER: I mean it's a  
5 really important point. We could be thinking  
6 about feasibility like what will our leadership  
7 accept tomorrow as a we have to do this kind of  
8 thing. And that's not what we're after. What  
9 we're after is are these measure idea things that  
10 can be moved forward quickly or not.

11 CO-CHAIR MCDONALD: Right. Is it  
12 possible to measure something reasonable in this  
13 space in the short-term, medium-term or long-term  
14 by some organization in some way?

15 MEMBER NEWMAN-TOKER: Right.

16 MEMBER SINGH: And I don't think we  
17 should be really focusing on either pay-for-  
18 performance, penalties or public reporting when  
19 we think through some of these things. We're  
20 just not ready. The only thing that gets close  
21 to getting ready for anything accountability-wise  
22 is something on test results follow-up.

1 CO-CHAIR MCDONALD: Sue.

2 MEMBER SHERIDAN: Something, the third  
3 criterion in cost savings concerns me that this  
4 committee would potentially rank important  
5 quality measures on what we think is cost  
6 savings. And there might be cost savings to the  
7 health care system, but there's also human costs.

8 So I recommend we not touch this one.  
9 I think it could be limiting without us having  
10 the expertise to really know what are we saving.  
11 At this level, it concerns me when we're trying  
12 to say we're going to recommend or rank things  
13 like cost savings

14 CO-CHAIR MCDONALD: Other comments on  
15 cost?

16 MEMBER RADFORD: Yes, I just want to  
17 agree with you completely there. None of this is  
18 supposed to result a direct cost savings. There  
19 may be indirect cost savings related to fewer  
20 diagnostic errors. But I think that's really  
21 minor, a minor consideration, for this family of  
22 measures.

1 CO-CHAIR MCDONALD: Kerm.

2 MR. HENRIKSEN: Yes, the other concern  
3 is: How many health economists are in the group  
4 here?

5 CO-CHAIR MCDONALD: I know I  
6 definitely had a concern with it just being  
7 health care costs because societal costs would be  
8 an appropriate thing to think about. But then  
9 you need to the expertise to do the accounting  
10 and that gets pretty tough.

11 One approach might be to think about  
12 something related to burden. And I don't know if  
13 there's a concept related to burden that members  
14 of this group would have a way of tapping in to.

15 MEMBER SINGH: Unintended consequences  
16 of some kind must be considered as we go forward.  
17 And they couldn't be built into the additional  
18 two things. But rather than cost, I would rather  
19 weigh in on unintended consequences.

20 CO-CHAIR GRABER: Just to defend  
21 costs, we understand that it's difficult to know  
22 what the cost savings might be and all the

1        comments are very relevant. But at the moment  
2        health care organizations don't see diagnostic  
3        error as a priority at all.

4                If there were a couple concept areas  
5        that had prominent cost saving potential, I think  
6        it would be important to know what those were as  
7        a way to get some of these adopted more quickly  
8        by health care organizations. At the moment,  
9        there are no other leaders.

10               The Joint Commission has no  
11        performance expectations in regards to diagnosis  
12        by in large. So I think we do need to consider  
13        costs if we want to be effective.

14               MEMBER NEWMAN-TOKER: I agree with  
15        Mark that the lever to push for leadership is  
16        around cost. And I don't think we all  
17        necessarily have to be health economists to be  
18        able to estimate whether a measure has anything  
19        or not to do with the likelihood of driving, over  
20        testing or under testing or whatever.

21               But I am worried like the rest of the  
22        group. We know that some of these things are

1 more or less cost agnostic, probably a lot of  
2 them, other than the cost of implementing the  
3 measure in terms of how they change people's  
4 behavior. It's hard to know whether it's going  
5 to cause people to test more or not if you  
6 educate them better or there's more communication  
7 or whatever.

8 So I don't think that this is  
9 necessarily something we should spend a ton of  
10 time on. Maybe people could star the ones that  
11 they think could be used as better levers for  
12 leaders.

13 MR. LYZENGA: I think that's maybe a  
14 good approach instead of rating each one. We can  
15 indicate by star some of the ones that are maybe  
16 more likely to contribute to cost savings or  
17 something like that.

18 CO-CHAIR GRABER: The key thing,  
19 Andrew, is did you want us to reverse this scale  
20 or use the one that's printed here.

21 MR. LYZENGA: Reverse.

22 CO-CHAIR GRABER: Okay. So everybody

1 get that.

2 MR. LYZENGA: We'll print a new copy  
3 of this.

4 CO-CHAIR GRABER: We're going to print  
5 new pages and it's going to be the reverse of  
6 what's here. And if we get it backwards, it's  
7 going to totally screw up the tally. So  
8 everybody's got to use the same ranking criteria.

9 MEMBER SINGH: I think we should get  
10 a verbal acknowledgment from everybody in the  
11 room that they understood that three is the  
12 highest and one is the lowest.

13 MR. LYZENGA: Three is better.

14 MEMBER SINGH: Please, everybody,  
15 raise your hand if you understand that three is  
16 the way to go if you really, really like that  
17 measure.

18 MR. LYZENGA: Thank you.

19 CO-CHAIR MCDONALD: Three is the  
20 highest. Mike, did you want to comment?

21 MEMBER DUNNE: Can I recommend that  
22 for cost we simply say potential for cost savings



1 and put yes or no? I mean how are you going to  
2 grade this?

3 MEMBER SINGH: The cost proponent, I'm  
4 very practical in case you haven't noticed. Can  
5 you give me examples of some measures that are  
6 cost savings or potentially cost savings?

7 CO-CHAIR MCDONALD: Actually, you have  
8 to give an example of a measure concept.

9 MEMBER SINGH: Okay. That's what I  
10 meant.

11 CO-CHAIR MCDONALD: That's the  
12 challenge.

13 MEMBER SINGH: Fine. Measure concept.  
14 Please just tell me. Just try to convince us.

15 MEMBER NEWMAN-TOKER: The test  
16 appropriateness measure.

17 MEMBER SINGH: Okay. It may be one.

18 MEMBER DUNNE: Turnaround time to  
19 critical results. It's going to reduce overall  
20 hospitalization in certain circumstances.

21 MEMBER SINGH: So the inappropriate  
22 test is if we know that the tests are

1 inappropriate, right. We'll have to figure that  
2 out somehow. And how are we going to do that  
3 when? Wouldn't that involve costs to figure out  
4 which tests were inappropriate?

5 MEMBER NEWMAN-TOKER: Not really if  
6 you do it in a symptom disease frame. It's  
7 actually pretty easy with administrative data.  
8 Somebody gets diagnosed with BPPV with an ICD 9  
9 code of 386.

10 MEMBER SINGH: Outside of neurology,  
11 please give us an example.

12 MEMBER NEWMAN-TOKER: The fact that  
13 I've done that in neurology doesn't mean that it  
14 can't be done in other places.

15 MEMBER SINGH: Okay, one example. I'm  
16 just thinking of how we're going to use this  
17 framework. Other people can give examples.

18 CO-CHAIR MCDONALD: How about this  
19 because I bet we will debate this for a long,  
20 long time? How about just going with if you have  
21 some information that you think is relevant to  
22 thinking about costs or adverse effects of this

1       concept that you think are really important like  
2       write a little note about that?

3               I think this is something that leaders  
4       will pay attention to because it could seem like  
5       it could end up being net cost saving. Or I  
6       think nobody will pay attention to this because  
7       it will cost them way, way too much to pay  
8       attention to this.

9               You could write notes about that and  
10       you could write notes about whether you think  
11       this concept is really prone to severe adverse  
12       harm. Those are two things. We talked about  
13       that.

14              MEMBER SINGH: So use only two and  
15       then write notes on either cost or unintended  
16       consequences.

17              CO-CHAIR MCDONALD: Right, for the  
18       third. Don't try to do a rating. Then we can  
19       bring that back for discussion. It's going to  
20       depend on how different people are thinking about  
21       it to end up with a ranking.

22              MEMBER NEWMAN-TOKER: And one other

1 critical thing on the issue of cost, I think we  
2 should move away from the cost piece and just  
3 talk about if we think it's something that's  
4 going to drive down unnecessary or inappropriate  
5 utilization kind of behaviors or reduce length of  
6 stay.

7 In different payment model systems,  
8 those things mean different things. In this  
9 world, doing more testing that's unnecessary is  
10 to your financial advantage. But in a global  
11 budget system like Maryland, it's now to your  
12 disadvantage.

13 CO-CHAIR MCDONALD: David Hunt.

14 MEMBER HUNT: Yes, I just want to say  
15 that it sounds like what we really want to know  
16 is whether or not the measure is effective and  
17 improving diagnostic accuracy. In a global  
18 sense, if we get diagnoses better, then that will  
19 have an effect on the overall cost to the system.  
20 I think there's a general agreement to that.

21 I have a few issues with the cost  
22 thing, too. Cost is really tough to calculate

1 even if you have the CMS actuaries here.

2 CO-CHAIR MCDONALD: You're absolutely  
3 right on that side of it, too. If we're going  
4 for diagnostic accuracy, then you're going for  
5 optimal efficiency ultimately if that were  
6 gained.

7 One thing though I think in terms of  
8 your discussion, Mark, is this idea of  
9 organizational attention. When making a note  
10 about whether the measure concept does something  
11 that grabs organizational attention, we can just  
12 note that.

13 Feel free to note anything in terms of  
14 -- I think, Andrew, it would be cost burdens --

15 MR. LYZENGA: Cost burdens or other  
16 issues.

17 CO-CHAIR MCDONALD: Yes, other issues  
18 just based on this discussion you think are  
19 important in terms of conceptualizing this.

20 MR. LYZENGA: From a logistical  
21 standpoint, we did give you these printouts.  
22 Some of you seemed to think it was easier to go

1 manually in which case we'll have to enter these  
2 in and take a little bit of time to put them and  
3 tally them up.

4 If you'd like to do it electronically,  
5 we can send you a spreadsheet that you can use.  
6 It may be a little unwieldy. Excel can be a  
7 little buggy and things like that. If you would  
8 prefer that, we can send around the spreadsheet  
9 to have you enter in your rating in that  
10 document.

11 Would anybody like to do it  
12 electronically? Or would you all prefer to do it  
13 on paper? All right. We're doing paper.

14 CO-CHAIR MCDONALD: Feel free to take  
15 a break and do the ratings.

16 (Whereupon, the above-entitled matter  
17 went off the record at 10:51 a.m. and resumed at  
18 11:45 a.m.)

19 MS. SKIPPER: All right. We'll move  
20 to our member and public comment period.  
21 Operator, could you please open the lines to hear  
22 if there are any comments.

1 OPERATOR: Okay, at this time if you  
2 would like to make a public comment, please press  
3 star and then the number one. And there are no  
4 public comments at this time.

5 MS. SKIPPER: Thank you. Are there  
6 comments in the room?

7 Hearing none, you all please continue  
8 working. Lunch should be set up soon. And I'm  
9 going to estimate that we can come back around  
10 12:30 p.m., 12:40 p.m. or so. About 50 minutes.  
11 Thank you.

12 (Whereupon, the above-entitled matter  
13 went off the record at 11:46 a.m. and resumed at  
14 12:58 p.m.)

15 MR. LYZENGA: Maybe we can reopen and  
16 maybe first just get some reflections on that  
17 exercise, whether you, I don't know, were finding  
18 it difficult or easy to do the ratings, if you  
19 were having any difficulty or confusion applying  
20 the criteria, and just sort of thoughts or  
21 reflections on how that went and we'll have the  
22 results, again, momentarily. But, initially, any

1 thoughts?

2 MEMBER NEWMAN-TOKER: I'd have  
3 preferred a five-point scale rather than --

4 MR. LYZENGA: Yes.

5 CO-CHAIR MCDONALD: Kerm?

6 MR. HENRIKSEN: Yes. We were just  
7 discussing how useful the averaged information  
8 that you get will be, because we're going to  
9 regress towards the mean here and so, you're  
10 going to have a lot of averages that perhaps  
11 certain around two, at least, I think, for  
12 feasibility.

13 There's probably a predominance of  
14 importance here that's almost hard to say  
15 something is not a three and so, you might get  
16 finer degradations for importance. But I'll be  
17 interested in what the averages look like and if  
18 those are useful for making fine distinctions,  
19 but maybe at the end of the day, you're not  
20 interested in maybe fine discriminations among  
21 items.

22 We're still sort of measuring with --



1 we're going to implementing with a hatchet and  
2 so, you don't really need a micrometer for  
3 measurement. And so, I was just wondering how  
4 satisfied --

5 MR. LYZENGA: Yes, well --

6 MR. HENRIKSEN: -- you will be with it.

7 MR. LYZENGA: -- we'll have to see. It  
8 did seem like there was a lot of threes in that  
9 importance column, from the ones that I was  
10 helping to enter in. So, I do have a sense that  
11 there's going to be not a whole lot of  
12 discrimination in that category, but we'll see  
13 how it comes out to be useful.

14 MEMBER NEWMAN-TOKER: So, I have to  
15 say, I tried to be ruthless in the sense that --  
16 because clearly it's all important, right? No  
17 one's arguing that -- I mean, we've come to this  
18 point, we've all argued a lot that all of this  
19 stuff that we've put out there is important.

20 So, I guess what I tried to use, for  
21 me personally anyway, was this question of, if I  
22 had the measure, how likely would it be that

1 having the measure alone would move the needle on  
2 the diagnostic error problem?

3 And I do think if you frame it that  
4 way, instead of saying, is this an important  
5 idea, like, that we should all do, maybe there's  
6 more room to differentiate between threes and  
7 non-threes.

8 CO-CHAIR MCDONALD: I think there's  
9 also, I mean, because we went through -- part of  
10 this is process, right? So, we've gone through a  
11 process where we've been in subgroups, presented,  
12 but the others haven't gotten to say, I agree  
13 with you Subgroup 1 or Working Group 1.

14 So, I think it just allows us to be  
15 sure that the entire Committee does actually feel  
16 that the set are an important set and nobody says  
17 whether a set should be ten or 20 or 50 or 1,000  
18 concepts. I mean, there's not a number that we  
19 have to shoot for.

20 MR. LYZENGA: And we've also got,  
21 again, a large amount of sort of rich discussion  
22 around this that's going to help us add context

1 to whatever the ratings are for each of the  
2 concepts.

3 CO-CHAIR MCDONALD: David?

4 MEMBER HUNT: I was going to say,  
5 actually, as someone who has actually used one of  
6 the products from our last work on Health IT  
7 Safety Measures that we did with NQF, as someone  
8 who has actually used this end product report, is  
9 the discussion that really it adds so much flavor  
10 and texture to it.

11 So, the numbers are important and  
12 they're good, but it's the context of the  
13 discussion that really produces a lot of value  
14 for us. And the -- I will say, also, one thing  
15 that we found is that the feasibility numbers are  
16 important, but as, I think it was Martha who  
17 said, feasibility in many ways is just a synonym  
18 for data availability.

19 And when we see something that may  
20 have been, say, a low score in feasibility, but  
21 then we realize, we actually can get that data,  
22 it makes all the difference in the world to know

1        what the importance of this then was for the  
2        entire group. So, it's of tremendous value and  
3        discriminating between those two makes a big, big  
4        difference.

5                MEMBER SINGH: So, I was just thinking,  
6        in the next couple of hours that are left, we're  
7        going to have a discussion on these, just to sort  
8        of go through and see? Because I think the main  
9        message here should be what kind of an actionable  
10       report we can produce so that people like you  
11       would get the most bang for their buck and it  
12       doesn't look like it's just another ivory tower  
13       report that nobody's going to do anything about.  
14       So, I think that sort of should be our --

15               CO-CHAIR MCDONALD: I think that's the  
16       idea, right? We're going to look at what these  
17       scores were, not so much discriminating, but just  
18       it will allow us to sort of see them in some  
19       order, and find out if there were some that got  
20       sifted out or some that just looks like they're  
21       nailing it and then, talk about the usefulness of  
22       how to present the information and what else is

1       needed.   Yes.

2                   MR. LYZENGA: Something else we kind of  
3       wanted to get input from you on is, it would be  
4       helpful for us, again, as we're talking about  
5       writing the report, are just kind of overarching  
6       issues. Any issues that sort of cut across these  
7       different concepts and measurement areas that you  
8       think would be important for us to highlight in  
9       the report, to discuss some of those.

10                   Again, the things that have come up  
11       are burden, and we've had some discussions around  
12       that and we'll try to flesh out a little bit of  
13       the Committee's discussion. If you have anything  
14       to add on that issue, we'd welcome any thoughts.

15                   Anything else that's emerged from  
16       this, sort of these exercises in the last couple  
17       of days that you think are worth talking about.  
18       I know I'm going to pull some things out of the  
19       previous discussion and I think we've got some  
20       sort of themes that are emerging here that we're  
21       going to talk about. But anything that you would  
22       -- that came into your mind that should be

1 highlighted as part of this.

2 One thing I also kind of wanted to get  
3 just an initial thought on, and I think maybe we  
4 may seek some further input from you after this  
5 call is, is the question of accountability,  
6 whether we've seen any concepts or areas of  
7 measurement that may be suitable for things like  
8 public reporting and even maybe payment and  
9 whether -- how far we are away from that.

10 If you don't see any at this moment,  
11 but if you do see any areas that might be  
12 promising and what those might be, or just any  
13 thoughts in general on that issue that we can,  
14 again, kind of work through in the report a  
15 little bit and have some discussion about. So,  
16 I'll just sort of open it up, does anybody have  
17 any thoughts?

18 MEMBER SINGH: And are we thinking  
19 maybe, like, what would be just one or two things  
20 that the organizations could relate to and say,  
21 this is so important we need to work on it, and  
22 it might get close to some kind of an

1 accountability measure and we prioritize just  
2 that one thing and that could come out in the  
3 report? Is that what you're trying to get to?

4 MR. LYZENGA: It doesn't have to be,  
5 like, something that we identify as, this is the  
6 Committee's highest priority, but we may want to  
7 sort of highlight a few issues or we may want to  
8 have, say, a section on accountability and say,  
9 the Committee identified some areas of  
10 measurement that may be promising for public  
11 reporting or payment in the future.

12 As these measures get developed, these  
13 would be something that we could -- as the field  
14 tries to move towards accountability, as measures  
15 are developed, where should we be looking? Does  
16 that make sense?

17 CO-CHAIR MCDONALD: Yes. I mean, I  
18 think that's a discussion topic for sure.

19 MR. LYZENGA: Yes.

20 CO-CHAIR MCDONALD: So, we tagging it  
21 as a discussion topic, do we want to try to  
22 discuss that now --

1 MR. LYZENGA: Yes.

2 CO-CHAIR MCDONALD: -- while we're  
3 still -- and, Martha, you had something to say, I  
4 don't know if it was on this.

5 MEMBER RADFORD: It was kind of, I just  
6 wanted to say that, first of all, I gave a fair  
7 number of ones, I don't know, mainly because I  
8 felt like they were a little bit tangential to  
9 diagnostic quality.

10 Second thing was, I really look  
11 forward to what I hope is the next stage of this,  
12 which is a draft of the document, because I think  
13 that the discussion has been wonderful and very  
14 rich and will provide, if you can summarize sort  
15 of the take-homes from that in the document  
16 around -- I think that will provide a tremendous  
17 amount of context. Thanks.

18 CO-CHAIR MCDONALD: So, I think --

19 MR. LYZENGA: And we hope you are not  
20 going to -- this isn't going to be the last time  
21 you provide input on that. We'll try to give you  
22 drafts and what have you.



1 MEMBER RADFORD: No, I'm sure it won't  
2 be. But do we have another in-person?

3 MR. LYZENGA: Another in-person --

4 MEMBER RADFORD: No? Okay.

5 MR. LYZENGA: -- we do have another, I  
6 think we have two more calls and we'll be  
7 actually talking about that in a moment. But  
8 hopefully we can also just do some work online  
9 via SharePoint or email and just get input, share  
10 -- circulate some ideas and drafts and things  
11 like that.

12 CO-CHAIR MCDONALD: Kerm?

13 MR. HENRIKSEN: Yes. Going back to  
14 Andrew's earlier question about accountability,  
15 there are -- and I imagine there's not much that  
16 is being recommended for those purposes from  
17 comments from Hardeep and David, but there are  
18 other uses for the information that's being  
19 gathered and it all depends on how you package  
20 the materials.

21 So, there may not be measures for  
22 public reporting, but there certainly are for

1 quality improvement projects that anybody can  
2 undertake. And there's also other measures that  
3 are more relevant to research.

4 And so, in terms of how the report is  
5 sort of divided into modules or chapters or  
6 sections, do you sort of help the broadest  
7 audience possible that might be interested in  
8 diagnostic safety to find their place in the  
9 report so that they can -- so that there's  
10 something in there for them --

11 MR. LYZENGA: Right.

12 MR. HENRIKSEN: -- sort of action items  
13 or things that are within recent --

14 MR. LYZENGA: That's definitely a  
15 helpful suggestion and we can try to, yes,  
16 incorporate some concept like that, a way of  
17 indicating for different audiences who are  
18 looking for different things --

19 MR. HENRIKSEN: Yes.

20 MR. LYZENGA: -- where they can find  
21 what they're looking for.

22 CO-CHAIR MCDONALD: Yes, that's a good

1 idea. Would it be worth articulating what maybe  
2 the top three or four or five audiences are?

3 MR. HENRIKSEN: Yes. Well, I would  
4 think researchers, for one.

5 CO-CHAIR MCDONALD: Researchers.

6 MR. HENRIKSEN: And then, the other is  
7 closer to the clinical practice, in terms of  
8 things that they can be doing. And, as David  
9 mentioned, this can help start a conversation for  
10 people that are really looking -- it's not so  
11 much the value of its importance or feasibility,  
12 but it helps to start a conversation.

13 CO-CHAIR MCDONALD: So, maybe it's  
14 researchers, it's the delivery system, it's those  
15 who are involved at policy level.

16 MR. HENRIKSEN: Yes, policy level.

17 CO-CHAIR MCDONALD: Okay.

18 MR. HENRIKSEN: So, those are the major  
19 groups.

20 MEMBER HASKELL: And patient advocacy.

21 MR. HENRIKSEN: Yes, patient advocates.  
22 Yes, definitely. Patients themselves or patient

1 advocates --

2 MEMBER HASKELL: Yes.

3 MR. HENRIKSEN: -- definitely.

4 MEMBER SINGH: Yes. In this day and  
5 age, when there's so much lack of emphasis, I  
6 would say, on scientific momentum to push this  
7 forward from many stakeholders who should be  
8 involved, could we actually just outline some  
9 agencies who would take this work forward and  
10 especially say what's in it for them.

11 Why would CMS want to do anything with  
12 this report? Do we have a good case? Can we  
13 build it? Can we build a paragraph which is,  
14 this is why CMS should be interested in this  
15 report? And I'm going to pick on my friend David  
16 here as well, this is why ONC should be  
17 interested in this report.

18 And I think, that is a type of an  
19 accountability that I think we need to be giving.  
20 It's a shared responsibility, just like we say  
21 for Health IT, improving diagnosis is also a  
22 shared responsibility and I think we need to try

1 to think about, who are the stakeholders who are  
2 going to take the brunt of moving this forward?

3 CO-CHAIR MCDONALD: This is -- okay, so  
4 that was a little bit on making this useful. If  
5 there's more ideas, let's get through those.  
6 Yes, Martha?

7 MEMBER RADFORD: We've already  
8 mentioned specialty societies as being an  
9 important contributor and they've got skin in the  
10 game, potentially.

11 CO-CHAIR MCDONALD: And they're  
12 professional societies, since Marilyn's left.

13 MEMBER SEIDENWURM: I don't think we  
14 have to do a whole ton of work getting CMS  
15 interested in this, because it's in the QPP and  
16 it's a major priority and they've actually  
17 emphasized that now for at least one or two or  
18 three rulemaking cycles. And I don't know which  
19 -- they overlap. So, I think CMS gets that this  
20 is important. Now --

21 MEMBER SINGH: They are, I was just  
22 making a point. Yes, it's actually in their 2016

1 report --

2 MEMBER SEIDENWURM: Right. Which we --

3 MEMBER SINGH: -- for diagnostic  
4 measures, yes.

5 MEMBER SEIDENWURM: Right. Which we  
6 helped write.

7 DR. BURSTIN: It couldn't hurt to just  
8 be very clear about what the actions are. And  
9 actually, I was just saying to Andrew earlier, I  
10 think a lot of what we've talked about has  
11 blended, has sort of sailed between measure  
12 concepts and, really, recommendations for the  
13 field broadly. And so, I think we can try to  
14 tease that out.

15 And I was actually suggesting to  
16 Andrew, maybe we could actually send it around to  
17 -- the report, one of the reports our committees  
18 did a couple years ago on rural health and  
19 specifically how to handle low volume providers,  
20 it's maybe a little off topic, but the way they  
21 organized it in terms of a clear set of  
22 recommendations of what needs to be done, beyond

1 even just the measure framework and the concepts,  
2 I think is an important element.

3 Because so much of what has been said  
4 here fit into that almost policy recommendations,  
5 but not yet really a measure. And I don't want  
6 us to feel like you're only in the box of  
7 everything, because it's NQF, being a measure.

8 And I'm glad David's nodding his head,  
9 because I do think some of this is about  
10 standards for EHRs, some of this is about policy  
11 direction, some of this is about measurement.  
12 And, again, CMS funded this, so they fully  
13 recognize they want measures in this space.

14 CO-CHAIR MCDONALD: Good.

15 MEMBER HUNT: And I'll just say,  
16 particularly when you're working in policy,  
17 having a good idea of what is an area for  
18 measurement or is not saves a tremendous amount  
19 of time.

20 It allows you to triage things, to,  
21 okay, well, this needs to head over to this  
22 group, rather than this group and we can use this

1 as a good solid meal for starting some  
2 measurement development.

3 Having done the work of discriminating  
4 what is in and what's out of different spheres,  
5 what is good for quality improvement activity,  
6 but perhaps not suitable for reporting purposes  
7 on a national basis.

8 These are the questions that are  
9 always brought up when we talk about actually  
10 starting a new initiative or starting a  
11 measurement initiative. So, all of this is  
12 incredibly helpful.

13 CO-CHAIR MCDONALD: And, actually, as  
14 a segue from that, so you -- we're not quite  
15 ready yet with -- are we ready for that?  
16 Because, I mean, I think -- so, we could look at  
17 that.

18 Maybe as we look at that, one of the  
19 lenses we should look at it is through that lens,  
20 Andrew, you're asking for, which is, are some of  
21 these areas more important for pushing towards  
22 some sort of accountability?



1           I mean, my own personal view is that  
2     the measurement field in this space is very far  
3     from being able to be effectively used for  
4     accountability in a way that we can feel  
5     confident would actually improve diagnosis.  
6     That's my own opinion writ large.

7           But as we look at this at a more  
8     granular level, there could well be some areas in  
9     here that would be ones where you would think,  
10    hey, it would be really good to have measures in  
11    here that make the system accountable. So, we  
12    can try to tease that part out and have comments  
13    on that too, so that NQF has that as they're  
14    working on the report.

15           MR. LYZENGA: Actually, just before we  
16    see this, as a caveat, we entered this all pretty  
17    quickly, I haven't seen the results and we may  
18    have had some data entry issues. I can't be  
19    confident yet, so this is sort of a preliminary  
20    look. We'll go back and kind of clean up and  
21    reconcile everything and get you final numbers,  
22    but we can at least get the first look here.

1                   MEMBER HUNT: Can I just go on record  
2                   that, after today, that someone owes Vanessa a  
3                   lunch?

4                   (Laughter.)

5                   CO-CHAIR MCDONALD: Yes.

6                   MEMBER NEWMAN-TOKER: Just to follow up  
7                   briefly on David's excellent point about the  
8                   helpfulness of knowing what's not a good measure.  
9                   I think, in terms of getting, not just sort of,  
10                  these are areas we think are promising and these  
11                  others here should go to policy things, but even  
12                  a little richer.

13                  Like the context of, we discussed this  
14                  idea, right, that came to the table and the  
15                  reason why this wasn't a good measure was X, Y,  
16                  and Z, so that people don't think -- because  
17                  there is a tendency for people to think that  
18                  we're just sort of thoughtless idiots when we  
19                  leave stuff out, as opposed to -- at least me  
20                  anyway.

21                  And so, the -- I think, really,  
22                  bringing that in in a richer way somehow and kind

1 of explaining the logic of why something wasn't  
2 included, will stave off a certain amount of  
3 criticism from all the people who have their own  
4 passionate interest in a particular measure.

5 MR. LYZENGA: Sorry, it turns out we're  
6 not quite ready yet.

7 CO-CHAIR MCDONALD: I kind of object to  
8 summing between importance and -- yes. Yes. How  
9 about doing -- how about just leaving those two  
10 as they are and just sorting it first by  
11 importance, letting us look at it that way, and  
12 then sorting it, after we've looked at it by  
13 importance, on feasibility.

14 So, let's look at importance first.  
15 So, they've got a summary for each concept. They  
16 do, they have a summary for importance and they  
17 have a summary for feasibility.

18 MR. LYZENGA: So, here's our highest  
19 rated concepts. I'm not sure how that happened.  
20 Yes, we've got some higher than three ratings,  
21 I'm not sure how that happened. All right, we'll  
22 go with what we -- again, we'll clean this up.

1 I'm not sure how that could have happened, but --

2 CO-CHAIR MCDONALD: They're probably  
3 relatively still about right, so --

4 MR. LYZENGA: I would guess, yes. It's  
5 divided by the -- so, maybe we got that number  
6 wrong. We were going to go in and reconcile that  
7 too, so that -- it's the number of raters, yes,  
8 so we may have missed one.

9 CO-CHAIR MCDONALD: Yes, the importance  
10 is there and it looks like it's still ordered the  
11 same, at least as far down as we can see. So,  
12 the top one has 44 as the sum.

13 MR. LYZENGA: Right. There were also  
14 some blanks that we needed to go in and --

15 CO-CHAIR MCDONALD: Yes.

16 MR. LYZENGA: -- clean up, so that may  
17 have thrown off our -- yes. I did take your  
18 names out of there before I did that. So, that's  
19 -- we're still basically in the same place, but  
20 these are the -- those are the totals.

21 CO-CHAIR MCDONALD: That's good. Can  
22 you make it just a tiny bit bigger?

1 MR. LYZENGA: So, we'll clean up those  
2 averages, figure out --

3 CO-CHAIR MCDONALD: Yes, that's nice.

4 MR. LYZENGA: -- what went wrong there.

5 CO-CHAIR MCDONALD: Okay, yes. This  
6 way we can look at about five at a time, which is  
7 --

8 MR. LYZENGA: A little bit more.

9 CO-CHAIR MCDONALD: There we go. Yes,  
10 we've got five there, that's good. So, the first  
11 observation, we have measures from five different  
12 tabs in the top five. It's kind of nice. We  
13 want these, yes. Okay, there we go. Yes, now  
14 we've got next set of four to five.

15 MR. LYZENGA: We'll take a look at that  
16 too, see if we can get some ranges and --

17 CO-CHAIR MCDONALD: You can go to the  
18 next, yes. So, a little bit more. One more.  
19 There we go. It took a while to get to  
20 diagnostic error as a subdomain. There's not  
21 much difference here, we're still at 41, these  
22 are all tied, these are all still tied.

1                   Okay, show us some more. Yes, this is  
2 Kerm's hypothesis, yes. Oh, look at that. Okay,  
3 yes. Actually, go down to the bottom. Go down  
4 to the bottom and let's move up from the bottom  
5 now. Okay. So, starting right there. Yes, the  
6 bottom one is not a measure, so some people --

7                   MR. LYZENGA: Oh, right, yes.

8                   CO-CHAIR MCDONALD: -- realized that,  
9 probably. But there, the composite, that was a  
10 measure. So, the composite was the lowest of our  
11 group. Make it bigger? There.

12                  MR. LYZENGA: Yes.

13                  CO-CHAIR MCDONALD: And now you can  
14 start going back up. So, just -- okay, yes.  
15 That will -- no, like, yes, we'll just -- yes, go  
16 up just the next chunk, sort of chunk of four or  
17 five to chunk of four or five.

18                  (Laughter.)

19                  MEMBER SINGH: I lost count, are we  
20 kind of in the middle or are we --

21                  CO-CHAIR MCDONALD: We have that too,  
22 it's a mess. We're close to the bottom --

1 MR. LYZENGA: Still close to the  
2 bottom.

3 CO-CHAIR MCDONALD: -- right now. So,  
4 we're doing, like, the utility analysis where you  
5 go high, low, high, low.

6 (Laughter.)

7 CO-CHAIR MCDONALD: Don't get anchored.  
8 The next five is still near the bottom. Okay,  
9 yes. You can go another five up. Okay, go ahead  
10 up again. Special one.

11 MR. LYZENGA: I can't remember why that  
12 was --

13 CO-CHAIR MCDONALD: It got de-  
14 escalated.

15 (Laughter.)

16 CO-CHAIR MCDONALD: Yes. There was  
17 another patient experience that was lower than  
18 that one, yes. Okay, go on up. Okay. Yes,  
19 exactly, we're in the middle of the pack now.  
20 You can go again.

21 MR. LYZENGA: You can scroll up one.

22 CO-CHAIR MCDONALD: Yes. Pop up one

1 more. I mean, another chunk, yes. There we go.  
2 Okay, again. Yes, now we're --

3 MEMBER SINGH: This is by importance,  
4 right?

5 CO-CHAIR MCDONALD: Yes.

6 MR. LYZENGA: Yes, this is by  
7 importance, we haven't --

8 CO-CHAIR MCDONALD: And by feasibility.

9 And I'm also thinking, maybe what would be nice  
10 when we look at the next category is to actually  
11 go ahead and categorize by subdomain first and  
12 then, like, feasibility second, just to see  
13 within our domains, because we might have an  
14 easier time seeing it that way.

15 But go up, we're almost -- we have to  
16 get back to 40. Yes, but we're still looking at  
17 importance, we haven't quite hit 40 yet. I mean,  
18 now we're in the top half. Okay. Okay. Okay.  
19 There's another closed loop one that's really  
20 high that was in the first five, it was the  
21 second, I think. Yes. Yes. Yes, the other  
22 external environment one, it was low on



1 feasibility too. Yes.

2 Okay, go on. Okay, we're back at 40,  
3 so there may have been a whole batch of forties.  
4 Okay, go up again. Okay, go up again. Up a  
5 little bit more. We haven't seen these yet, so  
6 we're still moving back to that place where we'll  
7 bump up -- go up. Yes, I think we -- yes, we're  
8 now back in the top range there. Okay.

9 Everybody want to see the top again,  
10 the top five? And then, you can resort. See,  
11 there it was, closed loop was the second one.  
12 Yes. You just want to see the feasibility list  
13 through 40 of them or do you want to look by  
14 subdomain at feasibility? You want to see all?  
15 Okay. Feasibility for everything, yes. Yes,  
16 okay. Yes.

17 MEMBER SINGH: You just sorted it by  
18 feasibility?

19 CO-CHAIR MCDONALD: Yes. Though this  
20 next one is an outcome -- that's -- yes. Scroll  
21 down, there we go. Yes. Okay, go ahead, go down  
22 another set. Want to go down another set? Yes.

1                   MEMBER HUNT: Remember that analysis by  
2 committee is like art by committee.

3                   CO-CHAIR MCDONALD: Yes, we can't --  
4 yes, exactly. And I'm thinking one of the ways  
5 to have the conversation is to be looking at  
6 maybe the top ten, just to sort of say, okay,  
7 here's the importance rating, here's the  
8 feasibility rating, kind of, what do people think  
9 of that? What's sort of the -- yes.

10                  DR. BERNOT: And, also, just to even  
11 validate that we look at the top ten and see that  
12 that is actually the ones that we think should be  
13 there?

14                  MEMBER SINGH: So, will we do the top  
15 ten for importance and then the top ten for  
16 feasibility? Like that? And that way, there  
17 could be a little separate discussion. And then,  
18 some will be in top ten for both, so you'll only  
19 end up doing, like, 14 or 15, maybe, max.

20                  CO-CHAIR MCDONALD: Use your  
21 microphone, Martha. Yes.

22                  MEMBER RADFORD: I'm not sure why we

1 need to discuss it, because, I mean, we have  
2 discussed these measures pretty much ad nauseam.

3 (Laughter.)

4 MEMBER RADFORD: And I think that,  
5 since there's some consensus about what's  
6 important, that's something that we can  
7 celebrate, frankly. And there's enough votes on  
8 all of these to say we have some consensus here.  
9 I don't -- yes.

10 I mean, we're not going to -- this is  
11 not going to be the final ranking, by any means,  
12 and maybe we won't even have a final ranking. I,  
13 personally, feel like we're kind of done, in the  
14 sense that the next thing I want to see is a  
15 draft.

16 CO-CHAIR MCDONALD: That will be over  
17 the next lunch hour.

18 MEMBER RADFORD: With a bunch of  
19 tables, yes.

20 (Laughter.)

21 MEMBER RADFORD: No. We're not --  
22 we're going to let you have a couple days off

1       there.

2                   DR. BURSTIN: I'm not sure if summing  
3       it makes sense, I think they're very different  
4       concepts. I mean, traditionally, what we've  
5       tended to do is, it's really a four-quadrant map,  
6       right? You have importance on one axis, you have  
7       feasibility on the other axis.

8                   The measures that are ready for prime  
9       time, David could pass off, we could pass off and  
10      try to get measured, are going to be in the high  
11      importance/high feasibility quadrant. We can  
12      separate them all out that way.

13                  There are going to be some that are  
14      going to be high importance/really low  
15      feasibility and those are going to be important  
16      and those are probably on a slower track until we  
17      figure out how to do them.

18                  So, there's nothing about this, I'm  
19      with Martha, there's nothing about this exercise  
20      that's going to get us any closer to, at this  
21      moment, doing that, other than you clearly -- I  
22      think the face validity of, did the top ten on

1 importance look like they were important? And I  
2 saw a fair number of heads nodding. And I think  
3 we can then go back and do the analysis and then  
4 share back with you sort of the quadrant  
5 analysis.

6 CO-CHAIR MCDONALD: Yes, that's what I

7 --

8 DR. BURSTIN: Or even lay out for you  
9 the importance measures across the range of  
10 feasibility. And if you could even help us  
11 identify, so, based on this, which are the ones  
12 we should really push on trying to get developed  
13 in the next one to two years? Which are the ones  
14 that are really important, but are probably going  
15 to take three to five years, given data sources?

16 Which are the ones that are just so  
17 important, but you know what, they're probably  
18 never going to be a measure, but maybe they  
19 should be a standard for the Joint Commission,  
20 maybe they should be a standard for ONC, maybe  
21 they should be a policy direction for CMS. And  
22 so, I think that's where there's a lot of work to

1       tease this out and to do that, you've got to  
2       really sit and be with these data.

3               MEMBER SINGH: And you're almost  
4       suggesting there should be another meeting face-  
5       to-face.

6               (Laughter.)

7               DR. BURSTIN: I don't know that we have  
8       the budget for that, but we will certainly do all  
9       the pre-work so that that next meeting, whether  
10      it's virtual or whatever, I think we can get the  
11      work done.   Yes.

12              MR. LYZENGA: And we'll, again, we'll  
13      clean this up, we'll send it back to you so you  
14      guys can play with it and kind of sort and cut it  
15      up how you'd like.

16              And then, we'd like to get some  
17      discussion going, again, via email or maybe a  
18      discussion board or something like that and try  
19      to work through some of these issues that Helen  
20      was just talking about and, again, crosscutting  
21      things or where we want to -- what we want to  
22      emphasize as part of the report and how.   And

1 guidance on all of that would be very much  
2 welcome as we get into that.

3 CO-CHAIR MCDONALD: Good. Is there --  
4 oh, go ahead.

5 MEMBER HUNT: That way we'll get a  
6 chance to hear the voices of those who had to  
7 leave early and -- yes, that'll be important.

8 CO-CHAIR MCDONALD: Okay. So, we've  
9 gotten to look at this. Now, the question is,  
10 what else do you need from us to help do the work  
11 you're going to have to do when we're not sitting  
12 here? And there's still enough of us here that -  
13 -

14 MR. LYZENGA: Yes. I mean, again --

15 CO-CHAIR MCDONALD: -- use us how you  
16 need us.

17 MR. LYZENGA: The most, from my  
18 perspective, the most important thing we need,  
19 again, is the discussion, sort of broadly  
20 construed what do we want to address through this  
21 report? How do we want to present this? What  
22 are the large issues we want to highlight?

1 Again, we'd like to kind of continue that  
2 discussion as we move forward, but just any  
3 thoughts that you have.

4 Again, reflections on the last couple  
5 of days, things that you think that we ought to  
6 cover or anything you think would be helpful for  
7 us as we begin to craft this report. Just talk  
8 at us, we'll get the transcript, we're going to  
9 go through it and we'll pull things out, so just  
10 give us material.

11 MEMBER NEWMAN-TOKER: Well, let me  
12 start by saying that you guys have done an  
13 amazing job. A round of applause.

14 (Applause.)

15 MEMBER NEWMAN-TOKER: Obviously,  
16 dealing with a complicated subject, an unruly  
17 crowd with at least one loud mouth, and so, we  
18 really appreciate all that you've done, for  
19 making this happen.

20 I think, for me, the same issue that's  
21 come up repeatedly, this issue of granularity, is  
22 I think kind of central to the way that this gets



1 framed into a report. Because, clearly, not all  
2 -- some of these were more like measurement  
3 themes or ideas and others were more like measure  
4 concepts that were one rung down in the food  
5 chain.

6 And I think evening that out in some  
7 way with one or two people at the helm of kind of  
8 maintaining that consistency as you guys write  
9 the report will be a critical place for you guys  
10 to massage what we've done here into something  
11 others can digest.

12 And I would advocate for making sure  
13 you try to maintain the level in between the  
14 subdomain and the measure concept, because I  
15 think, what I found for myself at least during  
16 this process, was that when I got to write things  
17 down, I just found myself jotting down whether we  
18 had covered stuff.

19 I had errors, harms, accuracy,  
20 timeliness, reliability, and appropriateness.  
21 Just, like, if I had those as kind of the sub-  
22 headers within some of these fields, the

1 subdomains, at least I kind of made sure that  
2 there was something there substantive that I  
3 could latch onto, like I'd covered this space.

4 And I think for people who are coming  
5 to this for the first time, if they have that  
6 sort of intermediate step, they'll kind of get  
7 it, that we kind of covered each of the  
8 subdomains a little bit more thoroughly. So, I  
9 think that will be the most important thing for  
10 you guys to do to help us.

11 MEMBER HUNT: And one thing I should  
12 say, again, as someone who has used one of the  
13 products of this type of process, you can rest  
14 assured that, particularly because of the  
15 strength of the NQF process in general in terms  
16 of when a measure actually gets up for  
17 endorsement, you can have faith that a measure  
18 developer will look, and if something's a  
19 concept, even if we think that it's a pretty good  
20 measure, and they start to say, well, what's the  
21 numerator, what's the denominator, what are the  
22 exclusions, if it doesn't shake out, they'll work

1 with it, tease it, and try to make it into  
2 something.

3 Because one of the beauties of having  
4 NQF is that the process now for a measure that  
5 actually is endorsed is pretty solid, that  
6 there's a rigor and a structure to it that you  
7 can be sure that at the end of the tunnel that it  
8 will come out with some validity and strength.

9 MEMBER RADFORD: I say this with some  
10 trepidation, because what I'm really doing is  
11 volunteering to help you, as opposed to you  
12 volunteering to help us, which is, it's possible  
13 that some of these concepts might benefit from  
14 drafting specifications. Which is kind of what I  
15 heard in your comment as well.

16 And as someone who basically does this  
17 on a daily basis, I'm willing to do that for a  
18 few and maybe other people who do this also might  
19 be willing as well. And I have a very, very sort  
20 of compulsive way that I write measure specs and  
21 I'm happy to share that with you. Just, I mean,  
22 I can't do it for all of them, but I can do it

1 for a few. So, pick your poison.

2 MR. LYZENGA: That's not a trivial  
3 offer, that's tremendous. That's -- wow.

4 MEMBER RADFORD: Well, this -- I know  
5 it's not going to be the final --

6 MR. LYZENGA: Yes, but --

7 MEMBER RADFORD: -- but at least it  
8 gives somebody an idea of how someone might  
9 measure it, yes.

10 CO-CHAIR MCDONALD: Yes, I think that's  
11 actually an incredible offer and it would behoove  
12 us if you see any concept on here where you can  
13 do that, as just sort of -- I mean, they're  
14 almost like -- yes, examples. Yes.

15 MEMBER MIDDLETON: And along that vein,  
16 I'm happy to add content to the FPPE, OPPE, and  
17 examples for diagnostic accuracy, because that's  
18 kind of where I live right now. I'm happy to do  
19 that.

20 CO-CHAIR MCDONALD: Actually, examples,  
21 I'm thinking examples tagged a little bit to that  
22 context from which you sit would be helpful too,

1       because many times a measure can be made because  
2       you have access to particular data or a  
3       particular frame of reference and it shows that,  
4       here's an example of how it would be done in an  
5       environment like mine. So, I think we would want  
6       to include that too.

7               MEMBER SINGH: I was just going to add,  
8       as we think about this, should we also sort of  
9       think about who the stakeholder would be whose  
10      measure this would most apply to and who could  
11      make things like this happen?

12             Again, I'm just picking on this one  
13      since it's the chief complaint from the EMR,  
14      let's say, if we go forward with this, I mean,  
15      this may be something that the institutions could  
16      also do, but this is something that your shop,  
17      David, could do very well. And so, I'm just  
18      thinking, do we need to sort of also think about  
19      sort of --

20             MR. LYZENGA: Yes, that would be really  
21      helpful --

22             MEMBER SINGH: Yes.

1 MR. LYZENGA: -- I think, if we could  
2 think about --

3 MEMBER SINGH: And that would make it  
4 more operational. I like Martha's idea, I'm not  
5 sure how you would want to write that, because I  
6 was thinking, okay, how she's going to write  
7 that?

8 But when you start thinking, some of  
9 these things might sort of drop off as  
10 recommendations, not specifically measures. I'm  
11 not saying this one will, but I just think that  
12 might help us determine, what's the actionability  
13 that's going to come out of it when somebody  
14 looks at this from, let's say, a healthcare  
15 system perspective.

16 And they're going to say, well, I  
17 can't do anything, this is under ONC's realm.  
18 And, therefore, we need to be thinking  
19 proactively that this should be moved somewhere  
20 else.

21 MR. LYZENGA: Yes, I think that would  
22 be really helpful, if you could think about, yes,

1 for each of these who might be the accountable  
2 entity or accountable entities. If you had a  
3 measure of this, that might help think through  
4 how you would then further specify the measure  
5 and kind of flesh it out.

6 CO-CHAIR MCDONALD: Also, where the  
7 data might be coming from. Any other comments?  
8 We're in free range comment zone.

9 (Laughter.)

10 CO-CHAIR MCDONALD: Okay. I'm hearing  
11 that we --

12 MR. LYZENGA: Should we do --

13 CO-CHAIR MCDONALD: -- can probably do  
14 public comment.

15 MR. LYZENGA: -- public comment?

16 CO-CHAIR MCDONALD: Yes.

17 MR. LYZENGA: Operator, could you see  
18 if anybody on the line has public comment?

19 OPERATOR: Yes, sir. At this time, if  
20 you would like to make a comment, please press  
21 star, then the number 1. And there are no public  
22 comments at this time.

1 MR. LYZENGA: Do we still have Paul in  
2 the room? No comments? You did have something  
3 you wanted to maybe mention and you can if you  
4 want, or we can --

5 MR. EPNER: Oh, okay

6 MR. LYZENGA: -- so, we --

7 CO-CHAIR MCDONALD: Okay. We have Kerm  
8 with his card up, too.

9 MR. LYZENGA: Oh, okay.

10 CO-CHAIR MCDONALD: So, Kerm, go ahead.

11 MR. HENRIKSEN: Yes. Just going back  
12 to the last comment. One way of sort of pointing  
13 out the relevance of different stakeholder groups  
14 for a particular measurement concept is through a  
15 bubble chart. And you can do that in various  
16 ways.

17 You can do it for each individual  
18 concept, just little circles with the initials of  
19 the stakeholder group, and you would have, maybe,  
20 it might be relevant to three or four different  
21 stakeholder groups, but at least they know they  
22 have a place at the table and that they've been



1 thought about in terms of the measures or the  
2 concepts that are being evaluated.

3 CO-CHAIR MCDONALD: Human factors  
4 visualization? Paul?

5 MR. LYZENGA: To introduce, Paul has  
6 been doing some work with the Society to improve  
7 diagnosis in medicine and I think -- and among  
8 the other things he'll talk about, located some  
9 examples of measures related to diagnostic  
10 quality that might be helpful as we try to spec  
11 these out, I think they may relate. But I'll let  
12 you kind of talk through what --

13 MR. EPNER: This will be quick. So,  
14 there's something called the Coalition to Improve  
15 Diagnosis. Several of your organizations are  
16 already in it, 31 organizations are currently a  
17 member. We have three collective actions.

18 One of them is to do a, try to do a  
19 census, literally, of any intervention that  
20 anyone is trying anywhere to improve diagnosis.  
21 Just, what's going on in the field? And one of  
22 the questions in this very short survey is, do

1       you measure diagnostic quality? And, if so, what  
2       is your measure?

3               And so, as of this -- this will be  
4       open all April, this survey. As of today, we  
5       only have 186 respondents. But in just scanning  
6       the responses an hour or two ago, and I showed  
7       them to Helen, there was -- I saw -- first thing,  
8       it's amazing, 70 percent are saying they measure  
9       diagnostic quality.

10              And you look through their answers --  
11       they say they do, but they don't. So, yes. So,  
12       when you look at the answers, they just lump it  
13       in patient safety or lump it in quality or  
14       something like that.

15              But one of the first ten that showed  
16       up was, there was this site that was measuring  
17       day one, day three, and final day diagnosis  
18       discordance. So, that's actually being used  
19       somewhere, which is kind of surprising to me.

20              So, Helen suggested we send each of  
21       you the link to the survey, not the results yet,  
22       it'll be open all the month of April. To the

1 degree that you can further disseminate it, AHRQ  
2 was kind enough to send it to 55,000 people, they  
3 told us to expect maybe 100 respondents, but  
4 we're asking every one of the 31 organizations to  
5 disseminate it.

6 It's open all of April, it's a very  
7 short survey, you can take it yourself. And,  
8 again, it's nothing statistical, we're collecting  
9 minimal demographics. High response rate from  
10 risk managers, high response rate so far,  
11 relatively speaking, from academic medical  
12 center, lower community, lower primary care, et  
13 cetera. But we're hoping we'll get hundreds of  
14 responses by the end of April. Any question  
15 about that? So, you'll see it from Andrew.

16 Thank you.

17 MEMBER SINGH: Yes. I just wanted to  
18 add something. This is a very common response, I  
19 know some of you were surprised. Many  
20 organizations will say, yes, we address diagnosis  
21 all the time, because we're sort of teaching  
22 people, residents, the clinicians are taking CME,

1 we're improving our diagnostic skills.

2           There's a lot of difference, and I  
3 know this came up in the first report and it  
4 didn't come up in this -- not the first report,  
5 the first session, but it didn't come up in this  
6 one, I think there's a difference between just  
7 trying to do stuff to improve diagnosis and  
8 trying to do actual stuff to reduce diagnostic  
9 errors. And I think there's still a lot of  
10 confusion in the field, oh, yes, we're improving  
11 diagnosis, so, therefore, we are solving the  
12 problem. It is actually not true.

13           And I think as you couch the report,  
14 also, we need to be careful, and that's why the  
15 preventable diagnostic harm comments that I made  
16 before, we need to be able to make sure that  
17 whatever measures or measurement concepts that  
18 we're coming up with directly address the safety  
19 component and the preventable diagnostic harm,  
20 rather than couching it as, oh, just general  
21 improving diagnostic quality, because we're not  
22 getting anywhere with that.

1                   We haven't got anywhere with that for  
2                   the last several decades. And unless we move the  
3                   needle on sort of safety and preventable  
4                   diagnostic harm, it's going to be hard. And so,  
5                   I think we need to sort of weave that into the  
6                   report. At least, that's what I would recommend.

7                   MS. SKIPPER: Kerm, did you have a  
8                   comment? No? Okay.

9                   MR. LYZENGA: David?

10                  MEMBER HUNT: Yes, I would just agree  
11                  with what Hardeep said. That we've got to make  
12                  sure that people understand that, just because  
13                  you're a healthcare organization and you do  
14                  diagnosis, that you're not necessarily improving  
15                  on it and you don't necessarily do it with any  
16                  rigor or any method, necessarily. And part of  
17                  the reason for this whole effort is that we need  
18                  to take it from an art to a science, maybe.

19                  MS. SKIPPER: David?

20                  MEMBER NEWMAN-TOKER: Yes. I mean,  
21                  just to flip -- to say it in a slightly different  
22                  way, but echo the comments that were just made,

1 in a systems engineering framework, every system  
2 produces exactly the number of errors that it was  
3 designed to produce.

4 And that's what we have now. Like,  
5 the old way of doing things, whatever it is that  
6 we think we're doing to improve diagnosis  
7 produces exactly the number of diagnostic errors  
8 we get, which is way too many. And the question  
9 is, what can we measure to improve beyond where  
10 we are today, rather than what can we say, we  
11 patted ourselves on the back, that we've done in  
12 the past?

13 CO-CHAIR MCDONALD: Okay. I think  
14 we're at the point where we've given a lot of  
15 comments, had a great -- a lot of wonderful  
16 inputs, some volunteering for the future. What  
17 do you all want to do to sort of set us on our  
18 way?

19 MS. SKIPPER: I have a couple of  
20 announcements. Yes. So, first, thank you, Kathy,  
21 for stepping up to help co-chair the meeting the  
22 past couple of days, you did a great job.

1 (Applause.)

2 MS. SKIPPER: And thank you to all of  
3 you in the room for your help and hard work over  
4 the past couple of days and for looking at these  
5 measures over and over. And I think we're in a  
6 much better place.

7 So, following this meeting, we do have  
8 a webinar, originally scheduled for Tuesday.  
9 That's a little bit too close for us to be able  
10 to sort of clean up some of the work that we've  
11 done over these two days, so we want to  
12 reschedule it.

13 I'll be sending out a Doodle poll for  
14 dates, either the 25th or the 26th. So, I'm  
15 hoping that will work for most of you, but I'll  
16 be sending that -- no, Martha's shaking her head  
17 no. Well, we're going to do our best to try to  
18 schedule a follow-up webinar that works best for  
19 everyone.

20 And then, you'll see a couple other  
21 emails, hopefully one other email, from me  
22 containing the information that Paul shared. And

1       there was also information that Sue shared and  
2       mentioned about a CMS special session, QIO 12th  
3       Scope of Work, she wanted to share the  
4       information with you all, so I'll also be  
5       forwarding that link. And then, the discussion  
6       guide or the slide sets that you all put together  
7       of your report-backs, in case that will be  
8       helpful in any way for you.

9               So, those are my announcements. We  
10       will, once we have that follow-up webinar, we  
11       will be working very hard to write the report and  
12       we will be posting it for our second public  
13       comment period on May 16.

14              So, that's right around the corner, so  
15       we have a lot going on over the next couple of  
16       weeks. And then, we'll reconvene you all again  
17       to sort of respond to any comments received on  
18       the draft framework, the report, and your  
19       concepts.

20              MEMBER SINGH: So, you will be sending  
21       the report to us before it goes for public  
22       comment or not?



1 MR. LYZENGA: Yes.

2 MS. SKIPPER: Yes. I was --

3 MEMBER HUNT: If I could just say, you  
4 mentioned the CMS and the information on the 12th  
5 Scope of Work, and that's where for the QIO  
6 program, I hope I'm preaching to the choir,  
7 that's for the QIO 12th Scope of Work, correct?

8 MS. SKIPPER: Yes.

9 MEMBER HUNT: Those of you who don't  
10 know, the QIO program is basically the CMS army  
11 in the field for quality improvement. And  
12 there's a tremendous amount of power that can be  
13 leveraged by getting things into the statement of  
14 work or the scope of work that these  
15 organizations across the country do.

16 And so, many times, you hear  
17 statements like, wouldn't it be good if everyone  
18 could start working on X, Y, or Z, and this is  
19 one way, this is -- CMS has gone through a number  
20 of iterations of developing how they decide what  
21 these organizations do.

22 So, if you have any interest in a

1 national effect on, not just this, but virtually  
2 anything in quality improvement, I really  
3 encourage you to take a look and get involved as  
4 much as possible.

5 Before, it was a very cloistered, very  
6 insular process of deciding what it was that the  
7 QIOs would do and now, this is opening up  
8 tremendously and I encourage everyone to try to  
9 support that if you can.

10 MR. LYZENGA: Okay. Well, yes, thank  
11 you all so much. It's been fantastic.

12 CO-CHAIR MCDONALD: Thank you.

13 MR. LYZENGA: We really appreciate all  
14 of you.

15 CO-CHAIR MCDONALD: Thank you to all of  
16 you. You guys have just done an absolutely  
17 tremendous job. I mean, we've been saying it,  
18 but we really mean it.

19 MR. LYZENGA: Same to you. And safe  
20 travels home.

21 (Whereupon, the above-entitled matter  
22 went off the record at 1:58 p.m.)

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