National Quality Forum

Moderator: First and Last Name
June 5, 2017
12:00 p.m. ET

Operator: This is Conference # 22334590

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

Christy Skipper: Good afternoon, everyone, and welcome to the fourth Web meeting of the Improving Diagnostic Quality and Safety webinar. I want to thank everyone for joining us today.

The purpose of the call today is to do a sort of a final discussion and hear feedback from the committee on the diagnostic quality and safety framework and report as a whole before we open up for public comment next week. And I just want to say thank you to those of you who have already sent in some comments and feedback via email.

So, we're just wanting to make sure that the committee is all on the same page as far as what is included in the report and the framework. And the idea is not to get unanimous consent but just overall agreement from the committee that our report is ready to go out and has included and reflected your thoughts as appropriate.

So, just let me introduce myself. I'm Christy Skipper, Project Manager. And around the table, I do have our teams, Senior Director John Bernot, Senior Director Andrew Lyzenga, our Project Analyst Vanessa Moy and we also

have Tracy Lustig, Senior Director. And so, right now, I'll just turn it over to Vanessa for a quick roll call.

Vanessa Moy: OK, thank you, Christy. Is Mark Graber here? OK, how about Missy Danforth?

Missy Danforth: Yes, I'm here, thanks.

Vanessa Moy: OK, thank you. Jennifer Campisano? OK, how about Michael Dunne?

Michael Dunne: Yes.

Vanessa Moy: Hello, thanks. David Grenache?

David Grenache: Yes, yes, I'm here.

Vanessa Moy: OK, thank you. Helen Haskell? OK, Carlos Higuera-Rueda? OK, Marilyn Hravnak? Mira Irons? Nicholas Kuzma?

Nicholas Kuzma: Yes, I'm present.

Vanessa Moy: OK, thank you. Kathryn McDonald?

Kathryn McDonald: I'm here, thanks.

Vanessa Moy: Prashant Mahajan? Lavinia Middleton? David Newman-Toker? Martha Radford? David Seidenwurm? Thomas Sequist?

Thomas Sequist: Yes, I'm here.

Vanessa Moy: OK, thanks. And Hardeep Singh? OK, is there anyone else that is on the line that I may have missed or just joined recently?

David Seidenwurm: Hi, David Seidenwurm. I just joined, thank you.

Vanessa Moy: OK, thank you. I'll hand it back to Christy.

Christy Skipper: Thank you, Vanessa. I just want to note that you need to be dialed in on the phone and logged in to the computer to view the slides and to be able to

respond. I just wanted to point that out. And if you are logged on your computer, mute your computer to eliminate any feedback as we jump into the discussion of the report.

So, the next slide, please. OK, so, just an overview, we've done the welcome, we're going to go through and discuss the report and hear your feedback and then open up for member and public comments and close out with some next steps.

OK, so, overall, the report was divided into three major sections summarizing the domains and sub-domains, any prioritized measures and overall themes and recommendations. And so, within each section, we sort of summarized the committee's feelings and discussion within these major topics. And within the prioritized measures section of the report, we listed any concepts or measurement areas related to those domains and sub-domains.

And if I remember from the meeting, we did note that some concepts are really better as ideas and weren't specified as -- specified enough. So, we try to note out whether they're listed as concepts or measurement areas within each section.

And so, some of the major themes and recommendations that we pulled from the -- from your discussion was the impact of electronic health records on diagnostic quality and safety, hearing the opportunity for medical specialty societies to provide any guidance, inter-professional education and credentialing and as well as communication and health literacy.

Next slide. So, I won't read everything on the slide here but this just summarizes each of the major domains and the sub-domains agreed upon at our -- at our last in-person meeting.

So, just to jump right in with the committee's discussion, we just want to know have we accurately described the measurement framework, and if so -- or if not then is there anything that's missing?

So, I'll turn it over to our committee just to sort of kick that off if you have any feedback or comments on the report as far as the domain. We'll start with the domain. Or even, you know, you, guys, did a great job, there's nothing to add. We will gladly take those comments as well.

Michael Dunne: I think it accurately reflected the discussion during the last face-to-face meeting.

Male: I would agree with that.

Christy Skipper: OK.

Thomas Sequist: I agree, this is Tom.

Christy Skipper: OK. Was there anything that -- does anybody has anything to add? You agree but are there any voices that there were something that we missed or that you needed to add?

Missy Danforth: Christy, can you go back to the previous slide?

Christy Skipper: Sure.

Missy Danforth: This is Missy, sorry. Great, thanks. So, unfortunately, I actually wasn't able to attend the last in-person meeting, I had an emergency (that we talked about). Can you just remind me where the patient-reported outcomes piece went in? Did you decide not to make that its own sub-domain?

Andrew Lyzenga: Yes, Missy, this is Andrew. So, we sort of viewed patient-reported outcomes as cutting across potentially each of these different areas. We had talked a little bit about in the last meeting how we found upon reviewing the list of concepts that they -- it didn't make as much sense to us to sort of split them out over the -- as -- in terms of domains out into structure, process and outcome because, again, those sort of cut across the different measurement areas, we thought we're sort of emerging from the concept list.

And as I think we were thinking about it, patient-reported -- patient-reported outcomes could potentially land in any one of these domains depending on,

you know, maybe slightly less so in the diagnostic process, but -- or others, but they can really fit in anywhere depending on how, you know, those concepts -- I have to take a look back at the concept list again.

But you could have sort of patient-reported or patient surveys or that sort of thing as the source of data potentially across the different domains. And maybe we can talk a little bit more about that in the report itself and make that a little bit more clear.

And we would certainly also welcome any thoughts or input on measurement areas where sort of patient feedback and input and reported sort of outcomes would be particularly relevant in terms of, again, the data source or a way to gain insight into diagnostic quality and safety issues. Does that make sense?

Missy Danforth: It does, that's helpful, thank you for the summary.

Christy Skipper: Any other thoughts or feedback on the domains and sub-domains and whether there's anything that should be added in the report?

Kathryn McDonald: Christy, this is Kathy McDonald. I'm having trouble, I can't get on the webinar and I am looking for the email that had the report, so I can be looking at it now. I've looked at it previously but I -- could somebody either send the slides or tell us where we've got the report and what the subject line was?

Christy Skipper: Sure. We can resend that out to you now. And if you're having trouble seeing the slides on the screen, press the Request button at the top. And I'm going to resend that email containing the report right now.

Kathryn McDonald: Thank you.

Christy Skipper: And so, while we're -- I'm sending that out, we can just move on to the next topic. As far as the recommendations that we summarized previously, were there any recommendations that were left out, anything that you, all, want to add, any feedback on those?

Andrew Lyzenga: And maybe this is a good place to note that we -- so we wanted to mention as part of this call, I mean this is partly an opportunity for you to give a little bit

of the input, you know, beyond what you've written back to us via email, which again, as Christy mentioned, is very much appreciated.

But also to let you know that we do intend to actually do another around of rating of the concepts themselves to get a little bit more sort of prioritization of those concepts.

We found that the ratings that we did at the in-person meeting weren't quite giving us enough sort of meaningful differentiation among the concepts we have demoed on the three point scale and we're now thinking that it was better to do it on a five-point scale for each of the criteria, the importance and feasibility and are hoping that will give us a little bit more, again, sort of differentiation, allow us to find a few that may be rise to the top a little bit more in terms of what are seen as most important by our committee.

So, I wanted to give you a heads up to anticipate that coming to you during the comment period. Go ahead. (It was something again?)

David Newman-Toker: Yes, sorry, this is David Newman-Toker. I apologize, I was -- I was on the computer but not on the phone. So, I'm probably -- my talking to the machine wasn't (helping) anybody.

So, I haven't had a chance to really do a deep, deep dive into the report but my sense is that there is a lot in there about process and much less about outcomes. Could you talk a little bit about whether you perceive that to be the case and whether that's deliberate, if so?

Andrew Lyzenga: Yes, I think that's may be fair because I am just still looking -- sort of paging back through the report here myself. There were a number of -- the sort of outcomes really kind of fell into a couple particular areas where sort of the diagnostic efficiency and diagnostic error which were within process category or diagnostic process category.

And, you know, in some of the other -- in terms of organizational and policy issues, there is -- may be a little less -- you have fewer outcome measures which you would kind of expect.

Sorry, I'm, again, just looking back through here to see.

I think that may be a good point in any case that we could may be try to emphasize outcomes a little bit and maybe we could pull out -- pull that out as sort of a theme separate from just the listing of the concepts themselves and talk a little bit about diagnostic outcomes and how we're thinking about them and how in some ways they differ from, you know, what your sort of usual clinical outcomes are and some just sort of themes that emerged from the concepts that we did identify as part of this work.

So, maybe that's something we'll try to incorporate as part of the next version of the report and we would definitely welcome any thoughts you have on that.

David Newman-Toker: Sure.

Kathryn McDonald: This is Kathy real quickly. I do think from a prioritization standpoint, we might -- you might think about having us prioritize structure process and outcomes separately.

Andrew Lyzenga: OK.

Kathryn McDonald: Right? Because we're talking about concepts, so it's -- you know, we're really just giving our sense of the weight and I think people have -- you know, we'll think, "Oh, outcomes are most important but they are hard to get at and so that makes process more important." Some will go, "Well, outcomes are more important to (figure out some of the) more important." So, and that's a different debate than...

Andrew Lyzenga: Right.

Kathryn McDonald: ... among -- you know, within a category which ones of these concepts and actual indicators are going to help produce impact.

David Newman-Toker: So, I guess -- this is David. Let me just sort of articulate a couple of ideas around kind of why I bring that up and where I'm headed. So, I think one of the places where the patient safety movement thus far and the patient

safety and quality movement thus far may have gone a little bit off the rails, where it has, and it hasn't -- you know, a lot of it has been good.

But where it's gone off the rails as often because it has sought after intermediate process outcome measures that don't have any intrinsic meaning but were easy to measure and then people end up sort of teaching to the (task) and gaining the system, and also (it's the bizarre) ways.

And I think this problem of sort of looking where the light is, is a real risk around the whole diagnostic error space. The light is somewhere other than micromanaging everybody's process through quality measures.

The light is in encouraging people to get it right and to do it efficiently. And I -- and I guess what I would say is, when you have a long report that has a few outcome measures buried in a couple of sub-sections as bullet points, it doesn't come across as a report that emphasizes the relevance and importance of an area that may need more work, right?

Like what we're saying is this is a framework for measurement. This is not measures that are ready for primetime. This is sort of an aspirational look at how we might measure diagnostic errors.

I do think that your suggestion, Andrew, of sort of having a section that sort of elaborates that discussion around outcomes is a really important thing to have and I do think, you know, whether it's the way Kathy suggested to highlight it by sort of, you know, separating structure process and outcome and kind of ranking those in some sense as opposed to hitting them against each other which in some sense doesn't make as much sense, you know, whether it's that way or some other way, I do think somehow you have to kind of draw these things out and make them more than just sort of a couple of one-off one-liners in the report.

Andrew Lyzenga: All right. That's really helpful. So, we'll -- yes, we can -- we'll sort of incorporate a lot of those thoughts and think through how we can highlight those better.

I do think also after we do this sort of re-ranking and prioritization, we'll probably have a little bit of restructuring of the concept section as well, so maybe we'll think through how we can kind of reframe that a little bit better to emphasize the outcomes more and these issues that you just talked about. So, that was very helpful, thank you.

David Newman-Toker: Thanks, Andrew. I appreciate it.

Kathryn McDonald: And this is Kathy -- this is Kathy again. I'd like to add on the process side that often process (that have speed up) through micromanaging, and I agree completely with David that that's incredibly counterproductive in this area of diagnostic performance.

However, it's possible to also look at the process at a higher level and there are measures of higher level, you know, things like teamwork if you're talking about right focus in the team, for example.

So, you know, the measurement space within process I think this could be constructed to be useful. Of course, you know, history has shown us that that's -- that may be hasn't been done, but I'm just adding that as another nuance within the process side (mapped through) diagnosis.

Andrew Lyzenga: Yes, absolutely, thank you.

Missy Danforth: Yes. And this is Missy. Just to support what David and Kathy said, I completely agree. And I think communication also is one of those processes that's actually really important to patients and also important to ultimate outcomes. And Hardeep has given some examples of some process measures related to timeliness and communication of lab tests, for example, that I think really exemplify that.

So, I agree with David. You know, the (report) could benefit from increased emphasis on the importance of outcomes, but there may be some process measures that are important and indicative of outcomes and easily understandable by patients as well.

Andrew Lyzenga: OK.

Mira Irons: This is -- this is Mira. I just wanted to add on to the issue about communication because communication per patient is very important but also this issue of communicating between the physicians and the staff that's involved in the diagnostic process itself.

And I know that we do address that but I might ask whether in the workforce, I'm now looking at the Workforce section on Page 14. We do talk about the fact that providers have adequate time for gathering.

But I don't know that we explicitly state and maybe I missed it if we did, that it's an organizational responsibility to provide the resources to ensure that the diagnostic team has the time needed for communication review of testing. I don't know what others think about that.

Andrew Lyzenga: I can -- I can say we can certainly highlight that a little bit more in the report as well. I think that's -- that point is well-taken. There were some concepts that emerged out of that but I think we could may be sort of give a little bit richer -- more of a rich discussion about sort of what the committee was thinking about the importance of that issue and maybe pull that out as another theme possibly by question of the organization providing adequate and appropriately sources to make sure there is enough time and everything to do diagnosis right.

Mira Irons: Thank you.

Andrew Lyzenga: Thank you.

John Bernot: We have a little bit of a pause here. This is John. Again, thanks, everybody, for joining us. One of the questions I had regarding the report was outside of the domains and sub-domains and we started to touch on this already.

We have a section called cross-cutting themes and recommendations. And this came out of a good group discussion that we had. And I remember David

Hunt and Helen Burstin were involved and saying, you know, not everything is a measure. And so, we wanted to capture that sentiment.

And what -- if you had not had a chance to review the whole report, that's OK. I'll read you the themes that we've captured and just make sure that we have the themes and there wasn't anything else we missed and/or take any feedback that you might have if you have read those sections and have specific feedback.

So, the first one was just the impact of the electronic health record on diagnostic quality and safety. The second was the opportunity for medical specialty societies to provide guidance. The third one was the inter-professional education and credentialing and the fourth one was communication and health literacy.

And those are the themes that we heard that wrap around measurement and/or stand beside the measurement, we had so much around the electronic health record, for example, that I think we had a number of discussions where we said, perhaps this is something that (O&C) or other entities need to deal with, but we want to still make sure we addressed, that we talked about it, it just might not be something that deserves a measure or measure concept.

So, I will open it up for -- if anyone has comments about whether those four are the appropriate themes or if there are other themes that you would like us to add into the report. With one thing, Mira, to your point, if possible that resources is something that needs to be added or that communication piece needs to be bolstered up to have the resources included.

Mira Irons: All right, thank you.

Lavinia Middleton: So, hi, this is Lavinia Middleton. I read the report, I thought it was very well-written and captured a lot of what we've talked about. I particularly like the cross-cutting themes towards the end of the report and think that there is a real opportunity if we work synergistically with the medical societies with our -- with the joint commission regarding education and credentialing to kind of build in a lot of these diagnostic performance and outcome measures into

other assessments that are, you know, all geared towards improving the patient outcome and the patient experience and reducing cost and inefficiency. So, I really like that part and I believe I sent my specific recommendations in.

Christy Skipper: Yes, we have those, thank you.

John Bernot: Any other thoughts on this particular section whether it'd be again the content within one of the recommendations or whether it'd be that we're missing a theme that the committee had talked about?

Kathryn McDonald: I guess one of the themes that was talked on, I'm not sure how we've hit it, this is Kathy, in terms of measurement on whether it's cross-cutting is all of -- all the organizational boundaries that sort of create havoc in the diagnostic space.

You know, folks in one organization can do measurements or organizations to be held accountable from a measurement perspective but, you know, a lot of diagnosis where there are failures can be about misses and gaps when patients have to cross various organizational boundaries, you know, and patient -- outpatients, et cetera. Would that be something that we could frame in a cross-cutting way?

John Bernot: We certainly can take a crack at it, yes, and get it back. So, when you're seeing organizational boundaries, I just wanted to make sure I clarify is, are you talking about the actual different settings of the organization? You mentioned inpatient, outpatient, or is it inter -- obstacles, administrative obstacles within the organization or both?

Kathryn McDonald: It's for the patients, that the patient may transfer from one organization to another organization sometimes -- you know, so when one organization has full responsibility for a patient, yes, there can be barriers and problems there. But I'm thinking about when patients go from organization or setting to setting and they're not under one organizational, you know, umbrella, they're actually moved in.

Missy Danforth: So, transition of care issues?

Kathryn McDonald: Yes. I mean from a patient perspective, patients often don't know when they're falling out of one organizations, you know, realm of coordination and into another organization's realm of coordination. Of course, those barriers are stronger when the organizations are actually not run by the same, you know, boss.

John Bernot: That makes perfect sense, Kathy.

Missy Danforth: Yes.

John Bernot: Yes, and here -- so, it's Helen who said transition of care, whoever that was, I'm not sure, but that was actually I think very good. And we have plenty of information within the transcript and in our notes. That I think we could crack out a section on that. So, that's a really good idea, thank you.

Missy Danforth: Sorry, that was Missy.

John Bernot: Oh, Missy, I'm sorry, Missy.

Missy Danforth: No...

(Off-Mic)

Male: But the whole issue of interoperability and information transfer can't be overemphasized. I mean there is no amount of pages or (bold type) that would be overdoing it.

Michael Dunne: I'm convinced that there is a fair amount of that intra rather than inter.

Kathryn McDonald: Yes, I didn't want to -- I didn't want to say it doesn't happen inter, but it's, you know, certainly -- or the other way around, intra, yes.

Michael Dunne: Yes.

Kathryn McDonald: It can happen in both places but part of it is the patient actually does not necessarily know, which could...

(Multiple Speakers)

Michael Dunne: Yes. So, maybe those things need to be stratified like first clean up your own backyard before you start criticizing others.

Kathryn McDonald: Right.

Helen Haskell: It's actually an interesting point, this is Helen. I think in many ways that concept of intra-operability particularly when you think of the care team including the patient, is a really interesting way to frame it.

John Bernot: Great, thank you.

Male: And particularly, emphasizing cooperation among the uneconomically related entities because although it's been pointed out there is plenty of room for improvement within these organizations, exchanges among them are even worst.

John Bernot: All right. And our silences are feverishly taking notes on everything that is happening in this conversation, so this is -- this is very helpful and I certainly see the ability for us to put a theme in on this as well as potentially bolster up some of the things we put in the electronic health record also because they are -- they certainly have a lot of overlap between them. So, we'll try to crack away that encompasses all of that. So -- but this is great discussion so feel free to continue.

Prashant Mahajan: So, this is Prashant. I have a quick question or clarification. You know, I understand that cross-cutting themes and recommendations, those that had been called out, what I'm trying to understand is, you know, if you look at issues with external environment, some of those could be cross-cutting across different domains too.

So, do you think it might be a little confusing to separate for the reader to understand why is it saying electronic health record as a cross-cutting theme but did not (also) as a part of individual domain, you know, or is that a risk that only I am seeing?

John Bernot: Well, I think maybe you need some clarification, that's a good point. I think what we want to highlight, and this is a wording thing, is that in the cross-cutting themes and recommendations , we really want to make sure we point out things from the committee that we don't think fit necessarily, perfectly into measurement.

So, there is going to be some overlap of things that we can measure, but also a part of that. So, your point is well-taken though, that we need to make sure we -- that the reader understands why we're putting the cross-cutting themes and recommendations separate from the domains, and again, these would be the items that may be not a performance measurement addresses but -- I don't want to use broad policy strokes specifically, but as a generic statement that that's the kind of thing the committee wanted people to be thinking about. Does that answer your question or is it still unclear?

Prashant Mahajan: Yes. No, no, it makes it clear. So, where I was struggling with is, you know, for instance, payment reform or healthcare policy changes at the -- at the national level, you know, not the macroeconomic level.

To me, like those are broader themes that can really impact at the individual patient level up to -- ranging from, you know, access to healthcare to delay in presentation, you know, the whole issue with immigration and then avoiding accessing healthcare and thus presenting late and thus having risk for delayed diagnosis. So, I'm just wondering, is that something that would need to be spelled out more than (monthly).

Andrew Lyzenga: Yes. And maybe it's even worth thinking about sort of extracting that external environment section from the concepts because it's not an area that really lends itself well to measurement. They're not being very clear accountable entity, you know, to measure in that space.

So, maybe we'll give that a little bit of thought and we welcome your thoughts and feedback about whether that should actually just be sort of framed up more as a cross-cutting theme and consideration rather than an area of measurement specifically.

Prashant Mahajan: And one other suggestion could then be then if some of these levels or areas of measurement, you know, which could be another control or measurable at -- say, at the institutional level versus at the -- you know, at the society level or international level. You know, so where the level of measurement and accountability of that measurement needs to happen, that could be a potentially sub-bullet for each of these measurement concepts.

David Newman-Toker: This is David. The whole external environment section, I think one could make an argument that the whole issue of legal and payment, which probably, you know, could have their own separate section since they're not intrinsically tied to one another.

I think (it makes it better) under cross-cutting themes and recommendations like to the extent that people are -- people are probably not going to develop and employ metrics of what their -- you know, whether their payment model necessarily supports the -- you know, the diagnostic process or maybe they will but I guess, I don't know, maybe that -- maybe that's not a metrics-based as much as the cross-cutting themes. I'm curious what other people think.

Kathryn McDonald: Well, isn't this section of cross-cutting themes about -- OK, this isn't specifically measurement but it's so important to think about as you're thinking about measurements as well as that it's cross-cutting in some way?

So, it's -- I guess each one of these cross-cutting areas I would -- I'm thinking that the reason that they're in this measure report is that they're areas that there are some relationship to measurements and that that needs to be a measurement in this particular area of diagnostic quality and accuracy.

So, it's probably important for each cross-cutting themes to make sure to motivate why it's incredibly important to lay it out in this particular report, so hit on the why it's important for diagnosis and that's particularly, you know, unique, special way, and why it's important for measurements, otherwise, we'll have a 100 cross-cutting areas because diagnosis, it's all parts of healthcare.

Andrew Lyzenga: Yes, that's helpful and we'll work on that.

David Newman-Toker: I guess what I would say is, I supposed I would like to see just a little bit of -- you know, just to do what Kathy just said in terms of linking, it would be great if we had, you know, something that said, it's presumed but payment mechanisms and approaches are going to ultimately be linked in the pay for performance or the weight to these measures.

And so, how those links are developed is critically related to what measures actually get used and whether they drive positive change or just tail-chasing busy work. And so, at some level, I think, you know, there is a space there to talk a little more about that.

You talked about it in a very sort of -- under the external environment, your paragraph sort of talks about the fact that -- more about kind of the discussion of whether this is a measurement thing or not a measurement thing.

But it doesn't -- it doesn't do what your cross-cutting themes and recommendations do which is kind of articulate the importance and relevance of those areas to the measurement framework. I mean it seemed like -- I'm not saying that have to be removed from the external environment and put somewhere else.

I'm just saying I think maybe a little bit of emphasis on payment and/or legal especially payment though would be really -- I think it's as importance an issue as inter-professional education or, you know, the inputs in medical specialties.

I think payers are ultimately going to drive the behavior in the space. So, I think saying something about that, you know, in a more focused way would help the readers of the report understand that link.

Andrew Lyzenga: Yes, agreed. We'll definitely take a crack at that, and again, we'd welcome your feedback and thoughts on any way we can sort of do that most effectively, but we will definitely -- I think you're exactly right, so we'll work on that.

And then just to sort of add to that, we'll probably circulate another draft at some point, you know, before final -- you know, we make this final. So, again, we'd encourage you to, once we do that, take a look and give us here your thoughts and feedback. All of this is really helpful and is helping us, you know, again, flush these things out and (bulk up) the report and, you know, make sure we have a good discussion of all of these issues.

So, it's very much appreciated. And as we -- as we move forward, still, we'll welcome as much of these sort of thoughts and comments and feedback that you can give us while we're doing the rating and prioritization and other (ways) just another sort of entreaty to keep giving us your thoughts like -- just like you're doing right now. This is all extremely helpful.

Christy Skipper: Thank you, Andrew. So, I think as we (talked) this one and we kind of covered some of the other questions that we had written out in our slide, but not to limit any discussion or feedback, but is there anything else that you, all, would like to share with us about this report and the frameworks?

Kathryn McDonald: It sounded like it would be useful to have a little bit more conversation on outcomes. I think that was queued up earlier and then we move into some other areas. Was that something we should may be loop back to that we haven't made outcomes in a focused way enough?

Andrew Lyzenga: Yes, yes.

Kathryn McDonald: And this would be our (stand)?

Andrew Lyzenga: Yes, we talked about that a little bit earlier and we'll definitely be (hitting that).

Kathryn McDonald: Yes.

Andrew Lyzenga: We'll make sure to sort of highlight that a little bit more, emphasize it, pull it out and talk through the issues around sort of diagnostic outcomes in a little bit more scale and try to -- and what the implications of it are.

Kathryn McDonald: OK, you don't need -- I was just sort of wondering if you needed more committee discussion of specific outcomes?

Andrew Lyzenga: Any discussion is helpful.

Kathryn McDonald: (Drilling in) to the outcomes space more as opposed to its importance.

Thomas Sequist: Yes. No, I think anything -- any input you could provide on this call would be really welcome. I don't know in terms of (the reaming) or specific outcomes, yes.

Kathryn McDonald: So, do we have any of our patient representatives on because I think that's an area where it's really important to get, Jennifer's and (Holland's) and (Cruz's) input. I think they might not have been on the call so.

Andrew Lyzenga: You know...

Kathryn McDonald: I guess my recommendation will be to loop back to them.

Andrew Lyzenga: Yes, we'll may be (reach out to them).

David Newman-Toker: This is David.

Andrew Lyzenga: Oh, sorry, go ahead, David,

David Newman-Toker: This is David. I'm sort of doodling on this idea in the background and I'll send you an email, guys, with, you know, sort of some of my thoughts. But I do think that this area of diagnostic error measurement has the potential to feel absolutely overwhelming to people.

Almost every medical condition that's been diagnosed with some frequency, often a non-trivial frequency, and you could just, you know, pick a measure based on if you stood in the cafeteria, it's on (Hopkins) where, you know, you have people from all different disciplines coming through, you can just sort of take whoever ran into you first and say, "OK, you know, it's misdiagnosis of migraine headache and it's misdiagnosis of appendicitis and it's misdiagnosis of some sinus disease and asthma and everything else." And everybody will have a story to tell.

So, I think that in the outcome space, one of the key things is that harms are really important and the notion of using measurement as a mechanism for prioritizing, I think is a really important one that at some level, we can't measure everything about diagnostic errors. We have to sort of pick our battles.

And I think one of the ways to make this whole problem seem more tractable and less overwhelming is to say, "OK, look, let's keep going back to the issue of harms to patient." And say, "What are the things that are causing the most harm the most often and tailoring measurement approaches to try to get at that information so that institutions can continue to have a focus in that -- in that sort of way."

I mean it -- so, for instance, if you look in your section here on diagnostic errors, I can pull it up here, you've got -- you have this -- password it -- but you have this -- the measure -- sorry, I apologize. (Show the time and) the space.

OK, here we go. So, you have the first bullet point under diagnostic error escalation, early care escalation, primary care, the emergency department, the emergency department to ward, ward to (ICU) since there is a diagnosis change link (to be indexed with) counter symptoms, signs or test results. That on paper looks like one in a scene of potential outcome measures in this measurement framework.

But that alone could be an entire family of measures across a broad range of diseases and conditions that links back to this issue of adverse outcomes for patients, that is if anybody who ends up with a care escalation has in some sense been harmed by whatever diagnostic error occurred and to the extent that those can be measured across a broad range of (physician) allows you to kind of focus on that issue of harms. This is for example.

And in terms of kind of how an important idea like that could easily get buried in the report, if that just comes across the sort of one a bazillion different

measurements that could possibly be done instead of sort of refocusing people's attention on the fact that the ways to measure harm, whatever they are, and ways to measure diagnostic errors that cause harm is really essential to a lot of this discussion and to getting people to sort of stop their head spinning and focus on something that matters to patients.

Andrew Lyzenga: OK, yes, that's also helpful. And I think that can -- that section in general can sort of flush out a little bit and some additional discussion add in, but that's a really good point.

And again, as we do the sort of rating and prioritization a little bit more, I think may be some of these issues will emerge a little bit more as well, and we'll try to incorporate in the discussion some of the issues that you just talked about, again, very helpful.

Lavinia Middleton: Hi, it's Lavinia one more time. Along that same theme, and I think we wouldn't have to be actually very prescriptive about it if we were able to say in our organizational policy issues that the organization has the established mechanism we say for providing feedback to the diagnostic theme but if we measure and assess harm and then each organization can determine what -- you know, what's the biggest number of RCAs, harms, peer review incidents that both go through the cafeteria and also our collated and measured and then acted upon.

I mean in our institution, one of the biggest issues is decoding harm and understanding the contribution to it and giving the feedback to the appropriate providers -- theme-based providers. And so, if the organization has a way to do that and then -- and it's not just the number of RCAs that are -- and I think I'm reiterating something I said in our group meeting, not the number of RCAs that are performed but the number of actionable items that come out of those RCAs, the number of changes in policies, not an outcome measure in and of itself based on -- or based on the results of deconstructing a harm event.

Andrew Lyzenga: OK.

Kathryn McDonald: It should be quoted, that was really well-put.

Andrew Lyzenga: OK. We'll look back at the transcript and make sure we capture that accurately.

Lavinia Middleton: Thank you.

Prashant Mahajan: This is Prashant. You know, and just going back to the section of diagnostic error and -- I mean that section for is the reader, is a little bit hard to grasp because the language is so broad, right?

Male: Yes.

Prashant Mahajan: So, I'm just wondering, is there any value in giving one or two concrete examples which could give me an example of a diagnostic error and probably one or two examples which could be (a new one) in such a way that they are not diagnostic errors but just progression of an illness, right?

So, for example, if a patient was diagnosed to have sepsis but stable, you know, and then six hours later, those two septic shocks potentially could be a different code which could come up as a different diagnosis and may not necessarily be a diagnostic error, you know. So, I'm just wondering if there is any value in clarifying some of these.

Andrew Lyzenga: Yes, we'd welcome again any input from the rest of the committee on that.

(Multiple Speakers)

Kathryn McDonald: I think that -- I think that idea is helpful from the perspective of making the report very accessible to different audiences including patients, so that could be nice.

Mira Irons: This is Mira. I also agree that it was help -- it would be helpful.

Marilyn Hravnak: This is Marilyn. I agree also. I think it took quite a bit of conversation to -- even our committee to get the consensus on some of this. And so, if we can

give some example, it would be very helpful for (clarity) for those who are just coming on this (meeting).

Andrew Lyzenga: So, that's something we would definitely, again, welcome. If you have any sort of an example you could come up with and send them to us, that would be extremely helpful for us.

It's a little difficult for some of -- some of us who aren't sort of in the clinical environment if you -- if you do have sort of specific examples, sort of maybe even, you know, vignettes or anything like that that you could provide us with and we can kind of work with them, that would be very helpful. So, we would love to get anything like that that you could -- you can think of.

Prashant Mahajan: Yes, I can share some with you, just as examples, and you could -- feel free to choose, you know.

Andrew Lyzenga: OK, great.

David Newman-Toker: And this is David. That our group, I'm pretty sure, the few groups that I was involved with, we had examples there, you probably trimmed them off to kind of save space and whatever, but you may be able to find some in the -- in the last round of stuff. And if you can't, I'm happy to provide them for any of the error or efficiency ones that we didn't already get into you.

Andrew Lyzenga: OK, great.

Christy Skipper: Any other thoughts or feedback for us? OK. Hearing none, we can ask the operator to open the line for member and public comment.

Operator: Thank you. If you'd like to make a comment, please press star then the number 1 on your telephone keypad. We'll pause for just a moment. And there are no public comments at this time.

Andrew Lyzenga: We'll maybe leave it over -- open for just a little longer. We've actually gotten a little feedback recently that sometimes we cut the public comments off a little too soon. So, we will just -- let's take another moment and just make sure we don't have any public comments here.

Operator: Thank you. As a reminder, please press star, one to make a comment.

Andrew Lyzenga: All right.

Operator: And there are no comments at this time.

Andrew Lyzenga: Thank you.

Christy Skipper: OK. So, now, we will turn it over to Vanessa for a couple of next steps.

Vanessa Moy: OK. Thank you so much for everyone for all your feedback. And we'll -- from your feedback, we'll incorporate them into this framework, draft framework report.

And so, the next step is that on June 12th through July 12th, we'll bring this draft report out for public comment, for public and member comment. And we welcome it and you will just log into the website and just put in those feedbacks for us.

And then the next webinar we'll have is on July 25th where we'll respond to those comments and adjudicate those comments and then we'll finalize that report and framework. And we'll also have a CSAC meeting on August 8th which will provide additional information about. And lastly, the report will be out final on September 19th. And I'll hand it -- give it back to Christy.

Christy Skipper: OK, thank you, Vanessa. So, that concludes our webinar for today. And the slide just shows how you can contact us and send us over any examples or additional feedback you have for this report. Thank you, all, for your time and we will be talking with you later this month.

Kathryn McDonald: Thank you.

(Multiple Speakers)

Male: Thank you.

Kathryn McDonald: Thank you for all your work.

Christy Skipper: Thank you.

Male: Thanks, everybody. You, guys, are doing a great job.

(Multiple Speakers)

Female: Thank you, everyone.

Male: Bye.

Male: Bye-bye.

Female: Bye.

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

END