NATIONAL QUALITY FORUM

Moderator: Improving Diagnostic Accuracy
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Operator: This is Conference # 61096781.

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

Christy Skipper: Good afternoon, everyone. Welcome to the 5th webinar of the Improving Diagnostic Quality and Safety Meeting. So my name is Christy Skipper, Project Manager. And again just welcome to the last call within the project.

Before we get started, I just want to go around the room and have the team introduced themselves and then we'll go into roll call.

Vanessa Moy: Hi, everyone. This is Vanessa Moy, Project Analyst, happy to hear all your feedbacks for this last webinar.

Andrew Lyzenga: Andrew Lyzenga, Senior Director.

John Bernot: This is John Bernot, Senior Director.

Vanessa Moy: OK. And I'll just start with the roll call. Is Mark Graber here?

Mark Graber: I am here.

Vanessa Moy: OK, thank you. Is Missy Danforth here? OK, how about Jennifer Campisano? Is Michael Dunne here? David Grenache? How about Helen Haskell?

Helen Haskell: Here.

Vanessa Moy: OK, thank you. Carlos Higuera-Rueda? OK. Now, Marilyn Hravnak, she can't make it today. How about Mira Irons? Nicholas Kuzma?

Nicholas Kuzma: Yes, I'm present.

Vanessa Moy: OK, thank you. Kathryn McDonald?

Kathryn McDonald: Yes, here.

Vanessa Moy: OK, thank you. We know Prashant Mahajan can't make it but he has a few of his colleagues on the line. How about Lavinia Middleton?

Lavinia Middleton: I'm here, thank you.

Vanessa Moy: Thank you. David Newman-Toker?

David Newman-Toker: I'm here.

Vanessa Moy: Thanks. Martha Radford?

Martha Radford: I'm here.

Vanessa Moy: David Seidenwurm?

David Seidenwurm: Here.

Vanessa Moy: OK, thank you. Thomas Sequist?

Thomas Sequist: Here.

Vanessa Moy: And Hardeep Singh.

Hardeep Singh: Yes, I'm here. Thanks.

Vanessa Moy: OK, thank you. Is there anyone else on the line who I may missed or just joined in?

Missy Danforth: Yes, (hi). This is Missy Danforth.

Vanessa Moy: OK, thanks. Thanks, Missy.

Now, I turn it over …

(Sue Sheridan): (Sue Sheridan) is on the line.

Vanessa Moy: OK. Thanks, thanks, (Sue).

David Hunt: Hi, and this is David Hunt too.

Vanessa Moy: OK, thanks. Thanks, David.

Christy Skipper: Welcome everyone and thank you, Vanessa.

So, the purpose of our call today is to review comments received on the draft report. If you all will recall we posted our draft report in framework on June 12th and the 30-day public and member comment closed on July 12th. So the purpose of this call is to review those comments, received feedback and adjudication from you all and then also to give you an update on the measure concept rating.

So just to back up a moment at our last in-person meeting, you all did some concept ratings and we decided to, after your feedback, to do a second round of rating. So we've collected those ratings and we'll give a brief presentation of what you all thought.

We also work with our team here to develop a framework graphic to illustrate the measurement framework for Diagnostic Quality and Safety. So we'll present that to you as well. And just hear any feedback and then we'll open the line for a public and member comments to hear from them. And we'll close out with next step.

I do want to note that you do need to be logged on to the computer and both dialed in to listen and view the slides presented today. And please also be sure to either mute your computer or mute your phone so that we don't get any of that feedback.

So, as I've said, this is the last webinar of the Diagnostic Quality and Safety committee. And so this is really the committee's last chance to give any input on the overall report or framework and we have a whole two-hour schedule for this call so we're looking forward to an interactive conversation today.

So, just to jump right in to the comments received. We received 24 comments from 14 individuals and organizations during that comment period. And what we did was we're not going to go through every comment individually. We went through the comments and theme them, and so we'll present each theme and sort of take each theme one by one and wait for your – and hear your feedback.

We also sent out a comment table with each individual comment listed there so you may reference that throughout the call today if you would like.

But just to jump in, our five major themes were evidence for measure concepts, use of diagnostic quality and safety measures, questions about the need or the rationale for measurement of certain issues, and there are also several suggestions for new or revised measure concepts, and then also request for additional crosscutting theme or asking us to provide more emphasis on certain theme.

So as we go through each theme, we'll present the theme, the summary present the proposed response or the action that NQF took to sort of address the comment. And we'll be asking for the committee to sort of approve the actions that we would like to take. So, next slide.

So our first theme is Evidence for Measure Concepts. Several comments came in that felt that some concepts shouldn't be included unless there is an evidence base for that concept. And so, what we proposed to do was to update our report to clarify the distinction between a measure and a measure concept and then also make it a little more clear the point of this project which is really to provide guidance to the field on measurement of diagnostic quality and safety.

So, you know, we weren't expecting to come out of these developing fully-formed measures. We weren't trying to recommend specific measurement for

implementation and use that which is, again, to provide guidance to the measurement field.

Andrew Lyzenga: You know, just to add a little bit more to that. Because of that – because we're not actually doing, you know, measure development here, we wouldn't expect to have, you know, a full evidence review of each of these concepts. And, in fact, in some cases, would not really be possible for some of these concepts because you don't have the actual specifications that you could sort of look at what evidence would be underlying, you know, the specific measure focus, the numerator, denominator, et cetera.

So we, you know, thought that it would be useful to, again, add some language into their report, make a little bit clearer sort of that. We did not intend for these measures to be sort of pick up right here and use. But as – to be, to serve as basically ideas that measure developers could then explore, pursue, do, you know, their sort of due diligence in finding, you know, whether evidence supports them or, you know, as evidence supports them other approach to take that approach and then to do all the kind of requisite testing and everything for any measures that they went develop based on these recommendations.

Another thing that we're doing which kind of covers sort of more broadly some of these other themes, the one other reasons for your last round of reading that we kind of moved up a little bit of a level from the concept level to what we're sort of calling measurement themes, is again to sort of de-emphasize the actual specific concepts a little bit and to sort of make that point a little bit clearer again that our recommendations are – that, you know, that we believe that these are areas of measurement which should be – you know, areas of focus for measure developers.

You know, here are some ideas within those measurement areas of possible concepts that could be explored. But, again, we're not trying to dictate that you ought to take these concepts specifically necessarily unless they are, in fact, you know, found to be based on good evidence and reliable and valid and so on. So, just to sort of – and again, sort of setting out a little bit more clearly and explicitly what we intend to do with this – intended to do with this project

and its recommendations. And we hope that that will address some of these concerns about a lack of evidence for some of the measure concepts.

So we'd welcome any of your thoughts and comments on that.

Mark Graber: This is Mark. That all sounds very appropriate. Thanks, Andrew.

Andrew Lyzenga: Thanks.

Martha Radford: This is Martha – this is Martha and I agree. I agree with the approach. I would also, perhaps, suggest that possibility of acknowledging that the evidence base for diagnostic quality and safety measures has been perhaps in some areas. And that in the sense, these measurement concepts also suggest avenues for developing that evidence base, in other words research, in addition to measure development.

Andrew Lyzenga: That's a great idea, thank you.

Hardeep Singh: This is – Andrew, this is …

(David Newman-Toker): Sorry, go ahead, Hardeep.

Hardeep Singh: No, go ahead.

(David Newman-Toker): I was just going to suggest that you would sort of pointed this idea that we were sort of put this out there and then let people sort of search for the literature to support them or not support them. And while I totally agree that it's not within the scope of the project to do an exhaustive literature search on everything. I'll bet you that in this room, if you ask people for the evidence base for, you know, their favorite measures or whatever, that you could find, you know, five or six citations for a few of them, or one or two citations anyway for a few of them.

And I wonder whether there might be a low intensity strategy that would make the report more useful to the users by referencing them to look, to where to look next without taking an enormous amount of time and effort on everybody's part.

Andrew Lyzenga: Yes. Well, we'd certainty welcome any suggestion you have as committee members if there are any particular concepts we've mentioned as part of this report. And you are aware of evidence that speaks for those concepts or sort of the area of measurement in general. We would love to have those – please do sent them our way, we can do a bit of digging around ourselves as well but it would be really helpful if you could – if you are aware of that kind of information to send it our way so that we can – and we'd be happy to sort of plug that in and sort of provide a little bit more of a roadmap in some of these areas to where developers can start looking in terms of evidence.

Hardeep Singh: So, Andrew, this is Hardeep. You know, couple of questions which are correlated. Are we actually going to keep all of these concepts that were provided in the report? Are we going to just drop some out and exclude them based on a low clarity from the report? That's number one and I have another follow-up.

Andrew Lyzenga: OK. I think our idea was to keep all of them. We're open to, you know, changing that approach if you think that would be appropriate. Again, because we're not sort of recommending, you know, the ideas that we're recommending this thing, each of these things specifically saying these are the measures, you know, for diagnostic quality and safety, you know, take these and, you know, either develop them or implement them, they're intended to be sort of ideas, you know, within a given measurement area to say, you know, appropriateness of testing, you know, that sort of a general area that, you know, the committee may have said was important, an important focus of measurement generally.

And then, here, it's impossible ways that you might approach that, you know, sort of specific concepts that might reflect the general measurement area. And, you know, we would expect the field to sort of take a look at those and say "does that makes sense" as a way of sort of expressing this measurement area in a particular measure or measure concept or not, or the other ways to take that measurement area and kind of translated it into an actual quality or performance measure.

So sort of that I think our ideas was to sort of have many of those as we can as examples so that, you know, those – reading those report and thinking about developing measure in this area might have a few different possibilities in a given measurement area that they might start exploring or, you know, go in a different direction. But if you think that there are some that ought not to be in there, we – I think that it would be appropriate if you identify those to remove them. If you think they're sort of going in the wrong direction for example.

Hardeep Singh: Yes. Well, you know, I think that's where – I mean, I'm going to just sort of respect committee consensus and other know how you going to tally up all of the responses. And maybe you have and you're going to show us but – I'm a little uncomfortable with letting very low priority areas that everybody agreed upon, not just me, to slip into the report where we've sort of become fairly broad and focus on all kind of domains and I clearly see some of the concerns coming out specially from AMA and AHAF, it was couple of others that mentioned – so with this evidence (comment).

And on one ring, you know, some of – this is also presentation of the way we sort of written examples of measure concepts because they are looking more and more like measures. So, what if we are some of the high priority areas where this, you know, very little evidence or when the push back is, well, you know, how do we do this, we just make it clear that for example, uncertainty may be a very important concept, but we don't know how to sort of measure documentation of uncertainty in the EMR for instance. And do we really need to sort of put this in tables or can we sort of just say, you know, these are important concepts we don't know how to measure them yet and there may not be as much evidence as people would like, but these are important concepts nonetheless.

Andrew Lyzenga: Yes. And we will sort of, you know, we're in a process of revising the report and it won't look the same as it is.

Hardeep Singh: Yes, that's good. Yes. That's what I was hoping. Because, you know, I think the people, many of the people (asking), was not just one person comment that they felt that they were performance measurement related and I think some of this might have to – I think you should clarify the language that some of this,

you know, yes, it's intended for – kind of future performance measurement but they are for quality improvement, and they are stimulate for their research.

I think those concepts probably need to be – and you were at the IOM meeting as well, where I mentioned the same thing. I think we need to think about these things as pushing quality improvement and learning and research not just sort of, you know, measurement for penalties or for something else.

Andrew Lyzenga: Yes. We absolutely intend to do that as well. That's sort of another theme that we'll come up on in a few minutes, I think. And I think your approach is essentially what we had proposed.

Hardeep Singh: OK, thanks.

Christy Skipper: Any other comments on our first theme here? OK.

I'll turn it over to Andrew for our second theme.

Andrew Lyzenga: OK. So, yes, actually now, we will get to that issue here. So we have a number of commenters sort of raise the issue of use of the measures, saying that, you know, may be some of these things that we brought up would be good for say internal quality improvement purposes or certification or something like that, but not necessarily for performance measurement or, you know, specifically to be used in accountability applications like payment programs or public reporting.

And I think that, most of the committee would agree with that, please let me know if you don't. But the, you know, that again the idea here is to identify important areas of measurement in diagnostic quality and safety, and not to say that any particular measures should be used, you know, for accountability purposes or quality improvement purposes.

But that, you know, that is another thing that would likely sort of emerge in, you know, the measure development process and thereafter if, you know, it would – and our intent was to or idea was to sort of, you know, make a statement agreeing that, you know, some are likely to be more suited for certain purposes and others. And that, you know, we'll have to – we think that

any measure that doesn't merge, any measures that are developed to address diagnostic quality and safety should be, you know, thoroughly vetted and tested to ensure that they are reliable and are valid reflections of diagnostic quality and safety before they are implemented in payment programs. But that we're not trying to say that any of this should sort of our priority be used in accountability applications.

Does that make sense? Does that, I mean, we'll sort of work out the language of that physically but that sort of the idea that, again, we weren't trying to dictate the use of these measures and certainly would not want if it turns out that any of these measures are not, you know, reflective of provider or hospital or whoever sort of quality that they would still be used in accountability applications. They would only do so if they are shown to be reliable and valid and so on.

Missy Danforth: Yes, this is Missy. It seems like some of the comments are a little bit related to your first statement which probably in the beginning of the report making more clear what the report really is. And then, that Hardeep's point …

Andrew Lyzenga: Yes.

Missy Danforth: … probably making the concepts look more like concepts and less like measures.

Andrew Lyzenga: Right. OK. Thanks, Missy.

David Newman-Toker: This is David again. I think to the extent that we can offer guidance on this point, you know, sort of point to the measures that maybe are more likely to eventually mature into this accountability metrics at some point, even though we're not ready yet. And the other ones that might be more for internal Q.I. purposes or whatever actually might help the audience.

So I don't know if there's a way to do that without, you know, creating a whole another round of discussions and disagreements, but if there is someway to sort of point people in the direction or at least give them some guidance on what kind of parameters around the measurement would make it better suited to, that kind of accountability framework at some point as

opposed to something else, I think would be, may be helpful in terms of, you know, again, trying to make the report as useful as people – as usual to the readers as possible rather than just saying, you know, some may be suited to more things than others, is there someway to give people a little bit of direction on that front.

Andrew Lyzenga: Yes. I think that would be good if we could do that. And I think it's probably fair to say that any measure or concept that we would identify is probably, you know, we would expect to be useful for quality improvement purposes. If not, then I don't know why we would recommend it even be measured.

But, maybe we could call out a few concepts or sort of general areas where we think accountability might, down the road, sort of want to – we might want to focus on for accountability purposes. If maybe you guys as committee members could take a look again at the list of concept and maybe pull out a few that you think, you know, again, contingent on them being developed and precisely specified in an appropriate way. And, you know, passing reliability and validity test, you know, sort of, you know, assuming that what are some of the concepts that you think might be promising for accountability purposes, and that you might suggest be pursued by developers for those purposes.

Would it something that you guys could do and we could, you know, again, re-circulate a list and ask you to maybe mark, you know, two, three, four, five concepts that you think might in the future be developed toward the goal of being used for accountability, maybe give us a few comments. And then, do you think that's doable?

Mark Graber: This is Mark. As I understood the comments that were being made, I had the sense that people thought that kind of suggestion was premature.

Andrew Lyzenga: Yes.

Mark Graber: You know, I would certainly would not want to go beyond recommending your very general things like some very basic structure and process things. And I agree …

(Crosstalk)

Mark Graber: … account diagnostic errors by a long shot.

Kathryn McDonald: Yes, this is Kathy. And, you know, I was sort of having the same feeling as you're talking, Andrew. It is like if we were to try to engage in anything where there would be some concepts or themes that would be somehow prioritizes more emendable potentially to accountability. And I'm agreeing with Mark that that's not probably the best path.

But if others feel that that is a good path then I would add that it would be really important for people to comment on what they think the potential adverse downside consequences of such concepts would be for measurements. So that would be part of what would be, you know, put together. You know, with any, you know, anything that was tagged as potentially amendable for accountability. I want the (thought) experiment of and how could that awry so that measure developers would have to think about that as well.

Hardeep Singh: So, Andrew …

David Newman-Toker: This is David. Go ahead, Hardeep.

Andrew Lyzenga: Go ahead, Hardeep.

Hardeep Singh: Andrew, this is Hardeep. You know, I think we'd like to see what the list looks like in terms of priorities. I think there's two different things we're talking about here. One is that accountability kind of issues and one is have some high priority areas that are ready for further growth and development and what are the growth and development might be, and wherever it takes us, quality improvement learning possible future use in some kind for public reporting or whatever else that might be.

And I think it's the high priority areas that we as a group should sort of think about as a main product. Areas that are fertile for further development, wherever the further development might be irrespective of going and saying, "Well, this is for accountability or public reporting".

I won't be surprised if there are some areas that emerge as the areas that are fairly ripe. And I can, you know, if they don't emerge, I would like to kind of call and contribute to something saying that we need – we are kind of ready for some of these things and comes up future growth.

(Crosstalk)

David Newman-Toker: So this is David. I'll just – I'll take a – I won't call it contrary view you but sort of a left turn at Albuquerque kind of view. I don't think it's necessary to – necessary call out specific measures and say, these are ones that are, you know, sort of promising for future development as accountability metrics. I think you can accomplish the same goal that I sort of articulated with this comment originally of making the report more useful rather than saying, you know, measures can be used for lots of different things and some will be suited and some won't be.

And you could achieve the same end of being more specific by outlining the kinds of criteria or parameters that would be relevant or a measure that was ultimately matured into accountability spaces like, you know, the four measures are considered for accountability. Obviously, they require scientific vetting and validation but, you know, parameters that would support that kind of things include ease of standardization, ready availability of data sources, you know, whatever they are like some of kind parameterization of what make something a better measure than others, you know, focus on outcomes that matter to patients or whatever it is.

I just think in general, it's very easy in these reports to kind of take the safe road of saying less. And sometimes I think the bold right thing to do is to put your stake in the ground and point in a direction rather than being, you know, as safe a possible and saying, well, you know, anything could be anything.

Andrew Lyzenga: Yes.

Helen Burstin: And Andrew, if I can make a quick comment, it's Helen. This is incredibly important conversation we're having about this. I think some of these relates to a lot of our internal thinking broadly about some of these emerging measures and really wanting to take a more graduated approach to

measurement. And I think, well, certainly and many of these will not be at ready for full accountability.

I think it's important to make the case that they need to begin to be used for improvement for benchmarking, et cetera, on the path towards making them if they could at some point become accountability. But I think if we weave in this notion that – it isn't just what the criteria would be for accountability, which I agree with David on, but I think also that you would actually recognize there's a path towards getting there. And a lot of this is using those measures gaining experience with them, having an opportunity for sharing and benchmarking before we move forward, not just a clear line of yes-no.

David Newman-Toker: Yes. And I think, Helen, you said much better what I was trying to say, thank you.

Andrew Lyzenga: All right. That's really helpful so we can incorporate that. And I think, David, we were just sort of thinking the same – along the same line as you as, you know, right before you made your comment and maybe – and we can follow-up after this and maybe we could get some thoughts from committee and writing on what, you know, some of the parameters, again, or attributes maybe would be of measures that might be used for accountability if that, you know, approach make sense.

But I think, Helen, you were right on and we can sort of add some language about – to make that case that we need to use some of these – use these measures, implement them for improvement purpose and sort of pave the way towards, you know, different kinds of use and potentially accountability in the future.

Thanks, everybody. Any other comments on this theme? OK, hearing none, we'll move on to our next.

And, you know, these are – a lot of these are kind of similar but we sort of saw a number of comments – not about specific concepts, these are necessarily the kind of raising the question of whether it make sense to measure – to go about measurement in certain areas in general whether there was really a rationale for that. Some of the commenters concerns included,

you know, that we may be adding to measurement burden without, you know, the sort of reward for doing that.

And that they weren't sure that measurement in these areas would improve diagnostic accuracy in their words. And this came up specifically around. It seems some of those concepts that we came up with which related to communication with patients and ensuring the patients, for example, understood their diagnosis and red flag systems or whether organizations were adequately capturing informal caregiver's roles, that sort of thing. Also, this question of documenting diagnostic confidence or certainty the AMA and, you know, suggested that that may not be an appropriate thing to do or an appropriate area of measurement.

One thing we wanted to sort of state was that, we, you know, reiterate that we did sort of broaden the scope of this project beyond just diagnostic accuracy if you are thinking of terms of improving diagnostic accuracy sort of per se, you know, then it doesn't necessarily follow that you'd want to encourage providers to help the patient to understand their diagnosis and be aware of red flags symptoms and so on.

But we did broaden the scope a little bit to sort of include those areas identified by the IOM report in terms of communication, the importance of communication with patients and other issue sort of related to quality broadly construed in the area of diagnosis and that we wanted to reiterate that those things were important and that we thought they were important to measure.

This one has sort of take the temperature of the committee on that whether you still support, recommending, you know, pursuit of measurement of things like patient's understanding of their diagnosis, assessment of whether an organization has a documentation system that captures informal caregiver's roles, et cetera. And those maybe sort of lower priority, but I don't, you know, that we would say, want to say that those are not appropriate at all for measurement.

And the sense that I've gotten from our previous discussion is that – our committee members here actually felt pretty strongly about trying to

encourage providers to document or at least consider, you know, a sort of somehow push the field towards being more open about diagnostic on certainty or confidence and sharing that information with patients and documenting within the record, that was, again, our sense from our previous conversations.

But, again, I'll open it up to the committee, are these areas that you do think weren't measurement, or do you think that we should remove any reference to these general topic areas and not recommend that measurement occur in these areas?

Any thoughts or comments? Go ahead.

Helen Haskell: This is Helen Haskell. And I certainly think this is really important to patient's understanding of diagnosis and red flags symptoms. I think it's essential to diagnostic accuracy. I am – I thought there were also some comments that supported that pretty strongly.

Andrew Lyzenga: They were, yes.

Helen Haskell: Yes. So, I, you know, I would support leaving them out, I think it would be a huge gap if we didn't like, I mean – and in terms of uncertainty, I'm a little puzzled that the resistance to that, that seem to me a sort of fairly straightforward assessment in a way to, you know, use the coding system without having yourself in, so I'd be interested …

(Crosstalk)

Mark Graber: Helen, this is Mark …

Male: Go ahead Mark, (please), go ahead.

Mark Graber: This is Mark. I thought the comments on uncertainty were really interesting and I'm surprise to see opposition to those. I would definitely not back off on that. I would try to and keep that in our report that it's important to move – be moving away from this designation of certainty especially when it's done prematurely. And that we need to start embracing uncertainties as the way

things really are in a better pathway. But we need to keep in mind Kathy's comment that we really haven't tested the unintended consequences of going that route.

John Bernot: Thank you, Mark. Mark, this is John Bernot. And just to give a little context, these comments about the confidence or certainty tended in. I don't want to put words in people's mouth, but they tended to run with the same concerns about the evidence. And I am hopeful that perhaps clarifying the language based on what Helen Burstin said and what other folks on the call have said, that whenever we really clarify that we are not trying to say this or accountability ready, that may take away some of this thing because I do think this tended to run with the same concerns about evidence almost as if how can you make me accountable for this, and that's not what we're saying. We're saying at some level of the organization, we need to start looking at this.

So, I am hopeful that might correct some of this. That's just my thoughts on it.

Hardeep Singh: Yes, with John, this is Hardeep. I would add that I think it's just not that, it's also the fact that I don't think some of these concepts are easily measurable and when we put this in tables like we did with the report and made it sound like measures rather than measure concepts or areas that are potentially useful for measurement because they are really important to what this is all about. I think it gave the impression that we're trying to measure something that is not really measurable very well.

And I'm saying that, I mean, we just did a review on, you know, uncertainty diagnostic uncertainty and really, though, we don't know enough about how it's define and how it's measured. And so in a way those comments are fairly genuine, they are right on the (dot). They are not currently very well measurable. But that doesn't mean they're not going to be measurable, that doesn't mean they are not important.

So, I think framing the presentation of some of this "immeasurable concepts" right now in a different way, in a different part of their report or maybe the

same part of the report, but saying that they are potential areas for growth that's probably going to be important as we reframe the report.

John Bernot: Thanks, Hardeep. But I think you – I didn't say anything near delinquently as you did, but that was actually what I was trying to get at certainly. So I think your point is very well taken and I think we can change some of the word and – wording and craft this so that it is clear on that front.

Lavinia Middleton: Hi, this is Lavinia Middleton. I would like to add that there are some specialties that do incorporate uncertainty and diagnosis. And so perhaps you'd want to highlight those. And not – to me some of the comments regarding that seem to be almost defensive, but like the American College of Radiology incorporate some certainty in their diagnosis, they even have a criteria for it, but American College Pathology, we, you know, we render diagnosis with criteria for suspicious or for malignancy or, you know, uncertainty in our diagnosis.

So, framing that measure concept around other specialties that have incorporated on certainty on their diagnosis, I think might lend others to be more accepting of it.

Andrew Lyzenga: OK. Thank you.

John Bernot: So I think this trend is just – was mentioned is thought to introduce concepts of the varying predictive values, or varying finding and varying combinations of radiology, pathology, clinical finding. So I think that we should encourage that rather than discourage it, recognizing that we are, you know, in an infant state of this approach to diagnosis.

David Newman-Toker: This is David. I started little bit with this, this comment. So, on the – on a specific point of confidence or certainty, it strikes me that there is a failure in our system that forces us to undue certainty for billing reasons and so on so forth. And that's the pushing people away from that is probably a good idea overall for the system and the potential to kind of code whether there's uncertainty or not might actually allow us to monitor better – that are whether diagnostic errors are mostly happening when people are uncertain or as Hardeep had suggested that – when they're over certain.

But, you know, whether – that's in some sense that's not the question that was on the table and there was the basis for this comment, it was whether the specific measure that references certainty which I believed was a structural measure of whether the EHR should allow the documentation of uncertainty, was a good measure of quality of diagnosis.

And I think it's a trickier question, right? Like it's – even if you firmly believe that we should push people in that direction and that some how sort of having this was a "quality metric" is a way to sort of alert people to something that we think is important. I'm still not convinced necessarily that having the EMR capability to document that uncertainty is going to ultimately be something that actually is a marker of diagnostic quality or health of an institution.

So I think may be there's a disconnect between what we're trying to say and principle and what's we've sort of put on the paper for public comment and may be that's where there's a little bit of a struggle around this issue, at least for me anyway.

Andrew Lyzenga: Yes, I would agree with that. I think that to certainly the intent of the concept as I understood it was as you said to a sort of again moving towards having the capability of expressing that in, for example, documentation in electronic health record. So I'm not to and certainly not to measure, you know, from a sort of evaluate, you know, providers based on whether they were for example confident or not confident in their diagnosis, I think that would be may be exactly the opposite intent.

But there did seem in my interpretation of the comment to be sort of, you know, as someone had said sort of in defensive or general kind of – they seem put off by the very idea of addressing this issue of confidence or certainty. And so maybe we can, yes, sort of finesse the language a little bit to make clear what the intent is there and to make clear where we're trying to go with them.

Richard Frank: Now – this is Richard Frank with Siemens. With regard to this most recent comment, I think it may be useful to take into account the issue of patient

compliance with recommended treatment care pathways the impact of diagnostic uncertainty which ultimately accrues to not just a single test, but that in the aggregate of diagnostic testing leading to a conclusion, and therefore treated pathway.

So, I mean have you done any thinking about implications for patient compliance as regards this issue of confidence and the distinction between a diagnose – a diagnosis which relies on a number of diagnostics.

Andrew Lyzenga: Well, we could – just to – for the folks on the call, maybe we could, those not on the committee maybe we could wait until the public comment portion. But it's – may be worth asking the committee if you have any particular reactions or responses to that comment.

Martha Radford: This is Martha, I have two comments. One is in response to that last one which to me is really a research question more than anything else. But it kind of synergizes with the other comment that I wanted to make which is someone brought up the idea of – sort of separating out the concepts that are closer to prime time versus the concepts that aren't closer to prime time and, you know, I think that that might be a useful way to deal with this issue of uncertainty which I would agree is, an important concept and we don't quite know where we are with it frankly, because of all the things that have been brought up about, you know, all the forces forcing us into either complete lack of confidence or complete confidence one way or the other.

So, I don't know, I just thought that having those concepts slightly separate might be helpful when we issue the final document.

Helen Haskell: And this is Helen also, I just would weigh in on the concept of compliance. I'm not sure compliance with what we use to think of this treatment rather than diagnosis. And I would think if there were a misdiagnosis, and the patients were non-compliant that might be sort of a good thing. But it might be recorded in a way that was misleading, that's just my thought.

Andrew Lyzenga: OK. And I seat down maybe that this idea of, you know, kind of which ones are little more ready for prime time and which aren't. This is kind of what we had in mind and with the incorporating the element of feasibility into the

ratings, although as well show you a little bit later on, we still didn't quite – get quite as much sort of differentiation and clarity out of that as we were hoping to. But we can give that a little bit more thought and see if we can maybe solicit some additional comments from you guys on that.

Martha Radford: Yes, I mean, feasibility is one aspect of prime time in this, but there's other aspects as well including evidence base. So, I think, you know, maybe just developing that a little bit more might be helpful.

Andrew Lyzenga: Yes. OK, any more comments on this issue?

Christy Skipper: OK. Thank you, Andrew. So, our next theme focuses on the request for additional cross-cutting issues or emphasis on existing theme. So we close out our report listing cross-cutting themes and recommendations that sort of comment on both the development of performance measures and the overall advancement of the field of diagnostic quality and safety.

And really the recommendations we're aiming to influence policy themes where they intersect with the field of diagnostic quality. So there were two that came in, commenters wanted us to focus more on patient engagement, noting that the client does have extensive knowledge about their own condition and that it should be considered and – they should be consulted within the diagnostic process.

And then also the commenters ask us to call out physician's feedback and satisfaction stressing that physician feedback and satisfaction regarding the diagnostic process, noting that system level issues can lead to burnout and over work.

We do have a couple of measure concepts that specifically talk to burnout like way to burnout or vacancy rate for diagnostic specialties. And we do – we have sub-domains related to patient, but the call out here was they want us to emphasize more of these two themes, so we just want to hear back from you all whether or not we can beat that up and add that into the report.

Do you agree with this strategy? And I don't think that anybody would disagree, you know, we have talked about a lot at our in-person meeting the

importance of the patient in the diagnostic process, and we know that hearing back from the people who are doing the diagnosis is important. So, I'm thinking you all will agree that we can add this to the report.

OK. And so hearing this agreement, we'll move on to …

David Seidenwurm: Can I just …

Christy Skipper: Yes.

David Newman-Toker: This is David. Can I just say these are – a lot of these things if we just go back our, you know, obviously, the sort of mom and apple pie thing. I think one of the key things to make sure that you guys articulate in the final report though, as we've talked about many times, the distinction between something that's good and important for quality and something that is a good measure, or likely to mature into a good measure.

And so, you know, for instance the importance of the patient and use of her knowledge of the medical history on the diagnostic process can't be – that couldn't be overemphasized, right. Again, it's critical issue whether it's the subject for a good measure, it's an entirely separate conversation that I think it's important that you kind of walk that line when you're writing the report. Where you kind of make it clear to people that not everything that's good for quality improvement is necessarily a good thing to be measuring.

Christy Skipper: Yes, we definitely agree with that. And we'll spell that out within the report. Thank you.

So our next theme was in regard to additional concepts that came in. That people thought that you all should consider. So, the first concept, for each concept are idea just want us to run through discuss each for a couple of minutes and decide whether or not you all agree to add these within our concept with or if you have other ideas.

Andrew Lyzenga: And just to sort of clarify that we would – again, because we're not – and hope to sort of make this a little bit clearer, kind of recommending – again, specific

measures for adaption and use necessarily but, you know, recommending these broader measurement areas as priority.

We thought that it could be reasonable if you guys agree that we could plug some of this additional concept in as examples. And we would, you know, fit those into our existing measurement areas as appropriate, as additional examples of how those measurement areas might be reflected in actual measures, if that make sense. Go ahead.

David Newman-Toker: So the first one for instance falls under the – I think we have an appropriateness measure.

Andrew Lyzenga: Right, yes.

David Newman-Toker: So that would be passed as an example in the appropriateness measure concept section.

Andrew Lyzenga: Right, exactly.

David Newman-Toker: That idea is already in there.

Andrew Lyzenga: Right, the overall idea is there and this would be, you know, again another way that measurement area might be manifested in a very specific area.

Mark Graber: Yes. And I want to say I think we need to add a whole lot of new things. And just going to be quick. I think two is, the number two is quite nonspecific. I'm not really sure what means.

Andrew Lyzenga: We were a little bit unclear as well that.

Mark Graber: And here we we're sort of trying to get more concreteness and actionability, I would just sort of ignore that. I hate to say that but that what I would …

Andrew Lyzenga: And that one is something where we could, again, incorporate a little bit into the narrative, you know, that many of concepts identified relate to, you know, root cause analysis in this sort of subject area and retrospective learning. But that we would encourage, you know, organizations to also engage in prospective learning and something …

Mark Graber: So that is a good point. I think that could be highlighted better. That if we can give me the example that – actually we already have, right. We already have some structure and processes around I think technique that organizations use to learn, right. We have a – I'm pretty sure we have that as some sort of a measure concept somewhere.

But I think we can also add. If you really wanted to add specific, you know, test result area is a big one. And we have sort of a proactive risk assessment guide that I sort of mentioned to you guys as well before a safer guide. So if you want to give an example of something that organization can do proactively for, you know, preventing these things not just, you know, reactive and retrospective. You could give some sort of example for that. I'm not sure how that would be a proper measure or measure concept but I think that sort of the thing I was looking at. And I saw this number two.

I don't know about number three. I think it goes into information availability and information availability kinds of things have been covered if I'm not mistaken, and others.

Andrew Lyzenga: It is, sort of again, one of that sort of broader measurement areas that we identified. But again this could potentially be plugged in as an example or as just, you know, to add to the narrative around that section to suggest that it's also important for testing professional to have access to this much information on the patient's diagnosis. And their, you know, any information that would be relevant to the testing process so that they can do their sort of best job at that.

So we could either incorporate that as potential, you know, as an example of a concept or just stressed in the sort overall description.

Mark Graber: Yes, I think we already have it but if you want to sort of give an example. I guess the more we put things like these examples, the more people are going to say, “Oh this looks like measures.” So I'd be a little careful here.

Number four, accuracy of diagnostic test, I think this area, I mentioned this in my response as well. I think COLA and CAP, College of American

Pathology, sort of cover these areas. So we should sort of acknowledge them. And say that this is an important area, so already sort of covered.

And the number five, shared decision making, we already include that. I mean that's the whole thing about the socio-technical approach, that's the technical part. So I think we've got five that have covered. Let's say for the extreme work also which you mentioned include so the patient in the middle and sort of the technology around it. So we kind of have number five, that's what I would feel.

Andrew Lyzenga: And I think the specific point the commenter was trying to make there, was trying to suggest that in addition encouraging shared decision making generally about, you know, the diagnosis and treatment that shared decision making process should specifically involved discussion of new technologies. And maybe useful context, this was coming from an association of medical technology provider is that I think is that particular sort of interest there. I don't want to impute any …

Kathryn McDonald: Was it new diagnostic technology like sort of the genetic testing or because I mean there is something there. This is Kathy.

Andrew Lyzenga: Yes, and I think Dr. Brotman from AdvaMed is on the line, maybe we could get some additional thought or feedback from him during the public comment portion of the call. Or maybe we could open it up right now. Is Dr. Brotman on the line? Could you – operator, could you open up his line, if he is – maybe only on the webinar.

Female: Yes, he is.

David Newman-Toker: This is David. I echo what Hardeep said about the measurement of the factor of diagnostic test. I do think that that's something that we should at the very least allude to, and maybe it's worthy that's on, you know, measure concept recognizing that we sort of call out other agencies that are already sort of aggressively working in the space. I think that the rationale for doing more than just pointing to those agencies is that they actually don't cover all diagnostic tests.

So there are many diagnostic tests that are not actually monitored by anybody. You know, we do our vestibular function test and we've been them for years and not just talking about the new tangled stuff, I mean, like stuff we've been doing for 20 years in clinic.

And there is no international standard. There is no agency that monitors performance. We just, you know, we learn how to do it. And we learn what the pitfalls are and then we critic each other. When they send us their report and they're not done to specs. But there is no external monitoring.

So I do you think there is some rule for the many test especially physiologic test of which there are numerous, where there are no standards. But there's something there worth talking about that may have been on omission from the lists?

David Grenache: So this is David Grenache. So I don't disagree with David. Early on, and what – I think on our last face to face meeting, the issue of accuracy of diagnostic test or harmonization of diagnostic test came up in the ranking process. And this was – it was ranked pretty low like I was disappointed by that.

I'm glad to see this comment made. And I think it does require any sort of framework that we proposed on diagnostic accuracy to acknowledge that this is an area that needs to be address if we're ever going to have some sort of standardized interpretative guidelines on and from where I'm speaking in laboratory test not so much the physiological test that David talking about.

Steve Brotman: Hi. I'm sorry and I don't mean to interrupt. It's Steve Brotman and my line just got opened. We have trouble I think opening up the line. And I know that you guys had – graciously, you mentioned having me talk about the shared decision making. Whenever you'd like to talk, my line is open. I just wanted to let you know.

Andrew Lyzenga: OK. And then just to clarify you, the idea there was that shared decision making should, you know, the idea you are trying to get across is that it should specifically include discussion of new diagnostic technologies, is that correct?

Steve Brotman: Well, in the options for not only the new ones but in the different diagnostic technologies. You know, there's been a number of papers and I'm very happy you guys were able to have our comment in total. They're separate in the grid sheet that you have I guess. But in there, we go through a couple examples that support the idea of having a choice actually it serves to engage the patient and increase participation.

So, if you offer a patient a choice between and, you know, having a fecal, occult blood, our CT colonography, it's more likely if you offer the different choices depending upon the situation, they're more likely to get screened.

And, you know, it also encourages, you know, practitioners and groups to take the time to have this engagement with patient for potential new technologies when they're available in the option of care, and gives them away to incorporate the new technology and to practice, new procedures and new practice. And, you know, giving the idea of having beneficial or beneficial outcomes in reducing healthcare disparities in the whole process.

So, it all – it just adds in the whole mix of things. But the studies do show quite amazingly that if you do offered a different choices in technology you are, specially in the screening world, you do get more participation and the ability to engage the patient is much appreciated. So, we just want to make sure that that in the shared decision – shared decision component was that at least the new technologies and options of technologies are out there for patient care.

Has that explain it?

Andrew Lyzenga: Yes, I think that helps. Any reactions or comments in response to that from the committee?

Hardeep Singh: So, I'm going to – this is Hardeep. I'm just going to say that I think it's obviously this is unarguable. This is very important stuff and we all acknowledge it. The question is, how are we going to propose that we, you know, measure this stuff? And if it's a concept that needs to be emphasize, I think there's definitely an opportunity to do that very easily. And the

framework, the draft framework that NQF created already acknowledge, this is technology within sort of the socio-technical environment.

The question is, I mean, are we coming up with measurement around shared decision making and the use of technology? And if so, where – what would that even look like even as the concept going forward.

Andrew Lyzenga: Maybe it's something that we could incorporate not into the specific concepts but maybe include, you know, a note, again in the narrative that there has been some evidence that know the broader, you know, that presenting the broad range of technologies to patient and the sort of shared decision making process improves compliance and potentially outcomes. We can, again, work with that language, but maybe just an acknowledgment of the information that the commenters submitted and in the appropriate place but not necessarily incorporating into specific comments or concepts rather.

Steve Brotman: Yes. That might work. I mean, I think, it's really important to recognize it but I'm not sure how we can turn it into something concrete in terms of a measurement area or measure.

Andrew Lyzenga: OK.

Kathryn McDonald: This is Kathy. It's a little bit like, you know, uncertainty, we were just talking about in terms of diagnostic testing accuracy, like, there's – these are things that we drew out quite a few measures, like what's the patient understanding, what's the use of this information, you know, in clinical practice by the team.

And so, I mean, I like the idea of making sure that anything related to the actual technology and testing and their capabilities in the way they are described and used, that's a key piece of diagnosis. So, it should not be ignored but agree with the comments about how do we get up that for a measurement standpoint. Maybe that relates to quite a few measures in different ways.

Christy Skipper: Any other comments on those five? We do have two more on the next slide for you all to consider timeliness of access to medical diagnostic technologies,

and then also ensuring that diagnostic testing aligns with the most current clinical guidelines.

And for that last one there, number seven, we do have a related concept that talks about the initial diagnostic accuracy for particular disease and whether there is a reference to a gold standard. So, any reactions for those two?

David Newman-Toker: Will number seven again is the appropriateness measure?

Christy Skipper: Yes.

David Newman-Toker: So, I think we have that one. We did have a conversation about six, I think, in our subgroup of any of our fellow members may remember this conversation. I think there was some point in time where we talked about sort of different ethics of time, like the time from the initial manifestations to decision making to order test, and then that's from the test to sort of obtaining them and reading them and communicating them.

And maybe there is place around that timeliness measure concept to sort of elaborate that idea a little bit. It may have gotten sort of streamline out at some point. David – does David Seidenwurm remember that conversation? Or is David no longer with us or muted?

Christy Skipper: Let's see. I believe we did hear him earlier. We did hear his name called.

Andrew Lyzenga: And, in here, we can look back on our third notes remembering and explore that a little bit and maybe flash it out a little bit. In case it did get sort of sidelined a little bit.

David Newman-Toker: You know what, I take that back it's still in there. I just pulled it out, the measurement themes. It specifically has two separate bullet points about timeliness and diagnosis – initial diagnosis from symptoms to explanation and timeliness of diagnostic refine from explanation to management. So, it could probably be elaborate in that space.

Andrew Lyzenga: OK.

Christy Skipper: Thank you.

Andrew Lyzenga: Yes.

Steve Brotman: And this is Steve Brotman again, that was my comment. And, you know, we were pleased to see a lot of timeliness issues address in one of the concepts. But we thought the timeliness of the access to the diagnostic technologies is from different stages whether it's the initial component to diagnosis or staging any other portion would be important to sort of not have that drop out. Appreciate it.

Christy Skipper: All right. So, our last seven concepts, these were all concepts that were already included in the report. And we've heard some comments that they wanted additional clarity. So what you're – what you see on your screen anything that's bold and underlined in black is additional wording that commenters wanted to add into the measure concept.

So, you take a moment, read through those first three. Indicate whether the committee is in agreement or do you want to revise it another way or not revise it at all?

Hardeep Singh: I'm OK – this is Hardeep. I'm OK with the first comment about notes. But I think we don't have right now mechanism for patient to add their own feedback. And again, going back to the thing about putting things before evidence, I think there are people working on, how patients can make, you know, contribute to their note. To the project to have open notes, folks but I think we should not be adding that. That is still under sort of experiment stages. I know it's a high priority topic that people talk about. But I don't think we should take a position on saying that about the feedback.

Now, I think this – whoever gave this comment meant to be in the record. Now you could give feedback to anybody but we have measures on those things. But I think this was supposed to be within the record.

Helen Haskell: I agree, it's difficult to measure something that doesn't exist. This is Helen, but I'm wondering if this is not something that it could at least be added in the text as desirable and important.

Christy Skipper: Yes.

Andrew Lyzenga: I think that's a reasonable approach. I think a number of this subsequent ones as well could, you know, just taking corporate into some of the near to text. You know, suggesting that and some of these other ones that appropriate. But it is important to, you know, make all the appropriate diagnostic options, present them to the patient and make them available but not necessarily incorporate them into the specific concepts.

Again, in particular we've given that we're trying to sort of de-stress a little bit those particular concept, and point a little bit more towards the general measurement areas with these concepts just being examples of those.

Hardeep Singh: Yes, Andrew, this is Hardeep, yes. I would say for two and three, you should do that for both two and three. They're both are important so again that just probably for the text only.

David Newman-Toker: I would agree – this is David, I would agree with that. And I think partly that's because they actually changed substantially what these measures would be in practice, right. So, like the patient was reported experience of diagnostic care about whether problems were explained is actually a patient reported measure that we can expect patients to know, whether the least they felt like their problems were explained. But they can't possibly know whether all appropriate diagnostic options were presented to them.

That would actually require a totally different approach to measurement. Than asking the patient if they felt like the problems are explained to them. You have to then have them report back of what were – what options were presented, and then double fact check those against what should have been presented. It's a totally different thing.

So, I think it's an important concept for patient care, but actually putting it in this kind of a measure actually changes the measure in such a radical way. That I think for that measure concept in such a radical way that it would become unmeasurable.

Kathryn McDonald: This is Kathy. I'm getting a little confused because – so we have measure which we're not doing. We have concepts which we have a big list of concepts, and then we have themes. And this spokes to me like, you know, the way the slides set up, these are the themes even though it says concepts ideas. Now, the themes, the themes were generally a bit broader and could include multiple concepts.

Andrew Lyzenga: I think these we're actually were specific concepts that we had suggestions we're rewording on …

Kathryn McDonald: For the concept not the theme because it's listed at the top of the slide theme, because it's listed on such ideas. OK. We're talking about concepts, then I agree with the discussion. We're talking about themes when I think things could be broader.

Andrew Lyzenga: Right. And I think that's probably the right approach is to incorporate some of these ideas into the broader discussion of the theme rather than into the specific concepts that have been suggested. It's all there.

Christy Skipper: OK. So, if you can go back to slide 2. So, again these were additional language that was suggested to add in to measure concept. So …

Andrew Lyzenga: And I think maybe the theme …

Christy Skipper: OK.

Andrew Lyzenga: … sort of things that we just discussed to apply to this as well, maybe.

Hardeep Singh: Yes, but even when – yes, this is Hardeep. But even when we reframed them as language of sort of just text or language in the report, you know, that provide support pathway that provide all appropriate diagnostic options for diagnosis of common symptoms. I mean, I think that's a little bit of stretch when we put things like all in there. I just don't know what that means. I mean this could vastly increase the amount of things that like options that we're going to present to providers.

I'm not sure how much of this new language would be useful. So, we should be careful when we put this in the text. I mean, you know, what's innovative and state of the art.

Martha Radford: Yes, this is Martha. I kind of agree with that comment. I mean, with this – I'm interpreting this as, you know, have as broad a differential as you can and communicate that to the patient. And sure, but, you know, that's like really tough, It's like impossible to measure really, and I'm not sure it's worth it because it really has a lot to do with patient-physician relationship, and I mean a whole bunch of other things.

So, I'm kind of – I want to not do that too much at this point. We're not just far enough along on this.

David Newman-Toker: So, this is David, I read that specific report I guess was from AdvaMed and we may have people on line who can comment during the public commentary. But I think this sort of insertion of, you know, all of the appropriate options, all the diagnostic test options, was really intended to sort of, you know, open up that space to make sure that different testing avenues in diagnosis were sort of presented to patients. And that might include point of care testing and other types of new technologies that are showing up on the scene.

I do think that it's reasonable to make sure that there's some kind of text in the report that alludes to this idea that, you know, technology is constantly evolving and it's not enough to just provide what used to be the standard of care 20 years ago, and to have measures around that. That we have to be forward thinking and incorporating new technologies into our quality measures as science evolves, and as appropriate scientific research develops that demonstrate the effectiveness or efficacy of these particular tests.

I think it's reasonable to put that kind of a language in their somewhere in the text. But I do think it's agree with everybody else who said that it's sort of premature to start honing in on that point in each of the measure concepts.

Andrew Lyzenga: OK, that's helpful. I think that's a good approach.

Hardeep Singh: And I mean I – I just – I mean this is on (inaudible) NQF style and all that. I'm just wondering I think we're becoming more and more into the IOM report. The more conversations I heard today and some of the comments, I think we got to be careful how does this measurement report, you know, two and half years later, are going to be different in advance to science compared to what was put forth, you know, two years ago.

And I think the more we make it broader and the more we make it sort of all encompassing, we lose our message completely. Just we have to be careful, that's all.

Christy Skipper: OK. Thank you.

Kathryn McDonald: Fair point, yes.

Christy Skipper: So now, we will turn to an update on the measure of concept rating. I believe, John, you're on?

John Bernot: Yes. Thank you, Christy. So this is the part that I've heard several people alluding to really wanting to see how the rankings came from the committee.

So, just first of all thank you all for turning this in. We know that it's a lot of work to do this. And a bit about the methodology and rationale if you forgot, we had originally done each of the concepts on. We did not see a lot of differentiation between the top, and the bottom.

And on a webinar subsequently, we had talked about the need for something maybe between the level of a concept and the sub-domain. And that's where what we did is take the themes and group them together so that we didn't have one person randomly picking, a timeliness concept and another one picking the different one and we did it at the level of the theme.

So what we were able to come back with here. I put this scatter plot up to show you where the numbers rank. And this is the importance by the feasibility and really not trying to over analyze it. Except to show that even with the themes, we still didn't really have the distribution that I think we would like to have.

We certainly saw some clear winners and some there a little lower. But a lot of them really did cluster into the middle. And I just wanted to point that out, so I'll present it as a fact but I'm not trying to put any sort of importance or significance to it. But just let us see where they came and then maybe as a group we can say these are resonate, does it make the litmus test and then decide how to include, if to include these in the final report. So …

(Off-Mic)

David Newman-Toker: So this – this is David. Could I just ask a quick analytic question? Did you strive to either map individual radar's patterns, to see if there were big variances across radar's or look at overall variants for individual means on feasibility or importance, like in a box plot kind of format behind the scenes.

You may be showing those to us in a few minutes but I'm just curious where you did that. Because I'll be – I'll wonder whether that's also an important question of variability, like, are there certain measure where there was more consensus, not just an average that was in a particular spot but that the general consensus was similar across people as opposed to widely divergent?

John Bernot: So, to answer your question. I know exactly what you're talking about. We thought about that, have not done that at this point. It is something that we could still do, if you think it would help going forward.

But I do know and we are trying to look at some of the statistics we could apply to this. And I sense that we're going to have a difficult time getting again to statistical significance on this. But it maybe and maybe good enough to show that there is – there are some clear themes that took a higher and a lower but I know it's the same …

Hardeep Singh: John? John, this is Hardeep. So, this, what you're presenting, are based on themes alone. There is no individual data of measure concepts in here, is that correct?

John Bernot: That is correct.

Hardeep Singh: So, you know, I have a measurement problem with that because I'm looking at my ratings right now and we didn't do the ranking or rating rather on themes. We did it on the individual measure concepts because that's what you told me to do. And I have …

Female: Now we did – we did it on themes. We did on themes. We're given (30) themes.

Male: No, we did it within themes but if you recall …

Hardeep Singh: Within themes.

Male: … this concept.

John Bernot: Yes. Hardeep, we do. We followed up with you, I don't know, if you remember and actually moved it up to the theme level and we actually average to your concept rating within the themes and I don't know if that was the appropriate thing to do but we chatted with you and would …

Male: Isn't that what everybody did? Or did other people individually (r) the themes …

(Crosstalk)

Hardeep Singh: I do – I did on concept level. So, I have escalation the three of them and I rank them one on five and one on one. So, I guess that's they were wrong.

John Bernot: Most did rate at the theme level but there is a – there were a few that rated at the concept level and we reached out to the …

(Off-Mic)

David Newman-Toker: Oh OK, got it. Got it. OK. Now, I – sorry. I'm sorry, I scratch whatever I just said. I was completely …

(Off-Mic)

Kathryn McDonald: I have a comment too, this is Kathy. On the comment that you made, John, about kind of wanting more variability, I would have been surprised to see we'd have more variability and because these are all sort of theme at the theme level that, you know, are based on what this group that has, you know, a lot of expertise and some, you know, different pockets of expertise. You know, have come forward and said, this is a theme, you know, these are concepts that would build to a theme that is actually important.

Feasibility part could be more variable. I could see that being more variable. And I think people were also from a schematic standpoint, like, well, something might be feasible in this, you know, in this theme, you know. So, that again gets it more, you know, in the middle as opposed to fit in that high end or low end. So, I'm not so surprised by that having done the exercise of trying to rate this and thinking about the process of which we've got to these themes.

David Newman-Toker: I guess what I would say is this, I don't think you need to do it like huge deep dive six months, you know, dense data analytic work on this. But I do think that looking at the variants and each of these measures and seeing whether the variance is roughly similar across them or very different and whether it's generally pretty wide or not, actually would be at least also for your internal consideration.

Because if what you see is that all of these measures are widely divergent in terms of variants and like there's a moderate about, a variability across radar's for each of these things, what that is telling you is that, people are operating in different mental frames about what's important and, you know, what's important or what's feasible and that issue is important to draw out in the report. Like essentially, that the – the whole bunch of expert raters really don't agree on the relative rankings of what's important, know what's feasible.

Whereas, if they're tightly clustered an either feasibility or importance, so at least for some of them that pointing to that general agreement is I think a meaningful, I don't think you need to, you know, spend hundreds of thousands of dollars in six months doing statistical analysis. But I do think looking at the variants would at least tell you something in general about whether you've

got just sort of the amalgam of a mean, of a lot of different opinion or whether there's some consensus.

(Crosstalk)

John Bernot: Go ahead, (Sue).

(Sue Sheridan): Hey, John, this is (Sue Sheridan). Sorry I've been quiet this whole webinar. I've been in a very noisy place, so I've just been listening. And something I'm asking myself and maybe you can help answer it is, you know, when we rated these themes or topics and what question were we answering, was it about improving the accuracy of diagnoses or was it about improving quality and improving safety or largely preventing harm? What was our direction, I'm not recalling?

John Bernot: It was the improving diagnostic quality and safety, I think is how we tried to …

(Sue Sheridan): OK.

John Bernot: … frame it.

(Sue Sheridan): Because I see, I kind of struggle with this – because improving accuracy of diagnoses and I think it's really very different than improving safety. I think, what – I mean, improving safety and quality, I think is much more focus. And so, I'm kind of wonder, because have we all been thinking the same way through this process? You know, and you know, it from my previous presentations, when I think of this improving diagnoses and preventing harm, diagnostic errors, I tend to sort of, you know, gravitate to, you know, the outcomes that matter to patients.

And so, I've looked at it through that lens but I have a feeling from listening to everybody there's another mindset or another camp about improving diagnoses or accuracy of diagnoses, which I think is a really – I think they're really two different things.

(David Newman-Toker): Well, (Sue) for what it's worth, I've did my ratings in your camp.

(Sue Sheridan): OK.

(David Newman-Toker): That that is – that is I explicitly – I didn't allow any measure that was remote to patient-centered outcomes to get anything higher than a three.

(Sue Sheridan): Yes.

(David Newman-Toker): Like, it only made it up into that top tier for me, if patient outcomes were very close to what was being measured.

Hardeep Singh: So, this is Hardeep. I did mine, obviously, wrong, but on every measure concept and the highest, so important area that I rank, was preventable diagnostic harm. If the measure was not connected to preventable diagnostic harm, I give it, you know, lower ratings even if I thought, I mean maybe in terms of feasibility sometimes is important.

(Sue Sheridan): Right.

Hardeep Singh: But I did one. And I varied a lot between one and five because of the variations.

(Sue Sheridan): Right. And just one other comment before I have to step back into a very loud environment, you know, and looking at the themes and listening to some of the dialogue, I think whatever our next steps are, you know, I think whatever we proposed should be an actionable as possible. And I also think that the report and recommendations or next steps should be written in very understandable language.

If a patient reads one of our proposed themes or measures and doesn't understand it, then we have not communicated appropriately. You know, measurement world is very foreign to patient committee and we need to get patients more engaged in this and they need to understand this. (So if the measure the patients) to understand then I don't think we're writing it the right way.

So, I think we need to be as direct, concise, actionable, and understandable when we take our next steps.

John Bernot: And all of these is a very good feedback, so thank you. And I do think I – just to get through the initial comment from David, I do think that is important that we can go back and it will not be a lot of problem for us to run and see how much variability there is and make that comment to your point about how much consensus is around this. So, we should have done that, but I do think it's all we can do on the back end and certainly make some sense out of it.

The next few slides, I just want to let you know, what we've done is just we're going to show you the top 10 of important space on the numbers we got from this exercise, then we'll look at the feasibility and then look at the ones that rise into both, we go back one side to importance.

And I just want to just take a second just to have everybody, glance at this and get that – got litmus test on here, does this make sense. So this look like something that actually separated what we think is important or any comments about this and we'll look at feasibility also.

OK. If there's no comment that's fine …

(David Newman-Toker): I just – I'm sorry, I'm just doing my cross referencing, trying to figure out look at the other page. So it looks like some of the things that were – what is the diagnostic, because I'm not correlating this well, let me just see if I understand. So, are none of these ones that are in the outcomes space?

Christy Skipper: We're pulling out that document that shows the measurement theme and then examples of concepts for you right now at the moment.

(David Newman-Toker): Because this feels like it's a very process heavy instead of measures if I – again I'm seeing this for the first time, but if feels like they're extremely process heavy.

Andrew Lyzenga: That was something kind of jump out to me as well, I was a little surprise that the outcomes – outcome-oriented sort of themes or concepts didn't rise a little higher and there's the timeliness of diagnosis is something that we had as sort of an outcome category and to some extent patient understanding of diagnosis.

But a number of these other ones and then there's patient reported diagnostic error a little bit lower on that list. But I think you're right, it was a little surprising to see the sort of process oriented themes, a little bit higher in importance.

David Newman-Toker: Well, it's interesting, because, you know, it's funny that I don't know how many other people, you know, (Sue) and Hardeep and I all are articulated this idea that patient harm was that, you know, and outcomes for patients where the sort of that the most important things. I don't know whether other people felt that way or differently. But actually, I wonder whether even the three of us interpreted that the same way, in terms of what measures we thought were important.

But it is strange to hear, you know, three people say, yes, the most important thing is patient harms and outcomes and then to not see much of that on the top 10 list.

John Bernot: Yes, David, this is John. And I just want to reiterate. I do I agree with your initial assessment with – as Andrew mentioned, the numbers did seem to have these outcomes lower. And as a matter of fact, the adverse events as a marker of central diagnostic error was actually – it's really tie for second to last. So it could be either way that the vote was or it could be that there really is a difference of opinion within the committee.

Again, trying not to add any personal significant to just presenting the numbers to get that as I've got reactions. And if it is the sense of the whole committee that this doesn't feel right, then I think that's important for us to know now, so we can decide if and or how to put this in the final report.

Lavinia Middleton: Hi, this is Lavinia Middleton. So if a patient is harmed, there's usually a root cause analysis in the hospital, I mean that's their requirement, and most places recommendation probably in all. So, would not RCAs and evidence of improvement from RCA be a surrogate for harm.

(David Newman-Toker): I don't think so …

(Crosstalk)

(David Newman-Toker): And none in the sense, none in the general measurement sense, because there are way more patient that get harm from diagnostic error than end up in the root cause analysis, I'd venture to guess that if less than 1 percent of them end up in a root cause analysis.

Lavinia Middleton: But I would – I think in our institution we have harm levels and so I guess with the definition of harm, it's the …

(David Newman-Toker): No, it's a question of ascertainment, not a question of harm level like, there going to be some harms that happened in the hospital that people, you know, come to peoples attention and they end up as morbidity and mortality and maybe root cause analysis and malpractice cases.

But there are way more people that got harm from diagnostic error, than we ever realize we're harmed. I mean most of them don't ever come to anybody's attention. They're just attributed to, oh well, you know, the patient came in and said they had chest pain and then they came back with a heart attack and nobody even links the two events.

Hardeep Singh: So I think that I'm not – this is Hardeep. I'm not that surprise by this and I think there's plenty of outcomes out there. This patient understanding of diagnosis, even though it's probably going to be lower on feasibility, I mean that's an important thing, very important thing that it's out there. And if you can understand how to analyze any preventable diagnostic harm, how we're going to make progress.

I don't – I'm with Lavinia, I think there's a reason why RCA and measurement – quality measurement types of things (are arose) because people felt these to be the next steps to make them feel go forward. And I'm not …

Kathryn McDonald: Yes.

Hardeep Singh: Yes.

Kathryn McDonald: Yes, Hardeep, this is Kathy. I know as I was thinking about this, I was thinking about those preventable harms but I was also thinking about the learning system potential. And how important that is if this juncture.

Of course, I have comments about, you got to be careful about window dressing with these things, I mean just saying there's RCA and there's clinical improvement activities. In one organization, that may be very meaningful and a lot could be doing it, could be incredibly useful and makes progress towards better diagnosis and some places, it could just be, you know, the lightest of effort and you wouldn't want the same credit to go to the two.

(David Newman-Toker): So, I'm going to voice a slightly different opinion here. I think that probably a lot of these differences are more about the size of the categories and the wording in the titles of the themes. Like I think, in many respects these things that are listed here are words that sound that resonate with people about what's important around diagnosis although I'm still surprise with something like accuracy of diagnosis doesn't make the list.

But the – I think that to some extent, we may also have it a communication problem around things that didn't sound quite the same. And so for instance timeliness of diagnosis doesn't sound the same as a measurement theme of escalation, de-escalation, right like those are, those don't feel like the same size buckets, or equally intelligible as idea.

So I think there may have been some of that going on, when we look at the differences, smaller they may be between these categories.

Andrew Lyzenga: And it is probably important to note that there is pretty small differentiation if you look at those numbers, there's a very small differences, so it's not like this were, you know, really separating them – separating themselves from the pack that distinctly, is a pretty small range of difference here. But that's I think a fair point. And …

John Bernot: OK. Well in the interest of time, why don't we look at the feasibility and then the combined list and really to see if we can get the conscious again whether or not to include this, because I know we have just over 15 minutes left and I

want to make sure that we have time for us to really come to some sort of conclusion.

I think the feasibility one might a little less contentious because I do think that it's a little bit clearer on this compared to the other one that might be of this more objective. But just if there's any reaction to this at all, feel free to speak up. If not, I'll just (inaudible) that to the combined list that seems to rise in both feasibility and importance.

David Newman-Toker: So I think it's a little bit of the same thing, I mean obviously, I'm speaking up in large part because my ratings are almost exactly inverse to whatever is written here, as far as I can tell. But, I also think there's this question of whether people viewed things that were unfamiliar as not feasible and things that were familiar as feasible.

So I personally – I mean, I maybe the lone voice in the wilderness, and if so it is truly that consensus of the group that, you know, these are all the most feasible things to measure that's great. We've got, you know, seven papers that we can say it about for instance how easy it is to measure escalation and de-escalation as a marker of diagnostic errors. So and most of these things don't have any data to support them.

So I guess, there's a question here about the – in my mind about whether everybody was working with the same set of data in their heads when they were making these ratings, or whether people were feeling different parts of the (elephant).

John Bernot: Understood. Any reactions to that from the committee?

Hardeep Singh: I also think that's splitting them up, you know, within the theme, there were several different concepts and those are very different. And so my – if I was to do an overall rating, I would be stuck. You know, one these concepts is really feasible, but the other one is not really as feasible.

So if any rating should have been done, maybe it should have been not giving any measure concept. So I couldn't see what the examples were, because the

example bias you in your thinking because I clearly have fives and ones in the same – within the same theme.

So I think that could have caused a little bit of – but I mean, overall, I think it's still good. We can definitely measure the first few things, you know, fairly straightforward. I mean, I'm not surprise by this.

John Bernot: OK. And this is just a combined – go ahead, I'm sorry, comment.

Martha Radford: Yes, this is Martha. When I was doing this exercise, I was really struck by the issue of evidence base and kind of some of these are really research questions. And that we need to address a lot of these areas really quickly and thoroughly, but some of it is a research agenda. And I felt like, I did add a lot of comments on that, you know, in all the blank spaces that we had.

But it's just challenging that's all. To me this is big learning from this whole group is that, we need to suggest that we get more information from our – kind of epidemiologic research aspect.

David Newman-Toker: So I would ask the questions on that point. Other than the first one on this top eight list, timeliness of test result follow-up, which of the subsequent seven have been shown to be linked to any kind of patient outcome measure.

I mean, I guess, we can exempt patient understanding of diagnosis just by definition of this, but all the others like, any of them that relate specifically to whether a patient is harmed by diagnostic that are – are there any evidence to support any of those as being link to improvements in reducing diagnostic harms, other than the first one?

Mark Graber: This is Mark. I just like to say I think we're over analyzing this data in the extreme. The main finding is that there are – they are all tightly grouped and I think it indicates that the science in this area is really, you know, there's so much more we have yet to learn and really had no idea which one of these are going to be most important in improving diagnostic safety and reducing harm. And that's should be the main message.

John Bernot: So, Mark, on that note, would you be in favor of just not including any of these numbers other than to say that something in a text based format that the committee did vote on this, and there really was not a lot of grouping – not a lot of information to separate the importance of these topics or is there – or would you want the data in an appendix just as it is, but not with a lot of verbiage around it or analysis? Do you have nay suggestions for that?

Mark Graber: Yes. You know, you got the data and show it to people. Maybe it will be important to know about someday. But I think the main message is that, you know, we're just so early in this game. And at the moment, there is no way to say, which is the most important place to start and which is going to have the greatest impact.

John Bernot: Great. Thank you. And so what is the rest of the committee comfortable just to ask consensus to put the data in just the table probably and appendix just it is there, it did happen and then to put the language around it that we really do not know what the important and it is early in the game and trying to make that – the message of the rating or any other amended language.

David Newman-Toker: What I would say – this is David – sorry go ahead.

Kathryn McDonald: This is Kathy. Yes. I think that's good. I actually think there's some extra detail here that also should be part of it which is, you know, I'm hearing that people, you know, were really thoughtful about this and have this in comments. And so I don't know how you're going to digest those comments, but to me that – they're maybe some really important use from the comment to reflect back about this date of potential we have for measurement right now?

I'm – you know, I agree that there isn't this great ranking that we want to do, but I felt as I was doing it. But I almost want to be talking – I'm glad we're having this discussion. I want to be talking within the committee more about what we were thinking and why we were thinking it. And whether there is some consensus, you know, around "Oh this would be more important than that."

And, you know, I don't think they have time to get there. But using the comment in some way made may shed a little bit more light. Just like Mark

saying, you know, like, go ahead, give the information, you know, it was collected and give the information. And consider doing something with the comments.

David Newman-Toker: This is David.

(Crosstalk)

John Bernot: Go ahead, David. Go ahead, David.

David Newman-Toker: I agree completely with Kathy. I think because this was really basically the first round of Adelphi without finishing the Delphi which is we, you know, normally what happen is, you'd go over these ratings, you go, "Why did you think that" and "my god, what is the thing down to the bottom". And then you would kind of re-jigger and then you would revote, like we're not doing all of that.

So I think putting it all in the appendix, having the all data and not just the top best of the top of that, but just all the data and actually giving all of the specific individual comment on the things in the same appendix.

I think I actually, would give people the most robust opportunity to see that dialogue about why people were doing what they thought they were doing, at least for those who made comments. And that richness which is lost in the sort of numerical averages without having kind of gone through that consensus building process I think is brought out at least somewhat in the commentary.

John Bernot: Great. Thank you. And I just wanted to reiterate what Kathy and others have said, the rationale and the comments provided were extremely rich and they were very thoughtful, not a problem at all to share that with the ratings that we have. So that will be very depress to do and I completely agree that they'll add a lot.

OK. No other comments, I'll turn it over back to Christy to review the framework graphic which I have to personally say I think it's fantastic, but just my two sense.

Christy Skipper: I was going to say, the same thing, John. So we meet with our communications team and talks a little bit about this project and present it. Our ideas for how we would like to have this depicted. And so what you see is the patient family and caregiver at the center of the model, and then the other two domains surround it, and then pointing out from each domains, all the lists of sub-domains that you all agreed on.

And then, off to the left just sort of showing some of those cross-cutting themes, those things that all wanted us to point out within the report. So I guess, just looking at this illustration, is it clear – does it make sense to people, and can we include it in our final report.

Male: If you add the word and outcomes to diagnostic process, if you say diagnostic process and outcomes. And I think that's pretty good.

Christy Skipper: OK.

Male: Yes.

Christy Skipper: OK.

(Crosstalk)

Missy Danforth: This is Missy. Sorry. This is Missy. The only thing is so the diagram is very clear so the concentric circles, but then if you're just reading the sub-domains top to bottom, it looks like the organization and policy opportunities are most important. Is there a way that move the line so the green line is at the top of the circle and patient experience – patient engagement can go first …

Christy Skipper: Sure.

Missy Danforth: … diagnostic process can stay where it is, and then the organizational and policy opportunities can go at the bottom. Just because I actually look at the text before I looked at the …

Christy Skipper: OK

Missy Danforth: … circles. And so I think would just be a little of more consistent with what the graphic is.

Lavinia Middleton: Hi. It's Lavinia Middleton. I like it very much. Is there any way to add with patient experience, patient engagement, patients understanding of diagnosis, or patients. I mean, or is that being too redundant? But I do think that's a common theme that we had since the very first day, and kind of bring that up.

Some people may only see this graphic. And we'll say OK, we're already engaging in experiencing the patient, you know, what else do we need do?

(Sue Sheridan): Yes, it's (Sue). Maybe still at a noisy place, but it would be great to get to (Sue) or (Helen) trying us to do, because of the idea of making the report more focused on how patients might see this measurement area.

(Crosstalk)

Helen Burstin: Go ahead, Helen.

Helen Haskell: No, I'm just going to say I support both of those comments.

Missy Danforth: Yes. And, you know, when – oh, sorry.

Helen Haskell: No. Go ahead.

(Sue Sheridan): I, you know, when I read the IOM report and I reviewed it, and when I continue to be involved in discussion, I always gravitate to the foundation being the value preference and outcomes that matter to patient. And I think David I think you already articulated that.

And that patients are engaged throughout the whole diagnostic process, so that's the patient engagement piece there. They're engaged with the whole process based on the outcomes that matter to them. And I think a lot of times, people say "we put patients at the center" and quite frankly, I rarely know what they mean by that. But if we say, that the delivery of health care and the diagnostic process is based on outcomes (inaudible) patient I think that really helps clarify.

So that's my first and I'm still digesting this. So that's my first comment, but go ahead and I'll keep looking at it, as you discuss to see if anything else comes to mind.

David Newman-Toker: The other thing for me that now that I'm reading the details on the right, I think, you know, Hardeep pointed earlier to misharms as being a critical issue. (Sue) pointed to patient outcomes that matter. I think having some wording under diagnostic efficiency and accuracy that's says diagnostic outcomes or misdiagnosis related harms or something …

(Sue Sheridan): Yes.

David Newman-Toker: … that actually gets to that sort of outcomes and harm that it just feels like it's – outcomes again been sort of vanished from the graphic in it's entirety and I think …

(Sue Sheridan): Right.

David Newman-Toker: … that's a real risk in this space that we sort of fall into trap some of the patients safety things are falling too in the past, that just becoming so enamored of process measures that we're sort of micro-managing process and not measuring outcomes.

Hardeep Singh: I think, you know, the concept of reducing preventable diagnostic harm should be at the center. I think that's where we really intended this report …

(Sue Sheridan): Right.

Hardeep Singh: … I'm not sure what it ultimately going to do. So I would say put it so to next to where a patient experience, patient engagement and something like reducing preventable harm to patients should be right at the center of this.

(Sue Sheridan): Right.

Female: The bulls-eye, the bulls-eye.

(Crosstalk)

David Newman-Toker: I agree completely.

(Crosstalk)

Helen Haskell: Yes. I agree with that. This is Helen. I think one of the things that was bothering me as I was sort of fighting this is the categories are not parallel, so patient families and caregivers at the center really feels more like sort of, you know, a bone in the direction …

(Crosstalk)

Female: Yes.

Helen Haskell: … it doesn't say anything really. And so I think we think preventable harm to patient and families is a much stronger statement.

Vanessa Moy: OK. Thank you all for that feedback. We will work with our communications team and incorporate some of these changes and shoot it back out to you all, just for any other comments.

All right, so right now, I just want to turn it over to our operator to hear if there are any member in public comments.

Operator: And at this time, if you would like to make a public comment, pleas press star then the number one on your telephone keypad. Again, that's star one to make a public comment.

And we have no public comments at this time.

Andrew Lyzenga: I just wanted to – before we get off, Christy mentioned this is the last time we'll be sort of together as a committee on the phone at the same time. But we do have some more time as we're, you know, we're refining the report and findings and we do hope to still be engaged with you offline and via writings.

So we hope this won't be our last engagement with you just last time we'll be on the phone most likely. So I just wanted to add that.

Vanessa Moy: So just next step as Andrew mentioned. Thank you all for all your feedback and opinions, and we'll incorporate your feedback into the final report. The next step would be internally we'll bring this to CSAC and we will just give them a brief update about our framework and then after that, we'll give you just brief summary about it what we discussed via e-mail.

And lastly, after all those feedbacks that we incorporate into report will go to the copy editing internally, and then the final report will be out on September 19th. And yes. So thank you all for all your time and effort for this committee and we appreciate it.

And I'll hand it back to you Christy or Andrew, if you have any additional comment.

Christy Skipper: Thank you, Vanessa. We are about to wrap, but I just want to know that one comment did come in through the chat box from (Amanda Broth) just noting that she agrees with pointing out the importance of patients and families. However, would also like to see the way providers will be supported as well. It seems they are lost in work force, the work force sub-domain, and would like to see measure of provider experience as well.

So I know we're at the top of the hour, but if there is any feedback or comment from the committee, in response to that?

(Crosstalk)

Lavinia Middleton: Hi, it's Lavinia. Of course, that would go along with IHI recognition of the provider's experience, so that would link well with that.

Female: I think it's a great idea.

David Newman-Toker: Yes. I agree. And I just want to say before we sign off that you guys have done an incredible job. It's been a real joy and pleasure to work with the team from NQF on this. And thank you for all the hard work that you put in to this in service of the great cause, so thank you.

Female: Ditto. I think ditto.

Male: Thanks.

Female: Hear, hear.

Female: Thank you.

Female: Thank you.

Christy Skipper: Thank you all for being such an interactive and responsive committee. And yes, this is the last time we're on phone, but you will be hearing us from us via e-mail. So I will adjourn here. Thank you all and have a good afternoon.

END