NATIONAL QUALITY FORUM

Final Roster

Reducing Diagnostic Error: Measurement Considerations Standing Committee, Fall 2019

COMMITTEE CHAIRS

David Andrews
Patient Advisor
Aiken, South Carolina

David Andrews is a retired professor of psychology. His particular area was cognitive neuroscience, notably individual differences in how brains learn, think, and remember (of significance in understanding medical errors). Along the way he taught several courses on tests and measurement and evaluation. For the last 14+ years he has been patient advisor—10+ years at Medical College of Georgia and 7+ with a wide range of regional and national organizations. Of particular note, he is currently a member of the NQF Neurology Standing Committee and the Patient and Caregiver Engagement Advisory Group.

David Newman-Toker, MD, PhD
Professor of Neurology, Director AI Center for Diagnostic Excellence, Armstrong Institute for Patient Safety and Quality at Johns Hopkins University
Baltimore, Maryland

David E. Newman-Toker, MD PhD is Professor of Neurology, Otolaryngology, and Emergency Medicine at the Johns Hopkins University School of Medicine. His clinical training is in Neurology, Neuro-ophthalmology, and Neuro-otology. He received his doctoral degree in Clinical Investigation from the Johns Hopkins Bloomberg School of Public Health. He has published more than 100 journal articles and given more than 200 invited lectures on dizziness and diagnostic errors. He currently serves as President of the Society to Improve Diagnosis in Medicine (SIDM) (2018-2020). He is Director of the Armstrong Institute's Center for Diagnostic Excellence at Johns Hopkins Medicine.

COMMITTEE MEMBERS

Flavio Casoy, MD, FAPA
NYS Office of Mental Health
New York, NY

Dr. Casoy is a community psychiatrist and currently works as Director of Special Projects for the NY State Office of Mental Health. He attended college and medical school at Brown University and completed his residency at the University of California, San Francisco and a public psychiatry

fellowship at Columbia University. In his work as an inpatient and emergency psychiatrist, he repeatedly encountered patients who had been misdiagnosed and given the wrong treatment, wasting their time, potential, and resources. He is passionate about exploring ways that the public mental health system can measure and improve rates of misdiagnosis.

Karen Cosby, MD

Gordon and Betty Moore Foundation
Mountain View, CA

Dr. Karen Cosby is a program officer with the Moore Foundation, an Associate Professor at Rush Medical College and a senior emergency medicine physician at Cook County Hospital. Her career has focused on improving diagnosis and patient safety. She is a founding member of the Society to Improve Diagnosis. She is co-editor of two books, *Diagnosis: Interpreting the Shadows* and *Patient Safety in Emergency Medicine*. Her contributions to patient safety include a framework for classifying factors that contribute to error in emergency medicine and a 15-year review of problems identified in Mortality and Morbidity reviews.

Sonali Desai, MD

Medical Director Ambulatory Patient Safety, Brigham and Women's Hospital
Boston, Massachusetts

Dr. Sonali Desai is the Medical Director of Ambulatory Patient Safety at Brigham and Women's Hospital, the Medical Director of Quality for the Department of Medicine, a practicing rheumatologist, and Assistant Professor of Medicine at Harvard Medical School. She conducts research on quality improvement and ambulatory patient safety, with over 30 peer-reviewed publications. She has developed programs in safety reporting and feedback, medication reconciliation, staff safety, and safety nets to reduce error from missed and delayed diagnosis of colon and lung cancer and is actively developing new safety nets for other cancers, diagnostic errors, and medication errors.

Jane Dickerson, PhD

Seattle Children's Hospital
Seattle, WA

Dr. Dickerson is a clinical chemist with responsibilities and oversight over several laboratory sections at Seattle Children's Hospital, including special chemistry, biochemical genetics, reference lab and preanalytical services, and informatics. She is a faculty member at Seattle Children's and the University of Washington Department of Lab Medicine, focusing her research on the science of the delivery of care—improving processes to get the right test ordered, performed, and resulted for the best patient care. Dr. Dickerson is a co-founder and Director of Clinical Services for PLUGS, a national collaboration whose mission is to improve test ordering, retrieval, interpretation, and reimbursement.

Andreea Dohatcu, PhD, DABR, MRSC, CMQ

University of Texas-MD Anderson Cancer Center
Houston, Texas

Dr. Dohatcu is a diagnostic medical physicist with experience in checking and assuring image quality and safety for Radiology Departments in hospitals and clinics. Her daily tasks include

identifying and troubleshooting artifacts in the images acquired using a variety of scanner types: computed tomography (CT), magnetic resonance imaging (MRI), ultrasound (US), mammography, fluoroscopy, and general radiography using either x-rays, electromagnetic, or mechanical waves.

Mark Graber, MD

President, Society to Improve Diagnosis in Medicine
Plymouth, Massachusetts

Dr. Graber is a patient safety pioneer, founding Patient Safety Awareness Week (2002), the Diagnostic Error conferences (2008), the Society to Improve Diagnosis in Medicine (2011). He is a recipient of the John M. Eisenberg Award from The Joint Commission and National Quality Forum, the nation's top honor in patient safety. He has an extensive background in biomedical and health services research, with over 100 peer-reviewed publications and 5,000 citations. As Chief Medical Officer of SIDM, he oversees a diverse range of projects, and serves as co-Editor in Chief of *DIAGNOSIS*, now the official journal of the society.

Helen Haskell, MA

President, Mothers Against Medical Error
Columbia, South Carolina

Since the medical error death of her son Lewis, Helen Haskell has devoted herself to enhancing the patient contribution to healthcare safety and quality. She is president of the patient organizations, Mothers Against Medical Error and Consumers Advancing Patient Safety; serves on the boards of directors of the Institute for Healthcare Improvement and the Accreditation Council for Graduate Medical Education; and is co-chair of the World Health Organization's Patients for Patient Safety Advisory Group. She is author of numerous articles, book chapters, and patient educational materials, including a co-edited textbook of case studies in patient safety from the patient perspective.

Cindy Hou, DO

Infection Control Officer, Jefferson Health New Jersey
Voorhees, New Jersey

Dr. Cindy Hou is an infectious diseases physician and is the Infection Control Officer for Jefferson Health New Jersey. She leads committees for the three hospitals for sepsis, antimicrobial stewardship, and infection prevention. Dr. Hou is the physician champion for the New Jersey Hospital Association's Antimicrobial Stewardship Collaborative. In addition, she was the recipient of a Hero of Infection Prevention in Patient Safety from the Association of Professionals in Infection Control (APIC). Dr. Hou received the designation of fellow from the American College of Osteopathic Internists, the American College of Physicians of Physicians, and the Infectious Diseases Society of America.

John James, PhD

Founder/Chief Executive Officer, Patient Safety America
Houston, Texas

John James became a patient safety advocate in 2002 after the death of his son due to several medical errors, including a missed diagnosis. He has a PhD in pathology. His advocacy has included a paper in the *Journal of Patient Safety* estimating that medical errors, including diagnostic errors,

are much more common than estimated by the IOM in 1999. He has co-edited a book called *The Truth about Big Medicine* and just had an article published by *BMJ Open* showing that hospitalized patients want to know far more information than is generally given to them for a medical decision.

Joseph Kunisch, PhD Health Informatics

Enterprise Director of Clinical Quality Informatics, Memorial Hermann Health System
Houston, Texas

Joseph Kunisch PhD, RN-BC, CPHQ currently serves in the role of Enterprise Director for Clinical Quality Informatics for Regulatory Performance for Memorial Hermann Health System. He oversees the quality measure reporting program at a large, integrated healthcare systems and collaborated with quality measure developers to develop and test their eCQMs. He has served on multiple quality-related TEPs to share his knowledge of quality measurement from the clinician's perspective and to integrate the domains of quality and performance improvement with clinical informatics in an effort to advance the success of reporting clinical quality measures directly from the EHR.

Prashant Mahajan MD, MPH, MBA

Vice-Chair, Department of Emergency Medicine Section Chief, Pediatric Emergency,
University of Michigan Health System
Ann Arbor, Michigan

Dr. Mahajan a tenured Professor of Emergency Medicine and Pediatrics, Vice-Chair for the Department of Emergency Medicine and Section Chief for Pediatric Emergency Medicine at C.S. Mott Children's Hospital at University of Michigan. He has served as the immediate past Chair of the Section on Emergency Medicine for the American Academy of Pediatrics (AAP). He is the AAP representative for the Coalition to Improve Diagnosis and has co-authored the policy statement for the AAP's Committee on Quality and Patient Safety on Diagnostic Errors. He has been researching patient safety (including diagnostic safety) in emergency settings for the past two decades.

Kathy McDonald, MM, PhD

Executive Director at the Center for Health Policy and the Center for Primary Care and Outcomes Research
Stanford School of Health Policy
Stanford, CA

Kathryn McDonald is the Executive Director of CHP/PCOR and a senior scholar at the centers. She is also Associate Director of the Stanford-UCSF Evidence-based Practice Center (under RAND). Her work focuses on measures and interventions to achieve evidence-based patient-centered healthcare quality and patient safety.

McDonald has served as a project director and principal investigator on a number of research projects at the Stanford School of Medicine, including the development and ongoing enhancement of the Quality and Patient Safety Indicators for the Agency for Healthcare Research and Quality. She has authored numerous peer-reviewed articles and government reports, including several with wide enough followership to merit recent updates: Care Coordination Measures Atlas, Closing the Quality Gap, and Patient Safety Practices. She served on the Institute

of Medicine Committee that produced Measuring What Matters: Pediatric and Adolescent Health and Health Care and currently is part of the IOM Committee on Diagnostic Errors in Health Care.

Previously, she worked as a manager for technology optimization and business development at Stanford Hospital, and as a research and development manager for new product development for a medical device company. She received a PhD in Health Policy from UC Berkeley with a specialization in organizations and management, a master of management degree (MBA and MHA equivalent) from Northwestern University's Kellogg School of Management, with an emphasis on the healthcare industry, and she holds a BS in chemical engineering from Stanford University.

Lavinia Middleton, MD

Deputy Chief Medical Officer, University of Texas-MD Anderson Cancer Center
Houston, Texas

Dr. Middleton currently serves as Deputy Division Head for Quality and Divisional Director, Quality Operations in the Division of Pathology/Lab Medicine at MD Anderson Cancer Center. Her distinguished career as an oncologic pathologist subspecializing in breast diseases contributes to her extensive experience in complex cancer diagnoses. Dr. Middleton has published over 100 peer-reviewed papers on a variety of topics related to diagnostic cancer diagnoses and quality improvement. She developed MD Anderson's core curriculum on quality for pathology and laboratory medicine trainees and formerly led monthly Medical Staff Committees on a variety of topics related to healthcare quality and resource utilization.

Craig Norquist, MD

Patient Safety Officer and Associate CMIO, HonorHealth
Scottsdale, AZ

Dr. Norquist is a community-based, emergency physician for over 15 years trying to optimize his diagnosis skills. Having been a patient safety officer for our organization, he had insight into the errors and harm that can occur when the diagnostic error occurs. As a chief medical information officer, he works with tools that aid providers in clinical decision making and providing feedback to help optimize their cognitive algorithms.

Shyam Prabhakaran, MD

University of Chicago Pritzker School of Medicine
Chicago, IL

Dr. Prabhakaran is a board certified stroke neurologist. He completed a neurology residency at New York-Presbyterian Hospital/Weill Cornell Medical College and a fellowship in vascular neurology at New York-Presbyterian Hospital/Columbia University Medical Center, a T32 training program in neuro-epidemiology, and a master of science in epidemiology. He has over 15 years of clinical and research expertise with funding from the NIH, Agency for Healthcare Research and Quality (AHRQ), and Patient-Centered Outcomes Research Institute (PCORI). He is a fellow of the American Heart Association and the American Neurological Association, and serves as chair of the AHA's Stroke Performance Measures Oversight Committee.

Ricardo Quinonez, MD, FAAP

Chief of the Section of Pediatric Hospital Medicine, Baylor College of Medicine/Texas Children's in Houston
Houston, Texas

Dr. Quinonez is an Associate Professor of Pediatrics at Baylor College of Medicine and the Chief of the Section of Pediatric Hospital Medicine at Texas Children's Hospital in Houston, Texas. Dr. Quinonez has served in national panels assessing quality indicators for pediatric conditions ranging from IBD to respiratory illnesses including as a member of the Standing Pediatrics Committee of the National Quality Forum. Currently he is Vice-chair of the Council on Quality Improvement and Patient Safety of the AAP where amongst many other projects he helped author the AAP's policy statement on diagnostic errors.

Roberta Reed

Patient Caregiver/Advocate, National Kidney Foundation
Wexford, Pennsylvania

From her education in Family and Consumer Sciences to working for AT&T, and now with a small family-owned insurance agency, Roberta Reed needed every ounce of knowledge and "know how" to help her now 29-year-old son find his living, nonrelated kidney donor. Kidney disease is a journey, and transplant is a treatment and not a cure. For this reason she continues to advocate, educate, and learn through her involvement in areas that will improve and save lives of those who are impacted with kidney disease. Patients and caregivers deserve paths leading to better health and quality of life.

Hardeep Singh, MD, MPH

Physician Researcher, Houston VA and Baylor College of Medicine
Houston, Texas

Dr. Singh is a practicing internist and leads an internationally recognized multidisciplinary research and innovation team focusing on measurement and improvement of diagnostic safety. His work has been translated into several deliverables, tools, guides and policy initiatives. His experience, knowledge, and impact on the field of diagnostic safety has been recognized by several awards including AcademyHealth Alice S. Hersh New Investigator Award in 2012, the prestigious Presidential Early Career Award for Scientists and Engineers (PECASE) from the White House in 2014, and the VA Health System Impact Award for significant impact on clinical practice and policy in 2016.

Colleen Skau, PhD

Assistant Director, Performance and Quality Measures Portfolio, College of American Pathologists
Washington, District of Columbia

Colleen Skau is the Assistant Director of Performance and Quality Measures at the College of American Pathologists, where she has primary responsibility for overseeing development and maintenance of quality measures for pathologists. Her background in basic science research led her to be interested in how quality in healthcare is quantified and how we can improve quantification to drive better care. She is particularly interested in the unique challenges faced by pathologists and other nonpatient facing diagnostic specialties and is dedicated to using quality measures to promote the right test at the right time for patients.

Michael Woodruff, MD
Intermountain Healthcare
Salt Lake City, Utah

Mike Woodruff, MD is the Senior Medical Director of Intermountain Healthcare's Office of Patient Experience. Mike reports to the Chief Patient Experience Officer and provides leadership to a team that guides excellence in patient safety, clinical risk management, patient and caregiver experience, quality measurement and improvement, antibiotic stewardship, infection prevention, and survey readiness for Intermountain's hospitals, clinics, and homecare. At Intermountain since 2007, Mike has worked in clinical quality improvement, patient safety, Emergency Department operations, and EHR deployment and content development. His research involves patient safety and emergency department and urgent care utilization. He co-leads Intermountain's diagnostic safety initiative.

Ronald Wyatt, MD
CQO, Cook County Health & Hospital System
Chicago, Illinois

Dr. Ronald Wyatt is Chief Quality Officer at Cook County Health. In 2010, Ron served as Director of the Patient Safety Analysis Center in the U.S. Department of Defense (DoD), now the Defense Health Agency (DHA). In 2012, Dr. Wyatt was appointed as the Medical Director in the Division of Healthcare Improvement at The Joint Commission. Dr. Wyatt has contributed to multiple publications on Health Equity, racial bias, and implicit bias. He presents nationally and internationally on leadership, safety culture, patient experience, and health equity. He has been named a top 50 patient safety expert, by Becker's.

FEDERAL LIAISONS

Andrea Benin, MD
Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention
National Center for Emerging Zoonotic and Infectious Diseases

David Hunt
Office of the National Coordinator for Health Information Technology

Dr. Marsha Smith
Centers for Medicare and Medicaid Services, Division of Program & Measurement Support