NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Improving Diagnostic Quality and Safety/Reducing Diagnostic Error: Measurement Considerations, Committee Web Meeting 4

The National Quality Forum (NQF) convened a web meeting for the Improving Diagnostic Quality and Safety/Reducing Diagnostic Error: Measurement Considerations project on January 29, 2020.

Welcome, Review of Web Meeting Objectives, and Introductions

Meredith Gerland, NQF Director, opened the call and welcomed participants before provided opening remarks and reviewing the meeting objectives, which included:

- Review and discussion of use cases 1 and 2, focusing on identifying actionable global and granular solutions as well as measurement considerations;
- Identification of cross-cutting recommendations for measures to reduce diagnostic error and improve patient safety; and
- Identification of use cases 3 and 4 from three possible options which will be further discussed during the March web meeting.

The NQF staff introduced themselves, before Carolee Lantigua, NQF Project Analyst, called the roll to determine which Committee members were present.

Discussion of Use Case 1 and 2

Jesse Pines, NQF Consultant, began the discussion by sharing an overview of the reframing of use cases 1 and 2. Use Case 1: Cognitive Error—Missed Subtleties focuses on subtle clinical presentations of dangerous conditions when the disease "signal" is too low. Use Case 2: System Error—Communication Failure focuses on the failure to "close the loop" on communicating diagnostic test results for important conditions.

The Committee proceeded with a discussion of Use Case 1: Cognitive Error—Missed Subtleties. The Committee reviewed three case exemplars developed to illustrate the cognitive errors and missed subtleties in practice, and to identify solutions to prevent the errors. The Committee suggested various ways to make the cognitive error more explicit within the case exemplars, including adding pertinent positive and negative results explored by the clinician in the case, as well as including more subtleties to highlight key pieces of information that were overlooked.

The Committee then discussed diagnostic challenges and global and granular solutions for the use case, and agreed that the set of solutions presented was effective and should be listed in the final report. The Committee identified additional solutions to augment the usability of the case and ensure broad applicability to different settings. The additional solutions included acknowledging and employing a team approach that includes patients, family members, and allied health professionals, as well as establishing processes to check in with patients to determine if the clinical team has addressed the patients' specific concerns and to confirm the accuracy of diagnosis after discharge (e.g., a "diagnostic check-in").

The Committee concluded the discussion of use case 1 by reviewing measurement considerations. The Committee commented about the need to incentivize insurers to partner with medical societies and health systems to share claims data in innovative ways to help inform accurate and timely diagnoses. Committee members also shared ideas around measuring the use of clinical decision support for high-risk and/or commonly missed diagnoses.

The Committee then discussed Use Case 2: Systems Error—Communications Failure. The Committee reviewed three case exemplars to illustrate communication failures in practice and to identify solutions to prevent the error. The Committee recommended refining the case exemplars to eliminate specific pieces of information that distract from and/or confound the error being discussed (e.g., clinicians not reporting child abuse to federal authorities as required per law).

The Committee had a robust discussion about diagnostic challenges and solutions for use case 2 and agreed that the set of solutions presented should be included in the report, but highlighted the need for multiple safety nets and solutions to truly prevent errors (i.e., the Swiss Cheese model). The Committee also shared ideas for additional solutions that were not already mentioned, such as identifying a system back-up to share responsibilities with the diagnosing clinician, educating patients about what types of communication to expect, and advocating for ancillary staff to augment the workforce by assisting with managing competing priorities and workloads.

The Committee also identified opportunities to partner with payers, such as by creating trigger alerts for when secondary follow-up encounters are not billed for or by identifying opportunities for clinicians to access claims data and systems to gather information about previous patient encounters (e.g., location of visits or test results ordered) that may not have been previously communicated to them. Additionally, the Committee also shared solutions and mechanisms for policymakers and state agencies to use incentives to support optimal communication, including incentivizing providers to access information systems and incentivizing payers to assist in connecting patients to care to help "close the loop."

Finally, the Committee reflected on measurement considerations to address system errors and communication failures. The Committee shared ideas around measuring interoperability and the need to include accountability for electronic health record vendors, as well as measuring the developing of machine learning used to surveil for diagnostic errors in real time.

Review of Cross Cutting Recommendations

Jesse Pines led a brief discussion around cross-cutting measurement recommendations and themes that apply to use cases 1 and 2. The Committee agreed with the themes already identified, including engaging patients to provide feedback and share information, using technology as a measurement tool, and identifying how specific outcomes can provide information on delayed diagnoses and subsequent harm. The Committee highlighted the additional theme of shared accountability with health systems and electronic health record vendors for technology development that supports interoperability. The Committee also discussed how structural measures (e.g., access to specific resources, such as peer consults or radiologists) and process measures (e.g., use of decision support tools) can be used to support implementation of the identified solutions when outcome data are not available. Further discussion and review of cross-cutting recommendations will occur in web meeting 7 on June 30, 2020.

Identification of Use Cases 3 and 4

Co-chair David Newman-Toker presented three possible options for use cases 3 and 4: Cognitive Error—Information Overload, Cognitive Error—Dismissed Patient, and Systems Error—Delayed Screening. The

Committee discussed the three choices and agreed that Cognitive Error—Information Overload and Cognitive Error—Dismissed Patient should be chosen as the final two use cases.

Public Comment

Meredith Gerland opened the web meeting to allow for public comment. No public comments were offered.

Next Steps

Carolee Lantigua presented next steps. NQF will host the fifth web meeting on March 12, 2020. The fifth web meeting will involve identifying and obtaining the Committee's input on high-priority use cases 3 and 4.