NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Improving Diagnostic Quality & Safety/ Reducing Diagnostic Error: Measurement Considerations Project: Web Meeting 8

The National Quality Forum (NQF) convened a web meeting for the Improving Diagnostic Quality & Safety/Reducing Diagnostic Error: Measurement Considerations Project on September 14, 2020.

Welcome and Review of Meeting Objectives

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

- Provide an overview of the Draft Report
- Discuss Broad-scope, Comprehensive Recommendations for Applying the Framework, Measuring and Reducing Diagnostic Error, and Improving Patient Safety
- Review and Discuss Public Comments
- Share Closing Comments

Overview of the Draft Report

Meredith began with an overview of the Draft Report, noting that the broad-scope, comprehensive recommendations for applying the 2017 Diagnostic Quality and Safety Measurement Framework, measuring and reducing diagnostic error, and improving patient safety would be the focus of the discussion during the web meeting. Meredith reiterated the background and objectives of the project, highlighting that the work builds upon the 2017 report *Improving Diagnostic Quality and Safety* and focuses on the Diagnostic Process and Outcomes domain of the Framework. Meredith shared that the Report outlines practical guidance for operationalizing the Framework and reducing diagnostic error through the Use Cases and broad-scope recommendations. Meredith briefly described the focus areas of the four Use Cases in the Report, which include Use Case 1: Cognitive Error—Missed Subtle Clinical Findings, Use Case 2: System Error—Communication Failure, Use Case 3: Cognitive Error—Information Overload, and Use Case 4: Cognitive Error—Dismissed Patient.

Discussion on Broad-scope, Comprehensive Recommendations for Applying the Framework, Measuring and Reducing Diagnostic Error, and Improving Patient Safety

Meredith proceeded to discuss the recommendations outlined in the Report, sharing that NQF has revised the Report to include feedback from the Committee as well as from public comment. Meredith shared that the most notable change made to the Report following the previous Committee meeting was made to the recommendations section, which has been divided into two distinct parts: broad-scope, comprehensive recommendations for applying the Framework and recommendations for measuring and reducing diagnostic error, and improving patient safety. NQF made this revision in direct response to the Committee's previous suggestion to incorporate more measurement- specific recommendations in the Report. Meredith proceeded to provide an overview of the recommendations, and shared how each

recommendation for applying the Framework aligns with the specific subdomains of the Diagnostic Process and Outcomes domain of the 2017 Measurement Framework: Information Gathering and Documentation, Information Integration, Information Interpretation, Diagnostic Efficiency, Diagnostic Accuracy, and Follow Up.

Meredith went on to discuss the recommendations for applying the Diagnostic Process and Outcomes domain of the Framework, noting that very few changes were made aside from the inclusion of additional detail. Meredith made note of one significant change that was made, which was the addition of a recommendation to implement quality improvement activities to identify and reduce diagnostic error. Meredith emphasized the importance of this recommendation, noting that quality improvement plays a critical role in reducing diagnostic error and is the foundation for all of the recommendations included in the Report. Meredith also highlighted the graphic that has been incorporated to illustrate how each recommendation for applying the Framework directly relates to a subsequent recommendation for measuring and reducing diagnostic error and improving patient safety. The graphic was developed in response to feedback from the Committee Co-chairs to visually tie the recommendations together to ensure the information is digestible for end users.

Jesse Pines, NQF Consultant, proceeded to lead a detailed discussion of the recommendations to measure and reduce diagnostic error to seek feedback from the Committee regarding any additional information or actionable suggestions that should be included in the Report. Jesse provided a high-level overview of the recommendations before discussing each recommendation in detail. Jesse shared that the recommendations focus on using measurement as a mechanism for continuous improvement in the diagnostic process, using patient-reported measures to understand, assess, and improve the role of patients in the diagnostic process, and measuring clinicians' competency levels and adherence to protocols. Other recommendations relate to measuring clinician feedback, evaluating the impact of technology and leveraging technology to improve the ability of organizations to reduce errors, and measuring the use and communication of specialists, second opinions, and teamwork throughout the diagnostic process. Additional recommendations include assessing the appropriate use and follow-up of laboratory testing and radiology during the diagnostic process, measuring total cost, time, and other impacts of diagnostic odysseys, and measuring participation in health information exchanges and other data sharing programs.

Jesse facilitated a detailed discussion around the recommendations, inviting the Committee to share their feedback. The Committee discussed revising the recommendation on using measurement as a mechanism for continuous improvement by emphasizing that outcome measures and process measures are interrelated. Organizations can leverage outcome measures to drive better care and reduce diagnostic errors, and process measures can be implemented locally within organizations to positively impact outcomes measures. The Committee also discussed reiterating that the science behind the measurement of diagnostic error will continue to evolve and organizations should remain engaged in developments in the field as more information becomes available. The Committee proceeded to discuss the recommendation on integrating patients into the diagnostic process and suggested expanding the recommendation to highlight that organizations should obtain feedback from patients regarding all aspects of the diagnostic process, including parts of the process during which they do not necessarily have an active role. The Committee went on to discuss the recommendation related to measuring clinician competency in diagnosis and measuring clinician feedback. The Committee recommended emphasizing the bi-directional nature of the feedback process, stating that in addition to organizations having a process in place to share feedback with clinicians regarding their adherence to protocols, there must also be a process in place that allows clinicians to share feedback with organizations to improve the protocols. The Committee also discussed reframing the recommendation to focus on diagnostic performance rather than clinician competency.

The Committee briefly discussed the recommendation on evaluating the impact of technology and ways to leverage technology, and did not share any additional information or modifications. When discussing

the recommendation on measuring the use of and communication between specialists, second opinions and teamwork, the Committee suggested reiterating that measures should focus on the content of the communication rather than just the documentation.

When discussing the recommendation for assessing the appropriate use of testing, the Committee suggested clarifying that appropriate use relates to both the overuse and under use of laboratory and radiology testing. The Committee recommended including balancing measures to overuse, such as the NQF measure that addresses the overuse of bone scans in patients with low grade prostate adenocarcinoma. Additionally, the Committee recommended highlighting examples of existing guidelines and tools related to appropriate use, such as Choosing Wisely. The Committee proceeded to discuss the recommendation for measuring the cost, time, and other impacts of diagnostic odysseys. The Committee highlighted the importance of defining diagnostic odysseys, and discussed the need to understand the time to diagnosis for specific conditions in order to understand what constitutes a diagnostic odyssey. The Committee recommended emphasizing that certain rare conditions may take longer to diagnose than more common conditions. Additionally, the Committee discussed including more examples of the "other impacts," such as excess biopsies and complications resulting from diagnostic procedures.

Lastly, the Committee discussed the recommendation for measuring participation in health information exchanges and other data sharing programs. Given the depth and breadth of the Report, the Committee suggested that we consolidate some of the recommendations. In particular, Committee members recommended that this recommendation be included in the broader technology-focused recommendation.

Review and Discussion on Public Comments

Meredith proceeded with a discussion of the public comments received on the Report during the 30-day comment period. Meredith shared that NQF outlined a series of eleven questions to elicit targeted feedback on the Use Cases and recommendations as well as general comments on the Report. For each Use Case, NQF posed one question regarding whether any additional causal factors should be included and another question on whether the solutions outlined in the Use Cases provide specific, actionable guidance for addressing the causal factors. Meredith continued by summarizing the comments for each question and sharing the proposed responses, all of which will be included in an appendix in the Final Report. Meredith invited the Committee to share their feedback on the public comments and proposed responses following each question.

For the questions on Use Case 1, Meredith shared that commenters suggested including information on contingency plans to help patients address changes in clinical symptoms that are inconsistent with their diagnosis. Commenters also suggested including the use of specific software to improve the diagnostic process and discussing competing national quality initiatives regarding judicious resource utilization. Other comments suggested simplifying the language used to describe measure concepts related to the rate of clinical support. For Use Case 2, commenters expressed their agreement with the importance of patient empowerment as well as their agreement with the proposed solutions in the Use Case. Meredith shared that comments for Use Case 3 expressed agreement with including information on time to detection for clinical events as a measure concept. Additionally, commenters suggested including recommendations on optimizing the use of EHR notifications to reduce alert fatigue. For Use Case 4, commenters suggested highlighting the use of clinical decision support software to synthesize complex information and overcome biases. Meredith shared that in response to the comments on the Use Cases, NQF will thank the commenters for their feedback and indicate where revisions were made to incorporate their feedback. NQF will also note where no additional changes were made in instances where the suggestions were aligned with existing content in the Report.

Meredith continued to review public comments on the recommendations. Meredith shared that commenters were asked to provide feedback on whether the broad-scope comprehensive

recommendations outlined clear, actionable recommendations to apply the Diagnostic Process and Outcomes domain of the 2017 Framework and to measure and reduce diagnostic error. Meredith shared that commenters expressed agreement with various topics included in the recommendations, such as the use of clinical decision support tools and the inclusion of clinical protocols and pathways. Additionally, commenters noted that the scope of the Use Cases goes beyond measurement. In response, Meredith noted that the inclusion of implementation strategies in addition to measure concepts is within the scope of the project. Additional comments were related to the inclusion of machine learning, which Meredith noted is included in the Report in discussions around artificial intelligence and other emerging technology.

Meredith shared that we also received a comment noting that some of the suggested concepts were not fully evaluated for feasibility, scientific acceptability, and implementation barriers. Meredith shared the proposed response, which states that the Report was revised to convey all measures would need to be fully tested prior to implementation. The Committee proceeded to have a robust discussion on this comment and how to best approach it in the Report. The Committee suggested revising the language in the recommendations to scale back the use of the term "should" where related information and evidence is still evolving. The Committee also suggested explicitly highlighting that scientific developments related to the measure concepts are anticipated, and emphasizing that measure concepts can be implemented locally based on the needs of individual organizations. Further, the Committee discussed the importance of noting that only fully developed measures should be used for accountability purposes, while measures with less evidence should be reserved for quality improvement efforts.

Meredith concluded the discussion on public comments by reviewing general comments received on the Draft Report. Meredith shared that commenters expressed their appreciation for the breadth and depth of the Report. Commenters also highlighted additional information that can be included, such as more information on discharge planning, specific guidance related to measurement, and information on the role of clinical bias. Commenters also suggested adding more detail to the executive summary regarding the Use Cases, incorporating language to distinguish between different types of subtle clinical findings, including additional information on competing cognitive demands on clinicians, and more clearly defining the connection between the Use Cases, solutions, and measurement approaches. Lastly, commenters also suggested some minor formatting revisions. Meredith invited the Committee to share their feedback. The Committee expressed that they agree with the proposed responses to address the commenters' concerns.

Public Comment

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

Next Steps

Udobi proceeded to outline next steps, sharing that the Final Report will be available on the project page on October 7.

Closing Remarks

Before closing the call, Meredith thanked the Committee for their valuable contributions and thanked the Committee Co-chairs, David Newman-Toker and David Andrews, for their leadership. The Co-chairs also provided final remarks, in which they expressed their appreciation for the work of the Committee as well as the NQF project team.