Federal Interagency Workgroup: Improving Diagnostic Safety and Quality in Healthcare

Workgroup Goal: Established by Senate Report 115-150. The Senate Committee on Appropriations requested "AHRQ to convene a cross agency working group that will propose a strategy to enhance scientific research to improve diagnosis in healthcare, as outlined in the 2015 NASEM report."

Workgroup Summary: The latest Workgroup meeting occurred virtually on November 19, 2021, from 1 p.m. to 3 p.m. and was attended by representatives from the following agencies:

AHRQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control and Prevention
DoD	Department of Defense
FDA	Food and Drug Administration
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
NIH/NIBIB	National Institutes of Health/Biomedical Imaging and Bioengineering
NIH/CC	National Institutes of Health/Clinical Center
NIH/NCI	National Institutes of Health/National Cancer Institute
ONC	Office of the National Coordinator for Health Information Technology
OASH	Office of the Assistant Secretary for Health
VA	Veterans Affairs

The aims of the meeting were to: (1) Provide agency updates related to diagnosis improvement research; (2) Discuss potential collaborative work in the space of health information technology (health IT) and improving diagnosis; and (3) Provide a guest presentation from the Gordon and Betty Moore Foundation.

Updates addressed during the meeting include the following:

Agency	Update
AHRQ	• Diagnostic Safety Capacity Building Contract: ○ An issue brief titled *The Contribution of Diagnostic Errors to Maternal Morbidity and Mortality During and Immediately After Childbirth* has been posted on the AHRQ website as part of a series of issue briefs on diagnostic safety topics. ○ The Toolkit for Engaging Patients To Improve Diagnostic Safety is publicly available on the AHRQ website. The resource includes two strategies, Be The Expert On You and 60 Seconds To Improve Diagnostic Safety, that, used together, enhance communication and information sharing within the patient-provider encounter to improve diagnostic safety.

Agency	Update
	○ The Evidence-based Practice Center Program draft report *Diagnostic Errors in the Emergency Department* was submitted in October for AHRQ's internal review. Peer review began in November and the public comment period will begin around the end of the year/early January 2022. • Common Formats: National Quality Forum Expert Panel meetings were held August 23, September 22, October 18, and November 18, 2021. • The Diagnostic Error in Medicine Conference included sessions or posters on the following AHRQ-supported work: Common Formats for Event Reporting - Diagnostic Safety, National Academy of Medicine Definitions Paper (submitted to peer review journal publication), Engaging Patients To Improve Diagnostic Safety Supplemental Item Set.
Indian Health Service	• Enhanced Adverse Event Reporting Capabilities: ○ Reporting of adverse events in the IHS Safety Tracking and Response (I-STAR) has been successful with agencywide reporting. IHS is using the enhanced functionalities of I-STAR to develop standard reports and dashboards for local process improvement and quality assurance projects. • Division of Patient Safety: The IHS Office of Quality has selected a nurse consultant for the Division of Patient Safety and Clinical Risk Management and is also looking to hire a medical officer.
VA	• The External Peer Review Program is being used to determine the quality of test results communication to patients and to measure implementation of national policy. ○ The aim is to accelerate the improvement of test result communication in the VA. • ONC SAFER Guidelines: The VA plans to use ONC SAFER Guides to assess their forthcoming electronic health record (EHR) implementation, including test result reporting and clinician communication. ○ These guides were recently adopted as a measure in the Centers for Medicare & Medicaid Services reimbursement policy. • JAMIA Publication: A new analysis published in JAMIA used the VA's national EHR repository to identify missed diagnosis of stroke.

Following agency updates and a presentation from the Gordon and Betty Moore Foundation, the Subcommittee on Health IT to Improve Diagnosis discussed their committee's goals and identified areas of further collaboration with the larger group. Co-Leaders of the IAWG Subcommittee will reconvene to formalize next steps and initiate potential project(s).

Next Steps: The next IAWG meeting is scheduled for March 11, 2022, at 11 a.m. EST.