

2023 Medicaid Quality Incentive Measure

Measure 7	
Contact Person	Trish Anderson, (206) 216-2524
Measure Name:	Diagnostic Excellence: identify potential or actual diagnostic errors in current processes
Measure eligibility:	All acute, psychiatric/BH, rehab and children’s hospitals that participate in MQI are eligible to complete this metric.
Why?	<p>The effects of diagnostic errors are currently estimated to affect upwards of 12 million Americans each year. Diagnostic errors cause more harm to patients than all other hospital errors combined. Analysis reveals that accurate and timely diagnosis depends nearly as much on the healthcare system as it does on the diagnosticians (providers) themselves. Diagnostic errors are common, harmful, and costly. Seventy – nine percent of diagnostic errors are related to the patient-clinician encounter. One in twenty patients reported a diagnostic error in the past five years. A recent study showed upwards of 58% of errors are occurring in the hospital setting. Patients and families go on to report that there have been (63%) serious health consequences from the diagnostic error. The most common types of diagnostic errors are mistakes made on tests, surgery or treatment(60%), followed by misdiagnosis(55%), wrong test, surgery or treatment(43%), incorrect medication(37%) followed by wrong or unclear instructions about follow up care (31%). Focusing on Diagnostic errors now is vital as errors and delays are low-value care. Last year WSHA learned that looking for diagnostic errors in WA state is in its infancy. Most WA facilities had a marked improvement in the close the loop process for important imaging and lab results. Finding diagnostic learning opportunities will help find system challenges for providers and patients as well as drive improvement in this area.</p>
Clinical rationale:	<p>Given the prevalence and impacts of diagnostic errors, health care leaders must address them as part of their quality improvement and patient safety programs.</p> <p>While there is no single cause of diagnostic error and therefore no single solution to the problem, this complex issue must be solved through systems improvement. In patient safety literature, several causes of diagnostic error were identified, including:</p> <ul style="list-style-type: none"> • Errors in clinical assessment and subsequent decision making • Lack of time with the clinician • Communication between clinicians and patients • Communication between clinicians • System failures <p>Selected References:</p> <ol style="list-style-type: none"> 1. National Academies of Sciences, Engineering, and Medicine. (2015). Improving diagnosis in health care. Washington, DC: The National Academies Press. 2. The Safer DX Checklist: 10 High – Priority Organizational Practices for Diagnostic Excellence. (March 2022). Baylor College of Medicine. 3. Measure Dx: A Resource to Identify, Analyze, and Learn from Diagnostic Safety Events (2022). Agency for Healthcare Research and Quality.

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Definition:	<p>Diagnostic Error Defined</p> <p>The National Academies of Sciences, Engineering, and Medicine defined a diagnostic error as the failure to (a) establish an accurate and timely explanation of the patient’s health problem(s) or (b) communicate that explanation to the patient. The diagnosis may be delayed, missed or wrong.</p>
Included Populations:	Any inpatient and ED patients.
Exclusions:	No exclusions.
Fields to be reported:	<p>Enter “-1” for not applicable/ not able to retrieve the data Enter “0” if no potential cases discovered in numerator. Enter denominator data even if a zero in numerator.</p> <p>Use quality and safety data already collected by the organization to report diagnostic errors, as defined above and complete gap analysis about current processes. Methods of identification are listed below.</p> <ol style="list-style-type: none"> 1. <u>Event Reporting System</u> Review cases in the event reporting system the potential for diagnostic error. Report the number of cases in this category that had a potential diagnostic error (numerator) over the total number of cases in the event reporting system reported (denominator) monthly for 6 months. (1 point) 2. <u>Root Cause Analysis (RCA)</u> Review RCA cases for the potential for diagnostic errors. Report the number of cases where a diagnostic error was found (numerator) over the total number of RCA cases (denominator) reported monthly for 6 months. (1 point) 3. <u>Provider Peer review</u> Review Provider Peer review cases for the potential for diagnostic error. Report the number of cases identified with a potential diagnostic error (numerator) over the total number of peer review cases (denominator) monthly for 6 months. (1 point) 4. <u>Patient-family reported complaints</u> Report the number of patient-family reported complaints that may have the potential for diagnostic error. Report the number of concerns/ complaints that mention diagnosis (numerator) over the total number of complaints reported (denominator) monthly for 6 months. (1 point) 5. <u>Electronic health record-enhanced chart review</u> From the EHR database queries and electronic triggers of the electronic health record report the number of potential diagnostic errors found. Report the total COUNT of potential diagnostic error cases using this method. Total for 6 months. (1 point) 6. Submit <u>Safer Diagnosis Gap Analysis</u> CMO or CQO to complete the Safer DX survey one time by August 31, 2023. (5 points) <p>Diagnostic Excellence Survey (smartsheet.com)</p>

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Data Collection period:	July 1, 2023 - December 31, 2023																																						
Reporting deadline:	31 days after the close of the performance period or by January 31, 2024.																																						
Audits and validation: Do not change	Data are subject to the audit by the state. WSHA will not audit but will complete a few basic validity checks.																																						
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS. Smartsheet survey																																						
Data Scoring:	<p>Measures to look for a diagnostic error in the systems already in place. (5 points) One point each for numerator and denominator where requested.</p> <p>Five points for completion of gap analysis. A zero numerator could be a valid entry for no cases found over the 6-month time period. When submitting data monthly, all 6 months of data must be present for each category for total points.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Numerator</th> <th>Denominator</th> <th>Total potential points</th> <th>Frequency</th> </tr> </thead> <tbody> <tr> <td>Measure 1</td> <td>Yes</td> <td>Yes</td> <td>1</td> <td>Monthly</td> </tr> <tr> <td>Measure 2</td> <td>Yes</td> <td>Yes</td> <td>1</td> <td>Monthly</td> </tr> <tr> <td>Measure 3</td> <td>Yes</td> <td>Yes</td> <td>1</td> <td>Monthly</td> </tr> <tr> <td>Measure 4</td> <td>Yes</td> <td>Yes</td> <td>1</td> <td>Monthly</td> </tr> <tr> <td>Measure 5</td> <td>None</td> <td>Total count only</td> <td>1</td> <td>6 month total</td> </tr> <tr> <td>Safer Dx Checklist Gap Analysis</td> <td>NA</td> <td>NA</td> <td>5</td> <td>Complete Once</td> </tr> </tbody> </table>					Numerator	Denominator	Total potential points	Frequency	Measure 1	Yes	Yes	1	Monthly	Measure 2	Yes	Yes	1	Monthly	Measure 3	Yes	Yes	1	Monthly	Measure 4	Yes	Yes	1	Monthly	Measure 5	None	Total count only	1	6 month total	Safer Dx Checklist Gap Analysis	NA	NA	5	Complete Once
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