Federal Interagency Workgroup on Improving Diagnostic Safety and Quality in Health Care
March Meeting Summary

Workgroup Goal: Established in response to Senate Report 115-150. The Senate Committee on Appropriations requested that "AHRQ 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. This should include a review of current research, as well as consideration of opportunities for public-private partnerships and the development of centers of excellence to improve diagnostic quality and safety while reducing healthcare costs." (NASEM stands for "National Academies of Sciences, Engineering, and Medicine.")

Workgroup Summary: The workgroup meeting occurred on March 8, 2019, and was attended by representatives from the following agencies:

AHRQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
DOD	Department of Defense
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
NIH/NLM	National Institutes of Health/National Library of Medicine
NIH/NCATS	National Institutes of Health/National Center for Advancing Translational Sciences
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	Department of Veterans Affairs

The aims of this first meeting were to: (1) understand the scope and breadth of diagnostic safety research already underway, (2) discuss ongoing challenges, and (3) begin to identify commonalities and opportunities for collaboration and coordination across agencies. Representatives provided a brief description of the diagnostic safety research activities occurring within their agency and priority areas.

A select sample of agency activities is outlined below.

VA	• Newly released Revised Safer Dx Instrument provides a strategy and framework for healthcare organizations to measure, analyze, and reduce diagnostic errors.
ONC	• The agency recently released a rule that will encourage exchange of diagnostic health information technology (IT) information between entities and between the patient and clinician.
NIH/NCI	• Program Announcements for: *Using Information Technology to Support Systematic Screening and Treatment of Depression in Oncology Practices* - R21 and R01. • Multiple Interventions in Cancer Care Delivery: Follow-up to Abnormal Screening Tests (R01). • Interest in IT and patient navigation, a key determinant in timely diagnosis.
NIH/NCATS	• Clinical and Translational Science Awards Program focusing on translational efforts. • Informatics to improve electronic health record (HER) use.
NIH/NLM	• Examining use of IT to establish correct diagnoses by healthcare professionals (e.g., deep learning and machine learning to help with imaging). • Promoting interoperability of electronic health information. • Disseminating health information to patients (e.g., Medline Plus or Genetic Home Reference to help patients understand their diagnoses and how to navigate the disease and the treatment).
IHS	• There is a need to explore the topic of disparities within the context of diagnostic safety.
HRSA	• "Comprehensive health homes" – analytically combine data from primary care and public health to deliver better population health outcomes.
DOD	• Deep-dive analysis of treatment delays that result in significant errors. • Contributions of human factors to errors that have led to harm. • Work on systemwide EHR implementation and maximizing clinical decision support. • Standardized mortality reviews. • Partnership with VA to look at data, trends, and solution for delay in treatment event type. • Partnership with AHRQ to develop the Quality and Safety Review System.
CDC	• Diagnostic Stewardship – Test ordering for *Clostridioides difficile* and urinary tract infections.

AHRQ	• In 2015, AHRQ issued two dedicated diagnostic error grant funding announcements. • AHRQ is interested in multidisciplinary research on the topic (with a heavy emphasis on human factors and solutions informed by an engineering perspective). • AHRQ released a patient safety learning lab request for application last year; half of the grants focus on diagnostic safety. • AHRQ's 2019 appropriations include an additional 2 million for research on diagnostic safety and quality.

Next steps include thinking about how to best organize and describe Federal activities and look for direct opportunities for coordination and collaboration. The aim is to share interest and not to duplicate effort.

The Society to Improve Diagnosis in Medicine will hold its annual Diagnostic Errors in Medicine meeting in November and the conference plan has a placeholder for a Federal panel.