SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

MEMORANDUM

DATE: April 13, 2017

TO: Randy Scott, President, and Members of the Health Service Board

FROM: Mitchell Griggs
Acting Director HSS

RE: Board Report: December 6, 2017 to January 4, 2017

HSS Personnel

- Recognition of Vadia Henry's years of service.
- We are currently recruiting for two, 9910 Employee Well-Being Interns.
- Two Benefits Analyst (1210) positions are open at this time.

Operations

- March inbound calls increased almost 20% over 2016. Call volume was up in March mainly due to questions regarding when 1095s.
- Speed to answer decreased 21%, only 33 calls were abandoned. Customer service levels are being met regularly after a very busy open enrollment and new plan year beginning.
- Operations management is performing a skills set inventory to assess training and skill development needs.
- Weekly QA audits have been created to reduce data entry errors and send "clean" enrollment files to carriers.

Data Analytics

- 54% of the File Room digitization project is complete. All member files have been prepped and 47,747 member files have been digitized. Completed onsite quality assurance checks.
- System remediation from split carrier implementation continues.
- Electronic filing with the IRS for form 1095-C on behalf of all four employers was completed ahead of the March 31st filing deadline.
- Conducted kick-off meeting with the eMerge team to review system requirements for eBenefits.
- Conducted downtime weekend server maintenance for key SFHSS systems 3/25 and 3/26.

Finance and Accounting

- Financial System Project – Completed Phase 2 Role Mapping, User Experience Testing for the General Ledger and Accounts Payable modules

Contracting and Vendor Management

- Issued Micro-LBE Set-Aside RFP for City-wide '2017 SFHSS Well-Being Campaigns' targeting nutrition, volunteerism and stress-mitigation.
- Issued RFP for 'Promoting Well-Being for Leaders Workshops', a management training series.
- Finalized and implemented Volunteer Waiver and Release of Liability form and policy.
- Finalized and implemented Publicity and Media Release form and policy.

Communications

- Completed the design, layout and email distribution of the following monthly flyers for Well-Being's projects:
    - Get Moving
    - Chair Yoga
    - Fitness Fair
    - Exercises At Your Work Station
    - Qi Gong Class
    - Healthy Start Week 7
    - Healthy Start Week 8
- Web stats: 3,163 unique visitors in March. eNews stats: out of 19,232 delivered and 13,343 opened.

Well-being

- Provided a Well-Being@Work update and overview to the City's department heads: 41 attended.
- 18 departments identified leaders who will help support employee well-being.
- The first Spotlight Nominations (stories to showcase the work being done by departments on employee well-being) were submitted.
- 92 Champions were trained about promoting physical activity during 11 trainings (1 more planned).
- 11 onsite events were offered at the departments including the launch of 2 more Healthy Weight Programs.

- EAP provided counseling to 63 clients in March. Participation in counseling so far in 2017 compared to 2016 represents a 35% increase in the number of hours and a 27% increase in the number of people counseled.
- EAP provided 38 organizational well-being services to 310 people in February. The majority of services were organizational consultations and trainings. The majority of people served attended trainings and orientations.
- On average, 190 unique individuals visited the Wellness Center monthly in the first quarter of 2017.
- There were 1656 visits to the Wellness Center in the first quarter of 2017. 81% were for group exercise classes, 12% for use of the space, 7% for seminars, and 5% for special events.
- Wellness Center group exercise classes had 1377 visits and an average of 11 participants. City Hall classes had 1595 visits and an average of 29 participants per class.
- Play Your Way is the upcoming physical activity program that will be offered April-June. To launch the event at the Wellness Center, there will be Play Your Way Week from April 24-28. It will include a Fitness Fair supported by our many health plan partners.
- Representatives from the Health Service Board and the San Francisco Health Service System staff attended the 2017 Integrated Benefits Institute Annual forum in San Francisco between March 27-29 as scholarship participants. The HSS Well-Being program was an award finalist for the 2017 Healthy Enterprise Health Management and Performance Award from IBI.

Directors Meetings/Presentations/Misc.

- Met weekly with Aon Hewitt
- Monthly eMerge Executive Steering Committee
- Attended UESF Retired Division's membership meeting
- Department Head meeting hosted by DHR and the Mayor's office
- Annual Kaiser Customer Advisory Group meeting
- Participated in Kaiser Permanente Performance Guarantees Review meeting
- Met with Mayor's policy and budget staff
- Met with Controller Ben Rosenfield regarding funding for Dependent Eligibility Verification Audit
- Worked with HSS staff and medical plans on Gender Dysphoria presentation
- PBGH 1st Quarterly Meeting

- Met with Dr. Tony Van Goor, MD, MMM, CPE, FACP, Senior Director, Medical Affairs and Medical Director for Policy and Health Technology Assessment, Blue Shield of California, regarding the medical necessity policy criteria used to evaluate gender dysphoria services

Question from Board member

President Scott, in the February 2017 meeting, requested additional information from Aon on the selection criteria used for the 220 claims pulled for their audit of UHC's claims audit.

Aon responded with their audit sample consisted of a random, stratified sample of 220 claims. The sample size of 220 claims has a statistically valid confidence level of 95.00%, with an interval of 3.75%, any similarly selected sample will produce similar results. A separate set of 10 high dollar and 10 End Stage Renal Disease (ESRD) targeted claims were additionally audited outside of the statistical random audit due to errors discovered during the 2008 audit. The overall targeted sample size is sufficient to provide a relevant picture of performance and to highlight areas of opportunity for improvement. Aon does not weight results for specialty claim audits.

Federal Update summarized by Lee Hagy Research Asst.
Repeal and Replacement of Affordable Care Act

After President Trump and Republican Congressional leaders of the U.S. House of Representatives introduced the American Health Care Act (AHCA) to repeal and replace the Patient Protection and Affordable Care Act (ACA), a sharp divide between Moderate Republicans and conservative members of the U.S. House Freedom Caucus emerged. Two forefront divisive issues within the Republican Party regarding replacement of the ACA included tax credits offered for health insurance and the future of Medicaid. Regarding Medicaid, the main issue of contention was whether to continue offering federal support for coverage to single adults without dependents through the expansion of the Medicaid program in states that expanded their insurance to cover this demographic group through the authority of the ACA during the Obama Administration.

A report from the Kaiser Family Foundation found that changes that were being considered to health insurance through repeal of the ACA and restructuring of Medicaid, including capping federal financing and eliminating enhanced federal funding for the Medicaid expansion, could negatively affect disparities in healthcare access. (Artiga, Ubri, Foutz, March 20, 2017).
Additionally, opposition to the AHCA began to increase after the independent Congressional Budget Office (CBO) and staff of the U.S. House Joint Committee on Taxation (JCT) estimated that enacting the American Health Care Act would reduce federal deficits by $337 billion over the coming decade but also increase the number of people who were uninsured by 24 million in 2026 relative to current law. (March 13, 2017, CBO Cost Estimate).

On Friday, March 24, 2017, the American Health Care Act bill was pulled from consideration from the U.S. House of Representatives floor at the request of President Trump, after it was clear that was not enough votes to pass it, due to a combination of Freedom Caucus and Moderate Republican party members' opposition to the bill. The vote had originally been promised by President Trump to occur Thursday, March 23, 2017. (Voice of America News, March 24, 2017).

The pulling of the American Health Care Act (AHCA) from consideration means that the ACA remains the law in place, for now. President Trump told attendees at a White House reception Tuesday March 28, 2017, that he expected lawmakers to reach another deal to repeal ObamaCare, after the first attempt failed. (Werner, AP, March 28, 2017). On Sunday, April 2, 2017, President Trump sent a message via Twitter stating: "Talks on Repealing and Replacing ObamaCare are, and have been, going on, and will continue until such time as a deal is hopefully struck."

However, with Congress set to take a two week recess beginning April 6th, Rep. Mark Sanford (R-SC), a member of the conservative House Freedom Caucus, said it is increasingly unlikely there will not be a deal to repeal the ACA at least until after the recess (Alonso-Zadivar and Fram, AP, April 5, 2017).

As of today, the Affordable Care Act remains in place, including the paying of cost subsidies to support health care exchanges, despite a U.S. House of Representatives lawsuit challenging the constitutionality of Obamacare cost-sharing subsidies. House Speaker Paul Ryan (R-WI) said Thursday March 29, 2017 that the Administration will continue to fund key Obamacare payments to insurers while the lawsuit runs its course. (Sullivan, March 30, 2017).
For HSS, this means that both the Health Insurance Tax (HIT) and the "Cadillac" tax on high cost health insurance plans remains in place and is scheduled to take effect in 2020, rather than being pushed back to 2025 as proposed under the American Health Care Act. It also means that for now an Employer Sponsored Insurance (ESI) tax on employees and employers will not take effect, although this tax could potentially come up in other legislation this year.

Center for Medicare and Medicaid Services (CMS) Administrator Confirmation – Seema Verma

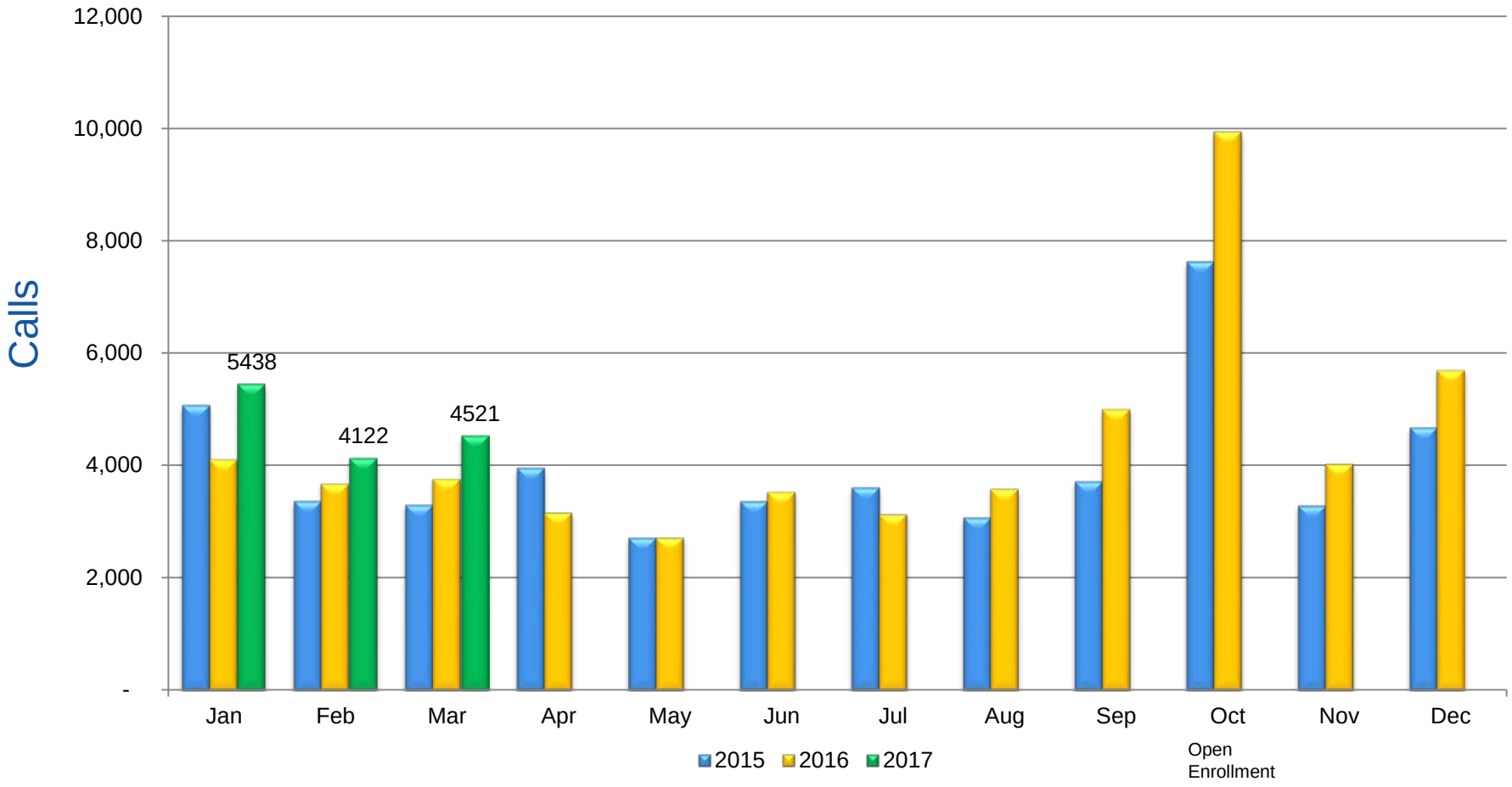
On Monday, March 13, 2017, the U.S. Senate voted 55-43, mostly along party lines (just 4 Democrats voted yes), to approve Seema Verma, President Donald Trump's nominee, as administrator of the Centers for Medicare and Medicaid Services. (Killough, Bradner, Barrett, CNN, March 13, 2017). It is anticipated that Ms. Verma will play a critical role in the future of healthcare policy, as Medicaid expansion has become one of the forefront issues of debate regarding possible replacement plans for the Patient Protection and Affordable Care Act (ACA). Ms. Verma was instrumental in advising states expanding under Medicaid, including

Indiana's approach that emphasized high deductible health plans paired with accounts similar to health savings accounts. (Leaventhal, Healthcare Informatics, March 2, 2017).

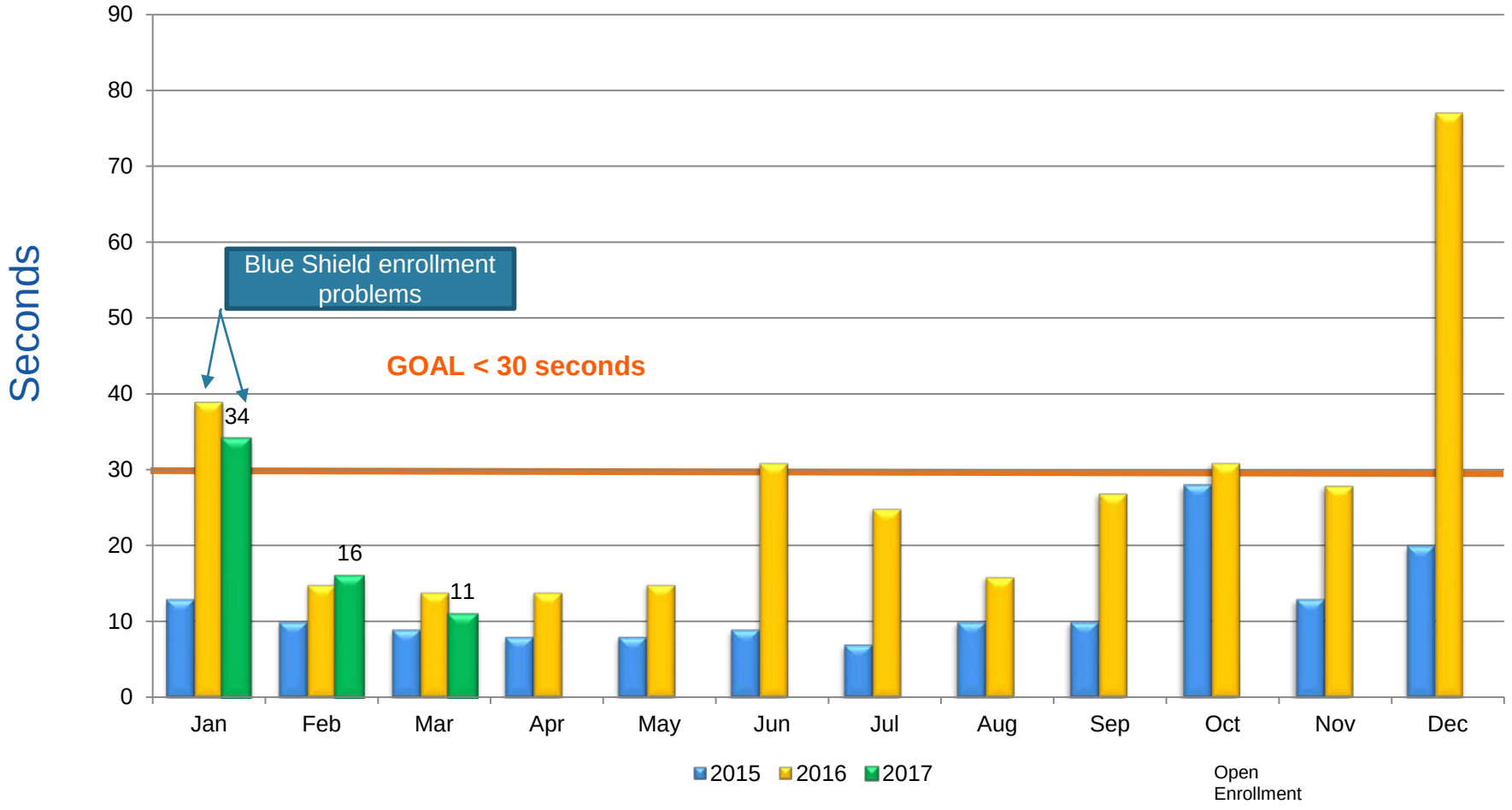
Calls and Office Visits: March 2017

- Calls and In-person Assistance total:
  - Inbound calls: 4,521 answered calls (19.4% ↑ from 2016)
  - Speed of answer: 11 seconds (21.4% ↓ from 2016)
  - Abandonment rate: 0.7% (33 Calls)
  - In-person assistance: 1,345 members (3% ↑ from 2016)

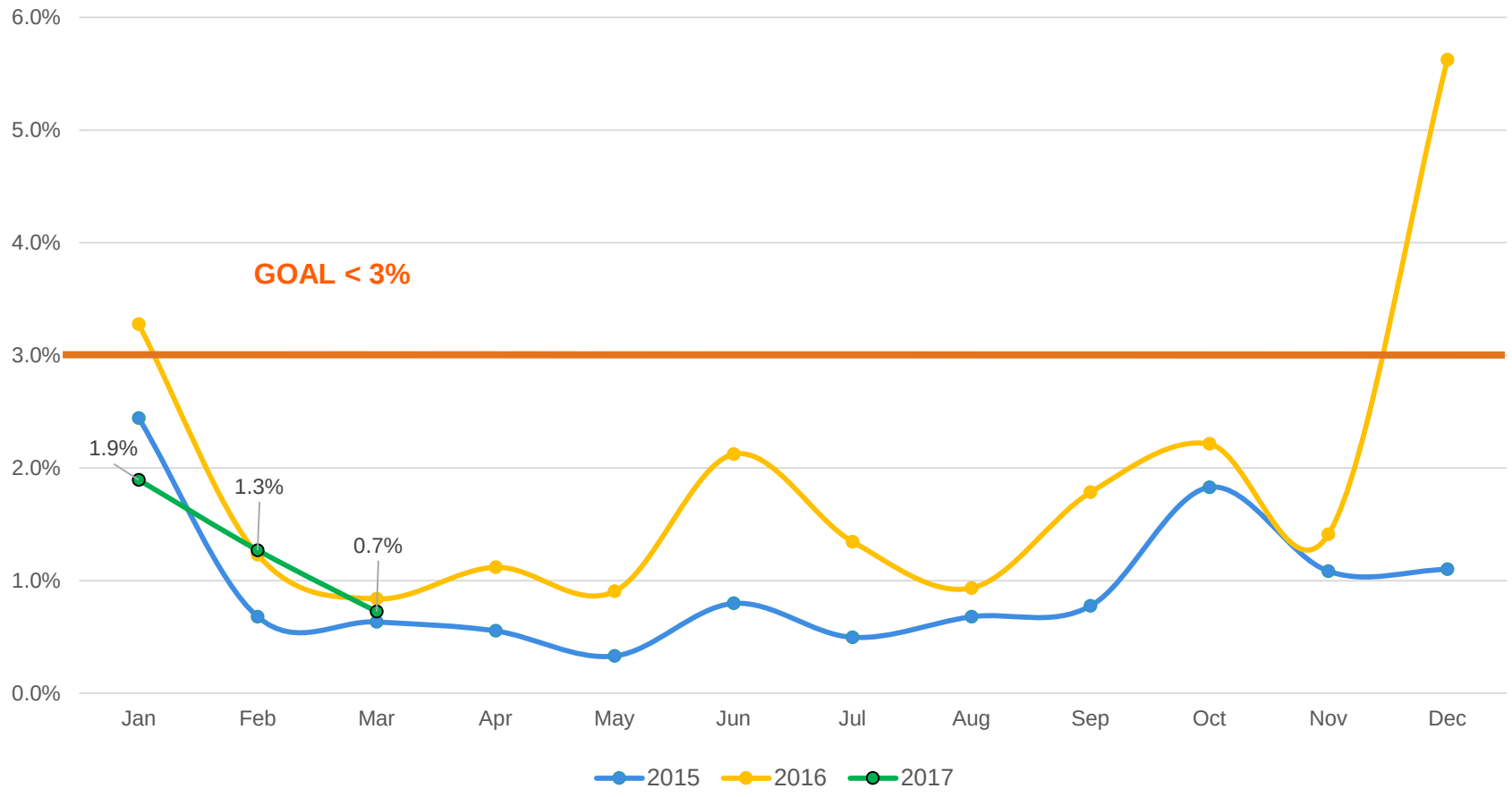
Inbound Calls: March 2017



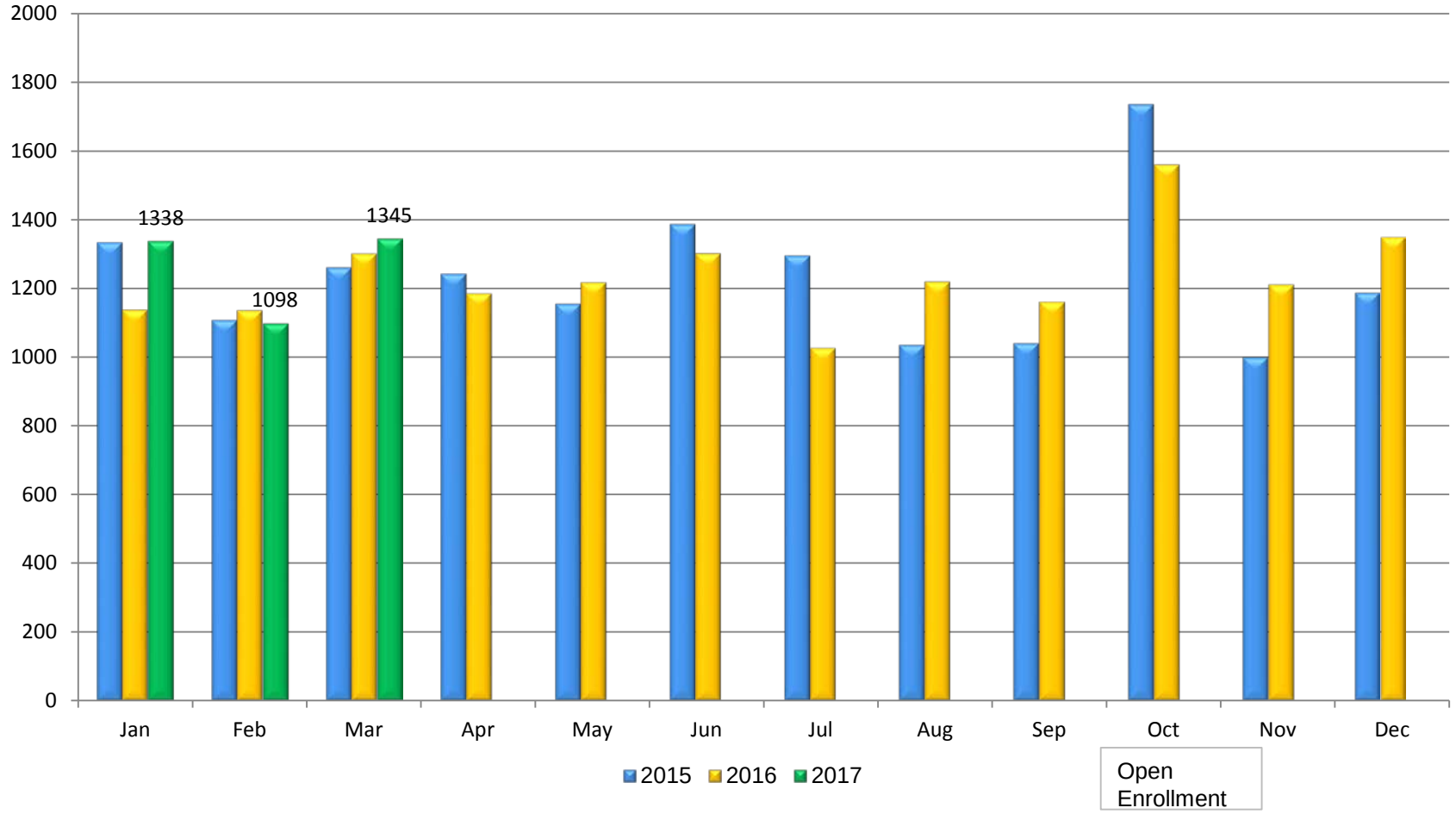
Call Speed of Answer: March 2017



Abandonment Rate: March 2017



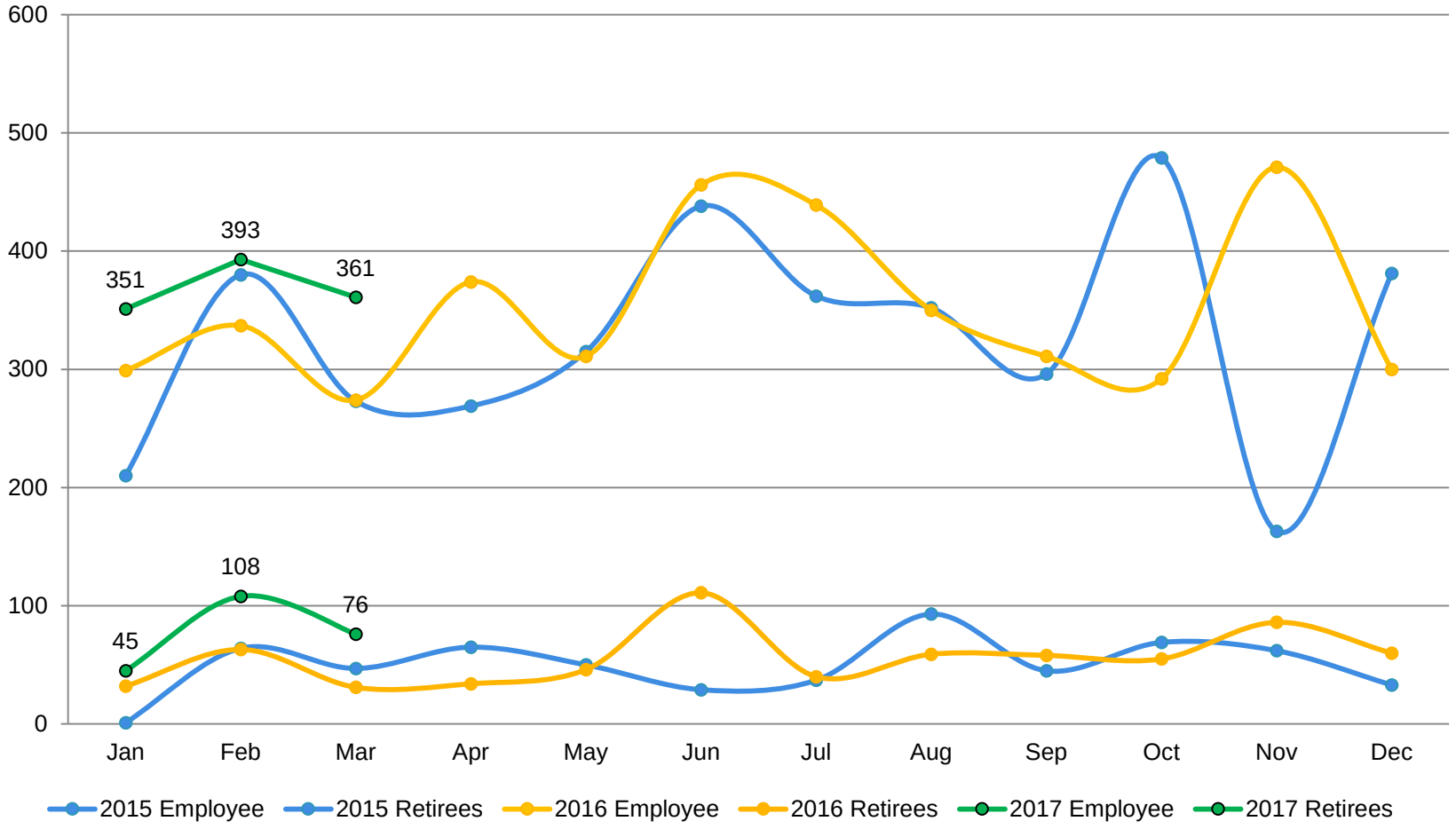
In-person Assistance: February 2017



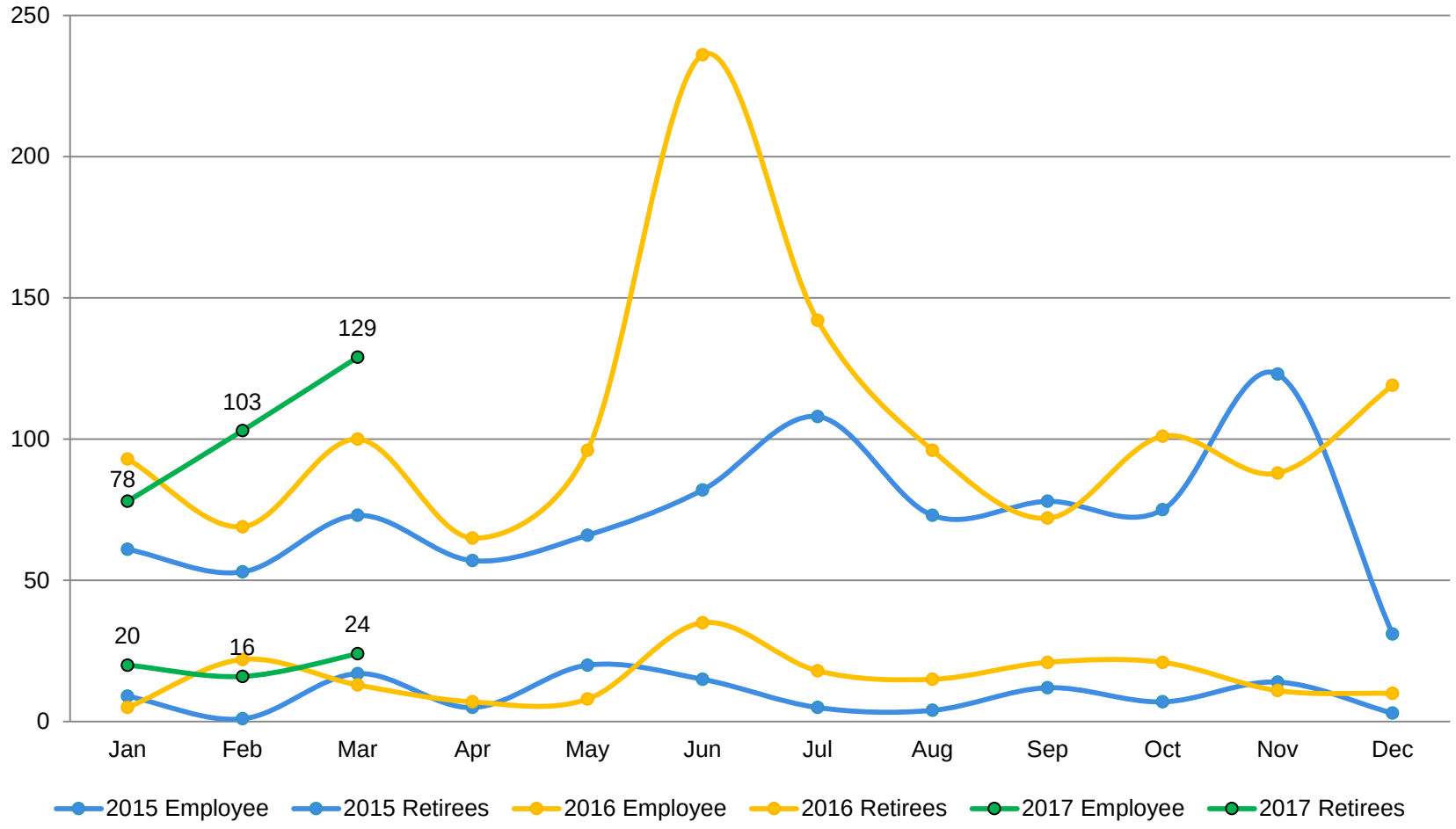
Delinquencies & Terminations: March 2017

- Delinquency Notices Sent
  - Employees: 361
  - Retirees: 76
- Termination Notices Sent
  - Employees: 129
  - Retirees: 24

Delinquency Notices: March 2017



Termination Notices: March 2017



Data Analytics Management Report

April 13, 2017

PEOPLESOFT / BENEFITS ADMINISTRATION SYSTEM:

- Continued system remediation from split carrier implementation:
  - Testing SF retirement system (SFR) inbound deduction file
  - SFR and STR (Teacher's retirement) resends
  - Identified new issue with UHC medical file related to dependent terminations for the member moving to New City Plan
  - Testing Overage Audit report with split enrollment
- Completed electronic filing with IRS for tax year 2016 Form 1095-C for all employers ahead of the March 31st filing deadline
- Provided additional audit queries to Member Services to ensure accurate and timely enrollments
- Held Kick-off meeting on March 15 with eMerge staff for eBenefits system configuration
  - Completed configuration of test user accounts
  - Completed initial steps for a testing/development environment

Data Analytics

- Fulfilled ad-hoc report requests:
  - Provided preliminary dependent enrollment information for analysis of dependent eligibility verification
  - Provided Employee Relations with aggregate dependent care FSA enrollment
  - Additional contextual information for research of appeal
- Conducted various analysis in support of rates & benefits:
  - Developed reports for extracting concurrent and prospective risk scores for 2016
  - Provided additional population details for retirees residing outside of California
  - Queried and analyzed aggregate costs related to gender dysphoria
- Working with Payroll Department on data request to complete annual FSA non-discrimination testing

IT INITIATIVES

File Room Digitization:

- Completed weekly loads into the Enterprise Content Management System (ECM):
  - 54% of the project is complete
  - 47,747 member files have been digitized
  - Conducted onsite audit at vendor on 4/4 to perform various quality checks. Vendor passed 100% all checks

Cyber Security:

- Attended monthly Multi-State Information Sharing & Analysis Center (MS-ISAC) webcast on 3/28

Miscellaneous:

- Met with Committee on Internet Technology (COIT) on 3/20 to review HSS submissions
- Presented to COIT on 3/24 HSS initiative for self-service and recurring online payments

IT INITIATIVES

Miscellaneous Continued:

- Conducted testing for phase two rollout of Identity Access Management
- Continued evaluation of electronic communication tools
- Completed updates for myhss.org and conducted training sessions with the Communications Manager
- Hosted Lexmark onsite on 3/21 to review our implementation and the product roadmap
- Coordinated through virtual warehouse two donations of old equipment
- Conducted downtime weekend server maintenance 3/25 and 3/26

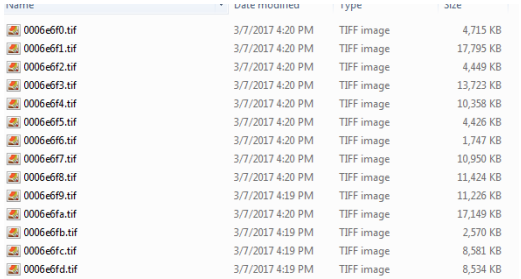
2017 Open Enrollment (OE):

- Released first open enrollment schedule to management
- Met with the Real Estate Department to discuss SFHSS self-service eBenefits lobby and interview room requirements

File Room Digitization

1. All member files were boxed up

2. Files were transferred to the scanning facility



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0006e6f1.tif	3/7/2017 4:20 PM	TIFF image	17,795 KB
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0006e6f3.tif	3/7/2017 4:20 PM	TIFF image	13,723 KB
0006e6f4.tif	3/7/2017 4:20 PM	TIFF image	10,358 KB
0006e6f5.tif	3/7/2017 4:20 PM	TIFF image	4,426 KB
0006e6f6.tif	3/7/2017 4:20 PM	TIFF image	1,747 KB
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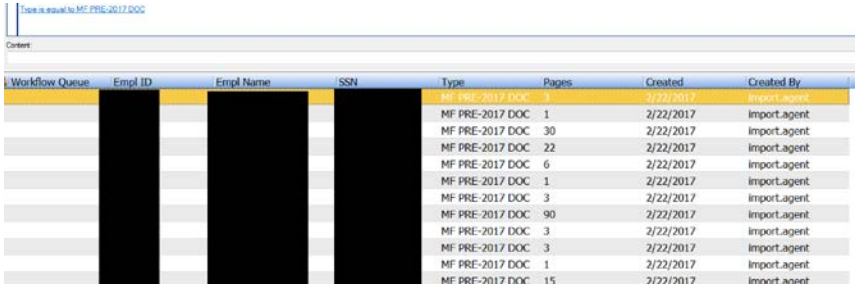
3. Vendor prepares the documents, digitizes the files, performs quality assurance checks and transmits the digitized files to SFHSS



Type is equal to MF PRE-2017 DOC

Content

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				MF PRE-2017 DOC	30	2/22/2017	import.agent
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4. SFHSS imports files into the Enterprise Content Management System

Finance and Contracting Activities Update

Finance and Accounting

- Finalized Self-Insured Delta Dental Actives claim experience for CY 2016
- Financial System Project – Completed Phase 2 Role Mapping, User Experience Testing for the General Ledger and Accounts Payable modules

Contracting and Vendor Management

- Issued Micro-LBE Set-Aside RFP for City-wide '2017 SFHSS Well-Being Campaigns' targeting nutrition, volunteerism and stress-mitigation
- Issued RFP issued for 'Promoting Well-Being for Leaders Workshops', a management training series
- Finalized and implemented Volunteer Waiver and Release of Liability form and policy
- Finalized and implemented Publicity and Media Release form and policy
- Initiated Q4 SFHSS Finance and Operations legacy scanning project with onboarding of dedicated temporary 1406 Clerk (TEX)
- Executed the Agreement with Kaiser Permanente

WELL-BEING MONTHLY REPORT

MARCH 2017 REPORT

Presented at the April 13, 2017 Health Service Board Meeting

Well-Being@Work Update: March

- Department Head Meeting – 3/7
  - 41 attendees
  - Provided a 2016 recap of employee well-being
  - Introduced the new Well-Being@Work framework designed to enhance employee well-being by providing the departments with resources (via Activities and Grants) and recognition (via Awards and Spotlights)
  - 2017 Well-Being@Work strategy involves created individual plans with each department around how they will address Organizational Commitment, Healthy Behaviors, and Emotional Well-Being
  - For more information, visit myhss.org/well-beingatwork

Well-Being@Work Update: March

- Department Lead Recruitment
  - Departments have been asked to identify a member of leadership who will help develop and implement the department's plan for employee well-being in 2017
  - 18 departments have leads so far
- Spotlights
  - 4 Spotlights (stories that highlight individuals or programs that are supporting employee well-being) were received by the April 1st deadline
- Grants
  - The first round of Grant Applications are due 4/14

Well-Being@Work Champion Update: March

- Champion Recruitment
  - Between January and March 2016 Champions were given the opportunity to renew their commitment for 2017
  - Unlike 2016, any Champion who did not actively renew was removed as a Champion
  - Currently there are 137 Champions
  - Departments will continue to be encouraged to recruit Champions until they have at least 1 Champion for every 200 employees
- Champion Training
  - 92 Champions were trained at 11 Champion Trainings (1 more planned) to help promote resources for the Play Your Way physical activity campaign

Campaign Preview: Play Your Way

- Play Your Way is the 2017 physical activity program (past programs included the Shape Up Walking Challenge and Move More, Feel Better: Get Fit on Route 66)
- Play Your Way consists of a campaign that will run from April-June and the 30-Day Challenge which will run in May
- All HSS members are eligible to participate in the Play Your Way 30-Day Challenge
- Details to come in April

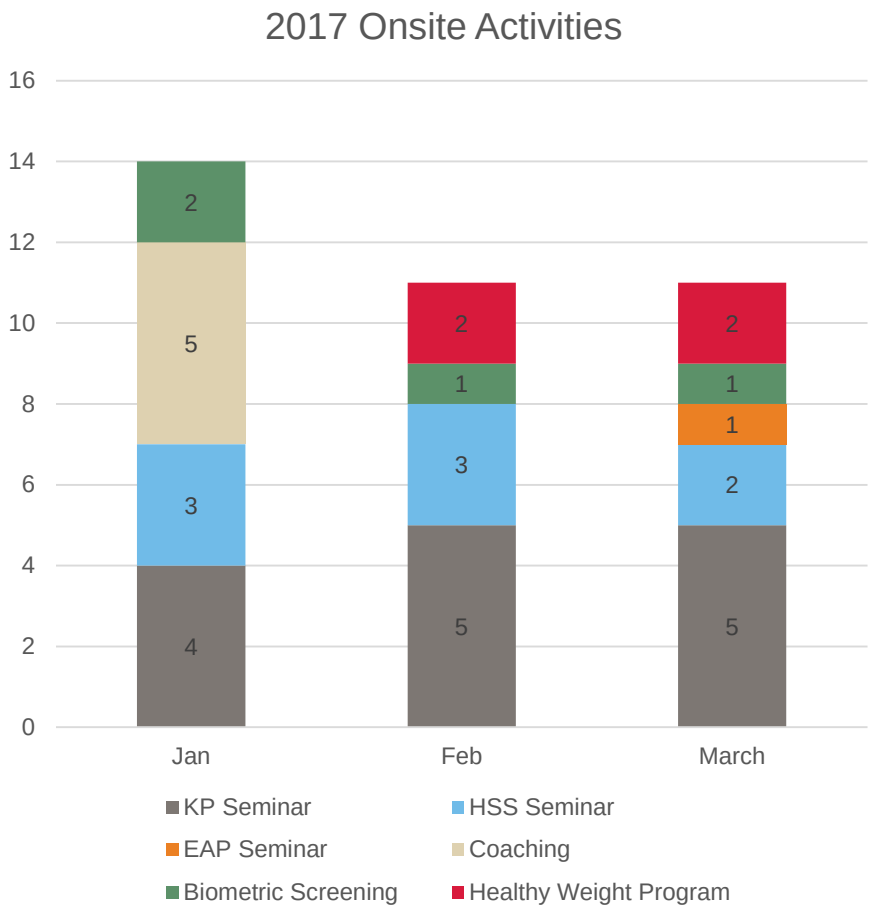
Better Every Day.

SAN FRANCISCO
HEALTH SERVICE SYSTEM

Onsite (Departments) Activities Update

March

- Champions hosted 11 different onsite events (36 YTD)
- Seminars represent the majority of onsite services
- 2 new Healthy Weight Programs (14-week series) launched: DPW and HSA-3120 Mission



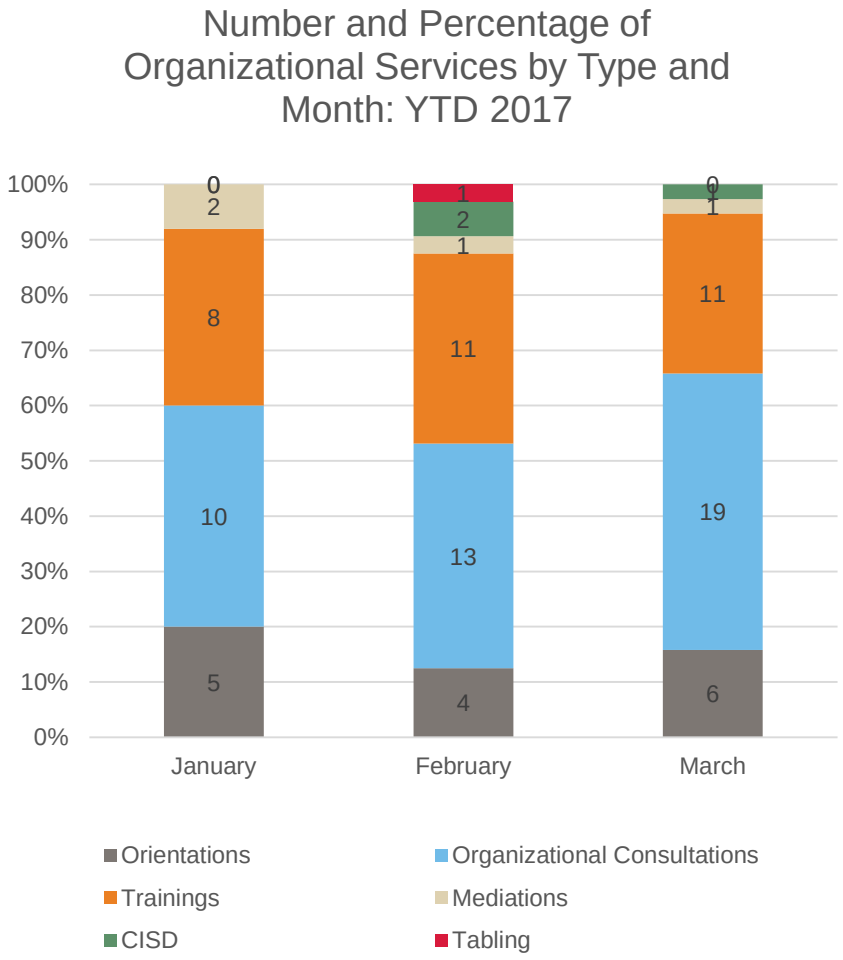
Employee Assistance Program: Organizational Well-Being

March: **Number of Organizational Services**

- 38 (95 YTD)
  - 50% were organizational consultations
  - 29% were trainings

Related Project Updates

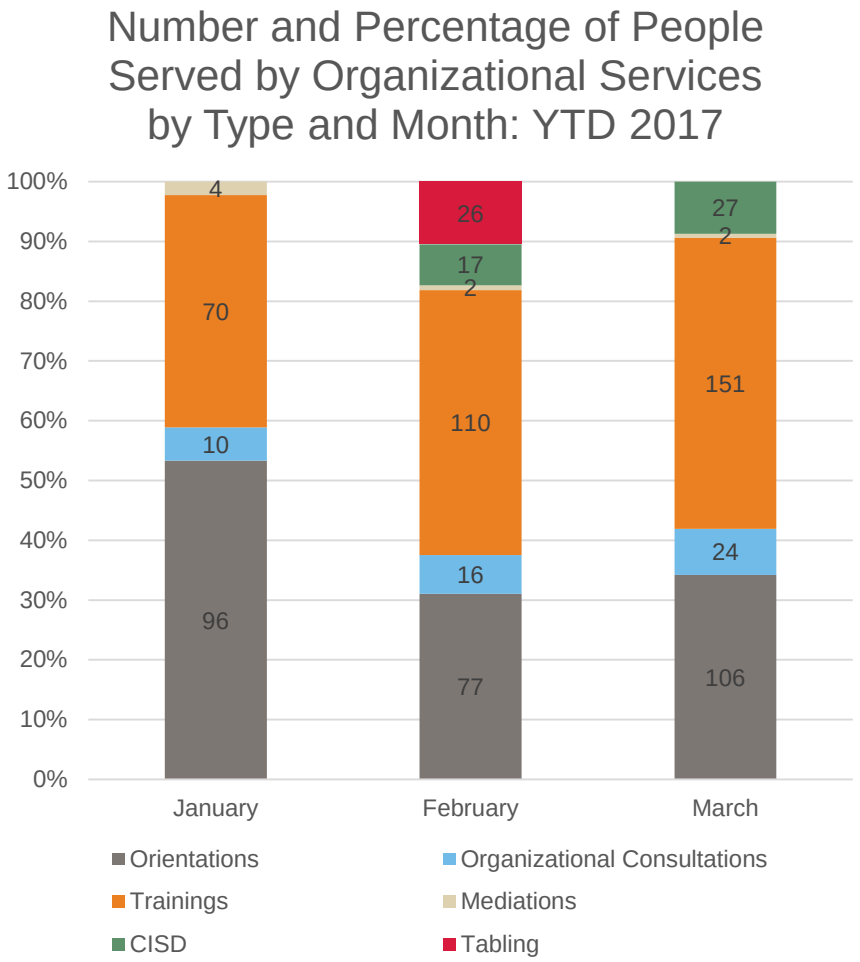
- Design and content of EAP 101 for Managers started
- Content of Managing 4 Success seminar series in development



Employee Assistance Program: Organizational Well-Being

March: **Number of People Served**

- 310 (738 YTD)
  - 49% of people served attended trainings
  - 34% of people served attended orientations



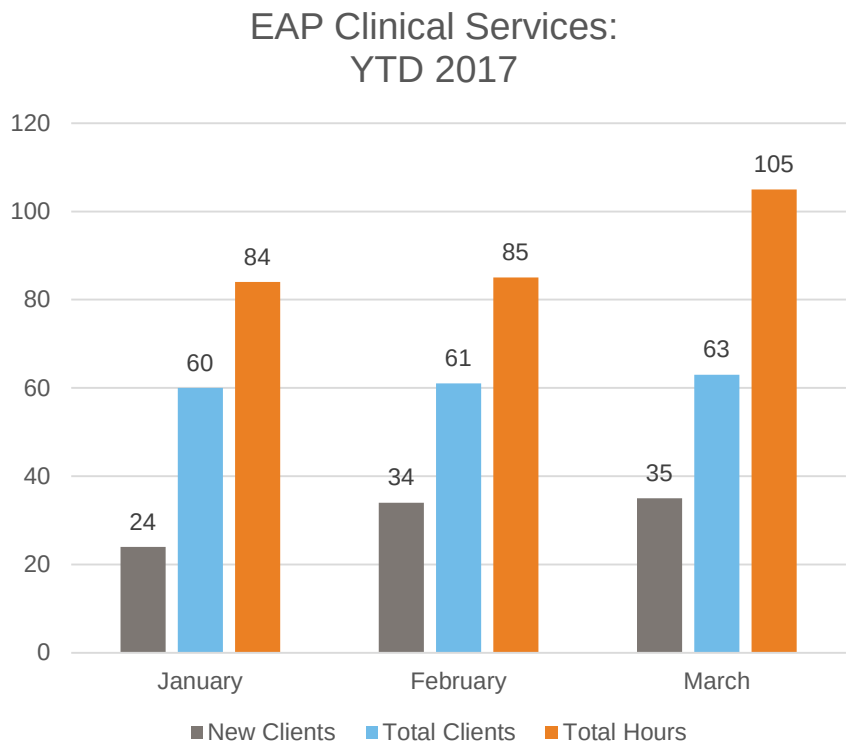
Employee Assistance Program: Counseling Update

EAP provided

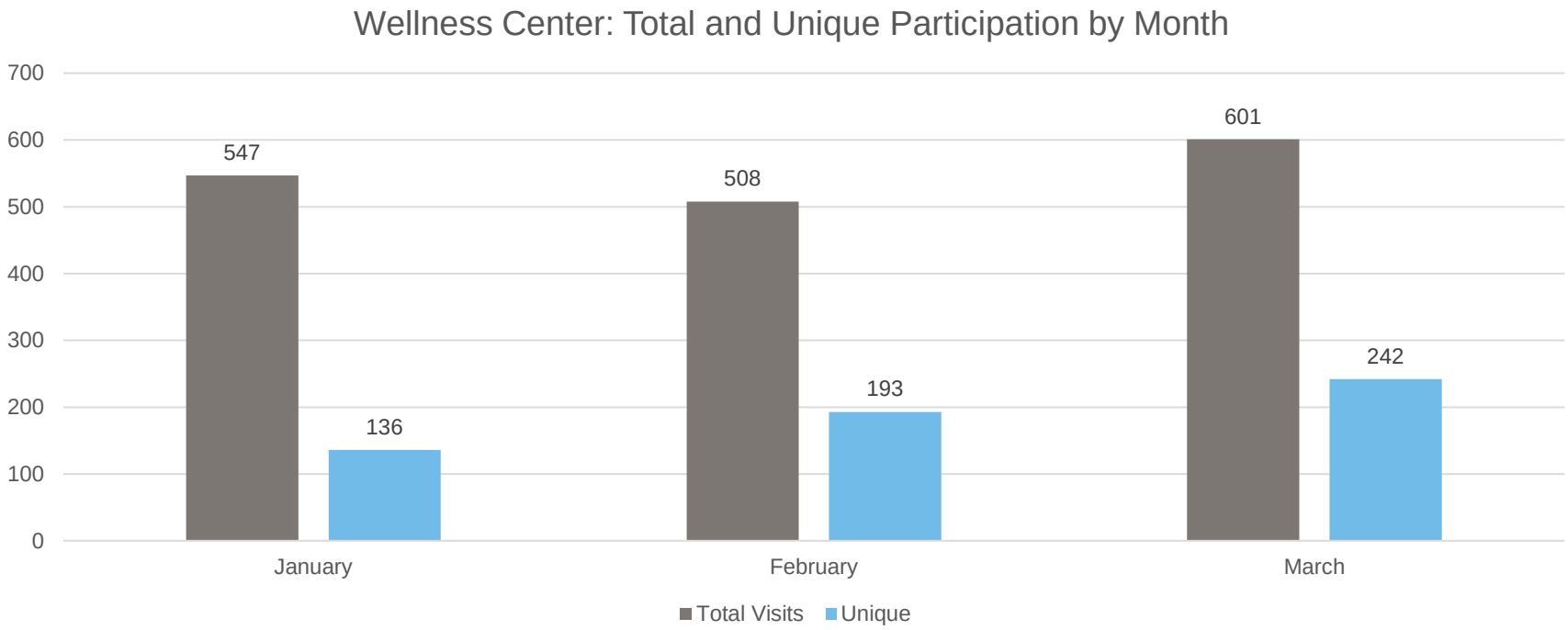
- 105 hours of counseling to
- 63 clients
- 35 new clients

Q1 2017 Compared to Q1 2016

- 35% increase in hours
- 27% increase in clients served



Wellness Center - Participation

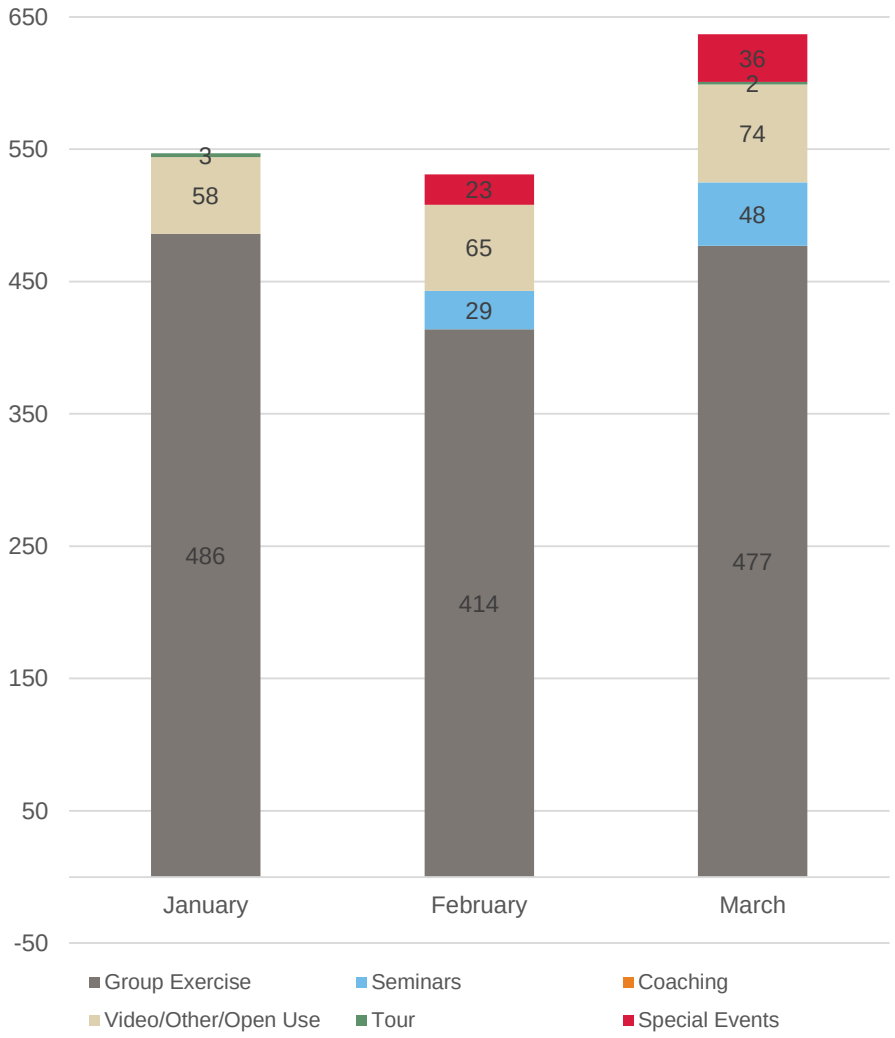


- There was a total participation of 1656 visits from January through March of 2017.
- On average there were 190 unique visits per month.

Wellness Center – Visits by Type by Month

Total visits by offering for January through March:

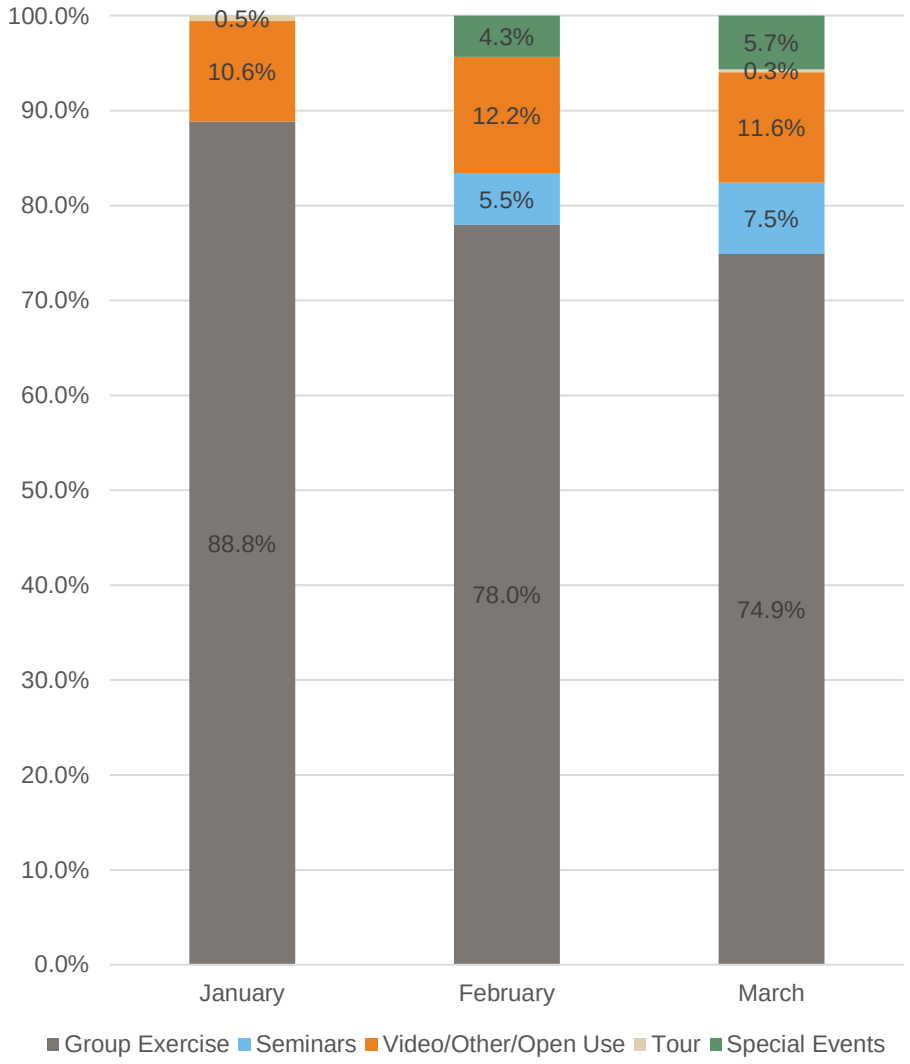
- Group Exercise – 1377
- Video/Open Use/ Other – 197
- Seminars – 77
- Special Events – 59
- Facility Tours - 5



Wellness Center - % of Visits by Type by Month

Average % Participation by offering for January through March:

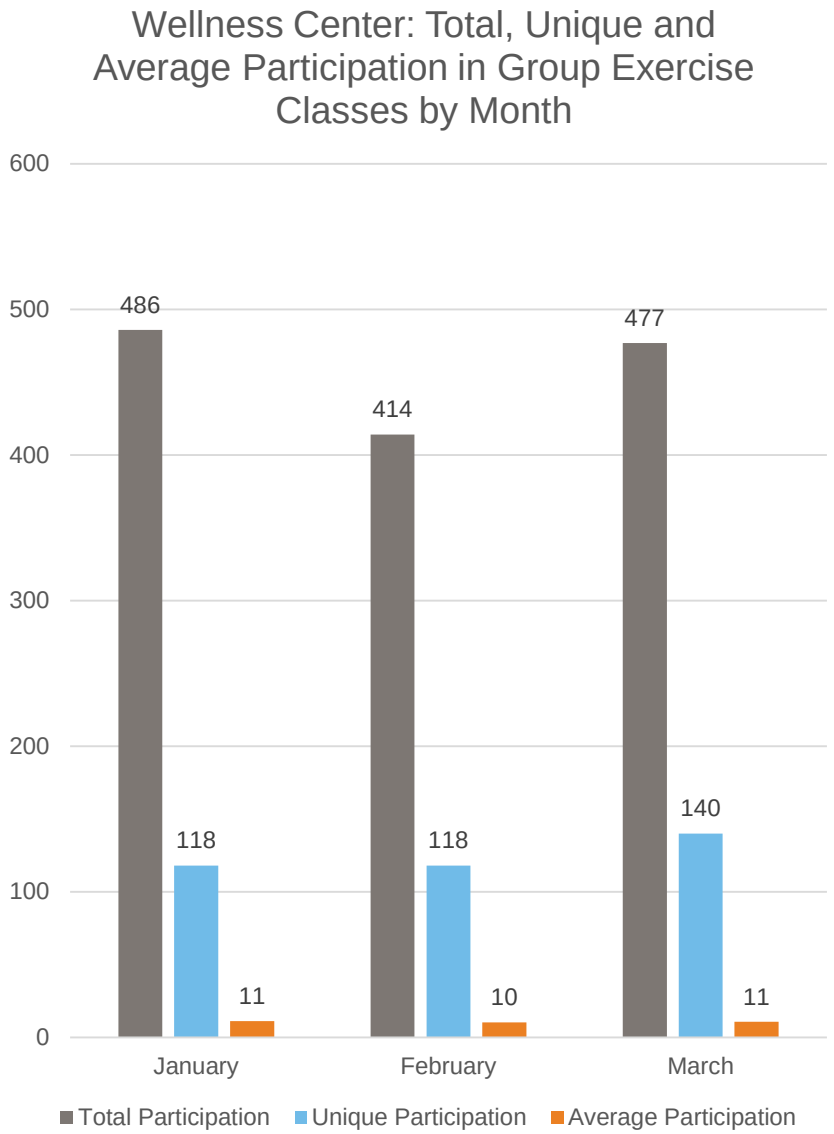
- Group Exercise – 80.6%
- Video/Open Use/ Other – 11.5%
- Seminars – 6.5%
- Special Events – 5.0%
- Facility Tours - .4%



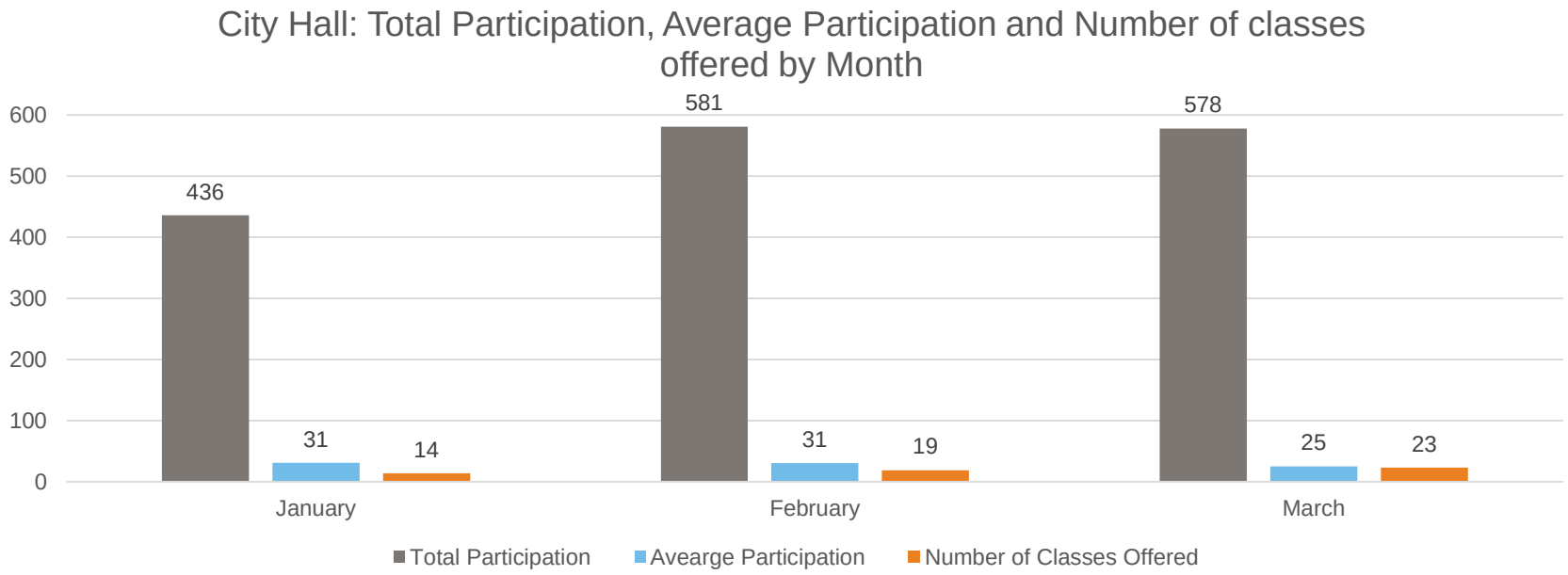
Wellness Center – Group Exercise

There were a total of:

- 1377 visits for group exercise for January – March
- 125 average unique participants per month
- 10.6 average participants per group exercise class



Group Exercise – City Hall



City Hall Group Exercise for January through March:

- 1595 visits
- 29 average participants per class
- 19 classes offered on average each month

Special Events in April at the Wellness Center include:

- Qigong class
- Play Your Way Week 4/24 - 4/28 which features:
  - Get Moving
  - Chair Yoga
  - Fitness Fair
  - Healthy Food Walk
  - Exercises at Your Workstation
  - Instant Recess Activities
- *Walk, Reuse, Recycle* shoe donation drive

The Washington Post

Health & Science

Misdiagnosis is more common than drug errors or wrong-site surgery

By Sandra G. Boodman May 6, 2013

Until it happened to him, Itzhak Brook, a pediatric infectious disease specialist at Georgetown University School of Medicine, didn't think much about the problem of misdiagnosis.

That was before doctors at a Maryland hospital repeatedly told Brook his throat pain was the result of acid reflux, not cancer. The correct diagnosis was made by an astute resident who found the tumor — the size of a peach pit — using a simple procedure that the experienced head and neck surgeons who regularly examined Brook never tried. Because the cancer had grown undetected for seven months, Brook was forced to undergo surgery to remove his voice box, a procedure that has left him speaking in a whisper. He believes that might not have been necessary had the cancer been found earlier.

"I consider myself lucky to be alive," said Brook, now 72, of the 2006 ordeal, which he described at a recent international conference on diagnostic mistakes held in Baltimore. A physician for 40 years, Brook said he was "really shocked" by his misdiagnosis.

But patient safety experts say Brook's experience is far from rare. Diagnoses that are missed, incorrect or delayed are believed to affect 10 to 20 percent of cases, far exceeding drug errors and surgery on the wrong patient or body part, both of which have received considerably more attention.

Recent studies underscore the extent and potential impact of such errors. A 2009 report funded by the federal Agency for Healthcare Research and Quality found that 28 percent of 583 diagnostic mistakes reported anonymously by doctors were life-threatening or had resulted in death or permanent disability. A meta-analysis published last year in the journal BMJ Quality & Safety found that fatal diagnostic errors in U.S. intensive care units appear to equal the 40,500 deaths that result each year from breast cancer. And a new study of 190 errors at a VA hospital system in Texas found that many errors involved common diseases such as pneumonia and urinary tract infections; 87 percent had the potential for "considerable to severe harm" including "inevitable death."

Misdiagnosis "happens all the time," said David Newman-Toker, who studies diagnostic errors and helped organize the recent international conference. "This is an enormous problem, the hidden part of the iceberg of medical errors that dwarfs" other kinds of mistakes, said Newman-Toker, an associate professor of neurology and otolaryngology at the Johns Hopkins School of Medicine. Studies repeatedly have found that diagnostic errors, which are more common in primary-care settings, typically result from flawed ways of thinking, sometimes coupled with negligence, and not because a disease is rare or exotic.

The problem is not new: In 1991, the Harvard Medical Practice Study found that misdiagnosis accounted for 14 percent of adverse events and that 75 percent of these errors involved negligence, such as a failure by doctors to follow up on test results.

Despite their prevalence and impact, such mistakes have been largely ignored, Newman-Toker and others say. They were mentioned only twice in the Institute of Medicine's landmark 1999 report on medical errors, an omission some patient safety experts attribute to difficulties measuring such mistakes, the lack of obvious solutions and generalized resistance to addressing the problem.

"You need data to start doing anything," said internist Mark L. Graber, founding president of the Society to Improve Diagnosis in Medicine and a leading errors researcher. Despite dozens of quality measures, Graber said, he is unaware of "a single hospital in this country trying to count diagnostic errors."

In the past few years, a confluence of factors has elevated the long-overlooked issue. In his 2007 bestseller, "How Doctors Think," Boston hematologist-oncologist Jerome Groopman vividly deconstructed the flawed thought processes that underlie many diagnostic errors, including several he made during his long career.

More recently, an influential cadre of medical leaders has been pushing for greater attention to the problem. They cite concerns about the growing complexity of medicine and increasing fragmentation of the health-

care system, as well as relentless time pressures squeezing doctors and the overuse of expensive, high-tech tests that have supplanted traditional hands-on skills of physical diagnosis.

Publicity about the death last year of 12-year-old Rory Staunton, sent home from an emergency room in New York after doctors missed the raging systemic infection that quickly killed him, have put a human face on the problem. At the same time, new digital databases such as IBM's Watson and Isabel promise to boost doctors' accuracy, although their usefulness remains a matter of debate.

"One of the reasons it's time to begin looking at it is that so many of the quality measures we use now assume that the diagnosis is the right one in the first place," said Christine Cassel; a member of the panel that wrote the 1999 IOM report, she is now president and chief executive officer of the American Board of Internal Medicine.

But what if it's not?

In a much-cited essay, Robert Wachter, associate chair of the Department of Medicine at the University of California at San Francisco, wrote that a hospital could earn "performance incentives for giving all of its patients diagnosed with heart failure, pneumonia and heart attack the correct, evidence-based and prompt care — even if every one of the diagnoses was wrong."

Discovered late — or never

Unlike drug errors and wrong-site surgery — mistakes that patient safety experts consider to be "low-hanging fruit" amenable to solutions such as color-coded labels and preoperative timeouts by the surgical team — there is no easy or obvious fix for diagnostic errors. Many are complex and multifaceted, and may not be discovered for years if ever, said Graber, a senior fellow at RTI International, a research firm based in Research Triangle Park, N.C.

"There is probably nothing more cognitively complicated" than a diagnosis, he said, "and the fact that we get it right as often as we do is amazing."

But doctors often don't know when they've gotten it wrong. Some patients affected by misdiagnosis simply find a new doctor; unless the mistake results in a lawsuit, the original physician is unlikely to learn that he blew it — particularly if the discovery is delayed. While diagnostic errors are a leading cause of malpractice litigation, the vast majority do not result in legal action.

Some environments are more susceptible to error than others. Graber calls the ER “a petri dish” for diagnostic mistakes: The doctor doesn’t know the patient, the patient doesn’t trust the doctor, and time pressures and frequent interruptions are the rule.

Misdiagnosis is not limited to hospitals; a recent commentary on the Texas VA study by Newman-Toker and Martin Makary estimates that “with more than half a billion primary care visits annually in the United States . . . at least 500,000 missed diagnostic opportunities occur each year at U.S. primary care visits, most resulting in considerable harm.”

There is another reason such mistakes have been long ignored: They are regarded as an unusually personal failure in a profession where diagnostic acumen is considered the gold standard.

“This really gets to who we are as clinicians,” said internist Robert Trowbridge, who directs the medicine clerkship program for Tufts University medical students at Maine Medical Center in Portland.

“Overconfidence in our abilities is a major part of the problem,” said Graber, who believes doctors have gotten a pass for too long when it comes to diagnostic accuracy. “Physicians don’t know how error-prone they are.”

Many, he noted, wrongly believe that the problem is “the other guy” and that they don’t make mistakes. A 2011 survey of more than 6,000 physicians found that 96 percent felt that diagnostic errors are preventable; nearly half said they encountered them at least once a month.

In the Texas VA study, more than 80 percent of cases lacked a differential diagnosis, in which a doctor not only declares what he believes is ailing the patient but also lists other potential causes of the problem based on symptoms, test results and a physical exam.

“A differential helps people to cognitively focus,” said Hardeep Singh, director of the Houston VA Patient Safety Center of Inquiry. Failure to ask “What else could this be?” can cause premature fixation on the incorrect diagnosis, said Singh, the study’s lead author.

At Maine Medical Center, Trowbridge spearheaded a pilot program launched in 2010 to persuade doctors to anonymously report diagnostic errors, which would then undergo comprehensive analysis. He said he had to “hound” his colleagues to report mistakes. During the first six months, 36 errors that would otherwise have gone unreported were identified; most were deemed to have caused moderate to severe harm.

Trowbridge said the program has changed how he practices. “I’m much more reflective, much more attuned to the errors I’m prone to make. I work with checklists more.”

It wasn’t fibromyalgia

While second opinions are one strategy believed to reduce misdiagnosis, the original error may be the basis of a cascade of mistakes.

For nearly three years, beginning in February 2008, financial executive Karen Holliman logged more than 50 visits with various doctors in Durham, N.C., trying to get help for the increasingly severe fatigue that had plagued her for several years as well as back pain so excruciating that she wound up in a wheelchair.

Doctors variously told her she had fibromyalgia, chronic fatigue syndrome or a psychiatric problem. The real reason for her symptoms was metastatic breast cancer, which had riddled her spine, fracturing her back. Signs of cancer had been found on an MRI scan performed in February 2008. But a bone scan performed a few weeks later did not indicate cancer; her internist told her she did not have cancer, and doctors repeatedly failed to investigate the discrepancy.

To make matters worse, Holliman was taking hormone replacement pills prescribed by her internist to combat hot flashes; the drug fed her breast cancer.

“I’m terminal,” she said. In December 2010, when she was told she had Stage IV breast cancer, an oncologist estimated her life expectancy at about three years. “I could have been diagnosed in 2008,” she said, adding that she believes timely diagnosis and treatment might have extended her life expectancy to 10 years.

Holliman has regrets: that she never got a second opinion from an internist or orthopedist, that she didn’t question the radiologists who performed her scans and that she failed to obtain her medical records earlier.

During meetings last year attended by her family, including a relative who is a prominent physician, as well as by her doctors and the hospital system for which they worked, Holliman said, a hospital lawyer called her case “a series of unfortunate events” but denied that the hospital was liable for the delayed diagnosis.

“I spent a lot of time being angry,” said Holliman, who is 52. She said she has not filed a malpractice suit because she was advised she was unlikely to win. “Now I’m just trying to live a really great life in the time I have left.”

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Kaiser Health News is a service of the Kaiser Family Foundation, a nonpartisan health-care-policy research organization unaffiliated with Kaiser Permanente.

Medical reporter Sandra G. Boodman writes a monthly column about the diagnosis of a puzzling case.

Rates and Benefits Calendar for Plan Year 2018

Meeting Date	Topics to be Addressed or Outcomes to be Achieved

February 9, 2017
1:00 pm
Room 416, City Hall
	• Black out Notice – Rates and Benefits
	• City Plan: Administrative fees
	• City Plan
	  o Review of claims experience
	  o Review of Stabilization Reserve
	• Copay benchmarking

March 9, 2017 1:00 pm Room 416, City Hall	• Presentation of 10-County amount • Stop loss recommendation for self-funded plans • Blue Shield Flex-Funded Non-Medicare review of claims experience, benefit design • Blue Shield Claims Stabilization Reserve
April 13, 2017 1:00 pm Room 416, City Hall	• Risk scores • Vision buy-up option • Aetna renewal • Dental renewal • Kaiser multi-region plan • Gender Dysphoria • Healthcare Value Initiative (“HVI”) • SimpleTherapy personalized pain recovery
May 11, 2017 1:00 pm Room 416, City Hall	• Kaiser Permanente actives/early retirees: review of claims experience, approve premium contributions for 2018 • Blue Shield Flex-Funded Non-Medicare: approve benefits and premium contributions for 2018 • City Plan actives and early retirees (self-insured): approve benefits and premium contributions for 2018 • VSP rate confirmation and buy-up option • Best Doctors YTD report and renewal • Kaiser multi-region plan

June 8, 2017 1:00 pm Room 416, City Hall	• UHC Medicare Advantage (fully-insured): approve retiree rates and premium contributions for 2018 • Kaiser Permanente Senior Advantage fully-insured retiree rates and premium contributions for 2018

END OF RATES AND BENEFITS PROCESS

Tentative Board of Supervisors ("BOS") Schedule for 2018 Rates and Benefits

Mid-June, 2017 (date to be determined) – Rates package introduced to BOS and assigned to BOS Budget and Finance Committee

July __, 2017 – BOS Budget and Finance Committee review of rates package (date to be determined)

July __, 2017 – First reading by full BOS (date to be determined)

July __, 2017 – Second reading by full BOS (date to be determined)