



QUALITY IS OUR IMAGE

**American College of Radiology  
Web Meeting Summary  
Closing the Loop Quality Measures Technical Expert Panel  
May 15, 2020**

**Meeting Attendees**

TEP Members: David Seidenwurm, MD, FACR (Co-Chair); Nadja Kadom, MD (Co-Chair); Christopher Moore, MD (Interim Co-Chair); David Andrews, PhD; Mary Barton, MD, MPP; Terri Ann DiJulio; Stella Kang, MD, MSc; John Lam, MD, MBA, FACS; Greg Loyd, MA, MPAS, PA-C; Linda Peitzman, MD, FAACP; Robert Pyatt, Jr., MD, FACR; Kesav Raghavan, MD; Mary Streeter, MS, RRA, RT(R)(CT); Banu Symington, MD, MACP; Sharon Taylor, Ben Wandtke, MD, MS; Jessica Zerillo, MD, MPH; Margaret Richek Goldberg, PhD, MA

TEP Members Unable to Attend: Arjun Venkatesh, MD, MBA, MHS (Co-Chair); Andrew Baskin, MD; Tessa Cook, MD, PhD

ACR Staff: Judy Burleson, MHSA; Mythreyi Chatfield, PhD; Nancy Fredericks; Karen Orozco, CHES; Samantha Shugarman, MS; Zachary Smith

PCPI Staff and Others: Neha Agrawal, MPH; Deborah Harper, MA; Jamie Lehner, MBA; Sam Tierney, MPH; Heidi Bossley, MSN, MBA (Independent Consultant)

**Welcome and Introductions**

Ms. Shugarman welcomed the technical expert panel (TEP) to the meeting and reviewed housekeeping details. During roll call panelists affirmed that their disclosures were unchanged since the TEP meeting on April 28, 2020.

**Web Meeting #2 Wrap Up**

Dr. Kadom summarized key points addressed during the April 28<sup>th</sup> TEP Web Meeting (#2), which included the panelists establishing the following.

1. The definition of incidental findings (IFs) specific to the measure set
2. Particular elements (organ, modality, and follow-up timeframe ) that the three closing the results follow-up loop (on incidental findings, pulmonary nodules, and abdominal aortic aneurysm) measures will capture
3. Measures will assess occurrences of follow-up recommendations
4. Narrow-topic measures will cover incidental pulmonary nodules (PN) and abdominal aortic aneurysms (AAA)

Dr. Kadom confirmed that the denominator of the overarching Measure #1: Closing the results follow-up loop on IFs will include patients of all ages with denominator exclusions for those who opted out of follow-up care. Opt-out reasons include documentation that the follow-up recommendation(s) is no longer needed, the patient is unavailable, and the patient-physician shared decision-making conclusion

was not to follow the recommendation, the patient declined, or the recommended follow-up occurred elsewhere.

### **Draft Measure Statements Discussion**

Dr. Seidenwurm facilitated the measure statement refinement discussion. He directed the TEP to provide input based on the draft measure statements' measure importance (e.g., existing care gap, performance variation, etc.), usability, feasibility, eligible patient populations, numerator actions, consideration of data elements, and specifications, including exclusions and exceptions. Ms. Tierney explained that exclusions are applied uniformly across patient populations to remove a subset of patients or exams from the measure denominator, removing this population of patients or exams before considering if the numerator action is appropriate for them. In contrast, exceptions are applied to individual patients or exams on a case-by-case basis and requires their clinician to exercise their professional judgment on an individual patient's characteristics. Exceptions are assessed if a patient or exam fails to meet the numerator quality action, and if a valid exception exists, they are removed from the denominator calculation. Ms. Tierney emphasized that in her experience developing measures, she does not typically include exceptions unless they fit within one of two broad categories: medical reasons and patient or other non-medical reasons.

### **Measure #1: Closing the follow-up loop on incidental findings**

The TEP returned to the overarching Measure #1 to discuss whether the draft language stating "additional 90 days for follow-up to occur" presents enough time for the recommendations to occur and for the results to be communicated. The TEP discussed capturing different follow-up intervals to accommodate each potential IF and the radiologists' recommendations. One panelist queried if the timeframe for follow-up occurrence could be predicated on a percentage variance related to the noted recommended timeframe. However, the ACR/PCPI staff team noted challenges with building such variability into one measure. Another panelist suggested providing use cases for how the reporting clinician could achieve the timing element and meet the measure. For example, if the recommended time for follow-up is 12 months, the measure would specify that the patient may receive the follow-up within 15 months after the index exam (the imaging study that resulted in the IF discovery). Potential unintended consequences posed by the recommended follow-up timeframe flexibility, if too broad or narrow, were also discussed. Some were concerned that incidents of following up too close to the index exam might pose detrimental clinical impacts. TEP-member input established that the majority of successful follow-up occurs within 60 days of the recommended timing for follow-up. The TEP agreed to impose parameters of the recommended follow-up to meet the measure; the recommended follow-up must occur no more than 30 days before or 60 days after the recommended interval. The TEP also agreed that follow-up recommendations should consist of imaging and biopsy for this measure.

### **Measure #2: Closing the results follow-up loop on IFs for AAA**

This measure statement is supported by the guidance published in ACR's Managing Incidental Findings on Abdominal and Pelvic CT and MRI, Part 2: White Paper of the ACR Incidental Findings Committee II on

Vascular Findings<sup>1</sup> and the 2018 Society for Vascular Surgery<sup>2</sup> guideline. Agreeing that consistency across the measure set is important, the TEP supported modifications to the draft statement's timeframe for the follow-up. The language now mirrors the TEP-agreed timeframe flexibility language for Measure #1. Specifically, follow-up imaging must occur not more than 30 days before or 60 days after the recommended interval. One panelist posited that this measure and Measure #6: Follow-up for incidental imaging findings for AAA was duplicative, and perhaps one should be eliminated. Ms. Tierney explained that an outcome or intermediate outcome measure (Measure #2) paired with a process measure (Measure #6) is considered complementary to the outcome or intermediate outcome.

Given the criteria emphasized by Dr. Seidenwurm at the start of the draft measure statement discussion, someone on the ACR/PCPI staff team reiterated that measures be developed in areas where care gaps exist. In response to Measure #2 addressing gaps in care, a panelist informed the TEP of the existing care gap regarding radiology reports recommending follow-up ultrasound imaging when 4.0 to 4.9 cm AAA or ectatic aorta are discovered within the abdomen or pelvis. Dr. Seidenwurm highlighted for the panel the benefit of including disease-specific use cases in the measure set. He explained that AAA and PN maintain the most robust evidence-base, making them immediately fit for the narrower-focused measures.

### **Measure #3: Closing the results follow-up on IFs for PN**

Like the revisions to Measure #2, for the sake of consistency across the measure set, the draft timeframe of 90 days will be modified to the recommended follow-up occurring not more than 30 days before or 60 days after the index exam. The TEP discussed the rationale for limiting the denominator to patients 35 years of age and older. Dr. Seidenwurm noted that PNs' associated cancers and disease progression are different for patients under 35 years.

### **Measure #4: Specificity of follow-up imaging recommended for IFs**

As Dr. Kadom noted during her wrap-up of web meeting #2, the radiology report with recommendations includes lesion location, follow-up timing, and modality.

### **Measure #5: Documented evidence-based follow-up recommendations**

Discussed as a companion measure to Measure #4, a panelist shared their experience and how they found it awkward for clinicians and patients to view the evidence-based citation with the follow-up recommendation in the imaging notes section of the radiology report. The panelist recommended moving the citation of the evidence-base to another part of the findings report.

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<sup>1</sup> Managing Incidental Findings on Abdominal and Pelvic CT and MRI, Part 2: White Paper of the ACR Incidental Findings Committee II on Vascular Findings Khosa F et al J Am Coll Radiol 2013; 10:789-794. Copyright © 2013 American College of Radiology.

<sup>2</sup> The Society for Vascular Surgery Practice Guidelines on the Care of Patients with an Abdominal Aortic Aneurysm. Chaikof EL et al, J Vasc Surg. 2018 Jan; 67(1):2-77.e2. doi: 10.1016/j.jvs.2017.10.044.

## **General Discussion**

Panelists commented that the goal of this measure set is to ensure that radiology IF follow-up recommendations are evidence-based, appropriately communicated to the clinician and patient, and that the follow-up occurs (completion of recommended follow-up). Despite the measure set's straightforward overarching goal, this is a broad-reaching and challenging concept that includes issues regarding recommendations from various medical specialty societies as well as implementation barriers, among others. Given the care gap (i.e., variation among radiology groups or facilities) and to ensure that closing the results follow-up loop occurs, panelists recommended that these measures (and measures developed in the future) are developed in a way that allows practices to choose from specific measures within the set to improve practice. In other words, some groups are more advanced and would not need a process measure, like Measure #5, to reach the outcome defined in Measure #6. A panelist responded by suggesting that the TEP develop a broader measure than the current draft Measure #1. The TEP agreed that such a measure should assess completed follow-up of recommendations within an appropriate timeframe for IFs not yet defined, but that have an indication recommended by the radiologist. Another panelist suggested replacing Measure #1 with two to four smaller disease-specific follow-up metrics. Measure #1 would closely track with the Centers for Medicare and Medicaid Services Merit-based Incentives Payment System (MIPS) quality measure structure.

## **Wrap-up and Adjourn**

Dr. Seidenwurm concluded the discussion by reviewing overarching feedback and themes from today's TEP discussion. He identified the following regarding measure edits and other revisions:

1. Change the timing to allow safe flexibility for the follow-up recommendation to occur
2. Limit the follow-up recommendations to imaging and biopsy
3. Recommend stratifying groups, when appropriate, for the broad measures by clinical and/or sociodemographic factors specific to institutions and reporting clinicians
4. Keep the AAA and PN use cases because they have the most robust evidence-base and demonstrate the care gap.

Mr. Smith provided a brief update on the progress on the environmental scan of the evidence, and Ms. Shugarman adjourned the meeting.