

American College of Radiology
Closing the Loop Quality Measures Technical Expert Panel (TEP)
Thursday, January 28, 2021
Web Meeting #6 Summary

Meeting Attendees

TEP Members: Nadja Kadom, MD (Co-Chair); Chris Moore, MD (Co-Chair); David Seidenwurm, MD, FACR (Co-chair); Arjun Venkatesh, MD (Co-Chair); Mary Barton, MD, MPP; Andrew Baskin, MD; Tessa Cook, MD, PhD; Terri Ann DiJulio; Margaret Richek Goldberg, PhD, MA; 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); Sharon Taylor, Ben Wandtke, MD, MS

TEP Members Unable to Attend: David Andrews, PhD; Banu Symington, MD, MACP; Jessica Zerillo, MD, MPH

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

Others: Heidi Bossley (Independent Consultant)

Welcome and Introductions

The meeting began with a welcome from ACR staff and the co-chairs. Zach Smith proceeded with the TEP roll call, requesting panel members to identify new disclosures since the September 22, 2020 meeting. As such, Dr. Seidenwurm informed the TEP of his appointment to the United Health Care Scientific Advisory Panel. Dr. Wandtke shared that he now serves in an advisory role for Within Health, a specific entity focused on closing the follow-up loop for radiologists. All other TEP panelists confirmed that their disclosure information remained unchanged. Reminding the panel that the first public comment period for the draft Closing the Results Follow-up Loop measure set closed on January 7, 2021, Zach explained that the meeting's purpose is to review the public comments collected to determine revisions to the current version of the draft measures' specifications.

Comment Discussions Per Measure

Measure 1: Closing the results follow-up loop on incidental findings requiring non-emergent follow-up

- **Should there be a medical exception for "clinician opt-out" in the measure numerator?**
After considering the benefits of incorporating "clinician opt-out" as a measure exclusion, the panel agreed that the patient exception regarding shared-decision making could result in the patient declining follow-up recommendations. Therefore "clinician opt-out" would be redundant. Also, adding a "clinician opt-out" exception would increase this measure's data collection burden. During their review, panelists decided that keeping the shared decision-making exception is important. However, it would be beneficial to remove the "patient unavailable" exception but retain the list of exceptions of those that are most relevant and least burdensome to collect. The TEP agreed that the "patient unavailable" exception would be removed from Measure 1: *Closing the results follow-up*

loop on incidental findings requiring non-emergent follow-up, Measure 2: Closing the results follow-up loop on incidental findings for abdominal aortic aneurysm (AAA), Measure 3: Closing the results follow-up on incidental findings for pulmonary nodules, and Measure 5: Communication to the practice managing on-going care.

- **Is it necessary to include “evidence-based recommendations” in the denominator?**

Concerns that removing “evidence-based” from the numerator would expand the number of incidental findings in the denominator. The group discussed whether revised language such as “actionable incidental finding,” “actionable finding,” or “new finding” should be considered. Panelists were concerned about widening the scope beyond the focus of the project and agreed to continue to use “incidental finding” to promote system-ness. They also agreed that defining incidental findings by acknowledging that they are actionable is integral for the measure to yield its intended concept. This issue will be addressed as the measures continue to be refined before entering beta testing.

During this discussion, the TEP emphasized the importance of promoting evidence-based recommendations for actionable incidental findings. Panelists were concerned that measure users could omit follow-up recommendations should they lack strong evidence currently required to meet the measure. A panelist noted that most rating scales of evidence permit expert opinion in the absence of strong evidence. The panel agreed that recommendations, regardless of the supporting evidence, should be followed up as the overarching goal is to close the loop. Measure 4: *Evidence documentation and specificity of follow-up imaging recommendations for incidental findings* will also capture this information as it focuses on ensuring that distinct components, including the evidence to support the recommendation, are in all contained in reports with incidental findings. The panel recognized that there would need to be adjustments in data collection and workflows but decided that it is crucial to continue closing the loop.

- **Should the follow-up time frame be extended to 6 months?**

The TEP discussed if the time frame specified in the measure should be extended to six months. They agreed that groups’ and facilities’ policies informing the different follow-up time processes should meet the recommended imaging within the three-month (90-day) timeframe. As such, the panel decided to retain the specified three-month time frame (30 days before and ending 60 days after the recommended time interval) for the follow-up to occur.

Measure 2: Closing the results follow-up loop on incidental findings for abdominal aortic aneurysm (AAA)

- **Should the follow-up time interval be extended to 6 months?**

Addressed during the TEP’s Measure 1 discussion, the measure will retain the three-month timeframe.

Measure 3: Closing the results follow-up on incidental findings for pulmonary nodules

- **Should a risk stratification data element be added?**

One commenter asked for guidance when final reports contain more than one recommendation (e.g., if/then statements). For example, should a radiologist lack relevant clinical information (e.g., a patient’s smoking status), their clinical decisions result in making two recommendations in the final report: one for low and the other for high risk. In these situations, the TEP decided that the

measure's guidance would designate that the measure captures the longer timeframe recommendation. Further, they discussed the potential for unintended consequences, should the follow-up occur according to the shorter timeframe, resulting in a "failed" measure. A panelist noted that most of the recommendations for pulmonary nodules greater than six mm utilize the same time frame; it is less concerning that follow-up recommendations would not appropriately occur. The TEP also acknowledged the frequency of this happening is low. Concluding their discussion of this measure, the TEP agreed to add guidance to the measure if the final report includes more than one recommendation, stating that the recommendation with the longer timeframe should be tracked.

Measure 4: Evidence documentation and specificity of follow-up imaging recommendations for incidental findings

Ms. Shugarman reminded the panel that the purpose of this measure is to ensure that patients are aware of radiologist recommendations. Panelists addressed commenters' feedback for including a patient-facing statement in the Findings section of the final report.

- **Should Measure 4's numerator include a "patient-facing statement?"**

During the public comment period, ACR sought input on whether such a statement added to the final report would promote patient engagement. Responses were mixed. Panelists questioned the utility of including this statement since not all states require epatients to access their final radiology reports. However, the panel recognized the likelihood of access growing among the states. The TEP acknowledged the importance of promoting transparency and patient access to their health information. In contrast, they also recognized that a patient-facing statement would increase measure complexity and data collection burden.

The TEP considered limiting the measure to only requiring the lesion's location, modality, and time interval and forming a separate measure regarding the evidence-based recommendation. ACR staff suggested collecting the individual requirements for the measure as specified. Explaining that reporting individual components' compliance rates and the overall performance could facilitate quality improvement, a panelist stated that published literature established that final reports with evidence result in better follow-up adherence. Because the definition of what constitutes evidence is broad, the TEP decided to maintain the measure currently written and exclude the patient-facing statement as numerator criteria.

Measure 5: Communication to the practice managing on-going care

- **Should the numerator be revised to require a one-business-day notification for Emergency Department patients instead of five?**

Most comments supported the five-business-day notification period. As such, the TEP agreed to retain the measure as specified.

The TEP also began a discussion concerning updates to the details in Measure 5: Communication to the practice managing on-going care and Measure 6: *Communication of IFs to the patient*. They deliberated over revising the measures from using the phrase "referring physician" to "the entity performing the technical service" or "the entity completing the exam and billing the technical fee." Some preferred the suggested revisions, recognizing that it may indicate that the communication is the responsibility of the health system or facility and not an individual clinician. Other members

expressed concern with the wording change. Monitoring the web meeting's chat log, it appeared as if most agreed to the suggested revisions. However, this will be revisited by the TEP during their next meeting.

Next Steps

Samantha informed the TEP that a second web meeting would be organized in the coming weeks to complete the comment review and the measure details would be revised according to their input. She adjourned the meeting.