



American College of Radiology
Closing the Loop Quality Measures Technical Expert Panel (TEP)
Tuesday, September 22, 2020
Web Meeting #5 Summary

Meeting attendees

TEP Members: David Seidenwurm, MD, FACR (Co-chair); Nadja Kadom, MD (Co-Chair); Chris Moore, MD (Co-Chair); David Andrews, PhD; Andrew Baskin, MD; Tessa Cook, MD, PhD; 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); Banu Symington, MD, MACP; Sharon Taylor, Ben Wandtke, MD, MS; Jessica Zerillo, MD, MPH

TEP Members Unable to Attend: Arjun Venkatesh, MD (Co-Chair)

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

Others: Heidi Bossley (Independent Consultant)

Welcome and Introductions

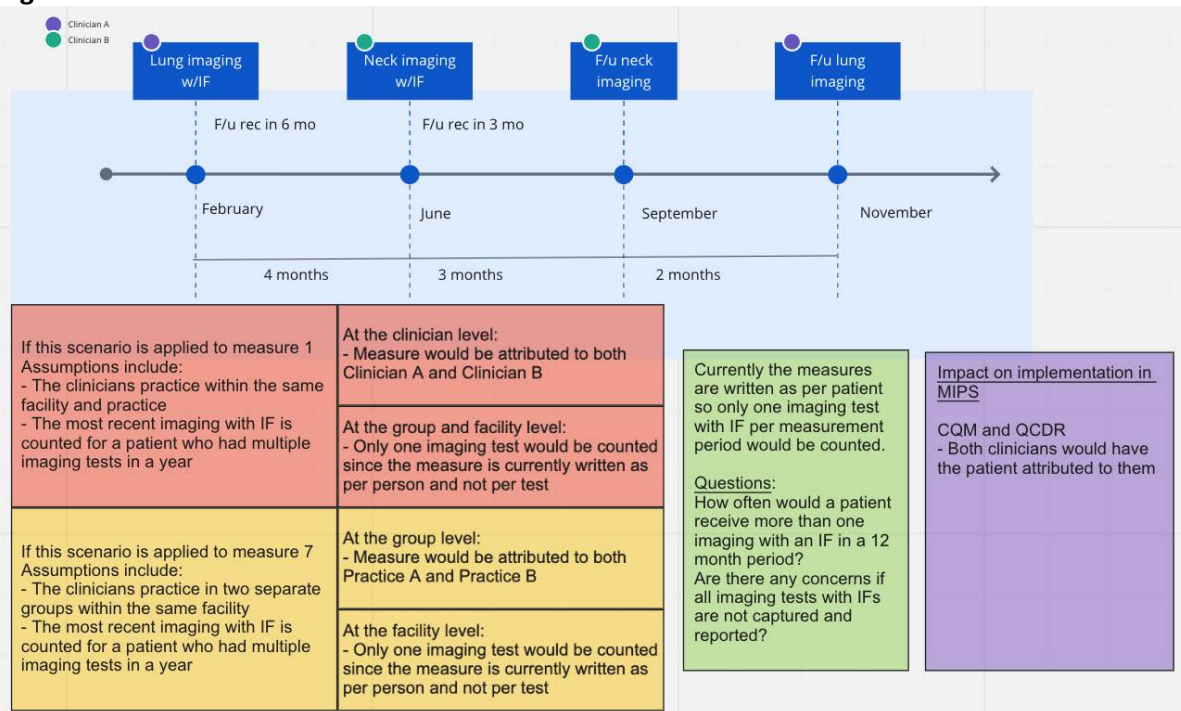
The meeting began with a welcome from ACR staff and the co-chairs. Ms. Shugarman proceeded with the TEP roll call, requesting panel members to identify new disclosures since the July 10, 2020 meeting. Dr. Cook identified new NIH funding as an update to her disclosure and designated that it is unrelated to the TEP's work; the remaining panelists acknowledged their disclosure information remained unchanged. ACR staff summarized the previous web meeting discussion and its connection to today's agenda. Ms. Shugarman explained that the purpose of the meeting is to evaluate measure attribution and the appropriate timeline for measure application using newly developed measure scenarios.

Measure Scenarios Discussion

The ACR measure development team devised imaging-exam scenarios to address an inquiry from the July 10, 2020, web meeting. The development team noted potential impacts on the measures' attribution and measurement level if the specifications do not appropriately capture imaging reports with recommendations (presently specified at the patient level).

Ms. Bossley introduced the two distinct scenarios. The first one, illustrated in Figure 1., applies to a patient who receives imaging on two anatomical regions (lung and neck) by separate physicians within a 12-month period.

Figure 1. Scenario 1

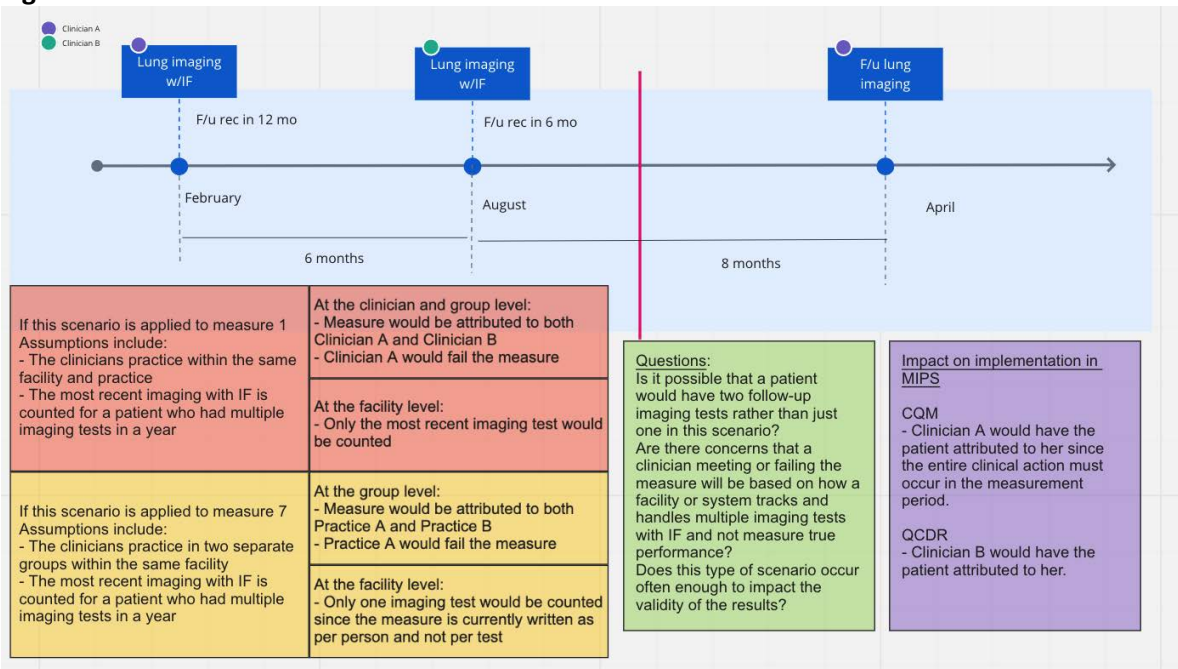


The TEP discussed whether the measures are specified accurately to capture their intents. Specifically, measure #7: *Communication to the practice managing ongoing care*. Panelists acknowledged the potential occurrence of overlapping incidental findings (IFs) and the measure’s intention of ensuring each IF is followed up on according to the recommended modality and time interval. Panelists considered implications posed by the measure based on possible specification edits resulting from Scenario 1’s discussion. For example, changing the measure to be defined by lesion or IF, rather than by patient (as drafted), designating an acceptable degree of imprecision of tracking for IF follow-up during measure utilization, and identifying potential unintended consequences, like overexposure to radiation and unnecessary testing encouragement. The TEP acknowledged the importance of devising an increased incentive for physicians, practices, facilities, and systems to cooperate and share information to reduce such unintended consequences while also increasing the IF recommendations’ follow-up rates.

As a result, the TEP agreed to revise measure #7 so that the denominator captures each lesion recommendation and contains the requirements outlined in measure #4: *Evidence documentation and specificity of follow-up imaging recommendations for incidental findings*. Panelists acknowledged the importance of ensuring the follow-up received aligns with the modality and interval defined within the recommendation. This revision confirms that the measure tracks individual lesions separately if an imaging report reflects multiple IFs.

The second scenario, presented by Ms. Bossley, regarded implications to measure performance calculation and attribution should an individual patient receive more than one chest imaging exam resulting in a lung IF on each chest exam interpreted by two radiologists during the same measurement period (Figure 2).

Figure 2. Scenario 2



The TEP discussed whether to revise the specifications to track lesion recommendations rather than the patient. Panelists agreed that radiologists face challenges with performing this measure with perfect accuracy. For instance, patients may receive care out-of-state or other health system and change health care providers, among other reasons. The panel supported the recommended specifications revisions, given that they present the “best” path forward. According to some panelists, physicians maintain responsibility for ensuring that their patients receive the follow-up, suggesting that the measure should incentivize this action. The TEP agreed that more than one physician should receive credit for the measure, regardless of who provided the follow-up, when the follow-up is known to have occurred.

The TEP discussed the feasibility of the measure’s data collection by defining the criteria required for identifying occurrence of follow-up. It was noted that data abstraction, completed by practice staff, may not automatically include the actual report or physician review. Instead, the presence of a CPT code, or other indication that the designated exam occurred in the specified time, would satisfy the numerator.

Measure Refinement

Measure 13: Outcome – Patients whose cancer was detected within 6 months of follow-up

Measure Purpose

The TEP addressed the difficulties associated with distinguishing high versus low rates of cancer detection to measure care quality. Panelists acknowledged that as drafted, the purpose of the measure is to demonstrate the value of a follow-up tracking system compared with the recommendation rate. The group agreed to revise the measure’s purpose as follows, “This measure aims to collect, or document cancer detection rates based on follow-up imaging recommendations.”

Unintended Consequences

Panelists discussed the following potential unintended consequences of this measure if misused.

1. Practices could increase their potential cancer detection rates by only recommending follow-up for IFs appearing most likely as cancer.
2. Practices could recommend follow-up for all IFs detected, thus inappropriately illustrate low detection rates.

Given these two consequences, the TEP agreed that the measure would benefit from increased evaluation focusing on how this measure is used, including influences from variables like case volume, geographical differences, and other factors unrelated to physician performance.

Measure Intent

One panelist emphasized that the current measure is limited to cancer diagnoses. However, other diagnoses could also be captured. The TEP discussed expanding the measure to include diagnoses of treatable diseases beyond cancer. However, such a measure would consist of a too broadly specified measure, thereby increasing the difficulty of specifying the measure and ensuring that the results are reliable and valid.

A panelist suggested that measure #13 is comparable to an existing measure that uses the adenoma detection rate as a quality indicator for colonoscopies. According to the panelist, adenomas/polyps are benign, but could be precancerous and one of the goals of colonoscopy is to find and remove polyps before they become cancerous. While the adenoma detection rate measure isn't intended to assess the detection of colon cancer, it does track growths that could become cancer. The measure requires that physicians identify sufficient numbers of patients with adenomas, resulting in improved colorectal cancer detection rates. The TEP asked if other similar applicable detection rates, like that of lung nodules, exist. Panelists addressed collecting the detection rates across the various lesions specified in the set's process measures to capture the data required to set their respective benchmarks. They agreed that the measure would be collected and stratified by lesion type, instead of aggregating the results across all recommendations. TEP leadership will examine ways to refine the measure with greater specificity and determine which lesions to include.

TEP Comments

The TEP reviewed the responses this measure elicited from the TEP-comment survey disseminated in July 2020. The discussion addressed the six-month timeframe and whether it was appropriate for reporting cancer detection rates or if an alternate timeframe was useful. Several panelists described limitations imposed by the six-month timeframe, including too short a time allowed to assess care quality and/or appropriate timeframes may vary among different lesions. Panelists also discussed specifying a particular time interval but were concerned that depending on the length of time designated, it may be difficult to benchmark a rate and appropriately attribute it to the follow-up provided by the radiologist.

Numerator Refinement

The panelists considered revising the numerator to "Patients for whom a diagnosis of cancer for a lesion that was recommended for follow-up by radiology (without a time frame identified)." Some described concern with tracking this information without knowing when the lesion was identified, making it difficult to distinguish quality care and performance variation. Others suggested that the measure could track cumulative cancer detection rates over time with a specific timeframe determined in the future.

ACR staff confirmed that the measure data, planned for collection in the National Radiology Data Registry (NRDR), captures detection dates allowing ACR to observe the timeframes for potential measure updates. The TEP agreed that revising the timeframe to two years, instead of six months, is reasonable for testing. The TEP decided to re-evaluate this interval following measure testing completion. Regarding the numerator identification of cancer detection, the TEP agreed to include all possible sources such as diagnosis codes or other imaging study results. Cancers unrelated to the IF recommendation would be excluded from the numerator.

All panelists agreed that this measure would require practices to participate in added data collection and resource allocation, given its difficulty collecting and reporting. Burden mitigation strategies mentioned include narrowing the focus to a smaller set of lesions and/or implementing data sources that impose less burden, like administrative claims data, compared to manual chart abstraction.

Next steps

1. Ms. Shugarman informed meeting attendants that the 30-day public comment period would open in October 2020, with the TEP meeting by video conference in December to discuss the comments. Comments or modifications made to the measures that require TEP review will be circulated by email.
2. A strategy for HIT/vendor community stakeholder input is under consideration by a subset of TEP members working with ACR staff, including those from the IT department.

Dr. Kadom thanked the TEP for their thoughtful participation and adjourned the web meeting.