



QUALITY IS OUR IMAGE

American College of Radiology
Closing the Loop Quality Measures Technical Expert Panel (TEP)
Friday, July 17, 2020 Call Summary

Meeting attendees:

TEP Members: David Seidenwurm, MD, FACR (Co-chair); Arjun Venkatesh, MD (Co-Chair); Chris Moore, MD (Interim Co-Chair); David Andrews, PhD; Mary Barton, MD, MPP; Andrew Baskin, MD; Margaret Richek Goldberg, PhD, MA; Stella Kang, MD, MSc; John Lam, MD, MBA, FACS; Linda Peitzman, MD, FAACP; Robert Pyatt, Jr., MD, FACR; Kesav Raghavan, MD; Banu Symington, MD, MACP; Sharon Taylor, Ben Wandtke, MD, MS;

Members Unable to Attend: Nadja Kadom, MD (Co-Chair); Tessa Cook, MD, PhD; Terri Ann DiJulio; Greg Loyd, MA, MPAS, PA-C; Mary Streeter, MS, RRA, RT(R)(CT); 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 opened with a welcome from ACR staff and the co-chairs. Ms. Burleson proceeded with the TEP roll call, requesting panel members to identify new disclosures since the May 15, 2020 meeting. None of the panelists in the meeting designated updates to their disclosures. Dr. Seidenwurm and the staff provided a summary of the previous web meeting discussion. He presented an overview of the tools and resources used to facilitate the development of these measures, including the multiple stakeholder surveys, the TEP comment period, and the environmental scan of the evidence.

TEP comment period measure refinement

Dr. Seidenwurm reviewed the results from the TEP comment period survey, stating that ten of the seventeen panelists, excluding co-chairs, completed the survey. Most of the responses will be discussed during today's meeting. The following topics were reserved for the upcoming fifth web meeting: 1) attribution comments and methodology and 2) technological feasibility and implementation issues.

General Themes

Measure set burden comments

The TEP Comment Period Survey results established that burdens imposed the measures outweigh the decision to omit them from practice. Panelists acknowledged that costs to implement the measures, including technical updates to health information technology, staffing updates, and clinical workflow updates, would diminish or plateau over time. The panelists were encouraged by the notion that data required to meet the measures may be utilized for other purposes, such as identifying gaps in care and improving the overall quality of care for patients. Such broader benefits offset data collection requirements and measure reporting. *Setting measurement levels*

Dr. Seidenwurm noted that the responses regarding the various measures' measurement levels varied throughout the survey, making it difficult to distinguish each measures' preferred level of measurement. However, some of the comment period results demonstrated that the highest percentage of "most appropriate" responses among the options of group-, facility-, or system-level delineated the preferred level of measurement for those particular measures. Several panelists highlighted that by specifying some of the measures for implementation at a more granular level, like the physician- or group-level, entities would aggregate those measures' results to illustrate measure performance on larger scales, like a facility or system. This method would present minimal concerns that the validity and reliability of the measure would be negatively impacted. The panelists underscored the difficulty with ensuring reliable and valid data when attempting the reverse (e.g., system- to physician-level). The TEP agreed that the purpose of these measures is to assess performance at the group and facility levels.

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

Based on the previously noted discussion, the TEP agreed to specify this measure for individual physicians and groups. With plans to aggregate the data for reporting at the facility level.

Measure 2: Closing the results follow-up loop on incidental findings for AAA

The TEP discussed whether additional modalities beyond ultrasound (preferred) should be considered adequate follow-up for this measure. Generally, the panel agreed that the specifications should indicate that ultrasound is preferred. However, the numerator should comprise of other modalities (e.g., MRI, angiogram, or CT), should they be used. A panelist emphasized that a complete list of imaging modalities appropriate to meet the measure must be identified.

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

Most TEP members who responded to the survey agreed that there was likely a gap in care for this measure (Question 8). Panelists addressed specific TEP comment period responses. ACR staff underscored the following issues.

- 1) The numerator action is attributed to the radiologist
- 2) The broad focus of the measure is more impactful than similar existing Centers for Medicare and Medicaid Services (CMS) Merit-based Incentive Payment Systems' (MIPS) measures
- 3) "No follow-up" recommendations are beyond the scope of the measure since the denominator only includes those individuals for whom follow-up was recommended.

The TEP agreed that broadening the measure to 'all individuals regardless of whether a follow-up recommendation was made' would be useful. However, they affirmed that unless there is a gap in care identified for the broader focus, the measure should remain as currently drafted. In other words, a follow-up recommendation must be made to be captured by this measure.

One panelist inquired about whether the measure would account for incidental findings that lack practice guidelines, requiring radiologists to rely on a standalone source of information. Specifically, should the measure require the radiologist to state the particular source and the risk that the recommendation carries? The TEP agreed that any recommendations included in the report from the radiologist would be considered expert opinion, and not require additional documentation.

Panelists also addressed whether there were justifiable reasons that the final report would exclude lesion location, time interval, or modality for follow-up imaging (Question 10). The majority of survey respondents agreed that reasons to exclude this information do not exist. However, one individual asked about the frequency of a non-unique finding. Some panelists proposed that the language in the measure align with the requirements of the evidence-based guidelines, so if more than one modality is appropriate, it should be documented in the final report.

Some discussion over including the term “cross-sectional” was suggested as appropriate to reduce the complexity of the numerator statement. This term could be used with a corresponding definition to simplify wording, though some were concerned that “cross-sectional” might not apply to a portion of the imaging studies (e.g., PET scans). The TEP agreed to update the numerator’s wording to state “at least one specific modality.”

Measure 5: Follow-up for incidental imaging findings for abdominal aortic aneurysm (AAA)

The TEP discussed the mixed results on whether there was any particular timeframe during which the follow-up ultrasound occurred (Question 19). A panelist explained that this is due to the conflicting evidence across specialty societies and may lead the TEP to determine that whatever interval of time is specified by the radiologist should be documented in the final report. For instance, low back pain is associated with more than 10 conflicting clinical practice guidelines on MRI for low back pain, with many recommendations diverging on age and other relevant characteristics or criteria. The panel was reminded that quality measures are not clinical practice guidelines. The goal of this measure is to achieve agreement from the guideline developer that the measure is representative of the evidence and obtain agreement from the TEP that the measure specifications sufficiently align with the evidence or test the measure in multiple ways to determine which better represents the evidence.

The TEP considered difficulty with assessing the effectiveness of this process measure against an outcome due to the various recommendations used and their consisting of different timeframes according to their respective guideline. Panelists questioned whether such discrepancies lead the TEP to prefer the broader Measure 2: *Closing the results follow-up loop on incidental findings for AAA*.

A portion of the TEP thought that this measure, targeted to AAA, would facilitate quality improvement and should, therefore, remain in the final measure set. Others questioned the value of the process measures that focus on procedural steps when an overall measure is also under development and requires a particular outcome to meet the measure. The TEP agreed with the co-chairs’ proposal to

review and potentially remove the measures that focus on processes that are less proximal to the outcome of interest.

Measure 6: Follow-up for incidental imaging findings for pulmonary nodules

The TEP discussed potential reasons why radiologists would not indicate specific follow-up recommendations based upon the pulmonary nodule finding, such as “unknown health risk factors” (Question 24) and whether this warrants revisions to the measure’s exclusions. Some panelists were concerned that a radiologist may not be aware of all possible risk factors for a given patient; instead, this information is more likely to be known by the referring clinician. The TEP agreed that the goal of the measure is to address the gap in follow-up and *not determine whether the initial assessment is accurate*. As a result, it would be difficult to require that the follow-up recommendation be specific to the risk stratification category. Still, it would be reasonable to require that the follow-up recommendations be provided based on the numerator’s risk category.

The TEP also agreed that the denominator should be modified to indicate that it applies to solid nodules only, not subsolid or ground glass nodules.

Measure 7: Communication to the practice managing on-going care

The TEP agreed that the measure would be specified for reporting at the group and facility levels (Question 33). They also informed on instances when action would be warranted (Question 34) and exclusions that should be added (e.g., hospice and palliative care and other types of terminal diagnoses). The panel also discussed how to best address those patients who receive more than one recommendation within a measurement period. For example, if a patient receives a second recommendation for a six-month follow-up within the initial recommendation’s six-month follow-up window. Should the first recommendation be excluded, and the performance tracked would be that of follow-up on the second recommendation? Given the multiple variations of how these scenarios could play out, ACR staff proposed that they map out the scenarios to help the panel identify the approaches that best address this concern.

Measure 10: Tracking system for incidental findings

The TEP determined that additional refinements to this measure are not needed (Question 42).

Measure 11: Reconciliation of reasons for missed follow-up appointment

The respondents indicated mixed results on whether the numerator’s required elements were comprehensive and efficient (Question 47). The TEP discussed whether the measure needed greater specificity and whether its benefits outweigh the burden of data collection. One of the co-chairs asked if measuring patients’ reasons for missing follow-up appointments could be reliably categorized and reproduced. Several TEP members expressed concern that the measure does not assess the most significant issue – the lack of follow-up. Instead, it seeks to determine why the appointment, while scheduled, was missed. While many agreed that addressing this gap is important and may be useful for

quality improvement, to improve patient care significantly, the focus should be on individuals for whom an appointment was not scheduled, and follow-up did not occur.

Co-chairs proposed that they further discuss the viability of this measure to determine whether it should be retained or removed from the set.

Measure 12: Clinician opt-in/out

The TEP agreed that the measure would be developed at the group and facility levels (Question 52). There was concurrence among a majority of the TEP comment period responses regarding the appropriate timeframe for which communication from the radiologist to the referring provider must occur. However, such timeframes varied from as-soon-as-possible up to 30 days. Several panelists questioned if 30 days is too long, particularly since that is longer than the industry standard. A co-chair clarified that the measure intends to determine whether the follow-up imaging did not occur due to an “acceptable” reason. Those reasons could then be formalized as measure exclusions. Panelists voiced their concerns with allowing reasons, such as patient refusal or patient moved away to count toward “clinician opt-out.” One member stated that the feasibility of capturing this information is very difficult and does not often lead to reliable and valid results due to potential gaming to meet the measure. Other members agreed with these concerns and proposed removing the measure.

Summary and next steps

Ms. Shugarman shared that the group will meet next via conference call in mid-August or late September. The co-chairs and ACR staff will solicit input from the Health Information Technology (HIT)/vendor community stakeholders over the next few weeks, to inform the questions around the measure specifications and feasibility of data collection. The 30-day public comment period is planned for October 2020. Dr. Seidenwurm thanked the TEP for their thoughtful participation and adjourned the web meeting.