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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Fall 2024 Cycle Endorsement and Maintenance (E&M) Technical Report

Initial Recognition and Management

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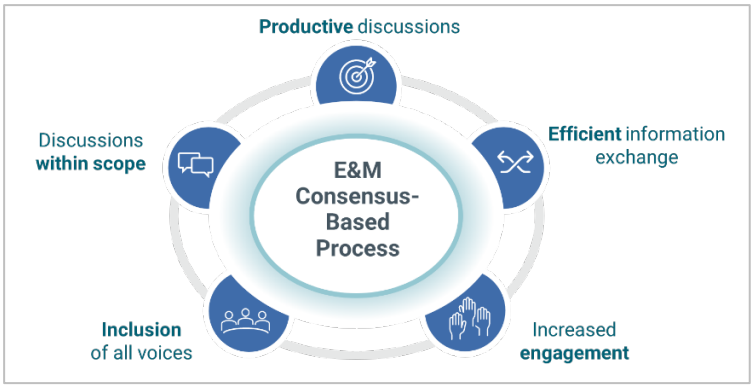
Executive Summary

For over 2 decades, the United States (U.S.) has focused on improving health care quality for Americans. One of the ways this has been done is by developing and implementing clinical quality measures to quantify the quality of care provided by health care providers and organizations. These clinical quality measures are based on standards related to the effectiveness, safety, efficiency, person-centeredness, and timeliness of care.[1]

At Battelle, we have a strong collective interest in ensuring that the health care system works as well as it can. Health care professionals use quality measures to support health care improvement, benchmarking, and accountability of health care services and to identify weaknesses, opportunities, and disparities in care delivery and outcomes.[1,2]

Battelle is a certified consensus-based entity (CBE) funded through the Centers for Medicare & Medicaid Services (CMS) National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract. As a CMS-certified CBE, we facilitate the review of quality measures for endorsement. Battelle's Partnership for Quality Measurement (PQM) members support consensus-based processes by serving on committees, ensuring informed and thoughtful reviews of quality measures across a range of focus areas aligned with a person's journey through the health care system. Battelle engages PQM members to carry out the consensus-based E&M process, which relies on robust and focused discourse, efficient information exchange, effective engagement, and inclusion of a multitude of voices that represent the health care community (Figure 1).

Figure 1. E&M Consensus-Based Process



One of those focus areas is initial recognition and management, which includes measures that address early signs and symptoms of conditions and diseases. This area also covers the early detection and management of changes in an individual's health status, as well as the patient experience, safety, and potential harm associated with the detection, diagnosis, or recognition of a condition. For the Fall 2024 cycle, the measures reviewed focused on excess antibiotic treatment for pneumonia patients, emergency care capacity, and timely follow-up after breast and colon cancer screenings. Addressing health care inefficiencies in these areas is crucial for improving outcomes and reducing costs.

Studies show 67.8% of pneumonia patients receive unnecessary antibiotics, increasing adverse events by 5% per day.[3] Emergency department (ED) crowding imposes substantial financial costs, but improving flow could save hospitals $10 million annually.[4] In cancer care, false-positive mammograms result in an average expenditure of $852 each, while reminder systems for colorectal screening are cost effective at $88-$97 per patient when implemented statewide.[5,6] These issues highlight the urgent need for targeted quality improvement initiatives in these areas, leading to improved patient outcomes and reductions in unnecessary health care expenditures.

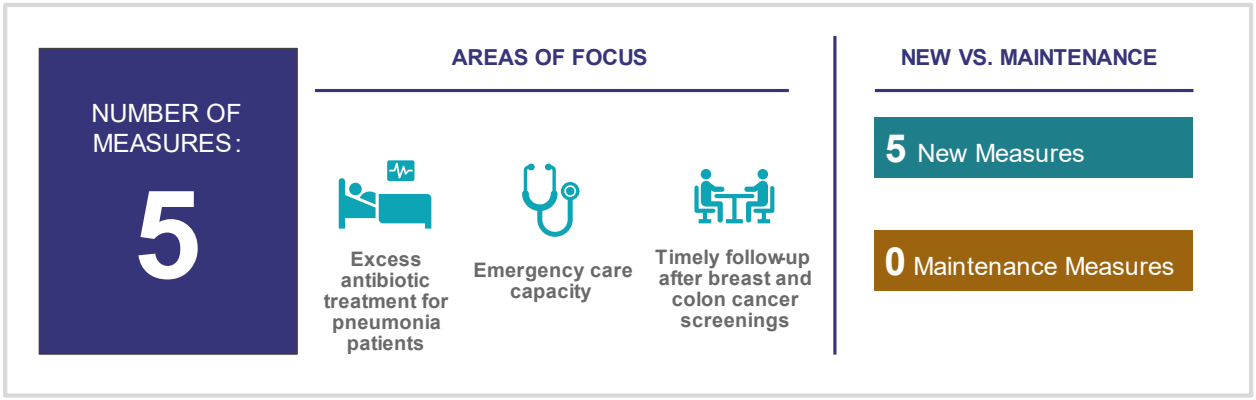
For this measure review cycle, developers submitted eight measures to the Initial Recognition and Management committee for endorsement consideration. Measure stewards withdrew three measures that were up for initial endorsement review (Table 5). Of the five remaining measures reviewed by the committee (Figure 2), the committee endorsed all five measures with conditions based on the PQM Measure Evaluation Rubric of version 1.2 of the E&M Guidebook.

Table 1. Measures Reviewed by the Initial Recognition and Management Committee

CBE Number	Measure Title	New/ Maintenance	Developer/ Steward	Final Endorsement Decision
4540e	Excess Antibiotic Duration for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia	New	University of Utah	Endorsed with Conditions
4545e	Inappropriately Broad Empiric Antibiotic Selection for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia	New	University of Utah	Endorsed with Conditions
4625e	Emergency Care Capacity and Quality eCQM*	New	Acumen/CMS	Endorsed with Conditions
4700e	Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection	New	Brigham and Women's Hospital	Endorsed with Conditions
4705e	Rate of Timely Follow-up on Positive Stool-based Screening Tests for Colorectal Cancer Detection	New	Brigham and Women's Hospital	Endorsed with Conditions

*Electronic clinical quality measure

Figure 2. Fall 2024 Measures for Committee Review

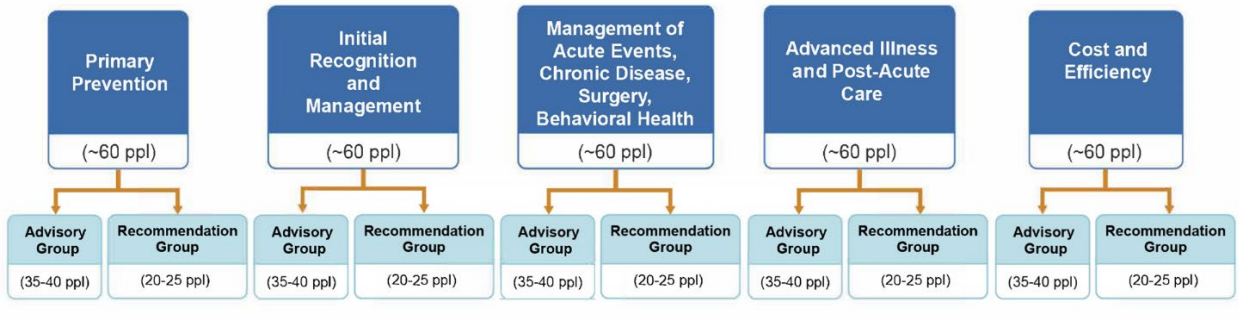


Endorsement and Maintenance (E&M) Overview

Battelle's E&M process ensures measures submitted for endorsement are evidence based, scientifically sound, and both safe and effective. This means that the use of the measure will increase the likelihood of desired health outcomes; will not increase the likelihood of unintended, adverse health outcomes; and is consistent with current professional knowledge.

We organize measures for E&M by five project areas. Each project topical area has a committee that evaluates, discusses, and assigns endorsement decisions for measures under endorsement review. These E&M committees are composed of diverse PQM members, representing all facets of the health care system. Each E&M committee is divided into an Advisory Group and a Recommendation Group (Figure 3).

Figure 3. E&M Committee Structure



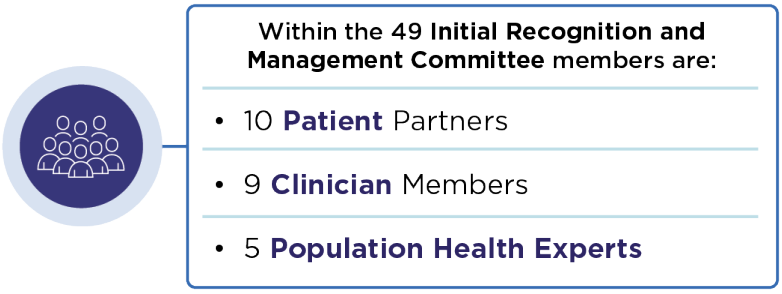
The goal is to create inclusive committees that balance experience, expertise, and perspectives. The E&M process convenes and engages interested parties throughout the cycle. The interested parties include those who are impacted or affected by quality and cost/resource use who come from a variety of places and represent multiple perspectives (Figure 4).

Figure 4. E&M Interested Parties

For the Initial Recognition and Management committee, membership for the Fall 2024 cycle consisted of nine patient partners (i.e., patients, caregivers, advocates) and nine clinicians, with specialties in cardiovascular pharmacotherapy, neonatal-perinatal medicine, radiology, and others (Figure 5). The committee also included five population health experts.

While a list of committee members is provided in Appendix A, full committee rosters and bios are on the respective project pages on the PQM website.

Figure 5. Initial Recognition and Management Committee Members



At the beginning of each E&M cycle, committee members complete a measure-specific disclosure of interest (MS-DOI) form identifying potential conflicts with the measures under endorsement review for the respective E&M cycle. Members are recused from voting on measures potentially affected by a perceived conflict of interest (COI) based on Battelle's COI policy.

Each E&M cycle (i.e., Fall or Spring) has a designated Intent to Submit deadline, when measure developers/stewards must submit key information (e.g., measure title, type, description, specifications) about the measure. One month after the Intent to Submit deadline (Table 2), measure developers/stewards submit the full measure information by the respective Full Measure Submission deadline.

Table 2. Intent to Submit and Full Measure Submission Deadlines by Cycle

E&M Cycle	Intent to Submit*	Full Measure Submission*
Fall	October 1	November 1
Spring	April 1	May 1

**Deadlines are set at 11:59 p.m. (ET) of the day indicated. If the deadline falls on a weekend or holiday, the deadline will be the next immediate business day.*

We then publish measures to the PQM website for a 30-day public comment period, which occurs prior to the endorsement meeting and concurrently with the development of the staff preliminary assessments. The intent of this 30-day comment period is to solicit both supportive and non-supportive comments with respect to the measures under endorsement review. Any interested party may submit a comment on any of the measures up for endorsement review for a given cycle (i.e., Fall or Spring). Prior to the close of the public comment period, we host a Public Comment Listening Session to gather additional public comments on the measures; this virtual session is organized by project with measures grouped by topic/condition. Any interested party may attend to give a brief spoken statement on one or more of the measures.

We post all public comments received during this 30-day period, including those shared during the Public Comment Listening Sessions, to the respective measure page on the PQM website. A summary of the comments received for the measures submitted to the Initial Recognition and Management for the Fall 2024 cycle is below.

Following the Public Comment Listening Sessions, we convene the Advisory Group of each E&M project during a public virtual meeting. The purpose of these meetings is to gather initial feedback and questions about the measures under endorsement review. Developers/stewards are given the opportunity to share written responses to Advisory Group feedback after these meetings. They can also provide written responses to any public comments received directly on

the measure's webpage. This process ensures comprehensive input and engagement from all stakeholders involved. For the Initial Recognition and Management, the Advisory Group convened on December 5, 2024, and we published a summary of the member feedback and developer/steward responses on the PQM website.

Prior to the Recommendation Group endorsement meeting, we share the full measure submission details, including all attachments, the PQM Measure Evaluation Rubric, the staff preliminary assessments, the public comments, Advisory Group feedback, and the developer/steward responses with the Recommendation Group for review. The Initial Recognition and Management Recommendation Group convened on February 12, 2025. Brief summaries of the Recommendation Group deliberations and voting results are below, while a detailed meeting summary is available on the PQM website.

During the endorsement meeting, the Recommendation Group focuses their discussions on key themes identified from the public comments, the Advisory Group meetings, the associated developer/steward responses, independent reviews, and the staff preliminary assessments. Measure developers/stewards attend endorsement meetings to provide a measure overview and answer questions from the Recommendation Group. The Recommendation Group considers the various inputs and renders a final endorsement decision via a vote. Consensus is reached when there is 75% or greater agreement among all active, non-recused Recommendation Group members (Table 3). However, if no consensus is reached, the measure is not endorsed due to no consensus.

Table 3. Endorsement Decision Outcomes

Decision Outcome	Description	Maintenance Expectations
Endorsed	**Applies to new and maintenance measures.** The E&M committee agrees by 75% or more to endorse the measure.	Measures undergo maintenance of endorsement reviews every 5 years with a status report review at 3 years (*see Evaluations for Maintenance Endorsement for more details*).± Developers/stewards may request an extension of up to 1 year (two consecutive cycles), except if it has been more than 6 years since the measure's date of last endorsement.
Endorsed with Conditions*	**Applies to new and maintenance measures**. The E&M committee agrees by 75% or greater that the measure can be endorsed as it meets the criteria, but committee reviewers have conditions they would like addressed when the measure comes back for maintenance. If these	Measures undergo maintenance of endorsement reviews every 5 years with a status report at 3 years, unless the condition requires the measure to be reviewed earlier (*see*

Decision Outcome	Description	Maintenance Expectations
	recommendations are not addressed, the developer/steward should provide a rationale for consideration by the E&M committee review.	*Evaluations for Maintenance Endorsement for more details*). The E&M committee evaluates whether conditions have been met, in addition to all other maintenance endorsement minimum requirements.
Not Endorsed°	**Applies to new measures only**. The E&M committee agrees by 75% or greater to not endorse the measure.	None
Endorsement Removed°	**Applies to maintenance measures only.** Either: • The E&M committee agrees by 75% or greater to remove endorsement; or • A measure steward retires a measure (i.e., no longer pursues endorsement); or • A measure steward never submits a measure for maintenance, and the steward does not respond after targeted outreach; or • There is no longer a meaningful gap in care, or the measure has topped out (i.e., no significant change in measure results for accountable entities over time).	None

±Maintenance measures may be up for endorsement review earlier if an emergency/off-cycle review is needed (see Emergency/Off-Cycle Reviews for more details).

**The E&M committee determines the conditions, with the consideration of what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.*

°Measures that fail to reach the 75% consensus threshold are not endorsed.

The "Endorsed with Conditions" category serves as a means of endorsing a measure but with conditions set by the Recommendation Group. These conditions take into consideration what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.

After the E&M endorsement meeting, committee endorsement decisions and associated rationales are posted to the PQM website for 3 weeks, which serves as the appeals period. During this time, any interested party may request an appeal regarding any E&M committee endorsement decision. If a measure's endorsement, including an "Endorsed with Conditions" decision, is being appealed, the appeal must:

- Cite evidence of the appellant's interests that are directly and materially affected by the measure, and provide evidence that the CBE's endorsement of the measure has had, or will have, an adverse effect on those interests; and
- Cite the existence of a CBE procedural error or information that was available by the cycle's Intent to Submit deadline but was not considered by the E&M committee at the time of the endorsement decision, which is reasonably likely to affect the outcome of the original endorsement decision.

In the case of a measure not being endorsed, the appeal must be based on one of two rationales:

- The CBE's measure evaluation criteria were not applied appropriately. For this rationale, the appellant must specify the evaluation criteria they believe were misapplied.
- The CBE's E&M process was not followed. The appellant must specify the process step, how it was not followed properly, and how this resulted in the measure not being endorsed.

If Battelle determines that an appeal is eligible, we convene the Appeals Committee, consisting of the co-chairs from all five E&M project committees (n=10), to review and discuss the appeal. The Appeals Committee concludes its review of an appeal by voting to uphold (i.e., overturn a committee endorsement decision) or deny (i.e., maintain the endorsement decision) the appeal. Consensus is determined to be 75% or greater agreement via a vote among members.

For the Fall 2024 cycle, the appeals period opened on March 4 and closed on March 24, 2025. The measures reviewed by the Initial Recognition and Management committee did not receive any appeals.

Initial Recognition and Management Measure Evaluation

For this measure review cycle, the Initial Recognition and Management committee evaluated five new measures against standard measure evaluation criteria. During the Recommendation Group endorsement meeting, the committee voted to endorse all five measures with conditions (Table 4).

Table 4. Number of Fall 2024 Initial Recognition and Management Measures Submitted and Reviewed

	Maintenance	New	Total
Number of measures submitted for endorsement review	0	8	8
Number of measures withdrawn from consideration*	0	3	3
Number of measures reviewed by the committee	0	5	5
Number of measures endorsed	0	0	0
Number of measures endorsed with conditions	0	5	5
Number of measures not endorsed/ endorsement removed	0	0	0

**Measure developers/stewards can withdraw a measure from measure endorsement review at any point before the committee endorsement meeting. Table 5 provides a summary of withdrawn measures.*

Table 5. Measures Withdrawn from Consideration

Measure Number	Measure Title	Developer/ Steward	New/ Maintenance	Reason for Withdrawal*
4660e	Emergency Care Capacity and Quality eCQM	Acumen/CMS	New	Combined with measure 4625e after ITS.
4720	Percentage of clinical assessments documented for patients with traumatic brain injury	Florida Department of Health Division of Emergency Preparedness and Community Support	New	Reason not given; plan to submit for future endorsement cycle.

Measure Number	Measure Title	Developer/ Steward	New/ Maintenance	Reason for Withdrawal*
4715	CVD Risk Assessment Measure- Proportion of Pregnant/postpartum patients who receive CVD Risk Assessment with a standardized tool	University of California, Irvine	New	Postponed to Spring 2025 cycle due to data extraction error used in reliability and validity analyses.

Public Comments Received Prior to Committee Evaluation

Battelle accepts comments on measures through the PQM website. For this evaluation cycle, the public comment period opened on November 15, 2024, and closed on December 16, 2024, during which time we hosted a Public Comment Listening Session on November 21, 2024. The measures received 50 public comments, and Battelle published the comments to the respective measure pages on the PQM website. If the measure received any comments, the measure's evaluation summary includes a summary of these comments. Developer/steward responses to the public comments are under the "Comments" tab of each measure page on the PQM website.

Summary of Major Concerns

The following brief summaries of the measure evaluation highlight the major concerns the committee considered.

Measure Validity and Applicability

The committee raised several concerns across multiple measures:

- CBE #4625e: The committee highlighted the myriad factors influencing emergency department wait times, which fall outside a facility's direct control, thus challenging the measure's fairness and achievability.
- CBE #4540e and #4545e: The committee perceived these measures as burdensome due to complex exclusion lists and coding requirements, prompting calls for clearer and empirically justified criteria.
- CBE #4540e, CBE #4545e, CBE #4700e, and CBE #4705e: The committee said that variations in electronic health records (EHRs) may complicate data capture and accuracy, potentially skewing results when patients receive care across multiple health systems. For 4540e and 4545e, the committee further requested the developer conduct additional validity testing in more than one EHR system.
- CBE #4705e: The committee questioned the applicability of the measure in rural settings, as the testing sites were unrepresentative, and the measure's current configuration might not be easily adaptable to resource-constrained environments.

To address these concerns, the Recommendation Group set conditions for endorsement requiring the developers to conduct additional validity testing across different EHR systems within a 3-year maintenance time frame, explore and revise exclusion criteria based on

empirical analyses, and monitor for unintended consequences, ensuring the measures' applicability, fairness, and accuracy.

Unintended Consequences and Access to Care

The committee raised concerns about CBE #4625e, noting that the measure could disproportionately affect safety-net hospitals, lead to patients bypassing nearby hospitals ("drive-bys"), potentially result in ED closures or inappropriate admissions, and undermine triaging best practices. Similarly, the committee noted CBE #4700e and CBE #4705e could potentially limit access to essential services such as mammography and colonoscopies and exacerbate health care access, particularly in rural areas. Additionally, the members raised concerns about "gaming" for CBE #4540e: extending antibiotic treatment durations might be strategically used to exclude patients from the measure's calculations.

Measure Evaluation Summaries

CBE #4540e – Excess Antibiotic Duration for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia [University of Utah] – New

Specifications | Discussion Guide

Description: The Excess Antibiotic Duration for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia measure is a process measure representing the annual percentage of hospitalized adults with uncomplicated community-acquired pneumonia who receive an excess antibiotic duration. The measure will be calculated using electronic health record (EHR) data and is intended for use at the facility level for both quality improvement and pay-for-performance.

Committee Final Vote: Endorse with Conditions

Conditions: When the measure returns for maintenance (3 years), the measure developer should have:

- Continued to explore the exclusion list to determine if changes are needed (e.g., empirical analyses with broader testing across entities) and to further clarify the conditions and justify them based on burden; and
- Conducted additional validity testing (data element in additional EHR).

Vote Count: Endorse (4 votes; 25.00%), Endorse with Conditions (9 votes; 56.25%), Not Endorse (3 votes; 18.75%); recusals (0).

Summary of Public Comments: Battelle received seven comments, five of which supported the measure. Multiple organizations—including the Centers for Disease Control and Prevention, Society of Infectious Diseases Pharmacists, and Patients for Patient Safety US—advocated for the endorsement of the measure and; emphasized the importance of antibiotic stewardship programs in hospitals to combat antimicrobial resistance. They suggested that the measure supports these efforts by providing a framework for responsible antibiotic use. The supporting comment emphasized the measure's feasibility and alignment. In addition, the measure aligns with existing quality efforts and complements antibiotic-use monitoring systems. Three

comments expressed concern about the measure's applicability in smaller or rural hospitals and whether the measure should be at the hospital level or provider level. These comments highlighted that EHR vendor engagement is needed to ensure successful implementation.

Summary of Measure Evaluation: This new measure is being reviewed for initial endorsement. The developer noted that the measure is currently used in the Michigan Hospital Medicine Safety Consortium.

Discussion Topic/Theme	Committee Discussion Summary
Definitions and Criteria	• The Advisory Group sought clarity on the definitions of "excess antibiotic duration" and "uncomplicated pneumonia," and raised questions about the inclusion criteria for inpatient versus observation status, as well as outpatient prescriptions. The developer noted that the measure includes both inpatient and observation individuals to ensure consistency across hospitals. They confirmed the measure accounts for both inpatient and outpatient antibiotic prescriptions, acknowledging that most excess antibiotic duration occurs after discharge. • The Advisory Group discussed the inclusion of sepsis and respiratory failure in the measure's denominator, expressing discomfort with these conditions being labeled as uncomplicated. Regarding sepsis and respiratory failure, the developer noted the issue is the upcoding (i.e., using a billing code that reflects a more severe diagnosis or more extensive procedure than what was provided to the patient). The developer shared that they did not want those patients to be missed simply because a facility is upcoding.
Data Concerns and Validity Testing	• The Advisory Group expressed concerns about the coding intensity and discrepancies, with suggestions to align more closely with clinical practices and possibly include additional education on coding. • The Advisory Group questioned the validity due to a high percentage of data falling outside acceptable ranges. The developer asserted the measure has 96% sensitivity and 93% specificity in looking at appropriate duration. • The Recommendation Group considered the Advisory Group's concerns and recognized that developer conducted validity testing of the data elements in only one EHR system. While the Recommendation Group did not have any significant concerns with the validity testing results provided, they did acknowledge that additional testing within other EHR systems may further address the Advisory Group's feedback. • Recognizing the need for further validity testing, the committee set **a condition for endorsement requiring the developer to conduct additional validity testing (data element in additional EHR) within a 3-year maintenance time frame.**
Exclusions and Value Sets	• The Advisory Group's discussions on exclusions revealed mixed opinions. Some members found the exclusions reasonable while others noted the potential burden due to the extensive exclusion list. • The Recommendation Group expressed similar concerns about the extensive exclusion list, which consequently led them to set a condition for endorsement; **the developer is to explore the exclusion list to determine if changes are**

Discussion Topic/Theme	Committee Discussion Summary
	needed (e.g., empirical analyses with broader testing across entities) and to further clarify the conditions and justify them based on burden. • Specifically, the Recommendation Group sought clarification on whether the measure includes or excludes pregnant patients. The developer clarified that pregnancy and breastfeeding were only identified in 0.04% of the population, so they did not include them on the exclusion list. The Recommendation Group also considered the exclusion of patients on antibiotics for longer than 14 days. The developer stated that they selected the 14-day threshold after observing data trends that indicated a notable spike at this point, with most patients receiving antibiotic treatments ranging from 7 to 10 days. • The Advisory Group identified gaps in the value sets, such as missing common antibiotics and mechanical ventilation. The developer clarified during the Recommendation Group meeting that they corrected the value sets based on feedback from the Advisory Group.
Gaming	• The Recommendation Group expressed concerns about gaming, questioning whether the current measure includes safeguards against such practices. Specifically, they highlighted a scenario in which extending a patient's antibiotic treatment from 13 to 15 days could exclude them from the measure's calculations, given a 14-day threshold. • In response to these concerns, the developer reported that, in their observations across 69 Michigan hospitals that have implemented the measure, there was no evidence of gaming.

Additional Recommendations for the Developer/Steward: The Recommendation Group suggested the developer consider distributing standardized educational information on antibiotics for hospitals or providers to give to patients, to monitor for gaming, and to talk directly with patients about whether the measure is meaningful.

CBE #4545e – Inappropriately Broad Empiric Antibiotic Selection for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia [University of Utah] – New

Specifications | Discussion Guide

Description: The Inappropriately Broad Empiric Antibiotic Selection for Adult Hospitalized Patients with Uncomplicated Pneumonia measure is a process measure representing the annual percentage of hospitalized adults with uncomplicated community-acquired pneumonia. Here, we defined "inappropriately broad" as any antibiotic therapy targeting methicillin-resistant Staphylococcus aureus (MRSA) or Pseudomonas aeruginosa in patients without risk factors for one of those organisms. The measure will be calculated using electronic health record (EHR) data and is intended for use at the facility level for both quality improvement and pay-for-performance.

Committee Final Vote: Endorse with Conditions

Conditions: When the measure returns for maintenance (3 years), the measure developer should have:

- Continued to explore the exclusion list to determine if changes are needed (e.g., empirical analyses with broader testing across entities) and to further clarify the conditions and justify them based on burden; and
- Conducted additional validity testing (data element in additional EHR).

Vote Count: Endorse (2 votes; 13.33%), Endorse with Conditions (12 votes; 80.00%), Not Endorse (1 votes; 6.67%); recusals (0).

Summary of Public Comments: Battelle received nine comments prior to the meeting. Five comments supported the measure for endorsement and came from organizations such as the Centers for Disease Control and Prevention, Society of Infectious Diseases Pharmacists, and Patients for Patient Safety US. Five comments supported the measure's feasibility and alignment, stating that the measure uses routine health care data, that electronic measures allow for efficient data collection and assessment while reducing the need for manual chart review, and that the measure aligns with existing quality efforts and complements antibiotic-use monitoring systems. Three commenters expressed concern about the measure's applicability in smaller or rural hospitals and whether the measure should be used at the hospital level or provider level. These comments highlighted that EHR vendor engagement is needed to ensure successful implementation.

Summary of Measure Evaluation: This new measure is being reviewed for initial endorsement. The developer has noted that the measure is currently used in the Michigan Hospital Medicine Safety Consortium.

Discussion Topic/Theme	Committee Discussion Summary
Value Sets	• Like CBE #4540e, the Advisory Group identified gaps in the value sets, such as missing common antibiotics and mechanical ventilation. This raised concerns about the value sets not functioning in the way the developer described. • During the Recommendation Group meeting, the developer clarified that they corrected the value sets based on feedback from the Advisory Group.
Feasibility	• The Advisory Group expressed concerns about the feasibility of the measure, highlighting its potential burden on hospitals, the extensive exclusion list, missing data, and variation in EHRs. • Regarding missing information from the EHR or patients going to a different health system, the developer noted that measure will miss a small number of patients. Additionally, the capture of data is likely to vary depending on the integration level of the health system or EHR. However, overuse remains a significant concern, and the missing information did not substantially impact the measure's sensitivity (96%) and specificity (92%) were not substantially impacted.
Denominator	• The Advisory Group raised concerns about the wording of the denominator and discomfort with sepsis and respiratory failure being considered uncomplicated. The developer noted the issue is upcoding and that patients should not be missed because a facility is upcoding.
Validity Testing	• Like CBE #4540e, the Recommendation Group discussed the need for additional validity testing, which led to the group to set a **condition for endorsement**

Discussion Topic/Theme	Committee Discussion Summary
	requiring the developer to conduct additional validity testing (data element in additional EHR) within a 3-year maintenance time frame.
Exclusions	• The Recommendation Group expressed similar concerns about the extensive exclusion list, which consequently led to a condition for endorsement: **the developer is to explore the exclusion list to determine if changes are needed (e.g., empirical analyses with broader testing across entities) and to further clarify the conditions and justify them based on burden.**
Applicability Across Different Settings	• In response to a question from the Recommendation Group about potentially expanding the measure beyond the hospital setting, specifically into the ED, the developer acknowledged that the hospital remains the most appropriate setting, given the limited number of studies conducted in other settings.

Additional Recommendations for the Developer/Steward: The Recommendation Group did not have any additional suggestions for the developer.

CBE #4625e – Emergency Care Capacity and Quality eCQM [Acumen/CMS] – New

Specifications | Discussion Guide

Description: This intermediate outcome eCQM captures the proportion of visits for patients of all ages that experience emergency care access barriers during a one-year performance period.

Committee Final Vote: Endorse with Conditions

Conditions: When the measure returns for maintenance (3 years), the measure developer should have:

- Explored any unintended consequences to patients and providers (burden) by engaging with the patient community and accountable entities (e.g., qualitative assessments, empirical analyses); and
- Explored the component measures to identify and address where challenges may persist, including engaging accountable entities.

Vote Count: Endorse (5 votes; 29.41%), Endorse with Conditions (9 votes; 52.94%), Not Endorse (3 votes; 17.64%); recusals (1).

Summary of Public Comments: Battelle received 30 comments prior to the meeting, all of which supported the measure by recognizing the need for setting standards, collecting data, and creating financial incentives to address emergency room boarding. Two comments from the American College of Emergency Physicians (ACEP) and San Jose State University focused on equity stratification; they emphasized the need to consider equity and potential disparities in treatment and suggested that the measure should include stratification by factors such as age, race, and payer type. ACEP also commented on the measure's specifications and requested the exclusion of ED visits with a transfer-out, as rural hospitals often face challenges in transferring patients, and larger hospitals bear the responsibility for coordinating such transfers. ACEP also suggested shorter ED durations as future targets, recommended reporting without volume standardization for certain outcomes, and recommended structuring the measure as a composite measure, with boarding weighted more heavily.

Summary of Measure Evaluation: This new measure is being reviewed for initial endorsement. The developer noted that the measure is planned for use in in the Hospital Outpatient Quality Reporting (HOQR) Program and the Rural Emergency Hospital Quality Reporting (REHQR) Program.

Discussion Topic/Theme	Committee Discussion Summary
Actionability	• The Advisory Group expressed concerns about the actionability of the measure, noting that many factors contributing to lengthy ED wait times are complex and beyond the control of the facility. The developer acknowledged that this measure would be challenging for most hospitals but reiterated its intent to encourage hospitals to ensure patients' privacy and safety, such as creating better holding areas. • Advisory Group members further expressed the need for hospitals to able to see the measure's component results to observe where improvement is most needed. • Considering the Advisory Group's concerns, the Recommendation Group members questioned whether EDs should be held accountable for systemic issues such as access to care and community violence. The developer acknowledged these challenges but emphasized the measure's potential to improve emergency care without penalizing hospitals, allowing for refinement over time. The developer further pointed out that a substantial body of well-established literature indicates that hospitals can implement various interventions to enhance emergency care capacity and quality. • Based on this discussion, the committee set **one condition for endorsement requiring the developer to explore component measures within a 3-year maintenance period to identify and address persistent challenges, including engaging with accountable entities.** • The developer also clarified that the measure is not intended to be used in pay-for-performance settings initially; therefore, hospitals will not be penalized for using the measure even if their performance is poor.
Exclusions	• The Advisory Group and Recommendation Group both considered whether the measure should have additional exclusions, such as psychiatric and pregnant patients. • The developer acknowledged that the measure accounts for the unique challenges of psychiatric patients. Specifically, the stratified nature of measurement allows CMS and hospitals to review a measure score for patients with psychiatric emergencies. This approach does not require that publicly reported scores include these patients, for whom the attribution of quality may not be as closely linked to the hospital. • Regarding exclusions for pregnant patients, the developer mentioned that they would consider discussing this exclusion with CMS if concerns for this population persist. However, they anticipate that ED pregnancy visits would have a limited impact on the measure's testing results due to their low frequency.
Unintended Consequences	• The Advisory Group shared concerns that the measure could lead to unintended consequences, including potentially harming safety-net and city- or state-run hospitals, increasing "drive-bys" (i.e., patients avoiding certain EDs and

Discussion Topic/Theme	Committee Discussion Summary
	overwhelming others), pushing patients out of EDs, potentially closing EDs when at capacity, inappropriately admitting or placing patients in observation, and compromising the safety of more severe patients by not considering triage levels, thereby interfering with the flow of the ED. • The Recommendation Group echoed the concern that the measure might undermine triaging best practices. • The developer responded that the measure aims to improve patient privacy and safety without financial penalties by focusing on reporting and potential cost savings. CMS will monitor unintended consequences, ensure fairness, and compare hospitals with similar characteristics. The REHQR program will compare REHs to other REHs. The developer expects minimal issues like "drive-bys" but will monitor impacts and may adjust for observation status concerns. • This discussion led the committee to set a **condition for endorsement, which requires the developer to explore any unintended consequences to patients and providers within a 3-year maintenance period by engaging with the patient community and accountable entities (e.g., qualitative assessments, empirical analyses).**
Accounting for Severity of Illness	• The Advisory Group expressed interest in the measure accounting for the severity of illness or injury (such as through the Emergency Severity Index [ESI]). • The developer noted the measure is not stratified or adjusted for differences in severity of illness distribution because each of the numerator outcomes measured should be considered an access failure regardless of illness severity.

Additional Recommendations for the Developer/Steward: The Recommendation Group suggested considering reporting the measure at the geographic level (e.g., city, county, or state) to hold appropriate legislative bodies accountable and to assess the impact of social factors such as homelessness, primary care access, and mental health disorders.

CBE #4700e – Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection [Brigham and Women's Hospital] – New

Specifications | Discussion Guide

Description: This electronic clinical quality measure (eCQM) reports the percentage of female patients aged 40 to 75 years with at least one abnormal screening (BI-RADS 0) or screening-to-diagnostic (BI-RADS 4, 5) mammogram during the measurement period (i.e., calendar year) who received follow-up imaging with negative/benign/probably benign results or a diagnostic sample extraction procedure within 60 days after their index (i.e., first) abnormal screening mammogram. Negative/benign/probably benign follow-up imaging was defined as diagnostic mammography, breast ultrasound or magnetic resonance imaging (MRI) with BI-RADS ratings of 1, 2, or 3. Relevant diagnostic sample extraction procedures were defined as breast biopsy, fine needle aspiration, and surgical excision. Breast Imaging – Reporting and Data System (BI-RADS) ratings: 0-incomplete, 1- negative, 2-benign, 3-probably benign, 4-suspicious, 5-highly suggestive of malignancy.

Committee Final Vote: Endorse with Conditions

Conditions: When the measure returns for maintenance (3 years), the measure developer should have:

- Conducted additional validity testing (data element in additional EHR); and
- Continued to monitor (e.g., qualitative assessments, empirical analyses) for unintended consequences (e.g., reduced access to mammography) during implementation.

Vote Count: Endorse (3 votes; 21.42%), Endorse with Conditions (11 votes; 78.57%), Not Endorse (0 votes; 0.00%); recusals (1).

Summary of Public Comments: Battelle received one comment prior to the meeting. In this comment, the American Medical Association (AMA) expressed support for the measure but raised concerns about its validity testing on only one EHR system, the reliability of BI-RADs data extraction, and external factors such as workforce shortages and follow-up at other facilities, which may affect the measure's effectiveness and fairness.

Summary of Measure Evaluation: This new measure is being reviewed for initial endorsement. The developer noted that the measure is planned for use in public reporting and quality improvement programs.

Discussion Topic/Theme	Committee Discussion Summary
Generalizability and Data Extraction	• The Advisory Group expressed concerns about tracking measures when patients seek follow-up care at different health care systems, particularly when these systems use different EHRs and lack structured fields for final diagnoses like BI-RADS. • In response, the developer noted that while EPIC and Cerner have discrete fields for BI-RADS ratings, facilities may not always use them. To address this, they developed a string-search algorithm that effectively retrieves the necessary information, ensuring accurate measure calculation even when the information is not in structured fields.
Validity Testing	• The Advisory Group noted validity testing was conducted at the patient-/episode-level (data element), which is acceptable for a new eCQM. However, the testing involved only one EHR vendor. • Additionally, the Advisory Group questioned the presentation of split-sample Spearman's Rank Correlation Coefficients and Interclass Correlation Coefficients (ICC) as measures of validity rather than reliability. In response, the developer acknowledged that these analyses were mistakenly placed in the validity section. • The Recommendation Group considered the Advisory Group's concerns, which led to the committee setting a condition for the measure's endorsement. **Within a maintenance time frame of 3 years, the developer is expected to conduct additional validity testing (data element in additional EHR).**
60-day Time Frame	• The Advisory Group expressed concerns about the 60-day follow-up time frame, sought clarity on what takes place within that time frame, and emphasized that quick follow-up time can reduce patient anxiety. The Advisory Group also acknowledged that rural and under-resourced facilities might need the full 60 days or more. Lastly, the Advisory Group noted the measure does not align with the National Committee for Quality Assurance's (NCQA's) Follow-Up after Abnormal Breast Cancer Assessment (BCF-E).

Discussion Topic/Theme	Committee Discussion Summary
	• The developer clarified that the 60-day period covers repeat imaging and potential biopsy, not initial screening results. They considered both 60- and 90-day time frames but chose 60 days based on guidance from the National Breast and Cervical Cancer Detection Program and their technical expert panel. The developer did not consider a 30-day time frame. • A Recommendation Group member shared that while the average time for follow-up was under a month, a third of patients did not receive the recommended follow-up at all, so this measure will help target that population.
Unintended Consequences	• The Recommendation Group considered potential gaming of the measure and restricted access to mammography, which led to a condition for endorsement. **Within a maintenance time frame of 3 years, the developer is expected to continue monitoring (e.g., qualitative assessments, empirical analyses) for unintended consequences (e.g., reduced access to mammography) during implementation.**

Additional Recommendations for the Developer/Steward: The Recommendation Group did not have any additional suggestions for the developer.

CBE #4705e – Rate of Timely Follow-up on Positive Stool-based Tests for Colorectal Cancer Detection [Brigham and Women's Hospital] – New

Specifications | Discussion Guide

Description: This electronic Clinical Quality Measure (eCQM) reports the percentage of patients aged 45 to 75 years with at least one positive stool-based colorectal cancer screening test (i.e., high-sensitivity guaiac fecal occult blood test, fecal immunochemical test, or Cologuard) during the measurement period (i.e., calendar year) who completed a colonoscopy within 180 days after their index (i.e., first) positive stool-based test result date.

Committee Final Vote: Endorse with Conditions

Conditions: When the measure returns for maintenance (3 years), the measure developer should have:

- Conducted additional validity testing (data element in additional EHR); and
- Continued to monitor (e.g., qualitative assessments, empirical analyses) for unintended consequences (e.g., reduced access to colonoscopies) during implementation.

Vote Count: Endorse (6 votes; 40.00%), Endorse with Conditions (9 votes; 60.00%), Not Endorse (0 votes; 0.00%); recusals (1).

Summary of Public Comments: Battelle received three comments prior to the meeting. The AMA, Guardant Health, and the American College of Gastroenterology (ACG) along with the American Society for Gastrointestinal Endoscopy (ASGE) stressed the importance of incorporating blood-based tests in the measure since positive results from these tests require follow-up colonoscopies. Three comments focused on the measure validity, testing, and performance targets. The AMA and ASGE noted that the measure was tested in only one EHR system, while ACG and ASGE argued that the performance target of over 80% was too high and

suggested lowering it to above 50%. Two comments focused on generalizability. The AMA and ACG/ASGE raised concerns about patients receiving follow-up care at different facilities, which could impact measure performance. They suggested adding exceptions to account for these scenarios to avoid unfairly penalizing facilities.

Summary of Measure Evaluation: This new measure is being reviewed for initial endorsement. The developer noted that the measure is planned for use in public reporting and quality improvement.

Discussion Topic/Theme	Committee Discussion Summary
180-Day Follow-up Time Frame	• The Advisory Group discussed the appropriateness of the 180-day follow-up time frame, with opinions split on whether it was too long or too short. An invited oncologist serving as the subject matter expert, supported the time frame, citing patients' reluctance to undergo colonoscopies. • Some Recommendation Group members agreed the time frame was reasonable, noting challenges such as limited resources and a low follow-up rate of around 50%, but suggested it could be shortened in the future. • The developer acknowledged the time frame seems lengthy but emphasized current evidence supports it and expressed hope for eventual reduction.
Generalizability	• The Advisory Group expressed concerns about the measure's applicability, noting that many rural practices might struggle with its current configuration and that testing sites were not representative. A member of the Advisory Group suggested adopting a hybrid measure to address these challenges. • The developer shared that they had submitted a large-scale grant to evaluate this measure in a rural health system and will have more information on the measure's impact once the study is completed.
Validity Testing	• Like CBE #4700e, the Advisory Group noted the measure had validity testing at the data element level, which is acceptable for a new eCQM. However, the testing involved only one EHR vendor. • Additionally, the Advisory Group questioned the presentation of ICC as a measure of validity rather than reliability. • The Recommendation Group considered the Advisory Group's concerns, which led to the committee setting a condition for the measure's endorsement. **Within a maintenance time frame of 3 years, the developer is expected to conduct additional validity testing (data element in additional EHR).**
Unintended Consequences	• The Recommendation Group considered a potential unintended consequence of the measure: that it could inadvertently restrict access to colonoscopies, especially for individuals with limited resources. The developer acknowledged nationwide colonoscopy resource constraints but argued the measure would help prioritize resource allocation. • Based on this discussion, the Recommendation Group proposed a condition for endorsement. **Within a maintenance time frame of 3 years, the developer is expected to continue monitoring (e.g., qualitative assessments, empirical analyses) for unintended consequences (e.g., reduced access to colonoscopies) during implementation.**

Discussion Topic/Theme	Committee Discussion Summary
Blood-based Tests	• A Recommendation Group member sought more information about incorporating blood-based tests in the measure. The developer explained that while approved by the U.S. Food and Drug Administration, guidelines have not yet incorporated blood-based tests, and validity testing would then be required.

Additional Recommendations for the Developer/Steward: The Recommendation Group did not have any additional suggestions for the developer.

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Appendix A: Initial Recognition and Management Committee Roster

Fall 2024 Cycle

Member	Affiliation/ Organization	Primary Perspective	Advisory/ Recommendation Group
Carole Hemmelgarn *(Patient Representative Co-chair)*	Med Star Institute for Quality and Safety; Self and Patients for Patient Safety U.S.	Patient Partner	Recommendation
Raymund Dantes *(Non-patient Representative Co-chair)*	Emory University School of Medicine; Centers for Disease Control and Prevention	Clinician	Recommendation
Kobi Ajayi	Texas Department of State Health Services	Patient Partner	Recommendation
Kory Anderson	Intermountain Physician Advisor Services; McKay-Dee Hospital, Intermountain Health	Facilities/Institution	Advisory
Matt Austin	Johns Hopkins Armstrong Institute for Patient Safety and Quality	Health Services Researcher	Recommendation
Jennifer Bailit	Case Western Reserve University	Other Interested Party	Advisory
Rebecca Bartles	University of Providence	Other Interested Party	Advisory
Juliet Batsch (inactive)	TNAA/INOVA Health System	Patient Partner	Recommendation
Jacqueline Blauvelt	Hackensack Meridian Health	Facility/Institution	Advisory
Jill Blazier	Intermountain Health	Rural Health	Recommendation
Gregary Bocsi	Department of Pathology, University of Colorado Anschutz Medical Campus	Facility/Institution	Recommendation
Darius Bradley Sr.	--	Patient Partner	Advisory
Kent Bream	University of Pennsylvania; Spectrum Health	Clinician	Recommendation

Member	Affiliation/ Organization	Primary Perspective	Advisory/ Recommendation Group
	Services, Inc.		
Nicole Cable	IGNITE HX, LLC	Patient Partner	Advisory
Billy Caceres	Columbia University	Health Equity Expert	Advisory
Emily Calvert	American Urological Association	Other Interested Party	Advisory
David Chand	Aetna/CVS	Purchaser/Plan	Advisory
Ashley Comiskey	Baptist Health Paducah	Clinician	Recommendation
Mark Ellison	Elevance Health	Purchaser/Plan	Recommendation
Karen Fernandes	AYR Consulting Group	Patient Partner	Advisory
Oren Guttman (inactive)	Jefferson Abington Health; Sidney Kimmel Medical College	Facility/Institution	Recommendation
April Harris	--	Patient Partner	Advisory
Janet Hurley	CHRISTUS Health	Facility/Institution	Recommendation
Hannah Ingber	National Quality Forum	Other Interested Party	Recommendation
Sonali Iyer	UCI Health	Clinician	Advisory
Abraham Jacob	University of Minnesota; M Health Fairview	Clinician	Advisory
Zainab Jah	Reproductive Health Impact: The Collaborative for Equity and Justice	Patient Partner	Advisory
Rebecca Jones	Northwest Health – Willow Creek Women's Hospital	Other Interested Party	Advisory
Kamyar Kalantar-Zadeh	Harbor-UCLA Medical Center	Clinician	Advisory
Barbara Kivowitz	--	Patient Partner	Advisory
Marianne Kraemer	Sepsis Alliance	Health Equity	Recommendation
Lisa Leckrone (inactive)	St. Mary Medical Center	Rural Health	Recommendation
Tammy Love	Oracle Health	Other Interested Party	Recommendation
Cindi McElhaney	Comagine Health	Health Services Researcher	Advisory
Patricia Merryweather-Arges	Project Patient Care	Patient Partner	Recommendation
Denise Morse	City of Hope National	Other Interested Party	Advisory

Member	Affiliation/ Organization	Primary Perspective	Advisory/ Recommendation Group
	Medical Center		
Sheila Owens-Collins	Lexington-Fayette County Health Department	Clinician	Recommendation
Darryl Roberts	RELI Group Inc.	Health Services Researcher	Advisory
Patrick Romano	University of California, Davis School of Medicine	Health Services Researcher	Advisory
Joseph Saseen	University of Colorado Anschutz Medical Campus	Clinician	Advisory
Talia Sasson	University of Rochester School of Medicine and Dentistry	Clinician	Advisory
Martha Abshire Saylor	The Johns Hopkins University School of Nursing	Health Services Researcher	Advisory
Thomas Spiegel	The University of Chicago Medicine	Facility/Institution	Recommendation
Phoebe Thriffiley	Surgery Partners	Quality Improvement	Advisory
Jean-Luc Tilly	The Leapfrog Group	Purchaser/Plan	Recommendation
Arjun Venkatesh	Yale University School of Medicine; Yale New Haven Hospital	Health Services Research	Recommendation
Usha Venugopal	NYC Health + Hospitals/Lincoln	Health Equity Expert	Advisory
Eric Weinhandl	DaVita Clinical Research	Health Services Researcher	Advisory
Janice Young	HCA Florida Ocala Health	Facility/Institution	Advisory

Measure Stewards

Brigham and Women's Hospital

Centers for Medicare & Medicaid Services (CMS)

University of Utah

Measure Developers

Acumen


Partnership for
Quality Measurement
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