

National Consensus Development and Strategic Planning for  
Health Care Quality Measurement

## **Final Fall 2023 Cycle Endorsement and Maintenance (E&M) Technical Report**

INITIAL RECOGNITION AND MANAGEMENT

*April 2024*



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The analyses upon which this publication is based were performed under Contract Number 75FCMC23C0010, entitled, "National Consensus Development and Strategic Planning for Health Care Quality Measurement," sponsored by the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

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## Executive Summary

Over the past 20+ years, the United States (U.S.) has been focused on improving health care quality for Americans. Health care quality measures have increasingly been developed and used to facilitate this goal by quantifying the quality of care provided by health care providers and organizations based on various standards of care. These standards relate to the effectiveness, safety, efficiency, person-centeredness, equity, and timeliness of care.<sup>1</sup>

At Battelle, we have a strong collective interest in ensuring that the health care system works as well as it can. Quality measures are used to support health care improvement, benchmarking, and accountability of health care services and to identify weaknesses, opportunities, and disparities in care delivery and outcomes.<sup>1,2</sup>

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. To support our consensus-based process, we formed the Partnership for Quality Measurement™ (PQM), which ensures informed and thoughtful endorsement reviews of quality measures across a range of focus areas that align with a person's journey through the health care system.

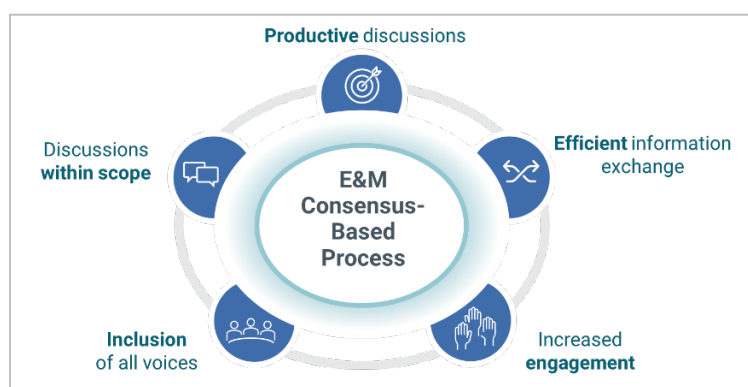


Figure ES-1. E&M Consensus-Based Process

One of those focus areas is the Initial Recognition and Management of disease, which includes measures that address early signs and symptoms of conditions and diseases; initial recognition and management of a change in a person's health status; and the experience, patient safety, and/or harm related to detection, diagnosis, or recognition of a condition.

Patient safety measures and those that focus on diagnostic excellence are foundational to safeguarding health care quality in a variety of settings. Implementing appropriate diagnostic practices can reduce diagnostic errors, which include failure to establish an accurate and timely explanation of a patient's health problem or to explain that to the patient. Establishing an accurate and timely diagnosis while using the fewest resources can maximize the initial recognition and management of a disease, improve the patient experience, and further ensure safety and efficacy in patient care.<sup>3,4</sup> Whether navigating the intricacies of respiratory care during critical transport, fine-tuning the recall rates for breast cancer screening, or streamlining imaging processes for acute ischemic stroke management, appropriate diagnostic practices are essential to optimizing the initial management of a condition or disease, further optimizing patient outcomes.<sup>5,6</sup>

For this measure review cycle, three measures were submitted to the Initial Recognition and Management committee for endorsement consideration. Of the three measures reviewed by the committee (Figure ES-2), the committee endorsed one measure with conditions but did not endorse the remaining two measures (Table ES-1).

**Table ES-1. Measures Reviewed by the Committee**

CBE Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
#0661	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation within 45 Minutes of ED Arrival	Maintenance	Lantana Group/ Centers for Medicare & Medicaid Services	Endorsed with Conditions
#4045	Waveform Capnography in Ventilated Patients: Percent of patient transport contacts with advanced airways in whom continuous waveform capnography was used	New	GAMUT Quality Improvement Collaborative	Not Endorsed due to No Consensus
#4220	Breast Cancer Screening Recall Rates	New	The Lewin Group/Centers for Medicare & Medicaid Services	Not Endorsed due to No Consensus

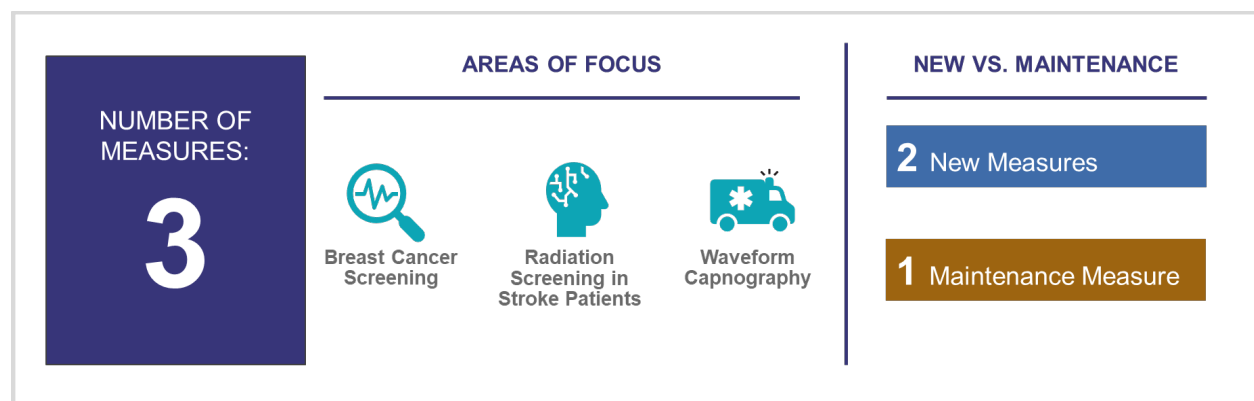


Figure ES-2. Fall 2023 Measures for Committee Review

## 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, meaning 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.

Each E&M cycle (e.g., Fall or Spring) has a designated Intent to Submit deadline, by which 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 1), measure developers/stewards submit the full measure information by the respective Full Measure Submission deadline.

The measures are then posted to the PQM website for a 30-day public comment period, which occurs prior to the endorsement meeting. 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 (e.g., Fall or Spring). All public comments received during this 30-day period are posted to the respective measure page on the [PQM website](#) for full transparency. Summaries of the comments received for the measures submitted to the Initial Recognition and Management Committee are provided [below](#). The committee considers all comments in its endorsement evaluation of the measures.

**Table 1. 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 ends on a weekend or holiday, the deadline will be the next immediate business day.*

E&M committees are composed of diverse PQM members, representing all facets of the health care system. There are five [E&M projects](#), each has a committee that evaluates, discusses, and assigns endorsement decisions for measures under endorsement review. Each E&M project committee is divided into an Advisory Group and a Recommendations Group (Figure 1).



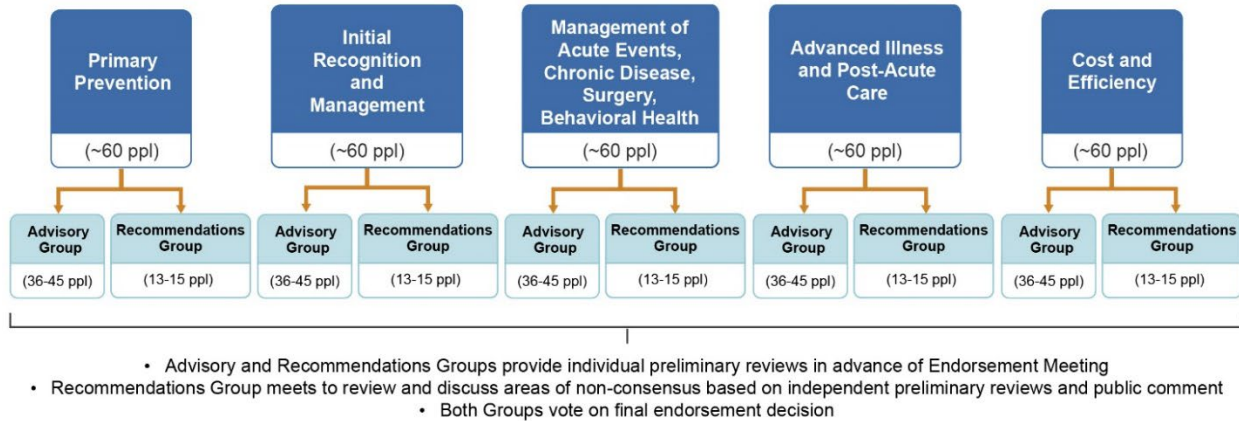


Figure 1. E&M Committee Structure

The goal was 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 a diverse group of people and perspectives (Figure 2 and Figure 3).

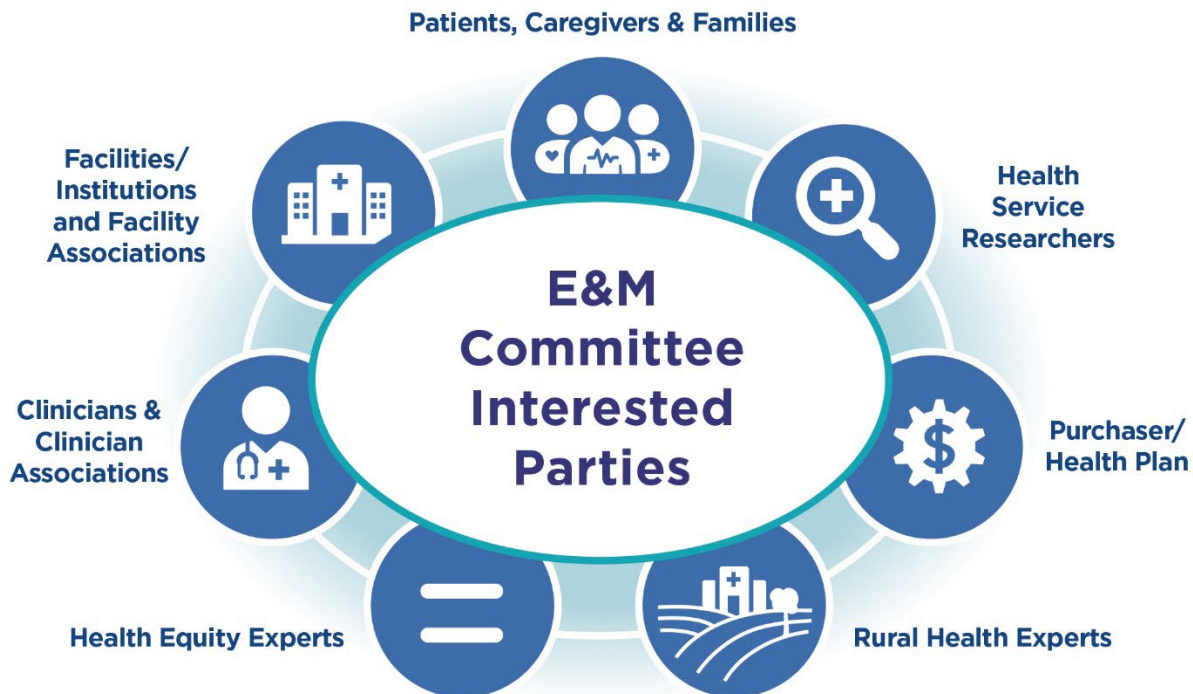


Figure 2. E&M Interested Parties

With respect to the Initial Recognition and Management committee, membership consisted of 10 patient partners (i.e., patients, caregivers, advocates) and 26 clinicians, with specialties in nursing, pediatrics, patient safety, and others (Figure 3). The committee also included four experts in rural health and seven in health equity.

All committee members completed a measure-specific disclosure of interest (MS-DOI) form to identify potential conflicts with the measures under endorsement review for the respective E&M cycle. Members were recused from voting on measures potentially affected by a perceived conflict of interest (COI) based on Battelle’s [COI policy](#). While a list of committee members is provided in [Appendix A](#), full committee rosters and bios are posted on the respective project pages on the [PQM website](#).



Figure 3. Initial Recognition and Management Committee Members

During the endorsement meeting, Advisory Group members listen to the Recommendations Group discussions before both groups cast an endorsement vote (Figure 4). This structure ensures a larger number of voices contribute to the consensus-building process.

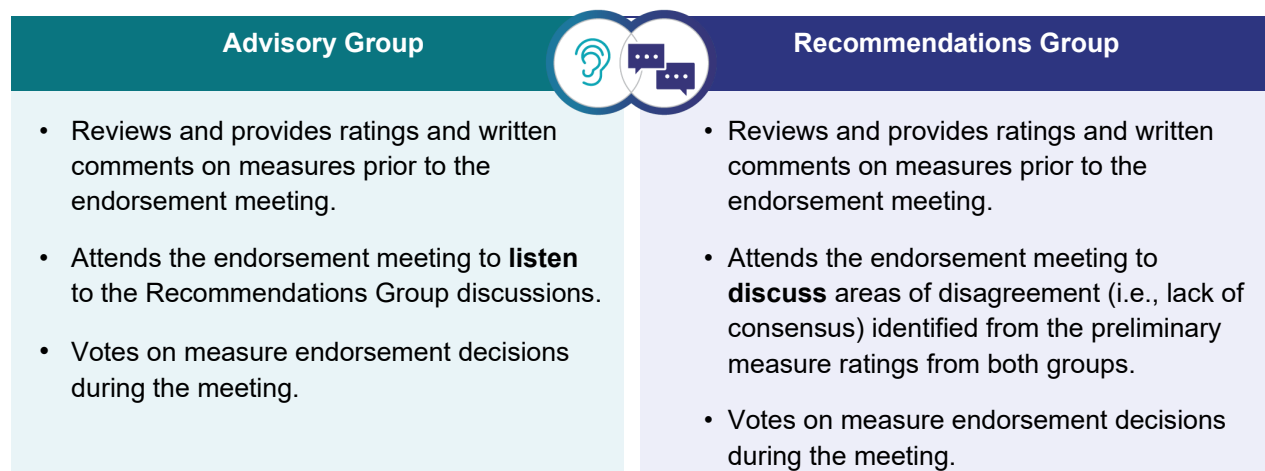


Figure 4. E&M Advisory Group vs. Recommendations Group

At least three weeks prior to an E&M committee endorsement meeting, the Recommendations Group and the Advisory Group received the full measure submission details for each measure up for review, including all attachments, the [PQM Measure Evaluation Rubric](#), the public comments received for the measures under review, and the E&M team preliminary assessments.

Members of both groups were asked to review each measure, independently, against the PQM Measure Evaluation Rubric. Committee members assigned a rating of “Met,” “Not Met but Addressable,” or “Not Met” for each domain of the PQM Measure Evaluation Rubric. In addition, committee members provided associated rationales for each domain rating, which were based on the rating criteria listed for each domain. Battelle staff [aggregated](#) and [summarized](#) the results and distributed them back to the committee, and to the respective measure developers, and/or stewards, for review within one week of the endorsement meeting. These independent committee member ratings were compiled and used by Battelle facilitators and committee co-chairs to guide committee discussions.

Under the Battelle process, measures reach their endpoint when an endorsement decision is rendered by the E&M project committees (Table 2).

**Table 2. Endorsement Decision Outcomes**

Decision Outcome	Description	Maintenance Expectations
Endorsed	<p><b>Applies to new and maintenance measures.</b></p> <p>There is 75% or greater agreement for endorsement via a vote by the E&amp;M committee.</p>	<p>Measures undergo maintenance of endorsement reviews every 5 years with a status report submission at 3 years (see <a href="#">Status Report/Annual Update</a> for more details).<sup>‡</sup></p>
Endorsed with Conditions *	<p><b>Applies to new and maintenance measures.</b></p> <p>There is 75% or greater agreement via a vote by the E&amp;M committee that the measure can be endorsed, as it meets the criteria, but there are recommendations/areas committee reviewers would like to see when the measure comes back for maintenance. If these recommendations are not addressed, then a rationale from the developer/steward should be provided for consideration by the E&amp;M committee review.</p>	<p>Measures undergo maintenance of endorsement reviews every 5 years with a status report submission at 3 years (see <a href="#">Status Report/Annual Update</a> for more details), unless the E&amp;M committee assigns a condition requiring the measure to be reviewed earlier.</p>



Decision Outcome	Description	Maintenance Expectations
		At maintenance review, the E&M committee evaluates whether conditions have been met, in addition to all other maintenance endorsement minimum requirements.
Not Endorsed <sup>°</sup>	<b>Applies to new measures only.</b> There is 75% or greater agreement via a vote by the E&M committee to not endorse the measure.	None
Endorsement Removed <sup>°</sup>	<b>Applies to maintenance measures only.</b> Either: <ul style="list-style-type: none"> <li>• There is 75% or greater agreement for endorsement removal by the E&amp;M committee; or</li> <li>• A measure steward retires a measure (i.e., no longer pursues endorsement); or</li> <li>• A measure steward never submits a measure for maintenance and there is no response from the steward after targeted outreach; or</li> <li>• There is no longer a meaningful gap in care, or the measure has plateaued (i.e., no significant change in measure results for accountable entities over time).</li> </ul>	None

*±Maintenance measures may be up for endorsement review earlier if an emergency/off-cycle review is needed.*

*\*Conditions are determined by the E&M committee, 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 committee. 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, E&M committee endorsement decisions and associated rationales are posted to the [PQM website](https://www.p4qm.org) for three weeks, which represents an appeals period, during which any interested party may request an appeal regarding any E&M committee

endorsement decision. If a measure's endorsement is being appealed, including an "Endorsed with Conditions" decision, the appeal must:

- Cite evidence of the appellant's interests that are directly and materially affected by the measure, and 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 was 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 an eligible appeal is received, we convened the Appeals Committee, consisting of the co-chairs from all five E&M project committees, 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.

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For the Fall 2023 cycle, the appeals period opened on February 26 and closed on March 18, 2024. No appeals were received for the measures reviewed by the Initial Recognition and Management committee.

## Initial Recognition and Management Measure Evaluation

For this measure review cycle, the Initial Recognition and Management committee evaluated two new measures and one measure undergoing maintenance review against standard [measure evaluation criteria](#). During the endorsement meeting, the committee voted to endorse one measure with conditions and to not endorse two measures (Table 3).

Brief summaries of the committee's deliberations for each measure along with any conditions for endorsement are noted under the [measure's evaluation summary](#) below. The committee's endorsement [meeting summary](#) can be found on the respective E&M project page on the PQM website.

**Table 3. Number of Fall 2023 Initial Recognition and Management Measures Submitted and Reviewed**

	Maintenance	New	Total
Number of measures submitted for endorsement review	1	2	3
Number of measures withdrawn from consideration*	0	0	0
Number of measures reviewed by the committee	1	2	3
Number of measures endorsed	0	0	0
Number of measures endorsed with conditions	1	0	1
Number of measures not endorsed/endorsement removed	0	2	2

*\*Measure developers/stewards can withdraw a measure from measure endorsement review at any point before the committee endorsement meeting.*

## Public Comments Received Prior to Committee Evaluation

Battelle accepts comments on measures under endorsement review through the [PQM website](#). For this evaluation cycle, the pre-evaluation commenting period opened on December 1, 2023, and closed on January 2, 2024. No pre-evaluation comments were received prior to the measure evaluation meeting on February 9, 2024.

## Summary of Potential High-Priority Gaps

During the committee's evaluation of the measures, no potential high-priority measurement gap areas emerged.

## Summary of Major Concerns or Methodological Issues

The committee did not discuss any major concerns and/or methodological regarding the measures under endorsement review.

## Measure Evaluation Summaries

### CBE #4220 – Breast Cancer Screening Recall Rates [The Lewin Group/Centers for Medicare & Medicaid Services] – New

[Specifications](#) | [Committee Independent Review Summary](#)

**Description:** The Breast Cancer Screening Recall Rates measure calculates the percentage of beneficiaries with mammography or digital breast tomosynthesis (DBT) screening studies that are followed by a diagnostic mammography, DBT, ultrasound, or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting within 45 days.

**Committee Final Vote:** Not Endorsed due to No Consensus

**Conditions:** None.

**Vote Count:** Endorse (3 votes; 8.33%), Endorse with Conditions (17 votes; 47.22%), Not Endorse (16 votes; 44.44%); recusals (1).

**Summary of Public Comments:** None received.

**Appeals:** None

Discussion Theme	Recommendations Group Discussion
Appropriate Recall Rates	<ul style="list-style-type: none"> <li>The committee considered the measure recall rate range of 5-12% and the lack of information directly relating the measure to improved outcomes.</li> <li>The developer asserted that the measure functions as a tool for facilities to identify cancer cases, emphasizing that ideally, knowing the exact rate of cancer can help identify which individuals need to be recalled.</li> <li>Acknowledging the absence of such detailed information, the developer opined, based on existing literature, that a recall range of 5-12% is a good indication of true cancer rates, aiming to strike a balance between not overlooking patients and avoiding unnecessary exposure to follow-up.</li> <li>The developer further reminded the committee that the measure is a process measure, and the developer hopes there will be more related measures that can evaluate outcomes in the</li> </ul>

Discussion Theme	Recommendations Group Discussion
Potential Unintended Consequences and Incentives	<p>future.</p> <ul style="list-style-type: none"> <li>• Committee members discussed the possibility of facilities outside the specified range withholding follow-ups to enhance their reported performance.</li> <li>• The developer clarified that the measure operates on a pay-for-reporting basis and not pay-for-performance, therefore, there are no financial consequences linked to performance.</li> <li>• Despite the clarification, the committee expressed concern about the lack of incentives for improvements since the measure is not pay-for-performance.</li> </ul>
Equity Considerations	<ul style="list-style-type: none"> <li>• The committee determined the measure met the optional equity criterion but noted the absence of information on how the rates vary in different populations.</li> <li>• The developer stated that the measure, based on the American College of Radiology (ACR) guideline, has not established benchmarks for subpopulations.</li> <li>• The committee highlighted that a limitation of the measure was that it will not capture populations at risk for receiving inequitable recall rates and that the measure submission does not establish how the measure will address these differences.</li> </ul>

### Additional Recommendations for the Developer/Steward and Future Directions

Several committee members requested more evidence in support of the logic model and more information on how the measure is impacted by age, race, and ethnicity.

[CBE #0661 – Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation within 45 Minutes of ED Arrival \[Lantana Group/Centers for Medicare & Medicaid Services\] – Maintenance](#)

[Specifications](#) | [Committee Independent Review Summary](#)

**Description:** This measure calculates the percentage of acute ischemic stroke or hemorrhagic stroke patients who arrive at the emergency department (ED) within two hours of the onset of symptoms and have a head computed tomography (CT) or magnetic resonance imaging (MRI) scan interpreted within 45 minutes of ED arrival. The measure is calculated using chart abstracted data, on a rolling, quarterly basis and is publicly reported, in aggregate, for one calendar year. The measure has been publicly reported, annually, by CMS as a component of its Hospital Outpatient Quality Reporting (OQR) Program since 2012.

**Committee Final Vote:** Endorsed with Conditions



**Conditions:** Explore, with the developer’s technical experts and facilities, why the measure has leveled out in performance ratings.

**Vote Count:** Endorse (6 votes; 16.67%), Endorse with Conditions (21 votes; 58.33%), Remove Endorsement (9 votes; 25.00%); recusals (0).

**Summary of Public Comments:** No comments received.

**Appeals:** None

Discussion Theme	Recommendations Group Discussion
Use and Usability	<ul style="list-style-type: none"> <li>The committee recognized that this measure is currently used in the CMS Hospital Outpatient Quality Reporting Program, and while performance scores show room for improvement, they have been stable from 2015 to 2021 (range: 71.28% - 75.89%). In addition, the number of hospitals reporting each year changes considerably (range: 502 - 1607), making it difficult to interpret changes in the rate (e.g., the highest rate was reported in the year with the fewest reporting hospitals).</li> <li>The committee further considered some of the low reporting on this measure, highlighting that a significant number of hospitals in Chicago do not have any cases reported for this measure.</li> <li>The committee suggested the developer remove the ED aspect of the measure due to potential misleading impressions about large university hospitals not accepting stroke patients.</li> <li>The developer responded that the ability to obtain head imaging rapidly contributes to optimal treatment of stroke patients, and this imaging is increasingly done in an outpatient setting.</li> <li>The developer also stated that since the measure has been endorsed, there has been improvement and although the numbers have been stable, the measure has not topped out.</li> <li>The committee placed a condition on the measure, which was to review the measure in three years rather than five, to understand why the measure seems to be leveling out.</li> <li>The developer noted that the improvement of scores is dependent upon the facilities, but they could engage with facilities and the technical expert panel to understand more about performance trends.</li> </ul>
Path towards an Electronic Clinical Quality Measure (eCQM)	<ul style="list-style-type: none"> <li>Committee members inquired about the potential for this measure to be an eCQM, to which the developer noted that an eCQM is not being considered since some data elements, notably the CT interpretation time, does not align with the existing structured fields within electronic health record (EHR) systems.</li> </ul>

Discussion Theme	Recommendations Group Discussion
Reliability Testing	<ul style="list-style-type: none"> <li>The committee considered the reliability testing conducted at the accountable entity-level using a signal-to-noise analysis. The median reliability was 0.68 among facilities meeting the minimum count of 11 cases. Approximately 30-35% of entities have reliability less than 0.6, likely from facilities with a low denominator size.</li> <li>The committee discussed having the developer consider increasing the minimum case volume to improve the reliability results.</li> <li>The developer responded that hospitals with low deciles do not exhibit inherent differences in sample size, explaining that the quality in those facilities is inconsistent.</li> </ul>
Integrity of Information	<ul style="list-style-type: none"> <li>The committee questioned the integrity of the information in the database used for this measure and the measure's ability to accurately measure stroke management.</li> <li>The committee highlighted alternative metrics for evaluating stroke management, such as the time to thrombolytic therapy, emphasizing the stagnant results associated with CT/MRI interpretation time.</li> </ul>

### Additional Recommendations for the Developer/Steward and Future Directions

Not discussed.

**CBE #4045 – Waveform Capnography in Ventilated Patients: Percent of patient transport contacts with advanced airways in whom continuous waveform capnography was used [Ground & Air Medical Quality in Transport (GAMUT) Quality Improvement Collaborative] – New**

[Specifications](#) | [Committee Independent Review Summary](#)

**Description:** This metric is designed to measure the critical care transport team's utilization of waveform capnography during critical care medical transport. Waveform capnography has evolved as the standard for the safe placement and maintenance of advanced airways (e.g., endotracheal tubes) in adult and pediatric patients. The metric specifically focuses on transported patients with advanced airways in whom continuous waveform capnography is appropriately used. This metric is stratified by age into the following three categories: neonatal (defined as infants <29 days), pediatric (defined as patients aged 29 days to <18 years), and adults (defined as age 18 or older). This metric is reported as "Percent of patients with advanced airways in whom waveform capnography was utilized." Transport programs track this metric for each applicable transport and report their average utilization percentage monthly.

**Committee Final Vote:** Not Endorsed due to No Consensus

**Conditions:** None

**Vote Count:** Endorse (7 votes; 19.44%), Endorse with Conditions (14 votes; 38.89%), Not Endorse (15 votes; 41.67%); recusals (0).

**Summary of Public Comments:** No comments received.

**Appeals:** None

Discussion Theme	Recommendations Group Discussion
Measures Creating Standards of Care	<ul style="list-style-type: none"> <li>The committee considered a concern regarding the creation of standards of care based on this measure.</li> <li>The developer acknowledged existing literature supporting the use of capnography in different environments, while also highlighting the use of this measure as a supportive element for creating a standard.</li> <li>The developer drew the committee's attention to a collaborative process involving two national consensus conferences in which waveform capnography was selected as one of the metrics identified as necessary for ensuring the excellence of transport organizations.</li> <li>The committee suggested providing documentation of these consensus conferences within the measure submission as additional evidence to support the importance of the measure.</li> </ul>
Feasibility	<ul style="list-style-type: none"> <li>The committee acknowledged that the data for this measure are reported to GAMUT.</li> <li>Recognizing that the measure data are manually captured, rather than being in an electronic format, and that the data reported to GAMUT are not routinely audited, the committee questioned the feasibility of the measure.</li> <li>Recognizing the committee's concern, the developer noted plans to accept reporting via comma separated values (csv) files, which may decrease potential errors.</li> </ul>
Equity Considerations	<ul style="list-style-type: none"> <li>The committee discussed the potential for data stratification and the broader implications of the measure's lack of stratification in overlooking disparities in health care outcomes among different demographic groups.</li> <li>The developer responded that they do not collect protected health information, so it may be challenging to stratify the data by certain patient populations.</li> <li>The committee suggested the measure could be stratified by geographic location and emphasized the importance of understanding any differences between rural and urban settings.</li> </ul>

Discussion Theme	Recommendations Group Discussion
Accountability, Use, and Usability	<ul style="list-style-type: none"><li>• The committee raised concerns about accountability and the potential to selectively count patients to manipulate statistics.</li><li>• The developer defined patient contacts as the basis for accountability noting that critical care transport teams are accountable regardless of transport.</li><li>• The committee inquired about the implications of hospitals owning transport teams, which the developer clarified that the measure assesses the performance of transport teams, not hospitals.</li><li>• The committee further questioned whether there is a plan for use within a CMS program or other accountability application.</li><li>• The developer responded that the measure is not used in a CMS program, but that it can be used to improve hospital care.</li><li>• Committee members discussed the measure's accessibility to consumers. The developer indicated that the current state of the health care system might not foster active consideration of such information by patients for decision-making.</li></ul>

### **Additional Recommendations for the Developer/Steward and Future Directions**

Not discussed.

## References

1. Claxton G, Cox C, Gonzales S, Kamal R, Levitt L. Measuring the quality of healthcare in the U.S. Kaiser Family Foundation. September 10, 2015. Accessed March 20, 2024. <https://www.healthsystemtracker.org/brief/measuring-the-quality-of-healthcare-in-the-u-s/>
2. Quality Measurement and Quality Improvement. Centers for Medicare & Medicaid Services. Updated 09/06/2023. Accessed March 20, 2024. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-Improvement->
3. Singh H, Graber ML, Hofer TP. Measures to Improve Diagnostic Safety in Clinical Practice. *J Patient Saf.* Dec 2019;15(4):311-316. doi:10.1097/pts.0000000000000338
4. Singh H, Connor DM, Dhaliwal G. Five strategies for clinicians to advance diagnostic excellence. *BMJ.* 2022;376:e068044. doi:10.1136/bmj-2021-068044
5. Singh H, Bradford A, Goeschel C. Operational measurement of diagnostic safety: state of the science. *Diagnosis.* 2021;8(1):51-65. doi:doi:10.1515/dx-2020-0045
6. Olson APJ, Linzer M, Schiff GD. Measuring and Improving Diagnostic Safety in Primary Care: Addressing the “Twin” Pandemics of Diagnostic Error and Clinician Burnout. *Journal of General Internal Medicine.* 2021/05/01 2021;36(5):1404-1406. doi:10.1007/s11606-021-06611-0



## Appendix A: Initial Recognition and Management Committee Roster

### Fall 2023 Cycle

Member	Affiliation/Organization	Advisory or Recommendation Group
Patricia Merryweather ( <i>Patient Representative Co-chair</i> )	Project Patient Care	Recommendation
Matt Austin ( <i>Non-Patient Representative Co-chair</i> )	Johns Hopkins Armstrong Institute for Patient Safety and Quality	Recommendation
Abraham Jacob	University of Minnesota; M Health Fairview	Advisory
Anne Llewellyn	-	Advisory
Arjun Venkatesh	Yale University School of Medicine; Yale New Haven Hospital	Advisory
Ashley Comiskey	Baptist Health Paducah	Advisory
Barbara Kivowitz	-	Advisory
Billy A. Caceres	Columbia University	Advisory
Carol Sakala	National Partnership for Women & Families	Recommendation
Carole Hemmelgarn	MedStar Institute for Quality and Safety; Self and Patients for Patient Safety US	Advisory
Cecilia Purcell	-	Recommendation
Danny Barker	Intermountain Health	Recommendation
Edward Bailly	Mount Sinai Health Partners	Recommendation
Geeta Sood	Johns Hopkins Medical Center	Recommendation
Gregary Bosci	Department of Pathology, University of Colorado Anschutz Medical Campus	Advisory
Hannah Ingber	National Quality Forum	Advisory
Helen Haskell	Mothers Against Medical Error	Recommendation

Member	Affiliation/Organization	Advisory or Recommendation Group
Janet Hurley	CHRISTUS Health	Advisory
Janice Young	HCA Florida Ocala Health	Advisory
Jean-Luc Tilly	The Leapfrog Group	Advisory
Jennifer Bailit	Case Western Reserve University	Recommendation
Jill Blazier	Intermountain Health	Advisory
Juliet Bartsch	TNAA/INOVA Health System	Advisory
Karen M. Fernandes	AYR Consulting Group	Recommendation
Karen Johnson	American Urological Association	Recommendation
Karen Wilding	Nemour's Childrens Health	Recommendation
Kent Bream	University of Pennsylvania; Spectrum Health Services, Inc.	Advisory
Kobi Ajayi	Texas Department of State Health Services	Advisory
Kory Anderson	Intermountain Physician Advisor Services; McKayDee Hospital, Intermountain Health	Advisory
Kyle Campbell	Health Services Advisory Group, Inc.	Recommendation
Lisa Leckrone	St. Mary Medical Center	Advisory
Marianne Kraemer	Sepsis Alliance	Advisory
Mark Ellison	Elevance Health	Advisory
Oren Guttman	Jefferson Abington Health; Sidney Kimmel Medical College	Advisory
Pranali Trivedi	Acension	Recommendation
Raymond Dantes	Emory University School of Medicine; Centers for Disease Control and Prevention	Advisory

Member	Affiliation/Organization	Advisory or Recommendation Group
Selena McCord	National Rural Health Resource Center	Advisory
Sheila Owens-Collins ( <i>inactive</i> )	Lexington-Fayette County Health Department	Advisory
Sherly Binu	RELI Group Inc	Recommendation
Talia Sasson	University of Rochester School of Medicine and Dentistry	Advisory
Tamaire Ojeda-Avila	Commission of Dietetic Registration	Recommendation
Tammy Love	Oracle Health	Advisory
Thomas Spiegel	University of Chicago Medicine	Advisory
Tracey H. Brasel	Pinckneyville Community Hospital	Advisory
Usha Venugopal	NYC Health +Hospitals/Lincoln	Advisory
Zainab Jah	Reproductive Health Impact: The Collaborative for Equity and Justice	Advisory

## Partnership for Quality Measurement Organizations

Battelle

Institute for Healthcare Improvement

Rainmakers

### Measure Stewards

Centers for Medicare & Medicaid Services

GAMUT Quality Improvement Collaborative

### Measure Developers

GAMUT Quality Improvement Collaborative

Lantana Group

The Lewin Group

