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Dr. Robert Otto Valdez, Ph. D., M.H.S.A.
Director
Agency for Healthcare Research and Quality (AHRQ)
Department of Health and Human Services
5600 Fishers Lane, 7th Floor
Rockville, MD 20857

Re: AHRQ Request for Information on Diagnostic Excellence Measurement

Dear Director Otto Valdez,

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on the AHRQ Diagnostic Excellence Measurement Request for Information (RFI). Founded in 1964, The Society of Thoracic Surgeons is a not-for-profit organization representing more than 7,800 surgeons, researchers, and allied health care professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lungs, and esophagus, as well as other surgical procedures within the chest.

In this RFI, AHRQ aims to address gaps in diagnostic excellence measurement with a population health lens to develop a set of standardized measures to produce national benchmarks and foster healthcare quality improvement. As part of that mission, AHRQ seeks feedback on four lung cancer diagnosis measures.

STS is supportive of measurement that addresses the gap in lung cancer diagnosis. Lung cancer is the leading cause of cancer deaths in the U.S., responsible for approximately one in five cancer deaths. Though lung cancer rates are high, the national rate of lung cancer screening remains low, at under 6%. When caught in its early stages, patients have a 20-year survival rate of 80%, compared to a five-year survival rate of 8% for late-stage lung cancer.[1] It is important that more focus be shifted to early patient diagnosis made possible with improved access to lung cancer screening services and appropriate measurement may help address this gap. However, the appropriateness of the measures proposed in this RFI are dependent on how the information is being used. Measures leveraged for quality improvement and accountability purposes should be considered distinct from those used in research.

Measure 1B: Missed red flag SaferDx e-measure 2

Sub-measure 2: The proportion of red flag abnormal test results suspicious for possible cancer (chest imaging flagged by a radiologist as suspicious for malignancy) in non-deceased patients aged 18 and over, where neither a clinical exclusion reason for additional evaluation, nor an appropriate follow-up action exists within 30 days of the test results at the hospital or health system.

[1] https://www.cancer.org/cancer/types/lung-cancer/about/key-statistics.html#:~:text=Lung%20cancer%20is%20by%20far,breast%2C%20and%20prostate%20cancers%20combined.

STS is supportive of a measure that identifies the rate of patient adherence to lung cancer screening follow-up. According to the American College of Radiology, up to 10% of all radiology reports contain follow-up recommendations, but approximately half of those recommended follow-up exams are never performed.[2] Lung nodules represent about half of all imaging follow-up recommendations, and noncompliance.

However, the details of this measure are unclear. What constitutes "follow-up" is undefined. It is not specified whether the measure is intended to assess if the clinician reached out to the patient for follow-up, or whether it refers to the patient's adherence to the follow-up plan. For example, is the measure assessing whether the surgeon referred a patient to an oncologist, or whether the patient connected to oncology care after being referred by the surgeon.

Based on the supplementary data for the measure, it seems as though the measure is meant to suggest the onus is on the provider. If that is an accurate read of the measure intent, it would not account for patients who receive their follow-up care outside of the hospital or healthcare system. For example, if a patient receives their oncology care in a different health system they would be counted in the denominator but not in the numerator despite receiving follow up care. Additionally, if the measure were to capture both patient and clinician follow-up action, it would be difficult to determine how to improve quality without separating into two measures. Targeting clinician compliance and patient adherence requires different strategies. To more accurately capture data for a given process, we feel it is necessary to address these concerns within the measure specifications.

Measure 2A: Emergency presentation SaferDx e-measure 1

Sub-measure 1: The proportion of newly diagnosed lung cancers with emergency presentation, among total new lung cancer diagnoses at the hospital or health system.

STS is supportive of methods to identify missed opportunities for diagnosis; however, we have questions on how the data collected from Measure 2A will be used. If the purpose is quality improvement and accountability, it is essential that the measure capture only patients identified through an emergency who were also previously eligible for lung cancer screening. If the patient was not previously eligible for lung cancer screening, it is inappropriate to hold a provider accountable for a newly diagnosed lung cancer with emergency presentation.

Conversely, if the data collected were to be used for research purposes only, it could be beneficial to capture data on newly diagnosed lung cancers with emergency presentation as an opportunity to study trends in patients outside of the screening eligibility requirements and to evaluate what factors might be driving emergency presentations.

Measure 3A: Late-stage diagnosis SaferDx e-measure 1

Sub-measure 1: The proportion of late-stage (Stage 3 and 4) lung cancer diagnoses at the time of initial diagnosis, among total new lung cancer diagnoses at the hospital or health system.

[2] https://www.acr.org/Practice-Management-Quality-Informatics/ACR-Bulletin/Articles/December-2023/Following-Patients-Through-Incidental-Findings

Similar to our comments for Measure 2A, while we are supportive of the measure intent, in order to accurately reflect quality, the patients with late-stage lung cancer at the time of diagnosis would need to be eligible for traditional lung cancer screening requirements to represent a missed opportunity in diagnosis.

Measure 6: Closing the loop on completion of follow-up recommendations for actionable incidental findings of pulmonary nodules

Percentage of patients, aged 35 years and older, with a single >6.0mm pulmonary nodule actionable incidental finding who received follow-up imaging within the recommended time interval, among all images ordered throughout the hospital or health system. (An actionable incidental finding is a mass or lesion detected on cross-sectional imaging [CT, MRI, PET, and SPECT] of the neck, chest, or abdomen not related to the reason for imaging that represents a finding for which non-emergent follow-up is recommended.)

STS is supportive of this measure which aims to quantify failure to follow-up on incidentally identified lung nodules on imaging. A recent study from Denmark highlighted the critical need for proper follow-up, revealing that incidental findings were responsible for detection of 85% of early lung cancer cases. This underscores the importance of timely and accurate follow-up to improve patient outcomes.[3]

Thank you for the opportunity to provide these comments. Please contact Molly Peltzman, Associate Director, Health Policy at mpeltzman@sts.org, or Derek Brandt, Vice President of Government Relations at dbrandt@sts.org should you need additional information or clarification.

Sincerely,

Joseph F. Sabik III, MD
President

[3] M Borg, O Hilberg, MB Andersen, UM Weinreich, TR Rasmussen. Increased use of computed tomography in Denmark: stage shift toward early stage lung cancer through incidental findings. https://pubmed.ncbi.nlm.nih.gov/36264585/