This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The sub-criteria and most of the footnotes from the evaluation criteria are provided in Word comments and will appear if your cursor is over the highlighted area (or in the margin if your Word program is set to show revisions in balloons). Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all yellow highlighted areas of the form. Evaluate the extent to which each sub-criterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: If there is no TAP or workgroup, the SC also evaluates the sub-criteria (yellow highlighted areas).

Steering Committee: Complete all pink highlighted areas of the form. Review the workgroup/TAP assessment of the sub-criterion, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few sub-criteria as indicated)

(for NQF staff use) NQF Review #: ACP-043-10 NQF Project: Patient Safety Measures

<table>
<thead>
<tr>
<th>MEASURE DESCRIPTIVE INFORMATION</th>
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<tbody>
<tr>
<td>De.1 Measure Title: Ultrasound guidance for Internal Jugular central venous catheter placement</td>
</tr>
<tr>
<td>De.2 Brief description of measure: Percent of adult patients aged 18 years and older with an Internal Jugular central venous catheter placed in the emergency department (ED) under ultrasound guidance.</td>
</tr>
<tr>
<td>De.3 If included in a composite or paired with another measure, please identify composite or paired measure</td>
</tr>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>De.4 National Priority Partners Priority Area: safety</td>
</tr>
<tr>
<td>De.5 IOM Quality Domain: effectiveness, safety, patient-centered</td>
</tr>
<tr>
<td>De.6 Consumer Care Need: Getting Better</td>
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</tbody>
</table>

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<tr>
<th>CONDITIONS FOR CONSIDERATION BY NQF</th>
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</thead>
<tbody>
<tr>
<td>Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:</td>
</tr>
<tr>
<td>A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed.</td>
</tr>
<tr>
<td>Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.</td>
</tr>
<tr>
<td>A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes</td>
</tr>
<tr>
<td>A.2 Indicate if Proprietary Measure (as defined in measure steward agreement): proprietary measure</td>
</tr>
<tr>
<td>A.3 Measure Steward Agreement attached: txNQFMeasureStewardAgreement_020309_Final[1].pdf</td>
</tr>
</tbody>
</table>

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section

C. The intended use of the measure includes both public reporting and quality improvement.

**Purpose:** public reporting, quality improvement Accreditation, Payment Incentive, Accountability

D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement.

D.1 Testing: No, testing will be completed within 12 months

D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? Yes

(For NQF staff use) Have all conditions for consideration been met?

Staff Notes to Steward (if submission returned):

Staff Notes to Reviewers (issues or questions regarding any criteria):

Staff Reviewer Name(s):

---

**1. IMPORTANCE TO MEASURE AND REPORT**

Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.

1a. High Impact

(for NQF staff use) **Specific NPP goal:**

1a.1 Demonstrated High Impact Aspect of Healthcare: frequently performed procedure, patient/societal consequences of poor quality

1a.2

1a.3 Summary of Evidence of High Impact: Emergency physicians frequently place central venous catheters, an invasive procedure with significant complication rates. Multiple studies have shown that use of ultrasound to guide placement of CVCs increases first-attempt success, overall success and reduces complications. Routine US guidance for placement of CVCs has been recommended by systematic evidence reports—a 2001 Agency for Healthcare Research and Quality Evidence Report rates use of real-time ultrasound guidance during central line insertion to prevent complications among 11 of the most highly rated patient safety practices in terms of strength of the evidence supporting more widespread implementation. Routine US guidance for placement of CVCs has also been deemed cost effective (NHS). The 2008 American College of Emergency Physicians (ACEP) ultrasound guidelines list ultrasonographic guidance for CV access as a "core or primary emergency ultrasound application." The criteria for inclusion as core are widespread use, significant evidence base, uniqueness in diagnosis or decision-making, or importance in primary emergency diagnosis and resuscitation.

As cited in the literature above ultrasound guidance of CVC insertion reduces complications such as reductions in complications. The Third Sonography Outcomes Assessment Program (SOAP-3) Trial. Critical Care Medicine. 33(8):1764-9, 2005 Aug.


### 1b. Opportunity for Improvement

**1b.1 Benefits (improvements in quality) envisioned by use of this measure:** This measure will identify institutions and individual clinicians who are not uniformly using ultrasound guidance and thus opportunity for quality improvement. Hospitals focusing on patient safety have embraced national and international safety guidelines that strongly recommend the use of ultrasound in current venous access; a critical procedure with significant potential complications that was routinely performed “blindly” before the clinical use of ultrasound.

Use of ultrasound during CVC is also an excellent risk reducing tool by decreasing complications from a blind procedure that carries an inherent level of complications. An important step to managing risk is ensuring that physicians are properly trained and credentialed according to national guidelines such as those set by ACEP. Proper quality assurance and improvement programs should be in place to identify and correct substandard practice. Lastly, the standard of care for emergency ultrasound is the performance and interpretation of ultrasound by a credentialed emergency physician within the limits of the clinical scenario.

**1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:**

Recent studies indicate that the use of ultrasound during CVC remains limited and is most strongly associated with the availability of equipment and that current use of ultrasound during CVC is limited and differs from existing evidence-based recommendations.

**1b.3 Citations for data on performance gap:**


**1b.4 Summary of Data on disparities by population group:**

None.

**1b.5 Citations for data on disparities:**

None.

### 1c. Outcome or Evidence to Support Measure Focus

**1c.1 Relationship to Outcomes (For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population):** In 2001, the Agency for Healthcare Research and Quality recommended the use of ultrasound for the placement of central venous catheters (CVCs) as one of their 11 practices to improve patient care. These recommendations were based on the results of several randomized clinical trials showing significantly improved overall success as well as reductions in complications.

**1c.2-3. Type of Evidence:** randomized controlled trial, evidence based guideline

**1c.4 Summary of Evidence (as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome):**

As cited in the literature above ultrasound guidance of CVC insertion reduces complications such as.
Pneumothorax and results in a higher success rate in placement of the CVCs.

Ultrasound guidance has been studied as a useful adjunct to many common ED procedures, including venous access. Studies since the early 1990s have demonstrated the efficacy of ultrasound guidance for central venous cannulation, and recently, a randomized controlled study of 201 patients undergoing central venous cannulation demonstrated a higher success rate with dynamic ultrasound guidance (98% success) when compared with static ultrasound guidance (82%) or landmark-based methods (64%).

1c.5 Rating of strength/quality of evidence (also provide narrative description of the rating and by whom):

Some Class I evidence (Randomized controlled trials (RCTs)) exists for ultrasound-assisted central venous cannulation, but most publications are Class II evidence (data collected prospectively, and retrospective analyses from clearly reliable data). Currently, a Level 1 recommendation for use of clinical sonography may be assigned to ultrasound-assistance of central venous cannulation: “convincingly justifiable based on the available scientific information alone.”

1c.6 Method for rating evidence: 1. Literature review in which emergency ultrasound applications graded in the Fryback-Pearl hierarchical model of effectiveness assessment.

2. Assessment of scientific evidence traditionally presented as classes:
   - Class I Evidence: Randomized controlled trials (RCTs) are the gold standard
   - Class II Evidence:
     A. Data collected prospectively
     B. Retrospective analyses from clearly reliable data
     C. Class III Evidence: Most studies based on retrospectively collected data

3. After completing an assessment of the scientific evidence, the confidence in recommending the use of clinical sonography can be rendered and presented as levels:
   - Level 1: Convincingly justifiable based on the available scientific information alone
   - Level 2: Reasonably justifiable by available scientific evidence and strongly supported by expert opinion
   - Level 3: Supported by available data but adequate scientific evidence is lacking.

1c.7 Summary of Controversy/Contradictory Evidence: No negative data has been published and it is formally recommended by the Agency for Healthcare Research and Quality.


1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number): ACEP Emergency Ultrasound Guidelines. Annals of Emergency Medicine, April 2009 (Vol. 53, Issue 4, Page 551). Includes ultrasound guidance for CVC as one of 11 core or primary emergency ultrasound applications. The criteria for inclusion as core are widespread use, significant evidence base, uniqueness in diagnosis or decisionmaking, or importance in primary emergency diagnosis and resuscitation.

1c.10 Clinical Practice Guideline Citation: Emergency Ultrasound Guidelines. Annals of Emergency Medicine, April 2009 (Vol. 53, Issue 4, Pages 550-570).


1c.12 Rating of strength of recommendation (also provide narrative description of the rating and by whom):

See 1c. 5. above

1c.13 Method for rating strength of recommendation (if different from USPSTF system, also describe rating and how it relates to USPSTF):

See 1c. 6. Above

1c.14 Rationale for using this guideline over others:

Strength of evidence; see 1c. 5. and 1c.6. above

TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for Importance to Measure and Report?

Steering Committee: Was the threshold criterion, Importance to Measure and Report, met? Rationale:

1 Y N

2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)

2a. MEASURE SPECIFICATIONS

S.1 Do you have a web page where current detailed measure specifications can be obtained? S.2 If yes, provide web page URL:

2a. Precisely Specified

2a.1 Numerator Statement (Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome):

Number of adult patients aged 18 years and older who underwent ultrasound guided Internal Jugular central venous catheter insertion in the emergency department (ED).

2a.2 Numerator Time Window (The time period in which cases are eligible for inclusion in the numerator):

None

2a.3 Numerator Details (All information required to collect) calculate the numerator, including all codes, logic, and definitions):

--Procedure codes for central venous catheter and
--CPT E/M Service Codes: 99281, 99282, 99283, 99284, 99285, 99291 and
--Procedure codes for ultrasound guidance

Or

--Chart review evidence of ultrasound guidance

(Recommend new CPT2 or G codes be created)

2a.4 Denominator Statement (Brief, text description of the denominator - target population being measured):

Number of adult patients aged 18 years and older who underwent Internal Jugular central venous catheter insertion in the emergency department (ED).
2a.5 Target population gender: Female, Male
2a.6 Target population age range: 18 and older

2a.7 Denominator Time Window (The time period in which cases are eligible for inclusion in the denominator):
None.

2a.8 Denominator Details (All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions):
--Procedure codes for central venous catheter and
--CPT E/M Service Codes: 99281, 99282, 99283, 99284, 99285, 99291

2a.9 Denominator Exclusions (Brief text description of exclusions from the target population): 1. Patients receiving central lines in other sites (subclavian, femoral) 2. Patients with allergy to US gel 3. Central line placed in code situation (clinician documents that there was no time to perform ultrasound guidance)
4. US machine with high frequency linear probe not available
   --Not at bedside due to time constraint
   --ED does not have access to ultrasound
5. Clinicians not credentialed in ultrasound guided central venous cannulation, or not credentialed in ultrasound guided procedures.

2a.10 Denominator Exclusion Details (All information required to collect exclusions to the denominator, including all codes, logic, and definitions):

2a.11 Stratification Details/Variables (All information required to stratify the measure including the stratification variables, all codes, logic, and definitions):
N/A

2a.12-13 Risk Adjustment Type: no risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method):
N/A

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: count
2a.20 Interpretation of Score: better quality = higher score
2a.21 Calculation Algorithm (Describe the calculation of the measure as a flowchart or series of steps):
N/A

2a.22 Describe the method for discriminating performance (e.g., significance testing):
N/A

2a.23 Sampling (Survey) Methodology If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):
N/A

2a.24 Data Source (Check the source(s) for which the measure is specified and tested)
   paper medical record/flowsheet, Electronic administrative data/claims, Electronic clinical data, electronic Health/Medical Record

2a.25 Data source/data collection instrument (Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.):
   Data will be collected from the medical record. These can be easily recorded either electronically or on paper using institution-specific instruments.

2a.26-28 Data source/data collection instrument reference web page URL or attachment:

Comment (k9): 11 Risk factors that influence outcomes should not be specified as exclusions.
12 Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.
### 2e. Risk Adjustment for Outcomes/ Resource Use Measures

#### 2e.1 Data/sample (description of data/sample and size):
No risk adjustment necessary

#### 2e.2 Analytic Method (type of risk adjustment, analysis, & rationale):
N/A
### 2a.3 Testing Results (risk model performance metrics):

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2a.4 If outcome or resource use measure is not risk adjusted, provide rationale: N/A

#### 2f. Identification of Meaningful Differences in Performance

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#### 2f.1 Data/sample from Testing or Current Use (description of data/sample and size): N/A

#### 2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis & rationale):

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#### 2f.3 Provide Measure Scores from Testing or Current Use (description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance): N/A

#### 2g. Comparability of Multiple Data Sources/Methods

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#### 2g.1 Data/sample (description of data/sample and size): N/A

#### 2g.2 Analytic Method (type of analysis & rationale): N/A

#### 2g.3 Testing Results (e.g., correlation statistics, comparison of rankings): N/A

### 2h. Disparities in Care

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#### 2h.1 If measure is stratified, provide stratified results (scores by stratified categories/cohorts): N/A

#### 2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans: N/A

#### TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for Scientific Acceptability of Measure Properties?

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#### Steering Committee: Overall, to what extent was the criterion, Scientific Acceptability of Measure Properties, met? Rationale:

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### 3. USABILITY

#### Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria) Eval Rating

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### 3a. Meaningful, Understandable, and Useful Information

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#### 3a.1 Current Use: testing not yet completed

3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) (If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years): This measure is not in use.

3a.3 If used in other programs/initiatives (If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years): N/A

---

**Comment [KP18]:** 2f. Data analysis demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful differences in performance.

**Comment [k19]:** 2f. With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74% vs. 75%) is clinically meaningful; or whether a statistically significant difference of $25 in cost for an episode of care (e.g., $5,000 vs. $5,025) is practically meaningful. Measures with overall poor performance may not demonstrate much variability across providers.

**Comment [KP20]:** 2g. If multiple data sources/methods are allowed, there is demonstration they produce comparable results.

**Comment [KP21]:** 2h. If disparities in care have been identified, measure specifications, scoring, and analysis allow for identification of disparities through stratification of results (e.g., by race, ethnicity, socioeconomic status, gender); OR rationale/data justifies why stratification is not necessary or not feasible.

**Comment [KP22]:** 3a. Demonstration that information produced by the measure is meaningful, understandable, and useful to the intended audience(s) for both public reporting (e.g., focus group, cognitive testing) and informing quality improvement (e.g., quality improvement initiatives). An important outcome that may not have an identified improvement strategy still can be useful for informing quality improvement by identifying the need for and stimulating new approaches to improvement.
### 4. FEASIBILITY

Extant to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.  

**Data Generated as a Byproduct of Care Processes**

**Testing of Interpretability**  (Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement)

| 3a.4 Data/sample (description of data/sample and size): | N/A |
| 3a.5 Methods (e.g., focus group, survey, QI project): | N/A |
| 3a.6 Results (qualitative and/or quantitative results and conclusions): | N/A |

#### 3b. Harmonization

If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population): No

**3. Distinctive or Additive Value**

4. FEASIBILITY

#### 4a. Data Generated as a Byproduct of Care Processes

**4a.1-2 How are the data elements that are needed to compute measure scores generated?**

coding/abstraction performed by someone other than person obtaining original information.

**4b. Electronic Sourced**

**4b.1 Are all the data elements available electronically?**  (elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims)

No

**4b.2 If not, specify the near-term path to achieve electronic capture by most providers.**

In EDs where EMR is present data elements will be available electronically, as adoption improves.

<table>
<thead>
<tr>
<th>3b Harmonization</th>
<th>C</th>
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<tbody>
<tr>
<td>If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population):</td>
<td>N/A</td>
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<tr>
<td>3b.2 Are the measure specifications harmonized? If not, why?</td>
<td>NA</td>
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<tr>
<td>3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:</td>
<td>N/A</td>
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<tr>
<td>5.1 Competing Measures: If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), describe why it is a more valid or efficient way to measure quality:</td>
<td>N/A</td>
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**Steering Committee: Overall, to what extent was the criterion, Usability, met?**

**Rationale:**

### Comment [KP23]: 3b. The measure specifications are harmonized with other measures, and are applicable to multiple levels and settings.

### Comment [K24]: 16 Measure harmonization refers to the standardization of specifications for similar measures on the same topic (e.g., influenza immunization of patients in hospitals or nursing homes), or related measures for the same target population (e.g., eye exam and HbA1c for patients with diabetes), or definitions applicable to many measures (e.g., age designation for children) so that they are uniform or compatible, unless differences are dictated by the evidence. The dimensions of harmonization can include numerator, denominator, exclusions, and data source and collection instructions. The extent of harmonization depends on the relationship of the measures, the evidence for the specific measure focus, and differences in data sources.

### Comment [KP25]: 3c. Review of existing endorsed measures and measure sets demonstrates that the measure provides a distinctive or additive value to existing NQF-endorsed measures (e.g., provides a more complete picture of quality for a particular condition or aspect of healthcare).

### Comment [K26]: 5. Demonstration that the measure is superior to competing measures - new submissions and/or endorsed measures (e.g., is a more valid or efficient way to measure).

### Comment [KP27]: 4a. For clinical measures, required data elements are routinely generated concurrent with and as a byproduct of care processes during care delivery. (e.g., BP recorded in the electronic record, not abstracted from the record later by other personnel; patient self-assessment tools, e.g., depression scale; lab values, meds, etc.)

### Comment [KP28]: 4b. The required data elements are available in electronic sources. If the required data are not in existing electronic sources, a credible, near-term path to electronic collection by most providers is specified and clinical data elements are specified for transition to the electronic health record.
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<tr>
<th><strong>4c. Exclusions</strong></th>
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<tbody>
<tr>
<td>4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?</td>
<td>No</td>
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<tr>
<td>4c.2 If yes, provide justification.</td>
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<th><strong>4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences</strong></th>
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<tr>
<td>4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.</td>
<td>None</td>
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<tr>
<th><strong>4e. Data Collection Strategy/Implementation</strong></th>
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<tr>
<td>4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/implementation issues:</td>
<td>Measure has not been tested by ACEP</td>
</tr>
<tr>
<td>4e.2 Costs to implement the measure (costs of data collection, fees associated with proprietary measures):</td>
<td>The cost to implement this measure will depend on the method used to collect data. Personnel time will be needed if paper medical records are to be reviewed in order to determine whether ultrasound was used for internal jugular central venous insertion.</td>
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<tr>
<td>4e.3 Evidence for costs:</td>
<td>Not available</td>
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<td>4e.4 Business case documentation:</td>
<td>Not available</td>
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**TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for Feasibility?**

**Steering Committee: Overall, to what extent was the criterion, Feasibility, met?**

**Rationale:**

**RECOMMENDATION**

(For NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.

**Steering Committee: Do you recommend for endorsement?**

**Comments:**

**CONTACT INFORMATION**

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Co.1 Organization
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Co.2 Point of Contact
## Measure Developer If different from Measure Steward

| Co.3 Organization | American College of Emergency Physicians | 2121 K Street, NW, Suite #325 | Washington | District Of Columbia | 20037 |

## Point of Contact

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## Submitter If different from Measure Steward POC

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## Additional organizations that sponsored/participated in measure development

| Co.6 Name | N/A |

## ADDITIONAL INFORMATION

### Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

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<table>
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<th>Ad.2</th>
<th>If adapted, provide name of original measure:</th>
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<td>Ad.3-5</td>
<td>If adapted, provide original specifications URL or attachment</td>
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<tr>
<td><strong>Date of Submission (MM/DD/YY):</strong></td>
<td>05/07/2010</td>
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DATE: May 10, 2010
TO: NQF Ambulatory Care Steering Committee
FROM: Angela Franklin, Esq.
SUBJECT: ACEP Ambulatory Care Measure ACP-043-10: “Ultrasound guidance for internal jugular central venous catheter placement”

The American College of Emergency Physicians (ACEP) is pleased to submit this revision to its submitted measure, ACP-043-10 "Ultrasound guidance for internal jugular central venous catheter placement". The measure has been amended, per the Steering Committee’s recommendation, to more clearly state in the denominator exclusions that clinicians who are not appropriately credentialed should be excluded from the measure. The change in the denominator exclusion was to restate exclusion # 5 as “Clinicians not credentialed in ultrasound guided central venous cannulation, or not credentialed in ultrasound guided procedures”, as shown below.

2a.9. Denominator Exclusions (Brief text description of exclusions from the target population)
1. Patients receiving central lines in other sites (subclavian, femora)
2. Patients with allergy to US gel
3. Central line placed in code situation (clinician documents that there was not time to perform ultrasound guidance)
4. US machine with high frequency linear probe not available
   --Not at bedside due to time constraint
   --ED does not have access to ultrasound
5. Emergency physicians not credentialed to use US machine for procedural guidance
   Clinicians not credentialed in ultrasound guided central venous cannulation, or not credentialed in ultrasound guided procedures.

ACEP worded the revision in this way because many hospitals have "global" credentialing in ultrasound and thus credential under "procedural guidance" and do not delineate central venous catheter placement, nor to a greater extent, internal jugular central venous catheter placement. Please contact Angela J. Franklin, Director, Quality and Health IT, with any questions at (202) 728-0610 or afranklin@acep.org.