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 subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. 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 subcriterion 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 subcriteria (yellow highlighted areas).

Steering Committee: Complete all pink highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, 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 subcriteria as indicated)

---

**Measure Descriptive Information**

<table>
<thead>
<tr>
<th>De.1 Measure Title:</th>
<th>Median Time to ECG</th>
</tr>
</thead>
<tbody>
<tr>
<td>De.2 Brief description of measure:</td>
<td>Median time from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with probable cardiac chest pain).</td>
</tr>
<tr>
<td>1.1-2 Type of Measure:</td>
<td>Process</td>
</tr>
<tr>
<td>De.3 If included in a composite or paired with another measure, please identify composite or paired measure:</td>
<td>N/A</td>
</tr>
<tr>
<td>De.4 National Priority Partners Priority Area:</td>
<td>Safety</td>
</tr>
<tr>
<td>De.5 IOM Quality Domain:</td>
<td>Timeliness</td>
</tr>
<tr>
<td>De.6 Consumer Care Need:</td>
<td>Getting better</td>
</tr>
</tbody>
</table>

---

**Conditions for Consideration by NQF**

<table>
<thead>
<tr>
<th>Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. 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):</td>
</tr>
<tr>
<td>A.3 Measure Steward Agreement: Government entity and in the public domain - no agreement necessary</td>
</tr>
<tr>
<td>A.4 Measure Steward Agreement attached:</td>
</tr>
<tr>
<td>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</td>
</tr>
</tbody>
</table>

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
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: Yes, fully developed and tested
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):

TAP/Workgroup Reviewer Name:

Steering Committee Reviewer Name:

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, 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: Affects large numbers, Leading cause of morbidity/mortality

1a.2

1a.3 Summary of Evidence of High Impact: Guidelines recommend patients presenting with chest discomfort or symptoms suggestive of ST-segment elevation myocardial infarction (STEMI) have a 12-lead electrocardiogram (ECG) performed within a target of 10 minutes of emergency department arrival (Krumholz, 2008). Evidence supports reperfusion benefits patients with identified STEMI (Antman 2004). The diagnosis and management of STEMI patients is dependent upon practices within the emergency department. Timely ECGs assist in identifying STEMI patients and impact the choice of reperfusion strategy (Peacock, 2007). This measure will identify the median time to ECG for chest pain or AMI patients and potential opportunities for improvement to decrease the median time to ECG.

1a.4 Citations for Evidence of High Impact:


Comment [KP1]: 1a. The measure focus addresses:
   • a specific national health goal/priority identified by NQF's National Priorities Partners; OR
   • a demonstrated high impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use (current and/or future), severity of illness, and patient/societal consequences of poor quality).
1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Guidelines recommend patients presenting with chest discomfort or symptoms suggestive of ST-segment elevation myocardial infarction (STEMI) have a 12-lead electrocardiogram (ECG) performed within a target of 10 minutes of emergency department arrival (Krumholz, 2008). Evidence supports reperfusion benefits patients with identified STEMI (Antman 2004). The diagnosis and management of STEMI patients is dependent upon practices within the emergency department. Timely ECGs assist in identifying STEMI patients and impact the choice of reperfusion strategy (Peacock, 2007). This measure will identify the median time to ECG for chest pain or AMI patients and potential opportunities for improvement to decrease the median time to ECG.

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

Q1 2010 Analysis Provider Level
2583 Providers
Median 9 minutes
Min 0 minutes
Max 540 minutes *capped
5th percentile 30 minutes
10th percentile 22 minutes
25th percentile 14 minutes
75th percentile 5 minutes
90th percentile 2.5 minutes
95th percentile 1 minute

1b.3 Citations for data on performance gap:
2,582 hospitals submitted 41,965 eligible cases. Median patient time was 8 minutes. Median provider time was 9 minutes.

1b.4 Summary of Data on disparities by population group:
N/A

1b.5 Citations for data on Disparities:
N/A

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): Target median times are as close to arrival as possible.

1c.2-3. Type of Evidence: 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):
Guidelines recommend patients presenting with chest discomfort or symptoms suggestive of ST-segment elevation myocardial infarction (STEMI) have a 12-lead electrocardiogram (ECG) performed within a target of 10 minutes of emergency department arrival (Krumholz, 2008). Evidence supports reperfusion benefits patients with identified STEMI (Antman 2004). The diagnosis and management of STEMI patients is dependent upon practices within the emergency department. Timely ECGs assist in identifying STEMI patients and impact the choice of reperfusion strategy (Peacock, 2007). This measure will identify the median time to ECG for chest pain or AMI patients and potential opportunities for improvement to decrease the median time to ECG.

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
1c.11 STEMI. The 12-lead ECG in the ED is at the center of the therapeutic decision pathway because of the strong
ED arrival for all patients with chest discomfort (or anginal equivalent) or other symptoms suggestive of
“..." A 12-lead ECG should be performed and shown to an experienced emergency physician within 10 minutes of

• Peacock WF, Hollander JE, Smalling RW, and Bresler MJ. Reperfusion Strategies in the emergency

Task Force on Performance Measures (Writing Committee to Develop Performance Measures for ST-Elevation
FM, Fihn SD, Foody JM, et al. ACC/AHA 2008 performance measures for adults with ST-elevation and non-ST-

• Peacock WF, Hollander JE, Smaling RW, and Bresler MJ. Reperfusion Strategies in the emergency

1c.12 Rationale for using this guideline over others:
ACC/AHA Strength of Evidence and Meta Analysis

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

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

Rationale:

2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
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):
Continuous Variable Statement:
Time (in minutes) from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with Probable Cardiac Chest Pain)

Included Populations:
• ICD-9-CM Principal or Other Diagnosis Code for AMI as defined in Appendix A1, OP Table 6.1 or an ICD-9-CM Principal or Other Diagnosis Code for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A1, OP Table 6.1a, and
• E/M Code for emergency department encounter as defined in Appendix A1, OP Table 1.0a, and
• Patients receiving an ECG as defined in the Appendix A1, and
• Patients discharged/transferred to a short term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital.

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

2a.3 Numerator Details (All information required to collect/calculate the numerator, including all codes, logic, and definitions):
Patients with:
• An E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0, and
• Patients discharged/transferred to a short term general hospital for inpatient care, or to a Federal healthcare facility, and
• An ICD-9-CM Principal Diagnosis Code for AMI as defined in Appendix A, OP Table 1.1 or an ICD-9-CM Principal or Other Diagnosis Codes for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A, OP Table 1.1a, and
• Patients receiving an ECG as defined in the Data Dictionary

2a.4 Denominator Statement (Brief, text description of the denominator - target population being measured):
Continuous Variable Statement:
Time (in minutes) from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with Probable Cardiac Chest Pain)

2a.5 Target population gender: Female, Male
2a.6 Target population age range: 18 years of age and older

2a.7 Denominator Time Window (The time period in which cases are eligible for inclusion in the denominator):
During the measurement period.

2a.8 Denominator Details (All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions):
Patients with:
• An E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0, and
• Patients discharged/transferred to a short term general hospital for inpatient care, or to a Federal healthcare facility, and

Comment [KP8]: 2a. The measure is well defined and precisely specified so that it can be implemented consistently within and across organizations and allow for comparability. The required data elements are of high quality as defined by NQF’s Health Information Technology Expert Panel (HITEP).
- An ICD-9-CM Principal Diagnosis Code for AMI as defined in Appendix A, OP Table 1.1 or an ICD-9-CM Principal or Other Diagnosis Codes for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A, OP Table 1.1a, and
- Patients receiving an ECG as defined in the Data Dictionary

2a.9 Denominator Exclusions *(Brief text description of exclusions from the target population):*

- Patients less than 18 years of age

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: *Continuous variable*

2a.20 Interpretation of Score: *Better quality = Lower score*

2a.21 Calculation Algorithm *(Describe the calculation of the measure as a flowchart or series of steps):*


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)):*

**Sampling Approaches**

As previously stated in this section, hospitals have the option to sample from their population, or submit their entire population. Hospitals that choose to sample must ensure that the sampled data represent their outpatient population by using either the simple random sampling or systematic random sampling method and that the sampling techniques are applied consistently within a quarter. For example, quarterly samples for a sampling population must use consistent sampling techniques across the quarterly submission period.

- **Simple random sampling** - selecting a sample size \( n \) from a population of size \( N \) in such a way that every case has the same chance of being selected.
- **Systematic random sampling** - selecting every \( k \)th record from a population of size \( N \) in such a way that a sample size of \( n \) is obtained, where \( k = N/n \) rounded to the lower digit. The first sample record (i.e., the starting point) must be randomly selected before taking every \( k \)th record. This is a two-step process:
  a) Randomly select the starting point by choosing a number between one and \( k \) using a table of random numbers or a computer-generated random number; and
  b) Then select every \( k \)th record thereafter until the selection of the sample size is completed.

Each hospital is ultimately responsible that the sampling techniques applied for their hospital adhere to the sampling requirements outlined in this manual. Performance measurement systems are responsible for ensuring that the sampling techniques are applied consistently across their client hospitals.

**Monthly Sampling Guidelines**

It is important to point out that if a hospital elects to use the monthly sampling guidelines, the hospital is still required to meet the minimum quarterly sampling requirements. A hospital may choose to use a larger sample size than is required. Hospitals whose population size is less than the minimum number of cases per 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.
Quarter for the measure set cannot sample (i.e., the entire population of cases must be selected). Given the potential for substantial variation in monthly population sizes, the monthly sample sizes should be based on the known or anticipated quarterly population size. When necessary, appropriate oversampling should be employed to ensure that the hospital meets the minimum quarterly sample size requirements. Refer to Table 3 below for guidelines in determining the number of cases that need to be sampled for each population per month per hospital based on the quarterly population size.

Table 3: Sample Size Guidelines per Month per Hospital

<table>
<thead>
<tr>
<th>Population per Quarter Monthly Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>80 use all cases</td>
</tr>
<tr>
<td>81-100</td>
</tr>
<tr>
<td>101-125</td>
</tr>
<tr>
<td>126-150</td>
</tr>
<tr>
<td>151-175</td>
</tr>
<tr>
<td>176-200</td>
</tr>
<tr>
<td>201-225</td>
</tr>
<tr>
<td>226-250</td>
</tr>
<tr>
<td>251-275</td>
</tr>
<tr>
<td>276-300</td>
</tr>
<tr>
<td>301-325</td>
</tr>
<tr>
<td>326-350</td>
</tr>
<tr>
<td>351-375</td>
</tr>
<tr>
<td>376-406</td>
</tr>
<tr>
<td>401-425</td>
</tr>
<tr>
<td>426-450</td>
</tr>
<tr>
<td>451-500</td>
</tr>
<tr>
<td>501-600</td>
</tr>
<tr>
<td>601-700</td>
</tr>
<tr>
<td>701-800</td>
</tr>
<tr>
<td>801-900</td>
</tr>
<tr>
<td>901-1,000</td>
</tr>
<tr>
<td>1,001-2,000</td>
</tr>
<tr>
<td>2,001-3,000</td>
</tr>
<tr>
<td>3,001-4,000</td>
</tr>
<tr>
<td>4,001-5,000</td>
</tr>
<tr>
<td>5,001-10,000</td>
</tr>
<tr>
<td>10,001-20,000</td>
</tr>
</tbody>
</table>

2a.24 Data Source (Check the source(s) for which the measure is specified and tested)
Paper medical record/flow-sheet, Electronic administrative data/claims, 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.): N/A

2a.26-28 Data source/data collection instrument reference web page URL or attachment: URL
http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244

2a.32-35 Level of Measurement/Analysis (Check the level(s) for which the measure is specified and tested)
Facility/Agency, Population: national

2a.36-37 Care Settings (Check the setting(s) for which the measure is specified and tested)
Hospital, Ambulatory Care: Emergency Dept, Ambulatory Care: Hospital Outpatient

2a.38-41 Clinical Services (Healthcare services being measured, check all that apply)
Clinicians: Nurses, Clinicians: PA/NP/Advanced Practice Nurse, Clinicians: Physicians (MD/DO)
<table>
<thead>
<tr>
<th>2b. Reliability testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2b.1 Data/sample (description of data/sample and size):</td>
</tr>
<tr>
<td>2b.2 Analytic Method (type of reliability &amp; rationale, method for testing):</td>
</tr>
<tr>
<td>2b.3 Testing Results (reliability statistics, assessment of adequacy in the context of norms for the test conducted):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2c. Validity testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2c.1 Data/sample (description of data/sample and size):</td>
</tr>
<tr>
<td>2c.2 Analytic Method (type of validity &amp; rationale, method for testing):</td>
</tr>
<tr>
<td>2c.3 Testing Results (statistical results, assessment of adequacy in the context of norms for the test conducted):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2d. Exclusions Justified</th>
</tr>
</thead>
<tbody>
<tr>
<td>2d.1 Summary of Evidence supporting exclusion(s):</td>
</tr>
<tr>
<td>2d.2 Citations for Evidence:</td>
</tr>
<tr>
<td>2d.3 Data/sample (description of data/sample and size):</td>
</tr>
<tr>
<td>2d.4 Analytic Method (type analysis &amp; rationale):</td>
</tr>
<tr>
<td>2d.5 Testing Results (e.g., frequency, variability, sensitivity analyses):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2e. Risk Adjustment for Outcomes/ Resource Use Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2e.1 Data/sample (description of data/sample and size):</td>
</tr>
<tr>
<td>2e.2 Analytic Method (type of risk adjustment, analysis, &amp; rationale):</td>
</tr>
<tr>
<td>2e.3 Testing Results (risk model performance metrics):</td>
</tr>
<tr>
<td>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2f. Identification of Meaningful Differences in Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2f.1 Data/sample from Testing or Current Use (description of data/sample and size):</td>
</tr>
<tr>
<td>2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis &amp; rationale):</td>
</tr>
</tbody>
</table>
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):

<table>
<thead>
<tr>
<th>Q1 2010 Analysis Provider Level</th>
<th>2583 Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median 9 minutes</td>
<td>Min 0 minutes</td>
</tr>
<tr>
<td>Max 540 minutes *capped</td>
<td>5th percentile 30 minutes</td>
</tr>
<tr>
<td>10th percentile 22 minutes</td>
<td>25th percentile 14 minutes</td>
</tr>
<tr>
<td>75th percentile 5 minutes</td>
<td>90th percentile 2.5 minutes</td>
</tr>
<tr>
<td>95th percentile 1 minute</td>
<td></td>
</tr>
</tbody>
</table>

2g. Comparability of Multiple Data Sources/Methods

| 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

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

<table>
<thead>
<tr>
<th>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Scientific Acceptability of Measure Properties?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steering Committee: Overall, to what extent was the criterion, Scientific Acceptability of Measure Properties, met?</td>
</tr>
<tr>
<td>Rationale:</td>
</tr>
<tr>
<td>2n</td>
</tr>
</tbody>
</table>

3. USABILITY

3a. Meaningful, Understandable, and Useful Information

3a.1 Current Use: In use

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): CMS Hospital Outpatient Quality Data Reporting Program http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244

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)
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/3c. Relation to other NQF-endorsed measures

3b.1 NQF # and Title of similar or related measures:

(for NQF staff use) Notes on similar/related endorsed or submitted measures:

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):
3b.2 Are the measure specifications harmonized? If not, why?

3c. Distinctive or Additive Value
3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:

5.1 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:

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Usability?

Steering Committee: Overall, to what extent was the criterion, Usability, met?
Rationale:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)

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 (E.g., DRG, ICD-9 codes on claims, chart abstraction for quality measure or registry)

4b. Electronic Sources

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)

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

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

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, is a more valid or efficient way to measure).

Comment [KP26]: 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 [KP27]: 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.
### Pending funding, e-specifications will be developed.

#### 4c. Exclusions

4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?
- **No**

4c.2 If yes, provide justification.

#### 4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences

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.
- **N/A**

#### 4e. Data Collection Strategy/Implementation

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:
- Limited abstraction burden.

4e.2 Costs to implement the measure (costs of data collection, fees associated with proprietary measures):
- **N/A**

4e.3 Evidence for costs:
- **N/A**

4e.4 Business case documentation:
- **N/A**

#### TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Feasibility?

- **4**

#### 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.

- **Time-limited endorsement:**

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

- **Comments:**

### CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner)
Co.1 Organization
Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop 53-01-02, Baltimore, Maryland, 21244-1850

Co.2 Point of Contact
Wanda, Govan-Jenkins, MS, MBA, RN, Wanda.Govan-Jenkins@CMS.hhs.gov, 410-786-2699.

Measure Developer if different from Measure Steward
Co.3 Organization
<table>
<thead>
<tr>
<th>Co.4 Point of Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wanda, Govan-Jenkins, MS, MBA, RN, <a href="mailto:Wanda.Govan-Jenkins@CMS.hhs.gov">Wanda.Govan-Jenkins@CMS.hhs.gov</a>, 410-786-2699</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Co.5 Submitter If different from Measure Steward POC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebecca, Jones, MSN, RN, <a href="mailto:rjones@ofmq.com">rjones@ofmq.com</a>, 405-840-2891-342, Oklahoma Foundation for Medical Quality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Co.6 Additional organizations that sponsored/participated in measure development</th>
</tr>
</thead>
</table>

**ADDITIONAL INFORMATION**

Workgroup/Expert Panel involved in measure development

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

N/A

Ad.2 If adapted, provide name of original measure: N/A

Ad.3-5 If adapted, provide original specifications URL or attachment URL

http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.6 Year the measure was first released: 2008

Ad.7 Month and Year of most recent revision: 07, 2010

Ad.8 What is your frequency for review/update of this measure? Bi-annual

Ad.9 When is the next scheduled review/update for this measure? 01, 2011

Ad.10 Copyright statement/disclaimers: N/A

Ad.11 -13 Additional Information web page URL or attachment: URL

http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244

Date of Submission (MM/DD/YY): 12/07/2010
4 Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multi-step process, the step with the greatest effect on the desired outcome should be selected as the focus of measurement. For example, although assessment of immunization status and recommending immunization are necessary steps, they are not sufficient to achieve the desired impact on health status - patients must be vaccinated to achieve immunity. This does not preclude consideration of measures of preventive screening interventions where there is a strong link with desired outcomes (e.g., mammography) or measures for multiple care processes that affect a single outcome.

9 Examples of validity testing include, but are not limited to: determining if measure scores adequately distinguish between providers known to have good or poor quality assessed by another valid method; correlation of measure scores with another valid indicator of quality for the specific topic; ability of measure scores to predict scores on some other related valid measure; content validity for multi-item scales/tests. Face validity is a subjective assessment by experts of whether the measure reflects the quality of care (e.g., whether the proportion of patients with BP < 140/90 is a marker of quality). If face validity is the only validity addressed, it is systematically assessed (e.g., ratings by relevant stakeholders) and the measure is judged to represent quality care for the specific topic and that the measure focus is the most important aspect of quality for the specific topic.

2d. Clinically necessary measure exclusions are identified and must be:
- supported by evidence of sufficient frequency of occurrence so that results are distorted without the exclusion; AND
- a clinically appropriate exception (e.g., contraindication) to eligibility for the measure focus; AND
- precisely defined and specified:
  - if there is substantial variability in exclusions across providers, the measure is specified so that exclusions are computable and the effect on the measure is transparent (i.e., impact clearly delineated, such as number of cases excluded, exclusion rates by type of exclusion);
  - if patient preference (e.g., informed decision-making) is a basis for exclusion, there must be evidence that it strongly impacts performance on the measure and the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately).

2e. For outcome measures and other measures (e.g., resource use) when indicated:
- an evidence-based risk-adjustment strategy (e.g., risk models, risk stratification) is specified and is based on patient clinical factors that influence the measured outcome (but not disparities in care) and are present at start of care; OR rationale/data support no risk adjustment.

13 Risk models should not obscure disparities in care for populations by including factors that are associated with differences/inequalities in care such as race, socioeconomic status, gender (e.g., poorer treatment outcomes of African American men with prostate cancer, inequalities in treatment for CVD risk factors between men and women). It is preferable to stratify measures by race and socioeconomic status rather than adjusting out differences.

14 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% v. 75%) is clinically meaningful; or whether a statistically significant difference of $25 in cost for an episode of care (e.g., $5,000 v. $5,025) is practically meaningful. Measures with overall poor performance may not demonstrate much variability across providers.