National Quality Forum

Comments on Draft Report: National Voluntary Consensus Standards for Ambulatory Care – Additional Outpatient Measures 2010

The Steering Committee reviewed the submitted comments and proposed responses on a conference call on July 8, 2010.

Number	Organization Contact	Measure Number, Title, and Steward	Comment	Response
1	Rebecca Zimmerman, America's Health Insurance Plan (AHIP)	General comments	AHIP appreciates the opportunity to provide comments on the NQF Outpatient Measures. After discussing the proposed measures with our member health plans, we offer the following comments. Several of the proposed measures (e.g., ACP-032-10 and ACP-011-10) assess the same clinical process but have different data sources for reporting data, claims codes vs. use of CPT 2 codes. It would be helpful to better understand the rationale of the measure review panel that resulted in recommending two measures that assess the same clinical process. We continue to urge the NQF to recommend measures that are "best in class." Fourteen out of seventeen measures included in this report are recommended for time-limited endorsement. These measures have not been tested and are not ready to be used for public reporting of quality performance data. It is unclear why so many measures are being recommended for time-limited endorsement. We encourage to NQF to consider a process where measures not be considered for endorsement until adequately tested. NQF should provide a clear rationale as to the need for granting time-limited endorsement for a numerous set of measures prior to testing.	**NQF's response:** The NQF Time-limited Endorsement Policy has been modified as follows: • Limited Use. Time-limited endorsement is only available for use if all of the following conditions are met: o An incumbent measure does not address the specific topic of interest in the proposed measure; o A critical timeline must be met (e.g., legislative mandate); and o The measure is not complex (e.g., composite, requires risk adjustment). • Time Period. The measure steward verifies a timeline and committed resources to conduct testing within 12 months if granted time-limited endorsement. **Steering Committee's response:** The Committee reiterated that each measure met NQF's measure evaluation criteria, with the exception of testing. Pursuant to the endorsement policy, measure stewards have verified timelines and committee resources to conduct testing within 12 months of endorsement date.

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2	Rebecca Zimmerman, America's Health Insurance Plan (AHIP)	General comments	Hospital outpatient departments do not generally collect CPT 2 codes on their claim form. Some of the time-limited measures included below (e.g., ACP-003-10, ACP-002-10, ACP-043-10) include the use of CPT 2 codes to identify clinical processes. The alternative to CPT 2 codes is medical record review. NQF should clarify how hospitals will collect these measures.	**NQF's response:** Data collection methodology should be explicility outlined within each measure's specifications.
3	Janet Leiker	General Comments	Although it may be difficult at this time to collect the data, it would be beneficial to have a measure addressing the connection of the patient back to the primary care physician, or help the patient find one, and include the transmission of complete information from the ED visit to the PCP.	Thank you for your comments.
4	Catherine MacLean, WellPoint	General Comments	WellPoint believes that the measure topic (head CT for children with minor trauma) is particularly important, and looks forward to seeing measures in this area.	Thank you for your comments.
5	Debra Ness, National Partnership for Women & Families	General Comments	The National Partnership for Women & Families appreciates the opportunity to comment on this set of ambulatory care measures. We are very supportive of many of the measures in this set, given that they will provide a broader understanding of	Thank you for your comments.

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			where processes and prescriptions are being overused, and where patient safety is potentially being compromised. That being said, we urge the National Quality Forum and the measure developers to push for the data from these measures to be stratified by race, gender, and ethnicity, so that stakeholders can further identify and address where disparities in care are occurring. In addition, we urge NQF to clarify -- in this report and others -- how certain measures would truly be useful and meaningful to consumers. We understand that process measures have a place in the measurement enterprise, but feel that it would be very helpful to have some of these measures "translated" to convey how their endorsement would affect the way care is provided and experienced.	
6	Nancy Foster, American Hospital Association	General Comments	With this project, the Steering Committee is putting forward for endorsement several measures that are almost identical to existing NQF-endorsed measures. The proposed measures differ only slightly in the dataset that is being used. It is extremely confusing when there are multiple NQF-endorsed measures that are nearly identical. We believe there should be only one measure on each health care structure, process and outcome. We strongly suggest that when multiple measures on the same topic are put forward for endorsement, the NQF should pick a best-in-class measure – or one that could be used	**NQF's response:** The Consensus Standards Approval Committee (CSAC) discussed NQF's best-in-class criteria during their July 14-15, 2010 meeting.

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			most widely – and drop other similar measures. The NQF should convene a committee to develop a formal process for such situations and adopt a policy on this issue following usual and customary member comment and voting.	
7	Rita Munley-Gallagher, American Nurses Association	General comments	The American Nurses Association concurs that demand and capacity issues have contributed to increased patient wait time and decreased clinician productivity, placing patients at risk for poor health outcomes. ANA applauds NQF's efforts to encourage hospitals and clinicians to improve their quality of care through implementation and to empower consumers with appropriate information to make informed decisions about their healthcare. NQF's efforts in that regard are laudable. Finally, the American Nurses Association respectfully requests the revision of the opening sentence in the "Executive Summary" and "Background" to read: Ambulatory health care is the predominant method of providing healthcare services in the United States.	**NQF's response:** NQF changed line # 2 and 3 of the draft report from "Ambulatory medical care is the predominant method of providing healthcare services in the United States" to ANA's suggested text.
8	Rita Munley-Gallagher, American Nurses Association	ACP-002-10: Ultrasound determination of pregnancy location (ACEP)	The American Nurses Association wishes to comment specifically on ACP-002-10: Ultrasound determination of pregnancy location for pregnant patients with abdominal pain. The proposed measure does address a significant cause of morbidity and mortality in first trimester pregnancy. The application of bedside transvaginal ultrasound	**Measure developer's response:** • An Intrauterine pregnancy is determined by ultrasound using well established sonographic criteria. For example an intrauterine pregnancy can be defined as a gestational sac located within the endometrial echo with a yolk sac and/or a

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			with females presenting with abdominal pain that may potentially have an ectopic pregnancy provides a quick method of evaluation. The data presenting the dramatic decrease is ruptured ectopic pregnancy is compelling for this indicator. What is not clearly detailed in the measure specifications is whether (or not) there must be a positive hCG with the presenting pain to warrant a transvaginal ultrasound. The utilization of bedside ultrasound in emergency care has had support as an appropriate non invasive mechanism of evaluation that extends the physical examination of the patient. It allows the clinician to define a path of action for the presenting complaint of the patient without lengthy/costly diagnostic testing, or to recommend further diagnostic evaluation when needed. The exclusionary criteria require additional scrutiny. The American Nurses Association suggests consideration be given to two questions: • By what mechanism will it be determined that a pregnancy is intra-uterine in the first trimester in order to eliminate the potential that the abdominal pain is most likely not caused by ectopic pregnancy? • What specific indicators provide for the classification that ultrasound is not feasible?" The measure proposed is both practical and	fetal pole (+/- FHR) . • ACEP recommends adding additional exclusions, #4 and #5: 1. Women for whom location of pregnancy is already documented or reported as intra-uterine 2. Patient refusal 3. Ultrasound is not feasible (facility reason) 4. US machine not available • Not at bedside due to time constraint • ED does not have access to ultrasound 5. Emergency physicians not credentialed in ultrasound guided procedures **Steering Committee's response:** The Committee noted that credentialing is often difficult to determine; ultrasounds may be performed by clinicians and/or technicians other than emergency physicians; and guided procedure may have a different radiological meaning. The Committee recommended that the developer broaden the definition for those not credentialed in ultrasound beyond emergency physicians. They also suggested that the developer remove all references to guided procedures. The developer modified the specifications as recommended by the Committee.

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			meaningful and does not add risk associated additional evaluation if not needed. The data collection methodology, however, requires further clarification to facilitate implementation.	
9	Nancy Foster, American Hospital Association	ACP-002-10: Ultrasound determination of pregnancy location (ACEP)	The AHA supports this measure as an important area in which opportunity for improvement exists. We note that ACP-002-10 is similar to existing NQF endorsed measure #0502: Pregnancy test for female abdominal pain patients. We would suggest that these measures be implemented together. Thus, we ask the measure steward of ACP-002-10 to harmonize the measure specifications with the currently endorsed measure.	**Measure developer 's response:** ACEP agrees that the measure should be harmonized with NQF # 0502 and is determining the feasiblity. **Steering Committee's response**: The Committee agrees with the recommendation.
10	Robert Pyatt, MD, American College of Radiology	ACP-002-10: Ultrasound determination of pregnancy location (ACEP)	The specifications do not clearly detail how the denominator will pull out patients with lower abdominal pain or vaginal bleeding when using administrative/claims data. How will patients with abdominal pain be identified? Is it patients with abdominal pain, lower abdominal pain or pelvic pain?Only CPT I codes are used in the denominator. Shouldn't ICD9 codes be used in the denominator to clearly identify the population?	**Measure developer 's response:** ACEP has revised the specifications to include the following ICD-9-CM codes for lower abdominal pain and/or vaginal bleeing: specifications: ICD-9-CM 789.0, 789.1, 789.2, 789.3, 789.4, 789.5, 789.6, 789.7, 789.9; ICD-9-CM 623.8. **Steering Committee's response**: The Committee agrees with the recommendation.
11	Catherine MacLean, WellPoint	ACP-002-10: Ultrasound determination of	WellPoint supports this measure.	Thanks for your comment.

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		pregnancy location (ACEP)		
12	Nancy Foster, American Hospital Association	ACP-003-10: Rhogam for Rh negative pregnant women at risk of fetal blood exposure (ACEP)	The AHA supports this measure as an important area in which opportunity for improvement exists. We note that ACP-003-10 is similar to existing NQF endorsed measure #0014: Prenatal anti-D immune globulin. We would suggest that these measures be implemented together. Thus, we ask the measure steward of ACP-003-10 to harmonize the measure specifications with the currently endorsed measure.	**Measure developer 's response:** ACEP is determining the feasibility of harmonizing this measure with endorse measure #0014. **Steering Committee's response**: The Committee agrees with the recommendation.
13	Catherine MacLean, WellPoint	ACP-003-10: Rhogam for Rh negative pregnant women at risk of fetal blood exposure (ACEP)	WellPoint would like to note that patients may receive rhogam in an OB office within 72 hours of fetal blood exposure, which is also appropriate care. Also, WellPoint would ask the measure developer to clarify exclusion #3 - OB/GYN consultation documenting no Rh immunoglobulin. As written, it is unclear what the exclusion means.	**Steering Committee's response**: The Committee concludes that the exclusions are clearly stated; however, they request that the measure developer provide clarification that pregnancy will be confirmed before rhogam is adminsitered. **Measure developer's response:** The developer revised the denominator statement as follows: "All women, confirmed pregnant, who are Rh negative at significant risk of fetal blood exposure…"
14	Wanda Govan-Jenkins, CMS	ACP-003-10: Rhogam for Rh negative pregnant women at risk of fetal blood	The denominator statement included patients who undergo invasive obstetric procedures in the ED. Is this very likely to occur under ED supervision? By what mechanism will it be determined that a	**Measure developer's response:** • An Intrauterine pregnancy is determined by ultrasound using well established sonographic criteria. For example an

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		exposure (ACEP)	pregnancy is intra-uterine in the first trimester in order to eliminate the potential that the abdominal pain is most likely not caused by ectopic pregnancy? • What specific indicators provide for the classification that ultrasound is not feasible?" The measure proposed is both practical and meaningful and does not add risk associated additional evaluation if not needed. The data collection methodology, however, requires further clarification to facilitate implementation.	intrauterine pregnancy can be defined as a gestational sac located within the endometrial echo with a yolk sac and/or a fetal pole (+/- FHR) . • ACEP recommends adding additional exclusions, #4 and #5: 1. Women for whom location of pregnancy is already documented or reported as intra-uterine 2. Patient refusal 3. Ultrasound is not feasible (facility reason) 4. Ultrasound machine not available • Not at bedside due to time constraint • ED does not have access to ultrasound 5. Emergency physicians not credentialed in ultrasound guided procedures. **Steering Committee's response:** The Committee accepts the developer's response.
15	Debra Ness, National Partnership for Women & Families	ACP-009-10: Acute otitis externa (AOE) topical therapy (AMA PCPI)	We understand that this measure would be reported jointly with ACP-011-10. On its own, however, we do not necessarily understand the importance of this measure. The question of whether this measure meets the "clinical importance" test, let alone the "meaningful measure to consumers" test, is unclear.	**NQF's response:** The Committee recommended ACP-009-10 paired with ACP-011-10, not as a standalone measure. The measure was evaluated on its own merits in accordance with NQF's measure evaluatation criteria. **Measure developer's response:** The developer states that topical therapy

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				effectively treats AOE and asserts that the measure improves clinical outcomes. Additionally, there is evidence suggesting that clinicians are underutlizing topic therapy. It is important to examine AOE comprehensively by addressing the under utilization of topical therapy (#ACP-009-10) and the overuse of systemic antimicrobial therapy (#ACP-011-10). The measure developer agreed that pairing these two measures represented appropriate patient care. **Steering Committee's response:** The Committee accepts the developer's response.
16	Catherine MacLean, WellPoint	ACP-009-10: Acute otitis externa (AOE) topical therapy (AMA PCPI)	WellPoint supports this measure.	Thank you for your comment.
17	Debra Ness, National Partnership for Women & Families	ACP-011-10: AOE: Systemic antimicrobial therapy - avoidance of inappropriate use (AMA PCPI)	We think it is very important to have a measure of avoidance of inappropriate use of antibiotics. However, we would be more apt to support measure ACP-032-10, given that it has already gone through the testing process. It does not seem necessary to have two such similar measures endorsed, particularly since the measure developer here has noted that the two measures cannot be	**Steering Committee's response:** The Committee evaluated ACP-011-10 and ACP-032-10 on their own merit and recommended ACP-032-10 as a standalone and ACP-011-10 as a paired measure with ACP-009-10. The paired measures both assess appropriate treatment for acute otitis externa, while ACP-011-10 evaluates inappropriate treatment.

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			harmonized.	
18	Catherine MacLean, WellPoint	ACP-011-10: AOE: Systemic antimicrobial therapy - avoidance of inappropriate use (AMA PCPI)	WellPoint supports this measure.	Thank you for your comment.
19	Debra Ness, National Partnership for Women & Families	ACP-012-10: OME: Antihistamines or decongestants - avoidance of inappropriate use (AMA PCPI)	We are very much in favor of this measure, along with measures ACP-013-10 and ACP-015-10 being reported as a composite, and believe that they will provide important information on overuse that we do not currently have. We would like clarification, however, on how the measure developer plans to weight the three measures in the composite.	**Steering Committee's response:** The Committee recommended measures #ACP-012-10, ACP-013-10, & ACP-015-10 as a grouped measure, with future consideration as a composite measure during maintenance review. **Measure developer's response:** The developer agrees with current pairing of these measures.
20	Catherine MacLean, WellPoint	ACP-012-10: OME: Antihistamines or decongestants - avoidance of inappropriate use (AMA PCPI)	WellPoint supports this measure; however, we believe it would be clearer if the measure required physicians to actively recommend against the use of antihistamines or decongestants.	**Measure developer's response:** This measure was worded consistently with other measures that were submitted related to AOE and OME. **Steering Committee's response:** The Committee reiterated the difficulty in requiring physicians to actively recommend against the use of antihistamines and and decongestants. The widespread availability of these drugs confounds the problem.

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21	Catherine MacLean, WellPoint	ACP-013-10: OME: Systemic corticosteroids - avoidance of inappropriate use (AMA PCPI)	WellPoint supports this measure.	Thank you for your comment.
22	Catherine MacLean, WellPoint	ACP-015-10: OME: Systemic antimicrobials - avoidance of inappropriate use (AMA PCPI)	WellPoint supports this measure.	Thank you for your comment.
23	Catherine MacLean, WellPoint	ACP-016-10: Endoscopy/polyp surveillance: follow-up for normal colonoscopy (AMA PCPI)	WellPoint supports this measure since the literature indicates that this is an area of overuse; however, we have some concern as to whether it will drive improvement. While the measure does encourage physicians to recommend follow-up intervals of at least ten years for normal colonoscopies, it does not address other issues that may reduce overuse (reminder systems or patient health records that track a patient's last colonoscopy and remind patient's of timing for follow-up colonoscopies).	**Measure developer's response:** The comments are appreciated. Indeed, data may be lacking to indicate that provision of appropriate guidance for subsequent screening will independently drive appropriate screening intervals. Never-the-less, this guidance from the endoscopist is required to close the loop of the gastroenterologist/endoscopist's consultative service to both the patient and the referring primary care provider. Tracking systems and subsequent notices to patient for return are primarily employed to avoid excessively long intervals or total loss to follow-up, particularly for patients at increased risk. They haven't been employed to delay potentially premature procedures. Logistics of patient notices in

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				advance of premature procedure scheduling would be problematic. **Steering Committee's response:** The Committee accepts the developer's response.
24	Nancy Foster, American Hospital Association	ACP-016-10: Endoscopy/polyp surveillance: follow-up for normal colonoscopy (AMA PCPI)	The AHA agrees that this measure addresses a topic for which an opportunity for improvement exists. However, we are concerned that this measure does not truly capture whether high-quality, evidence-based, efficient care has been delivered. Just because a patient has documentation of the recommended follow-up interval in his or her chart does not mean that the recommended follow-up interval is actually followed. We believe the science of quality measurement development has evolved to the point where we should no longer be endorsing so-called "check the box" measures that do not capture the processes of care that actually make a difference for patient outcomes.	**Measure developer's response:** We agree that performance and outcome measures demonstrating appropriate screening intervals would provide the strongest evidence of best practice. This is the design employed in measure 11 for shorter intervals in high risk patients. For average risk individuals, there is concern that relying on confirmation of prior pathology and absolute intervals would place an undue burden on the referring and performing physician 10 years or more after the prior exam. During that interval many patients relocate and employ different physicians or delivery systems. Many patients change insurance carriers or migrate to Medicare coverage, yielding greater difficulty with tracking the index procedure at time of follow-up. Pathology results are often missing at late follow-up 10 years later. As noted in response to comment #99, appropriate guidance on follow-up intervals is an

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				expectation of the consultation inherent in the procedure. Thereafter the patient management is primarily guided by the primary care physician. **Steering Committee's response:** The Committee accepts the developer's response.
25	Cleveland Clinic	ACP-016-10: Endoscopy/polyp surveillance: follow-up for normal colonoscopy (AMA PCPI)	Our subject matter experts had some concerns about this measure. This measure is important for proper resource utilization. Colonoscopy is over utilized but it is mostly over utilized in the post polypectomy population, not the screening population. It is established that the majority of individuals who develop CRC are "average risk" i.e., without a personal or family history of IBD, or CRC. However, it is clearly established that obesity, smoking, African American race, male gender, physical inactivity and immunosuppressant can increase the risk of polyps and cancer. Since interval cancers have been shown to occur in up to 5% of individuals after colonoscopy, up to 24% of small neoplasm are missed on colonoscopy and a 10 year interval has never been directly shown in a randomized controlled trial to be the safe interval, there needs to be some allowance for variability in the interval for higher and lower "average risk	**Measure developer's response:** The comment is correct in stating that the numerical majority of CRC occurs in "average risk" individuals, however this is from a much larger denominator and the proportional risk for these patients is far lower than currently defined "high risk" groups. The comment is also correct that some data suggest that risk varies with race, gender, medication use and various personal traits that are not included in current definitions of "high risk" populations. However, to date, all relevant organizations that have assessed the risk stratification criteria have proposed 10 year intervals for "average risk" individuals based on current risk group definitions employing primarily personal and family colorectal neoplasia history. Several of the scenarios identified as needing prompt or earlier colonoscopy are not screening in nature –

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			groups" when the reason for the shorter interval is documented. This should also extend to incomplete colonoscopy. Additionally, individuals who have undergone interval screening tests such as fecal DNA or guiac test which are positive should undergo a colonoscopy to evaluate the results. The GI community believes the observational data supports a longer interval in the majority of average risk individuals. Gastroenterologists are more uniform in following guidelines while other practioners recommend shorter intervals.	including those being performed for abnormal results on other screening exams such as stool guiac or Fecal DNA studies. At that point they are diagnostic studies, just as for abnormal results on a CT or Barium study. Other scenarios, such as incomplete colonoscopy or inadequate preparation are allowed for in the Measure, based on exclusion criteria. We acknowledge the apparent alternate opinion of the local subject matter expert regarding intervals for screening low risk patients, but respectfully note that all published national guidelines provide the uniform guidance employed in this measure, based upon "expert opinion, consensus and observational evidence". Future refinement of risk group definitions may indeed allow tailored guidance, and revised performance measures, at a later date. We look forward to that data and future new consensus. **Steering Committee's response:** The Committee accepts the developer's response.
26	Cleveland Clinic	ACP-016-10: Endoscopy/polyp surveillance: follow-up for normal	(continued) This will provide more consistent recommendations. Often time's patients are concerned about the quality of colonoscopy, missed cancers and some	See response to comment #25.

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		colonoscopy (AMA PCPI)	physicians and patients are concerned over the lack of direct data to support this interval. Perhaps an exclusion recognizing these situations are warranted. Colonoscopy is overused mostly in the postpolypectomy population. However, many observational studies have emerged recently that have shown the development of interval cancers in individuals undergoing recent colonoscopy. Additionally, the 10 year interval for screening colonoscopy has not been studied in a randomized controlled study and is established by expert opinion, consensus and observational evidence. Our subject matter experts disagreed with the recommended interval of 10 years from a normal colonoscopy to the next screening in average risk patients. There is data on adenoma miss rates, which have been reported as 24% overall, and 27% for small adenomas. There is also evidence to support an adenoma-cancer interval of 10 years, therefore if a small adenoma is missed at the initial exam, and the next exam is at 10 years, one might expect a significant rate of interval cancers. One of our subject matter expert's preference was to recommend an interval of 8 years.	
27	Cleveland Clinic	ACP-016-10: Endoscopy/polyp surveillance: follow-up for normal	The quality indicator would be more appropriate to state that there should be at least 7 years between screening colonoscopies in average risk patients after an adequate initial examination. Our subject	**Measure developer's response:** Long interval allows physician to conduct the correct guidance. Current evidence/guidelines suggest 10-year intervals. In certain settings,

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		colonoscopy (AMA PCPI)	matter experts brought up the point that some higher risk people within the "average risk" group might be considered for an interval less than 10 yrs. African American, obese, smokers, and the immunosuppressed. The guidelines have noted that they are at increased risk but came short to recommending them to have a shorter interval than people without those risks. We suspect as the supportive data on obesity and smoking grows, the guidelines will eventually incorporate those risk factors.	colonoscopies should be provided earlier but those cases are no longer considered screening procedures.Exclusions appropriately address commenters concerns. **Steering Committee's response:** The Committee accepts the developer's response.
28	Catherine MacLean, WellPoint	ACP-017-10: Endoscopy/polyp surveillance: colonoscopy for patients with history (AMA PCPI)	WellPoint agrees that the measure topic (appropriate follow-up intervals for colonoscopies) is important; however, we believe that without a template in the EHR, it will be difficult for physicians to systematically capture the necessary information for this measure in a standardized way. For example, the timing of a surveillance colonoscopy depends on the nature and number of polyps found in a previous colonoscopy. Providers would have to judge when the next colonoscopy should occur, leading to subjectivity. For these reasons, we do not support this measure.	**Measure developer's response:** As for low risk patients delineated in measure 10, the performing endoscopist should be responsible for providing appropriate follow-up guidance, based not on subjectivity, but on the findings of his/her procedure, resulting pathology, the patient and family history, and national guidelines. This becomes the basis for the patient, primary provider and subsequent endoscopist to anticipate and plan for the next surveillance interval. The subsequent endoscopist should have access to the prior report and guidance and should adhere to standard guidelines based on the findings. Accountability rests on the index endoscopist who should adhere to guidelines and

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				appropriately provide information that is accessible to subsequent providers. **Steering Committee's response:** The Committee accepts the developer's response.
29	Nancy Foster, American Hospital Association	ACP-017-10: Endoscopy/polyp surveillance: colonoscopy for patients with history (AMA PCPI)	The AHA agrees that this measure addresses a topic for which an opportunity for improvement exists. However, we are concerned that this measure does not truly capture whether high-quality, evidence-based, efficient care has been delivered. Just because a patient has documentation of the recommended follow-up interval in his or her chart does not mean that the recommended follow-up interval is actually followed. We believe the science of quality measurement development has evolved to the point where we should no longer be endorsing so-called "check the box" measures that do not capture the processes of care that actually make a difference for patient outcomes.	**Measure developer's response:** The measure is defined not by documented recommendations, but rather by actual intervals of performance, as proposed in the comment. **Steering Committee's response:** The Committee accepts the developer's response.
30	Catherine MacLean, WellPoint	ACP-018-10: Endoscopy/polyp surveillance: comprehensive colonoscopy documentation (AMA PCPI)	WellPoint believes that this measure will be difficult to capture and difficult to change. As mentioned in comments for ACP-017-10, without a standard template in the EHR, this measure will require subjective interpretations by both physicians and data abstractors. Data abstractors will have to interpret physician notes in the medical record. For	**Measure developer's response:** Pilot benchmarking data from the GIQuIC collaborating sites demonstrates that these data elements are easily recorded and reported in practice and easily recognized and scored during data audits - whether employing dictated and manual reporting of the elements or automated

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			this reason, WellPoint does not support this measure.	endoscopy reports. These data are particularly suited to benchmarking efforts but can also be defined by submitted billing reports, as proposed in the measure. **Steering Committee's response:** The Committee accepts the developer's response.
31	Nancy Foster, American Hospital Association	ACP-018-10: Endoscopy/polyp surveillance: comprehensive colonoscopy documentation (AMA PCPI)	The AHA agrees that this measure addresses a topic for which an opportunity for improvement exists. However, we are concerned that this measure does not truly capture whether high-quality, evidence-based, efficient care has been delivered. Just because a patient has a complete colonoscopy report does not mean that the performance of the colonoscopy was of high quality. However, there is a significant gap in performance on the documentation of colonoscopy reports. This measure may serve as a "checklist" to highlight the importance of thorough documentation, and it may be useful to improve performance in this area. As additional measures that assess the quality of the performance of the colonoscopy and patient outcomes are developed, this measure could be retired.	**Measure developer's response:** We concur with the comment that documentation alone does not ensure quality in technical performance. Never-the-less, the documented gap in documentation, and the importance of optimal documentation for subsequent clinical management, highlight the importance of improving this element of procedural care. We agree with the comment that future performance measures are also needed. **Steering Committee's response:** The Committee accepts the developer's response.
32	Debra Ness, National Partnership for Women & Families	ACP-018-10: Endoscopy/polyp surveillance:	We would like to express our support for this measure. Granted, it is technically a documentation measure and not a direct quality of care measure.	**Measure developer's response:** We agree with the concern that this measure, like other process measures, not devolves to

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		comprehensive colonoscopy documentation (AMA PCPI)	However, we feel that because of poor documentation of colonoscopy procedures, patients' are being subjected to potentially unnecessary repeat colonoscopies, which is a negative experience for the patient as well as a drain on the health care system as a whole. We urge that this measure be specified in such a way so as to make sure that it does not become a "check the box" measure, and retains its integrity as a true outcome-related process measure.	become a thoughtless "check-off" without complete consideration of the findings underlying the elements being documented. Inattention or lackadaisical entries, without correlation to patient and procedure findings, risks significant patient harm. We believe this is unlikely, given the data points specified are integral to describing the planning, performance, and findings of a procedure. **Steering Committee's response:** The Committee accepts the developer's response.
33	Lea Anne Gardner, American College of Physicians	ACP-018-10: Endoscopy/polyp surveillance: comprehensive colonoscopy documentation (AMA PCPI)	the ACP Performance Measurement Technical Advisory Committee feels that the documentation requirement should include recorded colonoscope withdrawl time.	**Measure developer's response:** We appreciate the comment and acknowledge significant discussion on this specific point during measure development. Withdrawal time is actually a proxy for a more useful measure that will hopefully be approved in the future – namely, adenoma detection rate. Published data on the correlation of withdrawal time to adenoma detection generally correlate average withdrawal times for a given endoscopist with the proportion of patients in whom they identify polyps. Additionally, studies of withdrawal time are not uniform and not all studies can correlate withdrawal times with optimal rates for polyp identification. Hence, withdrawal time in an

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				individual patient is not reliable as a quality indicator, yet it generates significant potential for inappropriate interpretation and use in considerations of liability. The developer discussed how the measure will be used and the potential of requiring photographic documentation of the cecum. They conferred with NQF on potential consequences and use of the measures. **Steering Committee's response:** The Committee accepts the developer's response.

Comments on Draft Report: National Voluntary Consensus Standards for Ambulatory Care – Additional Outpatient Measures 2010

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Number	Organization Contact	Measure Number, Title, and Steward	Comment	Response
34	Arjun Sharma, Boston Scientific Corp	ACP-019-10: Troponin for ED patients with AMI or chest pain within 60 min. (CMS)	Comments 1. I am very excited to see ambulatory measures studied. 2. I am disappointed to see that the measures are all still hospital based (ED) 3. The proposals are still process based rather than outcomes based ACP 019-10 Might want to add that early Troponin result contributes to early diagnosis of non-STEMI and therefore will help reduce door to cath lab time.	**Measure developer's response:** Thank you for the comment. As noted in the ACC/AHA 2007 Guidelines for the Management of Patients With Unstable Angina/ Non–ST-Elevation Myocardial Infarction (J Am Coll Cardiol, 2007; 50:1-157), "Patients who present with chest discomfort or other ischemic symptoms should undergo early risk stratification for the risk of cardiovascular events (e.g., death or [re]MI) that focuses on history, including anginal symptoms, physical findings, ECG findings, and biomarkers of cardiac injury, and results should be considered in patient management." **Steering Committee's response:** The Committee accepts the developer's response.
35	Lea Anne Gardner, American College of Physicians	ACP-019-10: Troponin for ED patients with AMI or chest pain within 60 min. (CMS)	the ACP Performance Measurement Technical Advisory Committee is not clear if the measure of 60 mins from arrival is realistic versus 60 mins from the time of the test being done which is a more realistic goal	**Measure developer's response:** Thank you for the comment. While we understand the concern here, it is generally agreed that patients who present to the emergency room with chest pain deserve urgent evaluation for possible myocardial infarction. As noted in the ACC/AHA 2007 Guidelines for the Management of Patients With Unstable Angina/Non–ST-Elevation Myocardial Infarction (J Am Coll Cardiol, 2007; 50:1-157), "Patients

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Number	Organization Contact	Measure Number, Title, and Steward	Comment	Response
				who present with chest discomfort or other ischemic symptoms should undergo early risk stratification for the risk of cardiovascular events (e.g., death or [re]MI) that focuses on history, including anginal symptoms, physical findings, ECG findings, and biomarkers of cardiac injury, and results should be considered in patient management." While there is no specific reference in guidelines to completion of a troponin within 60 minutes of hospital arrival, the measure developer and the NQF committee that evaluated the measure felt that a reasonable metric of timeliness of the test was 60 minutes after presentation with chest pain. The measure evaluates the timeframe from patient arrival to completion of troponin results. Note that the measure is only assessed in those patients for which the clinician makes the decision to draw a troponin blood test. **Steering Committee's response:** The Committee accepts the developer's response.

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Number	Organization Contact	Measure Number, Title, and Steward	Comment	Response
36	Nancy Foster, American Hospital Association	ACP-019-10: Troponin for ED patients with AMI or chest pain within 60 min. (CMS)	The AHA agrees that this measure addresses a topic for which an opportunity for improvement exists. The measure appears to be thoroughly developed and well-specified. However, we are concerned that this measure may not truly capture whether high-quality, evidence-based, efficient care has been delivered. The measure would be improved if it measured whether the appropriate treatment was administered following the timely receipt of test results, rather than simply the timing of when the test results were returned.	**Measure developer's response:** We agree that the provision of appropriate treatment following tests is important. However, this measure is a timing measure targeting a process that may improve the timely provision of care following receipt of test results. There are other measures that capture whether the appropriate care was provided for these patients. **Steering Committee's response:** The Committee accepts the developer's response.
37	Nancy Foster, American Hospital Association	ACP-019-10: Troponin for ED patients with AMI or chest pain within 60 min. (CMS)	This measure would apply only to patients who receive care in an emergency department for heart attack or chest pain and are then discharged or transferred to another acute care hospital. The measure population does not include patients admitted to the original hospital. We appreciate the fact that the measure population aligns with those used for the other heart attack/chest pain emergency department measures that hospitals report on for the Medicare hospital outpatient pay-for-reporting program. This measure would add to the established measures, providing more information to an already fairly robust measure set. The AHA has long advocated for measures to be added in measure sets around a particular condition	**Measure developer's response:** This denominator for this performance measure could be expanded in the future to include patients who are admitted to the hospital following their emergency department evaluation as part of a set of emergency department performance measures or measures that address acute myocardial infarction or chest pain care. The measure was one of a group submitted to the NQF as part of a call for ambulatory care measures and therefore was limited to the current population specified in the measure denominator.

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			or group of patients. Measure sets provide a more complete picture of care and lessen the reporting burden on hospitals because each individual measure adds only a few unique data elements to the sum of information that must be collected by hospitals. However, we are unsure whether this measure is appropriate exclusively for heart attack/chest pain transfer patients. Patients admitted to the hospital for heart attack/chest pain also would benefit from the timely reporting of test results.	We affirm that both ED and critical care codes are included in the denominator encounter coding. **Steering Committee's response:** The timeframe was discussed as a concern for STEMI patients. There was debate about the timing interval and whether the measure should include a median time, actual minutes to troponin test delivery or whether it should remain unchanged to focus on troponin received within 60 minutes. The Committee supported its original decision to assess the timing of results within 60 minutes. The Committee also agreed that the measure should apply to both inpatient and outpatient populations.
38	Nancy Foster, American Hospital Association	ACP-019-10: Troponin for ED patients with AMI or chest pain within 60 min. (CMS)	In addition, it is unclear whether or not those hospitals that are transferring heart attack and chest pain patients, hospitals that are likely to be smaller and have less access to technology, realistically have the capability to perform troponin testing and receive the test results within the measure time frame. We suggest that the measure developer perform extensive testing on this measure in small, rural hospitals.	**Measure developer's response:** We agree that there needs to be additional testing of the measure to evaluate performance in small rural hospitals. We have already discussed the possibility of expanding the denominator population to include chest pain/AMI patients who present to any hospital ED who are discharged or transferred. **Steering Committee's response:**

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				Timeframe is addressed in the response to comment #37. Furthermore, the Committee noted that troponin is fairly prevalent regardless of setting of care (rural v. academic).
39	Catherine MacLean, WellPoint	ACP-019-10: Troponin for ED patients with AMI or chest pain within 60 min. (CMS)	WellPoint supports this measure.	Thank you for your comment.

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40	Nancy Foster, American Hospital Association	ACP-021-10: Head CT scan results for stroke who received CT scan interpretation in 45 min. (CMS)	The AHA agrees that this measure addresses a topic for which an opportunity for improvement exists. The measure appears to be thoroughly developed and well-specified and aligns with national stroke guidelines. However, we are concerned that this measure is the only measure put forward regarding emergency department stroke care. The AHA has long advocated for measures to be added in measure sets around a particular condition or group of patients. Measure sets provide a more complete picture of care and lessen the reporting burden on hospitals because each individual measure adds only a few unique data elements to the sum of information that must be collected by hospitals. We suggest that the measure developer look to the set of stroke care measures previously endorsed by the NQF and harmonize the measure specifications for this measure to those of the previously endorsed measures wherever possible.	**Measure developer's response:** The Joint Commission maintains a set of stroke measures used in the accreditation process, however, they are inpatient measures. Harmonization was achieved with the Joint Commission stroke measures by using the same ICD-9 CM Diagnosis Codes. We recognize, however, that this is the only ED performance measure that specifically addresses the care of stroke patients. **Steering Committee's response:** The Committee accepts the developer's response.
41	Ralph L. Sacco, American Heart Association	ACP-021-10: Head CT scan results for stroke who received CT scan interpretation in 45 min. (CMS)	The AHA would like to support the adoption of ACP-021-10, if the following modifications are made to the measure by the developer. First, the ASA recommends that the measure be modified to include MRI as well as CT. Both the ASA5 and the NIH6 recognize both CT and MRI as a legitimate first-line imaging options in acute stroke	**Measure developer's response:** We agree with the inclusion of MRI as a first-line imaging modality and will include this in the measure specifications. We are not opposed to including "ED arrival" in the name of the measure and to also reflect CT/MRI in the title. The measure specifications do not require a full written

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			patients. Therefore, we would recommend expanding the definition to include MRI. In fact, the ASA, through its campaign Target Stroke, has adopted the use of CT/MRI within 45 minutes as one of the best practices strategies that hospitals should adopt to reduce door to needle times for IV r-TPA in acute ischemic stroke. Second, the ASA recommends that the title and measure time ordering element be changed to the time of "ED arrival." This is what has been documented by providers, has been indicated in the measure description, and is consistent with NIH recommendations. Third, the ASA would note, that while a full, written interpretation is optimal, it may be sometimes impractical in this brief window. Notifying the ED or care team verbally with the key findings should also be acceptable. Therefore, the ASA would recommend that the measure developer consider using the time of posting of the written interpretation in the medical chart or the documented time that the ED or lead clinical provider MD was notified of the key findings, whichever occurs first. With these suggested changes to the measure, we believe that the measure would help to improve the quality of care rendered to stroke patients. In conclusion, we would support the adoption of the	interpretation of the CT/MRI to define the "Head CT scan Interpretation Date and Time" data element. A hospital is able to record the earliest time that interpretation is completed. We allow the hospital to define "interpretation" which may be a verbal report to an ED physician. The measure developer modified the measure specifications as follows: • Added MRI to the measure's numerator statement; and • Revised the measure title to remain consistent with inclusion of MRI. **Steering Committee's response:** The Committee agrees with the recommendation to add MRI as another first-line option for acute stroke patiens.

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			ACP-021-10: Head CT scan results for stroke who received CT scan interpretation in 45 min with the modifications to the measure aforementioned.	
42	David Seidenwurm, MD, American College of Radiology	ACP-021-10: Head CT scan results for stroke who received CT scan interpretation in 45 min. (CMS)	The denominator should include only patients who are admitted and with an ICD9 code for the stroke diagnosis rather than the symptom. That way it is truly limited to "stroke code" patients.	**Measure developer's response:** The denominator for the measure is those patients with a diagnosis of acute ischemic stroke or hemorrhagic stroke. **Steering Committee's response:** SC agrees with the developer's response.
43	Lea Anne Gardner, American College of Physicians	ACP-021-10: Head CT scan results for stroke who received CT scan interpretation in 45 min. (CMS)	the ACP Performance Measurement Technical Advisory Committee is not clear if the measure of 45 mins from arrival is realistic versus 45 mins from the time of the test being done which is a more realistic goal	**Measure developer's response:** Thank you for the comment. The goal is to complete the CT brain within 45 minutes of hospital arrival. This is consistent with the previously published National Institute of Neurological Disorders and Stroke (NINDS) stroke-time targets that specify that the brain CT should be read within 45 minutes of emergency department (ED) arrival in patients who present with symptoms of acute stroke. As per the 2007 AHA/ASA Guidelines for the Early Management of Adults With Ischemic Stroke (Circulation. 2007;115:e478-e534) "For patients who are candidates for treatment with rtPA, the goal is to complete the CT examination within 25 minutes of arrival at the ED, with the study interpreted within an additional 20 minutes

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				(door-to-interpretation time of 45 minutes)." **Steering Committee's response:** The Committee accepts the developer's response.
44	Kay Jewell, Center for Consumers of Healthcare	ACP-021-10: Head CT scan results for stroke who received CT scan interpretation in 45 min. (CMS)	Support - This is consistent with the goals of the Stroke Performance measures and timely diagnosis to allow treatment with tPA and management for ICH.	Thank you for your comment.
45	Nancy Foster, American Hospital Association	ACP-023-10: Median time to pain management for long bone fracture (CMS)	The AHA agrees that this measure addresses a topic for which an opportunity for improvement exists. The measure appears to be thoroughly developed and well-specified. We are concerned that this measure is the only measure put forward regarding pain management in the emergency department setting. The AHA has long advocated for measures to be added in measure sets around a particular condition or group of patients. Measure sets provide a more complete picture of care and lessen the reporting burden on hospitals because each individual measure adds only a few unique data elements to the sum of information that must be collected by hospitals.	**Measure developer's response:** This measure is a part of a set of measures that focus specifically on the timely provision of care in the ED. **Steering Committee's response:** The Committee accepts the developer's response.
46	Catherine MacLean, WellPoint	ACP-023-10: Median time to pain management for long	WellPoint supports this measure.	Thank you for your comment.

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		bone fracture (CMS)		
47	Debra Ness, National Partnership for Women & Families	ACP-032-10: Patient(s) with AOE NOT prescribed systemic antimicrobial therapy (Ingenix, Inc.)	We support this measure of inappropriate use of antimicrobial therapy for AOE.	Thank you for your comment.
48	Rebecca Zimmerman, America's Health Insurance Plan (AHIP)	ACP-032-10: Patient(s) with AOE NOT prescribed systemic antimicrobial therapy (Ingenix, Inc.)	3. ACP-032-10: Patient(s) two years of age and older with acute otitis externa who were NOT prescribed systemic antimicrobial therapy (Ingenix, Inc.) Support; However some patients should be prescribed systemic therapy if topical antimicrobial therapy has not proven to work. The measure developer should explore if an exclusion for these patients is necessary.	**Measure developer's response:** In order to address this concern, the specifications for this measure exclude any episodes of acute otitis externa where there is a preceding instance of otitis externa in the sixty days prior. **Steering Committee's response:** The Committee accepts the developer's response.
49	Catherine MacLean, WellPoint	ACP-032-10: Patient(s) with AOE NOT prescribed systemic antimicrobial therapy (Ingenix, Inc.)	WellPoint supports this measure.	Thank you for your comment.
50	Arjun Sharma, Boston Scientific Corp	ACP-035-10: Patient(s) with an emergency medicine	ACP 035-10 This should be corrected to be "syncope of unknown etiology" rather than syncope.If the cause of syncope is already known	**Measure developer's response:** 1. This measure is based on the American College of Emergency Physicians (ACEP)

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		visit for syncope that had an ECG (Ingenix, Inc.)	then a repeat ECG may not be needed, and will incur unecessary cost.	guidelines. This guideline recommends an ECG for all patients with synocope, even when the history or exam suggests a cause of the syncopal episode. This is because an ECG can occasionally identify potentially lifethreatening conditions such as preexcitation syndrome. 2. There is only one ICD-9 code for syncope. No ICD-9 codes distiguish "synocope" from "syncope of unknown etiology." 3. A CPT II code with modifier can be submitted to exclude patients from the denominator if there is a medical or patient reason to do so. **Steering Committee's response:** The Committee accepts the developer's response.
51	Lea Anne Gardner, American College of Physicians	ACP-035-10: Patient(s) with an emergency medicine visit for syncope that had an ECG (Ingenix, Inc.)	the ACP Performance Measurement Technical Advisory Committee is concerned about this measure and several others that seem to be duplicate measures to previously NQF endorsed measures from the PCPI. Duplicate measures seem to be a waste of resources and should be discouraged and not endorsed.	**Measure developer's response:** This measure significantly differs from the endorsed AMA PCPI measure in that the Ingenix measure, unlike the PCPI measure, does not require CPT II submission for numerator compliance. CPT II code submission remains at less than 5 percent. Since the PCPI measure is dependent on the submission of a CPT II code for numerator compliance, the burden of data collection is high and the measure is not usable. The Ingenix measure uses a robust code set consisting of CPT I and LOINC codes for

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				numerator compliance (that is, to identify patients who had an ECG). Since these codes are submitted during the course of care and billing, the burden of collection is extremely low, results are more accurate due to data completeness, and the measure is usable. **Steering Committee's response:** The Committee accepts the developer's response.
52	Wanda Govan-Jenkins, CMS	ACP-035-10: Patient(s) with an emergency medicine visit for syncope that had an ECG (Ingenix, Inc.)	When this measure was previously analyzed by CMS for ED use in 2007, it was determined that this measure may be topped out and there may not be any room for improvement. Is there any new evidence to support the use of this measure in the ED setting today?	**NQF's response:** The measure steward submitted preliminary testing results, which will be reviewed by the CSAC in August/September 2010. 2007 PQRI data indicate a performance gap of nearly 25%.
53	Rebecca Zimmerman, America's Health Insurance Plan (AHIP)	ACP-035-10: Patient(s) with an emergency medicine visit for syncope that had an ECG (Ingenix, Inc.)	1. ACP-035-10: Patient(s) with an emergency medicine visit for syncope that had an ECG (Ingenix, Inc.) 2. ACP-036: 10: Patient(s) with an emergency medicine visit for non-traumatic chest pain that had an ECG (Ingenix, Inc.) Support. The measures align with medical evidence.	Thank you for your comments.

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54	Nancy Foster, American Hospital Association	ACP-035-10: Patient(s) with an emergency medicine visit for syncope that had an ECG (Ingenix, Inc.)	The AHA supports this measure as an important area in which opportunity for improvement exists. However, the specifications of the measure limit its applicability in the hospital outpatient setting. The measure uses CPT II codes, which are not reported on hospital claims, to identify the numerator and denominator populations. More importantly, the measure is specified around an "emergency medicine event" that is defined as the period of time from one day prior to the emergency medicine encounter through one day after that encounter. The measure considers services provided by physicians and other providers in addition to the hospital emergency department, and thus, the measure cannot be used to compare hospitals. However, as we look toward the future of the health care delivery system, it is likely that providers will become more integrated with the growth of bundled or episodic payment models and accountable care organizations. This measure may be an excellent example of a quality measure for an integrated system. ACP-035-10 is very similar to existing NQF endorsed measure #0093: Electrocardiogram performed for syncope with the exception of the dataset that is used. As we noted in our general comments, it is confusing to have multiple measures that are	**Measure developer's response:** 1. CPT II codes are not used to define the denominator population. Also, CPT II is not exclusively used to define numerator compliance; they are used only if submitted. In most cases, numerator compliance will be satisfied based on the submission of ECG CPT I and LOINC codes, which are included in this measure. ECG CPT I and LOINC codes would be submitted in any outpatient setting. The presence of these codes would satisfy numerator compliance, regardless of any CPT II code submission. 2. This measure addresses compliance at the level of the member/patient. Users of the measure will then have the flexibility to aggregate results by provider, facility, region, or other categories depending on their need and available member detail. 3. The differences and strengths of this measure, compared to the similar AMA PCPI measure, were addressed in an earlier response. **Steering Committee's response:** The Committee accepts with the developer's response.

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			nearly identical, and we strongly suggest that NQF develop a process for performing head-to-head comparisons of similar measures.	
55	Catherine MacLean, WellPoint	ACP-035-10: Patient(s) with an emergency medicine visit for syncope that had an ECG (Ingenix, Inc.)	WellPoint supports this measure.	Thank you for your comment.
56	Nancy Foster, American Hospital Association	ACP-036: 10: Patient(s) with an emergency visit for chest pain that had an ECG (Ingenix, Inc.)	The AHA supports this measure as an important area in which opportunity for improvement exists. However, the specifications of the measure limit its applicability in the hospital outpatient setting. The measure uses CPT II codes, which are not reported on hospital claims, to identify the numerator and denominator populations. More importantly, the measure is specified around an "emergency medicine event" that is defined as the period of time from one day prior to the emergency medicine encounter through one day after that encounter. The measure considers services provided by physicians and other providers in addition to the hospital emergency department, and thus, the measure cannot be used to compare hospitals. However, as we look toward the future of the health care delivery system, it is likely that providers will become more integrated with the	**Measure developer's response:** Please see response to comment #54.

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Number	Organization Contact	Measure Number, Title, and Steward	Comment	Response
			growth of bundled or episodic payment models and accountable care organizations. This measure may be an excellent example of a quality measure for an integrated system. ACP-036-10 is very similar to existing NQF endorsed measure #0090: Electrocardiogram performed for non-traumatic chest pain with the exception of the dataset that is used. As we noted in our general comments, it is confusing to have multiple measures that are nearly identical, and we strongly suggest that NQF develop a process for performing head-to-head comparisons of similar measures.	
57	Lea Anne Gardner, American College of Physicians	ACP-036: 10: Patient(s) with an emergency visit for chest pain that had an ECG (Ingenix, Inc.)	the ACP Performance Measurement Technical Advisory Committee is concerned about this measure and several others that seem to be duplicate measures to previously NQF endorsed measures from the PCPI. Duplicate measures seem to be a waste of resources and should be discouraged and not endorsed.	**Measure developer's response:** This measure significantly differs from the endorsed AMA PCPI measure in that the Ingenix measure, unlike the PCPI measure, does not require CPT II submission for numerator compliance. CPT II code submission remains at less than 5 percent. Since the PCPI measure is dependent on the submission of a CPT II code for numerator compliance, the burden of data collection is high and the measure is not usable. The Ingenix measure uses a robust code set consisting of CPT I and LOINC codes for numerator compliance (that is, to identify patients who had an ECG). Since these codes

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Number	Organization Contact	Measure Number, Title, and Steward	Comment	Response
				are submitted during the course of care and billing, the burden of collection is extremely low, results are more accurate due to data completeness, and the measure is usable. **Steering Committee's response:** The Committee accepts the developer's response.
58	Wanda Govan-Jenkins, CMS	ACP-036: 10: Patient(s) with an emergency visit for chest pain that had an ECG (Ingenix, Inc.)	When this measure was previously analyzed by CMS for ED use in 2007, it was determined that this measure may be topped out and there may not be any room for improvement. Is there any new evidence to support the use of this measure in the ED setting today?	**NQF's response:** The measure steward submitted preliminary testing results, which will be reviewed by the Consensus Standards Approval Committee in August/September 2010. 2007 PQRI data indicate a performance gap of nearly 25%.
59	Catherine MacLean, WellPoint	ACP-036: 10: Patient(s) with an emergency visit for chest pain that had an ECG (Ingenix, Inc.)	WellPoint supports this measure.	Thank you for your comment.
60	Arjun Sharma, Boston Scientific	ACP-036: 10: Patient(s) with an emergency visit for chest pain that had an ECG (Ingenix, Inc.)	ACP 036-10 agree completely	Thank you for your comment.
61	Wanda Govan-Jenkins, CMS	ACP-043-10: Ultrasound guidance for IJ central venous	CMS is recommending this measure to be expanded beyond the emergency department (ED). We recommend the measure to be broadly	**Measure developer's reponse:** ACEP agrees that the measure should apply to all settings, and this is supported by the

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		catheter placement (ACEP)	applicable to all hospital outpatient settings and not limited to just the ED.	literature. **NQF's response:** There are no measures dealing with ultrasound guidance. Moreover, the future, the measure could be applied more broadly. **Steering Committee's response** The Committee suggests that this meausre apply only to the emergency department at present, with feature consideration for utilization in other settings (e.g., infusion clinics).
62	Nancy Foster, American Hospital Association	ACP-043-10: Ultrasound guidance for IJ central venous catheter placement (ACEP)	The AHA agrees that this measure addresses a topic for which an opportunity for improvement exists. However, we are unsure as to whether the gap in performance on this measure is due to providers' underutilization of suggested practices or the unavailability of the technology or trained practitioners in many hospital emergency departments. The measure developer's NQF measure submission form acknowledges that recent studies show that the use of ultrasound during central venous catheter placement is strongly associated with the availability of equipment. We suggest further testing be done on this measure before it is endorsed to determine the proportion of hospitals that could be included in any broad-scale application of this measure.	**Measure developer's reponse:** Though there is clearly both a performance and and access gap in some instances, the data supporting ultrasound guided central access is supported by the AHRQ and is now 10 years old. Measurement is both warrented and prudent. **Steering Committee's response:** The Committee accepts with the developer's response.

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63	Debra Ness, National Partnership for Women & Families	ACP-043-10: Ultrasound guidance for IJ central venous catheter placement (ACEP)	We are very supportive of this measure, given the relationship between central venous catheter placement and patient safety and infection reduction. However, we are concerned by the exclusion policy specified in the measure. We would hope that this measure will spur greater training in the outpatient setting for clinicians to use ultrasound guidance, and by making an exception for those settings where the clinicians are not trained, we worry that this measure may not be as strong. Please clarify if there is a way to strike a balance between not condemning a setting for not having the available equipment and staff, versus allowing settings to avoid having to take on this responsibiity.	**Measure developer's reponse:** ACEP was seeking to balance the specifications with the current state of credentialing; these specifications may be modified in future to stregthen the measure. **Steering Committee's response:** The Committee accepts with the developer's response.
64	Catherine MacLean, WellPoint	ACP-043-10: Ultrasound guidance for IJ central venous catheter placement (ACEP)	WellPoint supports this measure.	Thank you for your comment.
65	Jean Brereton, American Academy of Otolaryngology-Head and Neck Surgery	Not Recommended	ACP-010-10: AOE: Pain assessment The Academy continues to support the measure for endorsement. The measure will have an impact in multiple settings including the emergency department, urgent and outpatient care. Assessment and management of pain is integral to maximizing the health-related quality of life of individuals with AOE.	**Steering Committee's response:** The Committee thanks you for your comments. We re-evaluated these measures (ACP-008-10, ACP-010-10, and ACP-014-10; however, our decisions remain unchanged.

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Number	Organization Contact	Measure Number, Title, and Steward	Comment	Response
			ACP-014-10: OME: Diagnostic Eval.- Assessment of tympanic membrane mobility The Academy continues to support the measure for endorsement. OME is often characterized by a cloudy tympanic membrane with distinctly impaired mobility which can best be determined with pneumatic otoscopy or tympanometry. Correct diagnosis of OME is fundamental to proper management and ultimate clinical resolution. ACP-008-10: OME: Hearing testing The Academy continues to support the measure for endorsement. Children who experience repeated and persistent episodes of OME and associated hearing loss during early childhood may be at a disadvantage for learning speech and language. Hearing tests for patients with severecases of OME would lead to early identification and strategies or interventions to improve developmental outcomes.	