THE NATIONAL QUALITY FORUM

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NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR

AMBULATORY CARE-OUTPATIENT MEASURES 2010

MEETING

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WEDNESDAY

APRIL 7, 2010

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The Steering Committee met in Suite 600 North of the Homer Building, 601 13th Street, NW, Washington, D.C., at 9:00 a.m., John Moorhead and Suzanne Stone-Griffith, Co-Chairs, presiding.

PRESENT:
JOHN MOORHEAD, MD, CO-CHAIR
SUZANNE STONE-GRIFFITH, RN, CNAA, MSN, CO-CHAIR
JAMES ADAMS, MD, MEMBER
EVALINE A ALESSANDRINI, MD, MSCE
TANYA ALTERAS, MPP
ARA CHALIAN, MD, FACS
VICTOR COHEN, BS, PHARMD, BCPS, CGP
BEVERLY COLLINS, MD
JEFFREY COLLINS, MD, MA
ANDREW C. EISENBERG, MD, MHA, FAAFP
EDWARD JAUCH, MD, MS
LEIGH ANN MCCARTNEY, RN, MBA
NATHAN NEWMAN, MD, FAAFP
ROBERT O'CONNOR, MD, MPH
CATHERINE ROBERTS, MD
JOHN SALTZMAN, MD
HEIDI BOSSLEY, NQF STAFF
HELEN BURSTIN, MD, MPH, NQF STAFF
DELL CONYERS, NQF STAFF
ANN HAMMERSMITH, ESQ., NQF STAFF

PRESENT (Cont'd):

ELISA MUNTHALL, NQF STAFF

EMMA NOCHOMOVITZ, NQF STAFF

JESSICA WEBBER, NQF STAFF

C-O-N-T-E-N-T-S

P-R-O-C-E-E-D-I-N-G-S

9:09 a.m.

CO-CHAIR MOORHEAD: Well, good morning. We're ready to go, I think most of us are here.

Thank you to staff for helping us arrange our dinner last night. We had a very nice time. Thank you. That was very helpful. And thanks for everyone who was able to make.

I know there's some people under a little bit of time pressure for flights today. I'm anticipating we'll be done by 3:00. So we're going to do our best.

We're planning on starting with measures 16, 17 and 18. But before we get there, we're going to have a little recap our activities and decisions that we made yesterday. And Elisa is going to do that for us.

MS. MUNTHALI: Good morning, everyone.

Before I go through the recap, I

just wanted to remind you that the meeting is being taped. So whenever you're presenting, please make sure that you speak into the microphone.

And all of those who are coming towards the table, make sure that you're near a microphone so we can pick up all of your comments.

I wanted to first go over the candidate measures that you have recommended for endorsement.

And the first ones are ACP-009-10, and that's the Acute Otitis Externa: Topical Therapy. And the measure steward is AMA, American Medical Association.

You have recommended this for endorsement paired with ACP-011-10 Acute Otitis Externa: Systemic Antimicrobial Therapy - Avoidance of inappropriate use. And the measure steward is also AMA. There's some conditions and questions that you have for the measure steward and we've included them here.

I just wanted to run through the endorsement list and those that you haven't endorsed and those that may be pending.

The next measure that you have recommended as a stand alone measure is ACP-032-10 Patient(s) two years of age and older with acute otitis externa who were NOT prescribed systemic antimicrobial therapy. And the measure steward is Ingenix.

The next measure is ACP-012-10 Otis Media with Effusion: Antihistamines or decongestants - Avoidance of inappropriate use. And the measure steward is AMA. You have recommended this for a time limited endorsement as a paired measure with ACP-013-10 Otitis Media with Effusion: Systemic corticosteroids - Avoidance of inappropriate use. Also the measure steward is AMA.

And the third measure is Otitis Media with Effusion, Systemic antimicrobial - Avoidance of inappropriate use. Also AMA as the measure steward.

You're hoping that this measure after a measure maintenance will be endorsed as a composite measure.

There are a couple of measures that are pending your decision.

The first one is ACP-008-10 Otitis Media with Effusion. You have several questions that you've raised for the measure steward and we've recorded those, and we'll pass them on to AMA.

The second measure that is pending is an Ingenix's measure that is similar to a currently endorsed AMA measure, and that is ACP-035-10 Patient(s) with an emergency visit with syncope that had an ECG.

And the final measure that is pending is also similar to an AMA measure. And you're hoping these two measures, there might be some possibility of harmonizing. You've recognized some differences in coding and we've recorded those as well.

This measure is ACP-036-10

Patient(s) with an emergency visit for non-traumatic chest pain that had an ECG. And the measure steward is Ingenix.

There are three measures that you have not recommended for endorsement.

The first one is ACP-010-10 Acute Otitis Externa: Pain assessment. The measure steward is AMA.

The second measure is ACP-014-10 Otitis Media with Effusion: Diagnostic evaluation - Assessment of tympanic membrane mobility. And the measure steward is AMA.

The third measure is ACP-029-10 Patient(s) treated with an antibiotic for acute sinusitis that received a first line antibiotic. The measure steward is Ingenix.

And the final measure that you have not recommended for endorsement is ACP-030-10 Adult(s) with community-acquired bacterial pneumonia that had a chest x-ray. And Ingenix is the measure steward.

We will probably schedule a call

within the next two weeks to discuss the measures that are not pending from yesterday's discussion, and perhaps there may be some that you bring forward today.

So I'd like to turn it over to Dr. Moorhead.

CO-CHAIR MOORHEAD: And who do we have here to discuss our measures?

PARTICIPANT: I just got an email from some people that are trying to call in. I believe they're on the line, but they can't hear us. They said that they're on hold.

CO-CHAIR MOORHEAD: Does everybody have these forms? They were in a separate email that came in. These three measures were sent on Monday.

The Chair would entertain an emergency measure for technology hook up for the Steering Committee if you've got some language for it.

(Whereupon, off the record at 9:15 a.m. until 9:29 a.m.)

CO-CHAIR MOORHEAD: I think we are ready to go.

DR. PETERSEN: Thank you. I'm Bret Petersen. I'm a gastroenterologist at the Mayo Clinic in Rochester, Minnesota. And a member of the original measure development cohort sponsored by the AMA Physicians Consortium, the AAGA, the Gastroenterological Association and the ASGE, the Endoscopy Society in America.

And we're happy to be here to discuss some measures with you.

Also present are Beth Tapper from the AMA and Debbie Robin from the AGA. And online I think we have Jill Blim, Senior Staff Member at the ASGE and Joe Brill representing the AGA who is also on the development group. And I believe Brian Jacobson of the AGE, who is also on the development group.

So, I understand you've not touched on these measures as of now, beginning yesterday.

So the three measures under consideration deal with appropriate performance and documentation of both screening and surveillance colonoscopy, which of course are primarily outpatient endeavors and hence, in this ambulatory setting, being considered an ambulatory setting. And they're employed primarily to identify and prevent colorectal cancer, the second leading cause of cancer deaths in the country.

We believe that efforts to optimize the quality of endoscopy to improve the coordination of care around endoscopy and to reduce inappropriate use will both enhance health outcomes in the country as well as reduce expenditures.

All of these measures have been approved by the AQA, and measure 2 is currently in the CMS PQRI program.

All three measures are process measures. They're derived from clinical guidelines which are available currently and

have been for several years to guide provider decision making. Hence, they're very, very usable at the most basic clinical level for use by clinicians. They allow for both individual attribution and accountability and enable local and individual QI activities.

They should also be relevant to payers for value-based purchasing and to consumers in the form of transparent report cards.

The measures are designed to rely on clinically enriched administrative data, including paper records, electronic records, a combination of those and additional data from CPT Category 2 codes.

Well, actually, this group of measures addresses aspects of care that are not currently covered by other measures that are available. So they provide entry to value-based purchasing initiatives for practicing endoscopists in multiple different specialties, not just one specialty. So we'll

be happy to address questions as they come up this morning, along with those on line who include both some content experts and some measure development experts.

CO-CHAIR MOORHEAD: Thank you very much.

So our primary reviewer is John with Andrew a secondary.

John?

DR. SALTZMAN: Good morning.

So the first measure that we're going to be looking at is ACP-016-10, which is entitled Endoscopy -- it should be polyp, it says "poly," but it should be polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients.

I should say that the first two measures that we're going to be looking at look at follow-up intervals after a colonoscopy. And the third measure we're looking at is different than the first two,

it's quality indicators. So you can sort of lump the first two together, although they're different populations and issues that they're trying to address.

So the description of this measure is the percentage of patients 50 and older receiving a screening colonoscopy without biopsy or polypectomy that are recommended follow-up in full of at least ten years for repeat colonoscopy documented in their colonoscopy report.

As Bret mentioned, this is a process measure and really the priority area that this addresses is over use and doing too frequent colonoscopies.

The conditions for consideration by the NQF were met and are mentioned there.

In terms of importance to measure and report, Bret already gave the introduction about the importance of colon cancer and colonoscopy is the most common test done, and probably done about eight million patients per

year in the United States. I think the importance is really quite clear, and I gave the 1a a C recommendation.

In terms of opportunity for improvement, all guidelines currently say if you're average risk 50 years and older and have a normal colonoscopy, there should be a ten year interval exam. And there is data that exists in one study of over 3,000 patients said that 49 percent of low risk patients underwent a second colonoscopy within seven years. Actually a median of 3. years, and 35 percent actually had two negative examinations, the mean 3.3 after the prior study. So there definitely is overuse reported and other guidelines have said the compliance with recommendations in current guidelines is only 37 percent. So I think there is clear opportunity for improvement and I gave the 1b a C recommendation.

And then finally in terms of this section, the outcome of evidence to support

the measure. Again, there is good data looking at this and there are multiple recommendations and guidelines now. And the strength of rating of evidence is actually 1a, randomized trials without limitations. So it's really quite strong rating. So I also gave 1c a C and overall recommended to the Steering Committee that this met the threshold and we should proceed.

DR. EISENBERG: I agree completely with all those, but the only mention would be that there's no data on disparities yet. But I suspect that that would be a very important topic to look at with this particular measure in relating to racial and ethnic disparities.

CO-CHAIR MOORHEAD: Jeff?

DR. JEFFREY COLLINS: Sanja Percac-Lima at Mass General has done actually a fair amount of research, and a recently published paper in annuals looking at Latino communities and colonoscopy rates in Boston. So there is some research out there.

DR. SALTZMAN: Well, I think the data is about access to colonoscopy, not necessarily the follow-up interval post-colonoscopy that exists.

All right. So we'll move on to the next section, the scientific acceptability of the measure of properties, measure of specifications.

The numerator statement was patients who had a recommended follow-up interval of ten years for repeat colonoscopy documented in the colonoscopy report. I think this is relatively easy information to get, but it's not necessarily --

DR. BURSTIN: I apologize. I think the phone's working. We may have to dial back in.

(Whereupon, off the record at 9:37 a.m. until 9:39 a.m.)

CO-CHAIR MOORHEAD: Okay. I think we're ready to resume. All right. We will keep moving on.

DR. SALTZMAN: With the measure and specifications the numerator statement was the patients were recommended follow-up until at least ten years for the repeat colonoscopy in their colonoscopy report. I thought this was a pretty clear numerator, although it's not always easily obtained. And I understand that they're trying to get a CPT 2 code.

And the denominator was all patients who received a screening colonoscopy who did not have a biopsy or a polypectomy were 50 and older. And there were two exclusions which I thought were reasonable exclusions.

(1) If somebody is an above average risk patient, so they have a family history, the interval would too long and that would not be appropriate.

And the other, if there was an inadequate prep so that they did not visualize the colon adequately to provide that.

So I thought those were reasonable

indicators. I wasn't quite sure how easy it is to get that information, so I gave that a P rating.

In terms of testing and analysis, reliability testing, validity testing they did not provide specific information that this has been done. I know that there has been some work on this area since these guidelines were set up that preliminarily has shown it's feasible. But I gave both of these an M rating. So that's 2b and 2c M.

In terms of exclusions justified. Now I'm on 2d. You know, supporting the exclusions, I thought that those were reasonable and I gave that a P. Again, my only hesitations about how reliable they identify that.

Risk adjustment for outcomes and resource use. I actually didn't think this applied and gave this an NA.

In terms of identification and meaningful differences in performances, at

least historically looking at the current practices I gave this a P.

Comparability of multiple data sources, I did not know what to do with this one and I gave it an N rating.

And then disparities in health care I didn't think was applicable to this part, although it certainly could be used to investigate it going forward.

So overall for this section I gave a P rating.

DR. EISENBERG: I think the only difference I would have had was with 2g, maybe making that a P because I think there might be, whether it's a paper source or a electronic source or how far along they are in the HRs. But I'm happy with -- I think you had M, right? Either way.

DR. SALTZMAN: Yes. Again, I wasn't sure with that.

DR. EISENBERG: But I think there will be some difficulties, but it's pretty

straightforward information that doesn't require a lot of thought.

DR. PETERSEN: There is a little bit of data that's being generated by the National Colonoscopy Data Repository. This is a pilot study originating in the Tidewater area that is in the process of being generalized to a national benchmarking program for all endoscopists. And in the pilot study after accrual of about 5,000 -- I think 12,000 colonoscopy procedures they assessed one percent of them with a clear audit of patient charts and reporting either manually, which is about 60 percent of procedures, or via automated links from electronic records which was about 40 percent of the procedures.

And they had good evidence that they could document and report appropriately the indications for a procedure and the type of procedure whether it's screening surveillance or therapeutic procedure going in and based on indication.

And more pertinent to measure 3 that the same study had good evidence that both manual capture and subsequent entry manually as well as electronic capture were reliable in transfer of appropriate data. Although in a setting where some data points aren't completely used, in other words downstream there's not a specific use for them, on the electronic entry some of those data points were neglected. In a setting where they are used, their data points are very easily transmitted.

So I think the feasibility is quite evident.

CO-CHAIR MOORHEAD: So moving on to the next section --

DR. CHALIAN: I have a quick question.

Some of these measures actually lend themselves to big public health measures. And my question is, is there a way to turn this measure into one that allows us to

capture whether people have been screened between the age of 50 and 60, especially in light of the fact, you know the Census is going on. Can this be paired in such a way to make this data even more powerful for an organization like the NQF?

DR. SALTZMAN: I mean, I don't know the answer to that question. I think that part of the reasoning behind a NQF like this is because they're doing too much colonoscopy and people have already had it, and then that's potentially excluding people who have not had their initial colonoscopy from being surveyed. So they are tightly linked.

DR. CHALIAN: But if this data was tracked for three years, you would be able to look at Census data and death data and understand whether only 30 percent of the population was screened. And that would really be something that would have a --

DR. PETERSEN: I'm not a measure

expert, but I believe there are other measures not intended for the endoscopy group of practitioners, but more for primary generalists to enhance the levels of screening. I don't know if one of our callers on line can identify which of those they are.

DR. BRILL: This is Joel Brill who is talking.

I agree. There is apparently a preventative services measure in the measure set which looks at colorectal cancer screening and looks at it by all methods currently recommended with a grade of B or higher by the USTFCF. So that includes FOBT, FIT, and flex sig in addition to colonoscopy. And that measure begins at age 50 and goes beyond 60, actually. It goes to age 75. And so it does address the public health issues that you're referring to, namely what is the incident of colon cancer screening by any method in the population.

DR. PETERSEN: Great. Thank you.

DR. BURSTIN: This is Helen Burstin.

And just to follow-up on that, it also makes sense that potentially as you think about these measures living in an EHR, inoperable EHR, you could imagine that the screening measure could be connected to the follow-up interval measure really getting at your point to make it a much more powerful measure. Actually, we can do that with the current data sources. But it's intriguing as you kind of get to the next level.

DR. EISENBERG: Well, the additional problem is access to care and people that aren't --

DR. BURSTIN: OF course, yes.

DR. EISENBERG: I mean, you say you got a huge -- you can't account for that population, it's not even showing up. And then documenting declination of the procedure may be a difficult -- you know, it's offered but declined and how you're going to count

that, whether it gets in too.

DR. BURSTIN: It's not easy. I'm saying it's future doable.

CO-CHAIR MOORHEAD: But is there a mechanism where that can be included in our recommendation?

DR. BURSTIN: Absolutely.

DR. EISENBERG: Because it seemed to me to be very helpful.

DR. BURSTIN: Yes.

DR. EISENBERG: Okay.

DR. BURSTIN: Well, you'll have a chance to put forward a set of recommendations around measure development you think would be important and we'll make sure something like that gets into it.

CO-CHAIR MOORHEAD: Thank you.

DR. SALTZMAN: Okay. In terms of the third section usability in terms of meaningful, understandable useful information, I thought that -- I gave this a P. Evaluation is 3a is a P.

Harmonization, I'm not aware that there is any existing in the measure, so I think that is not applicable. So that's 3b is not applicable.

And 3c is the distinct added value of this to existing. And I thought there was distinct value to this, so I gave that a C.

And overall for this usability section, I would rank it a P.

DR. EISENBERG: The only question I would have as far as harmonization is, is this something that we could look at for both of these two measures?

DR. SALTZMAN: Right. So for the next measure --

DR. EISENBERG: Slightly different populations, but --

DR. SALTZMAN: We can think about whether it's appropriate to merge measure 1 and this measure and the next one.

All right. Then moving on to 4 feasibility. Data generated is a byproduct

here. I thought this was generated, again I wasn't quite sure how easy the data was to get at. But I gave that a P recommendation.

Electronic sources. Bret mentioned about electronic data. I believe somewhere around 40 to 50 percent of endoscopy reports are electronically generated by a structure reporting database that could get this information easily, but which means that 50 or 60 percent are not currently and would have to be manually searched.

Exclusions. I did not think this was applicable. Overall maybe I didn't understand it.

And susceptibility to inaccuracies, I didn't know how to rank that one. So I gave that an N.

Data collection strategies in implementing to a plus. I didn't see any data about that so I gave that an M rating. But I did think overall that the feasibility was a P.

DR. EISENBERG: I came up with the same overall as in 4.

For the exclusions, I thought most of the exclusions we had if you were able to abstract them would be fine and therefore, there wouldn't be any barriers to doing it because you had a large enough population of people that were excluded.

DR. SALTZMAN: Yes.

DR. EISENBERG: So I didn't know how to rate it, it'd be NA or even a C almost because you've already I think defined it very well the population of people who it doesn't apply to.

The susceptibilities of 4d. I was kind of between a P and an M. And my concern was abstracting those written records without the third part of this, whatever, that's 18 that we're going to talk about, the standardization of writing up your report. Until that's implemented, it may be difficult to actually go back and abstract some of that

data.

And all the rest I agreed with. With a final P as well.

CO-CHAIR MOORHEAD: Okay. John?

DR. SALTZMAN: So just to put that altogether, my recommendation is to endorse this. You know, so that is my conclusion in this measure.

CO-CHAIR MOORHEAD: Any comments or question? All right.

DR. SALTZMAN: All right.

CO-CHAIR MOORHEAD: So the recommendation is to endorse. We need a vote.

All those in favor? Opposed? Abstaining? Unanimous.

All right.

DR. SALTZMAN: All right. Number 2, the second one that is somewhere is entitled ACP-017-10: Endoscopy/Polyp Surveillance Colonoscopy interval for patients with a history of Adenomatous polyps- Avoidance of inappropriate use. And the brief

description is percentage of patients age 18 or older receiving a surveillance colonoscopy with a history of prior colon polyp and a previous colonoscopy reports that have followed interval of three years or more since their last colonoscopy documented in their colonoscopy report.

Again, the type of measure, this is a process measure and the priority area is to look at overuse and decrease overuse.

It met the considerations by the NQF, which is why we're talking about it.

So moving on to the importance to the measure report, the 1a the impact on the health care is similar to the last measure. So I gave that a C without further discussion.

In terms of the opportunity, this is a little bit of a different question that is being asked. These are not patients who had a normal colonoscopy. These are patients who had a polyp and the issue is are they coming back at an appropriate interval or are

they coming back too soon. So it's a similar problem.

There's good data now that says both one and three years are similar, so you do not need to go back before three years in most patients. And there is also data showing that this is not universally done by providers and that there is frequent overuse of colonoscopy but more frequent, shorter intervals.

So I gave that 1b a C recommendations.

And then in terms of the type of evidence, again, the data is quite strong here. It's from 1a, randomized trials without limitations. So I also gave that a C. And then I thought it met the overall threshold criteria for the Steering Committee to proceed.

DR. EISENBERG: I agree completely.

DR. SALTZMAN: Okay. So moving on

to the measure specifications.

The numerator statement was patients who had an interval of three or more years since their last colonoscopy. And the denominator statement was age 18 or older receiving a surveillance colonoscopy with a history of prior colon polyp.

There are exclusions to this in that some of the patients will have multiple polyps, meaning ten or more, and should have a sooner colonoscopy. They may not have an adequate prep to removal. They may have taken off the polyps in pieces and need to go back, or they may have an inadequate prep. So there are exclusions that apply to this which I thought were appropriate exclusions.

Overall for this setting 2a, I gave it a P recommendations.

For testing, analysis and validity testing, again I think this is really quite feasible theoretically, but I didn't see data that it had been done. So I gave both of these

sections an M rating and maybe this is related to what Bret was saying in terms of the information that's going on now and we're getting this data. But I didn't see it documented.

The exclusions being justified, I think these there were very reasonable exclusions and I gave that a P. So that's for 2d.

For risk adjustment, I didn't think this applied, so I gave this an NA. That's 2e.

For 2f identification meaningful differences. Perhaps we didn't understand this one, and I gave this one an M rating. I didn't see that there was anything documented there.

Comparability of multiple data sources. I should give this a P rating, similar to the last one.

And disparities in care, again there may be disparities here but I didn't

think that that was related to how this was performed. So I gave that an NA recommendation.

So overall I gave this section a P recommendation.

DR. EISENBERG: Let's see, it was the same overall recommendation. I think where I differed was, let's see, so b and c were both P. But I think you gave Ms to -- a little further down, that's g and h. And I thought -- where is it? Here we are, e was fine as an NA.

But 2f, I think this measure is trying to show differences in performances and improve them.

DR. SALTZMAN: Yes.

DR. EISENBERG: So I think it's very meaningful. I don't know if I'd call it an N because it sounds like we're starting to get some of that data to be able to compare. So I would have raised that higher as probably a P or even a C. Because what it may be

doing, even though we're not there yet.

And agree with the rest.

DR. SALTZMAN: Okay. So any other comments? All right.

So we'll move on to the 3 section, which is usability, meaningful, understandable and useful information. I though this was a P and that this was going to be useful and meaningful information to get.

Harmonization again is NA. There is not a similar measure and competing measures, there is no competing measures. So I thought there was distinct additive value to this.

The only thing that's similar is the one that we just spoke about and I would just say different population with a similar concept. So I gave this a C for 3c. A C recommendation.

So overall I gave a P to this section 3.

DR. EISENBERG: I think I would

have gone for a C recommendation for both, the last d.

And as far as the usability, this seems to be one of the most understandable of things that we've -- you know, it's not an easy of looking at moveability of eardrums, et cetera. You know, it's pretty straightforward: Here's what you have on your biopsy report, this is what you need for your next procedure.

DR. SALTZMAN: Yes.

DR. EISENBERG: So, I mean, I would have called that a C because I think the public can understand that, everybody can look at that and say you either did it or you didn't and it's the right interval.

DR. ALESSANDRINI: Could I ask a quick question? I just want to make sure. The measures reporting -- and I guess the question is, is there a recommendation for how often; when the next colonoscopy should be done or is it just don't do one for at least

three years? Because I think the former would be more useful to clinicians and the public as opposed to the latter.

DR. SALTZMAN: Yes. My understanding is this just addresses the latter, which is the overuse issue and it does not specifically say the right interval is this intervals. And there are a lot of variables that impact and that what is the right interval in terms of polyp size and type and other factors. So I think it gets a little -- you know, it's not clean when you do that.

Bret, I don't know if you could--

DR. PETERSEN: I think that's right. The multiple guidelines for multiple groups, societies are very similar in their recommendations, but they all include lots of exclusion criteria for this type of measure based on clinically relevant numbers, sizes, the endoscopist's interpretation of adequacy of removal, the endoscopist's interpretation

of adequacy of the preparation. So it's very hard to write guidelines that apply to nuanced individual patients. But it's very much easier to write a guideline that says if all of those exclusions aren't present, this shouldn't be done before three years.

Admittedly, there is some concern about patients who should be followed up, perhaps even earlier, who don't get followed up. But in practice we all daily see the much bigger problem of overuse at early dates.

MS. ALTERAS: This isn't incumbent on this measure specifically, or on the last one. I just wanted to make sort of a global comment that I think the next generation measure on overuse should also be paired with some sort of patient experience component or have a component in patient experience so that not only does the doctor not schedule the patient for another endoscopy for another one or three or ten years, but explain to the patient why you don't need this for another

one or three or five years. And this is not about rationing your care. This is really it's because of the evidence. And so you build in that component to really teach the patient what it means to be part of the system.

DR. PETERSEN: Certainly that's a legitimate point. Some overuse or premature performance is physician-based, in fact a fair amount of it. But some of it is patient-based and we're regularly teaching patients why they don't need a procedure as soon as they would like it.

DR. EISENBERG: The other component of that is co-morbidities that might be present. So prescribing three years from now you need something, in the interval you develop something where your life expectancy is markedly shortened, then the utility of performing more screening exams for competing illness is dropped significantly.

So you really wouldn't want to

prescribe something like that up front. It would just be don't do it before three years, and then revisit at that time.

DR. PETERSEN: Yes.

MEMBER PRICE: Great piece by David Leonhardt in The New York Times called "In Medicine, the Power of No." It's really a brilliant piece about overuse and exactly that point about how important it is to get patients to understand the issues of no is actually good for you.

DR. JAUCH: Yes. Yes.

DR. SALTZMAN: Okay. So on the final section is 4 feasibility. The data I thought in terms of 4a was generated as a byproduct, and I gave that a P.

Electronic sources, we've sort of discussed that there are some electronic and some that will be manually entered. I also gave that a P.

Terms of exclusions. Again, I wasn't quite sure what to do with this one. I

gave this an NA.

Susceptibility to inaccuracies 4d, I gave this a P.

And collection strategy I gave it a P.

So overall, I thought feasibility was a P.

DR. EISENBERG: I agree.

DR. SALTZMAN: And then overall for this -- any comments on that? Okay.

So overall for this measure I recommended endorsement of it.

DR. EISENBERG: I concur.

CO-CHAIR MOORHEAD: The motion is to endorse. Those in favor? Opposed? Abstaining? All right. That's unanimous.

DR. SALTZMAN: All right. So the last one of these is a little bit different, and I'll go over that.

This is ACP-018-10: Endoscopy/Polyp Surveillance: Comprehensive colonoscopy documentation. And the brief

description is percentage of final colonoscopy reports for patient age 18 and older that include documentation, all the following:

Preprocedure risk assessment;

Depth of insertion;

Quality of bowel prep;

Complete description of polyps found including location of each polyp size, number and growth morphology, and;

Recommendations for follow-up.

This is a process type of measure that is to improve patient centered care.

It met the conditions for the NQF.

The summary, moving on to the importance of this. The summary, again, was similar to the prior ones so that A 1a.

The opportunities are a little bit more complex in this one than the prior ones. Because this is looking at the quality of exams and how they are reported. And we know that not all reports contain all these measures, and these were the ones that was

said that at a minimum you should include so.

So ASA is the American Society of Anesthesiologists classification of illness on patients and was not completed in 10 percent of reports in a review of over 400,000 endoscopy reports. That physicians do not always report the depth of insertion, which means how far they got with their instrument where they should be getting all the way through to the cecum.

And bowel prep quality, which is very important, is not noted in about 14 percent of preps overall in certain practices, up to 20 percent.

And then when you get to the polyp details, it seems like a lot of details they're asking. It did not seem burdensome to me when I was thinking about this.

Polyp size morphology which does mean is if it has been pedunculated, sessile or flat, which has different implications for future follow-up.

And whether they retrieve the polyp, that's not found in somewhere up to 15 percent of exams.

And then having interval suggested at the end, which is often not done correctly, 39 percent were done correctly.

So I thought it met all criteria and gave that a C.

When we get to the next section, the 1c section, the strength of the evidence does vary depending on which indicator you're looking at. So if you look at high/low risk, the strength is 1c. If you look at depth of insertion, the evidence 1c. If you get to quality of the bowel prep, it's 2c. So overall, I gave that a P. And from this section I recommended that it met the threshold criteria of the importance measure to report.

DR. EISENBERG: I think the only time -- 1b I put as a P because I was a little concerned with there were so many subjective

measures in some of the recommended things, you know as far as good, poor, excellent.

Prep and measurement of how far you are in the colon is a very subjective measure as well. I mean, you can have a scope in a certain amount but depending on how much that's dragging well, how well you got it in there, how redundant it might be. So I put that as a P. But otherwise I agree with everything else.

DR. SALTZMAN: Yes, so I agree with what you just said about the insertion of the scope and the fact that they don't report it at all, which is the issue --

DR. EISENBERG: Correct.

DR. SALTZMAN: -- more whether they're right about it. But the quality of the preps has not been universally utilized.

DR. PETERSEN: Although that's rapidly evolving to a standardization based on recent studies and rather than very arbitrary excellent, good, fair, poor now are using the

borderline quality of skills as good, fair, but adequate to identify all five millimeter or larger polyps. Fair but inadequate to identify all five millimeter or larger polyps and poor. So that's becoming, and especially in the electronic systems, a more standardized procedure.

DR. CHALIAN: Would the recommendation for follow-up change based on the size of the polyps?

DR. PETERSEN: The recommendation is based especially on the sense of adequacy of removal, whether it's removed in one piece or in multiple pieces. And the morphology and the shape of the polyp is a bigger issue than size, and the number of polyps is a bigger issue than size.

DR. CHALIAN: Because perhaps that should be put in there as well, like whether the polyp was completely removed. I'm not aware of -- from my angle.

DR. PETERSEN: That's a fair

statement. It actually becomes slightly more subjective then current how did you remove it. Was it removed in one fell swoop, which usually implies completeness, or was it removed in piecemeal fashion, which is more an exclusionary criteria No. 2 than is present here. So that might have not been adequately addressed.

DR. CHALIAN: Good. Thank you.

DR. SALTZMAN: So we're moving on to --

DR. NEWMAN: It would seem to me that cecal intubation is something that would be essential and might consider adding that. You know, insertion is certainly important you know when it's incomplete, but isn't the key that a cecal intubation and description of what's there?

DR. PETERSEN: Yes. This encompasses documentation of cecal intubation as depth of insertion based on either the description of identifying the valve or the

appendix or use of photography. So that's a component of documentation and noting the depth of insertion, the presumption that 95 or greater percent of all screening exams are cecal are higher.

DR. BURSTIN: This is Helen.

It's a good starting place, obviously, for colonoscopy since there's very few measures that we have. But just getting back to that point. I mean this doesn't actually get at the quality of the colonoscopy performance. It doesn't get at did you achieve cecal intubation, did you do the things. It's simply saying you documented these things on your colonoscopy report.

So I would hope that if nothing else, there should be a set of subsequent measures that get you at the real stuff, which is what is the quality of the colonoscopy and the adequacy of the colonoscopy.

DR. EISENBERG: I think that's a fair comment. You know, Bret mentioned that

95 percent of colonoscopy should be the cecum or more. That may not be true actually in practice through the country. And so trying to raise that standard I think is a fair point, but it's not what it suggests here.

DR. BURSTIN: Or, at least thinking about another -- perhaps a next level measure that's a composite of did you have an adequate prep, did you get to the cecum. I mean, the key quality inference as opposed to just the documentation inference. I just know there's going to be a lot of pushback from the folks externally about the idea of a documentation measure that doesn't actually get at the quality of the procedure.

DR. PETERSEN: Yes. Yes. There was a lot of debate about this point. Should there be cecum intubation rates? Should there be withdrawal times?

DR. BURSTIN: Right.

DR. PETERSEN: And there are a lot of concerns about use of numbers in the

setting of a single procedure when the data that's held up to demonstrate quality is all aggregated data on large populations, especially pertaining to the withdrawal rate, which is a proxy for adenoma detection rate. So when we reach a point where it's easy to quote an adenoma detection rate, that would be the ideal as opposed to these times and distance.

DR. BURSTIN: Yes.

CO-CHAIR MOORHEAD: Ara?

DR. CHALIAN: But in some ways if you describe the visualization and photograph the cecum, you actually have a detection.

DR. PETERSEN: That's right.

DR. CHALIAN: And you have a scope insertion rate there.

DR. PETERSEN: There's right.

DR. CHALIAN: And in fact, you've gotten to the outcome. We want to see the outcome as a visualized cecum. And so it's the secondary calculation that gets you there.

DR. EISENBERG: Yes, but that's not entirely true. Because just getting there is not -- I mean, that tells you that you're at least at the starting point for withdrawal when you're really going to be identifying what you're looking for.

DR. CHALIAN: That is step one, that's right.

DR. EISENBERG: But the benefit of the three of these measures together is then the next step is take them as a composite where you've now got a baseline of documentation rates, et cetera. Then we can move forward and say okay, here's where we're starting from, this is where we want to be. But I don't think we can get there until we take the first step.

DR. CHALIAN: I think that's right.

DR. SALTZMAN: Okay. So moving ahead with Part 2 scientific acceptability. The numerator statement we discussed, these

five different areas to look at: Risk assessment, depth of insertion, quality of bowel prep, complete description of polyps, recommendations for follow-up. I think those are quite clear and the denominator is simple. All colonoscopy reports. So this is a quality measure that doesn't apply to what your indication is. So I gave that a C. So 2a is C.

CO-CHAIR MOORHEAD: Could I just anticipate a question, Eva?

DR. ALESSANDRINI: I don't think so.

CO-CHAIR MOORHEAD: Okay.

DR. SALTZMAN: The reliability and validity testing, again I didn't see data that showed that this had been done, yet I know it is possible but I gave both of these an M because of that.

And exclusion justified. Well, there are not really many denominator exclusions, but the particular top ones, so

that I gave that a P. So that's 2d.

DR. PETERSEN: The National Colonoscopy Data Repository that I referenced earlier does have data specifically speaking towards documentation and submission to benchmarking aggregated systems of cecum landmarks. identified cecum landmarks photographed. So feasibility of documenting and submitting that manually or electronically has been nicely done.

DR. SALTZMAN: Risk adjustment. I thought this was an A.

Identification of meaningful differences and performances. That was 2f, I gave it P.

Comparability and multiple data sources. I gave that a P.

Disparities in care. Again, I didn't think that this was applicable and gave this an NA.

So overall, I gave this section a P.

DR. EISENBERG: And I think the only difference that I had was the 2b and 2c, I put as P. And then having heard your other information on that, probably not a C yet but maybe a little better than I thought.

DR. PETERSEN: Yes, right.

DR. SALTZMAN: Yes, I wasn't aware of that information.

Moving on to 3 usability. I think this is understandable information that's useful. I gave that a P.

Harmonization, again, is not applicable. It's not a similar measure. The value I thought was a C because it's at least a starting point to talk about all these areas that we have been discussing. Overall, I gave this section a P.

DR. EISENBERG: I think I'd give it a C because I'm a little bit more, maybe, optimistic that you could harmonize this with the other ones that we've been talking about. And that it seems like a pretty

straightforward set of criteria for documenting your procedure. I mean, here's a checklist of things. If you put that checklist on, you've done it. Very little subjective. I mean, you may subjectively determine how you did things, but at least documenting it I thought was a little bit more powerful. So I did the whole section as a C instead of a P.

MS. ALTERAS: Okay. Could I ask you a question?

On the question of usability, I think a consumer would say shouldn't a provider be doing this anyway?

DR. SALTZMAN: Right.

MS. ALTERAS: You know, documenting all these things when I get a colonoscopy.

So, I don't know. This is another one of those standard practice questions I have. I just feel like this measure in particular, you know if I saw this on a

website, I'd be a little dumbfounded. Like, what happens when I'm under a colonoscopy. So--

DR. PETERSEN: Well, that's the legitimate point to express. And in the public comment period generated by the AMA's process, that was expressed numerous times. And despite that we know that there's a significant gap in care.

I think the gaps we heard about earlier actually under estimate the gaps. Because some of the literature was based on data that comes out of electronic systems, which is only 40 percent of national practice. So if we look at manual documentation or transcribed dictations, undoubtedly the gap is even greater.

So this is a starting point to go onto the different more specific quality outcomes or quality documentation that will lead to outcomes. And it seems like a no-brainer but like most measures that are based

on guidelines, they're all really standard of care.

DR. BRILL: This is Joel.

I'd like to try to address that question in a slightly different manner as well, in addition to what Bret has just said.

One of the things that one must do sometimes is to go back to the root definition of colonoscopy according to how CPT defines it. And colonoscopy is defined as an examination from the rectum to the cecum.

So I apologize, I don't know the name of the person who just asked that question, but I think that you've raised a correct issue which is that one's expectation as a consumer would be that the physician has performed a complete examination.

Having said that, there are going to be times when because of physical ailments of the patient, for example if the person has had previous surgery, the sigmoid is fixed, other issues prevent intubation of the cecum.

And so that is a question that I'm not sure we can fully address today, which is that if the endoscopist, and recognizing that all colonoscopy is not done by a gastroentrologists. There's a fair amount done by surgeons and family practice internists and the like, that the physician doesn't reach the cecum, you know does that say something from a process standpoint?

DR. BURSTIN: And one more response to tell you. I agree to a certain extent, is also that there are a couple of issues in here that are actually safety issues. So I think from that lens it's something to consider as well. If you don't have a good prep, if they haven't -- those would be the kind of things with me anxious if this rate isn't like through the roof.

MS. ALTERAS: Right. And just from the purchaser hat for a minute, I mean I can also see the issue of having to go back and get it done again and having your paper,

you know, presuming that if there's not the correct documentation.

I'm trying to look at all these measures as if I wasn't on the Steering Committee and if, you know, I'm just reading the report like when the public comment period starts and think what would my initial reaction to this be.

DR. BURSTIN: My question exactly, because I know that's the exact comment we will get. Because this is a documentation level measure that doesn't address the quality of the procedure. How well the procedure was done or the outcome of the procedure.

So, just get it on the table. Always good to have the discussion before.

CO-CHAIR STONE-GRIFFITH: And additionally the burden of capturing this data. I mean, we talked a little bit about that yesterday. But to your point, 60 percent are transcribed or manually documented. So you're going to have to extract all this.

DR. PETERSEN: Well, it's intended to be submitted by the physicians. So abstraction would be in an audit situation rather than in the large population of procedures, I would think.

DR. BRILL: This is Joel.

I'll also comment that some of the commenters to this made mention of having further documentation or some other sort of process to confirm an external audit perspective.

Putting my rock hat on. There is no payment for photo documentation that accrues to either the physician or the facility where the procedure is performed.

So it's neither here nor there from the insurance perspective, but it is a question that has been raised.

DR. JACOBSON: This is Brian Jacobson.

I think if I may, so just to add one more thing or maybe a reiteration. But

while we recognize this is very much a documentation type measure, we see this as very important in terms of care coordination and getting very important information both to the referring physician whether it's a prime care physician or someone else, as well as communication with future gastroenterologists or endoscopists that will see the patient. So it is documentation, but it completes a picture so that proper care decisions can be made in the realm of care coordination. And without it, there's just this vacuum of knowledge that prevents proper decision making as far as appropriate follow-up.

CO-CHAIR MOORHEAD: Thank you.

John?

DR. SALTZMAN: Okay. So moving on to section 4, which is feasibility. The data generated is a byproduct of care. I thought this was a P 4a.

Electronic sources we've just talked about over again, as I also gave 4b a

P.

Exclusions. Again, I was a little unclear about how to handle this question. But I think overall it was reasonable and gave this a P.

Susceptibilities, inaccuracies, errors on intended consequences, 4d. I thought this was a P.

4e, data collection. It's a P.

So overall I thought this was a P across the board, actually.

DR. EISENBERG: I agree.

DR. SALTZMAN: Okay. Agreed. So overall I do recommend that the Committee endorse this measure.

CO-CHAIR MOORHEAD: The motion is to recommend. All in favor? Opposed? Abstaining?

Jeff, are you opposed or abstaining?

DR. JEFFREY COLLINS: Opposed.

DR. ROBERTS: No. No. No.

DR. BURSTIN: You were a yes.

DR. ROBERTS: I was a yes. I thought we were redoing the yeses. I was confused.

CO-CHAIR MOORHEAD: Okay. Thank you.

I think we have some people calling in for the next group. I hear some people calling in.

MS. MUNTHALI: Yes, just actually Bill reminded me of one more thing.

CO-CHAIR MOORHEAD: Oh, we wanted to go back there.

MS. MUNTHALI: We potentially talked about 16 and 17 --

CO-CHAIR MOORHEAD: Yes.

MS. MUNTHALI: This may be something you'd want to stick together or combine in some way.

DR. SALTZMAN: My issue with it, an Andrew and I spoke about this before we started about physically combining the first

two measures, this is a different denominator, it's a different reason. One who is purely screening and you're trying to decide what to do, and the other that had polyps. And can those be combined or is it any better off staying as separate measures?

DR. EISENBERG: Yes. I think what we talked about earlier makes more sense. If we get these measures going ahead, and then fold them all into one composite, then you could start addressing the quality issue, which is what we're concerned with.

CO-CHAIR MOORHEAD: So we'll recommend a lead on this, okay. All right.

So we're moving on the next group, the Emergency Department Measures number 2.

Would you introduce yourself, please.

DR. BRATZLER: Which measure are you to? I want to make sure we're to the right.

CO-CHAIR MOORHEAD: Well, we're in

the grouping emergency department measures. Two, 3, 19 --

DR. BRATZLER: Right. Okay. So I'm not here representing 2 or 3. I'm not here for ACP.

DR. BURSTIN: Angela, are you on the line? Is everybody else from ACP on the line?

CO-CHAIR MOORHEAD: As of my understanding yesterday, is they were calling in at 10:45.

DR. BURSTIN: It's a little bit early. So perhaps we can just proceed and go back to them.

CO-CHAIR MOORHEAD: You're in here for No. 19?

DR. BRATZLER: Yes. For 19, 20, 21, 22, 23 and 24 and 25.

CO-CHAIR MOORHEAD: Okay. So if we can begin with 19, then when our folks join us on the phone, if we could break to accommodate them.

DR. BURSTIN: Yes. Or we could just ask them to do an opening if you'd like about the set of measures and the logic of putting them forward.

CO-CHAIR MOORHEAD: Yes.

DR. BRATZLER: Right. So good morning. My name is Dale Bratzler. I'm with the Oklahoma Foundation for Medical Quality. And I'm here today representing the Optium Solutions Group that is submitting a set of emergency department measures that were developed under contract to the Centers for Medicare and Medicaid Services.

I was looking back in my notes this morning. This work actually goes back all the way to 2007. We had a technical expert panel, some of you who are representatives here in the room participated in that meeting on April 3, 2007. We had 26 representatives of a variety of emergency departments, specialties and other groups including groups like the American Hospital

Association that came together.

We reviewed at that time a set of 13 candidate emergency department performance measures. NQF has previously endorsed three of the measures that focused on total throughput time. NQF has already endorsed a set of measures that have been rolled out in the ambulatory setting looking at total throughput time from arrival to departure of the emergency department. Measures that were felt to be very useful to consumers.

The set of measures today continue to focus on the entire issue of emergency department throughput, for the most part, looking at time to lab, time to x-rays, time to CT. And I think the rationale that supported these measures was that these are the bottlenecks that often result in delays and patients moving through emergency department care.

So while the first set of measures that are already endorsed by NQF kind of

provide the consumer focus of how long it takes from the time you hit the door until you get out, the measures that are being reviewed today largely focus on the internal processes of care within the emergency department that cause part of the bottlenecks that occur in moving patients through the emergency department. So they're very useful for improvement and other things.

So most of the measures that you'll be discussing focus on time to lab tests. So, quite frankly, when the technical panel met, they picked common tests that were done on emergency department patients. So things like CBCs or electrolyte panels, chest x-rays on patients who come in, or head CT, you know how quickly the results are available to the treating emergency department physician. Because those often result in the delays.

There's also a measure on time to pain management. Specifically we limited the

denominator to a group of patients who have long bone fractures as a principal diagnoses. We did that very specifically to make sure that we were addressing patients that almost always would require pain management, but not necessarily to include the multi-trauma patients and others that might have questionable indications for pain management. You know, if you had a head trauma patient, here we're focusing on principal diagnoses of long bone fractures.

And then finally the performance measure on leaving the emergency department prior to being seen. An important measure again that often reflects the length of time for throughput through emergency department care.

So I'll be happy to answer any questions as you go through the conversation today.

The measures were developed, at the time they have been tested in a very

limited way through focused review of medical records, but also we know that some of these measures have been tested by other groups, perhaps by some in the room. And many of these measures can be collected from electronic data sources when those electronic data sources are available in emergency departments.

I know in our preliminary review of a number of emergency room records, particularly around our state, many of the emergency rooms capturing some of this data is challenging because you have to go to radiology logs and other places to find the data. But there are emergency departments that have fairly good electronic systems and ultimately that would be the goal that these would be measures captured from electronic systems.

CO-CHAIR MOORHEAD: Okay. We'll begin with No. 19, and Victor, I think you have the primary and then Suzanne.

DR. COHEN: This measure I was assigned to review is ACP-019-10. This measure reports the median time to troponin order to time. Troponin results are reported to the emergency department staff.

This is a process of care measure and an NPP area of safety. I would think this is more quality, that's one thing I was wondering: Safety versus quality. This seemed to be a more quality issue than safety. That was just one comment I wanted to make.

In terms of meeting the four criteria that's required for conditions for consideration, it does meet all four criteria. So that was met.

In terms of as for importance. The measure addresses importance to measure and report for all criteria -- well, I said that already.

This is a time limited endorsement. The testing will be completed within 12 months. I guess testing has not been

done.

In terms of 1a the measure does address a national goal identified by NQF NPP. It represents an important quality issue of reduced turnaround time of lab data that can influence all areas of quality of care in overcrowded EDs.

This is a high impact issue. Chest pain and ACS are common presentations and diagnoses in ED data. However, data on specific troponin tests to reduce cost, improve time to outcome improvement is cited, but it's not described in the description in the specs. There is data saying that troponin tests would reduce costs and improve time to outcome -- well, outcome improvement. So I believe that was a good criteria that was met.

This measure provides an opportunity for improvement as it provides reduced length of stay in overcrowded EDs, improved efficiency and improved throughput.

Delay can hinder timely

interventions, and that's another reason for this measure.

Disparities are vaguely described, so therefore I gave a partially met at this point. They don't really describe where there are disparities in terms of racial or ethnic differences.

Racial disparities were noted. Blacks have longer length of stay than whites, but no specificity to troponin values as the cause were indicated. It's a general statement that there are racial disparities in terms of care, but not specific to this specific laboratory value.

The measure is an intermediate outcome of process of care, it's relationship to outcome that shorter turnaround times results in shorter lengths of stays and more efficient care. This is based on a cohort and observational studies. It's again, not specifically to troponin alone. It's generally speaking that if you reduce overall lab

results, lab time to obtaining, you'll reduce overall length of stay.

The strength of evidence is level B at this point, which is pretty decent.

There was controversy and contradictory evidence, concern over less testing to avoid the measurement. That may occur. I don't think this is likely simply because this is an important value to obtain to confirm an ACS, you know a Q-wave or confirm the myocardial infarction. I did write partially meets the criteria in this respect.

Data not found to tie troponin to the outcome of improvement, the stay in the ED.

Furthermore, my institution, I know we board patients. These patients, irrespective of their troponin value, they're going to stay in the ED for a longer length of time.

Furthermore, the nonemergent

patients this may have an impact to them. But again, if the beds are not available still their throughput time will be still delayed despite this turnaround time of the lab data.

Furthermore, the emergent patients usually will go right to the cath lab immediately without the troponin value coming. So basically, again, it wouldn't matter much initially.

Although this measure, though, I felt meets the importance criteria at this point from looking at 1a, b, c overall. That it is a good thing to measure, at least it demonstrates efficiency and it is important to have an efficient process of care.

CO-CHAIR MOORHEAD: Suzanne?

CO-CHAIR STONE-GRIFFITH: Yes. I agreed with the primary reviewer.

I'm a little conflicted on this because I see while the lab tests are very important in overall length of stay, that it seems like an intermediate measure. It seems

like something that would be better served in a quality improvement effort as opposed to something that we necessarily need to have publicly reported.

I agree with you that there's a lot of other factors that might impact crowding, and a lot of the crowding data really speaks to hospital throughput --

DR. COHEN: System.

CO-CHAIR STONE-GRIFFITH: -- averages of system, as opposed to specific lab or radiology tests.

So while I agree with it being important, I'm a little conflicted in terms of whether it is something we would want to put out there in the public space for reporting.

CO-CHAIR MOORHEAD: I think this is probably worth a little discussion. Jim?

DR. ADAMS: So I think everybody would agree that these submetrics and the whole collection of the submetrics are essential components for not only the

throughput of the emergency department, but we've all seen cases where individual patients have been harmed because of just an incremental delay. So it's important to individual care, but it's also important to the overall throughout. The question is: Is it connected enough that we really think that this is national reporting?

And I think certainly in 2007 you absolutely did. And I do think that these have to be benchmarked across emergency departments and emergency departments have to have pressure to optimize in these regards. The question is where does that pressure need to reside and should it reside at NQF? And I think that on some of the measures I'm going to feel yes and on some I feel no. So just an aggregate.

The troponin, what we're really trying to get at is to timeliness of diagnoses of acute MIs. Because only 50 percent ischemic events will show up on an EKG. And

the definition of an acute MI is really EKG criteria plus troponin, plus patient symptoms. So we're trying to get to how fast are we diagnosing heart attacks, and that's the metric. This submetric is this the way to go or should we have it in a different form?

CO-CHAIR MOORHEAD: Other thoughts on this?

MS. ALTERAS: On public reporting of these types of measures, you know we always say that consumers don't necessarily look at hospital reporting unless they're pregnant or need hip replacement. So, you know, if you're having a heart attack, you're probably not going to look on Hospital Compare. But, you know, at the same time I guess I feel like for accountability purposes and for hospitals to look at the data and act on it, you know for that purpose I think public reporting of this type of measure is useful.

CO-CHAIR MOORHEAD: Anyone else? Ed?

DR. JAUCH: I'm just leery that troponin by itself is going to be any indicator whatsoever of the quality of care that was delivered at a particular institution or for a particular patient. There might be a lot of better measures than troponin itself, or time to.

CO-CHAIR MOORHEAD: Anyone else?

DR. COHEN: I would just say I agree with comments that have been made. I wish the rationale for doing this had been to more quickly diagnose acute MIs. I think timeliness to throughput, to me, doesn't have face value. It just doesn't feel like it's such an intermediate step, it doesn't really hold. And so I'm going to probably vote a little differently on each of these measures as well.

But I think your rationale is the one that I would have liked to have seem for this measure, and I think is worth noting.

CO-CHAIR MOORHEAD: Anyone else?

MS. ALTERAS: I know we can't do this now, and these are different measure developers so this is a totally stupid question. But, you know, we had an EKG measure yesterday that if there was some way to --

DR. COHEN: Bundle it.

MS. ALTERAS: -- bundle them.

DR. COHEN: Yes.

MS. ALTERAS: But it could get closer to diagnosing AMI.

DR. COHEN: Like a chest pain bundle, so to speak, or an ACS bundle.

DR. BRATZLER: So there is an endorsed measure for median time to ECG. And as you know, for certain patients like STEMI patients you don't actually need to wait for the troponin before you make the decision. The ECG is sufficient. So I think that's the one challenge about bundling the two because you can make a diagnoses of the STEMI without a troponin. And you should, in fact.

CO-CHAIR MOORHEAD: Okay.

DR. COHEN: I would just say in terms of throughput, my memory is streaking to one of my physicians, he had said -- we were introducing public pharmacists and providing immunization in ED. He said if you at all extend that throughput, we got to close you down completely. And that's by minutes, seconds, he said.

So I do feel that if at all the troponin getting faster to the physician improves our throughput by any second, minute it is worth doing. That's the only -- even though it's independent of all the other confounding factors of throughput.

DR. ADAMS: I just wanted to know move aside and talk about the median, the central tendency statistics, too. Because while median is important, what's equally important, and I might argue more important, is the variability.

So a median time if one hospital has 30 minutes, another has 40, we would think

the 30 is better. But if that 30 is because a lot come back in 12 minutes and some come back in 90 minutes or 2 hours, that's less quality then if in that 40 minutes everyone came back plus or minus one minute. I would take plus or minus one minute 40 over high variability 30 median.

So I think an emergency department has so many time dependent metrics, that I'd like to see the central tendency statistic plus a variability. And I would vote strongly for this is it was no troponin should exceed 60 minutes ever.

DR. ALESSANDRINI: Yes, that's what I was going to say. Like a nice thing might be proportion of test that come --

DR. ADAMS: Outliers. Right.

DR. ALESSANDRINI: -- back within X period of time. Right. Because our expectation is really, you know I'm sending this lab on a stat basis. I want to see the result in 30 minutes.

DR. ADAMS: Right.

DR. ALESSANDRINI: So if we were to set, you know, setting a cut point that's clinical relevant I think would take it from just adding another throughput measure to really impacting the quality and decision making and safety.

DR. SALTZMAN: So is there a benchmark in this area that we know we should be within a certain time period? I mean not wise to this, but it's not clear to me that 20 minutes is better than 25 minutes and they all should be 30 minutes and less.

And I appreciate your last comment that under 60 minutes, you know you need to get that information.

Does this exist?

DR. COHEN: It fits into a lot of organization's critical values policies or stat lab policy, and especially when it comes to abstraction, the simpler it is, the more likely we're going to have quality data.

So even the mean is not -- or medians and the variabilities are too hard to calculate.

DR. ALESSANDRINI: Yes.

CO-CHAIR MOORHEAD: Okay. Victor?

DR. COHEN: Okay. In terms of scientific acceptability of the measure properties. The measure is scientifically acceptable, well defined and precisely specified so that it can be implemented consistently and compared across organizations.

The numerator, it measures a time from initial troponin order to results reported to the ED staff.

The denominator, ED patients with an order for a troponin. Exclusions seem appropriate. I did mention STEMI patients immediately brought to the cath lab. Other emerging chest situations that require immediate interventions, those probably are appropriate exclusions that should be listed

there weren't. But, obviously, it was discussed that you don't need it.

The measure will allow for stratification of results by volume, race, age, gender. No data was specified for survey method. There was discussion of suggested sampling data. It wasn't clear, it was just a blob of information of how to sample, say, a 100 charts or 80 charts but it didn't really say anything of how the survey method was going to take place.

The source of data is claims data, which is appropriate.

The liability and validity. The measure appears to be reliable and valid, yet no data was provided. Only side comments provided. So therefore, I put down this partially meets the criteria.

No data on supporting exclusions was provided. So just in general, no data.

No risk adjustment is provided or why data supports no risk adjustment.

2f, g, h I graded as minimal as no data has been provided.

Overall, I put as partially meets scientific acceptability. I thought some of this was minimal, it wasn't completely meeting all. There was some missing elements to scientific acceptability.

CO-CHAIR MOORHEAD: Suzanne?

CO-CHAIR STONE-GRIFFITH: Yes. I guess the other issue that I have if we think about the importance of this measure, there are two things that sort of troubled me in this section.

The first thing is the results getting back to the emergency department staff. So you actually spoke about coming back to the provider, which really that's sort of the brain to vein idea here is that from the time it's ordered until it gets into the hands of the provider, you know so that the provider can make a determination. And then we generalize it to staff. How are we going to

measure that? That's widely variable and many of our emergency departments I know there are electronic systems that can automatically time capture that. But in many, many emergency departments we do not see that captured at all.

We know when it's resulted, it comes off the equipment, regardless of what that equipment is.

And then I guess on another level, although ordered to resulted, very important as an intermediate time stamp. If I could back to the consumer, what do I really care about, what would I care about if it was my mother in the emergency department? It would be a rival to when it is in the hands of the provider to make the determination.

So although that is an important intermediate step, I mean I really want to know how long if we're really trying to change the care of the chest pain or the AMI patient, I'd really want to know from the time I hit

the door.

DR. BURSTIN: And the EKG measure is that, by the way.

DR. JAUCH: It is. And I was going to say this reminds me of the discussion we had with regards to the EKG.

Did you want to respond to that?

DR. BRATZLER: I mean, I think you all are reflecting a lot of conversations that we've had in the background. This conversation has been going on for a long time. We recognize that we're talking about components of a stay that's complex that has lots of steps. And that's why I think we pushed through the total troop of time measures first thinking that that was the most important thing to get into the hands of consumers was total time in the emergency department. Now we're looking at bottlenecks and trying to figure out the best way to identify the bottlenecks in emergency department care that may result in prolonged

stays, patients leaving on the scene and other things.

CO-CHAIR MOORHEAD: Pardon?

DR. EISENBERG: And I would just point out also paradoxically often if there's an abnormal report on a point of care troponin, it's going to be reflex to do another test. So your positive tests are all repeated. So your time to getting your report back may actually be prolonged. So the very population might be using that data 4, it's going to be even longer than it would be in the negative.

MS. GOVAN-JENKINS: Just to note, the data source --

CO-CHAIR MOORHEAD: I'm sorry, could you just come to a microphone?

MS. GOVAN-JENKINS: The data source is to try extraction and with a possibility of EHR for the future.

CO-CHAIR MOORHEAD: Yes. I just would comment on the ordering part of this.

I think for other testing, I have significant concern about this. The troponin is a little different because I think it gets ordered pretty much automatically as part of a panel that is initiated as soon as you hit the door. So I think it's a little different from a couple of years ago because I think our practices have changed.

I'm worried about unattended consequences, not with the troponin, but some of our other testing that now is ordered up front. And if we introduce this time, I'm worried that we're going to provide a disincentive for some of that ordering that occurs up front because people are worried about the times.

I do not think that will occur with troponin ordering. I think that will continue as a bundle.

And so for this particular one I think I'm comfortable with that.

Are there other comments? Okay.

DR. COHEN: In terms of usability, no current use data as testing is not completed yet.

It is related to other time dependent processes, such as fibrinolytics, aspirin, et cetera. So it's easy to use and understand.

There is harmonization with other NQF measures, for example aspirin, other time dependent processes, just to give you an example.

There is direct added value of the measure. So overall I stated that it partially meets criteria for usability. Once testing occurs then in terms of public use, the measure may meet the criteria completely. But at this point there is no public use assessments.

Any comment on this?

CO-CHAIR STONE-GRIFFITH: I agree.

DR. COHEN: Feasibility 4a, b, c data generated by coding and extraction. No

available source, but they're suggesting that once the Health Information Act or standards come through, these data elements will become available.

To be honest with you, we have an Allscripts Electronic Medical Record. We capture this data. The only problem is we're not always sure how valid it is, but we do capture it and we know it up front. So it's a great tool. And once it's implemented, I think it's easily captured.

No supporting data for exclusion was provided.

4d f, errors not likely not here.

4e, the costs were not described. But if you have electronic medical records, it's probably minimal. You have your EDIS director handle it. Quality Assurance Performance Improvements Committees can handle this. They do this all day, that's their job. I don't think it would be otherwise overwhelming unless you don't have that

infrastructure. So I did give it a partially met feasibility.

And overall, I did say it was a yes, though there are issues with it.

CO-CHAIR MOORHEAD: You want to come in on 4 or the overall?

CO-CHAIR STONE-GRIFFITH: If I just evaluate the measure as it was delivered, you know I agree. I think it's an important measure and all of those other considerations. I'm just having trouble agreeing at the end of the day that I would recommend that measure.

So that's where I would differ.

CO-CHAIR MOORHEAD: Other comments?

DR. ADAMS: The final thing, just to take into account, is there is bedside troponins and this may push some momentum in that direction. And that would be a change without necessarily a value added. I could get the troponin back, but the rest of the system, the rest of the lab tests still go on

its own way.

And I would hate to see that unintended consequence. We'd like the pressure to be a meaningful positive change for the patients.

DR. COHEN: But in terms of point of care testing, the Joint Commission requires a lot more standards. And I don't know if everyone would want to go to that point of care testing type. That would be one thing against bedside testing the troponin.

CO-CHAIR MOORHEAD: Okay. So the recommendation is to support or recommend--

DR. COHEN: Endorse the measure.

CO-CHAIR MOORHEAD: Suzanne?

CO-CHAIR STONE-GRIFFITH: Yes. I'm a no. Yes.

CO-CHAIR MOORHEAD: Are you more comfortable, you want to defer the vote on this until we go through some of the other ones?

CO-CHAIR STONE-GRIFFITH: You

know, maybe. Or maybe I'd be more comfortable if it was a yes with recommendations of some changes to make it a more meaningful measure. I guess that's where I am.

CO-CHAIR MOORHEAD: You want to talk about that?

DR. BURSTIN: Did you have specific conditions that would be useful?

CO-CHAIR STONE-GRIFFITH: Well, I mean I think Jim brought the idea of the measurement.

I think the other idea -- I mean, again, it's very much getting hard wired into process that is in hospitals right now. So I would be more interested in that we're advancing better quality care through this measure. So arrival as opposed to order.

And again, I have trouble saying it's got to be in the hands of the provider, although I agree that's where it's important. I am worried about the burden of collecting that in a lot of hospitals. So if it was

resulted, I might be more comfortable than it has to be an internal process how you get that in the hands of the providers or communicated.

So that's where I am.

CO-CHAIR MOORHEAD: You said part of your discussion had been the arrival. You had that discussion in the development.

DR. BRATZLER: Right. Right. So we've had most of these conversations, particularly recognizing that this whole list of measures that you're going to be evaluating look at component pieces of the time that really add to the entire group of time of a patient in the emergency department. And I definitely agree with you, we know that a lot of the throughput is driven by what happens upstairs, not in the emergency room alone. So we've had all those conversations. However, there was a general sense that there are delays that occur because of lab, x-ray and other tests that don't get done in a timely fashion and that we needed some performance

metrics around those.

I was curious about your comments that if we took the measure back, let's say we change to arrival to result, then you would I would assume, limit the denominator population to those patients that had principal diagnoses and acute myocardial infarction --

CO-CHAIR STONE-GRIFFITH: Which is chest pain.

DR. BRATZLER: -- rather than -- or chest pain and not limited to just anybody that had the test.

CO-CHAIR STONE-GRIFFITH: Yes.

DR. ADAMS: On a separate note, could I just raise the thought: This seems much more a quality metric for the clinician pathologists because that's who has to do the work. Even though it shows up in the emergency department, it's really their laboratory who has to respond to it.

I would not feel good if somebody was doing quality metrics where I had to

respond to it but I wasn't involved in the discussion. Should the clinical pathologists be involved in this.

DR. BURSTIN: They'll certainly have a chance to comment on whatever you put out, so that's fine. And again, it's getting so difficult in this day and age to assign accountability to any one person: Who orders it, who does the results, who ships it back, who enters it into the chart. I mean, there's got to be at least five people who is involved in this going from point A to point E.

So, you know, I think they should be involved because part of their rule, obviously, the throughput of the lab is critical here. But, you know, I think it's kind of bigger than that. Yes.

I don't know what you guys in that. You're not in ED all the time, so--

CO-CHAIR STONE-GRIFFITH: And you know, the other thing I do think this measure is a little bit different than the other

measures we're going to talk about. Because to your point, I mean there are always exceptions in how effective we are in throughput in the ED, but I think there's a tremendous focus on chest pain AMI on a number of fronts.

So troponin is to me a little bit different then when we start talking about lytes, CBC. We order those on a lot of other patients and we do use those and the results of those to often times serve as taking the next step in the flow of a patient, whereas troponin may not be. If we have a STEMI, we're going right to the cath lab.

To your point if we have a point of care, often times we repeat it. Point of care if clearly more expensive than running that same lab reported test in the lab. But there's the timing issue.

So, I mean, there's a lot of different issues with troponin than there are with the other tests.

CO-CHAIR MOORHEAD: Angela, do you have any comments about this particular one.

MS. FRANKLIN: Not on this one, no.

CO-CHAIR MOORHEAD: Okay.

DR. COHEN: Can I just say one thing in its defense Have you read the Checklist Manifesto? This is just another one that's a part of the checklist, even though it's confounding. It still is part of the process and it should be done. And if it's not done, you could miss a diagnosis of an MI at times. That's a risk.

CO-CHAIR MOORHEAD: I guess I'll go back and will comment now. Because I do not support this as a throughput measure. My reading of the literature and review is I'm not encouraged in terms of throughput through the ED on what's happened in England. And I view the time in the department as probably the best measure that we can get. And in England they put a four hour time in the

department and put a measure in, and it totally changed performance. And the research that's coming out of England I think is extremely favorable. And I think there are many in this country who feels that four hours is probably too short, but if we had a six period, that's probably one thing we could do in terms of monitoring and a measure that would really effect throughput.

And getting at these individual intermediaries to me is a lot of work and maybe without the quality change that we're looking for.

So I look at this particular measure as supporting -- quickly making the diagnosis of acute MI. And that's why I would tend to support your view of this, which is time to arrival like the EKG one to the result. And I would be more favorably inclined to look at a measure that proposed that.

CO-CHAIR STONE-GRIFFITH: And I do

like Jim's idea to look at that time in terms of where do we not have tolerance. You know, when we should always have those results coming back. To me, that's more of a failure than from the time it was ordered -- a median time from the time it was ordered until it was back. I would like to have that as well.

DR. BRATZLER: So I've heard two different approaches to that. One is to set a proportion and the other is to report the distribution of the tests. So central tendency but distribution also. And frankly, either one could be done.

I will comment, the U.K. four hour measure was explicitly and at length discussed by the technical expert panel and thrown out largely because of the concern of the unintended consequence of making the decision to admit patients unnecessarily when a little bit longer emergency department visit might result in a discharge of a patient if an acceptable evaluation was completed. So long,

long discussion on that particular measure. And it was not recommended by the technical panel.

CO-CHAIR MOORHEAD: Bob, did you have a comment?

DR. O'CONNOR: Yes. I think I'm pretty much in agreement with what's been said.

I sort of view this test a little bit differently, though. I think it is absolutely related to the discussion of STEMI and ECG because that's the only way to make the diagnosis of STEMI. This is the only way to make the diagnosis NSTEMI. So I think they're paired strategies.

I would love to have a mandate that we have a four hour, five hour, whatever hour limit in the ED and let the smart people that work in hospitals figure out to get patients through the department.

And, you know, while I understand of intent of looking at these different

processes, this one is a little bit different because it's a test that's used to make a specific diagnosis.

So, thanks.

CO-CHAIR MOORHEAD: Do you want to comment on whether the time to arrival to the test result being available would be a more useful measure then the time of ordering to the result.

DR. O'CONNOR: Yes. I think time of arrival is important. Because it cuts to the waiting time. It's much like a patient comes in with chest discomfort. The time, the clock starts when they walk in the door for an ECG. This should be the same thing because it's the other aspect of the acute coronary syndrome that we're trying to capture.

CO-CHAIR MOORHEAD: Okay.

DR. EISENBERG: I think you're going to have different responses at different facilities as well. So it makes more sense, I'd be in favor of the broader term: Time to

presentation to four hour, five hour, six hour, whatever you pick as the limit and let each facility which has to deal with its particular problems, whether it's time to the x-ray return, whether it's time to the particular lab return, whether it's the issue of getting staffing or moving somebody to bed, whether it's time from triage to be seen. Because the process is going to be different, very different at different facilities.

Large places that have a cath lab are different smaller places that don't that are going to ship somebody out.

And it's an aggregate measure. You're going to have plenty of people that present to the emergency department that are nonemergent, that are still seen, that are going to be dispositioned in a much quicker period of time. And then you have the other set of people that, you know you're really going to observe for six years in the ER. The child with the possible ingestion that you're

not going to admit, you're going to sit and watch them for a while because you don't have the space, and send them back out.

So I'd be much more in favor of let each facility figure out where their problem is to make the process better. Because this is not like STEMI where you're going to see it right away. Any individual test is not going to make as much of a difference as having that set of results available to dispose of a patient appropriately.

CO-CHAIR MOORHEAD: Would this be viewed, I mean two of choices are here as it is, time to ordering to the result versus time to presentation at the emergency department. So would the time to the ED to the result be more meaningful to the public?

MS. ALTERAS: I think so, but I think it also is if it's median time. I mean what James was saying, I agree with. But the median time might not really mean anything.

But, yes, I think from

presentation to the ED until the results is just -- would not only be meaningful to the patient, but also might have more of an effect on internal quality improvement on the hospital.

CO-CHAIR MOORHEAD: Okay. We have a recommendation to recommend this measure. Does anyone want to amend that?

DR. JEFFREY COLLINS: I have a question about arrival time. So, you know, a lot of these patients you may have a diabetic who is not presenting with chest pain, they're presenting with something else. And so, after the assessment that happens four hours later in your ER, you decide that a troponin is an important test. So it's, you know, presentation becomes difficult.

DR. BURSTIN: It sounds like your discussion, at least from what's gone on so far, it sounds like there are several potential conditions. And maybe you'd want to vote on a measure with conditions, at least to

allow for the developer to come back, to add time of arrival to result.

Perhaps one option to get it at that issue is limit the population analogous to the EKG viewing time, which specifically patients with AMI or chest pain with probable cardiac chest pains. There should be some limitation to that very vague "chest pain" diagnosis curve as one option just to again, just make it a little bit cleaner.

And then potentially since it's still untested, Jim's idea about a meeting with some view of distribution to get at that might be a way to at least put it forward for the Committee. I don't know if there's other ones, but that sounds like from what I heard the three major conditions.

DR. CHALIAN: I guess I would look at what a cardiologist or an ER doc say is the critical value time. Because if the troponin's positive and we're actually tracking medians, we don't actually set a

standard that helps people realize they're out of bounds. We want to set a standard that actually defines out of bounds.

DR. BURSTIN: Is there a standard?

CO-CHAIR MOORHEAD: I don't think there is.

DR. CHALIAN: So the generalizable standard is to look at what organizations view as the time to look at a critically abnormal value, perhaps. And in our organization if it's abnormal and it doesn't hit the bedside within an hour, you're broken. So you don't meet the standard. And perhaps something like that would be the applicable metric.

CO-CHAIR MOORHEAD: Yes. My sense is if you try to do that, it would be an hour. And I think some of us would be uncomfortable because that seems too long for many patients. But I think the consensus would probably get us down to about an hour.

DR. CHALIAN: Which I guess brings up why are we measuring it? Because if you

think the number is uncomfortable or unachievable or maybe even irrelevant, then do you want to measure it? Which goes back to the discomfort.

I'm going to share my gut feeling on this is I track this more from a 30,000 foot perspective, this discussion. Because it's a little out of domain. And I immediately disconnected from whether this was a measure I would really want to dive in on. And that's not the totally scientific way of looking at it, but I immediately read everyone's trepidation and I started to pull away from it.

And from a consumer perspective, I was a consumer at this moment. So it's kind -- maybe you're all feeling something that I'm validating or you're just saying he should have shut up and shared that he disconnected from this. But that's one way of looking.

You know, the first pass on data, was it really like grabbing you or not. And

to me it didn't really grab me as a metric.

DR. JEFFREY COLLINS: You know, troponin also takes hours to rise. So theoretically you may get a poor history of the patient and you end up getting a negative troponin back in the exact amount of time and the patient goes home and is having a huge MI, and you've delivered lousy care. But you've measured a metric that you're achieving.

CO-CHAIR MOORHEAD: So I think just summarize. It sounds like our options are to recommend endorsement, potentially recommend endorsement with conditions, to potentially send this back to look at time and as well as some central tendency issues, or not to support. I mean, those are our choices.

DR. ALESSANDRINI: I think it would be really useful to me, and I don't know if the other Committee members feel this way, if we could through some more of the measures and then come back and vote. I think it would

really still impact our decision making.

I really still feel like if we're supposed to be getting better, we should have stretch goals. And that reporting medians and little tiny throughput things is just not important to me.

And I think my gut with all of these is to send them back to the measure developer and say, you know to work with us to bring something to the public and to clinicians and to hospitals to make us get better and stretch and work harder. And I don't think that any of these measures meet that, but I think it would at least help me to sort of be able to go through all of them and be able to have that discussion.

CO-CHAIR MOORHEAD: Is that acceptable to the group?

DR. BRATZLER: To that comment, I just want to keep reiterating that there are measures that are already endorsed and some are rolled out and some are ready to be rolled

out. So arrival to departure for admitted patients, arrival to departure for discharged patients, decision to admit to departure is already endorsed. And then for patients that are in rural facilities transferred to centers for cardiac interventions we have a measure of time from arrival to departure to get at that whole issue of how long they're sitting in the rural facility. Those are already out there endorsed and either in use or ready to be used already.

DR. ALESSANDRINI: Right. And many of us were on the Committee that endorsed those. And so, we agree with those. And those I think kind of get at more of that totality of the care. And they might not be phrased right now because when we did this two years ago, we may -- I think we were just all younger, you know, and less -- well, we definitely were all younger. Time's going backward.

But I think as we grow and learn

more from this, I think we have to push ourselves a little bit harder and not just -- you know, and I do still think that there is something relevant about the total duration and that from the consumer perspective and from an overall global hospital flow, you know, that makes those things a little more impactful from my perspective.

CO-CHAIR MOORHEAD: Are we at a point that we may need a break? Anybody want ten minutes?

Let's just take a break for 10 minutes, then we'll move ahead.

(Whereupon, at 11:09 a.m. off the record until 11:20 a.m.)

CO-CHAIR MOORHEAD: We have some folks with some short timelines who are on the phone. And Angela Franklin is here from American College of Emergency Physicians. So we're going to move to numbers 2 and 3, and then come back to the list we were working on.

So, Angela.

MS. FRANKLIN: And the last measure.

CO-CHAIR MOORHEAD: I'm sorry. 2,3 and 43. Thank you.

Jay Schurr. Jay, do you want to introduce yourself. And are you making comments, or Angela are you introducing this one? Jay will?

Yes, come to the --

MS. FRANKLIN: Sorry. Jay Schurr is presenting the measures for us. He's a member of our Quality and Performance Committee. And also overseen the development of this measure.

And, Jay, are you still there?

DR. SCHURR: Yes.

MS. FRANKLIN: Okay. Okay.

DR. SCHURR: This is the discussion ultrasound --

CO-CHAIR MOORHEAD: We'll begin with ultrasound determination of pregnancy.

DR. SCHURR: Okay.

CO-CHAIR MOORHEAD: But if you wanted to make any general comments about these measures, go ahead.

DR. SCHURR: The general comments are that these measures came out of a process from the American College of Emergency Physicians. Over the last several years we had a panel of emergency physicians on the Quality and Performance Committee that brainstormed a number of measures, did the literature review. Narrowed those down and then did a voting process of the Quality and Performance Committee, the Clinical Guidelines Committee and they were also referred to the Quality and Patient Safety Interest Group that has several hundred members for comments.

And then, a select group have been moved forward.

CO-CHAIR MOORHEAD: Okay. Thank you.

If we can begin with No. 2

DR. EISENBERG: Okay.

CO-CHAIR MOORHEAD: Did you want to make any specific comments about No. 2, ultrasound?

DR. SCHURR: Sure. The specific comments are that the goal of the measure is to avoid misdiagnosis of ectopic pregnancy. And that's the goal of the measure.

That's probably all I need to give as a background. The rest is in the measure.

CO-CHAIR MOORHEAD: Okay.

Andrew?

DR. EISENBERG: Okay. This is ACP-002-10. And this is looking at ultrasound determination of pregnancy location for pregnant patients with abdominal pain. And in other places it also added vaginal bleeding. And this was to receive a transabdominal or transvaginal ultrasound process measure looking at safety.

And as far as the importance to measure and report, this is demonstrated to be high impact because ectopic pregnancy is a

relatively common condition. It results in morbidity and mortality, especially if misdiagnosed or resulting in a delay of appropriate treatment.

Abdominal pain is a frequent presenting complaint of women with a ruptured ectopic, as well as often prior to its rupture. And ultrasound can establish pregnancy as intrauterine or identify high risk features for ectopic pregnancy such as pelvic free fluid or a complex mass. And it can greatly shorten the time to diagnosis of ectopic pregnancy, which helps stratify a patient's high risk with positive pregnancy test and abdominal pain or vaginal bleeding.

So we looked at the opportunities for improvement and benefits as far as far as the summary of data and the citations. There's some very good data looking at reduction in ruptured ectopic to 50 percent compared to historical controls of 9 percent when an ultrasound was used.

So it's demonstrated, so 1b is a C.

1c is the outcome or evidence to support the measure focus. The incidence of ectopic pregnancy when presenting to emergency department with vaginal bleeding or pain in the first trimester is approximately ten percent. So it's a relatively high number of women that are presenting. Again, god data.

And evidence to support this is an intervention, 1c is also C.

A lot of the data that we were given was from Royal College of Obstetricians. It was graded as C looking at beta hCG measurement and unexplained abdominal pain. I think when Kat and I talked about it, we thought that the potential risk given the number of people presenting is very high, so that this definitely rated the C category for that.

Again, the use of emergency ultrasound in public disorder centers on

detection of intrauterine pregnancy or ectopic, looking at fetal heart rate, significant free fluid. Done in the emergency department with these presentations has a good sensitivity of 76 to 90 percent, specificity of 88 to 92 percent. And this was emergency providers who were able to detect intrauterine pregnancy in 70 percent of patients with suspected ectopic. And negative predictive value was essentially 100 percent, which makes it a very good test.

And therefore, our recommendation was to -- this was a yes as far as a number 1.

CO-CHAIR MOORHEAD: In importance?

DR. EISENBERG: In importance, correct.

DR. ROBERTS: Mine were the same. Same scores.

CO-CHAIR MOORHEAD: Any other comments, questions? No. Okay.

DR. EISENBERG: The scientific acceptability of the measure, our time window

was throughout the emergency department visit. This was all patients presenting with the chief complaint of lower abdominal pain and/or vaginal bleeding, aged 14 to 50, obviously female. And the denominator was -- the exclusions for women who was already documented or reported as intrauterine, so prior knowledge of a lack of an ectopic. Patient refusal. And a little bit more problematic one was whether or not ultrasound was feasible for a facility reason, either lack of access, lack of availability of somebody to do it which unfortunately does occur in a relative high basis, but is a reasonable exclusion that I think in the future needs to be looked at it because it shouldn't be.

That we rated as a P because of those factor. So 2a would be a P.

For reliability testing there is no data as of yet, so it's another one of those it's probably an N. As well as validity

testing, no data.

The exclusions are definitely justified. It's really not applicable, however. I mean, it's women who are pregnant between the ages of 14 and 50. So that's 2d and a.

2e risk estimates. Same thing, it's really not applicable.

2f meaningful difference in performance. Probably is not applicable either in this circumstances. So 2f, there's really no NA reading, but it doesn't quite fit.

And then 2g is comparability of multiple data sources. This was saying not applicable. We thought you should be able to abstract that data from virtually anywhere because that should be reported. I mean if an ultrasound is done and a pregnancy test is done, we should be able to have that information from whether it's written or electronic data.

Disparities may exist, but there's no data looking into it at this point.

So I think our overall criterion would have been difficult to say because of the lack of any data in there. I feel strongly it's a C like a no-brainer. But I think we kind of had a little bit of difference in that.

DR. ROBERTS: Oh, just because there wasn't any testing or analysis information provided. Yes, I'd bring them down to a P. Yes, I'd bring them down.

DR. EISENBERG: Yes.

Usability?

DR. BURSTIN: I had a question.

DR. EISENBERG: Oh, questions.

DR. BURSTIN: I know there is a current endorsed ACEP measure, which you guys introduced last round, recommended last time, which is pregnancy test for female abdominal pain patients. And my clinical experience is I don't often know these people are pregnant

when they walk in the door. And I check them and they're pregnant. Would they be in this measure or not? Because it's all pregnant patients. Can you establish diagnosis of pregnancy and then make sure you get the test, the ultrasound done? That was confusing to me. So it didn't seem that precise unless I'm missing a nuance here.

MS. ALTERAS: I was actually to ask or consider just making the denominator all women who present with abdominal pain or vaginal bleeding.

DR. SCHURR: Can I answer that?

CO-CHAIR MOORHEAD: Jay, go ahead.

DR. SCHURR: So this is somewhat complimentary to the prior ACEP measure. And the thinking is that ultrasound is the appropriate next step in a patient who has confirmed pregnancy but unknown location with a undiffering chief complaint of lower abdominal pain or vaginal bleeding.

So patients of childbearing age

who have lower abdominal pain and it is not clear if they're pregnant, the first step would be to determine if they're pregnant. And then if they're not pregnant, there's not a need for an ultrasound. But if they're pregnant, then a timely ultrasound it is helpful to exclude ectopic pregnancy.

DR. BURSTIN: Yes, Jay. But that's not exactly my question.

This is Helen.

It's just from the way the specifications are written it looks like it's all pregnant patients. So it's not clear to me can you establish pregnancy at that same visit and be in this measure, or do you have to come and then be pregnant. It's not clear.

DR. SCHURR: You can establish the same day, but we can definitely make that more clear.

DR. BURSTIN: Yes, it's not clear in this case.

DR. SCHURR: It was just that we

did not want this to be all patients.

DR. BURSTIN: Great. Good. Thanks.

CO-CHAIR MOORHEAD: Okay. Jeff?

DR. JEFFREY COLLINS: I just had a question on who is actually doing the ultrasounds. Are these ER physicians who are -- I mean one of the issues we have in our emergency room is an ER doc will do a scanning quick, ultrasound. It's never reported anywhere. And then ultimately they may get an official one that as a radiologist does. And so, you know, we sometimes see people back and they'll say they've had an ultrasound and there's no record of it. So it --

DR. SCHURR: So we think that can be further specified. But I think we think that can be determined by the facility.

I would just make it a point of clarification that generally the preferred term is emergency department. We're not generally a room anymore.

And that ER doc is probably not a correct term as generally emergency departments are generally trying to be staffed with residency trained board certified emergency physicians. And there are places were that's not the case, but part of that residency training is now generally ultrasound training and many emergency physicians are credentialed in ultrasound, either nationally or at their institution. So that would be a facility decision.

DR. EISENBERG: And we recognized that and deliberated about that a bit. Because even the quality of the technician reporting it, the quality of the equipment being used and the presentation of images all bear into the quality of the study.

DR. NEWMAN: Was there any thought of looking at weeks of gestation as far as limiting when the ultrasound would be required?

DR. EISENBERG: At least the way I

understand this no. I mean, if you come in and you get a positive pregnancy test with either the indicators of abdominal pain or bleeding, you're going to get an ultrasound. It may be inconclusive, a pseudogestational sac, too early to define per se. But that should at least be done as a baseline for further follow-up, whether that's repeat ultrasound, further beta hGC testing, admission and observation. But the fact that it's done and at least can be clarified free fluid in the pelvis, so there's other markers that might be useful for determination of where the patient goes.

I mean, it's positive, it's positive, 100 percent pregnant.

CO-CHAIR MOORHEAD: Jay, any comment?

DR. SCHURR: That's correct. The exclusion would be patients who had documented or had personal knowledge that they had an ultrasound or pregnancy before. The idea is

not to do an ultrasound on patients who are known to be pregnant -- known to have an IEP.

CO-CHAIR MOORHEAD: Jim?

DR. ADAMS: So we do know that the incidents of ectopic pregnancy is increasing even if there's a substantial mortality associated with this. And so I do agree with this standard. I think it's quite important.

The challenge that I have with it is there are still OB/GYN textbooks that says if the quantitative beta hCG is below 1,500 an ultrasound does not have to be performed. The patient can be followed.

We in the emergency department know that that could be because there's an ectopic pregnancy that's not producing a lot of beta hCG. But the textbooks are going to still have the algorithm very clearly stated as followed.

CO-CHAIR MOORHEAD: Okay. Andrew?

DR. EISENBERG: Usability. Meaningful, understandable and useful. We

thought that this would be a key, relative straightforward and useful.

There is an additional measure with 05-02 which was checking HCG in any woman that came in with pain. So it's complimentary to that, but not exclusive in the least bit. Certainly harmonizing if you do a pregnancy test on somebody with pain and vaginal bleeding and the ultrasound is linked to that. So it could be harmonized with 05-02, which would also be a key for 3b.

Distinctive or additive value at 3c. No competing measures. It does add value because this is clearly identified earlier on as a major cause of morbidity, mortality with a relatively low performance rate at this point. I don't know if you'd want to call it -- I think it's a C to a large degree. This is something that definitely is measurable and something that we can improve.

And then the overall, to what extent the criterion are usable for 3 in total

was somewhere between a C and a P. I tend to be more optimistic that it's a C. But I'm willing to downgrade.

DR. ROBERTS: I gave it a P. Just I thought it probably deserved some comment with 02-05 for harmonization.

CO-CHAIR MOORHEAD: Other comments or questions?

Okay. Andrew?

DR. EISENBERG: And then feasibility. Data generated is a byproduct of peer process. We thought that this really is a C. This is -- you know, bearing in mind that sometimes it is done. Typically ultrasounds are documented somewhere and charged for. So there should be a code and there sound be some way of capturing virtually all the data. So 4a would be a C.

Electronic sources. Again, it's going to be mixed depending on what department it's coming, so that's probably a P for 4b.

The exclusion criteria were very

straightforward. So that's 4c should be a C.

4d susceptibility to inaccuracies or errors or unintended consequences. And that deals with we mentioned the pseudogestational sac, the experience of the provider, the experience of the person reading it.

Patient characteristics might impact that to a certain extent.

So 4d was a P.

4e data collection and implementation. It's not been tested, but should be relatively straightforward. And the cost to implement might go up some, but the costs to not implement it probably outweigh that. So that's either a P or a C.

The overall 4 would probably be a P with the caveats about the unintended risks of either missing something early on, or patient characteristics, or unavailability or poorly done study.

DR. ROBERTS: I agree. This is an

important measure and certainly the benefits outweighed the risks of misdiagnosis. But for 4d unintended consequences, the thing that first came to mind was something that has already sort of been brought up. That, you know, if you're trying to increase utilization of ultrasound, that it may start being used in less experienced hands. And there is a pseudogestational sac that can be seen with ectopic pregnancy and can be misdiagnosed as an intrauterine pregnancy. So then you have this situation where someone says I've had an ultrasound, I've a documented pregnancy in my uterus, but they really don't because it was misdiagnosed first. And so you have the potential to delay their ectopic treatment should they come back because the clinician would already be thinking, yes, we have a documented one.

So certainly a potential risk, but a small one. And I think it probably deserves some comment.

So that was a P for me, yes.

CO-CHAIR MOORHEAD: Okay.

DR. EISENBERG: And our overall recommendation was to endorse.

DR. ROBERTS: Yes. My recommendation was to endorse.

CO-CHAIR MOORHEAD: Okay. Any comments or questions?

The recommendation is to recommend endorsement. Those in favor? Opposed? Abstaining? It's unanimous. Okay.

Thank you.

We'll move to No. 3 Rhogam. Andrew, you're the primary, I'm the secondary.

Jay, did you have any comments about this one, anything specific?

DR. SCHURR: The specific comment I think I have is that there was a fair amount of debate about the specification of this measure. And the question was what to do in the first trimester of pregnancy indication to have a threatened abortion, miscarriage,

significant vaginal bleeding.

There was pretty general agreement that standard practice in the United States is to give those patients Rh immunoglobulin. At the same time, the evidence behind that is not strong. The evidence is stronger is second and third trimester. And the only sort of published guidelines around this have level of evidence and higher level of support for the second and third trimester. So we devised the measure to include patients in the second and third trimester because we didn't want to set a standard that was beyond what the evidence was.

CO-CHAIR MOORHEAD: Okay. Thank you.

DR. EISENBERG: Okay. This is ACP-003-10 and measure title is Rh immunoglobulin or Rhogam, although there's others, for Rh-negative pregnant women at risk of fetal blood exposure. And this measure was to look at the percent of Rh-negative pregnant

women at risk of fetal blood exposure who have received Rhogam in the emergency department as a process measure effecting safety.

Importance to measure. This was high impact because of the potential for maternal exposure to fetal blood is a concern among pregnant patients who present at the emergency department with a number of different common complaints or diagnoses including but not limited to abdominal pain, blunt abdominal trauma, vaginal bleeding, ectopic pregnancy, a threatened or a spontaneous abortion or pelvic instrumentation. And of course as Jay had mentioned, this concern increases after the first trimester as the RBC mass increases in the fetus.

Now we know that exposure to less than .1 ml of fetal blood of different Rh antigenicity among Rh-negative patients has been shown to increase the risk of maternal alloimmunization, and this can result in a

hemolytic disease of the fetus or newborn which can included spontaneous abortion, a fetal hemolytic anemia, fetal hydrops fetalis or severe neonatal jaundice in subsequent pregnancies.

Anti-D-immunoglobulin reduces the likelihood of alloimmunization occurring and the routine administration of anti-natal anti-D-immunoglobulin has been demonstrated as an effective prophylaxis and is recommended by the American College of Obstetricians and Gynecologists. And then guidelines in the U.K. recommend administration of that after the first trimester for a number of sensitizing episodes including but not limiting to uterine bleeding and for recurrent painful or heavy uterine bleeding in the first trimester. And that's where a little bit of the difficulty comes because the measurement of heavy bleeding and necessity for alloimmunization early on is a little nebulous.

Routine use of this is sometimes controversial since this is done to prevent so called silent sensitization occurring in the absence of clear hemorrhage. But this is generally performed in the U.K. and in the U.S. at anti-D-immunoglobulin does cross the placenta there is some concerns that this could cause fetal anemia, however this was felt to be a minor concern.

Other citations for high impact are quoted there.

Benefits would be management for early pregnancy loss, prevention of Rh alloimmunization in subsequent pregnancy problems.

The summary of the data for performance gaps did look at recent studies suggested recommendations for antenatal anti-D-immunoglobulin administration were not closely followed and close reviewance might further reduce the number of de-immunization.

No evidence of anti-D-

alloimmunization in the Rh-negative woman. 300 micrograms of Rh immunoglobulin should be administered intramuscularly at 28 weeks of gestation. And that's where some of the issues might occur because what's the responsibility? In the emergency department it's whether they have prenatal care or not, whether they're presenting at a given time with even no indication other than being 28 weeks with or without a known what their Rh factor is.

So this practice has been reported to reduce the incidence of antenatal alloimmunization from a 2 percent barrier down to a .1 percent. So it's a significant reduction if done routinely, which is the typical practice in an office base setting.

Evidence for the use of Rh globulin in other scenarios that breach the fetal placenta barrier is lacking.

And there's no data in the U.S. situation unless there's something new that

they can bring forward. This was report from July of 2008.

And a lot of data came out of Canada.

Looking at most patients, 86 percent were not Rh typed in one study that presented to the hospital. Some of the mothers may have known their blood type or clinicians may have had access to prenatal records, but that was not known.

So this lack of awareness for anti-Rh requirement in the U.K. was confirmed by a telephone survey of senior house officers working in accident and emergency departments. They were given the clinical scenario of a patient who presented to the department at 18 weeks gestation following closed abdominal trauma from domestic violence and asked what their management would be. So these are clearly patients that would be indicated to receive this.

Only 20 of the 62 surveyed, which

is 31 percent recognized the possibility of Rh sensitization. And of those, three said that they might request a KB or Kleinhauer-Betke test. And the remainder said they would check Rh status.

In the case of an Rh-negative result, nine of the doctors reported that they would administer anti-Rh-D in the emergency department. But in the remainder answered that they would refer the patient to the on call obstetrician.

So they may or may not have received the appropriate care, but it's a discouragingly low amount of recognition or thought of higher risk patients. And then of course, they quote that more worryingly 23 of 44, which was 52 percent, who did not recognize the 114 different possibilities for Rh sensitization in the first instance, still did not appreciate the risk when informed of the Rh-negative status of the patient in question. So the potential for improvement is

rather high.

Data wasn't complete. It's not from the United States. So I gave 1b a P recommendation, or a rating, rather.

CO-CHAIR MOORHEAD: I agree. I agree with the same rationale.

DR. EISENBERG: The outcome or evidence to support the measure focus. Some of these I didn't think bared quite as much into it, other than what I just mentioned above as far as blunt trauma and other risk factors. They quoted some of the evidence looking at amniocentesis, keratocentesis, intrauterine transfusions and things which not too many emergency departments are really performing those kinds of procedures. I think the prior mentioned abdominal trauma, blunt trauma without bleeding is the one that's probably the most worrisome. And then the general lack of knowledge.

This was, they went through a whole bunch of who gets what and how much

which probably isn't as much germane to our conversation right now.

There were varying degrees of evidence. Grade B was that nonsensitized Rh women should receive it in the following situations: Ectopic, all miscarriages over 12 weeks gestation including threatened and all miscarriages where the uterus is evacuated whether medically or surgically. Again, a difficult thing to follow but that was a grade D.

And then there was some grade C evidence. Should only be given for threatened miscarriages under 12 weeks gestational age when bleeding is heavy or associated with pain. I didn't find that particularly convincing.

We could actually go through all of the rest of those. But I think the bottom line for the whole thing is that I would recommend this criterion as a yes.

CO-CHAIR MOORHEAD: So 1c if you

have --

DR. EISENBERG: I'm sorry. That's a P. It was on another page.

CO-CHAIR MOORHEAD: I had a P as well.

DR. EISENBERG: I mean, there were other criteria I'd be glad to read through with that, but I don't know if it'll change anything.

CO-CHAIR MOORHEAD: Are there questions or comments? Okay.

DR. EISENBERG: Scientific acceptability. The measure specifications. Numerator was basically the time period and then the number of appropriate patients who received Rhogam in the emergency department.

The denominator was those who, again, might undergo invasive or surgical procedure which typically doesn't occur, those diagnosed with an ectopic and those in second or third trimester with any of the criteria of threatened abortion who report to have had

significant vaginal bleeding beyond spotting. A difficult measure, I thought. And those who had sustained blunt abdominal trauma.

I rated that as an M because I didn't think that it was quite as clear as it could be.

CO-CHAIR MOORHEAD: I had N or M.

DR. EISENBERG: As far as testing and analysis. There has been no testing. I had that as an N for 2b.

CO-CHAIR MOORHEAD: Agree.

DR. EISENBERG: Validity testing, same. There's none. So N for 2c.

2d, again not applicable. So 2d is NA.

2e also not applicable.

2f indication of meaningful differences in performance. I think if we gather the data we'll find that out. But at this point it's an N since there's no data for it.

CO-CHAIR MOORHEAD: I agree.

DR. EISENBERG: And the comparability of multiple data sources. Again, it's really not applicable at this point.

Disparities of care probably exist, but again we have no data, or not applicable.

And I rated that overall to the extent that scientific acceptable as an M.

CO-CHAIR MOORHEAD: I did as well.

DR. EISENBERG: Okay. Questions?

CO-CHAIR MOORHEAD: Comments? Okay.

DR. EISENBERG: Usability. Meaningful, understandable and useful. It's complicated information. It was complicated for residents and fellows in the U.K. who clearly made multiple mistakes. So this does not appear to be a clear cut easy to understand useful measure, So I gave that an M. I think it's an important thing to track, but it's not going to be easy to necessarily

explain a lot of the nuances.

CO-CHAIR MOORHEAD: I have a P on that.

DR. EISENBERG: Let's see, so for harmonization, it's really not applicable for 3b.

CO-CHAIR MOORHEAD: Right.

DR. EISENBERG: Distinctive or additive value, I rated that as a C. I mean, I think this is a very important value added thing that we could be allowing that we are not doing as of yet.

CO-CHAIR MOORHEAD: I gave it a P. I agree with it innately, I just didn't think we had all the evidence.

DR. EISENBERG: And then I gave the total board just an N, though, because of the difficulties we might have in conveying what this actually means to the intended audience. You think it should be higher or--

CO-CHAIR MOORHEAD: I had a P.

DR. EISENBERG: I'm not adverse to

that.

And then feasibility. Data generated is a byproduct of the care. It should be nearly universal that this is being reported. But it probably won't be. So a P for 4a.

CO-CHAIR MOORHEAD: I have a C, but --

DR. EISENBERG: A C?

DR. ADAMS: But P is fine.

DR. EISENBERG: Electronic sources. Are all the data elements available electronically? This seemed like a more -- they are not currently to my awareness. And this is a relatively complicated measure that I think would not led itself to easy data collection because of the 114 different variables and trying to pull those out.

I read it as an M for 4b.

CO-CHAIR MOORHEAD: I had a P.

DR. EISENBERG: 4c exclusions, really wasn't applicable. The exclusions --

so it was an NA for 4c.

4d identify susceptibility to inaccuracies. I thought this had quite a bit of potential unintended consequences of both overuse early on and misuse appropriately at the current time. So I think there is quite a high degree.

If they're over 12 weeks, how do you really rate pain? How do you rate the amount of bleeding that people come in with? It's very subjective. People often come in with complaints of copious vaginal bleeding, they're there for two hours and they haven't changed a pad. You know, it's subjective measurements for a lot of it.

And I don't really know whether that is actually something that is highly susceptible to inaccuracies is how I would view that. But I'm not sure how to grade that then.

CO-CHAIR MOORHEAD: Jay, did you want to respond to that?

DR. SCHURR: I think those are valid points.

CO-CHAIR MOORHEAD: Thank you.

DR. SCHURR: I think it is in the area the Committee found was clinically important and that we sort of have done our best to define it. But particularly the amount of bleeding there is not a quantitative measure.

DR. EISENBERG: And also date is often difficult. You know, you're getting one measure of a beta HCG and you may or may not have an ultrasound in this. It's a little bit problematic.

CO-CHAIR MOORHEAD: So did you have a P or an M?

DR. EISENBERG: I'd go for an M then.

CO-CHAIR MOORHEAD: Okay.

DR. EISENBERG: And then 4e data collection. I think it can be collected, so I put it as a P.

CO-CHAIR MOORHEAD: I did as well.

DR. EISENBERG: And then my final recommendation for feasibility was a P. Because I think it can be done. And then that makes the final recommendation that, yes, as a time limited recommendation with the potential to refine it once we started gathering better data and more useful data.

CO-CHAIR MOORHEAD: Okay. Comments or questions from the Committee?

All right. I'm sorry.

DR. BURSTIN: I just have one question. This is Helen again.

Jay, I wasn't sure if you had looked at the existing measures that was left blank. There wasn't one in the ED, but there is a prenatal anti-D-immunoglobulin measure for pregnant D-negative. I guess that's going to be slightly different. It's just anti-D. Is that different or is that the same? Same.

CO-CHAIR MOORHEAD: Same.

DR. BURSTIN: Give birth during a

12 month period and receive anti-D-immunoglobulin at 26 to 30 weeks.

CO-CHAIR MOORHEAD: Right.

DR. BURSTIN: So we may want to at least interject -- I think a recommendation back even if you approve it, just ask Jay to go back and compare and make sure it's harmonized with the existing measure, that it's not just ED specifically.

CO-CHAIR MOORHEAD: Okay.

DR. EISENBERG: Although that is in the measure for somebody --

CO-CHAIR MOORHEAD: It's mentioned.

DR. EISENBERG: -- presenting to the emergency department. If they presented it and you had a reasonable date, and you got an Rh and there are 28 weeks, regardless of any other complaint, if that's all they find, it seems that by this measure it's incumbent upon the emergency department --

DR. BURSTIN: That's right.

DR. EISENBERG: -- to do the intervention.

DR. BURSTIN: I mean, at least in terms of the evidence the way it's represented, the numerator/denominator, at least try to make sure, at least including the same --

CO-CHAIR MOORHEAD: Okay. Recommendation is to recommend approval. Those in favor? Opposed? Abstaining? All right. Thank you.

No. 43. Jay, any general comments?

DR. SCHURR: And 43 is ultrasound guidance for internal jugular central venous catheter placement?

CO-CHAIR MOORHEAD: Correct.

DR. SCHURR: Yes. So two general comments.

The first is that this measure was originally submitted to a different work group, to the Patient Safety Work Group. And

I think it's been moved over to this committee.

Although the measure is written up largely because we're the American College of Emergency Physicians was written for the emergency department, the evidence to support this has been developed both in emergency departments and in hospital critical care units, and also to some degree in surgical settings. So we believe this measure would be reasonable to consider for all in-hospitals locations, although we've submitted it just for the emergency department.

DR. BURSTIN: And, Jay, this is Helen.

Our thinking was that since it is specific to the ED and we've got an ED Committee constituted, let's start there. If you want to bring it back as a broader measure, that would be fine. But at least get through this as a starting point.

DR. SCHURR: Okay.

CO-CHAIR MOORHEAD: All right. Jim and Bob.

DR. ADAMS: All right. This ultrasound used to place internal jugular central lines is important, but it's an important subelement to reduce complications. So the quality goal is to have decreased complications, but the immediate complication is putting it in the artery instead of the vein. But also infection rates, too. And so that thinking is important for the broader consideration of this goal.

So to discuss the importance, 1a--

CO-CHAIR MOORHEAD: Can you just go ahead and list the numbers.

DR. ADAMS: This is NQF review ACP-043-10. And I'm James Adams reporting on it.

And so to discuss the importance. There is a literature basis showing that it does reduce complications to use the ultrasound. And this is a frequently performed

procedures in emergency departments, so it is quite applicable.

There is evidence of high impact, both the frequency and the use. And was reported in 2001 by the AHRQ as one of the 11 most highly rated patient safety practices if implemented. So there is clearly an opportunity for improvement. And on these criteria, I would say that it completely meets the standard.

The outcome or evidence to support the measure focus, while there is evidence I think that if we consider this narrowly just to reduce immediate complications, it is one submetric that is important to a larger package of metrics to reduce complications, infection rates.

And so on 1c I gave it a partial rating.

But in summary was the threshold criteria an importance to measure and report met? Clearly, I would say yes.

CO-CHAIR MOORHEAD: Bob, any comment?

DR. O'CONNOR: Yes, I think it was met.

CO-CHAIR MOORHEAD: Comments or questions? Okay.

DR. ADAMS: Now we move to scientific acceptability, 2a. The numerator statement: Adult patients age 18 years or older who underwent ultrasound guided IJ central venous catheter insertion in the emergency department.

I think that that's quite clear, so I would say that that numerator statement is completely met.

And the denominator statement: The number of patients age 18 years and older who wanted the IJ central venous catheter insertion is similarly clear.

So I think that that's without debate.

In the testing and analysis, 2b,

the reliability testing. There has been no testing for reliability. No validity testing that I'm aware of. Now there could be an argument that the validity testing is not applicable, but I don't agree with that. I think that I would say just no.

Exclusions justified. I think that's not applicable.

In 2e the risk adjustment for outcomes, resource use, measures. I think that that is completely met.

The identification of meaningful differences in performance. Completely met.

Comparability of multiple data sources. I think that's not applicable.

And disparities in care. I'm not sure that there should be issues with disparities in care. It could be not applicable. But I would just say no, leave that open for further discussion.

In aggregate, the scientific acceptability of this measure because of some

of the uncertainties, I would say it's partially met.

CO-CHAIR MOORHEAD: Bob?

DR. O'CONNOR: I gave it a P also.

DR. ADAMS: The usability, is it meaningful, understandable, useful information. The testing is not yet completed, but I say that that was partially met. And I'd like to discuss some of these usability issues a bit.

That as a public reporting measure, and this gets a bit to feasibility, but I'd like to just discuss a little about the central line insertion. Because it's using ultrasound to insert the line. Now ultrasounds are not uniformly present in emergency departments, so there's an equipment issue.

There will be a documentation issue because there may be a procedure note, but it's not always included whether an ultrasound was used, and there's no CPT code

for this. So it's going to be a chart audit.

But that's some of the documentation and extraction concerns. My greater concern is if I use the ultrasound for central line placements, I look for the vein. I set the ultrasound sound and do a blind stick. That's not using ultrasound. Ultrasound is I have to have it there under direct visualization and I insert at that moment under active visualization. So we could have people say well I used ultrasound, but they're really not using ultrasound.

This is particularly important in the real world when the private practitioner is out practicing alone, it's really had to do with one person. We do it together where there's a person holding it and staying sterile and so I'm holding it, the resident puts in the line. And so it's best done as a multi-person procedure that's not currently done. And that's why a lot of the community folks just do a blind stick.

So it's technically a little bit challenging. Is this important? Well, we've already established that it was. Is it a direction where we need the industry to go? I think yes.

The potential negative unintended consequence is well if I can't do it, sit it down, and count back, well maybe I should just go to subclavian lines, that would be acceptable. Worst, maybe I should just go to femoral lines, that's terrible.

So without a push to prevent the move to femoral lines, so it gets a little more complicated I think as we delve into the realities.

So coming back to usability, meaningful understanding and useful, I gave it partial.

Harmonization, I gave it partial because I think that we have look if there's other central line infection things out there. I would like to just assess that.

And distinctive or added value, I would say partial, but you could say not applicable. But I think partial.

So overall in category 3, overall to what extent was the criterion usability met, I rated partial but it's really more complicated. It sounds like a simple measure. But it's really more complicated than it sounds. It's just it's kind of important.

Are there comments about that.

DR. O'CONNOR: I graded it a little bit lower, I gave it a marginal for usability.

The one operator issue may be a reason for exclusion.

I gave it a marginal. But your point about the one operator possibly going through another line, that may be a justification for an exclusion. Maybe an additional exclusion I didn't see cited. Because you don't want the unintended consequences going to a less dirty line, for

example.

DR. ADAMS: Right.

DR. CHALIAN: And I guess I'm flipping back to 1 because that study that's referenced is from Anesthesia and Analgesia in 2007.

DR. ADAMS: Right.

DR. CHALIAN: And does this group feel that in the domain we're studying or setting this as a standard, that actually that use statistic is legitimate? In other words, are most of these ERs -- it's going to ER. EDs, sorry. It's no longer a room.

DR. ADAMS: We'll reprimand you.

DR. CHALIAN: I stand politically corrected.

DR. ADAMS: We're teasing.

DR. CHALIAN: No. But is this really an under used process. Because it's a process measure and is it really going to have value. If 90 or 80 percent of the forms are already using it, then is this the one that's

going to help drive that last 10 percent? No, it's really dramatically under utilized. And I would say it's the minority of people are using ultrasound for line placement.

DR. ADAMS: I would actually like to see that statistic more strongly stated in here. Because this seems kind of a weak justification for it, the way it's written, but it sounds like it's not. But having watched ultrasound guided by -- the two operator issue actually sometimes is a three operator issue. You need somebody to man the ultrasound machine, too. And in the ultrasound guided biopsy world, it's usually the physician is holding the probe and the other hand is the clinical hand doing the biopsy. So I don't know if it makes easier or more complicated in some ways.

DR. CHALIAN: Yes.

CO-CHAIR MOORHEAD: Jay, did you want to respond to that?

DR. SCHURR: Sure. A couple of

points.

I think we would agree with Dr. Adams that this is an under used procedure. At large centers and academy centers it's widely used, but we don't think it's widely used in the community.

I guess the second point is in terms of the specifications, I think that's a good -- particularly what would count as ultrasound use, that is saying it could be more clearly specified and we were hoping to have one of the members of the Ultrasound Committee on this call, but they had a limited time window. And I think we could come back with a more specific definition. And I think probably something that had a visualization of the procedure or visualization of the guide wire in the vein prior to dilation or something like that could be specified.

DR. SIERZENSKI: Jay, I'm on the line.

DR. SCHURR: Oh, sorry.

DR. SIERZENSKI: Yes. This is Paul Sierzenski.

Several things. First is that there is a defined CPT code for real time ultrasound guidance for central venous cannulation. And that that CMS stipulates visual vision under real time. Generally the training of residents and even attending in the community is to understand and perform this as a single operator technique, not necessarily as a dual operator technique. Or often times it is performed as a dual operator technique for residents as they require really time guidance by the attending during the critical component or procedure. But in the vast majority of them who I should probably say actually do the procedure, it is done real time as a single operator. And when it is not done real time, it includes visualization generally of the wire prior to cannulation.

DR. ADAMS: What's your assessment, what percentage of people just

emergency physicians in the country doing this?

DR. SIERZENSKI: Now the general industry data from the standpoint of this is the most common application of health care ultrasound technology in ED is using it for cannulation both central and peripheral.

The best numbers that we have is currently is we're probably at about 55 percent.

CO-CHAIR MOORHEAD: But the only information -- the American Board of Emergency Medicine who does the certification exams has surveyed the community and came up with a number that was in the 40s. And so that, for example, in our initial certification process graduating residents who are tested on this, but in our maintenance of certification is not because it's such a low utilization in the community. So it's an evolving sort of number.

Catherine?

DR. ROBERTS: I think the question was answered on the phone there. But as someone who does this, I do it as one person. You just hold the probe in your nondominant hand. Just takes a little practice. But if you have extra people, right.

DR. ADAMS: And my concern was that if we put it out as a measure, that people who have the skill to do it as a single operator, can do that. But it takes practice.

DR. ROBERTS: Yes.

DR. ADAMS: I mean, you have to start as a two person and then progress to one person. And now we put it to the other 50 percent, the people not doing it, and how are we going to make sure that they have the skill to do it right rather than doing it and sitting it down, which is the critical flaw?

DR. ROBERTS: That's an excellent point. Because ultrasound, although extremely important and definitely should be used, can be used badly. And I can tell you a story of

if people don't understand how ultrasound works, it can actually be dangerous.

So, you know, if you turn on color doppler, you know and you see blood flow, one's blue, one's red, I can tell you that it has happened where the person looking at the screen thinks red means artery and blue means vein. And the color just depends whether the blood is flowing towards the transducer or away from the transducer. The ultrasound machine does not know whether it's an artery or a vein. And thus, they are then picking which vessel to put the catheter in based on the color on the screen. And they can choose unwisely and dangerously. And it has happened.

So you bring up an excellent point that facilities need to be mindful of training.

DR. ADAMS: And so that's some of the unintended consequences I could document as ultrasound used, but unless that was

validated they could be doing it wrong over and over and over because they're in a room alone.

DR. ROBERTS: Absolutely.

DR. ADAMS: So documented correctly and having it be apparent. So that was just some of the concerns.

I'm not sure if it should hold up the standard necessarily or it just complicates the standard.

This does go to the feasibility and why I said the feasibility were partially met. The electronic sources, hearing that CPT code that I was actually unaware of, I think that's probably completely met if that CPT code does exist.

The exclusions I think are completely met.

The susceptibility to inaccuracies, errors, unintended consequences. I didn't know how to rate that. I put it as partially.

And the data collection strategy implementation I put as partially.

So the overall feasibility I put as partially. And I did recommend this measure.

CO-CHAIR MOORHEAD: So Bob on the fourth part?

DR. O'CONNOR: Yes, I gave it partial also.

CO-CHAIR MOORHEAD: Okay.

DR. O'CONNOR: For the same reasons.

CO-CHAIR STONE-GRIFFITH: And I was just going to add some anecdotal information, you know looking for a number. We just happened to have gone through a survey trying to determine what kind of utilization we had out there. And we had about a 43 percent utilization. So your numbers seem to fit pretty well. So there's not broad utilization.

And I do agree with you,

Catherine, about putting this in the context of a programmatic approach. So from a hospital standpoint appropriate credentialing and privileging an a program. I mean, you can't just say tomorrow I'm going to start utilizing this. And this is something that we have just recently supported and adopted, but it's got to be within a programmatic approach.

CO-CHAIR MOORHEAD: Okay. Your overall recommendation is to recommend support?

DR. ADAMS: It is.

DR. O'CONNOR: Yes.

CO-CHAIR MOORHEAD: All right. Comments or questions? Helen?

DR. BURSTIN: I am still somewhat concerned about the unintended consequences of putting this out there as a measure and then a rush to do something. And I guess my question is, again, as a general internist who doesn't do this, thank God. You know, how much does the unintended consequence without

a lot of provisos around who could do it credentially, and I know there's an exclusion for emergency physicians not credentialed to use the ultrasound procedural guidance, but that still sounds pretty minimal. And the question would be: Could be potential, if we're going to move this forward, are there a set of conditions that would make this tighter so that you're not actually increasing the safety concerns?

CO-CHAIR MOORHEAD: Jay?

DR. SCHURR: Sure, and I'll also answer.

I'm not -- you know, generally radiology use is a credentialing issue within hospitals. And so I'm not sure that we need to do anything further than that. Hospitals generally have a robust process with this, and if there was a measure, they'd have even more of a reason.

CO-CHAIR MOORHEAD: Usually my understanding is that credentialing process is

specific to the -- so it's you get credentialed for ultrasound, you get credentialed for -- you know, it's fairly specific.

DR. BURSTIN: So it may be something as simple as the -- exclusion would be. You're not credentialed to use the ultrasound machine for this specific purpose. I'm just really concerned with the Catherine's comment and Jim's that there's real potential. We've seen unintended consequences of ED measures in the past, so I don't want us to push something out there that's going to be harmful rather than helpful.

CO-CHAIR MOORHEAD: Jim, is that--

DR. ADAMS: I think that that would be really good to say that we have to be credentialed for this procedure. The hospital then would do it properly, and then we can measure. I think that that's a very wise approach.

CO-CHAIR MOORHEAD: Bob?

DR. O'CONNOR: Well, you know if you look at, is it 2a.9, the denominator exclusions, emergency physicians not credentialed to use ultrasound machine for procedural guidance, I think that really covers it. Although I think what I'm hearing is that we should go one step further and encourage credentially.

CO-CHAIR MOORHEAD: I'm not sure I heard that. I think it was really just the specificity of the credentialing is what I think I was hearing.

DR. O'CONNOR: Yes.

DR. BURSTIN: It just sounds to me like procedural guidance is quite broad. It could be ultrasound in the pregnancy case we just talked about.

CO-CHAIR MOORHEAD: Yes.

DR. BURSTIN: It could be a whole broad set of ultrasound. And if this is really very specific, then I think it should be specific.

CO-CHAIR MOORHEAD: Yes. And I think that's the general.

DR. BURSTIN: Yes.

CO-CHAIR MOORHEAD: Jay, any comments?

DR. SCHURR: Paul, are you still on the line? You probably know more about possible credentialing.

CO-CHAIR MOORHEAD: Paul?

DR. SIERZENSKI: Yes. I think that having a quality measure that moves beyond just making credentialing as a comment is probably not where I think 2f is really looking to go unless that specific measure is to measure credentialing itself.

I think when everyone looks at the issue of unintended consequences, the reality is, is that that's reality in any procedure that is either adopted or expanded. But what we've actually noted and where this technology is it is the convergence between not just ultrasound guidance but also to mandate for

central intravenous sepsis and sepsis-like states. And so we're seeing an increasing number of central lines being placed, we're seeing an increased burden, and the needs for access. And they're difficult, you know, but although I would agree that there are certainly some measured aspects of this longitudinally. The data is fairly latent here at nine plus years for a recommendation, both of the AHRQ and NICE for the use of real time ultrasound values for central venous access.

So it probably got the strongest evidence that we had out of either measures that were presented.

DR. CHALIAN: Ara Chalian.

I had a question. On a technical procedure like this where there may be people that have extensive experience and very high success rates, what's been the approach of adding in a technology that may not add value in the ER?

DR. SCHURR: The studies that have done have looked at operators with low levels of skill, trainees. But they've also look at board certified emergency clinicians. And the improvement has been across the board.

DR. CHALIAN: Thank you.

DR. ADAMS: And part of that is because the number of sticks increase your infection rate. So now you can do it with one stick and it lower long term infection.

CO-CHAIR MOORHEAD: The recommendation is to recommend support with the added comment.

DR. BURSTIN: You guys agree?

CO-CHAIR MOORHEAD: Is that --

DR. O'CONNOR: Yes. Absolutely, yes.

CO-CHAIR MOORHEAD: Okay. All right. Those in favor? Opposed? Abstaining? Okay. It's unanimous.

All right. Thank you both for being on the phone. We appreciate it.

DR. SIERZENSKI: Thank you.

DR. SCHURR: Thank you.

CO-CHAIR MOORHEAD: All right. We're ready to go back to -- people hungry or you want to keep going? We're going to do working lunch, so do you want to get your lunch? Is lunch here? Lunch is here? You want to take a minute and get some lunch and we'll bring it back to the table and continue?

(Whereupon, at 12:18 p.m. off the record until 12:31 p.m.)

CO-CHAIR MOORHEAD: Okay. We can move to No. 20. And general comments on No. 20?

DR. BRATZLER: No. None other than we heard already.

CO-CHAIR MOORHEAD: Okay. Leigh?

MS. McCARTNEY: Okay. This is NQF measure ACP-20-10: Median time to BMP or electrolyte results. And the conditions for consideration have been met, but this is up for a time limited study. There's not been

any testing done at this point.

So importance to measure and report. The summary of evidence of high impact, although I think most of us know that a BMP is ordered on most ED patients. The evidence that was presented was basically on the number of ED visits and not the number of BMPs ordered. You know, you can assumption isn't really the data that we would want, or that I would think that I would want to see to see how many of these tests are actually ordered in the ED. So I gave that an M. So 1a I gave an M.

CO-CHAIR MOORHEAD: I agree.

MS. McCARTNEY: The opportunities for improvement, this measure is actually, again, looking at the throughput of turnaround tests of lab tests for ED throughput and not the quality aspect of getting the tests back sooner so that you can make a clinical decision. So the benefits of this measure would be to reduce shorter turnaround times

reduce the time in the ED.

The summary of data demonstrating performance gap, again, there wasn't any specific turnaround time benchmark given. They quoted one study that found 90 percent of the time that lab tests are turned around in 60 minutes. But what that really doesn't say is where we should be with it. It just really is kind of a statement.

We did provide some citations on the performance gap.

And the summary of data on disparities, they did address the fact that African-Americans tend to wait longer in the ED than other cultures. And they did mention on citation on the disparity. But I still gave this section an M.

CO-CHAIR MOORHEAD: I did as well for the same reason.

MS. McCARTNEY: All right. Outcome of evidence to support the measure focus. The relationship to outcomes, delays

in obtaining tests results effecting ED overcrowding, shorter turnaround times result in a shorter length of stay. I think that that is true. But it's only one component of it and I'm not sure that there's a direct link or it hasn't been shown here that there is a direct link between the two.

And then the summary of evidence, again, decreasing turnaround times obviously are going to move patients through faster.

Rating of the strength of the quality of the evidence. It's given a level B, which is a well designed nonrandomized clinical trial, a nonquantitative systematic review with appropriate search strategies.

Summary of controversies. Again, I think this was mentioned in the troponin one that the risk of advancing measures that address timeliness may decease the testing so that, you know, they can improve their times.

They did provide some citations of evidence. But overall, I guess my feeling on

this even before all the discussion earlier was that this measure is more of an internal quality improvement measure for a facility to decrease their ED length of stay. And that I honestly would not recommend this as a stand alone measure.

So I would say at this point it doesn't meet the threshold for importance to measure and report as a stand alone measure.

CO-CHAIR MOORHEAD: I actually agreed. I had no to the first section for the same rationale.

Anyone else have any comments or questions?

If we're in agreement that the answer is no, then we don't go further.

CO-CHAIR STONE-GRIFFITH: That's vote on that.

CO-CHAIR MOORHEAD: So if we can vote on that particular aspect, those in support of no for number 1? Those opposed? any abstaining? All right. I think we can

leave it at that.

So we can go to No. 25. Jim?

DR. ADAMS: So this is NQF review 025-10. And it's the median time to the CBC results.

And the CBC is an incredibly commonly performed test and it is an important -- the turnaround time is important to the quality and to the throughput. In fact, delays to CBC turnaround can be and have been associated with adverse patient outcomes. And it is a key contributor to the throughput times.

On the important, however, though it affects large numbers, it is frequently performed. It is high resource. It is a component indicator. So it doesn't attach directly to a disease or condition. It is a submetric of the overall throughput time.

So the question is: How many of the subindicators do we at the NQF level wish to monitor? And my bias, while this is

incredibly important, I think that hospitals need to benchmark according to this, needs to drive improvement around this. I don't think that this coordinates with the NQF goals.

And so the demonstration of high impact because of its lack of association to a patient and/or a disease, condition or outcome, I actually rated that as no, as N.

The opportunity for improvement. I think minimally.

The outcome or evidence to support the measure focus I think is minimum simply because the existing turnaround times are not that far off of -- there's not that great of an opportunity.

The overall threshold criteria of importance while it's commonly done and it does have independent importance, the key importance is really to the aggregate throughput time and to many other diseases and conditions, which I think NQF would more properly focus on. And so therefore, my

evaluation of doesn't meet the threshold criterion for importance I said is no because it's a submeasure.

CO-CHAIR MOORHEAD: Okay. And we didn't have a secondary on that.

Ara?

DR. CHALIAN: I have a question. Is there one metric that one as a consumer -- that we would say a consumer could look to and say generally I want something to look at and help me identify reasonably a good ER to go to? And would any of these pass that test as a surrogate for that?

DR. ADAMS: So I would like to respond to that. I think that we have that overall throughput time metric and we have several process metrics that I think are very important and were brought forth before.

I think as hospitals try to optimize to that, which the consumers I do think properly look at and feel they're experienced, these all have to be optimized in

order to get to that. So that's why I was not thinking these would provide meaningful additional.

CO-CHAIR MOORHEAD: I think we're moving to more measures, and the last Steering Committee passed a measure of a subset bundle, a whole bundle. And I think that's where the field is going in terms of quality, and then there's the throughput issue. So it's moving in that direction, but no, there's no overall.

So the recommendation on the importance is no. Any comments or questions about that? Those supporting the recommendation no? Opposed? Abstaining? All right.

Thank you, Jim.

So we can no go to No. 24. And Tanya?

MS. ALTERAS: Yes. Measure 24, might look familiar to some of you who were in the last ED Steering Committee. It's patient left before being seen. And meets all the NQF

conditions for consideration.

On importance to measure and report, as with -- I didn't look at the measure submission form from the previous measure. It's already been endorsed for time limited endorsement. But I'm going to presume that it had several similar issues. In fact, I think it cites the same exact study that this developer cites, which is that 4« percent of patients in a certain study left the ED without being seen.

It's a patient safety issue. I would argue it's a population health issue as well.

It does look like this an area where there is opportunity for improvement, so I gave that a C.

CO-CHAIR STONE-GRIFFITH: I did as well.

MS. ALTERAS: Is there 1a? 1a, for high impact, I also gave that a C.

On 1c, outcome or evidence to

support the measure focus. Actually, I didn't think that they presented great evidence, but the evidence that they do provide and the fact that it's on level B, I believe, on the ABC Scale. I rated it -- I gave it a C, I thought it was somewhere in between. But just intuitively, I felt that this is sufficient evidence.

CO-CHAIR STONE-GRIFFITH: I could go either way.

MS. ALTERAS: Okay. So on the issue of importance, I gave it a yes.

CO-CHAIR STONE-GRIFFITH: I did as well.

MS. ALTERAS: And I don't know when we want to discuss the issue of this measure versus the one that's already endorsed. If we want to stop here and talk about that.

CO-CHAIR MOORHEAD: That's be fine.

MS. ALTERAS: Okay. You know, on

a very basic read and if you look at this chart that compares the two, you know the main difference are this new measure that's before us does have two exclusions. It excludes patients under 18 years of age and patients who died in the emergency departments. And those seem like very rational exclusions to me, especially the 18 years of age.

CO-CHAIR STONE-GRIFFITH: Yes.

MS. ALTERAS: Okay.

DR. ALESSANDRINI: This measure is completely relevant to every kid that walks -- every patient that walks into the emergency department there should be no exclusion. I don't think you have the opportunity to leave if you die in the ED. And we've -- and I guess I'm just not sure why -- I guess you can leave if it's under different circumstances. And we could not see you.

I guess there's the questions that I have, and I know that we've probably talked about this before is why are we reviewing this

measure when there's already one that's been endorsed?

CO-CHAIR MOORHEAD: Right. And it's still in the timeline.

CO-CHAIR STONE-GRIFFITH: Right.

MS. ALTERAS: And there's no data from the endorsed measure to compare to the no data from this measure.

CO-CHAIR MOORHEAD: So is there any other information?

MS. ALTERAS: Well, they used different data sources. That's the other difference here.

CO-CHAIR STONE-GRIFFITH: Right.

MS. ALTERAS: Although there's some overlap.

CO-CHAIR STONE-GRIFFITH: Now Helen had mentioned that there was difficulty with the previous endorsed measure. Do you know what that difficulty has been.

DR. BURSTIN: Oh, perfect timing.

CO-CHAIR MOORHEAD: Left without

being seen, some issues regarding implementing.

DR. BURSTIN: The most noncompliant patient I know in the universe is my mother.

CO-CHAIR MOORHEAD: Well, let's study her.

DR. BURSTIN: Absolutely. Absolutely. So briefly, the AHQA was actually looking at potentially using the AHQA -- the measure that was endorsed from Louisiana State University. And they specifically checked with the measure developer who said that they are in the process of testing it. They found the measure particularly difficult to implement. And they said because many of the EDs within their systems have put into place standard protocols and tests to begin once the patient has been triaged. So I think it's a little hard to figure out when the clock starts to a certain extent, is my interpretation of that.

So for example a patient presents with a UTI and a set of standardized tests has already been ordered by a nurse or other medical professional before they've been seen by a doctor. And so what they're left without being seen is getting more difficult to determine.

And in some instances the patients left after completing the tests that were started but before seeing that medical professional. So the developer has not yet determined how to account for those challenges of implementation. But they're working on it.

So that's what we know so far.

DR. ALESSANDRINI: Just as a comment. The Child Health Corporation of America is putting together a bunch of whole system measures for children's hospitals and several of the measures are emergency department related. And so the way that that measure and the operational definition of that measure had hopefully avoided that problem

because the data is being collected and reported within the CHCA hospital organizations is that the patient physically has to be seen by a licensed independent practitioner. So even if there was some triage, you know protocol started and orders were put in, they're still considered left without being seen if he hadn't been seen by a licensed independent practitioner.

DR. BRATZLER: So the other issue, and I actually have to tell you I was a bit surprised. I didn't realize this one was on the list because there were other implementation issues with this measure that we knew about. And the big one was let's say you come into an emergency department where you don't have any triage or any standard tests that are done, you know usually no charges are generated. Many hospitals have policies that they don't submit any charges if the patient leaves without being seen. And so the only way to identify the denominator --

well the numerator population here would be look at a log or something else that often is not electronic. So we are aware of that issue, too.

So we're familiar with the Louisiana measure, and we just think that this is probably an important measure but capturing it is really tough.

DR. ADAMS: So I agree. It's surprisingly difficult to capture. But I'll just speak for my system. And any patient who engages the system that doesn't have an authentic physician note completed, now that could be for any reason, that seems to be a very big deal to me. So they've registered, but they don't have anything completed. And we do have a way to designate this left without being seen. This was against medical advice. So this was the physician just failed to complete. But many systems don't.

But defining that, and I would say a different quality measure these patients who

engage the system but didn't have a completed record, that's a big problem in my estimation. And then it should incumbent on the institutions to really clarify that. Because that presents a risk for patients. Because really they may have left without being seen, and the majority do. But, I think we need to think differently about it as a system. Why they didn't get the service, that alone is the problem.

MS. ALTERAS: So do I continue to consider this measure or --

CO-CHAIR MOORHEAD: Well, it is an important measure. The difference from this one, what we're hearing, is that it's a different population than are already endorsed measure?

MS. ALTERAS: Right. Well, it has two exclusions, and that's the only difference.

CO-CHAIR MOORHEAD: Okay.

CO-CHAIR STONE-GRIFFITH: Well,

actually, I went back and I looked at our other measure. And the numerator -- I don't we haven't got into the specification. But our numerator in this particular measure is registered.

MS. ALTERAS: Right. Right. Logged in.

CO-CHAIR STONE-GRIFFITH: Which I have -- well, logged in, registered; they all mean different things, triage. And really our first measure was arrival. And we said arrival is a time that you have to capture, or the earliest time, that becomes your arrival. You have to do that for core measures. You have to do that for your central log from a federal requirements. So you should have that in every facility. And this really says "registered." I sort of had a problem with that.

MS. ALTERAS: But in the supporting document that came with this it also talked about recording the time. Is that

the concern?

CO-CHAIR STONE-GRIFFITH: Right. No, recording the time of arrival as opposed to the time that was registered.

MS. ALTERAS: Yes. I see. So if you arrive, pardon my ignorance about this. But what's the difference between arriving and registering? I mean, when you arrive you go to the front desk and you register?

CO-CHAIR STONE-GRIFFITH: Not necessarily.

DR. ALESSANDRINI: Usually there's just a click-click place; somebody signs you in and they electronically enter you into a system.

MS. ALTERAS: And that's arrival?

DR. ALESSANDRINI: And that's arrival. Many people don't even get registered. They could even be seen by the doctor. So in order to improve your throughput--

MS. ALTERAS: Got it.

DR. ALESSANDRINI: -- you're getting seen, you're getting a workup initiated, you're getting registered at the same time.

MS. ALTERAS: I see. Okay.

DR. ALESSANDRINI: Concomitantly to move things forward.

MS. ALTERAS: You can tell I don't go into the emergency room very much.

DR. BRATZLER: So I actually think the intent, though, was arrival. The term "registered" may have been used, but I think intent was arrival.

There's people on the phone that may be able to address that. But I think that was the intent.

CO-CHAIR MOORHEAD: Is there someone on the phone?

DR. BRATZLER: Wanda or Rebecca, can you tell whether --

DR. JONES: Tell me what was that again. It was breaking up.

DR. BRATZLER: So the question is was the intent the first arrival time or some separate registration process? You know, in other words there's a distinction between the two: Somebody that arrives at the emergency department and somebody that then goes to a separate registration process.

DR. JONES: Right. The intent was to capture the earliest presentation or earliest registration process time.

DR. BRATZLER: But that's the issue, Rebecca. It's the registration versus arrival. So I think what you're saying the intent as I always understood it was arrival time, the first documented time.

DR. JONES: Right, exactly. But, as you say, different facilities are charting different process and whether or not the registration time versus arrival time is comparable between sites is a valid question.

CO-CHAIR MOORHEAD: Sounds like it might be helpful to just go through the rest

of this.

Ara?

DR. CHALIAN: I guess the simple question is, is there enough difference or is there enough homology here to view these as the same.

As the advocate for this measure, would you say we should march forward?

DR. BRATZLER: So if I were speaking for NQF, I think there should be harmonization currently. And, you know, I've not talked to the Louisiana team, but we've recognized the same implementation challenges that they have. That we think that this is a really important measure. We think it's tough to operationalize it from a measurement standpoint.

DR. BURSTIN: I pulled up your old report and what you had actually made several recommendations to the measure developer, which they took. So I went through this. But you specifically recommended that the new

measure be revised to read "number of patients left without being seen by a qualified medical personnel."

CO-CHAIR STONE-GRIFFITH: Yes. So that was the position of the Committee, by the way.

DR. BURSTIN: And you also suggested that it be defined as "time of arrival to initiation of contact qualified medical personnel. And then in your follow-up call you specifically wanted to interpret what was meant by "qualified medical personnel" the way you trying to get that with MDAP and today.

And you guys felt strongly you should clarify which type of professionals should be included. And then ultimately you defined it as "time of arrival to initiation of contact with a provider," in parenthesis you had "medical student, resident, nurse practitioner." So I guess there was a whole discussion about if the medical student was

initiating the workup. I remember that very long discussion about medical students, as I recall. And they modified the recommendations based on what you had suggested. So that's what they're testing.

CO-CHAIR MOORHEAD: Think your previous question was is there a benchmark. And maybe the assumption is it's zero, but most practitioners don't believe it's zero, or at least I don't think they do even though it may seem to the public it should be zero, I think the reality is the way this is monitored as a QI function is sort of you bump along at 2 to 3 percent and then if you see any change in that, that's a sentinel event and you look at what's going on. But there's an acceptance that there's some rate.

And so I know you'd asked that question about a previous measure. It sort of applies here a little bit too.

MS. ALTERAS: All right. Well, I just sort of run through the rest of it since

I think the bigger discussion is whether we want to consider it at all.

As we just mentioned, the denominator is all patients who arrive at the emergency department. Numerator is patients who left without being seen with the two exclusions being those under 18 years old and those who die in the emergency department. Although I was confused, maybe it doesn't matter, but whether they die before being seen. Anyway.

So for 2a, I actually gave it a C because I think it is clear how it's specified. But now I'm thinking that it's erroneous how it's specified, especially with these exclusions.

Okay. Stratification. They say it will be stratified by volume, race, ethnicity, age and gender which I think is excellent.

No risk adjustments, not an issue.

DR. ALESSANDRINI: Tanya, I think this still brings up problems because unless

you're able to adjust for equity, you look like you have racial and ethnic disparities.

MS. ALTERAS: Okay.

DR. ALESSANDRINI: And I think we went through all this the last time that we reported, you know that we endorsed the measure. So I guess my question is, is there something that we think that the proposer thinks is something that this measure adds to the one that we already have, or if the one that we already have just needs to go through a time limited endorsement and get some information back. Because I'm not really sure that this one is really, other than those exclusion criteria which I think we could debate, adds anything or is different than what we currently have.

MS. ALTERAS: Okay. Well instead of going through the ratings then, I'll just say for usability I thought that this is a measure that is meaningful and understandable to consumers.

And scientific acceptability there's no testing to really look at it. So I'll forget about that.

Feasibility. Again, there was no testing so all we have to go on is sort of the issues that the Louisiana State measure has dealt with in terms of the feasibility of actually collecting the data.

So would just open it up now, I guess, to talk about whether this is something we want to even vote on or table it until testing results are back from the endorsed measure.

CO-CHAIR MOORHEAD: Suzanne, any comments?

CO-CHAIR STONE-GRIFFITH: Well, I would agree. I just think that this needs to return to the developer, and it needs to be harmonized. And we need to get results from our original measure.

CO-CHAIR MOORHEAD: Are there other comments? Jim?

DR. ADAMS: You know, this is something of a philosophical comment. But in complex industrious, service or manufacturing industries, there's a science to processes and engineering. And whether it's a small discreet service encounter from the first encounter to the cash register, it's a median of 14 seconds or whether it's a complex getting arms and ammunition to fight a war, those are engineered and there's business sciences processing engineering and the hard engineering operations engineering with computer simulation in complex industries, FedEx and others. But these tools have not be applied to health care.

And because they're not applied to health care, we will never solve this measure. And in operations theory, in process measurement theory a person who attempts to engage, doesn't register and leave is in formal language balking and so it's counted as a balk. And a person who does register but

then chooses to leave, that's reneging. And there's a science and there's a formal language but we don't use that vocabulary. We've not structured our systems to learn what's already in complex industries, both in business and in engineering.

And so as we try to move quality forward we're never going to be able to solve these complex problems, especially the interrelationships between operating room and discharge times, and emergency department waiting rooms without the application of this.

And so the next generation of quality sciences will be building on this. And this is what I am trying to do in my department. But it's really hard. So I worry that we're not going to solve without being seen without getting a language and a theory that we all commonly understand.

And literally the language of a left without being seen because you can't measure it because everybody's a different.

Sorry for the editorial, but it's appropriate.

CO-CHAIR MOORHEAD: So I'm hearing a recommendation from Suzanne that this not be recommended and go back and look for the results of implementation issues with regarding the existing measure.

MS. ALTERAS: Yes, I agree with that.

CO-CHAIR MOORHEAD: Is that acceptable?

MS. ALTERAS: Yes.

CO-CHAIR MOORHEAD: Any other comments or questions?

Those in favor of that recommendation? Opposed? Abstain? Thank you very much.

So we will now go back to No. 21. And I don't think we have a primary and --

DR. JAUCH: Well, you have me, for what it's worth, for what it's worth.

CO-CHAIR MOORHEAD: Well, you're a

primary.

DR. JAUCH: Yes, I am the primary.

We can be fairly brief on this. This is NQF review ACP-021-10. This is median time from head CT scan order to head CT scan interpretation. And the brief description you can see there is the median time from initial CT order until to the time to CT results are reported to emergency department staff, although that's not specific as to whom that represents.

It falls under the priority area of a safety item. And apparently this is a CMS measure steward application.

So briefly, as you see, their hypothesis is that the throughput, as we talked about before, is dependent upon a lot of processes that occur in the emergency department and they provide significant literature that suggests that the time it takes to do radiology studies as well as obtain those interpretations leads

considerably to some of the delays that we experience in the emergency department. Although in any of the supporting documentation they do not specifically document the time to cross sectional interpretation or more specifically, to interpretation of noncontrast head CTs.

They do briefly talk about the volumes of CT scans that are performed in the emergency department. It is a fairly frequent study that we use for a very heterogeneous patient population, both in terms of disease spectrum as well as acuities. So, you know, they feel that this is a significant problem in that it can lead to delays. And that, again, purportedly there can be some safety issues with this.

So let me go through this.

And obviously the NQF group felt that this was appropriate.

So 1a, I gave this a partial. And again, it's probably being generous at this

point. It does seem to be an issue. CT imaging can be very important in terms of making some critical diagnoses in a timely fashion and initiating therapy. Again, it's not clear as to how much of a delay that can actually occur because of that, although many of us experience delays in getting these types of images read.

Regarding the opportunities for improvement, I gave this an M. There are citations, again, regarding the overall length of stays that are related to imaging, but not related specifically to CTs.

There are no data on disparities by population group. So 1b I gave an M.

Regarding outcome of evidence to support measure focus. Again, it's difficult in the absence of having any previous data that suggested that CT scans need to be formed in a certain time, and anytime beyond that leads to safety or throughput issues. So I gave that one also an M.

Then regarding the type of evidence that they provided. There really is a paucity of any evidence that looks at CT imaging and times and delays that relate to both throughput as well as safety issues. So I actually gave that one I think in here an M as well.

So in the end I think that, you know the challenge with this is that it's not disease specific, it's not severity specific. And for all the reasons we've heard about regarding troponins and CBCs and things like that, I think there's a lot of challenges to try to implement a temporal benchmark across this spectrum of diseases and actually I'll even get into the settings. Not just the emergency department, but also the acuities of the patient.

So as a big fan of the brain, and that's what my work is in, I think that getting CT scans is very important and getting timely interpretations of this, but I don't

think that this particular measure will really give us data that will be usable either for myself or for the average consumer not knowing what people are going to do with this.

So I'll stop there.

DR. ALESSANDRINI: Well, I agree with all your comments. I had a couple of other thoughts as well.

First of all, I think the intent of this is good. If you order a head CT, you should get an interpretation in a timely manner.

Then I look at this and say now if I look at this measure, will this show the excellence of my institution. And there are a couple of things that will come into play.

One of these is very broad. This is talking about all head CTs. And as your radiologist, I will be triaging as well. So if you have a patient in your emergency department having a stroke, they are going to get scanned immediately no matter what else is

going on. If you have a patient they've ordered a head CT on who is healthy, you know, neurologically intact, chronic headaches, I'm going to image all the people who are really, really before I image your headache person. So that's a little hard when you basing that on all just head CTs.

So one of my thoughts was this would be more powerful if it had a more focused intent instead of all head CTs.

The other thing is a small terminology item. And that is I like the measurement title. But on the brief description of the measure they do actually say "results are reported to emergency department staff." Now that's fine if it's a lab result. But a lot of different things come into play, and there will be times when your radiologist will not report it to emergency department staff.

Say, I'm standing in the scanner with the neurosurgeon. I will talk directly

to the neurosurgeon, neurosurgeon takes patient, patient goes. So does that reflect bad care because it might show up poorly on this metric because you're saying when did you report this to the emergency department staff.

So the terminology there, that's fixable. You know if it's just saying something more like median time from initial head CT order or initiated from the emergency department to the head CT, interpretation results available, then it doesn't say it has to be going to the ED. That would be fixable, more powerful if it's focused.

And then, again, the reported how will be sort of a challenge. And we could get to that for the metrics. Like, is resident prelim verbal interpretation reported? How are you time stamping that? Is it a handwritten interpretation? Is it a general radiologist's interpretation? Is it the subspecialist neuroradiologist's final read?

DR. JAUCH: You want to talk about

TELERAD?

DR. ROBERTS: Yes. Do you know, do you have TELERAD from India overnight and it's giving you a prelim but then your real interpretation is in the morning? There's just so many different factors that can go into this.

But I would like to say the intent is good. If you order a head CT, you should have an interpretation in a timely manner. This just doesn't quite get to I think what the intent was.

DR. JAUCH: Yes. And she said it very nicely. And I think that, again, you know a lot of times the circumstances if I've ordered a head CT, I'll go with the patient to the CT scanner reader right there. So I don't want on these types of results.

So I think it's better off if we're going to have this type of imaging criteria set forth, either for all imaging not just head, you know cross sectional imaging

should be read within a certain time period, plain films in a certain period. And that may not be something that NQF wants to get into. But if we were going to look at CT and specifically, I think we need to be more disease specific. So get the guidelines, which is a registry for stroke captures this information.

We have recommendations that we came up in 2002 that at least for acute ischemic stroke if you have a stroke, you should have a CT scan within 25 minutes and you should have the interpretation within 45.

So, again, it's a very specific subselect population that's more definable and more reportable. And those weren't based on any data that we ever collected. We just randomly chose that in 2002, one of our consensus panels. But it seemed like a reasonable thing, again, mirroring what we do for the golden hour of trauma, the golden door to vein for a STEMI. But I think this is too

broad in scope and not specific enough to be meaningful.

CO-CHAIR MOORHEAD: So is your scoring of section 1 in terms of importance, are you --

DR. JAUCH: Again, that's the challenge. I mean I --

CO-CHAIR MOORHEAD: The contact stuff of this measure?

DR. JAUCH: I'm going to say no because I think if it's endorsed as it is, it will not be usable.

DR. ROBERTS: I had said no, but I would consider going back to them with discreet recommendations on how it could be improved and perhaps more accurately reflect whether an institution is doing well or poorly. Although you could argue that there may be some institutions doing exceptionally poorly that would have results that are entirely unacceptable.

DR. BRATZLER: So I've heard

several suggestions. So the whole issue of available versus reported to somebody was discussed fairly extensively with the technical expert panel. So I get the sense that I don't your specialty doing the primary review. But I suspect that you're skilled at interpreting CT scans. But there are many emergency rooms around the country that aren't staffed by individuals that are skilled at interpreting. And so the word of having an interpretation done that was available was specifically specified that way because we were concerned about just having the test done, that there needed to be somebody.

And we weren't looking for the final report. We were looking for some initial interpretation that got to the person providing care to the patient. So we thought that was important.

And that could be, I would certainly agree, that if you had the neurosurgeon standing there in the CT scanner,

then it's been reported to somebody that's taking responsibility for the patient.

The denominator could clearly be limited to certain diagnoses. I mean, it could be limited to stroke. And I don't know if Jim's got any ideas about way back in those conversations about why we kind of broadly defined just kind of a general time frame to get the CT done. Because it, again, was seen as one of the bottlenecks to getting patients kind of moved through the emergency department.

And the other one was some stratification. I mean, you mentioned the fact that if you have three patients lined up for a CT, one's an acute stroke and the others are headache patients, well I understand that there would be a difference in the prioritization of some of those patients. But if you're just reporting median time or a median in range for all the patients, why that may kind of work out at the end of the

measure.

So, I guess if there was a recommendation for conditional changes, what would those be specifically be?

DR. JAUCH: I kind of view this, as was mentioned before with troponin, I mean I believe that it is an important thing to track and that we should have a minimal expectation of a time for turnaround for interpretation whether it's reported or not. Just availability. It doesn't have to be that I get called. I just need to be able to access that data.

And I think as a community we need to come up with expectations regardless of the disease, we should could up with expectations almost like clinical pathology. Where if you're providing this service, we should expect a certain turnaround time. That's separate than saying we're going to track medians and means. Because reporting that, again, with central tendencies is not

reflective of those who need to have it done acutely within 10 minutes and those who can really done within two hours, and it's not going to make a difference.

So by using the central tendencies argument and by using this overall reporting, it really is dilutional to what is important. The ultra urgent traumatic brain injury, you know some of the pediatric cases and some of the stroke patients versus those chronic headaches or somebody being admitted for urosepsis who is just not quite right and the admitting service ends up getting a CT just to be sure.

And so I think we either need to separate this from -- we need to put this in the context of the overall process of throughput looking at performances and standards and expectations by ancillary services within the hospital, like laboratory. In this case radiology. Or we need to put it in the context of a specific time sensitive

disease like ACS and consider it an EKG and say we need to have this type of information in a certain time period. But I think when you straddle fence, you don't accomplish either very well.

CO-CHAIR STONE-GRIFFITH: Helen, the imaging efficiency measures, is this not -- it is not.

DR. BURSTIN: This is probably one of our more interesting, somewhat notorious aspects of IQ history here. This was a measure that went through the last imaging Committee that Dell oversaw a couple of years ago, which was called Code Stroke CT Narrow Imaging and Evaluating Patients of Acute Stroke Symptoms. And this was specifically about assessing performance for CT scan interpretation.

Again, referring to the guidelines, it was the issue of being able to meet the 45 minute window for interpretation. I think there was some discussion. It was

never very clear. We asked the measure developer to specify further. We didn't get back specifications. They didn't respond, although it did wind up in The Wall Street Journal, but they never actually responded to the request for new specifications.

But it was never very clear when the time window began because patients would come in and if they didn't recognize they had stroke symptoms, when did the clock begin was a complicating factor. So that was one of the clarifications that they wanted to be clear.

This whole issue of a written preliminary report also was something they wanted to clarify exactly, as you had pointed out Catherine.

And they wanted it it was the goal of reading the CT within 15 minutes of completion of a study was also recommended.

So, you know again, if you didn't want to go down this road, Dell would be happy to share with you the deliberations of that

Committee. Because they really did dive pretty deep. But being able to figure out who is presenting with the potential stroke is not so easy. They could have a vague kind of symptoms presenting to the triage nurse and they may not pick up on it. Or God knows they could have my mother in front of them and they'd never get a history. So it's really a challenge. But I think overall the Committee felt it was a good measure of efficiency of the emergency department and they just really were concerned about the specifics and just wanted to see if there was anyway to make it better. So there's a way to potentially to take stroke and/or the other two conditions that were just listed out about acute brain injury in kids, maybe a separate one for kids, but the ones where there are really the highest triage ones, maybe that would be a possibility. And it may be as simple as just asking potentially if you're willing to elect and bring back a measure within a couple of

week for you to take a look at one a conference call with a bit more specificity to get at the high urgency ones.

MS. McCARTNEY: You know, for a stroke from the Joint Commission their measure is actually for order to review by the care team, meaning the independent licensed practitioner that's caring for the patient. So it could be the neurosurgeon, it could be the ED physician to whoever is making the decisions about that patient's care. But it is from order until that review time. So it might be a radiology interpretation that then is reviewed by the care team or somebody on the care team. So that might make it a little bit more -- I hate to say broad, but then just the ED staff.

But I will tell you it is very difficult to get that time because people don't document it.

DR. BURSTIN: And actually, the Joint Commission stroke measure that we do

have, and there isn't one currently about CT interpretation.

MS. McCARTNEY: No.

DR. BURSTIN: Is all about time last known well --

MS. McCARTNEY: Right.

DR. BURSTIN: Not a term of art, I think. By patient of when symptoms began. We're actually retooling that one right now for electronic health records and it's a bear to figure out what time last known well means. So there's definitely some issues of going down this road, but it is I think very much like what we talked about earlier with troponin.

CO-CHAIR MOORHEAD: So the last I heard was that on the importance issues, that this was too broad in its current form was your recommendation?

DR. JAUCH: Yes.

CO-CHAIR MOORHEAD: And I guess what we need to know is whether we'd like them

to go back and try to work on this, is this something that can be done relatively quickly or is this something we just don't want to go with?

DR. JAUCH: Well, unfortunately, I don't know what's been before. So, unfortunately, I've not seen these previous measures. I'm not sure how specific they've been and now successful they've been in terms of implementation. So with that type of knowledge you kind of know is it really feasible to construct one in a more focused application. And if they've already had trouble with the focused application because some of the challenges we just heard, then I'm not sure two weeks will give us enough time to do that. And that's just being the new person on the Committee.

But I think, again, the importance in general to getting timely interpretation of all imaging, cross sectional, plain films, is beyond doubt. The question is an we -- you

know, just as easily a plain film recommendation here saying that plain films should be read within an hour. And, you know, do you really want to make it that broad because I think that's a challenge to implement and really understand what those data will be telling us.

So I don't think, no.

DR. ROBERTS: I agreed. I think that would be sort of challenging to have them come up with something at the last minute that certainly an entire Imaging Committee has struggled with.

CO-CHAIR MOORHEAD: Okay. So the recommendation on No. 1 in importance is no.

Any further comments?

Those supporting the recommendation? Opposed? Abstaining? Okay.

So we'll now move to 22. This is Bob.

DR. O'CONNOR: This is measure ACP-022-10: Median time to chest x-ray.

The definition is the median time from initial chest x-ray order to time the chest x-ray exam is completed.

The measure met all conditions for consideration by NQF.

I think I can go right into the importance and recommend no, and I'll tell you why, to sort of do it do it backwards.

You've heard a lot of the arguments already today on either metabolic profile, CBC, head CT. This is a heterogeneous population. Measuring the median I don't think would be, you know because the measure is central tendency would not be the best. You know, I would favor something along the lines of to have 90 percent of the films done within a specified time period as opposed to a median for all chest films, which are obtained for a variety of reasons ranging from detection of life threatening illness to routine preoperative studies.

The idea behind this is a good one. You know, I think if I were a patient in an emergency department getting the chest x-ray, I'd like to have it done as quickly as possible and have a good interpretation of that film done quickly as well. However, the goal of the measure is to reduce throughput in an emergency department. And this is just one of many tests for many factors, actually a myriad of factors that effect throughput in the emergency department.

You could argue that there's nothing really special about chest x-rays compared to other films, for example. That it should be part of a comprehensive radiology service to the emergency department that turnaround time is quick.

So I think with that, I will stop and just reiterate my recommendation as to say no to importance because it may be a useful quality improvement measure within the department. I don't think it will advance the

cause of reducing throughput in the emergency department, which is what much of the evidence that's cited in section 1 relates to.

CO-CHAIR MOORHEAD: Okay.

DR. ROBERTS: Now this is one that I was a bit more favorable one because --

CO-CHAIR MOORHEAD: Well, I wonder why.

DR. ROBERTS: Well, because this is a really -- it is kind of a nice QI project for radiology. And we used to track this in my institution for years because we wanted to make sure that when the ED ordered a chest x-ray, they knew about pneumonia, they knew about pneumothorax, everything, you know really, really quickly.

I guess on the alternate argument is that after several years we stopped tracking it because we had made all the improvements we can and occasionally patients are having other things done that are important, and can't interrupt the chest x-ray

being done right at that moment.

So I don't know. I wound up writing this a yes, but it is a quality improvement. It is one thing. And it would need the rest of you to decide how important that is for your ED throughput.

But this one was a lot cleaner. You know, it was easy for us to track. The order goes in, time stamp and then we time stamped image completion including returning the patient to the ED, again time stamp. So very easy to track. Very easy to see when things were out of whack and you'd try to work on improving. And people might have institutions where that could be improved. But again, that's only one little part of your emergency department experience. And so I would need the rest of you to have a sense of how big an impact this would make on your lives, or on nationally lies.

CO-CHAIR MOORHEAD: Comments from the Committee.

DR. COHEN: Just a lot of the comments you made on the CT scan are related to the chest x-ray in terms of the verbal discussion. You know, the verbal statement from the radiologist or who is doing the actual reading, all that applies also to the chest x-ray, I would think.

DR. BRATZLER: Although the specifications for this measure are to the completion of the exam because of that. Because we know that most ED physicians do interpret their own.

DR. ROBERTS: Exactly. So this one does not include --

DR. COHEN: This is a little more specific.

DR. ROBERTS: -- the interpretation. It's just how --

DR. COHEN: It's completion itself.

DR. ROBERTS: -- how efficiently my technologists are responding to the needs

of the emergency department.

CO-CHAIR MOORHEAD: So the recommendation is no question number 1 as a measure and more of a QI, to be used as a QI indicator.

Other thoughts? Suzanne?

CO-CHAIR STONE-GRIFFITH: Well, I would just agree. I really think, although it lends itself to measurement internally, if I think about this in the public space, how does that really add value in the big picture? I just don't see it.

DR. ROBERTS: I see your point. Absolutely.

CO-CHAIR MOORHEAD: All right. Those in favor of the recommendation, raise your hand. The recommendation that the answer to the importance is no.

Those opposed? Anyone abstaining? Okay.

We can move ahead. So the next is No. 23. So 23 is Victor.

DR. COHEN: Yes.

DR. BRATZLER: I just want to make just one real comment on this one before we start. So this one is one that we actually spent a lot of time with the technical panel on about carefully defining the denominator population. We clearly didn't want to create a measure that might make it broadcast that emergency rooms were held accountable for how quickly they gave pain medicines, that make people want to go and get their pain medicines. So the denominator population for this was limited to the population of patients with a principal diagnosis, or their first diagnosis in the ED of a long bone fracture.

So it was a very limited denominator for that specific reason.

I think one thing that's come up in all these conversations is I spent a ton of time doing literature reviews on a lot of these points about throughput to lab and x-ray. There's not much published out there.

There are a few studies on this particular topic about delays and personal experience. And when I went to an ER to an acute abdomen, and made the diagnosis long before I got there but had to wait for a surgeon to show up before I could get pain meds. I had special concern about this particular topic.

CO-CHAIR MOORHEAD: Okay.

DR. COHEN: Assigned ACP-023-10. It's median time to emergency department arrival to time of oral or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture. This is a process measure and it is a timeliness measure.

It did meet all four criteria for consideration in terms of conditions for NQF. But with that said, in terms of areas of importance this is a time limited endorsement and testing will be complete within 12 months.

1a, the measure does address a national goal identified by NQF, NPPP. It

represents an important quality issue, pain management within the ED.

Over 90,000 admits are related to fractures annually. Thus, a high impact aspect of health care, high use of resources and leading cause for morbidity.

1b, the measure provides an opportunity for improvement as it provides a standard of practice for patients presenting with long bone fractures to the ED.

Disparities have been identified. In one study one two-thirds of patients received opiates, and those taken care by PAs, other practitioners, physician extenders only half received opiates.

Racial disparities were noted as less black patients were treated with opiates than whites.

1c, the measure is an intermediate outcome of process of care. Its relationship to outcome the faster delivery of pain management, the improved satisfaction of care

provided. When pain management was delivered at an adequate time, patients were more satisfied; the second way to say it.

Strength of the evidence a level B and C. There are observational and cohort studies. These studies are hard to conduct ultimately because you cannot give pain medication to patients. So gold standard due to clinical limitations are not -- you can't have the gold standard. You can't just give placebo for pain.

Controversy. There is controversy and contradiction of more pain management before diagnosis. There's no reason to hold opiate therapy. What I'm trying to say here is they are suggesting that the controversy is you'll have more pain management even before the diagnosis is actually made. So diagnosis may not be made, and they still will give opiates; that's their concern.

I was considering anyone comes in suffering with pain, it's better to error on

the side of caution and treat them for pain management if they're complaining of pain visual analog score of 10 of 10. That's a reason to treat with pain.

So I think this completely met -- unquestionably meets criteria. Overall meets the importance criteria.

CO-CHAIR MOORHEAD: We don't have a secondary.

Is there any other comment about No 23?

DR. COHEN: Levine is -- oh, I guess Levine is not here.

CO-CHAIR MOORHEAD: Levine's not here.

Scientific acceptability of measure properties. Measure is scientifically acceptable, well defined and precisely specified so that it can be implemented consistently in comparative cross organizations.

Numerator. It measures a time

from arrival to the ED to time to first oral IV administration of opiate therapy. Now I think that's a problem.

You're not adding in new procedures; nerve block, local anesthetic treatments for fractures and various other types of bone fractures that physicians are doing. They're doing ultrasound guided local anesthesia to LB patients, provides greater duration of care. Pain management as opposed to morphine where you have to just keep providing.

Furthermore, opiate is not alone. You have Ketofol, ketamine plus propofol being used for pain management. So I think this doesn't include all pain therapy, so you may miss a good number of patients in terms of the measure.

DR. ALESSANDRINI: Can I ask a quick question. When you doing those other, like the nerve blocks and things like that, in my experience we usually still treat with an

oral or IV pain medication while preparing to do that. I mean, do you think that's pretty standard or do you think some people get nothing and will go right to one --

DR. COHEN: Our ultrasound physician is actually doing a study on this right now. And only if the patient complains of pain will they start an opiate. I don't believe he starts an opiate initially. But we only wait a short amount of time, like 30 minutes. So hopefully the onset of the anesthetic takes on. Pretty quickly.

He's seen very good results in that respect. But I don't remember exactly if he starts on morphine and then does the anesthetic.

DR. ALESSANDRINI: And as far as I'm aware there's not a contraindication to having both. So --

DR. COHEN: No, there's not.

You know, furthermore also you may not used an opioid, which this strictly says

opiates, you could NSAIDs. So those patients contraindicated to opiates, they're necessarily are excluded from this. They probably should be included as well. So that's just another issue.

CO-CHAIR MOORHEAD: Did you want to comment on this?

DR. BRATZLER: Yes. I just want to check on the phone for Rebecca for the table 8.1 does that include other? I didn't think we limited it strictly to opioids.

DR. JONES: I'm taking a look at it now just to make sure.

That is not limited to opioids. They are aspirin and NSAIDs on here, I believe. Yes. So it's not limited to opiates.

DR. COHEN: I think there was a statement somewhere where it said opiates, so that's why I was referring to opiate. But I'll take a look again to see if I find where it was referring to it. I think it would say

in the numerator.

DR. CHALIAN: The numerator it says oral adrenal --

DR. COHEN: Okay. That's fine. You know what I was looking at, I believe the codes. They also, a lot of the codes were opiate related. But I did see something on that issue.

So it's general. It's any pain management?

DR. BRATZLER: Yes.

DR. COHEN: Okay. In terms of denominator, the denominator is appropriate. Would want to not exclude contraindications to pain medications as there are always alternatives to use. Because there is a contraindication vein that's a very general, I mean you're going to have to provide some pain management so I'm not sure how you can be fully contraindicated to all pain medications. So that was one of the denominator exclusions. So I'm not sure if that's rational.

DR. BRATZLER: So that actually didn't show up on my list and maybe have a different. The form I have doesn't have that as an exclusion.

What that discussion was about the potential for some patient that had a long bone fracture and then might have some closed head trauma or something else that you might be reluctant to use an opioid on. But I would agree that you could use something else.

DR. COHEN: But you could use something else. So, yes. So just those patients with contraindications to pain medication.

CO-CHAIR STONE-GRIFFITH: What about aging?

DR. ALESSANDRINI: Yes. I mean, I think we would use at any age. I mean sometimes if you have a long bone fracture, you would get treated with pain medication and even a narcotic, just with close monitoring.

CO-CHAIR STONE-GRIFFITH: Right.

This is actually 18 or over, though, which I guess was the question. Need the 18 and over.

DR. ALESSANDRINI: Right. And I don't foresee any reason why it should be not any age patient.

We spent a significant amount of time operationalizing this measure at Cincinnati Children's. And the way that we found it to be most effective but it's easy for us in one institution to collect data, is we're tracking time to IV pain medication. It doesn't have to be a narcotic, but it does have to be IV because oral tends be inadequate for patients who present with deformities. Because that's who -- you know, I mean it's really hard to think you have a long bone fracture, particularly in kids. If you have a distal radial buckle fracture and who really needs the pain medication. And so it's worked very well for us to say in triage if you have a deformity, you know that the patient that's it noted, there's a special -- which occurs

that the patient gets treated, you know with IVP medication rapidly.

And so that seems to be like who really needs the treatment. I think it sometimes then it gets a little bit more difficult in these circumstances are you identifying the patient respectfully based on ICD codes. And when you're doing that, then it sort of goes back to that sort of like diluting the population. But maybe that's the right way to look at it. Because if you're including the oral pain medications in addition to intravenous, then you're sort of capturing the appropriate therapy for the appropriate diagnosis. But just a consideration.

But definitely there's no reason that I can think of unless anyone else can think that we should not include all patients in this measure.

DR. COHEN: The measure will allow for stratification of results.

No data was specified for survey method. It just suggested sampling data. Again, a description of the sampling source of data is charts and various other electronic medical records, which is good.

2b, 2c reliability and validity. The measure appears to be reliable and valid yet no date is provided. Only side comments are provided. So here I said N or minimal.

No data on supporting exclusions was provided. Again N or minimal. Actually, at minimal.

No risk adjustment is provided or why data supports no risk adjustment. Again, minimal.

2f, g and h are partial as actually minimal. Overall because no data was provided on these.

Overall partially, this measure partially meets the scientific acceptability in my view from that standpoint.

Do you want discussion or do you

want me to go on?

CO-CHAIR MOORHEAD: Any comments, questions?

Keep going. I'm sorry.

MS. ALTERAS: I mean, you rated everything minimal everything, right?

DR. COHEN: Yes. And it rated it partial because I was trying to be soft. I wasn't clear as to -- so I think it truly it is minimal in terms of meeting the criteria. But I didn't know the positives and the negatives.

In terms of usability, there's no current use as testing is not yet complete. It's related to other dependent processes that we have already, like fibrinolytics, et cetera. So it's easy to use and understand.

There is harmonization with other NQF measures.

There is direct additive value of the measure. Overall it partially meets criteria for usability once testing occurs and

on the public use. You know, I think it will be completely meet the criteria.

Feasibility it meets partially for a, b and c.

For d what I was suggesting for d is rather error on the side of caution with pain management than to not provide pain management, irrespective of diagnosis for patients suffering from pain.

And 4e costs with electronic medical records may be minimal. All Quality Assurance Performance Improvements can do this, especially if you have if electronic medical records. They can capture the pain management and that records pain scales and medication administration.

I say overall yes is my recommendation to endorse.

CO-CHAIR MOORHEAD: Comments, questions?

I guess the one suggestion is open this up to all ages. And the other is would it

help the measure to add the deformity that was helpful to you and get some feedback from the Committee in terms of whether that would be helpful>

DR. ALESSANDRINI: Yes. It would be interesting what the Committee thinks I would say if we added the deformity which decreases or limits or makes it less feasible to -- it makes it a little bit more out of the realm of the electronic down the road. But then I would say if you did deformity, I would recommend limiting it to IV medications. But if we just left it with the diagnoses and then there were any fracture, then I think doing it combined oral or IV approaches is acceptable.

DR. BRATZLER: And so I think if you're within a hospital measuring your own performance, it's--

DR. ALESSANDRINI: It's easier.

DR. BRATZLER: -- it's easier finding deformity from a performance

measurement standpoint rolling it out to 4,000 hospitals. Then you're looking at text fields of a chart or other things to find that information.

DR. ALESSANDRINI: Yes.

CO-CHAIR STONE-GRIFFITH: And are we going to limit to oral and IV, and are we including nerve blocks.

DR. COHEN: Right. All pain medication.

DR. BRATZLER: So we can certainly modify the table to include other forms of nerve block, regional anaesthesia and things like that.

DR. ALESSANDRINI: And also to essentially delete the exclusion for contraindication to pain meds is the other suggestion that was made.

DR. BRATZLER: Right.

CO-CHAIR MOORHEAD: Jim?

DR. ADAMS: Yes. I just wanted to think about the exclusions for the multi

trauma patient that may have devastating head injury to go to the OR. Do we have the exclusion sufficiently thought through? Especially at the high end traumas that may go to the operating room for other reasons.

DR. COHEN: Well, they may be intubated already anyway. So what's the concern? Well, then they probably don't need pain management anyway.

DR. ADAMS: Right. Or they rapid operative intervention and they go there and never get dilaudid.

DR. BRATZLER: Yes. So I think that's part of why we limited to the first diagnosis of a long bone fracture thinking that most of the severe head traumas and others would probably have some other first diagnosis. But that was the whole conversation around a contraindication to pain medication would be the patient that showed up with a mid-femur fracture and also a head injury that you might not want to sedate.

DR. JONES: And we captured that in the data element for pain medication in looking into whether or not they received it. We also have clauses that if there was sufficient documentation of reasons for not administering such as the patient was unconscious, decreased respiratory rate or patient refusal that those were acceptable.

DR. BRATZLER: So that's in the data element that's captured.

DR. ADAMS: And I think that's a point that will come out in testing also because most of the physicians under those circumstances are not going to document the negative of why it was withhold. And adding a burden I think that would make this received negatively.

The best metrics have people with multiple disciplines, you know our nurses, our pharmacists, our doctors, our surgeons coming together to achieve a goal. You know our STEMI stuff, everybody come together to

achieve a goal, and stroke and sepsis. And so in this I'd like people to come together to achieve a patient-oriented goal.

And I can see that here. I would vote for it.

I think the highest order of success would be the more relief of suffering because sometimes immobilization, ice, expression to caring are also part of that stuff. Just shoving dilaudid at everybody is what we'll get out of this. But I don't think we can measure that. I just wanted that kind of on the record that I wouldn't want a higher order, but this should be some minimal level of success that I would accept. I just don't think it's exactly the end point.

CO-CHAIR MOORHEAD: So I'm hearing a recommendation to recommend approval with the conditions that this be expanded in age and add other pain modalities. Is that accurate?

All right. Those in favor?

Opposed? Abstaining? All right.

We're now moved to No. 42.

DR. BRATZLER: I think I've done enough of them. I don't know if we ever got a decision around the troponin.

CO-CHAIR MOORHEAD: And while you're here let's go back and vote to No. 19. We deferred and wanted the discussion of our issues before we voted on that. So back to Victor. You have a recommendation for us?

DR. BRATZLER: The conditional notes that I have were to consider a rival to result with a limited denominator cardiac chest pain or AMI with some reporting of the distribution of the measuring, meaning perhaps plus distribution or something beyond just the simple tendency, or within an hour, or set a proportion.

You know, we've tended to avoid those set times in measures because there's almost evidence to ever base a number on. I mean, it's always controversial.

DR. ALESSANDRINI: Always controversial.

DR. BURSTIN: There is also the time of arrival.

DR. BRATZLER: Yes.

DR. COHEN: I guess perhaps stratify to where it would be used, for example, the NSTEMI. I think that there were comments stated something of that nature to when it's necessary, which may be a condition that may be more appropriate in that respect.

CO-CHAIR STONE-GRIFFITH: In the NSTEMI. Yes.

DR. COHEN: But I still support it.

CO-CHAIR MOORHEAD: So your recommendation is to recommend approval with these --

DR. COHEN: Conditions.

CO-CHAIR MOORHEAD: -- conditions?

DR. COHEN: Yes.

CO-CHAIR MOORHEAD: Are there --

DR. ALESSANDRINI: Can you go through the conditions one more time?

CO-CHAIR MOORHEAD: I think we're limiting this to presenting -- but to chest pain or is STEMI, not acute MI?

DR. BRATZLER: So it's cardiac chest pain or AMI. And remember you're only in the denominator if the test is even drawn. So if you had an EKG that showed a STEMI and you didn't even do the test, that case wouldn't even be in the denominator.

DR. COHEN: So it's not an issue.

DR. BRATZLER: So it's rival 2 result, cardiac chest pain or AMI.

CO-CHAIR MOORHEAD: Well, but just wait. Is it really cardiac chest pain?

DR. ALESSANDRINI: Well, how do you know that?

CO-CHAIR MOORHEAD: I mean, you don't know that.

DR. COHEN: I'm just going to say chest pain.

CO-CHAIR MOORHEAD: I think it's -- I mean that's one issues that we need to just clarify here.

DR. BRATZLER: We already have from other measures a denominator definition of patients who -- you know, chest pain generically is a whole pile of things. Trauma, chest wall pain and so if you don't have some way to specify cardiac chest pain, it gets very muddy. So we already have that defined for other measures, cardiac chest pain or AMI for some of the other ED measures that we already use that are NQF endorsed. Because if you just use the generic chest pain code, then a patient that fell down the stairs and comes in with chest pain gets thrown in the denominator.

CO-CHAIR MOORHEAD: At least non-traumatic chest pain in some of our measures.

DR. BRATZLER: Yes. We have it defined.

CO-CHAIR MOORHEAD: We're

reviewing this. So cardiac chest pain or is it STEMI or acute MI?

CO-CHAIR STONE-GRIFFITH: It's the MI.

CO-CHAIR MOORHEAD: It's an MI. Is the population with the change being from time of arrival to the time troponin results are reported. And --

CO-CHAIR STONE-GRIFFITH: Reported or resulted. Because again, I'm concerned about the burden of trying to find the --

DR. BRATZLER: So this would be the lab time stamp.

CO-CHAIR MOORHEAD: So made available.

CO-CHAIR STONE-GRIFFITH: So it essentially resulted by the lab reporting?

DR. CHALIAN: So at the end we'll end up with a median time and everyone will be compared?

DR. BRATZLER: And we also agree there will be some distribution.

DR. CHALIAN: And who is the winner? As a consumer, what do I look for? Do I want the 18 minute one or does it matter if it's 60 minutes? So a measurement that we don't define as winning or failing is irrelevant? That's what I'm struggling with on this measure.

CO-CHAIR MOORHEAD: We're all --

DR. BURSTIN: You know, there are a fair number of measures that don't have a threshold. And it's often early in the sort of development when you don't have a threshold yet, but for example what's the right rate of episiotomy, we have a measure on that. What's the right of readmissions, for example, you want it to be low but you don't want it to be zero.

I think it's that same thing as a measure goes into place often times we don't have a threshold.

DR. CHALIAN: And, Helen, as a clinician and as a consumer, I have to say our

responsibility is to put these out into the public domain in a way that we don't invalidate the ones that we really feel are highly valuable, and we put a limited number out because there's a burden of collecting this and there's going to be a judgment executed based on this that will take up other resources.

CO-CHAIR MOORHEAD: Well, I -- I'm sorry. Go ahead.

DR. BURSTIN: No, no. Go ahead.

CO-CHAIR MOORHEAD: Well, I was just going to go back to Jim's comment earlier. I'm much more concerned about any troponin that's not available within an hour. I mean, that to me is a big deal. Whether it's ten minutes or 12 minutes, I don't think matters to the individual patient. And so that would be another opportunity.

DR. CHALIAN: Yes. So when I sit in my patient's safety officer hat and we're juggling critical values in our organization,

again I'm bringing it up again, we have a timeline. So I think I would define this as what's the time that has a critical value? And maybe the issue here is when a troponin is abnormal, how quickly is it reported to the persons, and that affects the outcome and the quality of care.

To use troponin as a surrogate for throughput, which is what this is being used as, kind of takes our next measure on the importance of troponin away. And so another thought.

CO-CHAIR STONE-GRIFFITH: But if we change it from a surrogate of throughput to a focus on cardiac, then we're removing that issue. But, of course, that brings me to we have a new dilemma, which is we've been measuring cardiac chest pain and AMI for a while now on the inpatient side, and now on the transfer measures. It's interesting that troponin has not been part of that package.

DR. BRATZLER: Interestingly,

almost all of the AMI measures that are in the public domain focus on STEMI. None-STEMI, even though there are great studies out there around non-STEMI, there are almost no publicly reported measure sets around non-STEMI right now.

So I think the troponin is very important in terms of non-STEMI.

CO-CHAIR STONE-GRIFFITH: Well, yes, right now, right.

CO-CHAIR MOORHEAD: That's what we would like. We'd like to --

CO-CHAIR STONE-GRIFFITH: Right.

CO-CHAIR MOORHEAD: What I would sense is the group saying we'd like you to come back and give us a measure on non-STEMI. And not times, and not individual markers, but give us some measure of the non-STEMI.

DR. CHALIAN: We find that we used to get at troponin quickly, because we don't want to miss non-STEMI.

DR. COHEN: How about non-

diagnostic also.

DR. CHALIAN: Non-diagnostic, too.

DR. COHEN: Well, non-diagnostic and non-STEMI and STEMI? Because non-STEMI still has some depressions, but non-diagnostic you have nothing in females, I believe, present with non-diagnostic.

DR. O'CONNOR: I think, if I may, we have the language already if you look at the ECG ACP No. 36. Emergency medicine visit for non-traumatic chest pain. And I think if we insert the analogous language for a timely troponin into that entry criteria, we'll hit the non-STEMI.

And I think going back to your point, that maybe part of the reason this has not been addressed is that until recently the troponins have not been as accurate as the new generation ones are. So it's pretty much if they're abnormal, you have the diagnoses of NSTEMI, in most cases.

DR. COHEN: I also bet that

fibrinolytics and use of fibrinolytics is dependent upon whether you had a STEMI. And I'm sure the company funded issues made it more important to get these values and make it cost effective.

CO-CHAIR STONE-GRIFFITH: I mean, where we're almost going to is some sort of a pairing of a measure or composite of a measure to address the non-STEMI, the --

DR. COHEN: Undiagnostic, right.

CO-CHAIR STONE-GRIFFITH: Right.

CO-CHAIR MOORHEAD: So we could recommend pairing this with ECG for patients with non-traumatic chest pain?

CO-CHAIR STONE-GRIFFITH: That's a different developer.

DR. BURSTIN: Yes, those are a different developer. They already have -- that's in yours.

CO-CHAIR MOORHEAD: Okay.

DR. O'CONNOR: Whether we pair it or not, I think it's the same idea. It's an

analogous clinical scenario.

CO-CHAIR MOORHEAD: So you're recommending rather than cardiac chest pain AMI to be non-traumatic chest pain?

DR. O'CONNOR: Yes.

CO-CHAIR STONE-GRIFFITH: And non-diagnostic.

DR. COHEN: Well, including NSTEMI and non-diagnostic.

CO-CHAIR MOORHEAD: Yes. Non-traumatic chest pain captures --

DR. COHEN: It captures all those, right.

CO-CHAIR STONE-GRIFFITH: Okay.

DR. BURSTIN: And actually our other EKG for non-traumatic chest pain from the PCPI does use the non-traumatic chest pain term because we all said that those within the portfolio as well if that's a preferred term.

DR. O'CONNOR: Just one comment on that. The alarm goes off, you know, because if this becomes a mandate for people to order

a test they wouldn't otherwise order, we could have a problem. So I think we need to be very careful in how define the denominator, that it's the ordering of the test which I think someone said earlier. That if the clinician opts not to order the test, then that case is not going to meet the denominator.

DR. BRATZLER: Because it's a timing measure. If you don't order the test, you can't calculate a risk.

CO-CHAIR MOORHEAD: Say it again.

DR. BRATZLER: Yes. If you don't order the test you can't calculate a risk.

CO-CHAIR MOORHEAD: But Greg Henry's voice is ringing in my ears. You know, never order one troponin. Never order one troponin or you'll be in court, you know, sort of thing. It's an allowed method.

Jim, you were out of the room. I went back to your comment that we'd like a measure on non-STEMI rather than a time sort of thing. I heard you say that. So we need

some help here.

Do we want to recommend this with some conditions? Do you want to go to the airport? I know you want to go to the airport, but we got to get --

DR. BURSTIN: Just on process. But I think Dell's heard sort of the general suggestions. He will bring you back a new measurement to look at it so you'll have a chance to vote on the revised measure.

So, I mean, I think at this point if you just vote all you're doing is moving it forward for him to respond. So if you want to recommend what the conditions, you'll still have a chance to look at it with the conditions put in and decide then. So there's not a whole lot to lose, I guess, at this point since you've given a set of conditions to just kind of dispose of it and move it in that direction.

DR. ADAMS: Back to the philosophy that I like to have a patient-oriented goal

and have all the disciplines have to work together to achieve that, kind of like a basketball team. And one of the key partners there is really the clinical pathologist. And the clinical pathologist, it turns out to be pretty important depending upon the technology that they have. Because if the troponins are often run after the chemistries just because of the sequences of the labs. If they're the more expensive systems, then they can separate it out and run it simultaneously.

So the more profitable hospitals actually have the bigger advantage to be able to have a more timeable turnaround time.

Now on the other hand, the hospitals that don't have as much capital and don't invest in their laboratories, do they have to sell this in a different way? How to bring the people together? How do they do that?

So, I would like to see a non-STEMI because we want the patients to get the

same care every place.

The troponin turnaround time in isolation is critically meaningful. But I just wanted that message heard as we go back and try to reformulate something that would bring people together and solve something meaningful for the patient.

CO-CHAIR MOORHEAD: Is the way this reads now that we will be recommending median time from patient of arrival with non-traumatic chest pain to troponin result. I have a real problem with that. I mean, we're going to order troponins on a lot of people that we wouldn't order troponins on.

DR. BRATZLER: No. No. The denominator only includes patients for which the test is ordered is the way I interpret this. So the denominator is the patient who presents with non-traumatic chest pain who has a troponin ordered.

CO-CHAIR MOORHEAD: Okay.

DR. BRATZLER: That's how I'd

define it.

CO-CHAIR MOORHEAD: Okay. Thank you.

DR. O'CONNOR: And it would be from the time ordering, not backtracking to arrival.

CO-CHAIR MOORHEAD: Well, that's at least what we had, or the last thing on the table was from time of arrival.

CO-CHAIR STONE-GRIFFITH: If we change this to sort of addressing the non-traumatic chest pain, then we're going to have to move away from arrival too. It's going to have into the order too, right? Order resulted, same thing.

DR. BRATZLER: You could do it either way.

CO-CHAIR MOORHEAD: Right.

DR. BRATZLER: And we capture the times.

CO-CHAIR MOORHEAD: Why would you need to do that? So if a patient arrives with

non-traumatic chest pain for which you order a troponin, we'll go back and report the time?

DR. BRATZLER: Yes. We can look at either time, to be honest.

CO-CHAIR STONE-GRIFFITH: Okay. I'd rather have it arrival. I mean from a consumer standpoint, right, I'd rather have it arrival.

CO-CHAIR MOORHEAD: Yes.

DR. CHALIAN: To some degree now I'm going to flip into let's make this a research project. It's a hypothesis driven project.

If our hypothesis is that throughput can be enhanced by quickened reporting times or shorten an interval to drawing the test, that's one hypothesis.

What we're all coming back to is, though, is we feel like improving the care of this MI subpopulation that's hard to diagnose. And this metric doesn't allow us to drill down on that process enough is what I'm hearing Jim

saying. So from really delivering this -- and I also picked up another point Jim was making. There is disparities in what each organization can actually accomplish. And this group will be driving some organizations potentially to a point where they actually can't deliver.

So this measure from a perspective -- of my perspective, which is way outside of where my comfort is clinically, but as a process engineer is really one that I wouldn't want to put up as the first troponin metric. Because it really distracts us. We want troponin to do something else.

DR. ADAMS: And then the question is -- so I agree with everything you've said. And the question is then is that, you know, if that system is -- is that wrong and then is it driving toward -- is a faster diagnosis of these non-STEMIs meaningful enough to create that tiering that will happen? Because the other place is the suburban places will just bedside troponins and look really good. And

is that then looking good, the academic centers looking second rate and the poorest places looking worse, is that meaningful enough with creating an outcome for the patient for us to push it forward, or are we just that's kind of nice, but not that important?

You know, I'm just throwing out there what I think will happen.

CO-CHAIR MOORHEAD: Well, is there a process where we don't actually recommend this but give you the benefit of our discussion and still afford you the opportunity to come back to us by the time of our conference call and potentially make a different recommendation?

DR. ADAMS: Because I don't want to lose, I mean non-STEMI and troponin is very important. I don't want to lose it. But I don't --

CO-CHAIR MOORHEAD: So are people more comfortable with that; not making a

formal recommendation but just hearing the discussion, come back to us? All right? People are nodding.

Thank you very much for your time. We appreciate it.

All right, group. We're close.

We have No. 42. Migraine. Victor, got you working way at the end here.

DR. COHEN: I appreciate that. Just to tell you that.

CO-CHAIR MOORHEAD: With no secondary.

DR. COHEN: My birthday was yesterday and I've reached my fourth decade. And today is my first day after my fourth decade, and I feel like I'm 20 years old. So I really appreciate the experience, I guess. So thank you very much.

CO-CHAIR MOORHEAD: Can you help us understand that? Is there a quality measure to make there.

DR. COHEN: On a more serious

note, this is ACP-042-10. The measure identifies patients with frequent migraine ER -- ER/ED. This is where I was going to say that it's the ED, not the ER. We don't work in a room, we work in a department.

The emergency department encounters oral frequent migraine medication use that had an office visit within the last six reported months.

This is a process measure. Had an NPPP area of care coordination, which is its priority area.

The measure meets all conditions for consideration by NQF for public reporting. The measure has been tested fully. And so it does meet all conditions for consideration.

As for importance, 1a -- you're saying no, Jim? Okay.

As for importance, the measure does address national goal identified by NQF NPPP. It represents an important quality issue of consequence support care as it affects

large numbers, 18 percent of men, 6 percent of woman are untreated and undiagnosed for migraines. So it is a big impact issue.

1b I put down as partially. The measure provides an opportunity for improvement as it will identify patients with evidence of poor disease control who may benefit from face-to-face provider encounter.

Here's where I got a little confused, which is good in a way. This provides opportunity to evaluate etiology and intervention to reduce ER visits. I think that's what the premise is.

I'm not sure that this is the answer. As a patient care for migraines the outcome of poor face-to-face encounter -- so what I'm trying to say here is that is it the face-to-face encounters that resulted in the over usage in the first place? So they're suggesting that if we can identify whose have high amounts of usage, they should go for that face-to-face encounter. But in fact a lot of

people go to that face-to-face encounter, start pain medications or migraine medications and then resultingly don't get their care appropriate and then have to go to the ER because they have an exacerbation of their migraine headache. So I didn't see where this was going.

I know this is an identification issue more, like understanding what the rates are. I don't know if I made myself clear on that.

So a 66 percent compliance rate, and this is a 15 million member benchmark database. So clear areas for improvement. This was Ingenix data in terms of care.

Disparities are not described, but I did find a lot of information that there are disparities; racial especially.

1c, the measure is an intermediate outcome of process of care, it's relationship to outcome. That identifying patients with poor disease control who may benefit from the

face-to-face provider encounter to allow for all very more intensive evaluation of care and management.

Again, I'm not sure that this would translate into that just because you have another face-to-face encounter. I guess you're going according to a guideline or a management. I think the problem here is that there's no standard for follow-up of care. And that's the major issue, and that's where I sort of started to get a problem with this whole process.

The evidence provided is guidelines based and based on expert opinion alone, expert consensus recommendations. I'm almost to the point where this is a little conflict of interest. They're asking for another face-to-face and it's a neurology group and a bunch of other groups. But this was a multidisciplinary panel, but it is expert opinion. It's not evidenced-based recommendation.

The controversy and contradictory evidence. Concern is that there are no clinical standards for follow-up care for migraine headaches. The measure is based on an expert panel consensus.

Furthermore, it's apparent that only 4 percent of patients database were identified based on the current definition of denominator. So there's a need for reworking of the current inclusion definition. So that was that.

I was getting confused in terms of the numbers. There was one place where they had 70,000 and then there was another place it was just 4,000 that was identified. And then 1900 were actually the numerator. So it was confusing, the numbers.

The steward quotes the guidelines for the need for this measure. Based on poor care an overuse of less than optimal tolerable medications.

The guide provides

recommendations, but that are not based on evidence-based medicine as written.

Experts based -- this is a multidisciplinary committee that basis.

So basically I stated that it is an important measure. I just don't know if the way they're going at it if there's available follow-up care standards that will help meet this intended issue. I still said yes in terms of importance, overall importance in terms of measuring and reporting.

Did you get that? Is that clear? Do you want me to go on?

CO-CHAIR MOORHEAD: Any reaction?

MS. ALTERAS: I think -- well, I just was curious from all the ED folks here. I mean, it seemed to me that there should be a measure for migraine patients of whether the person that you saw in the emergency department if you presented to the emergency department gave you a referral to a primary care provider and helped coordinate your care

versus just asking whether you had visits in the last six months. I just don't see what value there is in reporting that information without acting on it. And this doesn't consider whether you act on it.

DR. ALESSANDRINI: I mean, it seems to me this is more of a recognition of the quality of the care of your primary care doctor and your neurologist. Are you getting adequate care and pain relief for acute exacerbation that keep you out of the ED. So it almost seems like the measure is not in the right form.

DR. COHEN: Actually, I was going to say that.

DR. NEWMAN: It's an issue of access as well, so --

MS. ALTERAS: Right. And if it's an issue of access and someone doesn't have a neurologist that they go to, you know I think the point would still be how do you help this person get the --

DR. NEWMAN: And what do you do with this information?

MS. ALTERAS: -- non-emergency care.

DR. COHEN: Well I guess it's a face-to-face intervention is what they're recommending. But there's no standard as to the follow-up care, right?

DR. NEWMAN: So you get that value and then what do you do with it?

DR. COHEN: Right.

MS. McCARTNEY: It might be nitpicky, but what -- mean. I don't know what that means.

DR. NEWMAN: It's defined.

MS. McCARTNEY: Oh, it's defined later?

DR. NEWMAN: Later it's defined in there.

MS. McCARTNEY: Okay.

DR. COHEN: It's two times, I believe, in a certain amount of period of

time. 180 days, I believe, or 90 days, six months. Yes. It is defined.

CO-CHAIR MOORHEAD: So I guess let's just -- your recommendation is yes at this point for number 1 and there's some concern about this --

DR. COHEN: I think it's important to know, but they don't have a solution to fix. There no standard for follow-up care, yet an expert panel was saying we need more face-to-face interventions to manage the care better. But there's no follow-up care standard. And this is an expert panel among the neurology headache groups who are recommending this without strong evidence-based medicine.

CO-CHAIR STONE-GRIFFITH: How would you capture this information?

MS. RIEHLE: Well, this measure is built for claims. Are you talking specifically to the follow-up visits?

DR. O'CONNOR: Right. So it would

be a documentation in the provider's record that said have you been to the office? Yes, I have. And that's what you're going to go look for?

MS. RIEHLE: So it would go by CPT codes for encounters or revenue codes for encounters.

MS. McCARTNEY: Well, if this is ED measure, who are the results -- as it was said, it's more of PT to your neurologist management. So if it's ED measure, who gets the feedback?

DR. BURSTIN: Oh, it is not. It's an advocate --

MS. RIEHLE: It wouldn't be applied to emergency doctors.

CO-CHAIR STONE-GRIFFITH: I see.

MS. ALTERAS: So you mean there's a CPT code for whether a doctor asked the patient if they have --

MS. RIEHLE: No. It's actually just looking for any encounter. So just the

regular encounter with a provider. It's not specific to a follow-up for this particular--

MS. ALTERAS: But if the question is -- I mean, it's looking at whether the patient who is going for an emergency visit has gone to see -- has had visits with a non-emergency provider in the past six months. I'm just confused. What's the CPT code? Is it for the emergency provider to check up whether they ask --

MS. RIEHLE: No. It's for the actual office visit --

DR. NEWMAN: So it's an indication of the primary care in the nature that the primary care physician has evaluated a patient, their patient who is frequenting an ED?

MS. RIEHLE: Right.

MS. ALTERAS: But which one first?

DR. NEWMAN: It sounds like the primary care came first.

MS. McCARTNEY: Would this a

physician-specific measure then? I mean, are you going to look at a practice or I mean if I'm Dr. X and I have three patients that have migraines and visit the ED, how are those practitioners going to get that information? I mean, how is this going to be publicly reported as a practice group or just as PCPs in general? I guess I don't understand how the group would get the feedback that they're doing well. What would group would that be?

MS. RIEHLE: I mean it could be used in a couple of different ways. You know, there are some programs that look at kind of like patient centered medical home -- you know, programs where they're identifying a PCP and making sure that the PCP patient relationship is foster all the aspects of care that should be given.

It could also be used for a physician measurement like the more public reporting.

CO-CHAIR STONE-GRIFFITH: See, and

I think about women who might use their OB/GYM as their primary care for a period of time.

MS. RIEHLE: But this doesn't specify a specialty.

DR. O'CONNOR: Correct. Well, right.

MS. McCARTNEY: So if I was a patient and went out and saw this publicly reported data, what is it going to mean to me? That my PCP is doing a good job or a bad job? My neurologist is doing a good job or a bad job? Or my gynecologist is doing a good job or a bad job?

DR. ADAMS: So in keeping with that, I can't figure out to repeat who is accountable.

MS. McCARTNEY: Right. Right. I don't know what it means to me as a consumer to know that I don't know this information and who is accountable for that care.

DR. BURSTIN: Well currently this is a health plan, not a metric, right?

MS. RIEHLE: Yes.

DR. BURSTIN: So the issue is within a health plan it's got a whole different perspective because the health plan should be responsible for identifying the frequent flyers in a given condition or using the ED rather than more appropriate care places or people. I assume that's what the measure is trying to get at. But, again, it comes at the level -- did you specifically bring this in for level analysis for health plan?

MS. RIEHLE: I don't think so. I mean, I think the argument could be made that, you know, if you have somebody who is a PCP or a regular PCP, you know and you have this patient who is using a lot of these frequent medications or going to the ED, you know it would be ideal to be following up with this patient more often. I mean, one could argue that that's really a patient behavior sort of issue as opposed to a clinician behavior. I

mean, there's only so much you can control that.

But ideally if you're in theory prescribing all these acute medications, you should be following up with the patient semi-regularly to make sure to check on their status.

DR. JAUCH: So the dataset that you're going to use, though, is only on patients who have some form of insurance? Because I kind of work in the inner city where a lot of the follow-up goes to the community clinics where it's very hard to capture this type of information, right?

MS. RIEHLE: Yes. And this measure is only really ever been used in a commercial population.

CO-CHAIR MOORHEAD: Jeff, I looked at this two ways. One is you have to be very careful because this is blaming the victim a little bit. And so we're really, you know as a clinician, you know this is Friday nights,

this is weekends, this is when PCPs aren't practicing that these people come in.

And to sort of take a subgroup that people who frequent ERs and are receiving multiple medications, it's a little bit dangerous there to isolate a subgroup like that of patients.

On the other side being a clinician, coordination of care is crucial. And so these sort of metrics are coming down the line and we're seeing more of these in terms of hospital discharges and contact with the PCPs, frequent ER visits and contact with the PCPs. So if our denominator is patients with PCPs, you know we may be able to get at that. But I think it's just a little too risky to kind of concentrate on this subgroup of patients.

IF it's all patients, it's something else.

MS. RIEHLE: I see what you're saying. So you're saying that this should be

-- it would be better to limit this to the population that actually sees a PCP regularly?

DR. O'CONNOR: There's a couple of people. I think what I'm hearing is that people think this is more of a quality indicator for a health plan as opposed to a public reportable measure.

DR. BEVERLY COLLINS: Yes. We're using similar measures like this where a patient is in a medical home, and it's to give feedback to the practices, independent but not for public reporting. It's to let them know what's going on with their patients because sometimes they have no idea that they're going to the ER or the hospital, or whatever. So that's to give them an idea to really coordinate their care and to really reach out to them. But for public reporting.

CO-CHAIR STONE-GRIFFITH: Suzanne?

DR. O'CONNOR: Well, not just that. It's the feedback to them to coordinate and prescribe a care plan that the patient can

be compliant with.

I mean, a lot of times what you hear is gee I don't like what's been prescribed. I don't react to it well. I'd rather just go to the ED and get my shot every so often because I'm not getting the regiment that really works for me. So it really is a care coordination, a care pathway for PCP.

MS. RIEHLE: Right.

CO-CHAIR STONE-GRIFFITH: And also working with some hospitals to develop some quality improvement programs so that they can link up more with the PCPs, too.

DR. BEVERLY COLLINS: Right.

CO-CHAIR STONE-GRIFFITH: So they're involved in the process.

DR. JEFFREY COLLINS: I mean it is frustrating as a clinician because every week you see somebody like this who has never been offered prophylactic treatment, who has never seen a neurologist. And so it's something we encounter all the time. So it's a measure

that has to be pursued, but you know on a public health reporting standpoint I don't think so.

DR. COHEN: Can I revert back my recommendation? Because I was confused as well. And I would say it meets importance, but it doesn't meet the reporting component.

CO-CHAIR MOORHEAD: It meets importance as a quality indicator for health plans?

DR. COHEN: Exactly. Not for public report.

CO-CHAIR MOORHEAD: Not for public report.

DR. BURSTIN: Well, NQF does, you know, does endorse measures for health plans. So the question would be does this seem like an important measure you'd want to know about your health plan? The measure got checked for every single level of analysis. And the question would be is that appropriate or is this something you'd put forward as a health

plan measure.

MS. ALTERAS: I mean, this is something I would want to see, you know, at an individual physician level measure being public reported. For a neurologist, I don't know how many private care providers manage migraine. Again, I have migraines. I don't even have a primary care provider, so I don't know.

So, yes, I mean if I had this condition I would like to see a physician level.

I mean, I think part of the problem is the way is the way it's just written. Even just the title is very confusing off the bat. So I think it could be presented in a way that would be very meaningful to consumers. But I'm not even sure at the health plan level. At the health plan and the individual physician level, I guess.

DR. BURSTIN: How is Ingenix using

it now with their clients? Is it being used at the physician level? Is it being used at the health care level?

MS. RIEHLE: It is being used at the physician level, but it's more common to be used as like a care and disease management. so there are a couple of health -- there's one health plan that I know of that's using it just anecdotally. And there could be others. But it's mostly something that would be used for care and disease management.

DR. BEVERLY COLLINS: There's a lot of these measures that are also being used by health plans for pay for performance programs for individuals docs. And a lot of them have not been tested or really validated, but they're out there everywhere. There's all kinds of measures. And --

DR. NEWMAN: We wouldn't want to do that for pay for performance, would we?

DR. BEVERLY COLLINS: Well, and my plan personally, we only promote measures that

have been through a process like this or nationally endorsed by programs like NQF and NCQA, but not others that have just been developed by a lot of vendors. But there's a lot of them out there.

DR. NEWMAN: From a devil's advocate, though, as a consumer I would certainly -- I may be interested which ERs don't regularly check up to ensure that patients have had follow-up appointments and maybe I'll go to that one across town for my pain medicine. Then I can answer those questions.

CO-CHAIR MOORHEAD: We're having a little trouble here. So the accountable -- what I'm hearing, that's the way you're using this, that the accountable person is the PCP or the practice and that's where the accountability would be. And so we could --

DR. NEWMAN: Which is appropriate.

DR. BURSTIN: Right. You could just narrow of levels of analysis you think

the measure is appropriate for as a condition if you think that's appropriate.

And by the way, we have now endorsed 70 of these vendor-specific clinically enriched admission of measures, as we call them, including Ingenix. So I mean a lot of them have been through our process. They are fairly well vetted and tested. So just to be cautious.

DR. COHEN: Is the sign of uncoordinated or discoordinated or inadequate migraine care falling into the ER or it could be equal measure be three visits to the same doctor, or three primary care visits, or your primary and your neurologist? I mean, is our concern that the coordination matrix is manifested by the repeated visit, or is actually favorable to go see your family doctor twice, but not favorable to see your ER twice?

CO-CHAIR MOORHEAD: Well, I think that's part of the sensitivity of emergency

docs is we feel like everyone points to us and says you're the problem and we feel like we're the solution. And then we get a little defensive about it. But I mean it's got to be patient focused. If we go back to the patient, how are they getting their care best provided. And it's a combination of primary and then special --

DR. NEWMAN: Being careful not to ostracize a patient. I think Jeff's point is well taken.

DR. BURSTIN: And the measure is not just ER encounters. It's or frequent acute medications. So you get it either way. If you're just getting Fiorinal and you're not getting other stuff, that will pick that up. So it is broader than just the ER visits. But there is an implication that an office visit outside of an ER setting perhaps get on prophylaxis might be a more appropriate way to go.

CO-CHAIR MOORHEAD: Jeff?

DR. JEFFREY COLLINS: I mean, every physician has walked into a room and seen somebody smiling on the gurney saying I'm having a migraine headache, and it's just one of those things. It's a lot of time to diagnoses is much more complicated then if they've actually through neurology and met the criteria and meet the diagnoses for having a migraine versus when I go back in my charts because I see how many headache visits are billed as migraines, it's very difficult.

CO-CHAIR MOORHEAD: So I'm hearing actually we recommend that this go forward and the unit of analysis then would be the practice, the primary care practice.

DR. BURSTIN: Just as one piece of information. I'd forgot about this. We actually did endorse another migraine measure from Ingenix which kind of gets at the issue we're talking about, which is adults with frequent use of acute medications -- prophylactic medications. So we've endorsed

the piece about kind of the action is actually to try to get them off the acute meds onto the prophylactic medications. We've already endorsed that measure this past year.

CO-CHAIR MOORHEAD: So it sounds like from the public, that's what you want and that's already endorsed. So does this actually add value?

MS. ALTERAS: Could there be either a composite or harmonization of this measure and the one that you just mentioned?

MS. RIEHLE: The other one is harmonized. I mean it uses all the same logic to decide the denominator and it uses the same logic to determine, you know, frequent medication use. So it's pretty harmonized.

CO-CHAIR MOORHEAD: Victor, what's your recommendation?

DR. COHEN: You want me to continue or --

CO-CHAIR MOORHEAD: Do you want to just summarize before and give us a few

minutes to think while you do that.

DR. COHEN: Okay. Scientific measured values, are they scientific acceptable. It's actually been specified, so it's accepted.

Numerator. Patients who are diagnosed with migraine and who have had frequent ER encounters or frequent acute medication use who had an office visit during the following time period: Last 180 days prior to the end of the report period and 90 days after the end of the report period, that gives sufficient time to assess overuse. But what is to say is overuse? It's a good question also that I had on this.

Where is the evidence? Again, where is the evidence of overuse or is it just a natural progression of the migraine? This occurs.

They list codes for capture in terms of numerator.

The denominator is appropriate.

Patient six years or older. The time window appears different from originally stated. There's several time periods that I was a little confused about: 24 month period until the end of the report for confirmation, criteria for capturing prescription use during the 12 month period. Fails to include other migraine remedies I stated.

The basis for a number of doses is not provided. There's a statement of how many doses as well that are quantified. And I'm not sure how you came up with those dosing I terms of the denominator. So I wasn't really clear on those issues.

MS. RIEHLE: And there is an attachment that it's pretty complicated logic. I mean, it's what we used for other NQF endorsed measure. It was put together by a team of two -- and a neurologist.

DR. COHEN: Okay. No denominator exclusion provided.

No stratification risk adjustment

provided.

Type of score is rate proportion.

Method for discrimination. Performance was confusing. Again, this 3600 patients met the denominator and 1900 did not meet the numerator. 1900 did not meet numerator compliance. So I was a little confused with the numbers as well. Initially you stated that 15 million benchmark database and --

MS. RIEHLE: And I'm not a 100 percent sure about this. And Kay, the Medical Director had to get off the line. But I believe that the larger number -- the 15 million is the size of the members in the benchmark.

DR. COHEN: The commercial business, right.

MS. RIEHLE: And then the next big number would be the people who met condition confirmation.

And then that 3600 is people who

qualified for this measure.

DR. COHEN: Specifics?

MS. RIEHLE: Yes.

DR. COHEN: That's really a small number.

MS. RIEHLE: Right.

DR. COHEN: Relatively speaking.

MS. RIEHLE: When we actually confirm the condition, we get a much larger number. But we're really limiting this to a very select population.

DR. COHEN: Okay. Okay.

Social data is Ingenix, I believe and claims data as well.

2b and 2c reliability and validity. The measure appears to be reliable and valid. Data is provided. Completely meet this criteria.

Customer acceptance testing was conducted. Face validity was conducted and supportability. So I believe that's completely met.

No data on supporting exclusion. No exclusion listed completely. No exclusion listed.

No risk adjustment.

2f, a medical doctor reviews results to verify prevalence rates of condition. Compliance rates of measures are comparable to report in published literature, as well. So he compares that.

2g and h. No data on disparities, but may want to discuss this as this may be an issue.

Overall I said in terms of scientific acceptability it overall doesn't meet scientific acceptability I believe in terms of, I'd say, completely meets scientific acceptability in that respect where it's applicable.

I don't know if you feel the same way.

DR. BEVERLY COLLINS: Can I just say something about I think you said there

were 15 million members in the database and only 3600 qualify for this measure. And if we're talking about using this as a physician specific metric, what we assume in our plan is that each physician has about 2,000 members. There's going to be no people available for each individual practitioner to be measured on this if you have such small numbers that qualify for the measure.

MS. RIEHLE: And when they developed this measure, we may have been too stringent in the criteria with the frequent medication use in the ED. I mean, we could entertain loosening up that constraint.

But, yes, it's a small number.

DR. CHALIAN: When that numerator and denominator are presented, what will be the conclusion the public sees? If it's 40 percent versus 60 percent, what are they supposed to conclude?

MS. RIEHLE: You know, 40 percent versus 60 percent I mean I guess I would say

that there's issues with the way that they're following up with these patients. That there's room for improvement with that.

DR. CHALIAN: And the numbers should be that everybody gets seen once and one and done? And is that a reasonable standard for a complex disease like migraine which may have very refractory patients even if they're on prophylaxis versus the misdiagnosed migraine? And so is this -- and I think this applies to all of our reviews. As a new member, I think it would be helpful to see when this data is presented to the public, what are they going to be able to extrapolate from it. And also us as people who are willing to look at the data and improve, what are we extrapolate from it and what's going to take it -- what's the data going to do to move the masses? Which we've seen the numerator/denominator, but I'm not sure we've seen the finished product in terms of what it would look like and how does it

affect us.

CO-CHAIR MOORHEAD: Well, I think part of the issue is that patients with migraine don't often just have migraine. I mean, we see kids with shunts who have migraines. And, yes, that's a whole -- and they come in -- you know you see them more frequently, obviously. And if they would fall into this, I would assume, and does that tell you anything, I guess?

Well, let's go on.

DR. COHEN: Okay. So usability, currently in use. It's not been tested in the public from what I see here. It is related to other time overuse NQF measures ECO9308. So there is a measure already.

There is harmonization with other NQF measures.

There is direct added value of the measure. The measure addresses poor migraine control. Who would benefit from a provider encounter to access a management plan.

Here I would say overall partially meets criteria for usability. Again, what is the standard for follow-up care? If there's no standard, then we're just sending them for another face-to-face, but what does that mean? Is it going to improve care? I don't know. I don't believe so. But, okay, it may.

It may reduce ED visits, but I'm not sure. It could just add to the cost of care.

Feasibility for a, b, c. Data generated by coding and abstraction. They're available. Electronic sources for this data is available. Supporting data for exclusion does not apply.

4d accept degrees of error of not capturing all patients who may benefit from this management plan. They understood that in terms of they described something in reference to error, but it wasn't anything that important.

4d costs again I believe were not

addressed. And then partially. So I stated that this was partially feasible, partially meets the criteria.

Overall, I think it's an important measure that is important to be endorsed. But the way it's written and where it's going to be applied is -- and the evidence-base to support it, it's all questionable.

CO-CHAIR MOORHEAD: Okay.

DR. CHALIAN: Does the world of neurology have a guideline that really would apply to help us in terms of where measurement would drive us?

MS. RIEHLE: I don't believe so. I mean, this is very loosely based on an AAN guideline, but it doesn't specifically address ambulatory visits.

DR. CHALIAN: From my perspective what I would suggest is that this goes into a small group and it's studied and shows whether this measure actually has any validity on any patient outcome. Of course, it would seem to

affect cost potentially. And then come back and say if this is a legitimate measure of any care pattern or outcome for patients with migraines.

CO-CHAIR MOORHEAD: So I'm hearing that we don't think this is ready for public reporting. Is that --so is that all right?

DR. COHEN: I would agree with that. Yes. But I don't know how you want to modify it to, where it has to go, though.

CO-CHAIR MOORHEAD: I mean the discussion we've talked about where we think the unit of analysis, this is a primary care practice-oriented --

DR. COHEN: Right.

CO-CHAIR MOORHEAD: -- quality improvement tool.

DR. COHEN: Right.

MS. ALTERAS: Sorry. Can I ask one more question?

CO-CHAIR MOORHEAD: Sure.

MS. ALTERAS: I don't know what

the timeline was for developing this, but if it's been available I'm just curious if it was proposed under the care coordination project methods?

MS. RIEHLE: I don't think so.

MS. ALTERAS: No?

DR. BURSTIN: Similar, but different measure-wise.

MS. ALTERAS: Okay. But that's going to be end one of our endorsement?

DR. BURSTIN: Yes.

MS. ALTERAS: Okay. I mean, it seems like this if it was reworked somewhat, it would just fit more in the care coordination umbrella.

CO-CHAIR MOORHEAD: All right. That's the recommendation. Those in favor? Opposed? Abstaining? All right.

We are -- I guess the time, we need some opportunity for public. Is there any public comment?

Is there anyone on the phone?

Okay.

Do we need to review today's? Do you want to review that or we confident -- we got it? Okay.

And so our next steps will be a conference call. Do you anticipate that?

MS. MUNTHALI: Yes. Probably in about two weeks. I will send everyone an email just to kind of get availability. But it definitely would be within two weeks.

As you know, we have a very tight deadline and we're trying to get the draft report together. So we want to make sure we iron out all of these issues before then.

CO-CHAIR MOORHEAD: Okay. All right. Anything else?

DR. BURSTIN: The only other thing we would like you to do, but you don't have to do today. Obviously, I think people are getting a little crunchy around the edges here. But certainly --

CO-CHAIR MOORHEAD: Obviously?

DR. BURSTIN: Myself included.

Is we also as a part of this process that's very important is identifying the measurement gaps. So for one, the measures that you think are really important that you didn't see that you wish you'd seen, really relates to that as a critical role of these really smart people sitting around the table. So if that's something you have the energy to kind of thread a couple today or if you'd like to do it on email, or follow-up calls; whatever the case may be. But Jim's got one.

DR. JEFFREY COLLINS: Yes, I do have one. So something that we haven't seen that I regret not submitting is the use of hypothermia for cardiac arrest survivors. There's a strong evidence-base. It's under utilized nationally. And it's absolutely understandable.

A cardiac arrest survivor comes in. Did they get their body cooled or not. It

increases the likelihood of neurologically intact survival.

DR. BURSTIN: I know the Joint Commission is working on a set of sudden death measures. And you may want to touch base with them and see if there might be an opportunity to link up with them.

DR. JEFFREY COLLINS: Yes. Okay. Good. Thanks.

CO-CHAIR MOORHEAD: Is there any measure on availability of advanced directives for ED patients? Because that's something I would really like to see. It would be helpful I think both to the public and to the practitioners in emergency medicine.

Anyone else have any thoughts?

DR. ALESSANDRINI: Yes. I've been sitting here trying -- about submitting a measure and looking at efficient use of head CT for children with minor traumatic -- and we pulled it because the AEP didn't feel like it was ready for prime time. So we're actually

starting, we're going to collect this data.

I mean, we now have a really good clinical prediction rule that has very high sensitivity and specificity for when there's no indications for SET. So we're in the process now of trying to implement some clinical decisions and then a template to accept the data electronically. But I think that's a nice efficiency measure where there is wide documentation of overuse and with some real harm, that could be as a result. Not only from radiation but from kids that get procedural sedation.

So, hopefully we'll get there sooner rather than later.

DR. COHEN: We may push forward a measure that looks at pharmacists in the emergency department as a safety and quality measure, to improve safety and quality, that is.

We've been doing it for 12 years. We've set up a model. And we've been able to

cost justify it and looking for -- we think every ED should have a pharmacist. I know there's debates about that. I think it'll help and improve safety and quality. And maybe improve the satisfaction of patients in the ED, which I know is an issue sometimes.

CO-CHAIR MOORHEAD: Great. Anything else? All right. Well, thank you everyone for your time and your expertise. And thank you to the staff. I'd like to thank you on behalf of the Committee for making our arrangements, getting here, putting us to bed last night. Great. So thank you.

MS. MUNTHALI: Thank you, everyone. And there's just a couple of announcements I have.

We do have an extra computer that was left here last night. So before you leave, check to make sure it's not yours.

And if you could please leave the flash drives behind and your measure evaluation forms. If you have them in hard

copy, if you could give those to us. If not, if you could email those to us so we could have your subcriteria ratings.

Thank you again, everyone. And I'll be communicating with you in a couple of weeks -- well soon.

(Whereupon, at 2:43 p.m. the meeting was adjourned.)

H