

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, CNA, MSN, CO-
CHAIR

JAMES ADAMS, MD, MEMBER

EVALINE A ALESSANDRINI, MD, MSCE

TANYA ALTERAS, MPP

ARA CHALIAN, MD, FACS

VICTOR COHEN, BS, PHARM, BCPS, CGP

BEVERLY COLLINS, MD

JEFFREY COLLINS, MD, MA

ANDREW C. EISENBERG, MD, MHA, FAFAP

EDWARD JAUCH, MD, MS

LEIGH ANN MCCARTNEY, RN, MBA

NATHAN NEWMAN, MD, FAFAP

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

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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

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

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

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

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

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

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

4 The next measure that you have
5 recommended as a stand alone measure is ACP-
6 032-10 Patient(s) two years of age and older
7 with acute otitis externa who were NOT
8 prescribed systemic antimicrobial therapy.
9 And the measure steward is Ingenix.

10 The next measure is ACP-012-10
11 Otitis Media with Effusion: Antihistamines or
12 decongestants - Avoidance of inappropriate
13 use. And the measure steward is AMA. You
14 have recommended this for a time limited
15 endorsement as a paired measure with ACP-013-
16 10 Otitis Media with Effusion: Systemic
17 corticosteroids - Avoidance of inappropriate
18 use. Also the measure steward is AMA.

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

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

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

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

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

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

22 This measure is ACP-036-10

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

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

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

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

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

17 And the final measure that you
18 have not recommended for endorsement is ACP-
19 030-10 Adult(s) with community-acquired
20 bacterial pneumonia that had a chest x-ray.
21 And Ingenix is the measure steward.

22 We will probably schedule a call

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 CO-CHAIR MOORHEAD: Thank you very
6 much.

7 So our primary reviewer is John
8 with Andrew a secondary.

9 John?

10 DR. SALTZMAN: Good morning.

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

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

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

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

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

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

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

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

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

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

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

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

16 CO-CHAIR MOORHEAD: Jeff?

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

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

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

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

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

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

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

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

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

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

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

22 So I thought those were reasonable

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

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

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

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

21 In terms of identification and
22 meaningful differences in performances, at

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

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

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

10 So overall for this section I gave
11 a P rating.

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

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

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

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

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

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

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

13 So I think the feasibility is
14 quite evident.

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

17 DR. CHALIAN: I have a quick
18 question.

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

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

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

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

22 DR. PETERSEN: I'm not a measure

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

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

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

22 DR. PETERSEN: Great. Thank you.

1 DR. BURSTIN: This is Helen
2 Burstin.

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

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

16 DR. BURSTIN: Of course, yes.

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

1 that, whether it gets in too.

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

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

7 DR. BURSTIN: Absolutely.

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

10 DR. BURSTIN: Yes.

11 DR. EISENBERG: Okay.

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

17 CO-CHAIR MOORHEAD: Thank you.

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

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

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

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

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

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

16 DR. EISENBERG: Slightly different
17 populations, but --

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

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

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

4 Electronic sources. Bret
5 mentioned about electronic data. I believe
6 somewhere around 40 to 50 percent of endoscopy
7 reports are electronically generated by a
8 structure reporting database that could get
9 this information easily, but which means that
10 50 or 60 percent are not currently and would
11 have to be manually searched.

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

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

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

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

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

9 DR. SALTZMAN: Yes.

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

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

1 data.

2 And all the rest I agreed with.

3 With a final P as well.

4 CO-CHAIR MOORHEAD: Okay. John?

5 DR. SALTZMAN: So just to put that

6 altogether, my recommendation is to endorse

7 this. You know, so that is my conclusion in

8 this measure.

9 CO-CHAIR MOORHEAD: Any comments

10 or question? All right.

11 DR. SALTZMAN: All right.

12 CO-CHAIR MOORHEAD: So the

13 recommendation is to endorse. We need a vote.

14 All those in favor? Opposed?

15 Abstaining? Unanimous.

16 All right.

17 DR. SALTZMAN: All right. Number

18 2, the second one that is somewhere is

19 entitled ACP-017-10: Endoscopy/Polyp

20 Surveillance Colonoscopy interval for patients

21 with a history of Adenomatous polyps-

22 Avoidance of inappropriate use. And the brief

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

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

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

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

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

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

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

11 So I gave that 1b a C
12 recommendations.

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

20 DR. EISENBERG: I agree
21 completely.

22 DR. SALTZMAN: Okay. So moving on

1 to the measure specifications.

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

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

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

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

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

6 The exclusions being justified, I
7 think these there were very reasonable
8 exclusions and I gave that a P. So that's for
9 2d.

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

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

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

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

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

4 So overall I gave this section a P
5 recommendation.

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

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

16 DR. SALTZMAN: Yes.

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

1 doing, even though we're not there yet.

2 And agree with the rest.

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

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

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

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

20 So overall I gave a P to this
21 section 3.

22 DR. EISENBERG: I think I would

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

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

11 DR. SALTZMAN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

22 So you really wouldn't want to

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

4 DR. PETERSEN: Yes.

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

12 DR. JAUCH: Yes. Yes.

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

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

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

1 gave this an NA.

2 Susceptibility to inaccuracies 4d,

3 I gave this a P.

4 And collection strategy I gave it

5 a P.

6 So overall, I thought feasibility

7 was a P.

8 DR. EISENBERG: I agree.

9 DR. SALTZMAN: And then overall

10 for this -- any comments on that? Okay.

11 So overall for this measure I

12 recommended endorsement of it.

13 DR. EISENBERG: I concur.

14 CO-CHAIR MOORHEAD: The motion is

15 to endorse. Those in favor? Opposed?

16 Abstaining? All right. That's unanimous.

17 DR. SALTZMAN: All right. So the

18 last one of these is a little bit different,

19 and I'll go over that.

20 This is ACP-018-10:

21 Endoscopy/Polyp Surveillance: Comprehensive

22 colonoscopy documentation. And the brief

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

4 Preprocedure risk assessment;

5 Depth of insertion;

6 Quality of bowel prep;

7 Complete description of polyps

8 found including location of each polyp size,

9 number and growth morphology, and;

10 Recommendations for follow-up.

11 This is a process type of measure

12 that is to improve patient centered care.

13 It met the conditions for the NQF.

14 The summary, moving on to the

15 importance of this. The summary, again, was

16 similar to the prior ones so that A 1a.

17 The opportunities are a little bit

18 more complex in this one than the prior ones.

19 Because this is looking at the quality of

20 exams and how they are reported. And we know

21 that not all reports contain all these

22 measures, and these were the ones that was

1 said that at a minimum you should include so.

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

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

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

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

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

4 And then having interval suggested
5 at the end, which is often not done correctly,
6 39 percent were done correctly.

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

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

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

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

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

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

15 DR. EISENBERG: Correct.

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

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

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

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

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

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

22 DR. PETERSEN: That's a fair

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

9 DR. CHALIAN: Good. Thank you.

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

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

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

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

6 DR. BURSTIN: This is Helen.

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

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

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

1 95 percent of colonoscopy should be the cecum
2 or more. That may not be true actually in
3 practice through the country. And so trying
4 to raise that standard I think is a fair
5 point, but it's not what it suggests here.

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

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

20 DR. BURSTIN: Right.

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

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

10 DR. BURSTIN: Yes.

11 CO-CHAIR MOORHEAD: Ara?

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

15 DR. PETERSEN: That's right.

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

18 DR. PETERSEN: There's right.

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

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

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

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

18 DR. CHALIAN: I think that's
19 right.

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

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

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

12 DR. ALESSANDRINI: I don't think
13 so.

14 CO-CHAIR MOORHEAD: Okay.

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

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

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

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

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

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

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

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

21 So overall, I gave this section a
22 P.

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

6 DR. PETERSEN: Yes, right.

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

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

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

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

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

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

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

15 DR. SALTZMAN: Right.

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

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

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

3 So--

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

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

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

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

3 DR. BRILL: This is Joel.

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

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

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

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

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

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

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

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

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

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

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

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

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

6 DR. BRILL: This is Joel.

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

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

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

19 DR. JACOBSON: This is Brian
20 Jacobson.

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

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

15 CO-CHAIR MOORHEAD: Thank you.

16 John?

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

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

1 P.

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

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

9 4e, data collection. It's a P.

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

12 DR. EISENBERG: I agree.

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

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

19 Jeff, are you opposed or
20 abstaining?

21 DR. JEFFREY COLLINS: Opposed.

22 DR. ROBERTS: No. No. No.

1 DR. BURSTIN: You were a yes.

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

5 CO-CHAIR MOORHEAD: Okay. Thank
6 you.

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

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

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

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

16 CO-CHAIR MOORHEAD: Yes.

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

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

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

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

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

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

17 Would you introduce yourself,
18 please.

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

22 CO-CHAIR MOORHEAD: Well, we're in

1 the grouping emergency department measures.

2 Two, 3, 19 --

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

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

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

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

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

17 DR. BRATZLER: Yes. For 19, 20,
18 21, 22, 23 and 24 and 25.

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

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

5 CO-CHAIR MOORHEAD: Yes.

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

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

1 Association that came together.

2 We reviewed at that time a set of
3 13 candidate emergency department performance
4 measures. NQF has previously endorsed three of
5 the measures that focused on total throughput
6 time. NQF has already endorsed a set of
7 measures that have been rolled out in the
8 ambulatory setting looking at total throughput
9 time from arrival to departure of the
10 emergency department. Measures that were felt
11 to be very useful to consumers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 done.

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

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

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

22 Delay can hinder timely

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

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

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

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

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

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

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

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

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

22 Furthermore, the nonemergent

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

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

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

16 CO-CHAIR MOORHEAD: Suzanne?

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

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

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

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

9 DR. COHEN: System.

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

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

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

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

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

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

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

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

7 CO-CHAIR MOORHEAD: Other thoughts
8 on this?

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

21 CO-CHAIR MOORHEAD: Anyone else?
22 Ed?

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

8 CO-CHAIR MOORHEAD: Anyone else?

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

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

22 CO-CHAIR MOORHEAD: Anyone else?

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

6 DR. COHEN: Bundle it.

7 MS. ALTERAS: -- bundle them.

8 DR. COHEN: Yes.

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

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

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

22 CO-CHAIR MOORHEAD: Okay.

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

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

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

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

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

8 So I think an emergency department
9 has so many time dependent metrics, that I'd
10 like to see the central tendency statistic
11 plus a variability. And I would vote strongly
12 for this is it was no troponin should exceed
13 60 minutes ever.

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

17 DR. ADAMS: Outliers. Right.

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

1 DR. ADAMS: Right.

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

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

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

17 Does this exist?

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

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

4 DR. ALESSANDRINI: Yes.

5 CO-CHAIR MOORHEAD: Okay. Victor?

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

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

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

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

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

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

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

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

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

1 2f, g, h I graded as minimal as no
2 data has been provided.

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

8 CO-CHAIR MOORHEAD: Suzanne?

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

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

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

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

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

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

1 the door.

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

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

7 Did you want to respond to that?

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

1 stays, patients leaving on the scene and other
2 things.

3 CO-CHAIR MOORHEAD: Pardon?

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

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

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

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

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

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

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

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

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

22 Are there other comments? Okay.

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

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

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

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

19 Any comment on this?

20 CO-CHAIR STONE-GRIFFITH: I agree.

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

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

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

12 No supporting data for exclusion
13 was provided.

14 4d f, errors not likely not here.

15 4e, the costs were not described.

16 But if you have electronic medical records,
17 it's probably minimal. You have your EDIS
18 director handle it. Quality Assurance
19 Performance Improvements Committees can handle
20 this. They do this all day, that's their job.
21 I don't think it would be otherwise
22 overwhelming unless you don't have that

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

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

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

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

13 So that's where I would differ.

14 CO-CHAIR MOORHEAD: Other
15 comments?

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

1 its own way.

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

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

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

14 DR. COHEN: Endorse the measure.

15 CO-CHAIR MOORHEAD: Suzanne?

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

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

22 CO-CHAIR STONE-GRIFFITH: You

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

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

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

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

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

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

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

4 So that's where I am.

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

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

1 metrics around those.

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

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

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

13 CO-CHAIR STONE-GRIFFITH: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

3 MS. FRANKLIN: Not on this one,
4 no.

5 CO-CHAIR MOORHEAD: Okay.

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

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

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

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

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

22 CO-CHAIR STONE-GRIFFITH: And I do

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

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

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

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

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

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

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

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

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

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

4 So, thanks.

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

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

18 CO-CHAIR MOORHEAD: Okay.

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

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

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

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

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

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

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

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

22 But, yes, I think from

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

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

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

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

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

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

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

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

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

4 DR. BURSTIN: Is there a standard?

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

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

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

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

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

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

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

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

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

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

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

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

1 really still impact our decision making.

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

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

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

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

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

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

22 But I think as we grow and learn

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

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

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

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

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

22 So, Angela.

1 MS. FRANKLIN: And the last
2 measure.

3 CO-CHAIR MOORHEAD: I'm sorry.
4 2,3 and 43. Thank you.

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

9 Yes, come to the --

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

15 And, Jay, are you still there?

16 DR. SCHURR: Yes.

17 MS. FRANKLIN: Okay. Okay.

18 DR. SCHURR: This is the
19 discussion ultrasound --

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

22 DR. SCHURR: Okay.

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

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

17 And then, a select group have been
18 moved forward.

19 CO-CHAIR MOORHEAD: Okay. Thank
20 you.

21 If we can begin with No. 2

22 DR. EISENBERG: Okay.

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

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

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

10 CO-CHAIR MOORHEAD: Okay.
11 Andrew?

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

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

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

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

16 So we looked at the opportunities
17 for improvement and benefits as far as far as
18 the summary of data and the citations.

19 There's some very good data looking at
20 reduction in ruptured ectopic to 50 percent
21 compared to historical controls of 9 percent
22 when an ultrasound was used.

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

3 1c is the outcome or evidence to
4 support the measure focus. The incidence of
5 ectopic pregnancy when presenting to emergency
6 department with vaginal bleeding or pain in
7 the first trimester is approximately ten
8 percent. So it's a relatively high number of
9 women that are presenting. Again, good data.

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

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

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

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

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

14 CO-CHAIR MOORHEAD: In importance?

15 DR. EISENBERG: In importance,
16 correct.

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

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

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

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

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

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

1 testing, no data.

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

7 2e risk estimates. Same thing,
8 it's really not applicable.

9 2f meaningful difference in
10 performance. Probably is not applicable
11 either in this circumstances. So 2f, there's
12 really no NA reading, but it doesn't quite
13 fit.

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

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

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

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

13 DR. EISENBERG: Yes.
14 Usability?

15 DR. BURSTIN: I had a question.

16 DR. EISENBERG: Oh, questions.

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

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

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

13 DR. SCHURR: Can I answer that?

14 CO-CHAIR MOORHEAD: Jay, go ahead.

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

22 So patients of childbearing age

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

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

10 This is Helen.

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

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

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

22 DR. SCHURR: It was just that we

1 did not want this to be all patients.

2 DR. BURSTIN: Great. Good.

3 Thanks.

4 CO-CHAIR MOORHEAD: Okay. Jeff?

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

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

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

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

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

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

22 DR. EISENBERG: At least the way I

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

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

17 CO-CHAIR MOORHEAD: Jay, any
18 comment?

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

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

3 CO-CHAIR MOORHEAD: Jim?

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

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

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

20 CO-CHAIR MOORHEAD: Okay. Andrew?

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

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

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

12 Distinctive or additive value at
13 3c. No competing measures. It does add value
14 because this is clearly identified earlier on
15 as a major cause of morbidity, mortality with
16 a relatively low performance rate at this
17 point. I don't know if you'd want to call it
18 -- I think it's a C to a large degree. This
19 is something that definitely is measurable and
20 something that we can improve.

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

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

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

7 CO-CHAIR MOORHEAD: Other comments
8 or questions?

9 Okay. Andrew?

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

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

22 The exclusion criteria were very

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

2 4d susceptibility to inaccuracies
3 or errors or unintended consequences. And
4 that deals with we mentioned the
5 pseudogestational sac, the experience of the
6 provider, the experience of the person reading
7 it.

8 Patient characteristics might
9 impact that to a certain extent.

10 So 4d was a P.

11 4e data collection and
12 implementation. It's not been tested, but
13 should be relatively straightforward. And the
14 cost to implement might go up some, but the
15 costs to not implement it probably outweigh
16 that. So that's either a P or a C.

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

22 DR. ROBERTS: I agree. This is an

1 important measure and certainly the benefits
2 outweighed the risks of misdiagnosis. But for
3 4d unintended consequences, the thing that
4 first came to mind was something that has
5 already sort of been brought up. That, you
6 know, if you're trying to increase utilization
7 of ultrasound, that it may start being used in
8 less experienced hands. And there is a
9 pseudogestational sac that can be seen with
10 ectopic pregnancy and can be misdiagnosed as
11 an intrauterine pregnancy. So then you have
12 this situation where someone says I've had an
13 ultrasound, I've a documented pregnancy in my
14 uterus, but they really don't because it was
15 misdiagnosed first. And so you have the
16 potential to delay their ectopic treatment
17 should they come back because the clinician
18 would already be thinking, yes, we have a
19 documented one.

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

1 So that was a P for me, yes.

2 CO-CHAIR MOORHEAD: Okay.

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

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

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

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

12 Thank you.

13 We'll move to No. 3 Rhogam.

14 Andrew, you're the primary, I'm the secondary.

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

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

1 significant vaginal bleeding.

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

15 CO-CHAIR MOORHEAD: Okay. Thank
16 you.

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

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

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

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

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

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

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

10 Other citations for high impact
11 are quoted there.

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

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

22 No evidence of anti-D-

1 alloimmunization in the Rh-negative woman.
2 300 micrograms of Rh immunoglobulin should be
3 administered intramuscularly at 28 weeks of
4 gestation. And that's where some of the
5 issues might occur because what's the
6 responsibility? In the emergency department
7 it's whether they have prenatal care or not,
8 whether they're presenting at a given time
9 with even no indication other than being 28
10 weeks with or without a known what their Rh
11 factor is.

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

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

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

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

3 And a lot of data came out of
4 Canada.

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

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

22 Only 20 of the 62 surveyed, which

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

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

12 So they may or may not have
13 received the appropriate care, but it's a
14 discouragingly low amount of recognition or
15 thought of higher risk patients. And then of
16 course, they quote that more worryingly 23 of
17 44, which was 52 percent, who did not
18 recognize the 114 different possibilities for
19 Rh sensitization in the first instance, still
20 did not appreciate the risk when informed of
21 the Rh-negative status of the patient in
22 question. So the potential for improvement is

1 rather high.

2 Data wasn't complete. It's not
3 from the United States. So I gave lb a P
4 recommendation, or a rating, rather.

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

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

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

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

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

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

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

22 CO-CHAIR MOORHEAD: So 1c if you

1 have --

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

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

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

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

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

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

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

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

7 CO-CHAIR MOORHEAD: I had N or M.

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

11 CO-CHAIR MOORHEAD: Agree.

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

14 2d, again not applicable. So 2d
15 is NA.

16 2e also not applicable.

17 2f indication of meaningful
18 differences in performance. I think if we
19 gather the data we'll find that out. But at
20 this point it's an N since there's no data for
21 it.

22 CO-CHAIR MOORHEAD: I agree.

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

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

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

10 CO-CHAIR MOORHEAD: I did as well.

11 DR. EISENBERG: Okay. Questions?

12 CO-CHAIR MOORHEAD: Comments?

13 Okay.

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

1 explain a lot of the nuances.

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

4 DR. EISENBERG: Let's see, so for
5 harmonization, it's really not applicable for
6 3b.

7 CO-CHAIR MOORHEAD: Right.

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

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

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

21 CO-CHAIR MOORHEAD: I had a P.

22 DR. EISENBERG: I'm not adverse to

1 that.

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

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

9 DR. EISENBERG: A C?

10 DR. ADAMS: But P is fine.

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

19 I read it as an M for 4b.

20 CO-CHAIR MOORHEAD: I had a P.

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

1 so it was an NA for 4c.

2 4d identify susceptibility to
3 inaccuracies. I thought this had quite a bit
4 of potential unintended consequences of both
5 overuse early on and misuse appropriately at
6 the current time. So I think there is quite
7 a high degree.

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

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

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

1 DR. SCHURR: I think those are
2 valid points.

3 CO-CHAIR MOORHEAD: Thank you.

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

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

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

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

19 CO-CHAIR MOORHEAD: Okay.

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

1 CO-CHAIR MOORHEAD: I did as well.

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

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

11 All right. I'm sorry.

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

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

21 CO-CHAIR MOORHEAD: Same.

22 DR. BURSTIN: Give birth during a

1 12 month period and receive anti-D-
2 immunoglobulin at 26 to 30 weeks.

3 CO-CHAIR MOORHEAD: Right.

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

10 CO-CHAIR MOORHEAD: Okay.

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

13 CO-CHAIR MOORHEAD: It's
14 mentioned.

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

22 DR. BURSTIN: That's right.

1 DR. EISENBERG: -- to do the
2 intervention.

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

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

12 No. 43. Jay, any general
13 comments?

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

17 CO-CHAIR MOORHEAD: Correct.

18 DR. SCHURR: Yes. So two general
19 comments.

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

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

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

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

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

22 DR. SCHURR: Okay.

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

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

13 So to discuss the importance, la--

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

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

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

1 procedures in emergency departments, so it is
2 quite applicable.

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

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

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

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

1 CO-CHAIR MOORHEAD: Bob, any
2 comment?

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

5 CO-CHAIR MOORHEAD: Comments or
6 questions? Okay.

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

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

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

20 So I think that that's without
21 debate.

22 In the testing and analysis, 2b,

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

7 Exclusions justified. I think
8 that's not applicable.

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

12 The identification of meaningful
13 differences in performance. Completely met.

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

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

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

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

3 CO-CHAIR MOORHEAD: Bob?

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

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

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

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

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

2 But that's some of the
3 documentation and extraction concerns. My
4 greater concern is if I use the ultrasound for
5 central line placements, I look for the vein.
6 I set the ultrasound sound and do a blind
7 stick. That's not using ultrasound.

8 Ultrasound is I have to have it there under
9 direct visualization and I insert at that
10 moment under active visualization. So we
11 could have people say well I used ultrasound,
12 but they're really not using ultrasound.

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

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

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

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

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

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

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

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

10 Are there comments about that.

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

14 The one operator issue may be a
15 reason for exclusion.

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

1 example.

2 DR. ADAMS: Right.

3 DR. CHALIAN: And I guess I'm
4 flipping back to 1 because that study that's
5 referenced is from Anesthesia and Analgesia in
6 2007.

7 DR. ADAMS: Right.

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

14 DR. ADAMS: We'll reprimand you.

15 DR. CHALIAN: I stand politically
16 corrected.

17 DR. ADAMS: We're teasing.

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

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

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

19 DR. CHALIAN: Yes.

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

22 DR. SCHURR: Sure. A couple of

1 points.

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

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

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

22 DR. SCHURR: Oh, sorry.

1 DR. SIERZENSKI: Yes. This is
2 Paul Sierzenski.

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

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

1 emergency physicians in the country doing
2 this?

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

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

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

22 Catherine?

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

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

11 DR. ROBERTS: Yes.

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

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

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

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

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

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

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

4 DR. ROBERTS: Absolutely.

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

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

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

17 The exclusions I think are
18 completely met.

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

1 And the data collection strategy
2 implementation I put as partially.

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

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

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

10 CO-CHAIR MOORHEAD: Okay.

11 DR. O'CONNOR: For the same
12 reasons.

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

22 And I do agree with you,

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

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

12 DR. ADAMS: It is.

13 DR. O'CONNOR: Yes.

14 CO-CHAIR MOORHEAD: All right.

15 Comments or questions? Helen?

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

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

11 CO-CHAIR MOORHEAD: Jay?

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

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

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

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

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

15 CO-CHAIR MOORHEAD: Jim, is that--

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

22 CO-CHAIR MOORHEAD: Bob?

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

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

13 DR. O'CONNOR: Yes.

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

18 CO-CHAIR MOORHEAD: Yes.

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

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

3 DR. BURSTIN: Yes.

4 CO-CHAIR MOORHEAD: Jay, any
5 comments?

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

9 CO-CHAIR MOORHEAD: Paul?

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

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

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

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

16 DR. CHALIAN: Ara Chalian.

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

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

6 DR. CHALIAN: Thank you.

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

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

14 DR. BURSTIN: You guys agree?

15 CO-CHAIR MOORHEAD: Is that --

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

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

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

1 DR. SIERZENSKI: Thank you.

2 DR. SCHURR: Thank you.

3 CO-CHAIR MOORHEAD: All right.

4 We're ready to go back to -- people hungry or
5 you want to keep going? We're going to do
6 working lunch, so do you want to get your
7 lunch? Is lunch here? Lunch is here? You
8 want to take a minute and get some lunch and
9 we'll bring it back to the table and continue?

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

12 CO-CHAIR MOORHEAD: Okay. We can
13 move to No. 20. And general comments on No.
14 20?

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

17 CO-CHAIR MOORHEAD: Okay. Leigh?

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

1 any testing done at this point.

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

14 CO-CHAIR MOORHEAD: I agree.

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

1 reduce the time in the ED.

2 The summary of data demonstrating
3 performance gap, again, there wasn't any
4 specific turnaround time benchmark given.
5 They quoted one study that found 90 percent of
6 the time that lab tests are turned around in
7 60 minutes. But what that really doesn't say
8 is where we should be with it. It just really
9 is kind of a statement.

10 We did provide some citations on
11 the performance gap.

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

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

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

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

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

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

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

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

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

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

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

13 Anyone else have any comments or
14 questions?

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

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

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

1 leave it at that.

2 So we can go to No. 25. Jim?

3 DR. ADAMS: So this is NQF review
4 025-10. And it's the median time to the CBC
5 results.

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

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

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

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

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

9 The opportunity for improvement.
10 I think minimally.

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

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

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

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

6 Ara?

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

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

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

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

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

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

16 Thank you, Jim.

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

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

1 conditions for consideration.

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

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

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

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

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

22 On 1c, outcome or evidence to

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

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

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

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

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

20 CO-CHAIR MOORHEAD: That's be
21 fine.

22 MS. ALTERAS: Okay. You know, on

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

9 CO-CHAIR STONE-GRIFFITH: Yes.

10 MS. ALTERAS: Okay.

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

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

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

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

5 CO-CHAIR STONE-GRIFFITH: Right.

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

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

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

14 CO-CHAIR STONE-GRIFFITH: Right.

15 MS. ALTERAS: Although there's
16 some overlap.

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

21 DR. BURSTIN: Oh, perfect timing.

22 CO-CHAIR MOORHEAD: Left without

1 being seen, some issues regarding
2 implementing.

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

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

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

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

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

14 So that's what we know so far.

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

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

10 DR. BRATZLER: So the other issue,
11 and I actually have to tell you I was a bit
12 surprised. I didn't realize this one was on
13 the list because there were other
14 implementation issues with this measure that
15 we knew about. And the big one was let's say
16 you come into an emergency department where
17 you don't have any triage or any standard
18 tests that are done, you know usually no
19 charges are generated. Many hospitals have
20 policies that they don't submit any charges if
21 the patient leaves without being seen. And so
22 the only way to identify the denominator --

1 well the numerator population here would be
2 look at a log or something else that often is
3 not electronic. So we are aware of that
4 issue, too.

5 So we're familiar with the
6 Louisiana measure, and we just think that this
7 is probably an important measure but capturing
8 it is really tough.

9 DR. ADAMS: So I agree. It's
10 surprisingly difficult to capture. But I'll
11 just speak for my system. And any patient who
12 engages the system that doesn't have an
13 authentic physician note completed, now that
14 could be for any reason, that seems to be a
15 very big deal to me. So they've registered,
16 but they don't have anything completed. And
17 we do have a way to designate this left
18 without being seen. This was against medical
19 advice. So this was the physician just failed
20 to complete. But many systems don't.

21 But defining that, and I would say
22 a different quality measure these patients who

1 engage the system but didn't have a completed
2 record, that's a big problem in my estimation.
3 And then it should incumbent on the
4 institutions to really clarify that. Because
5 that presents a risk for patients. Because
6 really they may have left without being seen,
7 and the majority do. But, I think we need to
8 think differently about it as a system. Why
9 they didn't get the service, that alone is the
10 problem.

11 MS. ALTERAS: So do I continue to
12 consider this measure or --

13 CO-CHAIR MOORHEAD: Well, it is an
14 important measure. The difference from this
15 one, what we're hearing, is that it's a
16 different population than are already endorsed
17 measure?

18 MS. ALTERAS: Right. Well, it has
19 two exclusions, and that's the only
20 difference.

21 CO-CHAIR MOORHEAD: Okay.

22 CO-CHAIR STONE-GRIFFITH: Well,

1 actually, I went back and I looked at our
2 other measure. And the numerator -- I don't
3 we haven't got into the specification. But
4 our numerator in this particular measure is
5 registered.

6 MS. ALTERAS: Right. Right.
7 Logged in.

8 CO-CHAIR STONE-GRIFFITH: Which I
9 have -- well, logged in, registered; they all
10 mean different things, triage. And really our
11 first measure was arrival. And we said arrival
12 is a time that you have to capture, or the
13 earliest time, that becomes your arrival. You
14 have to do that for core measures. You have
15 to do that for your central log from a federal
16 requirements. So you should have that in
17 every facility. And this really says
18 "registered." I sort of had a problem with
19 that.

20 MS. ALTERAS: But in the
21 supporting document that came with this it
22 also talked about recording the time. Is that

1 the concern?

2 CO-CHAIR STONE-GRIFFITH: Right.

3 No, recording the time of arrival as opposed
4 to the time that was registered.

5 MS. ALTERAS: Yes. I see. So if
6 you arrive, pardon my ignorance about this.
7 But what's the difference between arriving and
8 registering? I mean, when you arrive you go
9 to the front desk and you register?

10 CO-CHAIR STONE-GRIFFITH: Not
11 necessarily.

12 DR. ALESSANDRINI: Usually there's
13 just a click-click place; somebody signs you
14 in and they electronically enter you into a
15 system.

16 MS. ALTERAS: And that's arrival?

17 DR. ALESSANDRINI: And that's
18 arrival. Many people don't even get
19 registered. They could even be seen by the
20 doctor. So in order to improve your
21 throughput--

22 MS. ALTERAS: Got it.

1 DR. ALESSANDRINI: -- you're
2 getting seen, you're getting a workup
3 initiated, you're getting registered at the
4 same time.

5 MS. ALTERAS: I see. Okay.

6 DR. ALESSANDRINI: Concomitantly
7 to move things forward.

8 MS. ALTERAS: You can tell I don't
9 go into the emergency room very much.

10 DR. BRATZLER: So I actually think
11 the intent, though, was arrival. The term
12 "registered" may have been used, but I think
13 intent was arrival.

14 There's people on the phone that
15 may be able to address that. But I think that
16 was the intent.

17 CO-CHAIR MOORHEAD: Is there
18 someone on the phone?

19 DR. BRATZLER: Wanda or Rebecca,
20 can you tell whether --

21 DR. JONES: Tell me what was that
22 again. It was breaking up.

1 DR. BRATZLER: So the question is
2 was the intent the first arrival time or some
3 separate registration process? You know, in
4 other words there's a distinction between the
5 two: Somebody that arrives at the emergency
6 department and somebody that then goes to a
7 separate registration process.

8 DR. JONES: Right. The intent was
9 to capture the earliest presentation or
10 earliest registration process time.

11 DR. BRATZLER: But that's the
12 issue, Rebecca. It's the registration versus
13 arrival. So I think what you're saying the
14 intent as I always understood it was arrival
15 time, the first documented time.

16 DR. JONES: Right, exactly. But,
17 as you say, different facilities are charting
18 different process and whether or not the
19 registration time versus arrival time is
20 comparable between sites is a valid question.

21 CO-CHAIR MOORHEAD: Sounds like it
22 might be helpful to just go through the rest

1 of this.

2 Ara?

3 DR. CHALIAN: I guess the simple
4 question is, is there enough difference or is
5 there enough homology here to view these as
6 the same.

7 As the advocate for this measure,
8 would you say we should march forward?

9 DR. BRATZLER: So if I were
10 speaking for NQF, I think there should be
11 harmonization currently. And, you know, I've
12 not talked to the Louisiana team, but we've
13 recognized the same implementation challenges
14 that they have. That we think that this is a
15 really important measure. We think it's tough
16 to operationalize it from a measurement
17 standpoint.

18 DR. BURSTIN: I pulled up your old
19 report and what you had actually made several
20 recommendations to the measure developer,
21 which they took. So I went through this. But
22 you specifically recommended that the new

1 measure be revised to read "number of patients
2 left without being seen by a qualified medical
3 personnel."

4 CO-CHAIR STONE-GRIFFITH: Yes. So
5 that was the position of the Committee, by the
6 way.

7 DR. BURSTIN: And you also
8 suggested that it be defined as "time of
9 arrival to initiation of contact qualified
10 medical personnel. And then in your follow-up
11 call you specifically wanted to interpret what
12 was meant by "qualified medical personnel" the
13 way you trying to get that with MDAP and
14 today.

15 And you guys felt strongly you
16 should clarify which type of professionals
17 should be included. And then ultimately you
18 defined it as "time of arrival to initiation
19 of contact with a provider," in parenthesis
20 you had "medical student, resident, nurse
21 practitioner." So I guess there was a whole
22 discussion about if the medical student was

1 initiating the workup. I remember that very
2 long discussion about medical students, as I
3 recall. And they modified the recommendations
4 based on what you had suggested. So that's
5 what they're testing.

6 CO-CHAIR MOORHEAD: Think your
7 previous question was is there a benchmark.
8 And maybe the assumption is it's zero, but
9 most practitioners don't believe it's zero, or
10 at least I don't think they do even though it
11 may seem to the public it should be zero, I
12 think the reality is the way this is monitored
13 as a QI function is sort of you bump along at
14 2 to 3 percent and then if you see any change
15 in that, that's a sentinel event and you look
16 at what's going on. But there's an acceptance
17 that there's some rate.

18 And so I know you'd asked that
19 question about a previous measure. It sort of
20 applies here a little bit too.

21 MS. ALTERAS: All right. Well, I
22 just sort of run through the rest of it since

1 I think the bigger discussion is whether we
2 want to consider it at all.

3 As we just mentioned, the
4 denominator is all patients who arrive at the
5 emergency department. Numerator is patients
6 who left without being seen with the two
7 exclusions being those under 18 years old and
8 those who die in the emergency department.
9 Although I was confused, maybe it doesn't
10 matter, but whether they die before being
11 seen. Anyway.

12 So for 2a, I actually gave it a C
13 because I think it is clear how it's
14 specified. But now I'm thinking that it's
15 erroneous how it's specified, especially with
16 these exclusions.

17 Okay. Stratification. They say it
18 will be stratified by volume, race, ethnicity,
19 age and gender which I think is excellent.

20 No risk adjustments, not an issue.

21 DR. ALESSANDRINI: Tanya, I think
22 this still brings up problems because unless

1 you're able to adjust for equity, you look
2 like you have racial and ethnic disparities.

3 MS. ALTERAS: Okay.

4 DR. ALESSANDRINI: And I think we
5 went through all this the last time that we
6 reported, you know that we endorsed the
7 measure. So I guess my question is, is there
8 something that we think that the proposer
9 thinks is something that this measure adds to
10 the one that we already have, or if the one
11 that we already have just needs to go through
12 a time limited endorsement and get some
13 information back. Because I'm not really sure
14 that this one is really, other than those
15 exclusion criteria which I think we could
16 debate, adds anything or is different than
17 what we currently have.

18 MS. ALTERAS: Okay. Well instead
19 of going through the ratings then, I'll just
20 say for usability I thought that this is a
21 measure that is meaningful and understandable
22 to consumers.

1 And scientific acceptability
2 there's no testing to really look at it. So
3 I'll forget about that.

4 Feasibility. Again, there was no
5 testing so all we have to go on is sort of the
6 issues that the Louisiana State measure has
7 dealt with in terms of the feasibility of
8 actually collecting the data.

9 So would just open it up now, I
10 guess, to talk about whether this is something
11 we want to even vote on or table it until
12 testing results are back from the endorsed
13 measure.

14 CO-CHAIR MOORHEAD: Suzanne, any
15 comments?

16 CO-CHAIR STONE-GRIFFITH: Well, I
17 would agree. I just think that this needs to
18 return to the developer, and it needs to be
19 harmonized. And we need to get results from
20 our original measure.

21 CO-CHAIR MOORHEAD: Are there
22 other comments? Jim?

1 DR. ADAMS: You know, this is
2 something of a philosophical comment. But in
3 complex industrious, service or manufacturing
4 industries, there's a science to processes and
5 engineering. And whether it's a small
6 discreet service encounter from the first
7 encounter to the cash register, it's a median
8 of 14 seconds or whether it's a complex
9 getting arms and ammunition to fight a war,
10 those are engineered and there's business
11 sciences processing engineering and the hard
12 engineering operations engineering with
13 computer simulation in complex industries,
14 FedEx and others. But these tools have not be
15 applied to health care.

16 And because they're not applied
17 to health care, we will never solve this
18 measure. And in operations theory, in process
19 measurement theory a person who attempts to
20 engage, doesn't register and leave is in
21 formal language balking and so it's counted as
22 a balk. And a person who does register but

1 then chooses to leave, that's reneging. And
2 there's a science and there's a formal
3 language but we don't use that vocabulary.
4 We've not structured our systems to learn
5 what's already in complex industries, both in
6 business and in engineering.

7 And so as we try to move quality
8 forward we're never going to be able to solve
9 these complex problems, especially the
10 interrelationships between operating room and
11 discharge times, and emergency department
12 waiting rooms without the application of this.

13 And so the next generation of
14 quality sciences will be building on this.
15 And this is what I am trying to do in my
16 department. But it's really hard. So I worry
17 that we're not going to solve without being
18 seen without getting a language and a theory
19 that we all commonly understand.

20 And literally the language of a
21 left without being seen because you can't
22 measure it because everybody's a different.

1 Sorry for the editorial, but it's
2 appropriate.

3 CO-CHAIR MOORHEAD: So I'm hearing
4 a recommendation from Suzanne that this not be
5 recommended and go back and look for the
6 results of implementation issues with
7 regarding the existing measure.

8 MS. ALTERAS: Yes, I agree with
9 that.

10 CO-CHAIR MOORHEAD: Is that
11 acceptable?

12 MS. ALTERAS: Yes.

13 CO-CHAIR MOORHEAD: Any other
14 comments or questions?

15 Those in favor of that
16 recommendation? Opposed? Abstain? Thank you
17 very much.

18 So we will now go back to No. 21.
19 And I don't think we have a primary and --

20 DR. JAUCH: Well, you have me, for
21 what it's worth, for what it's worth.

22 CO-CHAIR MOORHEAD: Well, you're a

1 primary.

2 DR. JAUCH: Yes, I am the primary.

3 We can be fairly brief on this.

4 This is NQF review ACP-021-10. This is median
5 time from head CT scan order to head CT scan
6 interpretation. And the brief description you
7 can see there is the median time from initial
8 CT order until to the time to CT results are
9 reported to emergency department staff,
10 although that's not specific as to whom that
11 represents.

12 It falls under the priority area
13 of a safety item. And apparently this is a
14 CMS measure steward application.

15 So briefly, as you see, their
16 hypothesis is that the throughput, as we
17 talked about before, is dependent upon a lot
18 of processes that occur in the emergency
19 department and they provide significant
20 literature that suggests that the time it
21 takes to do radiology studies as well as
22 obtain those interpretations leads

1 considerably to some of the delays that we
2 experience in the emergency department.

3 Although in any of the supporting
4 documentation they do not specifically
5 document the time to cross sectional
6 interpretation or more specifically, to
7 interpretation of noncontrast head CTs.

8 They do briefly talk about the
9 volumes of CT scans that are performed in the
10 emergency department. It is a fairly frequent
11 study that we use for a very heterogeneous
12 patient population, both in terms of disease
13 spectrum as well as acuities. So, you know,
14 they feel that this is a significant problem
15 in that it can lead to delays. And that,
16 again, purportedly there can be some safety
17 issues with this.

18 So let me go through this.

19 And obviously the NQF group felt
20 that this was appropriate.

21 So 1a, I gave this a partial. And
22 again, it's probably being generous at this

1 point. It does seem to be an issue. CT
2 imaging can be very important in terms of
3 making some critical diagnoses in a timely
4 fashion and initiating therapy. Again, it's
5 not clear as to how much of a delay that can
6 actually occur because of that, although many
7 of us experience delays in getting these types
8 of images read.

9 Regarding the opportunities for
10 improvement, I gave this an M. There are
11 citations, again, regarding the overall length
12 of stays that are related to imaging, but not
13 related specifically to CTs.

14 There are no data on disparities
15 by population group. So 1b I gave an M.

16 Regarding outcome of evidence to
17 support measure focus. Again, it's difficult
18 in the absence of having any previous data
19 that suggested that CT scans need to be formed
20 in a certain time, and anytime beyond that
21 leads to safety or throughput issues. So I
22 gave that one also an M.

1 Then regarding the type of
2 evidence that they provided. There really is
3 a paucity of any evidence that looks at CT
4 imaging and times and delays that relate to
5 both throughput as well as safety issues. So
6 I actually gave that one I think in here an M
7 as well.

8 So in the end I think that, you
9 know the challenge with this is that it's not
10 disease specific, it's not severity specific.
11 And for all the reasons we've heard about
12 regarding troponins and CBCs and things like
13 that, I think there's a lot of challenges to
14 try to implement a temporal benchmark across
15 this spectrum of diseases and actually I'll
16 even get into the settings. Not just the
17 emergency department, but also the acuties of
18 the patient.

19 So as a big fan of the brain, and
20 that's what my work is in, I think that
21 getting CT scans is very important and getting
22 timely interpretations of this, but I don't

1 think that this particular measure will really
2 give us data that will be usable either for
3 myself or for the average consumer not knowing
4 what people are going to do with this.

5 So I'll stop there.

6 DR. ALESSANDRINI: Well, I agree
7 with all your comments. I had a couple of
8 other thoughts as well.

9 First of all, I think the intent
10 of this is good. If you order a head CT, you
11 should get an interpretation in a timely
12 manner.

13 Then I look at this and say now if
14 I look at this measure, will this show the
15 excellence of my institution. And there are
16 a couple of things that will come into play.

17 One of these is very broad. This
18 is talking about all head CTs. And as your
19 radiologist, I will be triaging as well. So
20 if you have a patient in your emergency
21 department having a stroke, they are going to
22 get scanned immediately no matter what else is

1 going on. If you have a patient they've
2 ordered a head CT on who is healthy, you know,
3 neurologically intact, chronic headaches, I'm
4 going to image all the people who are really,
5 really before I image your headache person.
6 So that's a little hard when you basing that
7 on all just head CTs.

8 So one of my thoughts was this
9 would be more powerful if it had a more
10 focused intent instead of all head CTs.

11 The other thing is a small
12 terminology item. And that is I like the
13 measurement title. But on the brief
14 description of the measure they do actually
15 say "results are reported to emergency
16 department staff." Now that's fine if it's a
17 lab result. But a lot of different things come
18 into play, and there will be times when your
19 radiologist will not report it to emergency
20 department staff.

21 Say, I'm standing in the scanner
22 with the neurosurgeon. I will talk directly

1 to the neurosurgeon, neurosurgeon takes
2 patient, patient goes. So does that reflect
3 bad care because it might show up poorly on
4 this metric because you're saying when did you
5 report this to the emergency department staff.

6 So the terminology there, that's
7 fixable. You know if it's just saying
8 something more like median time from initial
9 head CT order or initiated from the emergency
10 department to the head CT, interpretation
11 results available, then it doesn't say it has
12 to be going to the ED. That would be fixable,
13 more powerful if it's focused.

14 And then, again, the reported how
15 will be sort of a challenge. And we could get
16 to that for the metrics. Like, is resident
17 prelim verbal interpretation reported? How
18 are you time stamping that? Is it a
19 handwritten interpretation? Is it a general
20 radiologist's interpretation? Is it the
21 subspecialist neuroradiologist's final read?

22 DR. JAUCH: You want to talk about

1 TELERAD?

2 DR. ROBERTS: Yes. Do you know,
3 do you have TELERAD from India overnight and
4 it's giving you a prelim but then your real
5 interpretation is in the morning? There's
6 just so many different factors that can go
7 into this.

8 But I would like to say the intent
9 is good. If you order a head CT, you should
10 have an interpretation in a timely manner.
11 This just doesn't quite get to I think what
12 the intent was.

13 DR. JAUCH: Yes. And she said it
14 very nicely. And I think that, again, you
15 know a lot of times the circumstances if I've
16 ordered a head CT, I'll go with the patient to
17 the CT scanner reader right there. So I don't
18 want on these types of results.

19 So I think it's better off if
20 we're going to have this type of imaging
21 criteria set forth, either for all imaging not
22 just head, you know cross sectional imaging

1 should be read within a certain time period,
2 plain films in a certain period. And that may
3 not be something that NQF wants to get into.
4 But if we were going to look at CT and
5 specifically, I think we need to be more
6 disease specific. So get the guidelines,
7 which is a registry for stroke captures this
8 information.

9 We have recommendations that we
10 came up in 2002 that at least for acute
11 ischemic stroke if you have a stroke, you
12 should have a CT scan within 25 minutes and
13 you should have the interpretation within 45.

14 So, again, it's a very specific
15 subselect population that's more definable and
16 more reportable. And those weren't based on
17 any data that we ever collected. We just
18 randomly chose that in 2002, one of our
19 consensus panels. But it seemed like a
20 reasonable thing, again, mirroring what we do
21 for the golden hour of trauma, the golden door
22 to vein for a STEMI. But I think this is too

1 broad in scope and not specific enough to be
2 meaningful.

3 CO-CHAIR MOORHEAD: So is your
4 scoring of section 1 in terms of importance,
5 are you --

6 DR. JAUCH: Again, that's the
7 challenge. I mean I --

8 CO-CHAIR MOORHEAD: The contact
9 stuff of this measure?

10 DR. JAUCH: I'm going to say no
11 because I think if it's endorsed as it is, it
12 will not be usable.

13 DR. ROBERTS: I had said no, but I
14 would consider going back to them with
15 discreet recommendations on how it could be
16 improved and perhaps more accurately reflect
17 whether an institution is doing well or
18 poorly. Although you could argue that there
19 may be some institutions doing exceptionally
20 poorly that would have results that are
21 entirely unacceptable.

22 DR. BRATZLER: So I've heard

1 several suggestions. So the whole issue of
2 available versus reported to somebody was
3 discussed fairly extensively with the
4 technical expert panel. So I get the sense
5 that I don't your specialty doing the primary
6 review. But I suspect that you're skilled at
7 interpreting CT scans. But there are many
8 emergency rooms around the country that aren't
9 staffed by individuals that are skilled at
10 interpreting. And so the word of having an
11 interpretation done that was available was
12 specifically specified that way because we
13 were concerned about just having the test
14 done, that there needed to be somebody.

15 And we weren't looking for the
16 final report. We were looking for some
17 initial interpretation that got to the person
18 providing care to the patient. So we thought
19 that was important.

20 And that could be, I would
21 certainly agree, that if you had the
22 neurosurgeon standing there in the CT scanner,

1 then it's been reported to somebody that's
2 taking responsibility for the patient.

3 The denominator could clearly be
4 limited to certain diagnoses. I mean, it
5 could be limited to stroke. And I don't know
6 if Jim's got any ideas about way back in those
7 conversations about why we kind of broadly
8 defined just kind of a general time frame to
9 get the CT done. Because it, again, was seen
10 as one of the bottlenecks to getting patients
11 kind of moved through the emergency
12 department.

13 And the other one was some
14 stratification. I mean, you mentioned the fact
15 that if you have three patients lined up for
16 a CT, one's an acute stroke and the others are
17 headache patients, well I understand that
18 there would be a difference in the
19 prioritization of some of those patients. But
20 if you're just reporting median time or a
21 median in range for all the patients, why that
22 may kind of work out at the end of the

1 measure.

2 So, I guess if there was a
3 recommendation for conditional changes, what
4 would those be specifically be?

5 DR. JAUCH: I kind of view this,
6 as was mentioned before with troponin, I mean
7 I believe that it is an important thing to
8 track and that we should have a minimal
9 expectation of a time for turnaround for
10 interpretation whether it's reported or not.
11 Just availability. It doesn't have to be that
12 I get called. I just need to be able to
13 access that data.

14 And I think as a community we need
15 to come up with expectations regardless of the
16 disease, we should could up with expectations
17 almost like clinical pathology. Where if
18 you're providing this service, we should
19 expect a certain turnaround time. That's
20 separate than saying we're going to track
21 medians and means. Because reporting that,
22 again, with central tendencies is not

1 reflective of those who need to have it done
2 acutely within 10 minutes and those who can
3 really done within two hours, and it's not
4 going to make a difference.

5 So by using the central tendencies
6 argument and by using this overall reporting,
7 it really is dilutional to what is important.
8 The ultra urgent traumatic brain injury, you
9 know some of the pediatric cases and some of
10 the stroke patients versus those chronic
11 headaches or somebody being admitted for
12 urosepsis who is just not quite right and the
13 admitting service ends up getting a CT just to
14 be sure.

15 And so I think we either need to
16 separate this from -- we need to put this in
17 the context of the overall process of
18 throughput looking at performances and
19 standards and expectations by ancillary
20 services within the hospital, like laboratory.
21 In this case radiology. Or we need to put it
22 in the context of a specific time sensitive

1 disease like ACS and consider it an EKG and
2 say we need to have this type of information
3 in a certain time period. But I think when
4 you straddle fence, you don't accomplish
5 either very well.

6 CO-CHAIR STONE-GRIFFITH: Helen,
7 the imaging efficiency measures, is this not -
8 - it is not.

9 DR. BURSTIN: This is probably one
10 of our more interesting, somewhat notorious
11 aspects of IQ history here. This was a
12 measure that went through the last imaging
13 Committee that Dell oversaw a couple of years
14 ago, which was called Code Stroke CT Narrow
15 Imaging and Evaluating Patients of Acute
16 Stroke Symptoms. And this was specifically
17 about assessing performance for CT scan
18 interpretation.

19 Again, referring to the
20 guidelines, it was the issue of being able to
21 meet the 45 minute window for interpretation.
22 I think there was some discussion. It was

1 never very clear. We asked the measure
2 developer to specify further. We didn't get
3 back specifications. They didn't respond,
4 although it did wind up in The Wall Street
5 Journal, but they never actually responded to
6 the request for new specifications.

7 But it was never very clear when
8 the time window began because patients would
9 come in and if they didn't recognize they had
10 stroke symptoms, when did the clock begin was
11 a complicating factor. So that was one of the
12 clarifications that they wanted to be clear.

13 This whole issue of a written
14 preliminary report also was something they
15 wanted to clarify exactly, as you had pointed
16 out Catherine.

17 And they wanted it it was the goal
18 of reading the CT within 15 minutes of
19 completion of a study was also recommended.

20 So, you know again, if you didn't
21 want to go down this road, Dell would be happy
22 to share with you the deliberations of that

1 Committee. Because they really did dive
2 pretty deep. But being able to figure out who
3 is presenting with the potential stroke is not
4 so easy. They could have a vague kind of
5 symptoms presenting to the triage nurse and
6 they may not pick up on it. Or God knows they
7 could have my mother in front of them and
8 they'd never get a history. So it's really a
9 challenge. But I think overall the Committee
10 felt it was a good measure of efficiency of
11 the emergency department and they just really
12 were concerned about the specifics and just
13 wanted to see if there was anyway to make it
14 better. So there's a way to potentially to
15 take stroke and/or the other two conditions
16 that were just listed out about acute brain
17 injury in kids, maybe a separate one for kids,
18 but the ones where there are really the
19 highest triage ones, maybe that would be a
20 possibility. And it may be as simple as just
21 asking potentially if you're willing to elect
22 and bring back a measure within a couple of

1 week for you to take a look at one a
2 conference call with a bit more specificity to
3 get at the high urgency ones.

4 MS. McCARTNEY: You know, for a
5 stroke from the Joint Commission their measure
6 is actually for order to review by the care
7 team, meaning the independent licensed
8 practitioner that's caring for the patient. So
9 it could be the neurosurgeon, it could be the
10 ED physician to whoever is making the
11 decisions about that patient's care. But it
12 is from order until that review time. So it
13 might be a radiology interpretation that then
14 is reviewed by the care team or somebody on
15 the care team. So that might make it a little
16 bit more -- I hate to say broad, but then just
17 the ED staff.

18 But I will tell you it is very
19 difficult to get that time because people
20 don't document it.

21 DR. BURSTIN: And actually, the
22 Joint Commission stroke measure that we do

1 have, and there isn't one currently about CT
2 interpretation.

3 MS. McCARTNEY: No.

4 DR. BURSTIN: Is all about time
5 last known well --

6 MS. McCARTNEY: Right.

7 DR. BURSTIN: Not a term of art, I
8 think. By patient of when symptoms began.
9 We're actually retooling that one right now
10 for electronic health records and it's a bear
11 to figure out what time last known well means.
12 So there's definitely some issues of going
13 down this road, but it is I think very much
14 like what we talked about earlier with
15 troponin.

16 CO-CHAIR MOORHEAD: So the last I
17 heard was that on the importance issues, that
18 this was too broad in its current form was
19 your recommendation?

20 DR. JAUCH: Yes.

21 CO-CHAIR MOORHEAD: And I guess
22 what we need to know is whether we'd like them

1 to go back and try to work on this, is this
2 something that can be done relatively quickly
3 or is this something we just don't want to go
4 with?

5 DR. JAUCH: Well, unfortunately, I
6 don't know what's been before. So,
7 unfortunately, I've not seen these previous
8 measures. I'm not sure how specific they've
9 been and now successful they've been in terms
10 of implementation. So with that type of
11 knowledge you kind of know is it really
12 feasible to construct one in a more focused
13 application. And if they've already had
14 trouble with the focused application because
15 some of the challenges we just heard, then I'm
16 not sure two weeks will give us enough time to
17 do that. And that's just being the new person
18 on the Committee.

19 But I think, again, the importance
20 in general to getting timely interpretation of
21 all imaging, cross sectional, plain films, is
22 beyond doubt. The question is an we -- you

1 know, just as easily a plain film
2 recommendation here saying that plain films
3 should be read within an hour. And, you know,
4 do you really want to make it that broad
5 because I think that's a challenge to
6 implement and really understand what those
7 data will be telling us.

8 So I don't think, no.

9 DR. ROBERTS: I agreed. I think
10 that would be sort of challenging to have them
11 come up with something at the last minute that
12 certainly an entire Imaging Committee has
13 struggled with.

14 CO-CHAIR MOORHEAD: Okay. So the
15 recommendation on No. 1 in importance is no.

16 Any further comments?

17 Those supporting the
18 recommendation? Opposed? Abstaining? Okay.

19 So we'll now move to 22. This is
20 Bob.

21 DR. O'CONNOR: This is measure
22 ACP-022-10: Median time to chest x-ray.

1 The definition is the median time
2 from initial chest x-ray order to time the
3 chest x-ray exam is completed.

4 The measure met all conditions for
5 consideration by NQF.

6 I think I can go right into the
7 importance and recommend no, and I'll tell you
8 why, to sort of do it do it backwards.

9 You've heard a lot of the
10 arguments already today on either metabolic
11 profile, CBC, head CT. This is a
12 heterogeneous population. Measuring the
13 median I don't think would be, you know
14 because the measure is central tendency would
15 not be the best. You know, I would favor
16 something along the lines of to have 90
17 percent of the films done within a specified
18 time period as opposed to a median for all
19 chest films, which are obtained for a variety
20 of reasons ranging from detection of life
21 threatening illness to routine preoperative
22 studies.

1 The idea behind this is a good
2 one. You know, I think if I were a patient in
3 an emergency department getting the chest x-
4 ray, I'd like to have it done as quickly as
5 possible and have a good interpretation of
6 that film done quickly as well. However, the
7 goal of the measure is to reduce throughput in
8 an emergency department. And this is just one
9 of many tests for many factors, actually a
10 myriad of factors that effect throughput in
11 the emergency department.

12 You could argue that there's
13 nothing really special about chest x-rays
14 compared to other films, for example. That it
15 should be part of a comprehensive radiology
16 service to the emergency department that
17 turnaround time is quick.

18 So I think with that, I will stop
19 and just reiterate my recommendation as to say
20 no to importance because it may be a useful
21 quality improvement measure within the
22 department. I don't think it will advance the

1 cause of reducing throughput in the emergency
2 department, which is what much of the evidence
3 that's cited in section 1 relates to.

4 CO-CHAIR MOORHEAD: Okay.

5 DR. ROBERTS: Now this is one that
6 I was a bit more favorable one because --

7 CO-CHAIR MOORHEAD: Well, I wonder
8 why.

9 DR. ROBERTS: Well, because this
10 is a really -- it is kind of a nice QI project
11 for radiology. And we used to track this in
12 my institution for years because we wanted to
13 make sure that when the ED ordered a chest x-
14 ray, they knew about pneumonia, they knew
15 about pneumothorax, everything, you know
16 really, really quickly.

17 I guess on the alternate argument
18 is that after several years we stopped
19 tracking it because we had made all the
20 improvements we can and occasionally patients
21 are having other things done that are
22 important, and can't interrupt the chest x-ray

1 being done right at that moment.

2 So I don't know. I wound up
3 writing this a yes, but it is a quality
4 improvement. It is one thing. And it would
5 need the rest of you to decide how important
6 that is for your ED throughput.

7 But this one was a lot cleaner.
8 You know, it was easy for us to track. The
9 order goes in, time stamp and then we time
10 stamped image completion including returning
11 the patient to the ED, again time stamp. So
12 very easy to track. Very easy to see when
13 things were out of whack and you'd try to work
14 on improving. And people might have
15 institutions where that could be improved.
16 But again, that's only one little part of your
17 emergency department experience. And so I
18 would need the rest of you to have a sense of
19 how big an impact this would make on your
20 lives, or on nationally lies.

21 CO-CHAIR MOORHEAD: Comments from
22 the Committee.

1 DR. COHEN: Just a lot of the
2 comments you made on the CT scan are related
3 to the chest x-ray in terms of the verbal
4 discussion. You know, the verbal statement
5 from the radiologist or who is doing the
6 actual reading, all that applies also to the
7 chest x-ray, I would think.

8 DR. BRATZLER: Although the
9 specifications for this measure are to the
10 completion of the exam because of that.
11 Because we know that most ED physicians do
12 interpret their own.

13 DR. ROBERTS: Exactly. So this
14 one does not include --

15 DR. COHEN: This is a little more
16 specific.

17 DR. ROBERTS: -- the
18 interpretation. It's just how --

19 DR. COHEN: It's completion
20 itself.

21 DR. ROBERTS: -- how efficiently
22 my technologists are responding to the needs

1 of the emergency department.

2 CO-CHAIR MOORHEAD: So the
3 recommendation is no question number 1 as a
4 measure and more of a QI, to be used as a QI
5 indicator.

6 Other thoughts? Suzanne?

7 CO-CHAIR STONE-GRIFFITH: Well, I
8 would just agree. I really think, although it
9 lends itself to measurement internally, if I
10 think about this in the public space, how does
11 that really add value in the big picture? I
12 just don't see it.

13 DR. ROBERTS: I see your point.
14 Absolutely.

15 CO-CHAIR MOORHEAD: All right.
16 Those in favor of the recommendation, raise
17 your hand. The recommendation that the answer
18 to the importance is no.

19 Those opposed? Anyone abstaining?
20 Okay.

21 We can move ahead. So the next is
22 No. 23. So 23 is Victor.

1 DR. COHEN: Yes.

2 DR. BRATZLER: I just want to make
3 just one real comment on this one before we
4 start. So this one is one that we actually
5 spent a lot of time with the technical panel
6 on about carefully defining the denominator
7 population. We clearly didn't want to create
8 a measure that might make it broadcast that
9 emergency rooms were held accountable for how
10 quickly they gave pain medicines, that make
11 people want to go and get their pain
12 medicines. So the denominator population for
13 this was limited to the population of patients
14 with a principal diagnosis, or their first
15 diagnosis in the ED of a long bone fracture.

16 So it was a very limited
17 denominator for that specific reason.

18 I think one thing that's come up
19 in all these conversations is I spent a ton of
20 time doing literature reviews on a lot of
21 these points about throughput to lab and x-
22 ray. There's not much published out there.

1 There are a few studies on this particular
2 topic about delays and personal experience.
3 And when I went to an ER to an acute abdomen,
4 and made the diagnosis long before I got there
5 but had to wait for a surgeon to show up
6 before I could get pain meds. I had special
7 concern about this particular topic.

8 CO-CHAIR MOORHEAD: Okay.

9 DR. COHEN: Assigned ACP-023-10.

10 It's median time to emergency department
11 arrival to time of oral or parenteral pain
12 medication administration for emergency
13 department patients with a principal diagnosis
14 of long bone fracture. This is a process
15 measure and it is a timeliness measure.

16 It did meet all four criteria for
17 consideration in terms of conditions for NQF.
18 But with that said, in terms of areas of
19 importance this is a time limited endorsement
20 and testing will be complete within 12 months.

21 1a, the measure does address a
22 national goal identified by NQF, NPPP. It

1 represents an important quality issue, pain
2 management within the ED.

3 Over 90,000 admits are related to
4 fractures annually. Thus, a high impact
5 aspect of health care, high use of resources
6 and leading cause for morbidity.

7 1b, the measure provides an
8 opportunity for improvement as it provides a
9 standard of practice for patients presenting
10 with long bone fractures to the ED.

11 Disparities have been identified.
12 In one study one two-thirds of patients
13 received opiates, and those taken care by PAs,
14 other practitioners, physician extenders only
15 half received opiates.

16 Racial disparities were noted as
17 less black patients were treated with opiates
18 than whites.

19 1c, the measure is an intermediate
20 outcome of process of care. Its relationship
21 to outcome the faster delivery of pain
22 management, the improved satisfaction of care

1 provided. When pain management was delivered
2 at an adequate time, patients were more
3 satisfied; the second way to say it.

4 Strength of the evidence a level B
5 and C. There are observational and cohort
6 studies. These studies are hard to conduct
7 ultimately because you cannot give pain
8 medication to patients. So gold standard due
9 to clinical limitations are not -- you can't
10 have the gold standard. You can't just give
11 placebo for pain.

12 Controversy. There is controversy
13 and contradiction of more pain management
14 before diagnosis. There's no reason to hold
15 opiate therapy. What I'm trying to say here
16 is they are suggesting that the controversy is
17 you'll have more pain management even before
18 the diagnosis is actually made. So diagnosis
19 may not be made, and they still will give
20 opiates; that's their concern.

21 I was considering anyone comes in
22 suffering with pain, it's better to error on

1 the side of caution and treat them for pain
2 management if they're complaining of pain
3 visual analog score of 10 of 10. That's a
4 reason to treat with pain.

5 So I think this completely met --
6 unquestionably meets criteria. Overall meets
7 the importance criteria.

8 CO-CHAIR MOORHEAD: We don't have
9 a secondary.

10 Is there any other comment about
11 No 23?

12 DR. COHEN: Levine is -- oh, I
13 guess Levine is not here.

14 CO-CHAIR MOORHEAD: Levine's not
15 here.

16 Scientific acceptability of
17 measure properties. Measure is scientifically
18 acceptable, well defined and precisely
19 specified so that it can be implemented
20 consistently in comparative cross
21 organizations.

22 Numerator. It measures a time

1 from arrival to the ED to time to first oral
2 IV administration of opiate therapy. Now I
3 think that's a problem.

4 You're not adding in new
5 procedures; nerve block, local anesthetic
6 treatments for fractures and various other
7 types of bone fractures that physicians are
8 doing. They're doing ultrasound guided local
9 anesthesia to LB patients, provides greater
10 duration of care. Pain management as opposed
11 to morphine where you have to just keep
12 providing.

13 Furthermore, opiate is not alone.
14 You have Ketofol, ketamine plus propofol being
15 used for pain management. So I think this
16 doesn't include all pain therapy, so you may
17 miss a good number of patients in terms of the
18 measure.

19 DR. ALESSANDRINI: Can I ask a
20 quick question. When you doing those other,
21 like the nerve blocks and things like that, in
22 my experience we usually still treat with an

1 oral or IV pain medication while preparing to
2 do that. I mean, do you think that's pretty
3 standard or do you think some people get
4 nothing and will go right to one --

5 DR. COHEN: Our ultrasound
6 physician is actually doing a study on this
7 right now. And only if the patient complains
8 of pain will they start an opiate. I don't
9 believe he starts an opiate initially. But we
10 only wait a short amount of time, like 30
11 minutes. So hopefully the onset of the
12 anesthetic takes on. Pretty quickly.

13 He's seen very good results in
14 that respect. But I don't remember exactly if
15 he starts on morphine and then does the
16 anesthetic.

17 DR. ALESSANDRINI: And as far as
18 I'm aware there's not a contraindication to
19 having both. So --

20 DR. COHEN: No, there's not.

21 You know, furthermore also you may
22 not used an opioid, which this strictly says

1 opiates, you could NSAIDs. So those patients
2 contraindicated to opiates, they're
3 necessarily are excluded from this. They
4 probably should be included as well. So
5 that's just another issue.

6 CO-CHAIR MOORHEAD: Did you want
7 to comment on this?

8 DR. BRATZLER: Yes. I just want to
9 check on the phone for Rebecca for the table
10 8.1 does that include other? I didn't think
11 we limited it strictly to opioids.

12 DR. JONES: I'm taking a look at
13 it now just to make sure.

14 That is not limited to opioids.
15 They are aspirin and NSAIDs on here, I
16 believe. Yes. So it's not limited to
17 opiates.

18 DR. COHEN: I think there was a
19 statement somewhere where it said opiates, so
20 that's why I was referring to opiate. But
21 I'll take a look again to see if I find where
22 it was referring to it. I think it would say

1 in the numerator.

2 DR. CHALIAN: The numerator it
3 says oral adrenal --

4 DR. COHEN: Okay. That's fine.
5 You know what I was looking at, I believe the
6 codes. They also, a lot of the codes were
7 opiate related. But I did see something on
8 that issue.

9 So it's general. It's any pain
10 management?

11 DR. BRATZLER: Yes.

12 DR. COHEN: Okay. In terms of
13 denominator, the denominator is appropriate.
14 Would want to not exclude contraindications to
15 pain medications as there are always
16 alternatives to use. Because there is a
17 contraindication vein that's a very general,
18 I mean you're going to have to provide some
19 pain management so I'm not sure how you can be
20 fully contraindicated to all pain medications.
21 So that was one of the denominator exclusions.
22 So I'm not sure if that's rational.

1 DR. BRATZLER: So that actually
2 didn't show up on my list and maybe have a
3 different. The form I have doesn't have that
4 as an exclusion.

5 What that discussion was about the
6 potential for some patient that had a long
7 bone fracture and then might have some closed
8 head trauma or something else that you might
9 be reluctant to use an opioid on. But I would
10 agree that you could use something else.

11 DR. COHEN: But you could use
12 something else. So, yes. So just those
13 patients with contraindications to pain
14 medication.

15 CO-CHAIR STONE-GRIFFITH: What
16 about aging?

17 DR. ALESSANDRINI: Yes. I mean, I
18 think we would use at any age. I mean
19 sometimes if you have a long bone fracture,
20 you would get treated with pain medication and
21 even a narcotic, just with close monitoring.

22 CO-CHAIR STONE-GRIFFITH: Right.

1 This is actually 18 or over, though, which I
2 guess was the question. Need the 18 and over.

3 DR. ALESSANDRINI: Right. And I
4 don't foresee any reason why it should be not
5 any age patient.

6 We spent a significant amount of
7 time operationalizing this measure at
8 Cincinnati Children's. And the way that we
9 found it to be most effective but it's easy
10 for us in one institution to collect data, is
11 we're tracking time to IV pain medication. It
12 doesn't have to be a narcotic, but it does
13 have to be IV because oral tends be inadequate
14 for patients who present with deformities.
15 Because that's who -- you know, I mean it's
16 really hard to think you have a long bone
17 fracture, particularly in kids. If you have
18 a distal radial buckle fracture and who really
19 needs the pain medication. And so it's worked
20 very well for us to say in triage if you have
21 a deformity, you know that the patient that's
22 it noted, there's a special -- which occurs

1 that the patient gets treated, you know with
2 IVP medication rapidly.

3 And so that seems to be like who
4 really needs the treatment. I think it
5 sometimes then it gets a little bit more
6 difficult in these circumstances are you
7 identifying the patient respectfully based on
8 ICD codes. And when you're doing that, then
9 it sort of goes back to that sort of like
10 diluting the population. But maybe that's the
11 right way to look at it. Because if you're
12 including the oral pain medications in
13 addition to intravenous, then you're sort of
14 capturing the appropriate therapy for the
15 appropriate diagnosis. But just a
16 consideration.

17 But definitely there's no reason
18 that I can think of unless anyone else can
19 think that we should not include all patients
20 in this measure.

21 DR. COHEN: The measure will allow
22 for stratification of results.

1 No data was specified for survey
2 method. It just suggested sampling data.
3 Again, a description of the sampling source of
4 data is charts and various other electronic
5 medical records, which is good.

6 2b, 2c reliability and validity.
7 The measure appears to be reliable and valid
8 yet no date is provided. Only side comments
9 are provided. So here I said N or minimal.

10 No data on supporting exclusions
11 was provided. Again N or minimal. Actually,
12 at minimal.

13 No risk adjustment is provided or
14 why data supports no risk adjustment. Again,
15 minimal.

16 2f, g and h are partial as
17 actually minimal. Overall because no data was
18 provided on these.

19 Overall partially, this measure
20 partially meets the scientific acceptability
21 in my view from that standpoint.

22 Do you want discussion or do you

1 want me to go on?

2 CO-CHAIR MOORHEAD: Any comments,
3 questions?

4 Keep going. I'm sorry.

5 MS. ALTERAS: I mean, you rated
6 everything minimal everything, right?

7 DR. COHEN: Yes. And it rated it
8 partial because I was trying to be soft. I
9 wasn't clear as to -- so I think it truly it
10 is minimal in terms of meeting the criteria.
11 But I didn't know the positives and the
12 negatives.

13 In terms of usability, there's no
14 current use as testing is not yet complete.
15 It's related to other dependent processes that
16 we have already, like fibrinolytics, et
17 cetera. So it's easy to use and understand.

18 There is harmonization with other
19 NQF measures.

20 There is direct additive value of
21 the measure. Overall it partially meets
22 criteria for usability once testing occurs and

1 on the public use. You know, I think it will
2 be completely meet the criteria.

3 Feasibility it meets partially for
4 a, b and c.

5 For d what I was suggesting for d
6 is rather error on the side of caution with
7 pain management than to not provide pain
8 management, irrespective of diagnosis for
9 patients suffering from pain.

10 And 4e costs with electronic
11 medical records may be minimal. All Quality
12 Assurance Performance Improvements can do
13 this, especially if you have if electronic
14 medical records. They can capture the pain
15 management and that records pain scales and
16 medication administration.

17 I say overall yes is my
18 recommendation to endorse.

19 CO-CHAIR MOORHEAD: Comments,
20 questions?

21 I guess the one suggestion is open
22 this up to all ages. And the other is would it

1 help the measure to add the deformity that was
2 helpful to you and get some feedback from the
3 Committee in terms of whether that would be
4 helpful>

5 DR. ALESSANDRINI: Yes. It would
6 be interesting what the Committee thinks I
7 would say if we added the deformity which
8 decreases or limits or makes it less feasible
9 to -- it makes it a little bit more out of
10 the realm of the electronic down the road.
11 But then I would say if you did deformity, I
12 would recommend limiting it to IV medications.
13 But if we just left it with the diagnoses and
14 then there were any fracture, then I think
15 doing it combined oral or IV approaches is
16 acceptable.

17 DR. BRATZLER: And so I think if
18 you're within a hospital measuring your own
19 performance, it's--

20 DR. ALESSANDRINI: It's easier.

21 DR. BRATZLER: -- it's easier
22 finding deformity from a performance

1 measurement standpoint rolling it out to 4,000
2 hospitals. Then you're looking at text fields
3 of a chart or other things to find that
4 information.

5 DR. ALESSANDRINI: Yes.

6 CO-CHAIR STONE-GRIFFITH: And are
7 we going to limit to oral and IV, and are we
8 including nerve blocks.

9 DR. COHEN: Right. All pain
10 medication.

11 DR. BRATZLER: So we can certainly
12 modify the table to include other forms of
13 nerve block, regional anaesthesia and things
14 like that.

15 DR. ALESSANDRINI: And also to
16 essentially delete the exclusion for
17 contraindication to pain meds is the other
18 suggestion that was made.

19 DR. BRATZLER: Right.

20 CO-CHAIR MOORHEAD: Jim?

21 DR. ADAMS: Yes. I just wanted to
22 think about the exclusions for the multi

1 trauma patient that may have devastating head
2 injury to go to the OR. Do we have the
3 exclusion sufficiently thought through?
4 Especially at the high end traumas that may go
5 to the operating room for other reasons.

6 DR. COHEN: Well, they may be
7 intubated already anyway. So what's the
8 concern? Well, then they probably don't need
9 pain management anyway.

10 DR. ADAMS: Right. Or they rapid
11 operative intervention and they go there and
12 never get dilaudid.

13 DR. BRATZLER: Yes. So I think
14 that's part of why we limited to the first
15 diagnosis of a long bone fracture thinking
16 that most of the severe head traumas and
17 others would probably have some other first
18 diagnosis. But that was the whole
19 conversation around a contraindication to pain
20 medication would be the patient that showed up
21 with a mid-femur fracture and also a head
22 injury that you might not want to sedate.

1 DR. JONES: And we captured that
2 in the data element for pain medication in
3 looking into whether or not they received it.
4 We also have clauses that if there was
5 sufficient documentation of reasons for not
6 administering such as the patient was
7 unconscious, decreased respiratory rate or
8 patient refusal that those were acceptable.

9 DR. BRATZLER: So that's in the
10 data element that's captured.

11 DR. ADAMS: And I think that's a
12 point that will come out in testing also
13 because most of the physicians under those
14 circumstances are not going to document the
15 negative of why it was withhold. And adding
16 a burden I think that would make this received
17 negatively.

18 The best metrics have people with
19 multiple disciplines, you know our nurses, our
20 pharmacists, our doctors, our surgeons coming
21 together to achieve a goal. You know our
22 STEMI stuff, everybody come together to

1 achieve a goal, and stroke and sepsis. And so
2 in this I'd like people to come together to
3 achieve a patient-oriented goal.

4 And I can see that here. I would
5 vote for it.

6 I think the highest order of
7 success would be the more relief of suffering
8 because sometimes immobilization, ice,
9 expression to caring are also part of that
10 stuff. Just shoving dilaudid at everybody is
11 what we'll get out of this. But I don't think
12 we can measure that. I just wanted that kind
13 of on the record that I wouldn't want a higher
14 order, but this should be some minimal level
15 of success that I would accept. I just don't
16 think it's exactly the end point.

17 CO-CHAIR MOORHEAD: So I'm hearing
18 a recommendation to recommend approval with
19 the conditions that this be expanded in age
20 and add other pain modalities. Is that
21 accurate?

22 All right. Those in favor?

1 Opposed? Abstaining? All right.

2 We're now moved to No. 42.

3 DR. BRATZLER: I think I've done
4 enough of them. I don't know if we ever got a
5 decision around the troponin.

6 CO-CHAIR MOORHEAD: And while
7 you're here let's go back and vote to No. 19.
8 We deferred and wanted the discussion of our
9 issues before we voted on that. So back to
10 Victor. You have a recommendation for us?

11 DR. BRATZLER: The conditional
12 notes that I have were to consider a rival to
13 result with a limited denominator cardiac
14 chest pain or AMI with some reporting of the
15 distribution of the measuring, meaning perhaps
16 plus distribution or something beyond just the
17 simple tendency, or within an hour, or set a
18 proportion.

19 You know, we've tended to avoid
20 those set times in measures because there's
21 almost evidence to ever base a number on. I
22 mean, it's always controversial.

1 DR. ALESSANDRINI: Always
2 controversial.

3 DR. BURSTIN: There is also the
4 time of arrival.

5 DR. BRATZLER: Yes.

6 DR. COHEN: I guess perhaps
7 stratify to where it would be used, for
8 example, the NSTEMI. I think that there were
9 comments stated something of that nature to
10 when it's necessary, which may be a condition
11 that may be more appropriate in that respect.

12 CO-CHAIR STONE-GRIFFITH: In the
13 NSTEMI. Yes.

14 DR. COHEN: But I still support
15 it.

16 CO-CHAIR MOORHEAD: So your
17 recommendation is to recommend approval with
18 these --

19 DR. COHEN: Conditions.

20 CO-CHAIR MOORHEAD: -- conditions?

21 DR. COHEN: Yes.

22 CO-CHAIR MOORHEAD: Are there --

1 DR. ALESSANDRINI: Can you go
2 through the conditions one more time?

3 CO-CHAIR MOORHEAD: I think we're
4 limiting this to presenting -- but to chest
5 pain or is STEMI, not acute MI?

6 DR. BRATZLER: So it's cardiac
7 chest pain or AMI. And remember you're only
8 in the denominator if the test is even drawn.
9 So if you had an EKG that showed a STEMI and
10 you didn't even do the test, that case
11 wouldn't even be in the denominator.

12 DR. COHEN: So it's not an issue.

13 DR. BRATZLER: So it's rival 2
14 result, cardiac chest pain or AMI.

15 CO-CHAIR MOORHEAD: Well, but just
16 wait. Is it really cardiac chest pain?

17 DR. ALESSANDRINI: Well, how do
18 you know that?

19 CO-CHAIR MOORHEAD: I mean, you
20 don't know that.

21 DR. COHEN: I'm just going to say
22 chest pain.

1 CO-CHAIR MOORHEAD: I think it's -
2 - I mean that's one issues that we need to
3 just clarify here.

4 DR. BRATZLER: We already have
5 from other measures a denominator definition
6 of patients who -- you know, chest pain
7 generically is a whole pile of things.
8 Trauma, chest wall pain and so if you don't
9 have some way to specify cardiac chest pain,
10 it gets very muddy. So we already have that
11 defined for other measures, cardiac chest pain
12 or AMI for some of the other ED measures that
13 we already use that are NQF endorsed. Because
14 if you just use the generic chest pain code,
15 then a patient that fell down the stairs and
16 comes in with chest pain gets thrown in the
17 denominator.

18 CO-CHAIR MOORHEAD: At least non-
19 traumatic chest pain in some of our measures.

20 DR. BRATZLER: Yes. We have it
21 defined.

22 CO-CHAIR MOORHEAD: We're

1 reviewing this. So cardiac chest pain or is
2 it STEMI or acute MI?

3 CO-CHAIR STONE-GRIFFITH: It's the
4 MI.

5 CO-CHAIR MOORHEAD: It's an MI.
6 Is the population with the change being from
7 time of arrival to the time troponin results
8 are reported. And --

9 CO-CHAIR STONE-GRIFFITH: Reported
10 or resulted. Because again, I'm concerned
11 about the burden of trying to find the --

12 DR. BRATZLER: So this would be
13 the lab time stamp.

14 CO-CHAIR MOORHEAD: So made
15 available.

16 CO-CHAIR STONE-GRIFFITH: So it
17 essentially resulted by the lab reporting?

18 DR. CHALIAN: So at the end we'll
19 end up with a median time and everyone will be
20 compared?

21 DR. BRATZLER: And we also agree
22 there will be some distribution.

1 DR. CHALIAN: And who is the
2 winner? As a consumer, what do I look for?
3 Do I want the 18 minute one or does it matter
4 if it's 60 minutes? So a measurement that we
5 don't define as winning or failing is
6 irrelevant? That's what I'm struggling with
7 on this measure.

8 CO-CHAIR MOORHEAD: We're all --

9 DR. BURSTIN: You know, there are
10 a fair number of measures that don't have a
11 threshold. And it's often early in the sort
12 of development when you don't have a threshold
13 yet, but for example what's the right rate of
14 episiotomy, we have a measure on that. What's
15 the right of readmissions, for example, you
16 want it to be low but you don't want it to be
17 zero.

18 I think it's that same thing as a
19 measure goes into place often times we don't
20 have a threshold.

21 DR. CHALIAN: And, Helen, as a
22 clinician and as a consumer, I have to say our

1 responsibility is to put these out into the
2 public domain in a way that we don't
3 invalidate the ones that we really feel are
4 highly valuable, and we put a limited number
5 out because there's a burden of collecting
6 this and there's going to be a judgment
7 executed based on this that will take up other
8 resources.

9 CO-CHAIR MOORHEAD: Well, I -- I'm
10 sorry. Go ahead.

11 DR. BURSTIN: No, no. Go ahead.

12 CO-CHAIR MOORHEAD: Well, I was
13 just going to go back to Jim's comment
14 earlier. I'm much more concerned about any
15 troponin that's not available within an hour.
16 I mean, that to me is a big deal. Whether it's
17 ten minutes or 12 minutes, I don't think
18 matters to the individual patient. And so
19 that would be another opportunity.

20 DR. CHALIAN: Yes. So when I sit
21 in my patient's safety officer hat and we're
22 juggling critical values in our organization,

1 again I'm bringing it up again, we have a
2 timeline. So I think I would define this as
3 what's the time that has a critical value?
4 And maybe the issue here is when a troponin is
5 abnormal, how quickly is it reported to the
6 persons, and that affects the outcome and the
7 quality of care.

8 To use troponin as a surrogate for
9 throughput, which is what this is being used
10 as, kind of takes our next measure on the
11 importance of troponin away. And so another
12 thought.

13 CO-CHAIR STONE-GRIFFITH: But if
14 we change it from a surrogate of throughput to
15 a focus on cardiac, then we're removing that
16 issue. But, of course, that brings me to we
17 have a new dilemma, which is we've been
18 measuring cardiac chest pain and AMI for a
19 while now on the inpatient side, and now on
20 the transfer measures. It's interesting that
21 troponin has not been part of that package.

22 DR. BRATZLER: Interestingly,

1 almost all of the AMI measures that are in the
2 public domain focus on STEMI. None-STEMI,
3 even though there are great studies out there
4 around non-STEMI, there are almost no publicly
5 reported measure sets around non-STEMI right
6 now.

7 So I think the troponin is very
8 important in terms of non-STEMI.

9 CO-CHAIR STONE-GRIFFITH: Well,
10 yes, right now, right.

11 CO-CHAIR MOORHEAD: That's what we
12 would like. We'd like to --

13 CO-CHAIR STONE-GRIFFITH: Right.

14 CO-CHAIR MOORHEAD: What I would
15 sense is the group saying we'd like you to
16 come back and give us a measure on non-STEMI.
17 And not times, and not individual markers, but
18 give us some measure of the non-STEMI.

19 DR. CHALIAN: We find that we used
20 to get at troponin quickly, because we don't
21 want to miss non-STEMI.

22 DR. COHEN: How about non-

1 diagnostic also.

2 DR. CHALIAN: Non-diagnostic, too.

3 DR. COHEN: Well, non-diagnostic
4 and non-STEMI and STEMI? Because non-STEMI
5 still has some depressions, but non-diagnostic
6 you have nothing in females, I believe,
7 present with non-diagnostic.

8 DR. O'CONNOR: I think, if I may,
9 we have the language already if you look at
10 the ECG ACP No. 36. Emergency medicine visit
11 for non-traumatic chest pain. And I think if
12 we insert the analogous language for a timely
13 troponin into that entry criteria, we'll hit
14 the non-STEMI.

15 And I think going back to your
16 point, that maybe part of the reason this has
17 not been addressed is that until recently the
18 troponins have not been as accurate as the new
19 generation ones are. So it's pretty much if
20 they're abnormal, you have the diagnoses of
21 NSTEMI, in most cases.

22 DR. COHEN: I also bet that

1 fibrinolytics and use of fibrinolytics is
2 dependent upon whether you had a STEMI. And
3 I'm sure the company funded issues made it
4 more important to get these values and make it
5 cost effective.

6 CO-CHAIR STONE-GRIFFITH: I mean,
7 where we're almost going to is some sort of a
8 pairing of a measure or composite of a measure
9 to address the non-STEMI, the --

10 DR. COHEN: Undiagnostic, right.

11 CO-CHAIR STONE-GRIFFITH: Right.

12 CO-CHAIR MOORHEAD: So we could
13 recommend pairing this with ECG for patients
14 with non-traumatic chest pain?

15 CO-CHAIR STONE-GRIFFITH: That's a
16 different developer.

17 DR. BURSTIN: Yes, those are a
18 different developer. They already have --
19 that's in yours.

20 CO-CHAIR MOORHEAD: Okay.

21 DR. O'CONNOR: Whether we pair it
22 or not, I think it's the same idea. It's an

1 analogous clinical scenario.

2 CO-CHAIR MOORHEAD: So you're
3 recommending rather than cardiac chest pain
4 AMI to be non-traumatic chest pain?

5 DR. O'CONNOR: Yes.

6 CO-CHAIR STONE-GRIFFITH: And non-
7 diagnostic.

8 DR. COHEN: Well, including NSTEMI
9 and non-diagnostic.

10 CO-CHAIR MOORHEAD: Yes. Non-
11 traumatic chest pain captures --

12 DR. COHEN: It captures all those,
13 right.

14 CO-CHAIR STONE-GRIFFITH: Okay.

15 DR. BURSTIN: And actually our
16 other EKG for non-traumatic chest pain from
17 the PCPI does use the non-traumatic chest pain
18 term because we all said that those within the
19 portfolio as well if that's a preferred term.

20 DR. O'CONNOR: Just one comment on
21 that. The alarm goes off, you know, because
22 if this becomes a mandate for people to order

1 a test they wouldn't otherwise order, we could
2 have a problem. So I think we need to be very
3 careful in how define the denominator, that
4 it's the ordering of the test which I think
5 someone said earlier. That if the clinician
6 opts not to order the test, then that case is
7 not going to meet the denominator.

8 DR. BRATZLER: Because it's a
9 timing measure. If you don't order the test,
10 you can't calculate a risk.

11 CO-CHAIR MOORHEAD: Say it again.

12 DR. BRATZLER: Yes. If you don't
13 order the test you can't calculate a risk.

14 CO-CHAIR MOORHEAD: But Greg
15 Henry's voice is ringing in my ears. You
16 know, never order one troponin. Never order
17 one troponin or you'll be in court, you know,
18 sort of thing. It's an allowed method.

19 Jim, you were out of the room. I
20 went back to your comment that we'd like a
21 measure on non-STEMI rather than a time sort
22 of thing. I heard you say that. So we need

1 some help here.

2 Do we want to recommend this with
3 some conditions? Do you want to go to the
4 airport? I know you want to go to the
5 airport, but we got to get --

6 DR. BURSTIN: Just on process.
7 But I think Dell's heard sort of the general
8 suggestions. He will bring you back a new
9 measurement to look at it so you'll have a
10 chance to vote on the revised measure.

11 So, I mean, I think at this point
12 if you just vote all you're doing is moving it
13 forward for him to respond. So if you want to
14 recommend what the conditions, you'll still
15 have a chance to look at it with the
16 conditions put in and decide then. So there's
17 not a whole lot to lose, I guess, at this
18 point since you've given a set of conditions
19 to just kind of dispose of it and move it in
20 that direction.

21 DR. ADAMS: Back to the philosophy
22 that I like to have a patient-oriented goal

1 and have all the disciplines have to work
2 together to achieve that, kind of like a
3 basketball team. And one of the key partners
4 there is really the clinical pathologist. And
5 the clinical pathologist, it turns out to be
6 pretty important depending upon the technology
7 that they have. Because if the troponins are
8 often run after the chemistries just because
9 of the sequences of the labs. If they're the
10 more expensive systems, then they can separate
11 it out and run it simultaneously.

12 So the more profitable hospitals
13 actually have the bigger advantage to be able
14 to have a more timeable turnaround time.

15 Now on the other hand, the
16 hospitals that don't have as much capital and
17 don't invest in their laboratories, do they
18 have to sell this in a different way? How to
19 bring the people together? How do they do
20 that?

21 So, I would like to see a non-
22 STEMI because we want the patients to get the

1 same care every place.

2 The troponin turnaround time in
3 isolation is critically meaningful. But I
4 just wanted that message heard as we go back
5 and try to reformulate something that would
6 bring people together and solve something
7 meaningful for the patient.

8 CO-CHAIR MOORHEAD: Is the way
9 this reads now that we will be recommending
10 median time from patient of arrival with non-
11 traumatic chest pain to troponin result. I
12 have a real problem with that. I mean, we're
13 going to order troponins on a lot of people
14 that we wouldn't order troponins on.

15 DR. BRATZLER: No. No. The
16 denominator only includes patients for which
17 the test is ordered is the way I interpret
18 this. So the denominator is the patient who
19 presents with non-traumatic chest pain who has
20 a troponin ordered.

21 CO-CHAIR MOORHEAD: Okay.

22 DR. BRATZLER: That's how I'd

1 define it.

2 CO-CHAIR MOORHEAD: Okay. Thank
3 you.

4 DR. O'CONNOR: And it would be
5 from the time ordering, not backtracking to
6 arrival.

7 CO-CHAIR MOORHEAD: Well, that's
8 at least what we had, or the last thing on the
9 table was from time of arrival.

10 CO-CHAIR STONE-GRIFFITH: If we
11 change this to sort of addressing the non-
12 traumatic chest pain, then we're going to have
13 to move away from arrival too. It's going to
14 have into the order too, right? Order
15 resulted, same thing.

16 DR. BRATZLER: You could do it
17 either way.

18 CO-CHAIR MOORHEAD: Right.

19 DR. BRATZLER: And we capture the
20 times.

21 CO-CHAIR MOORHEAD: Why would you
22 need to do that? So if a patient arrives with

1 non-traumatic chest pain for which you order
2 a troponin, we'll go back and report the time?

3 DR. BRATZLER: Yes. We can look
4 at either time, to be honest.

5 CO-CHAIR STONE-GRIFFITH: Okay.
6 I'd rather have it arrival. I mean from a
7 consumer standpoint, right, I'd rather have it
8 arrival.

9 CO-CHAIR MOORHEAD: Yes.

10 DR. CHALIAN: To some degree now
11 I'm going to flip into let's make this a
12 research project. It's a hypothesis driven
13 project.

14 If our hypothesis is that
15 throughput can be enhanced by quickened
16 reporting times or shorten an interval to
17 drawing the test, that's one hypothesis.

18 What we're all coming back to is,
19 though, is we feel like improving the care of
20 this MI subpopulation that's hard to diagnose.
21 And this metric doesn't allow us to drill down
22 on that process enough is what I'm hearing Jim

1 saying. So from really delivering this -- and
2 I also picked up another point Jim was making.
3 There is disparities in what each organization
4 can actually accomplish. And this group will
5 be driving some organizations potentially to
6 a point where they actually can't deliver.

7 So this measure from a perspective
8 -- of my perspective, which is way outside of
9 where my comfort is clinically, but as a
10 process engineer is really one that I wouldn't
11 want to put up as the first troponin metric.
12 Because it really distracts us. We want
13 troponin to do something else.

14 DR. ADAMS: And then the question
15 is -- so I agree with everything you've said.
16 And the question is then is that, you know, if
17 that system is -- is that wrong and then is it
18 driving toward -- is a faster diagnosis of
19 these non-STEMIs meaningful enough to create
20 that tiering that will happen? Because the
21 other place is the suburban places will just
22 bedside troponins and look really good. And

1 is that then looking good, the academic
2 centers looking second rate and the poorest
3 places looking worse, is that meaningful
4 enough with creating an outcome for the
5 patient for us to push it forward, or are we
6 just that's kind of nice, but not that
7 important?

8 You know, I'm just throwing out
9 there what I think will happen.

10 CO-CHAIR MOORHEAD: Well, is there
11 a process where we don't actually recommend
12 this but give you the benefit of our
13 discussion and still afford you the
14 opportunity to come back to us by the time of
15 our conference call and potentially make a
16 different recommendation?

17 DR. ADAMS: Because I don't want
18 to lose, I mean non-STEMI and troponin is very
19 important. I don't want to lose it. But I
20 don't --

21 CO-CHAIR MOORHEAD: So are people
22 more comfortable with that; not making a

1 formal recommendation but just hearing the
2 discussion, come back to us? All right?

3 People are nodding.

4 Thank you very much for your time.

5 We appreciate it.

6 All right, group. We're close.

7 We have No. 42. Migraine.

8 Victor, got you working way at the end here.

9 DR. COHEN: I appreciate that.

10 Just to tell you that.

11 CO-CHAIR MOORHEAD: With no
12 secondary.

13 DR. COHEN: My birthday was
14 yesterday and I've reached my fourth decade.
15 And today is my first day after my fourth
16 decade, and I feel like I'm 20 years old. So
17 I really appreciate the experience, I guess.
18 So thank you very much.

19 CO-CHAIR MOORHEAD: Can you help
20 us understand that? Is there a quality
21 measure to make there.

22 DR. COHEN: On a more serious

1 note, this is ACP-042-10. The measure
2 identifies patients with frequent migraine ER
3 -- ER/ED. This is where I was going to say
4 that it's the ED, not the ER. We don't work
5 in a room, we work in a department.

6 The emergency department
7 encounters oral frequent migraine medication
8 use that had an office visit within the last
9 six reported months.

10 This is a process measure. Had an
11 NPPP area of care coordination, which is its
12 priority area.

13 The measure meets all conditions
14 for consideration by NQF for public reporting.
15 The measure has been tested fully. And so it
16 does meet all conditions for consideration.

17 As for importance, la -- you're
18 saying no, Jim? Okay.

19 As for importance, the measure
20 does address national goal identified by NQF
21 NPPP. It represents an important quality issue
22 of consequence support care as it affects

1 large numbers, 18 percent of men, 6 percent of
2 woman are untreated and undiagnosed for
3 migraines. So it is a big impact issue.

4 lb I put down as partially. The
5 measure provides an opportunity for
6 improvement as it will identify patients with
7 evidence of poor disease control who may
8 benefit from face-to-face provider encounter.

9 Here's where I got a little
10 confused, which is good in a way. This
11 provides opportunity to evaluate etiology and
12 intervention to reduce ER visits. I think
13 that's what the premise is.

14 I'm not sure that this is the
15 answer. As a patient care for migraines the
16 outcome of poor face-to-face encounter -- so
17 what I'm trying to say here is that is it the
18 face-to-face encounters that resulted in the
19 over usage in the first place? So they're
20 suggesting that if we can identify whose have
21 high amounts of usage, they should go for that
22 face-to-face encounter. But in fact a lot of

1 people go to that face-to-face encounter,
2 start pain medications or migraine medications
3 and then resultingly don't get their care
4 appropriate and then have to go to the ER
5 because they have an exacerbation of their
6 migraine headache. So I didn't see where this
7 was going.

8 I know this is an identification
9 issue more, like understanding what the rates
10 are. I don't know if I made myself clear on
11 that.

12 So a 66 percent compliance rate,
13 and this is a 15 million member benchmark
14 database. So clear areas for improvement.
15 This was Ingenix data in terms of care.

16 Disparities are not described, but
17 I did find a lot of information that there are
18 disparities; racial especially.

19 1c, the measure is an intermediate
20 outcome of process of care, it's relationship
21 to outcome. That identifying patients with
22 poor disease control who may benefit from the

1 face-to-face provider encounter to allow for
2 all very more intensive evaluation of care and
3 management.

4 Again, I'm not sure that this
5 would translate into that just because you
6 have another face-to-face encounter. I guess
7 you're going according to a guideline or a
8 management. I think the problem here is that
9 there's no standard for follow-up of care.
10 And that's the major issue, and that's where
11 I sort of started to get a problem with this
12 whole process.

13 The evidence provided is
14 guidelines based and based on expert opinion
15 alone, expert consensus recommendations. I'm
16 almost to the point where this is a little
17 conflict of interest. They're asking for
18 another face-to-face and it's a neurology
19 group and a bunch of other groups. But this
20 was a multidisciplinary panel, but it is
21 expert opinion. It's not evidenced-based
22 recommendation.

1 The controversy and contradictory
2 evidence. Concern is that there are no
3 clinical standards for follow-up care for
4 migraine headaches. The measure is based on
5 an expert panel consensus.

6 Furthermore, it's apparent that
7 only 4 percent of patients database were
8 identified based on the current definition of
9 denominator. So there's a need for reworking
10 of the current inclusion definition. So that
11 was that.

12 I was getting confused in terms of
13 the numbers. There was one place where they
14 had 70,000 and then there was another place it
15 was just 4,000 that was identified. And then
16 1900 were actually the numerator. So it was
17 confusing, the numbers.

18 The steward quotes the guidelines
19 for the need for this measure. Based on poor
20 care an overuse of less than optimal tolerable
21 medications.

22 The guide provides

1 recommendations, but that are not based on
2 evidence-based medicine as written.

3 Experts based -- this is a
4 multidisciplinary committee that basis.

5 So basically I stated that it is
6 an important measure. I just don't know if
7 the way they're going at it if there's
8 available follow-up care standards that will
9 help meet this intended issue. I still said
10 yes in terms of importance, overall importance
11 in terms of measuring and reporting.

12 Did you get that? Is that clear?
13 Do you want me to go on?

14 CO-CHAIR MOORHEAD: Any reaction?

15 MS. ALTERAS: I think -- well, I
16 just was curious from all the ED folks here.
17 I mean, it seemed to me that there should be
18 a measure for migraine patients of whether the
19 person that you saw in the emergency
20 department if you presented to the emergency
21 department gave you a referral to a primary
22 care provider and helped coordinate your care

1 versus just asking whether you had visits in
2 the last six months. I just don't see what
3 value there is in reporting that information
4 without acting on it. And this doesn't
5 consider whether you act on it.

6 DR. ALESSANDRINI: I mean, it
7 seems to me this is more of a recognition of
8 the quality of the care of your primary care
9 doctor and your neurologist. Are you getting
10 adequate care and pain relief for acute
11 exacerbation that keep you out of the ED. So
12 it almost seems like the measure is not in the
13 right form.

14 DR. COHEN: Actually, I was going
15 to say that.

16 DR. NEWMAN: It's an issue of
17 access as well, so --

18 MS. ALTERAS: Right. And if it's
19 an issue of access and someone doesn't have a
20 neurologist that they go to, you know I think
21 the point would still be how do you help this
22 person get the --

1 DR. NEWMAN: And what do you do
2 with this information?

3 MS. ALTERAS: -- non-emergency
4 care.

5 DR. COHEN: Well I guess it's a
6 face-to-face intervention is what they're
7 recommending. But there's no standard as to
8 the follow-up care, right?

9 DR. NEWMAN: So you get that value
10 and then what do you do with it?

11 DR. COHEN: Right.

12 MS. McCARTNEY: It might be
13 nitpicky, but what -- mean. I don't know what
14 that means.

15 DR. NEWMAN: It's defined.

16 MS. McCARTNEY: Oh, it's defined
17 later?

18 DR. NEWMAN: Later it's defined in
19 there.

20 MS. McCARTNEY: Okay.

21 DR. COHEN: It's two times, I
22 believe, in a certain amount of period of

1 time. 180 days, I believe, or 90 days, six
2 months. Yes. It is defined.

3 CO-CHAIR MOORHEAD: So I guess
4 let's just -- your recommendation is yes at
5 this point for number 1 and there's some
6 concern about this --

7 DR. COHEN: I think it's important
8 to know, but they don't have a solution to
9 fix. There no standard for follow-up care,
10 yet an expert panel was saying we need more
11 face-to-face interventions to manage the care
12 better. But there's no follow-up care
13 standard. And this is an expert panel among
14 the neurology headache groups who are
15 recommending this without strong evidence-
16 based medicine.

17 CO-CHAIR STONE-GRIFFITH: How
18 would you capture this information?

19 MS. RIEHLE: Well, this measure is
20 built for claims. Are you talking
21 specifically to the follow-up visits?

22 DR. O'CONNOR: Right. So it would

1 be a documentation in the provider's record
2 that said have you been to the office? Yes,
3 I have. And that's what you're going to go
4 look for?

5 MS. RIEHLE: So it would go by CPT
6 codes for encounters or revenue codes for
7 encounters.

8 MS. McCARTNEY: Well, if this is
9 ED measure, who are the results -- as it was
10 said, it's more of PT to your neurologist
11 management. So if it's ED measure, who gets
12 the feedback?

13 DR. BURSTIN: Oh, it is not. It's
14 an advocate --

15 MS. RIEHLE: It wouldn't be
16 applied to emergency doctors.

17 CO-CHAIR STONE-GRIFFITH: I see.

18 MS. ALTERAS: So you mean there's
19 a CPT code for whether a doctor asked the
20 patient if they have --

21 MS. RIEHLE: No. It's actually
22 just looking for any encounter. So just the

1 regular encounter with a provider. It's not
2 specific to a follow-up for this particular--

3 MS. ALTERAS: But if the question
4 is -- I mean, it's looking at whether the
5 patient who is going for an emergency visit
6 has gone to see -- has had visits with a non-
7 emergency provider in the past six months.
8 I'm just confused. What's the CPT code? Is
9 it for the emergency provider to check up
10 whether they ask --

11 MS. RIEHLE: No. It's for the
12 actual office visit --

13 DR. NEWMAN: So it's an indication
14 of the primary care in the nature that the
15 primary care physician has evaluated a
16 patient, their patient who is frequenting an
17 ED?

18 MS. RIEHLE: Right.

19 MS. ALTERAS: But which one first?

20 DR. NEWMAN: It sounds like the
21 primary care came first.

22 MS. McCARTNEY: Would this a

1 physician-specific measure then? I mean, are
2 you going to look at a practice or I mean if
3 I'm Dr. X and I have three patients that have
4 migraines and visit the ED, how are those
5 practitioners going to get that information?

6 I mean, how is this going to be publicly
7 reported as a practice group or just as PCPs
8 in general? I guess I don't understand how
9 the group would get the feedback that they're
10 doing well. What would group would that be?

11 MS. RIEHLE: I mean it could be
12 used in a couple of different ways. You know,
13 there are some programs that look at kind of
14 like patient centered medical home -- you
15 know, programs where they're identifying a PCP
16 and making sure that the PCP patient
17 relationship is foster all the aspects of care
18 that should be given.

19 It could also be used for a
20 physician measurement like the more public
21 reporting.

22 CO-CHAIR STONE-GRIFFITH: See, and

1 I think about women who might use their OB/GYN
2 as their primary care for a period of time.

3 MS. RIEHLE: But this doesn't
4 specify a specialty.

5 DR. O'CONNOR: Correct. Well,
6 right.

7 MS. McCARTNEY: So if I was a
8 patient and went out and saw this publicly
9 reported data, what is it going to mean to me?
10 That my PCP is doing a good job or a bad job?
11 My neurologist is doing a good job or a bad
12 job? Or my gynecologist is doing a good job
13 or a bad job?

14 DR. ADAMS: So in keeping with
15 that, I can't figure out to repeat who is
16 accountable.

17 MS. McCARTNEY: Right. Right. I
18 don't know what it means to me as a consumer
19 to know that I don't know this information and
20 who is accountable for that care.

21 DR. BURSTIN: Well currently this
22 is a health plan, not a metric, right?

1 MS. RIEHLE: Yes.

2 DR. BURSTIN: So the issue is
3 within a health plan it's got a whole
4 different perspective because the health plan
5 should be responsible for identifying the
6 frequent flyers in a given condition or using
7 the ED rather than more appropriate care
8 places or people. I assume that's what the
9 measure is trying to get at. But, again, it
10 comes at the level -- did you specifically
11 bring this in for level analysis for health
12 plan?

13 MS. RIEHLE: I don't think so. I
14 mean, I think the argument could be made that,
15 you know, if you have somebody who is a PCP or
16 a regular PCP, you know and you have this
17 patient who is using a lot of these frequent
18 medications or going to the ED, you know it
19 would be ideal to be following up with this
20 patient more often. I mean, one could argue
21 that that's really a patient behavior sort of
22 issue as opposed to a clinician behavior. I

1 mean, there's only so much you can control
2 that.

3 But ideally if you're in theory
4 prescribing all these acute medications, you
5 should be following up with the patient semi-
6 regularly to make sure to check on their
7 status.

8 DR. JAUCH: So the dataset that
9 you're going to use, though, is only on
10 patients who have some form of insurance?
11 Because I kind of work in the inner city where
12 a lot of the follow-up goes to the community
13 clinics where it's very hard to capture this
14 type of information, right?

15 MS. RIEHLE: Yes. And this measure
16 is only really ever been used in a commercial
17 population.

18 CO-CHAIR MOORHEAD: Jeff, I looked
19 at this two ways. One is you have to be very
20 careful because this is blaming the victim a
21 little bit. And so we're really, you know as
22 a clinician, you know this is Friday nights,

1 this is weekends, this is when PCPs aren't
2 practicing that these people come in.

3 And to sort of take a subgroup
4 that people who frequent ERs and are receiving
5 multiple medications, it's a little bit
6 dangerous there to isolate a subgroup like
7 that of patients.

8 On the other side being a
9 clinician, coordination of care is crucial.
10 And so these sort of metrics are coming down
11 the line and we're seeing more of these in
12 terms of hospital discharges and contact with
13 the PCPs, frequent ER visits and contact with
14 the PCPs. So if our denominator is patients
15 with PCPs, you know we may be able to get at
16 that. But I think it's just a little too
17 risky to kind of concentrate on this subgroup
18 of patients.

19 IF it's all patients, it's
20 something else.

21 MS. RIEHLE: I see what you're
22 saying. So you're saying that this should be

1 -- it would be better to limit this to the
2 population that actually sees a PCP regularly?

3 DR. O'CONNOR: There's a couple of
4 people. I think what I'm hearing is that
5 people think this is more of a quality
6 indicator for a health plan as opposed to a
7 public reportable measure.

8 DR. BEVERLY COLLINS: Yes. We're
9 using similar measures like this where a
10 patient is in a medical home, and it's to give
11 feedback to the practices, independent but not
12 for public reporting. It's to let them know
13 what's going on with their patients because
14 sometimes they have no idea that they're going
15 to the ER or the hospital, or whatever. So
16 that's to give them an idea to really
17 coordinate their care and to really reach out
18 to them. But for public reporting.

19 CO-CHAIR STONE-GRIFFITH: Suzanne?

20 DR. O'CONNOR: Well, not just
21 that. It's the feedback to them to coordinate
22 and prescribe a care plan that the patient can

1 be compliant with.

2 I mean, a lot of times what you
3 hear is gee I don't like what's been
4 prescribed. I don't react to it well. I'd
5 rather just go to the ED and get my shot every
6 so often because I'm not getting the regiment
7 that really works for me. So it really is a
8 care coordination, a care pathway for PCP.

9 MS. RIEHLE: Right.

10 CO-CHAIR STONE-GRIFFITH: And also
11 working with some hospitals to develop some
12 quality improvement programs so that they can
13 link up more with the PCPs, too.

14 DR. BEVERLY COLLINS: Right.

15 CO-CHAIR STONE-GRIFFITH: So
16 they're involved in the process.

17 DR. JEFFREY COLLINS: I mean it is
18 frustrating as a clinician because every week
19 you see somebody like this who has never been
20 offered prophylactic treatment, who has never
21 seen a neurologist. And so it's something we
22 encounter all the time. So it's a measure

1 that has to be pursued, but you know on a
2 public health reporting standpoint I don't
3 think so.

4 DR. COHEN: Can I revert back my
5 recommendation? Because I was confused as
6 well. And I would say it meets importance,
7 but it doesn't meet the reporting component.

8 CO-CHAIR MOORHEAD: It meets
9 importance as a quality indicator for health
10 plans?

11 DR. COHEN: Exactly. Not for
12 public report.

13 CO-CHAIR MOORHEAD: Not for public
14 report.

15 DR. BURSTIN: Well, NQF does, you
16 know, does endorse measures for health plans.
17 So the question would be does this seem like
18 an important measure you'd want to know about
19 your health plan? The measure got checked for
20 every single level of analysis. And the
21 question would be is that appropriate or is
22 this something you'd put forward as a health

1 plan measure.

2 MS. ALTERAS: I mean, this is
3 something I would want to see, you know, at an
4 individual physician level measure being
5 public reported. For a neurologist, I don't
6 know how many private care providers manage
7 migraine. Again, I have migraines. I don't
8 even have a primary care provider, so I don't
9 know.

10 So, yes, I mean if I had this
11 condition I would like to see a physician
12 level.

13 I mean, I think part of the
14 problem is the way is the way it's just
15 written. Even just the title is very
16 confusing off the bat. So I think it could be
17 presented in a way that would be very
18 meaningful to consumers. But I'm not even
19 sure at the health plan level. At the health
20 plan and the individual physician level, I
21 guess.

22 DR. BURSTIN: How is Ingenix using

1 it now with their clients? Is it being used
2 at the physician level? Is it being used at
3 the health care level?

4 MS. RIEHLE: It is being used at
5 the physician level, but it's more common to
6 be used as like a care and disease management.
7 so there are a couple of health -- there's one
8 health plan that I know of that's using it
9 just anecdotally. And there could be others.
10 But it's mostly something that would be used
11 for care and disease management.

12 DR. BEVERLY COLLINS: There's a
13 lot of these measures that are also being used
14 by health plans for pay for performance
15 programs for individuals docs. And a lot of
16 them have not been tested or really validated,
17 but they're out there everywhere. There's all
18 kinds of measures. And --

19 DR. NEWMAN: We wouldn't want to
20 do that for pay for performance, would we?

21 DR. BEVERLY COLLINS: Well, and my
22 plan personally, we only promote measures that

1 have been through a process like this or
2 nationally endorsed by programs like NQF and
3 NCQA, but not others that have just been
4 developed by a lot of vendors. But there's a
5 lot of them out there.

6 DR. NEWMAN: From a devil's
7 advocate, though, as a consumer I would
8 certainly -- I may be interested which ERs
9 don't regularly check up to ensure that
10 patients have had follow-up appointments and
11 maybe I'll go to that one across town for my
12 pain medicine. Then I can answer those
13 questions.

14 CO-CHAIR MOORHEAD: We're having a
15 little trouble here. So the accountable --
16 what I'm hearing, that's the way you're using
17 this, that the accountable person is the PCP
18 or the practice and that's where the
19 accountability would be. And so we could --

20 DR. NEWMAN: Which is appropriate.

21 DR. BURSTIN: Right. You could
22 just narrow of levels of analysis you think

1 the measure is appropriate for as a condition
2 if you think that's appropriate.

3 And by the way, we have now
4 endorsed 70 of these vendor-specific
5 clinically enriched admission of measures, as
6 we call them, including Ingenix. So I mean
7 a lot of them have been through our process.
8 They are fairly well vetted and tested. So
9 just to be cautious.

10 DR. COHEN: Is the sign of
11 uncoordinated or discoordinated or inadequate
12 migraine care falling into the ER or it could
13 be equal measure be three visits to the same
14 doctor, or three primary care visits, or your
15 primary and your neurologist? I mean, is our
16 concern that the coordination matrix is
17 manifested by the repeated visit, or is
18 actually favorable to go see your family
19 doctor twice, but not favorable to see your ER
20 twice?

21 CO-CHAIR MOORHEAD: Well, I think
22 that's part of the sensitivity of emergency

1 docs is we feel like everyone points to us and
2 says you're the problem and we feel like we're
3 the solution. And then we get a little
4 defensive about it. But I mean it's got to be
5 patient focused. If we go back to the
6 patient, how are they getting their care best
7 provided. And it's a combination of primary
8 and then special --

9 DR. NEWMAN: Being careful not to
10 ostracize a patient. I think Jeff's point is
11 well taken.

12 DR. BURSTIN: And the measure is
13 not just ER encounters. It's or frequent
14 acute medications. So you get it either way.
15 If you're just getting Fiorinal and you're not
16 getting other stuff, that will pick that up.
17 So it is broader than just the ER visits. But
18 there is an implication that an office visit
19 outside of an ER setting perhaps get on
20 prophylaxis might be a more appropriate way to
21 go.

22 CO-CHAIR MOORHEAD: Jeff?

1 DR. JEFFREY COLLINS: I mean,
2 every physician has walked into a room and
3 seen somebody smiling on the gurney saying I'm
4 having a migraine headache, and it's just one
5 of those things. It's a lot of time to
6 diagnoses is much more complicated then if
7 they've actually through neurology and met the
8 criteria and meet the diagnoses for having a
9 migraine versus when I go back in my charts
10 because I see how many headache visits are
11 billed as migraines, it's very difficult.

12 CO-CHAIR MOORHEAD: So I'm hearing
13 actually we recommend that this go forward and
14 the unit of analysis then would be the
15 practice, the primary care practice.

16 DR. BURSTIN: Just as one piece of
17 information. I'd forgot about this. We
18 actually did endorse another migraine measure
19 from Ingenix which kind of gets at the issue
20 we're talking about, which is adults with
21 frequent use of acute medications --
22 prophylactic medications. So we've endorsed

1 the piece about kind of the action is actually
2 to try to get them off the acute meds onto the
3 prophylactic medications. We've already
4 endorsed that measure this past year.

5 CO-CHAIR MOORHEAD: So it sounds
6 like from the public, that's what you want and
7 that's already endorsed. So does this
8 actually add value?

9 MS. ALTERAS: Could there be
10 either a composite or harmonization of this
11 measure and the one that you just mentioned?

12 MS. RIEHLE: The other one is
13 harmonized. I mean it uses all the same logic
14 to decide the denominator and it uses the same
15 logic to determine, you know, frequent
16 medication use. So it's pretty harmonized.

17 CO-CHAIR MOORHEAD: Victor, what's
18 your recommendation?

19 DR. COHEN: You want me to
20 continue or --

21 CO-CHAIR MOORHEAD: Do you want to
22 just summarize before and give us a few

1 minutes to think while you do that.

2 DR. COHEN: Okay. Scientific
3 measured values, are they scientific
4 acceptable. It's actually been specified, so
5 it's accepted.

6 Numerator. Patients who are
7 diagnosed with migraine and who have had
8 frequent ER encounters or frequent acute
9 medication use who had an office visit during
10 the following time period: Last 180 days
11 prior to the end of the report period and 90
12 days after the end of the report period, that
13 gives sufficient time to assess overuse. But
14 what is to say is overuse? It's a good
15 question also that I had on this.

16 Where is the evidence? Again,
17 where is the evidence of overuse or is it just
18 a natural progression of the migraine? This
19 occurs.

20 They list codes for capture in
21 terms of numerator.

22 The denominator is appropriate.

1 Patient six years or older. The time window
2 appears different from originally stated.
3 There's several time periods that I was a
4 little confused about: 24 month period until
5 the end of the report for confirmation,
6 criteria for capturing prescription use during
7 the 12 month period. Fails to include other
8 migraine remedies I stated.

9 The basis for a number of doses is
10 not provided. There's a statement of how many
11 doses as well that are quantified. And I'm
12 not sure how you came up with those dosing I
13 terms of the denominator. So I wasn't really
14 clear on those issues.

15 MS. RIEHLE: And there is an
16 attachment that it's pretty complicated logic.
17 I mean, it's what we used for other NQF
18 endorsed measure. It was put together by a
19 team of two -- and a neurologist.

20 DR. COHEN: Okay. No denominator
21 exclusion provided.

22 No stratification risk adjustment

1 provided.

2 Type of score is rate proportion.

3 Method for discrimination.

4 Performance was confusing. Again, this 3600
5 patients met the denominator and 1900 did not
6 meet the numerator. 1900 did not meet
7 numerator compliance. So I was a little
8 confused with the numbers as well. Initially
9 you stated that 15 million benchmark database
10 and --

11 MS. RIEHLE: And I'm not a 100
12 percent sure about this. And Kay, the Medical
13 Director had to get off the line. But I
14 believe that the larger number -- the 15
15 million is the size of the members in the
16 benchmark.

17 DR. COHEN: The commercial
18 business, right.

19 MS. RIEHLE: And then the next big
20 number would be the people who met condition
21 confirmation.

22 And then that 3600 is people who

1 qualified for this measure.

2 DR. COHEN: Specifics?

3 MS. RIEHLE: Yes.

4 DR. COHEN: That's really a small
5 number.

6 MS. RIEHLE: Right.

7 DR. COHEN: Relatively speaking.

8 MS. RIEHLE: When we actually
9 confirm the condition, we get a much larger
10 number. But we're really limiting this to a
11 very select population.

12 DR. COHEN: Okay. Okay.

13 Social data is Ingenix, I believe
14 and claims data as well.

15 2b and 2c reliability and
16 validity. The measure appears to be reliable
17 and valid. Data is provided. Completely meet
18 this criteria.

19 Customer acceptance testing was
20 conducted. Face validity was conducted and
21 supportability. So I believe that's
22 completely met.

1 No data on supporting exclusion.

2 No exclusion listed completely. No exclusion
3 listed.

4 No risk adjustment.

5 2f, a medical doctor reviews

6 results to verify prevalence rates of

7 condition. Compliance rates of measures are

8 comparable to report in published literature,

9 as well. So he compares that.

10 2g and h. No data on disparities,

11 but may want to discuss this as this may be an

12 issue.

13 Overall I said in terms of

14 scientific acceptability it overall doesn't

15 meet scientific acceptability I believe in

16 terms of, I'd say, completely meets scientific

17 acceptability in that respect where it's

18 applicable.

19 I don't know if you feel the same

20 way.

21 DR. BEVERLY COLLINS: Can I just

22 say something about I think you said there

1 were 15 million members in the database and
2 only 3600 qualify for this measure. And if
3 we're talking about using this as a physician
4 specific metric, what we assume in our plan is
5 that each physician has about 2,000 members.
6 There's going to be no people available for
7 each individual practitioner to be measured on
8 this if you have such small numbers that
9 qualify for the measure.

10 MS. RIEHLE: And when they
11 developed this measure, we may have been too
12 stringent in the criteria with the frequent
13 medication use in the ED. I mean, we could
14 entertain loosening up that constraint.

15 But, yes, it's a small number.

16 DR. CHALIAN: When that numerator
17 and denominator are presented, what will be
18 the conclusion the public sees? If it's 40
19 percent versus 60 percent, what are they
20 supposed to conclude?

21 MS. RIEHLE: You know, 40 percent
22 versus 60 percent I mean I guess I would say

1 that there's issues with the way that they're
2 following up with these patients. That
3 there's room for improvement with that.

4 DR. CHALIAN: And the numbers
5 should be that everybody gets seen once and
6 one and done? And is that a reasonable
7 standard for a complex disease like migraine
8 which may have very refractory patients even
9 if they're on prophylaxis versus the
10 misdiagnosed migraine? And so is this -- and
11 I think this applies to all of our reviews.
12 As a new member, I think it would be helpful
13 to see when this data is presented to the
14 public, what are they going to be able to
15 extrapolate from it. And also us as people
16 who are willing to look at the data and
17 improve, what are we extrapolate from it and
18 what's going to take it -- what's the data
19 going to do to move the masses? Which we've
20 seen the numerator/denominator, but I'm not
21 sure we've seen the finished product in terms
22 of what it would look like and how does it

1 affect us.

2 CO-CHAIR MOORHEAD: Well, I think
3 part of the issue is that patients with
4 migraine don't often just have migraine. I
5 mean, we see kids with shunts who have
6 migraines. And, yes, that's a whole -- and
7 they come in -- you know you see them more
8 frequently, obviously. And if they would fall
9 into this, I would assume, and does that tell
10 you anything, I guess?

11 Well, let's go on.

12 DR. COHEN: Okay. So usability,
13 currently in use. It's not been tested in the
14 public from what I see here. It is related to
15 other time overuse NQF measures ECO9308. So
16 there is a measure already.

17 There is harmonization with other
18 NQF measures.

19 There is direct added value of the
20 measure. The measure addresses poor migraine
21 control. Who would benefit from a provider
22 encounter to access a management plan.

1 Here I would say overall partially
2 meets criteria for usability. Again, what is
3 the standard for follow-up care? If there's
4 no standard, then we're just sending them for
5 another face-to-face, but what does that mean?
6 Is it going to improve care? I don't know. I
7 don't believe so. But, okay, it may.

8 It may reduce ED visits, but I'm
9 not sure. It could just add to the cost of
10 care.

11 Feasibility for a, b, c. Data
12 generated by coding and abstraction. They're
13 available. Electronic sources for this data
14 is available. Supporting data for exclusion
15 does not apply.

16 4d accept degrees of error of not
17 capturing all patients who may benefit from
18 this management plan. They understood that in
19 terms of they described something in reference
20 to error, but it wasn't anything that
21 important.

22 4d costs again I believe were not

1 addressed. And then partially. So I stated
2 that this was partially feasible, partially
3 meets the criteria.

4 Overall, I think it's an important
5 measure that is important to be endorsed. But
6 the way it's written and where it's going to
7 be applied is -- and the evidence-base to
8 support it, it's all questionable.

9 CO-CHAIR MOORHEAD: Okay.

10 DR. CHALIAN: Does the world of
11 neurology have a guideline that really would
12 apply to help us in terms of where measurement
13 would drive us?

14 MS. RIEHLE: I don't believe so.
15 I mean, this is very loosely based on an AAN
16 guideline, but it doesn't specifically address
17 ambulatory visits.

18 DR. CHALIAN: From my perspective
19 what I would suggest is that this goes into a
20 small group and it's studied and shows whether
21 this measure actually has any validity on any
22 patient outcome. Of course, it would seem to

1 affect cost potentially. And then come back
2 and say if this is a legitimate measure of any
3 care pattern or outcome for patients with
4 migraines.

5 CO-CHAIR MOORHEAD: So I'm hearing
6 that we don't think this is ready for public
7 reporting. Is that --so is that all right?

8 DR. COHEN: I would agree with
9 that. Yes. But I don't know how you want to
10 modify it to, where it has to go, though.

11 CO-CHAIR MOORHEAD: I mean the
12 discussion we've talked about where we think
13 the unit of analysis, this is a primary care
14 practice-oriented --

15 DR. COHEN: Right.

16 CO-CHAIR MOORHEAD: -- quality
17 improvement tool.

18 DR. COHEN: Right.

19 MS. ALTERAS: Sorry. Can I ask
20 one more question?

21 CO-CHAIR MOORHEAD: Sure.

22 MS. ALTERAS: I don't know what

1 the timeline was for developing this, but if
2 it's been available I'm just curious if it was
3 proposed under the care coordination project
4 methods?

5 MS. RIEHLE: I don't think so.

6 MS. ALTERAS: No?

7 DR. BURSTIN: Similar, but
8 different measure-wise.

9 MS. ALTERAS: Okay. But that's
10 going to be end one of our endorsement?

11 DR. BURSTIN: Yes.

12 MS. ALTERAS: Okay. I mean, it
13 seems like this if it was reworked somewhat,
14 it would just fit more in the care
15 coordination umbrella.

16 CO-CHAIR MOORHEAD: All right.
17 That's the recommendation. Those in favor?
18 Opposed? Abstaining? All right.

19 We are -- I guess the time, we
20 need some opportunity for public. Is there
21 any public comment?

22 Is there anyone on the phone?

1 Okay.

2 Do we need to review today's? Do
3 you want to review that or we confident -- we
4 got it? Okay.

5 And so our next steps will be a
6 conference call. Do you anticipate that?

7 MS. MUNTHALI: Yes. Probably in
8 about two weeks. I will send everyone an email
9 just to kind of get availability. But it
10 definitely would be within two weeks.

11 As you know, we have a very tight
12 deadline and we're trying to get the draft
13 report together. So we want to make sure we
14 iron out all of these issues before then.

15 CO-CHAIR MOORHEAD: Okay. All
16 right. Anything else?

17 DR. BURSTIN: The only other thing
18 we would like you to do, but you don't have to
19 do today. Obviously, I think people are
20 getting a little crunchy around the edges
21 here. But certainly --

22 CO-CHAIR MOORHEAD: Obviously?

1 DR. BURSTIN: Myself included.

2 Is we also as a part of this
3 process that's very important is identifying
4 the measurement gaps. So for one, the
5 measures that you think are really important
6 that you didn't see that you wish you'd seen,
7 really relates to that as a critical role of
8 these really smart people sitting around the
9 table. So if that's something you have the
10 energy to kind of thread a couple today or if
11 you'd like to do it on email, or follow-up
12 calls; whatever the case may be. But Jim's got
13 one.

14 DR. JEFFREY COLLINS: Yes, I do
15 have one. So something that we haven't seen
16 that I regret not submitting is the use of
17 hypothermia for cardiac arrest survivors.
18 There's a strong evidence-base. It's under
19 utilized nationally. And it's absolutely
20 understandable.

21 A cardiac arrest survivor comes
22 in. Did they get their body cooled or not. It

1 increases the likelihood of neurologically
2 intact survival.

3 DR. BURSTIN: I know the Joint
4 Commission is working on a set of sudden death
5 measures. And you may want to touch base with
6 them and see if there might be an opportunity
7 to link up with them.

8 DR. JEFFREY COLLINS: Yes. Okay.
9 Good. Thanks.

10 CO-CHAIR MOORHEAD: Is there any
11 measure on availability of advanced directives
12 for ED patients? Because that's something I
13 would really like to see. It would be helpful
14 I think both to the public and to the
15 practitioners in emergency medicine.

16 Anyone else have any thoughts?

17 DR. ALESSANDRINI: Yes. I've been
18 sitting here trying -- about submitting a
19 measure and looking at efficient use of head
20 CT for children with minor traumatic -- and we
21 pulled it because the AEP didn't feel like it
22 was ready for prime time. So we're actually

1 starting, we're going to collect this data.

2 I mean, we now have a really good
3 clinical prediction rule that has very high
4 sensitivity and specificity for when there's
5 no indications for SET. So we're in the
6 process now of trying to implement some
7 clinical decisions and then a template to
8 accept the data electronically. But I think
9 that's a nice efficiency measure where there
10 is wide documentation of overuse and with some
11 real harm, that could be as a result. Not only
12 from radiation but from kids that get
13 procedural sedation.

14 So, hopefully we'll get there
15 sooner rather than later.

16 DR. COHEN: We may push forward a
17 measure that looks at pharmacists in the
18 emergency department as a safety and quality
19 measure, to improve safety and quality, that
20 is.

21 We've been doing it for 12 years.
22 We've set up a model. And we've been able to

1 cost justify it and looking for -- we think
2 every ED should have a pharmacist. I know
3 there's debates about that. I think it'll
4 help and improve safety and quality. And
5 maybe improve the satisfaction of patients in
6 the ED, which I know is an issue sometimes.

7 CO-CHAIR MOORHEAD: Great.
8 Anything else? All right. Well, thank you
9 everyone for your time and your expertise.
10 And thank you to the staff. I'd like to thank
11 you on behalf of the Committee for making our
12 arrangements, getting here, putting us to bed
13 last night. Great. So thank you.

14 MS. MUNTHALI: Thank you,
15 everyone. And there's just a couple of
16 announcements I have.

17 We do have an extra computer that
18 was left here last night. So before you
19 leave, check to make sure it's not yours.

20 And if you could please leave the
21 flash drives behind and your measure
22 evaluation forms. If you have them in hard

1 copy, if you could give those to us. If not,
2 if you could email those to us so we could
3 have your subcriteria ratings.

4 Thank you again, everyone. And
5 I'll be communicating with you in a couple of
6 weeks -- well soon.

7 (Whereupon, at 2:43 p.m. the
8 meeting was adjourned.)

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