National Quality Forum

Measure Pre-Meeting Comment Report for Endocrine Project

Comments received as of February 10, 2014

Topic	Commenter	Comment
0416: Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear	Submitted by Ms. Vipra Ghimire, MPH	This measure suggests that all patients with diabetes should have vascular, neurologic, dermatologic exam annually. In addition, assessment for proper footwear and sizing are recommended. This recommendation, put forth by the American Podiatric Medical Association, differs from the ADA Standards of Medical Care 2014, which makes no mention of "sizing of the foot" as a component of the annual comprehensive foot exam. Usability: This practice of measuring the foot seems unrealistic at the primary care provider (PCP) level due to time constraints, the need for additional equipment to measure feet, and training gaps. Numerator/Denominator: It may be more appropriate to require sizing of the foot in the numerator assuming the denominator is limited to patients with risk factors for diabetic foot ulcers, such as diabetic neuropathy or PVD; and in this case, this specific component of the foot exam might be better performed by a podiatrist who would have sufficient training to evaluate for structural foot deformities and have the equipment to properly size the foot. It is not clear in the current measure whether the exam must be performed by the primary physician or whether referral to a podiatrist would fulfill the requirement. Possible unintended consequences of the measure: Primary care physicians may not have sufficient training to recognize structural foot deformities or assess proper footwear Primary care physicians would need to purchase equipment to "size" the foot. Increased time would be required to measure foot size in PCP visit and could lead to reduced productivity

0417: Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation	Submitted by Ms. Vipra Ghimire, MPH	Numerator: Patients who had a lower extremity neurological exam with risk catorization performed and a treat plan established at least once within 12 months. A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection. There is a spelling error in this statement. Catorization = categorization? What are the definitions of risk categorization? The components of the neurological exam do not directly align with those of the ADA. The ADA recommends monofilament plus one of the following: Vibration with tuning fork, pinprick, ankle reflex, vibration perception threshold. Given the time constraints in clinical practice, are all 5 components of the neurological exam required to establish the diagnosis of neuropathy? The definition does not make it explicitly clear how many components of the exam are required. For example, if only monofilament and vibration testing were performed, would this fulfill the requirement? Possible unintended consequences of the measure: If all 5 components of the foot exam are required, this will increase clinic visit times and may lead to loss of productivity. Without clear understanding of risk categories, providers may not understand what to do with the information they obtain from the foot exam
0519: Diabetic Foot Care and Patient Education Implemented	Submitted by Ms. Vipra Ghimire, MPH	This measure requires foot care education to be part of home health visits. Diabetic foot care education is standard of care for patients with diabetes. The only question I have about this measure is how can one know whether the patient already received foot care education by another provider shortly prior to the home visit? The ADA does not specify the frequency of diabetic foot education. Is there evidence that in this clinical situation, in particular, additional diabetic foot care education is beneficial? Moreover, is the frequency of diabetic foot care education that has been associated with improved outcomes known?

2362: Glycemic Control - Hyperglycemia	Submitted by Ms. Vipra Ghimire, MPH	Numerator Statement: Sum of the percentage of hospital days in hyperglycemia for each admission in the denominator Denominator Statement: Total number of admissions with a diagnosis of diabetes mellitus, at least one administration of insulin or any anti-diabetic medication except metformin, or at least one elevated blood glucose value (>200 mg/dL [11.1 mmol/L]) at any time during the entire hospital stay The definition of hyperglycemia is not defined up front in this metric as it was for hypoglycemia. This information was not apparent until much further down in the document. The definition is defined as: "two or more blood glucoses >200 mg/dL at least 6 hours apart or a single blood glucose >200 mg/dL if the only blood glucose measured on a given day or no blood glucose measured on that day if not preceded by two normoglycemic days." This should be defined upfront in the metric for the denominator. Another metric to consider is the percent of days with patient-day weighted mean blood glucose >200 mg/dL. This metric would capture patients with persistent hyperglycemia and avoid identifying patients with 1-2 isolated episodes of hyperglycemia in the setting of otherwise euglycemic values. It is unclear why patients on metformin are excluded from the denominator. Metformin is used to treat diabetes and pre-diabetes—the latter group may be more prone to experience hospital-related hyperglycemia and would still be a group we would want to capture. Feasibility: The algorithm for generation of the denominator is very complex as there are several conditions under which certain days are excluded. This will require a significant amount of programming in some systems to generate an automated report. In addition, like the hypoglycemia measures, it requires the point-of-care testing glucose data to be linked to the pharmacy data to identify the appropriate population. Usability: This will be a very usable measure for tracking glucose management quality as long as the above hurdle can be surmounted in some systems. Unintended consequences: Hyperglycemia frequency may be overestimated by using the percentage of patient-days with two blood glucoses >200 mg/dL as opposed to the percentage of patient-days with patient-day weighted mean blood glucose >200 mg/dL.

2363: Glycemic Control - Hypoglycemia	Submitted by Ms. Vipra Ghimire, MPH	Numerator Statement: Total number of hypoglycemic events (<40 mg/dL) that were preceded by administration of rapid/short acting insulin within 12 hours or an anti-diabetic agent other than short-acting insulin within 24 hours, were not followed by another glucose value greater than 80 mg/dL within five minutes, and were at least 20 hours apart. Optional numerator:Total number of hypoglycemic events (<70 mg/dL) that were preceded by administration of rapid/short-acting insulin within 12 hours or an anti-diabetic agent other than short-acting insulin within 24 hours, were not followed by another glucose value greater than 80 mg/dL within five minutes, and were at least 20 hours apart. Denominator Statement: Total number of hospital days with at least one anti-diabetic agent administered The two hypoglycemia thresholds are appropriate to distinguish severe and moderate hypoglycemia and linking the glucose value to anti-diabetic therapy administration is an important component of this measure to avoid non-diabetes mediated hypoglycemia due to severe illness. However, we are wondering how the 20 hour interval between two BG readings <40 mg/dl was determined to indicate separate hypoglycemic events? This implies if you have multiple hypoglycemia readings in a 24 hour period that these would all count as one event and not separate events. In clinical practice, given the duration of action of a rapid-acting insulin analogues, it is conceivable that two low BG readings in a 20 hour time period could result from more than one rapid-acting insulin administration and thus be two separate events. Feasibility of collection: In order to generate this measure appropriately in an automated manner, the point-of-care testing glucose data need to be linked to the pharmacy data in order to identify patients who are receiving anti-diabetic agents. Not all electronic systems currently house both sets of data in a common location where data can be linked easily without generating complex programming algorithms. Usability: This will be a very usable measure for tracking glucose management quality as long as the above hurdle can be surmounted in some systems. Unintended consequences: Hypoglycemia frequency in a given patient-day may be underestimated by requiring a 20 hour time period between episodes.

2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Andrew David Bunta, MD	Andrew D. Bunta ,MD As an orthopaedic surgeon with a long-standing interest in the bone health of our population and associated osteoporosis, I strongly support this as a required measure for patients with fragility fractures admitted to a hospital in an inpatient status. A laboratory evaluation of additional/secondary causes of osteoporosis is most essential in order to provide patients with the most appropriate treatment. This requirement, in regard to the total orthopaedic care of older adults and others with fragility fractures, is long overdue and will significantly increase awareness, among many medical specialists, as to the bone health issues of our population.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by John T. Schousboe, MD, PhD	From the International Society for Clinical Densitometry IISCD): Secondary causes of osteoporosis have been shown to be highly prevalent among individuals presenting with fragility fractures, which necessitates routine investigation. Identification of secondary causes of low bone mass can alter management, ultimately improving bone strength and reducing the risk of additional fractures In 2013, the International Osteoporosis Foundation published a set of internationally-endorsed professional standards of best practice in the care of fragility fracture patients by Fracture Liaison Services. Standard number 6 on secondary causes of osteoporosis among fragility fracture patients recognized the importance of identifying (and addressing) secondary causes. [See Standard 6 of Capture the Fracture: a Best Practice Framework and global campaign to break the fragility fracture cycle. Åkesson K et al. Osteoporos Int. 2013 Aug; 24(8): 2135-52. PubMed ID 23589162].

2416: Laboratory Investigation for Secondary Causes of Fracture	Kimberly Templeton, US Bone and Joint Initiative; Submitted by Kimberly Templeton, MD	Re: National Quality Forum Proposed Measures #2416, #2417, #2418 To Whom It May Concern: On behalf of the Executive Committee of the US Bone and Joint Initiative (USBJI), I would like to encourage the National Quality Forum to adopt proposed measures #2416, #2417, and #2418. The USBJI is an organization of more than 100 professional and patient organizations, committed to improving bone and joint health in the United States. There are few organizations within the Initiative whose members are not affected by the significant issues resulting from osteoporosis and low impact fractures. These fractures can lead to significant morbidity and mortality; in addition, people who sustain a low impact fracture are at significant risk for additional fractures. Osteoporosis and resulting fractures represent a significant burden on the United States. However, these are conditions for which early diagnosis and intervention are effective. The most efficacious time in which to intervene is when patients seek medical care for their fractures. Although relatively inexpensive, testing for poor bone health, including bone density testing (DXA) and a variety of laboratory tests, are readily available in most communities, these are not consistently utilized after patients sustain their first fracture. Assessment of bone health is even less likely among male and racial/ethnic minority patients. In addition, treatment modalities for osteoporosis, along with fall prevention measures, have been found to decrease the risk of additional fractures, yet are infrequently implemented. Assessment for osteoporosis and/or initiation of treatment, as outlined in Measures #2416 and #2417, while patients are hospitalized for fracture management, would significantly decrease the risk of future fractures. Measure #2418 addresses the more challenging issue of evaluating patient for osteoporosis when they present to an emergency department. These patients may seek follow-up care at health care facilities other than that which initially treated their fracture. In addition, their primary care provider may be unaware that the patient sustained a low impact fracture. Measure #2418 will increase the likelihood that the patient's primary care provider is made aware of the fracture, and that the patient will consequently be appropriately evaluated and treated to prevent additional fractures. The proposed measures listed above would seem to align with several of the National Quality Strategies priorities, especially those related to reducing preventable hospital admissions and readmissions, as well as improving quality of life. The US Bone and Joint Initiative strongly recommends that the National Quality Forum adopt the proposed measures. If you would be interested in additional comments or need more information, please do not hesitate to contact us. Sincerely, Kim Templeton, MD Immediate Past-President, US Bone and Joint Initiative

2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Carol Ann Sedlak, PhD	As a nurse researcher, I support this measure as integral for interventions and quality care.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Carol Ann Sedlak, PhD	As a nurse researcher, I support this measure as integral for interventions and quality care.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Paula Stern, Ph.D.	Published studies (Dumitrescu et al 2008, Bours et al 2011, Bogoch et al 2012) reveal that 1/3 - 1/2 of patients presenting with clinical vertebral or non-vertebral fractures had secondary causes or contributors to osteoporosis, including medications, hypogonadism, renal or gastrointestinal conditions, hyperthyroidism, hyperparathyroidism, smoking, excessive alcohol use, and insufficient vitamin D and or calcium intake. Most of these conditions are correctable or treatable. The laboratory investigation of secondary causes is therefore an important component of patient care.

2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Amy Porter	These comments are on behalf of the National Osteoporosis Foundation (NOF), the leading health organization dedicated to preventing osteoporosis and broken bones, promoting strong bones for life and reducing human suffering through programs of public and clinician awareness, education, advocacy and research. Osteoporosis is a major public health threat for an estimated 52 million Americans. Studies show that one in two women and up to one in four men over age 50 will break a bone due to osteoporosis in their lifetime. Secondary causes of osteoporosis have been shown to be highly prevalent among individuals presenting with fragility fractures, which necessitates approrpriate laboratory investigation. he following studies support this statement: · Secondary Causes of Osteoporosis in Fracture Patients. Bogoch ER et al. J Orthop Trauma. 2012 Sep; 26(9): e145-52.PubMed ID 22377504. · Contributors to secondary osteoporosis and metabolic bone diseases in patients presenting with a clinical fracture. Bours SPG et al. J Clin Endocrinol Metab. 2011 May; 96(5): 1360-7.PubMed ID 21411547. · Evaluation of patients with a recent clinical fracture and osteoporosis, a multidisciplinary approach. Dumitrescu B et al. BMC Musculoskelet Disord. 2008 Aug 5; 9: 109.PubMed ID 18680609. Further, in 2013, the International Osteoporosis Foundation published a set of internationally-endorsed professional standards of best practice in the care of fragility fracture patients by Fracture Liaison Services. Standard number 6 on secondary causes of osteoporosis among fragility fracture patients recognized the importance of identifying (and addressing) secondary causes. [See Standard 6 of Capture the Fracture: a Best Practice Framework and global campaign to break the fragility fracture cycle. Åkesson K et al. Osteoporos Int. 2013 Aug; 24(8): 2135-52.PubMed ID 23589162]. This is an important measure to ensure post-fracture patients receive appropriate tests to identify potential secondary causes of osteoporosis.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Brandi Bliss, RN, ONC	I support this measure. This would be a step in the right direction to diagnosing and treating osteoporosis.

2416: Laboratory Investigation for Secondary Causes of Fracture	David Lee, National Bone Health Alliance; Submitted by Mr. David Lee, MPA	These comments are provided on behalf of the National Bone Health Alliance (NBHA, www.nbha.org), a public-private partnership on bone health that includes 51 organizational members from the non-profit and private sectors as well as 4 government liaisons all working together to improve the overall health and quality of life of all Americans by enhancing their bone health. Secondary causes of osteoporosis have been shown to be highly prevalent among individuals presenting with fragility fractures, which necessitates laboratory investigation. The following studies support this statement: • Secondary Causes of Osteoporosis in Fracture Patients. Bogoch ER et al. J Orthop Trauma. 2012 Sep; 26(9): e145-52. PubMed ID 22377504. • Contributors to secondary osteoporosis and metabolic bone diseases in patients presenting with a clinical fracture. Bours SPG et al. J Clin Endocrinol Metab. 2011 May; 96(5): 1360-7. PubMed ID 21411547. • Evaluation of patients with a recent clinical fracture and osteoporosis, a multidisciplinary approach. Dumitrescu B et al. BMC Musculoskelet Disord. 2008 Aug 5; 9: 109. PubMed ID 18680609. Further, in 2013, the International Osteoporosis Foundation published a set of internationally-endorsed professional standards of best practice in the care of fragility fracture patients by Fracture Liaison Services. Standard number 6 on secondary causes of osteoporosis among fragility fracture patients recognized the importance of identifying (and addressing) secondary causes. [See Standard 6 of Capture the Fracture: a Best Practice Framework and global campaign to break the fragility fracture cycle. Åkesson K et al. Osteoporos Int. 2013 Aug; 24(8): 2135-52. PubMed ID 23589162].
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Patrick Liedtka	Merck fully supports this measure. We suggest considering a PTH lab test to help identify patients with secondary hyperparathyroidism due to conditions such as calcium malabsorption or renal calcium leak. When postmenopausal osteoporosis goes untreated, women with this disease are at a significantly increased risk for fractures in the spine or hip. Hip fractures, in particular, are associated with substantial morbidity, disability, and mortality. Consequently, osteoporosis is a serious disease that needs to be monitored and treated.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Catherine A. Rolih, MD	It is well recognized that there is a secondary cause of bone loss present in up to 50% of patients suffering fragiity fractures. In order to appropriately manage these patients and prevent subsequent fractures, these secondary causes must be identified and treated. In our clinic, examples of secondary causes which may be identified by laboratory testing have included: severe vitamin D deficiency, primary hyperparathyroidism, subclinical hyperthyroidism, male hypogonadism, and chronic renal insufficiency.

2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Monica Mowry, RN,MSN,NE-BC	As Director of Clinical Program Development for Carolinas Healthcare System, I am responsible for the system-wide implementation of a Fragility Fracture Program across the full continuum of care. I am a very strong advocate of implementing these measures. There could be a tremendous impact on LOS, Mortality, Morbid Complications and Readmission Rate for inpatient admissions and ED visits. In this era of cost containment and outcome driven solutions this growing patient population needs to be addressed. It is unlikely that it will unless these measures are formalized and officially implemented as the standard of care/quality.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by E. Michael Lewiecki, MD	I fully support this measure since the evaluation for secondary casues of osteoporosis is an important prelude to treatment to reduce fracture risk.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Laura Boineau	As a Nurse Practitioner for the past 17 years, with the past 4 years focusing on osteoporosis, I fully support this measure. Secondary causes of osteoporosis are more common than most people, including primary care providers, realize. Being able to identify these causes, while the patient is in the hospital, is critical in order to begin a treatment plan to reduce their risk of yet another fracture. This would reduce hospital admissions and readmissions and improve the quality of life for our patients and their families.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Denise Greene	As a nurse practitioner, I fully understand the importance of this measure and support it.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Linda Hightower, RN, ONC	As an organization who formerly had Disease Specific Care Certification in Osteoporosis, we had a measure that was very familiar to this one in our Fracture Order Set. This measure is long overdue and I fully support it.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Tahnee Maples	I support this measure because it will improve patient care and treatment evaluation.

2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Cynthia Emory, MD	Evaluation for secondary causes of fracture is essential in the prevention of subsequent low-energy fractures. If the underlying cause is not identified, then a treatment plan cannot be developed to help the patient, and the patient will end up with another broken bone that potentially could have been prevented. I fully support this measure.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Anna N. Miller, MD	As an orthopaedic trauma surgeon, I treat many patients with fractures of all types, including fragility fractures. We should be working to decrease fragility fractures, and especially repeat fragility fractures in patients throughout the country. In 2013, the International Osteoporosis Foundation published a set of internationally-endorsed professional standards of best practice in the care of fragility fracture patients by Fracture Liaison Services. Standard number 6 on secondary causes of osteoporosis among fragility fracture patients recognized the importance of identifying (and addressing) secondary causes. Without investigating these causes, the numbers of fragility fractures, and by extension, the patients suffering from these fractures, will continue to rise with the increase in the aging population.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Richard Dell, MD	I fully support this measure and strongly believe it is very important in improving the care of our patients with osteoporosis that have had a fragility fracture.
2416: Laboratory Investigation for Secondary Causes of Fracture	Submitted by Gary Kiebzak, PhD	Great job on developing this new measure. We need to get this approved and in the field to help improve care after fractures.
2417: Risk Assessment/Treatment After Fracture	Submitted by Andrew David Bunta, MD	As an orthopaedic surgeon with a long-standing interest in the bone health of our population, and as an individual closely aligned with the American Orthoapedic Association' s bone health program, Own the Bone, I lend my strong and ardent support to this measure. It is clear to those of us interested in this area of deficient medical care of patients with fragility fractures, that those patients do need close attention and follow-up. This certainly can include a bone density test/DXA scan or FDA approved pharmacotherapy depending on the patient's age and the nature of the fracture--or entry into a Fracture Liaison Service. Nevertheless, enforcement of this measure by the NQF and Joint Commission will serve to improve the bone health of our population and decrease future fractures in those who have already sustained a fragility fracture.

2417: Risk Assessment/Treatment After Fracture	Submitted by Dr. Jason Spangler, MD, MPH	Amgen recommends that Draft NQF measure 2417 be endorsed. Amgen supports performance measures that encourage post-fracture diagnosis, treatment, and coordination of care because these are critical for ensuring that individuals who suffer a fracture have the best opportunity to avoid a subsequent fracture and its complications, which may lead to a diminished quality of life as well as increased healthcare costs. Improving the quality of care for osteoporosis patients pre- and post-fracture must be a priority due to known gaps in care, and the enormous impact on patient outcomes and costs. Approximately 300,000 individuals suffer a hip fracture in the United States every year, at an estimated cost of more than $12 billion in 2005 (representing 72% of the total cost of the 2 million fragility fractures estimated to have occurred in 2005) [Incidence and economic burden of osteoporosis-related fractures in the United States, 2005-2025. Burge R et al. J Bone Miner Res. 2007 Mar; 22(3): 465-75]. Draft NQF measure 2417 would greatly enhance coordination of care, and benefit fracture patients by ensuring that fracture patients are tested for osteoporosis and prescribed pharmacologic therapy, if appropriate. Amgen also supports performance measures that encourage comprehensive clinician evaluation and monitoring of patient risk factors for osteoporosis and fracture. Furthermore, Amgen believes that clinician attention toward post-fracture identification, diagnosis and treatment is particularly well-placed, as these patients continue to be among the most chronically at-risk for on-going problems related to their osteoporotic condition, as well as the associated, additional healthcare costs that these patients represent to the healthcare system
2417: Risk Assessment/Treatment After Fracture	Submitted by John T. Schousboe, MD, PhD	From the International Society of Clinical Densitometry (ISCD): More than 300,000 individuals suffer a hip fracture in the United States every year, at an estimated cost of more than $12 billion in 2005 (representing 72% of the cost of the 2 million fragility fractures estimated to have occurred in 2005 [Incidence and economic burden of osteoporosis-related fractures in the United States, 2005-2025. Burge R et al. J Bone Miner Res. 2007 Mar; 22(3): 465-75. PubMed ID 17144789)]. Approximately half of these 300,000 hip fracture patients will have suffered a prior fragility fracture. Had reliable post-fracture osteoporosis care occurred for the 150,000 of these hip fracture sufferers who previously presented to urgent care services with the fragility fracture that preceded their hip fracture, osteoporosis treatment with the potential to reduce by 30 to 40 percent future hip fracture rates could have prevented 45,000 to 60,000 of these hip fractures.

2417: Risk Assessment/Treatment After Fracture	Kimberly Templeton, US Bone and Joint Initiative; Submitted by Kimberly Templeton, MD	Re: National Quality Forum Proposed Measures #2416, #2417, #2418 To Whom It May Concern: On behalf of the Executive Committee of the US Bone and Joint Initiative (USBJI), I would like to encourage the National Quality Forum to adopt proposed measures #2416, #2417, and #2418. The USBJI is an organization of more than 100 professional and patient organizations, committed to improving bone and joint health in the United States. There are few organizations within the Initiative whose members are not affected by the significant issues resulting from osteoporosis and low impact fractures. These fractures can lead to significant morbidity and mortality; in addition, people who sustain a low impact fracture are at significant risk for additional fractures. Osteoporosis and resulting fractures represent a significant burden on the United States. However, these are conditions for which early diagnosis and intervention are effective. The most efficacious time in which to intervene is when patients seek medical care for their fractures. Although relatively inexpensive, testing for poor bone health, including bone density testing (DXA) and a variety of laboratory tests, are readily available in most communities, these are not consistently utilized after patients sustain their first fracture. Assessment of bone health is even less likely among male and racial/ethnic minority patients. In addition, treatment modalities for osteoporosis, along with fall prevention measures, have been found to decrease the risk of additional fractures, yet are infrequently implemented. Assessment for osteoporosis and/or initiation of treatment, as outlined in Measures #2416 and #2417, while patients are hospitalized for fracture management, would significantly decrease the risk of future fractures. Measure #2418 addresses the more challenging issue of evaluating patient for osteoporosis when they present to an emergency department. These patients may seek follow-up care at health care facilities other than that which initially treated their fracture. In addition, their primary care provider may be unaware that the patient sustained a low impact fracture. Measure #2418 will increase the likelihood that the patient's primary care provider is made aware of the fracture, and that the patient will consequently be appropriately evaluated and treated to prevent additional fractures. The proposed measures listed above would seem to align with several of the National Quality Strategies priorities, especially those related to reducing preventable hospital admissions and readmissions, as well as improving quality of life. The US Bone and Joint Initiative strongly recommends that the National Quality Forum adopt the proposed measures. If you would be interested in additional comments or need more information, please do not hesitate to contact us. Sincerely, Kim Templeton, MD Immediate Past-President, US Bone and Joint Initiative

2417: Risk Assessment/Treatment After Fracture	Submitted by Carol Ann Sedlak, PhD	As a nurse researcher, I support this as integral for assessment and treatment of individuals with fragility fractures.
2417: Risk Assessment/Treatment After Fracture	Submitted by Paula Stern, Ph.D.	Fracture risk assessment by DXA or other specified method in patients who have had a fragility fracture is critical for the benefit of the patient and also in view of the high incidence and economic cost of treatment. Risk assessment, followed by treatment of the underlying disease constitute best medical practice.
2417: Risk Assessment/Treatment After Fracture	Submitted by Amy Porter	These comments are provided on behalf of the National Osteoporosis Foundation (NOF), the leading health organization dedicated to preventing osteoporosis and broken bones, promoting strong bones for life and reducing human suffering through programs of public and clinician awareness, education, advocacy and research. The majority of patients who suffer fragility fractures do not receive standards of secondary preventive care to reduce their risk of future fragility fractures. This near universal absence of best practice is costing older Americans, Medicare and, therefore, U.S. tax payers, dearly. All fragility fracture patients should undergo assessment of future fracture risk and, where clinically appropriate, be considered for treatment for their underlying disease. More than 300,000 individuals suffer a hip fracture in the United States every year, at an estimated cost of more than $12 billion in 2005 (representing 72% of the cost of the 2 million fragility fractures estimated to have occurred in 2005 [Incidence and economic burden of osteoporosis-related fractures in the United States, 2005-2025. Burge R et al. J Bone Miner Res. 2007 Mar; 22(3): 465-75.PubMed ID 17144789)]. Approximately half of these 300,000 hip fracture patients will have suffered a prior fragility fracture. NOF supports this measure, which will help to strongly encourage practitioners and hospitals to ensure that patients suffering from a fragility fracture receive appropriate diagnosis, follow-up and care.
2417: Risk Assessment/Treatment After Fracture	Submitted by Brandi Bliss, RN, ONC	I support this measure. As an Orthopedic Nurse Navigator supporting patients post fracture there are many challenges to getting these patient the proper diagnostic orders. There is a lack of ownership by internal medicine and orthopedics for bone health maintenance.

2417: Risk Assessment/Treatment After Fracture	David Lee, National Bone Health Alliance; Submitted by Mr. David Lee, MPA	These comments are being provided on behalf of the National Bone Health Alliance (NBHA, www.nbha.org), a public-private partnership on bone health that includes 51 organizational members from the non-profit and private sectors as well as 4 government liaisons all working together to improve the overall health and quality of life of all Americans by enhancing their bone health. Currently, the majority of patients who suffer fragility fractures do not receive secondary preventive care to reduce their risk of future fragility fractures (given that currently only 25 percent of older women who suffer from fragility fractures receive either a bone density test and/or treatment for their underlying disease within 6 months of the fracture, which represents a 75 percent care gap). This near universal absence of best practice is costing older Americans, Medicare and, therefore, U.S. tax payers, dearly. All fragility fracture patients should undergo assessment of future fracture risk and, where clinically appropriate, be considered for treatment for their underlying disease. More than 300,000 individuals suffer a hip fracture in the United States every year, at an estimated cost of more than $12 billion in 2005 (representing 72% of the cost of the 2 million fragility fractures estimated to have occurred in 2005 [Incidence and economic burden of osteoporosis-related fractures in the United States, 2005-2025. Burge R et al. J Bone Miner Res. 2007 Mar; 22(3): 465-75, PubMed ID 17144789)]. Approximately half of these 300,000 hip fracture patients will have suffered a prior fragility fracture. The 2012 NCQA State of Health Care Quality Report showed no significant change in the rates of post-fracture osteoporosis care from 2007 to 2011 regarding the HEDIS® measure for osteoporosis management in women who had a fracture [www.ncqa.org/reportcards/healthplans/stateofhealthcarequality.aspx, p. 16-17]. Therefore, this is a very important measure which could help drive practitioner and hospital improvement in this significant care gap around post-fracture care.
2417: Risk Assessment/Treatment After Fracture	Submitted by Patrick Liedtka	Merck fully supports this measure. We also suggest considering breaking the measure out into two measures: (1) one for diagnosis and treatment and (2) the other for the Fracture Liaison Service since both these components are very important to improving outcomes for patients with osteoporotic fractures. When postmenopausal osteoporosis goes untreated, women with this disease are at a significantly increased risk for fractures in the spine or hip. Hip fractures, in particular, are associated with substantial morbidity, disability, and mortality. Consequently, osteoporosis is a serious disease that needs to be monitored and treated.

2417: Risk Assessment/Treatment After Fracture	Submitted by Patrick Liedtka	Merck fully supports this measure. We also suggest considering breaking the measure out into two measures: (1) one for diagnosis and treatment and (2) the other for the Fracture Liaison Service since both these components are very important to improving outcomes for patients with osteoporotic fractures. When postmenopausal osteoporosis goes untreated, women with this disease are at a significantly increased risk for fractures in the spine or hip. Hip fractures, in particular, are associated with substantial morbidity, disability, and mortality. Consequently, osteoporosis is a serious disease that needs to be monitored and treated.
2417: Risk Assessment/Treatment After Fracture	Submitted by Mr. Douglas Fesler	These three post-fracture measures are sorely needed and extremely important for the safe management of patients. Secondary causes of osteoporosis have been shown to be highly prevalent among individuals presenting with fragility fractures, which necessitates routine investigation. The following studies support this statement: · Secondary Causes of Osteoporosis in Fracture Patients. Bogoch ER et al. J Orthop Trauma. 2012 Sep; 26(9): e145-52.PubMed ID 22377504. · Contributors to secondary osteoporosis and metabolic bone diseases in patients presenting with a clinical fracture. Bours SPG et al. J Clin Endocrinol Metab. 2011 May; 96(5): 1360-7.PubMed ID 21411547. · Evaluation of patients with a recent clinical fracture and osteoporosis, a multidisciplinary approach. Dumitrescu B et al. BMC Musculoskelet Disord. 2008 Aug 5; 9: 109.PubMed ID 18680609. Furthermore, the majority of patients who suffer fragility fractures in the United States do not receive nationally and internationally recognized standards of secondary preventive care to reduce their risk of future fragility fractures. This near universal absence of best practice is costing older Americans, Medicare and, therefore, U.S. tax payers dearly. Health care providers should always respond to the first fracture with the aim of preventing second and subsequent fractures. Clear written discharge instructions recommending the need for post-fracture osteoporosis care are an essential step in ensuring that long-term management plans are implemented to reduce future fracture risk.
2417: Risk Assessment/Treatment After Fracture	Pam Cupec, NAON National Association of Orthopaedic Nurses; Submitted by Pamela Ann Cupec, RN	On behalf of the National Association of Orhopaedic Nurses, we support this measure to related to risk assessment post fracture. it is imperative to have such measures in place in the pursuit to better identify and address variables to decreases occurance of additional fracture.Measures such as this will enhance our practice with specific quidelines for in assessmnet, education, and care of patients and family members. Such research builds on the baseline of knowledge in osteoporosis and shapes evidence based practice.

2417: Risk Assessment/Treatment After Fracture	Submitted by Catherine A. Rolih, MD	Over 300,000 hip fractures occur annually in the US, which in turn are responsible for 65,000 deaths and billions of dollars in direct health care costs. Unfortunately, fewer than 1 in 4 hip fracture patients receive any evaluation or treatment for osteoporosis, and 20% will have a second fracture within 2 yrs. Fracture liasion service (FLS) programs have been demonstrated again and again to effectively improve osteoporosis evaluation and treatment, decrease rates of subsequent fractures, save lives, and dramatically lower health care costs by closing the gaps in health care transitions and improving access to state-of -the art care. We strongly support a measure which would encourage the implementation of FLS programs on a wider scale.
2417: Risk Assessment/Treatment After Fracture	Submitted by Monica Mowry, RN,MSN,NE-BC	As Director of Clinical Program Development for Carolinas Healthcare System, I am responsible for the system-wide implementation of a Fragility Fracture Program across the full continuum of care. I am a very strong advocate of implementing these measures. There could be a tremendous impact on LOS, Mortality, Morbid Complications and Readmission Rate for inpatient admissions and ED visits. In this era of cost containment and outcome driven solutions this growing patient population needs to be addressed. It is unlikely that it will unless these measures are formalized and officially implemented as the standard of care/quality.
2417: Risk Assessment/Treatment After Fracture	Submitted by E. Michael Lewiecki, MD	I support this measure. It is essential that patients with fragility fractures be evaluated for osteoporosis and treated to reduce fracture risk when appropriate.
2417: Risk Assessment/Treatment After Fracture	Submitted by Laura Boineau	I am a Nurse Practitioner that has been employed by the Department of Orthopaedics, at the Greenville Health System in South Carolina, for the past 4 years to coordinate a post, fragility fracture liaison service. I fully support this measure. I have seen how difficult it is to get patients, their families and even some PCP's to understand how important it is to get a DXA scan and to be started on treatment as soon as possible to reduce their risk for another fracture. This measure would help improve the quality of care transitions and communications across care settings.
2417: Risk Assessment/Treatment After Fracture	Submitted by Denise Greene	This measure is extremely important for the safe management of patients.

2417: Risk Assessment/Treatment After Fracture	Submitted by Linda Hightower, RN, ONC	As an organization who formerly had Disease Specific Care Certification in Osteoporosis, we had a measure that was very familiar to this one in our Fracture Order Set. This measure is long overdue and I fully support it.
2417: Risk Assessment/Treatment After Fracture	Submitted by Tahnee Maples	This measure is critical to the appropriate evaluation of the fragility fracture patient and comprehensive fracture care.
2417: Risk Assessment/Treatment After Fracture	Submitted by Dan Solomon, MD, MPH	There are substantial data demonstrating the current sub-optimal state of post fracture care. We have data from a large US national provider the shows the post hip fracture treatment rates have declined from 40% in 2002 to 25% in 2011. As someone who has worked to improve osteoporosis care for the last 15 years, I speak with some knowledge that we need system changes that will accelerate quality improvement amongst providers. A post-fracture system of care has been developed in several health systems around the globe; many refer to it as a Fracture Liaison Service. This collaborative system organizes inpatient orthopedic providers with outpatient osteoporosis care teams. Creating Quality Measures that stimulate systems change is an important goal that is sorely needed in this area of medical care.
2417: Risk Assessment/Treatment After Fracture	Submitted by Cynthia Emory, MD	Post-fracture risk assessment is critical to minimize our patients' risk of subsequent fracture. It would be ideal if the patient can avoid the pain and disability of a fracture in the first place instead of just fixing the fracture once it occurs. I fully support this measure
2417: Risk Assessment/Treatment After Fracture	Submitted by Anna N. Miller, MD	As an orthopaedic trauma surgeon, I treat many patients with fractures of all types, including fragility fractures. We should be working to decrease fragility fractures, and especially repeat fragility fractures in patients throughout the country. The majority of patients in the United States who suffer these fractures do not receive secondary fracture preventative care. More than 300,000 individuals suffer a hip fracture in the United States every year, at an estimated cost of more than $12 billion in 2005 (representing 72% of the cost of the 2 million fragility fractures estimated to have occurred in 2005 [Incidence and economic burden of osteoporosis-related fractures in the United States, 2005-2025. Burge R et al. J Bone Miner Res. 2007 Mar; 22(3): 465-75.PubMed ID 17144789)]. Approximately half of these 300,000 hip fracture patients will have suffered a prior fragility fracture. With early intervention to prevent secondary fractures, $2-3 billion per year could have been saved by preventing these hip

		fractures.
2417: Risk Assessment/Treatment After Fracture	Submitted by Richard Dell, MD	The evidence is very strong that the post fracture assessment of patients is lacking in the USA and many other countries. This measure is an important step in seeing that patients get the correct assessment and treatment post fracture.
2417: Risk Assessment/Treatment After Fracture	Submitted by Gary Kiebzak, PhD	Great job on developing this new measure. We need to get this approved and in the field to help improve care after fractures.
2418: Discharge Instructions – Emergency Department	Submitted by Andrew David Bunta, MD	As a representative of orthoapedic surgery and the American Orthopaedic Association' s bone health program-Own the Bone, I strongly support this measure assesses the data in bone health information be given to patients seen an emergency room with a fragility fracture. Only through this measure supported by theNQF and the Joint Commission, can we begin to stem the tide of fragility fractures and our aging population. Patients must be made aware of the bone health issues which played a role in their fracture.

2418: Discharge Instructions – Emergency Department	Submitted by Dr. Jason Spangler, MD, MPH	Amgen recommends that Draft NQF measure 2418 be endorsed. Amgen supports performance measures that encourage post-fracture diagnosis, treatment, and coordination of care because these are critical for ensuring that individuals who suffer a fracture have the best opportunity to avoid a subsequent fracture and its complications, which may lead to a diminished quality of life as well as increased healthcare costs. Improving the quality of care for osteoporosis patients pre- and post-fracture must be a priority due to known gaps in care, and the enormous impact on patient outcomes and costs. A systematic review of models of care for the secondary prevention of osteoporotic fractures by Ganda and colleagues provides a useful framework for classification of various approaches to delivery of written discharge instructions to primary care providers in post-fracture care [Models of care for the secondary prevention of osteoporotic fractures: a systematic review and meta-analysis. Ganda K et al. Osteoporos Int. 2013 Feb; 24(2):393-406]. Models are classified as Type A to D, with Type A being the most intensive and Type D the least intensive. The main objectives of a Fracture Liaison Service (FLS) are to identify fragility fracture patients when they present to emergency departments, conduct investigations to diagnose osteoporosis and assess future fracture risk and, where appropriate, initiate osteoporosis treatment. Some FLS initiate the first prescription and subsequently rely upon written discharge instructions to the primary care provider to trigger long-term management (Type A), while less intensive FLS (Type B or Type C) undertake identification and/or investigations for fragility fracture patients, but rely on written discharge instructions to the primary care provider to trigger the initial and subsequent prescriptions for osteoporosis medicines. Ganda and colleagues concluded that Type A Fracture Liaison Service (FLS) models result in 79% of patients undergoing bone density testing and 46% receiving osteoporosis treatment, and Type B models result in 60% of patients undergoing bone density testing and 41% receiving osteoporosis treatment. While the analytic methods used by Ganda et al cannot be directly compared to national performance data, the osteoporosis treatment rates associated with both types of FLS models are promising: According to the 2013 State of Health Care Quality report, among female Medicare beneficiaries who were age > 67 and had a fracture, only 25% reported receiving either a prescription for an osteoporosis drug or a bone mineral density test in the six months following the fracture [National Committee for Quality Assurance. The State of Health Care Quality 2013, Osteoporosis Testing in Older Women, p. 111]. Draft NQF measure 2418 would greatly enhance coordination of care, and benefit fracture patients by ensuring that they are referred for the appropriate post-discharge care.

2418: Discharge Instructions – Emergency Department	Submitted by John T. Schousboe, MD, PhD	From the International Society for Clinical Densitometry (ISCD): A systematic review of models of care for the secondary prevention of osteoporotic fractures by Ganda and colleagues provides a useful framework for classification of various approaches to delivery of written discharge instructions to primary care providers in post-fracture care (Models of care for the secondary prevention of osteoporotic fractures: a systematic review and meta-analysis. Ganda K et al. Osteoporos Int. 2013 Feb; 24(2):393-406. PubMed ID 22829395). Models are classified as Type A to D, with Type A being the most intensive and Type D the least intensive. The main objectives of a Fracture Liaison Service (FLS) are to identify fragility fracture patients when they present to emergency departments or urgent care centers, conduct investigations to diagnose osteoporosis and assess future fracture risk and, where appropriate, initiate osteoporosis treatment. Some FLS initiate the first prescription and subsequently rely upon written discharge instructions to the patient to encourage follow-up with other providers who will then carry on fracture prevention management with that patient. Either way, communication to patients and other providers to ensure continuity of care and consistent, sustained application of appropriate fracture prevention therapies is essential. .
2418: Discharge Instructions – Emergency Department	Submitted by Carol Ann Sedlak, PhD	As a nurse researcher, I support this measure as integral to promoting quality care for individuals with fragility fractures.
2418: Discharge Instructions – Emergency Department	Submitted by Paula Stern, Ph.D.	Procedures should be in place to prevent recurrent fractures. In addition to education of patients, physicians and the public, well-coordinated systems for follow up to prevent secondary fractures are essential.

2418: Discharge Instructions – Emergency Department	Submitted by Amy Porter	These comments are provided on behalf of the National Osteoporosis Foundation (NOF), the leading health organization dedicated to preventing osteoporosis and broken bones, promoting strong bones for life and reducing human suffering through programs of public and clinician awareness, education, advocacy and research. The majority of patients who suffer fragility fractures in the United States do not receive secondary preventive care to reduce their risk of future fragility fractures. This near universal absence of best practice is costing older Americans, Medicare and, therefore, U.S. tax payers dearly. Health care providers should always respond to the first fracture with the aim of preventing second and subsequent fractures.Clear written discharge instructions recommending the need for post-fracture osteoporosis care are an essential step in ensuring that long-term management plans are implemented to reduce future fracture risk. NOF strongly supports this measure to better ensure patients have clear discharge instructions and to ensure they are supported post-hospitalization through fracture prevention programs like a fracture liaison service.
2418: Discharge Instructions – Emergency Department	Submitted by Brandi Bliss, RN, ONC	I support this measure. Patient receiving education about osteoporosis care after discharge will help prevent future fractures. Again there are so many challeneges to getting these patients the appropriate osteoporosis care. The measure would bring awareness and put in place resources for osteoporosis care.

2418: Discharge Instructions – Emergency Department	David Lee, National Bone Health Alliance; Submitted by Mr. David Lee, MPA	These comments are being provided on behalf of the National Bone Health Alliance (NBHA, www.nbha.org), a public-private partnership on bone health that includes 51 organizational members from the non-profit and private sectors as well as 4 government liaisons all working together to improve the overall health and quality of life of all Americans by enhancing their bone health. The majority of patients who suffer fragility fractures in the United States do not receive standards of secondary preventive care to reduce their risk of future fragility fractures. This near universal absence of best practice is costing older Americans, Medicare and, therefore, U.S. tax payers dearly. Health care providers should always respond to the first fracture with the aim of preventing second and subsequent fractures.Clear written discharge instructions recommending the need for post-fracture osteoporosis care are an essential step in ensuring that long-term management plans are implemented to reduce future fracture risk. A systematic review of models of care for the secondary prevention of osteoporotic fractures by Ganda and colleagues provides a useful framework for classification of various approaches to delivery of written discharge instructions to primary care providers in post-fracture care (Models of care for the secondary prevention of osteoporotic fractures: a systematic review and meta-analysis. Ganda K et al. Osteoporos Int. 2013 Feb; 24(2):393-406. PubMed ID 22829395). Models are classified as Type A to D, with Type A being the most intensive and Type D the least intensive. The main objectives of a Fracture Liaison Service (FLS) are to identify fragility fracture patients when they present to emergency departments, conduct investigations to diagnose osteoporosis and assess future fracture risk and, where appropriate, initiate osteoporosis treatment. Some FLS initiate the first prescription and subsequently rely upon written discharge instructions to the primary care provider to trigger long-term management (Type A), while less intensive FLS (Type B or Type C) undertake identification and/or investigations for fragility fracture patients, but rely on written discharge instructions to the primary care provider to trigger the initial and subsequent prescriptions for osteoporosis medicines. Ganda and colleagues' concluded that Type A Fracture Liaison Service (FLS) models result in 79% of patients undergoing bone density testing and 46% receiving osteoporosis treatment, and Type B models result in 60% of patients undergoing bone density testing and 41% receiving osteoporosis treatment, which is a significant improvement from the current nearly 75 percent care gap (more information available at the NBHA Fracture Prevention CENTRAL website, www.FracturePreventionCENTRAL.org).

2418: Discharge Instructions – Emergency Department	Submitted by Patrick Liedtka	Merck fully supports this measure. When postmenopausal osteoporosis goes untreated, women with this disease are at a significantly increased risk for fractures in the spine or hip. Hip fractures, in particular, are associated with substantial morbidity, disability, and mortality. Consequently, osteoporosis is a serious disease that needs to be monitored and treated.
2418: Discharge Instructions – Emergency Department	Pam Cupec, NAON National Association of Orthopaedic Nurses; Submitted by Pamela Ann Cupec, RN	On behalf of the National Association of Orthopaedic Nurses, we support this measure. As nurses, education of patients and family members is essential for preventaion and health maintenence. The majority of fractures are seen initially in the emergency department, and incorporating osteoporosis meaures into the discharge instructions not only increases awareness but reinforces prevention and care. Such research builds on the baseline of knowledge in osteoporosis and shapes evidence based practice.
2418: Discharge Instructions – Emergency Department	Submitted by Catherine A. Rolih, MD	It is well recognized that one of the greatest predictors of a hip fracture is the occurrence of a prior fragility fracture. In fact, as many as half of hip fracture patients have a history of prior fracture. By identifying and treating patients with non-hip fraglity fracture early, subsequent hip fractures can be prevented. Unfortunately, most ED physicians are focused on acute care, and and fewer than 1 in 5 fragility fracture patients receive follow up care for osteoporosis. Fracture liasion service (FLS) programs have been demonstrated again and again to effectively improve osteoporosis evaluation and treatment, decrease rates of subsequent fractures, save lives, and dramatically lower health care costs by closing the gaps in health care transitions and improving access to state-of -the art care. We strongly support a measure which would encourage the implementation of FLS programs on a wider scale.
2418: Discharge Instructions – Emergency Department	Submitted by Mr. Alan Brett, PhD	This is a very important measure related to the promotion of Fracture Liaison Services which have been shown in studies in many different countries to be very cost effective in reducing subsequent fractures for patient presenting with an initial fragility fracture, and I would strongly support it.
2418: Discharge Instructions – Emergency Department	Submitted by Monica Mowry, RN,MSN,NE-BC	As Director of Clinical Program Development for Carolinas Healthcare System, I am responsible for the system-wide implementation of a Fragility Fracture Program across the full continuum of care. I am a very strong advocate of implementing these measures. There could be a tremendous impact on LOS, Mortality, Morbid Complications and Readmission Rate for inpatient admissions and ED visits. In this era of cost containment and outcome driven solutions this growing patient population needs to be addressed. It is unlikely that it will unless these measures are formalized and officially implemented as the standard of care/quality.

2418: Discharge Instructions – Emergency Department	Submitted by E. Michael Lewiecki, MD	I support this measure. Patients who present to emergency facilities with fragility fractures need follow-up to evaluate for fracture risk and treat with medications to reduce fracture risk when appropriate.
2418: Discharge Instructions – Emergency Department	Submitted by Laura Boineau	I fully support this measure. Patient's that are seen through the Emergency Department, and sent home, are frequently not identified as having a fragility fracture. Having a Fracture Liaison Service, to be able to contact them and to help coordinate their follow up care, is critical in reducing future fractures. Approximately 50% of hip fracture patients had a prior fracture. If they could be identified, after a wrist fracture (for example) and appropriately treated, it would save on their future pain, suffering and quality of life as well as the future cost of hospitalization, surgery and rehabilitation after a hip fracture. Thank you.
2418: Discharge Instructions – Emergency Department	Submitted by Denise Greene	Discharge instructions are needed for patients and family to understand what is needed at the time of discharge from the hospital.
2418: Discharge Instructions – Emergency Department	Submitted by Linda Hightower, RN, ONC	As an organization who formerly had Disease Specific Care Certification in Osteoporosis, we were working toward an ED process and are now working on the FLS process through our PCMH for fractures in ED or the hospital. This measure is long overdue and I fully support it.
2418: Discharge Instructions – Emergency Department	Submitted by Cynthia Emory, MD	Implementation of a fracture liaison service plan of care needs to start on the day of the injury. Patients need to be engaged in their overall health and wellness. Instructions should be provided to the patient about the goals of a fracture liaison service so that they can take an active role in their care, understand what is happening, and how to prevent frctures from happening again.

2418: Discharge Instructions – Emergency Department	Submitted by Anna N. Miller, MD	As an orthopaedic trauma surgeon, I treat many patients with fractures of all types, including fragility fractures. We should be working to decrease fragility fractures, and especially repeat fragility fractures in patients throughout the country. Most patients who have a fragility fracture are not appropriately educated or sent for follow up treatment upon discharge from their emergency department visit. The main objectives of a Fracture Liaison Service (FLS) are to identify fragility fracture patients when they present to emergency departments, conduct investigations to diagnose osteoporosis and assess future fracture risk and, where appropriate, initiate osteoporosis treatment. Some FLS initiate the first prescription and subsequently rely upon written discharge instructions to the primary care provider to trigger long-term management (Type A), while less intensive FLS (Type B or Type C) undertake identification and/or investigations for fragility fracture patients, but rely on written discharge instructions to the primary care provider to trigger the initial and subsequent prescriptions for osteoporosis medicines. With these services in place, appropriate management can help prevent future fractures, saving billions of health care dollars per year
2418: Discharge Instructions – Emergency Department	Submitted by Richard Dell, MD	I also support this measure in improving the care of our patients after a fracture. By making sure proper discharge instructions are given to patients after a fracture hopefully the patient will more easily equate the fracture with the root cause of the fracture - the underlying osteoporosis. This is crucial since roughly 50% of patients with a hip fracture had a prior fragility fracture. Hopefully with better awareness and management we will see a decraese in the subsequent hip fractures after the index fragility fracture. There is strong evidence that shows that patienst that are properly identified in having osteoporosis both before and even after the index fracture will have a significantly lower rate of hip and other fractures.
2418: Discharge Instructions – Emergency Department	Submitted by Gary Kiebzak, PhD	Great job on developing this new measure. We need to get this approved and in the field to help improve care after fractures.

General Draft	Debra Sietsema, Orthopaedic Associates of Michigan; Submitted by Dr. Debra L. Sietsema, PhD, RN	National Quality Forum Attn: Endocrine Standing Committee 1030 15th Street NW Washington, DC 20005 Re: Comment on NQF Performance Measures 2416, 2417, and 2418 In 2008, Orthopaedic Associates of Michigan (OAM) implemented a Bone Health Program. OAM is recognized to have one of the largest Bone Health Programs in the United States. Our mission is to provide comprehensive orthopaedic bone health care; including osteoporosis screening, diagnosis, treatment, therapy, education, and research. Additionally, the program seeks to promote bone health, reduce fracture risk, accelerate healing, and prevent subsequent fractures. This program includes a Fracture Liaison Service, coordinated by two nurse practitioners. OAM's Bone Health Program is engaged in the Own the Bone program and patient registry as a means to ensure that patients who have suffered a fragility fracture receive appropriate screening, evaluation, counseling, and treatment for their underlying osteoporosis. Our program has been successful in meeting the needs of well over 4,000 western Michigan fragility fracture patients thus far to close the gap between fragility fractures and follow up treatment. Therefore, the OAM Bone Health Program Team strongly supports and endorses the adoption of the three post-fracture measures under consideration by the NQF Endocrine Standing Committee: • NQF# 2416: Laboratory Investigation for Secondary Causes of Fracture • NQF# 2417: Risk Assessment/Treatment After Fracture • NQF# 2418: Discharge Instructions – Emergency Department The OAM Bone Health Program Team believes the performance measures outlined are necessary to encourage and support clinicians in their quality reporting when evaluating, treating, and following up with osteoporosis patients.

General Draft	Tammy Beckett, Orthopaedic Associates of Michigan; Submitted by Dr. Debra L. Sietsema, PhD, RN	National Quality Forum Attn: Endocrine Standing Committee 1030 15th Street NW Washington, DC 20005 Re: Comment on NQF Performance Measures 2416, 2417, and 2418 In 2008, Orthopaedic Associates of Michigan (OAM) implemented a Bone Health Program. OAM is recognized to have one of the largest Bone Health Programs in the United States. Our mission is to provide comprehensive orthopaedic bone health care; including osteoporosis screening, diagnosis, treatment, therapy, education, and research. Additionally, the program seeks to promote bone health, reduce fracture risk, accelerate healing, and prevent subsequent fractures. This program includes a Fracture Liaison Service, coordinated by two nurse practitioners. OAM's Bone Health Program is engaged in the Own the Bone program and patient registry as a means to ensure that patients who have suffered a fragility fracture receive appropriate screening, evaluation, counseling, and treatment for their underlying osteoporosis. Our program has been successful in meeting the needs of well over 4,000 western Michigan fragility fracture patients thus far to close the gap between fragility fractures and follow up treatment. Therefore, the OAM Bone Health Program Team strongly supports and endorses the adoption of the three post-fracture measures under consideration by the NQF Endocrine Standing Committee: • NQF# 2416: Laboratory Investigation for Secondary Causes of Fracture • NQF# 2417: Risk Assessment/Treatment After Fracture • NQF# 2418: Discharge Instructions – Emergency Department The OAM Bone Health Program Team believes the performance measures outlined are necessary to encourage and support clinicians in their quality reporting when evaluating, treating, and following up with osteoporosis patients.

General Draft	Carole Donazzolo, Orthopaedic Associates of Michigan; Submitted by Dr. Debra L. Sietsema, PhD, RN	National Quality Forum Attn: Endocrine Standing Committee 1030 15th Street NW Washington, DC 20005 Re: Comment on NQF Performance Measures 2416, 2417, and 2418 In 2008, Orthopaedic Associates of Michigan (OAM) implemented a Bone Health Program. OAM is recognized to have one of the largest Bone Health Programs in the United States. Our mission is to provide comprehensive orthopaedic bone health care; including osteoporosis screening, diagnosis, treatment, therapy, education, and research. Additionally, the program seeks to promote bone health, reduce fracture risk, accelerate healing, and prevent subsequent fractures. This program includes a Fracture Liaison Service, coordinated by two nurse practitioners. OAM's Bone Health Program is engaged in the Own the Bone program and patient registry as a means to ensure that patients who have suffered a fragility fracture receive appropriate screening, evaluation, counseling, and treatment for their underlying osteoporosis. Our program has been successful in meeting the needs of well over 4,000 western Michigan fragility fracture patients thus far to close the gap between fragility fractures and follow up treatment. Therefore, the OAM Bone Health Program Team strongly supports and endorses the adoption of the three post-fracture measures under consideration by the NQF Endocrine Standing Committee: • NQF# 2416: Laboratory Investigation for Secondary Causes of Fracture • NQF# 2417: Risk Assessment/Treatment After Fracture • NQF# 2418: Discharge Instructions – Emergency Department The OAM Bone Health Program Team believes the performance measures outlined are necessary to encourage and support clinicians in their quality reporting when evaluating, treating, and following up with osteoporosis patients.

General Draft	Jane Walker, Orthopaedic Associates of Michigan; Submitted by Dr. Debra L. Sietsema, PhD, RN	National Quality Forum Attn: Endocrine Standing Committee 1030 15th Street NW Washington, DC 20005 Re: Comment on NQF Performance Measures 2416, 2417, and 2418 In 2008, Orthopaedic Associates of Michigan (OAM) implemented a Bone Health Program. OAM is recognized to have one of the largest Bone Health Programs in the United States. Our mission is to provide comprehensive orthopaedic bone health care; including osteoporosis screening, diagnosis, treatment, therapy, education, and research. Additionally, the program seeks to promote bone health, reduce fracture risk, accelerate healing, and prevent subsequent fractures. This program includes a Fracture Liaison Service, coordinated by two nurse practitioners. OAM's Bone Health Program is engaged in the Own the Bone program and patient registry as a means to ensure that patients who have suffered a fragility fracture receive appropriate screening, evaluation, counseling, and treatment for their underlying osteoporosis. Our program has been successful in meeting the needs of well over 4,000 western Michigan fragility fracture patients thus far to close the gap between fragility fractures and follow up treatment. Therefore, the OAM Bone Health Program Team strongly supports and endorses the adoption of the three post-fracture measures under consideration by the NQF Endocrine Standing Committee: • NQF# 2416: Laboratory Investigation for Secondary Causes of Fracture • NQF# 2417: Risk Assessment/Treatment After Fracture • NQF# 2418: Discharge Instructions – Emergency Department The OAM Bone Health Program Team believes the performance measures outlined are necessary to encourage and support clinicians in their quality reporting when evaluating, treating, and following up with osteoporosis patients

General Draft	Clifford Jones, Orthopaedic Associates of Michigan; Submitted by Dr. Debra L. Sietsema, PhD, RN	National Quality Forum Attn: Endocrine Standing Committee 1030 15th Street NW Washington, DC 20005 Re: Comment on NQF Performance Measures 2416, 2417, and 2418 In 2008, Orthopaedic Associates of Michigan (OAM) implemented a Bone Health Program. OAM is recognized to have one of the largest Bone Health Programs in the United States. Our mission is to provide comprehensive orthopaedic bone health care; including osteoporosis screening, diagnosis, treatment, therapy, education, and research. Additionally, the program seeks to promote bone health, reduce fracture risk, accelerate healing, and prevent subsequent fractures. This program includes a Fracture Liaison Service, coordinated by two nurse practitioners. OAM's Bone Health Program is engaged in the Own the Bone program and patient registry as a means to ensure that patients who have suffered a fragility fracture receive appropriate screening, evaluation, counseling, and treatment for their underlying osteoporosis. Our program has been successful in meeting the needs of well over 4,000 western Michigan fragility fracture patients thus far to close the gap between fragility fractures and follow up treatment. Therefore, the OAM Bone Health Program Team strongly supports and endorses the adoption of the three post-fracture measures under consideration by the NQF Endocrine Standing Committee: • NQF# 2416: Laboratory Investigation for Secondary Causes of Fracture • NQF# 2417: Risk Assessment/Treatment After Fracture • NQF# 2418: Discharge Instructions – Emergency Department The OAM Bone Health Program Team believes the performance measures outlined are necessary to encourage and support clinicians in their quality reporting when evaluating, treating, and following up with osteoporosis patients.

General Draft	James Stubbart, Orthopaedic Associates of Michigan; Submitted by Dr. Debra L. Sietsema, PhD, RN	National Quality Forum Attn: Endocrine Standing Committee 1030 15th Street NW Washington, DC 20005 Re: Comment on NQF Performance Measures 2416, 2417, and 2418 In 2008, Orthopaedic Associates of Michigan (OAM) implemented a Bone Health Program. OAM is recognized to have one of the largest Bone Health Programs in the United States. Our mission is to provide comprehensive orthopaedic bone health care; including osteoporosis screening, diagnosis, treatment, therapy, education, and research. Additionally, the program seeks to promote bone health, reduce fracture risk, accelerate healing, and prevent subsequent fractures. This program includes a Fracture Liaison Service, coordinated by two nurse practitioners. OAM's Bone Health Program is engaged in the Own the Bone program and patient registry as a means to ensure that patients who have suffered a fragility fracture receive appropriate screening, evaluation, counseling, and treatment for their underlying osteoporosis. Our program has been successful in meeting the needs of well over 4,000 western Michigan fragility fracture patients thus far to close the gap between fragility fractures and follow up treatment. Therefore, the OAM Bone Health Program Team strongly supports and endorses the adoption of the three post-fracture measures under consideration by the NQF Endocrine Standing Committee • NQF# 2416: Laboratory Investigation for Secondary Causes of Fracture • NQF# 2417: Risk Assessment/Treatment After Fracture • NQF# 2418: Discharge Instructions – Emergency Department The OAM Bone Health Program Team believes the performance measures outlined are necessary to encourage and support clinicians in their quality reporting when evaluating, treating, and following up with osteoporosis patients.