NATIONAL QUALITY FORUM

Memo

TO: Musculoskeletal Standing Committee

FR: NQF Staff

RE: Post-Comment Call to Discuss Public and Member Comments

DA: August 18, 2014

Purpose of the Call

The Musculoskeletal Standing Committee will meet via conference call on Thursday, August 21, 2014 from 11:00 AM – 1:00 PM ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period that ended on July 31, 2014.
- The Committee will decide whether reconsideration of any measures or other courses of action is warranted.
- The Committee will vote again on measures that did not reach consensus during the initial evaluation.
- The Committee will review proposed responses to the post-evaluation comments.

Due to time constraints on the call, staff will summarize the rationale for the Committee's decision on the measure and any new information that was included in the comments. We will review comments by exception, in the case the Committee disagrees with the proposed responses.

Standing Committee Actions

1. Review this briefing memo and Draft Report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Table and additional documents included with the call materials).
3. Be prepared to provide feedback and input on proposed post-evaluation action items and comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:
Leader/Speaker Dial-In #: (877) 219-9950 (for NQF Staff/Committee Members)
Public Dial-In: (866) 251-1054
Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?399666
Registration Link: Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?399666

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the

proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from March 25, 2014 to April 14, 2014 for the 12 measures under review. A total of three pre-evaluation comments were received and pertained to the specifications for measure NQF# 0514: MRI Lumbar Spine for Low Back Pain and NQF# 0052: Use of Imaging Studies for Low Back Pain. All of these pre-evaluation comments were provided to the Committee prior to their initial deliberations held during the workgroups calls.

Post-evaluation comments

The Draft Report went out for Public and Member comment from July 2, 2014 to July 31, 2014. During this commenting period, NQF received 23 comments from seven member organizations:

Providers – 1	Health Plans – 1
Supplier and Industry – 1	QMRI – 1
Professional – 3	

Additionally, 75 comments were received from 21 members of the general public.
Comments not included in the table were submitted by:

- American College of Emergency Physicians
- University of Oklahoma

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics and/or those measures with the most significant issues that arose from the comments. Note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

We have included all of the comments that we received (both pre- and post-evaluation) in the Comment Table. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses for the Committee's consideration. Please refer to this comment table to view and consider the individual comments received and the proposed responses to each.

Comments and their Disposition

Measures for which consensus was not reached by the Committee

2549 Gout: Serum Urate Target (Trial Measure Approval)

During evaluation of the measure at the in-person meeting, the Committee did not reach consensus on a recommendation for trial measure approval. The Committee will re-vote on the measure during the Post-Comment Call. The Committee initially questioned whether the measure specifications met the Scientific Acceptability criterion, noting that urate levels may not be a reliable method of monitoring a patient with a diagnosis of gout.

Eight comments were submitted for the measure. Seven of these comments were in support of

the measure and one was not in support of the measure.

One commenter again expressed concern over urate levels being a reliable method of monitoring a patient with gout, stating that the evidence does not strongly suggest that serum urate levels correlate with the disease state. The commenter also questioned whether the 6.8 mg/dL level most is appropriate, noting that the other measures use 6.0 mg/dL.

> ***ACTION ITEM:*** After review and discussion of the comments on this measure, the Committee will re-vote on the overall recommendation for trial measure approval.

Measures recommended

0054 Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Four comments were submitted for this measure. Although one commenter noted that there is likely a minimal gap in care for this measure, all four comments were supportive of the Committee's decision to recommend the measure for continued endorsement.

2523 Rheumatoid Arthritis: Assessment of Disease Activity

Ten comments were submitted for this measure. Although nine commenters were supportive of the measure, several expressed feasibility concerns. One commenter noted that technical challenges may exist relative to collecting data for this measure from an EHR due to variations in physician office workflow and adding the necessary data element fields into the EHR. Commenters agreed that the measure is conceptually important, but were concerned about the reliability of data extractions on the assessments from EHRs.

> ***Developer response:*** "As supported by growing evidence and established practice guidelines, we believe that the assessment of disease activity is a foundational concept in quality measurement and improvement. A tight control treatment strategy aiming for remission in early rheumatoid arthritis is more effective than usual care treatment in daily clinical practice."[i]
>
> "We initially also had concerns that collecting data for this measure could present implementations challenges. However, our measures testing sites have evidenced that it is feasible to support successful workflow and data extraction from an EHR to reliably collect and report data on this measure. We tested this measure in multiple sites with multiple different EHR systems and were able to successfully and reliably test this measure. In addition, the ACR also has experience with collecting this data through our RISE registry, which pulls data directly from practice's EHR systems to calculate performance. We have been able to successfully implement this measure in our RISE registry practices. Furthermore, this is a critically important clinical concept for rheumatologists and lays the foundation for future outcomes measures in the field.
>
> To address the commenter's second concern, the measure does in fact list specific tools for measuring disease activity, which can be found in the measure specification guide, including:
>
> - Simplified Disease Activity Index (SDAI)
> - Clinical Disease Activity Index (CDAI)
> - Patient Activity Score (PAS)
> - Patient Activity Score II (PASII)
> - Routine Assessment of Patient Index Data (RAPID3)

- Modified disease activity scores with twenty-eight-joint counts (DAS 28 CRP/DAS 28 ESR)

The ACR recently undertook an extensive multi-year project, involving systematic literature reviews, expert consensus ratings, and national surveys to reach consensus on which RA disease activity measures are valid, reliable, and responsive, and feasible to implement in routine clinical practice.[ii]

The ACR-endorsed 6 RA disease activity measurement tools, which include overlapping core elements. All include a patient-reported component (PRO). No measure is currently a gold standard; there is good scientific evidence supporting each endorsed measure. Therefore, clinicians can select from a range of valid options appropriate to their practice settings and available resources. This novel approach to measurement has been extensively validated in RA over a period of several decades."[iii]

Committee response: Pending discussion

2524 Rheumatoid Arthritis: Functional Status Assessment

Nine comments were received for this measure. Commenters were generally supportive of the measure, however there were several concerns noted.

One commenter noted that feasibility may be challenging for implementation for family physicians, due to the fact that different functional status assessments are available for use.

One commenter expressed concern over the accuracy of functional assessments and their use in a quality measure. Another commenter agreed that while assessing pain and functional status with a validated tool is important, concerned was expressed that this measure may not lead to improvement in functional status as an outcome.

Developer response: "We appreciate this feedback, but maintain that functional status assessment is foundational to patient care and has been noted to be a primary concern for patients. There is strong agreement among national and international guidelines that measuring functional status is important to judge response to therapy and also to assess prognosis. We agree with the commenter that functional status does not always reflect RA disease activity; Disease activity and functional status are related, but distinct and not perfectly correlated concepts. Therefore, this measures provides an essential complement to the disease activity measure (2523: rheumatoid arthritis: assessment of disease activity) in order to capture the full spectrum of the patient's experience and provide the clinician with complete information to make evidence-based clinical care decisions."

Committee response: Pending discussion

Measures recommended for Trial Measure Approval

2522 Rheumatoid Arthritis: Tuberculosis Screening (Trial Measure Approval)

Eleven comments were submitted for this measure, all in support of the Committee's decision to recommend the measure for trial measure approval.

2525 Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy (Trial Measure Approval)

Six comments were submitted for this measure. Five comments were in support of the Committee's decision to recommend the measure for trial measure approval. One commenter suggested that the measure only include patients who accept therapy and that the provider should not fail the measure when he/she has documented the recommendations for a DMARD and patient elects to forego it. The commenter also noted concerns about exclusions, specifically patients with comorbidities that DMARDs are contraindicated or deemed excessively risky.

Developer response: "We appreciate this comment and have discussed the topic throughout our measure development and also with NQF staff. The NQF discourages using patient preference as an exclusion or exception to measures. "Merely indicating that a patient declined a service or intervention does not indicate the quality of the exchange that occurred between the healthcare provider and patient. Exclusions for patient preference (refusal) could be related to quality problems" from NQF Measure Evaluation Criteria. National Quality Forum. "CSAC Guidance on Quality Performance Measure Construction." May 2011.
We do not anticipate a 100% performance rate with this measure and plan to work with entities implementing this measure to clarify appropriate performance targets."
CY2013: 96.8%
CY2012: 86.6%
CY2011: 97.9%

Committee response: Pending discussion

2550 Gout: ULT Therapy (Trial Measure Approval)

Six comments were submitted for this measure. Five of the comments were in support of the Committee's recommendation to recommend the measure for trial measure approval. One commenter expressed concern that "this type of measure may over-emphasize pharmacologic management when dietary or education may be more effective at certain levels of serum urate".

Developer response: "In addition to the 2012 ACR Gout Guidelines, the threshold of 2 or more attacks per year was previously endorsed in the 2006 EULAR gout guidelines and 2007 British Society for Rheumatologists gout guidelines. These recommendations have been consistent across 3 separate agencies for the last decade, and we feel the threshold of 2 attacks per year should be retained.
Severe/recalcitrant and polyarticular patients are unlikely to have fewer than 2 attacks per year and therefore would already be included in the denominator population.
Nephrolithiasis in a gout patient is an ACR gout guideline indication; however, this is relatively small group of patients and ascertaining whether a stone is urate based is likely difficult to abstract from the chart."

Committee response: Pending discussion

Measures not recommended

0052 Use of Imaging Studies for Low Back Pain

Four comments were submitted for this measure; three were in support of the Committee's decision to not recommend the measure for continued endorsement.

0514 MRI Lumbar Spine for Low Back Pain

Three comments were submitted for this measure. Two comments were in support of the Committee's recommendation not to recommend the measure for continued endorsement. One

commenter requested that the Committee reconsider the measure for endorsement, and the developer has requested reconsideration of the measure.

In making its decision, the Committee agreed the measure met the Importance to measure and report criterion, but did not meet the Scientific Acceptability criterion. While the reliability of the measure was sufficient, the measure did not pass the validity criterion.

The Committee questioned the exclusions in the measure, expressing concern that patients with a history of prior back surgery and previous trauma were not among the exclusions. While there is an exclusion in the measure for patients with lumbar spine surgery in the 90 days prior to MRI, the Committee noted that history of surgery should be an absolute exclusion, rather than a 90-day exclusion, as post-operative back surgery patients cannot be categorized as uncomplicated back pain patients.

There was also concern that the inclusion of multiple data sources to identify evaluation and management (E&M) claims negatively impacted the validity of the measure. The developer noted that multiple data sources are used to identify E&M claims so as to capture a wide range of encounters.

Developer response: Pending discussion

Committee response: Pending discussion

ACTION ITEM: After review and discussion of the comments on this measure, does the Committee wish to re-vote on the measure?

0662 Median Time to Pain Management for Long Bone Fracture

One commenter and the developer have requested reconsideration of this measure for endorsement.

In making its decision, the Committee agreed the measure did not meet the Importance to Measure and Report criterion, specifically the evidence sub-criterion. While evidence provided by the developer to support the measure included studies that evaluated pain management practices for long bone fractures in the hospital emergency room, the Committee was concerned that the evidence provided by the developer did not directly support the measure focus, which is to improve the median time of pain medication administration from emergency department arrival for emergency department patients with a principal diagnosis of long bone fracture.

Committee members noted that the studies presented did not link the process of measuring and reporting the time gap between arrival and administration of pain medication for long bone fractures to improved clinical outcomes. Committee members agreed that less time to administration is likely better, but the evidence was also lacking to support a particular timeframe for treating pain in long bone fractures. It was also acknowledged that there are no clinical guidelines that support or give a particular timeframe for treatment.

Developer response: Pending discussion

Committee response: Pending discussion

ACTION ITEM: After review and discussion of the comments on this measure, does the Committee wish to re-vote on the measure?

Measures not recommended for Trial Measure Approval

2521 Gout: Serum Urate Monitoring

During evaluation of the measure at the in-person meeting, the Committee noted that no trials were cited in the evidence that establish a linkage between monitoring serum urate levels, treating to uric acid level targets and improved patient outcomes. Although the Committee agreed that there was an opportunity for improvement in the management of gout, the Committee agreed the measure would have a low impact and the measure did not pass Importance to Measure and Report.

Twelve comments were submitted for this measure. Two commenters agreed with the Committee's decision not to recommend the measure for Trial Measure Approval.

Commenters against the Committee's decision argued that "there is good evidence that achieving a serum urate level <6 mg/dl is associated with a marked reduction in gout flares and disappearance of tophi. Commenters noted that "serum urate monitoring will detect intentional and unintentional medication non-adherence by patients, giving clinicians the opportunity to reinforce education about gout treatment, and will give clinicians important goals for treatment that will improve outcomes for people with gout". Other comments included "the vast majority of gout patients started on ULT do not have a repeat serum urate assessed and without titrating ULT to the dose necessary to achieve the therapeutic target, patients will be left suboptimally treated, with ongoing complications from gout".

> ***Committee response: P e n d i n g d i s c u s s i o n***

2526 Gout: Anti-inflammatory Prophylaxis with ULT Therapy

Eleven comments were submitted for this measure. Two commenters agreed with the Committee's decision not to recommend the measure for Trial Measure Approval .

One commenter noted that "there are a large number of anti inflammatories that would serve to prophylaxis against gout attack while starting or increasing urate lowering therapy. There are a number of different glucocorticoid prepartations, large number of NSAIDS not to mention colchicine. Would need to be very broad in the number medications acceptable to meet the measure."

> ***Developer response:*** " We appreciate the feedback and agree that there needs to be a variety of medications that meet the measure. As a result, we have provided an expansive list of medications in the measure specifications."

One commenter stated that "this is an appropriate measure since flare risk is higher when initiating ULT; provision of anti-inflammatory prophylaxis will reduce that risk (i.e., prevent flares), thereby improving patient adherence to ULT. Duration of prophylaxis upon initiation of ULT is dependent upon disease activity (flares, tophi), but should be for at least 6 months in the uncomplicated case with appropriate disease control."

> ***Developer response:*** " We appreciate the stated support for this measure; we chose not to dictate the durations of prophylaxis as, although there are data supporting the use of prophylaxis when initiating urate lowering therapy, there are fewer data guiding the specific duration of the prophylaxis. Therefore, we propose this measure as an important first step in increasing evidence-based practice through the use of

prophylaxis and will refine the measure as evidence becomes available to define best practice regarding the duration of prophylaxis."

One commenter stated that "this is a reasonable quality measure but need to include some sense of a timeframe around initiation of ULT - it says this is for patients "initiated on ULT" but after a period of time (e.g. 6 months), the patient may no longer need prophylaxis, so it might be good to qualify this as pertaining to patients "during the first 3-6 months of ULT" or something to that effect."

> ***Developer response:*** **"** We appreciate your feedback and have timing specifications for the initiation of ULT. After initiating urate lowering therapy, there is an increased rate of acute gout flares for several months. From recent randomized control trials, where prophylaxis was continued for only 8 weeks, 40% of patients flared upon cessation of prophylaxis, whereas if prophylaxis was continued for 6 months, only 5% of patients flared. In a small randomized control trial using colchicine vs. placebo, patients assigned to colchicine had fewer flares at 0-3 and 3-6 months (0.57 and 0 flares) vs. patients assigned to placebo (1.91, 1.05 flares), both differences statistically different."

Appendix A

Letters received

[i] Dutch Rheumatoid Arthritis Monitoring, Ann Rheum Dis, 2012) (Smolen JS et al., Ann Rheum, 2010) (Grigor C et al., Lancet, 2004) (Singh J et al. 2012, Arthritis Care Res, 2012) (Smolen JS et al., Ann Rheum, 2014) (Smolen J et al., Ann Rheum, 2010) (National Institute for Clinical Excellence (NICE). Rheumatoid arthritis: The management of rheumatoid arthritis in adults: NICE clinical guidance, 2009) (van Hulst LT, Fransen J, den Broeder AA, et al., Ann Rheum, 2009) (Anderson J et al., Arthritis Care Res (Hoboken), 2012.

[ii] Anderson J et al., Arthritis Care Res (Hoboken), 2012.

[iii] Anderson J et al., Arthritis Care Res (Hoboken), 2012.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

July 31, 2014

Roger Chou, MD, FACP (Co-Chair)
Kim Templeton, MD (Co-Chair)
Musculoskeletal Standing Committee
National Quality Forum
1030 15th Street NW, Suite 800
Washington DC 20005

RE: NQF #0662 (OP-21): Median Time to Pain Management for Long Bone Fracture

Dear Drs. Chou and Templeton:

On behalf of the 33,000 members of the American College of Emergency Physicians (ACEP), we greatly appreciate the opportunity to provide comments in support of the re-endorsement of NQF *Measure #0662 (OP-21): Median Time to Pain Management for Long Bone Fracture*. With nearly 2 million emergency department (ED) visits for long bone fractures presenting each year, we implore the National Quality Forum to re-consider and re-evaluate this measure.

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Firstly, the importance, evidence and performance gap for OP-21 has already been well established. Not only by the Oklahoma Foundation for Medical Quality (OFMQ) and Centers for Medicaid and Medicare multi-stakeholder Technical Expert Panels, but also by a National Quality Forum Steering Committee in 2011. Since that time the NQF evidence criterion has not substantially changed, nor has any conflicting evidence been published since that time. In fact, a more recent study published in 2013 in the *Annals of Emergency Medicine*, researchers noted "previous studies have shown that there may be inadequate pain management among patients with long bone fracture (LBF) presenting to the ED. **Certain patient populations, especially pediatric (<18 years) and geriatric (65 years), may be unable to communicate their needs effectively; as a result, these patient groups may not be receiving appropriate pain management in the ED**."[1] In another correlational study using patient data from 2 major urban medical centers, which was published in 2012 it was also demonstrated that 36% of patients received no medication while in the emergency department despite a mean pain score of 6.9 (SD = 2.5) on a 0 to 10 scale representing moderate to severe pain.[2] Patients who received pain medication waited for the medication an average of 1.76 hours. Among the patients who received an analgesic, younger patients, black patients, and those with higher pain severity were more likely to receive inadequate pain management than were white patients. Although the practice of prescribing pain relief for LBF pain has improved in recent years, these data indicate that more progress is needed.

With an urgent need for additional measures for the Physician Quality Reporting System (PQRS) ACEP's Quality Measures (QMs) Technical Expert Panel (TEP), which is a collaborative between ACEP, the American Board of Emergency Medicine (ABEM), and the Emergency Medicine Action Fund (EMAF), began evaluating potential measure concepts in May of 2013. When the TEP first convened on May 22, 2013, they reviewed over 90 potential measure concepts and only one concept received a 100% approval rating: OP-21/NQF # 0662.

Domain	Patient Safety & Clinical Effectiveness Measures	TEP Acceptability (%)
Care Coordination	OP 21: Median Time to Pain Management for Long Bone Fracture	100%

In July of 2013, the ACEP QMs TEP further evaluated the concept for congruence with the following NQF criteria and again OP-21 received the highest ranking of all 30 measures that were evaluated in detail.

Measure	Overall Average	Importance: 1=very important, 5=not important		Performance Gap: 1=significant gap, 5=no gap		Actionability: 1=completely actionable, 5=not actionable		Mean Of Means
Care Coordination		**Mean**	**Median**	**Mean**	**Median**	**Mean**	**Median**	
OP 21: Median Time to Pain Mgmt for Long Bone Fracture	1.9	1.65	1	2.25	2	1.85	2	1.917

In August 2013, the measure was again ranked the highest for overall approval.

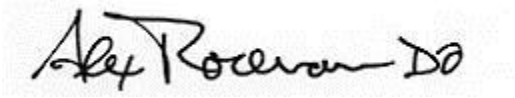
Measure Name	Support (Yes : No)
1. OP 21: Median Time to Pain Management for Long Bone Fracture	19:0

In September of 2013, the ACEP Board also reviewed and approved this measure as appropriate and important to emergency care. In January of 2014 the ABEM Board also approved this measure for Maintenance of Certification Part IV activities. During this time the NQF Measures Application Partnership (MAP) Clinician Workgroup and Coordinating Committee also reviewed and approved this measure for PQRS reporting. Finally, fully confident that this measure would fulfill all NQF criteria for a quality measure, as well as PQRS program criteria, and MOC Part IV criteria, ACEP approached CMS and OFMQ for the re-tooling of this measure for physician level reporting for 2015, and their plans are currently underway.

Although timeliness and pain management may not be the primary outcomes of interest for other measures under evaluation by the Musculoskeletal Standing Committee, the NQF has numerous endorsed measures that address both. In fact, because of the nature of emergency care, most measures of ED quality have a timeliness component, and timeliness remains an important domain of care as defined by the IOMs *Crossing the Quality Chasm* report in 2001. Pain assessment and pain management also remains a high priority for the Medicare population as noted by CMS focus on this area in the PQRS, the Outpatient Quality Reporting (OQR) program, and the Inpatient Quality Reporting (IQR) program. We hope you agree.

ACEP echoes the measure steward's support for re-endorsing this measure. The emergency medicine community is committed to meaningful quality metrics and is hopeful that this measure will be re-evaluated and re-endorsed. Thank you for your leadership in promoting the highest quality of emergency care.

Sincerely,



Alex M. Rosenau, DO, CPE, FACEP
President

References/Attachments:

1. Boccio E, et al. The Relationship Between Patient Age and Pain Management of Long Bone Fracture in the Emergency Department. *Ann Emerg Med* 2013 S127; 62 (48).
2. Minick, et al. Long-bone fracture pain management in the emergency department. *J Emerg Nurs* 2012;38:211-7.
3. ACEP Quality Measures Technical Expert Panel Roster 2013

ACEP
Quality Measures (QMs) Technical Expert Panel (TEP)
2013 Roster
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The University of Oklahoma
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COLLEGE OF PUBLIC HEALTH

July 28, 2014

Helen Burstin, MD, MPH
Senior Vice President
Performance Measures
National Quality Forum
1030 15th Street NW, Suite 800
Washington DC 20005

RE: NQF 0662 Median Time to Pain Management for Long Bone Fracture Musculoskeletal Project

Dear Dr. Burstin:

I am writing a letter asking for re-consideration of the recent vote on May 8, 2014 of the Musculoskeletal Standing Committee against the re-endorsement of NQF Measure 0662, "Median Time to Pain Management for Long Bone Fracture." I was surprised that the measure was discussed as part of the portfolio of musculoskeletal measures when all of the other emergency department (ED) performance measures that focus on timely delivery of care (NQF 0495, 0496, and 0497) are being evaluated in the Care Coordination Measures project. This measure on time to pain management for ED patients with long bone fractures specifically focuses on the coordination and timely delivery of care to ED patients and should have been evaluated as part of the Care Coordination Measures project.

When the Committee met on May 8th there were two primary reasons the measure was not recommended for full discussion and re-endorsement:[1]

1. *The Committee cited a lack of evidence linking the process of care to defined patient outcomes;*
   Response: Numerous studies have demonstrated that pain is often inadequately managed in the ED.[2-5] Pain management is an important component of patient-centered care and patient experience of care. Recent studies continue to demonstrate inadequate and delayed pain management in EDs with the youngest and oldest patients at greatest risk of inadequate pain management.[6-8]

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2. *The Committee highlighted a lack of exclusion in the measure for patients who potentially have a health condition that could be exacerbated by the administration of pain medications.*
   Response: This concern is not relevant to the performance measure. Because this performance measure focuses on the "median time to pain management" patients who do not receive pain medications cannot be included in the calculation of the median time.

Because the measure did not make it past the discussion of the evidence criterion and the vote, the measure was not considered further by the committee.

This performance measure on time to pain management for patients with long bone fractures was developed, with extensive input from representatives of the American College of Emergency Physicians (ACEP), as a part of a group of measures targeting efficiency of care in the ED. The fact that the measure happens to focus on patients with long bone fractures was made after lengthy discussions with the ED technical expert panel that we had assembled:

- Few would argue that most patients with long bone fractures need pain management. While any number of conditions could have been considered, the ED TEP felt that we could clearly define the denominator population for the measure by targeting only those patients who presented to the ED with a long bone fracture;
- When the measure was initially developed we had concern of the potential unintended consequence that patients who were seeking opioid medications might come into EDs knowing that there was a performance measure targeting timely management of pain. However, the technical expert panel felt that limiting the metric to those patients with long bone fractures would prevent this unintended consequence (it would be a rare patient who would break a long bone in an effort to seek opioid medications).

This measure was previously endorsed by an NQF committee focusing on efficiency measures along with the additional ED measures of timely throughput of patients. Again I was surprised that the measure was considered as a part of the Musculoskeletal Project since the fact that the metric was targeting long bone fractures was only for the convenience of defining a denominator population of patients for whom pain management is almost always warranted.

Approximately 4 million patients present to the ED each year in the United States with fractures.[9] In the most recent evaluation of the Hospital Outpatient Quality Reporting (HOQR) Program data, approximately 3200 hospitals reported data on pain management for more than 330,000 patients with long bone fractures in 2013. While the "benchmark" hospitals currently administer pain medications to patients with long bone fractures within 33 minutes (median time) of hospital arrival, the national average performance for all reporting US hospitals is 54 minutes (median time). In my recent conversations with representatives from ACEP, they continue to support this measure (and are in the process of developing a PQRS measure to mirror the HOQR measure). I am copying colleagues from the Centers for Medicare & Medicaid Services as I believe they continue to strongly support NQF 0662 as an important measure of efficiency and patient-centered care. It would seem appropriate to re-evaluate this performance measure as a part of the Care Coordination Measures project along with the other ED measures that focus on timely delivery of care in this setting.

I would be happy to provide additional information if requested. Don't hesitate to contact me if you have any questions. Thanks for consideration of this request.

Sincerely,

Dale W. Bratzler

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Professor and Associate Dean

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