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Comments on the Second Draft Report: Patient Safety Measures

Comment Number	Submitter	Organization	Member Council/ Public	Comment Type/ Measure Name	Comments
3	Ms. Tanya Alteras, MPP	National Partnership for Women & Families	Consumer	Comments on the general draft report	The Consumer-Purchaser Disclosure Project appreciates the opportunity to provide comments to NQF on the second set of patient safety measures currently being recommended for endorsement. Overall, we are very disappointed with the five measures that are now out for comment. Regarding the three colonoscopy measures, we feel that these reflect standard-of-practice activity, and that the NQF endorsement process should not be a means of enforcing basic standards. Standards related to colonoscope cleanliness and reprocessing guidelines should be certainly be enforced, but through other oversight and accreditation bodies, not through the quality measurement enterprise. The bigger question here is where does this type of measurement activity end? If NQF endorses these types of colonoscope measures in the name of patient safety, does that open the door to discrete measures for every type of medical equipment used in practice for which special training and guideline updates are the norm? Regarding the two radiation dosing measures, it is not clear how these passed the importance test, given the statements in the report that radiation indices are not reflective of actual radiation dosing. Further, it is unclear how these measures would be useful to consumers, purchasers or other stakeholders, without a better sense of what the radiation index means for patient safety. Overall, while the first set of infection measures to come out of this project added value to the patient safety portfolio, we do not believe that the measures being recommended for endorsement in this second phase of the project meet the high bar that NQF endorsement represents.
8	Ms. Samantha Burch	Federation of American Hospitals	Provider	Comments on the general draft report	The FAH appreciates the opportunity to comment on the five Patient Safety Measures in the 2ndReport recommended for endorsement by the steering committee. We are generally concerned that these five measures will not strengthen the NQF portfolio and do not meet the evaluation criteria for endorsement. We have provided specific comments on each of the measures that further outline our concerns.

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12	Ms. Maureen Dailey, DNSc, RN	American Nurses Association	Health Professionals	Comments on the general draft report	The Steering Committee advocated for the creation of broader medication safety measures with far reaching impact on patient health outcomes (line 502-503, pg. 21). The American Nurses Association (ANA) respectfully submits the following comments: Medication safety in computer provider order entry (CPOE) has been noted to be problematic to clinicians without adequate training on the health care professional team (e.g., e.g., physicians, nurses), which may negatively impact patient safety outcomes (i.e., may increase errors of omission and commission related to lack of evidence-based practice) ANA supports the development of broader cross-cutting medication safety measures as identified by the Steering Committee in the Additional Comments section (line 510-511)
13	Ms. Rabia Khan, MPH on behalf of Michael Rapp	Centers for Medicare and Medicaid Services	Purchaser	Comments on the general draft report	I agree with the Committee that cross cutting measures for medication safety are needed and more measures are needed for perinatal care.
18	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	Comments on the general draft report	On behalf of our more than 5,000 member hospitals and health systems the American Hospital Association (AHA) appreciates the opportunity to comment on the National Quality Forums (NQF) National Voluntary Consensus Standards for Patient Safety Measures, Second Report. We commend the NQF for recognizing the importance of ensuring proper protocols around colonoscopy equipment and consideration of dosing levels associated with certain imaging services. We are not providing specific comments on the colonoscopy measures because the denominator population does not include patients seen in hospitals. The measure developer specifically noted that these measures only apply to patients in ambulatory surgical centers and office-based practices. We have included specific comments on the imaging services below.

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25	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	Comments on the general draft report	Finally, we wanted to support a recommendation made by the SC regarding the overall NQF consensus development process. The report states: Committee members challenged the current way of thinking about quality improvement by placing measures within a certain spectrum related to their intended use or their relevance for different objectives within health care. The Committee suggested categorizing measures into classes or tiers base on their place in this spectrum. For instance, standards could be split into three groups: 1) measures suitable for public accountability and reporting; 2) measures geared towards quality improvement; and 3) practice guidelines, or baseline standards of care. The Steering Committee recommends further study of this idea and possible development of a framework or system for classifying measures. We support the notion that different measures may be useful for different purposes and we echo the Steering Committees recommendation that NQF develop a framework for classifying measures.
29	Dr. Mark S. Antman, DDS, MBA on behalf of Ardis D. Hoven, MD	American Medical Association	Health Professional	Comments on the general draft report	The American Medical Association (AMA) appreciates the opportunity to comment on the National Quality Forums (NQF) National Voluntary Consensus Standards for Patient Safety Measures, Second Report: A Consensus Report. As we have noted previously, the AMA strongly believes in improvements in patient safety. The development of performance measures for patient safety is an important step in improving patient care and in ensuring adverse events are minimized.
35	Ms. Carmella Bocchino, MBA, RN	America's Health Insurance Plans	Health Professional	Comments on the general draft report	Thank you for the opportunity to provide comments on the NQF Patient Safety Measures, 2ndReport. We support NQFs efforts to advance the measurement of patient safety and focus specifically on patient outcomes. We recognize that preventable medical errors represent a significant public health concern and cost to the U.S. health care system and appreciate efforts to promote measures that focus on these key areas.

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4	Ms. Tanya Alteras, MPP	National Partnership for Women & Families	Consumer	PSM-014-10: Colonoscope Processing Personnel Instruction	The three colonoscope measures reflect activity that should be standard of practice, and at the very most, may be appropriate for internal quality improvement. While the goal of reducing the rates of viral infection associated with colonoscopy is certainly one that we support, we do not feel that the best method of doing so, within the quality enterprise, is by endorsing structural measures of whether an office or Ambulatory Surgery Center a) receives colonoscope operating instruction updates annually, b) reviews colonoscope device reprocessing guidelines annually; or c) documents that their staff are competent at reprocessing colonoscopies and/or changes made in the equipment or recommendations. As noted in the report, issues of adherence to training and cleaning guidelines are more appropriately addressed through state and medical licensing bodies. When we consider measures for NQF endorsement, we must consider whether we believe the measures should be linked to public reporting or payment programs, and in this case, we believe the answer is no. In addition, these measures are yet further removed from evidence-based linkage to outcomes; they are not even measuring adherence to cleanliness and equipment sterilization standards, but, rather, whether proper training has taken place.
9	Ms. Samantha Burch	Federation of American Hospitals	Provider	PSM-014-10: Colonoscope Processing Personnel Instruction	The FAH believes that patient safety related to colonoscopy is an important area to focus on, however, we are concerned that the three colonoscope measures fall more within the purview of compliance with accreditation standards and are not true quality measures. If the research shows a concrete, scientific link between colonoscope reprocessing and viral infections (which would be helpful to have had presented in more detail in the report), we believe it would be more appropriate to seek development of a measure with a stronger focus on outcomes rather than create dual tracking of standard practices. We believe these measures illustrate the reason why we have accreditation standards in place and we do not support them as quality measures. We are further concerned, based on the discussions of the Steering Committee, that endorsement of these measures could open the door to similar accreditation-style measures for other devices. We believe this is the wrong approach to promoting quality improvement.

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14	Ms. Rabia Khan, MPH on behalf of Michael Rapp	Centers for Medicare and Medicaid Services	Purchaser	PSM-014-10: Colonoscope Processing Personnel Instruction	The following comments refer to all of the Colonoscope measures: It is a great topic area, as it is high cost and high volume to Medicare. The data source for these measures is problematic, because they rely on survey methods or self reporting by the provider. Surveys only capture a snapshot in time. Capturing all of the requirements of the measures would be burdensome, especially to ASCs who have limited resources and staff. According to line 215, it appears that reprocessing standards may not exist to the extent that facilities or individual providers can be held accountable. Are there evidenced-based guidelines developed by specialty societies that can work together to create these standards? Not all facilities use the same scopes/equipment to do their procedures. Therefore, each individual manufacturer specifications would need to be taken into account, as they would more than likely have their own maintenance recommendations. Time-limited endorsement is appropriate in order to facilitate collection of feasibility and testing data in the ASC and office settings, and provide data on variation and opportunity for improvement.
26	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	PSM-014-10: Colonoscope Processing Personnel Instruction	We are not providing specific comments on the colonoscopy measures because the denominator population does not include patients seen in hospitals. The measure developer specifically noted that these measures only apply to patients in ambulatory surgical centers and office-based practices.

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30	Dr. Mark S. Antman, DDS, MBA on behalf of Ardis D. Hoven, MD	American Medical Association	Health Professional	PSM-014-10: Colonoscope Processing Personnel Instruction	Measures PSM-014-10 and PSM-015-10 are being put forward as appropriate for accountability at all level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at higher levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that the measure developer remove can be measured at all levels from the level of analysis.
37	Ms. Carmella Bocchino, MBA, RN	America's Health Insurance Plans	Health Plan	PSM-014-10: Colonoscope Processing Personnel Instruction	NQF should consider whether this measure may be more appropriate as a guideline for processing personnel, as it may have the unintended consequence of causing centers that currently provide more frequent instructions to drop back the frequency to annual.
42	Ms. Carmella Bocchino, MBA, RN	America's Health Insurance Plans	Health Plan	PSM-014-10: Colonoscope Processing Personnel Instruction	General Comments on Proposed Colonoscope Measures We request that additional clarification be provided on whether these measures intend to be reported as a composite. Additional clarification is also needed on how these measures align with existing accreditation standards, for both the ambulatory care and office-based settings. It would be helpful for NQF to request that the developer provide greater clarity with respect to the feasibility of implementing the three Colonoscope measures, particularly as to the Committees request for clarification regarding the differences between existing standards required as part of ambulatory surgical centers accreditation process and these proposed performance metrics.

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27	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	PSM-015-10: Colonoscope Processing Currency	We are not providing specific comments on the colonoscopy measures because the denominator population does not include patients seen in hospitals. The measure developer specifically noted that these measures only apply to patients in ambulatory surgical centers and office-based practices.
31	Dr. Mark S. Antman, DDS, MBA on behalf of Ardis D. Hoven, MD	American Medical Association	Health Professional	PSM-015-10: Colonoscope Processing Currency	Measures PSM-014-10 and PSM-015-10 are being put forward as appropriate for accountability at all level. While these measures address important areas of care, we cannot support them as accountability measures at the clinician level to be used for public reporting. There are other factors beyond the care directly provided by clinicians, including the efforts of other health care professionals that would affect the care of those patients who would be impacted by these measures. We believe that performance measures are only appropriate at the clinician level when it has been consistently shown that the measure is directly dependent on the clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care a clinician provides. Accordingly, this type of measure is best represented at higher levels of data collection or aggregation. Reporting of these measures at higher levels of collection or aggregation does not take away from their value to individual clinicians and others who are part of the team of care. We recommend that the measure developer remove can be measured at all levels from the level of analysis.
38	Ms. Carmella Bocchino, MBA, RN	America's Health Insurance Plans	Health Plan	PSM-015-10: Colonoscope Processing Currency	Given the evidence showing the potential for a colonoscope to carry contaminates, processing currency of the colonoscope needs to be carefully monitored. As this measure has received time-limited endorsement, it would be important to ascertain the correlation of infections and perforations in relationship to the measurement score.
28	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	PSM-016-10: Colonoscope Processing Competency	We are not providing specific comments on the colonoscopy measures because the denominator population does not include patients seen in hospitals. The measure developer specifically noted that these measures only apply to patients in ambulatory surgical centers and office-based practices.

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39	Ms. Carmella Bocchino, MBA, RN	America's Health Insurance Plans	Health Plan	PSM-016-10: Colonoscope Processing Competency	The measure specifications need to clarify the process for which reprocessing personnel at ambulatory surgery centers and office based practices are documented to be competent at reprocessing. More specifically, the specifications should define who determines competency (these specifications are presumably the ones used in the 2010 Colonoscopy Study of the AAAHC, but they should be specified here).
1	James A. Brink, MD	Yale Diagnostic Radiology	Public	PSM-043-10: Participation in a Systematic National Dose Index Registry	Commonly used dose indices (CTDIvol and DLP) are measures of the radiation output of the CT scanner, not the radiation dose absorbed by an individual patient. These measures vary greatly according to body habitus. A large person is expected to have values that are much greater than a small person. When analyzed for a large group of people, variations based on body habitus are averaged, and meaningful comparisons can be made. Similarly, estimates of the effective dose human beings rely on conversion factors that are applied to these measures of machine output and generate a dose estimate for a standard size human, not for a specific patient. Thus, I support measure PSM-043-10 (Participation in a Systematic National Dose Index Registry) as it reflects the population-basis of these measures. I also support measure PSM-044-10 (Radiation Dose of Computed Tomography) so long as it is made clear that the reported measures are not indicative of the dose absorbed by an individual patient.
5	Ms. Tanya Alteras, MPP	National Partnership for Women & Families	Consumer	PSM-043-10: Participation in a Systematic National Dose Index Registry	It is unclear what value this measure would add to the NQF portfolio as currently described in the report or in the measure submission form. The report notes (in line 264) that dose indices are not directly related to the amount of radiation absorbed by patients, which begs the question of why being able to compare dose index levels will be useful to consumers, purchasers, or providers. We would appreciate NQF explaining in greater detail how being able to compare and benchmark CT dosing levels which is the argument for why this measure is important -- will lead to patient safety improvements related to radiation absorption. We ask that the pre-voting report from this committee discuss this with more clarity and detail so that consumer and purchaser members can make an informed voting decision.

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7	Stephen Vastagh on behalf of David Fisher	Medical Imaging & Technology Alliance	Public	PSM-043-10: Participation in a Systematic National Dose Index Registry	National Quality Forum Public Comments Docket -Submitted via the NQF Web Portal Re: Support of PSM-043-10: Participation in a Systematic National Dose Index Registry The Medical Imaging Technology Alliance (MITA), a division of the National Electrical Manufacturers Association (NEMA), is the collective voice of medical imaging and radiation therapy equipment manufacturers, innovators, and product developers, including companies that manufacture x-ray, computed tomography (CT), diagnostic ultrasound, nuclear medicine, magnetic resonance imaging (MRI), and medical imaging informatics equipment. CT manufacturers have developed a new standard for an important new dose notification feature, the CT Dose Check Standard (http://www.nema.org/stds/xr25.cfm#download). The availability of dose index data assists the hospitals and other providers in the implementation and utilization of this feature. Further, MITA also manages the DICOM Standard, the international standard for the communication of digital images and related data. The DICOM standard includes provisions for the reporting of dose index data; dose index databases facilitate the utilization of data recorded to the DICOM reporting specifications. Therefore, MITA supports the Systematic National Dose Index Registry proposal by ACR. Sincerely, Dave Fisher Executive Director
10	Ms. Samantha Burch	Federation of American Hospitals	Provider	PSM-043-10: Participation in a Systematic National Dose Index Registry	The FAH is unclear how, with a focus on dose indices and not the amount of radiation absorbed, this measure would provide useful information to clinicians, hospitals, or patients. Further, the FAH continues to be concerned about introducing additional check the box measures that track only participation in a given type of registry. While participation in a registry could lead to quality improvement, we believe it is misleading to consumers to suggest that registry participation is an absolute indication of quality. Hospitals use a variety of methods for tracking their performance and improvement, including internal data capture and analysis within their institution. With the implementation of electronic health records, hospitals will greatly increase their capacity to do much of the measurement and analysis that registries perform today.

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15	Ms. Rabia Khan, MPH on behalf of Michael Rapp	Centers for Medicare and Medicaid Services	Purchaser	PSM-043-10: Participation in a Systematic National Dose Index Registry	This measure supports decreased radiation levels and improved quality of images that facilitate successful interpretation and diagnosis both patient safety issues. Feasibility for this measure is strong, supported by electronic image archiving and communication by most radiology practices. This is an attestation measure, indicating whether the reporting facility participates in a national dose index registry or standard data collection program, similar to the national registry of the ACR, which will be ready for use mid-late 2011. Specifications state this data would come from the medical record, is this something that is normally recorded in the medical record?
24	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	PSM-043-10: Participation in a Systematic National Dose Index Registry	Though we recognize the need to collect imaging procedure dosing data, we do not support a quality measure for participating in a national dose registry. Participation in a dose registry is not tightly linked to improving quality and patient care. For many quality measures, such as providing beta-blockers upon discharge to heart attack patients, there is a great deal of scientific evidence that providing that particular process of care can improve patient outcomes. The dose registry participation measure fails to meet that standard. There is no established connection between whether provider answers yes or no to registry participation measures and the quality of the care provided.
32	Dr. Mark S. Antman, DDS, MBA on behalf of Ardis D. Hoven, MD	American Medical Association	Health Professional	PSM-043-10: Participation in a Systematic National Dose Index Registry	The AMA is in support of a measure, such as this, that recommends that facilities which utilize imaging technology participate in a national dose index registry. However, as we have stated elsewhere, it is important to distinguish between the overuse of imaging from instances when there is a true necessity to re-image. Measures related to the use of imaging technologies should provide a means for clinicians and other healthcare professionals to distinguish between these two. We caution that the omission of opportunities to distinguish necessity and medical judgment can lead to undue punitive actions against clinicians and other healthcare professionals.

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2	James A. Brink, MD	Yale Diagnostic Radiology	Public	PSM-044-10: Radiation Dose of Computed Tomography (CT)	Commonly used dose indices (CTDIvol and DLP) are measures of the radiation output of the CT scanner, not the radiation dose absorbed by an individual patient. These measures vary greatly according to body habitus. A large person is expected to have values that are much greater than a small person. When analyzed for a large group of people, variations based on body habitus are averaged, and meaningful comparisons can be made. Similarly, estimates of the effective dose human beings rely on conversion factors that are applied to these measures of machine output and generate a dose estimate for a standard size human, not for a specific patient. Thus, I support measure PSM-043-10 (Participation in a Systematic National Dose Index Registry) as it reflects the population-basis of these measures. I also support measure PSM-044-10 (Radiation Dose of Computed Tomography) so long as it is made clear that the reported measures are not indicative of the dose absorbed by an individual patient.
6	Ms. Tanya Alteras, MPP	National Partnership for Women & Families	Consumer	PSM-044-10: Radiation Dose of Computed Tomography (CT)	We have similar concerns with this measure as we do with PSM-043-10, and would like more explanation as to why measuring the radiation dosing index would be meaningful to consumers and purchasers, given the statement in the report about lack of relationship between the index quantity and how much radiation is absorbed by patients. We are supportive of the measure developer's statement, noted in the report on line 323, that transparency around dosing information is important for fostering accountability and driving improvement. But as currently described in the report, we do not see how this measure achieves that goal.
11	Ms. Samantha Burch	Federation of American Hospitals	Provider	PSM-044-10: Radiation Dose of Computed Tomography (CT)	The FAH reiterates our concerns related to the usefulness of this measure to providers and patients as, per the report, dose indices are not directly related to the amount of radiation absorbed by the patient. This is an area where additional clarification would be extremely useful prior to voting on these measures.

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16	Ms. Rabia Khan, MPH on behalf of Michael Rapp	Centers for Medicare and Medicaid Services	Purchaser	PSM-044-10: Radiation Dose of Computed Tomography (CT)	Who would this measure be attributable to? Would it be the ordering physician or the radiology tech that performs the scan? Is it normal practice to record the data elements required for the measure? A minimum sample size (number of scans for adults and children) is needed; therefore, the measurement period for the numerator will vary depending on the facility. Also, the measure addresses dose indices rather than dose levels sustained by the patient. An advantage is the increased transparency regarding dosing and accountability for improvement at the facility level. Also, the measure facilitates aggregate data collection and public reporting, and feedback and comparison by facilities to regional and national practices.
19	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	PSM-044-10: Radiation Dose of Computed Tomography (CT)	AHA fully supports measuring radiation doses associated with imaging services. However, we have several concerns with the current construct of this measure concept. We request that the Steering Committee (SC)/measure developer provide more detailed information on the typical range of radiation associated with each of the CT procedures (head, chest, abdomen/pelvis and lumbar spine). Since the measure is currently based on a sample of these procedures, it is critical to understand the range of dosing associated with each type of procedure. Oversampling of one type of procedure may make a particular facility look like an outlier when in fact the problem is over-sampling of a higher dose procedure.
20	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	PSM-044-10: Radiation Dose of Computed Tomography (CT)	We request that the measure developer provide more detail on the testing process this measure has endured. The measure application states that the measure is fully developed and tested, but neither the report nor the measure application provide any additional details. How many facilities was the measure tested in? What types of facilities was the measure tested in? Further, the report states that minimum sample size for this measure to generate sufficient accuracy for adults is 100 scans and the minimum sample size for children is 50. How were these numbers derived? Why is the minimum threshold for these populations so different?

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21	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	PSM-044-10: Radiation Dose of Computed Tomography (CT)	The absence of benchmarking information available for this measure is problematic. The report states the measure will lead to the creation of diagnostic reference levels, this will lead to dose awareness and inevitable improvements as it will enable physicians to consider dose as an important measure. The report also states absence of widely published guidelines for acceptable ranges of dose in the US would make it difficult for an institution to know if they are doing well in minimizing this important harm of CT. These two statements from the measure developer speak volumes about the measures readiness for improving patient care. The purpose of measurement is to address gaps in care delivery. Without clearly established diagnostic reference levels, providers will not know if a modification in his/her ordering/rendering of CT scans is warranted. The report states this measure is initially proposed for internal quality efforts, and thus reduction in average doses over time is the goal. Reduction to what dose level? Over what time period?
22	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	PSM-044-10: Radiation Dose of Computed Tomography (CT)	In addition to the concerns raised above, we were limited in the feedback we are able to provide because the documentation did not include a reference to the detailed measure specifications. Further, the report states that if a multi-phase study is done, the doses will be higher than if a single-phase study is done. This seems like a situation in where a measure exclusion would be warranted, but we cannot tell of if this step is built into the measure without access to the detailed measure specifications.
23	Ms. Lisa M. Grabert, MPH on behalf of Nancy Foster	American Hospital Association	Provider	PSM-044-10: Radiation Dose of Computed Tomography (CT)	Finally, the measure application form does not include enough information on the burden associated with collection of this measure. The report states a busy facility center can abstract data on scans that were conducted over a few days to have sufficient sample size, whereas smaller centers may compile date from a month, 6 months or a year to generate sufficient data within each anatomic area/age/machine type category. We are very concerned that this measure may be overly burdensome for small and rural providers. Further, the report states the costs should be minimal. How does the developer define minimal? We request additional detailed information on the actual cost of implementing this measure.

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33	Dr. Mark S. Antman, DDS, MBA on behalf of Ardis D. Hoven, MD	American Medical Association	Health Professional	PSM-044-10: Radiation Dose of Computed Tomography (CT)	The AMA has previously recommended that patients have a radiation exposure record similar to a vaccination and thus we are in support of this measure. However, we believe that in addition to efforts to track patient exposure to radiation on the part of clinicians and other healthcare professionals, it is important that manufacturers of imaging technologies collaborate to achieve uniformity through calibration standards. Such uniformity on the part of manufactures will reduce variability in patient exposure to radiation and will make the assessment of patient exposure more systematic.
34	Ms. Judy Burleson	American College of Radiology	Health Professional	PSM-044-10: Radiation Dose of Computed Tomography (CT)	The ACR supports the concept of measure PSM-044-10 Radiation Dose of Computed Tomography (CT), in that it encourages acquiring and analyzing radiation dose levels associated with CT procedures. This addresses a real safety concern and is a step forward in reducing variation of the dose indices associated with CT and ultimately unnecessary exposure to ionizing radiation. Using this measure and the resulting data in local quality improvement programs can enable facilities to optimize dose levels. However, the ACR believes that the measure does not adequately address the issue of patient size in the calculation of estimated dose. The second part of the measure -- reporting a measure of radiation dose, i.e. DLP, CTDIvol or Effective Dose in the radiology final report-- is particularly concerning. Reporting DLP or CTDIvol may be technically correct, but providing such information without context to patient size and exam has little meaning and is difficult to act upon. Reporting effective dose is more problematic. The determination of ionizing radiation dose to humans is very complex.

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36	Ms. Judy Burleson	American College of Radiology	Health Professional	PSM-044-10: Radiation Dose of Computed Tomography (CT)	comment continued: To determine the absorbed radiation dose, the initial exposure and the absorption in each organ must be known. It is impossible to estimate the total radiation dose absorbed by a patient without detailed information of the patient habitus and the many technical factors that go into the production of the image. It is important to understand that the reported numerical values for individual radiation doses may vary by factors of 5 to 10 depending on individual patients and the manner of image acquisition. Thus the ACR does not support this part of the measure. We would like to provide clarification regarding the reference to the American College of Radiology's relative small and new CT Accreditation Program as stated in the PSM-044-10 measure evaluation form. Our first CT facility accreditation was completed in 2002; there are currently close to 5,000 actively accredited CT facilities. Recent analysis of the CT accreditation program statistics has shown a decrease in dose levelsat sites that are renewing their 3 year accreditation, indicating the educational aspect of the program. In 2008, based on previous year statistics, the program implemented a dose reference level pass-fail criterion. Subsequently, facilities are submitting images with lower doses.
40	Ms. Carmella Bocchino, MBA, RN	America's Health Insurance Plans	Health Plan	PSM-044-10: Radiation Dose of Computed Tomography (CT)	Although the ACR measure as currently specified, only tracks participation in a registry, it would be helpful to clarify how radiation dosing is measured in the ACR registry and if it aligns with the measure proposed by the University of California, San Francisco. We feel this is a positive step in assessing the level of radiation patients receive, as it places the radiologist in the position of monitoring the radiation, just as other physicians monitor the dosage of pharmaceuticals.
17	Ms. Rabia Khan, MPH on behalf of Michael Rapp	Centers for Medicare and Medicaid Services	Purchaser	Comments on measures not recommended	PMS-010-10, 11, 12, 13agree with not endorsing these measures, as they are check box measures. Comments on Medication Safety Measures (017-10 through 031-10): Related to the importance criterion, evidence-based support for these measures was not grounded in studies or clinical trials to provide guidelines for appropriate monitoring. Adverse events related to the medications and conditions is lacking in formal documentation, but in general is considered low volume. These measures would be improved if re-considered and re-specified under a Prevention theme for medications with better evidence-based support for measure concept, measurement period and opportunity for improvement.

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41	Ms. Carmella Bocchino, MBA, RN	America's Health Insurance Plans	Health Plan	Comments on measures not recommended	We received a variety of comments from our members regarding NQFs Medication Safety Measures, and have summarized some of the key themes below. These comments do not represent an industry consensus position but member-specific comments on these measures. Concerns with the lack of scientific evidence associated with these measures. Focus efforts to measure patient safety on patient outcomes. Suggestion that the measure developer assess the feasibility of creating a medication safety composite measure, which could be integrated into a checklist for the management of patients with chronic disease. The focus could then be placed on examining the success of such monitoring on patient outcomes measures such as measuring renal, hematologic or hepatic complications or ER visits.