AMBULATORY CARE

# National Voluntary Consensus Standards For Ambulatory Care—Additional Outpatient Measures 2010

A CONSENSUS REPORT

National Quality Forum

The National Quality Forum (NQF) operates under a three-part mission to improve the quality of American healthcare by:

- building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;
- endorsing national consensus standards for measuring and publicly reporting on performance; and
- promoting the attainment of national goals through education and outreach programs.

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**AMBULATORY HEALTHCARE IS THE** predominant means of providing healthcare services in the United States. In 2006, there were approximately 1.1 billion patient visits across a wide range of settings, including clinician offices, emergency departments (EDs), and outpatient departments. Although the majority of ambulatory care services are provided in physician offices, approximately 11 percent are provided in EDs and 9 percent in outpatient departments. From 1996 to 2006 the number of ED visits in the United States increased by 32 percent, while the number of EDs decreased by about 12.4 percent. Demand and capacity issues have contributed to increased patient wait time and decreased clinician productivity, placing patients at risk for poor health outcomes.

The National Quality Forum (NQF) has endorsed more than 100 ambulatory care measures for assessing the quality of care provided in outpatient facilities, including hospital outpatient departments (HOPD), EDs, urgent care facilities, ambulatory surgery centers, community health centers, and clinician offices. These measures address issues ranging from timely treatments, antibiotic use, patient admissions and discharges, and appropriate documentation by staff. Specifically, the measures recommended for endorsement in this report focus on pediatric conditions, antibiotic overuse, endoscopy and polyp surveillance, and appropriate time to patient treatment, and they are applicable to the ED or urgent care settings. The endorsement of these measures, as well as those that have preceded them, is intended to encourage hospitals and clinicians to improve their quality of care through implementation and to empower consumers with appropriate information to make informed decisions about their healthcare.

Under NQF's current Ambulatory Care project, 16 process measures are recommended for endorsement. These measures were submitted by the American College of Emergency Physicians (ACEP), the American Medical Association-convened Physician Consortium for Performance Improvement (AMA PCPI), and the Centers for Medicare & Medicaid Services (CMS), and Ingenix, Inc. and are listed below:

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# Background

**AMBULATORY HEALTHCARE** is the predominant means of providing healthcare services in the United States. In 2006, there were approximately 1.1 billion patient visits across a wide range of settings, including clinician offices, emergency departments (EDs), and outpatient departments (OPDs). Although the majority of ambulatory care services are provided in physician offices, approximately 11 percent are provided in EDs and 9 percent in outpatient departments.[1] From 1996 to 2006 the number of ED visits in the United States increased by 32 percent, while the number of EDs decreased by about 12.4 percent. Demand and capacity issues have contributed to increased patient wait time and decreased clinician productivity, placing patients at risk for poor health outcomes.[2]

The National Quality Forum (NQF) has endorsed more than 100 ambulatory care measures through general ambulatory care consensus development projects, as well as more specialized projects focused on clinically enriched administrative data and specialty clinician measures. Those measures lend themselves to addressing larger issues within ambulatory care, such as capacity, productivity, and improving patient outcomes. The current project focuses on emergency and urgent care across settings. Ultimately, these measures will provide stakeholders with an improved picture of the quality of ambulatory care delivered in the United States.

# Strategic Directions For NQF

NQF's mission includes three parts: 1) building consensus on national priorities and goals for performance improvement and working in partnership to achieve them; 2) endorsing national consensus standards for measuring and publicly reporting on performance, and 3) promoting the attainment of national goals through education and outreach programs. As greater numbers of quality measures are developed and brought to NQF for consideration of endorsement, it is incumbent on NQF to assist stakeholders to "measure what makes a difference" and address what is important to achieve the best outcomes for patients and populations. For more information see **www.qualityforum.org.**

Several strategic issues have been identified to guide consideration of candidate consensus standards:

**DRIVE TOWARD HIGH PERFORMANCE.** Over time, the bar of performance expectations should be raised to encourage the achievement of higher levels of system performance.

**EMPHASIZE COMPOSITES.** Composite measures provide much-needed summary information pertaining to multiple dimensions of performance and are more comprehensible to patients and consumers.

**MOVE TOWARD OUTCOME MEASUREMENT.** Outcome measures provide information of keen interest to consumers and purchasers, and when coupled with healthcare process measures, they provide useful and actionable information to providers. Outcome measures also focus attention on much-needed system-level improvements, because achieving the best patient outcomes often requires carefully designed care processes, teamwork, and coordinated action on the part of many providers.

**CONSIDER DISPARITIES IN ALL WE DO.** Some of the greatest performance gaps relate to care of minority populations. Particular attention should be focused on identifying disparities-sensitive performance measures and on identifying the most relevant race/ethnicity/language/socioeconomic strata for reporting purposes.

# National Priorities Partnership

NQF seeks to endorse measures that address the National Priorities and Goals of the National Priorities Partnership.[3] The Partnership represents those who receive, pay for, provide, and evaluate healthcare. The National Priorities and Goals focus on these areas:

- patient and family engagement,
- population health,
- safety,
- care coordination,
- palliative and end-of-life care,
- overuse,
- equitable access, and
- infrastructure support.

# NQF's Consensus Development Process

NQF's National Voluntary Consensus Standards for Ambulatory Care: Additional Outpatient Measures 2010 project[4] sought to endorse additional outpatient measures that address ED and urgent care and invasive procedures in which sedation or general anesthesia is utilized in the outpatient setting. These consensus standards address a broad range of areas including safety and effectiveness of outpatient care, coordination of care and timely communication, appropriateness of care, pediatric urgent care, and clinician or facility-level analysis. Additionally, the project identifies gaps in important outpatient measures.

This report does not represent the entire scope of NQF work relevant to the quality of outpatient care. NQF has endorsed emergency department-specific consensus standards through Phase I and II of the National Volun-

tary Consensus Standards for Emergency Care project[5] and clinician-level standards through the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures project.[6]

The full constellation of consensus standards, along with those presented in this report, provide a growing number of NQF-endorsed® voluntary consensus standards that directly reflect the importance of measuring and improving the quality of care provided to patients. Organizations that adopt these consensus standards will promote the delivery of safer and higher-quality care for patients.

## Evaluating Potential Consensus Standards

Candidate standards were solicited though an open Call for Measures in January 2010 and were actively sought by NQF staff through literature reviews, a search of the National Quality Measures Clearinghouse, NQF Member websites, and an environmental scan. The Ambulatory Care Steering Committee evaluated 27 measures for appropriateness as voluntary consensus standards for accountability and public reporting using the standardized measure evaluation criteria of importance to measure and report, scientific acceptability of the measure properties, usability, and feasibility.[7]

# Recommendations For Endorsement

This report presents the results of the evaluation of 27 measures considered under NQF's Consensus Development Process. Sixteen measures are recommended for endorsement as voluntary consensus standards suitable for public reporting and quality improvement. All but three measures are recommended for time-limited endorsement.

## Candidate Consensus Standards Recommended for Endorsement

### 664: **Patient(s) with an emergency medicine visit for syncope that had an ECG** (Ingenix, Inc.)

*Patients with an emergency medicine visit for syncope that had an electrocardiogram as part of their evaluation*

Syncope is a common presentation to the ED, and although many factors underlying its presentation are benign and self-limited, others are associated with significant morbidity and mortality. Syncope causes may remain ambiguous during initial ED evaluation; therefore, risk stratification through electrocardiogram (ECG) testing is essential in identifying patients who require additional attention and treatment. The measure developer presented data suggestive of a significant performance gap. The Steering Committee recognized the measure's importance and favorably viewed its use of multiple data sources. The Committee recommended this measure for harmonization[8] with NQF-endorsed Measure 0093: Electrocardiogram performed for syncope. The measure developer asserted that the proposed measure is harmonized with the endorsed measure to the extent possible (e.g., identical code set definitions of syncope), with the exception of data sources, because this measure relies solely on electronic

administrative data. This process measure addresses the National Priority of safety.

665: **Patient(s) with an emergency medicine visit for non-traumatic chest pain that had an ECG**
**(Ingenix, Inc.)** *Patients with an emergency medicine visit for non-traumatic chest pain that had an electrocardiogram as part of their evaluation*

Clinical guidelines state that adults who present to an ED with non-traumatic chest pain should undergo a 12-lead ECG that is read by a physician within 10 minutes of arrival. Prompt identification of ischemia or infarction on an ECG can result in quick initiation of life-saving interventions such as anti-embolic medication or percutaneous procedures.[9] The measure developer presented data suggestive of a significant performance gap, close to 20 percent. The Committee recognized the measure's importance and favorably viewed its use of multiple data sources. The Committee recommended this measure for harmonization with NQF-endorsed Measure 0090: Electrocardiogram performed for non-traumatic chest pain. The measure developer asserted that the proposed measure is harmonized with the endorsed measure to the extent possible (e.g., identical code set definitions of chest pain), with the exception of data sources, because this measure relies solely on electronic administrative data. This process measure addresses the National Priority of safety.

663: **Patient(s) two years of age and older with acute otitis externa who were NOT prescribed systemic antimicrobial therapy**
**(Ingenix, Inc.)** *Patients two years of age and older with acute otitis externa who were or were not prescribed systemic antimicrobial therapy*

The annual incidence of acute otitis externa (AOE), commonly referred to as swimmer's ear, is as high as 10 percent. Topical preparations are recommended as the initial therapy for uncomplicated AOE because of safety and efficacy.[10] Although systemic oral antibiotics are frequently prescribed to treat uncomplicated AOE, there is no evidence to support their efficacy. The Committee agreed that the exclusion criteria are defined extensively and that the data sources are comprehensive enough to evaluate quality and to facilitate improvement for a broad population base. The Committee also commended the measure developer for presenting a strong case about the cost and patient-related ramifications associated with oral antibiotic overuse. The prospect of harmonization with proposed Measure 654: Acute otitis externa: systemic antimicrobial therapy—avoidance of inappropriate use was discussed at length but eventually abandoned because of differences with the denominator populations, specifically the time period eligible for inclusion.

The Committee suggested the measure's title be changed to an affirmative statement—one that clearly expresses a desired standard and reflects a behavioral modification. The measure developer responded that changing the title will give the impression that systemic antibiotics

are recommended for treating AOE. The Committee agreed with the measure developer's perspective and recommended the measure for endorsement. This process measure addresses the National Priority of overuse.

## Consensus Standards Recommended for Time-Limited Endorsement[11]

653: **Acute otitis externa: topical therapy** (AMA PCPI)
*Percentage of patients aged two years and older with a diagnosis of acute otitis externa who were prescribed topical preparations*
paired[12] with
654: **Acute otitis externa: systemic antimicrobial therapy—avoidance of inappropriate use** (AMA PCPI)
*Percentage of patients aged two years and older with a diagnosis of acute otitis externa who were not prescribed systemic antimicrobial therapy*

The Committee noted the data were strong and demonstrated the high incidence of AOE. However, some members noted considerable geographic variation in disease rates, with some areas having lower AOE incidence. The measure developer cited clinical practice guidelines that recommend topical preparations as the initial therapy for uncomplicated AOE because of safety and efficacy against common AOE pathogens. Although resolution is estimated to occur with 65 percent to 90 percent of patients who are prescribed topical preparations, antibiotics exclusively or amalgamated with topical treatments are increasingly prescribed to treat AOE. Some Committee members debated whether topical preparations in the absence of debridement and wick replacement are sufficient treatments. As a whole, the Committee believed neither measure on its own accurately captures the scope of inappropriate treatment and therefore recommended the measures be paired to comprehensively assess the care provided. The Committee suggested greater specificity be added to the ICD-9-CM coding and exclusions to distinguish patients for whom this aspect of care is not appropriate (e.g., patients presenting with complicated AOE, comorbidities, or specified immune-compromised conditions). The measure developer responded that omission of an exhaustive list of exclusions is intentional and in accordance with their methodology that uses three broad categories (medical, patient, and system) to define exclusions and that relies on clinicians to link those exclusions with documented reasons for not adhering to recommended treatment guidelines (e.g., reason for not prescribing topical preparation only). Some Committee members were concerned about potential unintended consequences of measurement resulting from a perceived lack of exclusions specificity. To address the Committee's concerns, the measure developer added examples to the exclusions as follows:

- 653: Medical reason(s) for not prescribing topical preparation (e.g., coexisting acute otitis media, tympanic membrane perforation); and
- 654: Medical reason(s) for prescribing systemic antimicrobial therapy (e.g., coexisting diabetes, immune deficiency).

The Committee accepted these modifications and recommended the measures for time-

limited endorsement. These paired measures address the National Priorities of overuse and safety.

655: **Otitis media with effusion: antihistamines or decongestants—avoidance of inappropriate use** (AMA PCPI) *Percentage of patients aged 2 months through 12 years with a diagnosis of otitis media with effusion who were not prescribed or recommended to receive either antihistamines or decongestants*

grouped with

656: **Otitis media with effusion: systemic corticosteroids—avoidance of inappropriate use** (AMA PCPI) *Percentage of patients aged 2 months through 12 years with a diagnosis of otitis media with effusion who were not prescribed systemic corticosteroids*

and

657: **Otitis media with effusion: systemic antimicrobials—avoidance of inappropriate use** (AMA PCPI) *Percentage of patients aged 2 months through 12 years with a diagnosis of otitis media with effusion who were not prescribed systemic antimicrobials*

Ninety percent of children have otitis media with effusion (OME) at some time before they start school. The majority of those cases resolve spontaneously with indications for therapy if the condition persists. Evidence does not exist to support the efficacy of antihistamines, decongestants, systemic corticosteroids, and antimicrobials in treating OME; furthermore, these medications have potential adverse side effects. The measure developer presented data that indicate a lack of adherence to recommended guidelines for OME. The majority of the Committee's discussion focused on issues related to over-the-counter antihistamines and decongestants. Committee members debated the feasibility of capturing data on utilization and active counseling against the use of non-recommended, non-prescribed, over-the-counter antihistamines or decongestants within the current electronic health record (EHR) environment. Although the Committee recognized the importance of capturing this information, they noted significant documentation and data abstraction challenges. For these reasons, the Committee believed grouping all three measures together would result in a more comprehensive assessment of inappropriate care for OME. The Committee further recommended these measures be developed into a composite measure for consideration during the next measure maintenance review. The Committee also suggested that development of a standard that captures whether or not clinicians provide proactive counseling against the use of antihistamines and decongestants for uncomplicated OME would be a valuable component for inclusion in the composite. These measures address the National Priority of overuse.

651: **Ultrasound determination of pregnancy location for pregnant patients with abdominal pain** (ACEP) *Pregnant patients who present to the emergency department with a chief complaint of abdominal pain and/or vaginal bleeding and receive a trans-abdominal or trans-vaginal ultrasound*

The Committee agreed this process measure is important in identifying and rendering timely treatment for ectopic pregnancy, a leading cause of maternal morbidity and mortality in

the first trimester. The inclusion criteria were discussed at length; specifically whether the denominator is inclusive of all women regardless of timing of pregnancy determination (before and during the ED visit). The measure developer affirmed that both populations are included in the denominator. Committee members weighed the unintended consequences of this performance metric, including delayed treatment if initial ultrasound testing reveals a pseudogestational sac, which at times presents with ectopic pregnancy and leads to a misdiagnosis of an intrauterine pregnancy. The measure developer considered harmonization with NQF-endorsed Measure 0502: Pregnancy test for female abdominal pain patients but determined it was not feasible at the time. This measure addresses the National Priority of safety.

652: **Rh immunoglobulin (Rhogam) for Rh negative pregnant women at risk of fetal blood exposure** (ACEP) *Percentage of Rh negative pregnant women at risk of fetal blood exposure who receive Rhogam in the emergency department*

The Steering Committee recognized the importance of administering Rhogam as an effective prophylaxis for all confirmed pregnant women who are Rh negative and at risk of maternal exposure to fetal blood. There is a fair amount of debate about the administration of Rhogam during the first trimester because of indications for threatened abortion, miscarriage, significant vaginal bleeding, and other complications; however, the data for second- and third-trimester efficacy remain strong. The measure developer also noted concern that anti-D immunoglobulin may cross the placenta and cause fetal anemia; nonetheless, this was believed to be a minor concern. Although the Committee commended the measure's intent, it also noted the subjectivity of pain and bleeding assessment for patients over 12 weeks of gestation and the difficulty clinicians and consumers may face in fully comprehending the complexities of the measure. The measure developer considered harmonization with NQF-endorsed Measure 0014: Prenatal anti-D immune globulin but determined it was not feasible at the time. This process measure addresses the National Priority of safety.

658: **Endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients** (AMA PCPI) *Percentage of patients 50 and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report*

The Committee agreed that assessing whether the appropriate follow-up interval for normal colonoscopy in average-risk patients as addressed is an important process measure. All current guidelines recommend colonoscopy screening for average-risk patients at 10-year intervals.[13] Screening has increased in recent years, often resulting in repeated and unnecessary procedures. Although the Committee was concerned about the exclusion of endoscopy reports not captured in an electronically generated reporting format (roughly 50 percent of all reports at this time), they believed these concerns will subside as healthcare moves

closer to a fully integrated EHR environment. This measure addresses the National Priority of overuse.

659: **Endoscopy/polyp surveillance: colonoscopy interval for patients with a history of adenomatous polyps—avoidance of inappropriate use** (AMA PCPI)

*Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp in previous colonoscopy findings who had a follow-up interval of three or more years since their last colonoscopy documented in the colonoscopy report*

Colorectal cancer is the second leading cause of cancer death in the United States. Colonoscopy is recommended for surveillance after the removal of adenomatous polyps because it significantly reduces subsequent colorectal cancer incidence;[14] however, there is growing evidence for overutilization of colonoscopies. Although the Steering Committee noted this measure's importance, it also debated its usefulness without specific recommendations for appropriate follow-up screening intervals. The measure developer clarified that the timing of a follow-up colonoscopy is dependent on a number of variables, including clinically relevant polyp numbers, sizes, the endoscopic interpretation of adequate removal, and preparation. At the same time, the measure developer recognized that the absence of specific guidelines may result in patient and physician confusion. The Committee suggested that future measures for endoscopy screening and surveillance incorporate a component of patient experience to facilitate discussion between patients and clinicians about appropriate testing intervals. This measure addresses the National Priority of overuse.

660: **Troponin results for emergency department acute myocardial infarction (AMI) patients or chest pain patients (with probable cardiac chest pain) received within 60 minutes of arrival** (CMS)

*Emergency department acute myocardial infarction patients or chest pain patients (with probable cardiac chest pain) with an order for troponin during the stay and having a time from ED arrival to completion of troponin results within 60 minutes of arrival*

At first, the measure developer submitted a broad measure that assessed, for all patients, the median time from initial ordering of troponin to reporting of troponin results to ED staff. Although Committee members agreed that timely reporting of troponin results is important to patient health outcomes and to setting minimal expectations, they also agreed that a disease-specific approach would be easier to define and report. Committee members therefore suggested limiting the denominator population to non-traumatic chest pain or acute myocardial infarction (AMI). Additionally, some members expressed concern that reporting based on central tendency may not reflect outliers on either side of the timing interval. The measure developer proposed revising the measure to assess the proportion of patients who have the test completed within 60 minutes of arrival and agreed to revise the denominator statement to include only patients with non-traumatic chest pain or AMI with an order for troponin. The measure developer also changed

the measure title to reflect these modifications.

In response to a Committee recommendation to broaden application of the measure to include inpatient populations, the measure developer clarified that both ED and critical care are included in the denominator encounter coding. The Committee recommended the measure for endorsement following the measure developer's modifications. This measure addresses the National Priority of safety.

661: **Head CT or MRI scan results for acute ischemic stroke or hemorrhagic stroke patients who received head CT or MRI scan interpretation within 45 minutes of arrival** (CMS)

*Acute ischemic stroke or hemorrhagic stroke patients who arrive at the emergency department within two hours of the onset of symptoms and have a head computed tomography or magnetic resonance imaging scan performed during the stay, with a time from emergency department arrival to interpretation of the head CT or MRI scan within 45 minutes of arrival.*

At first, the measure developer submitted a broad measure that assessed, for all patients, the median time from initial ordering of a head CT scan to reporting of the head CT scan results to ED staff. Although Committee members agreed that timely head CT scan interpretation is very important to patient health outcomes and to setting minimal expectations of interpretation of turnaround time, they also agreed a disease-specific approach would be easier to define and report. The Committee also recommended the measure developer include MRI as another first-line imaging option for acute stroke patients. One Committee member suggested a metric that evaluates timely head CT scan for ischemic stroke because the guidelines are clear and well established.

Reporting to the ED was viewed as problematic and not necessarily indicative of hospital efficiency. Additionally, some Committee members were concerned that reporting based on median timing may not reflect outliers on either side of the timing interval. Upon recommendation from the Steering Committee, the measure developer modified the measure's title to reflect the proportion of stroke patients with acute onset of symptoms who have a CT brain scan interpreted within 45 minutes of arrival; this modification is consistent with national stroke guidelines. The measure developer also agreed to expand the definition of the measure to include MRI. The Committee recommended the measure for endorsement following the measure developer's modifications. This measure addresses the National Priority of safety.

662: **Median time to pain management for long bone fracture** (CMS)

*Median time from emergency department arrival to time of initial parenteral pain medication administration or other regional/local anesthesia pain management for emergency department patients with a principal diagnosis of long bone fracture*

The measure developer presented data revealing patients with bone fractures typically do not receive adequate pain medication as part of treatment regimens. The data also reveal significant disparities in treatment for pain according to race, ethnicity, age, and other fac-

tors.[15] Although the Committee recognized this measure's importance to quality improvement, it expressed concern that the denominator exclusions include contraindications to pain medications. Committee members suggested this metric should also apply to pediatric patients because they also require close monitoring of medications. Based on the Committee's recommendations, the measure developer revised the specifications as follows:

- inclusion of only mid-shaft long bone fractures (femur, tibia, and humerus only) in the denominator (parenteral pain medications and or regional anesthesia); and
- addition of regional/local anesthesia pain management medications to the list of pain medications.

The measure developer appropriately excluded from the denominator patients with contraindications to pain medication. Additionally, the measure developer broadened the specifications to also address the use of oral medications to manage pain in patients aged 2 to 17 years with long bone fractures (LBFs) in addition to specifications that address patients 18 years and older and the use of parenteral medications and regional or local anesthesia for LBF pain. The restriction of shaft fractures of the femur, tibia, and humerus is applicable only to the adult populations. The Committee approved of the measure developer's modifications. This measure addresses the National Priority of safety.

### 666: **Ultrasound guidance for internal jugular central venous catheter placement** (ACEP)

*Percentage of adult patients aged 18 years and older with an internal jugular central venous catheter placed in the emergency department under ultrasound guidance*

The Committee recognized the importance of ultrasound guidance in increasing first-attempt success of internal jugular central venous catheter placement and in minimizing complications associated with the procedure. The measure developer stated that the procedure is grossly underutilized and has broad application across care settings, including hospital critical care units and, to some degree, surgical settings. Committee members offered several potential limitations to the measure's usability, including the scarcity of ultrasound equipment in many EDs and the lack of documentation of ultrasound use in medical records. Some Committee members noted this ultrasound procedure requires multiple personnel, which may not be possible because of staffing restrictions. The Committee expressed concern that inexperienced clinicians may be asked to complete the procedure to boost compliance with the measure. To avoid this unintended consequence, the measure developer revised the denominator exclusions to include "clinicians not credentialed in ultrasound guided central venous cannulation, or not credentialed in ultrasound guided procedures." The Committee recommended the measure for time-limited endorsement following the measure developer's modification. This measure addresses the National Priority of safety.

## Candidate Standards Not Recommended for Endorsement

ACP-008-10: **Otitis media with effusion: hearing test** (AMA PCPI)
*Percentage of patients aged 2 months through 12 years with a diagnosis of otitis media with effusion who received tympanostomy tube insertion who had a hearing test performed within six months prior to tympanostomy tube insertion*

The Committee agreed this measure does not pass the threshold criterion of "importance to measure and report." Although the Committee noted this assessment's importance, it believed the data provided were not sufficient to demonstrate a strong link between the process of care and the desired outcome; specifically, the Committee was unclear about the patient age criteria and the degree to which OME results in hearing loss.

ACP-010-10: **Acute otitis externa: pain assessment** (AMA PCPI)
*Percentage of patient visits for those patients aged two years and older with a diagnosis of acute otitis externa with assessment for auricular or periauricular pain*

The Committee agreed this measure does not address a high-impact area because pain assessment is a standard clinical practice. The measure was further weakened because treatment recommendations have not been linked to pain assessment.

ACP-014-10: **Otitis media with effusion: diagnostic evaluation—assessment of tympanic membrane mobility** (AMA PCPI) *Percentage of patient visits for those patients aged 2 months through 12 years with a diagnosis of otitis media with effusion, and an assessment of tympanic membrane mobility with pneumatic otoscopy or tympanometry*

Committee members noted that the hierarchal approach to diagnostic tools, pneumatic otoscopy followed by acoustic reflectometry, was not sufficiently differentiated. Furthermore, the measure specifications did not include the results of diagnostic methods that assess OME sensitivity and specificity. The Committee also highlighted the shortage of pneumatic otoscopy/audio scopes in many settings as a key barrier to implementing this measure. For these reasons, the Committee did not recommend this measure for endorsement.

ACP-018-10: **Endoscopy/polyp surveillance: comprehensive colonoscopy documentation** (AMA PCPI) *Percentage of final colonoscopy reports for patients aged 18 years and older that include documentation of all of the following: pre-procedure risk assessment, depth of insertion, quality of the bowel preparation, complete description of polyp(s) found (including location of each polyp, size, number, and gross morphology), and recommendations for follow-up*

The measure developer presented data indicative of significant gaps in the specificity of documentation on several procedures related to colonoscopy testing. The Committee debated the utility of a measure that solely evaluates the

quality of colonoscopy report documentation rather than the quality of colonoscopy performance. Committee members concluded it is imperative to address these serious documentation gaps before developing a colonoscopy effectiveness measure.

Although comments received by NQF Members and the public were generally supportive (several acknowledged the documentation gap and potential unintended consequences), others viewed the measure as purely a documentation measure (i.e., check box measure) and questioned whether implementation would result in substantial improvements in quality and patient care outcomes. Comments also expressed concern with the burden associated with collecting data in the absence of a completely integrated EHR environment.

After lengthy discussion, and following the Committee's recommendation, NQF Member and public comments, and NQF Member voting, the Consensus Standards Approval Committee (CSAC) did not recommend this measure for endorsement to the Board of Directors. For each dissenting vote, CSAC members were asked to provide the rationale for their decision based on the following criteria: cross-cutting issues concerning measure properties; CDP process issues; lack of adequate consensus across stakeholders; and importance of the measure. The majority of dissenting members based their decision on the importance criteria, noting that the metric is a documentation measure that does not add significant value to the overall NQF portfolio.

ACP-020-10: **Median time to BMP or electrolyte results** (CMS) *Median time from initial basic metabolic panel (BMP) or electrolyte order to time BMP or electrolyte results are reported to the emergency department staff*

The Steering Committee agreed this measure does not meet the threshold criterion of "importance to measure and report." The Committee noted that the measure only evaluates the ability of a system to provide lab results and does not address the quality of care that would be associated with timely results. The Committee suggested that a more meaningful measure would be one that is disease-specific and evaluates the number of tests ordered related to that disease.

ACP-020-10: **Median time to chest x-ray** (CMS) *Median time from initial chest x-ray order to time chest x-ray exam is completed*

The Committee agreed this measure does not meet the threshold criterion of "importance to measure and report." The Committee concluded that a specified time period rather than a median time for results to be reported is more likely to improve patient care. Committee members also noted the goal of reducing inefficiencies in EDs throughput is dependent on several extenuating factors. The Committee stated that the metric only evaluates the ability of a system to provide lab results and does not address the quality of care that would be associated with timely results.

ACP-024-10: **Patients left before being seen (CMS)** *Percentage of emergency department patients who left before evaluation by the physician/APN/PA*

The Committee agreed this measure meets the "importance to measure and report" criterion and therefore assessed the feasibility of its harmonization with NQF-endorsed Measure 0499: Left without being seen. When comparing the two measures, the Committee noted different numerator and denominator populations; specifically, Measure 0499 assesses all patients who present to the ED, while Measure ACP-024-10 evaluates patients registered in the ED log only. Additionally, Committee members questioned the exclusion of patients younger than 18 years from the proposed measure's population. The Committee was informed of the difficulty the endorsed measure's steward has encountered in capturing relevant and accurate data for that measure. Because this measure has not been tested and does not address any of the potential concerns that have been raised with the endorsed measure, the Committee did not recommend this measure for endorsement.

ACP-025-10: **Median time to CBC results (CMS)** *Median time from initial complete blood count (CBC) to order to time CBC results are reported to emergency department staff*

Although the Steering Committee recognized the importance of timely CBC results, it determined this measure does not meet the threshold criterion of "importance to measure and report." The Committee believed this measure is not directly linked to a specific disease or condition, therefore making it difficult to demonstrate impact.

ACP-029-10: **Patient(s) treated with an antibiotic for acute sinusitis that received a first-line antibiotic (Ingenix, Inc.)** *Patient(s) treated with an antibiotic for acute sinusitis that received a first-line antibiotic*

The Committee noted this is a clinically important topic but recognized the difficulty in differentiating viral upper respiratory infections from acute bacterial sinusitis in patients with symptoms lasting more than 5 to 10 days. The Committee also discussed the complexity in capturing accurate data from claims information entirely. The Committee was interested in future research that assesses community cost disparities of treating bacterial sinusitis with first-line agents.

ACP-030-10: **Adult(s) with community-acquired bacterial pneumonia that had a CXR (Ingenix, Inc.)** *Patients with community-acquired bacterial pneumonia treated as outpatients that had a chest x-ray*

The Committee recognized the importance of the measure; however, they questioned the appropriateness of treating patients with antibiotics for community-acquired bacterial pneumonia (CAP) without confirmation of diagnosis through a chest x-ray (CXR). The Committee also noted the typical lag time in radiologic findings of pneumonia and actual onset of CAP. Additionally, the Steering Committee was concerned that the numerator was not clearly defined and cited a discrepancy between the

evidence in support of the measure's importance, which examined patients 65 years and older, and the targeted age in the measure specifications (18 years and older).

ACP-042-10: **Patient(s) with frequent ER migraine encounters or frequent acute migraine medication use that had an office visit in last six reported months** (Ingenix, Inc.)
*Patients with frequent migraine encounters or frequent migraine abortive medication use that had an office visit within the last six reported months*

Although the Steering Committee noted the importance of evaluating frequent ED migraine encounters and medication use, it was concerned there are no clinical standards for follow-up. The recommendations presented were based solely on expert panel consensuses and not on evidence-based medicine. Furthermore, the Committee believed the measure is more appropriate for assessing primary care quality improvement and is not necessarily useful for public reporting. The Committee suggested a more effective proactive measure that evaluates care coordination through ED referral to a primary care provider rather than assesses the frequency of ED visits.

# Additional Recommendations

The Steering Committee discussed recommendations for future measurement, including measures that address hypothermia protocols for cardiac arrest survivors. Despite significant evidence in support of their efficacy, the Committee believed these protocols are grossly underutilized.

Committee members were also interested in measures that evaluate the efficient use of head CT scans for children with minor trauma. The Committee stressed the importance of using existing clinical prediction rules since there is substantial data on overuse and associated harm from radiation and other procedures in which sedation is utilized.

The Committee expressed interest in measures that focus on ED pharmacists, noting that pharmacists' presence in the ED could lead to more thorough review of medications, thus reducing the incidence of adverse drug events; expedite drug therapy, while potentially reducing ED expenditure; and provide another source for screening therapies (i.e., smoking cessation).

Finally, Committee members discussed research opportunities for advance directives, which could be viewed as a potential resource for the public and practitioners in emergency medicine.

# Notes

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3. National Quality Forum (NQF), *National Priorities Partnership*, Washington, DC: NQF. Available at www.nationalprioritiespartnership.org. Last accessed May 2010.
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7. NQF. Measure Evaluation Criteria (December 2009). Available at www.qualityforum.org/docs/measure_evaluation_criteria.aspx. Last accessed May 2010.
8. Harmonization refers to the standardization of specifications for similar measures on the same topic (e.g., *influenza immunization* of patients in hospitals or nursing homes), related measures for the same target population (e.g., eye exam and HbA1c for *patients with diabetes*), or definitions applicable to many measures (e.g., age designation for children) so that they are uniform or compatible, unless differences are dictated by the evidence. The dimensions of harmonization can include numerator, denominator, exclusions, and data source and collection instructions. The extent of harmonization depends on the relationship of the measures, the evidence for the specific measure focus, and differences in data sources.
9. National Guideline Clearinghouse (NGC), ACC/AHA 2007 *Guidelines for the Management of Patients with Unstable Angina/Non ST-elevation Myocardial Infarction.* Available at www.guideline.gov/summary/summary.aspx?doc_id=11333. Last accessed May 2010.
10. National Guideline Clearinghouse (NGC), *Clinical practice guideline: acute otitis externa.* Available at www.guideline.gov/summary/summary.aspx?ss=15&doc_id=9310#s21. Last accessed May 2010.
11. Information regarding NQF's time-limited endorsement policy and the 2010 addendum is available at www.qualityforum.org/News_And_Resources/Press_Releases/2010/NQF_Updates_Policy_on_Time-Limited_Endorsement.aspx. Last accessed May 2010.
12. Paired or grouped measures refer to two or more measures grouped together for the purpose of public reporting. The measures maintain separate scores.
13. National Guideline Clearinghouse (NGC), *Practice Parameter for Detection of Colorectal Neoplasms: An Interim Report (Revised).* Available at www.guideline.gov/summary/summary.aspx?doc_id=10785&nbr=005613&string=colonoscopy+AND+screening. Last accessed May 2010.
14. Levin B, Lieberman DA, McFarland B, et al., Screening and surveillance for the early detection of colorectal cancer and adenomatous polyps, 2008: a joint guideline from the American Cancer Society, the U.S. Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology, *Gastroenterology* 2008; 58. Available at www.gastrojournal.org/article/S0016-5085(08)00232-1/fulltext. Last accessed May 2010.
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# Appendix A

# Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Additional Outpatient Measures 2010

**THE FOLLOWING TABLE PRESENTS** the detailed specifications for the National Quality Forum (NQF)-endorsed® *National Voluntary Consensus Standards For Ambulatory Care—Additional Outpatient Measures 2010*. All information presented has been derived directly from measure sources/developers without modification or alteration (except when the measure developer agreed to such modification during the NQF Consensus Development Process) and is current as of July 13, 2010. All NQF-endorsed voluntary consensus standards are open source, meaning they are fully accessible and disclosed. Measure stewards include Ingenix,Inc; American Medical Association Physician Consortium for Performance Improvement; American College of Emergency Physicians; and Centers for Medicare & Medicaid Services.

| **664: PATIENT(S) WITH AN EMERGENCY MEDICINE VISIT FOR SYNCOPE THAT HAD AN ECG** |
|---|
| *Measure Steward:* Ingenix, Inc. |
| *Measure Description:* This measure identifies patients with an emergency medicine visit for syncope that had an ECG done as part of their evaluation. |
| *Numerator:* Patients who have an emergency medicine visit for syncope, who had an (ECG) during the event |
| *Denominator:* Patients 60 years of age or older who have an emergency medicine encounter with a diagnosis of syncope |
| *Exclusions:*<br>1. Exclude emergency medicine events which included hospitalizations<br>2. Exclude emergency medicine events without a preceding clear window<br>3. Exclude emergency medicine events where the member was less than 60 years of age on the episode end date |
| *Data Source:* Lab data, Electronic administrative data/claims |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group, Population: States, Population: Counties or cities, Program: Disease management, Program: QIO, Facility/Agency, Health plan, Integrated delivery system, Multi-site/corporate chain, Can be measured at all levels. |
| **665: PATIENT(S) WITH AN EMERGENCY MEDICINE VISIT FOR NON-TRAUMATIC CHEST PAIN THAT HAD AN ECG** |
| *Measure Steward:* Ingenix, Inc. |
| *Measure Description:* This measure identifies patients with an emergency medicine visit for non-traumatic chest pain that had an ECG done as part of their evaluation. |
| *Numerator:* Patients who have an emergency medicine visit for non-traumatic chest pain, who had an electrocardiogram (ECG) during the event |
| *Denominator:* Patients 40 years of age or older who have an emergency medicine encounter with a diagnosis of chest pain |
| *Exclusions:*<br>1. Exclude emergency medicine events that included hospitalizations<br>2. Exclude emergency medicine events without a preceding clear window<br>3. Exclude emergency medicine events where the member was less than 40 years of age on the episode end date |
| *Data Source:* Electronic administrative data/claims, lab data |
| *Level of Analysis: Clinicians:* Individual, Clinicians: Group, Facility/Agency, Health plan, Integrated delivery system, Multi-site/corporate chain, Population: States, Population: Counties or cities, Program: Disease management, Program: QIO, Can be measured at all levels. |

| **663: PATIENT(S) TWO YEARS OF AGE AND OLDER WITH ACUTE OTITIS EXTERNA WHO WERE NOT PRESCRIBED SYSTEMIC ANTIMICROBIAL THERAPY** |
|---|
| *Measure Steward:* Ingenix, Inc. |
| *Measure Description:* This measure identifies patients two years of age and older with acute otitis externa who were or were not prescribed systemic antimicrobial therapy. |
| *Numerator:* Patients who have a diagnosis of acute otitis externa who were NOT prescribed systemic antimicrobial therapy during the otitis externa event—the day of the initiating otitis externa encounter through two days after that encounter |
| *Denominator:* Patients who are two years of age or older at the end of the report period who have an outpatient encounter with a diagnosis of acute otitis externa.<br>(The following time period will be used to find eligible acute otitis externa encounters: 60 days after the start of the 12-month report period through 10 days prior to the end of the 12-month report period.) |
| *Exclusions:*<br>1. Exclude acute otitis externa events without a preceding disease free clear window<br>2. Exclude acute otitis externa events with hospitalizations or outpatient surgeries during the event<br>3. Exclude acute otitis externa events with relevant co-morbid infections<br>4. Exclude patients with recent organ transplants or recent chronic otitis externa<br>5. Exclude additional complex patients with any of the following diseases: AIDS, HIV sero-positive without AIDS, immunodeficiencies, diabetes mellitus, cystic fibrosis, leukemia, malignant neoplasm of the head and neck, or congenital and acquired anomalies of ear/nose/throat<br>6. Exclude patients who have had recent cochlear implant procedures<br>7. Exclude patients who did not have at least two face-to-face office visits with any diagnosis during the 12 months prior to the end of the report period |
| *Data Source:* paper medical record/flowsheet, electronic administrative data/claim |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group, Facility/Agency, Health plan, Integrated delivery system, Multi-site/corporate chain, Population: States, Population: Counties or cities, Program: Disease management, Program: QIO, Can be measured at all levels. |

| **653: ACUTE OTITIS EXTERNA: TOPICAL THERAPY (PAIRED WITH MEASURE 654) TIME-LIMITED ENDORSEMENT** |
|---|
| *Measure Steward:* AMA PCPI |
| *Measure Description:* This measure identifies the percentage of patients aged two years and older with a diagnosis of acute otitis externa who were prescribed topical preparations. |
| *Numerator:* Patients who were prescribed topical preparations |
| *Denominator:* All patients aged two years and older with a diagnosis of AOE |
| *Exclusions:*<br>1. Reason(s) for not prescribing topical preparations (e.g., coexisting acute otitis media, tympanic membrane perforation)<br>2. Documentation of patient reason(s) for not prescribing topical preparations (e.g., patient refusal) |
| *Data Source:* Electronic administrative data/claims, electronic Health/medical record, Paper medical record/ flowsheet, Special or unique data |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group |
| **654: ACUTE OTITIS EXTERNA: SYSTEMIC ANTIMICROBIAL THERAPY-AVOIDANCE OF INAPPROPRIATE USE (PAIRED WITH MEASURE 653) TIME-LIMITED ENDORSEMENT** |
| *Measure Steward:* AMA PCPI |
| *Measure Description:* This measure identifies the percentage of patients aged two years and older with a diagnosis of acute otitis externa who were not prescribed systemic antimicrobial therapy. |
| *Numerator:* Patients who were not prescribed systemic antimicrobial therapy once within the denominator time window |
| *Denominator:* All patients aged two years and older with a diagnosis of AOE<br>Each episode* of AOE within a 12-month period<br>*An episode of AOE is defined as a 30-day period from onset of acute otitis externa (as indicated by the first occurrence of qualifying diagnosis and CPT codes). |
| *Exclusions:* Documentation of medical reason(s) for prescribing systemic antimicrobial therapy (e.g., coexisting diabetes, immune deficiency) |
| *Data Source:* Electronic administrative data/ claims, Survey: Patient, lab data, pharmacy data |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group |

| **655: OTITIS MEDIA WITH EFFUSION: ANTIHISTAMINES OR DECONGESTANTS—AVOIDANCE OF INAPPROPRIATE USE (GROUPED WITH 656 & 657) TIME-LIMITED ENDORSEMENT** |
|---|
| *Measure Steward:* AMA PCPI |
| *Measure Description:* This measure identifies the percentage of patients aged 2 months through 12 years with a diagnosis of otitis media with effusion who were not prescribed or recommended to receive either antihistamines or decongestants. |
| *Numerator:* Patients who were not prescribed or recommended to receive either antihistamines or decongestants |
| *Denominator:* All patients aged 2 months through 12 years with a diagnosis of OME |
| *Exclusions:* Documentation of medical reason(s) for prescribing or recommending to receive either antihistamines or decongestants (e.g., patient has a coexisting condition like rhinitis for which antihistamines or decongestants are indicated. |
| *Data Source:* Electronic administrative data/claims, Electronic health/medical record, Paper medical record/ flowsheet, Special or unique data |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group |
| **656: OTITIS MEDIA WITH EFFUSION: SYSTEMIC CORTICOSTEROIDS—AVOIDANCE OF INAPPROPRIATE USE (GROUPED WITH 655 & 657) TIME-LIMITED ENDORSEMENT** |
| *Measure Steward:* AMA PCPI |
| *Measure Description:* This measure identifies the percentage of patients aged 2 months through 12 years with a diagnosis of otitis media with effusion who were not prescribed systemic corticosteroids. |
| *Numerator:* Patients who were not prescribed systemic corticosteroids |
| *Denominator:* All patients aged 2 months through 12 years with a diagnosis of OME |
| *Exclusions:* Documentation of medical reason(s) for prescribing systemic corticosteroids (e.g., patient has a coexisting condition like rhinitis for which systemic corticosteroids are indicated) |
| *Data Source:* Electronic administrative data/claims, Electronic health/medical record, paper medical record/ flowsheet, Special or unique data |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group |

| **657: OTITIS MEDIA WITH EFFUSION: SYSTEMIC ANTIMICROBIALS—AVOIDANCE OF INAPPROPRIATE USE (GROUPED WITH 655 & 656) TIME-LIMITED ENDORSEMENT** |
|---|
| *Measure Steward:* AMA PCPI |
| *Measure Description:* This measure identifies the percentage of patients aged 2 months through 12 years with a diagnosis of otitis media with effusion who were not prescribed systemic antimicrobials. |
| *Numerator:* Patients who were not prescribed systemic antimicrobials. |
| *Denominator:* All patients aged 2 months through 12 years with a diagnosis of OME |
| *Exclusions:* Documentation of medical reason(s) for prescribing systemic antimicrobials (e.g., salvage therapy prior to surgery) |
| *Data Source:* Electronic administrative data/claims, Electronic health/medical record, Paper medical record/ flowsheet, Special or unique data |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group |
| **651: ULTRASOUND DETERMINATION OF PREGNANCY LOCATION FOR PREGNANT PATIENTS WITH ABDOMINAL PAIN TIME-LIMITED ENDORSEMENT** |
| *Measure Steward: ACEP* |
| *Measure Description:* This measure identifies pregnant patients who present to the emergency department with a chief complaint of abdominal pain and or vaginal bleeding and receive a trans-abdominal or trans-vaginal ultrasound. |
| *Numerator:* Number of appropriate patients who receive a trans-abdominal or trans-vaginal ultrasound |
| *Denominator:* All pregnant patients who present to the ED with a chief complaint of lower abdominal pain, and/or vaginal bleeding |
| *Exclusions:*<br>1. Women for whom location of pregnancy is already documented or reported as intra-uterine<br>2. Patient refusal<br>3. Ultrasound is not feasible (facility reason)<br>4. Ultrasound machine not available<br>-ED does not have access to ultrasound<br>5. Licensed independent provider not credentialed in ultrasound |
| *Data Source:* Paper medical record/ flowsheet, Electronic administrative data/claims, Electronic clinical data, Electronic health/Medical record |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group, Can be measured at all levels |

| **652: RH IMMUNOGLOBULIN (RHOGAM) FOR RH NEGATIVE PREGNANT WOMEN AT RISK OF FETAL BLOOD EXPOSURE TIME-LIMITED ENDORSEMENT** |
|---|
| *Measure Steward:* ACEP |
| *Measure Description:* This measure identifies the percentage of Rh negative pregnant women at risk of fetal blood exposure who receive Rhogam in the emergency department. |
| *Numerator:* Number of appropriate patients who receive Rhogam in the ED |
| *Denominator:* All women, confirmed pregnant who are Rh negative pregnant women at significant risk of fetal blood exposure, including:<br>1. Those diagnosed with an ectopic pregnancy<br>2. Those in the second or third trimester:<br>a. With a threatened abortion (threatened, partial, complete, or spontaneous)<br>b. Those who report or are found to have significant vaginal bleeding (not just spotting)<br>c. Those who have sustained blunt abdominal trauma<br>3. Those who have undergone an invasive procedure that previously occurred and present in the ED |
| *Exclusions:*<br>1. Patient refusal<br>2. Patients who have received appropriate Rh immunoglobulin previously<br>3. OB/GYN consultation documenting Rh immunoglobulin not recommended |
| *Data Source:* Paper medical record/flowsheet, Electronic administrative data/claims, Electronic health/medical record, Electronic clinical data |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group, Can be measured at all levels. |
| **658: ENDOSCOPY/POLYP SURVEILLANCE: APPROPRIATE FOLLOW-UP INTERVAL FOR NORMAL COLONOSCOPY IN AVERAGE RISK PATIENTS TIME-LIMITED ENDORSEMENT** |
| *Measure Steward:* AMA PCPI |
| *Measure Description:* This measure identifies the percentage of patients 50 and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report. |
| *Numerator:* Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report |
| *Denominator:* All patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy |
| *Exclusions:* Documentation of medical reason(s) for not recommending at least a 10-year follow-up interval (e.g., above average risk patient, inadequate prep) |
| *Data Source:* Electronic administrative data/claims, Electronic clinical data, Electronic health/medical record, Paper medical record/ flowsheet, Special or unique data |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group |

| **659: ENDOSCOPY/POLYP SURVEILLANCE: COLONOSCOPY INTERVAL FOR PATIENTS WITH A HISTORY OF ADENOMATOUS POLYPS—AVOIDANCE OF INAPPROPRIATE USE TIME-LIMITED ENDORSEMENT** |
|---|
| *Measure Steward:* AMA PCPI |
| *Measure Description:* This measure identifies the percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp in previous colonoscopy findings who had a follow-up interval of three or more years since their last colonoscopy documented in the colonoscopy report. |
| *Numerator:* Patients who had an interval of 3 or more years since their last colonoscopy |
| *Denominator:* All patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior colonic polyp in a previous colonoscopy |
| *Exclusions:* Documentations of medical reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas)<br>OR<br>Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., unable to locate previous colonoscopy report, previous colonoscopy report was incomplete) |
| *Data Source:* Electronic administrative data/claims, Paper medical record/ flowsheet, Electronic health/medical record, Special or unique data |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group |
| **660: TROPONIN RESULTS FOR EMERGENCY DEPARTMENT ACUTE MYOCARDIAL INFARCTION (AMI) PATIENTS OR CHEST PAIN PATIENTS (WITH PROBABLE CARDIAC CHEST PAIN) RECEIVED WITHIN 60 MINUTES OF ARRIVAL TIME-LIMITED ENDORSEMENT** |
| *Measure Steward:* CMS |
| *Measure Description:* This measure identifies emergency department acute myocardial infarction patients or chest pain patients (with probable cardiac chest pain) with an order for troponin during the stay and having a time from ED arrival to completion of troponin results within 60 minutes of arrival. |
| *Numerator:* Emergency department acute myocardial infarction (AMI) patients or chest pain patients (with probable cardiac chest pain) with an order for troponin whose time from ED arrival to completion of troponin results is within 60 minutes of arrival |
| *Denominator:* Emergency department acute myocardial infarction (AMI) patients or chest pain patients (with probable cardiac chest pain) patients with an order for troponin |
| *Exclusions:*<br>• Patients less than 18 years of age<br>• Patients who expired in the emergency department<br>• Patients who left the emergency department against medical advice or discontinued care |
| *Data Source:* Electronic administrative data/claims, Paper medical record/flowsheet, Electronic health/medical record, Electronic clinical data, Lab data |
| *Level of Analysis:* Facility/Agency |

| **661: HEAD CT OR MRI SCAN RESULTS FOR ACUTE ISCHEMIC STROKE OR HEMORRHAGIC STROKE PATIENTS WHO RECEIVED HEAD CT OR MRI SCAN INTERPRETATION WITHIN 45 MINUTES OF ARRIVAL TIME-LIMITED ENDORSEMENT** |
|---|
| *Measure Steward:* CMS |
| *Measure Description:* This measure identifies acute ischemic stroke or hemorrhagic stroke patients who arrive at the emergency department within two hours of the onset of symptoms and have a head computed tomography or magnetic resonance imaging scan performed during the stay, with a time from emergency department arrival to interpretation of the head CT or MRI scan within 45 minutes of arrival. |
| *Numerator:* Emergency department acute ischemic stroke or hemorrhagic stroke patients arriving at the ED within two hours of the time last known well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the head CT or MRI scan is within 45 minutes of arrival |
| *Denominator:* Emergency department acute ischemic stroke or hemorrhagic stroke patients arriving at the ED within two hours of the time last known well with an order for a head CT or MRI scan. |
| *Exclusions:*<br>• Patients less than 18 years of age<br>• Patients who expired in the emergency department<br>• Patients who left the emergency department against medical advice or discontinued care |
| *Data Source:* Electronic administrative data/claims, Electronic clinical data, Electronic health/medical record, Paper medical record/ flowsheet, Lab data |
| *Level of Analysis:* Facility/Agency |
| **662: MEDIAN TIME TO PAIN MANAGEMENT FOR LONG BONE FRACTURE TIME-LIMITED ENDORSEMENT** |
| *Measure Steward:* CMS |
| *Measure Description:* This measure identifies median time from emergency department arrival to time of initial parenteral pain medication administration or other regional/local anesthesia pain management for emergency department patients with a principal diagnosis of long bone fracture. |
| *Numerator:* Continuous variable statement: time (in minutes) from emergency department arrival to time of initial parenteral pain medication administration, or other regional/ local anesthesia pain management for emergency department patients with a diagnosis of a (long bone) fracture. |
| *Denominator:* Emergency department patients with a principal diagnosis of long bone fracture (LBF). |
| *Exclusions:*<br>•Patients less than 2 years of age<br>•Patients who expired in the emergency department<br>•Patients who left the emergency department against medical advice or discontinued care |
| *Data Source:* paper medical record/flowsheet, Electronic administrative data/claims, pharmacy data, Electronic clinical data, electronic Health/Medical Record |
| *Level of Analysis:* Facility/Agency |

| 666: ULTRASOUND GUIDANCE FOR INTERNAL JUGULAR CENTRAL VENOUS CATHETER PLACEMENT TIME-LIMITED ENDORSEMENT |
|---|
| *Measure Steward:* ACEP |
| *Measure Description:* This measure identifies the percentage of adult patients aged 18 years and older with an internal jugular central venous catheter placed in the emergency department under ultrasound guidance. |
| *Numerator:* Number of adult patients aged 18 years and older who underwent ultrasound guided internal jugular central venous catheter insertion in the emergency department |
| *Denominator:* Number of adult patients aged 18 years and older who underwent internal jugular central venous catheter insertion in the emergency department |
| *Exclusions:*<br>1. Patients receiving central lines in other sites (subclavian, femora)<br>2. Patients with allergy to ultrasound (US) gel<br>3. Central line placed in code situation (clinician documents that there was not time to perform ultrasound guidance)<br>4. US machine with high frequency linear probe not available<br>• Not at bedside due to time constraint<br>• ED does not have access to ultrasound<br>5. Clinicians not credentialed in ultrasound guided central venous cannulation, or not credentialed in ultrasound guided procedures |
| *Data Source:* Paper medical record/ flowsheet, Electronic administrative data/claims, Electronic clinical data, Electronic health/medical record |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group, Can be measured at all levels. |
| *Exclusions:*<br>1. Patients receiving central lines in other sites (subclavian, femora)<br>2. Patients with allergy to ultrasound (US) gel<br>3. Central line placed in code situation (clinician documents that there was not time to perform ultrasound guidance)<br>4. US machine with high frequency linear probe not available<br>• Not at bedside due to time constraint<br>• ED does not have access to ultrasound<br>5. Clinicians not credentialed in ultrasound guided central venous cannulation, or not credentialed in ultrasound guided procedures |
| *Data Source:* Paper medical record/flowsheet, Electronic administrative data/claims, Electronic clinical data, Electronic health/medical record |
| *Level of Analysis:* Clinicians: Individual, Clinicians: Group, Can be measured at all levels |

# Appendix B
# Steering Committee and NQF Staff

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# Appendix C: NQF-Endorsed Measures

As of April 2010

**MEASURES PREVIOUSLY ENDORSED** as part of the National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures Project

| MEASURE NUMBER/TITLE | DESCRIPTION | IP OWNER[a] |
|---|---|---|
| 0090 Electrocardiogram performed for non-traumatic chest pain* | Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had an electrocardiogram (ECG) performed | ACEP[b]/AMA PCPI[c]/ NCQA[d] |
| 0092 Aspirin at arrival of AMI** | Percentage of patients with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay | ACEP/AMA PCPI/NCQA |
| 0093 Electrocardiogram performed for syncope* | Percentage of patients aged 18 years and older with an emergency department discharge diagnosis of syncope who had an ECG performed | ACEP/AMA PCPI/NCQA |
| 0094 Assessment of oxygen saturation for community-acquired bacterial pneumonia | Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with oxygen saturation assessed | ACEP/AMA PCPI/NCQA |
| 0095 Assessment of mental status for community-acquired bacterial pneumonia* | Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with mental status assessed | ACEP/AMA PCPI/NCQA |
| 0096 Empiric antibiotic for community-acquired bacterial pneumonia* | Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed | ACEP/AMA PCPI/NCQA |

* Time-limited endorsement through May 8, 2009.

## Measures Previously Endorsed as Part of the National Voluntary Consensus Standards for Emergency Care—Phase I: ED Transfer Measures Project *(continued)*

| MEASURE NUMBER/TITLE | DESCRIPTION | IP OWNER[a] |
|---|---|---|
| 0286 Asprin at arrival | Percentage of ED AMI or chest pain (with Probable Cardiac Chest Pain) adult (≥18 years old) patients without aspirin contraindications who received aspirin received within 24 hours before emergency department arrival or administered prior to transfer | CMS[e] |
| 0287 Median to fibrinolysis | Median time (in minutes) from emergency department arrival to administration of fibrinolytic therapy in AMI adult (≥18 years old) patients with ST-segment elevation or LBBB on the ECG performed closest to ED arrival and prior to transfer | CMS |
| 0288 Fibrinolytic therapy received within 30 minutes of ED arrival | Percentage of ED AMI adult (≥18 years old) patients with ST-segment elevation or LBBB on ECG whose time from ED arrival to fibrinolysis is 30 minutes or less | CMS |
| 0289 Median to ECG | Median time (in minutes) from emergency department arrival to ECG (performed in the ED prior to transfer) for AMI or chest pain patients (with Probable Cardiac Chest Pain) | CMS |
| 0290 Median time to transfer to another facility for acute coronary intervention | Median time (in minutes) from emergency department arrival to transfer to another facility for acute coronary intervention | CMS |
| 0291 Administrative communication | Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that administrative information was communicated to the receiving hospital within 60 minutes of departure | UMRHRC[f] |

## Measures Previously Endorsed as Part of the National Voluntary Consensus Standards for Emergency Care—Phase I: ED Transfer Measures Project *(continued)*

| MEASURE NUMBER/TITLE | DESCRIPTION | IP OWNER[a] |
|---|---|---|
| 0292 Vital signs | Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that the entire vital signs record was communicated to the receiving hospital within 60 minutes of departure | UMRHRC |
| 0293 Medication information | Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that medical information was communicated to the receiving hospital within 60 minutes of departure | UMRHRC |
| 0294 Patient information | Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that patient information was communicated to the receiving hospital within 60 minutes of departure | UMRHRC |
| 0295 Physician information | Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that physician information was communicated to the receiving hospital within 60 minutes of departure | UMRHRC |
| 0296 Nursing Information | Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that nursing information was communicated to the receiving hospital within 60 minutes of departure | UMRHRC |
| 0297 Procedures and tests | Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that procedure and test information was communicated to the receiving hospital within 60 minutes of departure | UMRHRC |

## Measures Previously Endorsed as Part of the National Voluntary Consensus Standards for Emergency Care—Phase I: ED Transfer Measures Project *(continued)*

| MEASURE NUMBER/TITLE | DESCRIPTION | IP OWNER[a] |
|---|---|---|
| 0495 Median time from ED arrival to ED departure for admitted ED patients* | Median time from emergency department arrival to time to department from the emergency room for patients admitted to the facility from the emergency department | CMS |
| 0496 Median time from ED arrival to ED departure for discharged ED patients* | Median time from emergency department arrival to time of department from emergency room for patients discharged from the emergency department | CMS |
| 0497 Admit decision time to ED departure time for admitted patients* | Median time from admit decision time to time of departure from the emergency department from emergency department patients admitted to inpatient status | CMS |
| 0498 Door to diagnostic evaluation by a qualified medical personnel* | Time of first contact in the ED to the time when the patient sees the physician (provider) for the first time | Louisiana State University Health Care Services Division |
| 0499 Left without being seen* | Percent of patients leaving without being seen by a physician. | Louisiana State University Health Care Services Division |
| 0500 Severe sepsis and septic shock: management bundle* | Initial steps in the management of the patient presenting with infection (severe sepsis or septic shock) | Henry Ford Hospital |
| 0501 Confirmation of endotracheal tube placement* | Any time an endotracheal tube is placed into an airway in the emergency department or an endotraceal tube is placed by an outside provider and that patient arrives already intubated (EMS or hospital transfer) or when an airway is placed after patients arrives to the ED there should be some method attempted to confirm ETT placement. | Cleveland Clinic |

* Time-limited endorsement through May 1, 2009.

## Measures Previously Endorsed as Part of the National Voluntary Consensus Standards for Emergency Care—Phase I: ED Transfer Measures Project *(continued)*

| MEASURE NUMBER/TITLE | DESCRIPTION | IP OWNER[a] |
|---|---|---|
| 0502 Pregnancy test for female abdominal pain patients* | Pregnancy test for female abdominal pain patients | ACEP |
| 0503 Anticoagulation for acute pulmonary embolus patients* | Anticoagulation for acute pulmonary embolus patients | ACEP |
| 0504 Pediatric weight documented in kilograms | Percent of emergency department patients < 18 years of age with a current weight in kilograms documented in the ED record | AAP[CG] |

* Time-limited endorsement through October 24, 2010.

## Measures Previously Endorsed as Part of the National Voluntary Consensus Standards for Emergency Care—Phase I: ED Transfer Measures Project *(continued)*

| MEASURE NUMBER/TITLE | DESCRIPTION | IP OWNER[a] |
|---|---|---|
| 0148 Blood cultures performed in the emergency department prior to initial antibiotic received in hospital | Percentage of pneumonia patients 18 years of age and older who have had blood cultures performed in the emergency department prior to initial antibiotic received in hospital | CMS/TJC[H] |
| 0527 Prophylactic antibiotic received within 1 hour prior to surgical incision SCIP-Inf-1 | Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time. | ACS/NCQA/ AMA PCPI |
| 0232 Vital signs for community-acquired bacterial pneumonia* | Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed | AMA PCPI |
| 0233 Assessment of oxygen saturation for community acquired bacterial pneumonia* | Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed | AMA PCPI |
| 0234 Assessment of mental status for community acquired bacterial pneumonia* | Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with mental status assessed | AMA PCPI |
| 0325 Discharged on antiplatelet therapy* | Percentage of patients aged 18 years and older with the diagnosis of ischemic stroke or transient ischemic attack (TIA) who were prescribed antiplatelet therapy at discharge | AMA PCPI |

* Time-limited endorsement through May 1, 2009.

## Measures Previously Endorsed as Part of the National Voluntary Consensus Standards for Emergency Care—Phase I: ED Transfer Measures Project *(continued)*

| MEASURE NUMBER/TITLE | DESCRIPTION | IP OWNER[a] |
|---|---|---|
| 0263 Patient burn | Percentage of ASC admissions experiencing a burn prior to discharge | ASC Quality Collaboration[l] |
| 0264 Prophylactic intravenous (IV) antibiotic timing | Percentage of ASC patients who received IV antibiotics ordered for surgical site infection prophylaxis on time | ASC Quality Collaboration |
| 0265 Hospital transfer/admission | Percentage of ASC admissions requiring a hospital transfer or hospital admission prior to being discharged from the ASC | ASC Quality Collaboration |
| 0266 Patient fall | Percentage of ASC admissions experiencing a fall in the ASC | ASC Quality Collaboration |
| 0267 Wrong site, wrong side, wrong patient, wrong procedure, wrong implant | Percentage of ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant | ASC Quality Collaboration |
| 0271 Discontinuation of prophylactic antibiotics (non-cardiac procedures)* | Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time | ACS/NCQA/ AMA PCPI |
| 454 Anesthesiology and critical care: perioperative temperature management* | Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom either active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 30 minutes immediately after anesthesia end time | American Society of Anesthesiologists/ AMA PCPI |

* Time-limited endorsement through July 31, 2010.

## Measures Previously Endorsed as Part of the National Voluntary Consensus Standards for Emergency Care—Phase I: ED Transfer Measures Project *(continued)*

| MEASURE NUMBER/TITLE | DESCRIPTION | IP OWNER[a] |
|---|---|---|
| 0512 Percentage of patients undergoing cervical spine radiographs in trauma who do not have neck pain, distracting pain, neurological deficits, reduced level of consciousness or intoxication | Percentage of patients undergoing cervical spine radiographs in trauma who do not have neck pain, distracting pain, neurological deficits, reduced level of consciousness or intoxication | Harborview Medical Center |
| 0515 Ambulatory surgery patients with appropriate method of hair removal | Percentage of ASC admissions with appropriate surgical site hair removal | ASC Quality Collaboration |

# Notes

A. Intellectual Property owner. For the most current specifications and supporting information please refer to the IP owner.

B. ACEP—American College of Emergency Physicians (**www.acep.org**)

C. AMA PCPI—American Medical Association-convened Physician Consortium for Performance Improvement (**www.physicianconsortium.org**)

D. NCQA—National Committee for Quality Assurance (**www.ncqa.org**)

E. CMS—Centers for Medicare & Medicaid Services (**www.cms.hhs.gov** )

F. UMRHRC—University of Minnesota Rural Health Research Center (**www.hpm.umn.edu/rhrc/**)

G. AAP—American Academy of Pediatrics (**www.aap.org**)

H. TJC—The Joint Commission (**www.jointcommission.org**)

I. ASC Quality Collaboration—Ambulatory Surgical Centers Quality Collaboration (**www.ascquality.org/**)

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