Quality Improvement Committee Actions by Project

December 15, 2006

NQF NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR PREVENTION AND CARE OF VENOUS THROMBOEMBOLISM

Measure	Consensus Outcome*	Comments
* Measures not included in this database were measures for which the QIC abstained, usually because they did not meet the QIC Selection Criteria.		
May 5, 2006		
Statement of Policy, including four domains of prevention and care	Disapprove	Although risk assessment is ideal, it is not clinically practical and will present significant, real-world barriers to implementation, based on the following: The NQF document notes (C-5), "While adequate data exist to determine absolute risk, there is insufficient evidence to support the use of a specific risk assessment tool. Additionally, often patients often have multiple risks factors, and no validated tool currently exists for ranking risk factors in patients who have multiple risks. This is tempered somewhat by (C-8) how institutions execute risk assessment ... should not be specified..." Despite this, several issues persist and speak against implementing risk stratification: First, the guideline upon which the recommendations are based (Antithrombotics 7, page 341S) states, "because the approach of individual prophylaxis prescribing, based on formal risk-assessment models has not been adequately validated and is cumbersome without the use of computer technology, it is unlikely to be used routinely by most clinicians." This guideline does, however, note a potential practical stratification tool for surgical patients (341S), but no such tool is presented for medical patients with only general (not all encompassing) recommendations made on page 371S. Therefore,

		although the NQF recommendation is not prescriptive, as it stands, variability in risk stratification will likely be immense and lead to variability in patient care. Such variability seems an anathema of the goals of NQF. Alternately, NQF should focus upon the fact that most medical and surgical patients have risk factors requiring prophylaxis (page 1). Instead of requiring clinicians to risk stratify in variable ways, given no standardized approach, require physicians to deliver prophylaxis or document why no DVT prophylaxis is given. This approach will achieve the goal of prophylaxis (the ultimate goal of risk stratification) without building a significant barrier to that goal, performing formal risk stratification.
General Recommendation 1. Ensure that multidisciplinary teams develop facility protocols and/or "adopt" established evidenced protocols	Disapprove	If an institution is already doing very well, then to mandate all of these is not an efficient use of resources.
General Recommendation 2. Have in place documented system for ongoing quality improvement that demonstrates acting on evidence-based guidelines/practices	Disapprove	If an institution is already doing very well, then to mandate all of these is not an efficient use of resources.
General Recommendation 3. Include provision for risk assessment/stratification, prophylaxis, diagnosis, and treatment	Approve with Comments	Approval is offered, absent any policy on risk stratification, referred to comment for the Statement of Policy.
General Recommendation 4. Include appropriate QI activity/monitoring for all phases of care with periodic assessment of compliance with policies and measures	Approve with Comments	Approval is offered, absent any policy on risk stratification. We are also concerned with the implications of requiring an institutional policy for the care of a specific disease. Institutional policies require multiple levels of approval, usually including the Medical Board. It would be onerous to change the policy whenever new knowledge mandates a change in practice. Finally, looking at the precedent this would set, imagine the consequences when advocates for other diseases asked for the same and every disease required its own

		institutional policy.
General Recommendation 5. Provide for system of provider education that encompasses all aspects of VTE prevention and care	Approve	This is about education and education regarding risk stratification is important.
Risk Assessment/Stratification Recommendation 1. Provide for risk assessments on all patients based on evidence-based institutional policy	Disapprove	Same Comments as in STATEMENT OF POLICY: Although risk assessment is ideal, it is not clinically practical and will present significant, real-world barriers to implementation based on the following: The NQF document notes (C-5), "While adequate data exist to determine absolute risk, there is insufficient evidence to support the use of a specific risk assessment tool. Additionally often patients often have multiple risks factors and no validated tool currently exists for ranking risk factors in patients who have multiple risks. This is tempered somewhat by (C-8) how institutions execute risk assessment ... should not be specified ..." Despite this, several issues persist and speak against implementing risk stratification: First the guideline upon which the recommendations are based (Antithrombotics 7, page 341S) states, "because the approach of individual prophylaxis prescribing, based on formal risk-assessment models has not been adequately validated and is cumbersome without the use of computer technology, it is unlikely to be used routinely by most clinicians." This guideline does however note a potential practical stratification tool for surgical patients, (341S) but no such tool is presented for medical patients with only general (not all encompassing) recommendations made on page 371S. Therefore, although the NQF recommendation is not prescriptive, as it stands, variability in risk stratification will likely be immense and lead to variability in patient care. Such variability seems an anathema of the goals of NQF. Alternately, NQF should focus upon the fact that most medical and surgical patients have risk factors requiring prophylaxis (page 1). Instead of requiring clinicians to risk stratify in variable ways given no standardized approach, require physicians to deliver prophylaxis or document why no DVT prophylaxis is given. This approach will achieve the goal of prophylaxis (the ultimate goal of

		risk stratification) without building a significant barrier to that goal, performing formal risk stratification.
		Same comment as in GR4: We are also concerned with the implications of requiring an institutional policy for the care of a specific disease. Institutional policies require multiple levels of approval, usually including the Medical Board. It would be onerous to change the policy whenever new knowledge mandates a change in practice. Finally, looking at the precedent this would set; imagine the consequences when advocates for other diseases asked for the same and every disease required its own institutional policy.
Risk Assessment/Stratification Recommendation 2. Require documentation in the patient's health record that risk assessment/ stratification was completed	Disapprove	Same Comments as in STATEMENT OF POLICY: Although risk assessment is ideal, it is not clinically practical and will present significant, real-world barriers to implementation based on the following: The NQF document notes (C-5), "While adequate data exist to determine absolute risk, there is insufficient evidence to support the use of a specific risk assessment tool. Additionally often patients often have multiple risks factors and no validated tool currently exists for ranking risk factors in patients who have multiple risks. This is tempered somewhat by (C-8) how institutions execute risk assessment ... should not be specified ..." Despite this, several issues persist and speak against implementing risk stratification: First the guideline upon which the recommendations are based (Antithrombotics 7, page 341S) states, "because the approach of individual prophylaxis prescribing, based on formal risk-assessment models has not been adequately validated and is cumbersome without the use of computer technology, it is unlikely to be used routinely by most clinicians." This guideline does however note a potential practical stratification tool for surgical patients, (341S) but no such tool is presented for medical patients with only general (not all encompassing) recommendations made on page 371S. Therefore, although the NQF recommendation is not prescriptive, as it stands, variability in risk stratification will likely be immense and lead to variability in patient care. Such variability seems an anathema of the goals of NQF. Alternately, NQF should focus upon the fact that most medical and surgical patients have risk factors requiring prophylaxis

		(page 1). Instead of requiring clinicians to risk stratify in variable ways given no standardized approach, require physicians to deliver prophylaxis or document why no DVT prophylaxis is given. This approach will achieve the goal of prophylaxis (the ultimate goal of risk stratification) without building a significant barrier to that goal, performing formal risk stratification.
Prophylaxis Recommendation 1. Provide for type and intensity of prophylaxis based on and commensurate with assessment and documentation of risk/benefit and efficacy/safety for the patient	Disapprove	Same Comments as in STATEMENT OF POLICY: Although risk assessment is ideal, it is not clinically practical and will present significant, real-world barriers to implementation based on the following: The NQF document notes (C-5), "While adequate data exist to determine absolute risk, there is insufficient evidence to support the use of a specific risk assessment tool. Additionally often patients often have multiple risks factors and no validated tool currently exists for ranking risk factors in patients who have multiple risks. This is tempered somewhat by (C-8) how institutions execute risk assessment ... should not be specified ..." Despite this, several issues persist and speak against implementing risk stratification: First the guideline upon which the recommendations are based (Antithrombotics 7, page 341S) states, "because the approach of individual prophylaxis prescribing, based on formal risk-assessment models has not been adequately validated and is cumbersome without the use of computer technology, it is unlikely to be used routinely by most clinicians." This guideline does however note a potential practical stratification tool for surgical patients, (341S) but no such tool is presented for medical patients with only general (not all encompassing) recommendations made on page 371S. Therefore, although the NQF recommendation is not prescriptive, as it stands, variability in risk stratification will likely be immense and lead to variability in patient care. Such variability seems an anathema of the goals of NQF. Alternately, NQF should focus upon the fact that most medical and surgical patients have risk factors requiring prophylaxis (page 1). Instead of requiring clinicians to risk stratify in variable ways given no standardized approach, require physicians to deliver prophylaxis or document why no DVT prophylaxis is given. This approach will achieve the goal of prophylaxis (the ultimate goal of

		risk stratification) without building a significant barrier to that goal, performing formal risk stratification.
Prophylaxis Recommendation 2. Prophylaxis is based on formal risk assessment and is consistent with nationally accepted, evidence-based measures/guidelines, including NQF-endorsed A20**TM Safe Practice 17.**	Disapprove	Same Comments as in STATEMENT OF POLICY: Although risk assessment is ideal, it is not clinically practical and will present significant, real-world barriers to implementation based on the following: The NQF document notes (C-5), "While adequate data exist to determine absolute risk, there is insufficient evidence to support the use of a specific risk assessment tool. Additionally often patients often have multiple risks factors and no validated tool currently exists for ranking risk factors in patients who have multiple risks. This is tempered somewhat by (C-8) how institutions execute risk assessment ... should not be specified ..." Despite this, several issues persist and speak against implementing risk stratification: First the guideline upon which the recommendations are based (Antithrombotics 7, page 341S) states, "because the approach of individual prophylaxis prescribing, based on formal risk-assessment models has not been adequately validated and is cumbersome without the use of computer technology, it is unlikely to be used routinely by most clinicians." This guideline does however note a potential practical stratification tool for surgical patients, (341S) but no such tool is presented for medical patients with only general (not all encompassing) recommendations made on page 371S. Therefore, although the NQF recommendation is not prescriptive, as it stands, variability in risk stratification will likely be immense and lead to variability in patient care. Such variability seems an anathema of the goals of NQF. Alternately, NQF should focus upon the fact that most medical and surgical patients have risk factors requiring prophylaxis (page 1). Instead of requiring clinicians to risk stratify in variable ways given no standardized approach, require physicians to deliver prophylaxis or document why no DVT prophylaxis is given. This approach will achieve the goal of prophylaxis (the ultimate goal of risk stratification) without building a significant barrier to that goal, performing formal risk stratification.
Diagnosis Recommendation 2. Include institution-specific	Disapprove	Same comment as in GR4: We are also concerned with the implications of requiring an institutional policy for the care of a

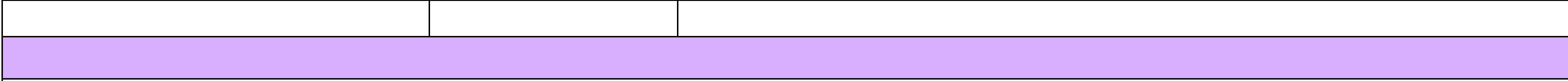
algorithm(s) for establishing diagnosis and require documentation if the algorithm(s) is not followed		specific disease. Institutional policies require multiple levels of approval, usually including the Medical Board. It would be onerous to change the policy whenever new knowledge mandates a change in practice. Finally, looking at the precedent this would set; imagine the consequences when advocates for other diseases asked for the same and every disease required its own institutional policy.
Treatment and Monitoring Recommendation 1. Ensure anticoagulation is administered safely and that the setting in which anticoagulation occurs is part of the safety consideration	Approve with Comments	The principle is great but we woul,d like a more clear definition of what is meant by administered "safely."
Treatment and Monitoring Recommendation 3. Provide for initiation of treatment based on empiric evidence with high degree of suspicion and assessment of safety concerns that, for continued therapy, is confirmed with objective testing	Disapprove	While we agree that continued treatment of VTE should ideally be based on objective testing, there may be difficulty in defining what is an acceptable objective test, such as in a critically ill patient with suspected PE, who is at high risk from contrast-induced renal failure if a CT-angiogram is performed. In such a situation, an echocardiogram demonstrating right heart strain may be the safest test, even if it does not demonstrate "objective evidence of pulmonary embolism." We are also concerned with the implications of requiring an institutional policy for the care of a specific disease. Institutional policies require multiple levels of approval, usually including the Medical Board. It would be onerous to change the policy whenever new knowledge mandates a change in practice. Finally, looking at the precedent this would set, imagine the consequences when advocates for other diseases asked for the same and every disease required its own institutional policy.
Treatment and Monitoring Recommendation 4. Provide for accurate verbal and written patient education appropriate to setting and patient reading levels	Approve with Comments	We approve this but are concerned that documentation will be a challenge when this is converted into a performance measure.
Treatment and Monitoring Recommendation 5. Provide for	Disapprove	There is no supporting guideline or evidence.

guideline-directed therapy addressing five specified situations—heparin and anticoagulation therapy, IVC filters, thrombolytic therapy and embolectomy, postthrombotic syndrome and chronic thromboembolic pulmonary hypertension		
Treatment and Monitoring Recommendation 6. Provide for guideline-directed therapy that addresses care setting transitions	Approve with Comments	We approve this but are concerned that documentation will be a challenge when this is converted into a performance measure.
NQF NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR AMBULATORY CARE: CYCLE 1		
Measure	**Consensus Outcome**	**Comments**
May 5, 2006		
Asthma/Respiratory illness		GENERAL COMMENTS FROM THE ACCP:
MEASURE 1. Asthma assessment	Conditional Approval	We APPROVE with all patients age 5 and older in the denominator.
MEASURE 2. Management plan for people with asthma	Disapprove	We are opposed to this measure as even the NHLBI admits that there is insufficient evidence to support the use of written action plans for asthma.
MEASURE 3. Use of appropriate medications for people with asthma	Disapprove	Measures 3 and 4 should be combined, the language should be clarified, and the age range inconsistencies resolved.

MEASURE 4. Asthma: Pharmacologic Therapy	Disapprove	Measures 3 and 4 should be combined, the language should be clarified, and the age range inconsistencies resolved.
MEASURE 5. Inappropriate antibiotic treatment for adults with acute bronchitis	Disapprove	The principle is important but circuitous language should be clarified. Where did the 3 days come from?
MEASURE 8. COPD – Spirometry evaluation	Conditional Approval	The ACCP approves this measure but recommends that it could be improved by requiring that spirometry must be documented once but not performed yearly.
MEASURE 9. COPD – Inhaled bronchodilator therapy	Conditional Approval	The ACCP approves this measure as long as there is clarification of documentation of exclusion in cases such as if a patient is not interested.
MEASURE 20a and 20b. Tobacco use prevention and cessation for infants, children and adolescents	Disapprove	The ACCP agrees to vote against this measure but suggests one set of tobacco measures that would not be disease-specific. Age and co-morbidity should be eliminated and cessation should be addressed with everyone.
MEASURE 21a and 21b. Tobacco use prevention and cessation for adults and mature adolescents	Disapprove	The ACCP agrees to vote against this measure but suggests one set of tobacco measures that would not be disease-specific. Age and co-morbidity should be eliminated and cessation should be addressed with everyone.
MEASURE 22. Tobacco use in COPD	Disapprove	The ACCP agrees to vote against this measure but suggests one set of tobacco measures that would not be disease-specific. Age and co-morbidity should be eliminated and cessation should be addressed with everyone.
MEASURE 23a, 23b, 23c. Smoking cessation – medical assistance	Disapprove	The ACCP agrees to vote against this measure but suggests one set of tobacco measures that would not be disease-specific. Age and co-morbidity should be eliminated and cessation should be addressed with everyone.
MEASURE 24a and 24b. Tobacco use assessment and Tobacco cessation intervention	Disapprove	The ACCP agrees to vote against this measure but suggests one set of tobacco measures that would not be disease-specific. Age and co-morbidity should be eliminated and cessation should be addressed with everyone.
MEASURE 25a and 25b. Coronary Artery Disease: Smoking cessation and	Disapprove	The ACCP agrees to vote against this measure but suggests one set of tobacco measures that would not be disease-specific. Age and co-morbidity should be eliminated and cessation should be addressed

Smoking cessation intervention		with everyone.
MEASURE 35. Flu shots for adults ages 50-64	Disapprove	Measure 37 is a better measure.
MEASURE 36. Flue shots for older adults	Disapprove	Measure 37 is a better measure.
MEASURE 38. Pneumococcal vaccine needed for all adults aged 65 years or older	Disapprove	Measure 40 is more robustly described and easier to document.
MEASURE 39. Pneumonia vaccination status for older adults	Disapprove	Measure 40 is more robustly described and easier to document.
NQF NATIONAL FRAMEWORK AND PREFERRED PRACTICES FOR PALLIATIVE AND HOSPICE CARE		
May 5, 2006		
GENERAL COMMENT: The ACCP considers these practices important but when developed into measures they should incorporate where the acute care provider would be involved, when relevant. We would like to review the eventual measures.		
NQF National Consensus Statements for Hospital Care: Round 2 Voting on Care Transition Measure		
May 10, 2006		
3-Item Care Transition Measure	Disapprove	HCAHPS already requires 27 items-16 patient report, 1 overall rating, 1 likelihood, 5 demographic and 4 navigation items. It is important to evaluate HCAHPS and how it works prior to moving forward on additional questions. 1.1 The survey language needs to be

		at a lower grade level (3rd grade or lower). The term "preference" may not be at the 3rd grade or lower level. 1.3 Should be changed to “I had the purpose of all my medications explained to me at the time I left the hospital.” The definition of "understood" or “understanding” will vary from patient to patient and an expression of understanding may not be remembered at a later time. 2. The phrase "managing my health" is broad. 2.2 There are many instances where it is better for a caregiver to be responsible for giving and "understanding" the medications. This should read: "a fully responsible caregiver may answer the question." 2.3 It is not clear whether patients with no phone and no valid address for mailings were excluded from the denominator. However, this may be taken into account in the calculations for expected survey return. One of our members reports that their hospital has significant (and documented) problems with both correct phone and address issues. Interviews indicate concerns for "billing and collections," ie, not being able to pay bills and being "dunned."



NQF Cardiology CSMC Measures for Review

June 2, 2006

Measure	**Consensus Outcome**	**Comments**
Measure 4: Beta blocker prescribed at discharge for AMI patients:	no vote required	The QIC questions the deletion of the rule regarding beta blockers when blood pressures are less than 90. In standard cardiology guidelines, if the systolic BP<90, we don’t administer an IV followed by an oral beta blocker; we wait for the blood pressure to rise.
Measure 27:	no vote required	The definition of renal failure is an older and more simplistic notion of renal dysfunction. Today we use creatinine clearance of < 30 cc/minute based upon one of several commonly used algorithms.

NQF Pulmonary CSMC Measures for Review		
June 2, 2006		
Measure	**Consensus Outcome**	**Comments**
Measure 1. Use of relievers for inpatient asthma by AAP age groups:	no vote required	No comments.
Measure 2. Use of systemic corticosteroids for inpatient asthma by AAP age groups:	no vote required	No comments.
Measure 3. Under Hospitals, pneumonia: Oxygenation assessment:	no vote required	This measure seems reasonable and the exclusions seem appropriate. However, this is not a useful measure anymore; it is outdated because clinicians are 98% compliant. If NQF CSMC determines that this measure is no longer useful. Will it be withdrawn from the CMS measure set?
Measure 4. Under Hospitals, pneumonia:	no vote required	Initial antibiotic for CAP in immunocompetent patients: numerator states 'initial antibiotic regimen consistent with current guidelines during the first 24 hours of hospitalization': Reference the guidelines (Table 2). Clearly define pseudomonal risk.
Measure 5. Under Hospitals, pneumonia: Blood cultures performed in ED prior to antibiotic administration:	no vote required	Clarify the intent and wording of exclusion #1. Should one of the exclusions be 'already on antibiotics?' Should transfer patients be excluded if they have not yet received antibiotics?
Measure 6. Under Hospitals, pneumonia: Initial antibiotic received within 4 hours of hospital arrival:	no vote required	New ATS pneumonia guidelines say antibiotics should be given in ER and they will not use the 4-hour rule. The aims of this measure should not be 100% but somewhere around 80% as the appropriate number of patients for whom you can make the diagnosis of pneumonia within 4 hours is not 100%. If the optimal approach is not clearly defined and we cannot feasibly find this group then should this be a measure at all? We know the recommendations are going to change so maybe the measure should change. We recommend dropping this measure because of the accuracy, changing

		recommendations, and consequences
Measure 7. Under Hospitals, Pneumonia: Influenza vaccination:	no vote required	We recommend combining these influenza vaccination measures together. We also do not think these should be inpatient measures at all. This is like taking an outpatient issue and solving it with an inpatient approach. We are also concerned that the value of this measure may not even have been proven. These patients could be captured through screening whether the patients had the vaccine before admission and then could be referred for vaccination within 8 weeks. Look at validity of measure since there is controversy.
Measure 8. Nursing Homes, Influenza: CDC measures:	no vote required	We are more supportive of the influenza vaccine. However, the non-eligibles including those with up to date vaccination status, medical contraindications, and patient refusals should be in the exclusions section.
Measure 9. Under hospitals, pneumonia: pneumococcal vaccination:	no vote required	We recommend all pneumococcal vaccination measures be combined. Measures 9 and measure 10 are inconsistent because of varying definitions. This measure lists pneumococcal vaccination, the next one lists polysaccharide vaccination. The wording of the numerator needs to be clarified and the language standardized. Unlike the subsequent measure on pneumococcal vaccination, this one does not address the issue of eligibility and therefore may not produce accurate information, *ie,* patients may not have been vaccinated because of being already vaccinated or otherwise not eligible and would, therefore, lower the numerator relative to the denominator. This has not been captured.
Measure 10. Nursing Homes, Pneumonia: pneumococcal polysaccharide vaccination of residents age 65 or older.	no vote required	Here the eligible/ineligible are framed so that ineligibles are accounted for both in the denominator and numerator, but that is inconsistent with the way other measures are written. We recommend clarification of the numerator and denominator. Patients < 65 years of age in nursing home should be included.
Measure 11. Under Hospitals, smoking cessation (AMI): Smoking cessation advice/counseling for AMI:	no vote required	We recommend that Measures 11-13 should be combined and not separated by conditions. All in-patient smokers should be included.
Measure 12. Under Hospitals,	no vote required	See comment above for Measures 11-13.

smoking cessation (HF):		
Measure 13. Under Hospitals, smoking cessation advice/counseling (pneumonia):	no vote required	See comment above for Measures 11-13.
Measure 14. Home Health Physiologic Domain: Improvement in dyspnea.	no vote required	How can this feasibly be measured consistently across multiple home health providers? This measure fails both the usability and feasibility criteria. Also the developer needs to clarify the primary intent. If the patient does not do well is it reflective of the physician or the home health agency care?

NQF Serious Reportable Events Project

June 15, 2006

Measures	**Consensus Outcome**	**Comments**
1A. Surgical Events: performed wrong body part	Approved with Comments	The ACCP QIC recommends the addition of procedures such as bronchoscopy and thoracoscopy.
1B. Surgical Events: performed wrong patient	Approved with Comments	The ACCP QIC recommends the addition of procedures such as bronchoscopy and thoracoscopy.
1C. Surgical Events: Wrong procedure	Approved with Comments	The ACCP QIC recommends the addition of procedures such as bronchoscopy and thoracoscopy.
2A. Product or Device Event: Contamination	Approved with Comments	The ACCP QIC recommends the addition of procedures such as bronchoscopy and thoracoscopy.
4B. Care Management Events: ABO/HLA incompatible blood or products	Approved with Comments	A question posed by the ACCP QIC is whether the adoption of this safe practice would mean that all blood products would have to be HLA matched. Is that routine?
4F. Care Management Events: Pressure ulcers	Approved	This is an ICU care issue of which the ACCP QIC approves.

NQF Safe Practices Project

June 28, 2006

Measure	Consensus Outcome	Comments
Practice 3: Ensure that written documentation of the patient's preferences for life-sustaining treatments is prominently displayed in his or her chart.	Approved	This practice was approved as written.
Practice 7: All patients in general ICUs (both adult and pediatric) should be managed by physicians having specific training and certification in critical care medicine ("critical care certified").	Approved with comments	The Committee voted to approve this practice but conveys the following comments: This is a laudable goal but with the current manpower shortage, this may not be feasible unless there are improvements in manpower. All patients in general medical and surgical ICUs (both adult and pediatric) should be managed by physicians having specific training and certification in critical care. This practice should apply in geographic areas where such personnel are reasonably available. In locations where critical care specialists are not available, reasonable attempts should be made to recruit these specialists or to obtain some of their services utilization information technology.
Practice 19: Action should be taken to prevent ventilator-associated pneumonia by implementing ventilator bundle intervention practices	Approved with Comments	The Committee voted to approve this practice but conveys the following comments: This should be renamed. Many QIOs and other groups are now calling this the 'critical care bundle' or 'optimal critical care management'. This is based on several issues: a. Only one of the measures (head of bed) has any direct correlation with VAP. b. Difficulty in defining VAP despite CDC 'guidelines.' One organization may be defining differently than another making

		benchmarking difficult. Specific recommendation: Change the name of this 'safe practice' to 'action should be taken to provide optimal critical care.' Also, no reference for sedation vacation was provided. We request that NQF please provide a more completely reference for this.
Practice 20: Adhere to effective methods of preventing central venous catheter-related blood stream infections and specify the requirements in explicit policies and procedures.	Approved with Comments	The Committee voted to approve this practice but conveys the following comments: Articles were controversial about pneumothorax, especially the purported advantage of subclavian over internal jugular for the preferred site for non-tunneled catheters, which is not clear. Again, we request that NQF please provide clearer references or the evidence base providing preferences for subclavian over internal jugular insertion.
Practice 26: Evaluate each patient undergoing elective surgery for risk of acute ischemic perioperative cardiac event and provide prophylactic treatment with beta-blockers for patients who either: 1. have required beta-blockers to control symptoms of angina or patients with symptomatic arrhythmias or hypertension, or 2. are at high cardiac risk owing to the finding of ischemia on preoperative testing and are undergoing vascular surgery.	Approved with Comments	The Committee voted to approve this practice but conveys the following comments: NQF is requested to clarify the denominator, providing clarification about which patients are included and which are not in the group who should receive the beta-blockers. Why does the denominator not say (for 'pediatric asthma inpatients (ages 2-17) for whom systemic corticosteroids is not contraindicated.' In other words, it seems that the denominator should only reflect those patients eligible for the treatment if one is going to measure adherence by numerator/denominator. This argument actually could be made for measure #1 and for many others. In general, one of the confusions (and one of the things that should be standardized) is what is considered an exclusion and what is considered a legitimate part of the denominator.
Practice 28: Evaluate each patient upon admission, and	Disapprove	The Committee voted to disapprove this practice and provides the following comments: The ACCP QIC continues to reject the practice

regularly thereafter, for the risk of developing VTE/DVT. Utilize clinically appropriate, evidence-based methods of thromboprophylaxis.		of risk assessment for VTE. Instead, the Committee proposes that the NQF should revise the recommendations such that physicians will be required to deliver VTE prophylaxis to all medical and surgical inpatients or document why it will not be prescribed for that patient. While adequate data exist to determine absolute risk, there is insufficient evidence to support the use of a specific risk assessment tool. Additionally often patients have multiple risks factors and no validated tool currently exists for ranking risk factors in patients who have multiple risks. The guideline upon which the recommendations are based (The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy: Evidence-Based Guidelines CHEST 2004; 126(suppl), page 341S) states, 'because the approach of individual prophylaxis prescribing, based on formal risk-assessment models has not been adequately validated and is cumbersome without the use of computer technology, it is unlikely to be used routinely by most clinicians.' This guideline does, however, note a potential practical stratification tool for surgical patients (p. 341S), but no such tool is presented for medical patients with only general (not all encompassing) recommendations made on page 371S. Therefore, although the NQF practice is not prescriptive, as it stands, variability in risk stratification will likely be immense and lead to variability in patient care. Instead of requiring clinicians to risk stratify in variable ways given no standardized approach, we recommend the standards require physicians to deliver prophylaxis or document why no DVT prophylaxis is given. This approach will achieve the goal of prophylaxis (the ultimate goal of risk stratification) without building a significant barrier to that goal, performing formal risk stratification. This practice is best suited at present as a research agenda.
Practice 29: Every patient on long-term oral anticoagulants	Approved with comments	The Committee voted to approve this practice but conveys the following comments: NQF needs to clarify the denominator and

should be monitored by a qualified health professional using a careful strategy to ensure an appropriate intensity of supervision.		geographic location. If this practice is intended for all care settings, clarification should be provided on how this would be accomplished across the outpatient and inpatient spectrum. Monitoring is really an outpatient measure and not the same as bridging. In the outpatient setting physicians are already doing well and this may not be the best use of our resources.
End of Life in Cancer Patients		
July 8, 2006		
General Comments		Although these standards are brought forward with good intentions, given the absence of good quality evidence, we believe they are too vague at this current time. We recognize that standards #3-11 are intended only for surveillance purposes for now, but we wish to express concern for the following reasons: (1) They have a high probably of becoming performance measures in the future. (2) In the meantime, even as surveillance standards for data collection purposes, hospitals will have to incur costs to provide these data. (3) Furthermore, with the lack of evidence to support these measures and their lack of specificity (see below), we are concerned about how the generated data can be interpreted. The ACCP QIC recommends that there be a fourth tier of consensus standards, lower than surveillance, which would be a research agenda. Items 3-11 should fall into this area. In addition, the specificity of these standards needs to be improved. For example, emergency room visits, hospitalizations, and ICU admissions in the numerator should be specifically for reasons associated with the cancer diagnosis. Also, the science behind some of the time periods (eg, last 14 days of life, last 30 days of life)

		should be explained. Finally, there is a danger that by encouraging the withholding of care in cancer patients, even if it is usually appropriate, we may prevent patients for whom such care is appropriate from getting it, as hospitals attempt to achieve 100% performance. In this group of patients, in which there is occasionally an inappropriate bias against giving care, this is a real risk. Thus, this magnifies the dangers in developing these measures, without knowing what is the appropriate performance target.
Standard 1	APPROVED with comment	The QIC is somewhat uncomfortable with a performance measure being based on a “survey,” but the description of the development is fairly robust.
Standard 2	APPROVED with comment	APPROVED but there are concerns about specificity. Is 48 hours arbitrary? Please provide the science behind the 48 hours timeframe. Listed references were about how performance status is a better predictor of outcome so we question why performance status was not included. We agree with the listed set of weaknesses in the TP Discussion and Recommendation. This is a hospice measure, so the issue becomes how quickly can they (the hospice) control the patient’s pain.
Standard 3	Disapprove	a. The standard lacks construct validity to support 14-day timeframe. b. It is critical to add some measure of the patient’s performance status. c. Special attention should be paid to the potential confounders/exclusions, ie, the patient’s age, new diagnoses, patients dying from a complication of the chemotherapy, rather than the cancer itself.
Standard 4	Disapprove	4. DISAPPROVE with reference to the general comments above
Standard 5	Disapprove	DISAPPROVE with reference to the general comments above
Standard 6	Disapprove	6. DISAPPROVE with reference to the general comments above, as

		well as the following: a. The goal should not be 100%, as we will never get to 100%. b. This measure presumably means the proportion with progressive disease admitted to the ICU in last 30 days of life. c. Reference the commentary in appendix D, page D-20 regarding the proportion receiving chemotherapy in the last 30 days: One defined weakness of this measure was listed as 'imprecision in predicting when patients have 30 days to live.' We believe this is applicable to the 30-day time period for this measure on admissions to the ICU within the last 30 days of life, as well. Predicting the last 30 days of life and whether to admit the patient to the ICU can be problematic. That said, the data support that admission to the ICU in the last 30 days of life occurs all too frequently. Hence this measure is purely suggested for 'surveillance,' or as a research agenda. d. This is dependent on the facility, healthcare options, and treatment required. e. Patient and family preferences may dictate this more than the healthcare system.
Standard 7	Disapprove	DISAPPROVE with reference to the general comments above, as well as the following: a. The table on page 9 should really be under utilization.
Standard 8	Disapprove	DISAPPROVE with reference to the general comments above, as well as the following: a. The table on page 9 should really be under utilization. b. There are issues of access to hospice that are not addressed here.

		c. We would like to see more data on utilization of hospice. If 90% of the time it is under 4 days to the end of life, then that is not an abuse of hospice.
Standard 9	Disapprove	DISAPPROVE with reference to the general comments above, as well as the following: a. What about new diagnoses, or patients whose home or social situation changes? b. The table on page 9 should really be under utilization.
Standard 10	Disapprove	DISAPPROVE; as this standard is not being put forward by NQF, we state that we agree with the TAP DISAPPROVAL of this measure.
Standard 11	Disapprove	DISAPPROVE; as this standard is not being put forward by NQF, we state that we agree with the TAP DISAPPROVAL of this measure.

AMA-PCPI/NCQA Eye Care

August 4, 2006

Measure	Consensus Outcome	Comments
	Abstained	The ACCP Quality Improvement Committee abstains from commenting on the Eye Care measures as they are outside the expertise of our organization.

AMA-PCPI/NCQA Stroke and Stroke Rehabilitation

August 25, 2006

Measure	Consensus Outcome	Comments

Measure #1: DVT Prophylaxis for Ischemic Stroke	Disapproved	The ACCP Quality Improvement Committee disapproves of measure 1 because as they are currently written, the older 6th edition of the ACCP antithrombotic guidelines is referenced. Although the language appears to be the same, we recommend you change the reference to the 7th edition:
Measure #2: DVT Prophylaxis for Intracranial Hemorrhage	Disapproved	The ACCP Quality Improvement Committee disapproves of measure 1 because as they are currently written, the older 6th edition of the ACCP antithrombotic guidelines is referenced. We recommend you change the reference to the 7th edition: Reference: The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy: Evidence-Based Guidelines CHEST 2004; 126(suppl): 163S-703S. NOTE: The language between these two editions has changed. The more recent edition removes the use of elastic stockings and suggests low dose heparin may be initiated on day 2 based on patient values and preferences. Also, we are concerned whether the ACC/AHA guideline is the latest edition.
Measure #3	Abstained	The ACCP Quality Improvement Committee abstains from comment on measure 3
Measure #4: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	Disapproved	The ACCP Quality Improvement Committee disapproves of measure 4 because as they are currently written, the older 6th edition of the ACCP antithrombotic guidelines is referenced. Although the language appears to be the same, we recommend you change the reference to the 7th edition: Reference: Singer DE, et al. Antithrombotic Therapy in Atrial Fibrillation: The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. CHEST 126: 429S-456S. Also, Is the ACC/AHA guideline referenced the most recent edition?
Measures #5 – 11	Abstained	The ACCP Quality Improvement Committee abstains from comment on measures 5-11
AMA-PCPI/NCQA Gastroesophageal Reflux Disease		

September 29, 2006		
Measure	**Consensus Outcome**	**Comments**
	Abstained	The ACCP Quality Improvement Committee abstains from voting on these GERD measures at this time. However, we thank NCQA and the AMA-PCPI for the opportunity and look forward to future collaborative efforts.

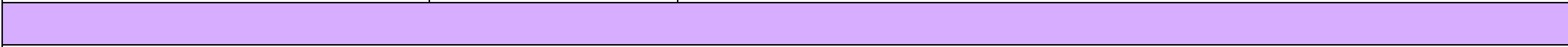
AMA-PCPI/NCQA Geriatrics

September 29, 2006		
Measure	**Consensus Outcome**	**Comments**
	Abstained	The ACCP Quality Improvement Committee abstains from voting on these geriatric measures at this time. However, we thank NCQA and the AMA-PCPI for the opportunity and look forward to future collaborative efforts.

AMA-PCPI/NCQA Emergency Medicine

September 29, 2006		
Measure	**Consensus Outcome**	**Comments**
	Abstained	The ACCP Quality Improvement Committee abstains from voting on these geriatric measures at this time. However, we thank NCQA and the AMA-PCPI for the opportunity and look forward to future

		collaborative efforts.



NQF Serious Reportable Events

September 22, 2006

Measure	Consensus Outcome	Comments
Event 4B: Patient death or serious disability associated with hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products.		The ACCP approves this serious reportable event as it is written. We abstain on the other six events. However, the ACCP approves all five of the research recommendations.

NQF End of Life Care in Cancer Patients

September 26, 2006

Measure	Consensus Outcome	Comments
		The ACCP Quality Improvement Committee abstains from voting on these End-of-Life Care measures at this time.

NQF Ambulatory Care

September 26, 2006		
Measure	**Consensus Outcome**	**Comments**
		The ACCP Quality Improvement Committee abstains from voting on these Ambulatory Care measures at this time.

NQF Safe Practices Project

September 28, 2006		
Measure	**Consensus Outcome**	**Comments**
Practice 3: Ensure that written documentation of the patient's preferences for life-sustaining treatments is prominently displayed in his or her chart.		This practice was approved as written.
Practice 7: All patients in general ICUs (both adult and pediatric) should be managed by physicians having specific training and certification in critical care medicine ("critical care certified").		The Committee voted to disapprove this practice but conveys the following comments:
Practice 8: Ensure that care information is transmitted and appropriately documented in a timely and clearly understandable form to patients and to all of the patient's healthcare		This practice was approved as written.

providers/professionals, within and between care settings, who need that information to provide continued care.		
Practice 9: For verbal or telephone orders or for telephonic reporting of critical tests results, verify the complete order or test results by having the person receiving the information record and "read-back" the complete order or test result.		This practice was approved as written.
Practice 19: Action should be taken to prevent ventilator-associated pneumonia by implementing ventilator bundle intervention practices.		The Committee voted to disapprove this practice but conveys the following comments: As noted in the June 28, 2006 response to the proposed Safe Practices from our Quality Improvement Committee, this measure should be renamed as "ICU bundle" or "critical care bundle" to more accurately reflect the intentions of this practice. This practice involves only one measure directly related to the prevention of VAP (HOB at 30 degrees). The other components (DVT prophylaxis, PUD prophylaxis, sedation vacation) are not directly related to VAP. Further, a fifth component is missing. The IHI bundle quoted in the background information adds a fifth component: assessment of mechanical ventilation weaning readiness on a daily basis, which should be added as a fifth component. All components should be more completely referenced. An additional issue with this bundle is the difficulty of defining ventilator-associated pneumonia and the fact that it is not uniformly applied. VAP should be removed as an outcome. This does not meet the cardinal NQF criteria of feasibility.
Practice 20: Adhere to effective methods of preventing central venous catheter-related blood stream infections and specify the requirements in		The Committee voted to disapprove this practice but conveys the following comments: The Committee suggests striking the language on page 176 line 3517, which reads "subclavian vein is the preferred site for non-tunneled

explicit policies and procedures.		catheters in adults," based on the paucity of high level evidence supporting this statement.
Measure 23: Immunize healthcare workers and patients who should be immunized against influenza annually.		This practice was approved as written.
Measure 28: Evaluate each patient upon admission, and regularly thereafter, for the risk of developing VTE/DVT. Utilize clinically appropriate, evidence-based methods of thromboprophylaxis.		The ACCP QIC continues to reject the practice of risk assessment for VTE. Instead, the Committee proposes that the NQF should revise the recommendations such that physicians will be required to deliver VTE prophylaxis to all medical and surgical inpatients or document why it will not be prescribed for that patient. While adequate data exist to determine absolute risk, there is insufficient evidence to support the use of a specific risk assessment tool. Additionally, often patients have multiple risks factors and no validated tool currently exists for ranking risk factors in patients who have multiple risks. The guideline upon which the recommendations are based (The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy: Evidence-Based Guidelines CHEST 2004; 126(suppl), page 341S) states, "because the approach of individual prophylaxis prescribing, based on formal risk-assessment models has not been adequately validated and is cumbersome without the use of computer technology, it is unlikely to be used routinely by most clinicians." This guideline does, however, note a potential practical stratification tool for surgical patients (p. 341S), but no such tool is presented for medical patients with only general (not all encompassing) recommendations made on page 371S. Therefore, using NQF's criteria for performance measures, this is neither usable nor feasible. A feasible and usable alternative to this would be: Instead of requiring clinicians to risk stratify in variable ways given no standardized approach, we recommend the standards require physicians to deliver prophylaxis or document why no DVT prophylaxis is given. This approach will achieve the goal of prophylaxis (the ultimate goal of risk stratification) without building a significant barrier to that goal, performing formal risk stratification. This practice, as currently written, is best suited as a research agenda

		item.
Practice 29: Every patient on long-term oral anticoagulants should be monitored by a qualified health professional using a careful strategy to ensure an appropriate intensity of supervision.		The Committee voted to approve this practice but would like clarification if NQF intends to develop these practices into performance measures in the future.

NQF Pneumonia Mortality Measures

December 14, 2006

Measure/Recommendation	**Consensus Outcome**	**Comments**
1. 30-Day Pneumonia Mortality	Disapprove	As written, we would not approve this measure but we offer the following specific comments: • We recognize that there has been an attempt to balance transfers out and transfers in. However, even if there are specific inclusionary and exclusionary clauses, this will no longer be measuring the quality of just one institution. • “Transfers out” (“inclusions”) in the denominator will falsely inflate the denominator and make the actual mortality rate look better than it is. • Instead, the ACCP proposes that “transfers out” of the hospital should be excluded from the analysis, both from the numerator and the denominator. • “Transfers in” to the hospital should be included (removed from the

		exclusions) and the hierarchical risk adjustment should handle the burden presented by these sicker patients. • Furthermore, the only way to get these data is from CMS and there is no methodology provided. To better understand this measure, the methodology for obtaining these data from CMS needs to be provided and data included regarding the validation of this methodology. • We question how risk stratification can be done with the CMS data and request that this issue be addressed. Specifically, no methodology and validation data for the hierarchical risk adjustment is provided. • Depending on the ratio of pay index and other social factors, there will be variability of outcomes. It is not clear if this will wash out with higher volume. How will the hierarchical risk adjustment model account for disparities in case mix (eg, race, sex, funding status, and degree of access to care)?
2. Inpatient Pneumonia Mortality	Disapprove	As written, we would not approve this measure but we offer the following specific comments: • The list of exclusions should not include "transfers out" (*ie,* remove it from the list) and "transfers in" should be included in the denominator. • NQF is requested to supply more information about the hierarchical model and how the hierarchical models will handle the social disparities (see similar request, Measure 1, above).
1.Mortality Measure Maintenance Recommendation	Approve	The ACCP approves this recommendation, as written.
2. Harmonization of Consensus Standards Recommendation	Approve	Consistent with our previous requests for harmonization of measures, the ACCP approves this recommendation. However, we suggest that the language be made more succinct and concise.
3. Amended Recommendation for Mortality Measure	Approve	The ACCP approves this recommendation, as written.

Implementation		
NQF Substance Abuse Measures		
February 20, 2007		
General Comments		We recommend that tobacco use be separated from alcohol and other drugs. However, as there are already several tobacco cessation measures in the hospital domain (AMI, HF, and pneumonia), it is imperative that the language be aligned. Inconsistencies lead to reporting burden.
Measure/Recommendation	**Consensus Outcome**	**Comments**
1. Patients in general and mental healthcare settings should be screened for alcohol use problems and illnesses and tobacco use.	Disapprove	A. Define what is meant by "general healthcare." B. Must specify all inpatients and outpatients. C. Define tobacco use as any smoking at all. Define a tobacco use problem as anyone who smokes any cigarettes. D. Change "screen" to "question" because we believe this refers to verbally questioning patients directly or by written questionnaire rather than blood or urine tests. Blood and urine tests would be cost prohibitive for this size population and the results do not come back instantly, while with patient questioning, the provider can take advantage of the teachable moment. Tobacco use is already being screened by nurses in the hospital setting.
2. Patients who have a positive screen for, or a clinical indication of, a substance use problem or illness should receive further assessment to confirm that a problem exists	Disapprove	A. This measure is a great concept but it is not usable or feasible in the current healthcare system. Most healthcare settings will not be able to do a multidimensional, biopsychosocial assessment. The Technical Advisory Panel even said there was a potential issue with usability and feasibility. B. Provide a more clear definition of what is meant by "substance

and determine a diagnosis. Patients diagnosed with a substance use illness should receive multidimensional, biopsychosocial assessment to guide treatment planning.		use illness" (substance use or a secondary effect due to substance use). It is not clear if this refers to behavioral or societal problems without medical consequences. These are not always objective. C. This may not apply to tobacco use.
3. All patients identified with alcohol use in excess of NIAAA guidelines and/or any tobacco use should receive a brief motivational counseling intervention by a healthcare worker trained in this technique.	Disapprove	A. Again, alcohol should be separated from tobacco use. B. Change "brief motivational counseling intervention" to "brief counseling" and as few clinicians have had the training to provide brief motivational counseling. There is evidence that brief interventions have an impact on tobacco use but since brief interventions may not be as beneficial in alcohol use, this provides another justification for separating alcohol use from tobacco use. C. This is incongruous with the Surgeon General's 5 A's.
5. Supportive pharmacotherapy should be available and provided to manage withdrawal symptoms, based on a systematic assessment of symptoms and risk, for all substance dependent patients. Withdrawal management alone does not constitute treatment for dependence and should be linked with ongoing treatment for substance use illness.	Disapprove	A. Varenicline is not in the specifications. B. In the first sentence, "provided" should be changed to "suggested." C. The last sentence does not apply in tobacco and it is difficult to measure. Furthermore, it is important to separate tobacco from other drugs for the following reasons: A. Treatment is effective in tobacco cessation but might not be as effective in the use of other drugs. B. The second sentence is more applicable to other substance abuse than tobacco. C. There is a feasibility issue because not every health plan will cover tobacco dependence treatment. D. This is also a feasibility issue since most nicotine replacement medications are available over-the-counter and, therefore, accountability will be problematic.
6. Empirically validated psychosocial treatment	Disapprove	A. Measures should not be empiric but should be evidence-based. B. In the real world this is not usable or feasible for all patients.

interventions should be initiated for all patients with substance use illness.		Psychosocial treatment interventions are sophisticated and generally physicians do not know how to provide these interventions. This measure will not be implementable.

NQF Pneumonia Mortality Measures

March 7, 2007

Measure	**Consensus Outcome**	**Comments**
1. 30-Day Pneumonia Mortality	Disapprove	As written, we would not approve this measure but we offer the following specific comments: • In pneumonia, unlike cardiology where there excellent process measures based on evidence from RCTs that are linked to outcomes, process measures for Community Acquired Pneumonia have not been linked with outcomes through excellent evidence-based studies (RCTs) and are only based on retrospective studies. We question the time and effort that must be expended to conform to a measure that appears not ready based on the current level of evidence. • The lack of validation of this measure and the risk stratification methodology remain an issue. • The efforts expended to ensure that there are a limited number of outliers (individuals not complying with the performance measure benchmark) indicates that this is not a very specific measure. • It is not clear how this measure will be used. We are concerned that this measure is not an appropriate measure for benchmarking for future value-based reimbursement. • We recognize that there has been an attempt to balance transfers out and transfers in. However, even if there are specific inclusionary and exclusionary clauses, this will no longer be

		measuring the quality of just one institution. • "Transfers out" ("inclusions") in the denominator will falsely inflate the denominator and make the actual mortality rate look better than it is. • Instead, the ACCP proposes that "transfers out" of the hospital should be excluded from the analysis, both from the numerator and the denominator. "Transfers in" to the hospital should be included (removed from the exclusions) and the hierarchical risk adjustment should handle the burden presented by these sicker patients.
2. Inpatient Pneumonia Mortality	Disapprove	As written, we would not approve this measure but we offer the following specific comments: • In pneumonia, unlike cardiology where there excellent process measures based on evidence from RCTs that are linked to outcomes, process measures for Community Acquired Pneumonia have not been linked with outcomes through excellent evidence-based studies (RCTs) and are only based on retrospective studies. We question the time and effort that must be expended to conform to a measure that appears not ready based on the current level of evidence. • The lack of validation of this measure and the risk stratification methodology remain an issue. • The efforts expended to ensure that there are a limited number of outliers (individuals not complying with the performance measure benchmark) indicates that this is not a very specific measure. • It is not clear how this measure will be used. We are concerned that this measure is not an appropriate measure for benchmarking for future value-based reimbursement. • The list of exclusions should not include "transfers out" (*ie,* remove it from the list) and "transfers in" should be included in the denominator.
Recommendations	**Consensus Outcome**	**Comments**
1. Mortality Measure	Disapprove	Consistent with our disapprovals, provided above, the ACCP QIC

Maintenance		does not approve of implementation of these measures.
2. Harmonization of Consensus Standards	Disapprove	Consistent with our disapprovals, provided above, the ACCP QIC does not approve of implementation of these measures.
3. Amended Recommendation for Mortality Measure Implementation	Disapprove	Consistent with our disapprovals, provided above, the ACCP QIC does not approve of implementation of these measures.

NQF Specialty Clinician Measures

March 22, 2007

General Comments		We suggest that the language should be changed to read "the healthcare provider" and not "the physician."
Measure	**Consensus Outcome**	**Comments**
Ambulatory Care Setting:		
20. Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia	Disapprove	We disapprove this measure as it is written. Most cases of pneumonia are not diagnosed as to whether they are bacterial or viral. We recommend that "Bacterial" be removed. This measure should be based on the broad diagnosis of Community-Acquired Pneumonia (CAP). While all vital signs are important and are used in clinical decision-making, requiring the provider to initial the O_2 saturations creates unnecessary burden. There is a high level of compliance already in the ED and it is probably high in the ambulatory setting, as well.
21. Assessment Mental Status for Community-Acquired Bacterial Pneumonia	Disapprove	We disapprove this measure as it is written. Again, most pneumonias are not diagnosed as to whether they are bacterial or not. We recommend that "Bacterial" be removed from the title. This measure

		should be based on the broad diagnosis of Community-Acquired Pneumonia (CAP). We recognize that in the ambulatory setting, mental status can be an important predictor of outcomes, even though it is unlikely to be applicable to the vast majority of ambulatory patients. Alertness and orientation are not often documented in the chart. Although physicians are likely assessing this during the entire visit, they do not habitually document it. A broad statement of "mental status" is non-specific and lacks proven prognostic accuracy (this measure is not written based on the data that supports it and does not reflect what was done in the study). There is no agreed upon specific measure of mental status and there is no clear definition provided for confusion. Is there a specific definition that the Technical Advisory Panel had in mind?
22. Empiric Antibiotic for Community-Acquired Bacterial Pneumonia	Disapprove	We disapprove this measure as it is written. In this measure, we recommend that "bacterial" should be included, as it is, but the ICD-9 code for influenza pneumonia, which obviously should not include administration of antibiotics, should be removed. Codes 481, 482, 485, 486 should be included, the rest excluded. [We are not certain about 484.] The language needs to be very clear that since these codes are at the time of the visit in question, if a specific infecting organism is coded, the treatment is not empiric. The way this now reads, a provider could give doxycycline for what they think is Pseudomonas pneumonia and "pass." However, that would be very inappropriate care.
Hospital Care Setting:		
19. Vital Signs for Community-Acquired Bacterial Pneumonia	Disapprove	We disapprove this measure as it is written. Most cases of pneumonia are not diagnosed as to whether they are bacterial or viral. We recommend that "Bacterial" be removed from the title. This measure should be based on the broad diagnosis of Community-Acquired Pneumonia (CAP). While <u>all</u> vital signs are important and need to be included in clinical

		care, requiring the provider to initial that they have seen the vital signs is a documentation burden. Physicians should be using the vital signs to direct their decision making, and the plan documented in the chart should follow this interpretation.
20. Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia	Disapprove	We disapprove this measure as it is written. Most cases of pneumonia are not diagnosed as to whether they are bacterial or viral. We recommend that "Bacterial" be removed from the title.. This measure should be based on the broad diagnosis of Community-Acquired Pneumonia (CAP). While <u>all</u> vital signs are important and need to be included in clinical care, requiring the provider to initial the O_2 saturations, creates unnecessary burden. In the hospital setting, this indicator does not serve as a discriminator as most facilities are already at or close to 100% compliance.
21. Assessment Mental Status for Community-Acquired Bacterial Pneumonia	Disapprove	We disapprove this measure as it is written. Again, most pneumonias are not diagnosed as to whether they are bacterial or not. We recommend that "Bacterial" be removed from the title. This measure should be based on the broad diagnosis of Community-Acquired Pneumonia (CAP). In the hospital setting, physicians often document a broad assessment of orientation and alertness. However, there is no agreed-upon definition of confusion or other altered levels of consciousness, which have shown prognostic accuracy in CAP.
22. Empiric Antibiotic for Community-Acquired Bacterial Pneumonia	Disapprove	We disapprove this measure as it is written. In this measure, we recommend that "bacterial" should be included, as it is, but the ICD-9 code for influenza pneumonia, which obviously should not include administration of antibiotics, should be removed. Codes 481, 482, 485, 486 should be included, the rest excluded. [We are not certain about 484.] The language needs to be very clear that since these codes are at the time of the visit in question, if a specific infecting organism is coded, the treatment is not empiric. The way this now reads, a provider could give doxycycline for what they think is Pseudomonas pneumonia and "pass." However, that would be very

		inappropriate care. If patients are admitted to the ICU, only some of these codes are appropriate. So this measure should be restricted to patients not admitted to the ICU.
29. Venous Thromboembolism (VTE) Prophylaxis	Disapprove	We disapprove this measure as it is written. It is difficult to identify hospitalized patients who do not need some form of VTE prophylaxis. For the majority of patients, prophylaxis should be provided unless it is documented why it should not. The responsibility should be on the provider to prove if the patient does not need prophylaxis.
30. Deep Vein Thrombosis (DVT) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage	Approve with comment	We approve this measure with the following comment: NQF needs to provide the definition of intermittent pneumatic impression.
The ACCP abstains from voting on all other measures in this set.		