



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 0662

Corresponding Measures:

De.2. Measure Title: Median Time to Pain Management for Long Bone Fracture

Co.1.1. Measure Steward: Centers for Medicare and Medicaid Services

De.3. Brief Description of Measure: Median time from emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF).

1b.1. Developer Rationale: Pain management in patients with long bone fractures is undertreated in emergency departments (Ritsema, Kelen, Pronovost, & Pham, 2007). Emergency department pain management has room for improvement (Ritsema 2007). Patients with bone fractures continue to lack administration of pain medication as part of treatment regimens (Brown, 2003). When standards are implemented for pain management of these patients administration and treatment rates for pain improve (Titler, 2009). Disparities continue to exist in the administration of medication for minorities (Epps, 2008 and Todd, 1993) and children as well (Brown, 2003 and Friedland, 1994).

S.4. Numerator Statement: Time (in minutes) from emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a diagnosis of a (long bone) fracture.

S.7. Denominator Statement: N/A Measure is a continuous variable.

S.10. Denominator Exclusions: N/A Measure is a continuous variable. See numerator details.

De.1. Measure Type: Efficiency

S.23. Data Source: Claims, Electronic Health Records, Other, Paper Medical Records

S.26. Level of Analysis: Facility, Other

IF Endorsement Maintenance – Original Endorsement Date: Jan 17, 2011 **Most Recent Endorsement Date:** Jan 17, 2011

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[MeasSubm_Evidence_0662._OP21-635294471082491996.docx](#)

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or

- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

Pain management in patients with long bone fractures is undertreated in emergency departments (Ritsema, Kelen, Pronovost, & Pham, 2007). Emergency department pain management has room for improvement (Ritsema 2007). Patients with bone fractures continue to lack administration of pain medication as part of treatment regimens (Brown, 2003). When standards are implemented for pain management of these patients administration and treatment rates for pain improve (Titler, 2009). Disparities continue to exist in the administration of medication for minorities (Epps, 2008 and Todd, 1993) and children as well (Brown, 2003 and Friedland, 1994).

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

2Q2013 data:

3253 hospitals reporting 98,936 cases: Benchmark is 34 minutes; National rate is 54 minutes.

Trends:

2Q2012 Benchmark:35 minutes 2Q2012 National:57 minutes

3Q2012 Benchmark:35 3Q2012 National :57

4Q2012 Benchmark:35 4Q2012 National :58

1Q2013 Benchmark:35 1Q2013 National :59

2Q2013 Benchmark: 34 minutes; National 54 minutes

1Q2013 Data from 3,225 hospitals; total cases 78,811

Deciles:

Min: 0 minutes; Max: 44710 minutes

Percentiles:5th: 29 mins; 10th: 35 mins; 25th: 45 mins; 50th: 59 mins; 75th: 74 mins; 90th: 90 mins; 95th: 103 mins.

Distribution:

0-30 minutes 209 hospitals

31-40 minutes 359 hospitals

41-50 minutes 545 hospitals

51-56 minutes 617 hospitals

61-70 minutes 542 hospitals

71-80 minutes 404 hospitals

81-90 minutes 228 hospitals

91-100 minutes 132 hospitals

101-110 minutes 79 hospitals

111+ minutes 110 hospitals

Note: One hospital had a median rate of 0 minutes and another hospital had a median of 44,710 minutes. Both hospitals had a denominator of 1.

The case with time 44,710 minutes is due to discrepancy in the arrival date and pain medication date (1/21/13 vs 2/21/13). Actual time to pain medication was 70 minutes for this case.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Median time by race:

Race/Ethnicity: White Median: 58 IQR: 33-98 Total cases: 56,995

Race/Ethnicity: Black Median: 66 IQR: 37-113 Total cases: 6695
Race/Ethnicity: Hispanic Median: 61 IQR: 33-106 Total cases: 9455
Race/Ethnicity: Other Median: 58 IQR: 32-100 Total cases: 5666
Gender and age are included in the testing report.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

Disparities are also addressed in the literature in the Measure Submission_Evidence attachment.

Ware LJ, Epps CD, Clark J, Chatterjee A. Do ethnic differences still exist in pain assessment and treatment in the emergency department? Pain Manag Nurs 2012; 13 (4): 194-201.

Direct quote from article:

"Although the provision of timely and appropriate analgesia is a primary goal of Emergency Department (ED) staff, pain continues to be undertreated (Bauman et al., 2007, Herr and Titler, 2009, Hwang et al., 2006, Kelly, 2000, Pletcher et al., 2008, Ritsema et al., 2007, Rupp and Delaney, 2004, Tamayo-Sarver et al., 2003, Todd et al., 2007 and Todd, 2001; Todd, Deaton, D'Adamo, and Goe, 2000; Todd, Samaroo, and Hoffman, 1993). Compounding this problem of undertreatment are long wait times before analgesics administration. Findings from earlier research studies indicate that patients wait on the average >1 hour for first medication when presenting to the ED (Grant, 2006 and Epps et al., 2008). Despite policies, protocols, and guidelines mandating pain assessment and treatment for patients, undertreatment of pain and inadequate assessment and documentation of pain persist in the ED (Colley and Crouch, 2000 and Epps et al., 2008). One possible contributing factor to the problem of oligoanalgesia is the existence of ethnic disparities in treatment of pain (Harrison & Falco, 2005; Institute of Medicine [IOM], 2003; U.S. Department of Health & Human Services, 2005) regardless of whether the disparities are intentional or not. A body of evidence suggests inadequate analgesia for ethnic and minority patients (Bonham, 2001, Cintron and Morrison, 2006, Ducharme, 2005 and Neighbor et al., 2004; Silka et al. 2004; Tamayo-Sarver et al., 2003 and Todd et al., 1993, Todd, Lee, & Hoffman, 1994; Todd et al., 2000, Weisse et al., 2001 and Weisse et al., 2003). The purpose of the present research study was to investigate pain assessment and treatment for adult patients (=18 years old) who were admitted to the ED suffering from long-bone fractures (LBFs). An additional purpose was to determine if ethnic disparities were evident in the assessment and treatment process."

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Other

1c.2. If Other: Pain Management/Quality of Care

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

Pain accounts for up to 78% of emergency department visits and is the most common reason for visiting.

In the United States, almost 2 million people are admitted to the emergency department with long-bone fractures (LBFs) every year. Most of these patients are experiencing moderate to severe pain.

1c.4. Citations for data demonstrating high priority provided in 1a.3

Minick P, Clark PC, Dalton JA, Home E, Green D, Brown M. Long-bone fracture pain management in the emergency department. J Emerg Nurs 2012;38:211-7.

Sills MR, Fairclough DL, Ranade D, Mitchell MS, Kahn MG. Emergency department crowding is associated with decreased quality of analgesia delivery for children with pain related to acute, isolated, long-bone fractures. ACADEMIC EMERGENCY MEDICINE 2011; 18:1330-1338.

Cordell WH, Keene KK, Giles BK, Jones JB, Jones JH, Brizendine EJ. The high prevalence of pain in emergency medical care. Am J Emerg Med. 2002;20:165-9.

Johnston CC, Bournaki MC, Gagnon AJ, Pepler CJ, Bourgault P. Self-reported pain intensity and associated distress in children aged 4–18 years on admission, discharge, and one-week follow up to emergency department. *Pediatr Emerg Care*. 2005;21:342–6.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Musculoskeletal

De.6. Non-Condition Specific (check all the areas that apply):

Care Coordination

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)
<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FSpecsManualTemplate&cid=1228773271302>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

[This is not an eMeasure](#) Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [AppA_C.xlsx](#)

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

[The intranasal route is now included for pain medication.](#)

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

[Time \(in minutes\) from emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a diagnosis of a \(long bone\) fracture.](#)

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

[Facilities report data quarterly](#)

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target

process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)
IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Included Populations:

- Patients with a patient age on Outpatient Encounter Date (Outpatient Encounter Date – Birthdate) \geq 2 years, and
- An ICD-9-CM Principal Diagnosis Code for a (long bone) fracture as defined in Appendix A, OP Table 9.0, and
- Patients with Pain Medication, and
- An E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0

Excluded Populations:

- Patients less than 2 years of age
- Patients who expired
- Patients who left the emergency department against medical advice or discontinued care

Data Elements:

- Birthdate
- Discharge Status
- E/M Code
- Arrival Time
- ICD-9-CM Principal Diagnosis Code
- Outpatient Encounter Date
- Pain Medication
- Pain Medication Date
- Pain Medication Time

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

N/A Measure is a continuous variable.

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

N/A Measure is a continuous variable. See numerator details.

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

N/A Measure is a continuous variable. See numerator details.

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

N/A Measure is a continuous variable. See numerator details.

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

At this time, this measure is not stratified.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the

risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

N/A

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

S.16. Type of score:

Continuous variable

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Lower score

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

Algorithm Narrative for OP-21:

Median Time to Pain Management for Long Bone Fracture

Continuous Variable Statement: Time (in minutes) from emergency department arrival to time of initial oral, intranasal or parenteral pain medication administration for emergency department patients with a diagnosis of a (long bone) fracture.

1. Start processing. Run cases that are included in the Pain Management Hospital Outpatient Population and pass the edits defined in the Data Processing Flow through this measure.

2. Check Discharge Code. a. If Discharge Code is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. b. If Discharge Code equals 6, 7, or 8, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing. c. If Discharge Code equals 1, 2, 3, 4a, 4b, 4c, 4d, or 5, continue processing and proceed to Pain Medication.

3. Check Pain Medication.

a. If Pain Medication is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Pain Medication equals No, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

c. If Pain Medication equals Yes, continue processing and proceed to Arrival Time.

4. Check Arrival Time.

a. If the Arrival Time equals Unable To Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Stop processing.

b. If Arrival Time equals a Non-Unable To Determine Value, continue processing and proceed to Pain Medication Date.

5. Check Pain Medication Date.

a. If Pain Medication Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Pain Medication Date equals Unable To Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Stop processing.

c. If Pain Medication Date equals a Non Unable To Determine Value, continue processing and proceed to Pain Medication Time.

6. Check Pain Medication Time.

a. If Pain Medication Time is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Pain Medication Time equals Unable To Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Stop processing.

c. If Pain Medication Time equals a Non Unable To Determine Value, continue processing and proceed to Measurement Value

Calculation.

7. Calculate Measurement Value. Measurement Value, in minutes, is equal to the Pain Medication Date and Pain Medication Time minus Outpatient Encounter Date and Arrival Time.

8. Check Measurement Value.

a. If Measurement Value is less than zero minutes, the case will proceed to a Measurement Category Assignment of X and will be rejected. Stop processing.

b. If Measurement Value is greater than or equal to zero minutes, the case will proceed to a Measurement Category Assignment of D and will be in the Measure Population. Stop processing.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1) Available at measure-specific web page URL identified in S.1

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Sampling Approaches

Hospitals have the option to sample from their population, or submit their entire population. Hospitals that choose to sample must ensure that the sampled data represent their outpatient population by using either the simple random sampling or systematic random sampling method and that the sampling techniques are applied consistently within a quarter. For example, quarterly samples for a sampling population must use consistent sampling techniques across the quarterly submission period.

- Simple random sampling - selecting a sample size (n) from a population of size (N) in such a way that every case has the same chance of being selected.
- Systematic random sampling - selecting every kth record from a population of size (N) in such a way that a sample size of n is obtained, where $k = N/n$ rounded to the lower digit. The first sample record (i.e., the starting point) must be randomly selected before taking every kth record. This is a two-step process:
 - a) Randomly select the starting point by choosing a number between one and k using a table of random numbers or a computer-generated random number; and
 - b) Then select every kth record thereafter until the selection of the sample size is completed.

Each hospital is ultimately responsible that the sampling techniques applied for their hospital adhere to the sampling requirements outlined in this manual. Performance measurement systems are responsible for ensuring that the sampling techniques are applied consistently across their client hospitals.

Monthly Sampling Guidelines

It is important to point out that if a hospital elects to use the monthly sampling guidelines, the hospital is still required to meet the minimum quarterly sampling requirements. A hospital may choose to use a larger sample size than is required. Hospitals whose population size is less than the minimum number of cases per quarter for the measure set cannot sample (i.e., the entire population of cases must be selected). Given the potential for substantial variation in monthly population sizes, the monthly sample sizes should be based on the known or anticipated quarterly population size. When necessary, appropriate oversampling should be employed to ensure that the hospital meets the minimum quarterly sample size requirements. Refer to Table 3 below for guidelines in determining the number of cases that need to be sampled for each population per month per hospital based on the quarterly population size.

Table 3: Sample Size Guidelines per Hospital Population per Quarter

Quarterly Sample Size

| | |
|---------|---------------|
| <= 80 | use all cases |
| 81-100 | 80 |
| 101-125 | 95 |
| 126-150 | 109 |
| 151-175 | 121 |
| 176-200 | 132 |
| 201-225 | 143 |

| | |
|--------------|-----|
| 226-250 | 152 |
| 251-275 | 161 |
| 276-300 | 169 |
| 301-325 | 177 |
| 326-350 | 184 |
| 351-75 | 191 |
| 376-400 | 197 |
| 401-425 | 203 |
| 426-450 | 208 |
| 451-500 | 218 |
| 501-600 | 235 |
| 601-700 | 249 |
| 701-800 | 260 |
| 801-900 | 270 |
| 901-1,000 | 278 |
| 1,001-2,000 | 323 |
| 2,001-3,000 | 341 |
| 3,001-4,000 | 351 |
| 4,001-5,000 | 357 |
| 5,001-10,000 | 370 |
| >=10,001 | 377 |

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

Missing data during submission causes the case to be rejected from the warehouse.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Claims, Electronic Health Records, Other, Paper Medical Records

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

The CMS Abstraction & Reporting Tool or other electronic tool supplied by the facility's vendor.

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available at measure-specific web page URL identified in S.1

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility, Other

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[MeasSubm_Testing_0662._OP21-635294469956244196.docx](#)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

[Coded by someone other than person obtaining original information \(e.g., DRG, ICD-9 codes on claims\), Abstracted from a record by someone other than person obtaining original information \(e.g., chart abstraction for quality measure or registry\)](#)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

[ALL data elements are in defined fields in a combination of electronic sources](#)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

[No feasibility assessment](#) Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

[Ongoing specification updates are performed based on abstractor feedback submitted via an online database. The next specification update will be October 2014. Cost/administrative burden has not been assessed, however it is expected facilities with dedicated EHRs will experience less burden in the collection of data.](#)

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (*e.g., value/code set, risk model, programming code, algorithm*).

[N/A](#)

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

| Planned | Current Use (for current use provide URL) |
|---|--|
| Quality Improvement (Internal to the specific organization) | <p>Public Reporting HOQR Program https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1191255879384</p> <p>Payment Program HOQR Program https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1191255879384</p> <p>Regulatory and Accreditation Programs Joint Commission Accreditation Program http://www.jointcommission.org/accreditation_process_overview/</p> |

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

HOQR Program for CMS; The Hospital Outpatient Quality Reporting (OQR) Program is a quality data reporting program implemented by the Centers for Medicare & Medicaid Services (CMS) for outpatient hospital services. Under this program, hospitals report data using standardized measures of care to receive the full annual update to their Outpatient Prospective Payment System (OPPS) payment rate, effective for payments beginning in calendar year (CY) 2009. The Hospital OQR Program is modeled on the current quality data reporting program for inpatient services, the Hospital Inpatient Quality Reporting Program. The Hospital OQR Program is a voluntary quality measure data reporting program for outpatient hospital services implemented by CMS. CMS focuses on reporting measure data that have high impact and support national priorities for improved quality and efficiency of care for Medicare beneficiaries.

Hospitals must submit data for 27 quality measures; these include clinical performance measures, imaging efficiency measures, and web-based (structural) measures. Participating hospitals agree that they will allow CMS to publicly report data for the quality measures, as is stated in the current OPPS/ASC final rule.

Hospitals that meet data reporting requirements during a given calendar year (CY) receive their full Outpatient Prospective Payment System (OPPS) annual payment update (APU) factor, also called the Outpatient Department fee schedule increase factor, for the upcoming calendar year; those hospitals that do not participate or fail to meet these requirements may receive a two percent reduction of their APU.

For 2Q2013, 3252 hospitals reported 98,936 cases for this measure. Cases are sampled at the hospital level, across the United States.

The information on Joint Commission accreditation is available on their website at the url above.

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program,

certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

For 2Q2013:

Number of hospitals: 3252; Number of cases for this measure: 98,936

Benchmark is 34 minutes, national average is 54 minutes.

For 1Q2013:

Data from 3,225 hospitals; total cases 78,811

Benchmark is 35 minutes, national average is 59 minutes.

There is a decrease in both the benchmark (top 10% of hospitals) and the national rate from 1Q2013 to 2Q2013. The number of hospitals reporting has increased and the number of cases submitted has increased.

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

The risk in advancing measures that address timeliness in administration of pain medication is that there may be an increase in unnecessary administration prior to a proper diagnosis. There have been no published studies of unintended negative consequences.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

Yes

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

There are no competing measures.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

A search on the NQF website and the NQMC website revealed no competing measures.

One related measure was identified, in use in Australia.

Pain management: percentage of paediatric patients who presented to the ED with a primary diagnosis of limb fracture and received analgesic therapy within 30 minutes of presentation, during the 6 month time period. 2012 Jan. NQMC:007678

Australian Council on Healthcare Standards - Nonprofit Organization

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Centers for Medicare and Medicaid Services

Co.2 Point of Contact: Kristie, Baus, Kristie.baus@cms.hhs.gov, 410-786-8161-

Co.3 Measure Developer if different from Measure Steward: OFMQ

Co.4 Point of Contact: Wanda, Johnson, wjohnson@ofmq.com, 405-302-3278-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

| |
|---|
| <p>Dr. Jim Adams Northwest University</p> <p>Dr. Brent Asplin Regions Hospital St. Paul</p> <p>Dr. James Augustine EMP Management Group</p> <p>Fiona Larbi CMS</p> <p>Felicia Diggs CMS</p> <p>Dr. Dale Bratzler Univ Oklahoma Health Sciences Center</p> <p>Katherine Brown Consumer Purchaser Disclosure Project</p> <p>Dr. Stephen Cantrill Denver Health</p> <p>Jennifer Eames Consumer Purchaser Disclosure Project</p> <p>Jennifer Faerberg AAMC</p> <p>Brent Fisher EMPATH</p> <p>Nancy Foster American Hospital Association AHA</p> <p>Irene Fraser AHRQ</p> <p>Dr. Leon Haley Jr. Emory</p> <p>Dr. Howard Isenstein FAH</p> <p>Dr. Rahul Khare Northwestern University</p> <p>Dr. Jon Krohmer Department of Homeland Security</p> <p>Dr. Jim Leo Long Beach Memorial Medical Center</p> <p>Donna Mason Vanderbilt University Medical Center</p> <p>Pamela Owens AHRQ</p> <p>Dr. Charles Reece Christiana Care Health System</p> <p>Dr. Matt Rice Team Health</p> <p>Tiffany Sanders CMS</p> <p>Robert Schafermeyer Carolinas Medical Center</p> <p>Dr. David Sklar University of New Mexico Medical Center</p> <p>Sharon Sprenger The Joint Commission</p> <p>Dr. Shari Welch IHI</p> <p>Marcia Wilson Urgent Matters-George Washington University</p> |
| <p>Measure Developer/Steward Updates and Ongoing Maintenance</p> <p>Ad.2 Year the measure was first released: 2012</p> <p>Ad.3 Month and Year of most recent revision: 01, 2014</p> <p>Ad.4 What is your frequency for review/update of this measure? Twice yearly</p> <p>Ad.5 When is the next scheduled review/update for this measure? 10, 2014</p> |
| <p>Ad.6 Copyright statement: Measure is in the public domain</p> <p>Ad.7 Disclaimers:</p> |
| <p>Ad.8 Additional Information/Comments:</p> |