



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 sub criterion 1b).

Brief Measure Information

NQF #: 0465

Corresponding Measures:

De.2. Measure Title: Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy

Co.1.1. Measure Steward: Society for Vascular Surgery

De.3. Brief Description of Measure: Percentage of patients undergoing carotid endarterectomy (CEA) who are taking an anti-platelet agent (aspirin or clopidogrel or equivalent such as aggrenox/tiglacor etc) within 48 hours prior to surgery and are prescribed this medication at hospital discharge following surgery

1b.1. Developer Rationale: VSGNE and SVS VQI registries use real time reporting of quality measures, such that all participating providers and centers receive anonymous benchmark reports which shows their rate of antiplatelet usage around CEA compared to all other providers or centers. Based on the number of procedures entered, confidence intervals are generated to allow providers or institutions to determine whether they are significantly above or below the mean for all procedures. Further, these registries have set a quality goal of 90% antiplatelet usage for CEA procedures, which allows each provider and center to compare their performance with this target.

S.4. Numerator Statement: Patients over age 18 undergoing carotid endarterectomy who received anti-platelet agents such as aspirin or aspirin-like agents, or P2y12 antagonists within 48 hours prior to the initiation of surgery AND are prescribed this medication at hospital discharge following surgery.

S.6. Denominator Statement: Patients over age 18 undergoing carotid endarterectomy.

S.8. Denominator Exclusions: Patients with known intolerance to anti-platelet agents such as aspirin or aspirin-like agents, or P2y12 antagonists, or those on heparin or other intravenous anti-coagulants; patients with active bleeding or undergoing urgent or emergent operations or endarterectomy combined with cardiac surgery. Patients with known intolerance to anti-platelet agents such as aspirin or aspirin-like agents, or P2y12 antagonists, or those on or other intravenous anti-coagulants; patients with active bleeding or undergoing urgent or emergent operations or endarterectomy combined with cardiac surgery.

De.1. Measure Type: Process

S.17. Data Source: Registry Data

S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Facility

IF Endorsement Maintenance – Original Endorsement Date: Jul 31, 2008 **Most Recent Endorsement Date:** Sep 03, 2015

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 sub criteria to pass this criterion and be evaluated against the remaining criteria.**

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

[SVS_-_measure-submission-evidence1.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

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., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

VSGNE and SVS VQI registries use real time reporting of quality measures, such that all participating providers and centers receive anonymous benchmark reports which shows their rate of antiplatelet usage around CEA compared to all other providers or centers. Based on the number of procedures entered, confidence intervals are generated to allow providers or institutions to determine whether they are significantly above or below the mean for all procedures. Further, these registries have set a quality goal of 90% antiplatelet usage for CEA procedures, which allows each provider and center to compare their performance with this target.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. 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 include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

[Year Variation Chart](#)

SURGEYEAR	% Antiplatelet Agents at Preop		% Antiplatelet Agents at Discharge	% Antiplatelet Agents at Preop and Discharge
2003	87%	86%	78%	
2004	82%	82%	72%	
2005	88%	83%	77%	
2006	90%	93%	88%	
2007	93%	96%	92%	
2008	91%	92%	88%	
2009	90%	94%	88%	
2010	90%	95%	88%	
2011	87%	95%	85%	
2012	87%	95%	85%	
2013	88%	96%	87%	
2014	88%	96%	86%	

This is VQI registry data re current pre, post, and both pre and post antiplatelet agent use around CEA done in VQI. Data are shown by year (note that n sites have increased significantly over time, so same centers are not being compared. Also there is variation across 180 centers in recent years listed in the testing form. Note that > 20% did not use periop antiplatelet in 80% of patients, and 50% did not achieve 90%.

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 maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

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 sub criteria 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):

Surgery, Surgery : Vascular Surgery

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

Primary Prevention

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

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.)

N/A

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)

No data dictionary Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

Minor changes made to the numerator and denominator exclusion statements to reflect additional anti-platelet agents being approved since this measure was created and endorsed in 2008.

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) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patients over age 18 undergoing carotid endarterectomy who received anti-platelet agents such as aspirin or aspirin-like agents, or P2y12 antagonists within 48 hours prior to the initiation of surgery AND are prescribed this medication at hospital discharge following surgery.

S.5. 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, time period for data collection, 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 (S.14).

Numerator coding, These are fields that are collected via the data form for the VQI registry, which is approved for PQRS:

Gxxx1: Documentation that oral antiplatelet therapy was given within 48 hours prior to surgical incision

Gxxx2: No documentation that oral antiplatelet was given within 48 hours prior to the initiation of surgery

Gxxx3: Oral antiplatelet therapy prescribed at hospital discharge

Gxxx4: Oral antiplatelet therapy NOT prescribed at hospital discharge, Gxxx5 does not apply

Gxxx5: Patient expired, left against medical advice, discharged to hospice, or transferred to another acute care hospital or federal hospital

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

Patients over age 18 undergoing carotid endarterectomy.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, 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 target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

This is a patient-level measure that is anticipated to be reported a minimum of once per reporting period. To report this measure use the appropriate G-codes for carotid endarterectomy. It is anticipated that physicians providing the procedure of carotid endarterectomy will report this measure. To report, physician must include:

BOTH

--Gxxx1 OR Gxxx2

AND

--Gxxx3 OR Gxxx4 OR Gxxx5

OR

--Gxxx6 OR Gxxx7

Numerator coding:

Gxxx1: Documentation that oral antiplatelet therapy was given within 48 hours prior to surgical incision

Gxxx2: No documentation that oral antiplatelet was given within 48 hours prior to the initiation of surgery

Gxxx3: Oral antiplatelet therapy prescribed at hospital discharge

Gxxx4: Oral antiplatelet therapy NOT prescribed at hospital discharge, Gxxx5 does not apply

Gxxx5: Patient expired, left against medical advice, discharged to hospice, or transferred to another acute care hospital or federal hospital

Exclusion coding:

Gxxx6: Medical reasons for not prescribing antiplatelet therapy: patient allergy to both ASA and clopidogrel; patient admitted on heparin; patient admitted on coumadin/warfarin; patient has active bleeding

Gxxx7: Patient admitted from emergency department or patient is a direct admit or patient has other cardiac procedures done during same operation as the CEA

Denominator Coding:

CPT code 35301

OR

ICD-9 code 38.12

2014 ICD-10-PCS 03CH0ZZ Extirpation of Matter from Right Common Carotid Artery, Open Approach

2014 ICD-10-PCS 03CJ0ZZ Extirpation of Matter from Left Common Carotid Artery, Open Approach

2014 ICD-10-PCS 03CK0ZZ Extirpation of Matter from Right Internal Carotid Artery, Open Approach

2014 ICD-10-PCS 03CL0ZZ Extirpation of Matter from Left Internal Carotid Artery, Open Approach This is a patient-level measure that is anticipated to be reported a minimum of once per reporting period. To report this measure use the appropriate G-codes for carotid endarterectomy. It is anticipated that physicians providing the procedure of carotid endarterectomy will report this measure. To report, physician must include:

BOTH

--Gxxx1 OR Gxxx2

AND

--Gxxx3 OR Gxxx4 OR Gxxx5

OR

--Gxxx6 OR Gxxx7

Numerator coding:

Gxxx1: Documentation that oral antiplatelet therapy was given within 48 hours prior to surgical incision

Gxxx2: No documentation that oral antiplatelet was given within 48 hours prior to the initiation of surgery

Gxxx3: Oral antiplatelet therapy prescribed at hospital discharge

Gxxx4: Oral antiplatelet therapy NOT prescribed at hospital discharge, Gxxx5 does not apply

Gxxx5: Patient expired, left against medical advice, discharged to hospice, or transferred to another acute care hospital or federal hospital

Exclusion coding:

Gxxx6: Medical reasons for not prescribing antiplatelet therapy: patient allergy to both ASA and clopidogrel; patient admitted on heparin; patient admitted on coumadin/warfarin; patient has active bleeding

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2014 ICD-10-PCS 03CL0ZZ Extirpation of Matter from Left Internal Carotid Artery, Open Approach

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Patients with known intolerance to anti-platelet agents such as aspirin or aspirin-like agents, or P2y12 antagonists, or those on heparin or other intravenous anti-coagulants; patients with active bleeding or undergoing urgent or emergent operations or endarterectomy combined with cardiac surgery. Patients with known intolerance to anti-platelet agents such as aspirin or aspirin-like agents, or P2y12 antagonists, or those on or other intravenous anti-coagulants; patients with active bleeding or undergoing urgent or emergent operations or endarterectomy combined with cardiac surgery.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, 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.)

Exclusion coding:

Gxxx6: Medical reasons for not prescribing antiplatelet therapy: patient allergy to both ASA and clopidogrel; patient admitted on heparin; patient admitted on coumadin/warfarin; patient has active bleeding

Gxxx7: Patient admitted from emergency department or patient is a direct admit or patient has other cardiac procedures done during same operation as the CEA

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – 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.)

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. 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 = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or 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; time period for data, aggregating data; risk adjustment; etc.)

The proportion of patients who do receive antiplatelets as is recommended

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

If an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Registry Data

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database,

clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

VQI or other clinical registries that provides data for preoperative and discharge medications for patients undergoing carotid endarterectomy (CPT 35301, ICD 9 38.12 or ICD 10:

2014 ICD-10-PCS 03CH0ZZ Extirpation of Matter from Right Common Carotid Artery, Open Approach

2014 ICD-10-PCS 03CJ0ZZ Extirpation of Matter from Left Common Carotid Artery, Open Approach

2014 ICD-10-PCS 03CK0ZZ Extirpation of Matter from Right Internal Carotid Artery, Open Approach

2014 ICD-10-PCS 03CL0ZZ Extirpation of Matter from Left Internal Carotid Artery, Open Approach

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available in attached appendix at A.1

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual, Facility

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital, Outpatient Services

If other:

S.22. 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.)

2. Validity – See attached Measure Testing Submission Form

[SVS_-_measure-submission-form_testing-635588458725184122.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

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.

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) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in electronic clinical data (e.g., clinical registry, nursing home MDS, home health OASIS)

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. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

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. Please also complete and attach the NQF Feasibility Score Card.

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. Required for maintenance of endorsement. Describe difficulties (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 instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

VQI/SVS found over a 99% completion rate of these data elements in the VQI registry.

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.

Specific Plan for Use	Current Use (for current use provide URL)
	<p>Public Reporting PQRS Approved Registry http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html</p> <p>Quality Improvement (Internal to the specific organization) Vascular Quality Initiative http://www.vascularqualityinitiative.org/</p>

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

The Vascular Quality Initiative® is designed to improve the quality, safety, effectiveness and cost of vascular health care by collecting and exchanging information. It consists of a distributed network of regional quality groups that function under an AHRQ-listed Patient Safety Organization using the M2S cloud-based data collection and reporting system. It is available to all providers of vascular health care and their respective institutions.

2015 PQRS

2015 Physician Quality Reporting System (PQRS): Registry Reporting Made Simple

This beginner-level document outlines the steps necessary in selecting a qualified registry for 2015 PQRS reporting and applies to individual eligible professionals who wish to report via qualified registry or group practices that registered for qualified registry-based reporting under the GPRO. To view click on following link: 2015 Registry Reporting Made Simple.

4a1.2. 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?)

4a1.3. 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.)

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

This measure is included in the Vascular Quality Initiative (VQI) QCDR Registry. Sites that decide to report this measure are provide their results in a center specific report. Site can also ask for their data to be compared to other centers reporting this measure in their region.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Using the M2S cloud-based system, bar graphs displaying comparison of key outcomes and complication rates among centers and

providers are available in real-time. These raw data reports provide each center and provider with a snapshot of their results in comparison to others in the region to facilitate continuous improvement within their practice.

VQI Report Key quality indicators that are tracked at the hospital level over time for each type of procedure are displayed in a dashboard format to give the viewer a comprehensive view of their center's performance. Each chart shows the rate of events in each center compared with the region average. The variation across centers at each time point is displayed, showing the maximum and minimum values. Benchmark information regarding the use of important pre-operative medications, such as beta blockers compares providers and hospitals over time is also available in real-time through the database.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

Feedback on all VQI measures is obtained through regional meetings. To date, we have not received specific feedback on this measure.

4a2.2.2. Summarize the feedback obtained from those being measured.

No specific feedback has been obtained.

4a2.2.3. Summarize the feedback obtained from other users

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Many of the members of the SVS Quality and Performance Measures Committee are participants in VQI. Their experience is considered with this measure is updated each year for CMS.

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.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (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.)

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.

4b2. 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).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

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.

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 of Related Measures

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 harmonized to the extent possible?

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

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.)

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.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [Society for Vascular Surgery](#)

Co.2 Point of Contact: [Jill Rathbun](#), Jill_Rathbun@galileogrp.com, 703-486-4200-

Co.3 Measure Developer if different from Measure Steward: [Society for Vascular Surgery](#)

Co.4 Point of Contact: [Jill Rathbun](#), Jill_Rathbun@galileogrp.com, 703-486-4200-

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.

This measure is maintained by the Society for Vascular Surgery's QPM Committee which is chaired by Dr. Vivienne Halpern and Drs. Brad Johnson and Rocco Ciocca worked specifically on updating materials for this measure. Dr. Jack Cronenwett, Medical Director for VQI, also provided information on the use of this measure.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released:

Ad.3 Month and Year of most recent revision: 03, 2014

Ad.4 What is your frequency for review/update of this measure?

Ad.5 When is the next scheduled review/update for this measure?

Ad.6 Copyright statement:

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: