



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 #: 2052

Corresponding Measures:

De.2. Measure Title: Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence

Co.1.1. Measure Steward: American Urological Association

De.3. Brief Description of Measure: Percentage of SUI surgeries for which cystoscopy was used during the surgical procedure to reduce complications

1b.1. Developer Rationale: The proposed measure is expected to encourage practitioners to utilize cystoscopy during surgery for SUI. This safety precaution will enable surgeons to immediately repair areas damaged during SUI surgery, thereby reducing the post-surgical complication rate, and minimizing patient recovery time.

The benefits of cystoscopy outweigh the harms to the patient; the addition of cystoscopy introduces no additional risk to the patient but the avoidance of bladder injury is significant. One of the known complications of surgery is mesh erosion or extrusion, and the only way to ensure proper mesh placement is through the use of cystoscopy.

S.4. Numerator Statement: Female patients who had SUI surgery for which cystoscopy was used during the surgical procedure to reduce complications

S.6. Denominator Statement: Female patients who had SUI surgeries (without concomitant surgery for prolapse

S.8. Denominator Exclusions: Documentation of medical reason(s) for not using cystoscopy during SUI surgery (patients for whom the use of a cystoscope may not be appropriate, such as the presence of a new cystostomy repair). The panel noted that endoscopy after a new repair should be cautiously used. Concomitant prolapse surgery is an exclusion.

De.1. Measure Type: Process

S.17. Data Source: Claims, Paper Medical Records

S.20. Level of Analysis: Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Nov 12, 2014 **Most Recent Endorsement Date:** Nov 12, 2014

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

2052_Evidence_MSF5.0_Data.zip,C2052_Eval_Form.pdf

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.

The proposed measure is expected to encourage practitioners to utilize cystoscopy during surgery for SUI. This safety precaution will enable surgeons to immediately repair areas damaged during SUI surgery, thereby reducing the post-surgical complication rate, and minimizing patient recovery time.

The benefits of cystoscopy outweigh the harms to the patient; the addition of cystoscopy introduces no additional risk to the patient but the avoidance of bladder injury is significant. One of the known complications of surgery is mesh erosion or extrusion, and the only way to ensure proper mesh placement is through the use of cystoscopy.

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.*

Performance rate with exceptions: 81.76%

Performance rate without exceptions: 81.76%

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.

The following data from peer-reviewed literature demonstrate a performance gap/opportunity for improvement in establishing more consistent utilization of cystoscopy to augment surgical treatment for SUI.

Although it is largely acknowledged that intraoperative cystoscopy improves safety for the patient, multiple studies have stated that cystoscopy is not necessary, and that it is economical to avoid performing the technique [10-12].

Wang et al. studied the frequency of lower urinary tract injury for women with SUI undergoing the tension-free vaginal tape procedure with or without concomitant procedures [13]. All study subjects underwent intraoperative cystoscopy; the bladder perforation rate related to the TVT device was 0.8% (5/600). The authors concluded that due to a high rate of reported bladder injury in literature, intraoperative urethroscopy is imperative in the TVT procedure.

Gill et al. reported that routine usage of cystoscopy was effective for patients undergoing the Burch procedure for SUI. One obstructed left ureter was detected by cystoscopy and relieved by the release of left paravaginal repair sutures. No unsuspected injuries that were detected by cystoscopy were attributable to the Burch procedure. The authors discuss other literature reporting the usage of cystoscopy, and note that without the technique, reported injuries during surgery were significantly lower: only 12% of injuries to the lower urinary tract were detected at the time of surgery [14].

10. Fischer A, Fink T, Zachmann S, Eickenbusch U: Comparison of retropubic and outside-in transoburator sling systems for the cure of female genuine stress urinary incontinence. European urology 2005, 48:799-804.

11. Abdel-Fattah M, Ramsay I, Pringle S: Lower urinary tract injuries after transobturator tape insertion by different routes: a large retrospective study. BJOG : an international journal of obstetrics and gynaecology 2006, 113:1377-1381.

12. Cindolo L, Salzano L, Rota G, Bellini S, D'Affio A: Tension-free transobturator approach for female stress urinary

incontinence. *Minerva urologica e nefrologica = The Italian journal of urology and nephrology* 2004, 56:89-98.

13. Wang AC: The techniques of trocar insertion and intraoperative urethrocystoscopy in tension-free vaginal taping: an experience of 600 cases. *Acta obstetrica et gynecologica Scandinavica* 2004, 83:293-298.

14. Gill EJ, Elser DM, Bonidie MJ, Roberts KM, Hurt WG: The routine use of cystoscopy with the Burch procedure. *American journal of obstetrics and gynecology* 2001, 185:345-348.

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.

Data on population disparities specific to intraoperative cystoscopy with surgery for SUI are not currently available.

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):

Genitourinary (GU) : Incontinence/pelvic floor disorders

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

Safety : Complications

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

Elderly, Populations at Risk

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)

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.

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).

Female patients who had SUI surgery for which cystoscopy was used during the surgical procedure to reduce complications

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).

The numerator will be calculated using CPT codes:

52000

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

Female patients who had SUI surgeries (without concomitant surgery for prolapse

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).

The denominator will be calculated using CPT codes and patient characteristics, such as gender and age (adult patients):

51840

51841

51845

51990

51992

57287

57288

57289

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

Documentation of medical reason(s) for not using cystoscopy during SUI surgery (patients for whom the use of a cystoscope may not

be appropriate, such as the presence of a new cystostomy repair). The panel noted that endoscopy after a new repair should be cautiously used. Concomitant prolapse surgery is an exclusion.

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.)*

Exclusions will be calculated using CPT codes and patient characteristics, such as gender and age. Concomitant prolapse surgery includes repair of cystocele, enterocele, rectocele or vaginal vault prolapse or hysterectomy performed due to uterine prolapse.

Exclusions:

57240
57250
57260
57265
57267
57280
57282
57283
57425

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)

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.)*

See algorithm in 2a2.2

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.

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.

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

If other, please describe in S.18.

[Claims, Paper Medical Records](#)

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.

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)*

[No data collection instrument provided](#)

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

[Clinician : Individual](#)

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

[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

[Template_MeasSubm_MeasTesting_4_14_14docx.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 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. 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.

FEASIBILITY TESTING

The objective of feasibility testing of the SUI surgery measures is to assess the feasibility of data collection, measurement and reporting of these performance measures in a timely manner and at a reasonable cost. To undertake this part of the measure testing process, information was gathered in several different ways:

- Observation and documentation of data elements that were absent or inconsistently documented in the EHR
- Pre-visit retrieval of data element availability from site
- Follow-up evaluation of whether data elements were in discrete fields and coded using a standard code set, as reported in the DECAT responses, provided by the site contact
- Time spent on abstraction

A Feasibility and Reliability Testing Protocol was drafted by Telligen and includes:

- Objectives
- Number of Records to be Sampled
- Sampling Method
- Pre-visit Procedures for On-site Data Abstraction
- On-site Visit Procedure
- Telligen Deliverables

As a component of feasibility testing, a detailed questionnaire (DECAT) was sent to the site to explore whether electronic capture of all necessary data elements to compute each measure was inherent in the EHR. Information obtained about each data element included whether the data element was located in a discrete field in the EHR and whether that field was in a standard codified

format.

For this measure : Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence, three sites reported that the cystoscopy data element was captured in a discrete field and the field was codifiable. Two sites reported that this measure could be calculated by their EHR.

DATA ELEMENT LOCATION TABLE

The location where each data element was abstracted was recorded, for each measure. The percentage of instances where the data elements were found in the identified locations was also noted.

The abstractors matched on a variety of data element locations, but there were numerous places where this information could be found within the medical record at each site. An example of this was Post Void Residual; in addition to the bladder scan report, documentation was often found in the office visit notes and Post Void Residual report. A second example is Urinalysis; results were often found in the office progress note, but were also found in the laboratory results, patient medical history, chart summary or H & P. Another example is, counseling on the risk factor, Mesh Pain; documentation was found in office progress notes, informed consent or the operative report. The chance of mismatches increases when elements can be found in multiple locations within the record.

Many of the data elements needed for measure calculation were located in free text progress notes, which are not located in discrete fields. For example, data elements for the measures Patient Counseling on Treatment Options and Patient Counseling on Risks Associated with the use of Mesh in Sling Surgery were typically found in progress notes. A limited number of discrete fields were identified to capture these data elements.

TIMING/COST

The time it took for the abstractors to abstract the data elements from each medical record ranged from 6 to 29 minutes, with an average abstraction time of 16 minutes. The abstraction times decreased as familiarity with the medical record increased. Another factor was the EHR system itself. Some systems were easier to navigate than others. Each of the four practice sites had a unique EHR system.

In the majority of medical records reviewed, the patients had multiple preoperative and postoperative visits. This required the abstractors to review multiple encounters when looking for the data elements required to meet the numerator for Measures 1, 2, 3 and 5. The abstraction time for these records was increased.

Assuming only cost for the abstraction of each medical record, and an average time of 16 minutes per record, the cost was \$19.20 per patient record. Travel expenses and any work with the sites prior to and following the site visit were not included, although all applicable overhead rates and administrative costs were applied.

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).

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)
Public Reporting Professional Certification or Recognition Program Quality Improvement (Internal to the specific organization)	

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

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?)

The measure is not currently reported because it is a de novo measure, it will be in public use in the future.

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.)

This program will collect data on the use of Cystoscopy during SUI surgery with the goal of adapting current healthcare practices to improve and insure that quality healthcare is being provided. The intended audience for this measure includes professionals in the field of Urology and other specialties that may diagnose and treat Stress Urinary Incontinence. An initial timeframe for data collection will be 3 years. The intended mode of data collection will be the AUA AQUA registry (AUA's newly-launched clinical data registry) as well as through PQRS and other public reporting mechanisms.

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.

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.

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.

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

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.

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.
[Yes](#)

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

0030 : [Management of Urinary Incontinence in Older Adults \(MUI\)](#)

0098 : [Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older](#)

0099 : [Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older](#)

0100 : [Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older](#)

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.

As a rule, AUA/ACOG seek to harmonize proposed measures with those currently in use for the same topics. For example, the first of the proposed measures "Complete Workup for Assessment of Stress Urinary Incontinence" describes procedures consistent with common standard practices. In developing the proposed set of measures, extant performance measures were considered and kept in mind but were of limited usefulness because they were designed to apply to urinary incontinence in general and to women over 65 years of age. In contrast, we required measures that focused on the surgical intervention for SUI in particular and included women under 65 year of age who constitute the majority of those affected by SUI. As a rule, AUA/ACOG seek to harmonize proposed measures with those currently in use for the same topics. For example, the first of the proposed measures "Complete Workup for Assessment of Stress Urinary Incontinence" describes procedures consistent with common standard practices. In developing the proposed set of measures, extant performance measures were considered and kept in mind but were of limited usefulness because they were designed to apply to urinary incontinence in general and to women over 65 years of age. In contrast, we required measures that focused on the surgical intervention for SUI in particular and included women under 65 year of age who constitute the majority of those affected by SUI.

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): American Urological Association

Co.2 Point of Contact: Suzanne, Pope, spope@auanet.org, 410-689-4026-

Co.3 Measure Developer if different from Measure Steward: American Urological Association

Co.4 Point of Contact: Suzanne, Pope, spope@auanet.org, 410-689-4026-

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.

American Urological Association

Roger R. Dmochowski, M.D., Panel Chair

Jennifer Anger, M.D.

J. Quentin Clemens, M.D., M.S.C.I.
David Penson, M.D.
J. Christian Winters, M.D.

American Congress of Obstetricians and Gynecologists
Peggy Norton, M.D., Vice Chair
Evan Myers, M.D.
Charles Nager, M.D.

American Academy of Family Physicians
Edward Hirsch, M.D.

American Board of Urology
William Steers, M.D.

American College of Surgeons
Alan J. Wein, M.D.

American Geriatrics Society
Catherine Dubeau, M.D.

American Urogynecologic Society
Stewart Wechtler, M.D.

Food and Drug Administration
Janine Morris

Society of Urologic Nurses
Diane Newman, D.N.P

United Healthcare
Tina Groat, M.D.

American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® (PCPI™)
Mark S. Antman, D.D.S., M.B.A.
Elvia Chavarria
Becky Kresowik
Samantha Tierney

AUA-ACOG Staff and Consultants
Jennifer Bertsch
Sean Currigan, M.P.H.
Heddy Hubbard, Ph.D., M.P.H., R.N., F.A.A.N.
San Keller, Ph.D.
Beth Kosiak, Ph.D.
Suzanne Pope, M.B.A
Stephanie Stinchcomb, CPC, CCS-P, ACS-UR
Janet Waters, RN, BSN, MLS
James Robert White, Ph.D.

The AUA appointed the SUI performance measure workgroup members from various backgrounds and organizations and tasked them with identifying and defining quality measures that reflect the most rigorous clinical evidence and address areas most in need of performance improvement. The workgroup is a diverse group of members representing professional medical associations, government agencies, and healthcare specialties such as urology, nursing, family medicine, urogynecology and geriatrics.

#2052 Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence, Last
Updated: Nov 30, 2018

A limited number of workgroup members initially met in March 2010 to review clinical flowcharts and suggest areas for measure development. The full workgroup then met in June 2010 for a technical meeting to discuss possible measures, measure descriptions and numerators/denominators. Several conference calls, webinars and e-mail review of materials preceded the June 2010 meeting. In addition, several conference calls and email communications followed the workgroup meeting to finalize the measure set and ensure full workgroup participation.

Once the measures were approved by the workgroup and submitted to NQF's GI/GU Pilot Project, the workgroup continued to provide clinical expertise, discussing the future usability of the measures and utilization of data collected. Finally, workgroup chairs continued to provide clinical guidance throughout the testing phase.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released:

Ad.3 Month and Year of most recent revision:

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: © 2012 American Urological Association. All Rights Reserved.

Ad.7 Disclaimers: Physician Performance Measures (Measures) and related data specifications have been developed by the American Urological Association (AUA) and the American Congress of Obstetricians and Gynecologists (ACOG)

These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. Neither AUA, ACOG, the American Medical Association (AMA), the AMA-convened Physician Consortium for Performance Improvement® (PCPI™) nor its members shall be responsible for any use of the Measures. AUA and ACOG encourage use of these Measures by other health care professionals, where appropriate.

Ad.8 Additional Information/Comments: