

National Quality Forum

Measure Comment Report for SURGERY ENDORSEMENT MAINTENANCE 2010, PHASE II

Comments received as of 10/27/2011

ID#	Council/ Public	Commenter	Comment	Response	Topic
1247	HPR	Richard Cambria, MD and Timothy Kresowik, MD; Society for Vascular Surgery	<p>The Society for Vascular Surgery (SVS), a professional medical society representing over 3500 vascular surgeons who are dedicated to the prevention and cure of vascular disease, respectfully offers the following comments on the National Quality Forum Surgical Consensus Standards Endorsement Maintenance 2010 Phase II Draft Report.</p> <p>Measures Recommended for Full Endorsement</p> <p>NQF Measure #1519 – Statin Therapy at Discharge after Lower Extremity Bypass</p> <ul style="list-style-type: none"> •SVS supports NQF’s recommendation for full endorsement of this measure. <p>NQF Measure #1540 – Postoperative Stroke or death in Asymptomatic Patients undergoing Carotid Endarterectomy</p> <ul style="list-style-type: none"> •SVS supports NQF’s recommendation for full endorsement of this measure. <p>NQF Measure #1543 – Postoperative Stroke or Death in Asymptomatic Patients undergoing Carotid Artery Stenting (CAS)</p> <p>SVS supports NQF’s recommendation for full endorsement of this measure.</p> <p>SVS appreciates the opportunity to submit these comments and looks forward to working with NQF regarding these recommendations. Please feel free to contact Lindsey Adams, Health Policy Manager, Society for Vascular Surgery at 202-787-1231 or ladams@vascularsociety.org, if we can provide further information.</p>		General

ID#	Council/ Public	Commenter	Comment	Response	Topic
1250	HPR	Richard Cambria, MD and Timothy Kresowik, MD; Society for Vascular Surgery	<p>Measures Recommended for Harmonization NQF Measures #1523 and #1534</p> <p>SVS expresses concern over NQF's recommendation for harmonization with competing measures for the following reasons:</p> <ul style="list-style-type: none"> •SVS anticipates that these measures will be recommended for harmonization with the competing AAA measures proposed by AHRQ. SVS has repeatedly expressed concern regarding the measures proposed by AHRQ. Despite AHRQ's recent decision to separate their mortality measures into separate measures for elective and emergent, and open surgical and endovascular repair, concerns remain regarding the risk adjustment and statistical models associated with the AHRQ measures. ◦The AAA mortality risk adjustment model should be tested prospectively for accuracy. •SVS continues to have serious misgivings regarding the validity and accuracy of the risk adjustment model associated with the AHRQ measures as it remains currently written. Additionally, we are troubled by the process with which it was developed and we have voiced these concerns to AHRQ and previously to the National Quality Forum (NQF). •Thus, SVS strongly supports development of accurate outcomes measures for AAA using clinical evidence, but we believe that the AHRQ mortality measures are conceptually flawed and operationally defective. 		General

ID#	Council/ Public	Commenter	Comment	Response	Topic
1251	HPR	Richard Cambria, MD and Timothy Kresowik, MD; Society for Vascular Surgery	<p>NQF Measures #1523 and #1534</p> <ul style="list-style-type: none"> •We are encouraged that NQF is considering modifications to AAA quality measures that would differentiate between emergent vs. elective AAAs and open vs. endovascular procedures and would include risk adjustment. We will continue to actively work with NQF in the development of these measures, which should more accurately reflect patients' outcomes. We will also continue to work with NQF regarding how best to publicly report these measures. SVS thanks NQF for noting our concerns. SVS appreciates the opportunity to submit these comments and looks forward to working with NQF regarding these recommendations. Please feel free to contact Lindsey Adams, Health Policy Manager, Society for Vascular Surgery at 202-787-1231 or ladams@vascularsociety.org, if we can provide further information. 		General
1196	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	<p>We do not support this measure being used on its own because it appears to be topped out (mean value > 95%), which diminishes its importance. Rather, it should be combined with measures #126 and 127 in a patient-centered (all-or-none) composite measure. The patient needs to have all 3.</p>		0117: Beta blockade at discharge
1255	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	<p>We support the harmonization of the CMS and Society of Thoracic Surgeons (STS) measure.</p>		0117: Beta blockade at discharge

ID#	Council/ Public	Commenter	Comment	Response	Topic
1275	HPL	Deborah J. Donovan Mills, RHIA, CPHQ; Highmark, Inc.	Highmark supports measure.		0117: Beta blockade at discharge
1282	CON	Debra L. Ness, MS; National Partnership for Women & Families	On behalf of the National Partnership for Women & Families, I feel that this measure should not be used on it's own given that performance on it is over 95%. It would be more useful if combined with measures #126 and #127, into a patient-centered, all-or-none composite measure on the processes that a patient should receive when presenting with the condition represented by these measures.		0117: Beta blockade at discharge
1197	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We do not support this measure being used on its own because it appears to be topped out (mean value > 90%), which diminishes its importance. Rather, it should be combined with measures #117 and 127 in a patient-centered (all-or-none) composite measure. The patient needs to have all 3.		0126: Selection of prophylaxis for cardiac surgery patients
1256	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We support this measure but recommend ongoing review and changes to measure specifications to ensure that the measure is consistent with changes to the evidence base.		0126: Selection of prophylaxis for cardiac surgery patients
1276	HPL	Deborah J. Donovan Mills, RHIA, CPHQ; Highmark, Inc.	We support this measure but recommend frequent assessment to assure compliance with current evidence based guidelines.		0126: Selection of prophylaxis for cardiac surgery patients

ID#	Council/ Public	Commenter	Comment	Response	Topic
1284	CON	Debra L. Ness, MS; National Partnership for Women & Families	Please see my comment under #117.		0126: Selection of prophylaxis for cardiac surgery patients
1198	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We do not support this measure being used on its own. Rather, it should be combined with measures #126 and 127 in a patient-centered (all-or-none) composite measure. The patient needs to have all 3.		0127: Preoperative beta blockade
1258	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We support the harmonization of the Society of Thoracic Surgeons (STS) and CMS measure.		0127: Preoperative beta blockade
1277	HPL	Deborah J. Donovan Mills, RHIA, CPHQ; Highmark, Inc.	We support this measure harmonized with CMS and STS measures.		0127: Preoperative beta blockade
1285	CON	Debra L. Ness, MS; National Partnership for Women & Families	Please see my comment under #117.		0127: Preoperative beta blockade

ID#	Council/ Public	Commenter	Comment	Response	Topic
1199	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	This measure appears to be topped out at 95% and should be put in reserve.		0134: Use of IMA in CABG
1259	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	While we support this measure, we suggest that this measure be reevaluated for placement in reserve status in the near future as performance on this measure has potentially topped out.		0134: Use of IMA in CABG
1278	HPL	Deborah J. Donovan Mills, RHIA, CPHQ; Highmark, Inc.	We support this measure.		0134: Use of IMA in CABG
1286	CON	Debra L. Ness, MS; National Partnership for Women & Families	We believe this measure should be put into the "reserve" category, given that performance appears to be at 95%.		0134: Use of IMA in CABG
1200	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support this measure being applied at the ASC level.		0264: Prophylactic IV timing

ID#	Council/ Public	Commenter	Comment	Response	Topic
1257	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We support this measure but recommend ongoing review and changes to measure specifications to ensure that the measure is consistent with changes to the evidence base.		0264: Prophylactic IV timing
1279	HPL	Deborah J. Donovan Mills, RHIA, CPHQ; Highmark, Inc.	We support this measure and request frequent assessment to assure adherence to current evidence based guidelines.		0264: Prophylactic IV timing
1201	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support this outcome measure for ASCs. We question whether this measure will generate the most valuable information possible. For example, this measure only gives a uni-dimensional picture of hospitalizations around ambulatory care, but does not tell the why of such outcomes. To be meaningful, this measure needs further finessing.		0265: Hospital transfer/admission
1238	HPL	Thomas James, III, MD; Humana, Inc.	We are pleased to be able to comment on this measure; and are supportive of it. We agree with Dr. Hopkins comments, recognizing that ambulatory surgical centers have had few measures until now. We would anticipate that on future reviews, these ASC measures will be more sophisticated to recognize subpopulations and risk factors for transfer.		0265: Hospital transfer/admission
1260	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance	While we support this measure, as it expands the number of measures for Ambulatory Surgical Centers (ASC), we recommend including a specified timeframe for the measure such as number of patients admitted within in a certain period (e.g., 30-day) to strengthen the meaningfulness of this measure.		0265: Hospital transfer/admission

ID#	Council/ Public	Commenter	Comment	Response	Topic
1280	HPL	Deborah J. Donovan Mills, RHIA, CPHQ; Highmark, Inc.	We support this measure but recommend incorporating a specific timeframe for hospital transfer/admissions such as within 30 days.		0265: Hospital transfer/admission
1287	CON	Debra L. Ness, MS; National Partnership for Women & Families	While we support the endorsement of this measure, we would also like to note the importance of understanding why such transfers and hospitalizations from an ASC setting occurred. To be truly meaningful, consumers need to know the reasons -- positive or negative -- for the action that this measure is calculating. Thus, we hope to see further work done on this measures and others like it, to make the data reported more useful to consumers.		0265: Hospital transfer/admission
1202	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We are supportive of the AHRQ PQI 2 measures because it's a good measure for delivery/payment programs that require management of general populations, such as ACOs.		0273: Perforated appendix
1237	HPL	Thomas James, III, MD; Humana, Inc.	Humana is pleased to have the opportunity to comment. This measure raises several concerns for us. First, in most communities simple appendicitis is managed surgically as outpatient surgery. so those who present late with perforation will represent a greater percentage of the discharges in the well-managed health systems than in those where simple appendicitis admissions dilute the sample. As a result better performing centers may have a higher percentage of discharges with perforated appendicitis. This trend toward ambulatory appendectomy may not have been a significant factor when this measure was first developed. Secondly, the denominator is for a Metro area or county making this measure one not useful for an ACO or any other organization that does not manage a county		0273: Perforated appendix

ID#	Council/ Public	Commenter	Comment	Response	Topic
1261	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We support but recommend expanding the scope of this measure to include the out-patient setting as patients frequently receive care in an inpatient setting because they have a perforated appendix.		0273: Perforated appendix
1281	HPL	Deborah J. Donovan Mills, RHIA, CPHQ; Highmark, Inc.	We appreciate the opportunity to comment. As other commenters have recommended, expanding this measure to the ambulatory setting would be of benefit. Additionally, the measure denominator includes only cases of appendicitis and we suggest adding perforated appendix to the denominator to capture those patients that perforated in the outpatient setting and were subsequently admitted.		0273: Perforated appendix
1203	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support measuring the performance of providers at all levels (e.g. individual physicians, physician groups, hospitals, ACOs, etc.). We question why this measure would not apply at the clinician level, noting that STS measures are recommended for both facility and clinician levels, with which we agree		0284: Surgery on beta blocker during perioperative period
1239	HPL	Thomas James, III, MD; Humana, Inc.	Unlike the STS measures where the data source is a standard registry, this measure lists "electronic administrative dat/claims, paper medical record/flow sheet" This opens the measure for inconsistencies in data capture unless there is a standardized data acquisition protocol and one that is not too resource intensive.		0284: Surgery on beta blocker during perioperative period

ID#	Council/ Public	Commenter	Comment	Response	Topic
1262	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We support the harmonization of the CMS and Society of Thoracic Surgeons (STS) measure.		0284: Surgery on beta blocker during perioperative period
1283	HPL	Deborah J. Donovan Mills, RHIA, CPHQ; Highmark, Inc.	We support harmonization of this measure with STS and CMS measurement.		0284: Surgery on beta blocker during perioperative period
1288	CON	Debra L. Ness, MS; National Partnership for Women & Families	We support this measure, and urge that it be specified to apply to the clinician level.		0284: Surgery on beta blocker during perioperative period
1204	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support this as a good measure of intermediate outcome.		0300: Cardiac patients with postop glucose

ID#	Council/ Public	Commenter	Comment	Response	Topic
1232	HPR	Denise Graham; Association for Professionals in Infection Control and Epidemiology	The Association for Professionals in Infection Control and Epidemiology (APIC) continue to support this measure.		0300: Cardiac patients with postop glucose
1235	HPR	Joseph P. Drozda, Jr., MD; American College of Cardiology	The level of glucose control in acute care scenarios including the postoperative setting has recently been the subject of some controversy. This includes concerns over the adverse impact of hypoglycemia on patient outcomes. For that reason, ACC would not support glucose control as a performance measure at this time.		0300: Cardiac patients with postop glucose
1240	HPL	Thomas James, III, MD; Humana, Inc.	While the STS Guidelines for Glucose Management During Adult Surgery (Ann Thoracic Surgery 2009; 87:663-9) demonstrate the value to the patient of avoiding hyperglycemia, Dr. Drozda makes an excellent point about the risks of hypoglycemia. We would prefer to have the measure developers include a glucose range in the measure to avoid hypo- or hyper-glycemia		0300: Cardiac patients with postop glucose
1263	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We support controlled postoperative blood glucose in the 18 to 24 hour timeframe after Anesthesia End Time for cardiac surgery patients. While hyperglycemic patients are included, the measure could be strengthened to include hypoglycemic patients by adding low to high end control range.		0300: Cardiac patients with postop glucose

ID#	Council/ Public	Commenter	Comment	Response	Topic
1325	SPI	Steven Brotman; AdvaMed	<p>AdvaMed supports the use of the 180 mg/dL blood glucose threshold. This is in line with published guidelines that have been developed based on evidence demonstrating clinical benefits for both diabetic and non-diabetic patients with glucose levels less than or equal to 180 mg/dL. In addition, AdvaMed applauds the proposal to eliminate the use of the POD 6AM timeframe. This is an arbitrary timeframe and does not account for the various times of the day that surgical procedures can end. However, there is concern with how the measure proposal considers hospital non-compliance. Currently, the proposed measure states that if more than a single glucose measurement value >180 mg/dL is collected between 18 and 24 hours after Anesthesia End Time, the hospital fails. AdvaMed believes that any measure should not discourage the use of protocols and/or new technologies that can provide more insight into the challenges of glycemic control in cardiac surgery patients. Specifically, future protocols and technologies that may be designed to identify glucose level trends by capturing multiple and even continuous measurements within a short period of time may be clinically helpful but may be avoided due to the perceived concern that more measurements have a greater likelihood of a reading above 180 mg/dL. An alternative method to avoid this unintended consequence is to use the average glucose level if more than one glucose measurement is obtained during the 18-24 hour timeframe.</p>		0300: Cardiac patients with postop glucose
1205	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	<p>Performance measurement data should be collected efficiently and measures should be used where they promise to continually improve health outcomes. We do not support this measure because, unlike most process of care measures, there is a simple one-time solution for achieving compliance: removal of razors from the operating room. Once that is done, compliance has been shown to be 100%. This measure should be retired rather than continuing to take up space in the ever-expanding measure universe.</p>		0301: Patients with hair removal

ID#	Council/ Public	Commenter	Comment	Response	Topic
1289	CON	Debra L. Ness, MS; National Partnership for Women & Families	We believe that this measure no longer meets the high bar set by NQF endorsement, reflected by the fact that CMS will no longer be collecting data on inappropriate hair removal in the Inpatient Quality Reporting program. There is a simple, one-time solution for achieving 100 % compliance on this measure, which is to remove razors from the operating room. We feel that retiring this measure would make room for higher-bar measures that are desperately needed.		0301: Patients with hair removal
1206	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support this outcome measure. We also support measuring the performance of providers at all levels (e.g. individual physicians, physician groups, hospitals, ACOs, etc.). We question why this measure would not apply at the clinician level, noting that STS measures are recommended for both facility and clinician levels, with which we agree.		0339: RACHS-1 ped heart mortality
1241	HPL	Thomas James, III, MD; Humana, Inc.	Since this is a facility level measurement of volume and has no description of risk adjustment or diagnostic subpopulations we have difficulty is seeing how beneficial this measure is. For that reason we do not support it . There would be greater value if there were listings of the volumes of such cases as extra-cardiac diagnoses, intra-cardiac, and complex cases that the developer could define. We do appreciate AHRQ's willingness to pair this measure with mortality to become a paired measure.		0339: RACHS-1 ped heart mortality
1290	CON	Debra L. Ness, MS; National Partnership for Women & Families	While we support this measure, we question why it is not specified for application at the clinician level.		0339: RACHS-1 ped heart mortality

ID#	Council/ Public	Commenter	Comment	Response	Topic
1207	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support this outcome measure. We also support measuring the performance of providers at all levels (e.g. individual physicians, physician groups, hospitals, ACOs, etc.). We question why this measure would not apply at the clinician level, noting that STS measures are recommended for both facility and clinician levels, with which we agree.		0340: Ped heart volume
1236	HPR	Joseph P. Drozda, Jr., MD; American College of Cardiology	Whereas it is clear that a certain level of experience, prior and ongoing, is required for surgeons and surgical teams to acquire and maintain their skills, defining the precise level of such experience (as is done with performance measures) required at the individual program and surgeon level remains difficult. For this reason, we cannot support a volume metric as a stand-alone performance measure. Perhaps it can be used in a bundle of measures. The concern is that volume measures are too easy to obtain and too easy to use as surrogates for quality—particularly as sine qua non requirements. This can lead to the unintended consequences of reduced access to services and reduced competition.		0340: Ped heart volume
1264	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	While historically surgery volume has served as a proxy measure for quality, the value of this measure is unclear given the current availability of more specific measures of quality such as complication rate, readmissions etc.		0340: Ped heart volume
1291	CON	Debra L. Ness, MS; National Partnership for Women & Families	While we support this measure, we question why it is not specified for application at the clinician level.		0340: Ped heart volume

ID#	Council/ Public	Commenter	Comment	Response	Topic
1208	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We question why this measure uses hierarchical risk modeling (HRM) when other mortality measures in the set were deemed appropriate with standard logistic regression? HRM is known to reduce sensitivity to detect outliers. Otherwise, this is a good outcome measure.		0351: Death among inpatients with treatable complications
1292	CON	Debra L. Ness, MS; National Partnership for Women & Families	While we support this outcome measure, we do question why there is continued reliance on hierarchical risk modeling (HRM), when standard logistic regression modeling is considered appropriate for other mortality measures in this set? We have long advocated against HRM, due to its reduced ability to show adequate distribution among the results, and its tendency to reduce all results to the mean.		0351: Death among inpatients with treatable complications
1209	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support this outcome measure. We also support measuring the performance of providers at all levels (e.g. individual physicians, physician groups, hospitals, ACOs, etc.). We question why this measure would not apply at the clinician level, noting that STS measures are recommended for both facility and clinician levels, with which we agree.		0352: Failure to rescue in-hospital mortality
1243	HPL	Thomas James, III, MD; Humana, Inc.	We support this measure as one that we have found is one consumers and patients feel is important. We do feel that measuring at the facility level is appropriate because of the matrix management of complicated measures by multiple physicians, it may not be appropriate to attribute a case to one doctor. A facility level measure does encourage a systems approach to management. We would prefer to see if there were a way to capture DNR orders so that hospitals would not be penalized for patient preferences at end of life		0352: Failure to rescue in-hospital mortality

ID#	Council/ Public	Commenter	Comment	Response	Topic
1265	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We recommend this measure is most appropriate for measuring hospital performance. We also support harmonization of this measure with the similar pediatric AHRQ measure.		0352: Failure to rescue in-hospital mortality
1293	CON	Debra L. Ness, MS; National Partnership for Women & Families	Again, we support this measure but question why it can't be specified to the clinician level?		0352: Failure to rescue in-hospital mortality
1210	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support this outcome measure. We also support measuring the performance of providers at all levels (e.g. individual physicians, physician groups, hospitals, ACOs, etc.). We question why this measure would not apply at the clinician level, noting that STS measures are recommended for both facility and clinician levels, with which we agree.		0353: Failure to rescue 30-day mortality
1245	HPL	Thomas James, III, MD; Humana, Inc.	Our comments for NQF#0352 also apply to this measure, which further encompasses the concepts of post-discharge care coordination.		0353: Failure to rescue 30-day mortality
1294	CON	Debra L. Ness, MS; National Partnership for Women & Families	Again, we support this measure but question why it can't be specified to the clinician level?		0353: Failure to rescue 30-day mortality

ID#	Council/ Public	Commenter	Comment	Response	Topic
1211	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	Performance measurement data should be collected efficiently and measures should be used where they promise to continually improve health outcomes. We do not support this measure because, unlike most process measures of care, there is a simple solution for achieving compliance: removal of razors from the operating room. Once that is done, compliance is at 100%. Finally, although ASC admissions who perform their own hair removal take some of the control out of provider's hands, there should be a way to account for which of these self-performers are told of the benefit of non-razor hair removal. For that reason, we question the wholesale exclusion of ASC admissions who perform their own hair removal.		0515: Ambulatory patients with hair removal
1266	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We support the expansion of this measure to ASCs and recommend harmonization with the measure#0301 including exclusions.		0515: Ambulatory patients with hair removal
1295	CON	Debra L. Ness, MS; National Partnership for Women & Families	Please see my comment on measure 0301, Surgery Patients with Appropriate Hair Removal. I echo that comment here, because it applies in the ASC setting as well.		0515: Ambulatory patients with hair removal
1212	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We do not support this measure being used on its own. Rather, it should be combined with measure #528 and the already-endorsed measure of cessation of prophylactic antibiotic administration in a patient-centered (all-or-none) composite measure. The patient needs to have all 3.		0527: Prophylactic received within 1 hour

ID#	Council/ Public	Commenter	Comment	Response	Topic
1233	HPR	Denise Graham; Association for Professionals in Infection Control and Epidemiology	The Association for Professionals in Infection Control and Epidemiology (APIC) continue its support of this measure.		0527: Prophylactic received within 1 hour
1296	CON	Debra L. Ness, MS; National Partnership for Women & Families	We strongly suggest that this measure be combined with measure #528, and the already-endorsed measure "Cessation of Prophylactic Antibiotic Administration" to create a patient-centered composite measure on use of prophylactic antibiotics in surgical settings.		0527: Prophylactic received within 1 hour
1214	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We do not support this measure being used on its own. Rather, it should be combined with measure #527 and the already-endorsed measure of cessation of prophylactic antibiotic administration in a patient-centered (all-or-none) composite measure. The patient needs to have all 3.		0528: Prophylactic selection
1234	HPR	Denise Graham; Association for Professionals in Infection Control and Epidemiology	The Association for Professionals in Infection Control and Epidemiology (APIC) continue its support of this measure.		0528: Prophylactic selection

ID#	Council/ Public	Commenter	Comment	Response	Topic
1267	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	The measure as currently specified seems too prescriptive and relies on a specific type of antibiotic used for compliance which can pose challenges if the guidelines change.		0528: Prophylactic selection
1297	CON	Debra L. Ness, MS; National Partnership for Women & Families	We strongly suggest that this measure be combined with measure #528, and the already-endorsed measure "Cessation of Prophylactic Antibiotic Administration" to create a patient-centered composite measure on use of prophylactic antibiotics in surgical settings.		0528: Prophylactic selection
1213	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	This is a prescription measure that does not generate the most valuable information possible. We encourage NQF to replace this measure with one that looks at health outcomes and whether treatment recommended at discharge is adhered to by patients. Also, the extent of linkage to outcomes is not clear.		1519: Statin therapy after LEB

ID#	Council/ Public	Commenter	Comment	Response	Topic
1242	HPR	Richard Cambria, MD and Timothy Kresowik, MD; Society for Vascular Surgery	SVS supports NQF's intent of providing superior vetting and endorsement of surgical quality measures. SVS continues to strive to be a leader in the area of surgical quality and therefore offers the following recommendations and comments for consideration at this time: Measures Recommended for Full Endorsement NQF Measure #1519 – Statin Therapy at Discharge after Lower Extremity Bypass •SVS supports NQF's recommendation for full endorsement of this measure.		1519: Statin therapy after LEB
1249	HPL	Thomas James, III, MD; Humana, Inc.	This is a process measure rather than an outcome measure, which would be preferable. However if there is a gap in care, then we would support this measure until an outcome measure could be developed.		1519: Statin therapy after LEB
1268	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We support this measure for which clinical guidelines already exist. The burden to health plans could be reduced through the use of claims data for calculating the measure.		1519: Statin therapy after LEB
1298	CON	Debra L. Ness, MS; National Partnership for Women & Families	We do not support this measure, and feel that it would be much more meaningful to have a measure that looks at health outcomes for patients with LEB, and whether patients are adhering to the treatments recommended at discharge. As currently specified, this measure does not generate what we would consider meaningful information, and it is unclear how strongly this process is linked to outcomes.		1519: Statin therapy after LEB

ID#	Council/ Public	Commenter	Comment	Response	Topic
1215	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support this as a good outcome measure. It would be more useful, however, if it were reported in categories reflecting the amount of improvement that the patient experiences.		1536: Cataracts-Improv. in visual function
1252	HPL	Thomas James, III, MD; Humana, Inc.	We support this measure, based upon work through the work of the Cataract Patient Reported Outcomes Team, AHRQ and the Academy. This is the start of more Patient Reported Outcomes Measures, which may be difficult to obtain but get to the real determiner of the outcomes of care-the patient		1536: Cataracts-Improv. in visual function
1269	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	In general, measures of patient functional status can serve as useful quality indicators. However, this measure poses certain challenges as there appear to be no guidelines defining meaningful levels of improvement in patient status. It would be important to establish a threshold of "improvement" to make this measure more objective.		1536: Cataracts-Improv. in visual function
1216	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support this as a good outcome measure.		1540: Postop stroke or death undergoing carotid endart.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1230	HPR	Christopher White, MD, FSCAI; The Society for Cardiovascular Angiography and Interventions	SCAI recommends endorsement of this measure. Our comments have been submitted to the National Quality Forum.		1540: Postop stroke or death undergoing carotid endart.
1244	HPR	Richard Cambria, MD and Timothy Kresowik, MD; Society for Vascular Surgery	SVS supports NQF's intent of providing superior vetting and endorsement of surgical quality measures. SVS continues to strive to be a leader in the area of surgical quality and therefore offers the following recommendations and comments for consideration at this time: Measures Recommended for Full Endorsement NQF Measure #1540 – Postoperative Stroke or death in Asymptomatic Patients undergoing Carotid Endarterectomy •SVS supports NQF's recommendation for full endorsement of this measure.		1540: Postop stroke or death undergoing carotid endart.
1270	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	The intent of this measure seems to be unclear. The measure would be more meaningful if either the current scope is broadened to include all adverse outcomes such as post-operative AMI and not just death, or if the measure scope is limited to only neurovascular complications.		1540: Postop stroke or death undergoing carotid endart.
1185	P	Jon George, MD; Deborah Heart and Lung Center	It is absolutely imperative that Carotid Surgery be held to the same standard as Carotid Artery Stenting with strict follow up of neurological outcomes post-procedure. This is analogous to performing a follow up test to confirm adequate completion of a procedure.		1543: Postop stroke or death undergoing CAS

ID#	Council/ Public	Commenter	Comment	Response	Topic
1217	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support this as a good outcome measure.		1543: Postop stroke or death undergoing CAS
1246	HPR	Richard Cambria, MD and Timothy Kresowik, MD; Society for Vascular Surgery	SVS supports NQF's intent of providing superior vetting and endorsement of surgical quality measures. SVS continues to strive to be a leader in the area of surgical quality and therefore offers the following recommendations and comments for consideration at this time: Measures Recommended for Full Endorsement NQF Measure #1543 – Postoperative Stroke or Death in Asymptomatic Patients undergoing Carotid Artery Stenting (CAS) •SVS supports NQF's recommendation for full endorsement of this measure.		1543: Postop stroke or death undergoing CAS
1271	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	The intent of this measure seems to be unclear. The measure would be more meaningful if either the current scope is broadened to include all adverse outcomes such as post-operative AMI and not just death, or if the measure scope is limited to only neurovascular complications.		1543: Postop stroke or death undergoing CAS

ID#	Council/ Public	Commenter	Comment	Response	Topic
1189	P	William Martin, III, MD; American Association of Orthopaedic Surgeons	<p>Risk Adjustment Vulnerable Populations: The AAOS believes more work needs to be done on risk adjustment in order to avoid the unintended consequence of denying care to the most vulnerable patients. The AAOS urges NQF to further develop a means for risk adjusting for the wide variation in patient characteristics.</p> <p>Socioeconomic Status: Specifically, the AAOS believes socioeconomic status (SES) should be included in the risk-adjustment models because low-SES patients are known to be at higher risk for post-operative complications and readmissions, and not including SES in the models could result in low-SES patients being denied much needed quality-enhancing treatments like THA and TKA.</p> <p>While the relationship between readmissions and quality of care is complex, income and socioeconomic status have been shown to play a role in risk of readmission for post-operative complications. SES is usually measured by level of education, income, occupation, or a composite of these dimensions. A patient's life circumstances are important factors in outcome determinations. Researchers involved in analyses of risk-adjusted outcomes and costs have suggested the need for a SES adjustment for patient populations, in addition to traditional risk-adjustment variables.</p>		1550: Hospital-level RSCR following THA and TKA
1218	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	<p>We question why this measure uses hierarchical risk modeling (HRM) when other mortality measures in the set were deemed appropriate with standard logistic regression? HRM is known to reduce sensitivity to detect outliers. Otherwise, it would be a good outcome measure.</p>		1550: Hospital-level RSCR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic
1219	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	We support measuring the performance of providers at all levels (e.g. individual physicians, physician groups, hospitals, ACOs, etc.). We question why this measure would not apply at the clinician level.		1550: Hospital-level RSCR following THA and TKA
1253	HPL	Thomas James, III, MD; Humana, Inc.	We are supportive of this measure as one that meets a need for a high volume procedure with significant regional variation, and is a strong outcomes measures.		1550: Hospital-level RSCR following THA and TKA
1272	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We support this measure and recommend that the measure be expanded to the commercial population for persons aged 18 to 64.		1550: Hospital-level RSCR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic
1299	QMRI	John Shaw; Next Wave	<p>Comment 1</p> <p>1.) The overall structure and intent of the measure is appropriate.</p> <ul style="list-style-type: none"> •The composite measure components are relatively frequent and at least partially actionable. •The variable time frames (7 days, 30 days, and 90 days) are appropriate for their respective components. •The rationales for each of the denominator exclusions are appropriate to exclude high risk patients. •The basic risk adjustment structure is reasonable, and incorporates demographic, THA/TKA procedure, and clinical risk factors likely to impact the frequency of the complication components. •This overall approach is in use in several NQF endorsed Medical measures (for AMI, Heart Failure, and Pneumonia). <p>2.) While we support this measure in concept, in practice we cannot support endorsement of this measure as currently specified for the reasons outlined below.</p>		1550: Hospital- level RSCR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic
1300	QMRI	John Shaw; Next Wave	<p>Comment part 2</p> <p>3.) This is the first application of this methodology approach to a Surgical event. It is previously used and endorsed for medical conditions. For surgery, the timing of the event relative to associated ICD-9-CM diagnoses is necessary for appropriate attribution. The current detailed Measure Specification for specific ICD9-CM code use is sufficiently incomplete such that it does not meet the intent of the measure, and is significantly biased and includes large numbers of complications occurring prior to the index admission surgical procedure to which the complications are attributed.</p> <p>1.The lists of ICD-9-CM codes in the final Measure Denominator Specification used to exclude hip fracture cases, revisions, and partial hip replacements from the denominator are incomplete, leaving many patients at high risk for mortality, complications, and readmissions in the measure denominator. Since these patients are disproportionately treated in a small number of hospitals, this produces a systematic bias in the results.</p> <p>2.The ICD-9-CM code logic in the Measure Numerator Specification does not distinguish diagnoses that are already present prior to admission for the index procedure (in either primary or secondary positions – risk factors) versus those occurring after the index admission and THA/TKA surgery (complications).</p> <p>See additional comments for continuation and further details.</p>		1550: Hospital- level RSCR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic
1301	QMRI	John Shaw; Next Wave	<p>Continuation - Part 3</p> <p>3.) Incomplete and significantly biased</p> <p>2. diagnoses prior to admission</p> <ul style="list-style-type: none"> •Because of this, patients admitted specifically for revision of failed screws, plates, wires, implants, etc. from a previous partial hip replacement or previous hip fracture repair (frequently performed at a different hospital) are included in the numerator complications. •Since these patients were not excluded from the denominator and are disproportionately treated in a small number of hospitals, this produces an additional systematic bias in the results. <p>3. Since treatment of failed hip fracture or partial hip by use of a total hip replacement is very common, the magnitude of the bias is very large, and overwhelms many of the other measure components.</p> <p>1.From analysis of several large datasets, we estimate that as specified, complications of prior orthopedic surgery accounts for over 1/3 of the “Mechanical Complication” component.</p> <p>See additional comments for continuation and more details</p>		1550: Hospital- level RSCR following THA and TKA
1302	QMRI	John Shaw; Next Wave	<p>Part 4</p> <p>3.) Bias is very large, 1. For Mechanical Complications (cont.)</p> <p>1.Many joint prosthesis specific complications are also POA - e.g. 98% of ICD-9-CM code 99641 – Mechanical loosening of prosthetic joint are POA, and represent failed partial hip replacements used to treat a prior hip fracture – usually caused by wear debris from the implant over a long period of time.</p> <p>2.This component has the greatest impact on the composite measure, with a frequency of occurrence more than three times the average of the other 8 measures in the composite.</p> <p>3.As a result, the systematic bias error has a greater weight on the composite measure than the average of the other 8 measures.</p>		1550: Hospital- level RSCR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic															
1303	QMRI	John Shaw; Next Wave	<p>Part 5: Other components are similarly biased with pre-existing numerator complications - to a lesser degree individually, but with a combined significant impact on the composite measure.</p> <p>1.For example, many orthopedic surgeons will not perform a THA/TKA on a patient with a history of an AMI, referring these higher risk patients to regional referral centers with protocols in place to safely treat them.</p> <p>2.ICD-9-CM coding rules require that the referral center code the AMI as a secondary diagnosis, since it requires additional monitoring resources, but with a Present on Admission (POA) code to indicate that the AMI occurred prior to the index THA/TKA admission. The current Measure Specification would count this as a numerator complication (ANY diagnosis listed during the index admission in ANY position, regardless of whether it occurred prior to the admission and surgery).</p> <p>See further comments</p>		1550: Hospital- level RSCR following THA and TKA															
1304	QMRI	John Shaw; Next Wave	<p>Part 6- 1.Hospital level impacts using the current Measure Specification of this systematic bias are perverse, with the hospitals in our sample admitting the greatest number of high risk patients with complications of prior orthopedic surgery receiving the worst complication scores, whereas, they actually have the best scores.</p> <table border="1" data-bbox="435 1039 1325 1245"> <thead> <tr> <th data-bbox="435 1039 833 1071">%Num. POA vs. Mean Hospitals</th> <th data-bbox="833 1039 1021 1071">Rate per Specs</th> <th data-bbox="1021 1039 1325 1071">Ratewo POA</th> </tr> </thead> <tbody> <tr> <td data-bbox="435 1071 833 1104">2+ SD above mean</td> <td data-bbox="833 1071 1021 1104">84.90%</td> <td data-bbox="1021 1071 1325 1104">1.70%</td> </tr> <tr> <td data-bbox="435 1104 833 1136">1-2 SD above mean</td> <td data-bbox="833 1104 1021 1136">144.10%</td> <td data-bbox="1021 1104 1325 1136">1.90%</td> </tr> <tr> <td data-bbox="435 1136 833 1169">Above mean</td> <td data-bbox="833 1136 1021 1169">393%</td> <td data-bbox="1021 1136 1325 1169">2.00%</td> </tr> <tr> <td data-bbox="435 1169 833 1201">Below mean</td> <td data-bbox="833 1169 1021 1201">973.30%</td> <td data-bbox="1021 1169 1325 1201">2.90%</td> </tr> </tbody> </table>	%Num. POA vs. Mean Hospitals	Rate per Specs	Ratewo POA	2+ SD above mean	84.90%	1.70%	1-2 SD above mean	144.10%	1.90%	Above mean	393%	2.00%	Below mean	973.30%	2.90%		1550: Hospital- level RSCR following THA and TKA
%Num. POA vs. Mean Hospitals	Rate per Specs	Ratewo POA																		
2+ SD above mean	84.90%	1.70%																		
1-2 SD above mean	144.10%	1.90%																		
Above mean	393%	2.00%																		
Below mean	973.30%	2.90%																		

ID#	Council/ Public	Commenter	Comment	Response	Topic
1305	QMRI	John Shaw; Next Wave	<p>Part 7 - Risk Adjustment: Since the bias is both systematic and large, the existing risk adjustment structure is also likely biased, since it is disproportionately affected by the propensity to explain the likelihood for patients with failures of prior orthopedic surgery to seek treatment in regional referral centers that specialize in orthopedic revision surgery. Complications, particularly common orthopedic complications, occurring prior to the index admission and surgery should be added to the risk model, not left in the measure numerator. The current risk adjustment Measure Specification is also incomplete, making quantitative evaluation of the risk methodology impossible. Specification of ICD-9-CM codes included in each of the CC “condition categories” that comprise the majority of the risk adjustment (as well as those considered and not included in the model) do not appear available in the public domain. The CMS link provided in the draft specifications did not work, and follow-up attempts to obtain this information from CMS directly were similarly unsuccessful. We did note a significant quantitative risk on the other risk factors that were specified (Age, sex, THA vs. TKA procedure, and number of procedures performed). These should remain in the risk model.</p>		1550: Hospital- level RSCR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic
1306	QMRI	John Shaw; Next Wave	<p>Part 8 - Disparities: The current Measure Specification does not risk adjust or stratify for Socio-Economic-Status (SES). The details in the application for Disparities Data addressed a companion measure (1551 Readmissions after THA/TKA), not this complication measure. It used Medicaid eligibility as a proxy for SES.</p> <p>1. We cannot comment on findings for this measure since they were not provided.</p> <p>2. We remain concerned over this issue, since large historical disparities have been shown historically in at risk populations for THA/TKA. Medicaid eligibility is a crude measure, since it relies on individual State Medicaid coverage policies which vary significantly from state to state.</p> <p>3. Other measures such as local population characteristics and minority serving “safety net” hospital status are currently being reviewed as alternatives to simply using Medicaid eligibility as an indicator.</p> <p>Overall refinements to NQF SES stratification policies are in process as a result of a number of other initiatives (Addressing Health Disparities, the Measures Application Partnership, etc.). The THA/TKA measures have demonstrated variability, and should be incorporated as examples into these broader initiatives.</p>		1550: Hospital- level RSCR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic
1307	QMRI	John Shaw; Next Wave	<p>Part 9 - Corrections: Our specification and systematic bias concerns can be easily addressed by the measure developer by updating the measure specification and re-running the risk model on a complete data set with all relevant factors and using appropriate ICD-9-CM codes. We hope that these refinements will be implemented prior to presenting these measures for a final vote:</p> <ol style="list-style-type: none"> 1. Adding other appropriate diagnoses to the denominator exclusion list for high risk patients with hip fractures and/or revision procedures (list of candidate codes will be provided to NQF and the measure developer). 2. Exclude all numerator complication codes listed on the index admission in either the principle diagnosis position or a secondary position if it is indicated as Present On Admission (POA). 3. Note: Only exclude for the index admission – leave in the numerator for ALL readmissions during the 7, 30, or 90 day time periods, since these likely ARE complications of the index THA/TKA. 4. Rerun the risk adjustment analysis, including reevaluation of the CC condition categories that did not make it into the current biased specification. 5. Complications from prior orthopedic surgeries present on admission in the index stay and surgery should be considered as potential risk factors for future complications, consistent with the literature. <p>Also, make the map of ICD-9-CM code to “CC condition category” (for all candidate measures) available for full transparency.</p>		1550: Hospital- level RSCR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic
1309	QMRI	John Shaw; Next Wave	Part 10 - Future Refinements: We have seen in our analysis (after making the recommended corrections to eliminate bias) that these same measures are also significant complications in the younger and non-Medicare population. While relative frequencies of the component measures and risk factor predictors differ, the corrected methodology can serve as a template for broader application to the growing number of patients receiving THA/TKA prior to age 65.		1550: Hospital-level RSCR following THA and TKA
1190	P	William Martin, III, MD; American Association of Orthopaedic Surgeons	<p>Risk Adjustment</p> <p>Vulnerable Populations: The AAOS believes more work needs to be done on risk adjustment in order to avoid the unintended consequence of denying care to the most vulnerable patients. The AAOS urges NQF to further develop a means for risk adjusting for the wide variation in patient characteristics.</p> <p>Socioeconomic Status: Specifically, the AAOS believes socioeconomic status (SES) should be included in the risk-adjustment models because low-SES patients are known to be at higher risk for post-operative complications and readmissions, and not including SES in the models could result in low-SES patients being denied much needed quality-enhancing treatments like THA and TKA. While the relationship between readmissions and quality of care is complex, income and socioeconomic status have been shown to play a role in risk of readmission for post-operative complications. SES is usually measured by level of education, income, occupation, or a composite of these dimensions. A patient's life circumstances are important factors in outcome determinations.</p> <p>Researchers involved in analyses of risk-adjusted outcomes and costs have suggested the need for a SES adjustment for patient populations, in addition to traditional risk-adjustment variables.</p>		1551: Hospital-level 30-day all-cause RSRR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic
1220	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	<p>We question why this measure uses hierarchical risk modeling (HRM) when other mortality measures in the set were deemed appropriate with standard logistic regression? HRM is known to reduce sensitivity to detect outliers. Otherwise, it would be a good outcome measure.</p> <p>We support measuring the performance of providers at all levels (e.g. individual physicians, physician groups, hospitals, ACOs, etc.). We question why this measure would not apply at the clinician level.</p>		1551: Hospital-level 30-day all-cause RSRR following THA and TKA
1254	HPL	Thomas James, III, MD; Humana, Inc.	We are supportive of this measure as it stands but if the 30-day all cause readmission rate measure is endorsed, then this should become a specific submeasure. In such a case the methodologies should be harmonized.		1551: Hospital-level 30-day all-cause RSRR following THA and TKA
1273	HPL	Carmella Bocchino, MBA, RN; America's Health Insurance Plans	We support this measure and recommend that the measure be expanded to the commercial population for persons aged 18 to 64.		1551: Hospital-level 30-day all-cause RSRR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic
1308	QMRI	John Shaw; Next Wave	<p>Comments are similar to those provided under the THA/TKA Complication measure (see detailed comments under measure 1550):</p> <ol style="list-style-type: none"> 1. We agree with the overall concept and approach. 2. We could not endorse as currently specified. 3. The denominator exclusions are similarly biased by not excluding all hip fractures, revisions, and patients with a partial hip replacement from the denominator. This will bias the measure against the smaller number of regional referral centers that admit these patients with a higher risk for readmission. 4. Better adjustments are necessary to address health disparities and SES. This measure (after correcting for bias in the current measure specification) should be an example for use in other NQF initiatives addressing disparities. 5. The specification for “CC condition categories” is incomplete, and does not provide a transparent description of the specific ICD-9-CM codes included in each CC. 6. The corrected measure can also inform application to other populations (e.g. <65). 7. Corrections could be easily implemented by the measure developer. 		1551: Hospital- level 30-day all-cause RSRR following THA and TKA

ID#	Council/ Public	Commenter	Comment	Response	Topic
1181	PUB/CO MM	Denise Love, MBA, RN; National Association of Health Data Organizations	<p>The National Association of Health Data Organizations (NAHDO) represents states with statewide hospital data reporting programs. NAHDO requests reconsideration of measures not recommended for endorsement: .</p> <ul style="list-style-type: none"> - Incidental Appendectomy in the Elderly (IQI 24) (NQF #364): States and policymakers are seeking to reduce unnecessary costs and reduce variation in overuse. Incidental appendectomies introduce risk of complication, add to costs. The uninsured/underinsured could end up paying more. This measure gets at one low hanging fruit of cost reduction. - Postoperative Wound Dehiscence (PDI 11) (pediatrics) (NQF #367) - Postoperative Wound Dehiscence (PSI 14) (adults) (NQF #368) <p>These measures indicate non-optimal care, add to the cost of care, and negatively affect the patient. Patient factors may affect the occurrence of this event, good post-op care and coordinated follow-up care can make a difference. This measure can be used today in most states, fits the NQF care coordination domains (medical home, transitions/handoffs, communication). NQF should reconsider its two-state hierarchical modeling approach, as this tends to wash out provider variation, which limits information's utility to consumers and purchasers.</p>		<p>Measures Not Recommended: 0364-Incidental append. In elderly, 0367-Postop wound (PDI 11) and 0368-Postop wound (PSI 14)</p>

ID#	Council/ Public	Commenter	Comment	Response	Topic
1183	PUR	Barbara Rudolph, PhD, MSSW; The Leapfrog Group	<p>The Leapfrog Group strongly encourages the reconsideration of the following measures: Incidental Appendectomy in the Elderly (IQI 24) (NQF #364): There are few overuse/misuse measures available. Incidental appendectomies introduce risk of complication, and add to costs for patients and payers.</p> <p>Postoperative Wound Dehiscence (PDI 11) (pediatrics) (NQF #367) and Postoperative Wound Dehiscence (PSI 14) (adults) (NQF #368) indicate sub-optimal care for patients and add to cost of care. While some patients may be at higher risk, good post-op care can make a difference. These measures fit with the NQF care coordination domains.</p>		<p>Measures Not Recommended: 0364-Incidental append. In elderly, 0367-Postop wound (PDI 11) and 0368-Postop wound (PSI 14)</p>

ID#	Council/ Public	Commenter	Comment	Response	Topic
1221	PUR	David S. P. Hopkins, MS, PhD; Pacific Business Group on Health	<p>The Surgical Steering Committee voted down three measures that we consider of importance:</p> <ul style="list-style-type: none"> •0364: Incidental appendectomy in the elderly rate (IQI 24) •0367: Postoperative wound dehiscence rate (PDI 11) (pediatric population) •0368: Postoperative wound dehiscence rate (PSI 14) (adult population) <p>We believe the rejection of these three measures is in error for the following reasons.</p> <p>Postoperative wound dehiscence (pediatric and adult populations): Evidence was provided to the Steering Committee showing that 30% of these are preventable. Furthermore, there are numerous other measures endorsed with similar or lower rates of preventability. We disagree with the committee's stance and see these measures as having the potential for a clear impact on the quality of care provided to patients.</p> <p>Incidental appendectomy in the elderly: The Steering Committee said it only happens 2% of the time and that there is questionable evidence of adverse affects; however, there are other endorsed measures that occur less than 2% of the time. Given that there is no evidence it does any good to remove the appendix while patients are already in surgery, we question why surgeons are doing the removals. There are precious few overuse measures endorsed and this one would be a good start in the right direction.</p>		Measures Not Recommended: 0364-Incidental append. In elderly, 0367-Postop wound (PDI 11) and 0368-Postop wound (PSI 14)

ID#	Council/ Public	Commenter	Comment	Response	Topic
1186	P	Cesar Jara, MD, FACC, FSCAI; Cape Canaveral Hospital	<p>Carotid artery stenting (CAS) has shown consistently in recent trials adequate outcomes compared with surgery (CEA) in the right patient population, and with an experienced physician. In spite of these clinical data, CAS is limited in availability and reimbursement. One assumption is that outcomes with CEA are similar to the ones achieved in trials, and no further data is being collected post-surgery, as opposed to CAS.</p> <p>Supporting collecting data for both, will help to elucidate better the equivalence of both procedures, as well as provide to the patient a more accurate statement of risk vs benefits at a local level, and not general statistics.</p>		<p>Measures Not Recommend ed: 1531- Follow-up assessment after carotid resvas.</p>

ID#	Council/ Public	Commenter	Comment	Response	Topic
1187	P	Timothy Murphy, MD; Society of Interventional Radiology	<p>The Society of Interventional Radiology, a professional association representing 4,700+ physicians & allied professionals committed to improving public health through image-guided therapy, submits the following comments on the draft report Surgery Consensus Standards Endorsement Maintenance (SCSEM). As a partner society on the ACCF's National Cardiovascular Data Registry (NCDR) Care Registry®, we support ACCF's comments on the measure: "1531 Follow-up assessment of stroke or death after carotid revascularization." We also recommend that patients post carotid revascularization have post procedure outcomes measured with the NIHSS and mRS. Per the SCSEM's comments, NQF is unclear that measuring outcomes improves outcomes for carotid revascularization. This criticism is surprising. In order for outcomes to improve, they must be measured. Given the narrow benefit over harm of carotid revascularization, it is impossible to identify inadequately performing facilities and physicians unless outcomes are measured. The measured outcomes from carotid stenting are an essential part of the carotid stent accreditation program that SIR and other societies have created, and we anticipate that CMS may soon require measured outcomes meeting national benchmarks. For the benefit of patients we recommend SCSEM reconsider its decision and move this important measure forward for endorsement by NQF.</p>		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1191	HPL	Mark D. Grant, MD, MPH; BCBSA	<p>When carotid endarterectomy or angioplasty and stenting are used to treat atherosclerotic stenosis, the balance of benefits and harms is determined largely by periprocedural stroke and death rates. The net health outcomes depend on the tradeoff of early (periprocedural or 30-day) stroke and death risk for a subsequent reduction in stroke incidence. The lack of accurate stroke and death rates following either procedure prevents facilities, providers, and patients from knowing whether net health outcomes are favorable. Only by having valid stroke and death data can the outcomes of care be evaluated, reported and improved. Furthermore, lacking those data the ability to identify safety signals is limited. A valid stroke ascertainment requires a certified examiner or neurologist. Furthermore, carotid angioplasty and stenting procedures may be followed by a certified exam, while endarterectomy may not. Consequently, comparing outcomes and quality of care for the two procedures is hampered. The CARE registry offers an important opportunity—to provide information that can potentially make certain carotid procedures are being performed safely and with likely benefit. Absent inclusion of a standard follow-up assessment that opportunity is limited.</p>		<p>Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.</p>

ID#	Council/ Public	Commenter	Comment	Response	Topic
1231	HPR	Christopher White, MD, FSCAI; The Society for Cardiovascular Angiography and Interventions	<p>We are writing to support the ACCF's comments regarding the measure: "Follow-up assessment of stroke or death after carotid revascularization."</p> <p>This measure was developed and tested through the NCDR Care Registry®. We recommend that patients post carotid revascularization have post procedure outcomes measured with the NIHSS and mRS. Per the SCSEM's comments, NQF is unclear that measuring outcomes improves outcomes for carotid revascularization. This criticism is surprising. In order for outcomes to improve, they must be measured. Given the narrow benefit over harm of carotid revascularization, it is impossible to identify inadequately performing facilities and physicians unless outcomes are measured. The measured outcomes from carotid stenting are an essential part of the carotid stent accreditation program that SCAI and other societies have created, and we anticipate that CMS may soon require measured outcomes meeting national benchmarks. We recommend that the SCSEM reconsider its decision and recommend this measure move forward for endorsement.</p>		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1274	HPR	Sarah Tonn, MPH; American Academy of Neurology	<p>The AAN supports measure #1531: Follow-up assessment of stroke or death after carotid revascularization. The AAN requests the NQF Review Steering Committee (SC) decision be reconsidered and that the #1531 measure be recommended for endorsement. The AAN believes that following carotid revascularization procedures, a 30 day assessment (+- 5 days) of the NIH stroke scale and modified Rankin Scale are desirable. The reasons for including this are as follows:</p> <ol style="list-style-type: none"> 1. Clinical trials in the past have included a 30 day assessment of stroke status and functional status. The periprocedure period traditionally extends 30 days after the index carotid procedure. 2. In order to determine whether real world results are matching clinical trials, a 30 day assessment is important. If 30 day results are worse than the benchmark clinical trials, this becomes a patient safety issue. 3. Carotid revascularization procedures in some cases have a narrow risk/benefit ratio. Documentation of the patient's status at 30 days is an important element in assessing the local hospital's performance, as recommended in a previous statement from the AAN. <p>The AAN supports Measure #1531 and we believe that the 30 day assessment is in the best interests of patients and the larger health care system. We ask that the SC reconsider their decision and recommend for endorsement.</p>		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.
1310	P	Stan Thornton, MD, FACC, FSCAI	<p>I am astounded at the decision not to endorse the reporting of outcomes following carotid revascularization. Not only is it a disservice to patients in their ability to choose a physician who provides the highest quality care, but allows operators who perform below the standard to continue to do so in relative obscurity. Please reconsider and support this measure.</p>		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1311	P	Jay K. Patel, MD, FACC, FSCAI, FACP; Hamilton Cardiology Associates	<p>We have reviewed the draft report and respectfully request the project Steering Committee reconsider the decision regarding the NCDR measure: "Follow-up assessment of stroke or death after carotid revascularization" and recommend the measure for endorsement by NQF. We offer the following comments for your consideration. This measure has been developed and tested through the National Cardiovascular Data Registry's (NCDR) Care Registry®. NCDR was given an opportunity to respond to concerns raised by the Steering Committee (SC) members regarding the importance, feasibility, relationship to outcomes, and reliability testing data criteria for this measure. Given that the SCSEM SC discussion regarding the NCDR response during a review conference call indicated consensus that all of these concerns had been adequately addressed, and in light of the fact that the SCSEM SC members vote indicated that the aforementioned criteria was deemed met or almost met by a majority of members and the vote to not endorse this measure was by a very narrow margin, we would like to request that the SCSEM SC SC reconsider its decision and recommend this measure move forward for endorsement.</p>		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1312	P	Jay K. Patel, MD, FACC, FSCAI, FACP; Hamilton Cardiology Associates	<p>Importance of this process measure: Data from the CARE Registry indicate that hospitals on average perform follow-up consistent with this measure 21% of the time, with 50% of hospitals performing it only 11% of the time. Given the risk and cost of this procedure, it is essential that patients be assessed after discharge to determine if the procedure prevented stroke and death, and to identify any complications. This measure encourages standardization of follow-up for this importance procedure to ensure that patients are evaluated using a standard neurologic evaluation by a certified examiner so that outcomes can be monitored reliably.</p> <p>Feasibility of collecting follow-up data, NIHSS certification: Many hospitals who participate in the CARE Registry (approximately 180 institutions) have been reliably and consistently submitting follow-up to the CARE Registry for several years and find the information provided to them from the registry for benchmarking to be valuable in quality improvement efforts. In addition to the modified Rankin score data, which is an option for data submission, SCSEM SC discussion focused on feasibility and potential burden of requiring individuals be certified on the National Institutes of Health Stroke Scale (NIHSS). The NIHSS stroke scale certification is available as an online learning module: http://www.nihstrokescale.org/. Certification can be obtained in under an hour by a variety of clinicians or therapists, and only needs to be renewed every other year. There is no cost for certification. Patient assessment using the NIHSS tool takes approximately 10 minutes. Timeframe of data collection and reliability data: In response to the SCSEM SC request to reconsider the follow-up data collection timeframe, NCDR modified the timeframe from 21-60 days to 14-60 days. In addition, we have provided additional reliability data to the SC to support expanding the measure</p>		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1313	P	Jay K. Patel, MD, FACC, FSCAI, FACP; Hamilton Cardiology Associates	<p>Importance of measures for quality improvement and public reporting: NCDR intends to include this measure as part of the portfolio of measures to be implemented in the ACCF's voluntary public reporting program currently under development and targeted for launch in 2012. The additional NCDR registry measures intended for use in this public reporting effort are undergoing review by the NQF Cardiovascular Endorsement Maintenance (CEM) Project, and while it would have been our preference to have all the measures considered under the same project, we deferred to the recommendation of the NQF to separate this measure for review under the SCSEM project. As such, the relationship of this measure to the NCDR's overall public reporting effort may not have been apparent to the SCSEM SC as it is to the CEM SC. Relationship of process measure to outcomes measure: NCDR recognizes the emphasis and importance of outcomes measures in quality improvement efforts. In putting this particular process measure forward for endorsement; ACCF contemplated submitting an outcome measure focused on stroke as the end point. Ultimately, as this submission reflects, the College determined a process measure is more appropriate for endorsement at this time as it demonstrates enough variation in practice for improvement and that variation would raise reasonable questions regarding the quality of assessments upon which an outcome measure would be based.</p>		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1314	P	Jay K. Patel, MD, FACC, FSCAI, FACP; Hamilton Cardiology Associates	<p>Commitment to efforts that support improvement on the measure: While the NCDR is nationally recognized as a model of excellence for its systematic, standardized data collection and quality and outcomes reporting activities, SCAI and ACCF are just as committed to assisting physicians, clinical care teams, hospitals and practices in "moving the measure" to improve the quality of care provided to patients. Specific to this measure, details related to the two possible neurological assessments (NIHSS and the modified Rankin score) are disseminated to participating hospitals in a variety of ways. Definitions of the NIHSS, information concerning the need for the assessment to be performed by a healthcare professional other than the operator (i.e. independent assessment), and information indicating that NIHSS examiners may become certified through the American Stroke Association are included in the CARE Registry data dictionary that is publically available on the NCDR.com website. Additionally, the secure login portion of the website provides participating hospital staff with frequently asked questions (FAQ) addressing issue about the assessments. Each hospital is provided with a CARE Registry welcome kit upon enrolling in the registry, which includes information about the NIH Stroke Scale and Modified Rankin Scale. Finally, NCDR clinical quality consultants who respond to calls and e-mails from current or potential participating hospital staff are trained in how to answer questions about the NIHSS and Rankin scores, including stroke scale tool training and implementation as well as data capture for the CARE Registry.</p>		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1315	P	Bryan W. Kluck, DO, FACC; Heart Care Group	I would like to have my voice join the many others responding on the topic of carotid revascularization outcomes. I strongly feel that it is in the interest of optimal patient care to measure all carotid procedure outcomes, and it is the responsibility of the performing physician and the hospital - both of whom collect fees - to make certain they assess the result of their procedure. This should apply evenly to CEA and CAS. The emphasis on choosing the strategy of revascularization may have unfortunately drifted away from the most important consideration, that of patient safety and well being. I think this measure is necessary to refocus the entire field on that goal.		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.
1316	P	Mike Schaeffer; Saint Joseph Medical Foundation	I would like to comment on the draft report of the National Quality Forum's Surgery Consensus Standards Endorsement Maintenance (SCSEM) project. As a member of the Society for Cardiovascular Angiography and Interventions (SCAI), I support your overall efforts to expand the NQF portfolio and to ensure that only the best measures become NQF-endorsed voluntary consensus standards. I respectfully request the project Steering Committee reconsider the decision regarding the NCDR measure: "Follow-up assessment of stroke or death after carotid revascularization (#1531)" and recommend the measure for endorsement by NQF.		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.
1317	PRO	Tim Bevelacqua, MN, RN, CENP; Memorial Hermann Healthcare System	Please accept this communication as formal commentary and endorsement of the National Quality Forum (NQF) proposed national standard related to "Follow-up assessment of stroke or death after carotid revascularization (#1531). Endorsement of this standard is on behalf of patients who should expect outcomes of this procedure to be measured by both hospitals and physicians performing the procedures. Thank you for your attention to this important issue.		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1318	CON	Julia Hallisy, DDS; The Empowered Patient Coalition	<p>I am writing on behalf of The Empowered Patient Coalition and as a voting member of NQF consumer council. We are supportive of the submitted process measure "Follow-up assessment of stroke or death after carotid revascularization" as an opportunity to monitor outcomes and collect follow-up data. We simply will never improve outcomes if we don't collect data and measure results. The NCDR Care Registry is a working example of data collection as a precursor to evidence-based medicine. Patients vigorously support data collection as a means to allow access to the information they need when making health care decisions. Without cutting-edge data, patients cannot make the best decisions for their individual situations and their physicians will make recommendations based on limited knowledge of the risks and outcomes. This is exactly what evidence-based medicine is seeking to change and improve. Progress is always challenging but taking that first step is a necessary part of the process. The availability of the Care Registry, free courses for NIHSS stroke certification, an amended time frame for collection of follow-up data and the fact that a variety of clinicians can perform the brief patient assessment make this measure workable and practical. We hope that the SCSEM will revisit its decision against this measure and decide to move forward for endorsement.</p>		<p>Measures Not Recommend ed: 1531- Follow-up assessment after carotid resvas.</p>

ID#	Council/ Public	Commenter	Comment	Response	Topic
1319	P	Ryan Saadi, MD, MPH; Cordis Corporation	Cordis Corporation appreciates the opportunity to comment on the draft report of the National Quality Forum’s (NQF) Surgery Consensus Standards Endorsement Maintenance (SCSEM) project. Cordis Corporation (Cordis), a Johnson & Johnson Company, is a worldwide leader in the development and manufacturing of interventional vascular technologies. Cordis partners with physicians worldwide to treat millions of patients who suffer from vascular diseases. Cordis is an affiliate member of the NQF through the Johnson & Johnson membership maintained by Ortho-McNeill-Janssen Pharmaceutical, Inc. Cordis supports NQFs’ efforts to identify and endorse measures that will result in quality improvements across all settings of care. We agree that only those measures providing a reasonable likelihood of enhancing patient care should become NQF endorsed voluntary consensus standards. We have reviewed the draft report pertaining to the Steering Committee’s recommendation against endorsing measure #1531 and respectfully request that the Steering Committee reconsider their decision and recommend this measure move forward for endorsement. We offer the following comments to support our request for reconsideration.		Measures Not Recommend ed: 1531- Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1320	P	Ryan Saadi, MD, MPH; Cordis Corporation	<p>The objective of the CARE registry is to improve outcomes of carotid revascularization patients. In their recent publication of the CARE protocol, White et al.,[i] noted that the findings of CARE will help to identify areas of excellence as well as opportunities for improvement. While the CARE registry provides an opportunity to report on early post-procedural stroke and death risk, currently fewer than 25% of hospitals are participating in this measure. National endorsement of this measure will increase the likelihood that these critical outcomes of stroke and death be monitored systematically which will allow for the development of an evidence base that would have important research and practical value. The availability of national data that is based on a valid and reliable standardized assessment of outcomes following carotid endarterectomy and stenting can address some limitations found in the published literature. It has been demonstrated that variation exists in the reported risk of stroke contingent upon the method and duration of assessment. Approved clinical studies currently being conducted for carotid stenting require the reporting of peri-operative outcomes assessment including completion of the National Institutes of Health (NIH) Stroke Scale by a certified examiner. Outcomes for patients currently undergoing carotid endarterectomy are not consistently reported upon in a similar manner. Such differences in methods of outcomes assessment and reporting requirements make it difficult to reliably compare real-world data for these two interventions.</p> <p>[i] White CJ et al. The Carotid Artery Revascularization and Endarterectomy (CARE) Registry: Objectives, Design and Implications. Catheterization and Cardiovascular Interventions 2008; 71: 721-725.</p>		Measures Not Recommend ed: 1531- Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1321	P	Ryan Saadi, MD, MPH; Cordis Corporation	<p>Clinical trials of carotid stenting and endarterectomy in higher surgical risk patients have incorporated neurological examinations, including assessment according to the NIH Stroke Scale, and have found higher risk of peri-procedural (i.e., 0 to 30 days) stroke, myocardial infarction or death compared to past publications.[ii] These findings may be partially due to increased sensitivity of detection of minor strokes. It would thus be important to validate findings of clinical trials in large populations of observed real-world practice using the proposed standardized assessment of stroke and death for both carotid stenting and endarterectomy patients. Finally, updating the carotid revascularization evidence base with standardized knowledge of stroke and death outcomes for different population types may help to better inform national decision-making. National guideline recommendations[iii] for patient selection of carotid endarterectomy versus stenting, as well as Medicare’s coverage criteria, are both fundamentally dependent on knowledge of the true peri-procedural risk of stroke and death. Such knowledge may thus contribute to enhancing the appropriateness of procedure selection for various population types. Having the most current and best available data for carotid revascularization outcomes in the real-world is anticipated to lead to improved clinical practice in the long-term through the identification of areas requiring quality improvement efforts, as well as the facilitation of clinical decision-making at both the national and hospital level.</p> <p>[ii] Ouriel K et al. Preprocedural risk stratification: identifying an appropriate population for carotid stenting. J Vasc Surg 2001; 33: 728-32.</p> <p>[iii] Brott TG et al. Guidelines on the management of patients with extracranial carotid and vertebral artery disease; JACC 2011; 57(8): e16-94.</p>		Measures Not Recommend ed: 1531- Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1322	SPI	Steven Brotman; AdvaMed	AdvaMed recommends reconsideration of the decision to not approve this measure and recommends the measure for endorsement by NQF. We offer the following comments for your consideration. This measure has developed and tested through the NCDR Care Registry®. The ACCF was given an opportunity to respond to concerns raised by the Steering Committee members regarding the importance, feasibility, relationship to outcomes, and reliability testing data criteria for this measure. The SCSEM Steering Committee has since indicated consensus that the ACCF adequately addressed all of those concerns. In light of the fact that the SCSEM Steering Committee members vote indicated that the aforementioned criteria was deemed met or almost met by a majority of members and the vote to not endorse this measure was by a very narrow margin, we would like to request that the SCSEM Steering Committee reconsider its decision and recommend this measure move forward for endorsement.		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.
1323	SPI	Steven Brotman; AdvaMed	AdvaMed recommends that NQF consider that data from the CARE Registry indicate that hospitals on average perform follow-up consistent with this measure 21% of the time, with 50% of hospitals performing it only 11% of the time. Given the risk and cost of carotid artery interventions, it is essential that patients be assessed after discharge to determine if the procedure prevented stroke and death, and to identify any complications. While data on the end point of death may be obtained through other options, such as matching patient data in the CARE Registry with the National Death Index or Social Security Master Death File, the only mechanism to determine the far more sensible end point of stroke is through direct patient follow-up. This measure encourages standardization of follow-up for this importance procedure to ensure that patients are evaluated using a standard neurologic evaluation by a certified examiner so that outcomes can be monitored reliably.		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1324	SPI	Steven Brotman; AdvaMed	<p>AdvaMed recognizes the concerns expressed by the Steering Committee about the feasibility of collecting follow-up data, however, many hospitals who participate in the CARE Registry (approximately 180 institutions) have been reliably and consistently submitting follow-up to the CARE Registry for several years and find the information provided to them from the registry for benchmarking to be valuable in quality improvement efforts. Additionally, concerns about the burden of requiring individuals to be certified on the National Institutes of Health Stroke Scale (NIHSS) before using the modified Rankin score data should be minimal as the NIHSS stroke scale certification is available as on online learning module: http://www.nihstrokescale.org/. Certification can be obtained in under an hour by a variety of clinicians or therapists, and only needs to be renewed every other year. There is no cost for certification. Patient assessment using the NIHSS tool takes approximately 10 minutes.</p>		<p>Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.</p>

ID#	Council/ Public	Commenter	Comment	Response	Topic
1326	SPI	Carol O'Brien, Esq; Abbott Laboratories	<p>We have reviewed the SCSEM draft report and respectfully request the Steering Committee reconsider the decision regarding measure #1531: “Follow-up assessment of stroke or death after carotid revascularization.”</p> <p>Abbott strongly recommends the measure for endorsement by NQF. Below, we review some of the concerns raised by the SCSEM Steering Committee and address them individually.</p> <ul style="list-style-type: none"> Proposed process measure is not strongly linked to patient outcomes: Abbott recognizes the importance of outcomes measures for quality improvement efforts. However, the proposed process measure is appropriate at this time. Furthermore, variation in this measure would raise reasonable questions regarding the quality of assessments upon which an eventual outcome measure would be based. The proposed measure demonstrates sufficient variation in practice to allow room for meaningful improvement as data from the National Cardiovascular Data Registry’s CARE Registry (‘CARE Registry’ hereafter) indicate only a minority of hospitals perform follow-up consistent with this measure. 		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1327	SPI	Carol O'Brien, Esq; Abbott Laboratories	<ul style="list-style-type: none"> • Data collection is not feasible or would represent a major drain on hospital resources: As the CARE Registry has demonstrated, hospitals can reliably and consistently collect and submit these data. Given the high likelihood of post-procedure follow-up visits, the assessment could be conducted as part of such visits. In addition, patient assessment using the National Institutes of Health Stroke Scale (NIHSS) tool only takes about 10 minutes. • Certification of hospital staff conducting NIHSS stroke assessments represents an undue burden for hospitals: Since hospitals are our major customers, Abbott Vascular is particularly sensitive to any additional burdens placed on them and their staff. However, certification is far from onus. The certification process is available on-line (at no cost) and certification can be obtained in less than an hour by a broad range of clinicians. Certifying staff need only renew annually. <p>Given the risks and costs of revascularization procedures, Abbott believes it is essential for patients to be assessed after discharge, as proposed measure #1531 would support. This post-discharge assessment would systematically determine if the revascularization procedure prevented stroke and / or death through the follow-up period, as well as identify any procedure-related complications. The proposed measure encourages post-discharge follow-up to ensure that patients are evaluated using a standard neurologic evaluation by a certified examiner so that outcomes can be monitored consistently and reliably.</p> <p>Abbott appreciates your consideration of these comments.</p>		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1328	HPR	Paul McCormick, MD, MPH; American Association of Neurological Surgeons	<p>As a partner society on the American College of Cardiology Foundation's (ACCF) National Cardiovascular Data Registry (NCDR) Care Registry®, we request that the project Steering Committee (SC) reconsider its decision to not recommend for endorsement the ACCF measure titled, "Follow-up assessment of stroke or death after carotid revascularization."</p> <p>This measure was developed and thoroughly tested through the NCDR CARE Registry®, and the vote to not endorse this measure was by a very narrow margin. The major concerns raised by the SCSEM SC and addressed by ACCF are summarized below:</p> <ul style="list-style-type: none"> • Importance of this process measure: Data from the CARE Registry indicate that hospitals, on average, perform follow-up consistent with this measure 21% of the time, with 50% of hospitals performing it only 11% of the time. Given the risk and cost of this procedure, it is essential that patients be assessed after discharge to determine if the procedure prevented stroke and death, and to identify any complications. This measure also encourages standardization of follow-up for this important procedure to ensure that patients are evaluated using a standard neurologic evaluation by a certified examiner so that outcomes can be monitored reliably. The 30-day outcome data that would result from this measure is critical for internal, as well as external, validity and is usually obtained not only by hospitals, but by physician offices, as well. 		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1329	HPR	Paul McCormick, MD, MPH; American Association of Neurological Surgeons	<ul style="list-style-type: none"> • Feasibility of collecting follow-up data, NIHSS certification: Many hospitals who participate in the CARE Registry (approximately 180 institutions) have been reliably and consistently submitting follow-up data to the CARE Registry for several years and find the information provided to them from the registry for benchmarking to be valuable in quality improvement efforts. In addition to the modified Rankin score data, which is an option for data submission, SCSEM SC discussion focused on feasibility and potential burden of requiring individuals be certified on the National Institutes of Health Stroke Scale (NIHSS). The NIHSS stroke scale certification is available as on online learning module: http://www.nihstrokescale.org/. Certification can be obtained in under an hour by a variety of clinicians or therapists and only needs to be renewed every other year. There is no cost for certification. Patient assessment using the NIHSS tool takes approximately 10 minutes. The burden of collecting this data is quite minimal relative to the benefit of this measure. • Timeframe of data collection and reliability data: In response to the SCSEM SC request to reconsider the follow-up data collection timeframe, NCDR modified the timeframe from 21-60 days to 14-60 days. In addition, we have provided additional reliability data to the SC to support expanding the measure timeframe. <p>Again, the AANS supports the ACCF measure, “Follow-Up Assessment of Stroke or Death after Carotid Revascularization.” We request that the SCSEM reconsider its decision and recommend this measure for NQF endorsement.</p>		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.

ID#	Council/ Public	Commenter	Comment	Response	Topic
1330	HPR	Steven Lichtman, EdD, FAACVPR; American Association of Cardiovascular and Pulmonary Rehabilitation	AACVPR would like to comment on and express our support of the ACCF's comments regarding the measure: "Follow-up assessment of stroke or death after carotid revascularization." This process measure would recommend using the NIH Stroke Scale 30 days after carotid revascularization. This would enable measurement and standardization of outcomes after this procedure. To ensure that processes improve and patients receive optimal care outcomes must be measured. Without measurement, improvement is at best unlikely and may not be achievable at all. Therefore, AACVPR recommends that the SCSEM reconsider its decision and recommend this measure move forward for endorsement. We thank you, in advance, for considering these comments.		Measures Not Recommended: 1531-Follow-up assessment after carotid resvas.
1248	HPR	Richard Cambria, MD and Timothy Kresowik, MD; Society for Vascular Surgery	Measures not Recommended for Endorsement NQF Measure #1548 – Surveillance after Endovascular Abdominal Aortic Aneurysm Repair (EVAR) SVS urges NQF to reconsider endorsement for measure #1548. SVS supports the efforts of this measure to establish imaging after EVAR as an important component of surgical quality measures. Measure #1548 was also chosen for inclusion in PQRS for 2012 pending final approval by CMS. SVS would ask NQF for full endorsement of this measure. SVS appreciates the opportunity to submit these comments and looks forward to working with NQF regarding these recommendations. Please feel free to contact Lindsey Adams, Health Policy Manager, Society for Vascular Surgery at 202-787-1231 or ladams@vascularsociety.org, if we can provide further information.		Measures Not Recommended: 1548-Surveillance after EVAR