National Consensus Standards for Surgical Procedures

Standing Committee Orientation

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NATIONAL QUALITY FORUM

Welcome & Introductions

NQF Project Staff

- Wunmi Isijola, MPH
  - Project Manager, Performance Measurement
- Andrew Lyzenga
  - Senior Project Manager, Performance Measurement
- Amaru Sanchez, MPH
  - Project Analyst, Performance Measurement
- Reva Winker, MD, MPH
  - Senior Director, Performance Measurement

Standing Committee

- Anthony Asher, MD, FAANS, FACS
- Joyce Bonnett
- Robert Cima, MD, MA
- Richard Dutton, MD, MBA
- Elisabeth Erekson, MD, MPH
- Lee Fleisher, MD
- Frederick Grover, MD
- William Gunnar, MD, MPH
- John Handy, MD
- Mark Jarrett, MD, MBA
- Clifford Ko, MD, MS, MSHS, FACS
- Barbara Levy, MD, FACOG, FACS
- Barry Markman, MD
- Kelsey McCarty, MS, MBA
- Lawrence Moss, MD
- Amy Moyer
- Keith Olsen, PharmD, FCCP, FCCM
- Collette Pitzen, RN, BSN, CPHQ
- Lynn Reede, DNP, MBA, CRNA
- Gary Roth, DO, FACOS, FCCM, FACS
- Christopher Saigal, MD, MPH
- Robert Sawin, MD, MS
- Allan Siperstein, MD
- Larissa Temple, MD
- A.J. Yates, MD

Agenda for the Call

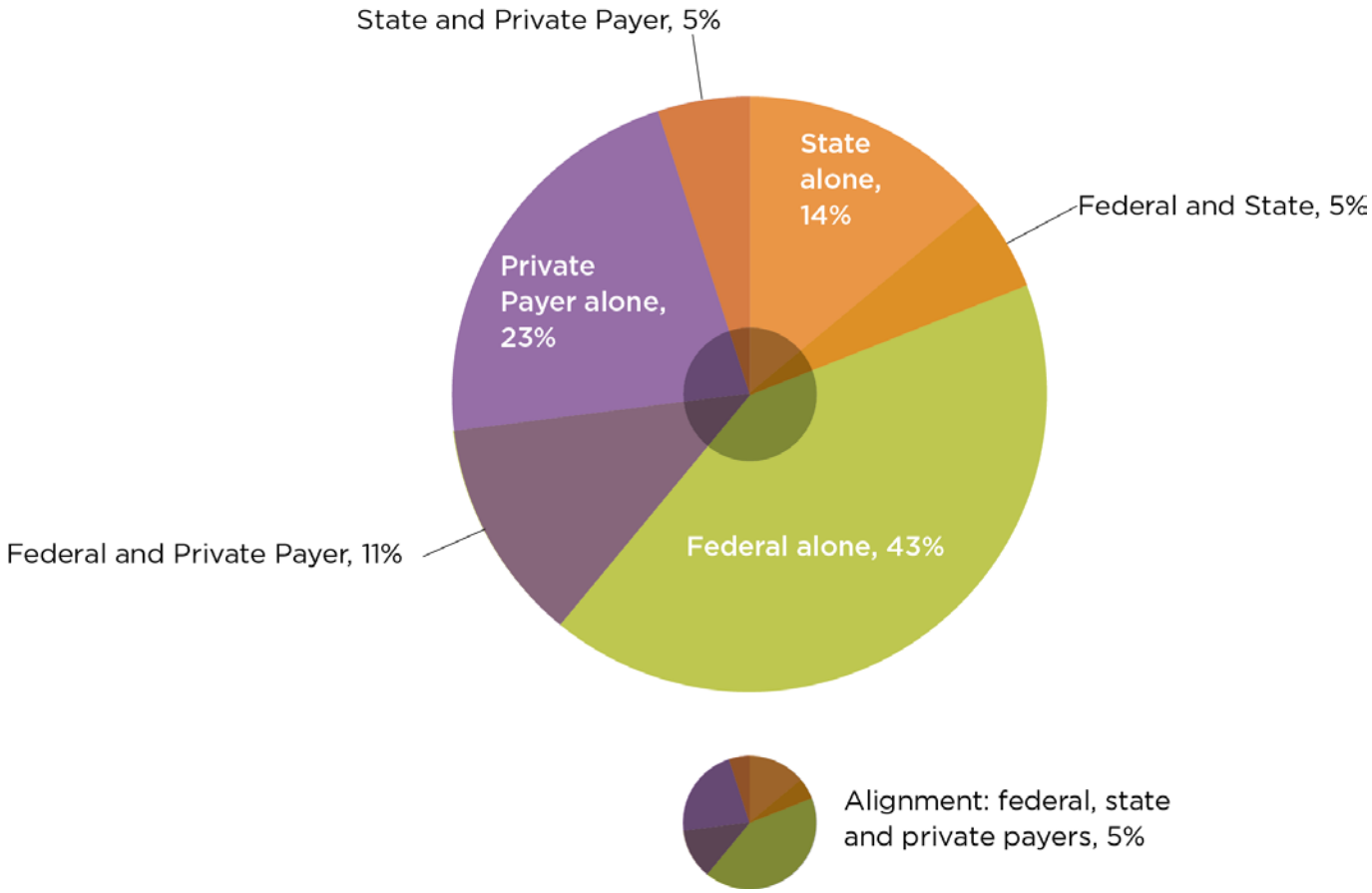
- Background on NQF and project
- Current project focus
- Overview of NQF criteria
- Role of the Committee
- SharePoint Tutorial
- Measure Evaluation Process

NQF Mission


Board of Directors
Standing Committees
8 Membership Councils
Measure Applications Partnership (MAP)
National Priorities Partnership (NPP)
Standing committees for clinical measures and information technology
Neutral Convener
Standard Setting Organization
1 Build Consensus
2 Endorse National Consensus Standards
3 Education and Outreach

Who Uses NQF-endorsed Measures?

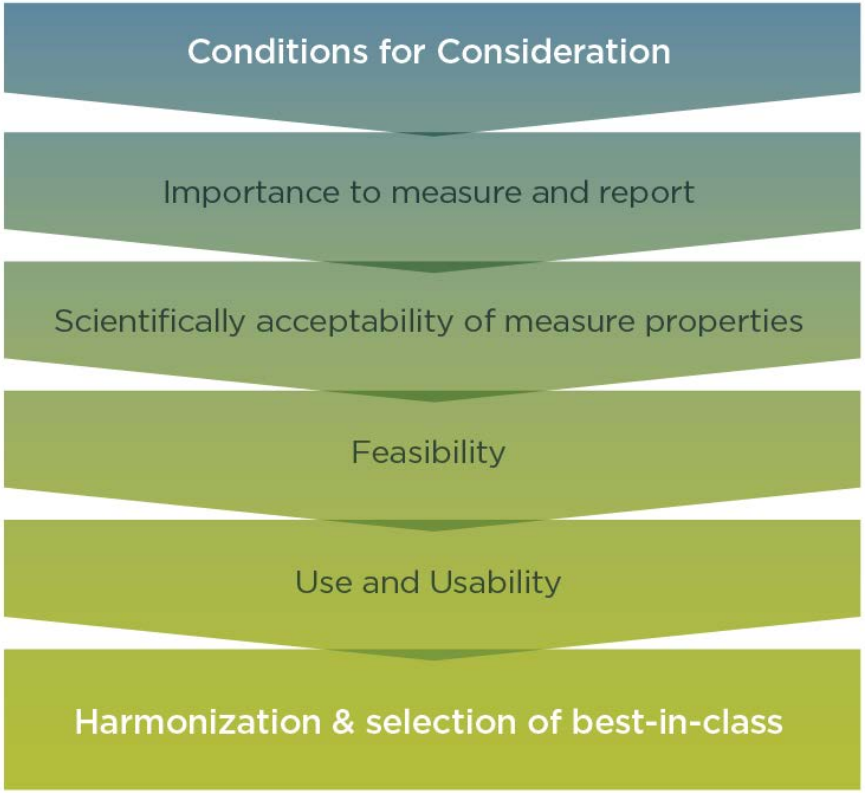
- Approximately 700 endorsed measures
- Various users
  - Federal
  - State
  - Community
  - Facility



NQF Consensus Development Process (CDP)

8 Steps for Measure Endorsement

NQF Measure Evaluation Criteria



Surgery Portfolio of Measures

- This project will evaluate measures related to surgical procedures that can be used for accountability and quality improvement for all populations and in all settings of care. The first phase of this project will address surgical areas including:
  - General perioperative care
  - Surgical database participation
  - Procedure specific (CABG, GU,etc.)
- NQF currently has more than seventy endorsed measures within the area of surgery.

Measures Under Review

- **0113**: Participation in a Systematic Database for Cardiac Surgery
- **0114:** Risk-Adjusted Post-operative Renal Failure
- **0119:** Risk-Adjusted Operative Mortality for CABG
- **0126:** Selection of Antibiotic Prophylaxis for Cardiac Surgery Patients
- **0128:** Duration of Antibiotic Prophylaxis for Cardiac Surgery Patients
- **0129:** Risk-Adjusted Prolonged Intubation (Ventilation)
- **0131:** Risk-Adjusted Stroke/Cerebrovascular Accident
- **0178:** Improvement in status of surgical wounds
  0264: Prophylactic Intravenous (IV) Antibiotic Timing
- **0268:** Perioperative Care: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin
- **0269:** Timing of Prophylactic Antibiotics - Administering Physician **0270:** Perioperative Care: Timing of Prophylactic Parenteral Antibiotics – Ordering Physician
- **0271:** Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)
- **0453:** Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero.
- **0454:** Anesthesiology and Critical Care: Perioperative Temperature Management
- **0456:** Participation in a Systematic National Database for General Thoracic Surgery
- **0458:**Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)
- **0465:** Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy
- **0527:** Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
- **0528:** Prophylactic Antibiotic Selection for Surgical Patients
- **0529:**Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
- **0533** : Postoperative Respiratory Failure Rate (PSI 11)
- **0534:** Hospital specific risk-adjusted measure of mortality or one or more major complications within 30 days of a lower extremity bypass (LEB).
- **0734:** Participation in a National Database for Pediatric and Congenital Heart Surgery
- **2038:** Performing vaginal apical suspension (uterosacral, iliococygeus, sacrospinous or sacral colpopexy) at the time of hysterectomy to address uterovaginal prolapse
- **2052 :** Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence
- **2063:** Use of cystoscopy concurrent with prolapse repair surgery
- **2556:** Yearly Surgical Case Volume of Primary Stapled Bariatric Procedures for Morbid Obesity
- **2557:**Hospital-level, 30-day all-cause readmission rate after elective primary bariatric surgery procedures
- **2558:** Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery
- **2559:** Bariatric Surgery Hospital Accreditation
- **2561:** STS Aortic Valve Replacement (AVR) Composite Score
- **2563:**STS Aortic Valve Replacement (AVR) + Coronary Artery Bypass Graft (CABG) Composite Score

Activities and Timeline

Process Step	Timeline
Measure submission deadline	3/17/2014
SC member orientation	3/25/2014
SC member preliminary review and evaluation	4/8/2014-4/28/2014
SC Work group calls	5/1/2014-5/19/2014
SC in-person meeting	5/28/2014-5/29/2014
Draft report posted for NQF Member and Public Review and Comment	7/3/2014-8/4/2014
SC call to review and respond to comments	6/10/2014
Draft report posted for NQF Member vote	9/5/2014-9/19/2014
CSAC review and approval	9/30/2014-10/21/2014
Endorsement by the Board	11/2/2014-11/11/2014
Appeals	11/12/2014-12/11/2014

Role of the Standing Committee
General Duties

- Act as a proxy for the NQF multi-stakeholder membership
- Serve 2-year or 3-year terms
- Work with NQF staff to achieve the goals of the project
- Evaluate candidate measures against the measure evaluation criteria
- Respond to comments submitted during the review period
- Respond to any directions from the CSAC

Role of the Standing Committee
Measure Evaluation Duties

- All Members review ALL measures
- Evaluate measures against each criterion
  - Indicate the extent to which each criterion is met and rationale for the rating
- Make recommendations to the NQF membership for endorsement
- Oversee Surgery portfolio of measures

Role of the Standing Committee Co-Chairs

- Facilitate Standing Committee (SC) meetings
- Work with NQF staff to achieve the goals of the project
- Assist NQF in anticipating questions and identifying additional information that may be useful to the SC
- Keep SC on track to meet goals of the project without hindering critical discussion/input
- Represent the SC at CSAC meetings
- Participate as a SC member

Role of NQF Staff

- **NQF project staff works with SC to achieve the goals of the project and ensure adherence to the consensus development process (CDP):**
  - Organize and staff SC meetings and conference calls
  - Guide the SC through the steps of the CDP and advise on NQF policy and procedures
  - Review measure submissions and prepare materials for Committee review
  - Draft and edit reports for SC review
  - Ensure communication among all project participants (including SC and measure developers)
  - Facilitate necessary communication and collaboration between different NQF projects

Role of NQF Staff
Communication

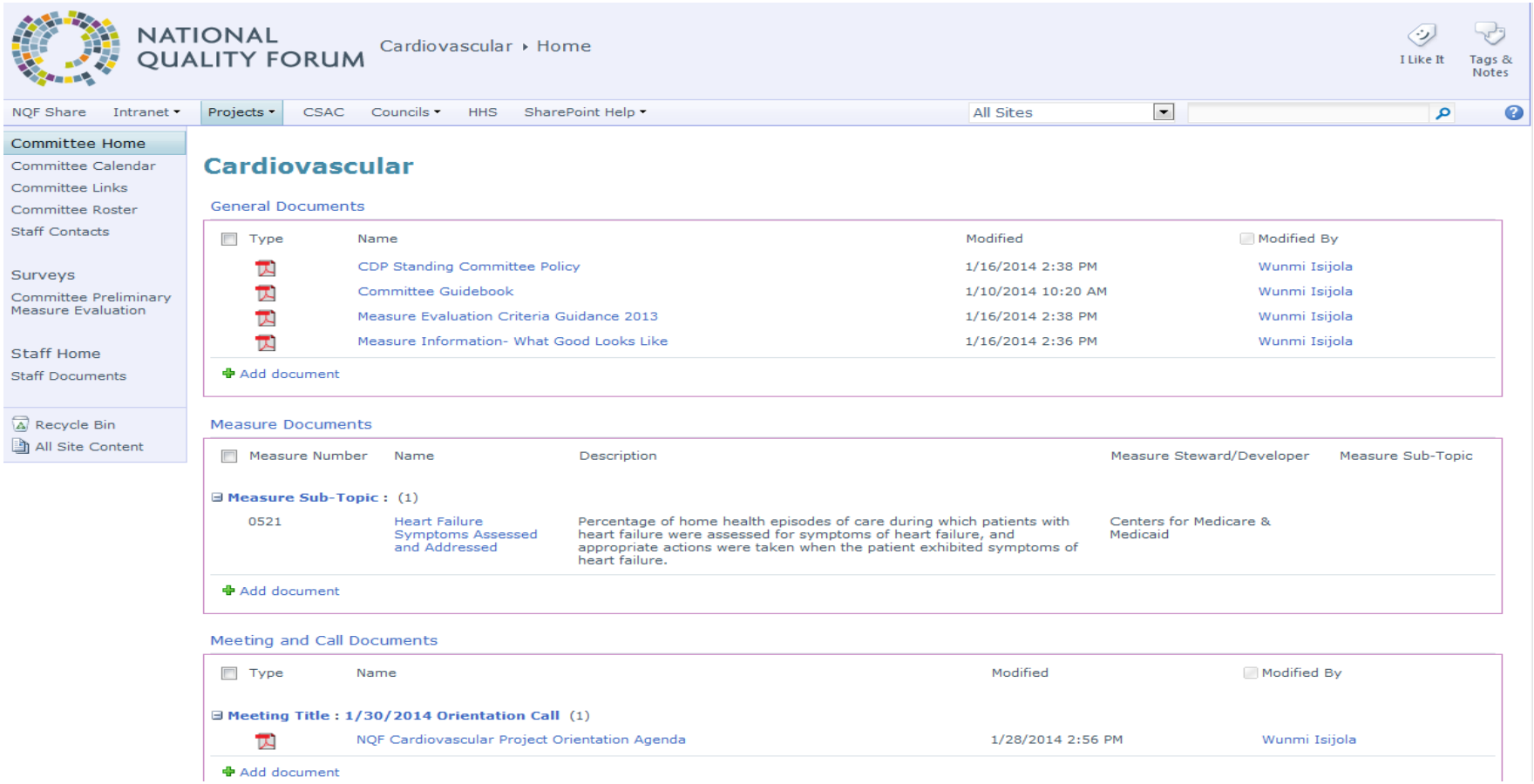
- Respond to NQF member or public queries about the project
- Maintain documentation of project activities
- Post project information to NQF website
- Work with measure developers to provide necessary information and communication for the SC to fairly and adequately evaluate measures for endorsement
- NQF project staff works with communications department to publish final report

SharePoint Overview

- Surgery Standing Committee SharePoint Site
  - **Committee Home**
    - General Documents :
      - *Standing Committee Guidebook*
      - *CDP Standing Committee Policy*
      - *Measure Evaluation Criteria*
      - *Measure Information-What Good Looks Like*
    - Measure Document Sets
    - Meeting and Call Documents
  - **Committee Calendar**
  - **Committee Links**
  - **Committee Roster**
  - **Staff Contacts**
  - **Survey Tool**

SharePoint Overview

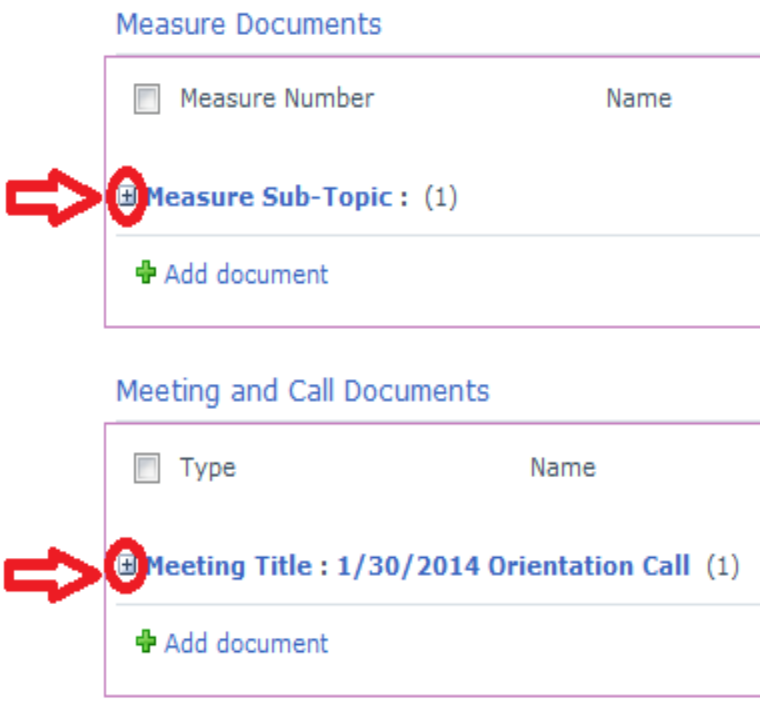
- **Screen shot of homepage:**

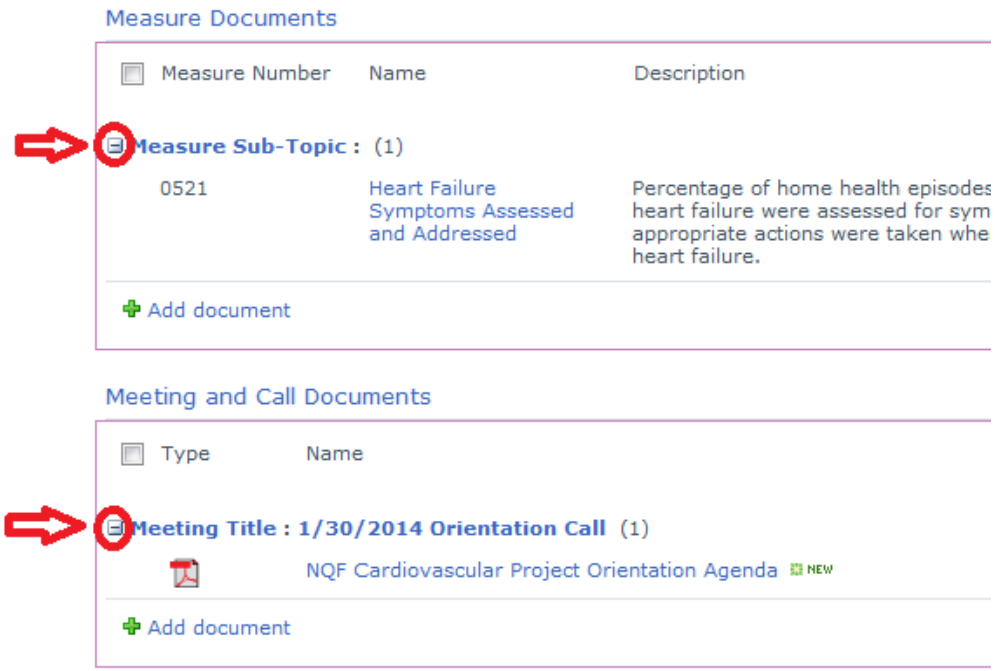


SharePoint Overview

Please keep in mind:

- + and – signs :





Measure Evaluation Overview

NQF Measure Evaluation Criteria for Endorsement

NQF endorses measures for accountability applications (public reporting, payment programs, accreditation, etc.) as well as quality improvement.

- Standardized evaluation criteria
- Criteria have evolved over time in response to stakeholder feedback
- The quality measurement enterprise is constantly growing and evolving – greater experience, lessons learned, expanding demands for measures – the criteria evolve to reflect the ongoing needs of stakeholders

Major Endorsement Criteria Hierarchy and Rationale (page 32)

- **Importance to measure and report**: Goal is to measure those aspects with greatest potential of driving improvements; if not important, the other criteria are less meaningful (***must-pass***)
- **Reliability and Validity-scientific acceptability of measure properties** : Goal is to make valid conclusions about resource use; if not reliable and valid, there is risk of improper interpretation (***must-pass***)
- **Feasibility**: Goal is to, ideally, cause as little burden as possible; if not feasible, consider alternative approaches
- **Usability and Use**: Goal is to use for decisions related to accountability and improvement; if not useful, probably do not care if feasible
- Comparison to related or competing measures

Criterion #1: Importance to Measure & Report (page 36-38)

1. **Importance to measure and report -** Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance.

   1a. Evidence – the measure focus is evidence-based.

   1b. Opportunity for Improvement - demonstration of quality problems and opportunity for improvement, i.e., data demonstrating considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or disparities in care across population groups (pages 41-42)

   1c. High Priority – the measure addresses a specific national health goal or priority and/or a high-impact aspect of healthcare. (page 42)

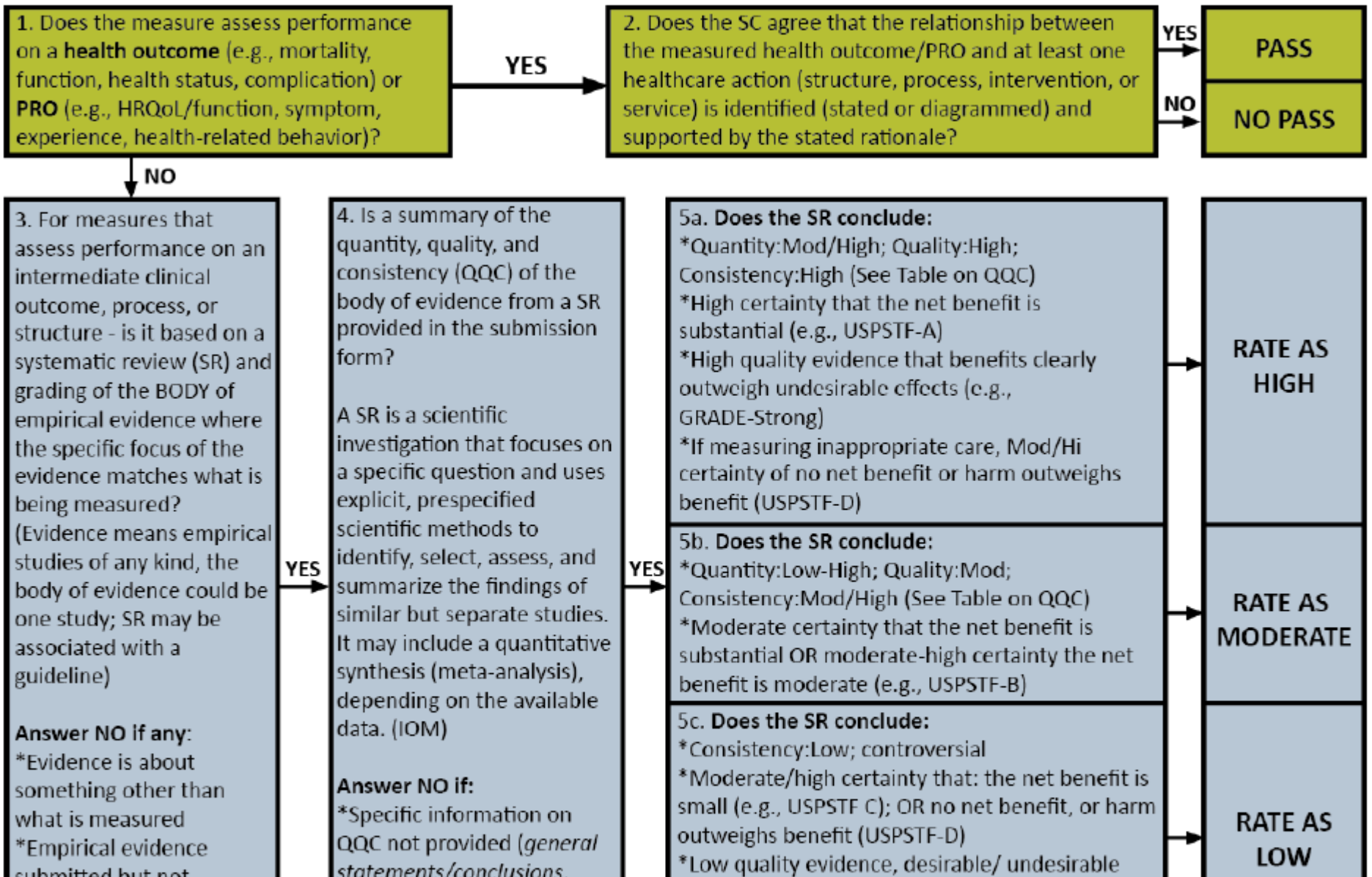
   1d. Quality construct and rationale (composite measures)

1a Evidence **(page 36-37)**

Requirements for 1a.

- Outcome measures –a rationale (which often includes evidence) for how the outcome is influenced by healthcare processes or structures.
- Process, intermediate outcome measures - the quantity, quality, and consistency of the body of evidence underlying the measure should demonstrate that the measure focuses on those aspects of care known to influence desired patient outcomes
  - Empiric studies (expert opinion is not evidence)
  - Systematic review and grading of evidence
    - » Clinical Practice Guidelines – variable in approach to evidence review

Algorithm #1 – page 37



Criterion # 2: Reliability and Validity – Scientific Acceptability of Measure Properties (page 43 -46)

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of health care delivery

2a. **Reliability (must-pass)**

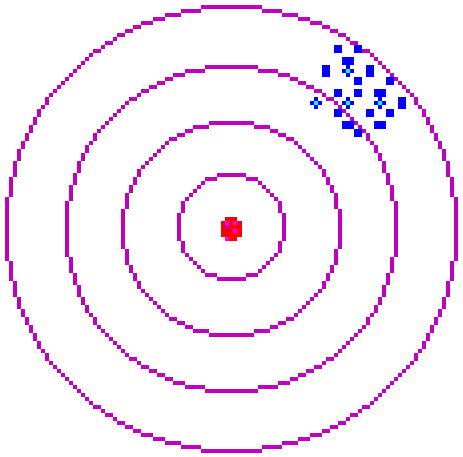
- 2a1. Precise specifications including exclusions
- 2a2. Reliability testing—data elements or measure score

2b. **Validity (must-pass)**

- 2b1. Specifications consistent with evidence
- 2b2. Validity testing—data elements or measure score
- 2b3. Justification of exclusions—relates to evidence
- 2b4. Risk adjustment
- 2b5. Identification of differences in performance
- 2b6. Comparability of data sources/methods

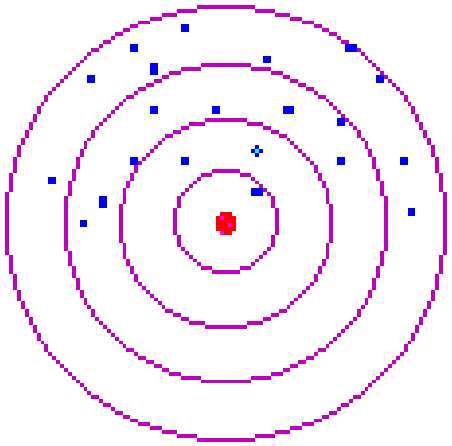
Reliability and Validity

Assume the center of the target is the true score…



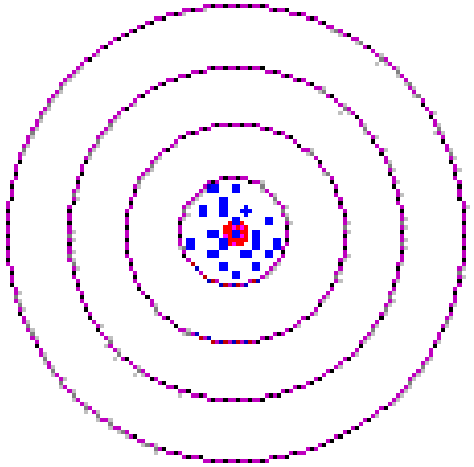
Reliable Not Valid

Consistent, but wrong



Neither Reliable Nor Valid

Inconsistent & wrong



Both Reliable And Valid

Consistent & correct

Measure Testing – (Key Points page 46)

Empirical analysis to demonstrate the reliability and validity of the *measure as specified,* including analysis of issues that pose threats to the validity of conclusions about quality of care such as exclusions, risk adjustment/stratification for outcome and resource use measures, methods to identify differences in performance, and comparability of data sources/methods.

Reliability Testing (page 46)
Key points - page 47

- Reliability of the ***measure score*** refers to the proportion of variation in the performance scores due to systematic differences across the measured entities in relation to random variation or noise (i.e., the precision of the measure).
  - Example - Statistical analysis of sources of variation in performance measure scores (signal-to-noise analysis)

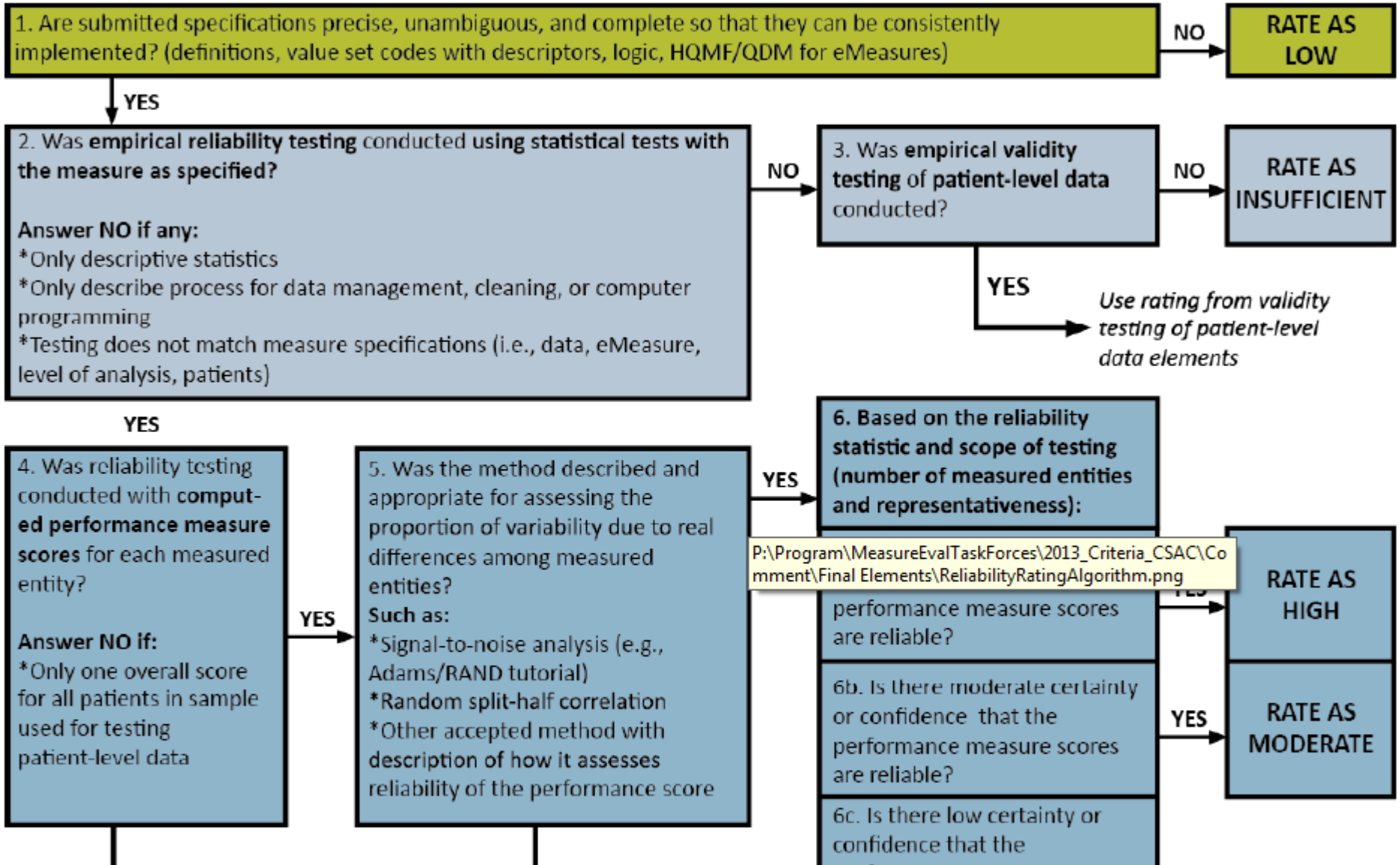
- Reliability of the ***data elements*** refers to the repeatability/reproducibility of the data and uses patient-level data
  - Example –inter-rater reliability

- Consider whether testing used an appropriate method and included adequate representation of providers and patients and results are within acceptable norms

- Algorithm #2 – page 48

Algorithm #2 – page 48

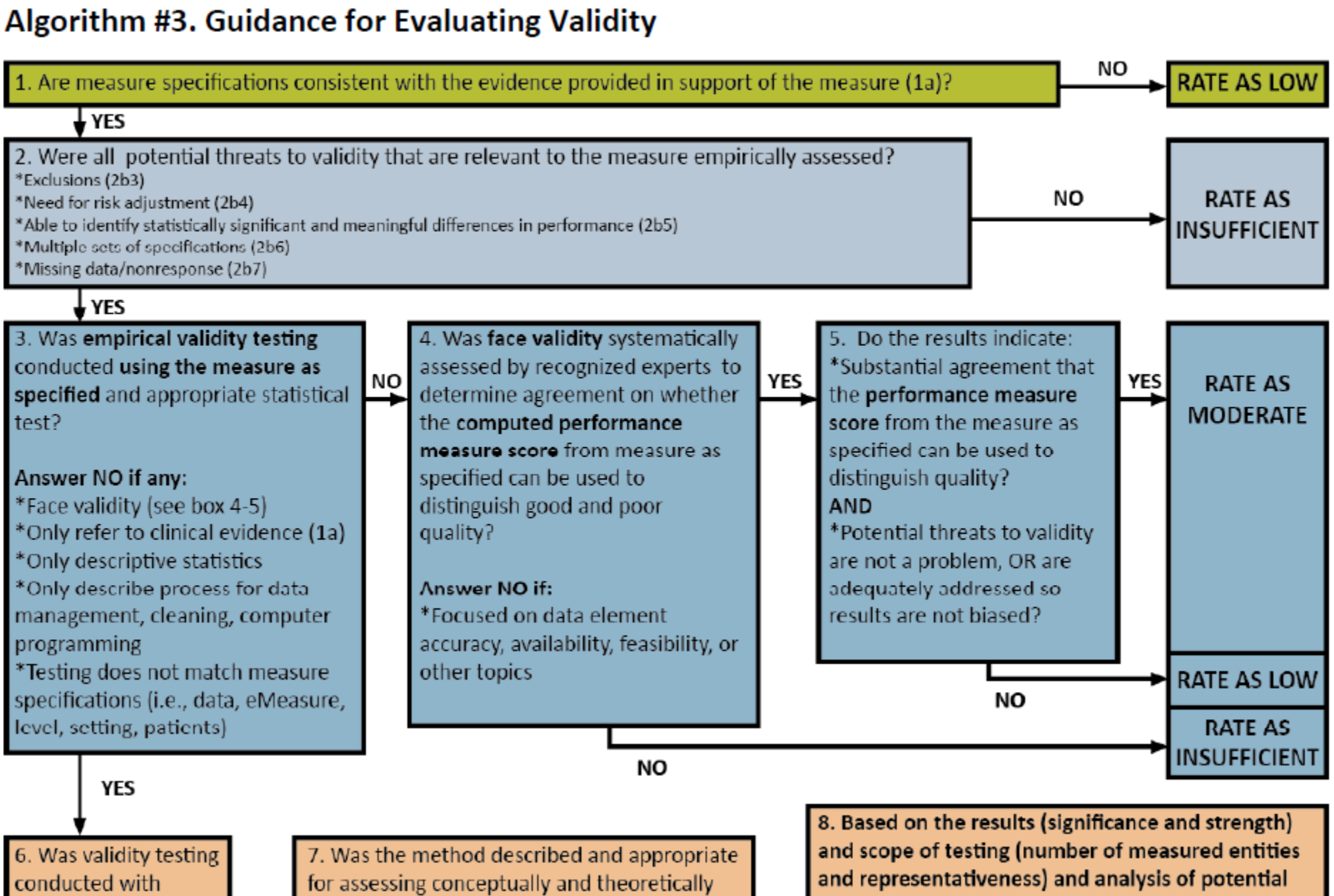
Algorithm #2. Guidance for Evaluating Reliability



Validity testing (pages 49- 51)
Key points – page 51

- **Empiric testing**
  - *Measure score* – assesses a hypothesized relationship of the measure results to some other concept; assesses the correctness of conclusions about quality
  - *Data element* – assesses the correctness of the data elements compared to a "gold standard"
- **Face validity**
  - Subjective determination by experts that the measure appears to reflect quality of care

Algorithm #3 – page 52



Threats to Validity

- Conceptual
  - Measure focus is not a relevant outcome of healthcare or not strongly linked to a relevant outcome
- Unreliability
  - Generally, an unreliable measure cannot be valid
- Patients inappropriately excluded from measurement
- Differences in patient mix for outcome and resource use measures
- Measure scores that are generated with multiple data sources/methods
- Systematic missing or “incorrect” data (unintentional or intentional)

Criterion #3: Feasibility (page 53-54)
Key Points – page 55

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

3a: Clinical data generated during care process

3b: Electronic sources

3c: Data collection strategy can be implemented

Criterion #4: Usability and Use (page 54)

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

4a: Accountability: Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement

4b: Improvement: Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated

4c: Benefits outweigh the harms: The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4d. Transparency: Data and result detail are maintained such that the resource use measure, including the clinical and construction logic for a defined unit of measurement can be deconstructed to facilitate transparency and understanding.

5. Related or Competing Measures (page 55-56)

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

- 5a. The measure specifications are harmonized with related measures **OR** the differences in specifications are justified.
- 5b. The measure is superior to competing measures (e.g., is a more valid or efficient way to measure) **OR** multiple measures are justified.

Measure Worksheet and Measure Information Form Example - [Measure 0521}

- Measure Worksheet
  - eMeasure Technical Review (if applicable)
  - Public comments
  - Workgroup comments (pre-workgroup call)
  - Workgroup discussion summary
- Measure Information Form – information submitted by the developer
  - Evidence and testing attachments
  - Spreadsheets
  - Additional documents

Questions?

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Next Steps

- Measure Evaluation Q&A Calls: April 15th and April 24th from 2-3pmET
- Complete your preliminary evaluation surveys: Varies by assigned work group; assignments will be made available in April
- Travel logistics information sent by mid-April
- Work Group calls will be May 1st through May 19th
- Full Committee meeting: Wednesday, May 28th and Thursday, May 29th in Washington, DC

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Questions?

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