Surgery Project 2013: NQF-Endorsement & Maintenance Standards Under Review

Measure Number	Title	Description	Measure Steward
0113	Participation in a Systematic Database for Cardiac Surgery	Participation in a clinical database with broad state, regional, or national representation, that provides regular performance reports based on benchmarked data	The Society of Thoracic Surgeons
0114	Risk-Adjusted Post-operative Renal Failure	Percent of patients aged 18 years and older undergoing isolated CABG (without pre-existing renal failure) who develop post-operative renal failure or require dialysis	The Society of Thoracic Surgeons
0119	Risk-Adjusted Operative Mortality for CABG	Percent of patients aged 18 years and older undergoing isolated CABG who die, including both 1) all deaths occurring during the hospitalization in which the CABG was performed, even if after 30 days, and 2) those deaths occurring after discharge from the hospital, but within 30 days of the procedure	The Society of Thoracic Surgeons
0126	Selection of Antibiotic Prophylaxis for Cardiac Surgery Patients	Percent of patients aged 18 years and older undergoing cardiac surgery who received preoperative prophylactic antibiotics recommended for the operation.	The Society of Thoracic Surgeons
0128	Duration of Antibiotic Prophylaxis for Cardiac Surgery Patients	Percent of patients aged 18 years and older undergoing cardiac surgery whose prophylactic antibiotics were discontinued within 48 hours after surgery end time	The Society of Thoracic Surgeons
0129	Risk-Adjusted Prolonged Intubation (Ventilation)	Percent of patients aged 18 years and older undergoing isolated CABG who require intubation for more than 24 hours	The Society of Thoracic Surgeons

0131	Risk-Adjusted Stroke/Cerebrovascular Accident	Percent of patients aged 18 years and older undergoing isolated CABG who have a postoperative stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that did not resolve within 24 hours	The Society of Thoracic Surgeons
0178	Improvement in status of surgical wounds	Percentage of home health episodes of care during which the patient demonstrates an improvement in the condition of surgical wounds.	Centers for Medicare and Medicaid Services
0264	Prophylactic Intravenous (IV) Antibiotic Timing	Rate of ASC patients who received IV antibiotics ordered for surgical site infection prophylaxis on time.	ASC Quality Collaboration
0268	Perioperative Care: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
0269	Timing of Prophylactic Antibiotics - Administering Physician	Percentage of surgical patients aged > 18 years with indications for prophylactic parenteral antibiotics for whom administration of the antibiotic has been initiated within one hour (if vancomycin, two hours) prior to the surgical incision or start of procedure when no incision is required.	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
0271	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
0453	Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero.	Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero.	Centers for Medicare and Medicaid Services
0454	Anesthesiology and Critical Care: Perioperative Temperature Management	Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom either active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 30 minutes immediately after anesthesia end time	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

0456	Participation in a Systematic National Database for General Thoracic Surgery	Participation in at least one multi-center, standardized data collection and feedback program that provides benchmarking of the physician's data relative to national and regional programs and uses process and outcome measures.	The Society of Thoracic Surgeons
0458	Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)	Percentage of thoracic surgical patients aged 18 years and older undergoing at least one pulmonary function test within 12 months prior to a major lung resection (pneumonectomy, lobectomy, or formal segmentectomy)	The Society of Thoracic Surgeons
0465	Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy	Percentage of patients undergoing carotid endarterectomy (CEA) who are taking an anti-platelet agent (aspirin or clopidogrel) within 48 hours prior to surgery and are prescribed this medication at hospital discharge following surgeryl	Society for Vascular Surgery
0527	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.	Centers for Medicare and Medicaid Services
0528	Prophylactic Antibiotic Selection for Surgical Patients	Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).	Centers for Medicare and Medicaid Services
0529	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	Surgical patients whose prophylactic antibiotics were discontinued within 24 hours after Anesthesia End Time. The Society of Thoracic Surgeons (STS) Practice Guideline for Antibiotic Prophylaxis in Cardiac Surgery (2006) indicates that there is no reason to extend antibiotics beyond 48 hours for cardiac surgery and very explicitly states that antibiotics should not be extended beyond 48 hours even with tubes and drains in place for cardiac surgery.	Centers for Medicare and Medicaid Services
0533	Postoperative Respiratory Failure Rate (PSI 11)	Percentage of postoperative respiratory failure discharges among adult, elective surgical discharges in a one year time period.	Agency for Healthcare Research and Quality

0734	Participation in a National Database for Pediatric and Congenital Heart Surgery	Participation in at least one multi-center, standardized data collection and feedback program that provides benchmarking of the physician's data relative to national and regional programs and uses process and outcome measures.	The Society of Thoracic Surgeons
2038	Performing vaginal apical suspension (uterosacral, iliococygeus, sacrospinous or sacral colpopexy) at the time of hysterectomy to address uterovaginal prolapse	Percentage of female patients undergoing hysterectomy for the indication of uterovaginal prolapse in which a concomitant vaginal apical suspension (i.e.uterosacral, iliococygeus, sacrospinous or sacral colpopexy)is performed.	American Urogynecologic Society
2052	Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence	Percentage of SUI surgeries for which cystoscopy was used during the surgical procedure to reduce complications	American Urological Association
2063	Use of cystoscopy concurrent with prolapse repair surgery	Percentage of patients that undergo concurrent cystoscopy at the time of surgery for correction of anterior and/or apical vaginal prolapse to check for lower urinary tract injury.	American Urogynecologic Society
2556	Yearly Surgical Case Volume of Primary Stapled Bariatric Procedures for Morbid Obesity	The single institutional yearly case volume of primary stapled bariatric surgical procedures performed on patients 18 and older who meet the 1991 NIH consensus conference recommendations for Bariatric surgery.	American Society for Metabolic and Bariatric Surgery
2557	Hospital-level, 30-day all-cause readmission rate after elective primary bariatric surgery procedures	This measure estimates hospital-level 30-day all-cause (not risk adjusted) readmission rates following elective primary bariatric surgery in patients age 18-65. Specific bariatric surgery procedures included in the measure are laparoscopic Roux-en-Y gastric bypass, sleeve gastrectomy, biliopancreatic diversion with duodenal switch, and laparoscopic adjustable gastric banding. The outcome is defined as readmission for any cause within 30 days of the discharge date for the index hospitalization. Population homogeneity is afforded by the exclusion of open, revisional bariatric surgery and extremes of age.	American Society for Metabolic and Bariatric Surgery
2558	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	The measure estimates a hospital-level, risk-standardized mortality rate (RSMR) for patients 18 years and older discharged from the hospital following a qualifying isolated CABG procedure. Mortality is defined as death from any cause within 30 days of the procedure date of an index CABG admission. The measure was developed using Medicare Fee-for-Service (FFS) patients 65 years and older and was tested in all-payer patients 18 years and older. An index admission is the hospitalization for a qualifying	Centers for Medicare & Medicaid Services (CMS)

		isolated CABG procedure considered for the mortality outcome.	
2561	STS Aortic Valve Replacement (AVR) Composite Score	STS AVR Composite Score comprises two domains consisting of six measures: Domain 1) Absence of Operative Mortality – Proportion of patients (risk-adjusted) who do not experience operative mortality. Operative mortality is defined as death during the same hospitalization as surgery or after discharge but within 30 days of the procedure; and Domain 2) Absence of Major Morbidity – Proportion of patients (risk-adjusted) who do not experience any major morbidity. Major morbidity is defined as having at least one of the following adverse outcomes: 1. reoperations for any cardiac reason, 2. renal failure, 3. deep sternal wound infection, 4. prolonged ventilation/intubation, and 5. cerebrovascular accident/permanent stroke. All measures are based on audited clinical data collected in a prospective registry and are risk-adjusted. Participants receive a score for each of the two domains, plus an overall composite score. The overall composite score was created by "rolling up" the domain scores into a single number. In addition to receiving a numeric score, participants are assigned to rating categories designated by one star (below average performance), two stars (average performance), or three stars (above average performance). Star ratings are currently publicly reported on the STS website and will soon be reported on the Consumer Reports website.	The Society of Thoracic Surgeons
2563	STS Aortic Valve Replacement (AVR) + Coronary Artery Bypass Graft (CABG) Composite Score	The STS AVR+CABG Composite Score comprises two domains consisting of six measures: Domain 1) Absence of Operative Mortality – Proportion of patients (risk-adjusted) who do not experience operative mortality. Operative mortality is defined as death during the same hospitalization as surgery or after discharge but within 30 days of the procedure; and Domain 2) Absence of Major Morbidity – Proportion of patients (risk-adjusted) who do not experience any major morbidity. Major morbidity is defined as having at least one of the following adverse outcomes: 1. reoperations for any cardiac reason, 2. renal failure, 3. deep sternal wound infection, 4. prolonged ventilation/intubation, and 5. cerebrovascular accident/permanent stroke. All measures are based on audited clinical data collected in a prospective registry and are risk-adjusted. Participants receive a score for each of the two domains, plus an overall composite score. The overall composite score was created by "rolling up" the domain scores into a single number. In addition to receiving a numeric score, participants are assigned to rating categories designated by one star (below average performance), two stars (average performance), or three stars (above average performance). Star ratings will be publicly reported on the STS website in August 2014 and will likely be reported on the Consumer Reports website as well	The Society of Thoracic Surgeons