



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 1534

Corresponding Measures:

De.2. Measure Title: In-hospital mortality following elective EVAR of AAAs

Co.1.1. Measure Steward: Society for Vascular Surgery

De.3. Brief Description of Measure: Percentage of patients undergoing elective endovascular repair of asymptomatic infrarenal abdominal aortic aneurysms (AAA) who die while in hospital. This measure is proposed for both hospitals and individual providers. The measure is currently reported in the Vascular Quality Initiative (VQI) Registry.

1b.1. Developer Rationale: Elective AAA repair is offered to prolong life by avoiding AAA rupture, which is fatal in more than 85% of cases. Rupture risk is primarily assessed by AAA diameter, with larger AAAs more prone to rupture. Surgical treatment carries risk, however, of mortality and morbidity, which must be balanced against the risk of rupture in order to determine which patients will benefit from elective repair.

Based on the UK aneurysm trial, the accepted diameter threshold for elective AAA repair is 5.5 cm, although women have a slightly higher risk than men, so a threshold of 5 cm is usually recommended for women. The key concept of this proposed measure is that patients who are at low risk for AAA rupture (<6cm dia in men and <5.5 cm dia in women) should ONLY be offered elective AAA repair if their predicted operative mortality is low. This concept avoids the need for risk adjustment, since this is implicit in the decision to offer elective repair of AAAs. This measure will highlight variation in proper patient selection by reporting unadjusted mortality rates for surgery in patients with small AAAs in whom this rate should be universally low. Providers or hospitals with high mortality rates are either not performing safe surgery or are not properly selecting low risk patients. The measure specifically excludes patients with larger AAAs because risk adjustment would be needed for such cases, and accepted risk adjustment algorithms are not available.

S.4. Numerator Statement: Mortality following elective endovascular infrarenal AAA repair of asymptomatic AAAs in men with < 6 cm dia and women with < 5.5 cm dia AAAs

S.6. Denominator Statement: All elective endovascular repairs of asymptomatic AAAs in men with < 6 cm dia and women with < 5.5 cm dia AAAs

S.8. Denominator Exclusions: = 6 cm diameter - men

= 5.5 cm diameter – women

Symptomatic AAAs that required urgent/emergent (non-elective) repair

De.1. Measure Type: Outcome

S.17. Data Source: Registry Data

S.20. Level of Analysis: Clinician : Individual, Facility

IF Endorsement Maintenance – Original Endorsement Date: May 01, 2012 **Most Recent Endorsement Date:** May 01, 2012

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Submitted SVS measure: In-hospital mortality following elective open repair of AAAs

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

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

[1534_Evidence_MSF5.0_Data_2016.doc](#)

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

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

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

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

Elective AAA repair is offered to prolong life by avoiding AAA rupture, which is fatal in more than 85% of cases. Rupture risk is primarily assessed by AAA diameter, with larger AAAs more prone to rupture. Surgical treatment carries risk, however, of mortality and morbidity, which must be balanced against the risk of rupture in order to determine which patients will benefit from elective repair.

Based on the UK aneurysm trial, the accepted diameter threshold for elective AAA repair is 5.5 cm, although women have a slightly higher risk than men, so a threshold of 5 cm is usually recommended for women. The key concept of this proposed measure is that patients who are at low risk for AAA rupture (<6cm dia in men and <5.5 cm dia in women) should ONLY be offered elective AAA repair if their predicted operative mortality is low. This concept avoids the need for risk adjustment, since this is implicit in the decision to offer elective repair of AAAs. This measure will highlight variation in proper patient selection by reporting unadjusted mortality rates for surgery in patients with small AAAs in whom this rate should be universally low. Providers or hospitals with high mortality rates are either not performing safe surgery or are not properly selecting low risk patients. The measure specifically excludes patients with larger AAAs because risk adjustment would be needed for such cases, and accepted risk adjustment algorithms are not available.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

There is significant regional variation in rates of AAA repair, indicating a performance gap. In 27 hospital referral regions, rates of AAA repair were at least 30% higher than the United States average of 1.0 per 1,000 Medicare enrollees. In 44 hospital referral regions, rates were more than 25% lower than the national average.(1)

Where these data have been monitored and reported to providers in VSGNE since 2003, among 11 centers and 48 providers treating 1380 patients since 2003, the median mortality rate for men and women with AAAs as defined above is 0%, but the range is 0-6%, indicating both a performance gap and opportunity for further improvement.

In 2016, VQI Registry conducted a study regarding the performance of this measure. The study included 216 centers with 972 providers reporting on 13,487 procedures performed over the five year period of 2010 - 2015. While the median mortality rate for both men and women was still 0%, with now a much larger experience, there is still a performance range of 0 - 14.3% demonstrating that we still have variation in care across the country and that this measure continues to be important given the range in mortality.

In looking at this measure at a 9 month endpoint, the variation by center was found to be even greater, 0.0% - 25%. The median

rose to 1.8% with an IQR of 0.0 - 4.5%.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

(1)Dartmouth-CMS-FDA Collaborative, "Trends and Regional Variation in Abdominal Aortic Aneurysm Repair, February 1, 2006.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Such data will become available if this measure is adopted for reporting and used by more centers with more varied population demographics than found in the New England region.

In the 2016 study conducted for this measure maintenance exercise cited above, we did find a slight variation in age with those older having a higher mortality. We also found that women had a higher mortality percentage to men - 0.9% versus 0.2%. Given the small sample size regarding non-whites, we did not see a difference in the data regarding their outcomes.

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

not available

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Surgery : Vascular Surgery

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

Safety : Complications

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

Elderly

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

http://www.vascularqualityinitiative.org/wp-content/uploads/2016_PQRS_Information-v2-1.pdf

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: EVAR defs v.01.09.doc

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

Attachment:

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

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

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

Have added the word, "infrarenal," to differentiate from the procedures using the new types of medical devices.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

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

Mortality following elective endovascular infrarenal AAA repair of asymptomatic AAAs in men with < 6 cm dia and women with < 5.5 cm dia AAAs

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

ANY registry that includes hospitalization details, AAA diameter and discharge status is required to identify patients for numerator inclusion. The Society for Vascular Surgery Vascular Quality Initiative (SVS VQI) and the Vascular Study Group of New England (VSGNE) are examples of registries that record such information, but the measure is not limited to these registries. It could be reported by other registries that collect this same information. No other registry is needed for computation. Patients who died in hospital following elective endovascular infrarenal AAA repair if their aneurysm was asymptomatic (< 6cm dia in men, <5.5 cm dia in women, judged by preoperative imaging (CT, MR or ultrasound)).

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

All elective endovascular repairs of asymptomatic AAAs in men with < 6 cm dia and women with < 5.5 cm dia AAAs

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

ANY registry that includes hospitalization details, AAA diameter and discharge status is required to identify patients for denominator inclusion. The Society for Vascular Surgery Vascular Quality Initiative (SVS VQI) and the Vascular Study Group of New England (VSGNE) are examples of registries that record such information, but the measure is not limited to these registries. Patients who died in hospital following elective endovascular infrarenal AAA repair if their aneurysm was asymptomatic (< 6cm dia in men, <5.5 cm dia in women, judged by preoperative imaging (CT, MR or ultrasound)).

S.8. Denominator Exclusions <i>(Brief narrative description of exclusions from the target population)</i> = 6 cm diameter - men = 5.5 cm diameter – women Symptomatic AAAs that required urgent/emergent (non-elective) repair S.9. Denominator Exclusion Details <i>(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)</i> Patients undergoing non-elective open repair of symptomatic AAAs or those with AAAs larger than the diameters noted above.
S.10. Stratification Information <i>(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)</i> NA S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment) No risk adjustment or risk stratification If other:
S.12. Type of score: Rate/proportion If other: S.13. Interpretation of Score <i>(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)</i> Better quality = Lower score S.14. Calculation Algorithm/Measure Logic <i>(Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)</i> Identify denominator, exclude non-elective repair of symptomatic or ruptured patients and men with AAA >6 cm, and women with AAA >5.5, find number of deaths Outcome = deaths/ # cases
S.15. Sampling <i>(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)</i> IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed. N/A S.16. Survey/Patient-reported data <i>(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)</i> Specify calculation of response rates to be reported with performance measure results.
S.17. Data Source <i>(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).</i> If other, please describe in S.18. Registry Data S.18. Data Source or Collection Instrument <i>(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)</i> IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration. Society for Vascular Surgery Vascular Quality Initiative Registry Vascular Study Group of New England Registry S.19. Data Source or Collection Instrument <i>(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</i>

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

Clinician : Individual, Facility

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

Inpatient/Hospital

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2. Validity – See attached Measure Testing Submission Form

[1534_MeasureTesting_MSF5.0_Data_v2.doc](#)

2.1 For maintenance of endorsement

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

2.2 For maintenance of endorsement

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

2.3 For maintenance of endorsement

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

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed

to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

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

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

In the VSGNE experience which has been tracking hospital mortality as a major endpoint since 2003, we have not experienced any difficulty with obtaining data related to this endpoint. Our percent missing for this variable has been less than 1%.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

N/A

4. Usability and Use

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

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	Payment Program Physician Quality Reporting Program www.cms.hhs.gov Physician Quality Reporting Program www.cms.hhs.gov

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

- Name of program and sponsor

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

This measure is approved for the Physician Quality Reporting Program as measure number 347 at the Centers for Medicare and Medicaid Services. It is a national program and its purpose is physician quality reporting

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

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

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

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

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

Describe how feedback was obtained.

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

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

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

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b2. Unintended Consequences

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

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

Size measurements of AAA should not significantly impact the measure, and symptom status is easily validated during chart review. We have not found inaccuracy in this measure.

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

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
No

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

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

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

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix
A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed. Attachment:
Contact Information
Co.1 Measure Steward (Intellectual Property Owner): Society for Vascular Surgery Co.2 Point of Contact: Sarah, Murphy, Smurphy@vascularsociety.org, 312-334-2305- Co.3 Measure Developer if different from Measure Steward: Society for Vascular Surgery Co.4 Point of Contact: Jill, Rathbun, Jill_Rathbun@galileogrp.com, 703-217-7224-
Additional Information
Ad.1 Workgroup/Expert Panel involved in measure development Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. N/A
Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: 2010 Ad.3 Month and Year of most recent revision: 05, 2016 Ad.4 What is your frequency for review/update of this measure? Annually Ad.5 When is the next scheduled review/update for this measure? 12, 2017
Ad.6 Copyright statement: N/A Ad.7 Disclaimers:
Ad.8 Additional Information/Comments: