

ASC Quality Collaboration

October 30, 2007

VIA HAND DELIVERY

Kerry Weems, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3887-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-3887-P; Background

Dear Acting Administrator Weems:

On behalf of the ASC Quality Collaboration, a cooperative effort of organizations and companies interested in ensuring that ambulatory surgical center (ASC) quality data is appropriately developed and reported, please accept the following comments regarding CMS-3887-P, Section I. Background as it pertains to quality measures appropriate to ambulatory surgical centers (ASCs). Early in 2006, the ASC Quality Collaboration came together to initiate the process of developing standardized ASC quality measures. The organization's stakeholders include ASC corporations, ASC associations, professional societies, accrediting bodies and government entities. We are pleased that Section 109 of the Tax Relief and Health Care Act of 2006 (TRHCA) will afford ASCs the opportunity to share standardized quality indicators with CMS and the public.

In this proposed rule, CMS solicits comments on quality measures appropriate to ASCs. Specifically, CMS has requested information regarding the extent to which ASCs are currently using quality measures, the data sources for those measures, and the extent to which data are maintained electronically. CMS also expressed an interest in how the measures were developed and why they are appropriate to measure the care provided to Medicare patients in ASCs. We appreciate this opportunity to share our knowledge of these matters with the agency.

I. Use of Quality Measures

Approximately 4600 ASCs are certified by the Medicare program. As certified providers, these ASCs maintain internal programs designed to assess the quality of care provided. These programs must monitor key indicators of quality and appropriateness on an ongoing basis and the information gathered is to be used to improve patient care.

In addition to being certified, many ASCs are also accredited by organizations such as the Accreditation Association for Ambulatory Health Care, the American Osteopathic Association

and The Joint Commission. Participation in this voluntary activity gives ASCs an opportunity for ongoing independent third party assessments of quality and performance against nationally recognized standards. Accreditation requirements include participation in quality improvement and benchmarking activities.

ASCs also have the opportunity to participate in clinical benchmarking programs offered by ASC industry associations such as FASA and the American Association of Ambulatory Surgery Centers; professional societies such as the Association of Perioperative Registered Nurses; and non-profit organizations, such as the AAAHC Institute for Quality Improvement . Participation allows ASCs to compare clinical indicators with their peers and identify opportunities for improvement.

While ASCs currently use a broad variety of programs and measures to assess quality and performance, these are not standardized across the industry.

II. Development of Outpatient Surgical Facility Quality Measures by the ASC Quality Collaboration

The quality of facility services for outpatient surgery is most appropriately evaluated by measures specifically designed to assess processes or outcomes of care germane to the specific services rendered by facilities that provide these services. It is crucial that measures selected for the evaluation of facility quality reflect processes or outcomes of care that are attributable to and reasonably the responsibility of the facility itself -- its staff, the equipment, the environment of care offered to its patients, and its roles in the delivery of patient care.

When the ASC Quality Collaboration was formed, we undertook a detailed evaluation of existing nationally endorsed quality measures to determine which could be directly applied to the outpatient surgery facility setting. Though several existing measures addressed surgical care, none had been developed specifically for the ASC setting. In fact, many of these measures are specific to procedures that are either uncommonly performed in outpatient facilities, or not performed at all for Medicare beneficiaries in the outpatient surgical setting. Other measures expressly exclude patients with a stay of less than 24 hours, effectively eliminating the entire ASC patient population. Still other measures focus on processes of care that are specific responsibilities of physicians, such as the selection and ordering of antibiotics.

Finding no nationally endorsed measures designed for public reporting and accountability specific to facilities performing outpatient surgery, the ASC Quality Collaboration developed a number of facility-level measures of ASC quality. These measures were based on those already commonly used by the ASC community for internal quality assessment and external benchmarking. After refining these standardized measures, the ASC Quality Collaboration piloted them in a sample of twenty ASCs and was able to confirm their feasibility and usability. To date, these measures have been reviewed by a technical advisory panel and a steering committee of the National Quality Forum (NQF). As a result of these evaluations, five measures have been recommended for endorsement. Public and NQF member comment on these five measures closed in September and NQF member voting is currently in progress. We anticipate that final action on these measures could be taken as early as November 2007.

One of the principles that guided the ASC Quality Collaboration was harmonization – the idea that the measures developed through our efforts should be applicable to all facilities offering ambulatory surgery, allowing comparison of quality across sites of service. The ASC measures currently under consideration for endorsement by the NQF are appropriate for other outpatient surgical settings, effectively addressing the need to harmonize quality measures whenever possible.

Of the five measures, four are outcome measures that have applicability to all outpatient surgical facilities and thereby ensure broad facility participation regardless of case mix. These measures focus on 1) patient falls, 2) patient burns, 3) hospital transfer/admission and 4) wrong site/wrong side/wrong patient/wrong procedure/wrong implant. The fifth measure is a process measure which evaluates the timing of the administration of intravenous antibiotics for prophylaxis of surgical site infection. This prophylactic antibiotic timing measure has been specifically designed to harmonize with, and be complementary to, similar measures (see, for example, PQRI #20 and PQRI #30) developed to evaluate physician performance in this area. Please see Attachment A for detailed information on the five outpatient surgical facility-specific quality measures.

The prophylactic antibiotic timing measure also addresses the statutory requirement under TRHCA for evaluation of medication errors. In their recent *MEDMARX® Data Report: A Chartbook of Medication Error Findings from the Perioperative Settings from 1998-2005*, the U.S. Pharmacopeia detailed the various types of medication errors in outpatient surgery, one of which was “wrong time.” The report specifically recommended “[d]eveloping strategies to ensure that medications, especially antimicrobial agents, are administered at the correct time.”

As of this writing, we are not aware of any other measures specifically addressing facility quality in the delivery of outpatient surgical services that have either been nationally endorsed for public reporting and accountability or are in the process of evaluation for endorsement. Therefore, we strongly recommend CMS consider these five facility-specific measures for ASC reporting, if they are endorsed by the NQF.

III. Appropriateness of ASC Quality Collaboration Measures

As noted above, the measures developed by the ASC Quality Collaboration were based on those commonly used by the ASC community for internal quality assessment and external benchmarking. As such, they measure processes or outcomes of care that are appropriate to the ASC setting. The specific rationale and applicability of each of the five measures that are currently in process for potential NQF endorsement are discussed in more detail below.

A. Patient Burn

There are numerous case reports in the literature regarding patient burns in the surgical and procedural setting. The diversity of the causative agents underscores the multitude of potential risks that must be properly mitigated to avoid patient burns.

The literature on burns suggests that electrosurgical burns are most common. In 2000, a Joint Commission Sentinel Alert indicated “burns from electrocautery used with a flammable prep solution” as one of the seven most frequent operative and postoperative complications.¹ A survey of members of the American College of Surgeons found that 18% of respondents had personally experienced an electrosurgical burn to their patient during laparoscopy.² A recent publication from the ECRI highlights the increased risk of burns with newer surgical devices that apply higher currents at longer activation times.³

Although electrical burns are most prevalent, other mechanisms of burn injury are frequently reported in case studies and case series. For example, a case series of 19 patients with intraoperative burn accidents severe enough to require subsequent surgical treatment found that although 13 were caused by electrical burns, five were caused by chemical burns and one had an unclear etiology.⁴ A closed claims analysis of 3000 claims found that of 54 burns, 28 were caused by patient warming devices.⁵

Surgical fires are rare; however, their consequences can be grave, killing or seriously injuring patients and surgical staff. The risk of surgical fires is present whenever and wherever surgery is performed, whether in an operating room, a physician’s office, or an outpatient clinic.^{6,7} Based on anecdotal evidence, there are at least 20-30 surgical patient fires each year in the United States.⁸

Recognizing the diversity of mechanisms by which a patient could sustain an unintentional burn in the ASC setting, the ASC Quality Collaboration chose a broad definition of burn, encompassing all six recognized means by which a burn can occur - scalds, contact, fire,

¹ Joint Commission. Joint Commission Sentinel Event Alert. Issue 12, February 4, 2000. Operative and Postoperative Complications: Lessons for the Future. Chicago, IL

² Tucker R. Laparoscopic electrosurgical injuries: survey results and their implications. *Surg Laparosc Endosc.* 1995;5(4):311-7.

³ ECRI. Higher currents, greater risks: preventing patient burns at the return-electrode site during high-current electrosurgical procedures. *Health Devices.* 2005;34(8):273-9.

⁴ Demir E, O'Dey D, and Pallua N. Accidental burns during surgery. *J Burn Care Res.* 2006 ;27(6):895-900.

⁵ Cheney F, Posner K, Caplan R, and Gild W. Burns from warming devices in anesthesia. A closed claims analysis. *Anesthesiology.* 1994;80(4):806-10.

⁶ Barker S and Polson J. Fire in the operating room: a case report and laboratory study. *Anesth Anal.* 2001;93:960-965.

⁷ Agency for Healthcare Research and Quality (AHRQ). A clinician’s guide to surgical fires: how they occur, how to prevent them, how to put them out. Available at: http://www.guideline.gov/summary/summary.aspx?doc_id=3688&nbr=002914&string=surgery+AND+burns. Last accessed October 4, 2007.

⁸ ECRI. Devastation of patient fires. *Health Devices.* 1992;21:3-39.

chemical, electrical, or radiation. This will allow stakeholders to develop a better understanding of the incidence of these events and further refine means to ensure prevention.

B. Patient Fall

“Falls per 100,000 patient days” has been endorsed as a serious reportable event by the NQF.⁹

According to the Agency for Healthcare Research and Quality’s *Prevention of Falls in Acute Care* guideline, patient falls may be reduced by following a four-step approach: 1. evaluating and identifying risk factors for falls in the older patient; 2. developing an appropriate plan of care for prevention; 3. performing a comprehensive evaluation of falls that occur in the hospital; and 4. performing a post-fall revision of plan of care as appropriate.¹⁰

This measure serves as an indirect assessment of adherence to these guidelines by quantifying the outcome of a patient fall.

While ASCs have been demonstrated to have a relatively low incidence of adverse events in general, information regarding the incidence of patient falls is not currently available. However, stakeholders have expressed a general interest in ASC oversight and the public reporting of such adverse events.¹¹ Due to the use of anxiolytics, sedatives, and anesthetic agents as adjuncts to procedures, patients undergoing outpatient surgery are at increased risk for falls.

C. Hospital Transfer / Admission

The need for transfer/admission is an unanticipated outcome and could be the result of insufficient rigor in patient or procedure selection. Hospital transfers/admissions also result in unplanned cost and time burdens that must be borne by patients and payors.

While ambulatory surgery has been shown to have good outcomes, routine procedures can still result in complications.¹¹ A recent study on same-day surgical patients demonstrated that of the 20,817 ambulatory surgical patients evaluated, 1,195 (5.7 percent) returned to the hospital within 30 days or were admitted directly after surgery. Of those unanticipated admissions and readmissions, 313 (1.5 percent) were directly related to the original procedure. Pain was the

⁹ National Quality Forum. *Serious Reportable Events in Healthcare*. Washington, DC: NQF, 2002.

¹⁰ Agency for Healthcare Research and Quality. National Guideline. Preventing Falls in Acute Care. Available at: http://www.guideline.gov/summary/summary.aspx?doc_id=3510&nbr=002736&string=patient+AND+falls. Last accessed October 4, 2007.

¹¹ Department of Health and Human Services, Office of Inspector General. *Quality Oversight of Ambulatory Surgical Centers*. Available at: <http://www.oig.hhs.gov/oei/reports/oei-01-00-00452.pdf>. Last accessed October 4, 2007.

most commonly reported reason for return, occurring in 120 (38 percent) of the admitted patients.¹²

Selected states have expressed an interest in the public reporting of such events^{13,14,15,16,17}. While hospital transfers and admissions undoubtedly represent good patient care when necessary, high rates of transfer and/or admission may be an indicator that practice patterns are in need of review.

D. Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

“Surgery performed on the wrong body part”, “surgery performed on the wrong patient”, and “wrong surgical procedure performed on a patient” have all been endorsed as serious reportable surgical events by NQF.⁹

This outcome measure serves as an indirect measure of providers’ adherence to the Joint Commission’s “Universal Protocol” guideline for eliminating wrong site, wrong procedure, wrong person surgery. The Universal Protocol is based on the consensus of experts and is endorsed by more than forty professional medical associations and organizations.¹⁸

The Agency for Healthcare and Research Quality’s *Making Healthcare Safer* evidence report includes the following statements regarding the incidence of wrong site surgery:¹⁹

¹² Coley K et al. Retrospective evaluation of unanticipated admissions and readmissions after same day surgery and associated costs. *J Clin Anesth.* 2002;14:349-353.

¹³ Florida Agency for Health Care Administration. *Ambulatory Surgical and Emergency Department Data*. Available at: <http://www.fdhc.state.fl.us/SCHS/apdunit.shtml>. Last accessed October 4, 2007.

¹⁴ Indiana State Department of Health. *Reporting a Complaint*. Available at: http://www.in.gov/isdh/regsvcs/asc_index.htm. Last accessed October 4, 2007.

¹⁵ New York State Department of Health. *Statewide Planning and Research Cooperative System*. Available at: <http://www.health.state.ny.us/statistics/sparcs/>. Last accessed April 30, 2007.

¹⁶ Commonwealth of Pennsylvania, Patient Safety Authority. Available at: <http://www.psa.state.pa.us/psa/cwp/view.asp?a=1165&q=441808&psaNav=|>. Last accessed October 4, 2007.

¹⁷ Texas Department of State Health Services. Available at: <http://www.dshs.state.tx.us/HFP/safety.shtm>. Last accessed April 30, 2007.

¹⁸ Joint Commission. *Universal Protocol For Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery*. Available at: www.jointcommission.org/NR/rdonlyres/E3C600EB-043B-4E86-B04E-CA4A89AD5433/0/universal_protocol.pdf. Last accessed October 4, 2007.

¹⁹ Agency for Healthcare Research and Quality (AHRQ). *Making Healthcare Safer. A Critical Analysis of Patient Safety Practices. Chapter 43.2 – Strategies to Avoid Wrong Site Surgery*. Available at: <http://www.ahrq.gov/clinic/ptsafety/chap43b.htm>. Last accessed October 4, 2007.

“From January 1995 to March 2001, JCAHO reviewed voluntary reports of 1,152 ‘sentinel events’. Wrong-site surgery accounted for 114 (9.9%) of these reports and included procedures in neurosurgery, urology, orthopedics, and vascular surgery. Despite the high profile of JCAHO’s Sentinel Event Policy, it is believed that under-reporting by healthcare organizations apparently affects these statistics. Only 66 percent of the 1,152 total events were self-reported by the institutions involved. The remainder came from patient complaints, media stories and other sources. Using a mandatory reporting system, the New York State Department of Health received 46 reports of wrong-site surgery from 1998 through 2004 compared with the 114 cases JCAHO received nationally over a period three times longer, suggesting that voluntary incident reporting may underestimate the true incidence by a factor of 20 or greater.

The Physicians Insurers Association of America (PIAA) reviewed claims data from 22 malpractice carriers representing 110,000 physicians from 1985 to 1995. These claims included 331 cases of wrong-site surgery. The complete PIAA database documents almost 1,000 closed malpractice claims involving wrong-site surgery. However, this figure also underestimates the prevalence of wrong-site surgery, as every case does not result in a claim. Most wrong-site surgeries involve relatively minor procedures such as arthroscopy, rather than limb amputations or major neurosurgical procedures. Consequently sequelae are minimal. The State Volunteer Mutual Insurance Company (Tennessee) released a series of 37 wrong-site surgery claims from 1977 to 1997. Performing the correct procedure on the wrong side constituted the most common error (e.g., arthroscopic knee surgery on the wrong knee in 15 of the 37 cases). Twenty-six of the patients experienced no sequelae beyond a scar, and only three patients suffered permanent disability. Given the rarity of significant harm, estimates of the incidence of wrong-site surgery derived from litigation data likely underestimate the true prevalence of this problem, as do estimates based on incident reports.”

In order to encompass the outcomes of all key identification verifications, the ASC Quality Collaboration’s measure incorporates not only wrong site, wrong side, wrong patient and wrong procedure, but also wrong implant in its specifications.

E. Prophylactic Intravenous Antibiotic Timing

The CMS Surgical Infection Prevention performance measure states the following:²⁰

“Surgical site infections occur in 2-5 percent of clean extra-abdominal surgeries and up to 20 percent of intra-abdominal surgeries.²¹ Each infection is estimated to increase a

²⁰ Centers for Medicare and Medicaid Services (CMS). 7th Statement of Work. Quality of care measure specifications: surgical infection prevention. Baltimore, MD: Centers for Medicare and Medicaid Services; 2002 Aug 1. Various p. Available at: http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?ss=1&doc_id=9513&string=. Last accessed October 4, 2007.

²¹ Horan T, Culver D, Gaynes R, Jarvis W, Edwards J, and Reid C. Nosocomial infections in surgical patients in the United States, January 1986-June 1992. National Nosocomial Infections Surveillance (NNIS) System. *Infect Control Hosp Epidemiol.* 1993;14(2):73-80.

hospital stay by an average of 7 days and add over \$3,000 in charges (1992 data).²² Patients who develop surgical site infections are 60 percent more likely to spend time in an ICU, five times more likely to be readmitted to the hospital, and have twice the incidence of mortality.²³ Despite advances in infection control practices, surgical site infections remain a substantial cause of morbidity and mortality among hospitalized patients. Studies indicate that appropriate preoperative administration of antibiotics is effective in preventing infection. Systemic and process changes that promote compliance with established guidelines and standards can decrease infectious morbidity.²³

The goal of pre-surgical antibiotic prophylaxis is to establish bactericidal tissue and serum levels at the time of skin incision. In a recent study of 2,847 surgery patients at Latter-Day Saints Hospital in Salt Lake City, it was demonstrated that the lowest incidence of post-operative infection was associated with antibiotic administration one hour prior to surgery."²⁴

There is no literature available on variation in adherence to recommended prophylactic IV antibiotic timing among ASC providers. However, variability in the accuracy of timing of administration has been demonstrated in other settings.²⁴

IV. Data Sources

Most ASCs use medical records, various clinical logs and occurrence/incident reports as the data sources for their quality assessment and improvement projects. Typically these are paper-based tools for data charting, although selected centers have the ability to generate certain forms as electronic documents in formats such as Microsoft Word.

V. Extent of Electronic Data

Few ASCs have electronic medical records. Hospital-owned ASCs are the most likely to have electronic databases and electronic medical records, however this ownership structure is the least common in the industry.

Selected states have implemented ASC data reporting requirements. The data elements required and means of reporting are quite variable, but most reporting is internet-based. In many cases the data is reported in a summary format, though a few states require patient-level data.

²² Marton W, Jarvis W, Culver D, and Haley R. Incidence and nature of endemic and epidemic nosocomial infections. In: Bennett J, Brachman P, editor(s). Hospital infections. 3rd ed. Boston, MA: Little, Brown and Co.; 1992. 577-596.

²³ Kirkland K, Briggs J, Trivette S, Wilkinson W, and Sexton D. The impact of surgical-site infections in the 1990s: attributable mortality, excess length of hospitalization, and extra costs. Infect Control Hosp Epidemiol. 1999;20(11):725-30.

²⁴ Burke J. Maximizing appropriate antibiotic prophylaxis for surgical patients: an update from LDS Hospital, Salt Lake City. Clin Infect Dis. 2001;33(Suppl 2):S78-83.

Depending on the state, the ASC may be required to prepare an electronic file in a specific format (such as XML) for uploading to the state website or may directly enter data into the state website.

VI. Quality Reporting Methodology for ASCs

To date, CMS has implemented a number of quality reporting systems that employ a variety of methods to collect patient-level quality data. Most of these systems require that data be submitted electronically to a repository. As recently proposed, hospital outpatient departments would adopt the same methodology currently used by hospitals for inpatient reporting. That process requires abstraction of clinical data based on chart review, followed by compilation and submission in specific XML format to an approved data submission vendor. This vendor then transmits the data to the QIO Clinical Warehouse.

On the other hand, under the CMS Physician's Quality Reporting Initiative (PQRI), physicians report patient-level quality data using administrative claims. Using either HCPCS Level II G codes or AMA Category II CPT codes adopted specifically for quality reporting, the physician is able to submit quality data in conjunction with codes for services rendered on the CMS-1500. Given the administrative burden of medical record extraction, physicians are likely to continue using a claims-based approach to quality reporting in the future.

We have carefully evaluated these approaches, taking into account the characteristics and resources of the typical ASC. Though there is significant variability, CMS data indicates a median of two operating/procedure rooms per facility (mean = 2.5). FASA's 2006 ASC Salary & Benefits Survey shows that the majority (62.2%) of ASCs have 20 or fewer full time equivalents, including both clinical and non-clinical staff. It is unusual for an ASC to have a medical records department staffed with multiple individuals.

Our evaluation of alternative reporting methodologies has focused on their complexity, staff resources needed for implementation, requirements for hardware and software, training requirements, and additional expenses, particularly related to contracting with data submission vendors. In all these areas, we find the administrative claims data approach to be the most practical, feasible and economical solution for ASCs.

The administrative and financial burden of reporting quality measures should be fully considered. CMS has estimated that approximately 73 percent of ASCs would be considered small businesses according to the Small Business Administration (SBA) size standards (see 72 Fed. Reg. 42538 (August 2, 2007) and 72 Fed. Reg. 42812 (August 2, 2007)). In this respect, ASCs more closely resemble individual physician practices than hospitals.

Further, ASCs will continue submitting their Medicare claims using the CMS-1500 at least through 2008. Therefore, ASCs are in a position to report quality data in the same manner as physicians, which will allow CMS to leverage the processes it has already developed under PQRI. If ASCs move to the UB-04 in the future (a change we support), these codes can continue to be reported on the new form and comparisons across multiple years would remain feasible.

We request CMS work with ASC leaders to develop HCPCS Level II G codes that would allow facility-level quality measures to be reported using a claims-based approach. Reporting data on the claim form using HCPCS codes is achievable across ambulatory settings and can be accommodated on both the CMS-1500 and the UB-04.

VII. Public Display of Quality Data

The ASC Quality Collaboration supports the development of transparency regarding health care information and welcomes a fair presentation of ASC cost and quality information to assist consumers in making decisions.

The success of transparency efforts is closely linked to how effectively information is shared with the public. A data reporting infrastructure should allow patients and payers to compare quality across Medicare's payment silos when a service or procedure can be delivered in multiple ambulatory settings.

Consumers should be able to access quality and cost information on websites that are organized to allow easy comparisons, while also protecting the rights of providers to assure the information is correct, up-to-date, and clearly presented. Specifically, web-based presentation of quality and cost data should address or incorporate the following principles.

- 1) Information should be presented on all available sites of service so consumers can compare a hospital outpatient department and an ASC for a procedure that could be performed in both locations.
- 2) There should be a mechanism for providers to raise concerns with any information to be posted prior to its public presentation.
- 3) There should be a provider narrative section for each provider-specific item presented to the consumer. This narrative box would allow the provider to advise the consumer of any concerns the provider has regarding the reliability or accuracy of the information presented.
- 4) In addition to reporting quality measures, other useful information such as accreditation status, state licensure and Medicare certification should be made available.

We request more detailed consideration and expanded description on this vital matter from CMS in future rulemaking.

VIII. Summary of Recommendations

The ASC Quality Collaboration fully supports public reporting of facility-level quality measures that evaluate outcomes or processes of care specific to the facility services rendered in the outpatient surgical setting. CMS should adopt facility-level quality measures that have been endorsed by the NQF specifically for ASC reporting. The five measures developed by the ASC Quality Collaboration that are currently being considered for NQF endorsement are all important indicators of the quality of care ASCs provide to Medicare beneficiaries.

Given the limited electronic capabilities and the manual processes required for quality assessment in ASCs, CMS should implement a claims-based reporting system for ASCs, similar to the quality reporting system the agency has implemented for physicians. Such a system would allow patient-level data collection without undue financial and administrative burden.

Presentation of quality data deserves careful consideration to achieve the most effective communication of information. At a minimum, the method CMS selects for sharing data should allow interested parties to directly compare measures of outpatient surgical facility services across facility types.

Thank you for considering these comments. I would be happy to assist with questions or provide additional information at your request.

Sincerely,

A handwritten signature in black ink, appearing to read "Donna Slosburg". The signature is written in a cursive style with a large, looping initial "D".

Donna Slosburg, BSN, LHRM, CASC
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ASC Quality Collaboration
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Appendix A

ASC Quality Collaboration Measures "*Recommended for Endorsement*" by the National Quality Forum (NQF)

PLEASE NOTE: These measures are subject to change pending additional action by the NQF.

Patient Burn	
<i>Intent</i>	To capture the number of admissions (patients) who experience a burn prior to discharge
<i>Numerator/Denominator</i>	Numerator: Ambulatory Surgery Center (ASC) admissions experiencing a burn prior to discharge Denominator: All ASC admissions
<i>Inclusions/Exclusions</i>	Numerator Inclusions: ASC admissions experiencing a burn prior to discharge Numerator Exclusions: None Denominator Inclusions: All ASC admissions Denominator Exclusions: None
<i>Suggested Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports and quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater Burn: Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical or radiation, (e.g. warming devices, prep solutions, electrosurgical unit or laser); Allowable values: The count for this data element would be represented by any whole number 0 or greater

Prophylactic IV Antibiotic Timing	
<i>Intent</i>	To capture whether antibiotics given for prevention of surgical site infection were administered on time
<i>Numerator/Denominator</i>	Numerator: Number of Ambulatory Surgery Center (ASC) admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection who received the prophylactic antibiotic on time Denominator: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection
<i>Inclusions/Exclusions</i>	Numerator Exclusions: None Denominator Exclusions: ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of infections other than surgical site infections (e.g. bacterial endocarditis); ASC admissions with a preoperative order for a prophylactic antibiotic not administered by the intravenous route
<i>Suggested Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports and quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater Antibiotic administered on time: Antibiotic infusion is initiated within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, insertion of needle, inflation of tourniquet) or two hours prior if vancomycin or fluoroquinolones are administered; Allowable values: 0 minutes to 24 hours reporting in military time format from 0:00 to 23:59; hours from 00 to 23 and minutes from 00 to 59. If unable to determine (UTD), "UTD" is assigned. Prophylactic antibiotic: an antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of this measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin and Vancomycin

Patient Fall in the ASC

<i>Intent</i>	To capture the number of admissions (patients) who experience a fall within the ASC
<i>Numerator/Denominator</i>	Numerator: Ambulatory Surgery Center (ASC) admissions experiencing a fall within the confines of the ASC Denominator: All ASC admissions
<i>Inclusions/Exclusions</i>	Numerator Inclusion: ASC admissions experiencing a fall within the confines of the ASC Numerator Exclusion: ASC admissions experiencing a fall outside the ASC Denominator Inclusion: All ASC admissions Denominator Exclusion: ASC admissions experiencing a fall outside the ASC
<i>Suggested Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports and quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater Fall: a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. (National Center for Patient Safety)

Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

<i>Intent</i>	To capture any ASC admissions (patients) who experience a wrong site, side, patient, procedure or implant
<i>Numerator/Denominator</i>	Numerator: All Ambulatory Surgery Center (ASC) admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant Denominator: All ASC admissions
<i>Inclusions/Exclusions</i>	Numerator Inclusions: All ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant Numerator Exclusions: None Denominator Inclusions: All ASC admissions Denominator Exclusions: None
<i>Suggested Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports, quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater Wrong: not in accordance with intended site, side, patient, procedure or implant; Allowable values: The count for this data element would be represented by any whole number 0 or greater

Hospital Transfer/Admission

<i>Intent</i>	To capture any ASC admissions (patients) who are transferred or admitted to a hospital prior to discharge from the ASC
<i>Numerator/Denominator</i>	Numerator: Ambulatory Surgery Center (ASC) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC Denominator: All ASC admissions
<i>Inclusions/Exclusions</i>	Numerator Inclusions: ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC Numerator Exclusions: None Denominator Inclusions: All ASC admissions Denominator Exclusions: None
<i>Suggested Data Sources</i>	ASC operational data, including administrative records, medical records, incident/occurrence reports and quality improvement reports
<i>Data Element Definition and Allowable Values</i>	Admission: completion of registration upon entry into the facility; Allowable values: The count for this data element would be represented by any whole number 0 or greater Hospital transfer/admission: any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room; Allowable values: The count for this data element would be represented by any whole number 0 or greater Discharge: occurs when the patient leaves the confines of the ASC

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For further information please contact Donna Slosburg, Executive Director @ donnaslosburg@ascquality.org