ASC Quality Measures: Implementation Guide

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ASC Quality Collaboration

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About the ASC Quality Collaboration

The ASC Quality Collaboration (ASC QC) is a cooperative effort of organizations and companies interested in ensuring that ASC quality data is measured and reported in a meaningful way. The ASC QC was formed in 2006 with a view toward developing standardized ASC quality measures. The organization's stakeholders include leaders from ASC management companies, industry associations, accreditation organizations, information technology companies, and professional physician and nursing associations with a focus on health care quality and safety in the ASC setting. A list of the current members of the ASC QC can be found on our website at www.ascquality.org.

The measures included in this implementation guide have been developed using a multi-step process. Each has been vetted with both our internal panel of technical experts and an external panel of individuals and/or organizations with relevant expertise. All of the measures have been pilot tested in ASCs and assessed for validity, feasibility, usability and reliability.

The quality measures presented in this guide are the intellectual property of the ASC Quality Collaboration.

Using This Implementation Guide

The ASC QC has developed this implementation guide to help ASCs implement and collect data for the ASC facility-level quality measures it has developed. This guide is updated periodically.

The measures developed by the ASC QC include both *outcome measures* and *process measures*. An *outcome measure* assesses patients for a specific result of health care intervention. A *process measure* evaluates a particular aspect of the care that is delivered to the patient.

Of the eleven ASC QC measures, nine are outcome measures. These measures include 1) all-cause hospital transfer/admission, 2) all-cause emergency department visit within one day of discharge, 3) all-cause unplanned hospital admission within one day of discharge, 4) normothermia, 5) patient falls, 6) patient burns, 7) toxic anterior segment syndrome (TASS), 8) unplanned anterior vitrectomy, and 9) wrong site/wrong side/wrong patient/wrong procedure/wrong implant. The remaining measures are infection control process measures that evaluate the timing of the administration of intravenous antibiotics for prophylaxis of surgical site infection and appropriate surgical site hair removal.

In the sections that follow, details regarding each measure are presented first in tabular form, followed by additional supporting information. The table displayed below shows both the general format for sharing key information regarding the measure as well as an explanation of each element.

Name of Measure	
Measure Type	States whether the measure is an outcome measure or a process measure.
Description	A brief description of what is measured.
Numerator/Denominator	Numerator: Patient population experiencing the outcome or process of care being measured.
	Denominator: The patient population evaluated.
Inclusions/Exclusions	Numerator Inclusions: Patients to be included in the patient population experiencing the outcome or process of care being measured.
	Numerator Exclusions: Patients to be excluded from the patient population experiencing the outcome or process of care being measured.
	Denominator Inclusions: Patients included in the population to be evaluated.
	Denominator Exclusions: Patients to be excluded from the population to be evaluated.
Data Sources	The documents that typically contain the information needed to determine the numerator and denominator.
Definitions	Specific definitions for the terms included in the numerator and denominator statements.

To report the results for each measure as a rate, count the number of patients meeting the numerator criteria and the number of patients meeting the denominator criteria. To calculate the results as a percentage, divide the numerator by the denominator and multiply by 100.

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The appendices to this guide include a Data Dictionary (Appendix A), sample data collection logs for the Normothermia, Prophylactic IV Antibiotic Timing and Appropriate Surgical Site Hair Removal measures (Appendix B) and the ASC QC Post-Discharge Surveillance Protocol (Appendix C).

Frequently Asked Questions about the ASC QC's Quality Measures

Do we count patients who are treated at the ASC, but not in an OR/procedure room? An example would be patients who come for a YAG Capsulotomy.

All ASC admissions are counted.

Do the measures offer opportunity for improvement?

Given there is little in the literature on ASC performance and outcomes, implementing these measures will provide a better understanding of the true incidence of these outcomes. The use of common definitions allows for standardized reporting of this information on a nationwide basis. This also allows ASCs to benchmark their results and focus their quality improvement efforts.

Why are these measures important to ASC industry?

These measures are important for several reasons:

1) There is little in the literature that is specific to ASC performance and outcomes and the frequency of these events is not currently known. Data collection will help provide the information needed and establish benchmarks.
2) Since most ASCs track at least some of these outcomes, they already recognize these as important measures of quality and therefore there is a greater opportunity for acceptance by the ASC industry, a greater chance that systems are in place to collect data, and a greater chance for compliance with reporting.
3) The outcomes and processes can be applied to any setting that performs outpatient surgery such as hospital outpatient departments, freestanding ASCs, and physician's offices - allowing the opportunity to apply these measures across patient care different settings.

How will the measures be updated?

These measures are updated by re-evaluating and updating the specifications on an annual or as-needed basis.

Who can I contact with questions?

If your question is not answered after reading the implementation guide, you can access www.ascquality.org for more information.

How do I collect data for these measures?

For selected measures, sample data collection logs are available in Appendix B. For measures that evaluate outcomes occurring after discharge, please reference the Post-Discharge Surveillance Guidelines in Appendix C.

Measure Information: All-Cause Hospital Transfer/Admission

All-Cause Hospital Transfer/Admission	
Measure Type	Outcome
Description	This measure is used to assess the percentage of ASC admissions (patients) that are transferred or admitted to a hospital upon discharge from the ASC.
Numerator/Denominator	Numerator: Ambulatory Surgery Center (ASC) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC.
	Denominator: All ASC admissions.
Inclusions/Exclusions	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.
Data Sources	ASC medical records, incident/occurrence reports and variance reports are potential data sources.
Definitions	Admission: completion of registration upon entry into the facility.
	Hospital transfer/admission: any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room.
	Discharge: occurs when the patient leaves the confines of the ASC.

Rationale

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 can result in unplanned cost and time burdens that must be borne by patients and payers.

Selected states have expressed an interest in the public reporting of such events. While hospital transfers and admissions undoubtedly represent good patient care when necessary, high rates may be an indicator that practice patterns or patient selection guidelines are in need of review.

Clinical Practice Guidelines

No clinical practice guidelines addressing transfers or admissions from ASCs to acute care hospitals are available at this time.

Frequently Asked Questions for All-Cause Hospital Transfer/Admission

Should patients who go to a hospital emergency room sometime after their discharge be counted?

To allow consistent reporting, only patients who are directly transferred or directly admitted to the hospital upon their discharge from the ASC are counted for purposes of this measure.

Do we count ASC patients who are admitted to the hospital sometime after their discharge from the ASC secondary to a complication of surgery?

No, only patients who are directly transferred or admitted to the hospital upon their discharge from the ASC should be counted.

The quality measures presented in this guide are the intellectual property of the ASC Quality Collaboration.

Do we capture data for all ASC patients who are directly transferred or admitted to the hospital setting regardless of reason?
Yes, all transfers or admissions to the hospital that take place upon discharge from the ASC should be counted, regardless of the reason for the transfer or admission.

Do we count patients who are transferred to the hospital setting in an automobile upon discharge?
Yes. All transfers or admissions upon discharge from the ASC are counted, regardless of the mode of transportation.

How could a facility benefit from this measure?
If transfers/admissions are determined to be at a level higher than expected, ASCs could assess their center's guidelines for patient and/or procedure selection. If commonalities are found in patients who are transferred or admitted, guidelines may require revision.

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Measure Information: All-Cause Emergency Department Visit Within One Day of Discharge

All-Cause Emergency Department Visit Within One Day of Discharge	
Measure Type	Outcome
Description	This measure is used to assess the percentage of ASC admissions (patients) that have an emergency department visit within one day of discharge from the ASC.
Numerator/Denominator	Numerator: All ASC admissions who had an emergency department visit within one day of discharge from the ASC.
	Denominator: All ASC admissions.
Inclusions/Exclusions	Numerator Exclusions: ASC admissions who were transferred/admitted directly to an acute care hospital, including a hospital emergency room, upon discharge from the ASC (report using the All-Cause Hospital Transfer/Admission measure); ASC admissions who had an unplanned hospital admission within one day of being discharged from the ASC (report using All-Cause Unplanned Hospital Admission Within One Day of Discharge measure)
	Denominator Exclusions: None.
Definitions	Admission: completion of registration upon entry into the facility.
	Discharge: occurs when the patient leaves the confines of the ASC.
	Emergency department visit: any visit to the emergency department of an acute care hospital that does not result in admission (including an observation stay) to the hospital
	Within one day: within one day, where the day of discharge is day 0
Implementation Requirement	To ensure comparable results, this measure must be implemented using the ASC QC Post-Discharge Surveillance Guidelines.

Rationale

An emergency department visit within the first day of ASC discharge is an unanticipated outcome that results in unplanned cost and time burdens that must be borne by patients and payers.

Selected stakeholders have expressed an interest in the public reporting of such events. While emergency department visits undoubtedly represent good patient care when necessary, high rates may be an indicator that practice patterns or patient selection guidelines are in need of review.

Clinical Practice Guidelines

No clinical practice guidelines addressing emergency room visits following ASC discharge are available at this time.

Frequently Asked Questions for All-Cause Emergency Department Visit Within One Day of Discharge

Should patients who are transferred directly from the ASC to a hospital emergency room be counted?

No, only patients who have an emergency department visit following their discharge from the ASC should counted for purposes of this measure. ASC admissions that were transferred

directly to an emergency room upon discharge from the ASC should be reported using the All-Cause Hospital Transfer/Admission measure.

Do we count ASC patients who are admitted to the hospital within one day of their discharge from the ASC?
No, only patients who have an emergency department visit following their discharge from the ASC should be counted. ASC admissions that had an unplanned hospital admission within one day of being discharged from the ASC should be reported using the All-Cause Unplanned Hospital Admission Within One Day of Discharge measure.

Do we capture data for all ASC patients who are directly transferred or admitted to the hospital setting regardless of reason?
Yes, all emergency room visits that take place within one day of discharge from the ASC should be counted, regardless of the reason.

How do I collect data for this measure?
To ensure reliable results, this measure must be implemented using the ASC QC Post-Discharge Surveillance Protocol, which can be found in Appendix C.

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Measure Information: All-Cause Unplanned Hospital Admission Within One Day of Discharge

All-Cause Unplanned Hospital Admission Within One Day of Discharge	
Measure Type	Outcome
Description	This measure is used to assess the percentage of ASC admissions (patients) that have an unplanned hospital admission, including an observation stay, within one day of discharge from the ASC.
Numerator/Denominator	Numerator: All ASC admissions who had an unplanned hospital admission within one day of discharge from the ASC.
	Denominator: All ASC admissions.
Inclusions/Exclusions	Numerator Exclusions: ASC admissions who were transferred/admitted directly to an acute care hospital, including a hospital emergency room, upon discharge from the ASC (report using 'All-Cause Hospital Transfer/Admission' measure); ASC admissions who had a visit to the emergency department of an acute care hospital within one day of discharge that did not results in an admission to the hospital (report using All-Cause Emergency Department Visit Within One Day of Discharge measure); ASC admission who had a previously planned hospital admission within one day of discharge from the ASC.
	Denominator Exclusions: None.
Definitions	Admission: completion of registration upon entry into the facility.
	Discharge: occurs when the patient leaves the confines of the ASC.
	Unplanned hospital admission: any admission to an acute care hospital, including an observation stay, which was not already scheduled at the time of the patient's admission to the ASC.
	Within one day: within one day, where the day of discharge is day 0
Implementation Requirement	To ensure comparable results, this measure must be implemented using the ASC QC Post-Discharge Surveillance Guidelines.

Rationale

An unplanned hospital admission within the first day of ASC discharge is an unanticipated outcome that results in unplanned cost and time burdens that must be borne by patients and payers.

Selected stakeholders have expressed an interest in the public reporting of such events. While hospital admission undoubtedly represents good patient care when necessary, high rates may be an indicator that practice patterns or patient selection guidelines are in need of review.

Clinical Practice Guidelines

No clinical practice guidelines addressing unplanned hospital admissions following ASC discharge are available at this time.

Frequently Asked Questions for All-Cause Unplanned Hospital Admission Within One Day of Discharge

Should patients who are transferred directly from the ASC to a hospital be counted?

No, only patients who have an unplanned hospital admission following their discharge from the ASC should be counted for purposes of this measure. ASC admissions that were admitted

directly to a hospital upon discharge from the ASC should be reported using the All-Cause Hospital Transfer/Admission measure.

Do we count ASC patients who have an emergency department visit within one day of their discharge from the ASC?
No, only patients who have an unplanned hospital admission following their discharge from the ASC should be counted. ASC admissions that had an emergency department visit within one day of being discharged from the ASC should be reported using the All-Cause Emergency Department Visit Within One Day of Discharge measure.

Do we count ASC patients who have a hospital observation stay within one day of their discharge from the ASC?
Yes, for purposes of this measure, an observation stay that occurs within one day of discharge from the ASC is considered an unplanned hospital admission.

Do we capture data for all ASC patients who are admitted to the hospital within one day of discharge regardless of reason?
All *unplanned* hospital visits that take place within one day of discharge from the ASC should be counted, regardless of the reason. *Planned* hospital admissions that occur within one day of ASC discharge should not be counted.

How do I collect data for this measure?
To ensure reliable results, this measure must be implemented using the ASC QC Post-Discharge Surveillance Protocol, which can be found in Appendix C.

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Fox JP, Vashi AA, Ross JS, Gross CP. Hospital-based, acute care after ambulatory surgery center discharge. Surgery. 2014 May;155(5):743-53.

Measure Information: Appropriate Surgical Site Hair Removal

Appropriate Surgical Site Hair Removal	
Measure Type	Process
Description	This measure is used to assess the percentage of admissions (patients) that have appropriate surgical site hair removal.
Numerator/Denominator	Numerator: ASC admissions with surgical site hair removal with a razor or clippers from the scrotal area, or with clippers or depilatory cream from all other surgical sites.
	Denominator: All ASC admissions with surgical site hair removal.
Inclusions/Exclusions	Numerator Inclusions: ASC admissions with surgical site hair removal with a razor or clippers from the scrotal area, or with clippers or depilatory cream from all other surgical sites.
	Numerator Exclusions: None
	Denominator Inclusions: None
	Denominator Exclusions: ASC admissions who perform their own hair removal.
Data Sources	Potential data sources include records such as a pre-surgical checklist, nursing notes, operating room record, and operative report documenting the method of hair removal. Clinical logs designed to capture information relevant to preoperative hair removal are also potential sources.
Definitions	Admission: completion of registration upon entry into the facility.

Rationale

Razors can cause microscopic cuts and nicks to the skin, not visible to the eye. Use of razors prior to surgery increases the incidence of wound infection when compared to clipping, depilatory use, or no hair removal at all. (Seropian. *Am J Surg*. 1971;121:251)

Clinical Practice Guidelines

The CDC's guidelines for the prevention of surgical site infection include recommendations which specifically address preoperative hair removal practices. The CDC guidelines state that providers should not remove hair preoperatively unless the hair at or around the incision site will interfere with the operation. If hair is removed, it should be removed immediately before the operation, and preferably with electric clippers. See eAppendix 1 to the Centers for Disease Control and Prevention Guideline for Prevention of Surgical Site Infection, 2017. Berrios-Torres SI et al; Hospital Infection Control Practices Advisory Committee. JAMA Surg.2017;152(8):784-791.

AORN's standards of recommended practice are in alignment with this measure.

Frequently Asked Questions for Appropriate Surgical Site Hair Removal

Do we capture data for all patients who are admitted to the ASC?

No, only those patients with surgical site hair removal are counted.

Do we count ASC patients who shave themselves?

No, ASC admissions that perform their own hair removal are excluded.

How do I collect data for this measure?
A sample data collection log is available in Appendix B.

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Measure Information: Normothermia

Normothermia	
Measure Type	Outcome
Description	This measure is used to assess the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration are normothermic within 15 minutes of arrival in PACU.
Numerator/Denominator	Numerator: Surgery patients with a body temperature equal to or greater than 96.8 Fahrenheit/36 Celsius recorded within fifteen minutes of Arrival in PACU
	Denominator: All patients, regardless of age, undergoing surgical procedures under general or neuraxial anesthesia of greater than or equal to 60 minutes duration
Inclusions/Exclusions	Numerator Exclusions: None.
	Denominator Exclusions: Patients who did not have general or neuraxial anesthesia; patients whose length of anesthesia was less than 60 minutes; patients with physician/APN/PA documentation of intentional hypothermia for the procedure performed
Data Sources	ASC medical records, as well as anesthesia administration and nursing records may serve as data sources. Clinical logs designed to capture information relevant to normothermia are also potential sources.
Data Element Definitions	Anesthesia duration: the difference, in minutes, between the time associated with the start of anesthesia for the principal procedure and the time associated with the end of anesthesia for the principal procedure
	Arrival in PACU: Time of patient arrival in PACU*
	General anesthesia: drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation
	Intentional hypothermia: A deliberate, documented effort to lower the patient's body temperature in the perioperative period
	Neuraxial anesthesia: Epidural or spinal anesthesia
	Temperature: A measure in either Fahrenheit or Celsius of the warmth of a patient's body. Axillary, bladder, core, esophageal, oral, rectal, skin surface, temporal artery, or tympanic temperature measurements may be used.

* Definition of Arrival in PACU is consistent with the definition in the Procedural Times Glossary of the Association of Anesthesia Clinical Directors as approved by the ASA, ACS and AORN.

Rationale

Impairment of thermoregulatory control due to anesthesia may result in perioperative hypothermia. Hypothermia, even when mild, is associated with consequences such as increased susceptibility to infection, impaired coagulation, cardiovascular stress and cardiac complications, as well as post-anesthetic shivering and thermal discomfort. Several methods to maintain normothermia are available.

There is no literature available on variation in rates of normothermia among ASC providers. However, variability in maintaining normothermia has been demonstrated in other settings.

The quality measures presented in this guide are the intellectual property of the ASC Quality Collaboration.

Clinical Practice Guidelines

This performance measure is aligned with current guidelines regarding temperature management in patients undergoing general or neuraxial anesthesia lasting 60 minutes or more.

Frequently Asked Questions for Normothermia

If the patient receives local or regional anesthesia, should they be included?
No, only patients having surgery under general or neuraxial anesthesia should be included in the denominator.

This patient was under general anesthesia for 60 minutes. Should they be counted?
Yes, any patient having general anesthesia that lasts for 60 minutes or more should be counted in the denominator.

We checked this patient's temperature 20 minutes after they arrived in PACU and it was 98.7 F. Since they were normothermic, do we count them in the numerator?
No, only patients who were normothermic within 15 minutes of arrival in PACU can be included in the numerator.

Our center does not have a formal PACU. Patients recover in their pre-op room. Should these patients be counted?
Yes, these patients should be counted. Other locations in the center may, for purposes of this measure, function as a space for post-anesthesia recovery in the facility.

Is the start of anesthesia the same as the start of anesthesia billing time?
No. The basis for this measure is the physiologic impairment in temperature regulation associated with the administration of general/neuraxial anesthesia. It is not related to billing time.

Is it possible to have a measure score greater than 100%?
No. The numerator cannot be larger than the denominator. To use the measure, first identify the patients that meet the criteria outlined in the denominator, and then evaluate each of those patients to see if they meet the criteria defined in the numerator. For example, if you identify 100 patients that meet the denominator criteria, you would then evaluate each of those 100 patients to determine which of them meet the numerator criteria. A score of 100% is the maximum possible.

How do I collect data for this measure?
A sample data collection log is available in Appendix B.

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Measure Information: Patient Burn

Patient Burn	
Measure Type	Outcome
Description	This measure is used to assess the number of admissions (patients) that experience a burn prior to discharge.
Numerator/Denominator	Numerator: Ambulatory Surgery Center (ASC) admissions experiencing a burn prior to discharge.
	Denominator: All ASC admissions.
Inclusions/Exclusions	Numerator Inclusions: ASC admissions experiencing a burn prior to discharge.
	Numerator Exclusions: None.
	Denominator Inclusions: All ASC admissions.
	Denominator Exclusions: None.
Data Sources	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.
Definitions	Admission: completion of registration upon entry into the facility.
	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).
	Discharge: Occurs when the patient leaves the confines of the ASC.

Rationale

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. A publication from the ECRI highlights the increased risk of burns with newer surgical devices that apply higher currents at longer activation times. Although electrical burns are most prevalent, other mechanisms of burn injury are frequently reported in case studies and case series. These include chemical and thermal burns.

Surgical fires are rare; however, their consequences can be grave, killing or seriously injuring patients and surgical staff. The risk of surgical fire is present whenever and wherever surgery is performed, whether in an operating room, a physician's office, or an outpatient clinic.

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

Clinical Practice Guidelines

The risk of burns related to laser use can be reduced by adherence to the guidelines published by the ANSI (American National Standards Institute) for safe use of these devices in the health care setting. Similarly, the risk of burns related to the use of electrosurgical devices can be reduced by following the electrosurgery checklist published by ECRI.

The risk of surgical fires can be reduced by minimizing ignition, oxidizer, and fuel risks (the "classic triangle"). The American Society of Anesthesiologist's Practice Advisory for the Prevention and Management of Operating Room Fires (2013) seeks to prevent the occurrence of OR fires, reduce adverse outcomes associated with OR fires and identify the elements of a fire response protocol.

Frequently Asked Questions Regarding the Patient Burn Measure

Do all ASCs have conditions that would result in a patient burn?

Yes, because the definition of burn in this measure is comprehensive, every ASC has the potential for a patient to experience a burn during an episode of care.

Did the ASC Quality Collaboration consider stratifying by type of burn?

Stratification by type of burn was considered, but the consensus of the workgroup was that a burn is an unexpected outcome in an ASC and should not occur regardless of the source, degree or type of burn.

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Measure Information: Patient Fall in the ASC

Patient Fall in the ASC	
Measure Type	Outcome
Description	This measure is used to assess the number of admissions (patients) that experience a fall within the ASC.
Numerator/Denominator	Numerator: Ambulatory Surgery Center (ASC) admissions experiencing a fall within the confines of the ASC.
	Denominator: All ASC admissions.
Inclusions/Exclusions	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 Exclusions: None
Data Sources	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.
Definitions	Admission: completion of registration upon entry into the facility.
	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)

Rationale

"Falls per 100,000 patient days" has been endorsed as a serious reportable event by the NQF. While ASCs 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 the public reporting of such adverse events. Due to the use of anxiolytics, sedatives, and anesthetic agents as adjuncts to procedures, patients undergoing outpatient surgery are at increased risk for falls.

Clinical Practice Guidelines

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; and 4) performing a post-fall revision of plan of care as appropriate.

Frequently Asked Questions for Patient Fall in the ASC

Should we count assisted falls under this measure?

Yes, assisted falls are considered falls for the purposes of this measure.

What about falls in the parking lot? Should those be counted?

The physical plant and location of ASCs is highly variable. In order to assure that the measure would be applicable to all settings, reportable falls are limited to those that occur within the confines of the facility itself. Falls in the parking lot should not be counted.

The quality measures presented in this guide are the intellectual property of the ASC Quality Collaboration.

Should we count falls that are not witnessed?
All patient falls are counted, regardless of whether they are witnessed or not.

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(Please note this is not intended to be an exhaustive list of the organizations issuing statements or guidance related to falls.)

Measure Information: Prophylactic IV Antibiotic Timing

Prophylactic IV Antibiotic Timing	
Measure Type	Process
Description	This measure is used to assess whether intravenous antibiotics given for prevention of surgical site infection were administered on time.
Numerator/Denominator	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.
Inclusions/Exclusions	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.
Data Sources	ASC medical records, as well as medication administration records, and variance reports may serve as data sources. Clinical logs designed to capture information relevant to prophylactic IV antibiotic administration are also potential sources.
Data Element Definitions	Admission: completion of registration upon entry into the facility.
	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.
	Intravenous: Administration of a drug within a vein, including bolus, infusion or IV piggyback.
	Order: a written order, verbal order, standing order or standing protocol.
	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, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin and Vancomycin.

Rationale

The CMS Surgical Infection Prevention performance measure states, **"**Surgical site infections occur in 2-5 percent of clean extra-abdominal surgeries and up to 20 percent of intra-abdominal surgeries. Each infection is estimated to increase a hospital stay by an average of 7 days and add over $3,000 in charges (1992 data). 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. 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."

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.

Clinical Practice Guidelines

This performance measure is aligned with current surgical infection prevention guidelines recommending that prophylactic antibiotics be administered within one hour prior to surgical incision, or within two hours prior to incision when vancomycin or fluoroquinolones are used.

Frequently Asked Questions for Prophylactic IV Antibiotic Timing:

For prophylactic antibiotics, do we only count those ordered for IV administration? Not eye drops when used for the same purpose?

Only patients with orders that specify an intravenous route of administration should be counted.

If an antibiotic is ordered that is not included in the list of prophylactic antibiotics for this measure, should we count it?

No, the only antibiotics that are considered for inclusion in this measure are those that are included in the definition of "prophylactic antibiotic".

If an antibiotic is ordered for the prophylaxis of spontaneous bacterial endocarditis (SBE), should we count it?

No, the only antibiotics administered for the prophylaxis of surgical site infection are included for measurement.

What happens when two or more prophylactic antibiotics are given to the same patient for the same procedure?

The infusion of all prophylactic IV antibiotics ordered for surgical site infection would need to be initiated within the one-hour time frame (two hours for vancomycin or fluoroquinolones). In cases involving more than one antibiotic, all antibiotics must be initiated within the appropriate time frame in order for the case to meet criteria.

Does the timing of the antibiotic start at the completion of the antibiotic or the start of the antibiotic?

The timing begins at the time the antibiotic infusion is initiated. To meet the intent the antibiotic should be initiated within one hour of the initial surgical incision or the beginning of the procedure (two hours for vancomycin or fluoroquinolones).

Do you include patients who do not have an order for prophylactic IV antibiotics?

Patients without an order for prophylactic IV antibiotics are not included.

If the order for the antibiotic is given after the procedure has started, should the case be counted?

If the order for the antibiotic is given after the procedure has started, the case should not be included. The denominator for this measure specifically requires a preoperative order.

This measure is difficult to track. Why did you develop an IV antibiotic timing measure?
Evidence shows initiating prophylactic antibiotics within one hour of incision, procedure, or tourniquet results in better outcomes.

Is tourniquet time a substitute for incision time?
Tourniquet time is included based on published studies that demonstrate higher tissue concentrations of prophylactic antibiotics when the administration is prior to tourniquet inflation. The use of tourniquet time is consistent with the American Academy of Orthopedic Surgery Advisory Statement that recommends infusion prior to inflation of a proximal tourniquet, rather than prior to incision.

How do I collect data for this measure?
A sample data collection log is available in Appendix B.

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Measure Information: Toxic Anterior Segment Syndrome (TASS)

Toxic Anterior Segment Syndrome (TASS)	
Measure Type	Outcome
Description	This measure is used to assess the number of ophthalmic anterior segment surgery patients diagnosed with TASS within 2 days of surgery.
Numerator/Denominator	Numerator: All anterior segment surgeries after which the patient is diagnosed with TASS within 2 days of surgery
	Denominator: All anterior segment surgeries
Inclusions/Exclusions	Numerator Exclusions: None
	Denominator Exclusions: None
Data Sources	Physician diagnosis and report, clinical administrative data, paper medical records, incident/occurrence reports and variance reports are potential data sources
Definitions	Anterior segment surgery: for purposes of this measure, CPT codes 65400-65756, 65760-66986, and 66999
	Toxic Anterior Segment Syndrome (TASS): an acute, sterile post-operative anterior segment inflammation that develops following anterior segment surgery
	Within 2 days of surgery: within 2 days of surgery, where the day of surgery is day 0

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Rationale

Toxic anterior segment syndrome (TASS), an acute, noninfectious inflammation of the anterior segment of the eye, is a complication of anterior segment eye surgery that typically develops within 24 hours after surgery. Various contaminants, including those from surgical equipment or supplies, have been implicated as causes of TASS. Although most cases of TASS can be treated, the inflammatory response associated with TASS can cause serious damage to intraocular tissues, resulting in vision loss. Prevention requires careful attention to solutions, medications, and ophthalmic devices and to cleaning and sterilization of surgical equipment because of the numerous potential etiologies. Despite a recent focus on prevention, cases of TASS continue to occur, sometimes in clusters. With millions of anterior segment surgeries being performed in the United States each year, measurement and public reporting have the potential to serve as an additional tool to drive further preventive efforts.

Clinical Practice Guidelines

The American Society of Cataract and Refractive Surgery Ophthalmic Instrument Cleaning and Sterilization Task Force has published recommended practices for cleaning and sterilizing intraocular surgical instruments. The goal of these recommended practices is to prevent single-facility outbreaks of TASS related to contaminated or degraded instruments, and to facilitate the identification of causes of TASS and resolution of single-facility outbreaks of TASS when they occur.

Frequently Asked Questions for Toxic Anterior Segment Syndrome

Do we count all our patients who are having some kind of intraocular surgery?

No, only patients having anterior segment surgery should be included in the denominator.

What day is considered to be day 2?

For purposes of this measure, the day of surgery is considered to be day 0. So day 2 would be the second day following the day of surgery. For example, if July 1 were the day of surgery, day 2 would be July 3.

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Measure Information: Unplanned Anterior Vitrectomy

Unplanned Anterior Vitrectomy	
Measure Type	Outcome
Description	This measure is used to assess the percentage of cataract surgeries that have an unplanned anterior vitrectomy.
Numerator/Denominator	Numerator: All cataract surgeries that had an unplanned anterior vitrectomy
	Denominator: All cataract surgeries
Inclusions/Exclusions	Numerator Exclusions: None
	Denominator Exclusions: None
Data Sources	ASC medical records, incident/occurrence reports and variance reports are potential data sources
Definitions	Cataract surgery: for purposes of this measure, CPT code 66982 (Cataract surgery, complex), CPT code 66983 (Cataract surgery w/IOL, 1 stage) and CPT code 66984 (Cataract surgery w/IOL, 1 stage)
	Unplanned anterior vitrectomy: an anterior vitrectomy that was not scheduled at the time of the patient's admission to the ASC

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Rationale

The need for unplanned anterior vitrectomy is an unanticipated event that can decrease the probability of good postoperative visual acuity, and generally result in worse long-term outcome after cataract surgery. Because cataract surgery is the most common surgery performed in ASCs, with millions being performed every year, even low unplanned anterior vitrectomy rates translate to relatively high total numbers of affected patients. ASCs can help keep rates low by tracking and comparing rates to established benchmarks, and facilitating mentoring as needed.

Clinical Practice Guidelines

No clinical practice guidelines addressing unplanned anterior vitrectomy in cataract surgery are available at this time. However, rates of unplanned anterior vitrectomy have been published in the clinical literature and can serve as comparative benchmarks of performance.

Frequently Asked Questions for Unplanned Anterior Vitrectomy

One of our cataract surgery patients was also scheduled for an anterior vitrectomy. Should this patient be counted?

No, only patients who had an unplanned anterior vitrectomy should be counted.

Do we count all our patients who are having any kind of intraocular surgery?

No, only cataract surgeries should be included in the denominator.

How could a facility benefit from this measure?

If unplanned anterior vitrectomies are determined to be at a level higher than expected, ASCs could facilitate mentoring within their facility.

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Measure Information: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	
Measure Type	Outcome
Description	This measure is used to assess the number of ASC admissions (patients) experiencing a wrong site, side, patient, procedure or implant.
Numerator/Denominator	Numerator: All Ambulatory Surgery Center (ASC) admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant.
	Denominator: All ASC admissions.
Inclusions/Exclusions	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.
Data Sources	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.
Definitions	Admission: completion of registration upon entry into the facility.
	Wrong: not in accordance with intended site, side, patient, procedure or implant.

Rationale

"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. 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. 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.

Clinical Practice Guidelines

The Joint Commission's "Universal Protocol" is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.

Frequently Asked Questions for Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Isn't the incidence of wrong site, etc. surgery low in surgery centers?

While the incidence of wrong-site surgeries is low, the potential for wrong-site (bilateral options) and the impact on patient care associated with each incident make this a priority in ASCs.

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Do you count a block (preoperative or intraoperative) given on the incorrect side?
Yes, you count any procedure that was done on the wrong side.

Do you count an injection of local given on the incorrect side?
Yes, you count this as a wrong side event.

Should the administration of topical anesthetic drops in the wrong eye be considered a wrong site event?
No, administration of topical anesthetic drops in the wrong eye should not be counted as a wrong site event. Such an occurrence would be considered a medication administration variance.

Is the placement of an expired implant considered a wrong implant event?
Yes, the placement of an expired implant is considered a wrong implant event. Such an occurrence is not considered to be in accordance with the intended implant.

How do I collect data for this measure?
A sample data collection tool is available in Appendix B.

References

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Appendix A:
Data Dictionary

Admission: Completion of registration upon entry into the facility

Anesthesia duration: the difference, in minutes, between the time associated with the start of anesthesia for the principal procedure and the time associated with the end of anesthesia for the principal procedure

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

Arrival in PACU: Time of patient arrival in PACU (Procedural Times Glossary of the Association of Anesthesia Clinical Directors)

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)

Discharge: Occurs when the patient leaves the confines of the ASC

Emergency department visit: any visit to the emergency department of an acute care hospital that does not result in admission (including an observation stay) to the hospital

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)

General anesthesia: drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation

Hospital transfer/admission: Any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room or emergency department

Intravenous: Administration of a drug within a vein, including bolus, infusion or IV piggyback

Neuraxial anesthesia: Epidural or spinal anesthesia

Order: A written order, verbal order, standing order or standing protocol

Prophylactic antibiotic: An antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of the Prophylactic IV Antibiotic Timing measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin and Vancomycin

Toxic Anterior Segment Syndrome (TASS): an acute, sterile post-operative anterior segment inflammation that develops following anterior segment surgery

Unplanned anterior vitrectomy: an anterior vitrectomy that was not scheduled at the time of the patient's admission to the ASC

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Unplanned hospital admission: any admission to an acute care hospital, including an observation stay, which was not already scheduled at the time of the patient's admission to the ASC

Within one day: within one day, where the day of discharge is day 0

Wrong: Not in accordance with intended site, side, patient, procedure or implant

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Appendix B:
Sample Data Collection Logs

The following pages present sample data collection logs for three of the measures (Appropriate Surgical Site Hair Removal, Normothermia, and Prophylactic IV Antibiotic Timing) developed by the ASC Quality Collaboration. These are examples only; their use is not required.

Sample Data Collection Log: Prophylactic IV Antibiotic Timing

This tool may be used to track patients with an order for prophylactic IV antibiotics for surgical site infection. It is not necessary to track patients who do not have a preoperative order for IV antibiotic prophylaxis.

Center Name: _____ **Data Collection Period:** _____

Date of Service	Pt Identifier	Antibiotic Ordered	Infusion Start Time	Procedure Start Time	Elapsed Time	Timely Administration Yes	Timely Administration No

Instructions:

1. Enter the date of service in the first column.
2. Enter the unique patient identifier in the second column.
3. Enter the prophylactic IV antibiotic ordered in the third column. For purposes of this measure, the following antibiotics are considered prophylaxis for surgical site infection: Ampicillin/sulbactam (Unasyn), Aztreonam (Azactam), Cefazolin (Ancef), Cefmetazole (Zefazone), Cefotetan (Cefotan), Cefoxitin (Mefoxin), Cefuroxime (Zinacef), Ciprofloxacin (Cipro), Clindamycin (Cleocin), Ertapenem (Invanz), Erythromycin (Erythrocin), Gatifloxacin (Tequin), Gentamicin (Garamycin), Levofloxacin (Levaquin), Metronidazole (Flagyl, Metro IV), Moxifloxacin (Avelox), Neomycin and Vancomycin (Vancocin).
4. Enter the time the intravenous infusion of antibiotic was started in the fourth column.
5. Enter the start time of the procedure or surgery in the fifth column. The start time is the time the initial surgical incision is made. For procedures involving a tourniquet, the start time is the time the tourniquet is inflated. For procedures that do not involve an incision, the start time is the time the needle is inserted or the time the endoscope is introduced.
6. Determine the elapsed time between the start of the infusion and the start of the procedure and enter that value into the sixth column.
7. If the antibiotic was initiated within 60 minutes of the start of the procedure (within 120 minutes for fluoroquinolones and vancomycin), the timely administration requirements of the measure have been met.

NOTE: If more than one prophylactic IV antibiotic from the list above was ordered, each of the antibiotics must be given timely for the requirements of the measure to be met. For patients with more than one antibiotic ordered, use additional lines as needed to record the data for each additional antibiotic.

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Sample Data Collection Log: Appropriate Surgical Site Hair Removal

This tool may be used to track patients with surgical site hair removal. It is not necessary to track patients who do not have surgical site hair removal.

NOTE: Cases in which the patient performed their own surgical site hair removal are excluded from the measure and should not be included below.

Center Name: _____ **Data Collection Period: _____**

Date of Service	Pt Identifier	Scrotal Hair Removal with Razor	Hair Removal with Clippers	Hair Removal with Depilatory Cream	Hair Removal with Razor from Non-Scrotal Sites	Specifications Met: Yes	No

Instructions:

1. Enter the date of service in the first column.
2. Enter the unique patient identifier in the second column.
3. Indicate the method of surgical site hair removal by marking removal with a razor from the scrotum in the third column, removal with clippers in the fourth column, removal with depilatory cream in the fifth column and removal with a razor from non-scrotal surgical sites in the sixth column.
4. If hair removal at the surgical site was accomplished using a razor or clippers from the scrotal area, or with clippers or depilatory cream from all other surgical sites, the measure specifications have been met.

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Sample Data Collection Log: Normothermia

This tool may be used to track patients who undergo general or neuraxial anesthesia. It is not necessary to track patients who do not undergo general or neuraxial anesthesia.

Center Name: _____ **Data Collection Period:** _____

Date of Service	Pt Identifier	Anesthesia Duration	Time Into PACU	Time Temp Measured	Elapsed Time (mins)	Patient Temp		Specifications Met:	
						°F	°C	Yes	No

Instructions:

1. Enter the date of service in the first column.
2. Enter the unique patient identifier in the second column.
3. Enter the duration of general or neuraxial anesthesia in the third column. If the duration of anesthesia was less than 60 minutes, no further data entry is necessary.
4. Enter the Time into PACU in the fourth column.
5. Enter the time the patient's temperature was taken after arriving in the PACU in the fifth column.
6. Determine the elapsed time by subtracting the Time into PACU from the time the patient's temperature was taken after arriving in the PACU. Record the number of minutes in the sixth column.
7. Enter the patient's temperature in the seventh column under either the Fahrenheit (°F) or Celsius (°C) heading.
8. If the patient's temperature was greater than or equal to 96.8°F/36°C within 15 minutes of the time into PACU, the requirements of the measure have been met. Enter "Yes" section of the eighth column. If these requirements have not been met (temperature is less than 96.8°F/36°C, and/or temperature was not taken within 15 minutes of the Time into PACU), enter "No" section of the eighth column.

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Appendix C: Post-Discharge Surveillance Guidelines

In order to ensure comparable measure results for outcomes that occur after patient discharge, centers must use the same approach to surveillance when implementing the following measures:

- All-Cause Emergency Department Visit within One Day of Discharge
- All-Cause Unplanned Hospital Admission within One Day of Discharge

Surveillance guidelines for each of these measures are presented in the pages that follow.

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Surveillance Guidelines for the All-Cause Emergency Department Visit Within One Day of Discharge Measure

To ensure measure results are comparable, all facilities employing the All-Cause Emergency Department (ED) Visit within One Day of Discharge measure should use the same approach to case detection. All patients must be included for follow-up.

Procedure:

A. Prior to procedure or surgery:
1. Physicians should be made aware in advance of your plans to follow-up for ED visits that occur within one day of discharge.
2. Patients (or guardians for patients who are incapacitated or less than 18 years of age) should be informed that you intend to contact them for follow-up and that you will need to know the best way to reach them. Patients should also be advised that you would like to hear from them if they go to an emergency department for any reason within one day of their discharge from the center.
3. Patients should be asked to provide the name and contact information for another person whom they would allow to be contacted in the event the patient cannot be reached.

B. Following discharge
1. No sooner than one day after the patient's discharge, contact the patient for follow-up.
2. If the patient cannot be reached after three attempts on different days of the week and at different times, the center should contact the patient's proxy for follow-up.
3. If the patient does not have a proxy, or the proxy cannot be reached after three attempts on different days of the week and at different times, the center should contact the patient's surgeon/physician for follow-up.

Reporting Instructions:

To report an ED visit, at least one of the following criteria must be met:
1. The patient reports an ED visit within one day of discharge, OR
2. The patient's proxy reports an ED visit within one day of discharge, OR
3. The patient's physician reports an ED visit within one day of discharge, OR
4. The emergency department contacts the ASC and reports the patient was seen within one day

To report NO ED visit, at least one of the following criteria must be met:
1. The patient reports they did not visit an ED within one day of discharge OR
2. The patient's proxy reports that the patient did not visit an ED within one day of discharge.

In the event that the patient cannot be reached/does not respond AND the patient's proxy cannot be reached/does not respond AND the patient's physician does not report an ED visit within one day of discharge AND no report is received from an emergency department regarding an ED visit within one day of discharge, the case is considered "unable to determine".

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Surveillance Guidelines for the All-Cause Unplanned Hospital Admission Within One Day of Discharge Measure

To ensure measure results are comparable, all facilities employing the All-Cause Unplanned Hospital Admission within One Day of Discharge measure should use the same approach to case detection. All patients must be included for follow-up.

Procedure:

A. Prior to procedure or surgery:
1. Physicians should be made aware in advance of your plans to follow-up for hospitalizations that occur within one day of discharge.
2. Patients (or guardians for patients who are incapacitated or less than 18 years of age) should be informed that you intend to contact them for follow-up and that you will need to know the best way to reach them. Patients should also be advised that you would like to hear from them if they are hospitalized for any reason within one day of their discharge from the center.
3. Patients should be asked to provide the name and contact information for another person whom they would allow to be contacted in the event the patient cannot be reached.

B. Following discharge
1. No sooner than one day after the patient's discharge, contact the patient for follow-up.
2. If the patient cannot be reached after three attempts on different days of the week and at different times, the center should contact the patient's proxy for follow-up.
3. If the patient does not have a proxy, or the proxy cannot be reached after three attempts on different days of the week and at different times, the center should contact the patient's surgeon/physician for follow-up.

Reporting Instructions:

To report a hospitalization, at least one of the following criteria must be met:
1. The patient reports a hospitalization within one day of discharge, OR
2. The patient's proxy reports a hospitalization within one day of discharge, OR
3. The patient's physician reports a hospitalization within one day of discharge, OR
4. The admitting hospital contacts the ASC and reports the patient had an unplanned admission within one day of discharge.

To report NO hospitalization, at least one of the following criteria must be met:
1. The patient reports they were not hospitalized within one day of discharge OR
2. The patient's proxy reports that the patient was not hospitalized within one day of discharge.

In the event that the patient cannot be reached/does not respond AND the patient's proxy cannot be reached/does not respond AND the patient's physician does not report a hospitalization within one day of discharge AND no report is received from an admitting hospital regarding an unplanned hospital admission within one day of discharge, the case is considered "unable to determine".

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