



Measure Information

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

Brief Measure Information

NQF #: 0267

Corresponding Measures:

De.2. Measure Title: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Co.1.1. Measure Steward: Ambulatory Surgical Centers Quality Collaborative

De.3. Brief Description of Measure: Percentage of ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event.

1b.1. Developer Rationale: This measure supports the quality improvement vision articulated by the NQF in its "Serious Reportable Events in Healthcare - 2006 Update: A Consensus Report" by giving ASCs a means to consistently measure and publicly report wrong site, wrong side, wrong procedure, wrong patient and wrong implant events. As noted in the report, these occurrences are among those included in the list of serious reportable events, "a list of unambiguous, serious, preventable adverse events that concern both the public and healthcare providers and could form the basis for a national reporting system that would lead to substantial improvements in patient safety. The events on the list are identifiable and measurable, and the risk of occurrence of these events is significantly influenced by the policies and procedures of healthcare organizations. ...[p]ublic reporting of these events raises the awareness of all healthcare organizations regarding the potential for such occurrences and should stimulate the critical review of systems for their prevention."

S.4. Numerator Statement: All ambulatory surgery center (ASC) admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant

S.7. Denominator Statement: All ASC admissions

S.10. Denominator Exclusions: None

De.1. Measure Type: Outcome

S.23. Data Source: Paper Medical Records

S.26. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Nov 15, 2007 **Most Recent Endorsement Date:** Aug 09, 2012

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

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

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not applicable

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

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

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

0267_Evidence_MSF5.0_Data.doc

1b. Performance Gap

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

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

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

This measure supports the quality improvement vision articulated by the NQF in its "Serious Reportable Events in Healthcare - 2006 Update: A Consensus Report" by giving ASCs a means to consistently measure and publicly report wrong site, wrong side, wrong procedure, wrong patient and wrong implant events. As noted in the report, these occurrences are among those included in the list of serious reportable events, "a list of unambiguous, serious, preventable adverse events that concern both the public and healthcare providers and could form the basis for a national reporting system that would lead to substantial improvements in patient safety. The events on the list are identifiable and measurable, and the risk of occurrence of these events is significantly influenced by the policies and procedures of healthcare organizations. ...[p]ublic reporting of these events raises the awareness of all healthcare organizations regarding the potential for such occurrences and should stimulate the critical review of systems for their prevention."

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

Although data for 1,184 ASCs are included in our public reporting of this indicator, many ASCs report their data to their corporate managing partner. This data is aggregated and reported in total rather than being reported individually by an ASC. As a result, although the ASC QC database includes data for 1,184 facilities for this measure, center-level rates are only available for 541 ASCs. The statistics reported below are based on the 541 individually-reporting ambulatory surgery centers, which are located throughout the US.

The rates for this measure were collected for 541 ambulatory surgery centers throughout the US for services provided during January to March 2011.

The rate for surgeries involving the wrong site, side, patient, procedure or implant ranged from a minimum of 0.00% to a maximum of 0.31%. The mean rate was 0.00% (SD: 0.02%), while the median rate was 0.00%. The maximum rate for surgeries involving the wrong site, side, patient, procedure or implant of 0.31% demonstrates that there is an opportunity for improvement in this measure.

This study sample was a convenience sample, which is drawn from ASCs that actively participate in the public quality reporting project sponsored by the ASC Quality Collaboration. Participation in the ASC QC's reporting project is voluntary. Given this, the sample is likely biased toward those ASCs that have taken an interest in the quality measurement and reporting activities of the ASC QC. In addition, those ASCs that volunteer may choose to collect and submit data on a measure-by-measure basis. For this reason, it is possible that the sample may also be biased towards those with higher levels of performance for this measure.

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

A convenience sample of 541 ambulatory surgery centers reporting individual data was selected to assess the opportunity for improvement for this measure. The centers were located throughout the US. Services from the first calendar quarter of 2011 were included in this portion of the study.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

The data the ASC Quality Collaboration currently receives for this measure is collected at the ASC-level or at the level of the corporate parent of the ASC. Corporate parent data submissions combine data from multiple ASCs. Disparity measures by population group require the collection of patient-level data or collection of the data for individual populations of patients. At this time, the ASC Quality Collaboration does not have access to any patient-level or individual population level data that would allow for analysis of subpopulation disparities based on race, sex and age. However, we understand the importance of subpopulation data and are taking steps that would allow us to collect the necessary data. We are actively pursuing the development of a registry that

would allow us to develop subpopulation performance data for this measure and others. Potential registry development vendors have been identified and initial communications regarding the project have already taken place. We plan to select a vendor by fourth quarter of 2011, initiate the development of the registry database immediately upon contract acceptance, and have a functioning registry three months thereafter.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

Not available. Please see 1b.4. above and recopied here: The data the ASC Quality Collaboration currently receives for this measure is collected at the ASC-level or at the level of the corporate parent of the ASC. Corporate parent data submissions combine data from multiple ASCs. Disparity measures by population group require the collection of patient-level data or collection of the data for individual populations of patients. At this time, the ASC Quality Collaboration does not have access to any patient-level or individual population level data that would allow for analysis of subpopulation disparities based on race, sex and age. However, we understand the importance of subpopulation data and are taking steps that would allow us to collect the necessary data. We are actively pursuing the development of a registry that would allow us to develop subpopulation performance data for this measure and others. Potential registry development vendors have been identified and initial communications regarding the project have already taken place. We plan to select a vendor by fourth quarter of 2011, initiate the development of the registry database immediately upon contract acceptance, and have a functioning registry three months thereafter.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Frequently performed procedure, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

As a result of advances in surgery and anesthesia, approximately 80 percent of surgeries in the United States are now performed on an outpatient basis. Ambulatory surgical centers perform approximately 40%, or more than 22 million, of those outpatient surgeries.

1 The risk of a wrong site/site/patient/procedure/implant event must be managed for each of these surgeries.

There is strong consensus that these events can and must be prevented. The importance of taking steps designed to eliminate these events is consistently highlighted in efforts to ensure surgical patient safety. 2-10

1c.4. Citations for data demonstrating high priority provided in 1a.3

1 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. <http://www.cms.gov/>.

2 American Academy of Ophthalmology. Recommendations of American Academy of Ophthalmology Wrong-Site Task Force. http://one.aao.org/ce/practiceguidelines/patient_content.aspx?cid=d0db838c-2847-4535-baca-aebab3011217. Accessed August 9, 2011.

3 American Academy of Orthopaedic Surgeons. Wrong-Site Surgery. Information Statement 1015. <http://www.aaos.org/about/papers/advistmt/1015.asp>. Accessed August 9, 2011.

4 American College of Obstetricians and Gynecologists. ACOG committee opinion #464: patient safety in the surgical environment. *Obstet Gynecol.* 2010;116(3):786-790.

5 American College of Surgeons. [ST-41] Statement on ensuring correct patient, correct site, and correct procedure surgery. http://www.facs.org/fellows_info/statements/st-41.html. Accessed August 9, 2011.

6 AORN. AORN Position Statement on Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events. <http://www.aorn.org/PracticeResources/AORNPositionStatements/PositionCorrectSiteSurgery/>. Accessed August 9, 2011.

7 Institute of Medicine. To Err is Human: Building a Safer Health System. Washington, DC: National Academy Press, 2000.

8 Joint Commission. 2011 National Patient Safety Goals. http://www.jointcommission.org/standards_information/npsgs.aspx. Accessed August 9, 2011.

9 National Quality Forum. Serious Reportable Events in Healthcare – 2006 Update: A Consensus Report. March 2007.

10 World Health Organization. WHO Guidelines for Safe Surgery 2009. http://whqlibdoc.who.int/publications/2009/9789241598552_eng.pdf. Accessed August 9, 2011.

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

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

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

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)
<http://ascquality.org/documents/ASC-QC-Implementation-Guide-3.1-July-2015.pdf>

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

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)
No data dictionary Attachment:

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population,

i.e., cases from the target population with the target process, condition, event, or outcome)

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

All ambulatory surgery center (ASC) admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

In-facility, prior to discharge

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

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

DEFINITIONS:

Admission: completion of registration upon entry into the facility

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

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

All ASC admissions

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

DEFINITION:

Admission: completion of registration upon entry into the facility

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

None

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

Not applicable

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

The measure is not stratified

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

Not applicable

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

Not applicable

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Lower score

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

The number of admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event is divided by the number of ASC admissions during the reporting period, yielding the rate of wrong site, wrong side, wrong patient, wrong procedure, and wrong implant events for the reporting period.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

The measure is not based on a sample.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Paper Medical Records

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

ASC medical records, as well as incident/occurrence reports, and variance reports may serve as data sources. No specific collection instrument is required although the ASC Quality Collaboration has developed a sample data collection instrument that may be used as desired. Facilities may use any collection instrument that allows tracking of all wrong site, wrong side, wrong patient, wrong procedure, and wrong implant events.

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

URL

S.26. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

S.27. Care Setting (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[0267_MeasureTesting_MS5.0_Data.doc](#)

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

If other:

3b. Electronic Sources

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

3b.1. To what extent are the specified data elements available electronically in defined fields? (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)

No data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

Widespread adoption of electronic health records in ambulatory surgical centers would be needed to achieve electronic capture of data elements.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

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

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

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

The ASC Quality Collaboration has included "Frequently Asked Questions" in the Implementation Guide for the measure to assist users in their implementation of data collection.

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

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

Planned	Current Use (for current use provide URL)
Public Reporting	
Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

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

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

4b. Improvement

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

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

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

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

Experience with this measure and feedback from users indicates that it is easy to use and has limited susceptibility to inaccuracies and errors. Reliability is very high. The ASC Quality Collaboration is not aware of any unintended consequences as a result of the use of this measure.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

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

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

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications completely harmonized?

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

5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

No competing measures found

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Ambulatory Surgical Centers Quality Collaborative

Co.2 Point of Contact: Donna, Slosburg, donnaslosburg@ascquality.org, 727-867-0072-

Co.3 Measure Developer if different from Measure Steward: Ambulatory Surgical Center Quality Collaboration

Co.4 Point of Contact: Donna, Slosburg, donnaslosburg@ascquality.org, 727-867-0072-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

The ASC Quality Collaboration workgroup members meet via teleconference to develop, critique, and modify candidate measures; to maintain existing measures; and to offer sites willing to participate in testing. No contractors are used.

The following is a list of the individuals (and their affiliation at the time of their participation) serving on the workgroup and contributing to this measure:

AAHC: Naomi Kuznets, PhD

Ambulatory Surgery Foundation: Debra Stinchcomb, BSN, CASC, David Shapiro, MD,

Sarah Martin, RN, BS, CASC and Marian Lowe

AMSURG: Deby Samuels, Lorri Smith RN, BSN and Linda Brooks-Belli

AOA/HFAP: Monda Shaver, RN, BSN, CPHIT and Susan Lautner, RN, BSN, MSHL

AORN: Bev Kirchner BSN, CNOR, CASC and Bonnie Denholm, RN, MS, CNOR

ASCOA: Ann Geier RN, MS, CNOR, CASC

ASC Quality Collaboration: Donna Slosburg, BSN, LHRM, CASC

HCA: Kathy Wilson

The Joint Commission: Michael Kulczycki and Kathleen Domzalski

NATIONAL: Rhonda Arnwine, MBA and Terry Hawes, RN, BHA

Novamed: Cassandra Speier

NUETERRA: Rachelle Babin RN, BSN

Surgical Care Affiliates: Kim Wood, MD

Symbion: Steve Whitmore and Gina Throneberry RN, MBA, CASC

USPI: David Zarin, MD, Julie Gunderson RN, MM, CPHQ and Clint Chain, RN, BSN

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision: 12, 2010

Ad.4 What is your frequency for review/update of this measure? Annually, or more frequently if indicated

Ad.5 When is the next scheduled review/update for this measure? 12, 2011

Ad.6 Copyright statement: None

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: [None](#)