



## 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 #:** 0515

**Corresponding Measures:**

**De.2. Measure Title:** Ambulatory surgery patients with appropriate method of hair removal

**Co.1.1. Measure Steward:** ASC Quality Collaboration

**De.3. Brief Description of Measure:** Percentage of ASC admissions with appropriate surgical site hair removal.

**1b.1. Developer Rationale:** Improving the rate of appropriate surgical site hair removal is expected to reduce the risk of surgical site infection.

**S.4. Numerator Statement:** 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

**S.7. Denominator Statement:** All ASC admissions with surgical site hair removal

**S.10. Denominator Exclusions:** ASC admissions who perform their own hair removal

**De.1. Measure Type:** Process

**S.23. Data Source:** Paper medical record/flow-sheet

**S.26. Level of Analysis:** Facility/Agency

**IF Endorsement Maintenance – Original Endorsement Date:** Sep 25, 2008 **Most Recent Endorsement Date:** Jan 31, 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 included in a composite or paired with another measure

### 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**  
0515\_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)**  
Improving the rate of appropriate surgical site hair removal is expected to reduce the risk of surgical site infection.

**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.*

The rates for this measure were collected for 192 ambulatory surgery centers throughout the US for services provided during July to September 2010. The rate for appropriate surgical site hair with removal clippers or depilatory cream ranged from a minimum of 0.0% to a maximum of 100%. The mean rate was 96% (SD: 18%), while the median rate was 100%. The minimum rate of 0% and the fact that 7.3% of the centers reported a rate of lower than 100% demonstrate that there is an opportunity for improvement in 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 192 ambulatory surgery centers was selected to assess the opportunity for improvement for this measure. The centers were located throughout the US. Services from the third calendar quarter of 2010 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.*

This measure is not intended to evaluate disparities by population group.

**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.**

No data available for disparities by population group. Please see 1b.4. above, this measure is not intended to evaluate disparities by population group.

Regarding 1b.2. above, a convenience sample of 192 ambulatory surgery centers was selected to assess the opportunity for improvement for this measure. The centers were located throughout the US. Services from the third calendar quarter of 2010 were included in this portion of the study.

**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**

Affects large numbers, Frequently performed procedure, A leading cause of morbidity/mortality, High resource use, Severity of illness, 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.<sup>1</sup> Appropriate surgical site hair removal is measured for surgical patients in the hospital inpatient setting, and given the high volume of outpatient surgical procedures, should also be measured in the outpatient setting.

Accumulated evidence suggests that shaving the surgical site is associated with an increased incidence of surgical site infections. Razors are thought to cause microabrasions that may subsequently become infected. Hair removal with clippers has been demonstrated to reduce the rate of surgical site infections and associated healthcare expenditures. 2-12

Surgical site infection rates in ambulatory surgery are not well understood. However, in other settings, surgical site infections occur in 2 to 5 percent of clean extra-abdominal surgeries. Evidence suggests each infection increases a hospital stay by 7 to 10 days and adds from \$3,000 to \$29,000 in charges. Patients who develop surgical site infections are thought to have at least twice the incidence of mortality when compared to surgical patients without a surgical site infection. 13-19

**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. Alexander JW, Fischer JE, Boyajian M, Palmquist J, Morris MJ. The influence of hair-removal methods on wound infections. *Arch Surg*. 1983 Mar;118(3):347-52.
3. Balthazar ER, Colt JD, Nichols RL. Preoperative hair removal: a random prospective study of shaving versus clipping. *South Med J*. 1982 Jul;75(7):799-801.
4. Court-Brown CM. Preoperative skin depilation and its effect on postoperative wound infections. *J R Coll Surg Edinb*. 1981 Jul;26(4):238-41.
5. Kjonniksen I, Andersen BM, Sondenaa VG, Segadal L. Preoperative hair removal--a systematic literature review. *AORN J*. 2002 May;75(5):928-38, 940.
6. Ko W, Lazenby WD, Zelano JA, Isom OW, Krieger KH. Effects of shaving methods and intraoperative irrigation on suppurative mediastinitis after bypass operations. *Ann Thorac Surg*. 1992 Feb;53(2):301-5.
7. Powis SJ, Waterworth TA, Arkell DG. Preoperative skin preparation: clinical evaluation of depilatory cream. *Br Med J*. 1976 Nov 13;2(6045):1166-8.
8. Seropian R, Reynolds BM. Wound infections after preoperative depilatory versus razor preparation. *Am J Surg*. 1971 Mar;121(3):251-4.
9. Tanner J, Moncaster K, Woodings D. Preoperative hair removal to reduce surgical site infection. *Cochrane Database Syst Rev*. 2006 Jul 19;3:CD004122.
10. Thur de Koos P, McComas B. Shaving versus skin depilatory cream for preoperative skin preparation. A prospective study of wound infection rates. *Am J Surg*. 1983 Mar;145(3):377-8.
11. Gurkan I, Wenz Sr, JF. Perioperative infection control: an update for patient safety in orthopedic surgery. *Orthopedics*. 2006 Apr;29(4):329.
12. Fletcher N, Sofianos D, Berkes MB, Obremskey WT. Prevention of perioperative infection. *J Bone Joint Surg Am*. 2007;89:1605-18.
13. Cruse P. Wound infection surveillance. *Rev Infect Dis* 1981; 3:734-737.
14. Cruse PJ, Foord R. The epidemiology of wound infection: a 10-year prospective study of 62,939 wounds. *Surg Clin North Am* 1980; 60:27-40.
15. Engemann JJ, Carmeli Y, Cosgrove SE, et al. Adverse clinical and economic outcomes attributable to methicillin resistance among patients with *Staphylococcus aureus* surgical site infection. *Clin Infect Dis* 2003; 36:592-598.
16. Kirkland K, Briggs J, Trivette S, Wilkinson W, and Sexton D. The impact of surgical-site infections in the 1990s: attributable mortality, excess length of hospitalization, and extra costs. *Infect Control Hosp Epidemiol*. 1999;20(11):725-30.
17. Coello R, Glenister H, Fereres J, et al. The cost of infection in surgical patients: a case-control study. *J Hosp Infect* 1993; 25:239-250.

18. Vegas AA, Jodra VM, Garcia ML. Nosocomial infection in surgery wards: a controlled study of increased duration of hospital stays and direct cost of hospitalization. *Eur J Epidemiol* 1993; 9:504-510.

19. Whitehouse JD, Friedman ND, Kirkland KB, Richardson WJ, Sexton DJ. The impact of surgical-site infections following orthopedic surgery at a community hospital and a university hospital: adverse quality of life, excess length of stay, and extra cost. *Infect Control Hosp Epidemiol* 2002; 23:183-189.

**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):

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

Safety

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

<http://www.ascquality.org/qualitymeasures.cfm>

**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)

**URL 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.

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

**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

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

All ASC admissions with surgical site hair removal

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

**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)

**DEFINITIONS:**

Admission: completion of registration upon entry into the facility

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

ASC admissions who perform their own hair removal

**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)

To collect data for the denominator exclusion, centers must track patients who perform their own hair removal

**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)

**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 = Higher 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.)

1a. The number of admissions with surgical site hair removal is determined.

1b. The number of admissions who performed their own surgical site hair removal is determined.

1c. The value determined in step 1b is subtracted from the value determined in step 1a to yield the measure denominator.

2. The number of admissions with appropriate surgical site hair removal (hair removal with razor or clippers from the scrotal area, or hair removal with clippers or depilatory cream from all other surgical sites) is determined. This value is the measure numerator.

3. The number of ASC admissions with appropriate surgical site hair removal (step 2) is divided by the number of ASC admissions with surgical site hair removal (steps 1a through 1c) during the reporting period, yielding the rate of appropriate surgical site hair removal 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 record/flow-sheet

**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.

Facilities may review records such as a pre-surgical checklist, nursing notes, operating room record, and operative report as needed for documentation of method of hair removal. Clinical logs designed to capture information relevant to preoperative hair removal may also be used.

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 the method of hair removal for all admissions with surgical site hair removal.

<p><b>S.25. Data Source or Collection Instrument</b> <i>(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</i>  <a href="#">URL</a></p> <p><b>S.26. Level of Analysis</b> <i>(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)</i>  <a href="#">Facility/Agency</a></p> <p><b>S.27. Care Setting</b> <i>(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)</i>  <a href="#">Ambulatory Care : Amb Surgery Center</a>                      If other:</p>
<p><b>S.28. COMPOSITE Performance Measure</b> - Additional Specifications <i>(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)</i></p>
<p><b>2a. Reliability</b> – See attached Measure Testing Submission Form  <b>2b. Validity</b> – See attached Measure Testing Submission Form  <a href="#">0515_MeasureTesting_MSF5.0_Data.doc</a></p>

<p><b>3. Feasibility</b></p>
<p>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.</p>
<p><b>3a. Byproduct of Care Processes</b>                      For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).</p> <p><b>3a.1. Data Elements Generated as Byproduct of Care Processes.</b>  <a href="#">generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition</a>                      If other:</p>
<p><b>3b. Electronic Sources</b>                      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.</p> <p><b>3b.1. To what extent are the specified data elements available electronically in defined fields?</b> <i>(i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)</i>  <a href="#">No</a></p> <p><b>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.</b>  <a href="#">Widespread adoption of electronic health records in ambulatory surgical centers would be needed to achieve electronic capture of data elements.</a></p> <p><b>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.</b>  <b>Attachment:</b></p>
<p><b>3c. Data Collection Strategy</b>                      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.</p> <p><b>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</b></p>



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)

#### 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 reliability is high. Most errors appear to be the result of human factors, such as data entry errors. 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.)**

As noted above, this measure offers improved efficiency of data collection for ASC providers. Patients in both the numerator and denominator populations can be identified concurrent with the process of care, avoiding the additional cost, resource use and inefficiency that results when these determinations are made retrospectively.

Related Measures: #0301 Surgery patients with appropriate hair removal

## 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):** ASC Quality Collaboration  
**Co.2 Point of Contact:** Donna, Slosburg, [donnaslosburg@ascquality.org](mailto:donnaslosburg@ascquality.org), 727-867-0072-  
**Co.3 Measure Developer if different from Measure Steward:** ASC Quality Collaboration  
**Co.4 Point of Contact:** Donna, Slosburg, [donnaslosburg@ascquality.org](mailto: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:

AAAH: 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, Linda Brooks-Belli and Kathy Wilson  
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: Carol Harbin, RN, BSN, MBA  
The Joint Commission: Michael Kulczycki and Kathleen Domzalski  
NATIONAL: Rhonda Arnwine and Terry Hawes, RN, BHA  
Novamed: Cassandra Speier  
NUETERRA: Rachelle Babin RN, BSN and Mary Hibdon, RN  
Surgical Care Affiliates: Kim Wood, MD  
Symbion: Steve Whitmore and Gina Throneberry RN, MBA, CASC  
USPI: David Zarin, MD, Julie Gunderson RN, MM, CPHQ, Clint Chain, RN, BSN and Ann Shimek RN, BSN, CASC

### Measure Developer/Steward Updates and Ongoing Maintenance

**Ad.2 Year the measure was first released:** 2008

**Ad.3 Month and Year of most recent revision:** 03, 2011

**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?** 03, 2012

**Ad.6 Copyright statement:** [None](#)

**Ad.7 Disclaimers:**

**Ad.8 Additional Information/Comments:**