

NATIONAL QUALITY FORUM

Measure Evaluation 4.1 December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the [evaluation criteria](#) are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all **yellow highlighted** areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (yellow highlighted areas).*

Steering Committee: Complete all **pink** highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met

C = Completely (unquestionably demonstrated to meet the criterion)

P = Partially (demonstrated to partially meet the criterion)

M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)

N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)

NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) NQF Review #: 0265	NQF Project: Surgery Endorsement Maintenance 2010
MEASURE DESCRIPTIVE INFORMATION	
De.1 Measure Title: Hospital Transfer/Admission	
De.2 Brief description of measure: Rate of ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC	
1.1-2 Type of Measure: Outcome	
De.3 If included in a composite or paired with another measure, please identify composite or paired measure This measure is not included in a composite or paired with another measure	
De.4 National Priority Partners Priority Area: Safety	
De.5 IOM Quality Domain: Effectiveness	
De.6 Consumer Care Need: Staying healthy	

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	NQF Staff
<p>A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. <i>Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.</i></p> <p>A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes</p> <p>A.2 Indicate if Proprietary Measure (as defined in measure steward agreement): Proprietary measure</p> <p>A.3 Measure Steward Agreement: Agreement will be signed and submitted prior to or at the time of measure submission</p> <p>A.4 Measure Steward Agreement attached: NQF Measure Steward Agreement with ASC QC-634279428602873330.pdf</p>	<p>A</p> <p>Y <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

<p>B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section</p>	<p>B Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ► Purpose: Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations)</p>	<p>C Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1 Testing: Yes, fully developed and tested D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? Yes</p>	<p>D Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>(for NQF staff use) Have all conditions for consideration been met? Staff Notes to Steward (if submission returned):</p>	<p>Met Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>Staff Notes to Reviewers (issues or questions regarding any criteria):</p>	
<p>Staff Reviewer Name(s):</p>	

<p>TAP/Workgroup Reviewer Name:</p>	
<p>Steering Committee Reviewer Name:</p>	
<p>1. IMPORTANCE TO MEASURE AND REPORT</p>	
<p>Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria) 1a. High Impact</p>	<p>Eval Ratin g</p>
<p>(for NQF staff use) Specific NPP goal:</p>	
<p>1a.1 Demonstrated High Impact Aspect of Healthcare: Frequently performed procedure, High resource use, Patient/societal consequences of poor quality 1a.2 1a.3 Summary of Evidence of High Impact: 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 Patients selected for ambulatory surgery are not anticipated to require hospital care upon discharge. The need for a hospital transfer and/ or admission is an unanticipated outcome that can result in unplanned cost and other burdens. Mean charges for unanticipated admissions/readmissions due to pain have been estimated at \$1896 +/- \$4553 per visit; mean charges for unanticipated admissions/readmissions unrelated to pain have been estimated at \$12,000 +/- \$36,886 per visit. 2 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. Studies suggest providers can reduce rates of unplanned admissions through the use of strategies including: careful preoperative assessment and diligence in patient selection; screening for proper support at home; earlier operating time for certain surgical procedures; and the implementation of clinical pathways for early and</p>	<p>1a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

aggressive treatment of pain and postoperative nausea and vomiting. 3-10

1a.4 Citations for Evidence of High Impact: 1 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. <http://www.cms.gov/>.

2 Coley KC, Williams BA, DaPos SV, Chen C, Smith RB. Retrospective evaluation of unanticipated admissions and readmissions after same day surgery and associated costs. J Clin Anesth. 2002 Aug; 14(5):349-53.

3 Margovsky A. Unplanned admissions in day-case surgery as a clinical indicator for quality assurance. Aust N Z J Surg. 2000 Mar;70(3):216-20.

4 Tewfik MA, Frenkiel S, Gasparrini R, Zeitouni A, Daniel SJ, Dolev Y, Kost K, Samaha M, Sweet R, Tewfik TL. Factors affecting unanticipated hospital admission following otolaryngologic day surgery. J Otolaryngol. 2006 Aug;35(4):235-41.

5 Fortier J, Chung F, Su J. Unanticipated admission after ambulatory surgery--a prospective study. Can J Anaesth. 1998 Jul;45(7):612-9.

6. Lin D, Dalgorf D, Witterick IJ. Predictors of unexpected hospital admissions after outpatient endoscopic sinus surgery: retrospective review. J Otolaryngol Head Neck Surg. 2008 Jun;37(3):309-11.

7. Hofer RE, Kai T, Decker PA, Warner DO. Obesity as a risk factor for unanticipated admissions after ambulatory surgery. Mayo Clin Proc. 2008 Aug;83(8):908-16.

8. Lledó JB, Planells M, Espí A, Serralta A, García R, Sanahuja A. Predictive model of failure of outpatient laparoscopic cholecystectomy. Surg Laparosc Endosc Percutan Tech. 2008 Jun;18(3):248-53.

9. Lau H, Brooks DC. Predictive factors for unanticipated admissions after ambulatory laparoscopic cholecystectomy. Arch Surg. 2001 Oct;136(10):1150-3.

10. Junger A, Klasen J, Benson M, Sciuk G, Hartmann B, Sticher J, Hempelmann G. Factors determining length of stay of surgical day-case patients. Eur J Anaesthesiol. 2001 May;18(5):314-21.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: The measure can be used to benchmark rates of hospital transfer and admission upon discharge from ASCs. Benchmarking may prompt providers to take steps to reduce rates of unplanned transfers and admissions. Fewer hospital transfers and admissions result in more satisfactory and less costly care for ASC patients.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:

Although data for 1,185 ASCs are included in the ASC QC database for this measure, many report at the corporate level and do not report data for individual ASCs. The ASC QC database includes center-level rates for this measure for 526 ASCs throughout the US. The rates for this measure are based on the 526 individually-reporting ambulatory surgery centers throughout the US for services provided during April to June 2010. The rate for unscheduled transfer or admission to a hospital ranged from a minimum of 0.0% to a maximum of 2.3%. The mean rate was 0.1% (SD: 0.2%), while the median rate was 0.1%. The maximum transfer rate of 2.3% and a third quartile value of 0.2% demonstrate that there is an opportunity for improvement in this measure.

1b.3 Citations for data on performance gap:

Although data for 1,185 ASCs are included in the ASC QC database for this measure, many report at the corporate level and do not report data for individual ASCs. The ASC QC database includes center-level rates for this measure for 526 ASCs throughout the US. The 526 individually-reporting ambulatory surgery centers represent a convenience sample of the ASC population were used to assess the opportunity for improvement for this measure. The centers were located throughout the US. Services from the second calendar quarter of 2010 were included in this portion of the study.

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1b.4 Summary of Data on disparities by population group:
 This measure is not intended to measure disparities by population group.

1b.5 Citations for data on Disparities:
 No data available for disparities by population group. Please see 1b.4. above.

1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*): This measure describes hospital transfer and admission rates following admission to an ASC. The goal of measurement is to reduce preventable hospital transfers and admissions following care in an ASC.

The measure is currently used by ASCs to benchmark their performance. These comparisons may be helpful in performance improvement efforts seeking to minimize hospital transfers and admissions from the ASC setting.

1c.2-3. Type of Evidence: Expert opinion, Systematic synthesis of research

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*):

Prior research suggests there are many factors providers can use to both screen prospective patients to determine if they are appropriate candidates for ambulatory surgery, and to reduce the chances of an unanticipated hospital transfer or hospital admission. See citations provided in 1c.8. below as a sample of the available literature on this topic.

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom*):
 Not applicable

1c.6 Method for rating evidence: Not applicable

1c.7 Summary of Controversy/Contradictory Evidence: Measurement is limited to those patients directly transferred or admitted to the hospital upon discharge from the ASC. This measure does not seek to capture later admissions to the hospital because, at the present time, there is no reliable means of consistently detecting later admissions and attributing them to a given ASC.

1c.8 Citations for Evidence (*other than guidelines*): 1: Lin D, Dalgorf D, Witterick IJ. Predictors of unexpected hospital admissions after outpatient endoscopic sinus surgery: retrospective review. J Otolaryngol Head Neck Surg. 2008 Jun;37(3):309-11.

2: Hofer RE, Kai T, Decker PA, Warner DO. Obesity as a risk factor for unanticipated admissions after ambulatory surgery. Mayo Clin Proc. 2008 Aug;83(8):908-16.

3: Lledó JB, Planells M, Espí A, Serralta A, García R, Sanahuja A. Predictive model of failure of outpatient laparoscopic cholecystectomy. Surg Laparosc Endosc Percutan Tech. 2008 Jun;18(3):248-53.

4: Tewfik MA, Frenkiel S, Gasparrini R, Zeitouni A, Daniel SJ, Dolev Y, Kost K, Samaha M, Sweet R, Tewfik TL. Factors affecting unanticipated hospital admission following otolaryngologic day surgery. J Otolaryngol. 2006 Aug;35(4):235-41.

5: Shirakami G, Teratani Y, Namba T, Hirakata H, Tazuke-Nishimura M, Fukuda K. Delayed discharge and acceptability of ambulatory surgery in adult outpatients receiving general anesthesia. J Anesth. 2005;19(2):93-101.

6: Shaikh S, Chung F, Imarengiaye C, Yung D, Bernstein M. Pain, nausea, vomiting and ocular complications delay discharge following ambulatory microdissectomy. Can J Anaesth. 2003 May;50(5):514-8.

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<p>7: Coley KC, Williams BA, DaPos SV, Chen C, Smith RB. Retrospective evaluation of unanticipated admissions and readmissions after same day surgery and associated costs. J Clin Anesth. 2002 Aug;14(5):349-53.</p> <p>8: Lau H, Brooks DC. Predictive factors for unanticipated admissions after ambulatory laparoscopic cholecystectomy. Arch Surg. 2001 Oct;136(10):1150-3.</p> <p>9: Junger A, Klasen J, Benson M, Sciuk G, Hartmann B, Sticher J, Hempelmann G. Factors determining length of stay of surgical day-case patients. Eur J Anaesthesiol. 2001 May;18(5):314-21.</p> <p>10: Fortier J, Chung F, Su J. Unanticipated admission after ambulatory surgery--a prospective study. Can J Anaesth. 1998 Jul;45(7):612-9.</p> <p>11: Osborne GA, Rudkin GE. Outcome after day-care surgery in a major teaching hospital. Anaesth Intensive Care. 1993 Dec;21(6):822-7.</p> <p>12: Rudkin GE, Osborne GA, Doyle CE. Assessment and selection of patients for day surgery in a public hospital. Med J Aust. 1993 Mar 1;158(5):308-12.</p> <p>1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number): Not applicable</p> <p>1c.10 Clinical Practice Guideline Citation: Not applicable</p> <p>1c.11 National Guideline Clearinghouse or other URL: Not applicable</p> <p>1c.12 Rating of strength of recommendation (also provide narrative description of the rating and by whom): Not applicable</p> <p>1c.13 Method for rating strength of recommendation (If different from USPSTF system, also describe rating and how it relates to USPSTF): Not applicable</p> <p>1c.14 Rationale for using this guideline over others: Not applicable</p>	
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Importance to Measure and Report</i>?</p>	<p>1</p>
<p>Steering Committee: Was the threshold criterion, <i>Importance to Measure and Report</i>, met? Rationale:</p>	<p>1 Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES</p>	
<p>Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)</p>	<p>Eval Rating</p>
<p>2a. MEASURE SPECIFICATIONS</p>	
<p>S.1 Do you have a web page where current detailed measure specifications can be obtained? S.2 If yes, provide web page URL:</p> <p>2a. Precisely Specified</p>	<p>2a-spec s C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2a.1 Numerator Statement (Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome): Ambulatory surgical center (ASC) admissions requiring a hospital transfer or hospital admission upon</p>	

discharge from the ASC.

2a.2 Numerator Time Window (*The time period in which cases are eligible for inclusion in the numerator*):
In-facility, upon discharge from the ASC

2a.3 Numerator Details (*All information required to collect/calculate the numerator, including all codes, logic, and definitions*):
DEFINITIONS:

Admission: completion of registration upon entry into the facility

Hospital transfer or hospital admission: any transfer or admission from an ASC directly to an acute care hospital, including a hospital emergency room

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

2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured*):
All ASC admissions

2a.5 Target population gender: Female, Male

2a.6 Target population age range: All ages

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator*):
In-facility, upon discharge from the ASC

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions*):
DEFINITIONS:

Admission: completion of registration upon entry into the facility

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population*): None

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions*):
Not applicable

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions*):
Not stratified

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method*):
Not applicable

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Rate/proportion

2a.20 Interpretation of Score: Better quality = Lower score

2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps*):
The number of admissions experiencing a hospital transfer/admission upon discharge is divided by the number of ASC admissions during the reporting period, yielding the rate of hospital transfers/admissions upon discharge for the reporting period.

2a.22 Describe the method for discriminating performance (*e.g., significance testing*):
Facilities reporting data may compare their performance to the average performance. Alternatively, facilities may compare their performance to a percentile ranking (such as the 50th percentile (median)) to

<p>determine their relative performance.</p>	
<p>2a.23 Sampling (Survey) Methodology <i>If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):</i> The measure is not based on a sample</p>	
<p>2a.24 Data Source <i>(Check the source(s) for which the measure is specified and tested)</i> Paper Records</p>	
<p>2a.25 Data source/data collection instrument <i>(Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.):</i> 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 hospital transfers/admissions upon discharge.</p>	
<p>2a.26-28 Data source/data collection instrument reference web page URL or attachment: URL Not needed http://ascquality.org/documents/ASCQualityCollaborationImplementationGuide.pdf</p>	
<p>2a.29-31 Data dictionary/code table web page URL or attachment: URL Not needed http://ascquality.org/documents/ASCQualityCollaborationImplementationGuide.pdf</p>	
<p>2a.32-35 Level of Measurement/Analysis <i>(Check the level(s) for which the measure is specified and tested)</i> Facility</p>	
<p>2a.36-37 Care Settings <i>(Check the setting(s) for which the measure is specified and tested)</i> Ambulatory Care : Ambulatory Surgery Center (ASC)</p>	
<p>2a.38-41 Clinical Services <i>(Healthcare services being measured, check all that apply)</i> Other Ambulatory surgical center</p>	
TESTING/ANALYSIS	
<p>2b. Reliability testing</p>	
<p>2b.1 Data/sample <i>(description of data/sample and size):</i> A convenience sample of 16 ambulatory surgery centers was selected for a retrospective chart audit comparing the reported values for the measure versus the values identified from the medical record. The centers were located in eight different states throughout the US. Services from April 1, 2010 to June 30, 2010 were reviewed in the course of the reliability testing.</p>	
<p>2b.2 Analytic Method <i>(type of reliability & rationale, method for testing):</i> The numerator (number of Ambulatory Surgery Center (ASC) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC) and denominator (number of ASC admissions) values were compared for all 16 centers in the sample.</p>	
<p>2b.3 Testing Results <i>(reliability statistics, assessment of adequacy in the context of norms for the test conducted):</i> The error rates at all 16 of the ASCs (100%) were zero for both the numerator and denominator. The results show an excellent level of reliability with an overall 100% accuracy rate.</p>	<p>2b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2c. Validity testing</p>	
<p>2c.1 Data/sample <i>(description of data/sample and size):</i> Validity was measured via a formal consensus process. A questionnaire that included ratings of the various characteristics of the measure was distributed to 8 clinicians (RNs) who currently work in ambulatory surgery centers or have responsibility for multiple surgery centers. Two have credentials in quality and the others are involved in quality in their current positions. Responses were received from 7 of the panel members.</p>	
<p>2c.2 Analytic Method <i>(type of validity & rationale, method for testing):</i> Validity was measured via a formal consensus process. Six of the seven respondents responded with a 5/5</p>	<p>2c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

<p>rating for the question most related to content validity for this measure. Due to the high level of consensus on the primary validity question, multiple rounds of Delphi-type evaluations were not necessary. These results demonstrate a high level of agreement around the validity of the measure.</p> <p>2c.3 Testing Results (<i>statistical results, assessment of adequacy in the context of norms for the test conducted</i>): Each attribute was measured on a 5 point Likert Scale. The attributes related to validity and average scores are listed below: 1. The measure appears to measure what it is intended to. (Median: 5/5; Mean: 4.3/5.0) 2. The measure is defined in a way that will allow for consistent interpretation of the inclusion and exclusion criteria from center to center. (Median: 5/5; Mean 3.9/5.0) 3. The data required for the measure are likely to be obtained with reasonable effort. (Median: 5/5; Mean: 4.9/5.0) 4. The data required for the measure are likely to be obtained with reasonable cost. (Median: 5/5; Mean: 4.9/5.0) 5. The data required for the measure can be generated during care delivery. (Median: 5/5; Mean: 4.9/5.0)</p>	
<p>2d. Exclusions Justified</p> <p>2d.1 Summary of Evidence supporting exclusion(s): No exclusions</p> <p>2d.2 Citations for Evidence: Not applicable</p> <p>2d.3 Data/sample (<i>description of data/sample and size</i>): Not applicable</p> <p>2d.4 Analytic Method (<i>type analysis & rationale</i>): Not applicable</p> <p>2d.5 Testing Results (<i>e.g., frequency, variability, sensitivity analyses</i>): Not applicable</p>	<p>2d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>2e. Risk Adjustment for Outcomes/ Resource Use Measures</p> <p>2e.1 Data/sample (<i>description of data/sample and size</i>): This measure is not risk adjusted</p> <p>2e.2 Analytic Method (<i>type of risk adjustment, analysis, & rationale</i>): Not applicable</p> <p>2e.3 Testing Results (<i>risk model performance metrics</i>): Not applicable</p> <p>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale: Transfer or admission to a hospital should be a rare event if appropriate patient and procedure selection criteria are in place. Risk adjustment for patient characteristics would mask any measurement of performance difference. Thus we believe this measure should not be risk adjusted.</p>	<p>2e C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>2f. Identification of Meaningful Differences in Performance</p> <p>2f.1 Data/sample from Testing or Current Use (<i>description of data/sample and size</i>): Although data for 1,185 ASCs are included in the ASC QC database, many report at the corporate level and do not report data for individual ASCs. The ASC QC database includes center-level rates for this measure for 526 ASCs throughout the US. The rates for this measure were collected for the 526 individually-reporting ambulatory surgery centers throughout the US for services provided during April to June 2010.</p> <p>2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (<i>type of analysis & rationale</i>): An individual ASC's transfer rate may be compared to the standard rate from the ASC Quality website (http://www.ascquality.org/qualityreport.cfm#Transfer). A statistically significant difference in</p>	<p>2f C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

<p>performance may be detected by using a standard test of proportions as outlined in most standard statistical texts. Since each transfer may represent increased risk exposure for the patient, a rate higher than the standard of 1 per 1000 is also of practical significance. The null hypothesis for this test is that the sample proportion from the ASC is not different from the industry standard taken from the ASC Quality website. The alternative is that there is a statistically significant difference. We recommend that this test be performed in its two-sided form so that the ASC may determine if they are either statistically higher or lower than the standard. The recommended p-value for this test is the 0.05 level, but ASCs may have justification for different value. Using this statistical method for detecting significant variances from the industry standard will allow users to determine if differences may be due to sampling error or may indicate a true difference in performance.</p> <p>2f.3 Provide Measure Scores from Testing or Current Use (<i>description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance</i>): The rate for unscheduled transfer or admission to a hospital ranged from a minimum of 0.0% to a maximum of 2.3%. The mean rate was 0.1 (SD: 0.2%), while the median rate was 0.1%. The maximum transfer rate of 2.3% and a third quartile value of 0.2% demonstrate that there is an opportunity for improvement in this measure.</p>	
<p>2g. Comparability of Multiple Data Sources/Methods</p> <p>2g.1 Data/sample (<i>description of data/sample and size</i>): This measure is specified for a single data source (paper medical record/flow sheet) as noted in 2a.24 above</p> <p>2g.2 Analytic Method (<i>type of analysis & rationale</i>): Not applicable</p> <p>2g.3 Testing Results (<i>e.g., correlation statistics, comparison of rankings</i>): Not applicable</p>	<p>2g C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>2h. Disparities in Care</p> <p>2h.1 If measure is stratified, provide stratified results (<i>scores by stratified categories/cohorts</i>): This measure is not stratified</p> <p>2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans: At the present time, a federal quality reporting system has not yet been proposed or implemented for ambulatory surgical centers. We anticipate that CMS will issue its proposals for an ASC quality reporting system in the near future. 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 third quarter of 2011, initiate the development of the registry database immediately upon contract acceptance, and have a functioning registry three months thereafter.</p>	<p>2h C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Scientific Acceptability of Measure Properties</i>?</p>	<p>2</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Scientific Acceptability of Measure Properties</i>, met? Rationale:</p>	<p>2 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>3. USABILITY</p>	

<p>Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)</p>	<p>Eval Ratin g</p>
<p>3a. Meaningful, Understandable, and Useful Information</p> <p>3a.1 Current Use: In use</p> <p>3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) (If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years): The ASC Quality Collaboration posts a public report of quality data on six ASC quality measures endorsed by the NQF on a quarterly basis. This quarterly report includes aggregated performance data on the Hospital Transfer/Admission measure. The report for the second quarter of 2010 is available at: http://www.ascquality.org/qualityreport.cfm. One thousand one hundred eighty-five (1,185) ASCs submitted hospital transfer/admission date for the second quarter 2010 report.</p> <p>3a.3 If used in other programs/initiatives (If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years): This measure is in use in several other initiatives. For example, the ASC Association includes this metric in its Outcomes Monitoring Project, which is described at http://www.ascassociation.org/outcomes/.</p> <p>It is also in use in various state association quality data collection and reporting projects, including the Texas Ambulatory Surgery Center Association, located at http://tasc.org/.</p> <p>In addition, the measure has been adopted by the Minnesota Department of Health (MDH) for state reporting by ASCs beginning July 2011. This is described at the MDH website at: http://www.health.state.mn.us/healthreform/measurement/adoptedrule/QualityMeasurementAppendices_101129.pdf</p> <p>Testing of Interpretability (Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement)</p> <p>3a.4 Data/sample (description of data/sample and size): Interpretability was measured via a formal consensus process. A questionnaire that included ratings of the various characteristics of the measure was distributed to 8 clinicians (RNs) who currently work in ambulatory surgery centers or have responsibility for multiple surgery centers. Two have credentials in quality and the others are involved in quality in their current positions. Responses were received from 7 of the panel members.</p> <p>3a.5 Methods (e.g., focus group, survey, QI project): The survey was summarized to assess the panel's level of agreement with statements that measured the interpretability of the measure.</p> <p>3a.6 Results (qualitative and/or quantitative results and conclusions): Each attribute was measured on a 5 point Likert Scale. The attributes related to usability and average scores are listed below: 1. A provider can understand the results of the measure. (Median: 5/5; Mean: 4.3/5.0) 2. If necessary, a provider can use the results of the measure to take action. (Median: 5/5; Mean: 4.3/5.0) 3. This measure has a direct link to improving the outcome and/or process of care. (Median: 5/5; Mean: 4.0/5.0)</p>	<p>3a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>3b/3c. Relation to other NQF-endorsed measures</p> <p>3b.1 NQF # and Title of similar or related measures:</p>	
<p>(for NQF staff use) Notes on similar/related endorsed or submitted measures:</p>	
<p>3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source <u>or</u> different topic but same target population):</p>	<p>3b C <input type="checkbox"/> P <input type="checkbox"/></p>

<p>3b.2 Are the measure specifications harmonized? If not, why?</p>	<p>M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>3c. Distinctive or Additive Value 3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:</p> <p>5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality: Not similar to another measure endorsed by NQF</p>	<p>3c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Usability?</p>	<p>3</p>
<p>Steering Committee: Overall, to what extent was the criterion, Usability, met? Rationale:</p>	<p>3 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>4. FEASIBILITY</p>	
<p>Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)</p>	<p>Eval Rating</p>
<p>4a. Data Generated as a Byproduct of Care Processes</p> <p>4a.1-2 How are the data elements that are needed to compute measure scores generated? Data generated as byproduct of care processes during care delivery (Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition)</p>	<p>4a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>4b. Electronic Sources</p> <p>4b.1 Are all the data elements available electronically? (<i>elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims</i>) No</p> <p>4b.2 If not, specify the near-term path to achieve electronic capture by most providers. Widespread adoption of electronic health records in ambulatory surgical centers would be needed to achieve electronic capture of data elements.</p>	<p>4b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>4c. Exclusions</p> <p>4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? No</p> <p>4c.2 If yes, provide justification.</p>	<p>4c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences</p> <p>4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results. 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.</p>	<p>4d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>4e. Data Collection Strategy/Implementation</p>	<p>4e C <input type="checkbox"/></p>

<p>4e.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/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: 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.</p> <p>4e.2 Costs to implement the measure (<i>costs of data collection, fees associated with proprietary measures</i>): Because the information needed to determine the numerator and denominator(admission, patient disposition at discharge) are routinely collected as part of the patient care process, there are no additional costs for data element collection for this measure. There are no fees associated with the use of this measure and benchmarking data is publicly available on the ASC Quality Collaboration’s website.</p> <p>4e.3 Evidence for costs: The survey used for validity and interpretability also asked respondents about the feasibility and cost of collecting data. The following two questions support the premise that the cost to collect this information is reasonable for the ASC: The data required for the measure are likely to be obtained with reasonable effort. (Median: 5/5; Mean: 4.9/5.0) The data required for the measure are likely to be obtained with reasonable cost. (Median: 5/5; Mean: 4.9/5.0)</p> <p>4e.4 Business case documentation: Not applicable</p>	P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Feasibility</i>?</p>	4
<p>Steering Committee: Overall, to what extent was the criterion, <i>Feasibility</i>, met? Rationale:</p>	4 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
RECOMMENDATION	
<p>(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.</p>	Time-limited <input type="checkbox"/>
<p>Steering Committee: Do you recommend for endorsement? Comments:</p>	Y <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/>
CONTACT INFORMATION	
<p>Co.1 Measure Steward (Intellectual Property Owner) Co.1 Organization ASC Quality Collaboration, 5686 Escondida Blvd S, St. Petersburg, Florida, 33715</p> <p>Co.2 Point of Contact Donna, Slosburg, BSN, LHRM, CASC, donnaslosburg@ascquality.org, 727-867-0072-</p>	
<p>Measure Developer If different from Measure Steward Co.3 Organization ASC Quality Collaboration, 5686 Escondida Blvd S, St. Petersburg, Florida, 33715</p> <p>Co.4 Point of Contact Donna, Slosburg, BSN, LHRM, CASC, donnaslosburg@ascquality.org, 727-867-0072-</p>	
<p>Co.5 Submitter If different from Measure Steward POC Donna, Slosburg, BSN, LHRM, CASC, donnaslosburg@ascquality.org, 727-867-0072-, ASC Quality Collaboration</p>	
<p>Co.6 Additional organizations that sponsored/participated in measure development</p>	

ADDITIONAL INFORMATION
<p>Workgroup/Expert Panel involved in measure development Ad.1 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.</p> <p>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:</p> <p>AAAHC: 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</p>
<p>Ad.2 If adapted, provide name of original measure: Not adapted Ad.3-5 If adapted, provide original specifications URL or attachment</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.6 Year the measure was first released: 2007 Ad.7 Month and Year of most recent revision: 12, 2010 Ad.8 What is your frequency for review/update of this measure? Annually or more frequently if indicated Ad.9 When is the next scheduled review/update for this measure? 12, 2011</p>
<p>Ad.10 Copyright statement/disclaimers: None</p>
<p>Ad.11 -13 Additional Information web page URL or attachment:</p>
<p>Date of Submission (MM/DD/YY): 06/13/2011</p>