



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 #: 0265

Corresponding Measures:

De.2. Measure Title: All-Cause Hospital Transfer/Admission

Co.1.1. Measure Steward: ASC Quality Collaboration

De.3. Brief Description of Measure: Rate of ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC

1b.1. Developer Rationale: 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.

S.4. Numerator Statement: Ambulatory surgical center (ASC) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC.

S.7. Denominator Statement: All ASC admissions

S.10. Denominator Exclusions: None

De.1. Measure Type: Outcome

S.23. Data Source: Other, Paper Medical Records

S.26. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Nov 15, 2007 **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? This measure is 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
0265_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)

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. 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 1,185 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. 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.

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.

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 measure 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.

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, High resource use, 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

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

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 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.

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):

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_ImplementationGuide_3.0_January_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)

[This is not an eMeasure](#) 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.

[Ambulatory surgical center \(ASC\) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC.](#)

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, upon discharge from the ASC](#)

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](#)

[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](#)

[The observed outcome is identified by determining whether the patient was discharged from the ASC directly to an acute care hospital \(including a hospital emergency room\) as a transfer or admission.](#)

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)

DEFINITIONS:

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)

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 = 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 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.

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.

Other, 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 hospital transfers/admissions upon discharge.

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

0265_MeasureTesting_MSF5.0_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

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)	
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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.)

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, 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, 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 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: