NATIONAL QUALITY FORUM

Measure Evaluation 4.1
January 2010

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 sub-criteria and most of the footnotes from the evaluation criteria are provided in Word comments and will appear if your cursor is over the highlighted area (or in the margin if your Word program is set to show revisions in balloons). 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 sub-criterion 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* sub-criteria *(yellow highlighted areas)*.

Steering Committee: Complete all pink highlighted areas of the form. Review the workgroup/TAP assessment of the sub-criterion, 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 sub-criteria as indicated)

(for NQF staff use) **NQF Review** #: PSM-009-10 **NQF Project:** Ambulatory Care - Additional Outpatient Measures 2010

MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Medication Administration Variance
De.2 **Brief description of measure***:* This measure identifies the percentage of ambulatory surgery admissions experiencing a medication administration variance prior to discharge.
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** Not Applicable
De.4 **National Priority Partners Priority Area:** safety De.5 **IOM Quality Domain**: safety 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**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *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.* 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 A.2 **Indicate if Proprietary Measure** (*as defined in measure steward agreement*)**:**	**A** **Y**☐ **N**☐

A.3 Measure Steward Agreement: agreement signed and submitted **A.4 Measure Steward Agreement attached:** NQF Steward Agreement Addendum ASC QC 2010.doc	
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	**B** **Y**☐ **N**☐
C. The intended use of the measure includes both public reporting and quality improvement. ►**Purpose:** public reporting, quality improvement 0,0,0,	**C** **Y**☐ **N**☐
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.1Testing:** Yes, fully developed and tested **D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	**D** **Y**☐ **N**☐
(for NQF staff use) **Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	**Met** **Y**☐ **N**☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
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**	Eval Rating
(for NQF staff use) **Specific NPP goal**:	
1a.1 Demonstrated High Impact Aspect of Healthcare: frequently performed procedure, patient/societal consequences of poor quality, affects large numbers, high resource use **1a.2** **1a.3 Summary of Evidence of High Impact:** Numerous studies indicate medication administration errors (excluding wrong-time errors) are frequent, with error rates per dose ranging from 2.4 to 11.1 percent (1-5). One U.S. study found an administration error rate of 11 percent, excluding wrong-time errors (3). For the 36 facilities studied, the administration error rate (excluding wrong-time errors) ranged from 0 to 26 percent, with 8.3 percent as the median value. The morbidity and costs associated with medication administration errors are not well understood. Experts have conservatively estimated the annual cost of preventable adverse drug events (ADEs) in hospitals at $3.5 billion (6). While most studies that evaluate the impact of medication errors focus on ADEs, one study estimated that a 700-bed hospital has 300,000 medication errors per year, each resulting in approximately 20 extra minutes of work for providers (7). We were not able to locate any studies regarding medication errors in ambulatory surgical facilities. **1a.4 Citations for Evidence of High Impact:** 1 Dean BS, Allan EL, Barber ND, Barker KN. 1995. Comparison of medication errors in an American and a British hospital. American Journal of Health-System Pharmacy 52(22): 2543–2549. 2 Taxis K, Dean B, Barber N. 1999. Hospital drug distribution systems in the UK and Germany—a study of	**1a** **C**☐ **P**☐ **M**☐ **N**☐

medication errors. Pharmacy World & Science 21(1):25–31.
3 Barker KN, Flynn EA, Pepper GA, Bates DW, Mikeal RL. 2002. Medication errors observed in 36 health care facilities. Archives of Internal Medicine 162(16):1897–1903.
4 Tissot E, Cornette C, Limat S, Mourand JL, Becker M, Etievent JP, Dupond JL, Jacquet M, Woronoff-Lemsi MC. 2003. Observational study of potential risk factors of medication administration errors. Pharmacy World & Science 25(6):264–268.
5 Lisby M, Nielsen LP, Mainz J. 2005. Errors in the medication process: Frequency, type, and potential clinical consequences. International Journal for Quality in Health Care 17(1): 15–22.
6 Preventing Medication Errors (Quality Chasm Series.) By the Committee on Identifying and Preventing Medication Errors and the Board on Health Care Services. Edited by Philip Aspden, Julie A. Wolcott, J. Lyle Bootman, and Linda R. Cronenwett. 463 pp. Washington, DC, National Academies Press, 2007.
7 Bates DW, Boyle DL, Vander Vliet MB, Schneider J, Leape L. 1995. Relationship between medication errors and adverse drug events. Journal of General Internal Medicine 10(4): 100–205.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: At the present time, the ambulatory surgical center industry does not have a universally accepted method of defining and tracking medication administration variances. By adopting a standard approach, facilities will be able to more accurately benchmark their outcomes and performance, and implement improvement strategies when needed.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
No published data comparing the rate of medication administration variances among ambulatory surgical centers could be located. The lack of baseline comparative data pre-empts an assessment for variation in performance among providers in the ASC industry.

1b.3 Citations for data on performance gap:
Not applicable.

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

1b.5 Citations for data on Disparities:
Not applicable.

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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*)**:** Medication administration impacts the entire ambulatory surgical patient population.

1c.2-3. Type of Evidence: observational study, randomized controlled trial, other (specify), expert opinion
Multiple, including cross-sectional studies, performance improvement studies, safe practice recommendations

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*)**:**
There is a substantial body of evidence showing that providers can influence the rate of medication administration errors through processes including, but not limited to, staffing practices, limitation of distractions and interruptions, and improved documentation of patient allergies. This body of evidence is the foundation for selected NQF endorsed Safe Practices (see Safe Practices 13 and 18), intended to reduce the rate of medication errors.

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom***):**
Evidence not formally rated

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N☐

1c.6 Method for rating evidence: Evidence not formally rated

1c.7 Summary of Controversy/Contradictory Evidence: The National Coordinating Council for Medication Error Reporting and Prevention
does not recommend the use of medication error rates to compare health care organizations due to four issues: differences in organizational culture; differences in the definition of a medication error; differences in patient population served; and differences in the type(s) of reporting and detection systems.

1c.8 Citations for Evidence (*other than guidelines***):** Force MV, Deering L, Hubbe J, et al. Effective strategies to increase reporting of medication errors in hospitals. J Nurs Admin 2006;36:34-41.

Leape LL, Kabsenell AI, Gandhi TK, et al. Reducing adverse drug events: lessons from a breakthrough series collaborative. J Qual Improv 2000;26:321-31.

Nelson NC, Evans RS, Samore MH, et al. Detection and prevention of medication errors using real-time bedside nurse charting. J Am Med Inform Assoc. 2005 Jul-Aug;12(4):390-7

Pape TM. Applying airline safety practices to medication administration. MEDSURG Nurs 2003;12(2):77-94. 127.

Pape, TM, Guerra DM, Muzquiz M, et al. Innovative approaches to reducing nurses' distractions during medication administration. J Contin Educ Nurs 2005;36(3):108-16.

Rask K, Culler S, Scott T, et al. Adopting National Quality Forum medication safe practices: progress and barriers to hospital implementation. J Hosp Med 2007 July/Aug;2(4):212-8.

Schaubhut R, Jones C. A systems approach to medication error reduction. J Nurs Care Qual 2000;14(3):13-27.

Schneider PJ, Pedersen CA, Montanya KR, et al. Improving the safety of medication administration using an interactive CD-ROM program. Am J Health-Syst Pharm 2006;63:59-64.

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number***):**
No pertinent clinical practice guideline found.

1c.10 Clinical Practice Guideline Citation: No pertinent clinical practice guideline found. However, the AHRQ's Patient Safety Event Reporting System has established Common Formats for event reporting. Version 1.0 of AHRQ's Patient Safety Event Report for Medication or Other Substance was used as the basis for measure development.
1c.11 National Guideline Clearinghouse or other URL:
https://www.psoppc.org/c/document_library/get_file?p_l_id=34330&folderId=35934&name=DLFE-2405.pdf

1c.12 Rating of strength of recommendation (*also provide narrative description of the rating and by whom***):**
Not rated

1c.13 Method for rating strength of recommendation (*If different from* USPSTF system*, also describe rating and how it relates to USPSTF)***:**
Not rated

1c.14 Rationale for using this guideline over others:
No pertinent clinical practice guideline found.

TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria **for** *Importance to Measure and Report?*	**1**
Steering Committee: Was the threshold criterion, *Importance to Measure and Report***, met?**	**1**

Rationale:	**Y☐ N☐**
2. 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. (evaluation criteria)	Eval Rating
2a. MEASURE SPECIFICATIONS	
S.1 Do you have a web page where current detailed measure specifications can be obtained? **S.2 If yes, provide web page URL:** **2a. Precisely Specified**	
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 Surgery Center (ASC) admissions experiencing a medication administration variance(s) prior to discharge. **2a.2 Numerator Time Window (***The time period in which cases are eligible for inclusion in the numerator***):** In-facility, prior to discharge **2a.3 Numerator Details (***All information required to collect/calculate the numerator, including all codes, logic, and definitions***):** Numerator Exclusions: Any timing variance for the administration of IV antibiotics for the prophylaxis of surgical site infection; any adverse drug reactions with no apparent incorrect action. DEFINITIONS: Admission: completion of registration upon entry into the facility Discharge: occurs when the patient leaves the confines of the ASC Medication: a substance used in the diagnosis, cure, mitigation, treatment, or prevention of disease. For purposes of this measure, medications include prescription and over-the-counter drugs, medical gases, and contrast media. For purposes of this measure, blood or blood products, nutritional products, radiopharmaceuticals and vaccines are excluded from the definition of medication. Medication administration variance: For the purposes of this measure, medication administration variance(s) includes the following variances from a physician and/or Licensed Independent Practitioner (LIP) order when the medication is administered by a physician or facility staff: -Incorrect patient -Incorrect medication/substance -Incorrect dose (overdose, underdose, missed or omitted dose, extra dose) -Incorrect route of administration -Incorrect timing (too early, too late). Incorrect timing of intravenous antibiotics ordered preoperatively for the prophylaxis of surgical site infection should be reported using the Prophylactic IV Antibiotic Timing measure. -Incorrect rate (too quickly, too slowly) -Incorrect duration -Incorrect dosage form -Incorrect strength or concentration (too high, too low) -Incorrect preparation (such as inappropriate cutting of tablets, error in mixing) -Expired medication/substance -Medication/substance known to be contraindicated for the patient	**2a-specs C☐ P☐ M☐ N☐**

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

2a.5 Target population gender: Male, Female
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, prior to discharge

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***):**
This measure is not stratified.

2a.12-13 Risk Adjustment Type: Other (specify) No risk adjustment applied.

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 medication administration variance(s) is divided by the number of ASC admissions during the reporting period, yielding the rate of medication administration variances 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 determine their relative performance.

2a.23 Sampling (Survey) Methodology *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)*:
The measure is not based on a sample.

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested)*
paper medical record/flowsheet, Management data, organizational policies and procedures

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.***):**
ASC medication administration records, anesthesia records and other medical records, as well as incident/occurrence reports, variance reports, dashboards and quality improvement reports can serve as data sources. No specific collection instrument is required. Facilities may use any collection instrument that allows tracking of medication administration variances for all admissions.

2a.26-28 Data source/data collection instrument reference web page URL or attachment:

2a.29-31 Data dictionary/code table web page URL or attachment:

2a.32-35 Level of Measurement/Analysis (*Check the level(s) for which the measure is specified and tested)*
Facility/Agency

2a.36-37 Care Settings (*Check the setting(s) for which the measure is specified and tested)*
Ambulatory Care: Ambulatory Surgery Center

2a.38-41 Clinical Services (*Healthcare services being measured, check all that apply*)
Other Ambulatory surgical facility services

TESTING/ANALYSIS

2b. Reliability testing

2b.1 Data/sample *(description of data/sample and size)***:** Our due diligence established that the data collection for this measure is in keeping with the definitions established by the Agency for Healthcare Research and Quality (AHRQ), currently used to collect data regarding medication errors by Patient Safety Organizations using the Common Formats Version 1.0.

2b.2 Analytic Method *(type of reliability & rationale, method for testing)***:**
In 2005, AHRQ created an inventory of patient safety reporting systems, now numbering 66 systems, which encompasses private systems, including prominent academic settings, hospital systems, and international reporting systems as well as virtually all major governmental systems. This inventory provides an evidence base to inform the construction of the Common Formats. AHRQ also convened an interagency Patient Safety Work Group (PSWG) to develop draft Common Formats. AHRQ, in conjunction with the PSWG, developed, piloted, and released Version 0.1 Beta of the Common Formats in 2008. Through a contract with AHRQ, the National Quality Forum (NQF) solicited feedback on the formats from private sector organizations and individuals. The NQF, then convened an expert panel to review the comments received and provide feedback to AHRQ. Based upon the expert panel's feedback, AHRQ, working with the PSWG, further revised and refined the Common Formats, now available as Version 1.0.

2b.3 Testing Results *(reliability statistics, assessment of adequacy in the context of norms for the test conducted)***:**
See 2b.1. and 2b.2. above

2b
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N☐

2c. Validity testing

2c.1 Data/sample *(description of data/sample and size)***:** Our due diligence established that the data collection for this measure is in keeping with the definitions established by the Agency for Healthcare Research and Quality (AHRQ), currently used to collect data regarding medication errors by Patient Safety Organizations using the Common Formats Version 1.0.

2c.2 Analytic Method *(type of validity & rationale, method for testing)***:**
In 2005, AHRQ created an inventory of patient safety reporting systems, now numbering 66 systems, which encompasses private systems, including prominent academic settings, hospital systems, and international reporting systems as well as virtually all major governmental systems. This inventory provides an evidence base to inform the construction of the Common Formats. AHRQ also convened an interagency Patient Safety Work Group (PSWG) to develop draft Common Formats. AHRQ, in conjunction with the PSWG, developed, piloted, and released Version 0.1 Beta of the Common Formats in 2008. Through a contract with AHRQ, the National Quality Forum (NQF) solicited feedback on the formats from private sector organizations and individuals. The NQF, then convened an expert panel to review the comments received and provide feedback to AHRQ. Based upon the expert panel's feedback, AHRQ, working with the PSWG, further revised and refined the Common Formats, now available as Version 1.0.

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2c.3 Testing Results *(statistical results, assessment of adequacy in the context of norms for the test conducted)*:
Our due diligence established that the data collection for this measure is in keeping with the definitions vetted by AHRQ for the PSO Common Formats. We do not have access to AHRQ's testing results. However, we believe the PSO Common Formats represents the current de facto national standard for reporting medication administration variance events.

2d. Exclusions Justified

2d.1 Summary of Evidence supporting exclusion(s):
Timing variances for the administration of intravenous prophylactic antibiotics for surgical site infection are reported using a separate NQF-endorsed measure. (See NQF # 0264)

2d.2 Citations for Evidence:
Expert consensus

2d.3 Data/sample *(description of data/sample and size)*: Not applicable.

2d.4 Analytic Method *(type analysis & rationale)*:
Expert consensus

2d.5 Testing Results *(e.g., frequency, variability, sensitivity analyses)*:
Not applicable.

2d
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N☐
NA☐

2e. Risk Adjustment for Outcomes/ Resource Use Measures

2e.1 Data/sample *(description of data/sample and size)*: This measure is not risk adjusted.

2e.2 Analytic Method *(type of risk adjustment, analysis, & rationale)*:
This measure is not risk adjusted.

2e.3 Testing Results *(risk model performance metrics)*:
This measure is not risk adjusted.

2e.4 If outcome or resource use measure is not risk adjusted, provide rationale: An evidence-based risk adjustment methodology for medication administration variances in the ambulatory surgical facility setting has not been developed or validated.

2e
C☐
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M☐
N☐
NA☐

2f. Identification of Meaningful Differences in Performance

2f.1 Data/sample from Testing or Current Use *(description of data/sample and size)*: This measure was pilot tested in 148 ambulatory surgery centers for 3 consecutive months. Pilot sites included 14 ambulatory surgical centers from 10 states and 134 ambulatory surgery centers from one management organization with ASCs in multiple states. The pilot sites included both multi-specialty and single-specialty centers.

Data was collected for 3 consecutive months from 14 ASCs with a total of 18,044 admissions. In addition, data was collected for 3 consecutive months from one organization with a total of 291,290 admissions. Total sample was 309,334 admissions.

2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance *(type of analysis & rationale)*:
When data for a sufficiently large sample of providers is available, percentiles may be established and used for discriminating performance.

2f.3 Provide Measure Scores from Testing or Current Use *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:

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The average medication administration variance rate per month ranged from 0.00% to 8.12%.	
2g. Comparability of Multiple Data Sources/Methods 2g.1 **Data/sample** *(description of data/sample and size)*: Not applicable. 2g.2 **Analytic Method** *(type of analysis & rationale)*: Not applicable. 2g.3 **Testing Results** *(e.g., correlation statistics, comparison of rankings)*: Not applicable.	**2g** C☐ P☐ M☐ N☐ NA☐
2h. Disparities in Care 2h.**1 If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)*: Not applicable. 2h.2 **If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:** Not applicable.	**2h** C☐ P☐ M☐ N☐ NA☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria **for** *Scientific Acceptability of Measure Properties*?	**2**
Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, **met?** **Rationale:**	*2* C☐ P☐ M☐ N☐
3. USABILITY	
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)	Eval Rating
3a. Meaningful, Understandable, and Useful Information 3a.1 **Current Use:** in use 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*): Our organization publishes a public quality report on our website at www.ascquality.org. At this time, the quality report presents aggregated results for the six ASC facility-level measures developed by the ASC QC and endorsed by the NQF. It is our hope that the Medication Administration Variance measure would ultimately be endorsed and subsequently incorporated in this public reporting project. In the interim, selected organizations among our participants collect the data for this measure on a voluntary basis, submit it to the ASC QC for aggregation and subsequent internal reporting. If the measure is not endorsed, our leadership will need to determine whether the value of publicly reporting measure results overrides the lack of NQF endorsement for the measure itself. 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***):** Medication administration variances are commonly tracked in most ASCs as part of QI and risk management programs. At this time, no uniform specifications are used. The ASC Association's Outcomes Monitoring Project (http://www.ascassociation.org/omp/index.asp) allows ASCs to report medications errors, and the results of the survey are shared with participants to allow for external benchmarking and QI. Over 500 ASCs participate in the Outcomes Monitoring Project. **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*)	**3a** C☐ P☐ M☐ N☐

3a.4 **Data/sample** *(description of data/sample and size)*: Our environmental scan and due diligence indicate that ambulatory surgical facilities are familiar with benchmarking their performance for a variety of outcomes (not limited to medication administration variances)using a number of standard methods, including mean performance and percentile rankings. 3a.5 **Methods** *(e.g., focus group, survey, QI project)*: Environmental scan of our participants during the measure development process. 3a.6 **Results** *(qualitative and/or quantitative results and conclusions)*: Ambulatory surgical facilities are familiar with benchmarking their performance for a variety of outcomes (not limited to medication administration variance) using a number of standard methods, including mean performance and percentile rankings.	
3b/3c. Relation to other NQF-endorsed measures 3b.1 **NQF # and Title of similar or related measures:**	
(for NQF staff use) **Notes on similar/related endorsed or submitted measures:**	
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 or different topic but same target population): 3b.2 **Are the measure specifications harmonized? If not, why?**	**3b** C☐ P☐ M☐ N☐ NA☐
3c. Distinctive or Additive Value 3c.1 **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** 5.1 **Competing Measures 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:** This measure is not similar to measures already endorsed by NQF.	**3c** C☐ P☐ M☐ N☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria **for** *Usability*?	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability*, **met?** **Rationale:**	**3** C☐ P☐ M☐ N☐
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	Eval Rating
4a. Data Generated as a Byproduct of Care Processes 4a.1-2 **How are the data elements that are needed to compute measure scores generated?** data generated as byproduct of care processes during delivery,	**4a** C☐ P☐ M☐ N☐
4b. Electronic Sources 4b.1 **Are all the data elements available electronically?** (*elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims*) No	**4b** C☐ P☐ M☐ N☐

4b.2 **If not, specify the near-term path to achieve electronic capture by most providers.** Implementation of an electronic health record in ambulatory surgical settings.	
4c. Exclusions 4c.1 **Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?** No 4c.2 **If yes, provide justification.**	**4c** C☐ P☐ M☐ N☐ NA☐
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences 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.** The measure relies partially on self-reporting by the clinical staff administering medications in the facility. Potential errors of omission could be detected through audit of elements of the medical record (such as orders and medication administration records) or pharmacy services audit.	**4d** C☐ P☐ M☐ N☐
4e. Data Collection Strategy/Implementation 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:** For accurate data collection, emphasis needs to be placed on the separate reporting of incorrect timing variances for intravenous antibiotics ordered preoperatively for the prophylaxis of surgical site infection. 4e.2 **Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:** The time and cost of data collection will vary with the data source. Incident reports are the primary data source and chart review is typically not required. This measure should pose no additional burden to ASCs as most centers already informally collect the necessary data, though the specifications are not standardized within the industry. 4e.3 **Evidence for costs:** Not applicable. 4e.4 **Business case documentation:** Not applicable.	**4e** C☐ P☐ M☐ N☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria **for** *Feasibility*?	**4**
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, **met?** **Rationale:**	**4** C☐ P☐ M☐ N☐
RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	**Time-limited** ☐
Steering Committee: Do you recommend for endorsement? **Comments:**	Y☐ N☐ A☐
CONTACT INFORMATION	
Co.1 **Measure Steward (Intellectual Property Owner)**	

Co.1 Organization
ASC Quality Collaboration | 5686 Escondida Blvd S | St. Petersburg | Florida | 33715

Co.2 Point of Contact
Donna | Slosburg, BSN, LHRM, CASC | donnaslosburg@ascquality.org | 727-867-0072

Measure Developer If different from Measure Steward
Co.3 Organization
ASC Quality Collaboration | 5686 Escondida Blvd S | St. Petersburg | Florida | 33715

Co.4 Point of Contact
Donna | Slosburg, BSN, LHRM, CASC | donnaslosburg@ascquality.org | 727-867-0072

Co.5 Submitter If different from Measure Steward POC
Donna | Slosburg, BSN, LHRM, CASC | donnaslosburg@ascquality.org | 727-867-0072- |ASC Quality Collaboration

Co.6 Additional organizations that sponsored/participated in measure development

ADDITIONAL INFORMATION

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, and to offer sites willing to participate in testing. No contractors are used.

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

Ad.2 If adapted, provide name of original measure: Not applicable
Ad.3-5 If adapted, provide original specifications URL or attachment

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.6 Year the measure was first released: 2010
Ad.7 Month and Year of most recent revision: 2009-11
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? 2010-11

Ad.10 Copyright statement/disclaimers: Not applicable.

Ad.11 -13 Additional Information web page URL or attachment:

Date of Submission (*MM/DD/YY*)**:** 04/07/2010