NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

NQF #: 0266 NQF Project: Patient Safety Measures-Complications Project
(for Endorsement Maintenance Review) Original Endorsement Date: Nov 15, 2007 Most Recent Endorsement Date: Nov 15, 2007 Last Updated Date: Sep 13, 2011
BRIEF MEASURE INFORMATION
De.1 Measure Title: Patient Fall
Co.1.1 Measure Steward: Ambulatory Surgical Centers Quality Collaborative
De.2 Brief Description of Measure: Percentage of ASC admissions experiencing a fall in the ASC.
2a1.1 Numerator Statement: ASC admissions experiencing a fall in the ASC.
2a1.4 Denominator Statement: All ASC admissions.
2a1.8 Denominator Exclusions: ASC admissions experiencing a fall outside the ASC.
1.1 Measure Type: Outcome 2a1. 25-26 Data Source: Paper Records 2a1.33 Level of Analysis: Facility 1.2-1.4 Is this measure paired with another measure? No De.3 If included in a composite, please identify the composite measure (*title and NQF number if endorsed*): Not included in a composite

STAFF NOTES (*issues or questions regarding any criteria*)
Comments on Conditions for Consideration:
Is the measure untested? Yes☐ No☐ If untested, explain how it meets criteria for consideration for time-limited endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (*check De.5*): 5. Similar/related endorsed or submitted measures (*check 5.1*): Other Criteria:
Staff Reviewer Name(s):

1. IMPACT, OPPORTUITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT
Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence. *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: H☐ M☐ L☐ I ☐ (*The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.*)

De.4 Subject/Topic Areas *(Check all the areas that apply)*: Surgery
De.5 Cross Cutting Areas (*Check all the areas that apply)*: Safety, Safety : Complications

1a.1 Demonstrated High Impact Aspect of Healthcare: Frequently performed procedure, Patient/societal consequences of poor quality

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact *(Provide epidemiologic or resource use data)*:
As a result of advances in surgery and anesthesia, approximately 80 percent of surgeries in the United States are now performed on an outpatient basis. Ambulatory surgical centers perform approximately 40%, or more than 22 million, of those outpatient surgeries. 1 The patients served in the ASC setting are generally healthy, with few risk factors for falls. However, the nature of the procedures themselves and the medications that are used to conduct the procedures place these patients at high risk.

There is strong consensus that falls can and must be prevented. The importance of taking steps designed to eliminate these events is consistently highlighted in efforts to ensure surgical patient safety. 2-6

1a.4 Citations for Evidence of High Impact cited in 1a.3: 1 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. http://www.cms.gov/.

2 Boushon B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D. Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2008.

3 ECRI Institute. Falls Prevention Resources. https://www.ecri.org/Products/Pages/Fall_Prevention_Resources.aspx. Accessed August 9, 2011.

4 Joint Commission. 2011-2012 National Patient Safety Goals. http://www.jointcommission.org/standards_information/npsgs.aspx. Accessed August 9, 2011.

5 National Center for Patient Safety: United States Department of Veterans Affairs.
http://www.patientsafety.gov/CogAids/FallPrevention/index.html#page=page-1.
Accessed August 9, 2011.

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

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

1b. Opportunity for Improvement: H☐ M☐ L☐ I ☐
(*There is a demonstrated performance gap - variability or overall less than optimal performance*)

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

While the NQF limits patient falls to those that result in patient death or serious disability, we believe there is value in reporting all falls, as any fall may serve as an indication that facility safeguards require review and possible revision.

1b.2 Summary of Data Demonstrating Performance Gap *(Variation or overall less than optimal performance across providers)*:

[*For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]
Although data for 1,146 ASCs are included in our public reporting of this indicator, many ASCs report their data to their corporate managing partner. This data is aggregated and reported in total rather than being reported individually by an ASC.. As a result, although the ASC QC database includes data for 1,149 facilities for this measure, center-level rates are only available for 501 ASCs . The statistics reported below are based on the 501 individually-reporting ambulatory surgery centers, which are located throughout the US.

The rates for this measure were collected for 501 ambulatory surgery centers throughout the US for services provided during January to March 2011. The rate for patient falls ranged from a minimum of 0.00% to a maximum of 0.93%. The mean rate was 0.02% (SD: 0.07%), while the median rate was 0.00%. The maximum patient fall rate of 0.93% demonstrates that there is an opportunity for improvement in this measure.
This study sample was a convenience sample, which is drawn from ASCs that actively participate in the public quality reporting project sponsored by the ASC Quality Collaboration. Participation in the ASC QC´s reporting project is voluntary. Given this, the sample is likely biased toward those ASCs that have taken an interest in the quality measurement and reporting activities of the ASC QC. In addition, those ASCs that volunteer may choose to collect and submit data on a measure-by-measure basis. For this reason, it is possible that the sample may also be biased towards those with higher levels of performance for this measure.

1b.3 Citations for Data on Performance Gap: [*For Maintenance – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
A convenience sample of 501 ambulatory surgery centers reporting individual data was selected to assess the opportunity for improvement for this measure. The centers were located throughout the US. Services from the first calendar quarter of 2011 were included in this portion of the study.

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

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
Data not available. Please see 1b.4. above and recopied here:The data the ASC Quality Collaboration currently receives for this measure is collected at the ASC-level or at the level of the corporate parent of the ASC. Corporate parent data submissions combine data from multiple ASCs. Disparity measures by population group require the collection of patient-level data or collection of the data for individual populations of patients. At this time, the ASC Quality Collaboration does not have access to any patient-level or individual population level data that would allow for analysis of subpopulation disparities based on race, sex and age. However, we understand the importance of subpopulation data and are taking steps that would allow us to collect the necessary data. We are actively pursuing the development of a registry that would allow us to develop subpopulation performance data for this measure and others. Potential registry development vendors have been identified and initial communications regarding the project have already taken place. We plan to select a vendor by fourth quarter of 2011, initiate the development of the registry database immediately upon contract acceptance, and have a functioning registry three months thereafter.

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes☐ No☐ If not a health outcome, rate the body of evidence.

Quantity: H☐ M☐ L☐ I☐	Quality: H☐ M☐ L☐ I☐	Consistency: H☐ M☐ L☐ I☐	
Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes☐
L	M-H	M	Yes☐ IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No☐
M-H	L	M-H	Yes☐ IF potential benefits to patients clearly outweigh potential harms: otherwise No☐
L-M-H	L-M-H	L	No ☐

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	Does the measure pass subcriterion1c? Yes☐ IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship *(Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome)*:
This measure focuses on an intermediate clinical outcome. Managing the patient fall risk associated with procedural and surgical services helps ensure the safety (health outcome) of each patient while being cared for in the ASC.

1c.2-3 Type of Evidence *(Check all that apply)*:
Clinical Practice Guideline, Other, Selected individual studies (rather than entire body of evidence), Systematic review of body of evidence (other than within guideline development)
Expert opinion as reflected in publications such as position statements and consensus reports; State adverse event database reports

1c.4 Directness of Evidence to the Specified Measure *(State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population)*:
The majority of the evidence pertaining to the incidence of falls, fall risk assessment and fall prevention strategies addresses the needs of the elderly patient population, and is predominantly focused on the nursing home, hospital and community settings.

This measure focuses on patients of all ages receiving care in the ASC setting.

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)*: There are over 100 studies that address the related patient safety topics of falls incidence, falls risk assessment and falls prevention. The Cochrane Collaboration review entitled "Interventions for preventing falls in older people in nursing care facilities and hospitals" (2010) identified 41 randomized controlled trials of interventions to reduce falls in these populations.

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*): The quality of studies varies widely. There is good confidence in the importance of measuring the incidence of events as a precursor to quality improvement efforts. However, the definition of fall and the types of falls included for evaluation (e.g. with or without injury) varies. The patient setting studied varies, and the setting appears to be correlated with the types of assessments and interventions that are effective. Virtually all studies focus on the elderly and do not evaluate the more general surgical patient population.

Very few studies address the ambulatory surgical patient and environment.

The estimated incidence of falls in acute care settings varies widely and may be influenced by different definitions, different fall prevention processes, and incomplete reporting.

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):* The estimated incidence of falls in acute care settings varies widely. The efficacy of assessment and fall prevention interventions also varies widely.

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)*:
The evidence suggests a net benefit of selected processes tailored to prevent falls in a given setting, though none of these interventions has been found to be universally successful. The evidence does not suggest any harm from processes to reduce patient falls.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? No

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: The body of evidence was has not been graded.

1c.11 System Used for Grading the Body of Evidence: Other

1c.12 If other, identify and describe the grading scale with definitions: The body of evidence has not been graded.

1c.13 Grade Assigned to the Body of Evidence: Not applicable

1c.14 Summary of Controversy/Contradictory Evidence: We are not aware of any controversy regarding the value of measuring the incidence of falls or taking steps to prevent falls.

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)*:
Ackerman DB, Trousdale RT, Bieber P, Henely J, Pagnano MW, Berry DJ. Postoperative patient falls on an orthopedic inpatient unit. J Arthroplasty. 2010 Jan;25(1):10-4.

Agostini JV, Baker DI, Bogardus Jr ST. Chapter 26. Prevention of falls in hospitalized and institutionalized older people. In Making Health Care Safer: A Critical Analysis of Patient Safety Practices. The Agency for Health Care Research and Quality. July 2001.

Alcee D. "The experience of a community hospital in quantifying and reducing patient falls." Journal of Nursing Care Quality. Apr 2000, 14(3):43-53.

Ang E, Mordiffi SZ, Wong HB. Evaluating the use of a targeted multiple intervention strategy in reducing patient falls in an acute care hospital: a randomized controlled trial. J Adv Nurs. 2011 Sep;67(9):1984-92.

Anonymous. "Intensive safety effort cuts falls, ulcers, and drug errors at once-disgraced FL hospital." Clinical Resource Management. Oct 2000, 1(10):148-51.

Ash KL, Macleod P, Clark L (1998) A Case Control Study of falls in the hospital setting. Journal of Gerontological Nursing. 12, 7-15

Bates, DW, Pruess K, Souney P, Platt R. (1995). Serious falls in hospitalized patients: Correlates and resource utilization. American Journal of Medicine, 99(2):137-143.

Bernstein AB, Schur CL Expenditures for unintentional injuries among the elderly. J Aging Health. 1990 May;2(2):157-78.

Cameron ID, Murray GR, Gillespie LD, Robertson MC, Hill KD, Cumming RG, Kerse N.
Interventions for preventing falls in older people in nursing care facilities and hospitals. Cochrane Database Syst Rev. 2010 Jan 20.

Chang JT, Morton SC, Rubenstein LZ, et al. Interventions for the prevention of falls in older adults: systematic review and meta-analysis of randomized clinical trials. BMJ 2004;328:680-3.

Chu L, Conrad KW, Chiu A, Liu K, Chu M, Wong S, Wong A (1999) Risk Factors for falls in hospitalised older medical patients. Journal of Gerontology 54A(1): M38-M43

Church S, Robinson TN, Angles EM, Tran ZV, Wallace JI. Postoperative falls in the acute hospital setting: characteristics, risk factors, and outcomes in males. Am J Surg. 2011 Feb;201(2):197-202.

Commonwealth of Massachusetts Department of Public Health. Serious reportable events in Massachusetts acute care hospitals: January 1, 2009 – December 31, 2009. April 2010. http://www.mass.gov/Eeohhs2/docs/dph/quality/healthcare/sre_report_2009.pdf. Accessed August 15, 2011.

Commonwealth of Pennsylvania: Patient Safety Authority. 2010 Annual Report. April 28, 2011. http://patientsafetyauthority.org/PatientSafetyAuthority/Documents/2010_Annual_Report.pdf. Accessed August 9, 2011.

Coussement J, De Paepe L, Schwendimann R, Denhaerynck K, Dejaeger E, Milisen K.Interventions for preventing falls in acute- and chronic-care hospitals: a systematic review and meta-analysis. J Am Geriatr Soc. 2008 Jan; 56(1):29-36.

Dunton N, Gajewski B, Taunton RL, Moore J. (2004). Nurse staffing and patient falls on acute care hospital units. Nurse Outlook, 52, 53-9.

Dykes PC, Carroll DL, Hurley A, Lipsitz S, Benoit A, Chang F, Meltzer S, Tsurikova R, Zuyov L, Middleton B. Fall prevention in acute care hospitals: a randomized trial. JAMA. 2010 Nov 3;304(17):1912-8.

Eagle DJ, Salama S, Whitman D, Evans LA, Ho E, Olde J. "Comparison of three instruments in predicting accidental falls in selected inpatients in a general teaching hospital." Journal of Gerontological Nursing. Jul 1999, 25(7): 40-5.

Evans D, Hodgkinson B, Lambert L, Wood J. (1999) Fall Prevention: a systematic review. Clinical Effectiveness in Nursing 3, 106-111

Feder G, Cryer C, Donovan S, Carter Y. "Guidelines for the prevention of falls in people over 65. The Guidelines Development Group." British Medical Journal. Oct 21 2000, 321(7267): 1007-11.

Francis DL, Prabhakar S, Bryant-Sendek DM, Larson MV. Quality improvement project eliminates falls in recovery area of high volume endoscopy unit. BMJ Qual Saf. 2011 Feb;20(2):170-3.

Gillespie WJ, Cumming R, Lamb SE, Rowe BH (2000) Interventions for preventing falls in the elderly. The Cochrane Library (2000) Issue 4

Gowdy M, Godfrey S. Using tools to assess and prevent inpatient falls. Jt Comm J Qual Saf 2003;29:363-68.

Harrington L, Luquire R, Vish N, Winter M, Wilder C, Houser B, Pitcher E, Qin H. Meta-analysis of fall-risk tools in hospitalized adults. J Nurs Adm. 2010 Nov;40(11):483-8.

Healey F, Monro A, Cockram A et al. Using targeted risk factor reduction to prevent falls in older in-patients: a randomised controlled trial. Age Ageing 2004; 33:390-5.

Healey F, Scobie S. Slips, trips and falls in hospitals. National Patient Safety Agency. 2007.

Hignett S, Masud T. (2006). A review of environmental hazards associated with in-patient falls. Ergonomics, 49(5), 605-616.

Hitcho, EB, Krauss, MJ, Birge, S, Claiborne Dunagan, W, Fischer, I, Johnson, S, et al., (2004). Characteristics and circumstances of falls in a hospital setting: A prospective analysis. Journal of General Internal Medicine, 19(7), 732-329.

Joint Commission. Joint Commission Sentinel Event Statistics. http://www.jointcommission.org/sentinelevents/statistics. Accessed August 9, 2011.

Joint Commission. Focus on Ambulatory Care Fall Prevention in Ambulatory Surgical Centers. Joint Commission Perspectives on Patient Safety, Volume 9, Number 9, September 2009, pp. 6-7(2).

Joint Commission. (2007). National Patient Safety Goals — Facts about the 2007 National Patient Safety Goals. Retrieved July 7, 2007, from http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/07_npsg_facts.htm

Joint Commission. (2005a). Defining the problem of falls. In I.J. Smith (Ed.), Reducing the risk of falls in your health care organization (pp. 13-27). Oakbrook Terrace, IL: The Joint Com mission on Accreditation of Health care Organizations.

Joint Commission. (2005b). Strategies for addressing the root causes of falls. In I.J. Smith (Ed.), Reducing the risk of falls in your health care organization (pp. 29-50). Oakbrook Terrace, IL: The Joint Commission on Accreditation of Healthcare Organizations.

Lakatos BE, Capasso V, Mitchell MT, Kilroy SM, Lussier-Cushing M, Sumner L, Repper-Delisi J, Kelleher EP, Delisle LA, Cruz C, Stern TA. Falls in the general hospital: association with delirium, advanced age, and specific surgical procedures. Psychosomatics. 2009 May-Jun;50(3):218-26.

Lancaster AD, Ayers A, Belbot B, et al. Preventing falls and eliminating injury at ascension health. Jt Comm J Qual Patient Saf 2007;33:367-75.

Lane AJ. Evaluation of the fall prevention program in an acute care setting. Orthopaedic Nursing. Nov-Dec 1999, 18(6): 37-43.

Lovallo C, Rolandi S, Rossetti AM, Lusignani M. Accidental falls in hospital inpatients: evaluation of sensitivity and specificity of two risk assessment tools. J Adv Nurs. 2010 Mar;66(3):690-6.

Morse, JM. Enhancing the safety of hospitalization by reducing patient falls. Am J Infect Control 2002; 30(6): 376-80

Morse JM, Black C, Oberle K, Donahue P. A prospective study to identify the fall-prone patient. Soc Sci Med. 1989. 28(1): 81-86.

Nakai A, Akeda M, Kawabata I. Incidence and risk factors for inpatient falls in an academic acute-care hospital. J Nihon Med Sch. 2006 Oct;73(5):265-70.

Oliver D, Killick S, Even T, Willmott M. Do falls and falls-injuries in hospital indicate negligent care -- and how big is the risk? A retrospective analysis of the NHS Litigation Authority Database of clinical negligence claims, resulting from falls in hospitals in England 1995 to 2006. Qual Saf Health Care. 2008 Dec;17(6):431-6.

Oliver D, Daly F, Martin FC, McMurdo MET. Risk factors and risk assessment tools for falls in hospital in-patients: a systematic review. Age and Ageing 2004;33:122-30.

Oliver D, Hopper A, Seed P. "Do hospital fall prevention programs work? A systematic review." Journal of the American Geriatrics Society. Dec 2000, 48(12): 1679-89.

Passaro A, Volpato S, Romagnoni F, et al. Benzodiazepines with different half-life and falling in a hospitalized population: The GIFA study. J Clin Epidemiol 2000;53:1222-29.

Quigley PA, Hahm B, Collazo S, et al. Reducing serious injury from falls in two veterans´ hospital medical-surgical units. J Nurs Care Qual 2009;24:33-41.

Reiling, J. (2006). Safe design of healthcare facilities. Quality & Safety in Health Care, 15(Suppl. 1), i34-i40.

Rutledge, DN, Donaldson NE, Pravikoff DS. "Fall risk assessment and prevention in health care facilities. Online Journal of Clinical Innovations. 1998. 1(9): 1-33.

State of Indiana: Indiana State Department of Health Indiana. Indiana Medical Error Reporting System: Final Report for 2009. http://www.in.gov/isdh/files/2009_MERS_Report.pdf. Accessed August 9, 2011.

State of Minnesota: Minnesota Department of Health Web. Adverse Health Events in Minnesota: January 2011. http://www.health.state.mn.us/patientsafety/ae/2011ahereport.pdf. Accessed August 9, 2011.

Stern C, Jayasekara R. Interventions to reduce the incidence of falls in older adult patients in acute-care hospitals: a systematic review.Int J Evid Based Healthc. 2009 Dec;7(4):243-9.

Vassallo M, Stockdale R, Sharma JC, et al. A comparative study of the use of four falls risk assessment tools on acute medical wards. J Am Geriatr Soc 2005;53:1034-38.

Woolcott JC, Richardson KJ, Wiens MO, Patel B, Marin J, Khan KM, Marra CA. Meta-analysis of the impact of 9 medication classes on falls in elderly persons. Arch Intern Med. 2009 Nov 23;169(21):1952-60.

1c.16 Quote verbatim, the specific guideline recommendation *(Including guideline # and/or page #)*:
"Monitor fall incidence and incidences of patient injury due to a fall, comparing rates on the same unit over time."

This guideline is offered under the section entitled "Follow-up Monitoring of Condition" at the URL cited below.

1c.17 Clinical Practice Guideline Citation: Gray-Micelli D. Preventing falls in acute care. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008. p. 161-98. Summary available at: http://www.guideline.gov/content.aspx?id=12265. Accessed August 9, 2011.

1c.18 National Guideline Clearinghouse or other URL: http://www.guideline.gov/content.aspx?id=12265

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? No

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:

1c.21 System Used for Grading the Strength of Guideline Recommendation: Other

1c.22 If other, identify and describe the grading scale with definitions: Recommendation not graded.

1c.23 Grade Assigned to the Recommendation: Recommendation not graded.

1c.24 Rationale for Using this Guideline Over Others: Other related guidelines include the following:

American Geriatrics Society, British Geriatrics Society, American Academy of Orthopedic Surgeons (AGS/BGS/AAOS) Guidelines for the Prevention of Falls in Older Persons (2001). Journal of American Geriatrics Society, 49, 664–672.

American Medical Directors Association (AMDA). Falls and fall risk. Columbia, MD: American Medical Directors Association.

ECRI Institute: Falls Prevention Strategies in Healthcare Settings (2006). Plymouth Meeting, PA.

Institute for Clinical Systems Improvement. Prevention of Falls (Acute Care). Second Edition. April 2010.

Resnick, B. (2003). Preventing falls in acute care. In: M. Mezey, T. Fulmer, I. Abraham (Eds.) & D. Zwicker (Managing Ed.), Geriatric nursing protocols for best practice (2nd ed., pp. 141–164). New York: Springer Publishing Company, Inc.

University of Iowa Gerontological Nursing Interventions Research Center (UIGN). (2004). Falls prevention for older adults. Iowa City, IA: University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core.

This guideline was selected for its concise recommendation of measuring fall incidence over time.

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?
1c.25 Quantity: High 1c.26 Quality: Moderate1c.27 Consistency: Moderate
1c.28 Attach evidence submission form:

1c.29 Attach appendix for supplemental materials:

Was the threshold criterion, *Importance to Measure and Report*, met?
(*1a & 1b must be rated moderate or high and 1c yes*) Yes☐ No☐
Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.
For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & 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. (evaluation criteria)
Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See guidance on measure testing.

S.1 Measure Web Page *(In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained? Yes

S.2 If yes, provide web page URL: http://ascquality.org/documents/ASCQualityCollaborationImplementationGuide.pdf

2a. RELIABILITY. Precise Specifications and Reliability Testing: H☐ M☐ L☐ I☐

2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

2a1.1 Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome)*:
ASC admissions experiencing a fall in the ASC.

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)*:
In-facility, prior to discharge

2a1.3 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, codes with descriptors, and/or specific data collection items/responses*:
DEFINITIONS:

Admission: Completion of registration upon entry into the facility.

Fall: A sudden, uncontrolled, unintentional downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions (National Center for Patient Safety).

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
All ASC admissions.

2a1.5 Target Population Category *(Check all the populations for which the measure is specified and tested if any)*: Adult/Elderly Care, Children's Health

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)*:
In-facility, prior to discharge

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
DEFINITIONS:
Admission: Completion of registration upon entry into the facility.

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
ASC admissions experiencing a fall outside the ASC.

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
Falls occurring outside the confines of the ASC are excluded.

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses)*:
This measure is not stratified

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13)*: No risk adjustment or risk stratification 2a1.12 If "Other," please describe:

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.)*:
None

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score: Rate/proportion

2a1.19 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

2a1.20 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 fall in the ASC is divided by the number of ASC admissions during the reporting period, yielding the rate of patient falls in the ASC for the reporting period.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:

2a1.24 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

2a1.25 Data Source *(Check all the sources for which the measure is specified and tested*). If other, please describe:
Paper Records

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*): 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 patient falls in the ASC.

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment: URL
http://ascquality.org/documents/ASCQualityCollaborationImplementationGuide.pdf
Not needed

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:
URL
http://ascquality.org/documents/ASCQualityCollaborationImplementationGuide.pdf
Not needed

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested)*: Facility

2a1.34-35 Care Setting *(Check all the settings for which the measure is specified and tested)*: Ambulatory Care : Ambulatory Surgery Center (ASC)

2a2. Reliability Testing. (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability*.)

2a2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
A convenience sample of 22 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 September 30, 2010 were reviewed in the course of the reliability testing.

2a2.2 Analytic Method *(Describe method of reliability testing & rationale)*:
The numerator (the number of Ambulatory Surgery Center (ASC) admissions experiencing a fall within the confines of the ASC) and denominator (number of ASC admissions) values were compared for all 22 centers in the sample.

2a2.3 Testing Results *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
The error rates at all 22 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.

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H☐ M☐ L☐ I ☐

2b1.1 Describe how the measure specifications *(measure focus, target population, and exclusions)* are consistent with the evidence cited in support of the measure focus (*criterion 1c)* and identify any differences from the evidence:
In light of the evidence of increased fall risk associated with the use of medications such as sedatives, anesthetics agents and anxiolytics that are used in association with ASC procedures, the measure specifications evaluate all patients and also include all falls in the ASC.

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.)*

2b2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
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.

2b2.2 Analytic Method *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)*:
Validity was measured via a formal consensus process. All seven respondents responded with a 5/5 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.

2b2.3 Testing Results *(Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment)*:

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: 5.0/5.0; Mean: 5.0/5.0)
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: 5.0/5.0; Mean 5.0/5.0)
3. The data required for the measure are likely to be obtained with reasonable effort. (Median: 5.0/5.0; Mean: 5.0/5.0)
4. The data required for the measure are likely to be obtained with reasonable cost. (Median: 5.0/5.0; Mean: 5.0/5.0)
5. The data required for the measure can be generated during care delivery. (Median: 5.0/5.0; Mean: 5.0/5.0)

POTENTIAL THREATS TO VALIDITY. (*All potential threats to validity were appropriately tested with adequate results.*)

2b3. Measure Exclusions. (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

2b3.1 Data/Sample for analysis of exclusions *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
No exclusions

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference)*:
Not applicable

2b3.3 Results *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*
Not applicable

2b4. Risk Adjustment Strategy. (*For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.*)

2b4.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
This measure is not risk adjusted

2b4.2 Analytic Method (*Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables)*:
Not applicable

2b4.3 Testing Results *(Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata)*:
Not applicable

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: Patient falls should be rare if appropriate protocols 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.

2b5. Identification of Meaningful Differences in Performance. (*The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.*)

2b5.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
Although data for 1,146 ASCs are included in our public reporting of this indicator, many ASCs report at the corporate level and do not report data for their individual centers. The database includes center-level rates for this measure for 501 ASCs throughout the US. The statistics reported below include rates for this measure is based on the 501 individually-reporting ambulatory surgery centers throughout the US.

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)*:

An individual ASC's rate for patient falls may be compared to the standard rate from the ASC Quality website (http://www.ascquality.org/qualityreport.cfm#Fall). A statistically significant difference in performance may be detected by using a standard test of proportions as outlined in most standard statistical texts.

2b5.3 Results *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:
The rate for patient falls ranged from a minimum of 0.00% to a maximum of 0.93%. The mean rate was 0.02% (SD: 0.07%), while the median rate was 0.00%. The maximum patient fall rate of 0.93% demonstrates that there is an opportunity for improvement in this measure.

2b6. Comparability of Multiple Data Sources/Methods. (*If specified for more than one data source, the various approaches result in comparable scores.*)

2b6.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
This measure is specified for a single data source (paper medical record/flow sheet) as noted in 2a1.25. above.

2b6.2 Analytic Method *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure)*:
Not applicable

2b6.3 Testing Results *(Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted)*:
Not applicable

2c. Disparities in Care: H☐ M☐ L☐ I ☐ NA☐ (*If applicable, the measure specifications allow identification of disparities.*)

2c.1 If measure is stratified for disparities, provide stratified results *(Scores by stratified categories/cohorts)*: This measure is not stratified

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:
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 the end of 2011, initiate the development of the registry database immediately upon contract acceptance, and have a functioning registry three to six months thereafter.

In addition, a federal quality reporting system has not yet been implemented for ambulatory surgical centers. Based on recent proposals from the CMS, we anticipate the agency will begin implementing an ASC quality reporting system in 2012 and that the measure set for the quality reporting system might include this measure. When the system is implemented and if this measure is included in the measure set, patient level demographic data could be collected in association with ASC data on patient falls, allowing for the detection of any disparities.

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?
(*Reliability and Validity must be rated moderate or high*) Yes☐ No☐
Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

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)

C.1 Intended Actual/Planned Use *(Check all the planned uses for which the measure is intended)*: Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

3.1 Current Use *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: Public Reporting, Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

3a. Usefulness for Public Reporting: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for public reporting.*)

3a.1. Use in Public Reporting - disclosure of performance results to the public at large *(If used in a public reporting program, provide name of program(s), locations, Web page URL(s)).* If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: [*For Maintenance – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.*]
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 Patient Fall in the ASC measure. The report for the first quarter of 2011 is available at: http://www.ascquality.org/qualityreport.cfm. One thousand one hundred forty-six (1,146) ASCs submitted patient fall data for this report.

3a.2.Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: The patient fall rate is similar to measures reported by CMS on the Hospital Compare website. The concept of rates and percentages is commonly used in public reporting of health care and other quality indicators. This measure has an easy to understand numerator and denominator and is easily interpreted by healthcare professionals as well as lay-persons.

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s): The Centers for Medicare and Medicaid Services has proposed to include this measure in its ASC Quality Reporting Program. Please see CMS-1525-P, Section XIV.K.3.a.(2) at http://www.gpo.gov/fdsys/pkg/FR-2011-07-18/pdf/2011-16949.pdf.

3b. Usefulness for Quality Improvement: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for quality improvement.*)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s):
[*For Maintenance – If not used for QI, indicate the reasons and describe progress toward using performance results for improvement*].
This measure is in use in several QI initiatives. For example, the ASC Association includes this metric in its Outcomes Monitoring Project, which is described at http://www.ascassociation.org/outcomes/.

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://tascs.org/. data for the first quarter 2011 report.

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated *(e.g., QI initiative),* describe the data, method and results:
The patient fall rate is similar to measures reported by CMS on the Hospital Compare website. The concept of rates and percentages is commonly used in public reporting of health care. The definition of the indicator allows individual ASCs to calculate their rate and compare directly with the benchmark rates posted to the ASC Quality website.

Overall, to what extent was the criterion, *Usability*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)

4a. Data Generated as a Byproduct of Care Processes: H☐ M☐ L☐ I ☐

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*
Data used in the measure are:
generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

4b. Electronic Sources: H☐ M☐ L☐ I ☐

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields)*: No data elements are in electronic sources

4b.2 If ALL data elements 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.

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H☐ M☐ L☐ I ☐

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. 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.

4d. Data Collection Strategy/Implementation: H☐ M☐ L☐ I ☐

A.2 Please check if either of the following apply (*regarding proprietary measures*): Proprietary measure
4d.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 *(e.g., fees for use of proprietary measures)*:
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.

Overall, to what extent was the criterion, *Feasibility*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes☐ No☐
Rationale:

If the Committee votes No, STOP.
If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND 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 before a final recommendation is made.

5.1 If there are related measures *(either same measure focus or target population)* or competing measures *(both the same*

measure focus and same target population), list the NQF # and title of all related and/or competing measures:
0141 : Patient Fall Rate
0202 : Falls with injury
0674 : Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized? No

5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:
0141: Patient Fall Rate - This measure is designed for use in the hospital setting. The numerator statement quantitates the number of falls "by hospital unit". The denominator statement specifies "Patient days by hospital unit during the calendar month". The included populations include patients other than same day surgery patients. ASCs do not have units, do not use patient days for reporting and serve only the same day surgery patient population. The measure is not well-suited to application in the ASC setting as currently specified. 0202: Falls with Injury - This measure is designed for use in the hospital setting. The numerator statement quantitates the number of falls "by hospital unit" with an injury level minor or greater. The denominator statement specifies "Patient days by type of unit during the calendar month". The included populations encompass patients other than same day surgery patients. ASCs do not have units, do not use patient days for reporting and serve only the same day surgery patient population. The measure is not well-suited to application in the ASC setting as currently specified. It is also limited to falls with injury level minor or greater. The ASC QC measure includes all falls regardless of injury level, as any fall may be an indicator that patient safety processes are in need of review and/or revision. 0674: Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) - This measure is designed for nursing home use. The specifications are not pertinent to the ambulatory surgery center setting or the patients served there, as none are residents of the ASC.

5b. Competing Measure(s)

5b.1 If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures *(e.g., a more valid or efficient way to measure quality);* OR provide a rationale for the additive value of endorsing an additional measure. *(Provide analyses when possible)*:
No competing measures found

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): Ambulatory Surgical Centers Quality Collaborative, 5686 Escondida Blvd S, St. Petersburg, Florida, 33715

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

Co.3 Measure Developer if different from Measure Steward: Ambulatory Surgical Center 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: Donna, Slosburg, BSN, LHRM, CASC, donnaslosburg@ascquality.org, 727-867-0072-, Ambulatory Surgical Center Quality Collaboration

Co.6 Additional organizations that sponsored/participated in measure development:
No additional organizations participated in measure development.

Co.7 Public Contact: Donna, Slosburg, BSN, LHRM, CASC, donnaslosburg@ascquality.org, 727-867-0072-, Ambulatory Surgical Center Quality Collaboration

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; 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:

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 title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward: Not adapted

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.3 Year the measure was first released: 2007
Ad.4 Month and Year of most recent revision: 12, 2010
Ad.5 What is your frequency for review/update of this measure? Annually, or more frequently if indicated
Ad.6 When is the next scheduled review/update for this measure? 12, 2011

Ad.7 Copyright statement: None

Ad.8 Disclaimers: None

Ad.9 Additional Information/Comments: None

Date of Submission (*MM/DD/YY*): 09/13/2011