



*Association of periOperative Registered Nurses*

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August 30, 2009

Charlene Frizzera, Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1414-P  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: CMS-1414-P; Reporting Quality Data for Annual Payment Rate Updates**

Dear Acting Administrator Frizzera:

On behalf of the Association of periOperative Registered Nurses (AORN), please accept the following comments regarding CMS-1414-P, Section XVI. Reporting Quality Data for Annual Payment Rate Updates, particularly as it pertains to ASCs (74 Fed. Reg. 35232, July 20, 2009). AORN represents over 42,000 registered nurses and has a history of patient centered safety and quality activities.

AORN strongly advocates quality reporting. Sharing reliable quality information with the public gives consumers the opportunity to make informed health care choices. Quality data is also an important performance improvement tool. ASCs have a long history of commitment to high-quality care, and AORN is eager to make quality data available to the public. Recognizing that Medicare beneficiaries have a choice of providers and settings for many of the most common outpatient surgical services, we look forward to the time when direct comparisons between surgical care delivered in different settings will be possible.

Over the last few years, AORN has supported the efforts of the ASC Quality Collaboration communications with CMS through formal comments, letters, conference calls, and a face-to-face meeting. We appreciate this opportunity to present our recommendations for the future ASC quality reporting system.



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## **I. ASC Quality Reporting System**

We remain disappointed in the lack of progress the agency has made in issuing proposals for an ASC quality reporting system over the last two years. Perioperative nurses in ASCs continue to anticipate and actively prepare for quality reporting. Collection of quality data is a common practice in ASCs and has been a feature of the industry since its inception. When the first ASC was established in 1970, there was considerable skepticism surrounding the ambulatory model of delivering surgical care. This skepticism compelled the collection and reporting of data regarding safety, quality, and outcomes from the earliest days of ASC existence. ASCs now collect this data not only for internal performance improvement activities, but also report it for purposes of external benchmarking and to fulfill various requirements for state licensure, certification, and accreditation.

Earlier this year, the ASC Quality Collaboration initiated the online publication of a quarterly public report of ASC quality data. This report presents aggregated performance data for the six ASC facility-level quality measures developed by the ASC Quality Collaboration and endorsed by the National Quality Forum. These quarterly reports are made possible through the voluntary efforts of participants in the ASC Quality Collaboration and may be accessed at the ASC Quality Collaboration's website at: <http://www.ascquality.org/qualityreport.html>.

In short, AORN has supported the ASC industry's longstanding history of quality measurement to demonstrate its ability and readiness to move ahead independently. We encourage CMS to move forward by issuing its proposals as expeditiously as possible. Significant further delay in issuing proposals for the ASC quality reporting system is not helpful to the Medicare program, the public, or the ASC provider community, all of whom have a significant stake in timely progress in this area.

## **II. Quality Measures for Outpatient Surgery**

We believe that measures for the evaluation of outpatient surgical facility quality should reflect processes or outcomes of care that are directly attributable to the facility itself - its staff, equipment, environment of care, and its roles in the delivery of patient care - and for which the facility, by virtue of its specific functions in patient care, can reasonably be held accountable.



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When the ASC Quality Collaboration was formed, AORN supported a detailed evaluation of existing nationally endorsed quality measures to determine which could be directly applied to the outpatient surgery facility setting. Though several existing measures addressed surgical care, none had been developed specifically for the outpatient surgical setting. In fact, many of the measures are specific to procedures that are either uncommonly performed in outpatient facilities or not performed at all for Medicare beneficiaries in the outpatient surgical setting. Other measures expressly exclude patients with a stay of less than 24 hours, effectively eliminating the entire ASC patient population. Still other measures focus on processes of care that are specific responsibilities of physicians, such as the selection and ordering of antibiotics.

Finding no nationally endorsed measures designed for public reporting and accountability specific to facilities performing outpatient surgery, AORN supported the ASC Quality Collaboration development of a number of facility-level measures of outpatient surgical quality. These measures were based on those already commonly used by the ASC community for internal quality assessment and external benchmarking. After refining these standardized measures, the ASC Quality Collaboration piloted them and was able to confirm their feasibility and usability. Six of these measures have now been endorsed by the NQF.

Of the six measures, four are outcome measures that have applicability to all outpatient surgical facilities and thereby ensure broad facility participation regardless of case mix. These four outcome measures focus on 1) patient falls, 2) patient burns, 3) hospital transfer/admission and 4) wrong site/wrong side/wrong patient/wrong procedure/wrong implant.

The fifth measure is a process measure which evaluates the timing of the administration of intravenous antibiotics for prophylaxis of surgical site infection. This prophylactic antibiotic timing measure has been specifically designed to harmonize with similar measures already being reported by inpatient hospitals and hospital outpatient departments. The prophylactic antibiotic timing measure also addresses the statutory requirement under Section 109 of the Tax Relief and Health Care Act of 2006 (TRHCA) for evaluation of medication errors. Administering antimicrobial agents at the wrong time is a recognized type of medication error. In the *MEDMARX® Data Report: A Chartbook of Medication Error Findings from the Perioperative Settings from 1998-2005*, the U.S. Pharmacopeia detailed the various types of medication errors in outpatient surgery, one of which was “wrong time.” The report



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specifically recommended “[d]eveloping strategies to ensure that medications, especially antimicrobial agents, are administered at the correct time.”

In 2008, NQF endorsed a sixth ASC facility level measure developed by the ASC Quality Collaboration. This measure is a process measure addressing appropriate surgical site hair removal. This measure harmonizes with a similar measure currently in use for hospital inpatient reporting and being considered for hospital outpatient reporting in CY 2012.

We strongly recommend CMS implement these facility-specific measures for ASC reporting.

We further believe that the ASC facility-level measures, currently endorsed by the NQF, are appropriate for all outpatient surgical settings. Therefore, we encourage CMS to apply these measures for reporting by other providers of outpatient surgical services. Applying the same facility-level quality measures to all settings offering outpatient surgery would expand the points of comparison available to Medicare beneficiaries and would represent an important step forward in improving their ability to assess quality among different providers.

### **III. Public Reporting of Quality Data**

AORN supports transparency and welcomes a fair presentation of ASC cost and quality information to assist consumers in making decisions. The success of transparency efforts is closely linked to how effectively information is shared with the public. Consumers should be able to access quality and cost information on websites that are organized to allow easy comparisons, while also protecting the rights of providers by assuring that the information made available is correct, up-to-date, and clearly presented. Specifically, internet-based presentation of quality and cost data should address or incorporate the following principles:

- 1) Consumers should be able to directly compare providers of outpatient surgical services, such as a hospital outpatient department and an ASC.
- 2) There should be a mechanism for providers to raise concerns with any information to be posted prior to its publication.
- 3) There should be a provider narrative section for each provider-specific item presented to the consumer. This narrative box would allow the provider to advise the consumer



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of any concerns the provider has regarding the reliability or accuracy of the information presented.

- 4) In addition to reporting quality measures, other useful information such as accreditation status, state licensure, and Medicare certification should be made available.

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We encourage CMS to move promptly to develop and issue its proposals for the ASC quality reporting system

Thank you for considering these comments. We look forward to future opportunities to continue our dialogue with the agency on this very important matter. We would be happy to assist with questions or provide additional information at your request.

Sincerely,

**Linda Groah RN MSN CNOR FAAN**

Executive Director/CEO

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