GENERAL SURGERY MEASURES GROUP OVERVIEW

2016 PQRS OPTIONS FOR MEASURES GROUPS:

2016 PQRS MEASURES IN GENERAL SURGERY MEASURES GROUP:
#130 Documentation of Current Medications in the Medical Record
#226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
#354 Anastomotic Leak Intervention
#355 Unplanned Reoperation within the 30 Day Postoperative Period
#356 Unplanned Hospital Readmission within 30 Days of Principal Procedure
#357 Surgical Site Infection (SSI)
#358 Patient-Centered Surgical Risk Assessment and Communication

INSTRUCTIONS FOR REPORTING:

- The General Surgery Measures Group is relevant to the following surgical procedures:
  - Ventral Hernia
  - Appendectomy
  - AV Fistula
  - Cholecystectomy
  - Thyroidectomy
  - Mastectomy +/- Lymphadenectomy or Sentinel Lymph Node Biopsy (SLNB)
  - Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB
  - Bariatric Laparoscopic or Open Roux en Y Gastric Bypass
  - Bariatric Sleeve Gastrectomy
  - Colectomy

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

G9237: I intend to report the General Surgery Measures Group

- Report the patient sample method:
  20 Patient Sample Method: 20 unique procedures (a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2016).

- Patient sample criteria for the General Surgery Measures Group are patients aged 18 years and older that have a specific surgical procedure performed:

  One of the following procedure codes indicating general surgery: 19101, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 36818, 36819, 36820, 36821, 36825, 36830, 43644, 43645, 43775, 43846, 43847, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44160, 44204, 44205, 44206, 44207, 44208, 44210, 44950, 44960, 44970, 47562, 47563, 47564, 47600, 47605, 47610, 49560, 49561, 49565, 49566, 49567, 49572, 49585, 49587, 49650, 49652, 49653, 49654, 49655, 49656, 49657, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271

- To satisfactorily report the General Surgery Measures Group requires reporting a numerator option on all applicable measures, for each patient (unique procedure) within the eligible professional’s patient sample, a minimum of once during the reporting period. Include only procedures performed through December 1 of the reporting period.
• Measure #354 need only be reported when the patient has a procedure performed specific to gastric bypass surgery or colectomy as indicated by one of the following CPT procedure codes: 43644, 43645, 43846, 43847, 43775, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44160, 44204, 44205, 44206, 44207, 44208, 44210.

• Measure #358 does not need to be reported (is not applicable) when the patient has a procedure performed for one of the following AV Fistula CPT procedure codes: 36820, 36821, 36825. These codes are not available through a clinical data-based, patient-specific risk calculator.

• Instructions for qualifying numerator option reporting for each of the measures within the General Surgery Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when all quality clinical actions for all applicable measures within the group have been performed.

**Composite QDC G9235:** All quality actions for the applicable measures in the General Surgery Measures Group have been performed for this patient

• This measures group contains one or more inverse measures. An inverse measure is a measure that represents a poor clinical quality action as meeting performance for the measure. For these measures, a lower performance rate indicates a higher quality of clinical care. Composite codes for measures groups that contain inverse measures are only utilized when the appropriate quality clinical care is given.

• The composite code for this measures group may be reported when codes in the summary table below are applicable for reporting of each measure within the measures group.

**Table 11 - QDC Options**

<table>
<thead>
<tr>
<th>Measure</th>
<th>130</th>
<th>226</th>
<th>#354*</th>
<th>#355*</th>
<th>#356*</th>
<th>#357*</th>
<th>#358</th>
</tr>
</thead>
<tbody>
<tr>
<td>QDC options for acceptable use of the composite QDC</td>
<td>G8427</td>
<td>4004F or 1036F</td>
<td>G9305</td>
<td>G9307</td>
<td>G9309</td>
<td>G9311</td>
<td>G9316</td>
</tr>
</tbody>
</table>

*Indicates an inverse measure

• Measure Group Reporting Calculations:

Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each applicable measure within the measures group reported by the eligible professional.

Performance exclusion QDCs are not counted in the performance denominator. If the eligible professional submits all performance exclusion QDCs, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening for Osteoporosis for Women Aged 65-85 Years of Age would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.
When a lower rate indicates better performance, such as Measure #355, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting).

- **NOTE:** The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures group option.
Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record --
National Quality Strategy Domain: Patient Safety

DESCRIPTION:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a
list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

NUMERATOR:
Eligible professional attests to documenting, updating or reviewing a patient’s current medications using all
immediate resources available on the date of encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration

Definitions:
Current Medications – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication’s name, dosage, frequency and administered route.
Route - Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical).
Not Eligible - A patient is not eligible if the following reason is documented:
• Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.

NUMERATOR NOTE: The eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications.

Numerator Options:
Performance Met:
Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient’s current medications (G8427)

OR
Other Performance Exclusion:
Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional (G8430)

OR
Performance Not Met:
Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given (G8428)
**Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention -- National Quality Strategy Domain: Community/Population Health**

**DESCRIPTION:**
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user.

**NUMERATOR:**
Patients who were screened for tobacco use at least once within 24 months **AND** who received tobacco cessation intervention if identified as a tobacco user.

**Definitions:**
- **Tobacco Use** – Includes use of any type of tobacco.
- **Tobacco Cessation Intervention** – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

**NUMERATOR NOTE:** In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation intervention report **4004F with 8P**.

**Numerator Options:**

**Performance Met:**
- Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (**4004F**)

**OR**

**Performance Met:**
- Current tobacco non-user (**1036F**)

**OR**

**Medical Performance Exclusion:**
- Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons) (**4004F with 1P**)

**OR**

**Performance Not Met:**
- Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified (**4004F with 8P**)

DESCRIPTION:
Percentage of patients aged 18 years and older who required an anastomotic leak intervention following gastric bypass or colectomy surgery

NUMERATOR:
Intervention (via return to operating room, interventional radiology, or interventional gastroenterology) for presence of leak of endoluminal contents (such as air, fluid, GI contents, or contrast material) through an anastomosis. The presence of an infection/abscess thought to be related to an anastomosis, even if the leak cannot be definitively identified as visualized during an operation, or by contrast extravasation would also be considered an anastomotic leak.

Numerator Instructions:
INVERSE MEASURE - A lower calculated performance rate for this measure indicates better clinical care or control. The “Performance Not Met” numerator option for this measure is the representation of the better clinical quality or control. Reporting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control, and therefore an inverse measure at 100% does not qualify for reporting purposes, however any reporting rate less than 100% does qualify.

Numerator Options:

Performance Met: Intervention for presence of leak of endoluminal contents through an anastomosis required (G9306)

OR

Performance Not Met: Intervention for presence of leak of endoluminal contents through an anastomosis not required (G9305)
Measure #355: Unplanned Reoperation within the 30 Day Postoperative Period -- National Quality Strategy Domain: Patient Safety

**DESCRIPTION:**
Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period

**NUMERATOR:**
Unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure

**Numerator Instructions:**

**INVERSE MEASURE** - A lower calculated performance rate for this measure indicates better clinical care or control. The “Performance Not Met” numerator option for this measure is the representation of the better clinical quality or control. Reporting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control, and therefore an inverse measure at 100% does not qualify for reporting purposes, however any reporting rate less than 100% does qualify.

**NUMERATOR NOTE:** This measure is not intended to capture patients who go back to the operating room within 30 days for a follow-up procedure based on the pathology results from the principal operative procedure or concurrent procedure. Examples: Exclude breast biopsies with return for re-excisions; insertion of port-a-cath for chemotherapy.

The return to the OR may occur at any hospital or surgical facility.

**Numerator Options:**

**Performance Met:**
Unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure (G9308)

**OR**

**Performance Not Met:**
No return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure (G9307)
### Measure #356: Unplanned Hospital Readmission within 30 Days of Principal Procedure --
National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure

**NUMERATOR:**
Inpatient readmission to the same hospital for any reason or an outside hospital (if known to the surgeon), within 30 days of the principal surgical procedure

**Numerator Instructions:**
**INVERSE MEASURE** - A lower calculated performance rate for this measure indicates better clinical care or control. The “Performance Not Met” numerator option for this measure is the representation of the better clinical quality or control. Reporting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control, and therefore an inverse measure at 100% does not qualify for reporting purposes, however any reporting rate less than 100% does qualify.

**Numerator Options:**

- **Performance Met:**
  - Unplanned hospital readmission within 30 days of principal procedure (G9310)

- **Performance Not Met:**
  - No unplanned hospital readmission within 30 days of principal procedure (G9309)
Measure #357: Surgical Site Infection (SSI) -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients aged 18 years and older who had a surgical site infection (SSI)

NUMERATOR:
Number of patients with a surgical site infection

Numerator Instructions:
INVERSE MEASURE - A lower calculated performance rate for this measure indicates better clinical care or control. The “Performance Not Met” numerator option for this measure is the representation of the better clinical quality or control. Reporting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control, and therefore an inverse measure at 100% does not qualify for reporting purposes, however any reporting rate less than 100% does qualify.

Definitions:
Superficial Incisional SSI: Superficial incisional SSI is an infection that occurs within 30 days after the operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following:
- Purulent drainage, with or without laboratory confirmation, from the superficial incision
- Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision
- At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat AND superficial incision is deliberately opened by the surgeon, unless incision is culture-negative
- Diagnosis of superficial incisional SSI by the surgeon or attending physician

Deep Incisional SSI: Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (for example, fascial and muscle layers) of the incision and at least one of the following:
- Purulent drainage from the deep incision but not from the organ/space component of the surgical site
- A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (> 38 C), localized pain, or tenderness, unless site is culture-negative
- An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination
- Diagnosis of a deep incision SSI by a surgeon or attending physician

Organ/Space SSI: Organ/Space SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and the infection involves any part of the anatomy (for example, organs or spaces), other than the incision, which was opened or manipulated during an operation and at least one of the following:
- Purulent drainage from a drain that is placed through a stab wound into the organ/space.
- Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space
- An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathologic or radiologic examination
- Diagnosis of an organ/space SSI by a surgeon or attending physician
Numerator Options:

**Performance Met:**  Surgical site infection (G9312)

**Performance Not Met:**  No surgical site infection (G9311)
Measure #358: Patient-Centered Surgical Risk Assessment and Communication -- National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

DESCRIPTION:
Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.

NUMERATOR:
Documentation of empirical, personalized risk assessment based on the patient’s risk factors with a validated risk calculator using multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient and/or family.

Numerator Instructions: The number of adult patients (age 18 and over) having had non-emergency surgery as defined by CPT codes during the reporting period who had their personalized risk of procedure-specific, 30-day postoperative complications assessed and documented by their surgeon prior to surgery using a clinical data-based, patient-specific risk calculator and who had a documented personal discussion with their surgeon about these risks. The procedure-specific, patient-specific, data-based risk calculator should be based on a validated, risk-adjusted statistical model predicting 30-day postoperative complication (detailed below) for the procedure that is to undergo. Risk calculations should be based on preoperative patient-specific clinical data, and should include the following groups of variables: patient demographic characteristics (e.g., age, gender); relevant lifestyle and clinical risk factors (e.g., smoking status, American Society of Anesthesiologists class, body mass index); patient comorbidities (e.g., diabetes; neurologic event/disease; disseminated cancer); and procedure type.

Postoperative complications should include 30-day risk-adjusted mortality, 30-day risk-adjusted overall morbidity (superficial surgical site infection, deep incisional surgical site infection, wound dehiscence, pneumonia, deep venous thrombosis; pneumonia; renal failure; urinary tract infection; prolonged ventilator dependence; bleeding complications; sepsis; and pulmonary embolism), serious complications (cardiac arrest; myocardial infarction, pneumonia; progressive renal insufficiency; acute renal failure; pulmonary embolism; deep venous thrombosis; return to the operating room deep incisional surgical site infection; organ space surgical site infection; systemic sepsis; unplanned intubation; urinary tract infection; and wound dehiscence), surgical site infection, and average length of stay.

Risk calculators based on multi-institutional, validated clinical data are acceptable for this measure. ACS NSQIP now offers a risk calculator which can be used for operations in many surgical subspecialty (ACS NSQIP Risk Calculator). Other risk calculators are available and acceptable for this measure, including but not limited to the risk calculator from the Society of Thoracic Surgeons.

Numerator Options:
Performance Met: Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family (G9316)

OR

Performance Not Met: Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family not completed (G9317)
GENERAL SURGERY MEASURES GROUP RATIONALE AND CLINICAL RECOMMENDATION STATEMENTS

MEASURE #130 – DOCUMENTATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD

RATIONALE:
In the American Medical Association’s (AMA) Physician’s Role in Medication Reconciliation (2007), critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

As identified by The Agency for Healthcare Research and Quality in the National Healthcare Disparities report (2013), "different providers may prescribe medications for the same patient. Patients are responsible for keeping track of all their medications, but medication information can be confusing, especially for patients on multiple medications. When care is not well coordinated and some providers do not know about all of a patient's medications, patients are at greater risk for adverse events related to drug interactions, overdosing, or underdosing."

In addition, providers need to periodically review all of a patient’s medications to ensure that they are taking what is needed and only what is needed. Medication reconciliation has been shown to reduce both medication errors and adverse drug events (Whittington & Cohen, 2004).

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADE) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to the first study to utilize nationally-representative data to examine annual rates of ADEs in the ambulatory care setting "Adverse Drug events in U.S. Adult Ambulatory Medical Care," ADE rates increase with age, adults 25-44 years old had a rate of 1.3 per 10,000 person per year, those 45-64 had a rate of 2.2 per 10,000 per year, and those 65 years and older had the highest rate, at 3.8 ADEs per 10,000 persons per year. This study estimates that 13.5 million ADE related visits occurred between 2005-2007, estimating that approximately 4.5 million ambulatory ADE visits occur each year. These 4.5 million visits are associated with approximately 400,000 hospitalizations annually. According to the Institute of Medicine (IOM), in the US, as many as 98,000 deaths per year are attributable to preventable adverse events that occur in the hospitals setting with annual costs of between $17 billion and $29 billion. (Sarkar et al., 2011)

Additionally, findings of The Commonwealth Fund (2010) studies identified 11% to 28% of the 4.3 million visit related ADEs (VADE) in 2001 might have been prevented with improved systems of care and better patient education, yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of $946 million to $2.4 billion.

According to the AMA’s published report, The Physician's Role in Medication Reconciliation, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days in 2005. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005, in the United States 701,547 patients were treated for ADEs in emergency departments and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs. (AMA, 2007).
A Systematic Review on "Prevalence of Adverse Drug Events in Ambulatory Care" finds that "In the ambulatory care setting, adverse drug events (ADEs) have been reported to occur at a rate of 25%. Approximately 39% of these ADEs were preventable. Since many ADEs are associated with medication errors, and thus potentially preventable, understanding the nature of medication errors in ambulatory care settings can direct attention toward improvement of medication safety in ambulatory care." Data extracted and synthesized across studies indicated the median preventable ADE rates in ambulatory care-based studies were 16.5%. (Tache et al., 2011).

The Agency for Healthcare Research and Quality's (AHRQ) National's Healthcare Disparities Report (2011) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and sex. The disparities were identified as follows: older Asians were more likely than older Whites to have inappropriate drug use (20.3% compared with 17.3%); Older Hispanics were less likely than older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); Older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and communication, the Institute of Medicine and others have encouraged the incorporation of IT solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks et al. found there is an opportunity for universal medication lists utilizing health IT.

CLINICAL RECOMMENDATION STATEMENTS:
The Joint Commission's 2015 Ambulatory Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section "Use Medicines Safely NPSG.03.06.01" states the following: "Maintain and communicate accurate patient medication information. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected to reconcile current and newly ordered medications and to safely prescribe medications in the future." (Joint Commission, 2015, retrieved at: Joint Commission's 2015 Ambulatory Care National Patient Safety Goals guide).

The National Quality Forum's 2010 update of the Safe Practices for Better Healthcare, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

The AMA’s published report, The Physician’s Role in Medication Reconciliation, identified the best practice medication reconciliation team as one that is multidisciplinary and--in all settings of care--will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team’s variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.
MEASURE #226 – PREVENTIVE CARE AND SCREENING: TOBACCO USE: SCREENING AND CESSATION INTERVENTION

RATIONALE:
This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (U.S. Preventive Services Task Force, 2009)

MEASURE #354 - ANASTOMOTIC LEAK INTERVENTION

MEASURE #355 - UNPLANNED REOPERATION WITHIN THE 30 DAY POSTOPERATIVE PERIOD

MEASURE #356 - UNPLANNED HOSPITAL READMISSION WITHIN 30 DAYS OF PRINCIPAL PROCEDURE

MEASURE #357 - SURGICAL SITE INFECTION (SSI)

RATIONALE:
This is an adverse surgical outcome, which is often a preventable cause of harm, thus it is important to measure and report. It is feasible to collect the data and produces reliable and valid results about the quality of care. It is useful and understandable to stakeholders. As highlighted earlier, this measure was developed in a collaborative effort by the American College of Surgeons and the American Board of Surgery. This measure addresses the National Quality Strategy Priorities, and was identified by an expert panel of physician providers to be a critical outcome for this procedure. This measure addresses a high-impact condition as it is one of the most common procedures performed in the U.S. The measure aligns well with the intended use. The care settings include Acute Care Facilities/Hospitals. Data are being collected in a clinical registry that has been in existence for over 5 years, with over 4000 current users. Thus, we are requesting consideration of this measure in the “Registry Reporting” option. The level of analysis
is the clinician/individual. All populations are included, except children. The measure allows measurement across the
person-centered episode of care out to 30 days after the procedure whether an inpatient, outpatient, or readmitted.
The measure addresses disparities in care. The risk adjustment is performed with a parsimonious dataset and aims
to allow efficient data collection resources and data reporting. Measures have been harmonized when possible.

CLINICAL RECOMMENDATION STATEMENTS:
A modified-Delphi methodology using an expert panel of surgeons who are Directors of the American Board of Surgery identified this to be a critical outcome for this surgical procedure (Surgeon Specific Registry Report on Project for ABS MOC Part IV. Unpublished study by the American College of Surgeons in conjunction with the American Board of Surgery, 2011).

MEASURE #358 - PATIENT-CENTERED SURGICAL RISK ASSESSMENT AND COMMUNICATION
RATIONALE:
Preoperative risk assessment and communication between surgeons and patients is critical for effective informed consent and shared decision making in surgical care. Shared decision-making is considered an integral component of patient-centered care, especially for preference-sensitive issues. Evidence suggests that there is room for improving communication and the informed consent/shared decision-making processes between physicians and patients. Use of a risk calculator helps improve the quality of the informed consent/shared decision-making process by providing a personalized, customized, empirically-based estimate of a patient's risk of post-operative complications. Moreover, evidence suggests that sharing numeric estimates of patient-specific risk may enhance patient trust in providers. Risk assessment and communication between surgeons and patients is critical to inform and shared decision-making processes in surgical care. Shared decision-making is considered an integral component of patient-centered care, particularly within accountable care organizations.

Evidence suggests that there is room for improving communication and informed/shared decision-making processes between physicians and patients.

Use of a risk calculator may help improve the quality of informed/shared decision-making by providing a personalized, empirically-based estimate of a patient's risk of post-operative complications. Moreover, evidence suggests that sharing numeric estimates of patient-specific risk may enhance patient trust in providers.

CLINICAL RECOMMENDATION STATEMENTS:
Preoperative risk assessment and communication between surgeons and patients is critical for effective informed consent and shared decision making in surgical care. Shared decision-making is considered an integral component of patient-centered care, especially for preference-sensitive issues. Evidence suggests that there is room for improving communication and the informed consent/shared decision-making processes between physicians and patients. Use of a risk calculator helps improve the quality of the informed consent/shared decision-making process by providing a personalized, customized, empirically-based estimate of a patient's risk of post-operative complications. Moreover, evidence suggests that sharing numeric estimates of patient-specific risk may enhance patient trust in providers.
### Table 12 - Risk Factor Definitions

<table>
<thead>
<tr>
<th>Class</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ASA Class</td>
<td>Record the American Society of Anesthesiology (ASA) Physical Status Classification of the patient’s present physical condition on a scale from 1-5 as it appears on the anesthesia record. Most likely there will be a 2nd assessment of the ASA class prior to anesthesia induction. If this is available, report this most recent assessment. Some hospitals may note the ASA classification as the ‘Acuity Code’. The classifications are as follows: ASA 1 - Normal healthy patient ASA 2 - Patient with mild systemic disease ASA 3 - Patient with severe systemic disease ASA 4 - Patient with severe systemic disease that is a constant threat to life ASA 5 - Moribund patient who is not expected to survive without the operation None Assigned – For cases performed under local anesthesia that meet inclusion criteria but do not have an ASA class assigned, report as ‘none assigned’.</td>
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<tr>
<td>Emergent</td>
<td>Emergency Case: An emergency case is usually performed within a short interval of time (typically &lt;24 hours) between patient diagnosis or the onset of related preoperative symptomatology. It is implied that the patient’s well-being and outcome is potentially threatened by unnecessary delay and the patient’s status could deteriorate unpredictably or rapidly. The Principal Operative Procedure must be performed during the hospital admission for the diagnosis. Patients who are discharged after diagnosis and return for an elective, semi-elective, or urgent procedure related to the diagnosis would not be considered to have had an emergent case. The intent is to identify a patient population with heightened surgical risk due to an ongoing acute process that is currently having a negative impact on the patients’ health and for which continued, potentially rapid deterioration could occur. The increased risk might be partly due to the fact that the procedure is being performed with limited preoperative preparation time and the surgical team does not necessarily have the ability to optimize the patient’s status. The emergency case variable distinguishes between urgent/semi-elective/elective cases and true emergent surgeries. Urgent/semi-elective cases are not considered emergencies. Assign ‘YES’ if the surgeon and/or anesthesiologist report the case as emergent.</td>
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<tr>
<td>Functional Status</td>
<td>Functional Health Status: This variable focuses on the patient’s abilities to perform activities of daily living (ADLs) in the 30 days prior to surgery. Activities of daily living are defined as ‘the activities usually performed in the course of a normal day in a person’s life’. ADLs include: bathing, feeding, dressing, toileting, and mobility. Report the best functional status demonstrated by the patient within the 30 days prior to surgery. Report the level of functional health status as defined by the following criteria. (1) Independent: The patient does not require assistance from another person for any activities of daily living. This includes a person who is able to function independently with prosthetics, equipment, or devices. (2) Partially dependent: The patient requires some assistance from another person for activities of daily living. This includes a person who utilizes prosthetics, equipment, or devices but still requires some assistance from another person for ADLs. (3) Totally dependent: The patient requires total assistance for all activities of daily living. (4) Unknown: If unable to ascertain the functional status prior to surgery, report as unknown. All patients with psychiatric illnesses should be evaluated for their ability to function with or without assistance with ADLs just as the non-psychiatric patient. For instance, if a patient with schizophrenia is able to care for him/herself without the assistance of nursing care, he/she is considered independent. If there is a change in the patients functional status, (i.e. improvement to worsening) within the 30 days prior to surgery, report the patient’s best functional status.</td>
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<tr>
<td>Class</td>
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| Wound class                   | Wound Classification: Indicate whether the primary surgeon has classified the wound as: Multiple surgical procedures performed with different incision sites = Assign wound classification based on the Principal Operative Procedure being reviewed.  
Example:  
Principal Operative Procedure: Carotid Endarterectomy (clean) Other Procedure: I & D of an infected right big toe (dirty/infected). The wound class assigned to this case would be clean.  
Multiple surgical procedures performed through one incision (same operative space) = Assign wound classification based on the assessment of the overall operative space.  
Example:  
Principal Operative Procedure: Lysis of adhesions (clean) Other Procedure: cholecystectomy with gross bile spillage (contaminated). The wound class would be contaminated, as the spillage is in the same operative space as the Principal Operative Procedure.  
(1) Clean: An uninfected operative wound in which no inflammation is encountered and the respiratory, alimentary, genital, or uninfected urinary tract is not entered. In addition, clean wounds are primarily closed and, if necessary, drained with closed drainage. Operative incisional wounds that follow nonpenetrating (blunt) trauma should be included in this category if they meet the criteria. Examples of “Clean” cases include mastectomy, vascular bypass graft, exploratory laparotomy, hernia repair, thyroidectomy, total hip or knee replacement, total hip replacements for avascular necrosis, removal of ‘old’ hardware without evidence of infection.  
Note: Placement of any drain at the time of surgery does not change the classification of the wound.  
(2) Clean/Contaminated: An operative wound in which the respiratory, alimentary, genital, or uninfected urinary tracts are entered under controlled conditions and without unusual contamination. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in technique is encountered. Examples of “Clean/Contaminated” cases include cholecystectomy, colectomy, colostomy reversals, roux-en-Y, laryngectomy, small bowel resection, transurethral resection of the prostate, Whipple pancreaticoduodenectomy.  
(3) Contaminated: Open, fresh, accidental wounds. In addition, operations with major breaks in sterile technique or gross spillage from the gastrointestinal tract, and incisions in which acute, non-purulent inflammation is encountered including necrotic tissue without evidence of purulent drainage (for example dry gangrene) are included in this category. Examples of “Contaminated” cases include appendectomy for inflamed appendicitis, bile spillage during cholecystectomy, or open cardiac massage. Open surgical wounds returning to the OR. Examples of major break in sterile technique include but are not limited to non-sterile equipment or debris found in the operative field.  
(4) Dirty/Infected: Old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation. Examples of “Dirty/Infected” cases include excision and drainage of abscess, perforated bowel, peritonitis, ruptured appendix.  
Wound Class for Non-Skin Incision Surgeries (Natural Orifice): assign the wound classification based on which orifice was entered.  
Example: appendectomy performed via the vagina would, at minimum, be a clean/contaminated wound class. |
<table>
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<th>Class</th>
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<tr>
<td><strong>Sepsis</strong></td>
<td>Sepsis within 48 hours prior to surgery: Sepsis is a vast clinical entity that takes a variety of forms. The spectrum of disorders spans from relatively mild physiologic abnormalities to septic shock. The intent is to capture the patient population, whose physiology is compromised by an ongoing inflammatory or infectious process, thereby increasing the patient’s risk of complications during or after surgery. Please report the most significant level using the criteria below.</td>
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<td>1. SIRS (Systemic Inflammatory Response Syndrome): SIRS is a widespread inflammatory response to a variety of severe clinical insults. This syndrome is clinically recognized by the presence of two or more of the following:</td>
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<td>- Temp &gt;38°C (100.4 °F) or &lt; 36 °C (96.8°F)</td>
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<td>- HR &gt;90 bpm</td>
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<td>- RR &gt;20 breaths/min or PaCO2 &lt;32 mmHg(&lt;4.3 kPa)</td>
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<td>- WBC &gt;12,000 cell/mm³, &lt;4000 cells/mm³, or &gt;10% immature (band) forms</td>
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<td>- Anion gap acidosis: this is defined by either:</td>
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<td>- [Na + K] – [Cl + HCO₃ (or serum CO2)]. If this number is greater than 16, then an anion gap acidosis is present.</td>
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<tr>
<td></td>
<td>- Na – [Cl + HCO₃ (or serum CO2)]. If this number is greater than 12, then an anion gap acidosis is present.</td>
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<td>*If anion gap lab values are performed at your facilities lab, ascertain which formula is utilized and follow guideline criteria.</td>
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<td>Sepsis: Sepsis is the systemic response to infection. Report this variable if the patient has clinical signs and symptoms of SIRS listed above and meets either A or B:</td>
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<td>One of the following:</td>
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<td>- Positive blood culture</td>
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<td>- Clinical documentation of purulence or positive culture from any site for which there is documentation noting the site as the acute cause of sepsis.</td>
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<td>OR</td>
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<td>Suspected pre-operative clinical condition of infection or bowel infarction, which leads to the surgical procedure. The findings during the Principal Operative Procedure must confirm this suspected diagnosis with one or more of the following:</td>
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<td>- Confirmed infarcted bowel requiring resection</td>
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<td>- Purulence in the operative site</td>
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<td>- Enteric contents in the operative site, or</td>
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<td>- Positive intra-operative cultures</td>
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<tr>
<td><strong>Dyspnea</strong></td>
<td>Dyspnea: Dyspnea may be symptomatic of numerous disorders that interfere with adequate ventilation or perfusion of the blood with oxygen and is defined as difficult, painful or labored breathing. The intent of this variable is to capture the usual or typical level of dyspnea (patient’s baseline), within the 30-days prior to surgery. The intent is not to include patients solely because of an acute respiratory condition leading to intubation prior to surgery, but rather to reflect a chronic disease state. Characterize the patient's dyspnea status when they were in their usual state of health, prior to the onset of the acute illness, within the 30 days prior to surgery.</td>
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<td>(1) No dyspnea</td>
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<td>(2) Dyspnea upon moderate exertion (for example-is unable to climb one flight of stairs without shortness of breath)</td>
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<td>(3) Dyspnea at rest (for example: cannot complete a sentence without needing to take a breath)</td>
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<td><em>Note:</em> Acute pre-op dyspnea associated with the acute illness will be captured through other variables like pre-op vent dependence, emergency status or ASA Class. The previous requirement that the patient has to themselves state that they are symptomatic has been removed: not all patients are able to verbalize this symptomatology.</td>
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<td>Class</td>
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<td>Ascites</td>
<td>Ascites within 30 days prior to surgery: The presence of fluid accumulation in the peritoneal cavity noted on physical examination, abdominal ultrasound, or abdominal CT/MRI within 30 days prior to the operation. Documentation should state either active or a history of liver disease (for example, jaundice, encephalopathy, hepatomegaly, portal hypertension, liver failure, or spider telangiectasia). Minimal or trace ascites would not qualify; however; malignant ascites (exclusive of liver disease) due to extensive cancer would qualify.</td>
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<thead>
<tr>
<th>Surgical approach- Laparoscopic vs. Open</th>
<th>Operative Approach: Indicate the final surgical approach.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Open</td>
<td></td>
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<tr>
<td>(2) Laparoscopic/Robotic</td>
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<td>(3) Laparoscopic/Robotic Hand Assisted</td>
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<tr>
<td>(4) Laparoscopic/Robotic with Unplanned Conversion to Open</td>
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<tr>
<td>(5) Unknown</td>
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