

ASCs Leverage Technology Data to Deliver Better Patient Outcomes

There is no question that ambulatory surgery centers (ASCs) are under increasing pressure to capture, track and report key quality indicators (QI) and outcomes data. For evidence, one need look no further than the Centers for Medicare & Medicaid Services (CMS) and leading ASC accreditation bodies.

In 2007, CMS announced its intent to require ASCs to submit quality data beginning in 2009 as part of a congressionally mandated pay-for-performance system. Expectations were that CMS would use five quality measures developed by the ASC Quality Collaborative and endorsed by the National Quality Forum (NQF).ⁱ Though the initiative was ultimately postponed, CMS has gone on the record to say that its "clear intention is to implement ASC quality reporting in the future."ⁱⁱ Quality reporting is also required to be eligible for CMS incentive funds available under the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Quality indicators and outcomes data are also playing a greater role in accreditation from the Joint Commission and Accreditation Association for Ambulatory Health Care (AAAHC), as well as laboratory¹ and other accreditation bodies. In fact, beginning in 2010, the Joint Commission will require ASCs to collect data on infections and post-operative complications for 30 days after all procedures and one year after any procedures involving implantable devices.ⁱⁱⁱ

BENEFITS BEYOND COMPLIANCE

Looming federal mandates and more stringent accreditation standards are not the only impetus for ASCs to put a priority on quality and outcomes data. Private initiatives are also picking up steam. For instance, in 2009 the ASC Quality Collaboration published its first public report on ASC quality, based on aggregate performance data for six ASC facility-level quality measures submitted by nine leading organizations.²

Professional societies are also stepping up interest in tracking a broader array of quality measures to expand national benchmarks and position ASCs for the arrival of pay-for-performance reimbursement models. Among them are the American Society for Gastroenterology (ASGE) and the American College of Gastroenterology (ACG), which continue to focus on developing quality measures and

guidelines for gastroenterology through the National GI Endoscopy Quality Indicator Benchmarking project and the GI QI Pilot Program.

The Ambulatory Surgery Center Association (ASCA)³ offers the Outcomes Monitoring Project, which provides benchmarks for 38 key indicators that allow ASCs to compare their own data with national performance statistics on clinical outcomes, staff indicators, billing performance and other indicators. Also, the Medical Group Management Association (MGMA) conducts annual surveys that focus on compensation, revenue, expenses and other factors that many ASC administrators use when auditing practice performance.^{iv}

Though these initiatives are voluntary, they are excellent starting points for ASCs interested in reaping the clinical and operational rewards that can be

derived from measuring quality and outcomes data. Doing so can reveal how an ASC is performing compared to its competition in infection rates, hospital admissions and other areas, all of which can play a significant role in gaining and maintaining market share and negotiating higher reimbursement rates. Further, tracking supply costs, days in accounts receivable and other operational measures against national benchmarks can identify areas for operational improvements, particularly when they show significant variances between comparable ASCs.

ASCs can also benchmark against internal data to validate clinical and operational efficacy or identify areas for improvement. Such was the case for Central Bucks Specialists, a hospital-owned outpatient GI lab in Bucks County, PA.

Central Bucks began tracking indicators⁴ to determine the cause of inconsistent room turnover that was creating scheduling problems, patient frustrations and overall operating inefficiencies. In doing so, the ASC identified several inconsistent practice patterns that could be improved through adjustments. For example, one of the ASC's six physicians' "time-out to scope-in" procedure rate averaged nearly 20 minutes longer than that of the others. Follow up showed that the discrepancy was due to his conscious sedation practice, which differed from his peers' practices in the strength of his initial dosage.^v

CAPTURING DATA IS KEY CHALLENGE

Despite the demonstrated benefits that can be realized from tracking QI and outcomes data, many ASCs have been slow to jump on the bandwagon. The problem is not reluctance; 82 percent of ASCs responding to one survey reported that tracking quality indicators, including infection rate, turn-over time, patient satisfaction, complication rates and hospital transfers.

Rather, the greater challenge is the ASCs' inability to capture structured, compliant data efficiently and accurately. This is due largely to the fact that 82 percent of ASCs do not utilize an EHR, and 74 percent use dictation and transcription to generate physician procedure notes.^{vi}

In a paper-based environment, data must be gathered manually from patient charts, a time-consuming and error-prone process. Exacerbating the problem, there is no efficient means for querying discreet elements once data has been collected, making it difficult to generate the types of reports necessary to benchmark performance indicators and measure quality and operational outcomes effectively.

Given this lack of automation, many ASCs feel they derive little value from the time spent tracking QI data. In another study, 84 percent of gastroenterologists said they considered QI data to be

valuable, primarily for helping to improve their medical practices (81 percent) and ensuring quality care (80 percent). However, half also said their biggest hurdles were the capital investment needed to purchase a system to capture data (50 percent) and the labor-intensive nature of capturing and analyzing QI data (48 percent). Others cited the lack of software available to capture QI data (26 percent) or that could interface with their existing EHRs (24 percent).^{vii}

The good news is that many of these hurdles no longer exist. A growing number of health technology vendors now provide software and systems that are specifically designed for ASCs and are capable of capturing, tracking and analyzing a full range of QI and outcomes data.

THE TECHNOLOGY EDGE

The emergence of specialty-specific automated procedure documentation solutions for ASC-based services such as GI, General Surgery, Ophthalmology, Pain Management, Plastic Surgery and Urology help drive structured and compliant data capture for quality initiatives, benchmarking and other reporting statutes.

Menu-driven documentation processes enable fast, easy capture of compliant data at the point of care, without need for manual manipulation or intervention. The software automatically captures discreet data elements for each procedure, which can then be uploaded automatically to a central repository.

Built-in reporting and analytics tools further simplify quality reporting, clinical research and audit preparation. Their pre-built reports or customized query-writing capabilities enable every captured data element, including free text, to be queried, exported and submitted in appropriate formats.

Automation eliminates some of the most significant challenges provider organizations have faced when attempting to participate in some quality-based initiatives, such as the

Physician Quality Reporting Initiative (PQRI).⁵ Those challenges include technical and coding problems that resulted in non-payment for thousands of physicians who made a good faith effort to report data.^{viii}

For example, GI-specific procedure documentation and coding applications automatically and compliantly capture more than 90 data elements for each procedure before uploading them to a central repository for participation in the ASGE/ACG QI Pilot Program. Cardiology-specific software enables the compliant capture of all relevant procedure data elements for submission to the American College of Cardiology (ACC) National Cardiovascular Data Registry.

In both instances, capture happens naturally during the documentation process, without any additional steps or manual additions. As a result, data collection required for participation in QI programs takes place in the background, without disrupting workflows or consuming additional resources.

When ASC-specific EHRs are added to the technology mix, the opportunities to track QI and outcomes data expand exponentially – as do the ways to use that data to improve operational and clinical performance. For example, the EHR is an important tool to help ASCs comply with increasingly stringent Joint Commission and AAAHC care standards. It can generate safety alerts, record safety measures taken and significantly streamline data gathering and documentation should an audit occur.

To address state, facility and association requirements, documentation of items like pre-anesthesia assessments, ASA scores, "time-outs," informed consent and estimated blood loss can be built into the EHR workflow and documented automatically as part of an official record. Pathology tracking, patient instructions and repeat procedures, recall and surveillance can be simplified and ensured through an EHR's flag or reminder system.

Further, by leveraging the EHR's comprehensive data tracking capabilities, such as scope withdrawal time and adenoma detection and cecal intubation rates, ASCs are able to identify areas for practice improvements.

This is the case at the Jacksonville Center for Endoscopy (JCE), which utilizes a combined documentation and coding system and EHR to track key performance measures and prepare for audits and reviews. These technologies are tapped to track everything from monthly and yearly procedure counts to the number of times physicians reached the cecum during procedures. The information is then used to help identify potential areas for improvement.

Further, because it is no longer necessary to manually pull and review paper charts, JCE is now generating more – and more varied types of – reports to monitor every facet of clinical and operational performance.^{ix}

CONCLUSION

There is a great deal for ASCs to gain from the capture and tracking of key QI and outcomes data. Internal and external benchmarking can reveal areas for clinical and operational improvements that can directly impact an ASC's quality of care and bottom line health.

Further, with quality transparency gaining traction as consumers become more familiar with publicly reported

data, meaningful benchmarking against local and national competitors and the ability to validate clinical efficacy will play a greater role in gaining and maintaining market share.

Deploying the right technologies, such as automated procedure documentation and coding software, and ASC-specific EHRs, eliminates the drain on resources. These technologies can also minimize the potential for human error that can plague QI and outcomes data collection and reporting in a paper-based environment. They can also help ASCs improve operational and clinical effectiveness and efficiencies, while positioning them for future federal mandates and performance-based payment initiatives.

PROVATION® MEDICAL SOFTWARE PROVIDES RIGOROUS DATA CAPTURE AND REPORTING CAPABILITIES FOR QUALITY INITIATIVES, BENCHMARKING AND OTHER REPORTING STATUTES. IT DRIVES STRUCTURED AND COMPLIANT DATA CAPTURE, WHICH IS THEN PAIRED WITH ROBUST REPORTING AND ANALYSIS CAPABILITIES TO SIMPLIFY QUALITY REPORTING, CLINICAL RESEARCH AND AUDIT PREPARATION.

FROM COMPLIANT CODING OF PHYSICIAN DOCUMENTATION TO A COMPREHENSIVE SET OF PRE-BUILT DATA REPORTS AND CUSTOMIZED QUERY-WRITING TOOLS, PROVATION SOFTWARE DRIVES QI AND PAY-FOR-PERFORMANCE METRICS WHILE ALLOWING FOR FASTER, MORE ACCURATE REIMBURSEMENT AND HIGH ROI.

ProVation® MD

Replacing dictation and transcription, ProVation® MD allows physicians to document procedures efficiently at the point of care. It drives revenue recovery and provides greater protection against RAC audits by utilizing intuitive navigation to lead clinicians through the procedure documentation process efficiently, then automatically tying that documentation to reimbursement coding.

ProVation MD includes more than 80 standard pre-built data reports in such categories as patient information, risk management, procedures, coding, indications and findings, QI, center operations, staff members, use of facilities, instruments and referrals. It captures more than 90 QI data elements for each procedure and allows for the creation of additional ad-hoc queries. Queries can be saved for future use, and all reports can be exported easily to Microsoft Excel or Access.

ProVation® EHR

The first true EHR designed for busy, cost-conscious ASCs, ProVation® EHR offers electronic documentation and document imaging for all elements of the patient encounter, from past records and procedure documentation to follow-up care. It supports quality initiatives, benchmarking and other reporting statutes with a robust set of turnkey data reports and intuitive data query options, and also features a procedure data export that allows for customized QI data analysis.

With ProVation EHR, ASCs have affordable access to a single, patient-centric documentation system that eliminates printing and chart storage costs and streamlines workflow. It increases patient throughput and eliminates patient chart storage space and costs, providing an affordable solution with low monthly operating costs. It also interfaces seamlessly with vitals monitors, information systems and ProVation MD.

ProVation Medical software is built and backed by an in-house staff of more than 30 clinicians and coders. Both the software and ProVation's world-class customer service have been ranked #1 in KLAS for 2005, 2006, 2007 and 2008.

For more information on ProVation software, visit us at ProVationMedical.com.

- ¹ These include Intersocietal Commission for the Accreditation of Nuclear Medicine Laboratories (ICANL), Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL) and Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL).
- ² Participating organizations included: Ambulatory Surgery Center Association; Ambulatory Surgical Centers of America (ASCOA); AmSurg; HCA Ambulatory Surgery Division; National Surgical Care (NSC); Nueterra; Surgical Care Affiliates (SCA); Symbion and United Surgical Partners International (USPI). Performance data included Patient Fall in the ASC; Patient Burn; Hospital Transfer/Admission; Wrong Site, Side, Patient, Procedure, Implant; Prophylactic IV Antibiotic Timing and Appropriate Surgical Site Hair Removal.
- ³ ASCA was formed as a result of the 2007 merger between the Federated Ambulatory Surgery Association and the American Association of Ambulatory Surgery Centers.
- ⁴ Indicators tracked included arrival to patient-in-room, patient-in-room to time-out, time-out to scope-in, scope-out to recovery start, recovery start to discharge and polypectomy rates.
- ⁵ Participating eligible providers who bill under Medicare Part B for services provided at ASCs are included in PQRI, while ASC facility charges billed separately under the ASC fee schedule are not.
- ⁱ Rollins, Gina. "Final Five: ASCs Told to Target Patient Safety." Hospitals & Health Networks. December 2007. Available at http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/12DEC2007/0712HHN_FEA_Quality&domain=HHNMAG
- ⁱⁱ Health Law Update. "Proposed Changes to OPPS and ASC Payment Systems for CY 2010: A Sigh of Relief on Supervision and a Potpourri of Payment Changes." Bass, Berry & Sims PLC. July 31, 2009. Available at <http://www.bassberry.com/files/Publication/528837b6-f6e7-467b-9be8-040cf948887f/Presentation/PublicationAttachment/9de436ae-8bda-4a8c-8fe4-0213296d0d13/Health%20Law%20Alert.pdf>
- ⁱⁱⁱ Dunn, Lindsey and Tomcanin, Renee. "10 Critical ASC Accreditation and Patient Safety Challenges and Best Practices to Overcome Them." Becker's ASC Review. September 4, 2008. Available at <http://www.beckersasc.com/news-analysis-asc/accreditation-patient-safety/10-critical-asc-accreditation-and-patient-safety-challenges-and-best-practices-to-overcome-them.html>
- ^{iv} Beaver, Michelle. "ASC Benchmarking: Data-Collection Process Evolves." SurgiStrategies. July 2, 2007. Available at <http://www.surgistrategies.com/articles/771feat8.html>
- ^v ProVation® Medical Case Study. "Central Bucks Specialists Finds Quality Tracking, Efficiency with ProVation Software." Available at <http://www.provationmedical.com/Common/PDF/Central%20Bucks%20Case%20Study.pdf>
- ^{vi} Renaissance Research on behalf of Wolters Kluwer Health. "National Survey of Ambulatory Surgery Center Administrators: Report of Findings." March 2008.
- ^{vii} Renaissance Research on behalf of Wolters Kluwer Health and CARISDx. "Study of Quality Indicators for Gastroenterological Procedures: Report of Research Findings." January 2008.
- ^{viii} Arvantes, James. "AAFP Board Chair Confers With CMS, Urges Changes in PQRI Program." AAFP News Now. Dec. 16, 2008. Available at <http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20081216pqri-mtg.html>
- ^{ix} ProVation Medical Case Study. "Jacksonville Center for Endoscopy Goes Paperless with ProVation® EHR, ProVation® MD." Available at http://www.provationmedical.com/Common/PDF/ProVationMD_BorlandGrooverCaseStudy.pdf