ASCs are under increasing pressure to capture, track and report key quality indicators (QI) and outcomes data. As evidence of this, one need look no further than CMS and leading ASC accreditation bodies.

CMS had previously called for ASCs to begin submitting quality data in 2009 as part of a congressionally mandated pay-for-performance system. Though that requirement was eventually tabled, the agency has gone on the record that its "clear intention is to implement ASC quality reporting in the future."

Quality indicators and outcomes data also play a greater role in achieving accreditation from the Joint Commission. 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. AAAHC, laboratory and other accreditation bodies are also placing more emphasis on quality data.

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. Professional societies are also stepping up their 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.

Many associations offer benchmarks that allow ASCs to compare their data with national performance statistics on clinical outcomes, staff indicators and billing performance, as well as annual surveys that revolve around compensation, revenue and expenses, which many ASC administrators utilize when auditing practice performance.

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 against its competition in such areas as infection rates, hospital admissions, etc., all of which can play a significant role in gaining and maintaining market share and negotiating higher reimbursement rates.

Further, tracking operational measures such as supply costs, days in accounts receivable, etc., against national benchmarks can identify areas for operational improvements 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.

This was the case for Central Bucks Specialists, a hospital-owned outpatient GI lab in Bucks County, PA. After deploying an EHR and documentation system, the practice began tracking indicators 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 benefit from adjustments.

For example, one of the ASC's six physicians averaged a scope-in to scope-out time that was

significantly shorter than his peers. This was determined to be a practice preference, and the physician ultimately opted to slow his scope withdrawal to ensure greater consistency and better adhere to identified GI best practices.

Capturing data is critical 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; it is the ability to effectively and accurately capture structured, compliant data. This is due in large part to the fact that 82 percent of ASCs do not utilize an EHR and 74 percent utilize dictation and transcription to generate physician procedure notes.

In a paper-based environment, data must be manually gathered from patient charts, a time-consuming and error-prone process. Exacerbating the problem, once the data has been collected, there is no efficient means for querying discreet elements to generate the types of reports necessary to effectively benchmark performance indicators and measure quality and operational outcomes. Because of this lack of automation, many ASCs feel they derive little value from the time spent tracking QI data.

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 capable of capturing, tracking and analyzing a full range of QI and outcomes data and are designed specifically for ASCs.

Technology edge

The emergence of specialty-specific automated procedure documentation solutions for ASC-based services 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 the need for manual manipulation or intervention. The software automatically captures discreet data elements for each procedure, which can then be automatically uploaded to a central repository.

Built-in reporting and analytics tools further simplify quality reporting, clinical research and audit preparation with pre-built reports or customized query-writing capabilities that 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 quality-based initiatives, such as the Physician Quality Reporting Initiative. Among those were technical and coding problems that resulted in non-payment for thousands of physicians who made a good faith effort to report data.

When ASC-specific EHRs are added to the technology mix, the opportunities to track QI and outcomes data expand exponentially — as do the uses for 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 the gathering of data and documentation should an audit occur.

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

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 quality of care and the bottom line health of an ASC.

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 and the potential for human error that can plague QI and outcomes data collection and reporting in a paper-based environment. In doing so, it can help ASCs improve operational and clinical effectiveness and efficiencies and position them for future federal mandates and performance-based payment initiatives.

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