First in a series on quality improvement for ambulatory surgery centers.

Ambulatory surgery centers (ASC) have a new source for benchmarking data. The national ASC Quality Collaboration is now posting quarterly data on 6 quality and safety measures (sidebar). The measures, which are in the public domain, were developed by ASC leaders specifically for surgery centers.

“These are consensus standards developed by the ASC Quality Collaboration and endorsed by the National Quality Forum,” explains Donna Slosburg, RN, BSN, LHRM, CASC, the Collaboration's executive director. NQF, a nonprofit organization, endorses consensus health care quality measures. The data are posted at www.ascquality.org.

Depending on the measure, the data represent from 423 to 1,294 surgical facilities and from 433,000 to 1.5 million patient admissions. The latest results include figures from the ASC Association’s Outcomes Monitoring Project, with about 600 ASCs enrolled.

The measures with the most data to date are patient falls in the ASC and patient burns. There is less data on the 2 process measures, on-time administration of prophylactic antibiotics and appropriate hair removal.

Quality reporting

Quality measurement is becoming increasingly important to ensure quality as well as to meet regulatory requirements.

The Centers for Medicare and Medicaid Services (CMS) refers to 5 of the ASC Quality Collaboration measures as examples of ones surgery centers can use in its interpretative guidelines for state surveyors. The interpretive guidelines support the revised Medicare Conditions for Coverage (CfCs), which require ASCs to have a quality assessment and performance improvement (QAPI) program. According to the interpretive guidelines, ASCs may choose to use these measures but are also free to use different measures as long as they meet regulatory criteria.

How can ASCs use the data?

ASCs can use the ASC Quality Collaboration’s data to compare their own results with other facilities across the country, Slosburg suggests.

ASC quality measures


<table>
<thead>
<tr>
<th>Measure</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>Patient falls in the ASC</td>
<td>0.183 per 1,000 admissions</td>
</tr>
<tr>
<td>Patient burns</td>
<td>0.042 per 1,000 admissions</td>
</tr>
<tr>
<td>Hospital transfer/admission</td>
<td>0.997 per 1,000 admissions</td>
</tr>
<tr>
<td>Wrong site, side, patient, procedure, implant</td>
<td>0.032 per 1,000 admissions</td>
</tr>
<tr>
<td>Prophylactic antibiotic given on time</td>
<td>96%</td>
</tr>
<tr>
<td>Appropriate surgical site hair removal</td>
<td>98%</td>
</tr>
</tbody>
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Source: ASC Quality Collaboration. www.ascquality.org
For example, for patient burns, an ASC could compare its experience to the national rate. If that ASC’s rate of burns is significantly higher, “I would look to see if there were any trends. Then I would see what changes are needed to correct that,” she advises.

There are a couple of caveats about using the data.

First, ASCs need to make sure they are “comparing apples to apples” by using the same definitions, Slosburg notes. (The definitions are on the Collaboration’s website.)

For instance, the Collaboration defines patient falls as those that occur “within the confines of the ASC.” To compare its results, an ASC would need to use the same definition; that is, exclude falls that happen outside the ASC, such as in the parking lot or after the patient goes home.

In a second caveat, 4 of the measures are reported as the rate per 1,000 patient admissions. An “admission” is defined as a patient who has completed registration to the facility.

ASCs often use a percentage to measure their rates. To compare to the Collaboration data, they would need to divide by 10. For example, taking the patient fall rate of 0.183 per 1,000 admissions and dividing by 10, the rate would be 0.0183 falls per 100 patient admissions, or about 2/100th of 1%.

Many ASCs track their data on a quarterly basis. Now they can use the Collaboration’s data for comparison, Slosburg notes.

Medicare’s quality reporting plans

Surgery centers have been expecting Medicare to start requiring ASCs to report quality data, as hospitals now do. But CMS proposed not requiring ASC reporting for 2010. Still it would be wise to be ready. Though CMS is postponing reporting for now, the agency says in the proposed 2010 outpatient payment rule, “It is our clear intention to implement quality reporting in the future.”

The Collaboration “strongly advocates quality reporting for ASCs,” Slosburg says.

In its comment to CMS on the proposed rule, the Collaboration expressed disappointment in the agency’s lack of progress and encouraged CMS to move ahead quickly with ASC quality reporting.

The ASC Quality Collaboration data are at www.ascquality.org/qualityreport.html