

Quality Improvement for the Ambulatory Surgery Center

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Roadmap to the **FUTURE** of **PRACTICE**

Quality measurement and improvement extend into our ambulatory endoscopy centers (AECs), in addition to our practices and hospitals. There are over 5000 Medicare certified AECs in the United States, so we know that variability in safety and quality certainly exist. As gastroenterologists, we are dedicated to providing our patients a safe, efficient, and high-quality experience in our AECs. This month, Dr Bret Petersen, a leader in quality improvement, helps us understand how to develop a plan for measuring and improving quality in our AECs. The Centers for Medicare and Medicaid are most interested in this subject and have contracted with the Center for Outcomes Research and Education (CORE, from Yale University School of Medicine) to develop metrics that will become part of their value-based reimbursement program in the near future.

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Quality measurement and performance improvement now are accepted uniformly as key strategies and responsibilities in the delivery of health care,¹ including in the management of gastrointestinal endoscopic services. Numerous metrics for quality performance by endoscopists have been adopted in recent years²⁻⁶ and now are being updated for 2014. Unit-specific measures pertaining to customer care, safety and infection control, communication and continuity of care, efficiency and procedure-specific unit factors also are under development by gastrointestinal and surgical societies at this time. Until recently, the mandates and inducements for assessing and improving quality from the Centers for Medicare and Medicaid Services (CMS),

accreditation organizations, and state health departments have been very generic, but measures adopted for 2014 and beyond incorporate greater numbers of endoscopy-specific expectations. In contrast, private payers have been slow to delineate quality-based performance expectations or thresholds for reimbursement. Beyond regulatory requirements, additional issues warrant focused attention to maintain the quality of care delivery. In this article, I address quality-improvement principles for ambulatory endoscopy centers (ASCs).

A number of metrics commonly are used for tracking the financial health of endoscopy centers, including physician-, unit-, and practice-specific costs and revenues prorated to procedural volume, space, or unit of time. Similarly, the high-quality facility is also dependent on recruitment and care of a cohesive team of physicians, nurses, and supporting personnel. This is an ongoing task that requires specific intent and planning. Although benchmarks for personnel management and financial performance commonly are used, they are both beyond the scope of this article.

Quality Measurement Concepts

Quality-improvement efforts are based on the principle that performance can be measured and compared with optimal performance to identify needs for improvement (gaps) so that leaders then can alter structures or processes to improve health outcomes for patients. Performance on a given parameter (commonly termed a *metric*, *measure*, or *indicator*) is expressed as a ratio between a numerator, representing the incidence of correct performance, and a denominator, representing the opportunities for correct performance. To enable uniform data collection and interpretation, measures should be defined formally in advance of improvement efforts. Measures used for

Abbreviations used in this paper: ASC, ambulatory surgery center; CMS, Centers for Medicare and Medicaid Services; DHRP, Digestive Health Recognition Program; FFS, fee-for-service; GRS, global rating scale; IBD, inflammatory bowel disease; NQS, National Quality Strategy; PQRS, Physicians Quality Reporting System.



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regulatory or reimbursement purposes are rigidly standardized and often use cumbersome administrative codes for claims-based reporting, but those identified for submission via registries, or for local improvement efforts, can be stated more simply using clinical terminology.

Optimal metrics should correlate with pertinent clinical outcomes, and be evidence-based, reproducible, feasible to collect, and amenable to improvement. Measures typically are identified by the type of performance assessed: structural measures address features of the environment of care (such as training, staffing, facilities, and policies); process measures address performance in the delivery of care (routine use of antibiotics in cirrhotic patients admitted with gastrointestinal bleeding, use of appropriate intervals for screening and surveillance colonoscopy); and outcome measures address the results of care from the patient's perspective (resolution of infection, occurrence of interval cancer, and so forth).

Requirements for Successful Quality-Improvement Efforts

The requirements for effective quality-improvement initiatives in an ambulatory endoscopy center include the following: (1) recognition of the need for improvement; (2) motivation, leadership, and coherent advocacy for improvement from the unit's owners, partners, and management; (3) clear definition of the gaps or shortcomings in performance and their contributing factors; (4) availability of timely and accurate data; and (5) a process for achieving the desired change.⁷ Challenges to quality endeavors on a local level include insufficient awareness, willingness, knowledge base in expectations and solutions, improvement expertise, time, and financial resources.

Significant investments in infrastructure, staff time, and expertise are required for larger improvement efforts and fulfilling national expectations for performance and data submission. For short-term ad hoc improvement projects, manual data tracking and display typically are sufficient. Automated data accrual is helpful for larger settings, ongoing tracking of performance, and serial submission of data for benchmarking and regulatory or reimbursement purposes. The repetitive nature of gastrointestinal endoscopy simplifies uniform documentation and data accrual via standardized electronic report generators. CMS-qualified report generators and electronic health records are now becoming essential business tools.

In small ASCs, quality oversight may be shared by all partners or a managing partner and administrator. In large endoscopy facilities, quality improvement may be managed primarily by a nonphysician manager or

specialist. Adoption of electronic systems and submission of quality data requires expertise in information technology and CMS coding and billing. Quality monitoring and improvement efforts often benefit from skills in project management, statistical assessment, and process control charting. Many of the major skills involved can be contracted out, or acquired with purchased systems, but some degree of on-site employed expertise should be considered a modern cost of practice, despite a lack of funding to meet the evolving mandates.

Recognizing and Prioritizing Improvement Opportunities

Every facility has opportunities for improvement in safety, efficiency, clinical outcomes, cost, or service. However, the capacity to undertake quality-improvement initiatives usually is constrained, therefore departments must prioritize their efforts. Top priority should be given to the following: (1) gaps in care that pose a direct risk to patient safety or procedural outcomes (such as suboptimal processes or performance in preprocedure and postprocedure management of anticoagulants, antibiotics, hypoglycemic agents, and other medications; intraprocedural sedation practices; endoscope reprocessing; and major lapses in endoscopists' procedural safety or performance); (2) measures required to ensure full reimbursement, such as licensure, deemed status, and other measures stipulated by CMS and accreditation organizations; (3) glaring issues related to patient dissatisfaction; and (4) quality measures promulgated by national and international organizations. Additional quality needs can be identified by attention to near-miss, never, or sentinel events (all of which warrant investigation for structural or process failures), patient complaints, and repeated mention on patient, employee, or referring physician questionnaires. Units must be aware of health system, state, and federal requirements for reporting (eg, wrong site of surgery) and implement processes to comply with these regulations.

Most well-managed departments already have addressed basic quality issues, allowing them to focus on other less-glaring gaps in performance, including those unique to their specific environment or patient population. One useful practice for identifying improvement opportunities is to perform an assessment of lapses and bottlenecks in the sequential steps in care, from the referral process to scheduling, preprocedure exchange of information and patient guidance, preparation, check-in, procedure performance, recovery, dismissal process and guidance, and subsequent communication of results

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