ASC Quality Collaboration

February 16, 2024

RE: MUC 2023-2024 Hospital Committee PRMR Results

The ASC Quality Collaboration (ASC QC) is a non-profit organization whose efforts are directed at advancing high quality, patient-centered care in ambulatory surgery centers (ASCs) through a collaborative membership of ASC stakeholders, including leaders from ASC management companies, industry associations, professional physician and nursing associations, accreditation organizations and information technology companies. As part of our mission, the ASC QC develops, tests and implements quality measures for ASCs. Currently, six of our quality measures are included in the CMS ASCQR Program.

We submitted comments on the MUCs for the ASCQR Program in December 2023. Having attended the January 2024 meetings of the Hospital Committee recommendation panel remotely, we can attest that concerns raised by the ASC QC in our comments were not addressed. The only participants allowed to engage in the discussion were CMS, Battelle staff, and members of the recommendation committee, so there was no opportunity to raise the issues that were omitted.

The public comment process did not ensure the voices of all interested parties were heard, or that the concerns raised were fully acknowledged, adequately described and presented by staff, and discussed before decisions were made. As a result, we are reiterating our concerns regarding the two measures that the Hospital Committee recommended or recommended with conditions for the ASCQR Program.

A. MUC 2023-156: Screening for Social Drivers of Health (SDOH)

One of the five social risk factors selected for screening under this measure is interpersonal safety. Without proper conditions, screening for interpersonal safety may unintentionally result in harm to the patient. We are specifically concerned about three matters:

- Firstly, virtually all ASC patients receive some form of anesthetic, sedation and/or pain medication as part of their care. As a result, it is important for the patient to have a companion to return them home. While this companion may be anyone, it is often a domestic partner of the patient. This companion typically accompanies the patient through the intake process and preparation in the preoperative area before the patient is taken to the procedure or operating room; the companion then rejoins the patient in recovery. This involvement is intended to provide support for the patient and helps the companion learn how to best assist the patient during recovery at home. However, best practices dictate screening for

interpersonal safety should ONLY be done when the patient is alone, without exception. This would be difficult to incorporate into the typical ASC process of patient-centered care, which allows companions to be involved.

- Secondly, screening for interpersonal safety should always be done in a private setting. However, intake, preoperative and postoperative areas are often semi-private in surgery centers. Therefore, conversations may not be private.

- Finally, the process of recovery at home often involves the temporary use of pain medications and the need for additional sleep or rest which can impact the patient's ability to remain vigilant or to take necessary steps to avoid detection of the screening if the abuser was not present at the ASC. If resource and/or referral materials are provided at discharge and subsequently discovered by an abuser, this could trigger additional abuse.

The developer asserts that many facilities already have a SDOH screening tool integrated into their EHRs. This assertion is not supported by our experience. Many ASCs do not have an EHR. Past environmental scans have shown the use of EHRs in the ASC industry is significantly more limited than in other healthcare settings. As a result, implementing this measure would not be possible in most ASCs.

No information has been presented to indicate how the measure data could be used for performance improvement in the ASC setting. Even comparing data across centers would not be possible because the measure does not specify a particular survey tool. Further, it is not clear how the public could use the measure results to determine quality of surgical care.

There is no evidence that the process of screening for SDOH in ASCs would lead to better or more equitable care. Due to a lack of measure testing, there is no evidence to support the validity, reliability, feasibility and usability of the measure in ASCs. Per CMS, "[t]here should be a scientific basis for believing that the process, when executed well, will increase the probability of achieving a desired outcome." The measure does not have a scientific basis in the ASC setting.

B. MUC 2023-175: Facility Commitment to Health Equity

This measure was developed for use in hospitals and, according to the information provided with the measure, is being presented "as is" for use in ambulatory surgical centers. It is clear the measure has never been tested in an ASC because the specifications are not appropriate to this setting. Important differences between hospitals and ASCs should be, but have not been, considered.

For example, the measure assumes all ASCs have EHRs. As noted above, many ASCs do not have an EHR. While the HITECH Act of 2009 authorized financial incentives for hospitals and clinicians to adopt and meaningfully use certified EHR technology, ASCs were not included in the provisions of the Act and were subsequently ineligible for financial incentives under the Promoting Interoperability Program. This has perpetuated

cost barriers to EHR implementation in ASCs. As a result, many of the analyses required by the measure would not be possible.

The measure also assumes that ASCs are led by CEOs and have a board of trustees, which is not the case. ASCs are overseen by a governing body (which may be a small as one individual if the ASC has one owner). This governing body has direct oversight of the ASC's mandatory quality program, but strategic planning is not a required activity under Medicare's ASC Conditions for Coverage.

The measure also assumes ASCs have personnel and other resources that could be directed to all the activities required to achieve a full score on the measure. However, as CMS itself has indicated, approximately 73 percent of ASCs would be classified as small businesses according to the Small Business Administration size standards [72 Fed. Reg. 66901]. The predominance of small facilities is corroborated by CMS data indicating a median of two operating/procedure rooms per facility (mean = 2.5). The average ASC employs 33 clinical and non-clinical full-time equivalents, significantly fewer individuals than the average hospital.

Further, Federal regulations dictate that ASCs operate "exclusively for the provision of surgical services not requiring hospitalization". As a result of the Medicare Conditions for Coverage, ASC services are limited to the immediate preoperative, intraoperative and postoperative period. ASCs may NOT perform preoperative or postoperative clinic visits. As a result, staff expertise is focused on providing surgical services. Without social workers, case managers and other related professionals on staff, ASCs may find it difficult to perform all the stipulated activities and develop expertise (such as culturally sensitive collection of demographics and/or social determinant of health information) in matters outside the scope of surgery.

Achieving a 5/5 score on this measure would be challenging for ASCs not owned by hospitals (and the majority of ASCs are not hospital-owned), and impossible for those that do not have an EHR. The measure should be adapted for a small organization providing surgical care, to eliminate bias in favor of large facilities with greater resources, such as hospitals and hospital outpatient departments (HOPDs).

A more meaningful alternative approach to the topic of commitment to equity in ASCs would be a measure assessing whether an ASC's quality program addresses equitable care and equitable outcomes for surgical services. Placing the focus on actual quality improvement efforts around equitable care would measure commitment in a way that could be applied to all facilities, regardless of size and resources.

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We look forward to due consideration of our concerns, and for improvements in the PRMR process in the 2024-2025 MUC cycle.