Connecting Ambulatory Surgery Centers

Frameworks for EHRs in ASCs

Alex Taira, Regulatory Policy and Research Manager | Ambulatory Surgery Center Association
The Ambulatory Surgery Center Association (ASCA) is the national membership association that represents ambulatory surgery centers (ASCs) and provides advocacy and resources to assist ASCs in delivering high-quality, cost-effective ambulatory surgery to all the patients they serve.
ASCs and EHRs

• Low EHR penetration compared to other sites of service

• Structural barriers:
  » Diverse specialties
  » Diverse facility sizes, management structures
  » Between sites of service

• Future implications:
  » Value-based payment program participation
  » Need for better data as more complex surgical procedures migrate
Section 16003: Treatment of Eligible Professionals in Ambulatory Surgical Centers for Meaningful Use and MIPS

“...no payment adjustment may be made...in the case of an eligible professional with respect to whom substantially all* of covered professional services furnished by such professional are furnished in an ambulatory surgical center.”

Sunset Clause:

“shall no longer apply as of the first year that begins more than 3 years after the date on which the Secretary determines...that certified EHR technology applicable to the ambulatory surgical center setting is available.”

* “substantially all” defined in FY 2018 IPPS Final Rule as 75 percent or more of covered professional services in POS 24
ASCA EHR Stakeholder Group and Workgroup

• Open, volunteer-driven, vendor agnostic process

• General stakeholder group
  » Open to anyone
  » ASCA staff provides EHR-related regulatory and legislative updates
  » Workgroup updates
  » Education and general discussion

• Volunteer workgroup
  » ASCA members
  » One representative per vendor
  » Towards an ASC-specific EHR certification
ASC-Specific EHR Certification Standards

Executive Summary: A voluntary, Ambulatory Surgery Center (ASC)-specific electronic health record (EHR) certification is essential for effective coordination across the care continuum, and will ensure that ASCs remain providers of high-value care for patients. EHR standards and measures adapted for ASCs will facilitate the development of systems that allow ASCs to effectively and efficiently participate in value-driven health care initiatives. This will in turn expand opportunities for patients to take advantage of the convenient, low-cost, high-quality care offered by ASCs.

ASCs are located across every state and offer patients high-quality, convenient and low-cost choice for outpatient surgical care. Over 65% of all surgery* takes place in an outpatient setting, and ASCs are expected to handle 60% of outpatient surgical cases by 2026. ASC utilization will continue to grow thanks to advances in technology, improved anesthesia, and less invasive surgical procedures. Furthermore, prevailing value-based trends and emphasis on effective care coordination will make ASCs an increasingly attractive and beneficial setting for patients, physicians and payers alike.

While ASCs are an integral part of the nation’s health care delivery system, they have not been incorporated in federal programs that encourage and incentivize the use of health care information technology (HIT). Notably, ASCs have been excluded from the development of standards that designate HIT systems as certified EHR technology (CEHRT). This has produced several negative externalities, specifically slow product uptake by both ASCs and vendor developers, high-penalty physician workflow integration and ultimately impaired patient care coordination.

Stimulating Development

Standards requirements are crucial to guide vendors in creating high-quality, cost-effective systems designed to meet current and future health care needs. An EHR certification specifically designed for the ASC setting would allow vendors to develop systems that include ASC measures that matter. Since ASCs are not included as eligible participants, the standards regarding what constitutes a “certified EHR” were written without considering specific needs in the ASC environment. Although some hospitals or provider measures may be adapted to be applicable to outpatient surgery performed in an ASC, additional surgery specific measures are necessary. When standards are set the Healthcare Information Management Systems Society (HIMSS) stages of EHR adoption will elevate quickly and vendor innovation for the ASC setting will drive.

Standards and incentives provide market drivers that encourage facilities to make the significant financial investment necessary to implement EHR solutions. Conversely, the absence of such standards creates an environment of uncertainty in which facilities are reasonably hesitant to commit resources towards solutions that may be undermined by future regulation. While both vendors and facilities have expressed interest in EHR proliferation, the structural uncertainty caused by the lack of common standards has bred stakeholder hesitation.

Patient Safety & Quality

Improvements to quality of service and safety of care derived from a certified EHR in the ASC setting cannot be overstated. EHRs aid physicians in diagnostic evaluation, reduce the chance of clerical error, and streamline the overall care delivery process by facilitating care coordination among physicians and other caregivers. While some ASCs have implemented EHRs, access to CEHRT would ensure ASCs can more effectively participate in care coordination, thus creating greater value, convenience, engagement, and satisfaction for patients.

An e-prescribing system within an ASC EHR would alone reduce prescribing errors, improve efficiency, and reduce adverse events. Eligible providers could digitally sign and send electronic prescriptions for controlled substances to qualified pharmacies. The added interoperability within the care continuum would ensure that controlled substances, such as opioids, are documented in the longitudinal care record, reducing fraud and cost-prescribing.

Certified EHR technology (CEHRT) will also enhance the ability to accurately document and report quality performance in the ASC. Facilities would have the ability to report a wider range of performance metrics with greater accuracy and transparency. This data could be compared with other care settings to demonstrate quality performance for the benefit of patients and regulators. CEHRT would also facilitate ASC-based physician participation in modern value-based care programs such as the Merit-Based Incentive Payment System (MIPS) which rewards reporting of quality metrics via CEHRT.

Workflow Integration & Interoperability

ASCs are part of an evolving medical neighborhood which requires interoperable HIT for efficient care coordination. The demand for both public and private payers is the decline of fee-for-service (FFS) payments models and greater explanation of alternative payments models such as accountable care organization (ACO) bundled payments, capitation and shared-savings. As these models continue to evolve, care coordination is paramount and must include high value sites such as ASCs.

ASCs must be included in the coordination of longitudinal care with full participation in interoperable EHR systems. Physicians deliver the highest quality care when they can access patient’s longitudinal health record, considering medical history across care settings. However, ambulatory physicians are often forced into inefficient and awkward solutions to access information held in hospital or office software, increasing burden and risk of error. Without access to CEHRT, and the resultant ability to report data associated with the procedures performed, the ability of ASCs to fully-participate in care coordination and collaborative care models has been compromised. Voluntary certification will ultimately result in more meaningful and effective health care information exchange (HIE) of data, as well as more fully engaged physicians and other health care professionals participating in the coordination of patient care.
### ASCA EHR Workgroup Criteria Examination

<table>
<thead>
<tr>
<th>Regulation Text Citation</th>
<th>Certification Criterion</th>
<th>EHR</th>
<th>ASC</th>
<th>O</th>
<th>M</th>
<th>C</th>
<th>H</th>
<th>Test Tool/Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Comprised provider order entry (CPOE) - medications</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Risk</td>
</tr>
<tr>
<td>3</td>
<td>CPOE - laboratory</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>CPUE - diagnostics imaging</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Drug-drug, drug-allergy interaction checklist for CPOE</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Demographics</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Problem list</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Medication list</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Medication allergy list</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Clinical decision support</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Drug-harmatory and preferred drug list checks</td>
<td>Yes</td>
<td>No</td>
<td>Modifications in ASC are already limited in scope and size</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Smoking status</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Family health history</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Ye</td>
<td>Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Patient-specific education resources</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Implantable device list</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Social, psychological, and behavioral data</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Transitions of care</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Test Tool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Critical care information documentation and access</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Test Tool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Electronic prescribing</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Test Tool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Common Clinical Data Set summary record - generate</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Test Tool</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Criteria Master List**
ASCA EHR Workgroup Next Steps

• Feedback on clinical goals
  » Physicians
  » Administrative, clinical staff

• Broader education in the ASC community

• Strategic partnerships (AJRR)

• Advocacy, collaborative work with ONC
Thank you!

Alex Taira

ataira@ascassociation.org