Minnesota Statewide Quality Reporting and Measurement System

Presented by Denise McCabe and Alison Helm
(50-minute Webinar) [05-08-2012]

Vicki: Welcome to this Minnesota Statewide Quality Reporting and Measurement System call. This is our second annual call. Last year was the first year of reporting. I’m very pleased to introduce today we’ll be having two speakers. Denise McCabe, who’s the principal planner at the Minnesota Department of Health and is responsible for the Statewide Quality Reporting and Measurement System, as well as Alison Helm, who’s the Project Specialist at Minnesota Community Measurement related to direct data submission.

A few things just for logistics before we get started… Our objectives for today are to review the quality measurement statutory requirements and developments in Statewide Quality Reporting and Measurement System, describe the changes and the specifications for measures required of ambulatory surgery centers and understand the data submission process for this year and the deadlines for the quality data reporting.

We’ll start out talking about the review of the system and giving some background and history and then going to the specification changes and process for data submission. There will be time for questions and answers. I think we’re anticipating that this won’t take the full hour, but our time is here to be able to answer any questions.

I think I’ll toss it off to Denise to talk about the history and give you some background on the Quality Measurement System.

Denise: Thank you, Vicki. Hi, this is Denise McCabe. I work for the Minnesota Department of Health where I support activities related to the Minnesota Statewide Quality Reporting and Measurement System. Thank you for joining us today to learn more about the quality measures for ambulatory surgical centers. As Vicki said, I will provide a little context for these measures, and then our presenters from Minnesota Community Measurement will go into the details.

Minnesota’s nation leading health reform legislation was enacted in 2008, and at that time the executives and legislative branches of Minnesota government were well aware of the increasing and unsustainable costs of healthcare, and that research was showing that there was wide variation in costs and quality across different healthcare providers, with no evidence that higher costs or higher use of services was associated with better quality or better health outcomes for patients.

It was recognized that Minnesota could do better and that Statewide Quality and Measurement and public reporting could be a way to prompt this improvement as a means of increasing the transparency and accountability of the healthcare system.
Therefore, as part of the state’s 2008 health reform laws, the Commissioner of Health was charged with developing a standardized set of measures to assess the quality of healthcare services offered by healthcare providers, establishing standards for measuring health outcomes, establishing a system for risk adjusting quality measures and publicly reporting the quality measures results.

In the fall of 2008, the Minnesota Department of Health conducted a competitive procurement process for a contractor to assist in the completion of these tasks. As a result of this process, the Minnesota Department of Health has a four-year, $3 million contract with Minnesota Community Measurements as the lead member of the consortium, which all includes Stratis Health, the Minnesota Hospital Association, the Minnesota Medical Association and the University of Minnesota.

The overall objective of the Statement Quality Reporting and Measurement System is to create a uniform approach to quality measurement to enhance market transparency. The Minnesota Department of Health (MDH) public reporting quality goals are to make more quality information broadly available, use measures related to either high volume or high impact procedures and health issues, report outcome measures or process measures that are linked to improved health outcomes, and not increase administrative burden on healthcare providers where possible.

The Minnesota Department of Health reviews the quality measurement Administrative Rules on an annual basis. To assist the Department in this process, Minnesota Community Measurement works with stakeholders to develop and vet quality measurement recommendations as part of its contract with MDH. The Minnesota Department of Health also invites stakeholders to submit recommendations directly to the Department.

Currently, MDH is accepting recommendations on additions to, modifications to and deletions from the Statewide Quality Reporting and Measurement System for 2013 reporting. This comment period will close on June 1. Additionally, MDH has posted Minnesota Community Measurement preliminary recommendations for ambulatory surgical center measures for the 2012 rule and 2013 reporting and is accepting comments until May 15.

MDH will post the proposed 2012 rule for 2013 reporting this summer, which will also have a corresponding public comment period. MDH announces these and other public comment periods through our weekly health reform email updates and we post comments to our website. I will show these addresses at the end of the presentation, but in a pinch I’d just say you could Google MDH health reform and that should route you to the right place.

As this slide shows as per Minnesota statutes, an Ambulatory Surgical Center (ASC) is defined as a free-standing facility organized for the specific purpose of providing elective outpatient surgery for pre-examined, pre-diagnosed low-risk patients. This definition is also referenced in Minnesota Rules, Chapter 4654.

Three quality measures are required for reporting beginning in July 2012 on July 1, 2011 through June 30, 2012 dates of service. Prophylactic IV antibiotic timing, hospital transfer admission and appropriate surgical site hair removal. High level information about registration and data submission requirements for ASCs are included in the technical appendices to Minnesota Rules, Chapter 4654.
Minnesota statute Section 62U.02 requires that quality measurement results be risk adjusted. Of the three ambulatory surgical center measures, the hospital transfer admission measure is adjusted to account for severity of illness using the ASA physical status classification categories.

The Minnesota Department of Health, Stratis Health and Minnesota Community Measurement will continue to work together to educate providers about reporting requirements related to the Statewide Quality Reporting and Measurement System. The 2012 quality rules for 2013 quality reporting will be published for four years and likely in November 2012.

As I mentioned, please subscribe to the Minnesota Department of Health weekly health reform emails to stay apprised of these updates and public comment periods. This concludes my overview of the Minnesota Statewide Quality Reporting and Measurement System.

Please again note the resources on this slide, including the weekly email updates and the Reporting and Measurement System site, which contains information on the rule and rulemaking processes. Thank you for your time and interest, and I can turn things over to Minnesota Community Measurement.

Alison: Thank you, Denise. This is Alison. I am with Minnesota Community Measurement. I’m a Project Specialist and I will go over data submission for 2012 ASC reporting. Just a little bit of history regarding Minnesota Community Measurement. We publicly report healthcare quality measures with the goal of improving health for patients.

Our mission is to accelerate the improvement of health by publicly reporting healthcare information. To do this, we work with the collaboration of healthcare providers, purchasers, consumers and health plans.

A little bit of chronology history is that we started in 2004 with HEDIS measurements by medical groups and for this we used health plan data. In 2006, we developed a process called direct data submission, whereby MNCM received data directly from clinics after a medical record review by the clinics allowing for clinic level results, and this was on a volunteer basis for clinics.

In 2010, we started working with the Statement Quality Reporting and Measurement System. Then in 2010, clinics were required to report to Minnesota Community Measurement, and we started collecting from ASCs in 2011.

This is an overview of the timeline for registration and submitting data. The first step is registration, which hopefully most of you have already completed. If you haven't, you still are able to complete that and we ask that you do that.

The next step for data submission is the denominator certification process, followed by the actual submission of data. I’ll review both of those steps in the coming slides. You are able to submit your denominator certificates now. I know it says May 14th on the previous slide but they are available on the Resources tab right now, so you can submit those. Data submission cannot happen until the denominator certificate is submitted. Just know also that the portal will open on July 1, 2012, closing August 15th for data submission.
Registration opens March 1, and we recommend that you register as soon as possible. These are the steps that you can follow to register. You must go to our data portal, which is Data.MNCM.org, and request a login and password if you don’t have one already. If you have any questions, feel free to send an email to our support email—support@MNCM.org—regarding registration or any other questions that you may have.

We have three separate measures, as Denise went over in her presentation.

→ They are NQF or National Quality Form endorsed measures.

→ The dates of service of July 1, 2011 to June 30, 2012.

→ ASCs will provide summary counts for the numerators and denominators for the following measures.

1. The prophylactic IV antibiotic timing,
2. Hospital transfer and admission, and
3. Appropriate surgical site hair removal

I’ll briefly describe the measures along with information about the numerators and denominators and allowable exclusions. We won’t spend a lot of time on this section since many of you are probably familiar with these measures, since you probably submitted on them last year.

More details can be found in the Measures Specification section in the Data Collection Guide. Also just note that there are new flowcharts to help determine if patients should be included in the data submission in the Data Collection Guide for each measure.

1. The first measure is prophylactic IV antibiotic timing.

This is to assess the percentage of ASC admissions with an order for prophylactic IV antibiotics for the prevention of surgical site infection who receive the IV antibiotic on time. The denominator is all ASC admissions with a pre-operative order for prophylactic IV antibiotic for prevention of surgical site infection. The numerator is the number of ASC admissions with an order for the IV antibiotics who receive the prophylactic antibiotics on time.

2. Allowable exclusions include ASC admissions with a pre-op order for the IV antibiotics for the prevention of infections other than surgical site infections, such as bacterial endocarditis or ASC admissions with a pre-operative order for prophylactic antibiotics that are not administered by an IV route.

Just some definitions that may help with this measure are

Admission is the completion of registration upon entry into the ASC.

Antibiotic administered on time—this refers to the antibiotic infusion that is initiated within one-hour prior to the time of the initial surgical incision or the beginning of the procedure for most antibiotics or prophylactic antibiotics, or two hours prior if the prophylactic antibiotic is vancomycin or fluoroquinolones are administered and the timing starts at the time the antibiotic infusion is initiated.
**Intravenous** is the administration of a drug within a vein, including bolus infusion or IV piggyback.

**Order** is a written order, a verbal order, standing order or standing protocols.

**Prophylactic antibiotic** is an antibiotic prescribed with the intention of reducing the probability of an infection related to an invasive procedure. Within the Data Collection Guide, there is a more detailed list of prophylactic antibiotics. With the prophylactic IV antibiotic timing there were no changes in the measure from last year.

The hospital transfer admission – there are changes from last year.

This year, as Denise mentioned, you must categorize patients into ASA categories one, two or three and submit counts for each category. This measure is used to capture any ASC admissions that are transferred or admitted to a hospital upon discharge from the ASC, so the denominator is all ASC admissions who fall into the ASA physical status categories one, two or three. The numerator is the number of ASC admissions who fall into the above categories and require hospital transfer or admission upon discharge from the ASC.

There are no exclusions for this measure. Some definitions that may help with this measure include ASA physical status one, which is considered a normal, healthy patient. ASA physical status two is a patient with a mild systemic disease, and ASA physical status three is a patient with a severe systemic disease.

Hospital transfer or admission is any transfer or admission from an ASC directly to an acute care hospital, including a hospital emergency room. Discharge occurs when the patient leaves the confines of the ASC.

The last measure is appropriate surgical site hair removal. Just note there are no changes in this measure from last year. This measure is used to capture the number of ASC admissions who have appropriate surgical site hair removal.

- The denominator is all ASC admissions that require surgical site hair removal.
- The numerator is the number of ASC admissions with surgical site hair removal with clippers or depilatory cream. Allowable exclusions include ASC admissions that perform their own hair removal.

To review for the data submission, we do have some requirements. These are outlined in detail as well on Page 17 of the Data Collection Guide. We ask that you follow the timelines as reviewed earlier, that you agree to MNCM’s onsite terms of use agreement, submit data for all measures for all ASC locations and submit data in the required format – in this case it’s in the summary data counts – participate in validation processes as necessary and have rates publicly reported.

To begin after you register you will need to go through the denominator certification process. This just helps to ensure that the denominator or the patient population is pulled in a standardized way across all ASCs. This is a way to review the steps upfront to help prevent errors in the process and it provides assurance that the population or the denominator is identified according to measure specifications as outlined in the Data Collection Guide.
The necessary documentation is a description of the process used to identify patients and we do have a denominator form, which is on the Resources tab on the data portal. You'll want to choose ambulatory surgical centers from the dropdown menu, and you'll want to complete the denominator template form and then upload the form to the MNCM data portal.

We’ll review the form and then either approve the form or contact you to review the form as necessary if we need any clarifications or anything like that.

This is just an example of the denominator certificate. The documentation that we look for are the correct dates of service, allowable exclusions if applicable to the measure, whether you’ll be using a total population or a sample – and I'll review that in the next slide – the sampling method and the data sources for each measure, such as administrative records or insurance records. The choices will also be outlined on the form, if you have any questions about that. Also if you use another method, you'll be able to indicate that on the form and describe that method as well.

To go over the total population versus sample, the total population does provide the most precise rates for an ASC. You would submit data on all of your patients who meet eligible criteria but if the total admissions are less than 60, you would still submit all of your patients and this would still be considered total population.

A random sample includes obtaining a minimum random sample of 60 records per site per measure, plus an over-sample of 20 in case exclusions are identified of the initial 60, and then you would be able to replace them with the over-sample patients. There are two methods, in which you can pull a sample and these methods are also described in more detail on Page 23 of the Data Collection Guide.

1. The first method is using the excel list and using the ‘RAND’ function in excel.

2. The second method is if you're using a paper list to select every nth patient.

Once you have the denominator method certified, you’ll start with data collection and this needs to begin after the billing and patient records are completed for the dates of service for the measure, so in this case after June 30th of this year. The data collection methods, if you have an electronic medical record, you can do an EMR abstraction. If you are using paper charts, you can do a manual data abstraction. There are some data collection tools to help assist groups who use either EMR or the paper system. Again, these are on the data portal under the Resources tab by selecting ambulatory surgical centers from the dropdown menu.

The data collection forms – this tool is optional and this is best for ASCs using the paper chart method. The data spreadsheet template is an excel file. In this template you'll enter in all the patient information and then this is the document from which you’ll create the summary counts that you’ll submit to us.

Just a note about inter-rater reliability or IRR. Ideally using one data collector is preferred because it ensures that the data would be collected in a consistent way. However, if more than one person will collect the data, we do recommend improving the IRR by conducting an internal training and discussing the process with all persons who will collect the data to ensure that it will be collected in a consistent way.
For data collection, you'll be tracking data on a patient level. For all measures you'll need to collect the patient ID, the date of birth, admission date and the provider performing the procedure. For the prophylactic antibiotic IV timing, you'll also need to collect the type of antibiotic administered and the date and time of IV administration, as well as via incision or start of the procedure.

For the hospital transfer admissions, you'll need to also collect the documentation of the ASA physical status type, the documentation location – and this is where in the patient’s chart the hospital transfer is documented – and then the reason for the transfer.

For the appropriate surgical site hair removal, you'll also need to collect the hair removal method. Although you won’t submit this data to MNCM, you must keep these in your records for validation purposes. The Data Collection Guide outlines how to track this information in more detail. These are just a few examples of what you'll need to collect for each measure.

The data submission method – this refers to the process of submitting data through our secure Internet data portal. You'll want to use the spreadsheet of the detailed patient data to calculate your counts. This document is titled Data Collection Spreadsheet and it’s available on the portal under the Resources tab. This is where the ASC will calculate and submit the summary totals for each data element using the spreadsheet to calculate those counts.

For summary data submission for each measure, you'll submit the following counts. The number of patients who meet inclusion criteria, the number of patients submitting, the number of patients excluded if applicable, the number of patients meeting the numerator measure criteria – for example, the number of patients with an order for prophylactic IV antibiotics who received that antibiotic on time.

Again, just please note that for the hospital admission transfer measure, you will need to submit this information for each ASA category, as outlined in the Guide.

These are just a few screen shots of what the data submission steps will look like in the data portal. The steps for the submission process will be listed at the top, as you can see there, with you navigating through to the final steps. For example, this is where you will enter your population counts for the prophylactic IV antibiotic testing.

This is to show the hospital transfer admission measure and how you'll enter for each ASA physical status. You’ll be entering patients that meet inclusion criteria, the number of patients submitting and the number meeting the measure criteria for each category.

This is where you'll review your preliminary rates for each of the measures before you submit to MNCM. On this slide, if you were to notice anything you can go back and reenter the counts as necessary.

Data validation – this validates the ASC’s data collection process. The patient level, tracking sheet would be used during any validation processes that may happen. This is a collaboration between MNCM staff and ASC staff. The most important piece is that you keep the patient level tracking sheet or that data spreadsheet along with any additional documentation which would be used during any validation activity.
Results are reported with the Minnesota Department of Health reports. Minnesota Community Measurement also has a consumer-facing website at MNHealthScores.org, and ASC statewide rates are reported in the healthcare quality reports.

Just information about helping you stay informed is that you can visit our corporate website at MNCM.org, and we do have the registration instructions as well as the Data Collection Guide on this site. The MNCM data portal – the address is right there. This is where you would register the ASC and clinical staff. You can also enter in any contact information for staff to receive communications from MNCM.

On the Resources tab, as I mentioned, that’s where the Data Collection Guide and tools reside, and there are also FAQs for each measure. The data portal is also where you’ll be submitting the counts into MNCM. Our email address is right there if you have any questions. We also have a hotline number, and I apologize that it didn't make it onto the slide but that is 612-746-4522.

That is all I have for you today but at this time we can take any questions you may have.

Vicki: This is Vicki Olson again. Thanks Denise and Alison. We'll now move on to the next section. I also want to share with you, that you can enter questions in the chat area. You move to a tab that has the little balloon and can ask your questions in there or we'll also take questions if you want to unmute your lines and ask your questions.

Alison: This is Alison again from MNCM. I just have one other thing and I apologize. It’s just for ASCs to note that there is a requirement that’s new this year that you are required to submit total population for these measures if you had an electronic medical record in place prior full measurement year.

So, it would be for the dates of service 2011 to 2012, as well as dates of service 2010 through 2011. Essentially, if you’ve had the EMR in place since July 1, 2010, then you are required to submit total population for these measures. Thanks.

Vicki: Alison, I think there is one question in the chat area about vancomycin administration.

**Why is it two hours prior to surgery?**

Can you respond to that?

Alison: Yes, if you’ll give me just a moment. I have to admit, I don’t have a clinical background but I can look here quickly, if you’ll give me just a moment.

Unk: Because of the toxic nature of the medication, it needs to be administered slowly.

Alison: Thank you, whoever just prompted in with that but I do believe…

Unk: I’m the person that put the question in and I understand because of the toxic nature of the medicine you run it over at least 60 minutes, but what if you’ve got a patient that is late coming into your center and it’s still is in before the incision, but it’s 90 minutes prior to surgery?

Alison: It would be within two hours, so that would be considered on time.
Unk: I didn’t catch that before I thought it said two hours. Thank you.

Vicki: Alison, what was the hotline number again, and we’ll put it in the chat.

Alison: It’s 612-746-4522.

Vicki: Related to the slide, the recording and the slides will be on the Stratis website. Because we need to be 508 compliant, we need to do transcripts, so usually it takes a week or so before they’ll make it on the website.

Jerry: I have a question if I can jump in here. I’m Jerry from Riverside Endoscopy Center. Because we’re single-specialty, we only do endoscopy procedures, obviously we’re not administering prophylactic antibiotics and we’re not doing hair removal.

When I’m doing my reporting, I would report the hospital transfers but would I show up as zero percent, or is there any option on the other categories?

Alison: This is Alison again. You would still report for those other measures. You would just enter a zero for the count.

Jerry: That’s what I’m asking.

Is it going to appear that we’re having a very poor percent because we enter zero, rather than NA you put zero?

Alison: You put zero, and I apologize that I did not catch that earlier. You would still enter a zero in for the counts. I don’t think it wouldn’t affect your ratio.

Vicki: Alison, this is Vicki. When the denominator is zero, does it show up in the reporting differently?

Alison: No, it doesn’t.

Erin: So, less than 30, is there a minimum threshold for reporting?

If you have less than 30, which in your case Jerry you’d have zero, you wouldn’t even be publicly reported.

Jerry: Okay because hospital transfers for us are few and far between, so if I have less than 30 hospital transfers am I required to report? I mean I had two this year.

Erin: Yes, you’re required to submit the data. It just wouldn’t be publicly reported. You’d be in compliance still by submitting.

Jerry: Okay.

Unk: I’m calling from the ambulatory surgery center. We do single specialty endoscopy too. You have to report all patients for that measurement, so if you do 3,000 colonoscopies, they all have to be reported. You’re only going to have two admissions, but you’d have to report all 3,000 patients.

Jerry: I’m trying to clarify that as well because we’ll be in the 3,000 to 3,600 range of total patients, but very rarely do we have to transfer somebody.
Unk: Last year we had to submit every patient that we did, but we only had a few, which is good, knock on wood for you that you only have a few, but you have to report them all.

Alison: This is Alison again. That is true. The denominator for the hospital transfer admission measure is all ASC admissions who fall into the ASA physical status categories one, two or three. That would be the denominator, so you would need the full data for all of those patients who – then see if they were transferred or admitted to a hospital upon discharge from the ASC.

Jerry: Thank you.

Geri: This is Geri from Alyna.

*If you don’t have a status assigned, do we include them in our denominator or not?*

Alison: Well, it would only be for the status one, two or three. My understanding is that most patients should have an ASA physical status assigned. If they don’t, I believe then you would not include them because they won’t have a status assigned.

Unk: My preliminary information is the anesthesiologist usually assigns that, and I have to check with our endoscopy only centers, since they use RNs and it’s a different kind of sedation. They may not be doing that.

Jerry: This is Jerry at Riverside Endoscopy again. I think what you’re going to end up having is the ASA grade still needs to be assigned prior to the procedure because you need to have your pre-op H and P performed, and that’s when they should be assigning. Before the procedure, there has to be an ASA grade assigned, so they should be doing that if they aren’t.

Unk: That’s not correct because anesthesiologists are the ones who give the ASA. The rest of us give different kinds of classifications but anesthesiologists give the ASA number and if there’s no anesthesiologist, there’s no ASA number.

Unk: That’s my understanding.

Jerry: I just went through my inspection, and that was what I was told is that the ASA grade had to be assigned by the physician at that point.

Unk: That’s what we do at the Mankato Clinic Endoscopy Center. We have the ASA classification on the 40:56 and all that is assigned at the time before the procedure by the provider. We had our inspection in 2010 too and that was on there and they asked for it.

Alison: This is Alison again. Specifically if anyone else has questions about this, it probably would be best to give our hotline a call or send an email to our support email, just because this is a change that’s new for this year that we can work with you to figure out something specific for your APSE.

Mary: Alison, it’s Mary. Are you able to see the chat line to see questions there?

Alison: Sorry, I got logged out. Let me log back in.
Vicki:  This is Vicki. I’ll read the next question.

**Does the definition of admission for hospital transfers includes patients registered but never admitted to the OR. So a patient who wasn’t admitted to the OR but was registered, would they be included?**

Alison:  Was registered at the ASC but never admitted to the ASC OR, or the hospital, OR

Lisa:  This is Lisa. That was my question. If we register a patient at the front desk and the nurse reviews the blood pressure or whatever and says this patient is not a candidate for surgery, and they cancel and say they have a cardiac condition and we transfer them to the hospital, are those called admitted patients or are they not called admitted patients?

Alison:  I think they would be considered admitted patients. The definition for admission for all measure I should clarify is the completion of registration upon entry into the facility, so they would be considered admitted patients.

Vicki:  Next question.

**In regards to hair removal, if a patient does his own shave with clippers at the facility where does this fit into reporting?**

Alison:  Any ASC admissions that perform their own hair removal, those patients are considered and allowable exclusions, so they would not be counted in the denominator or the numerator. You would want to track those patients because you will need to enter in the number of allowable exclusions when submitting your data counts.

Vicki:  That would be true if they used clippers at home too.

Alison:  Yes, any patient that does their own hair removal.

Vicki:  Another question…

**What was the ASA two status?**

Alison:  ACA physical status two is a patient with a mild systemic disease.

Vicki:  Those are all the questions we have in the chat. Are there other questions from the group? It sounds like there's another one. Please clarify ASA classification for out procedures. For example, local via email once the information is retrieved.

Alison:  Diane, do you want to share any more information about that?

Diane:  Maybe I don’t understand the question, but you would want to categorize patients in ASA category one, two or three. Like I said, that would be assigned to the patient more than likely prior to the procedure. Does that help answer that question?

Vicki:  We’ll go on to the next question. If there is more clarification, people can also use the hotline.
Understanding ASA scoring is a long-term misunderstood process. The pre-procedure H and P should address ASAs core as this is determined as a risk to the patient in relationship to their total health condition risk.

The ASA is also a risk score for anesthesia risk. There’s information available about this. Marsha Anderson is sharing some information for understanding the ASA scoring. I wonder if this might be a helpful fact clarification as we go forward here related to this change.

Alison: We certainly can put up an FAQ on the data portal that clarifies the differences between the ASA physical status categories. I believe that there might be some information or there should be some information in the specifications from MDH as to why these were included this year. If you’re looking for more information regarding as to why they were included, that might be a better question for Denise. On our end, we certainly can put up information about the differences between the categories on our data portal.

Vicki: I’m hearing another question too. Alison and Steve might be somebody who is doing the ASA scoring, so if there are some variations because of these different purposes of whether they’re using it for anesthesia and it’s the anesthesiologist versus being done by the physician as part of the pre-procedure H and P. There also might be some variations expected out there related to this, so that might impact people’s data because of that variation. I guess these are the comments I’m hearing.

Alison: Okay, yes and that would be something that if an ASC has a specific question about that, please feel free to contact MNCM and we can do our best to help answer your question.

Esther: This is Esther at Maplewood Surgery Center. Can I ask a question on ASAs, why they didn’t include a four in there. Our policy does allow a four in certain cases.

Alison: From my understanding, most ASCs don’t allow fours, and so that would be a hospital admission for most ASCs. I believe that’s probably why most ASCs don’t have patients in the four category coming in.

Esther: I heard one recently say that we did a four after the fact. It’s not unusual for us either, but it is allowed in our policy.

Alison: That’s good to know for us, but yes that’s more than likely why we didn’t include fours.

Vicki: Would you include a patient like that in the denominator, Alison?

Alison: I would not since the most recent documentation would classify them as a four.

Shannon: This is Shannon from the Mankato Clinic Endoscopy Center. I’m looking at the CMS Guidelines and 416.42, says standard anesthetic risk and evaluation – a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. Then it lists ASA one, two, three like you listed – normal, healthy. CMS is going to look at that, so if people are not doing that for endoscopies, they will be looking at it.

Alison: Thanks so much for sharing that, Shannon.
Shannon:
You’re welcome.

Vicki: Any other questions? Okay, I think we’ll conclude our presentation for today. I’ll just mention, there is a hotline number that you can call and certainly the email address also to share your information.

I do want to say this call is being funded by Minnesota Community Measurement through a grant through the Minnesota Department of Health, so we thank them for that support. I also want to point out there is an ASCf fact sheet that went out and will also be on Stratis Health’s website if you find that it’s helpful in terms of sharing information with others.

Thank you very much and that concludes the call.