VIEWPOINT

The Need for a Better-Quality Reporting System for Ambulatory and Outpatient Surgery—Surgical Quality Without Walls

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One of the most important consequences of the COVID-19 pandemic on health care delivery in the US is the acceleration of a long-building shift from inpatient to outpatient delivery of operative care. Before the pandemic, enhanced recovery pathways and minimally invasive techniques opened the possibility of performing increasingly complex operations in hospital outpatient departments and ambulatory surgical centers. To create inpatient surge capacity during the pandemic, emergency waivers expanded the care that outpatient surgical centers could provide, rendering them increasingly important sites of care delivery for both the present need for inpatient capacity as well as the future of value-based care.

However, development of quality metrics and alternative payment models have not kept pace with this shifting pattern of care. The current Centers for Medicare & Medicaid Services paradigm for assessing ambulatory surgical quality relies on the specific site of care where the operation takes place, with separate quality reporting programs for hospital outpatient departments (Hospital Outpatient Quality Reporting [OQR] Program) and ambulatory surgical centers (Ambulatory Surgery Center Quality Reporting [ASCQR] Program). These separate programs use unique metrics and therefore are not directly comparable. Patients likely do not distinguish between hospital outpatient departments and ambulatory surgical centers. The separate quality reporting programs for these 2 sites of care reflect insurance reimbursement siloes built around different ownership structures (hospital-owned outpatient departments vs physician practice–owned ambulatory surgical structures). A more patient-centered paradigm would unify quality reporting across the 2 facility types to help policy makers and surgeons identify the procedures and patients who benefit from outpatient care.

Development of a meaningful and unified set of quality metrics to assess outpatient surgical care across all ambulatory delivery sites is an essential next step for this transition away from inpatient, hospital-based surgery. However, because procedures performed in the outpatient setting may be lower risk than their inpatient counterparts, identifying quality metrics sensitive enough to overcome low rates of traditional complications has thus far been unsuccessful. A better ambulatory surgery value-based payment program will focus on equity, incorporate patient-reported outcomes, and focus on the patient's longitudinal experience through a surgical episode.

First, this quality reporting program needs to account for access and equity up front, rather than through post hoc social risk adjustments currently used in most pay-for-performance programs. The few studies that have examined demographic patterns in access to ambulatory surgical care have found that Black patients have lower rates of use, pointing to inequitable access.[1,2] As more care is shifted to the outpatient setting, these disparities are likely to widen. More than a decade of work assessing disparities within the current incarnation of value-based payment programs has shown that post hoc adjustments for health disparities rarely ameliorate and sometimes worsen disparities in access for patients and in reimbursements for practitioners who care for complex populations.[3-5] Building a value-based payment program prospectively around equity, rather than adjusting retrospectively, is essential to ensure that the transition to outpatient care delivery serves all patients.

Reimbursement based on screening of social determinants of health—such as through *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* Z codes—would be a first, concrete step toward an equity-focused outpatient surgery quality program. This pay-for-equity approach would need to measure access and outcomes for different demographic groups within health systems as opposed to implementing penalties based on patient demographic mix. However, movement from the current reimbursement or penalty model to an alternative payment model, which would provide options with flexible use of up-front payment for practitioners caring for more complex patients, could counteract the financial disincentives of caring for more resource-intensive patients.

Second, assessment of ambulatory quality should incorporate patient-reported outcome measures, which would provide a standardized, validated method of assessing patient experience. Patient experience needs to be incorporated into the formal, quantitative assessments of value within health care delivery of inpatient as well as outpatient and ambulatory surgery. Patient-reported outcome measures focusing on common postoperative quality of life domains (eg, pain and functional outcomes) could provide a core set of data across heterogenous procedures. Use of a uniform set of patient-reported outcome measures for outpatient and ambulatory procedures would not obviate the need for more detailed, procedure-specific patient-reported outcome measures used within individual surgical fields. Historically, patient-reported outcome measures have been difficult to scale outside of clinical registries. However, the Centers for Medicare & Medicaid Services currently tracks patient experience and satisfaction through

the US Consumer Assessment of Healthcare Providers and Services (CAHPS) Outpatient and Ambulatory Surgery Survey. Two synergistic paths forward exist: (1) integration of CAHPS patient experience scores into hospital outpatient surgery and ambulatory surgery quality reporting or (2) integration of patient-reported outcome measures into the CAHPS survey questions.

Third, to improve quality of care for outpatient surgery, a transition needs to occur from pay for reporting to value-based payment around a clinical episode of surgical care. Both the OQR and ASCQR programs are currently pay for reporting. More than 20 years of data suggest pay-for-reporting programs generally do not help improve quality.[6,7] The eventual goal of pay for reporting is to transition to value-based payment programs with greater incentives to improve quality of care. Clinical improvement collaboratives built around quality metrics can lead to improvement without necessitating financial incentives or penalties (such as through the National Surgical Quality Improvement Program or adoption of enhanced recovery protocols).

However, before the ASCQR or OQR programs transition to value-based payment, a better set of quality metrics is needed to assess and compare ambulatory care provided at ambulatory surgical centers and hospital outpatient departments. In 2020, the OQR included 13 metrics compared with the 6 in the ASCQR, with 2 overlapping metrics: visual improvement after cataract surgery and hospital visit rate after colonoscopy. The OQR includes hospital visits after outpatient surgery, which has both clinical relevance and broad applicability. The ASCQR could adopt the 7-day hospital visit metric across conditions. Quality metrics of both programs would benefit from stakeholder engagement to identify useful metrics and eliminate those that are no longer useful to decrease overall measurement and reporting fatigue among surgeons. An additional consideration is the need for better risk adjustment through longitudinal assessment of comorbidities to ensure that patient groups (eg, patients with obesity) are not disproportionately excluded from the transition to outpatient procedures because of overly conservative perceptions of procedural risk.

Although the Patient Protection and Affordable Care Act mandated a value-based payment program for ambulatory surgical care, little progress has been made to date in understanding variations in ambulatory surgical cost and quality—and even less progress has been made in understanding how variation in access to quality outpatient surgical care affects the overall value of surgical care provided to patients. As care increasingly shifts from inpatient to outpatient settings and higher-acuity operations are increasingly performed in ambulatory settings, policy makers have an opportunity to build a reimbursement program that not only accurately rewards high-quality elective outpatient procedural care but also builds equitable access into the value-based payment program from its inception. A meaningful and universally applicable value-based payment program used for all ambulatory and outpatient surgery should focus on the patient's longitudinal experience throughout the surgical episode instead of the current focus on whether it was performed within or outside the walls of a hospital.

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