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INSIDE

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As High-deductible Plan Trend Continues, What's Next for Surgery Centers?

Payer consolidation also an issue

The trends of increasingly higher deductibles and payer consolidation are forcing surgery centers to change the way they negotiate contracts and handle costs. For ambulatory surgery centers (ASCs) that go about business as usual, there likely will be the day when administrators find they lose business to more efficient and contract-savvy competitors.

"Both trends put a lot of pressure on ambulatory surgery centers to control costs," says **Raymond Hino**, MPA, FACHE, corporate director of operations for Surgery Partners, a nationwide operator of surgical facilities and ancillary services. Hino also serves as administrator at Skyway Surgery Center in Chico, CA. "Payer consolidation and high-deductible plans are nothing new, but there's been a lot of recent activity. It is a concern for us out in the field. High-deductible plans are causing some disruption in the industry."

> HIGH-DEDUCTIBLE PLANS ARE CAUSING SOME DISRUPTION IN THE INDUSTRY.

So far, ASCs are the beneficiaries of much of that disruption as consumers choose these lower-cost settings over hospital surgeries, Hino notes.

"We're seeing a lot of patients that are paying out of pocket because of their high-deductible plans — more so than in the past," he says. "It can work in our favor. I know, for example, a recent case where there was a gentleman that was comparison shopping for surgery. He had a high-deductible plan, got a

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price quote from the local hospital in our area, and then came to us for a price quote. We were much lower."

This man told his doctor that he wanted to undergo surgery at Skyway Surgery Center instead of the hospital, Hino reports. In California, hospitals are required to make their charge masters accessible to the public. It is common for patients to know how much their surgery will cost and to check out price options, Hino explains.

The problem for ASCs is that deductibles, which once ranged up to $1,500, now range from $3,000 to $10,000. This means some patients will pay for same-day surgeries entirely out of pocket, says **Amy Coletti**, MHA, senior manager of ECG Management Consultants in Seattle. Coletti and Hino spoke about these payer trends at Becker's ASC 25th Annual Meeting: The Business and Operations of ASCs in October.

"I hope deductibles will stabilize," Coletti says. "In talking with people in the community, a $10,000 deductible from their perspective means they don't have benefits because everything is out of pocket until that point." Even when a procedure is negotiated to a lower price by the payer, patients still feel the financial pain of that high deductible cost. Higher deductibles will help shift more patients from the hospital surgery setting to the ASC setting. But this also could mean that more people delay undergoing elective surgeries. This is where a new trend could make a difference: Some payers and self-insured employers are giving patients incentives to undergo surgery in the ASC as that is the lower-cost alternative.

"Some plans encourage use of an ASC by having lower copay if the outpatient surgery is done in an ASC versus a hospital," Coletti explains. "It's important to understand what payers are offering and collaborate with payers."

Consumers are becoming more savvy about comparison shopping, even in healthcare, Hino notes.

"With the times we live in, Uber and online shopping and Amazon, I think the population is getting used to comparison shopping," he says. "It's part of the culture."

The new consumer culture wants low costs, but also high quality. These priorities favor ASCs.

"Hospitals will have a bit to be concerned about with the high-deductible plans and payer consolidation, but it positions ASCs well to be able to compete," Hino says. "Although, as low-cost

EXECUTIVE SUMMARY

Increasingly, people who need surgery have to pay for large chunks of the costs as employers and payers shift cost burdens to patients through high deductibles. This means ambulatory surgery centers (ASCs) need to know their costs and be transparent with what patients will pay out of pocket.

- Payer consolidations also are disrupting the industry, leading ASCs to conduct more research before negotiating new contracts.
- ASCs can benefit from these trends, but only if they are smart financially.
- Consumers and payers will study both costs and quality comparisons before making a selection of where to do business.

providers, they also receive lower reimbursements. For us to be successful, we need to keep our costs down because we're going to be paid less well than local hospitals."

This means ASCs with higher costs could run into problems. Even those with lower costs might not be doing enough to attract more patients and better payer contracts.

"Payers know ASCs are less expensive than hospitals, but what else can an ASC offer?" Coletti asks. "Can they move more cases? Do they have good quality scores? They need to do more than just sit back and say, 'Yes, we're a lower-cost setting.'" Payer consolidation also affects ASCs and their bottom lines. "As we look forward to more payer consolidation, I see pros and cons of that type of movement," Hino says. "On the positive side, it means fewer payers to deal with and negotiate with. On the negative side, it puts a lot more pressure on us to be successful in our contract negotiations so that we can continue to be an in-network provider for the major health plans."

Every contract with payers is important, Coletti notes. With consolidations occurring among payers, an ASC's contract with even a smaller payer could cause a big headache. For instance, suppose an ASC signed a contract with a small payer that was much more favorable to the payer than its contracts with larger payers. Since it was a small contract, the ASC administrator or business officer had signed it without looking closely at the details. But then a large payer consolidates with the small payer. Now, the large payer has access to that contract and its terms, and the large payer might decide to apply those same terms to all its contracts with the ASC, Coletti explains.

"It will be a negotiation issue after that," she says. "Read every contract before you sign, and don't just sign a contract that comes in the mail." ■

When It Comes to Negotiating Sustainable Contracts, Know Your Costs

Tips for navigating challenging territory

ASCs are entering a new era of higher deductibles and payer consolidation that will result in the survival of the fittest, centers that can cut costs to be more competitive and negotiate sustainable contracts with payers. Insiders offer some potentially useful tactics for making the most of the new payer environment:

• **Collect data.** "Be prepared to talk about the cases you are prepared to move to the surgery center and how you are prepared to expand your services," says **Amy Coletti**, MHA, senior manager of ECG Management Consultants in Seattle.

ASC leaders should talk about whether they plan to expand their offerings to include total joints, spine, or gynecological procedures currently performed at the local hospital. ASCs need to collaborate with payers, engage in meaningful discussions about reimbursement for these procedures, and decide whether there are surgeons on staff who are ready to move the cases. "Payers will want to know who is going to bring the cases — and not just that the ASC has a good idea, but how many cases can move to the ASC," Coletti says. "Some cases involving older or sicker patients with comorbidities will have to stay in the hospital. The ASC should talk about how many cases it can move to show volume to the payer."

• **Trim costs where possible.** "Over the last couple of years, one of the biggest opportunities for us to cut costs is in the supply chain: materials management and supply

EXECUTIVE SUMMARY

Data collection is an important first step to take when surgery centers start to cut costs and become more efficient.

- The supply chain is a key target area for cost cutting. Surgery centers can work with vendors and doctors to find the best supplies at the optimal cost.
- To negotiate the most favorable terms, a surgery center administrator needs to learn more about what payers want.
- With high deductibles the new reality, surgery centers should collect patients' copays up front.

costs," says **Raymond Hino**, MPA, FACHE, director of operations for Surgery Partners and administrator at Skyway Surgery Center in Chico, CA. "We work with vendors and our doctors to negotiate best practices with our vendors so that we're able to take advantage of volume purchasing and group purchasing contracts and also maintain local control." The ASC shares prices with surgeons so they can compare different costs from the various vendors, Hino adds.

Staffing is another area where cost efficiency can work. "We're lean-staffed at our facility," Hino says. "We have actually reduced our management positions at this facility so that we have fewer managers and more bedside staff."

When the surgery center's patient volume fluctuates, the ASC monitors activity and adjusts staffing accordingly.

• Negotiate favorable terms. "Understand payer opportunities," Coletti suggests. "If a payer is willing to offer a case rate that covers the day of surgery with surgeon fees, are you ready to have that discussion?" Know the answers to these questions:

- Will payment depend on CMS quality scores?

- Does the ASC administrator understand the payer's business well enough to engage in discussions with payers about case rates?

- What do the ASC's quality measures look like?

When looking to improve contracts, ASCs should consider negotiating with employer groups as well as payers. Increasingly, employer groups are pushing back against costs and shopping for the lowest cost providers. If employer groups do not believe their payer is negotiating the best rates, they will move on, Coletti says.

"A lot of employer groups used to have really rich benefits, but around the time of the recession, they started pushing more costs to their employees through high-deductible plans," she explains.

Often, employers and payers are open to incentive plans that encourage their insured populations to choose cheaper medical settings. For this reason, employers and payers could be open to entering into preferred provider contracts with ASCs that are less costly and maintain good quality scores, Coletti says. "It might be worth talking with the employer's human resources director about having a good, lower-cost surgical option for employees," she offers. "The more ASCs can collaborate with the payer or local employer group, the more it would bring business to the ASC."

• Collect deductibles up front. "We are very careful to collect the patient's responsibility for the cost of surgery," Hino says. "We ask for the entire amount that the patient is responsible for upfront."

Hino's ASC accepts credit cards and works with patients on financing the costs through lending institutions. When potential patients call to obtain an estimate on the costs, the business office manager is transparent with pricing and can give them a price range, Hino adds. ■

Healthcare Climate Breeds New Opportunities for ASC Growth

Patients were lining up for one such facility in North Carolina

The current healthcare environment appears to make this a good time to open a new ASC. The trend of employer-sponsored health plans and payers looking for lower-cost alternatives to hospital procedures is creating new opportunities for the industry's growth.

"There are so many benefits to an outpatient surgery center for patients and providers. It is a welcome addition to the healthcare offerings in our community," says **Corrie Massey**, MBA, the CEO of Wake Forest Baptist Health Outpatient Surgery in Clemmons, NC. The ASC was formed in a joint venture with Surgical Care Affiliates (SCA), which manages its operations.

The de novo ASC, which contains three operating rooms, serviced its first surgical case in February. Staff found that patients were eager to use the new facility. "We had patients who went into their doctor's office, saying, 'I want to go to the new surgery center,'" Massey says. "Some people waited until we opened to have their procedures."

In board meetings, during the ASC's planning stages, physicians were the most vocal about how the surgery center would not need an extensive marketing campaign. "A chief medical officer said, 'If you

build it, they will come,'" Massey recalls. "He said we'd have no trouble filling it. So far, he has been right."

While the operating rooms are full, some managed care contracts have taken longer than expected. "Part of our situation here is that contract negotiations are coinciding with renewing contracts for the health system. It's taken on a larger conversation than it normally would in a freestanding surgery center," Massey says.

This delay has not affected the ASC's ability to attract patients and find experienced staff and physicians. For instance, hiring surgeons to practice in the new ASC was not a challenge, says **Kevin E. Coates**, MD, MBA, MPT, assistant professor, orthopaedic surgery, sports medicine, Wake Forest School of Medicine in Winston-Salem, NC. Surgeons love the ASC setting, he says.

"It gets you out of the main facility and away from some of the burdens that come with being in the hospital," Coates says. "For example, you don't have people saying, 'Hey, since you're here ...'"

ASCs also are more efficient. "We have inpatient and outpatient operating rooms in the main facility, but they're not designed to be as efficient as an ASC," Coates says. "Spending less time waiting is something people like very much."

For instance, a 15- to 20-minute wait between procedures is what surgeons expect at an ASC, he adds. One reason why an ASC is more efficient is that surgeons have more autonomy to drive the schedule in the ambulatory setting. In the hospital, factors out of the surgeon's control affect his or her time, Coates notes.

Wake Forest anticipated the need for an ASC several years ago.

"They recognized they needed to increase operating room capacity," Massey says. "As North Carolina is a Certificate of Need state, they started that process many years ago of getting approval for additional operating rooms under their umbrella."

From the health system's perspective, the ASC handles less complicated surgeries, freeing hospital operating room beds for more complex surgical cases, Massey adds.

Massey and Coates describe early steps to take when opening an efficient and successful new ASC:

• **Plan according to procedures and surgeons.** "The first step is to speak with the various surgeons who are planning to go to the facility and get a list of procedures they perform to get an understanding which procedures would move to the surgery center," Coates says. "Know which procedures are going to be done before you buy the equipment."

This process means projecting ahead of today's needs as well. For example, the Wake Forest ASC has no immediate plans for 23-hour

observation stays, but has reserved that option for the future. "We built a room that could be used for overnight cases," Coates adds.

• **Provide price transparency.** "From an operational standpoint, patients are more aware, educated, and in control now, and I think that's amazing," Massey says. "It's great to see that patients are becoming more aware of their options and aware of potential outcomes, and they are better able to take part in those choices; patient engagement has increased."

Surgical costs and price transparency have long interested Coates.

"That is something I have an interest in and do talk with students, residents, and fellows about."

While in private practice, before moving to Wake Forest, Coates knew what his services cost and would give patients a good idea of what their bill would look like. At the medical center, Coates does not handle billing, but he still helps patients learn more about costs.

"Anytime patients have a question prior to surgery, I get them connected with the folks in our financial counseling office and give them CPT codes, written down, for what I'm planning on doing," he explains. "They can talk with our finance folks and find out what their bill will be from the medical center."

Patients want to know how much they will pay the surgery center, surgeon, and anesthesiologist. If patients believe they have met their deductible, they do not want to be told they still owe someone money, Massey notes.

"I know how it feels to be on the other side when you suddenly get a bill and don't understand where it comes from," she says. "Patients need to know exactly how much they owe, within reason, unless something changes in their treatment." The ASC provides a lot of education about the financial aspect of procedures so that the costs are transparent to patients, Massey adds.

• **Go above and beyond in customer service.** Patients complete an online satisfaction survey after their surgery. They can rate various experiences at the surgery center according to a 0-10 scale, with a score of 10 the best. Patients also can write some comments or complaints in a free text box in every section.

"Our goal is to have 100% satisfaction every single time," Massey says. "Even if someone says it was really cold in the waiting room, we appreciate that feedback."

Whenever there is a negative response, the ASC receives an alert. Massey uses that as an opportunity to reconnect with the patient. She has gone out of her way to resolve problems for patients, including helping patients discover payer errors and lowering their bills. ■

Study: Consumers Shop by Price When Payers Use Cost-sharing

Learn some of the benefits to reference pricing

Reference pricing, as it was implemented in California, reduces medical spending as people choose lower-price surgery centers.[1]

"We found that there was a modest reduction in prices for ambulatory surgery centers, but not for hospital outpatient departments," says **Timothy T. Brown**, PhD, associate director of research at Berkeley Center for Health Technology and associate adjunct professor of health economics at the University of California, Berkeley. If reference pricing, as it is used in California, were expanded nationally, it potentially could save nearly $20 billion, Brown says.

"For ASCs, the size of the price drop depended on the procedure in question and the proportion of local patients in the reference pricing program," Brown says. "The price drops [related to ASCs] applied to all private insurers studied, whether or not they implemented reference pricing."

Many patients shifted from hospital outpatient departments to ASCs. Reference pricing changed patients' decisions for every procedure studied, Brown explains. The price drops were concentrated among ASCs. Patients who used hospital outpatient departments valued hospitals more and were less sensitive to high prices.

"Thus, ambulatory surgery centers would lower prices due to competition for the price-sensitive patients, whereas hospital outpatient departments did not need to compete with each other as much, since the remaining patients

are likely not as sensitive to price differences across hospitals," Brown says.

The advantage to reference pricing, when payers give enrollees incentives to choose a lower-cost provider, is that it gives consumers direct incentives to comparative price shop.

"When faced with reference pricing, consumers do shop," Brown says. "The savings to employers and insurance companies from reference pricing are relatively large."

Another advantage is that reference pricing does not require any renegotiation of existing prices. "There are insurers and consulting organizations that can set up reference pricing for both shoppable medical procedures and shoppable pharmaceuticals."

Since Brown and his colleagues published the reference pricing study in late 2017, this trend has gained some momentum.

"This has been done with a number of different kinds of medical procedures, starting with pharmaceuticals, as well as with ambulatory surgery centers," Brown says. "The main take-up has been in California."

The California Public Employees Retirement System (CalPERS) implemented reference pricing in 2012. CalPERS uses cost-sharing to encourage people to shop for better prices. After starting with hip and knee procedures, CalPERS has added cataracts, arthroscopy, colonoscopy, endoscopic procedures, and pharmaceuticals.

"We did a website piece on colonoscopy and looked at what the savings would be for employers and insurers across the country — depending on variation of prices, and in most cases you would save money," Brown explains.

Reference pricing looks at cost variation for any given procedure. It addresses whether the variation is due to quality, which usually is not the case, Brown notes. "ASCs are happy. They're getting more business. The losers are the hospitals that charge really high prices," Brown explains. "It cuts off the top end variation, the really expensive providers that are not providing additional value for the higher price. Reference pricing moves people from high-price distribution to a more reasonable range. People have to decide whether they want to go to a hospital or to an ASC and save money. A lot of people make the choice to save the money." ■

EXECUTIVE SUMMARY

Reference pricing can save billions of dollars in healthcare costs. This model has proven to be successful at steering consumers to lower-cost providers, such as ASCs.

- Not all patients are cost-sensitive, but of those who are, ASCs' lower costs/high quality is appealing.
- The California Public Employees Retirement System (CalPERS) implemented reference pricing in 2012. CalPERS uses cost-sharing to encourage people to shop for better prices.
- Reference pricing looks at cost variation for any given procedure and considers whether the variation is due to quality.

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Staffing Biggest Cost Containment Target Area

Study patterns to adequately match resources with hourly needs

The first question for any ASC director to ask is, "Are my costs really where they need to be as far as staffing is concerned?"

It doesn't matter if it is an inpatient operating room or an outpatient OR, the most expensive component of care is staff, says **Zeev N. Kain**, MD, MBA, FAAP, chancellor's professor at the University of California, Irvine Department of Anesthesiology & Perioperative Care, director of system redesign and value-based healthcare at the university's Healthcare Policy Research Institute, and president of the American College of Perioperative Medicine.

Kain offers a few tips to surgery centers looking to contain costs:

• Examine staffing patterns.

"You have to look at which staff you are talking about," Kain says. "Are we talking about nurses or

the anesthesiologist?" Ensure each employee's time is optimized.

"Look at the time of day they work. Are nurses working 12-hour day shifts or eight-hour day shifts?" Kain asks. "If they're working eight-hour day shifts, and you are paying overtime, is this the right model?"

If staffers work 12-hour shifts, is that the right model? Can a surgery center really keep nurses busy from 7 a.m. to 7 p.m.? The key is to look at all starts and finishes over time and match staff to these hourly needs. "How many hours a day does the operating room work?" Kain asks. "No one wants to operate after noon. People like to operate in the morning."

But if all surgeries are scheduled in the morning, then what happens to staff in the afternoon? "The better model is to open only five rooms and staff those for a full day," Kain offers.

• Look at ratios in anesthesia staffing.

"How many nurse anesthesia technicians are you using?" Kain asks.

"What is the coverage ratio of nurse anesthesia to an anesthesiologist?" This ratio has to be reviewed carefully to ensure it is optimized, he adds.

• Use process maps.

One popular technique is the swim lane, a process map that shows which employee is handling what work and at which time. "With a process map, you can find a bottleneck," Kain notes.

If the holdup for an OR is because everyone is waiting for the room to be cleaned, then maybe the cutbacks on housekeeping were short-sighted. Surgery centers with inefficient staffing patterns will pay higher OR costs, which lowers investors' income.

"You have to make sure the surgery center is staffed appropriately," Kain stresses. "At net level, make sure you're not overstaffed."

• Address variability.

When selecting surgical instruments, supplies, and implants, a low level of variability is preferable, Kain says. To lower this variability, find a way to align physicians' incentives.

"You have to incentivize physicians to do the right thing," Kain says. "Align the incentives, and they will agree and change their practices." Kain says incentives do not have to be monetary. Incentives can be in clinical care if the change improves quality and is the right thing to do.

• Aim for maximum capabilities.

ASCs do not always make the best use of their infrastructure. Rooms might be used too little. Some technology and equipment could be gathering dust. These are inefficient practices that could change. "For example, I visited a facility last week where they had a CT scan in the facility," Kain recalls. "They just use the CT scan for their patients."

This expensive piece of equipment was convenient, but not used as often as it could.

"One question I had for them was, 'Why don't you rent the CT scan to other practices?'" Kain says. "Make sure any ancillary services you have — a CT scan, MRI, pathology — are used the entire day." If these services and equipment not used the entire day, then assess how to use that infrastructure when the ASC does not need it. ■

Surgeons Can Address Societal Structural Inequality

ASC surgeons can join their colleagues in urban EDs to effect change

Surgeons working in ASCs rarely confront the daily reminders of violence that urban ED physicians take as a mainstay of their professional lives. ASCs mostly are located in suburban, more affluent areas. The procedures and surgeries often are elective, so the population of patients served by ASCs is self-selectively better off than the people who wait in EDs for medical treatment. Some surgeons are calling on ASC physicians to raise their voices to help stop the structural violence that is tearing apart some urban areas and robbing thousands of young people of their childhoods.

There is a movement of trauma surgeons who have said they cannot sit silently anymore, and all surgeons can join them, notes **Carrie A. Sims**, MD, PhD, FACS, associate professor of surgery at The Hospital of the University of Pennsylvania and the Presbyterian Medical Center of Philadelphia.

"We need to talk about what leads to increased violence in an urban center, what we can do about it as a society, and [what we can do

about it] as individual practitioners," Sims says. Structural violence is a public health crisis, which affects the larger community and society. Violence is the number one killer of healthy black men; yet, health professionals often stay silent about it, Sims says.

"Surgeons who do colonoscopies obviously care about public health as well. We advocate healthy diets; we try to prevent cancers," Sims says. "And just like that, we as surgeons need to advocate for preventing things we know contribute to the public health crisis of violence."

The term "structural violence" acknowledges the role society plays in violence. This role includes proliferation of firearms and generational housing redlining, in which people who lived in certain urban neighborhoods were denied loans that would help them buy houses and improve their properties, Sims explains.

"Inequality is the biggest predictor of violence in cities," she says. "How do we address these inequalities that are influenced by race so we can improve the outcomes I care about as a trauma surgeon?"

Societal solutions include early childhood education, ending childhood hunger, improving housing opportunities, and addressing other socioeconomic factors. Surgeons also can speak up about guns.

"What do we do about regulating those? That's a big, hot topic," Sims says. "Gun violence gets a lot of publicity when it involves white people in mass shootings."

But the subject is less visible to many people when it is the everyday mass violence involving African-American kids shot in the cities, she says.

"There's a myth that it's all gang related, but that's not true. It is normal people violence happens to, but they live in a poor environment," Sims says.

When state legislatures debate actions to reduce violence, surgeons should speak up. Trauma surgeons can describe the physical impact of gun violence.

"We can raise awareness that the policies we put in place really have an impact on our patient population," she says. "Surgeons have a social responsibility to advocate for improving the circumstances of all members of our society. It's not enough to patch up the patient; we have to advocate for improving the structure of our society so every person has an equal opportunity for health, liberty, and the pursuit of happiness."

Sims suggests surgeons take these actions to draw attention to the problems of structural violence:

• Step up to the plate.

"If there is a mass shooting, then every surgeon should step up to the plate and come in to operate," Sims says. "If the local system is overwhelmed by trauma, then come in and lend a hand."

• Examine inward biases.

"Personally, I think people need to look at their own biases and do a self-assessment in terms of how they look at patients and members of society," Sims says. "Do critical analyses of your own biases."

• Advocate for change.

"If you want to see change, then you have to advocate for the things we know address violence from a public health perspective," Sims says. "You have to vote with your ballot, vote with your voice, and let people know you care about things contributing to structural violence, like poverty and race, and discuss this issue."

• Hold grand rounds.

"We can have grand rounds about structural violence," Sims offers. "Also, you can raise the issue of violence as a public health problem in your hospitals. This is an easy way for people who aren't trauma surgeons to see this issue."

• Support statements on violence.

Various surgeon and trauma organizations issue statements about gun violence, and concerned surgeons can lend their support to these efforts. It is a polarizing topic from a political perspective, but can be a unifying topic from a public health perspective. "The ways we'll make progress is to look at violence as a public health problem and also to look at the implications of structural racism," Sims says.

For instance, Sims pointed to research from 2017 that found that gunshot violence can spread as if it were an infectious disease. *(Editor's Note: Read much more about this investigation and methodology online at: https://bit.ly/2S8N37p.)* ■

COMING IN FUTURE MONTHS

- The latest legal issues affecting ASCs
- Best practices for handling payer appeals
- Latest growth areas for surgery centers
- Value-based care: What does it mean to surgery centers?

Bloat in the ASC

By Stephen W. Earnhart, RN, CRNA, MA
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Austin, TX

We step inside many ASCs and hospitals in our daily course of business. It just dawned on me last month that there is something that I have not noticed in the past, but I finally figured it out. It was not what I was missing; rather, it was what I could not see: clear space.

Somehow, we have lost sight of the clutter and the sheer hoarding of stuff. Look around your hospital or ASC. If you focus hard enough you will see what I'm talking about. You should be able to look down your sterile corridor and see the other end unobstructed.

Rare is the facility where one can do that without seeing a linen cart, suture cart, piece of equipment, stretcher, X-ray rack, or other obstacles taking up space. Our patients also see this, and it is disarming to those who consider hospitals and surgery facilities to be like they see on TV: neat and spotless.

This bloat is not limited to the operating area, but can metastasize to the waiting room, which is embarrassing in most centers. It spreads to the exposed front desk and the patient registration areas, all fully in view of our patients and their more focused family members. Would you go to a doctor if there was a dead plant in their waiting room?

If you are in the position to look at your budget, really study it — you can see bloat there, too. When an ASC spends money on completely unnecessary items or services that are no longer needed simply because the facility has always done it that way, that is bloat. Does no one have the time to investigate further what a facility is wasting money on? In most cases, no.

Preference cards are, for the most part, antiquated and need to be updated after the first six months the surgeon performs that procedure. If no one is updating these cards, then it is because no one is looking at them or checking with the surgeon.

Visit your supply rooms, janitor closets, locker rooms, waiting room, and lounge. Try to tell yourself these areas look neat, organized, and professional. Most just cannot do it.

In defense of all of this bloat, I agree when one says, "There is not enough storage area in this facility." For the most part, surgery centers allocate more space to income areas such as the number of operating rooms vs. storage space. Regulations dictate how much space per operating room a facility needs, but that is the minimum. Rarely does anyone offer more than the minimum because of the cost, but the minimum just is not enough. Everyone wants to cram another operating room into the smallest space available and not allocate enough for storage. You have to play the hand you were dealt and make do.

Everyone is busy. Everyone is short-staffed (or has convinced themselves they are). No one has the time to deal with it. But what is the solution? Pick a staff member to "police the area." That person is responsible for roaming the halls and identifying what needs to go and what needs to stay.

Eventually, the person in charge of this task also will lose sight of what is clutter and what is not, so it is important to rotate this duty among the staff. After taking stock of the clutter, leaders decide where the objects go (we have "just in time" inventory available to us with most vendors).

If nothing else, install some prefab cabinets to store material so clutter does not clog corridors or patient areas. One also can rent outside storage bins adjacent to the

CME/CE OBJECTIVES

After reading *Same-Day Surgery,* the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identify how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

facility for larger items there. Make sure everyone knows what inventory is stored where for easy access.

If you have not touched it in a year, you do not need it. If you can see it, hide it. If you cannot remember why you own it, then store it or lose it. ■

(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates can be reached at 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. Email: searnhart@earnhart.com. Web: www.earnhart.com.)

AAAHC Offers New Education, Resources on Disaster Preparation

Revised toolkit aims to help surgery centers comply with regulations

From Hurricane Michael destroying parts of the Florida panhandle to Hurricane Florence flooding the Carolinas to Hurricane Lane causing mudslides in Hawaii to the seemingly endless and devastating California wildfires, 2018 has been a cautionary tale when it comes to natural disasters. Lessons learned? They can be frequent, big, long, and deadly.

Surgery centers and other healthcare organizations should not grow complacent, believing a disaster will not affect their area.

To reinforce the message that every site should be prepared, the Accreditation Association for Ambulatory Health Care (AAAHC) has issued new educational resources about emergency preparedness. *(Editor's Note: Learn more about these resources at: http://bit.ly/2CKsoBX.)*

Emergencies include more than natural disasters; such events also include active shooters, terrorism, cyberattacks, drug/supply shortages, power outages, and infectious disease outbreaks. These events can occur in any healthcare setting, in any location, any time.

Surgery centers should start by creating a crisis plan and practicing scenarios before a disaster strikes. Studies show that ASCs can prepare for emergencies more effectively by holding simulations or disaster drills.[1,2]

AAAHC's survey data show that more than 10% of healthcare organizations experience difficulty complying with emergency preparedness standards set by AAAHC as well as CMS' Conditions of Coverage.

Thus, AAAHC decided to update its patient safety toolkit to make planning easier. The updated toolkit contains evidence-based recommendations for creating, instituting, and evaluating emergency drills to help organizations strengthen preparedness and meet standards compliance.

"Checklists, mock emergency drills, and other exercises allow organizations to assess emergency action plans as well as teams' readiness to respond to real crises," **Kris Kilgore**, RN, BSN, an AAAHC surveyor, said in an organization news release. "It is important to involve all staff in these exercises, as teamwork during simulations may help reduce errors and ensure better results when actual emergencies strike."

(Editor's Note: Kilgore led a webinar on this subject in September. AAAHC offers this webinar for purchase at: https://bit.ly/2yR4bXp.)

According to AAAHC, the six elements to emergency drills are:

- assess the internal disaster and emergency preparedness plan;
- plan for drilling and simulations;
- inform everyone that a drill will occur;
- run through the drill as if it were a real emergency;
- evaluate everyone's performance after the drill;
- take corrective actions as needed.

The evaluation process includes documenting each step taken and identifying each area of weakness. These include areas in which the ASC needs to improve to meet specific requirements and to boost efficiency. ■

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SAME-DAY SURGERY

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **Two recent healthcare trends have caused a disruption that affects ASCs, largely by shifting more cases their way. What are these trends?**

   a. Payer consolidation and high-deductible plans
   b. Bundled payments and generic pharmaceuticals
   c. Increasingly generous payer benefit packages and medical tourism
   d. All of the above

2. **How do surgery centers address the most expensive component of care when the goal is to improve efficiency?**

   a. Reuse unopened supplies
   b. Renegotiate facility rent
   c. Examine staffing patterns
   d. None of the above

3. **Which of the following best defines structural violence, an issue that has caused some surgeons to speak up?**

   a. The term "structural violence" acknowledges the role society plays in violence, including the proliferation of firearms and generational housing redlining, which leads to neighborhood breakdowns.
   b. Structural violence is related to how a building, including the physical space of surgery centers, could be designed too weakly to withstand a strong hurricane or earthquake.
   c. Healthcare organizations that experience disasters involving knife or gun attacks have been victims of structural violence.
   d. None of the above

4. **Which of the following is *not* one of the six elements to emergency drills, according to the Accreditation Association for Ambulatory Health Care?**

   a. Assess the internal emergency and disaster preparedness plan.
   b. Find local actors to perform the disaster drill.
   c. Inform all participants that the drill will be happening.
   d. Create and implement a corrective action plan as relevant.

SDS ACCREDITATION UPDATE

Covering Compliance with TJC, AAAHC, AAAASF, and Medicare Standards

AAAHC Asks ASCs, Others to Focus on Medication Reconciliation

New toolkit helps providers address discrepancies

When accreditation surveyors visit ambulatory settings, including ambulatory surgery centers (ASCs), they frequently find problems related to medication reconciliation.

"It's a relatively high deficiency standard for organizations surveyed for accreditation," says **Naomi Kuznets**, PhD, vice president and senior director at the Accreditation Association for Ambulatory Health Care (AAAHC). "Over 10% of certain healthcare settings, including surgery centers, have this deficiency. As studies have shown, when patients go into hospitals, their [listed] medications often are not accurate, and when they leave the hospital, they are not necessarily accurate, either."

There are an estimated 1 million ED visits each year in the United States attributed to medication errors. Medication reconciliation can reduce problems for patients and prevent some ED visits and hospital admissions.

For example, one medication reconciliation program in which an ambulatory setting pharmacist collaborates with nurses and physicians has positively affected patient care in an Arizona community. After the medication reconciliation program began, readmission rates dropped. They declined from 33% in 2014 to 10% in 2016, according to **Lindsay Sampson**, PharmD, BCPS, BCGP, clinical pharmacy coordinator at Winslow Indian Health Care Center in Winslow, AZ. This center received AAAHC's 2017-2018 Bernard A. Kershner Innovations in Quality Improvement Award for its medication reconciliation work.

"We looked at discharge summaries, did medication reconciliation, and gave them a phone call to work their medication issues and errors," Sampson says. "Sometimes, when people get to the hospital, they don't list their home medications or are confused and don't get the dosage correct."

> THERE ARE AN ESTIMATED 1 MILLION ED VISITS EACH YEAR IN THE UNITED STATES ATTRIBUTED TO MEDICATION ERRORS.

Within the Winslow program, nurses (called clinical coordinators) are assigned to specific physicians and are the first people to make contact with ambulatory clinics' patients after a hospital discharge. "They call the patient, put a note in the electronic health record, and if they have any questions about medications, they call providers," Sampson explains. "If [patients] have a long list or a confusing list of discharge medications, we give them a call as well."

AAAHC created a new toolkit to educate ambulatory providers about how to avoid preventable adverse drug events. It features the essential elements of medication reconciliation. *(Editor's Note: Learn more about the toolkit by visiting: http://bit.ly/2CKsoBX.)* The toolkit advises ASC providers to familiarize themselves with the medications their patients are taking before procedures and to ensure accurate medication information and instructions after surgery. The toolkit also outlines how the medications taken presurgery can affect patients if they are taking that medication in the days leading up to surgery.

For example, surgeons should know whether their patients are taking medications such as beta-blockers, calcium channel blockers, anticoagulants, or antiseizure medications so they can instruct patients about whether they need to stop taking these drugs in preparation for the procedure and when patients can restart the medication after surgery.

"There is a class of drugs — benzodiazepines — that interact poorly with opioids," Kuznets says. "If a patient is already on one of these drugs and you plan to use an opioid after the surgery, you can have a bad interaction."

Also, it is problematic when surgery patients have been on opioids prior to a surgery that will result in an additional opioid prescription.

"As a surgery center, you'd need to know what is going on with the patient if you are going to use opioids," Kuznets advises. "When people have pain and already take opioids, they may take more after surgery if they're not getting adequate pain control. This could lead to an overdose."

There also are patients on medication that can cause bleeding. "For instance, with a colonoscopy, where you have a number of biopsies, you don't want bleeding issues," Kuznets warns. "If you know the patient is taking an anticoagulant and stops it for the procedure, then, afterward, make sure the patient goes back on that medication after a period." In its toolkit, AAAHC lists essential elements of medication reconciliation, including:

- making medication reconciliation part of the organization's safety culture;
- tracking patients' current and past medications, using a single source document policy;
- verifying and documenting medications before and after each exam;
- comparing any medication collection form against the single source document;
- communicating with the patient, provider, and/or pharmacy to resolve any discrepancies;
- directing patients to verify they agree with the current medication list.

The toolkit does not specify how ASCs and other ambulatory sites can comply with accreditation standards, but it suggests the endpoint that surveyors want to see, Kuznets says. "We [explain] the issues here, and then we give [patients] evidence-based recommendations, including recommendations by the U.S. government."

ASC administrators can show the toolkit's poster and charts to physicians when they ask why the surgery center is making medication reconciliation changes.

"The surgery center manager can say, *'Here's why we might want to do this. All evidence points to this. We have a nice tool we can use to make sure we do this routinely and don't leave anything out,*'" Kuznets says.

In general, many patients do not take medications as prescribed, Kuznets notes.

"When you do medication reconciliation, you see if they're taking their medications as prescribed."

Medication reconciliation also concerns whether patients' current medications, vitamins, supplements, and over-the-counter drugs will interact with newly prescribed medications. When asked to list their drugs, patients often omit their herbals and vitamins, although these also can produce drug-drug interactions.

Kuznets and Sampson offer a few additional tips on how to improve medication reconciliation:

- **Coordinate with surgeon.**

"Coordinate with the surgeon or proceduralist to make sure they know what medications the patient is taking and what medication instructions are needed prior to the patient arriving onsite," Kuznets offers.

The physician should provide this information to the surgery center.

MEDICATION RECONCILIATION TOOLKIT

The AAAHC's new medication reconciliation toolkit includes this list of essential elements determined by the National Institute of Standards and Technology:

- Prescribed vs. dispensed medication;
- Prescriber name;
- Dispensing pharmacy;
- Prescription date;
- Dispensed date;
- Administration start and end dates;
- Drug status (active, on hold, history, no longer active);
- Indication/diagnosis;
- Textual drug description (name, strength, unit of measure, dosage form) or coded medication (name, strength, dosage form);
- Quantity prescribed;
- Quantity dispensed;
- Number of days' supply;
- Whether refills are allowed;
- Administration directions;
- Alerts (allergies or intolerances; drug interactions);
- Fulfillment instructions (substitutions or dispense as written).

ASCs should insist on knowing exactly what the patient is supposed to do prior to the procedure. Staff need to know what they will have to ask the patient at check-in.

"For instance, if the surgeon has instructed a patient to discontinue a certain medication for a certain period of time prior to the procedure, ASC staff need to ask whether the patient followed those instructions," Kuznets explains.

There are a few questions ASC staff can ask patients at check-in, including:

- *"Have you eaten since midnight?"*
- *"Did you take your medication?"*

Staff also can ask which medications (even aspirin and herbal supplements) patients have ingested recently and if patients stopped taking those medications 10 days earlier.

• Ensure the patient's discharge instructions are in writing.

"Instructions absolutely should be in writing because patients and families might not necessarily follow [the oral] post-procedure instructions," Kuznets notes.

Also, ASCs should make sure written instructions include a date for when the patient could resume presurgery medications.

• Call patients to ask about medications before and after surgery.

Surgery centers often call patients prior to the scheduled procedure to confirm the procedure itself and to answer any last-minute questions. But they also should find out if there are any new issues and whether the patient has discontinued medication as directed, Kuznets says.

After surgery, the ASC could follow up with a call to find out whether the patient is experiencing any complications and also to remind the patient to resume medication. The ASC caller might say, *"We see you are supposed to start your aspirin regimen again, but remember to wait a couple more days before starting it. Set up a reminder so you'll know when to start it."*

When healthcare providers call patients about their medications, they should know about drug-drug interactions and adverse events and explain these to patients, Sampson says.

"A lot of times, patients are told to stop taking a medication, but they're unclear or, occasionally, convinced they still should be taking it, so I document that in my notes," Sampson says. "I say that these medications can interfere with each other. Usually, I say to stop taking it until you see your doctor and the doctor can clear this up for you."

Expect these phone calls to last five to 15 minutes, depending on patients' medication list and chronic condition, Sampson adds.

• Follow through on medication lists, if needed.

Sometimes, there are no reliable lists of patients' medications. When this happens, nurses might call the patient's pharmacy to verify the drugs prescribed, dosages, medication allergies, and how regularly the patient picks up the medication, Sampson says.

"Sometimes, the patients — especially if they're on a lot of meds — will find it hard to remember everything and their exact doses," she says. "Or, they might confuse their medications with prior doses, and they might not be lucid."

• Learn of hospitalized patients and potential medication errors.

Medication problems can lead patients to the ED or result in hospital admission. When this happens after surgery, ASCs should know. Staff will need to communicate well with local hospitals to find out when their patients are hospitalized and to get to the bottom of the problem that led to this outcome.

For ASCs that are on the same electronic medical record system as local hospitals, this might make the task easier.

For example, Sampson logs into electronic medical records to compare patients' medications at discharge from the hospital with what the health organization put on its list for them.

"If something doesn't make sense — maybe they've changed their blood pressure medication — I go back and look at what it was when they were admitted to the hospital," Sampson says. ■

Joint Commission Advisory Addresses Ensuring Accurate Patient Identification

Technology can help, but it is not a silver bullet

Mistakes in patient identification can lead to wrong-patient errors, delays in treatment, and serious problems. In October, The Joint Commission issued an advisory on how healthcare providers can ensure accurate patient identification. Technology can help reduce patient identification mistakes, but healthcare organizations should not rely solely on these tools. *(Editor's Note: Learn more about the advisory online at: https://bit.ly/2yS9ntg.)*

"Despite advanced technology, patient misidentifications leading to wrong patient procedures still occur, suggesting that we cannot rely on technology alone," says **Gerard Castro**, PhD, MPH, project director, office of patient safety, The Joint Commission.

For instance, a common human factor that contributes to patient misidentification is a distraction. This can occur despite or even because of technology aides, Castro explains. These distractions include interruptions, too many people in the area, noise, and time constraints.

"Take, for example, a clinician who is completing documentation on a patient. Then, a colleague asks a question about a medication on another patient," Castro offers. "The clinician opens the record on the other patient, finds the information, and answers the question." Perhaps the clinician receives a phone call, answers another question, and then continues documenting on the record that is open, but it is on the incorrect patient. "Engagement of clinicians is essential to this process, but I'm unaware of any health systems that are working on this issue," Castro adds. "That is not to say, however, that they are not."

Other potential problems that can lead to patient misidentification include mistakenly creating duplicate charts, assigning a test to the wrong patient, and separating commingled patient information. The Joint Commission's recommended safety actions include:

- using an active confirmation process to help match the patient and documentation;
- standardizing the process for patient identification and capturing patient information (wherever registration occurs);
- implementing monitoring systems to readily detect identification errors, such as regular inspection for patient identification errors and possibly duplicate patient records;
- creating high-specificity alerts and notifications to ensure proper identification, including warning users when they attempt to create a record for a new patient whose first and last names are the same as of another patient.

These suggestions, such as implementing monitoring systems, include tactics that clinician researchers are employing, but possibly not many surgery centers or other healthcare providers, Castro notes.

"The vendor community is aware of this work because many vendors participate in the ECRI Partnership for Health IT Patient Safety, where much of the work is shared," he says.

The advisory suggests healthcare organizations use an identifier like a color photo in conjunction with other distinguishing identifiers.

"The idea is to add a visual cue to help corroborate the patient's identity with more standard attributes, such as name and date of birth," Castro says. "Currently, it is a recommended [tactic] that has been tested by some hospitals, but I am unsure of how widely the strategy is being used."

The Joint Commission's National Patient Safety Goal (NPSG.01.01.01) says organizations must use at least two identifiers when providing care, treatment, and services.

"It's up to each organization to determine which strategy helps meet this goal," Castro adds. ■