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INSIDE

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Rolling Out a COVID-19 Vaccine at Surgery Centers

Most healthcare employers will want to vaccinate their staff against COVID-19, but the task in surgery centers will not be easy.

On the positive side, one part of the access issue is solved: clinical trials produced positive interim results for several of the dozens of vaccine candidates. "It's an exciting time to be talking about vaccines in general, and to have two vaccines ready for FDA approval is historic," said **Kathleen M. Neuzil**, MD, MPH, FIDSA, fellow with the Infectious Diseases Society of America (IDSA). She spoke at IDSA's virtual COVID-19 vaccine briefing on Dec. 3.

"It couldn't come any later. We need it now, with the pandemic raging outside our doors," Neuzil said. "I've been involved in Operation Warp Speed from the beginning, and there has been no compromise on safety."

The Pfizer/BioNTech COVID-19 vaccine was the first to the finish line. When members of the data safety monitoring board (DSMB) met in November, they concluded this vaccine was safe and efficacious, says **Robert Salata**, MD, principal investigator for the Pfizer/BioNTech vaccine trial and chair of the department of medicine at University Hospitals Cleveland Medical Center.

An analysis revealed the Pfizer/BioNTech vaccine, which uses messenger RNA (mRNA) and targets the virus' spike protein through the use of new technology, was 95% efficacious.[1] The clinical trial authors did not offer comprehensive data on the actual infection rates of SARS-CoV-2 or whether asymptomatic volunteers transmitted the virus to others. But the study demonstrated volunteers in the placebo arm were much more likely to develop COVID-19 than those in the vaccine arm. "This degree of effectiveness is akin to other major effective vaccines like measles, mumps, rubella, and even tetanus," Salata says. "This is extraordinary, and it's what we were hoping for."

The Moderna vaccine, which also uses mRNA, was found in its

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first interim analysis to be 94.1% efficacious. All 30 severe cases of COVID-19 that were analyzed occurred in the placebo group.[2]

Both Moderna and Pfizer filed for emergency use authorization (EUA) with the FDA. Pfizer received its EUA on Dec. 11, and Moderna received its EUA on Dec. 18. A third drug, produced by AstraZeneca, showed 70% efficacy.[3]

Because there are multiple options, healthcare organizations will need to be careful in how they describe vaccines to employees. For instance, it is possible the first healthcare workers to be vaccinated will receive the Pfizer/BioNTech option. But depending on how later rollouts of the vaccine are prioritized, it is possible surgery center staff and others will receive a different vaccine.

The CDC Advisory Committee on Immunization Practices issued an interim recommendation on allocation of initial supplies of the COVID-19 vaccine on Dec. 3. The report authors said healthcare personnel and residents of long-term care facilities should be offered vaccinations first.[4] The term "healthcare workers" is broad and ambiguous, and the CDC guidelines are not the law. It will be up to each governor to decide who receives the first available doses, according to **Tinglong Dai**, PhD, associate professor of operations management and business analytics at Johns Hopkins University.

"The CDC will tell governors, 'Here are the people you should prioritize,'" he says. "My sense is that, clearly, healthcare workers who are exposed to COVID-19 patients and have a high risk of infection should be the ones who get the first doses of vaccine."

Other high-priority candidates may include essential workers in the food and transportation industries; teachers, college professors, and staff; and those at higher risk of serious illness because of their age and/or underlying health conditions.

Surgery centers likely will have little say about vaccine distribution in the early period of the rollout. No one knows when ambulatory healthcare settings can vaccinate staff, but surgery center leaders should prepare now. Be aware of the possibility of dealing with multiple

EXECUTIVE SUMMARY

Healthcare organizations are preparing for the first wave of COVID-19 vaccines.

- The Pfizer/BioNTech vaccine, which demonstrated 95% efficacy in a clinical trial, has received an FDA emergency use authorization. At least two other vaccine candidates are on the verge of receiving similar authorization.
- The CDC recommends the first round go to healthcare workers and nursing home residents. It is unclear when ambulatory healthcare workers will be vaccinated.
- Surgery center leaders should start educating staff about the vaccine candidates and create vaccine policies for employees and patients. Because vaccine demand is high, leaders also should prepare in case their facilities become designated vaccine administration sites.

options at one time. Make sure vaccines are separated and learn how each type is used. "Some vaccines require two doses, and those two doses of vaccine have to come from the same manufacturer. There are many opportunities for mistakes," Dai explains.

Another obstacle could be vaccine hesitancy among surgery center staff. A recent national poll revealed only half of Americans are willing to be vaccinated against COVID-19.[5] Some of those skeptics could be healthcare workers.

Surgery center administrators should consider designating a committee that provides vaccine education to staff and spearheads distribution. The committee also should consider logistics (e.g., vaccine storage and offsite access).

"If storage is an issue, where does it make sense to store it?" asks **Samantha Penta**, PhD, assistant professor in the College of Emergency Preparedness, Homeland Security, and Cybersecurity at the University at Albany (NY). "Do you have people go to their doctor to get it, or do you have the vaccine in a place where people can collectively go to be vaccinated? Think about the logistics that go in to drive-in testing centers, and think about how there are similar logistics for the vaccine rollout." Surgery centers will need to create a COVID-19 vaccination policy for both staff and patients. A surgery center employee who works directly with patients might need the vaccine. Unvaccinated staffers may be required to wear personal protective equipment even after the pandemic has calmed. Unvaccinated patients might end up on an exclusion list. Staff can create a procedure for finding alternative care arrangements.

Vaccine demand will be high. Thus, there might be a push to recruit primary care offices and surgery centers as vaccine administration sites.

"In the initial wave, there are companies like CVS and Walgreens that may be able to administer the vaccine, but the problem is finding enough qualified individuals to administer it," says **Frank Chapman**, MBA, chair of the standards development committee for the Accreditation Association for Ambulatory Health Care.

If a surgery center receives vaccine supplies, there will need to be space to receive the delivery and a safe storage area. The Pfizer/BioNTech vaccine requires extremely cold storage. Various sectors of the healthcare industry are ordering these ultra-cold storage freezers, and manufacturers are scrambling to keep up with demand. The entire situation is fluid. Whoever leads a surgery center's vaccine program should stay on top of new developments and communicate these to staff.

"Have clear information about what you do know and tell people where they can get reliable information," Penta says. ■

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Overcoming Vaccine Misinformation to Secure Staff Buy-In

An obstacle to vaccinating healthcare staff against COVID-19 is hesitancy cultivated through the consumption of spurious information.

Although public health officials usually promote a science-based approach to infection prevention and vaccination, some government officials, and even a few healthcare providers, support anti-vaccination, anti-mask views. In December, a Senate committee held a hearing about COVID-19 treatments and vaccines. Lawmakers made time to hear from some who oppose vaccine mandates.[1]

Considering the mixed messages from public figures, it is easy to understand why some, including healthcare workers, are skeptical of

vaccinations, particularly when the COVID-19 vaccines are so new. Some may be skeptical only of the COVID-19 vaccine just because of the unusually fast development process.

"Vaccine hesitancy is a complex topic," says **Kate Strully**, PhD, MA, associate professor of sociology at the University at Albany (NY). "When we discuss [hesitancy] in the U.S., even though it's becoming more nuanced now, it gets polarized, and you're [labeled] pro-vaccine or anti-vaccination. My collaborators did some focus groups with healthcare workers around the state of New York, and that work still is in progress. There were a lot of concerns around the role of racism and concerns about rushing the vaccine."

The Infectious Diseases Society of America (IDSA) held a virtual COVID-19 vaccine briefing on Dec. 3. During that session, panelists discussed the hesitancy issue. **C. Buddy Creech**, MD, MPH, FPIDS, principal investigator for the Phase III trials for Moderna's and Johnson & Johnson's SARS-CoV-2 vaccines, said the fast development process should not be a concern for the public or healthcare workers.

"We get so excited about seeing how quickly we can leverage resources," said Creech, director of the Vanderbilt Vaccine Research Program. "We've been laser-focused on leveraging our resources to find an end to this pandemic. We've had a call to arms to try to focus only on this, and we've lived and breathed COVID treatment and vaccine research."

That focus, combined with abundant resources, has made it possible for vaccine candidates to reach the public so quickly. "We're not cutting corners anywhere, but just are doing things in a deliberate and speedy way," Creech said. "We have to roll out these vaccines in a deliberate and staged manner. That's very important as we go to our healthcare workers."

Convincing staff a vaccine is important and safe will take a robust educational plan. Administrators can start by meeting with staff and encouraging them to ask questions. Leaders should emphasize the safety and efficacy data, according to **Robert Salata**, MD, principal investigator for the Pfizer/BioNTech vaccine trial and chair of the department of medicine at University Hospitals Cleveland Medical Center.

For example, the safety profile of the Pfizer/BioNTech vaccine shows that about 10% to 15% of people experience side effects, primarily at the site of the injection.

"But in one or two days, it's gone," said Salata, who also spoke at the Dec. 3 IDSA briefing. "Some can get a flu-like illness, but it's over in 48 hours. It's all been mild reactions."

The authors of a recent study examined the motivations of vaccine-hesitant people who also were social media influencers. Researchers found this group did not trust mainstream sources of health information, relying instead on alternative sources and search engines.[2]

"We found the networking that happens in social media between influencers and other social media users is a place where sentiment around vaccination beliefs is shared," says **Amelia Burke-Garcia**, PhD, MA, program area director of digital strategy and outreach in the public health department of NORC at the University of Chicago. "Many of our participants in our study were vaccinated themselves as children. In some cases, their older children had most or all of their vaccines."

Over time, these participants progressed to the belief that they should not vaccinate their younger children, at least with certain vaccines.

"We also heard of their mistrust of traditional sources of information and feeling platforms like Google and other social media platforms are biased in the information they share," Burke-Garcia explains. "They seek out alternative sources that they feel provide, from their perspective, a more balanced view, such as a search engine called Duck, Duck, Go."

Many participants relied on anecdotal and personal data.

"Some of them said, 'I had chicken pox as a child, and that was a rite of passage, a normal human part of life,'" adds **Amy E. Leader**, DrPH, MPH, who worked with Burke-Garcia on the study.

Beyond combatting all the misinformation, there are logistics problems. The Pfizer/BioNTech and Moderna vaccines require patients to receive two shots, administered at separate sessions. It is unknown whether everyone will have to receive a vaccine annually, and it is likely few, if any, people will have a choice about which vaccine they receive.

Even when the vaccine arrives, some healthcare organizations may not mandate staff to receive it.

"It's my understanding that many surgery centers and healthcare providers and settings are going to require this," says **Frank Chapman**, MBA, chair of the standards development committee for the Accreditation Association for Ambulatory Health Care. "It's the safest possible thing, especially for the next year. I think we're going to get into some legal areas that balance an individual's desire to not be

forced to take the vaccine against the overall safety concern of providing care, especially to patients at high risk, and that's going to play out."

Although mandatory vaccine policies can be controversial in some settings, they can make it easier to keep staff safe during the pandemic.

"It would be a best practice to have all the staff vaccinated against COVID-19," says **Sean A. Diehl**, PhD, an associate professor of microbiology and molecular genetics at the University of Vermont. ■

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COVID-19 Vaccine Does Not End Infection Prevention Programs

Surgery centers weathered the COVID-19 pandemic through a combination of shutdowns, social distancing, and equipping staff with personal protective equipment — all this on top of the usual infection prevention practices.

A vaccine is on the way, but it will be months before shots are available to everyone who needs one. Thus, the winter will not be the time to ease these precautions, especially with a resurgence of cases after the year-end holidays.

The CDC says people should wear a mask, wash hands often, and stay six feet or more away from others, even after receiving two doses of the COVID-19 vaccine.[1]

"What's important here is that along with having this great tool — a vaccine that is highly effective — we need to keep other strategies, such as reducing contact with other people and wearing masks," says **Eli Rosenberg**, PhD, associate professor of epidemiology and biostatistics at the University at Albany (NY).

It could take most of 2021 to vaccinate most Americans and stamp out the pandemic.

"We're going to have only partial community protection for quite some time," Rosenberg cautions. "We don't want people to think the pandemic is over as the first vaccines are rolled out, because it's so limited. Our society will look a lot like it does now for the next year."

Researchers still need more information about how well the vaccines can reduce viral transmission. Early data show the first vaccines prevent COVID-19 illness, but not every vaccine study participant was tested routinely for SARS-CoV-2 infection. The Pfizer/BioNTech study authors collected data on people with COVID-19 infection, with both mild and more severe symptoms, and found most of these infections occurred in the placebo arm.

Investigators must collect additional data on whether vaccination can prevent people who show no COVID-19 symptoms from testing positive. Also, more research is needed to know if vaccination can prevent people from spreading the virus to others.[2]

This is why it is necessary to continue with behavioral approaches as the vaccines are rolled out. "We know the vaccine can prevent severe illness, but we don't know if it's a public health tool yet because it hasn't shown that it prevents transmission," Rosenberg explains.

Until the pandemic ends, surgery center leaders must continue encouraging staff and patients to wear masks and follow hand hygiene protocols. Beyond that, surgery center administrators should provide more air ventilation where possible and disinfect frequently touched surfaces properly according to public health guidance.[3,4] ■

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The Best Qualities of a Good Administrator

One of the biggest mistakes a surgery center administrator can make is to talk too much and share too much.

"When they're upset with an employee, they share it with another team member, which should not happen," says **Beverly Kirchner**, BSN, RN, CNOR, CASC, chief compliance officer at SurgeryDirect in Denver.

It is lonely at the top, but that does not excuse administrators who forget the separation between management and staff.

"If you're having a major issue with an employee, you should have another leader in another department that you can go to and work through it," Kirchner says.

Administrators should look for support from another leader whom they trust, not from the people they supervise.

"The hardest part of being an ambulatory surgery center administrator is that you can like your employees and do all sorts of wonderful things for employees, but you can't be their friend," Kirchner says. "There's a fine line between respecting, working with, and being somebody's friend."

Kirchner offers these additional examples of administrative best practices:

• Follow rules and regulations, not emotions.

"You have to connect with your physician owners and stay focused on rules, regulations, and compliance," Kirchner says. "As the gatekeeper for everything in that facility, it can be very uncomfortable because you have to deliver messages that people don't like."

If an administrator lets emotions affect decisions, it can cause major problems down the road.

"If you allow too much of your emotions to be shown to your team, even if they understand that you're human and can make mistakes, they'll come back and use that against you in the future, if it's to their benefit," Kirchner explains.

This also is why leaders should not let their need to be liked or be friends with staff undermine their role as supervisor and administrator.

• Learn leadership communication skills.

Administrators have to develop new or different communication skills for dealing with the people they supervise.

"Share less of yourself. Keep conversations friendly. Listen to their needs," Kirchner suggests. "But don't cross the line to become their sympathetic friend."

• Form a support team or network.

One way to overcome the loneliness of leadership is to network with other surgery center leaders.

"You can go to conferences, network there, and build a team that you can call," Kirchner explains.

EXECUTIVE SUMMARY

Surgery center leaders must develop specific skills to help them navigate the difficult line between collegiality and staff management.

- Administrators should seek peer support from leaders and administrators at other organizations.
- An important skill to learn is to communicate better by sharing less and listening to employees' needs.
- Flexibility is an important quality in a leader, but it must be exercised within guiding rules and principles.

"People who are in the same position can discuss things safely with you."

No administrator can survive alone. Leaders need a team of supportive peers with whom they can discuss problems.

When Kirchner taught an administrative course, she would bring together nurses who planned to be surgery center leaders. She encouraged them to develop friendships and peer mentor relationships. "This was so they had a resource to fall back on," Kirchner notes.

Another source of leadership support is a professional society or organization. For example, the Ambulatory Surgery Center Association provides information about rules and regulations and offers leadership training.[1] "AORN [Association of periOperative Registered Nurses] also provides resources and helps nurses with compliance," Kirchner says.[2]

• Encourage flexibility, but maintain a leadership wall.

There are times when a leader needs to be flexible with scheduling and staffing rules. Other times, an administrator wants to help an employee with a personal issue. But while flexibility is important, the leader should not cross the line between an administrator and a friend. For example, Kirchner recalls the time when a postanesthesia care unit nurse was talking about her 18-month-old daughter's cough.

"She couldn't decide whether the cough was the child making funny growling noises or something was wrong, medically," Kirchner says. "She took off work early, with permission, to have her child seen by a pediatrician. They ended up in the pediatric emergency room. The child's heart had not developed correctly, and she was dying."

The child went into cardiac arrest and was kept alive while waiting for a heart transplant.

"This is where the line could be crossed, but you need to go in another direction," Kirchner says. "The administrator can support the team with sympathy and allow employees to do what they want to do for their colleague. But you don't want to lead that effort."

The administrator can explain the situation to the physician owners and see if they would like to support the nurse. In this example, they started a fundraising page for the nurse and provided meals for her family.

"The team supported her in all sorts of ways, and the surgery center supported the staff and gave them time to work through this," Kirchner says. "The leader showed empathy and support, but she did not cross the line and lead the fundraising and [meal donation] efforts."

Instead, the administrator worked with nurses and involved the surgery center's board. "She gave them time and space to help with what they were trying to do to help the family," Kirchner adds. "She kept her support at a leadership level."

• Delegate and trust the team.

Administrators can become overwhelmed with their workloads. In a surgery center setting, they can be responsible for compliance, safety, infection prevention, staffing, and other duties. There might be team members to help, but the administrator is the one who is responsible.

"I find that people have a hard time when they first come in as administrators in training their teams to help them with data collection, chart auditing, quality control, infection prevention, and observation," Kirchner observes. "If they don't learn how to train teams and do it quickly, then they become overwhelmed and burn themselves out."

Administrators need to learn to trust their teams and look for the people who they will want to help grow in responsibilities. "Help [teams] grow by giving them stuff of interest, and help them build up their résumé and career," Kirchner suggests. "Any good leader is helping team members build their résumé for that next job."

Delegation is important, but also is vital to verify what employees are doing.

"Trust, but verify. If you don't do that, it will get you in trouble," Kirchner cautions.

In the abstract, surgery center administrators should strive to be leaders who are viewed as transformational. "They have to be thought leaders as well, and they have to be lifelong learners," Kirchner adds. "Learning is something they have to embrace, or they will never succeed in this world." ■

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Poor Leadership Produces Shocking Outcome

Poor leadership in a surgery center can lead to dire consequences. Here is an example of what happens when a surgery center administrator is too casual and friendly with nurses or other staff:

"We had an instance where a nurse decided to play doctor," says **Beverly Kirchner**, BSN, RN, CNOR, CASC, chief compliance officer at SurgeryDirect in Denver. "When someone is the preadmission nurse, interviewing patients, and getting their disease history, it's easy for the nurse to come back and decide the patient needs something."

However, the nurse must contact the physician first. In this case, the nurse skipped that step.

"We had a preadmission nurse one time who discovered the patient had a heart condition. She decided to have the patient get an ECG and cardiac clearance before the patient arrived at the facility," Kirchner recalls.

The nurse had crossed the line of playing doctor without a license. "When this didn't go her way, [the nurse] went to the medical director and manipulated the medical director against the physician," Kirchner says. "That leader was very close to the nurse, and it was a struggle for her to separate what needed to be done vs. the friendship."

The medical director had been friendly and loving to her staff, but she crossed the line between leadership and friendship. This created an atmosphere in which this particular nurse felt empowered to make decisions beyond her scope of responsibility. Then, the whole situation went from bad to worse. Not only did the patient not need cardiac clearance, he became quite irate about his whole situation — to the point of threatening to bomb the facility.

In the end, although there was no bomb or any harm, there were repercussions. The patient had to answer to law enforcement. Meanwhile, both the nurse and medical director eventually left the facility, their nursing licenses were jeopardized, and their friendship was destroyed.

"If the nurse thought the patient did not meet our admission criteria due to heart disease, she should have gone back to the surgeon," Kirchner says. "This was a tragic incident that occurred ... had [the medical director] been a good leader and set boundaries, it wouldn't have happened." ■

Surgeons, Anesthesiologists Raise Alarm Over Medicare Fee Cuts

The Centers for Medicare & Medicaid Services (CMS) in December finalized the 2021 physician fee schedule (PFS), which went into effect Jan. 1. It includes telehealth expansion, targeted rural health assistance, and more streamlined coding and documentation regulations.[1]

The rule includes what CMS called "a historic increase" in the payment rates for office/outpatient face-to-face evaluation and management (E/M) visits. The agency added 11 procedures to the ambulatory surgical center covered procedures list (CPL). Further, within the next three years, CMS says it will eliminate the inpatient-only list (IPO) of 1,700 procedures that Medicare currently only will pay for when performed in a hospital inpatient setting.[2]

The American Hospital Association called the final rule "a blow to America's hospitals" and worries that "the continuation of

deep cuts in payments for 340B drugs exacerbates the strain placed on hospitals serving vulnerable communities."[3]

Ambulatory Surgery Center Association CEO **Bill Prentice** struck a different tone.

"CMS should be commended for recognizing that ASCs [ambulatory surgery centers] are increasingly able to safely provide a greater range of services as medical practice evolves," he said in a statement after the rule's release.[4] "We sincerely appreciate the policies relating to allowable procedures that rely on the critical role of physicians and their clinical judgment in making site-of-service determinations."

The Budget Neutrality Catch

Because of a federal stipulation regarding budget neutrality, to finance certain increases CMS had to make cuts elsewhere — in this case, payment reductions to other medical services covered by Medicare. Upon its release, surgeons, anesthesiologists, and others blasted the fee cuts at a time when the whole industry is struggling financially.

Some physicians accused CMS of turning a blind eye toward their sacrifices and the COVID-19 pandemic financial pain they experienced in 2020. "We're having our payments cut by 10% on the Medicare side, and this takes us back to rates that haven't existed since 1991" says **Beverly Philip**, MD, FACA, FASA, president of the American Society of Anesthesiologists. "We're at the forefront of the pandemic. We have medical expertise and care for COVID patients in critical care units and surgery."

> "IT'S NOT THAT WE WON'T CARE FOR THESE PATIENTS; IT WON'T BE FINANCIALLY VIABLE."

For example, anesthesiologists helped convert anesthesia machinery into ventilators for use in hospitals. This, at a time when facilities were filled past capacity and running out of supplies.

"As anesthesiologists, we are enthusiastic about contributing to the nation's response to the pandemic," Philip says. "At this time, when we are gladly doing more than ever before, we're getting funding cuts, and it will make our practice unsustainable."

Many anesthesiology practices and ASCs were closed in March and April 2020 because of the pandemic. When centers reopened, they followed COVID-19 prevention practices that reduced their patient volume and added more cost to their practices.

These cuts could affect the anesthesiology practice for a long time, perhaps discouraging new doctors from going into the field, according to Philip. "For decades, we've had a problem with Medicare payment," she says. "Our specialty, in the original system, gets paid less for Medicare rates."

Medicare's other big change, to send more procedures to ASCs, is a double-edged sword. Such providers welcome the potential to help more patients. On the other hand, the shift in Medicare payments for surgery in ASCs increases surgery centers' reliance on Medicare payments and cuts, according to Philip.

"What we're seeing year by year is that procedures that used to be hospital patients are now being driven to the ambulatory surgery center," she says. "ASCs are also subject to increasing exposure to Medicare payment cuts, more than they ever had before." If Medicare cuts to anesthesia services and certain surgical procedures continue, the

long-term result could be limited access to these procedures.

"If a business is not viable, then people don't go into it, and that is what I worry about," Philip says. "It's not that we won't care for these patients; it won't be financially viable."

Ophthalmology Especially Concerned

The Medicare changes could harm struggling ophthalmologists, since the proposed 6% cut in Medicare reimbursement for 2021 follows years of significant cuts in reimbursement, says **Dan Briceland**, MD, senior secretary for advocacy with the American Academy of Ophthalmology in San Francisco.

Ophthalmologists typically see many Medicare patients for cataract procedures and other eye surgeries. Any cuts in their Medicare reimbursement could affect these practices significantly. "Ophthalmology has a high overhead — 50% to 60% — because of its equipment. When you run a high-overhead office, you don't have margins that can take double-digit decreases, year to year," Briceland explains.

Plus, ophthalmology lost more patient volume during the pandemic than any other medical specialty.[5] "With the COVID pandemic and closing all of our practices down for two months, it was just devastating," Briceland adds.

Some ophthalmologists, especially those near retirement, might decide it is no longer worth continuing with their small surgical practices if the additional Medicare cut goes through.

"Other doctors are saying, 'You gave me double-digit cuts in cataract surgery last year, so I won't do as many surgeries,' and some will give up surgery," Briceland says. "This could happen in rural areas especially."

Another outcome might be small practices merging with larger ones, which already is a trend in surgery centers and healthcare generally.

"Some practices might offer a little more cosmetic surgery if they have training and interest in that. Some might sell products like vitamins for macular degeneration," Briceland says. "Some practices might do more upscale concierge cataract surgery, but that doesn't move the needle. That's not why we went into practice."

Congress Could Help

CMS' move is the culmination of a situation that has been brewing since last summer when the agency first released the rule proposal for public comment. Back then, healthcare groups asked CMS to postpone the budget neutrality provision or waive it altogether, at least this one time.

Now, preventing the controversial cuts from becoming reality would take congressional intervention. A bipartisan group of House lawmakers have been working on just such a proposal — "Holding Providers Harmless From Medicare Cuts During COVID-19 Act of 2020." The resolution would freeze the Medicare reimbursement rates at 2020 levels for two years.[6]

In November, a coalition of 74 healthcare organizations sent a letter to Congress in support of this proposal.[7] In December, 50 senators urged action.[8]

"We have been pushing majority and minority members of the Senate to include some fix for us in the last budget bill they're doing for the year," Philip says. "There is broad agreement that this is not reasonable, and it's an unintended consequence of an outdated budget [provision]."

If Congress fails to act, there is a contingency plan. "We will continue in January and February, if needed, to help our congressional supporters create a fix that will address the needs, especially of physician anesthesiologists who are going into another surge of the COVID-19 pandemic," Philip says. "If there's not time to sort out this ... the cuts will be terrible, and we will not stop with a broad medical coalition to get it fixed." ■

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Slamming Forward

By Stephen W. Earnhart, RN, CRNA, MA
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If you have been keeping up with the latest CMS regulations, you understand it is a completely new environment for surgery centers and hospitals. Accordingly, it is important to start planning for what is ahead:

• **Consider adding space.** Assess your facility and the possibility of adding more space for extra operating rooms, recovery beds, and overnight stay suites.

• **Consider adding capital.** Expanding the facility's physical footprint or buying more equipment means finding more capital. If your current surgeon investors cannot or do not want to invest more money, turn to outside, non-physician investors. I recently added $750,000 from private, non-physician individuals. It took two days to secure the commitments. The money is out there, you just have to ask.

• **Expand procedures.** Total joint, hip, knee, and shoulder procedures are evolving and expanding rapidly. But do not miss opportunities in spine (on a grander scale), cardiology, and even transplants.

• **Market to surgeons.** Many surgeons do not use surgery centers because the bulk of their procedures cannot be performed in ASCs. But as regulations update, that situation will evolve. Start searching for surgeons looking for a change of scenery.

• **Market to the public.** The public also needs to be aware what is happening at your facility. Use your website to connect with patients with updates on what is happening not just in your facility but also in the surrounding area. Make your website educational and informative.

• **Shoot for the stars.** Don't self-limit the procedures you think can be performed in your ambulatory surgery center. Remember that hospitals are bricks and sticks with the right equipment, training, and resources. You can be that, too — with the right motivation.

• **Expand your asset portfolio.** We work with many clients who own multiple surgery centers in the same town. For many clients, they started by building one center years ago that could not be expanded. Eventually, they added a second facility to handle another specialty. Others wanted to add a facility so they could be close to more clients in another part of town. Still others wanted to work on a project with a new group of surgeon investors. Imagine the resources available to you with two, three, or even more surgery centers under one partnership.

• **Invest in staff.** Staff will not stay with your organization simply because they like you. Instill confidence and excitement with incentives. A 15% pay increase is one option; profit-sharing is a better one.

• **Create a timeline.** Remember that an idea or plan is worthless without a timeline. Be realistic in what you can and cannot achieve.

Be excited about 2021. Avoid negative news, and focus on the positive without the distraction of hyperbole. Work on things you can change that make a difference in your workplace. ■

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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.

COMING IN FUTURE MONTHS

- Quality improvement tactics for 2021
- New accreditation standards target medication allergies
- Benefit from Medicare shift to surgery centers
- Shared decision-making works in surgery, study shows

SAME-DAY SURGERY

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CME/CE QUESTIONS

1. **The COVID-19 vaccine by Pfizer/BioNTech demonstrated about 95% efficacy in clinical trials. What are the vaccine's characteristic and target?**

   a. DNA and antibody response
   b. DNA and ACE inhibitors
   c. Messenger RNA and the viral spike protein
   d. RNA and the cell nucleus

2. **What is an obstacle to administering the COVID-19 vaccine?**

   a. Waiting on the FDA's full approval of a vaccine
   b. States giving vaccines to children first
   c. The first round of vaccines is less efficacious
   d. Vaccine hesitancy among staff

3. **When it comes to decision-making, good administrators set aside:**

   a. emotions.
   b. vacation days.
   c. peer administrators.
   d. rules, regulations, and data.

4. **The Centers for Medicare & Medicaid Services (CMS) issued its Medicare Physician Fee Schedule final rule on Dec. 1, 2020, creating big cuts for some physicians. What did critics say about the fee cuts for anesthesiology and ophthalmology?**

   a. They said the cuts were twice as much as in 2019, and should be reversed.
   b. They said the cuts were coming at a time when the industry was financially struggling.
   c. They said the cuts made it impossible to perform certain surgical procedures.
   d. They said CMS should issue increases to their rates or expect surgeons to stop performing procedures for Medicare patients.