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Under proposed rule, ASCs would be paid 62% of the hospital OPD rate

Viability of surgery centers questioned under proposed cuts

In a first step toward a new ambulatory surgery center (ASC) payment system, the Centers for Medicare & Medicaid Services (CMS) has issued a proposed rule that would pay ASCs 62% of the hospital outpatient department (HOPD) rate, beginning Jan. 1, 2008, with a two-year transition period.

The 62% is a disappointing number at best, says **Kathy Bryant**, president of FASA. "I don't understand how anyone thinks we can provide the same procedures as hospital outpatient departments for that much less," Bryant says.

Many ASCs, particularly ones that are single specialty, won't be feasible at these rates, she maintains. ASCs can't hire nurses at 62% of the hospital rate, and they can't pay medical suppliers 62% of what the hospital pays, Bryant points out. Gastrointestinal procedures and pain management procedures will receive some of the largest cuts under this plan, she says. "The irony is that if those procedures are sent back to the hospital, it will cost Medicare more money," Bryant says.

EXECUTIVE SUMMARY

Surgery center leaders are very disappointed that a proposed rule for a new ambulatory surgery center (ASC) payment system would pay ASCs 62% of the hospital outpatient department (HOPD) rate.

- Rates would be phased in over two years.
- ASCs would not receive the annual payment rate updates that hospitals receive.
- The proposal lists criteria for determining whether a procedure would be added to the ASC list. Procedures having overnight stays (past midnight) would be excluded.
- Fourteen procedures would be added to the ASC list. **(See list, p. 100.)**

The 62% figure was selected because CMS officials claim it's a budget-neutral number, but Bryant points out that ASC rates have been frozen for years. "We think this is a broad interpretation of budget neutrality," she says. "We think CMS will save more money if they pay us more so we can be viable competitors, and that's where we want to focus." According to sources, a coalition of industry groups is working to refute the budget neutrality figures.

The two-year phase-in also is a disappointment, Bryant says. "It's taken CMS more than two decades to change the payment system, but they expect ASCs, most of which are small businesses, to adjust," she says. Also, the phase-in period actually isn't two years, she maintains. For calendar year 2008, CMS proposes to phase in the new ASC payment rates as a blended payment equal to 50% of the applicable calendar year 2007 payment rate plus 50% of the applicable calendar year 2008 payment rate. "You get mixed rates for one year; and then the next year, you're fully implemented," Bryant says.

No safety net for surgery centers

Craig Jeffries, executive director of the American Association of Ambulatory Surgery Centers in Johnson City, TN, adds his voice to Bryant's criticisms.

"The level of payment reduction for high-volume Medicare procedures is significant, and the proposed two-year transition does not provide any safety net for affected centers," he said in a prepared statement.

Also, despite the fact that ASC rates will be based on hospital rates, ASCs will not receive annual payment rate updates, the same wage index adjustment as HOPDs, or the same add-ons that hospitals receive for innovative pharmaceuticals, medical devices, and implants. Instead, CMS would continue to adjust the national ASC payment amounts to reflect geographic wage differences using the hospital inpatient prospective payment system (IPPS) wage index.

"We had argued that if we are paid based on the hospital system, everything needs to be the same," Bryant says.

ASCs will be paid the lower of the ASC rate or the physician rate, she says. Bryant says that it is interesting that CMS doesn't want procedures to migrate from physician offices to ASCs, which will affect about 280 procedures. "Our rates could be very different from hospitals', even less than 62% of the HOPD rate," she says. Essentially, CMS officials are saying that procedures can migrate to hospitals, which are more expensive, but not ASCs, Bryant maintains. "The bottom line is that where the procedure is performed needs to depend on what that particular patient needs," she says.

ASC payment rates under the revised system would range from $3.68 to $16,146.03, based on 221 ambulatory payment classification groups (APCs). In contrast, the current nine payment

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Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@thomson.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@thomson.com).
Senior Production Editor: **Nancy McCreary**.

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Editorial Questions
Questions or comments?
Call **Joy Daughtery Dickinson** at (229) 551-9195.

groups range from $333 to $1,339. Medicare will continue to pay ASCs 100% for the first procedure, then 50% for each subsequent procedure, Bryant says.

Reform of the ASC list process

CMS proposes changing the criteria for how additions are made to the list of ASC-approved procedures. In past communication about the change, CMS had indicated that procedures would be excluded if they posed a significant health risk to the patient or required an overnight stay. These criteria are listed in the proposed rule, which indicates that an overnight stay is defined as one that is midnight or later. **(For more proposed changes from CMS, see story, p. 100.)**

Bryant questions whether midnight is a good defining point. "Is there any difference for a patient who stays to 11:59 than one who stays to 12:15?" she asks. "Arbitrary time lines and regulations create issues."

The proposed rule also says procedures added to the ASC list must not be on the inpatient-only list, have been performed more than 80% of the time in an inpatient hospital setting in 2005, involve major blood vessels, involve prolonged or extensive invasion of body cavities, involve extensive blood loss, and be emergent or life-threatening in nature.

What is considered "safe" changes over time, based on medical technology, Bryant says. "By putting in criteria to define what is safe, even if they are good criteria in 2008, they may be bad criteria by 2010," she says. Instead, the criteria should be simply whether the procedure is safe, Bryant says.

Officials with the American Hospital Association (AHA) are raising their own concerns with the proposed change. "We want to really look at methodology they're using to determine which items are not covered in an ASC," says **Don May,** vice president for policy at the AHA's Washington, DC, office. "We definitely have concerns about inappropriate use of ASCs for what should be [hospital] outpatient or inpatient procedures."

Many of the AHA's concerns revolve around surgery centers that may need to transfer patients for inpatient care, but that may not have transfer agreements in place or send medical records for the patients. "The more that complicated procedures are done in ASCs, the more we need better mechanisms to communicate with us, so the emergency department knows what drugs they had, for example, and how to care for the patient most appropriately," May says.

The news in the proposed regulation isn't all bad, Bryant says. "CMS staff members clearly have spent a lot of time working on these issues," Bryant acknowledges. However, the proposed rule needs extensive improvement, Jeffries said. "AAASC will work closely with our members and ASC and physician leaders over the next 90 days to prepare specific comments on the CMS rule and to educate members of Congress on the potential impact of the proposed rule on Medicare beneficiaries, ASC providers and the Medicare budget," he says.

Also, FASA has a Feedback Form on its web site which any surgery center managers can use to submit comments on procedures they think should be added to the ASC list. *(Editor's note: Go to www.fasa.org/Feedback.doc.)* Bryant says, "I think we should expect some changes."

Also, industry groups are still pushing the Ambulatory Surgical Center Medical Payment

RESOURCES

A copy of the proposed rule can be found at www.fasa.org/CMSproposal.pdf. The rule also was to be published in the *Federal Register* on Aug. 23, 2006.

More information on the proposed rule can be found at:

- **FASA's web site:** www.fasa.org/proposed.
- **American Association of Ambulatory Surgery Centers web site**: www.aaasc.org/advocacy/MedicarePaymentProposedRule.html.

To comment on the proposed revised ambulatory surgery center payment system, comments must be received by Nov. 6, 2006. Please refer to file code CMS-4125-P. To comment on all other sections of the proposed rule, comments must be received by Oct. 10, 2006. Please refer to file code CMS-1506-P. You may submit electronic comments at www.cms.hhs.gov/eRulemaking. Attachments should be in Microsoft Word (preferable), WordPerfect, or Excel. Or you may mail written comments (one original and two copies) to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-4125-P or CMS-1506-P, P.O. Box 8011, Baltimore, MD 21244-1850.

For further information on ambulatory surgery center issues, contact:

- **Dana Burley**, Centers for Medicare & Medicaid Services. Telephone: (410) 786-0378.

Modernization Act (S 1884 and HR 4204). That bill would have ASCs receiving 75% of the HOPD rate and would make policies more parallel between the two payment systems. "The [Sen. Mike] Krapo bill is more straightforward, and we think fairer," Bryant says. ■

CMS adds 14 procedures, but cuts other payments

In a proposed regulation, the Centers for Medicare & Medicaid Services (CMS) is adding 14 procedures to the approved list for ambulatory surgery centers (ASCs) in 2007 **(see list, below)** and plans to expand the list further in 2008.

"I'm extremely disappointment that lap chole isn't on here," says **Kathy Bryant**, president of FASA. Despite that disappointment, she acknowledges that she is pleased CMS moved ahead with the list update despite the fact that the entire system is changing in 2008. The expansions in the ASC list go a long way to making ambulatory surgery services more available to Medicare beneficiaries, she says. "They went forward without the [General Accounting Office] report, now 18 months overdue, so we can comment and work on the problems," Bryant says.

Craig Jeffries, executive director of the American Association of Ambulatory Surgery Centers in Johnson City, TN, said in a prepared statement that beneficiary access to ASCs is "modestly improved" with the limited expansion of procedures that would be covered in the ASC setting. "However, the proposed rule falls short of providing Medicare beneficiaries with the range of safe choices available in the commercial insurance market by continuing to impose a regulatory approach instead of relying on the judgment of the physician in consultation with their patient to choice a surgery setting," he said.

The proposed calendar year 2008 expansion of the ASC list includes 750 more procedures, two-thirds of which are currently performed mostly in physician offices. Bryant says, "In general removing arbitrary restrictions on what procedures that can be paid for ASCs in is a positive step. However, because of special payment limits and budget neutrality, the impact of added procedures needs to be carefully evaluated before the impact on ASCs can be assessed."

If the proposed rule for hospital outpatient departments (HOPDs) is adopted, then the ASC payment rate for 274 procedures will be reduced, Bryant says. This reduction is a result of a law passed by Congress in 2006 that limits the maximum ASC payment rate for any procedure to the HOPD payment rate for that same procedure.

"Our beef with that one is with Congress," Bryant says. "We don't like it."

Beginning in calendar year 2008, payment for office-based surgical procedures would be limited to the lesser of the Medicare Physician Fee Schedule nonfacility practice expense payment or the applicable ASC rate. Office-based procedures that are on the ASC list as of Jan. 1, 2007, would be exempt from the payment limitation. ■

Proposed ASC List Update

Procedure (CPT)	Group
Repair Wound, Lesion Add-on (13102)	1
Repair Wound, Lesion Add-on (13122)	1
Repair Wound, Lesion Add-on (13133)	1
Please breast catheter for rad (19297)	9
Treat cheek bone fracture (21356)	3
Percutaneous vertebroplasty (22520)	9
Percutaneous vertebroplasty (22521)	9
Percutaneous vertebroplasty (22522)	1
Repair venous blockage (35476)	9
AV fuse, upper arm, cephalic (36818)	3
Transcath IV stent, percutan (37205)	9
Transcath IV stent/perc, add (37206)	1
Reposition gastronomy tube (43761)	1
Ligation of hemorrhoids (46946)	1

Source: Centers for Medicare & Medicaid Services, Baltimore.

HOPDs rate updated, tied to quality measures

Hospitals to receive about 3% payment increase

Under a proposed regulation, the Centers for Medicare & Medicaid Services (CMS) would require hospital outpatient department (HOPD) payment rate updates to be tied to inpatient quality measures provided by the hospital, beginning in 2007. Under the proposal, hospitals that don't submit the required quality data would see their

HOPD rate updates reduced 2 percentage points.

For fiscal year 2008, CMS proposes that several quality measures be added, including the following from the Surgical Care Improvement Project (SCIP): venous thromboembolism (VTE) prophylaxis ordered for surgery patients, VTE prophylaxis within 24 hours pre-/post-surgery, and prophylactic antibiotic selection for surgical patients. CMS also proposes to move "as quickly as possible" to the use of additional quality measure that are specifically appropriate for hospital outpatient care, as such measures are developed, according to **Mark B. McClellan**, MD, PhD, CMS administrator, who held a media conference call on Aug. 8. McClellan also indicated that ambulatory surgery centers eventually will be required to provide quality data.

The proposed rule includes a 3.4% inflation update for HOPDs for 2007. After taking into account other factors that affect the level of payments, CMS estimates that hospitals will receive an overall average increase of 3% for HOPDs in 2007. *[Editor's note: For further information on hospital outpatient prospective payment issues, contact Alberta Dwivedi, CMS. Phone: (410) 786-0378.]* ■

Final report issued on specialty hospitals

Moratorium lifted, disclosure required

In a final report from the Centers for Medicare & Medicaid Services on specialty hospitals, the agency said it will fine these facilities $10,000 per day if they fail to report their financial structure to the federal government. It also will require specialty hospitals to disclose their financial relationships with physicians to patients and to treat all emergency patients regardless of their ability to pay.

The report coincides with the end of an 18-month moratorium on new specialty hospitals.

In a prepared statement, **Thomas Nickels**, senior vice president of the American Hospital Association (AHA), said, "Given the growing evidence that financial interest may be overtaking patient interest, the AHA continues to believe physician self-referral to limited-service hospitals they own should be banned." Patients should not have to question whether their physician is acting in the interest of patient care or in the physician's best financial interest, Nickels said. "We stand ready to work with Congress to address the very serious issues self-referral raises for patients and health care," he said.

The response from representatives of the specialty hospital industry to the final report is positive. "I think all members are fine with disclosing our ownership relations," says **James Grant**, president of the American Surgical Hospital Association in Sioux Falls, SD, and executive vice president of National Surgical Hospitals in Chicago. "They're proud to tell patients and others that they have ownership in these facilities so they can ensure the best quality care is delivered," Grant says. "In fact, many of our member facilities already are doing that."

Treating emergency patients is a condition of the Emergency Medical Treatment and Labor Act, he says. "Our hospitals have always been compliant," Grant says. "It's a condition of Medicare."

He says specialty hospitals are not doing any harm to general hospitals. "This is an issue of general hospitals complaining about the competition," Grant adds. "We're glad that, hopefully this is end of process and we can get on with our mission to serve our patients as effectively as we possibly can." ■

Do you hear me now? Do you understand me?

Patients don't always process instructions correctly

Fact sheets on the procedure are produced and distributed through the surgeon's office, brochures about your outpatient surgery program are in the packet the patient receives when surgery is scheduled, a nurse talks to the patient in a pre-admission telephone call, and a comprehensive instruction sheet is given to the patient upon discharge.

So, why is the patient making frantic calls in the middle of the night to report pain? Why didn't the patient call the surgeon's office two days postoperatively to report increasing redness at the incision site? Why is the patient calling the surgery program staff to ask about when to change the bandage?

There are a number of reasons that all of the information that the surgeon and the nurses provided was not heard or understood, says **Ilene Corina**, president of the Wantagh, NY-based

EXECUTIVE SUMMARY

Making sure that patients understand preoperative and postoperative instructions is a critical part of patient safety, but it's not always easy. Low health literacy can be attributed to several factors including use of medical language by physician and nurse, patient anxiety, and effects of anesthesia.

- Encourage patients to bring a friend or family member to listen to information about the surgical procedure and the aftercare.
- Keep handouts simple, easy to read, and legible.
- Do not discharge a patient unless another person is present to hear aftercare instructions.
- Be specific about signs of infection and levels of pain that are normal or abnormal following the surgical procedure.

Persons United Limiting Substandards and Errors in Healthcare (PULSE) and a member of the Joint Commission on the Accreditation of Healthcare Organizations' Board of Commissioners. "Low health literacy is a problem for many people, regardless of their income, education, or language," she says.

Health literacy is defined as the degree to which an individual can obtain, process, and understand basic health information needed to make health decisions, but the degree of literacy differs between provider and patient, Corina says. Information about a surgical procedure might be well written and well presented from the surgeon's or the nurse's point of view, but a patient with no medical experience doesn't understand some of the words used on a regular basis, she explains. "I don't know if instructions to take a medication three times a day means at mealtimes, or every eight hours because I don't know how the medicine works," Corina says. "It's the same as not knowing the difference between 'business class' and 'more leg room' when I fly, but when I fly, the employees are not wearing white coats, I am not naked, and no one is looking at their watch, so I feel comfortable asking questions."

The day that a patient learns that he or she will need surgery is not the day to give them all of the details of the procedure, says Corina. Anxiety and fear about surgery will make even the most intelligent patient stop listening to the surgeon once the words "you need surgery" are spoken, she explains. There are two ways to address this problem, she suggests. "If the surgery is elective, as most outpatient procedures are, then offer the patient a chance to come in at another time with a list of questions," Corina says. "You can also suggest that the patient bring a friend, family member, or other person who can be a health advocate."

Larry E. Gellman, MD, FACS, a surgeon in Great Neck, NY, encourages his patients to have someone with them to take notes, ask questions, and obtain clarification on information. "Doctors and surgery nurses present this information every day, so we don't always know how it sounds to someone who is experiencing a visit to a surgeon and discussing surgery for the first time," he admits. Patients will disconnect during the conversation, or they latch on to information they want to hear and stop listening to other information, he says. "A friend or family member can listen to the same information and remind the patient later about what was discussed," Gellman adds.

Advocate for procedures important

An advocate is especially helpful if the procedure is an outpatient procedure, says Gellman.

"People tend to think of an outpatient procedure as not very serious, but the reality is that they will be taking care of themselves as soon as they leave the surgery center, Gellman says, "so they need to understand care instructions more than an inpatient surgery patient does." Even before the surgery, a pre-admission visit to the surgery center with an advocate is very helpful so that the patient and the advocate know where it is located, what will happen on the day of surgery, and who will take care of the patient, he says.

While privacy concerns related to physician-patient confidentiality or Health Insurance Portability and Accountability Act (HIPAA) requirements might appear to discourage the use of advocates, Gellman points out that when the patient brings the advocate to the appointment, there are no problems. "I remind the patient that we will be discussing private information and ask them if they want the friend, family member, or advocate present," he says. "If they agree to the other person's presence, I proceed," he adds.

"I make a point of telling patients the process by simply explaining that they will go to the surgery center, a nurse will review their information, an IV will be inserted, an anesthesiologist will talk with them, and they'll go into the operating room," Gellman says. "When I describe each step, I know that they will not be anxious that they haven't met the anesthesiologist before they talk with a nurse

SOURCES/RESOURCES

For more information about improving communication with patients, contact:

- **Ilene Corina**, President, Persons United Limiting Substandards and Errors in Healthcare (PULSE) of New York, P.O. Box 353, Wantagh, NY 11793-0353. Telephone: (516) 579-4711. Fax: (516) 520-8105. E-mail: Icorina@aol.com.
- **Larry E. Gellman** MD, FACS, North Shore Surgical Specialists, 310 E. Shore Road, Great Neck, NY 11023. Telephone: (516) 482-8657. E-mail: larrygellman@aol.com.

- **The American College Of Physicians Foundation sponsored a conference** "Practical Solutions to the Problem of Low Health Literacy" in November 2005. To access copies of presentations and links to other resources, go to www.foundation.acponline.org/healthcom/hcc_reg.htm.
- **Persons United Limiting Substandards and Errors in Healthcare (PULSE) offers a patient safety brochure review service** that gives health care organizations an evaluation of the clarity of their information from the perspective of nonmedical readers. For more information about this and other services offered by PULSE, go to www.pulseamerica.org. Choose "About Us" on the left navigational bar, then choose "services." Scroll down to "To learn more about our Patient Safety Brochure reviewing capabilities, click here."

because they know that meeting the anesthesiologist is not the first step." This type of simple description of the process should be repeated throughout the day of surgery to let patients know that everything is happening as it should, he suggests.

Another key to making sure patients understand discharge instructions is to keep the instructions simple, suggests Corina. Put basic wording on instruction sheets and make them easy to read, using bullet points and clear headings, she says. "I also don't think aftercare instructions should only be given at the time of discharge," she says. "If the patient is undergoing a common procedure, have the discharge instructions given at the time the patient is scheduled for surgery."

Discharge instructions should be given not only to the patient, but also to a family member or other advocate as well, points out Gellman. "The patient is still feeling the after effects of anesthesia and will not remember instructions or be able to ask questions about printed instructions," he says.

Be sure that your instructions address the most common aftereffects of surgery, suggests Corina. "Be specific about what the signs of infection are and when a patient should call with concerns," she says. "Also, be specific about who to call. Sometimes the surgery program staff can answer questions; other times, the surgeon must talk to the patient." The most common concerns usually are signs of infection and level or duration of pain, Corina adds.

"When I first started practicing and performing laparoscopic hernia repairs, I would hear from 80% of my patients who were complaining about not feeling well and being bloated," says Gellman. "As a new surgeon, I would have them come into the office to be seen, only to discover that they had not moved their bowels in four days." His calls decreased when he added more information for patients as they were discharged. "My discharge instructions now include directions to drink plenty of liquids and take milk of magnesia or prune juice to stimulate bowel movement after surgery to prevent this discomfort," Gellman says. ■

AHA deplores migration to outpatient centers

'A biased attempt to protect the hospitals' turf'

A July report from the American Hospital Association (AHA) regarding the shift of care to nonhospital settings[1] brought strong reaction from FASA, which said the association is playing "the blame game."

The AHA report says the migration of cases might be harmful to the entire health care system. "Physician ownership of ASCs and in-office imaging equipment not only sets up financial incentives for physicians to increase utilization but also encourages the steering of patients by acuity and payer, directing the more complex, costly and less well-insured patients to hospitals," the association says.[1]

The loss of electives cases presents "a financial challenge" for hospitals, which need to provide a wide range of services, including emergency services, the report says. "Ironically, ASCs rely on but generally don't support the emergency standby capabilities of hospitals," the AHA says.[1] The report goes on to say, "ASC

EXECUTIVE SUMMARY

The American Hospital Association (AHA) and the Federated Ambulatory Surgery Association (FASA) square off over an AHA report criticizing the shift of cases from hospitals to outpatient centers.

- The migration has caused a financial hardship for hospitals due to patient acuity and reduced reimbursement. The shift may be driving health care costs up, the report indicates.
- The AHA questions the financial incentives of physicians in owning surgery centers and the safety and quality of centers.
- FASA touts surgery centers' quality record and the cost savings that centers provide to the Medicare system.

patients suffering from complications can appear in a hospital ED with no warning call, no medical history, no operative report, no information on the anesthesia used, and often no ability to reach the ASC's surgeon for consultation."

In its report, the AHA said "the potential for increased service use due to supply-induced and/or physician-induced demand — particularly in self-referral situations — has some payers concerned that the shift in care is driving overall costs for outpatient services up, not down. In addition, as the procedures performed in these settings have become more complex, patient safety and quality have come into question."

The AHA says that 37 states have some certificate of need (CON) oversight in place for hospitals, but this oversight often is not in place for other ambulatory settings. ASCs are more common in states that have minimal or no CON oversight, the AHA says.

The AHA report raises a set of policy questions, which includes:

• Is the public aware of differences in certification and quality standards across settings of care including hospitals, ASCs, and physician offices?

• Should ASCs be required to disclose the limitations of their service capabilities to patients?

Also, in the area of post-surgical recovery care centers, the AHA says that if those centers "in essence are providing hospital-type inpatient care, should they also meet hospital-level standards of inpatient care?" Hospital postoperative units are more likely to be better equipped to handle complications from surgical procedures, the report maintains.

The AHA report also had several sets of reports, including:

• "Medicare's standards for ASCs and physicians offices fall short of those required for hospitals" "while states' licensing requirements vary in filling in the gaps," "as do accreditation requirements."

• "Few states regulate surgeries performed in physician offices" followed by "and for those that

Highlights: MedPAC Report on Health Care Spending

- Most hospitals (86%) provide outpatient surgery. The number of hospitals that provide services under Medicare's outpatient prospective payment system (PPS) has dropped. A significant part of that reduction is due to the increase in the number of hospitals that have converted to critical access hospitals.
- In looking at the payments for services under the Medicare hospital outpatient PPS in 2004, procedures — including endoscopies, surgeries, and skin and musculoskeletal procedures — account for the highest amount (46%) of spending on services.
- Expenditures for the outpatient PPS system are concentrated in a handful of categories that have high volume, high payment rates, or both. Among those hospital outpatient services with the highest Medicare expenditures in 2004 were cataract procedure with intraocular lens insert (APC 0246), 4%; lower gastrointestinal endoscopy (APC 0143), 3%; upper gastrointestinal procedures (APC 0141), 2%; and Level II laparoscopy (APC 0131), 1%.
- Total Medicare payments for ambulatory surgery center (ASC) services are increasing at a rapid rate. Payment increases averaged 15.3% per year from 1999 through 2005.
- The number of ASCs that are Medicare-certified increased at an average annual rate of 8.3% from 1999 through 2005. An average of 337 new Medicare-certified facilities entered the market each year from 1999 through 2005. During those same years, an average of 71 closed or merged each year.
- Most Medicare-certified ASCs are for-profit (96% in 2005) and are in urban areas (87% in 2005).
- For 2005, there were 4,506 Medicare-certified ASCs. There were 467 new centers and 97 exiting centers that year.

Source: Medicare Payment Advisory Commission, *Healthcare Spending and the Medicare Program.* Washington, DC; 2006.

do, regulation is variable."

• "ASCs treat a less complex mix of Medicare patients . . ." followed by "and ASCs treat a smaller portion of low-income patients."

Kathy Bryant, executive vice president of FASA, said in a released statement that the AHA is sending the wrong message to consumers.[2] "Instead of empowering consumers to make their own health care decisions, the AHA is confusing Americans with biased reports, skewed rhetoric, and misplaced arguments that put preserving hospitals' market share above the needs of patients," she said.

The report is a "biased attempt to influence legislators to enact protective legislation," she said. "From the introduction to the policy questions raised at the end, the report demonstrates exactly what it is — a biased attempt to protect the hospitals' turf by throwing allegations at those winning the competition battle through better service, better outcomes, and better prices."

Bryant found it ironic that the report raises quality and safety concerns at ASCs "when data shows that ASCs are safe or safer than hospitals," she said. Bryant quoted the CDC's estimate that 2 million patients a year acquire hospital-related infections that result in 90,000 deaths. "Nearly 90% of ASCs report three or fewer infections per 1,000 patient encounters," she said. "Yet, the AHA alleges that there are higher standards in hospitals because they are required to have an infection control bureaucrat."

Bryant said another misleading section of the report is the part that discusses the tripling of Medicare payments to ASCs between 2001 and 2004. "The reality is that had those procedures been performed in hospitals, Medicare expenditures would have increased far more," she said. Research indicates that on average, outpatient procedures would cost $320 more per procedure at a hospital than at an ASC, Bryant says. **[For more information on hospital-provided and ASC care, see highlights of a recent Medicare Payment Advisory Commission (MedPAC) report, p. 104.]**

References

1. American Hospital Association. Trendwatch July 2006. *The Migration of Care to Non-hospital Settings: Have Regulatory Structures Kept Pace with Changes in Care Delivery?* Accessed at www.aha.org/aha/trendwatch/2006/twjuly2006migration.pdf.

2. Federated Ambulatory Surgery Association. AHA Attempts To Mislead Policy Makers with Flawed Report Statement: Kathy Bryant, FASA President. ■

Same-Day Surgery Manager

Want to make patients, staff, and surgeons happy?

By **Stephen W. Earnhart**, MS
CEO
Earnhart & Associates
Austin, TX

Do you really want to know how to make people happy at your facility? I mean, do you *really* want to know? I will step up and be honest; sometimes I don't know! Sometimes I really don't care and want someone to make *me* happy.

Making people happy at their job takes work and money. Sometimes we just want to bury our heads in the sand and not deal with the effort.

Making our patients happy is not just providing quality care. Oh, no. That is an entirely different level of stress-producing effort. But patients are not the only masters we have, although they do seem to be at the epicenter of our activity. But how much effort is directed at making sure they have a . . . pleasant experience?

How many efforts do we direct to the surgeons? They tend to play a fairly strong role in the process. The staff? It's difficult to make it happen without them. Let's not forget anesthesia.

How can we serve all these masters without opening a vein? And what about *your* happiness in this process?

My observations with patients tend to come down to a few salient points. One, make sure they have a bathroom close by. Surgical patients tend to focus on their elimination needs. Second, don't make them wait in one area for too long (unless it is a bathroom). Kneel or sit down when you are talking to them. Uncomfortable thought it may be, it increases their sense of control. Give them something they can take with them when they leave, such as a notepad with the surgery center's information on it. We shouldn't be in the gift-giving business, but apparently it is expected. Smile at them. It erases a world of errors and dissatisfaction.

Now, what about the staff? Recognition for effort still works. Praise in front of other staff

members works even better except for the audience that now hates you for not including them. I think that one-on-one acknowledgments are best. Slipping them a $50 bill is effective as well. At the end of the day, money, recognition, and a non-hassle environment seems to be the best motivators for most staff members.

Our surgeons! Ahh, always a challenge. Their prevailing issue seems to be, "but what have you done for me *today*?" It used to be they wanted better turnover times. Now we get the "*look*" because we are too fast and they don't have time to do . . . whatever! Keys to success here seem to focus on dedicated scrubs (who, by the way, are not allowed to take vacations or be sick). Starting their case on time helps. Patronizing though it may be, "Have you been working out?" still goes a long way to soothe missing paperwork. Giving them a second room for back-to-back cases is nirvana.

Anesthesia. Cleaning up after them has been known to crack a smile on some faces, while "Stop messing up my stuff!" is still the predominate response to such efforts. One thing that has worked for me is to simply ask them, "What can we do to make your day here better?" Of course, you can expect some of them to reply with, "Your demise." Don't take that personally though. Letting them play an active role in "running the board" will charm most of their hearts. I have always maintained that no surgical department can be effective or efficient without a great anesthesia staff. The more they are included in the operations, generally the better things run.

That leaves you. What about you?! You need to focus on your own needs as well as others. Because I tend to be selfish and self-centered at times, what makes me happiest is a sense of personal fulfillment. I leave work feeling better when I feel I have made a difference in whatever it was I was involved with that day. Look inward to see what makes you tick and then wind it up. I have learned that making a difference — makes a difference in me.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at e-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

Patients happy with liposuction procedure

Study also documents safety of procedure

A high level of patient satisfaction and a wide range in the number of body parts upon which surgeons performed liposuction were two of the results that stood out in the recently released Liposuction 2004-2005 Report by the Institute for Quality Improvement (IQI), part of the Accreditation Association for Ambulatory Health Care.

Most patients were happy with their decision to undergo liposuction, with 91% of the patients responding to this question indicating that they thought they had made the right decision. Of the 89% of patients responding to questions about satisfaction with the procedure and the outcome, 85% of them reported high levels of satisfaction or 5 on a scale of 1 to 5).

"This is significant because it shows that patients got what they wanted," says **Naomi Kuznets**, PhD, director of IQI. While this result indicates that patients were well prepared for the actual procedure as well as results that could be expected, IQI will be adding a question specific to pre-procedure education in the next study, she says.

EXECUTIVE SUMMARY

Twenty-three organizations participated in the recently released *Liposuction 2004-2005 Report* by the Institute for Quality Improvement (IQI). Results of the study showed low complication rate of only 6% along with high patient satisfaction rates.

- Body area most often chosen for liposuction was the abdomen (61%).
- Patient education and setting expectations prior to surgery were important to patient satisfaction.
- Most study participants followed published guidelines for liposuction regarding extraction of supranatant fat and fluid, lidocaine dose, and epinephrine dose.

COMING IN FUTURE MONTHS

- ■ New treatments for osteoporosis
- ■ Reducing surgical site infection
- ■ Marketing your accreditation status
- ■ Improve safety and quality of car: What works?
- ■ Innovative programs for liposuction patients

SOURCE/RESOURCES

For more information about the *Liposuction 2004-2005 Report*, contact:

- **Naomi Kuznets**, PhD, Director, AAAHC Institute for Quality Improvement, 5200 Old Orchard Road, Suite 200, Skokie, IL 60076. E-mail: nkuznets@aaahc.org.

To order a copy of this study, contact the Institute for Quality Improvement by phone at (847) 853-6060 or fax at (847) 853-9028. Copies of the study also can be purchased by going to www.aaahciqi.org and clicking on "order products." The cost of the study for organizations that did not participate is $85 for a CD-ROM and $110 for a hard copy. Shipping and handling charges start at $12.

Dermatology Physicians and Surgeons in Barrington, IL, one of the 23 participants in the study, starts educating the patient at the initial consultation, says **Mary Kaiser**, RN, staff nurse. "We talk about what happens during the day of surgery and what each patient should expect following surgery," she says. Because the patient's body doesn't look the same following liposuction, a description of what is normal during recovery is given to all patients, Kaiser adds. "We also call the patient the day after surgery to make sure there are no questions or concerns."

Although average costs, waiting times, procedure times, and discharge times were included in the study, the results should be viewed with the understanding that the type of procedure varied widely, says Kuznets. The number of body areas per procedure ranged from one to eight, with 72% of the cases involving between one and three body areas. "The more body areas that are involved, the longer the case will be and higher costs will be involved," she explains.

Body areas receiving liposuction most frequently during this study were:

- abdomen (61%);
- flank/waist (50%);
- hips (35%). *(Editor's note: these numbers add up to more than 100% because multiple procedures were performed on the same patient in many cases.)*

Although her facility performs liposuction on all areas of the body, Kaiser's program reported the lowest discharge time of all study participants, with 22 minutes. Other facilities posted discharge times up to 167 minutes, with an average discharge time of 72 minutes. "We perform liposuction on all areas of the body, but we perform only tumescent liposuction and use no anesthesia other than the local," says Kaiser. "We will give an oral sedative if needed."

The key to the early discharge is the fact that the patient is awake and alert throughout the procedure and rarely needs pain medication other than an extra-strength acetaminophen before leaving the office, she says. "We also have one nurse assigned to the patient throughout the entire process, so the patient is less anxious because someone is there to answer questions," Kaiser explains.

Study participants reported a complication rate of 6%, but Kuznets points out that few of the complications were serious.

"A few of the complications, such as arrhythmia, excessive bleeding, and hypotension-shock, are serious, but they were associated with cases that were more intrusive, affected more areas, and used more anesthesia," she says.

Overall, Kuznets was pleased to see that most cases did not exceed recommended guidelines for tumescent fluid infused, total lidocaine dose, total epinephrine dose, and extracted supranatant fat and fluid. "More than 5,000 ml of fluid was extracted in only 7% of the cases in the study," says Kuznets.

The American Society of Plastic Surgeons' guidelines recommends that the procedure be performed inpatient if the amount of anticipated aspirate is greater than 5,000 ml. The American Society for Dermatologic Surgery and the American Academy of Dermatology Guidelines of Care recommend that no liposuction be performed on an inpatient or outpatient basis if the amount of aspirate will exceed 5,000 ml. ■

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

9. For calendar year 2008, the new surgery center payment rates will be phased in as:
A. A blended payment equal to 30% of the applicable calendar year 2007 payment rate plus 70% of the applicable calendar year 2008 payment rate.
B. A blended payment equal to 40% of the applicable calendar year 2007 payment rate plus 60% of the applicable calendar year 2008 payment rate.
C. A blended payment equal to 50% of the applicable calendar year 2007 payment rate plus 50% of the applicable calendar year 2008 payment rate.
D. A blended payment equal to 60% of the applicable calendar year 2007 payment rate plus 40% of the applicable calendar year 2008 payment rate.

10. Why do patients not hear pre-op or discharge instructions correctly, according to Ilene Corina?
A. Anxiety
B. Lack of education
C. Language barriers
D. Poor instructions from health care providers

11. According to Stephen W. Earnhart, MS, what is a good way to keep anesthesia staff happy?
A. Perform a QI project to demonstrate their high-quality care.
B. Include them in operations.
C. Hold an appreciation dinner.
D. Leave them alone.

12. What is one reason for the high satisfaction level of liposuction patients at her facility, according to Mary Kaiser, RN?
A. Insurance pays for procedure.
B. There is no pain or discomfort with procedure.
C. Surveys are only given to select patients.
D. Patient education that starts with the consultation sets realistic expectations.

Answers: 9. C; 10. A; 11. B; 12. D.