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30 years later, ambulatory surgery is braced for market, payment changes

New ASC payment system, quality reporting to affect direction

(Editor's note: This issue marks the 30th anniversary of Same-Day Surgery. *In this issue we look at the growth of hospital-based outpatient surgery, freestanding centers, and office-based surgery practices, and we discuss how the field has changed. We discuss upcoming challenges, including a new payment system and quality reporting requirements for freestanding centers. We look at how you can draw the line, in terms of which patients are appropriate for outpatient surgery. We look at where OR technology is headed by examining digital ORs. As your editor since 1991, I — along with my editorial advisory board — look forward to helping your program survive these changes and thrive in the decades ahead. — **Joy Daughtery Dickinson)***

Even after 30 years, the outpatient surgery field still is constantly adjusting to changes in procedures, policies, and payments. Consider these recent actions:

• Surgical procedures are moving not only from traditional hospital-based setting into ambulatory surgery centers (ASCs), but also to physician offices.

• A payer has decreased payments for some procedures in the hospital and increased reimbursement for the same procedures in physician offices and ASCs — and a judge has affirmed that policy is OK. **(See**

EXECUTIVE SUMMARY

Most of the growth in the outpatient surgery market continues to be in ambulatory surgery centers (ASC) and office-based surgery programs.

- There is a leveling off of growth in some geographic areas, but overall national growth continues.
- The final ASC payment system will shape the future direction of the field.
- ASC leaders have joined to provide input on upcoming quality measures.

"Blue Cross sued over payment policy — Payments to increase for nonhospital endoscopies," ***Same-Day Surgery,*** **August 2006, p. 94.)**

• A Medicare reimbursement system has been proposed for ASCs that would pay 62% of the hospital outpatient department (HOPD) rate.

These actions and others have caused outpatient surgery managers to scratch their heads as they wonder from day to day, where are we heading? Even Wall Street is worried. Bank of America issued a downgrade to the ASC sector, and several ASC companied watched their stock prices subsequently dramatically drop.

If you manage an ASC, should you be worried too? Should hospital-based managers of outpatient surgery be celebrating?

Overall, the physician and surgery center markets are growing. When comparing growth in the number of facilities from 2000 to 2006, surgery centers have seen a growth of 65%, and the number of medical group practices that perform at least minor surgery have seen a 28% growth, according to Verispan, a Yardley, PA-based company that provides health care data and services. On the other hand, hospitals with outpatient surgery departments have grown by a 5.89% decline in their numbers during the same time period, according to Verispan. **(See chart, p. 3.)**

Physicians continue to have ownership in virtually all (90%) ASCs, according to a newly released report, Ambulatory Surgery Centers — A Positive Trend in Health Care," published by an ASC coalition that includes the American Association of Ambulatory Surgery Centers (AAASC) and the Federated Ambulatory Surgery Association. **(To obtain a free copy, go to www.aaasc.org/features/documents/ASCTrendReport118061.pdf.)**

However, hospitals also are cashing in on the outpatient surgery craze with their own outpatient surgery departments, freestanding centers, and, in some cases, joint ventures with physicians. "From the data we've looked at, we've certainly seen the movement of care from an inpatient basis to an ambulatory basis has been very rapid and driven by technology changes in anesthesia, surgical procedures — especially scopes, so there is a major shift in where care is delivered," says **Ellen Pryga**, director of policy for the American Hospital Association in Washington, DC. "As that shift occurred, most was in the hospital-based outpatient departments." Then, with the advent of growth in other ambulatory settings, a lot of the procedures shifted to ASCs and physician offices. "The reality is, care is shifting to the ambulatory setting," she says.

Will hospitals go out of business if all of their surgeons open ASCs? "It depends on how far it goes," Pryga says. If surgeons take most of their cases out of the hospital, then the hospitals are left caring for patients that are primarily uninsured or Medicaid patients, she warns. "If that is indeed the case, then you're not bringing in enough revenue to support that care, let alone other care or services that aren't attractive to niche players," she says. Could they go out of business? Yes, Pryga says, and some are having

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Growth of Outpatient Surgery, 2000-2006

Facility Type	2006	2005	2004	2003	2002	2001	2000
Surgery Centers	5,400	5,094	3,982	3,801	3,557	3,508	3,270
Hospitals w/ an OP surgery dept	5,193	4,826	4,868	4,899	4,992	5,313	5,518
Medical Group Practices that perform surgery (even minor) on site*	17,850	16,075	15,026	13,887	14,465	15,024	13,940
*MGP = location w/3 or more physicians							

Source: Verispan, Yardlley, PA.

difficulty already. "You have to have enough from the well-paying work to pay for the not-well-paying work."

The future of the hospital market depends on the payment and regulatory environment for ASCs and physician offices, Pryga predicts. Currently, ASCs and hospitals don't have to meet the same costly regulatory requirements, she maintains. "There's a much higher cost attached to that: the safety code requirements for structures, the frequency of maintenance, recalibration, inspection of equipment, certification of personnel, etc. The list is endless," Pryga says.

The report from the ASC coalition points out that ASCs and hospitals face the same Medicare requirements in several areas, including surgical services and compliance with state licensure law.

Pryga points to additional requirements for hospital outpatient quality reporting that ASCs are not currently required to meet, although outpatient data reporting requirements are being developed. **(See story, p. 4.)**

Will hospitals be jumping on to the ASC bandwagon with greater numbers of joint ventures? "Your crystal ball is as good as mine," says Pryga, who adds that the trends will be driven by payment policy. "It's always been that way for every service, and will be that way for this one, too, so it's important particularly for government programs that payment polices are appropriate she says." **(For more on the upcoming ASC payment system, see story, p. 4.)**

Caryl A. Serbin, RN, BSN, LHRM, president of Surgery Consultants of America in Fort Myers, FL, predicts that hospitals will be more interested in joint ventures. "I'm seeing hospital administrators who didn't embrace the prospect now saying this may be an opportunity to do a joint venture ASC," Serbin adds.

This interest stems from physician pressure and from hospital administrators wanting to grow their market share, she says. "We're starting to see a shift where hospitals will built next to a competitor to bring in new patients, new physicians," Serbin says. Also, she expects these joint ventures will be larger multispecialty facilities, due to the upcoming changes to the ASC payment list that will dramatically reduce payments for some specialties.

In terms of the ASC market, will the boom continue, or is the industry beginning to level off?

"There are some markets leveling out, but from a national perspective, the ASC market continues to grow," says **Craig Jeffries**, executive director of the AAASC.

The growth is not unrestrained however, he emphasizes. ASCs continue to face barriers, including state certificate of need (CON) laws and what Jeffries calls "legislative political pressure," mostly from state hospital associations.

However, even states with CON laws have seen significant growth, Serbin says. "The future is bright for ambulatory surgery center development," Serbin says. "We have seen continued growth as long as I can remember."

With this growth, the question arises: Are there too many surgery centers?

"There are some suburban markets where there is now more competition between surgery centers," Jeffries says. "The incidence of that is much less than other states where there's an underserved population. In other words, there are not enough surgery centers."

The more successful ASCs are the ones in which several physician practices come together to create a multispecialty, higher-volume center, Serbin says. "I think one of things the payment system changes, as that's proposed today, is that it's going to make physicians think twice about jumping out and doing a center, especially single specialty physician-owned centers," she says.

Also expect to see more hospital joint-ventured

SOURCE

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surgery centers, Serbin predicts. "Physicians are looking for someone to help them lessen the risk. They want a partner," she says.

Where do we go from here?

Surgery centers are facing significant changes, mostly in payment, that will profoundly affect future growth in the industry, says **Eric Zimmerman**, JD, MBA, partner with McDermott Will in Washington, DC.

"Many of the changes will be beneficial, others less so, but the overall impact on any given surgery center depends considerably on its specialty and case mix," Zimmerman says. "I think that we'll see a shift in the specialties typically practiced in the ASC environment, and many new opportunities arising as a result."

The recent stock drop is a "reflection of the impending change and uncertainty as to how that change will impact the market," he says. While some ASC payments will decline, others will increase, Zimmerman says. "Overall, the outlook is still good, although some individual centers may struggle if they resist change," he says.

Even with the recent stock fluctuation for same-day surgery companies, the mood of the field is one of cautious optimism, Serbin says. "I think there is a sense that it will rebound," she says. ■

Quality reporting on the ASC side

As outpatient surgical care has shifted from hospitals to alternative locations, the patient safety and quality regulations and the cost and quality reporting requirements have not moved into that setting, says **Ellen Pryga**, director of policy for the American Hospital Association in Washington, DC.

"We need to get to a place where we have comparable standards and requirements for comparable services, regardless of the services and where they are provided," Pryga says.

Many leaders in the ambulatory surgery center (ASC) field agree. An ASC Quality Collaboration has been formed to identify specific measures for quality appropriate to ASCs. "This group, the ASC Quality Collaboration, strongly endorses the vision that measures of quality which are appropriate to ASCs should be congruent with measures utilized for other outpatient surgery settings," according to a publication put out by an ASC coalition that includes the Federated Ambulatory Surgery Association and the the American Association of Ambulatory Surgery Centers (AAASC).[1]

The group is working with the National Quality Forum to achieve consensus on the proposed quality measures, according to the coalition. In fact, the coalition just submitted a list of quality measures for consideration, according to **Craig Jeffries**, executive director of the AAASC. They are in the process of establishing a technical advisory group," Jeffries says. "They will review and recommend to the forum board whether to adopt those ASC-specific standards."

Reference

1. ASC Coalition. *Ambulatory Surgery Centers — A Positive Trend in Health Care;* 2006. ■

Hoping for 70%+ of HOPD rate

The federal government can meet its budget neutrality requirements for the ambulatory surgery center (ASC) payment system and still pay ASCs 73% of the rate paid to hospital outpatient departments (HOPD), according to the Federated Ambulatory Surgery Association (FASA).

The proposed plan for the revised ASC payment system calls for paying ASCs 62% of the HOPD rate. In FASA's comments on the proposed rule, the association pointed out several ways that the proposal differs from the policies used to pay hospitals for outpatient surgery. For example, the Centers for Medicare & Medicaid Services (CMS) proposes that ASC and HOPD

In preparation for changes, ASC cuts 10% of supply costs

As ambulatory surgery centers (ASCs) face the stark reality that their upcoming payment system will provide less money for many specialties, managers are looking at their expenses to determine where they can cut costs. The Ambulatory Surgery Center of Spartanburg (SC) has taken steps that have resulted in a 10% reduction in total supply costs.

"I went to the distributor and said, 'I'm not happy with what I'm paying,'" says **Mike Pankey**, RN, MBA, administrator of the center. Pankey told them that due to cuts in Medicare payments, which account for 35% of their business, they needed a 10% discount on their supply costs. "I couldn't afford to continually pay him more when I was being reimbursed less," he says.

The supply manager at the center's hospital partner was a major help, Pankey says. That supply manager pressured the hospital's group purchasing organization, Premier, to aggregate the supply usage of the hospital and the surgery center so that the center could access better tier levels and obtain significantly larger discounts. "That gave us major savings," Pankey says. Over a year's time, the center saved $73,000 on custom sterile packs and at least $35,000 on sterile put-ups, including drapes and gowns.

Those centers that don't have a hospital partner and don't mind changing suppliers can start by obtaining a report of their highest-cost supply items. Focus on the top 20, Pankey suggests, then go to vendors to obtain competitive bids.

With other changes he made, Pankey has cut $134,000 from his supply budget, "all based on the fact that we think we will be reimbursed less," he says. The center isn't stopping there. Since individual CPT reimbursement is not yet known, the managers are looking at costs specialty by specialty. They now are looking at how to increase physician efficiency in the OR, including block utilization.

Also, Pankey is looking at future reimbursement by specialty. For example, reimbursement experts estimate that obstetrics will realize a 38% increase in payments. Pankey decided to be conservative in his estimate and count on a 30% increase for obstetrics. "That's how we budgeted to get moving forward," he says.

Additionally, Pankey is working with his billing company to ensure that future changes will be managed appropriately. He has been in constant contact with the company directors to ensure they have heard about the changes and are educating their staff. Pankey is working with them on an action plan so that the company is ready when the Centers for Medicare & Medicaid Services (CMS) moves to the new system. "When they flip the switch, I want to make sure we're ready to flip our switch too and go into billing. We want to be ready."

By being proactive, he hopes to avoid cash flow interruptions and overpayments from CMS that have to be paid back to the agency. **(For more information on prepared for the new ASC payment system, see "Will centers make money with the move to APCs? Start analyzing now to prepare for change," *SDS,* May 2006, p. 52.)** ■

rates be increased to account for inflation using different update factors. ASCs payment updates would use the consumer price index. (CPI). FASA argues in its comments that this measure will not address the cost increases that ASCs face. "ASCs and hospitals face the same rising costs to provide services, such as nursing services and medical devices," FASA said in a prepared statement. "FASA believes the same policies should be used unless there is a compelling reason for a different policy."

FASA also recommends that the procedures covered in the ASC be expanded beyond those in the proposal.

"We hope that the FASA recommendations will be implemented; however, I understand the mandate to save money," says **Mike Pankey**, RN, MBA, administrator of the Ambulatory Surgery Center of Spartanburg (SC). "I hope the final regulation will cover direct costs with a small profit and that yearly updates occur."

Expect several changes in the final rule, scheduled to be published in spring 2007 and implemented Jan. 1, 2008, says **Craig Jeffries**, executive director of the American Association of Ambulatory Surgery Centers in Johnson City, TN. "I'm optimistic that CMS will provide a much better broader recognition of procedures performed in the HOPD environment that can and will be done in ASC environment," Jeffries says. For example, he hopes that laparoscopic cholecystectomy will be included as a covered procedure in the final rule.

Also, Jeffries expects that CMS will move closer to parity between the HOPD payment mechanism and the ASC payment mechanism on technical issues such as the basis for rate updates. CMS received 2,713 comments on the proposed rule.

RESOURCE

The Hospital Outpatient Prospective Payment System Fact Sheet is available on the Centers for Medicare & Medicaid Services Medicare Learning Network (MLN) at www.cms.hhs.gov/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf. This fact sheet provides general information about the hospital payment system and ambulatory payment classifications, and it explains how payment rates are set.

Even as the date for a final payment rule creep closer, outpatient surgery leaders still support legislation that was previously introduced as the Ambulatory Surgical Center Medicare Payment Modernization Act and is expected to be reintroduced in the new Congress. That legislation would pay ASCs 75% of the hospital rate, apply the same policies as in hospital outpatient departments, and provide transition rules, according to FASA.

Caryl A. Serbin, RN, BSN, LHRM, president of Surgery Consultants of America in Fort Myers, FL, says "I know we had all hoped for 75% of [the Medicare hospital rate]. I don't think we're going to see that number." Serbin personally hopes for 72% of the hospital rate. "That would make me happy," Serbin says. Jeffries feels confident that CMS will decide upon an amount between 70% and 75% of the HOPD rate.

However, the proposed 62% reimbursement rate isn't necessarily bad news, says **Eric Zimmerman**, JD, MBA, partner with McDermott Will in Washington, DC. "Under the revised payment system, ASCs will in every instance be cheaper — and considerably cheaper — to the Medicare program than the hospital setting," Zimmerman points out. "While ASCs certainly would prefer higher payments, the payment relationship will make ASCs far more competitive and appealing both to policymakers and consumers."

The American Hospital Association (AHA) supports the lower payment for ASCs. "The reality is the sicker patients end up going to the hospital outpatient department, more comorbidity goes to the outpatient department, and most uninsured and Medicaid go to the hospital outpatient department," says **Ellen Pryga**, director of policy at the AHA in Washington, DC. "That needs to be reflected in whatever the payment mechanisms or formula is that's adopted."

While ASC managers wait on the final payment rule, what should managers be doing? Take time to understand the proposed changes and evaluate their impact on your revenues, Zimmerman suggests. "Then ASCs should take steps to adjust accordingly, whether that means adding or dropping specialties, adding or dropping service lines, moving some procedures into the ASC, and moving others out," he says. "Additionally, ASC owners should involve themselves in the regulatory and legislative process, and seek to impact these expected changes." **(See story on how one surgery center is being proactive and has reduced its supply costs by 10%, p. 5.)**

There's going to be winners and losers among different specialties, so single specialty centers need to be on alert, Serbin warns. "Multispecialty centers may lose money on one and gain on others, but if you are single specialty, and they just use a handful of codes, you essentially are more at risk." **(For more information on the proposed rule, see "Under proposed rule, ASCs would be paid 62% of the hospital OPD rate,"** ***Same-Day Surgery,*** **September 2006, p. 97. For more information about how the new payment system will affect specialties, see "Change to HOPD rates to impact specialties,"** ***SDS,*** **May 2006, p. 53.)** ■

You've come a long way, baby!

1-page charts, typewriters replaced by scopes, MAC

The year 1976 was a leap year that saw *Rocky* win the Academy Award and the Golden Globe Award for best picture, the first flight of the Concorde, the formation of Apple Computer Co., and the first issue of *Same-Day Surgery.*

That year, the surgery center that is now HealthSouth Surgery Center in Belleville, IL, opened its doors.

Although the surgery center has seen a lot of changes throughout the years, staff changes are not a problem, says **Diana Geoghegan**, administrator of the center. "I'm the new person on staff, and I've been here three years," Geoghegan says. "I've not had to hire anyone since I arrived." Although no one on the current staff was at the center when it opened, one employee has been here 25 years, she adds.

While she's not the employee with the longest tenure, **Janice Schepers**, RN, nurse manager, a

EXECUTIVE SUMMARY

Technology, anesthesia, staffing, and ownership are just a few of the areas in which changes have been noticed by veterans of the outpatient surgery industry.

- Accreditation requirements and regulatory requirements have increased the need for and amount of documentation.
- Anesthesia changes have greatly improved recovery times and reduced aftereffects of surgical anesthesia.
- Equipment such as laparoscopes and endoscopes has widened the range of procedures that can be performed on an outpatient basis.

22-year veteran of the surgery center, has noticed dramatic changes at her center and in outpatient surgery in general. The changes aren't limited to more procedures and new technology, Schepers says. "When I started, our charts were one page. Now, we have multiple forms and pages that must be included according to accreditation and regulatory requirements," she says.

Small and large changes noticed

Advances in anesthesia are responsible for the most significant changes in outpatient surgery centers, says Schepers. Monitored anesthesia care (MAC) is the most common anesthesia, with less use of general and local anesthesia, she points out. "This means that patients recover more quickly and have fewer after effects such as nausea and vomiting," Schepers adds.

"I've also noticed that patients are much better informed," she says. "Patients used to ask us why we wanted to know if they had allergies and why that was important for their surgeon." Now, patients volunteer information about allergies and medications before the staff can ask, Schepers says.

The Belleville center was owned by physicians until HealthSouth purchased the facility in 1998. "Being owned by a publicly traded company is very different because there are more financial controls and compliance issues to address," says Geoghegan. "It is also beneficial because we have more resources as part of a larger company than we would have if we were owned locally."

Hope Mangum, RN, director of the Davis Ambulatory Surgical Center in Durham, NC, also has seen significant differences between outpatient surgery 21 years ago, when she was a member of the original staff, and today. For example, today outpatient surgery is well known to be safe.

"All of the [original] staff came to the surgery center from the hospital operating room, and we found it hard to believe that we were sending patients home the day of their surgery," says Mangum. "The challenge was to reassure patients at the same time we were having our own doubts about the safety of outpatient surgery."

Scopes greatly changed the field

What has had the greatest effect on outpatient surgery? The development of laparoscopes and endoscopes, says Mangum.

"Scopes enable us to perform hysterectomies, cholecystectomies, shoulder ACL [anterior cruciate ligament] repairs, gastric bypasses, and carpal tunnel procedures, on an outpatient basis," she says. Not only does this technology mean more business for the surgery center, but also patients don't have to face weeks of slow recovery, she adds.

The technology can be a challenge, particularly for new staff, says **Pam Neiderer**, RN, BSN, nurse manager at the Surgical Center of York (PA), a 14-year veteran of outpatient surgery. "I'm glad that I'm not starting out today as an outpatient surgery nurse because I would hate to have to learn about all of the equipment and other technology in the surgery center at one time," she says.

Like the HealthSouth Center, Mangum's facility has changed ownership throughout the years, starting as a physician-owned center, then becoming hospital-owned and now owned by a health system. Even with increased competition in the area, Mangum's facility has grown steadily, performing 8,000 procedures each year, she says.

"My staff has quadrupled since we opened, and I now have 68 employees and 50 physicians," says Mangum. Because patients want a warm reception and a comfortable environment, it is important, even with a large staff, to foster a sense of community and family, says Mangum. "I start by hiring the right people with the right attitudes," she explains. "I can teach someone how to do a job, but I can't teach attitude if it's not already there," she adds.

Staff members are kept up-to-date with staff meetings and they are involved in committees that handle activities such as performance improvement, says Mangum. It also is important for the manager or director to stay visible and accessible, she adds. "I'm like a mother who is

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always there to listen to problems and help my family," she explains.

"It is also critical today to develop leadership within your outpatient surgery staff," says Neiderer. Involving nurses in performance improvement projects and other projects that affect the operation of the center improve staff members' accountability, she says. "I even have my nurses evaluate each other as part of annual employee evaluations, and I always have peer interviews where members of my current staff interview potential new employees," she adds.

Future changes for the Davis center include the introduction of electronic medical records, says Mangum. "When I started, we didn't have computers, e-mail, or fax machines," she points out. She laughs and says, "When I wrote policies, I used a typewriter and tried not to change the policy often." ■

Science fiction or fact? Lights come on by command

Digital ORs boost efficiency, communications

Ask a science fiction fan about the operating room of the future and you might hear about surgeons transporting from OR to OR, images and lab reports that magically appear, or lights and equipment that operate according to the surgeon's thoughts. While the technology for these actions is not yet available, digital technology now in use not only gets close to the science fiction picture but also offers a platform for even more advances in the future.

While some academic health facilities lead in theory but lag behind in practice, Massachusetts General Hospital in Boston has had to push forward into the operating room of the future to address the steadily increasing volume in its traditional hospital-based operating department that handled inpatient and outpatient procedures in the same area, says **Warren S. Sandberg,** MD, PhD, co-program leader of the OR of the Future project at the hospital. As the hospital-based surgery program grows, cases that were treated as 23-hour procedures have been moved to outpatient surgery, he says. There has been a steady growth in surgical volume, which increases the need to be more efficient, he explains. "We find ourselves in the interesting position of emulating the best practices of nonacademic-based ambulatory surgery facilities in order to handle our volume," he adds.

One way to improve efficiency in the operating room is to place all information needed during surgery in one place, says Sandberg. "We have a 42-inch flat panel screen on the wall at the foot of the bed that displays the surgical video and a series of tabbed windows that contain information such as patient identifiers, progress log, vital signs, and identification of personnel in the room," he says. All of the information displayed on the screen is gathered from various electronic data collection systems including the electronic nursing perioperative record, physiological monitors, and the hospital's computer system. Moving between different windows requires no effort, because the tabs advance automatically as data are entered into the clinical systems from which it

EXECUTIVE SUMMARY

As outpatient surgery managers look for ways to improve efficiency, decrease turnover time, and increase patient safety, digital technology in the OR becomes more attractive as a way to manage workflow, information, and clinical information.

- Controlling equipment and lights, and retrieving lab reports or X-rays from a central station speeds up the activities of the OR and cuts down on travel through the room.
- Voice activation offers a hands-free way for the surgeon to dictate notes and complete charts during procedures.
- Displaying information such as patient identifiers and patient allergies enables all staff members in the OR to avoid errors and improve patient safety.

is harvested, he explains. Massachusetts General is working with a vendor (LiveData; Cambridge, MA), but hospital staff have built most of the equipment they are testing. **(See resource box, p. 10, for vendor contact information.)**

The philosophy behind a system that gathers and displays information in one location is that it improves patient care and safety through improved communication, says Sandberg. Because patient information is displayed as the room is set up, one nurse who was preparing a standard setup for a procedure noticed that the patient who was coming into the room was allergic to latex. "The nurse told me that having that information displayed enabled her to save time because she knew to set up the room with no latex, so she did not have to redo the setup," he says. Having allergies to medication and products displayed for everyone to see enables all staff members to avoid exposing the patient to items to which they are allergic prior to or during the surgery, he adds.

In the future, there will also be smart alarms, suggests Sandberg. There could be alarms that remind physicians about the proper timing of prophylactic antibiotics, he says. Simple alarms such as notifying the staff that the patient has exceeded 60 minutes in a tourniquet are possible in the future, he says. Addressing physiologic alarms related to dangerously low blood pressure are more difficult because each patient's "normal" is different, he explains.

Centralize all functions

While he can't transport himself from one room to another, **Skip Whitman**, MD, an orthopedic surgeon at Hugh Chatham Medical Center in Elkin, NC, can speak to surgeons in other operating rooms or even to physicians in the emergency department from every operating room through the communication system in his digital operating room (Smith & Nephew; Andover, MA). **(See resource box, p. 10, for vendors.)** "This technology offers us an efficiency that we must have in outpatient surgery today," he says.

Although voice activation systems are still in their infancy, they are definitely helpful in the operating room, says Whitman. "I can operate the bed, the lights, instruments, and dictate notes using our voice activated system," he says. Whitman dictates his notes as the case is finishing, and he usually has completed them as the patient heads to recovery. "No more unfinished charts," he points out.

A central nursing station in each of the ORs at Hugh Chatham, enables the circulator to control lights, equipment, video displays, and even pull up X-rays or lab reports as needed without having to walk from place to place, Whitman says. "We also allow the patient's family to watch the surgery through a window, and I'll talk with them with a wireless microphone I wear during the procedure," he says. "I believe that more outpatient surgery programs will allow family members to watch [in the future] because people are more sophisticated and they want to be able to tell the surgical patient what happened during surgery and what the physician talked about during surgery."

Letting the family watch

Allowing the family member to watch and listen during surgery is just an extra step in patient/family education, he says. This knowledge does help when nurses are giving discharge instructions and explaining what the patient can expect as they recover at home, he adds. During surgery the family member can see exactly what happens and can hear Whitman explain where the incisions are placed and what is done during the procedure.

"Even though all of this is explained prior to the surgery, the patient often doesn't remember, and the family member can explain why they feel pressure or tightness in an area because the family member saw the surgery," he says. "The family member can tell the patient that the small incision is where the scope was placed."

Plan for future with system

Established outpatient programs that want to switch to digital operating rooms must look carefully at space requirements for the central information station, room for wires and cables, and electricity needs.

These were not issues faced by the staff of Bayside Surgery Center in North Falmouth, MA, an outpatient surgery program that opened in mid-2006. "We choose the digital operating room system we wanted to use prior to building so we were able to design the rooms to accommodate the system," says **Garry Brake**, MD, a general surgeon at the center (Smith & Nephew; Andover, MA). **(See resource box, p. 10.)** "All three operating rooms are designed exactly the

same, so there is no wasted time adjusting to a different setup," he says.

Because his program is small, there are many features that are not used at this time, but they did build the system to accommodate future expansion, says Brake. "It is better to invest in the potential for expansion than to have to start all over with a new system in the future," he says. However, even when planning for the future, keep it simple, he suggests. "Don't be swayed by presentations of different capabilities that you don't need," he says.

For example, Brake's facility has only three operating rooms and one procedure room, so the leaders thought there was no need for a communication system between the ORs, he explains. "Be clear about what you need today and what you realistically will need in the future," Brake says. ■

SOURCES/RESOURCES

For more information about digital operating rooms, contact:

- **Garry Brake**, MD, General Surgeon, Bayside Surgery Center, 39 Edgerton Drive N., Falmouth, MA 02556. Telephone: (508) 296-1010. E-mail: glbrake@aol.com.
- **Warren S. Sandberg**, MD, PhD, Massachusetts General Hospital, 55 Fruit St., Boston, MA 02114-2622. Phone: (617) 957-2161. E-mail: wsandberg@partners.org.
- **Skip Whitman**, MD, Surgeon, Hugh Chatham Medical Center, 108 S. State St., Yadkinville, NC 28621. Phone: (336) 679-2733. E-mail: Skip Whitman@tcosm.com.

A few of the companies that provide digital technology for the operating room are:

- **LiveData**, 1030 Massachusetts Ave., Cambridge, MA 02138. Phone: (800) 570-6211 or (617) 617-576-6900. Fax: (617) 576-6501. Web: www.livedata.com.
- **Smith & Nephew**, Endoscopy Division, 150 Minuteman Road, Andover, MA 01810. Phone: (978) 749-1000, ext. 1186. Web: www.smith-nephew.com. Select "Endoscopy," then choose "Americas" and "USA." Next, under "Product Areas," choose "digital OR."
- **Stryker Endoscopy**, 5900 Optical Court, San Jose, CA 95138. Phone: (408) 754-2000. Fax: (800) 729-2917. Web: www.stryker.com/endoscopy. Select "integrate OR."

Patient selection not determined by 1 factor

Age, procedure, and health status combined

The patients are sicker and older, and the procedures are lengthier. This is the challenge faced by surgeons and outpatient surgery staff. How do you make sure the patients that enter your outpatient program are appropriate for outpatient surgery?

There is no one answer to this question, says **Beverly Philip**, MD, professor of anesthesia at Harvard Medical School and medical director of the Day Surgery Unit at Brigham and Women's Hospital in Boston. When setting the policy for patient selection within your outpatient surgery program, you must take into account: the skill and experience of your staff; the comfort level of the staff in dealing with sicker patients and longer recovery times; the experience of the surgeon; and the availability of medical backup in an emergency, she suggests.

Don't forget to look at the capabilities of your facility as well, Philip points out. "Elderly and sicker patients don't bounce back as quickly, so you need the space and the time to allow them to take longer to recover," she explains.

Every outpatient surgery program should develop a clear policy of who is and who is not acceptable as a patient, says Philip. In addition to

EXECUTIVE SUMMARY

As more procedures and patients move to the outpatient surgery setting, it becomes critical to carefully evaluate the appropriateness of each patient as an outpatient surgical candidate. Well-developed policies help staff members and surgeons ensure patient safety.

- Look at the combination of age, length of procedure, and general health status for each patient to determine risk as opposed to setting only age limits or length-of-procedure limits.
- Use guidelines from the American Society of Anesthesiologists in the development of your policies.
- Consider factors such as staff experience and skill, surgeon skill, facility limitations, and medical backup plans when determining your parameters for patient selection.

SOURCES/RESOURCE

For more information about patient selection, contact:

- **Gail Avigne**, RN, Director of Surgical Services, Shands at the University of Florida, 1600 S.W. Archer Road, Gainesville, FL 32608. Phone: (352) 265-0023. E-mail: avignga1@shands.ufl.edu.
- **Beverly K. Philip**, MD, Director of the Day Surgery Unit, Brigham and Women's Hospital, 75 Francis St., Boston, MA 02115.

To access copies of the American Society of Anesthesiologists' guidelines for outpatient surgery, go to www.asahq.org. Select "Clinical Information" on the left navigational bar, then select "Standards, Guidelines, and Statements" on the right navigational bar. Choose "Ambulatory Anesthesia and Surgery" or "Office-Based Anesthesia" from the list of guidelines.

basing policies on your program's capabilities, be sure to follow guidelines created by the American Society of Anesthesiologists (ASA) in Park Ridge, IL, she recommends. **(See resource box, above, for information on guidelines.)**

Be sure that all staff members are able to respond to emergencies and follow a plan that has been developed specifically for your facility, says Philip. If transfer to another facility is needed, have that plan in place ahead of time, she says. "Accreditation requirements and regulatory requirements do differ, so some programs may need a transfer agreement; others might require the surgeon to have admitting privileges at a nearby hospital," she says. Whatever route you take, have the plan in writing with all staff members aware of the procedure. "Just [cold-] calling 911 is not satisfactory," she adds.

Basing your patient selection criteria only on age, health status, or procedure won't work well, says **Gail Avigne**, RN, director of surgical services at Shands Hospital at the University of Florida in Gainesville. "Our population is getting older, so we see more older patients, but a healthy 70-year-old can be at lower risk than a sick 45-year-old for a surgical procedure," she says. For this reason, Avigne's facility uses a combination of the ASA Physical Status Classification System and an evaluation of the surgical procedure's risk, she says. "We like to handle patients who are ASA 1 or 2, but we will take patients who are ASA 3 for some procedures,"

Low-risk procedures, such as for cataracts, are appropriate for higher-risk patients, but lengthy procedures, even cosmetic surgery, are questionable, says Avigne. "If a procedure is going to last longer than four hours, we require the medical director's and the nurse manager's approval," she explains.

The medical director of an outpatient surgery program is usually an anesthesiologist and can decide the appropriateness of a procedure, agrees Philip. If, however, the medical director is not an anesthesiologist, include the anesthesia provider in the decision process. The anesthesiologist can best determine how long the patient will require for recovery and how safe it will be for the patient to go home because they are responsible for the medical care of patients throughout recovery and they see how different patients react, she explains.

Everyone needs to set selection criteria

All outpatient surgery programs, office-based, freestanding, and hospital-based need to develop their patient selection criteria to produce the best patient outcomes and to provide the same high level of care in all settings, suggests Philip.

"Office-based practices need to ensure that procedures performed are within the scope of practice [of the health care practitioners and the capabilities of the facility]," she says.

Even hospital-based programs need to have boundaries to ensure patient safety, says Philip. The resources and backup available in an emergency make it possible for a hospital-based program to accept higher-risk patients, but choose the patients carefully, she says. It is not acceptable to just admit a lot of patients because the patients were not appropriate candidates for outpatient surgery, she says. "Most hospital-based outpatient surgery programs should admit no more than 1% to 2% of their patients for overnight stays."

Not only should your policies be clear and firm about which patients are appropriate and which are not appropriate for your staff and surgeons' use, but written policies also will help you when patients are insistent that they be treated as outpatients, says Avigne. "It is important that the patient understand that you are not making an arbitrary decision but a decision that is based on research and concern for patient safety," she explains. "Patients need to understand that even if the surgery is minimally invasive, all surgery carries some risk, and the patient's health status can increase that risk." ■

Same-Day Surgery Manager

Changes I have seen over three decades

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

Thirty years ago, *Same-Day Surgery* was launched. Such a long time ago. I was only . . . well, younger then. But lots of other things were happening in January 1977.

Gasoline was only $0.64 per gallon. The movie *Star Wars* (yes, the original) opened. Jimmy Carter was president. CNN still was three years away from beginning its new station. Minimum wage was $2.30 per hour.

A 1977 study conducted by Blue Cross Blue Shield revealed that, on average, procedures performed at ambulatory surgery centers (ASCs) cost 47% less than those same procedures performed on hospital inpatients. This study showed that facility fees for removal of tonsils, for example, cost an average of $464 in an ASC, compared with $998 if the procedure was performed in a hospital. Another example includes cataract surgery, which cost an average $835 in an ASC, compared with $2,012 in a hospital. Repair of inguinal hernia cost $601 in an ASC, compared to facility fees of $1,271 if this procedure were performed in a hospital.

The first ASC was opened in 1970 by a group of anesthesiologists in Phoenix. After that ASC opened, most of the early ambulatory facilities were plastic surgery centers. Only 12% of all surgeries were outpatient in 1977. ASCs more or less languished until about 1982, when safer anesthetic agents and accreditation of centers became the standard. Also, in 1982 Medicare would recognize and begin reimbursing ASCs.

Hospitals were going through changes as well. Back in 1977, management-owned hospital (corporately) accounted for only 6% of all hospitals verses about 40% today. Hospital diagnoses related groups (DRGs) still were six years away. Most reimbursement to hospitals was "cost plus," which meant it was pretty difficult to lose money when you were paid a percentage of what it cost you to provide a service.

The environment in hospitals is less bureaucratic than it used to be — a refreshing change for all of us. There is a greater emphasis on profitability, the physical environment, and efficiency. Unfortunately the efficiency is focused more on the hospital's needs and not on the surgeons, but that focus is improving as well. We just have a way to go.

Members of the nursing staff of hospital surgery departments are becoming more relaxed. It seems to me that the nurses and techs are more comfortable in their roles; there is a higher degree of confidence. I really enjoy working with them at all levels now. A couple of decades ago, many members of the nursing staff resented the top-down autocratic decision making in hospitals. Now, the nurses are the ones that are teaching administration.

Much of the staff in surgery centers, ironically, seem to have become very businesslike — almost too much so. It's hard to put into words, but we might be focusing too much efficiency and profits and losing sight of our other goals.

Probably the biggest change I've observed is in the area of anesthesia staff. They have dramatically changed the way they contract with hospitals and ASCs. They have become lean and very business-like in their dealings. I attribute much of this to consolidation of their industry from small individual groups to large corporately operated machines. Many of the large groups have professional business people running their operations. I have always maintained that a good anesthesia group can make or break a surgical facility. I still believe that statement; it's just that it might cost you more now.

I have seen changes in the surgeons in the hospital and ASC. It really is not the change I would have predicted 30 years ago. Many of the surgeons seem more passive than they were before. This might be that many of the more enterprising surgeons have built their own centers or have retired, but I don't see that strong drive to separate from the hospitals that was so prevalent even 10 years ago. Many of the surgeons are looking at become employees of large health systems. The younger ones (although there are radical exceptions) seem more focused on time off with family, a stable paycheck, and a slower pace than their older partners. The line between the surgeon and

the rest of the operating room team is blurring as opposed to the sharp lines of delineation between the two groups in the past. I am not sure if this is because the nursing staff is more business-like or the surgeons are more passive or we are just finally reaching homeostasis. I think there is a greater respect for the job the surgeons do, but they are treated less like royalty and more like a member of the team.

What about the next 30 years? I definitely will be around to give my reflections in 2037. But I think we will see the end of the independent surgeon and corporately owned surgery centers. I do believe that hospitals, once they understand the business of business, will come back and acquire and assimilate the existing surgery centers under their umbrella. All surgeons and anesthesia will be employees of large health care systems. Much of how health systems (vs. "hospitals") operate will be converted into large urban centers where patients will be forced to come to them, versus small community hospitals in every town. There will be suburban surgical facilities, but they will focus more on nuts-and-bolts surgery and the more complex procedures such as brain transplants and spinal cord replacements will be sent to the larger, urbanized centers.

What about consultants? I do see a continued need to pay someone a fee to essentially tell you what you already know or don't need to know in the first place. Thank heavens for that!

[Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.] ■

It's official — CMS changes H&P rule

Verbal orders can be signed by non-MD, if allowed

Under newly published Medicare requirements, hospitals now may complete a history & physical (H&P) within 30 days of outpatient surgery, and it must be added to the record within 24 hours of admission.

The Centers for Medicare & Medicaid Services (CMS) published a final rule revising requirements in the hospital conditions of participation (CoPs) for completion of history and physical examinations, authentication of verbal orders, securing medications. The new requirements reflect the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

"The new regulation is welcomed since it was

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) has published a final rule that affects the history & physical (H&P), verbal orders, and medication security.

- H&Ps may be completed within 30 days of surgery and must be added to the record within 24 hours of admission. CMS eliminated the requirement that the H&P must be signed by someone privileged by the medical staff, but that requirement remains for facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- For the next five years, verbal orders must be authenticated by the prescribing practitioner or another practitioner responsible for the care of the patient. CMS expects this time period will allow technology to advance and allow prescribing practitioners to authenticate their own orders promptly.
- CMS now requires that all drugs and biologicals be kept secure and locked, when appropriate, which will allow patients to keep their potentially life-saving medications with them.

Medicare hospital, physician data posted

The Centers for Medicare & Medicaid Services (CMS) has posted Medicare payment information for physicians and hospital outpatient departments on the web.

The data include payment rates for more than 70 physician services rendered in nonoffice settings as well as 19 services usually performed in a physician's office. The outpatient hospital payment data include information for commonly performed procedures.

This information has been added to the inpatient hospital and ambulatory surgery center data already posted on the CMS web site. **(For more information, see "CMS posts data on ASC payments," *Same-Day Surgery,* October 2006, p. 118.)** The information is available at www.cms.hhs.gov/HealthCareConInit. ■

confusing when JCAHO and CMS were so different," said **Sue Dill Calloway**, RN, MSN, JD, director of hospital risk management at OHIC Insurance Co., a medical malpractice insurance company in Columbus, OH, in an analysis for OHIC's clients.[1] "The old CMS seven-day rule was also felt to be too restrictive," Calloway said.

Under the new rule, outpatient surgery programs need to ensure there is an updated entry in the medical record to reflect any changes in the patient's condition, according to Calloway. She gives the example of a physician who performs an H&P two weeks before a patient has elective surgery. "The physician would want to assess on admission if there had been any change since the H&P had been performed two weeks ago," Calloway says. "The physician can document in the progress notes that the H&P has been reviewed and that the patient has been examined and the physician concurs with the findings of the H&P completed two weeks ago."

Some hospitals may add a stamp or box to the bottom of the H&P form that contains this information, Calloway said.

H&P doesn't have to be performed by physician

CMS also expanded who may perform an H&P, Calloway said. "For example, a physician may want to delegate the H&P to a physician assistant or advanced nurse practitioner," she said.

The physician still is responsible for what is written in the H&P and must authenticate or sign off the H&P when it is completed by someone else, Calloway said.

"The hospital must ensure that the person doing the H&P is qualified and allowed by state law and the hospital," she said.

The requirement that the person must be privileged by the medical staff was eliminated, which will be helpful when a family doctor performs the H&P and is not on the staff, Calloway said. "The family practitioner may perform the H&P for the surgeon, but hospitals should note the JCAHO standard on this which has not changed," she said. The Joint Commission still requires that the H&P be performed by someone who is credentialed at the facility doing the surgery, Calloway said. Under the CMS requirement, "the surgeon only has to look it over and update it, but not sign it," she said. The person who is doing the update is responsible for making sure that the H&P is complete and accurate, she added.

5-year rule implemented for verbal orders

CMS now is requiring that all orders, including verbal orders, must be dated, timed, and authenticated by the prescribing practitioner with a temporary exception says that these actions must be taken by the prescribing practitioner or *another practioner responsible for the care of the patient,* even if the order did not originate with him or her.

According to a published statement from the agency, "CMS believes this temporary revision to the authentication requirement will reduce burden and provide flexibility for hospitals until the advancement of health information technology is sufficient to allow the prescribing practitioner to authenticate his or her own orders promptly and efficiently."[2]

The verbal order does not have to be signed off by the ordering practitioner or the physician who gave it, Calloway said. "It could be signed off by any practitioner who is responsible for the care of the patient and who is allowed by the law and the hospital to do so," she said. Previously, a nurse practitioner or physician assistant never was allowed to sign off on a physician's verbal order, Calloway noted. "Now a nurse practitioner or physician assistant could only sign off on an order if they had authority to write the order themselves, as determined by hospital policy and state law," she said.

If state law doesn't specify a time frame for authenticating the verbal orders, they should be authenticated within 48 hours, CMS said. Authentication means the verbal order is signed off promptly by the ordering practitioner, Calloway said. "Physicians often forget to time the order and time when the order is signed off," she said. Orders can be authenticated in writing or electronically by fax, she said.

Avoid using verbal orders

CMS reinforces that the use of verbal orders should be minimized. "This means that physicians should not give verbal orders if he or she is in the nursing unit and can write them," Calloway said. Verbal orders can be used when the surgeon is scrubbed in during a procedure, she said. Also, verbal orders can be used when physicians call from their offices, Calloway said.

The final regulation also addresses the security of medications. CMS now requires that all drugs and biologicals be kept secure and locked, when appropriate. "Some hospitals would like to legally allow a patient to keep their Nitro at the bedside or allow a patient to keep their inhaler at the bedside," Calloway said. "These were previously not permitted, as all drugs were supposed to be locked up and secured."

The final rule was published in the *Federal Register* on Nov. 27, 2006. The effective date is Jan. 26, 2007. The rule can be accessed at a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/E6-19957.pdf.

References

1. Calloway SD. *Strategies*. Columbus, OH: OHIC Insurance Co.; December 2006.
2. Centers for Medicare & Medicaid Services. Medicare Publishes New Hospital Requirements. Baltimore; November 2006. ■

Back pain procedure OK'd for extra payment

The Centers for Medicare and Medicaid Services (CMS) has approved a pass-through payment that provides additional device payments for the X STOP procedure when the device is implanted in a hospital outpatient setting.

Manufactured by St. Francis Medical Technologies in Alameda, CA, X STOP is designed to treat lumbar spinal stenosis, a common spinal problem that involves the narrowing of the spinal canal. **(See "Streams of water, balloons offer back pain relief," *Same-Day Surgery*, November 2006, p. 125.)**

Effective Jan. 1, 2007, the new device pass-through code, C1821, will include device costs for single- and double-level treatments. Non-device related costs will be reimbursed under newly assigned APC 0050, at $1,455.67 per treated level. ■

Joint Commission revises look-alike/sound-alike list

For the first time in several years, the Joint Commission on Accreditation of Health Care Organizations has revised the look-alike/sound-alike drug list.

In addition to identifying pairs or groups of medications that easily can be confused, the list identifies potential complications and strategies to avoid confusion. Medication pairs added to the list for surgery programs are: hydroxyzine and hydralazine, metformin and metronidazole, and OxyContin and oxycodone. Medication pairs deleted from the list are: cisplatin and caroplatin, fentanyl and sufentanil, lantus and lente, and taxol and taxotere.

Ambulatory and office-based surgery program managers can view the list at www.jointcommission.org. Go to "Patient safety" on top navigation bar and select "National Patient Safety Goals." On right-hand side of page, look under "Resources" and select "Look-alike/sound-alike drug list." ■

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 **June** 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. ■

COMING IN FUTURE MONTHS

- Clearing up patient confusion on pre-op fasting
- OR staff share how they survived a disaster
- Should you add 'spa' procedures at your facility?
- How to manage 'superbugs' and reduce infections
- Post-op phone calls: Learn how other programs successfully handle them

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.

1. For ambulatory surgery centers (ASCs), what is the positive aspect of the proposed reimbursement rate that is 62% of the rate paid to hospital outpatient departments for the same procedures, according to Eric Zimmerman, JD, MBA?

A. ASCs have nowhere for their reimbursement to go but up.
B. ASCs will be considerably less expensive to the Medicare program than the hospital setting, which will make ASCs more competitive and appealing to policy-makers and consumers.
C. That rate is likely to improve the opportunity for passage of the Ambulatory Surgical Center Medicare Payment Modernization Act by Congress.

2. What step(s) is Mike Pankey, RN, MBA, taking with his billing company to prepare for payment changes?

A. Been in constant contact with the company directors to ensure they have heard about the changes.
B. Ensured the billing company is educating its staff.
C. Worked with the billing company on an action plan
D. All of the above

3. What factors should be considered when designing your program's patient selection criteria, according to Beverly Philip, MD?

A. Experience and skill level of your staff
B. Age and health status of the patient
C. Capabilities of your facility and length of procedure
D. All of the above

4. What Medicare payment information is available on-line from the Centers for Medicare & Medicaid Services?

A. Physicians
B. Hospital outpatient departments
C. Inpatient hospital departments
D. Ambulatory surgery center
E. All of the above

Answers: 1. B; 2. D; 3. D; 4. E.