Spring/Summer 2018 Vol. 2, No. 1

# ASC PHYSICIAN FOCUS

AN ASCA PUBLICATION >>

## Contents



## Message from the CEO

This issue covers innovation in many areas. As we continue to look at innovative ways to advance health care, there are some who continue to question the level of quality and safety ASCs provide.

The studies mentioned here and others show otherwise. Nevertheless, the need to validate the quality of care ASCs provide remains.

To that end, we encourage ASCs to collect data, analyze that data, share that data, participate in registries like the American Joint Replacement Registry and do whatever they can to continue positioning ASCs as the optimal site for outpatient surgical care.

Anyone with important findings that they are willing to share with the ASC community should contact Alex Taira, ASCA policy analyst, at ataira@ascassociation.org.

**Bill Prentice**
**Chief Executive Officer**

# Add More Complex Procedures

Four ASC leaders share considerations and guidance for bringing more complex procedures into ASCs.

**Anthony Asher, MD, Neurosurgeon and Senior Partner at Carolina Neurosurgery & Spine Associates in Charlotte, North Carolina, and ASCA Board Member:** We make preliminary determinations of procedures that might be suitable for migration to outpatient settings based on the potential for care standardization, cost reduction and achievement of equivalent or advanced outcomes. We subsequently perform an inpatient validation of the techniques we propose to migrate to outpatient environments through objective analyses of safety, technical feasibility, pain control and clinical effectiveness. Finally, once we have defined "appropriate" patient cohorts and case types based on these inpatient observations, we use quality science methods—particularly prospective registries and other clinical data tools—to continuously assess and promote quality, safety and effectiveness while patients are being cared for in ASCs.

**Matt Bush, MD, Orthopedic Surgeon at Central Maine Orthopaedics (CMO) in Auburn, Maine:** Before I performed my first total shoulder replacement at CMO, we performed two mock surgeries a few weeks apart. A team composed of myself, circulating nurses, technicians, a physician's assistant, an anesthesiologist and an implant company rep came together. A member of the staff pretended to be the patient. We then did a complete walkthrough of the surgical experience, from admitting through discharge. It was a very live process covering everything from patient and equipment positioning to cement preparation. We wanted to ensure staff was prepared and ready to perform this new procedure. That went a huge way with our crew. Everybody had an opportunity to ask questions. The mock surgeries created a more easily reproducible experience. When the day came for our first real total shoulder patient, everyone was comfortable and fired up. It was one of the easiest cases I've ever performed.

**Michael Patterson, President and Chief Executive Officer of Mississippi Valley Health in Davenport, Iowa, and ASCA Board Member:** Complex procedures can be transitioned safely and effectively to the ASC setting if there is appropriate planning and training. First, ensure your patient selection policy is updated to include specific screening tools for more complex procedures. Those should be discussed at the medical executive committee level and have input from the surgeons and anesthesia providers. Discharge planning and education should occur at the time of scheduling. Ensure patients and their families understand what will be expected of them when they leave the ASC. Develop clear clinical pathways and protocols for patients undergoing complex procedures, and review and update those protocols on a routine basis. Make improvements as your program develops. Finally, always prepare for emergencies. This should occur whether you are doing complex or routine procedures.

**Andrea Slavik, RN, Joint Care Coordinator for the Total Joint Center of St. Louis in Creve Coeur, Missouri:** For our ASC to continue its success, joint patients must receive preoperative education. Our preop class helps put patients at ease, eventually leading to better outcomes. Patients receive a total joint guidebook at their surgeon's office. They are encouraged to read it and perform the included preop exercises. When we review everything in the class, all the information seems to click and make sense. Patients and their caregivers develop confidence since they know what to expect on the day of surgery and during the recovery period at home. Patients also learn about complications to report and pain management. This process decreases anxiety about the surgery day, better preparing them for their procedure and supporting a more comfortable and safe recovery with better outcomes.

# Safely Moving Cardiology Procedures to ASCs

*By Donald (Buck) Cross, MD*

Over the last 10–15 years, advances in technology have changed the way we take care of cardiac patients. A growing number of patients are safely undergoing cardiac procedures in the hospital setting and returning home the same day. This presents an opportunity for cardiologists to explore whether opening an office-based cath lab (OBL) and/or ASC and moving select procedures to it is a worthwhile investment.

This model has proven such for myself and my partners at Waco Cardiology Associates in Waco, Texas. Approximately seven years ago, we partnered with National Cardiovascular Partners (NCP) and opened a hybrid cardiac OBL/ASC. It has allowed us to be more active in making decisions that affect patient care, while delivering lower-cost care and capturing more of the income generated by our procedures.

At a time when hospitals are increasingly acquiring specialty practices, we remain independent. While there remains pressure on cardiologists, like most physicians, to become hospital employees, we hold up NCP as an example for how to avoid such a scenario and pursue a model that can better serve the interests of physicians and their patients.

If opening an ASC sounds like it may be an appealing venture, make sure to address the following five questions.

**1. Who will be your partners?** Identify the other physician partners who will bring cases to the ASC and determine how to align the partnership. This can be addressed easily if a single group decides to open an ASC. Matters become more complicated when competitive groups decide to partner to open an ASC.

**2. What will your partners bring to the ASC?** Determine what each prospective partner will contribute to the new business, i.e., what cases and what level of commitment they will bring. If you have individuals who are interested in becoming business partners but show no commitment to bringing cases, that's a detriment.

**3. What do the laws permit?** Understand your state's rules concerning what procedures you can perform in an ASC. Not all states permit the same procedures. You need to know your state's laws so you can accurately assess whether you have the volume needed to justify the new facility.

**4. What will you be paid?** Once you identify the procedures permissible for the ASC, determine their reimbursement. Also gather information on the fixed and variable costs of running the facility. Assemble as much data as possible on the financials so you can run the numbers and determine whether the ASC makes sense from a business standpoint.

**5. How will you address the business and administrative components?** This is a critical question to answer before proceeding. As a group of physicians, do you believe you have the right experience, knowledge and education to run the business and administrative components of the new business or does it make sense to partner with a company that can provide those aspects while you concentrate on practicing medicine? That's important when addressing matters such as personnel, billing, building inspection and licensure, accreditation, data collection and reporting. For us, partnering with NCP made a lot of sense. They had the expertise to deal with the business and administrative aspects and this allowed us to do what we do best: provide quality cardiac care to our patients. In my opinion, our partnership is the biggest reason for our great success.

## Notes on Safety

Patient safety must always be at the front of your mind. Here are a few points about the safety of performing outpatient cardiology:

- Develop and follow comprehensive guidelines describing those patients you can safely take care of in an ASC and which patients should receive care in a hospital.
- Outpatient cath is still relatively new, so understand that you will be under the spotlight. Err on the side of caution by providing care to people at less risk of complications.
- Complications are possible when performing procedures in any setting. Make sure staff is trained in advanced life support and prepared to care for any patients should they become acutely sick and require stabilization before transfer to a hospital. Establish procedures that allow prompt transfer to your local hospital should the need arise.
- There are numerous published research papers demonstrating the safety of performing cardiac procedures at a site with no surgical backup. In addition, the American College of Cardiology and the Society for Cardiovascular Angiography and Interventions have published position statements stating that this type of work is safe at institutions with no surgical backups. This should instill confidence in pursuing the ASC model.

I have experienced firsthand the numerous benefits of moving cardiology procedures to an ASC. With careful planning and an unwavering focus on safety, I believe many cardiologists are in a position to emulate what we have accomplished at Waco Cardiology Associates. If you choose to pursue this model, good luck in your journey!

*Donald (Buck) Cross, MD, is an interventional cardiologist in Waco, Texas, and the national medical director for National Cardiovascular Partners. Write him at buckcross@msn.com.*

# Improving Your Governing Board's Effectiveness

*By Colin Rorrie*

You have been asked by your physician partners to serve as a physician representative on your ASC's board of directors. While you are honored to have been asked, you are also concerned since you haven't ever served on a governing board before. You want to make sure that you do a good job. The question is how to be prepared. A few recommendations follow.

## Background

Find out who is responsible for providing administrative services to the board, including managing meetings. Schedule a meeting with that individual to learn everything you need to know. How often does the board meet? When will you receive the meeting materials, including the agenda and background documents? Request minutes of the last two years of meetings. Obtain the current year's budget and financial statements. A good general request is for any materials that will help you be a more informed board member.

## First Meeting Preparation

Hopefully, you received the meeting materials with enough time to review them before the meeting. A best practice is a week in advance. Set aside enough time to review the documents. If you have questions, ask the board chair or a responsible staff member before the meeting. This doesn't mean you can't ask questions at the meeting, but obtaining answers beforehand will facilitate the meeting's effectiveness. Prior review of the materials is important because you don't want to be in a position of asking a question covered in the meeting documents.

Another good practice is to call the board chair before your first meeting to discuss the meeting dynamics. How do the different board members operate? Are there more dominant individuals? What is the protocol for asking a question? What is the chair's expectation of you as a board member?

## The Meeting

Your first meeting has arrived. The chair may ask you to make a few remarks about what you hope to offer through your participation. In your pre-meeting call with the chair, find out if you will be asked to make any opening comments. A common challenge for a new member of a board is knowing how often to speak. Some speak too much while others say little, if anything. A good practice is to pick out a couple of issues on the agenda where you feel you can best contribute. Make a note of the points you want to make, electronically or on an index card, so you will remember them when the issue comes up. By picking a few topics, you can easily move into the flow of the meeting. This doesn't mean, however, that you shouldn't offer your thoughts on other issues where you feel you have pertinent points to make.

## Post-Meeting

Either during the meeting or at its end, the chair may ask for assistance on issues requiring further work. You want to be viewed as a team player, so identify an issue where you feel you can contribute and volunteer to help. At the end of the meeting or shortly thereafter, follow up with the board member tasked with leading on the issue to learn how you can be helpful and the timeframe for your input. Make sure you meet the deadline. As a new board member, you don't want to be viewed as not fulfilling your responsibility.

## Final Points

In this period of facility consolidation and price sensitivity, it is essential that an ASC's physicians have active and consistent representation in the governance of the ASC. This means that those representing the center's physicians must ensure that they fulfill their responsibilities, whether it is by attending board meetings or completing an assignment for an upcoming meeting.

While there will be an occasional crisis that will prevent one from attending a meeting, it is important that nonattendance doesn't become a pattern. Consistent participation is critical to ensure that the physician voice is represented in the decisions guiding the center's operation. When an absence is anticipated, communication should occur with the other physician board members or the board chair to share one's views on the pending agenda items.

*Colin Rorrie is president of CCR & Associates, a consulting firm based in Dallas, Texas. Write him at crorrie1@yahoo.com.*



# Study: ASCs an Appropriate Site for Spine Surgery

Results of a recent study published in *Neurosurgery* indicate that ASCs are an appropriate setting for a variety of spine procedures.

The researchers reviewed literature published on PubMed. They specifically reviewed about 40 clinical studies reporting morbidity and outcomes data for cervical and lumbar surgeries performed in ASCs, focusing on anterior cervical discectomy and fusion, posterior cervical foraminotomy, cervical arthroplasty, lumbar microdiscectomy, lumbar laminectomy and minimally invasive transforaminal interbody fusion and lateral lumbar interbody fusion.

The literature review indicated there is ample retrospective comparisons and case series evidence to support the safety and effectiveness of outpatient cervical and lumbar surgery. They conclude with the following: "While further studies are needed to understand how best to select optimal patients for ASCs and maximize perioperative analgesia, the fact remains that the evidence for the safety and utility of multiple outpatient spine procedures is robust and growing. In light of this, providers, payers, hospitals, and patients all stand to benefit if greater investments are made in ASCs for spine surgery."

Access the study at https://goo.gl/NVfkze.

# Embracing the Self-Funded Model of Health Care

*By Jay W. Kempton*

We all know that the current health care system is unsustainable, difficult to navigate, expensive, confusing and often provides low value. While the media continuously discusses the direness of the situation for patients who have coverage through a carrier, what is not at the forefront of the never-ending discussion on costs, access and coverage is the impact on the more than 100 million citizens with benefits through their self-funded employer.

More than 60 percent (http://goo.gl/7YNqH5) of all employers in the United States elect to self-fund their employee benefits. In the simplest terms, this means that these employers are paying their employees' claims out of their own pockets. Being self-funded means the employers have more control over their Plan and can offer benefits tailored to their employees and control costs more effectively.

As an independent, third-party administrator (TPA), I believe helping self-funded employers manage their health Plans should be our primary focus. But it was in 2011, right after the passage of the Affordable Care Act, that I felt like I had run out of ideas to help these employers control their costs while providing high-value benefits. Many third-party vendors showed up on the scene shouting about the savings they could offer to health plans, all while claims costs continued to skyrocket. It was around this time that I met Dr. Keith Smith of the Surgery Center of Oklahoma and the idea of connecting self-funded employers with free market-friendly, high-value providers was born.

We formed a program in 2011 that was based on the premise that the buyers and sellers (employers and providers) needed to cut out the third-party vendors from the transaction and work directly with each other in a mutually beneficial way. Seven years later, there is a growing movement towards embracing the free market in health care, with many employers, TPAs, associations and advocacy groups all working toward the same goal.

## Understanding the Model

When a self-funded employer works directly with independent providers, the patient out-of-pocket expense can be eliminated (unless the employer offers a *qualified*, high-deductible health plan). Providers agree to a bundled, cash-based price paid by the employer. Providers have no accounts receivable to chase, and the employer can potentially save between 50 and 80 percent (http://goo.gl/3mYrgb) over the network allowables at hospitals. The patient is incented to use this option because there is no cost to them.

Since these are bundled, transparent prices offered voluntarily by the provider, there is no ability to upcode and upcharge for extra services or foreseeable complications if the provider is low quality as it is already included in the price. This means that facilities and surgeons will only offer services under this model that they are the best at performing in the most efficient way.

Self-funded employers using a free market program typically report a reduction in unnecessary procedures. Frequently, a patient would be told they needed a surgery or treatment by their hospital-employed physician or surgeon, but upon having their consultation with a free market provider, a more conservative, non-invasive treatment was found to be the better option.

## Momentum Building

The Free Market Medical Association (https://fmma.org/), an apolitical association for buyers, sellers and valuable vendors, reports that more than 300 independent facilities now offer bundled pricing. Half a million patients now have this option for their care. Not only have self-funded employers started to embrace this model, but a growing number of health care sharing ministries encourage their members to use these types of providers for services.

This movement is continuously expanding. As more TPAs create their own free market programs, everything from governments to large employers are working directly with providers without the interference of third parties. Many organizations are now helping to promote the goal of changing the paradigm of health care across the country.

We *can* change our health care system without more vendors, schemes, government intervention, regulations and mandates. To quote my friend Dr. Smith, "Health care is not expensive. What is charged for it is a whole other matter altogether." Let's change that.

*Jay W. Kempton is president and chief executive officer of The Kempton Group in Oklahoma City, Oklahoma. Write him at jkempton@kemptongroup.com.*



# Study: Fewer Post-Surgery Adverse Events in ASCs vs. HOPDs

A recent study published in the *Journal of Health Economics* compares the rate of adverse events, defined as inpatient admissions or emergency room (ER) visits, following outpatient procedures in ASCs and hospital outpatient departments (HOPDs).

The study examined Medicare claims data for physicians who operate in both ASCs and HOPDs, looking at the 10 most common procedures in ASC volume. Researchers found that patients experienced a reduction in ER visits when undergoing procedures in ASCs relative to HOPDs. The study also concluded that the reduction in post-procedure adverse events exists for low- and high-risk patients.

Access the study at https://goo.gl/JncbM1.