"GYNECONOMICS"

VALUE BASED HEALTHCARE IN GYNECOLOGIC SURGERY

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ASCA

EVOLUTION OF OUTPATIENT SURGERY SUMMIT

WASHINGTON, DC

MONDAY OCT 15, 2018

Objectives

1. Understand the numerous acronyms of the Value Based System
2. Develop an understanding of the factors impacting cost of surgical services in the U.S.
3. Identify ways to decrease cost of surgery
4. Understand the economic impact of Outpatient Surgery

Things Are Not Always as They Seem

The Patient Protection and Affordable Care Act of 2010

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"ObamaCare" "The ACA"

Most significant overhaul in the US healthcare system since 1965

Introduction of Medicare and Medicaid

Provisions over ten years 2010-2020

2409 pages (full length text)
974 page document (consolidated version)

Extend coverage of health benefits to previously uninsured Americans

Lower cost and improve efficiency

Eliminate practices of rescission (retro denial) and denial due to pre-existing conditions

The US Leads the World in One Category

Cost

50% greater than any other industrialized nation

We spend more on healthcare for 325 Million people than India spends on everything for 1.3 Billion people

18% of our Gross Domestic Product GDP ($3.2 trillion of ~$18trillion)

Monetary **measure** of the market value of all the **final goods** and services produced in a period (quarterly or yearly) of **time**

Quality

37 of **191**

National Healthcare Systems

Value-Based Healthcare

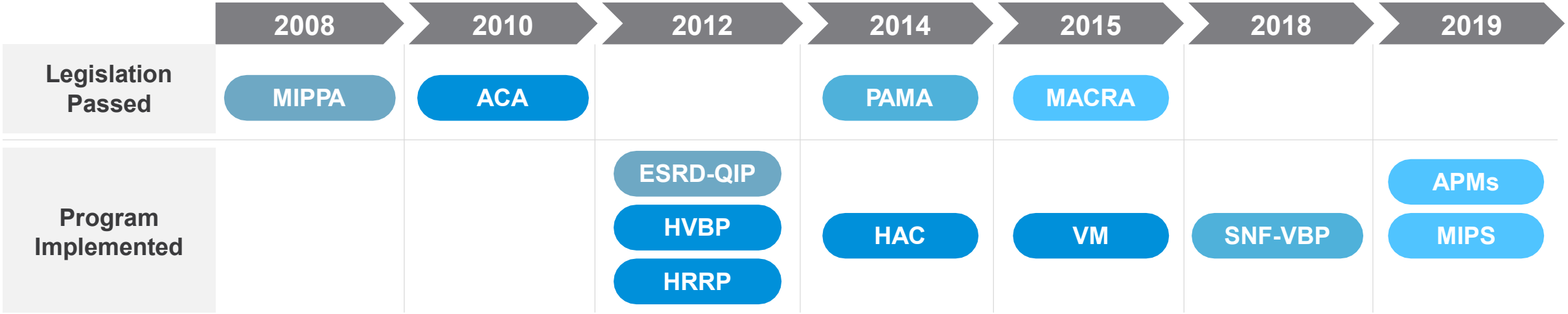
WIKI

Pay for performance or value-based purchasing is a payment model…with financial incentives for performance measures

CMS

Value based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare

Value-Based Programs



LEGISLATION

ACA: Affordable Care Act

MACRA: The Medicare Access & CHIP Reauthorization Act of 2015

MIPPA: Medicare Improvements for Patients & Providers Act

PAMA: Protecting Access to Medicare Act

PROGRAM

APMs: Alternative Payment Models

ESRD-QIP: End-Stage Renal Disease Quality Incentive Program

HACRP: Hospital-Acquired Condition Reduction Program

HRRP: Hospital Readmissions Reduction Program

HVBP: Hospital Value-Based Purchasing Program

MIPS: Merit-Based Incentive Payment System

VM: Value Modifier or Physician Value-Based Modifier (PVBM)

SNFVBP: Skilled Nursing Facility Value-Based Purchasing Program

Alphabet Soup of Acronyms

Shall We Play A Game?

Strategy to Win

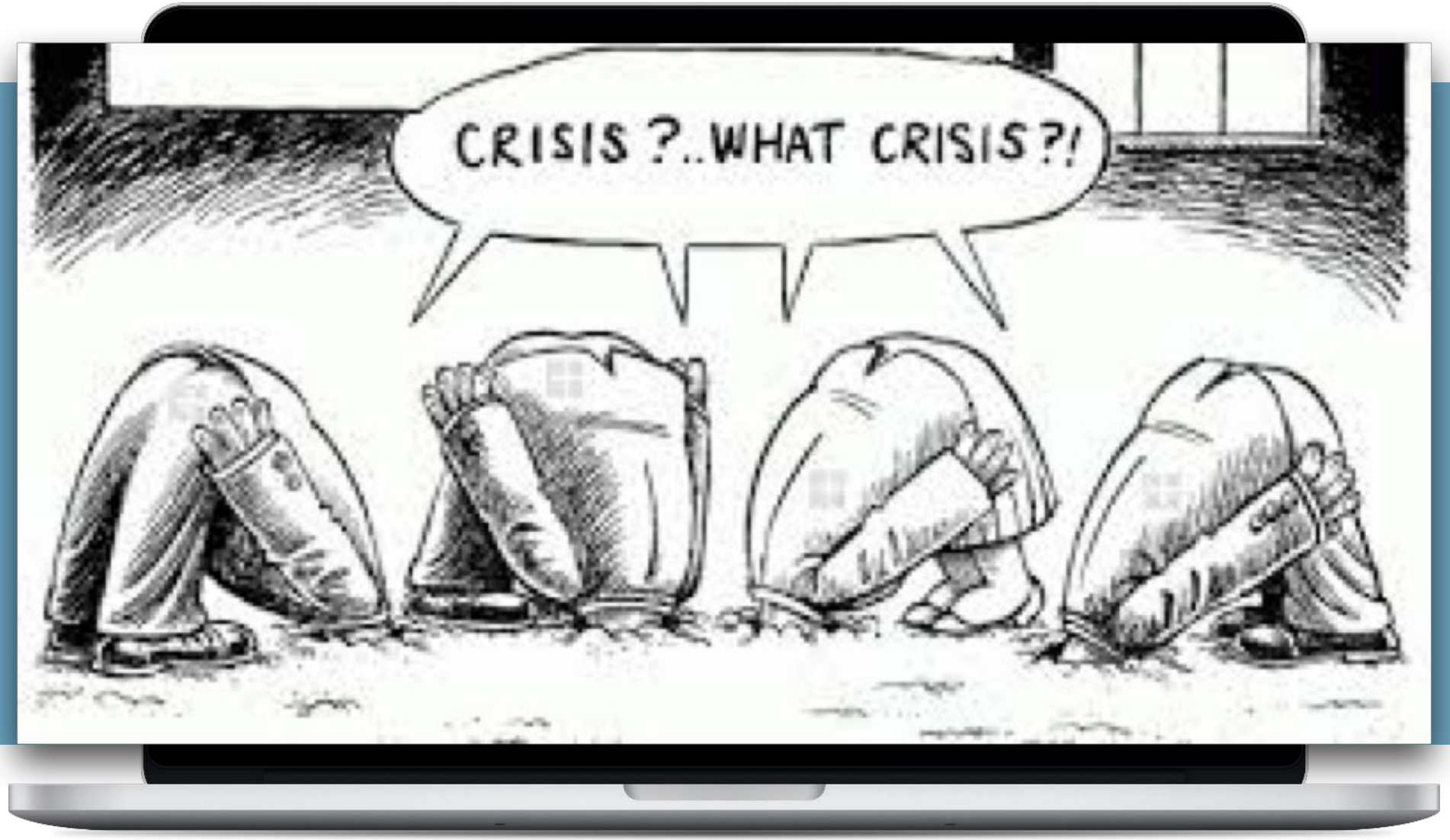
THE "GAME PIECES"

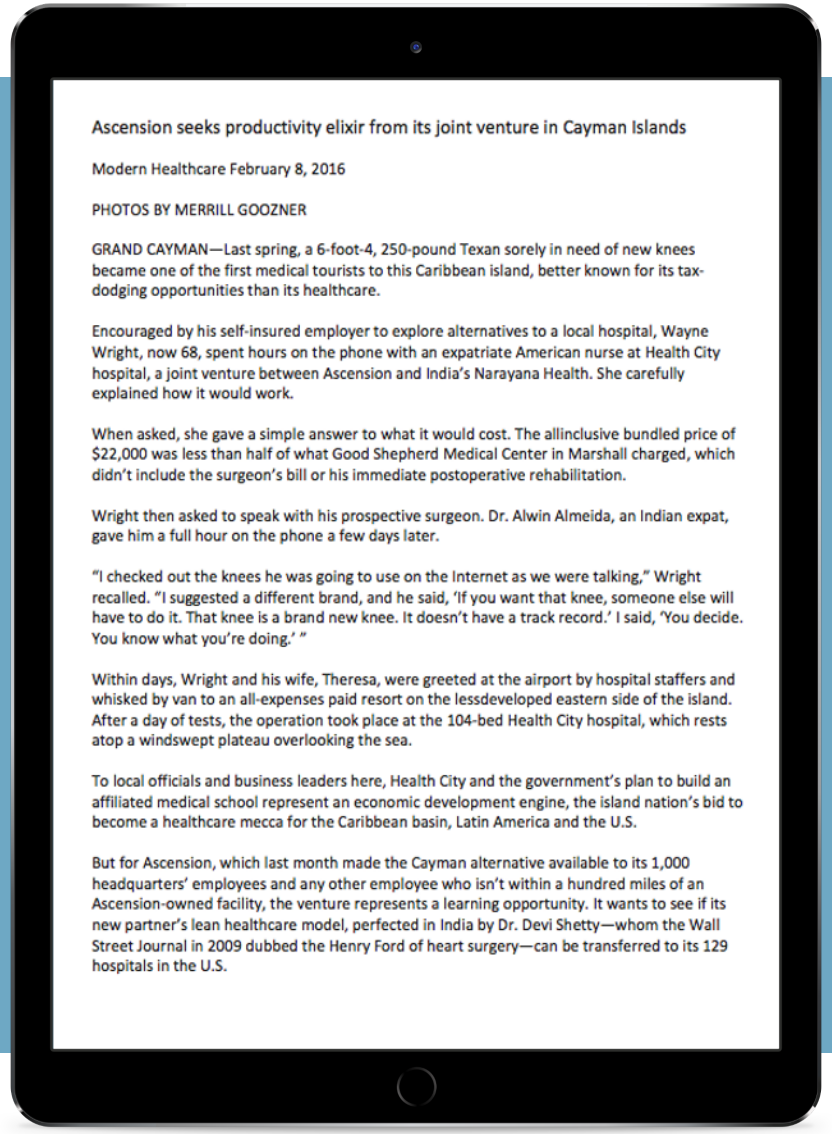
- **MACRA** is a piece of legislation, includes PQRS (quality reporting) CHIP (another legislative act)
- **MIPS** is "merit based incentive program"
- **APM** refers to Alternate Payment Methodology/Episodic Payment/Bundles

BILLING BASICS

- DRG (hospital) **APC** (HOPD) **ASC** (Amb surgical center)
- ~95% of Gyn surgical codes are billed as DRG, with some mixed in APC and VERY FEW ASC codes
- Bundle = facility + anesthesia + path + professional + pre/post/peri op

Nothing to worry about?





Ascension seeks productivity elixir from its joint venture in Cayman Islands

Modern Healthcare February 8, 2016

PHOTOS BY MERRILL GOOZNER

GRAND CAYMAN—Last spring, a 6-foot-4, 250-pound Texan sorely in need of new knees became one of the first medical tourists to this Caribbean island, better known for its tax-dodging opportunities than its healthcare.

Encouraged by his self-insured employer to explore alternatives to a local hospital, Wayne Wright, now 68, spent hours on the phone with an expatriate American nurse at Health City hospital, a joint venture between Ascension and India's Narayana Health. She carefully explained how it would work.

When asked, she gave a simple answer to what it would cost. The allinclusive bundled price of $22,000 was less than half of what Good Shepherd Medical Center in Marshall charged, which didn't include the surgeon's bill or his immediate postoperative rehabilitation.

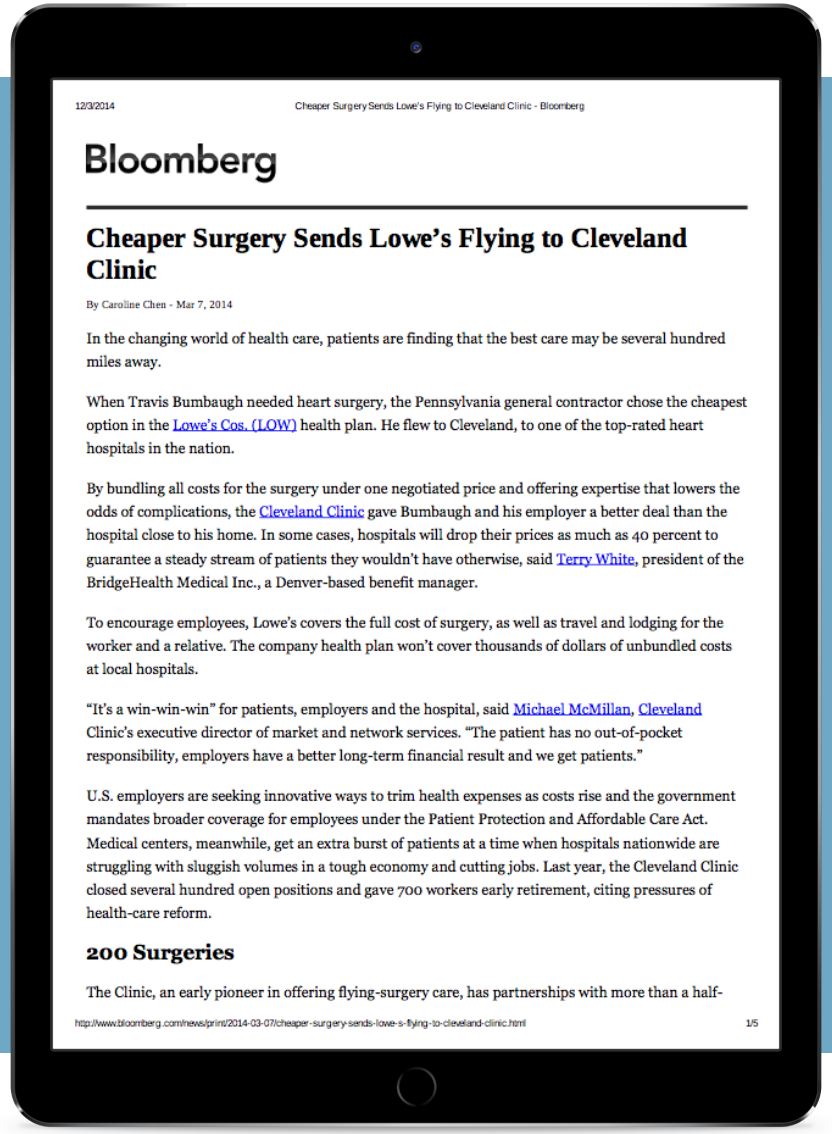
Wright then asked to speak with his prospective surgeon. Dr. Alwin Almeida, an Indian expat, gave him a full hour on the phone a few days later.

"I checked out the knees he was going to use on the Internet as we were talking," Wright recalled. "I suggested a different brand, and he said, 'If you want that knee, someone else will have to do it. That knee is a brand new knee. It doesn't have a track record.' I said, 'You decide. You know what you're doing.' "

Within days, Wright and his wife, Theresa, were greeted at the airport by hospital staffers and whisked by van to an all-expenses paid resort on the lessdeveloped eastern side of the island. After a day of tests, the operation took place at the 104-bed Health City hospital, which rests atop a windswept plateau overlooking the sea.

To local officials and business leaders here, Health City and the government's plan to build an affiliated medical school represent an economic development engine, the island nation's bid to become a healthcare mecca for the Caribbean basin, Latin America and the U.S.

But for Ascension, which last month made the Cayman alternative available to its 1,000 headquarters' employees and any other employee who isn't within a hundred miles of an Ascension-owned facility, the venture represents a learning opportunity. It wants to see if its new partner's lean healthcare model, perfected in India by Dr. Devi Shetty—whom the Wall Street Journal in 2009 dubbed the Henry Ford of heart surgery—can be transferred to its 129 hospitals in the U.S.



Bloomberg

Cheaper Surgery Sends Lowe's Flying to Cleveland Clinic

By Caroline Chen - Mar 7, 2014

In the changing world of health care, patients are finding that the best care may be several hundred miles away.

When Travis Bumbaugh needed heart surgery, the Pennsylvania general contractor chose the cheapest option in the Lowe's Cos. (LOW) health plan. He flew to Cleveland, to one of the top-rated heart hospitals in the nation.

By bundling all costs for the surgery under one negotiated price and offering expertise that lowers the odds of complications, the Cleveland Clinic gave Bumbaugh and his employer a better deal than the hospital close to his home. In some cases, hospitals will drop their prices as much as 40 percent to guarantee a steady stream of patients they wouldn't have otherwise, said Terry White, president of the BridgeHealth Medical Inc., a Denver-based benefit manager.

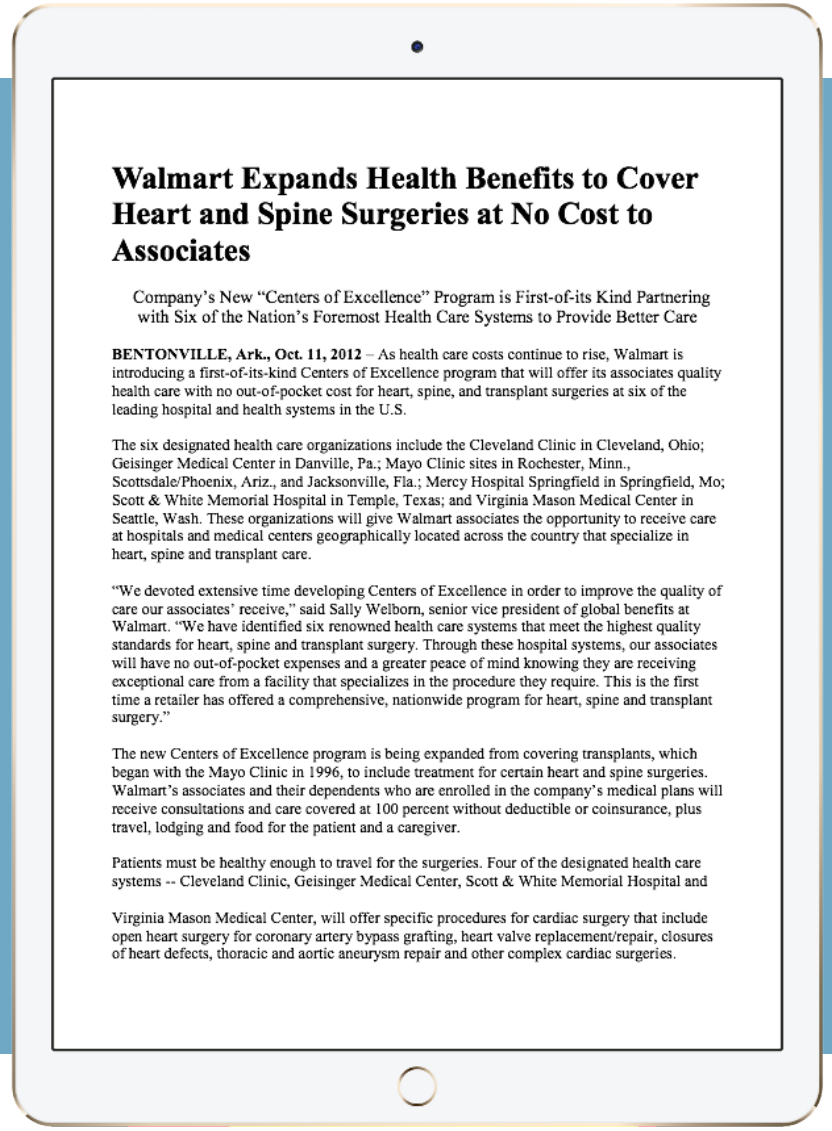
To encourage employees, Lowe's covers the full cost of surgery, as well as travel and lodging for the worker and a relative. The company health plan won't cover thousands of dollars of unbundled costs at local hospitals.

"It's a win-win-win" for patients, employers and the hospital, said Michael McMillan, Cleveland Clinic's executive director of market and network services. "The patient has no out-of-pocket responsibility, employers have a better long-term financial result and we get patients."

U.S. employers are seeking innovative ways to trim health expenses as costs rise and the government mandates broader coverage for employees under the Patient Protection and Affordable Care Act. Medical centers, meanwhile, get an extra burst of patients at a time when hospitals nationwide are struggling with sluggish volumes in a tough economy and cutting jobs. Last year, the Cleveland Clinic closed several hundred open positions and gave 700 workers early retirement, citing pressures of health-care reform.

200 Surgeries

The Clinic, an early pioneer in offering flying-surgery care, has partnerships with more than a half-



Walmart Expands Health Benefits to Cover Heart and Spine Surgeries at No Cost to Associates

Company's New "Centers of Excellence" Program is First-of-its Kind Partnering with Six of the Nation's Foremost Health Care Systems to Provide Better Care

BENTONVILLE, Ark., Oct. 11, 2012 – As health care costs continue to rise, Walmart is introducing a first-of-its-kind Centers of Excellence program that will offer its associates quality health care with no out-of-pocket cost for heart, spine, and transplant surgeries at six of the leading hospital and health systems in the U.S.

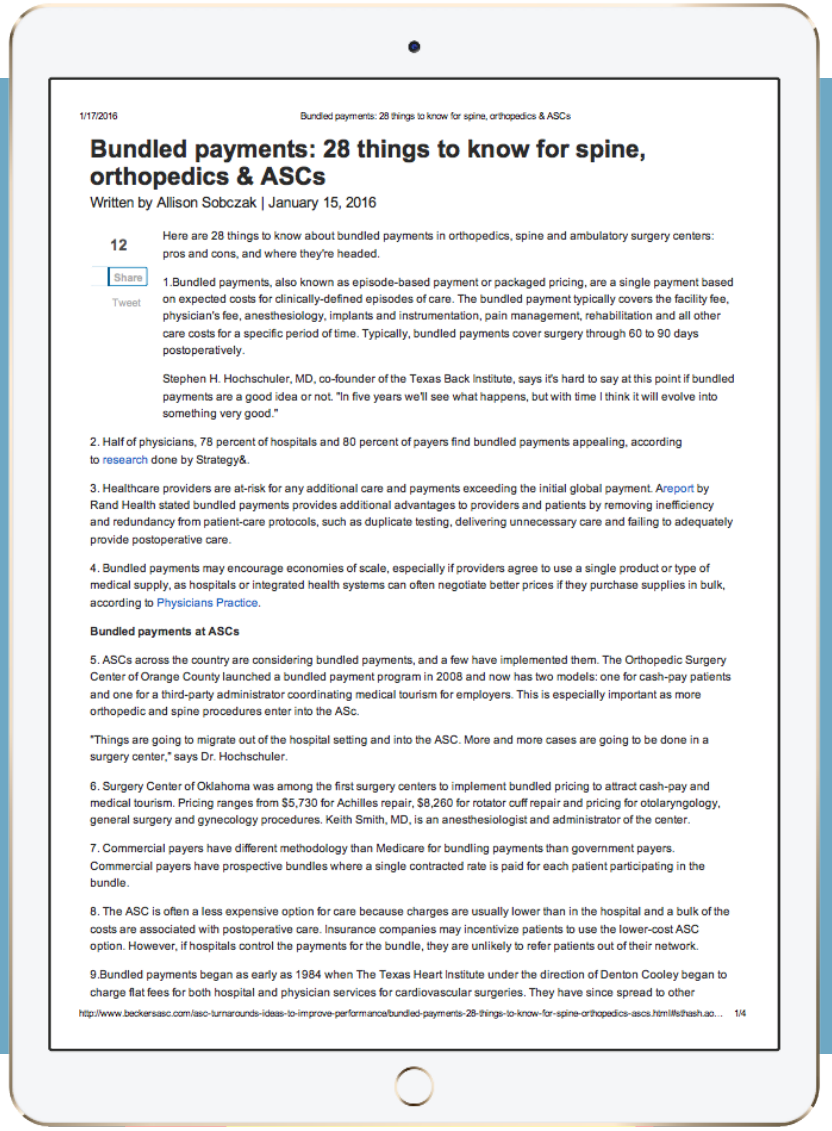
The six designated health care organizations include the Cleveland Clinic in Cleveland, Ohio; Geisinger Medical Center in Danville, Pa.; Mayo Clinic sites in Rochester, Minn., Scottsdale/Phoenix, Ariz., and Jacksonville, Fla.; Mercy Hospital Springfield in Springfield, Mo; Scott & White Memorial Hospital in Temple, Texas; and Virginia Mason Medical Center in Seattle, Wash. These organizations will give Walmart associates the opportunity to receive care at hospitals and medical centers geographically located across the country that specialize in heart, spine and transplant care.

"We devoted extensive time developing Centers of Excellence in order to improve the quality of care our associates' receive," said Sally Welborn, senior vice president of global benefits at Walmart. "We have identified six renowned health care systems that meet the highest quality standards for heart, spine and transplant surgery. Through these hospital systems, our associates will have no out-of-pocket expenses and a greater peace of mind knowing they are receiving exceptional care from a facility that specializes in the procedure they require. This is the first time a retailer has offered a comprehensive, nationwide program for heart, spine and transplant surgery."

The new Centers of Excellence program is being expanded from covering transplants, which began with the Mayo Clinic in 1996, to include treatment for certain heart and spine surgeries. Walmart's associates and their dependents who are enrolled in the company's medical plans will receive consultations and care covered at 100 percent without deductible or coinsurance, plus travel, lodging and food for the patient and a caregiver.

Patients must be healthy enough to travel for the surgeries. Four of the designated health care systems -- Cleveland Clinic, Geisinger Medical Center, Scott & White Memorial Hospital and

Virginia Mason Medical Center, will offer specific procedures for cardiac surgery that include open heart surgery for coronary artery bypass grafting, heart valve replacement/repair, closures of heart defects, thoracic and aortic aneurysm repair and other complex cardiac surgeries.



Bundled payments: 28 things to know for spine, orthopedics & ASCs

Written by Allison Sobczak | January 15, 2016

Here are 28 things to know about bundled payments in orthopedics, spine and ambulatory surgery centers: pros and cons, and where they're headed.

1.Bundled payments, also known as episode-based payment or packaged pricing, are a single payment based on expected costs for clinically-defined episodes of care. The bundled payment typically covers the facility fee, physician's fee, anesthesiology, implants and instrumentation, pain management, rehabilitation and all other care costs for a specific period of time. Typically, bundled payments cover surgery through 60 to 90 days postoperatively.

Stephen H. Hochschuler, MD, co-founder of the Texas Back Institute, says it's hard to say at this point if bundled payments are a good idea or not. "In five years we'll see what happens, but with time I think it will evolve into something very good."

2. Half of physicians, 78 percent of hospitals and 80 percent of payers find bundled payments appealing, according to research done by Strategy&.

3. Healthcare providers are at-risk for any additional care and payments exceeding the initial global payment. Areport by Rand Health stated bundled payments provides additional advantages to providers and patients by removing inefficiency and redundancy from patient-care protocols, such as duplicate testing, delivering unnecessary care and failing to adequately provide postoperative care.

4. Bundled payments may encourage economies of scale, especially if providers agree to use a single product or type of medical supply, as hospitals or integrated health systems can often negotiate better prices if they purchase supplies in bulk, according to Physicians Practice.

Bundled payments at ASCs

5. ASCs across the country are considering bundled payments, and a few have implemented them. The Orthopedic Surgery Center of Orange County launched a bundled payment program in 2008 and now has two models: one for cash-pay patients and one for a third-party administrator coordinating medical tourism for employers. This is especially important as more orthopedic and spine procedures enter into the ASc.

"Things are going to migrate out of the hospital setting and into the ASC. More and more cases are going to be done in a surgery center," says Dr. Hochschuler.

6. Surgery Center of Oklahoma was among the first surgery centers to implement bundled pricing to attract cash-pay and medical tourism. Pricing ranges from $5,730 for Achilles repair, $8,260 for rotator cuff repair and pricing for otolaryngology, general surgery and gynecology procedures. Keith Smith, MD, is an anesthesiologist and administrator of the center.

7. Commercial payers have different methodology than Medicare for bundling payments than government payers. Commercial payers have prospective bundles where a single contracted rate is paid for each patient participating in the bundle.

8. The ASC is often a less expensive option for care because charges are usually lower than in the hospital and a bulk of the costs are associated with postoperative care. Insurance companies may incentivize patients to use the lower-cost ASC option. However, if hospitals control the payments for the bundle, they are unlikely to refer patients out of their network.

9.Bundled payments began as early as 1984 when The Texas Heart Institute under the direction of Denton Cooley began to charge flat fees for both hospital and physician services for cardiovascular surgeries. They have since spread to other

There Is No Easy Fix

MACRA

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QPP
(Quality Payment Programs)

Medicare access and CHIP Reauthorization act of 2015
Includes PQRS (quality reporting)

Building on Basic Concepts and Facts

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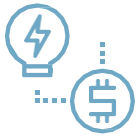
CMS is rolling out the Quality Payment Program

2 OPTIONS

Collect and submit data to get additional fees or penalized (MIPS)



Create an innovative payment model (APM) via CMS innovations division (must save money and improve quality of care)

GOAL

Better care, better outcomes, cost efficiency

CMS Facility Pricing—Flawed

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Who does this impact ?

Why?

CMS sets the standard
by which commercial contracts
are formed

Benign Gyn Cases are typically not Medicare patients

DRG 743 set the stage for HOPD/ASC rates (RVU is professional)

CMS rate is BELOW cost, but hospitals make money (will revisit this)

HOW ??? Complex claims, multiple codes, redundant billing

Where is the Problem?

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DRG: 743 in The National Dataset (MEDPAR)

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$8,883.00

The average estimated cost

$37,602.00

The average billed

$6,217.00

The average CMS payment

140 Million US Citizens and Their Employers Think

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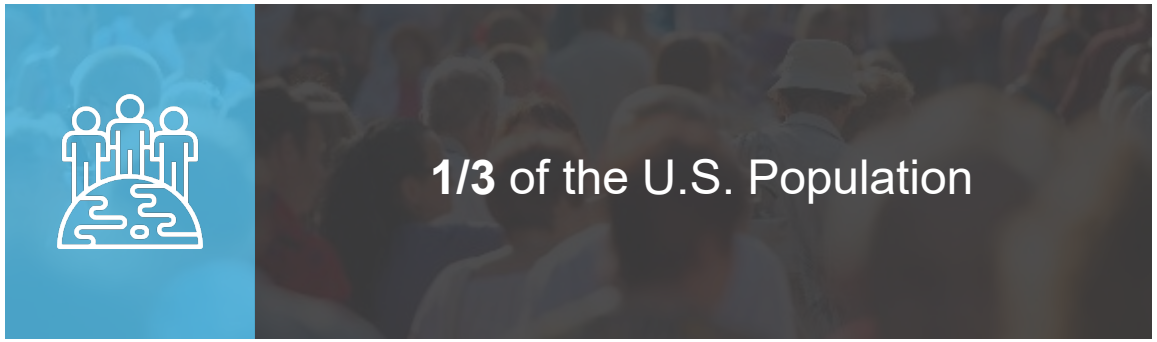
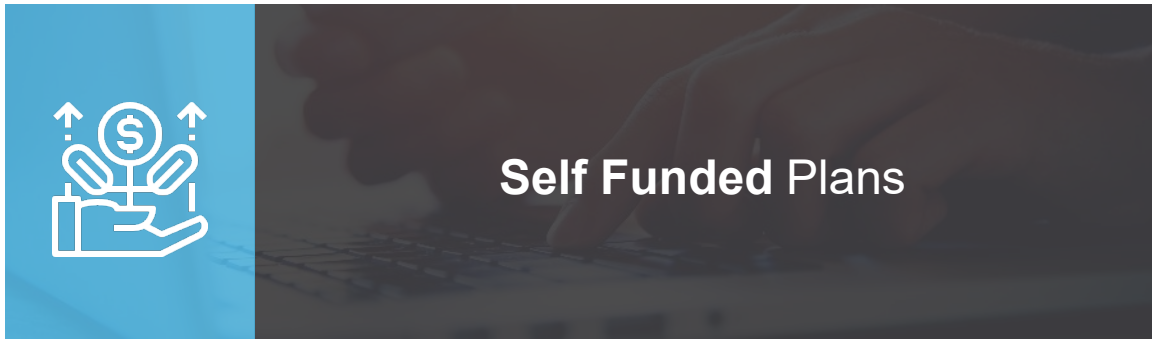
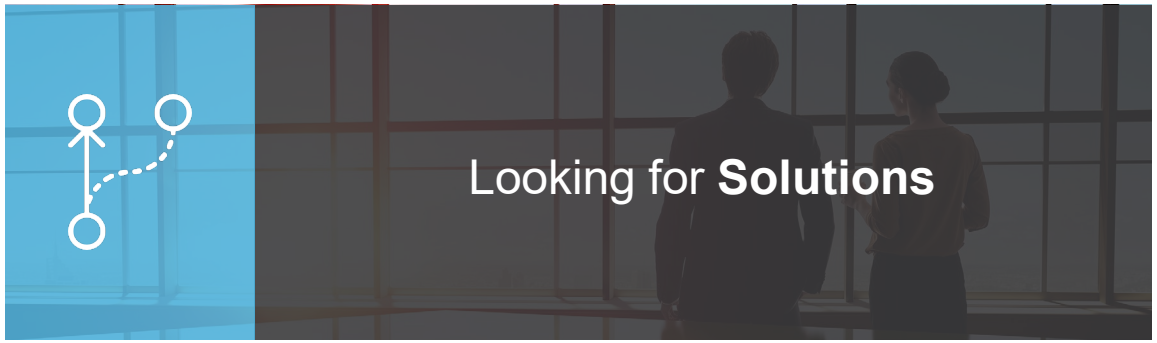
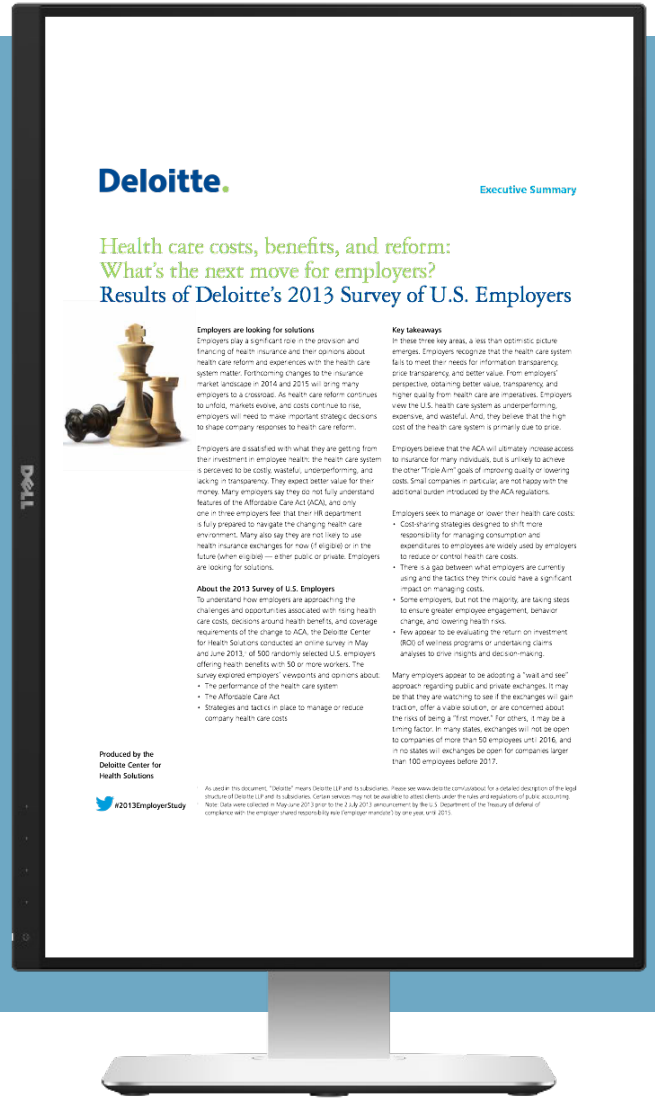
We Should Pay Attention





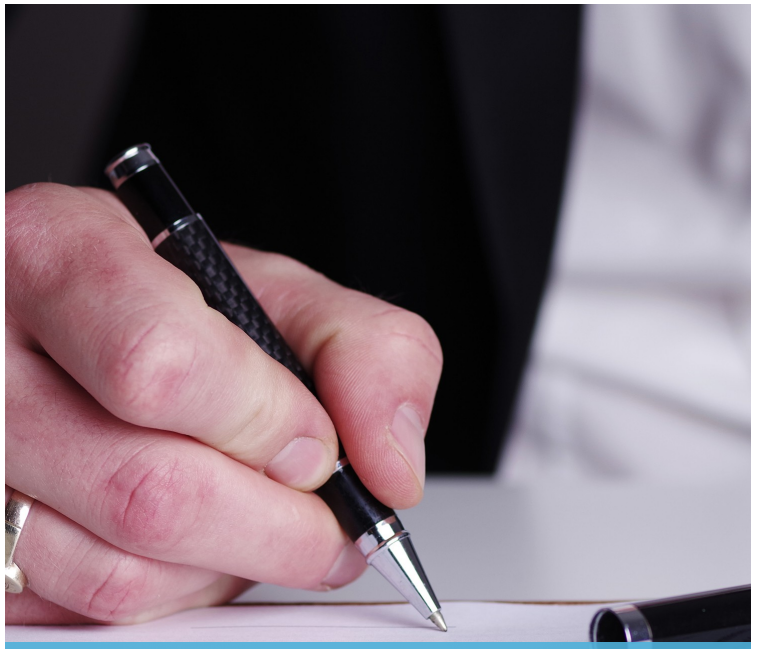



Deloitte.
Executive Summary
Health care costs, benefits, and reform:
What's the next move for employers?
Results of Deloitte's 2013 Survey of U.S. Employers
Employers are looking for solutions
Employers play a significant role in the provision and financing of health insurance and their opinions about health care reform and experiences with the health care system matter. Forthcoming changes to the insurance market landscape in 2014 and 2015 will bring many employers to a crossroad. As health care reform continues to unfold, markets evolve, and costs continue to rise, employers will need to make important strategic decisions to shape company responses to health care reform.
Employers are dissatisfied with what they are getting from their investment in employee health: the health care system is perceived to be costly, wasteful, underperforming, and lacking in transparency. They expect better value for their money. Many employers say they do not fully understand features of the Affordable Care Act (ACA), and only one in three employers feel that their HR department is fully prepared to navigate the changing health care environment. Many also say they are not likely to use health insurance exchanges for now (if eligible) or in the future (when eligible) — either public or private. Employers are looking for solutions.
About the 2013 Survey of U.S. Employers
To understand how employers are approaching the challenges and opportunities associated with rising health care costs, decisions around health benefits, and coverage requirements of the change to ACA, the Deloitte Center for Health Solutions conducted an online survey in May and June 2013, of 500 randomly selected U.S. employers offering health benefits with 50 or more workers. The survey explored employers' viewpoints and opinions about:
• The performance of the health care system
• The Affordable Care Act
• Strategies and tactics in place to manage or reduce company health care costs
Key takeaways
In these three key areas, a less than optimistic picture emerges. Employers recognize that the health care system fails to meet their needs for information transparency, price transparency, and better value. From employers' perspective, obtaining better value, transparency, and higher quality from health care are imperatives. Employers view the U.S. health care system as underperforming, expensive, and wasteful. And, they believe that the high cost of the health care system is primarily due to price.
Employers believe that the ACA will ultimately increase access to insurance for many individuals, but is unlikely to achieve the other "Triple Aim" goals of improving quality or lowering costs. Small companies in particular, are not happy with the additional burden introduced by the ACA regulations.
Employers seek to manage or lower their health care costs:
• Cost-sharing strategies designed to shift more responsibility for managing consumption and expenditures to employees are widely used by employers to reduce or control health care costs.
• There is a gap between what employers are currently using and the tactics they think could have a significant impact on managing costs.
• Some employers, but not the majority, are taking steps to ensure greater employee engagement, behavior change, and lowering health risks.
• Few appear to be evaluating the return on investment (ROI) of wellness programs or undertaking claims analyses to drive insights and decision-making.
Many employers appear to be adopting a "wait and see" approach regarding public and private exchanges. It may be that they are watching to see if the exchanges will gain traction, offer a viable solution, or are concerned about the risks of being a "first mover." For others, it may be a timing factor. In many states, exchanges will not be open to companies of more than 50 employees until 2016, and in no states will exchanges be open for companies larger than 100 employees before 2017.
Produced by the Deloitte Center for Health Solutions
#2013EmployerStudy
As used in this document, "Deloitte" means Deloitte LLP and its subsidiaries. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries. Certain services may not be available to attest clients under the rules and regulations of public accounting.
Note: Data were collected in May-June 2013 prior to the 2 July 2013 announcement by the U.S. Department of the Treasury of deferral of compliance with the employer shared responsibility rule ("employer mandate") by one year, until 2015.

This is a Math Problem

Advancing Technology

Diminishing or Static Funds Available for a Growing Population



Legislation Mandating Savings and Value

The Prices Continue to Climb with Technology

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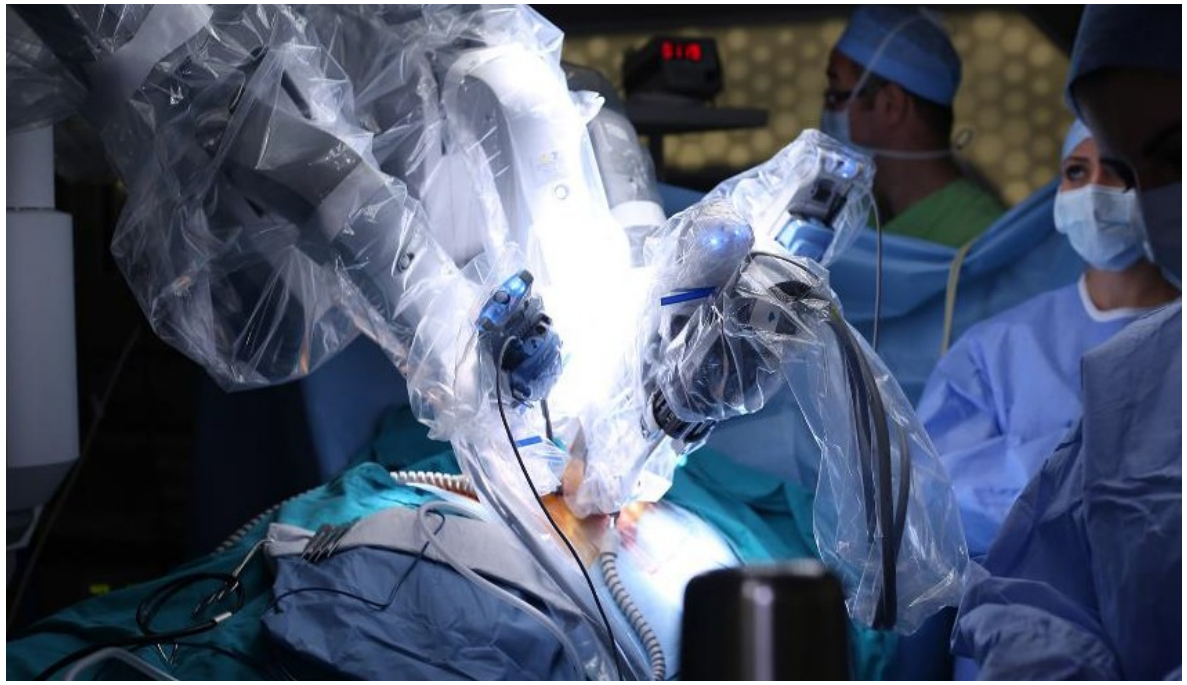
Cost Containment?



$2 Million

$30k generator, per case rates upwards of $350-500/case

"…if hospitals performing the fewest proportion of **minimally invasive operations** raised their rates to those of the national average of the top-third hospitals performing minimally invasive surgery, we **estimated potential savings could total $337 million annually**…"

Johns Hopkins General Surgery Dept

March 2015

600,000 hysterectomies per year/ 56,000 ACOG members = 10.7 cases per year

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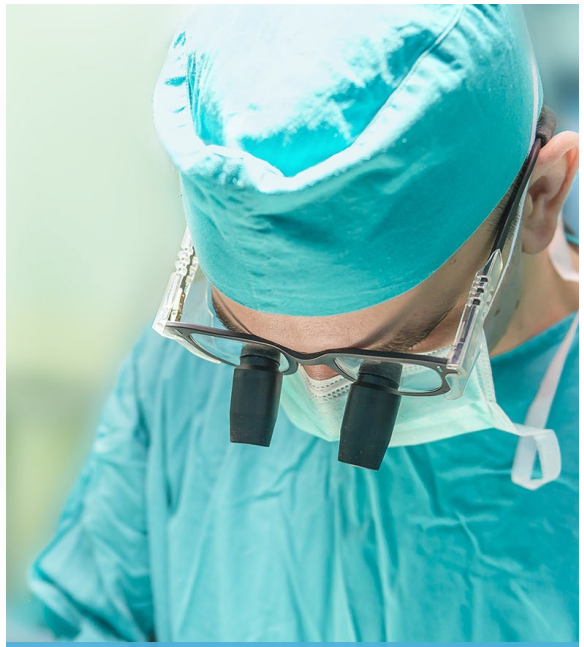
This is a CULTURAL problem

Where is the VALUE?

Wobegon Effect



Illusory Superiority

Human Tendency to Overestimate One's Capabilities

90% of surgeons will rank themselves in the top 50%

Self-Assessment will not work

Ok, so What Can We Do to Provide Value?

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Make rules?

No more robots?

No more Laparoscopy?

No more Disposable Instruments?

Low Volume Programs Do Not Provide Value

Low Volume

=

High Complications

Yield

=

High Profits + Worse Outcomes

Dr. Robert Pearl

CEO Permanente Medical Group

Mistreated: Why we think we are getting good healthcare and why we are usually wrong

---

200,000 premature deaths due to medical errors add lack of preventive care, **several hundred thousand deaths** per year in the US

Hysterectomy Survey

Department Chiefs asked about surgical volume

...

2-3/month
=
24-36 per year

Average < 10/year
in own group

2004 Quadruple Bypass Surgery

William Jefferson Clinton

42nd President of the United States

#33 of 35 cardiac programs based on risk adjusted outcomes in region

What Happened?

Reoperation in 6 months (effusion and scarring)

Why Is the System Broken?

- Spend lots on things that don't provide value
- Highest complication rates have highest profits
- Algorithms beat individuals
- Wobegon effect - 90% of us think we are in the top half
- Hospitals need to recognize that low volume programs do not provide value or quality- need volume for good outcomes

What is the biggest determinant of the dollars spent to complete a hysterectomy?

- Venue of Care
- Surgeon Technique/Experience
- Equipment Used
- Time in OR

Venue of Care

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Inpatient Operating Room (Hospital)

Hospital Outpatient Department (HOPD)

Ambulatory Surgery Center (ASC)

Why?

Diving Deep into Financial Reality Facility

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$25,000 +

Inpatient billed charges for a laparoscopic hysterectomy in Oregon with overnight stay

Allowable $16,000

Commercial Insurance

Patient with 80/20 and high deductible or OOP max can easily owe $5-10K with insurance

< 50% of hospital allowable

ASC Reimbursements

Patients pay less, even if using an out of network benefits

Aggregate charges in ASC for OR, professional fees, and Path are less than inpatient allowable for facility alone

...

So it costs less

But is there a clinical benefit?

Benefits for the Patient

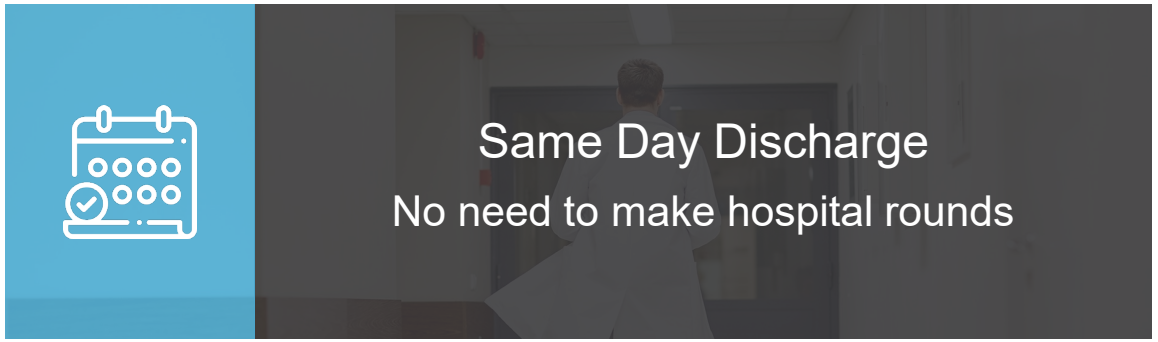
Customer Service/
Enhanced Patient Experience

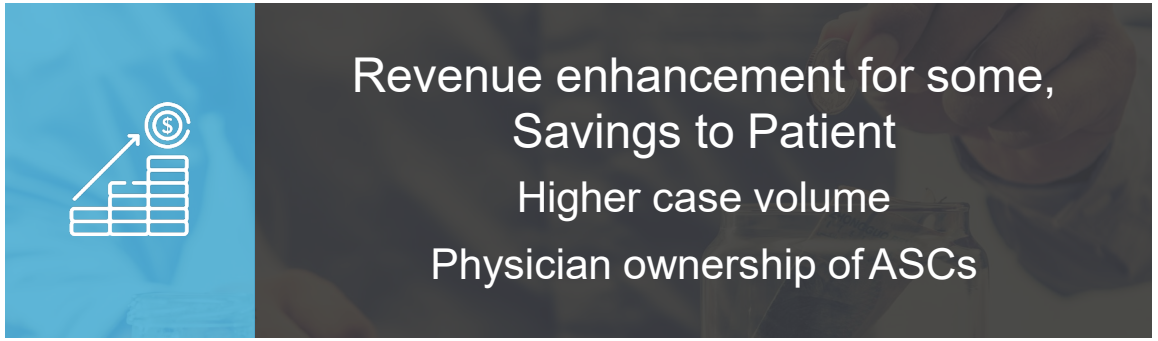
Avoiding Hospital, **Less** Stress
and Anxiety

Decreased Infection Rate

ERAS protocols **improve** outcomes

Benefits for the Surgeon



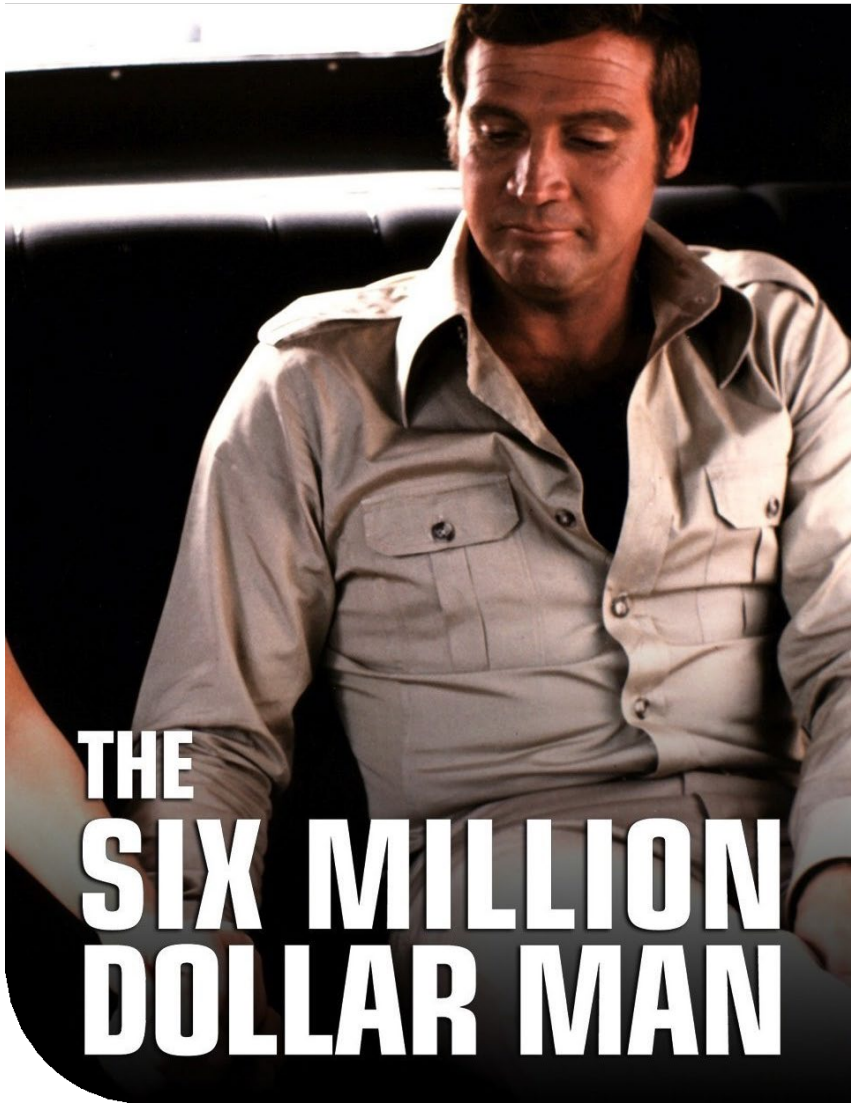


Economic Consideration

Outpatient Surgery costs much less to all parties involved than hospital based surgery

In an audience of 125

10 hysterectomies per year from the hospital to an ASC,
the room would **save $6.2 million**



The Single Biggest Thing You Can Do to Save Money in Gyn Surgery

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Use your outpatient options to perform safe surgery

Outpatient Pathways and ERAS protocols

Early Discharge Saves $$$

Enhanced Recovery After Surgery

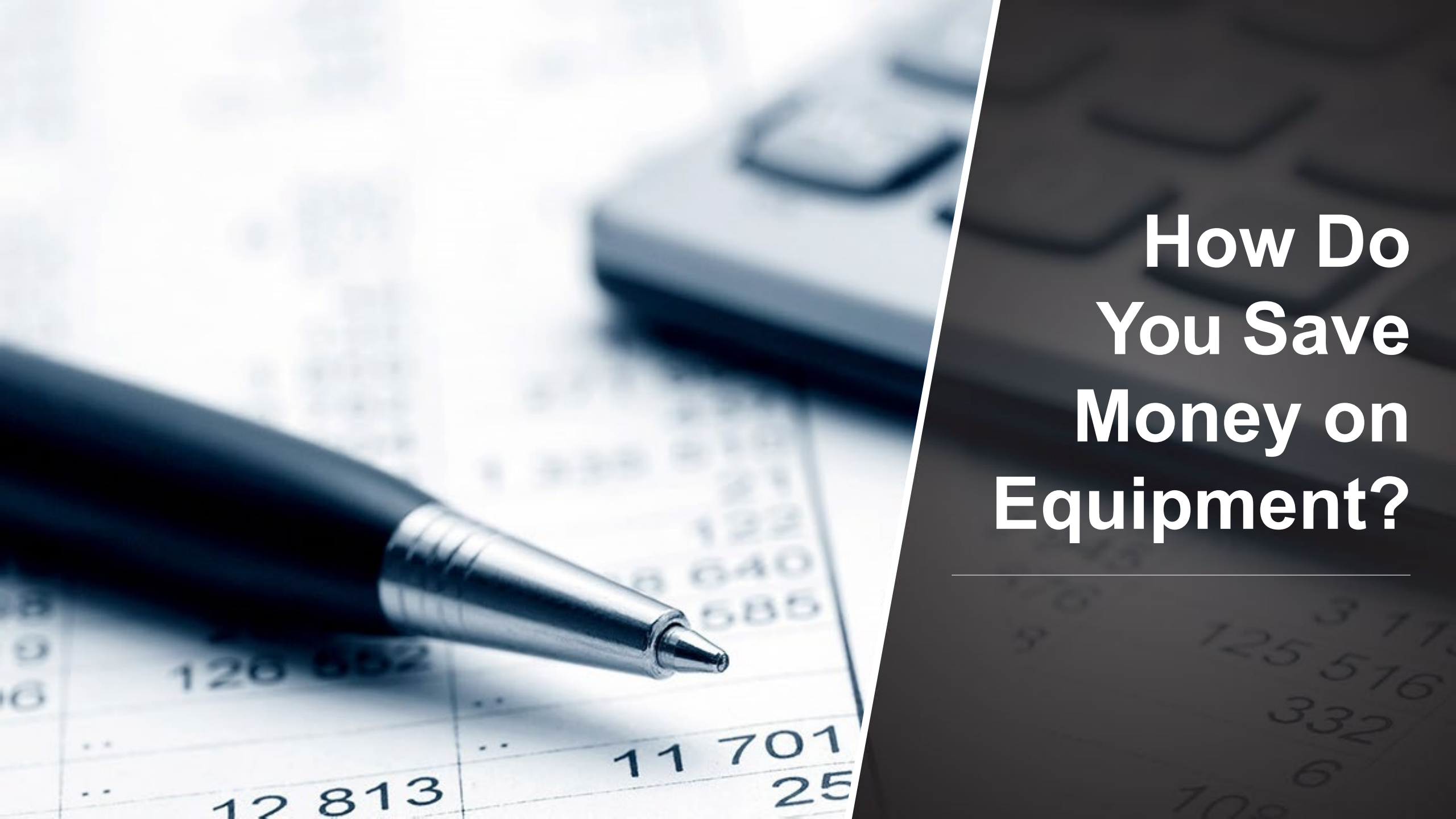
Evidence Based Protocols—goal is to maintain body homeostasis and reduce insulin resistance to accomplish better outcomes

Prehabilitation, Euvolemia, Early Ambulation, and Feeding

One liter of saline

x 36

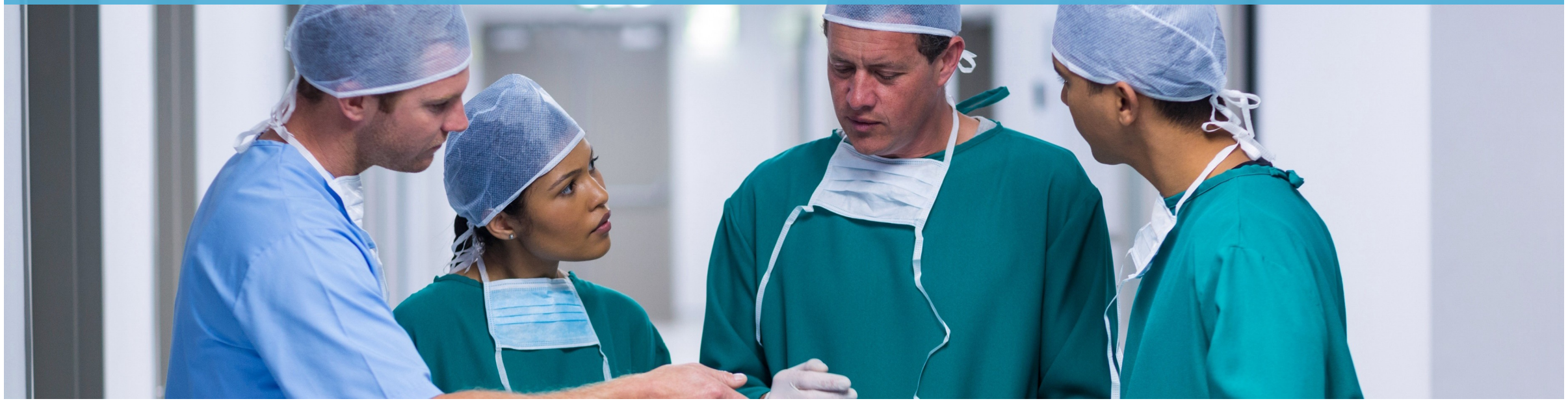
Courtesy of Andrew Shaw, MD



How Do You Save Money on Equipment?

Step 1

You have to care!



Step 2

Make less expensive choices


CONMED

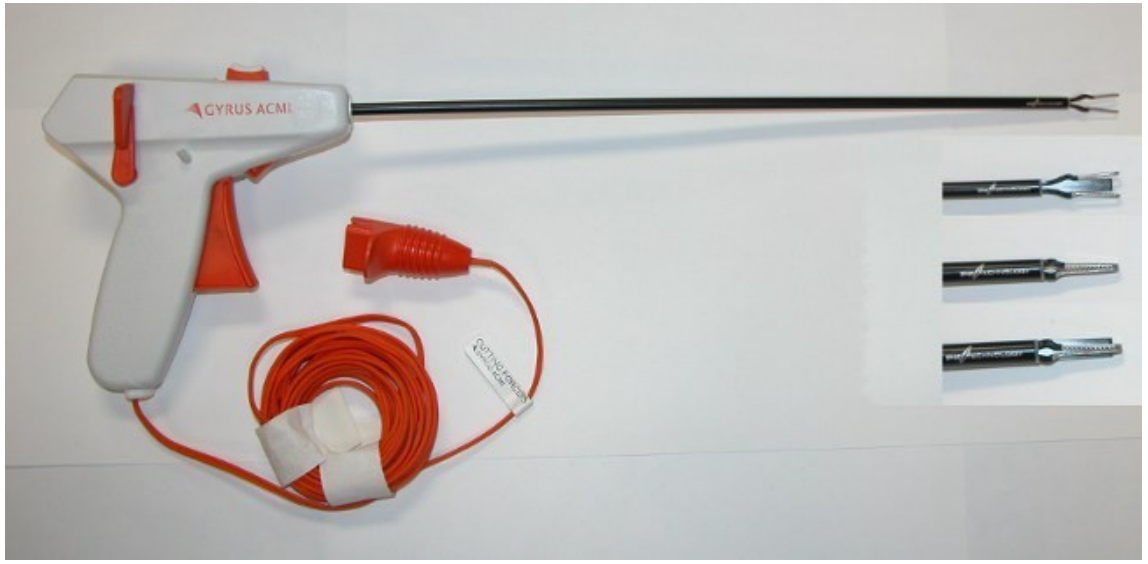
$ ~50

$ 20-30

$ 640

$ 850

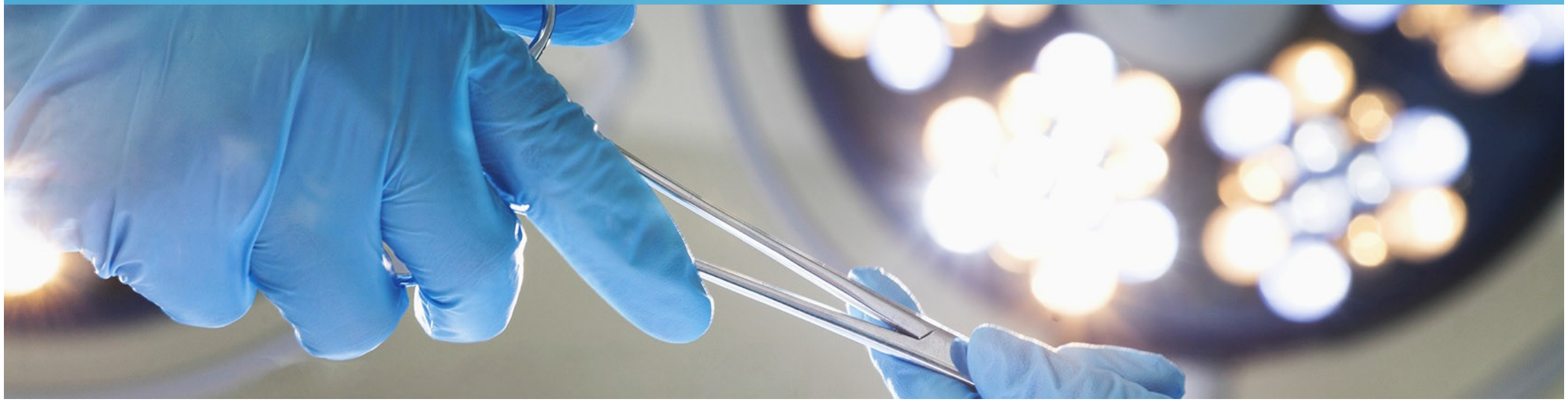
$ 720



< $400

Step 3

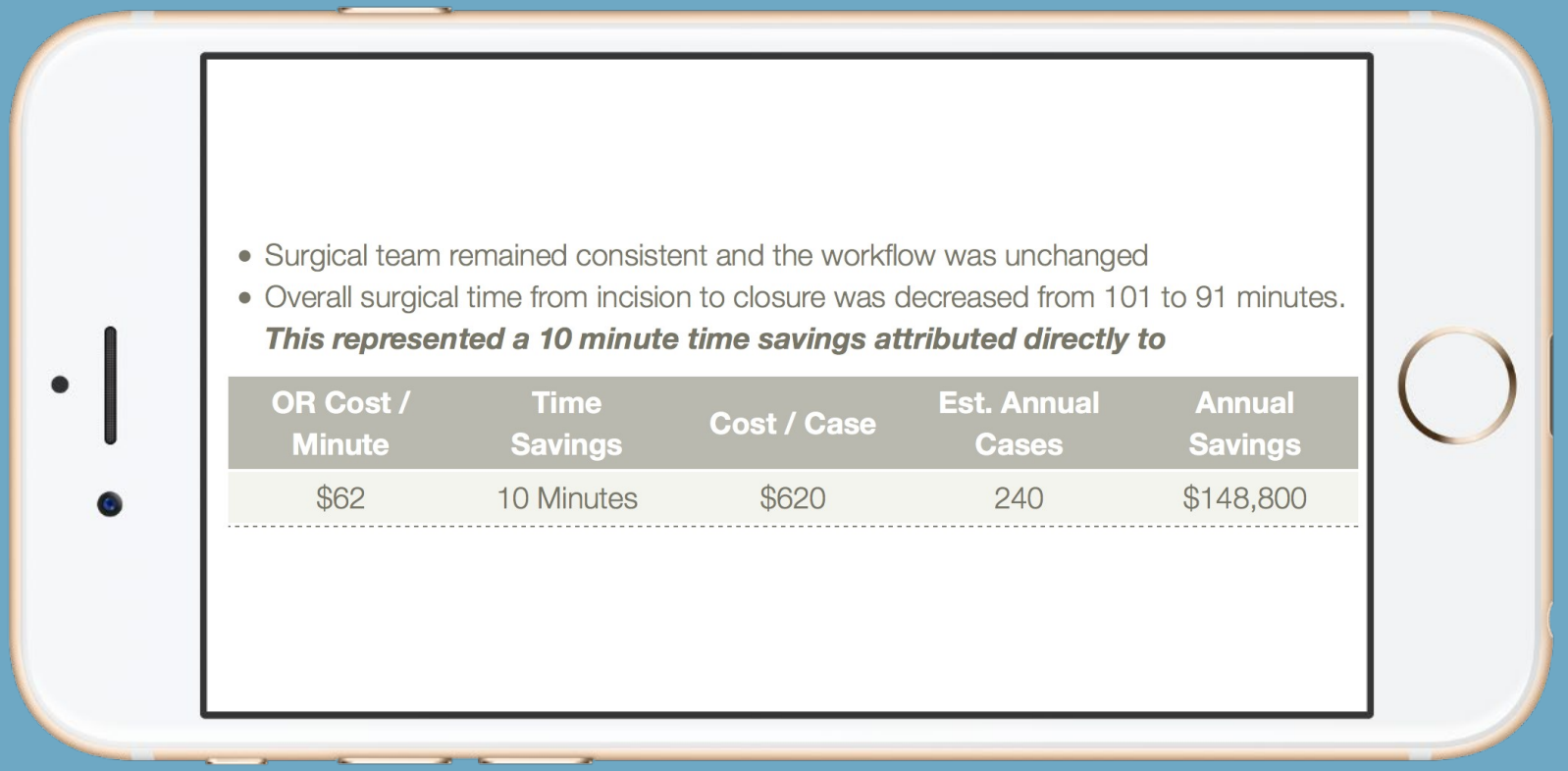
Don’t Drop Stuff!



...

OR Time is expensive!

Don't believe everything you hear


• Surgical team remained consistent and the workflow was unchanged
• Overall surgical time from incision to closure was decreased from 101 to 91 minutes.
This represented a 10 minute time savings attributed directly to
OR Cost / Minute
Time Savings
Cost / Case
Est. Annual Cases
Annual Savings
$62
10 Minutes
$620
240
$148,800

What costs the most in surgery?

Harvard 2013, School of Public Health

What About Bundles?

pëarl WOMEN'S CENTER

APM = Episodic Payment
= Innovative Disruption

Save on Total Cost per Case

Save on Cost of AFTERCARE

Complication Reduction is imperative to reduce burden on US Healthcare

Global Fee paid for Surgeon + Anesth + Path + Facility

Complication protection and vetted surgical team = **Success**

How Can We Motivate Surgeons?

pëarl WOMEN'S CENTER

Global Fee Bundle Concept

Lump sum paid for entire surgical episode

Use it however you like

What's left over is your payment

How many would pay more attention?

The Future of Surgical Care

pëarl WOMEN'S CENTER

The High Performance Network

NSQIP

American College of Surgery Risk Calculator

High Volume Surgeons have lower Complication Rates = Lower Cost

Who pays for Complications?

Risk Protection only available to surgeons with low complication rates

The Future (Cont.)

pëarl WOMEN'S CENTER

Competency Assessment Tools (FLS, EMIG, etc)

Pass Test = Qualify for Access to HPN (Narrow Network)

Participants in HPN get referrals from 142 Million self-funded plan recipients

State and federal plans next

Episodic Payments = Advanced APM = Bundles

Who Wants a Low Volume Surgeon?

...

Hospitals love the financial reality of slow surgeons with high complication rates

Eleven Years of Experience in Laparoscopic Hysterectomy in an Ambulatory Surgical Center

Richard Rosenfield, MD, Nicholas Fogelson, MD

Pearl Women's Center, Portland, OR Pearl Surgicenter, Portland, OR

INTRODUCTION

While laparoscopic hysterectomy now comprises a significant portion of all hysterectomies in the United States, performance of this procedure in the Ambulatory Surgical Center is still relatively uncommon. While this place of care provides clear cost benefits over an in-hospital procedure, many physicians have concerns about the safety and efficacy in this environment. Concerns include the lack of ability to transfuse blood, difficulty in transferring to a hospital emergently, and lack of availability of consultative surgical services.

The Pearl Surgicenter is an ambulatory surgical center in Portland, OR, where we have had an active laparoscopic hysterectomy program since 2005, associated with our sister practice Pearl Women's Center.

We present over 11 years of data on outpatient laparoscopic hysterectomy, including data on case type, demographics, complications, and patient satisfaction with care. We also present trends in surgical care over time in a high volume surgical setting with a consistent set of practitioners.

MATERIALS AND METHODS

•Retrospective analysis of data collected as part of routine practice at Pearl Surgicenter

•Demographic and performance data are reported, with chi-square, T-Tests, and ANOVA performed for comparisons as appropriate.

•Year by Year Trends in surgical times are reported, as well as the impact of case characteristics on surgical and recovery times.

•All cases were performed via traditional multi-port laparoscopy, in most cases using 4-5 non-disposable ports. Impedance measured bipolar electrosurgery(Gyrus Bipolar) and monopolar electrosurgery were used in the majority of cases for dissection and vessel sealing. Routine cystoscopy was performed. Uteri were removed either by vaginal morcellation, uncontained power morcellation, or via in-bag scalpel morcellation (adopted in 2016). Vaginal cuffs were closed (in TLH cases) using intracorporeal suturing technique using traditional or barbed suture.

•All cases were performed by either two experienced MIG surgeons, or by an experienced surgeon and an AAGL MIGS fellow.

•Total IV anesthesia was used throughout to prevent postoperative nausea and recovery delay. Ports were injected with local anesthesia, and in 2016 we began injecting the vaginal cuff as well. TAP blocks were introduced in 2016.

RESULTS

From October 2005 through September 2016 a total of 1,056 outpatient laparoscopic hysterectomies were performed. 857 (81%) were supracervical hysterectomies and 199 (19%) were total hysterectomies, with a strong trend towards more total procedures over time (13% TLH in year 1, 65% TLH in year 11, $p < 0.0001$) Indications included fibroids, menorrhagia, prolapse, pelvic pain, and simple/complex endometriosis. Patient mean age was 43, and mean BMI was 28, with 32% having a BMI > 30, and 15% with BMI > 35 (max BMI 56)

7% of cases involved a concomitant incontinence procedure, including uterosacral suspensions, colpopexy, sling procedure, or colporraphy, with similar frequency throughout the study period.

Uterine weight (or fundal weight in LSH procedure) averaged 185 g, with a median of 111 grams. 19% of cases involved a uterus greater than 250 grams, and 6% were > 500 grams, with a max weight of 2305 grams.

RESULTS (CONTINUED)

Approximately 50% of patients had had prior abdominopelvic surgery, with a mean number of surgeries per patient of 1.6.

Surgical times averaged 102 minutes for TLH procedures (95% CI 95.5-107.2) and 86 minutes for LSH procedures (95% CI 83.7 – 89.8).

Time from surgical completion to discharge averaged 138 minutes (95% CI 134.8 – 141.6). TLH procedures averaged 6 minutes longer in recovery time than LSH ($p = .007$) Patients that had concomitant incontinence procedures took on average 25 minutes longer to recover than those that did not ($p = 0.0001$)

1052 out of 1056 patients were able to be discharged same-day. Routine satisfaction surveys indicated 98% of patients were either satisfied or very satisfied with their experience.

Complications were rare over the study period. 3 patients has small bowel injuries, all of which were repaired laparoscopically, none required admission. One patient had uncontrolled bleeding intraoperatively and required emergent intraoperative transfer to the hospital, where she had a laparotomy and successful recovery.

There were no urinary tract injuries (intraoperative or postoperatively diagnosed). Two patients were transferred to the hospital postoperatively because of poor pain control in the ASC setting.

Four patients were found to have malignancies not diagnosed preoperatively. Two were ovarian cancers. One was in a patient having pre-emptive salpingoooperectomy for BRCA mutation, and one was a previously undiagnosed FIGO II ovarian cancer, which was power morcellated. One patient having a TLH for complex endometrial hyperplasia was found to have a FIGO I adenocarcinoma of the endometrium. One patient with large fibroids had a leiomyosarcoma, which was scalpel morcellated in a containment bag and diagnosed on pathology.

Mean surgical times decreased year over year. Surgical times in non-incontinence/prolapse repair procedures decreased over 30% in operative time from a mean of 105 minutes in year 1 to a consistent mean of approximately 70 minutes by year 5, with minimal variation year to year, despite a slight rise in TLH frequency over the same time period. Incontinence procedures showed a significant improvement year over year, with higher means due to increased surgical complexity.

CONCLUSION

- Laparoscopic supracervical and total hysterectomies of varying complexity can be safely and efficiently performed in the ambulatory surgical setting
- Increased complexity cases with incontinence and prolapse repair can be performed safely.
- Properly counseled patients provided good care in an ASC setting have a high degree of satisfaction, with no negative impact from same day discharge.
- High volume expert gynecologic surgeons can consistently perform efficient and safe procedures with minimal complication rates, far lower than published averages.
- An increased attention to ASC use for laparoscopic hysterectomies may reduce healthcare spending for hysterectomies while maintaining care standards.

The Future

...

Do what you love

Become exceptional at it

Follow your passion
in Healthcare

Become part of the Solution

How?

We **MUST** take control of our own future

We **MUST** admit that low volume inexperienced surgeons create avoidable risk and cost and therefore should seek mentorship and continued surgical training

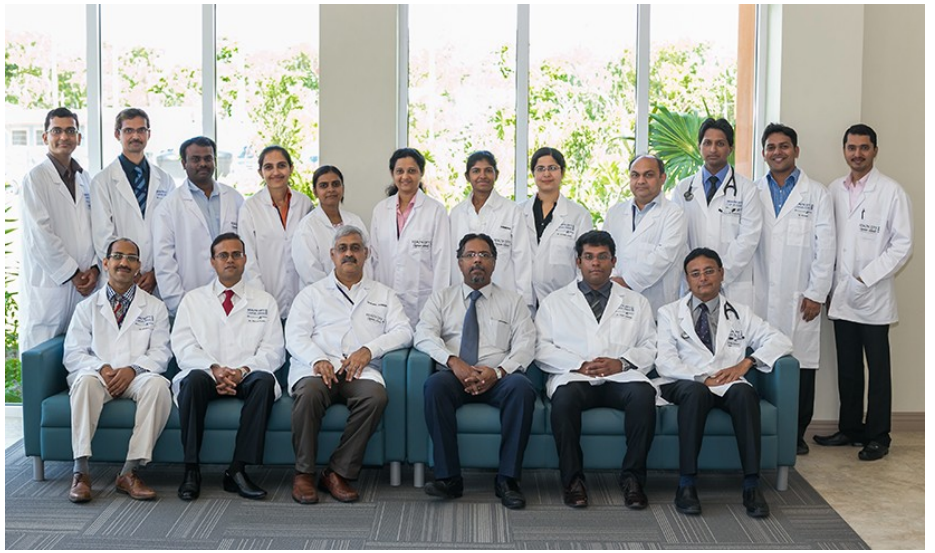
We **MUST** acknowledge the need for change

We **MUST** create a solution and lead the others

If we don’t do it, they will…

Health City, Grand Cayman

Cayman Islands



THANK YOU!