

ASC PHYSICIAN FOCUS

AN ASCA PUBLICATION >>

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Message from the CEO



On November 1, the Centers for Medicare & Medicaid Services (CMS) released its final 2018 ASC payment rule.

Key takeaways include:

- on average, ASC payment rates will increase by 1.2 percent in 2018;
- total knee arthroplasty was removed from the inpatient-only list for 2018 (but is not yet approved for ASC reimbursement);
- CMS is delaying mandatory implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey; and
- CMS removed three quality measures for the CY 2019 payment determination and subsequent years.

As I write this message, ASCA is conducting a comprehensive review of the final payment rule and working to update our Medicare rate calculator.

We will host a webinar on December 5 to discuss the final rule. Learn more and register today by visiting www.ascassociation.org.

Bill Prentice
Chief Executive Officer

Filling the Schedule: Getting Non-Owners into Your ASC

Four physician leaders share ideas for encouraging non-owners to bring cases to their ASCs.

Don Bartnick, Chief Executive Officer of Annapolis Surgery Center in Annapolis, Maryland, and Principal in Donveritas Consulting: Surgical scheduling for peak performance is an extremely challenging task requiring strategy, organization, flexibility, intelligence data, insight, persuasion and common sense. At the ASC, we strive to minimize the time a surgeon needs to be at the center. We implemented a mobile phone-based dictation system that is extremely surgeon-friendly. We offer block time to our non-owner surgeons to help their offices get patients posted easily. We even hired a valued scrub tech to join our staff to perform cases part-time for a specific surgeon.

We also employ a posting secretary with extraordinary awareness of the schedule. She monitors the postings into block time, identifies potential slack time and calls non-owner surgeons' surgical coordinators to encourage direction of cases to our center. Her observation of and relationships with the surgical coordinators result in the addition of cases that may have gone elsewhere.

Thomas Feldman, Chief Executive Officer of the Center for Health, Ambulatory Surgery Center in Peoria, Illinois: I try to target non-owners with different information based on their needs. I speak to the surgeons about specific equipment needs and preferences with regard to staff numbers and skill set.

Oftentimes it's about getting a single case in before they start their day elsewhere. I work to shoehorn them in at the top of the day with that case and trust that a good outcome and patient experience will get them interested in more time. We end up being able to secure a few cases (perhaps later in the

day) presented in a fashion that works for them within their practice pattern.

Scott Glaser, MD, Co-Founder and President of the Pain Specialists of Greater Chicago in Illinois: When you get right down to it, we're in a service industry. The first time that non-owner comes to your ASC, you need your key personnel greeting them at the door with open arms. Then you need a manager or lead nurse who serves as the face of your ASC to that physician. This is the individual who the physician feels most comfortable with and knows he or she can reach out to if there are any issues.

When the physician starts doing cases, it's a matter of blocking and tackling. Make sure staff is on time and no mistakes are made. If you can keep that up, everything will usually flow naturally. But that first impression really is a huge part of whether you succeed.

Dianne (Wallace) Appleby, RN, Executive Director of Menomonee Falls Ambulatory Surgery Center in Menomonee Falls, Wisconsin: Getting non-physician owners to use open time on the surgery schedule is challenging. For the most part, our owner physicians have reserved blocks of time on our schedule. These reserved blocks "release" several days ahead of time, providing an opportunity for other doctors to take those open slots.

Non-owner physicians are given the option to reserve time as well. For those who choose not to, our schedulers contact their offices periodically to inform them of available schedule time, particularly as blocks release and "prime" time becomes available.

We work hard to become our non-owner physicians' facility of choice. We work closely with them to identify their supply and equipment needs and try to pair them up with staff who are tuned into their unique surgical needs.

Emergence of the Mega Group Practice and Role of ASCs

By Henry Bloom



While the federal government remains stalemated on the future of the Affordable Care Act, private equity investors have flown under the radar, rapidly investing billions of dollars into health care services. I am not writing this to critique our political leaders nor am I interested in doing so. I would rather take this

opportunity to educate physicians on the forward-thinking partnerships we see forming all over the country. Ultimately, I believe these partnerships are setting us on the path to providing the highest quality, lowest cost to patients and taxpayers.

Mega group. Aggregation. Rollup. Consolidation. These are terms being thrown around today's health care business arena, and justifiably so. Independent physicians are increasingly coalescing in response to catalysts such as quality-based payment systems, regulatory reporting requirements, evolving technologies, and expanding and consolidating hospital-based health systems. In my nearly 30 years working with independent physicians, never before have I heard them unilaterally say that "bigger is better" like they are today.

Private Equity as an Emerging Player

The formation of large physician groups is not a brand new concept. Pioneering, entrepreneurial physicians have been creating large groups for decades. However, historically, the growth of the mega group has been slow. It takes many years of hard work. But over the past few years, private equity firms have supercharged consolidation.

Private equity firms and the operating partners that represent these firms make a living buying and growing businesses quickly. Much like the large group practice, private equity firms are not a new concept. The new trend is partnerships that harmonize the strengths of quality physician leaders and the professional business folks behind private equity.

In the 1990s, I saw the rise and fall of the physician practice management company (the "PPMC" days as we know it). Many PPMC models were destined for failure. Physicians were getting extremely rich valuations and selling their practices for, typically, stock in the acquiring company. The problem was that physicians were truly selling their entire business and gave up control. Physicians sold 100% equity, went on salary and passed management power to outsiders. Not surprisingly, it all came crashing down.

Physician Engagement Crucial

Today's money is smarter. Investors understand that engaged physicians with the proper incentives are the key to success. Investors build business around physicians with a managing voice and significant "skin in the game" when it comes to equity and compensation. For example, group practice models we are seeing are structured as a management services organization (MSO). The MSO is a vehicle into which physicians can contribute a minority share of their annual

take-home dollars. The MSO then serves as the vehicle through which physicians can monetize equity and create partnerships with investors who can create growth. For the right opportunities, and because money is still "cheap," many physician group practices are seeing double-digit valuation multiples on their business.

One of the critical components of the large group practice is robust ancillary services such as pathology, imaging, radiation therapy, anesthesia, pharmacy, physical therapy, clinical research and, as the title of this article alluded to, ASCs. In the last decade, we've witnessed the emergence of a core group of strong buyers, including Surgical Care Affiliates, AmSurg (Envision), United Surgical Partners International (Tenet), Physicians Endoscopy, Surgery Partners, Covenant Surgical Partners and private equity firms. These firms have spent years fine-tuning formulas for a successful ASC partnership.

I foresee a future where ASCs will thrive by embracing the concepts of the large physician group and partnerships. The lifeblood of an ASC comes from its physician partners and, in turn, the affiliated practices. Likewise, ASC management companies, private equity and local health systems provide the management, leverage and support needed to maximize long-term stability. Whether you are on the clinical or business side of the equation, it's the party that best delivers real value to their partnership and passes value onto patients that will have the most success.

Henry Bloom is founder and president of The Bloom Organization, a health care transaction advisory firm in Aventura, Florida. Write him at hbloom@bloomllc.com.

The advice and opinions expressed in this column are those of the author and do not represent official Ambulatory Surgery Center Association policy or opinion.

ASC Development Pros Share Secrets to Success

Developing & Managing Ambulatory Surgery Centers, a new book for ASC developers, owners and operators, offers insights and advice to anyone responsible for the start-up and long-term success of an ASC.

The new edition of the publication provides a soup-to-nuts examination of running an ASC, covering issues including business planning, key legal issues, raising equity, financing, risk management, governance and ancillary agreements. A "Lessons from the Field" section also looks at topics like what college football teaches about ASC management, surgery center turnarounds and effective bonus systems.

Developing & Managing Ambulatory Surgery Centers includes contributions from more than a dozen ASC industry leaders. The digital edition sells for \$79.99 for ASCA members and \$99.99 for nonmembers. Download your copy today.

Working for You: How ASCA Helps ASC Physicians

By Alex Taira



As it works to support ASCs and patient access to ASCs, ASCA invests a significant amount of time and attention to regulatory and

advocacy efforts that promote the interests of ASC physicians. Working with policymakers and in coalitions built around specific physician issues, ASCA has always found greatest success when ASC physicians are involved in providing input and championing the causes that help make ASCs an attractive care setting for physicians and patients alike.

A Collaborative Effort

One example of the work ASCA does on behalf ASC physicians is the formal comment letters that the association submits each year to the Centers for Medicare & Medicaid Services (CMS) on the proposed and final versions of the agency's Hospital Outpatient Prospective Payment System /ASC, Inpatient Prospective Payment System (IPPS) and Medicare Physician Fee Schedule (MPFS) rules. In all its comments, ASCA seeks to ensure that physicians operating in ASCs have access to fair payment structures and technological incentives that are at least equivalent to all other care settings.

When provisions in these rules affect ASCs and ASC physicians in subtle ways, their impact may not become apparent until years later. In other cases, their effect is immediately clear. This year, for example, the IPPS final rule put in place a definition that has immediate ramifications for ASC physician payment adjustments

under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP). ASCA has also responded with formal comments to proposed and final versions of the MACRA rule. Comments have advocated for lower performance thresholds, expanded exemption criteria, performance category reweighting and more. ASCA will continue to participate in the dialogue surrounding this issue in live forums and future written responses.

ASCA in-person outreach at the US Department of Health and Human Services (HHS) and its relevant sub-agencies includes representing the interests of ASCs and ASC physicians at roundtable discussions and listening sessions, conducting meetings with agency leaders and working to ensure that voices from the ASC surgical specialties are represented on CMS advisory committees. ASCA is eager to work with any ASC physician interested in serving on or as an advisor to the federal advisory bodies and committees with which we work. *Contact Alex Taira at ataira@ascassociation.org.*

Physician Representation

ASCA routinely helps build and participates in coalitions around issues relevant to ASC physicians. These include everything from granular level surgical issues (e.g., reimbursement rates for specific codes or addition of procedures to Medicare's ASC-payable list) to macro ASC industry topics and trends like evolving payment and care models.

ASCA regularly convenes representatives, including physicians, of all surgical specialties in ASCs to obtain input on the issues that concern them

most so that ASCA's formal advocacy activities align with physician interests and needs. This is particularly important as ASCA goes about formulating comments in response to the various payment rules it responds to each year.

ASCA has also been active in the electronic health record (EHR) space, bringing together a stakeholder group of more than 100 physicians, vendors, developers, facility administrators and corporate partners to stimulate the proliferation of EHR usage in ASCs. The lack of ASC-specific EHR certification standards prevents physicians from participating in the component of the QPP that can help physicians qualify for positive payment adjustments and, in a larger sense, creates a barrier to the most efficient workflows and transitions of care across settings. Goals of ASCA's EHR stakeholder group include creating the clinical standards necessary for an EHR certification and the proliferation of EHR technology in ASCs.

ASCA continues to be the only national organization representing ASCs of every specialty on Capitol Hill and remains committed to promoting the interests of all stakeholders that make ASCs a high-quality, low-cost care setting. Physician participation and leadership is crucial to ensuring that ASCs stay on the cutting edge of care delivery.

ASCA regulatory staff is always interested in hearing from physicians who want to become more involved in ASC advocacy or have recommendations for ways that ASCA can improve its efforts to represent ASCs and ASC physicians in Washington, DC, and across the country. Contact Alex Taira at ataira@ascassociation.org.

Study: ASC Colonoscopy Patients Prefer Propofol

Results of a new study published in *Diseases of the Colon & Rectum* indicate that patients undergoing outpatient colonoscopies prefer propofol over a combination of fentanyl/midazolam as their anesthetic.

To evaluate patient satisfaction with

propofol compared with nonpropofol (fentanyl/midazolam) anesthesia for outpatient colonoscopies, researchers conducted a clinical trial at an Ohio ASC within an urban teaching community health system. During the study, anesthesia personnel administered propofol to half of the patients and

fentanyl/midazolam to the other half. An experienced endoscopist performed all colonoscopies. Patients in the propofol group reported higher satisfaction and fewer complications.

Access the study's abstract [here](#).

Patient Selection in the ASC: An Ever-Changing Process

By Stanford R. Plavin, MD



As a practicing anesthesiologist with more than 20 years of clinical experience providing care in ASCs, I have noticed a dramatic change

in the patient selection process. There still seems to be a wide range of what clinicians and administrators feel is an appropriate candidate for their facilities. As patient care technologies have improved and physiologic monitoring capabilities have followed suit, we find ourselves more willing to provide care to those patients who, only a few short years ago, may not have been a suitable ASC patient.

The patient selection process should be viewed with a methodology and process that provides a comprehensive holistic approach. Factors that influence our decisions are many. These include the skill sets of the providers, the facility itself, the types of procedures, the anesthetic techniques being performed and, most importantly, the patient's physical health issues and characteristics.

Focus on BMI and the Obese

When an administrator, medical director, surgeons, staff and anesthesiologists evaluate suitability and criteria for appropriate candidates for their facility, one of the more challenging decisions is whether to provide a limit based upon a patient's body mass index (BMI). There are a number of factors to consider when working through this process as it specifically relates to BMI.

The prevalence of obesity continues to increase worldwide. Morbid obesity poses many challenges in providing safe and appropriate care. These include

technical challenges for procedures, those impacting health care personnel and medical issues that go along with this patient population.

When we assess or measure weight, we typically think of BMI as clinicians. BMI traditionally correlates with body fat but this isn't always the case. An increase in BMI has been shown to be a predictor of other health-related issues such as type 2 diabetes, hypertension, stroke, obstructive sleep apnea (OSA), depression, arthritis and mobility issues. The National Institutes of Health classify obesity as a BMI greater than 30. Class I obesity is a BMI of 30-34.9 kg/m²; Class II morbid obesity is a BMI of 35-39.9 kg/m²; Class III extreme obesity is a BMI of greater than 40kg/m²; BMIs greater than 50kg/m² are considered super morbid obesity.

In order to properly care for patients with excessive BMIs, facilities must possess necessary infrastructure and proper equipment. There is an inherent cost to provide these services, which include technical items such as larger stretchers and chairs, positioning devices and, in some cases, specific lift devices. These are typically fixed costs to the facility. Disposable costs include airway equipment, positioning items, larger gowns and blood pressure cuffs as well as higher uses of IV access materials due to technical challenges. Along with the challenges of providing this care are the risks to the staff who must be prepared and trained accordingly.

Appropriateness for the ASC

There is evidence showing that BMI alone is not an independent risk factor for perioperative complications. The majority of the patients in these studies (e.g., study on knee arthroscopy) had mild to moderate obesity with

BMIs less than 40 kg/m² and minimal comorbidities. There are studies (e.g., study on total hip arthroplasty) suggesting that super obesity (BMI > 50 kg/m²) may be associated with higher risk of postoperative complications, particularly those with comorbidities such as OSA and other cardiopulmonary sequelae.

Assigning an absolute to any situation is often challenging. In the absence of specific, high-quality evidence, decisions regarding the appropriateness of obese patients tend to be guided by what is available for review. In addition to the patient's characteristics, weigh several factors such as surgical competence, anesthetic technique and invasiveness of the surgery when deciding whether to provide care in the ASC setting.

Data has shown that patients with BMIs less than 40 kg/m² and limited comorbidities appear to be safe and appropriate candidates for outpatient surgeries. The super obese (BMI >50 kg/m²) may be at a higher risk of perioperative complications and should be carefully evaluated when considering them for ambulatory surgical procedures. For those patients who fall in between (BMI 40-50 kg/m²), perform an extremely thorough preoperative assessment to assess the suitability for their care as ambulatory surgery candidates.

Stanford R. Plavin, MD, is an anesthesiologist, owner of Technical Anesthesia Strategies and Solutions and ASCA board member. Contact Dr. Plavin at splavin@technicalanesthesia.com.

The advice and opinions expressed in this column are those of the author and do not represent official Ambulatory Surgery Center Association policy or opinion.

Study: Faster Discharge of Medicare TKA Patients Safe

Results of a new study published in *The Journal of Arthroplasty* indicate that select Medicare patients who undergo total knee arthroplasty (TKA) can be safely discharged within a day of their procedure.

The researchers examined data on nearly 2,300 hospital Medicare patients who underwent unilateral, primary TKAs. About 1,500 were discharged within a day of surgery. The remaining were discharged on day two or later. Shorter-stay patients did not experience

a higher 30-day readmission rate compared to the longer/traditional-stay patients. They also did not experience a higher rate of unplanned, 90-day readmissions.

Access the study's abstract here.