Game-changing 4-hour rapid readout biological indicator results give you the information you need while there’s still time to act. With the Attest™ Rapid Readout Biological Indicator System for vaporized hydrogen peroxide sterilizers, it’s now practical to implement Every Load Monitoring and provide patients with the highest and most consistent quality of care — no matter which sterilization modality is used.

Welcome to the sixth issue of Medline’s Outpatient Outcomes magazine. This edition is dedicated to ideas that help drive profitability and growth in your ambulatory surgery center.

Our cover story, “ASCs meet challenges head-on,” combines insight from our physician and administrator panel and industry consultants to provide ideas for how facilities like yours can drive profitability by improving physician and administrator relationships, maintaining reimbursement growth and driving case volume.

Staying on top of the latest healthcare trends and practices that drive profitability is key to growth. “Better together” outlines how payment models and outpatient care affect joint ventures. “Outpatient centers: Focus on millennials” details how meeting the expectations of this age group can positively influence your bottom line. Working long hours and dealing with stressful situations (including ownership stake) takes its toll on physicians. “Burned out?” highlights strategies to keep your surgeons engaged and productive.

Improving efficiency while increasing the bottom line is the primary objective of nearly every ASC. “Data-driven solutions, set in motion” outlines strategies for using your facility’s data to improve operations. “Saving with medical device reprocessing” addresses how you can improve your bottom line by reprocessing single-use devices, with the added benefit of being environmentally friendly.

In addition, we address the various challenges associated with implementing and maintaining an infection prevention program. “Making the case for infection prevention” covers common challenges such as meeting patient needs, driving innovation, improving outcomes and initiating system changes, and provides methods for making your business case.

Don’t forget to check out the latest products and processes that can make your job easier without sacrificing patient comfort or convenience. And, “Medline briefs” keeps you up to date on breaking industry news.

As always, we want to ensure we’re providing information that’s valuable to you. Feel free to contact us with feedback, ideas and suggestions for future articles at ASC@medline.com.

Josh Carter
Senior Vice President
Ambulatory Service Center Division
Medline Industries, Inc.

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FDA bans powdered gloves
On Jan. 18, the U.S. Food and Drug Administration published a final rule banning powdered medical gloves. The new rule — which went into immediate effect — bans the sale, distribution and manufacture of powdered surgeon gloves, powdered examination gloves and absorbable powder used to lubricate surgeon gloves.

The FDA initially proposed the ban in March 2016 based on mounting evidence that powdered gloves posed substantial health risks to patients and healthcare workers. These risks include, but are not limited to:

- Inflammation
- Post-surgical adhesions
- Respiratory allergic reactions

The ban does not apply to powdered radiographic protection gloves, powder used in the manufacturing process or powder intended for use in or on other medical devices.

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21st Century Cures Act a win for ASCs
Signed into law in December 2016, the 21st Century Cures Act includes two key provisions that benefit Medicare patients and the ASC physicians who care for them. Section 4012 mandates the creation of a searchable public website that allows Medicare beneficiaries to compare differences in their out-of-pocket costs and total expenses for procedures performed in both ASCs and hospital outpatient departments.

Section 16003 protects physicians who practice at ASCs from penalties linked to the Medicare meaningful use program. The current law requires Medicare providers to adopt and use certified electronic health record technology for a fixed percentage of patients; however, no CEHRT is currently available for ASCs. The legislation insulates physicians from facing cuts in professional fees if they perform procedures at ASCs.

ASCA leadership praised Congress for passing the bipartisan bill, which brings more transparency to the healthcare industry and recognizes the value that ASCs provide.

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Top EHR threats to patient privacy
The 2016 Medscape EHR report asked physicians to rank their top privacy concerns related to electronic health records. These were their top EHR threats to patient privacy.

1. Hacking and misuse of information: 60 percent
2. Loss of patient information through a malfunction: 57 percent
3. Unauthorized access to patient information: 57 percent
4. HIPAA compliance: 35 percent
5. Internal sabotage of records: 24 percent

In the 2012 survey, 77 percent of physicians said they had no patient privacy concerns related to EHRs. That number dropped to 8 percent last year, reflecting the growing focus on protecting personal data across all industries.

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TALK TO US
Have a comment on something you’ve read in Medline’s Outpatient Outcomes magazine? Have an idea for a story in a future issue?

Please submit comments and suggestions to ASC@medline.com.
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References

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events

June 2017

BECKER'S 15TH ANNUAL SPINE, ORTHOPEDIC & PAIN MANAGEMENT-DRIVEN ASC CONFERENCE + THE FUTURE OF SPINE
June 22-24
Swissotel Chicago
Chicago, IL
This conference offers a chance for spine, orthopedic and pain management physicians to connect. For more information, visit www.beckersasc.com/june-conference.

ARIZONA AMBULATORY SURGERY CENTER ASSOCIATION (AASCA) 2017 ANNUAL CONFERENCE
June 29-30
JW Marriott Scottsdale Camelback Inn Resort & Spa
Scottsdale, AZ
Events include Complying with Medicare Life Safety Code; HIPAA and Healthcare Provider Liens; Protecting Your Patients and Paying the Bills; and Operating your Center to Create the Ultimate Patient Experience. For more information, visit www.arizonaasc.org.

July 2017

2017 FLORIDA SOCIETY OF AMBULATORY SURGICAL CENTERS (FSASC) ANNUAL CONFERENCE & TRADE SHOW
July 12-14
Walt Disney World Swan and Dolphin Resort
Orlando, FL
The FSASC Annual Conference and Trade Show will bring together ASC professionals with industry experts and vendors to interact at the Walt Disney World Swan and Dolphin. The diversity of topics, from clinical to management to business, provides something for everyone. For more information, visit www.fsasc.org.

September 2017

CALIFORNIA AMBULATORY SURGERY ASSOCIATION (CASA) 2017 ANNUAL CONFERENCE
Sept. 6-8
Indian Wells, CA
This year’s conference sessions will include topics such as pharmaceutical compliance, clinical leadership, the 23-hour program, patient satisfaction and adverse event reporting, to name a few. Join us as we discuss finance, human resources, and clinical and quality oversight geared toward ambulatory surgery centers. For more information, visit www.casurgery.org.

October 2017

BECKER’S ASC 24TH ANNUAL MEETING: THE BUSINESS AND OPERATIONS OF ASCS
Oct. 26-28
Swissotel Chicago
Chicago, IL
This conference brings together surgeons, physician leaders, administrators and ASC business and clinical leaders to discuss how to improve your ASC and its bottom line, how to manage challenging clinical, business and financial issues and more. For more information, visit www.beckersasc.com/annual-ambulatory-surgery-centers-conference.

December 2017

5TH ANNUAL INFECTION CONTROL OFFICER TRAINING SEMINAR
Dec. 9
Le Méridien Hotel
Oak Brook, IL
The seminar focuses on the needs of ASCs to update policies, procedures and important practical steps specific to ASC infection prevention and control techniques. Medicare requires documentation of annual infection control and prevention training for your ASC’s designated Infection Control Officer. Certificates of training will be issued. For more information, visit www.associationdatabase.com.

If you would like to have your event listed here, please send an email to ASC@medline.com.
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Introducing Medline’s new pediatric anesthesia mask line

The Medline Anesthesia team is excited to introduce a new line of pediatric masks designed to make the surgical experience more kid friendly.

The shape and sizing of our new pediatric masks are reflective of industry needs and aligned with the competition. A low-profile design and minimal dead space are very important in pediatric masks because they allow the child to more easily inhale anesthetic gases. These masks are available both unscented and in bubble gum, cherry and strawberry scents.

Masks are designed with a rounded nose bridge and ergonomic cushion for a comfortable grip and optimal seal. Color-coded hook rings offer quick size selection, and a top side valve is loaded with a metallic spring to prevent deflation.

Samples are available. Please contact your Medline ASC representative today or email us at ASC@medline.com for more information.
3M™ unveils latest patient warming innovation

The preservation of a normal core temperature using forced-air warming systems has been frequently studied, resulting in a great deal of clinical evidence that it is a safe, effective therapy. Certain surgical cases, however, are more difficult to warm due to the lack of available skin surface area resulting from challenging patient positions.

The 3M Bair Hugger™ multi-position upper body blanket addresses these warming challenges. Its ability to bend and conform to the patient’s body while providing uniform temperatures is the latest innovation from a trusted brand — the 3M Bair Hugger normothermia system.

This innovative upper body blanket offers a new air-channel design, which results in a lower profile and greater flexibility while still including all the features that customers expect from a Bair Hugger upper body blanket. These features include:

- Integrated tie strips and a continuous adhesive strip that secures the blanket to the patient
- Two resealable hose ports that provide flexibility in positioning
- Soft, comfortable, lightweight and radiolucent material.

When deployed, the attached clear head drape and two neck vents keep warm air around an intubated patient’s head and allow observation.

For more information on the 3M Bair Hugger multi-position upper body warming blanket, contact your Medline representative.

VersaShield nitrile gloves offer dependable strength

When your job exposes you to potentially harmful bacteria, blood-borne pathogens and harsh chemicals, you need a glove you can trust. VersaShield, a thicker, quality nitrile glove, resists punctures and tears to provide you outstanding barrier protection and features textured fingertips for a more confident grip.

Key features are:

- **Thickness profile** – Resists rips, tears and abrasion.
- **Chemo testing** – Tested for use with chemotherapy drugs per ASTM D6978-05*.
- **Chemical testing** – Tested for use with harsh chemicals to ASTM F739-12*.
- **Fully textured** – Enhanced grip for handling various devices and products.
- **Extended cuff** – Available in a 12-inch extended cuff version for extra protection between your cuff and sleeve.

Feel confident when you need it most. Contact your Medline representative for more information about VersaShield nitrile gloves or to request a sample.

* Tested chemicals available upon request.
* Not for use with Carmustine and Thiotepa.
What is your center doing with its single-use medical devices (SUDs)? If you’re not reprocessing them with an FDA-approved third-party reprocessing company, you’re missing an incredible savings opportunity.

Did you know that centers that reprocess their single-use devices save, on average, $25,000 per operating room per year? With reimbursements continuing to go down, there’s no better way to decrease your case costs than reprocessing. In today’s healthcare environment, the demand for cost efficiencies that don’t compromise high levels of patient care or surgeon satisfaction is driving fast growth in the reprocessing market, which reached $1.079 billion globally in 2016 and is projected to grow by 10.6 percent in 2017.1

“ASCs that utilize reprocessed devices realize substantial cost savings that positively impact their bottom lines,” says Brian Harty, division sales manager for Medline ReNewal, Medline’s medical device reprocessing business. “Healthcare facilities need to look for ways to reduce expenditures, and most are eager to convert to new products for a 5 to 10 percent cost reduction. Now, consider that single-use device reprocessing can save a surgery center up to 50 percent off the price of a new device. Moreover, reprocessing diverts significant medical waste from landfills because a device that would have been discarded after one use may now be reused from two to 10 times.”

**Adding up savings**

A 2012 study examining seven healthcare facilities of varying sizes reported that reprocessing operating room devices would save about $57 per procedure over five years.2 An earlier U.S. Government Accountability Office report found facilities using reprocessed devices saved between $200,000 and $1 million annually.3 Other benefits include saving on expenses for disposing regulated or “red bag” medical waste, which costs up to five to 10 times more than regular solid waste removal, according to the Association of Medical Device Reprocessors.4

Given the tighter reimbursement conditions between surgery centers and hospitals, reprocessing could be more impactful in outpatient settings. A case could also be made that surgery centers can realize greater savings per procedure than hospitals, based on the potential for higher case volumes in outpatient settings versus hospitals.

**Safety standards**

Growth in the reprocessing market may also reflect the medical community’s increased comfort with the devices.

Available data indicate that reprocessed devices pose no greater risk to patients than new ones, according to a 2008 GAO report.5 The report also noted that federal oversight of SUD reprocessing has increased since the Food and Drug Administration issued guidelines and regulations that first became effective in 20006 requiring that third-party reprocessors meet the same standards as original equipment manufacturers.

“Every device is inspected multiple times by technicians at each stage of the process, from decontamination and cleaning, to refurbishing and testing to packaging and sterilization,” says Harty.6

**SOURCES:**

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In 2009, the Centers of Medicare and Medicaid Services (CMS) mandated that all ambulatory surgery centers have a comprehensive and appropriately monitored infection prevention/ control program in place. The task of implementing the CMS infection prevention and control requirements has certainly not been easy for many centers. The notion of formal infection prevention outside of the acute care hospital is still new and, therefore, few evidence-based best practices are available for those tasked with the challenge of implementing and maintaining an IP program.

**Demonstrating value**

One of the biggest challenges to maintaining a robust IP program is a lack of resources, both physical, in terms of people and equipment, and financial. Therefore, the role of the infection preventionist must include demonstrating the value of the IP program to healthcare executives in order to obtain the resources necessary to maintain the program. Building and presenting a business case for resources is not always a developed skill in many infection preventionists. Reduction of harm and the loss of life, or the clinical aspect of a business case, is most important. Protecting the patient from healthcare-acquired conditions and infectious disease should always be the goal when...
these areas are not addressed. This should not be done alone, but with the help of a multidisciplinary team from your facility. The process can also help provide data for a program that will yield the highest return on investment. Once you have selected an area that needs attention, you can begin to build your case.

Steps to follow
Some published methods for making a business case for infection control in the hospital can be easily adapted to the ambulatory setting. APIC published the white paper “Dispelling the Myths: The True Cost of Healthcare-Associated Infections,” which was designed to bring a better understanding of the business case process.\(^1\) One method for building a case is outlined in a paper published by Perencevich et.al (ICHE, 2007).\(^2\)

Here are the key steps.

• Frame or identify the problem (i.e., SSI reduction) and develop a hypothesis about potential solutions.
• Meet with key stakeholders. This is where the administrator or someone tied to finance becomes your best friend.
• Determine the annual cost.
• Determine what cost could be avoided through reduction of the infection rate.
• Determine the costs associated with the infection of interest at your facility.
• Calculate the financial impact.
• Include the additional financial or health benefits.
• Make your business case.
• Prospectively collect cost and outcome data once the program is in effect.

You may not be a whiz in healthcare economics or understand all the financial terms, but do not be intimidated. Communicate with your administrator and finance department. State that you want to learn to build a business case for important initiatives in the infection prevention program. By developing a partnership using their financial knowledge and your knowledge of infection prevention, you can create an impactful presentation.

Once you have gone through the process, you will have a nice template for other infection prevention initiatives. This process will allow you to focus on patients’ needs, drive innovation, improve outcomes and help initiate system changes.

REFERENCES:
Phil Meyer knows efficiency helps the bottom line. As chief operating officer of South Shore Ambulatory Surgery Center, he advocates for following the example of larger hospitals. “Surgery centers are under even more financial pressure,” says Meyer. “Hospitals have a wide variety of revenue streams; we have essentially two — our insurance payers and our patients. We don’t get revenue from a radiology, lab, etc.”

South Shore is a busy center in Lynbrook, New York. Of its roughly 700 cases per month, more than half are surgical procedures. The center’s physicians are leaders in their respective fields.

Before South Shore, Meyer worked in a variety of acute care settings, including “everything from critical access facilities with 10 beds, to my last position where I was over three hospitals, 60 ORs and 1,500 beds.”

In one past position, Meyer took advantage of Medline’s perioperative supply management consulting services. He knew it would be a good fit when Medline Representative Colin Brumsted suggested bringing the same services to South Shore.

Re-engineering perioperative supply management
Colin Brumsted and Maria Guarino, Medline regional vice president, recently traveled to the New York City suburb of Long Island for an in-depth perioperative review of South Shore. It began with a Lean Assessment, reviewing supply management processes to look for clinical, logistical and financial opportunities.

A day after completing the assessment, Medline presented data-driven findings, along with dozens of photos highlighting possible areas of improvement. The facility was very interested in the potential improvements and agreed to next steps, which included:

- **Data collection** — Documenting current practices by procedure, analyzing surgical volume reports and preference cards, viewing case setups and meeting with team leads.
- **Case cart and supply flow analysis** — Observing staff interactions with the OR and staff productivity within their existing space.
- **Taking physical measurements of storage areas** — Using 2D and 3D CAD drawings to identify areas for improvement.
Comprehensive supply management
South Shore Ambulatory Surgery Center agreed to a comprehensive supply management program. Clinicians from Medline created the supply management program with custom Complete Delivery System (CDS) modules for five cases: foot, hand, knee and two shoulder — 96 percent of South Shore’s procedures. The CDS modules contain all disposable and procedure-specific items for each case. At the time of writing this article, South Shore’s clinical staff had reviewed the samples and approved the contents and architecture. They are excited about the benefits they expect to see from the program, including:

- **Reduced costs** — Redundant products discovered during the assessment have been eliminated.
- **Streamlined ordering and stocking** — Each CDS module is one SKU instead of many, removing 63,324 components from South Shore’s annual supply stream.
- **Improved storage** — Module contents are protected from damage. Meyer says, “When using a non-CDS system, we’re ordering supplies, opening those boxes, taking them out, sliding them on metal racks, pulling them back off, if we don’t use them and pushing them back on. You can compromise packages that way. With CDS, you’re not moving it unless you need it.”
- **Faster setup** — The expression “time is money” applies particularly to surgery centers. “If we save 10 minutes with each turnover, we might do two more arthroscopies that day,” explains Meyer. CDS greatly reduces touch points for each component, decreasing case pick times by 54 percent, on average. At South Shore, the five modules will eliminate 487,000 touch points. “In the operating room, the goal is to handle a supply as few times as possible,” he adds.
- **Innovative packaging** — Medline’s exclusive packaging system includes color-coded labels with well-organized, at-a-glance information about the module contents. South Shore took the color-coding a step further: They containerized surgical instruments with color-coding to match the CDS modules.
- **Quick cleanup** — Red bags, wipes and other room turnover supplies are conveniently included and separated out within the container.
- **More environmentally friendly** — Protecting the environment is a priority at South Shore. With CDS, there is less wrapping and cardboard to throw away because many module components are not packaged separately. The container can be recycled or used for waste, whichever has the greater environmental benefit.

After completing the CDS build, a logistics consultant created a new process flow to improve productivity and ensure the modules would work within South Shore’s infrastructure. The consultation included illustrations showing proposed improvements to South Shore’s storage areas.

**Service matters**
Medline has worked closely with South Shore’s staff to prepare them for the changes. “CDS is a true partnership, not just a program,” says Guarino. “We will return to South Shore to implement the CDS modules, work with the staff to make any necessary changes and provide ongoing support.”

Meyer recalls how the team was “very professional” throughout the process. “We enjoyed working with [Medline],” he says. “They said, ‘Here’s exactly what you’re asking for; now let me show you a variation based on our experience.’ It’s good to get those perspectives.”

*Outpatient Outcomes* will check back in with South Shore Ambulatory Surgery Center after its implementation is complete. For now, the center’s data-driven solutions have been set in motion.

Like a three-legged stool, financially fit ambulatory surgery centers must be secure in three areas: physician engagement, reimbursement rates and business growth. When one falters, setbacks can occur.

Participants in a Medline-sponsored executive roundtable of ASC owners and administrators, held in October 2016 during Becker’s ASC 23rd Annual Meeting — The Business and Operations of ASCs, discussed these challenges and how their centers are addressing them. Their feedback served as a basis for the expansion of further thoughts from our contributors below. Although proposed solutions vary within the industry, the need for idea sharing remains constant.
Here are some of the challenges—and ideas for improvement.

**Physician engagement**
According to feedback shared during the executive roundtable, a cooperative culture and consistent communication are critical to keeping physicians engaged. So how can ASCs facilitate both?

At the Ophthalmology and Surgical Institute (OSI) of Central Pennsylvania, a 100 percent physician-owned ASC in Carlisle, Pennsylvania, administrators engage surgeons on many levels in order to maintain the bottom line and make their investment worthwhile, says Administrative Director Gina Hoffman.

“Together, we maximize the efficiency of our operating room scheduling,” Hoffman says. “We inform physicians of new state and federal regulations to maintain licensure and Medicare participation. They’re made aware of patient-related issues that come up in daily operations or from patient-satisfaction surveys.”

Physicians are also encouraged to share concerns about procedures, staff and even other surgeons with the facility’s clinical manager, clinical director and medical director, she says.

Getting buy-in for your ASC’s rules and regulations—from both physicians and staff—is also critical to building engagement, says Amy Reighard, administrator at Allegheny Regional Endoscopy in Altoona, Pennsylvania. The 100 percent physician-owned center regularly reviews its policies and procedures with the medical director, board members, physicians and staff.

“We also make it a point to know the expectations of our physicians when it comes to staffing and rooms setup,” Reighard says.

The staff plays an important role in physician engagement. Mark Dietrich, a CPA specializing in healthcare industry valuation and a member of the National Society of Healthcare Business Consultants says, “Surgical and administrative staff are critical to the surgeon and patient experience. Clinical staff should interact with the surgeons to learn whether they are meeting the surgeons’ needs while always displaying a caring attitude toward patients.”

David Zetter, founder and lead consultant with Zetter HealthCare in Mechanicsburg, Pennsylvania, says centers that recruit physicians must engage them in ways that motivate them to continue performing procedures at the ASC so they will keep generating revenue. Still, ASCs must prepare to react to physicians who are only interested in revenue opportunities and not in the overall success of the center.

“If the ASC allows such individuals to continue not being involved and engaged, and not following rules and procedures, the business is going to suffer,” says Zetter. “It’s important for the employment contracts to include terminology—and even bylaws—pertinent to being good corporate citizens. When everyone knows the rules up front, issues are less likely.”

**Improving reimbursements**
Another challenge at the forefront of the executive roundtable was the combination of increasing costs, stagnant reimbursement rates and contract payor negotiations.

With Medicare increasing fees for ASCs just 1.9 percent in 2017 and hospitals often having the upper hand in negotiating fees with payors (especially when compared to single-location ASCs), reimbursement growth is difficult for ASCs to achieve, Dietrich says.

“Affiliation with a publicly held or large private equity ASC management firm may afford an ASC access to...”
better rates, but doing so may result in a significant piece of the physicians’ equity being sold to the management company — albeit at what might be a good price,” Dietrich says.

Roundtable participants mentioned the importance of staying on top of payor contracts and looking at a new contract when procedures are added to the center. Zetter encourages ASCs to review payor contracts every two years, or when they notice declining reimbursements.

“Look at what you’re getting paid, and try to renegotiate contracts when you have a payor paying lower rates,” he says. “Centers need to run reports regularly that show reimbursements by payor and by procedure so they know where they have issues that may hurt them financially.”

Hoffman says her center limits payor contracts to three years to ensure they represent current reimbursement and cost-of-living adjustments, adding that contracts with payors are consistently reviewed, especially when adding new procedures.

Involving physicians in insurance compliance can also help ASCs improve reimbursements. Hoffman’s center, for example, took steps to curtail increasing payment denials on certain pain procedures that resulted from the lack of required documentation for medical necessity.

“The pain management doctor was consulted via the insurance coordinator and clinical director, and procedures were put into
place to ensure that appropriate documentation is included in all pain management charts, thus reducing the chance for payment denial,” she says.

When it comes to billing department staff, Hoffman recommends that ASCs ensure training remains current.

“We send our three-person billing department to billing and coding seminars,” she says. “These can be strictly ASC-related or specialty specific. Most recently, this training addressed the ICD-10 changes to procedure coding and diagnosis documentation.”

Above all, ASCs must stay proactive, she says.

“When the high-deductible/ASC copay plans came out, we made sure we had processes in place to address them,” says Hoffman. “We collected as much money up front as we could. If patients can’t afford their copay or deductibles, we address this on a case-by-case basis.”

Business growth

Driving case volume is a growing challenge, roundtable executives agreed. Some centers said they were considering adding young physician owners and purchasing physician practices to add cases. Others said they’d benefited from joint ventures with hospitals looking to send low-acuity cases to the ASC and free up their own ORs for high-acuity cases. There were also examples of ASC joint ventures in which a hospital allowed its physicians to practice at an ASC because there wasn’t enough space in the hospital for their cases.

Overall, the key to operating a financially successful ASC is to spread ownership over a sufficient number of surgeons who keep volume at or near capacity, says Dietrich.

“Mandatory retirement provisions for surgeons who cease to operate, relocate or become disabled are critical in allowing surgeons who utilize the facility to become owners,” he says.

Dietrich recommends centers draft provisions for buy-in and buyout with the help of an attorney experienced in ASC regulations and transactions – and with the input of a valuation expert with similar experience.

To achieve maximum capacity in the facility’s operating rooms, he adds, “Staff must be adept at moving patients to recovery safely and efficiently, cleaning the ORs after each case and having the next patient prepared and ready to be moved into the OR.”

In addition, the use of well-placed advertising can help ASCs grow awareness to boost business. Reighard says her facility runs TV spots on the local news and advertises on Pandora, an Internet radio service.

“We’re targeting specific months, such as Colorectal Cancer Awareness Month, and encouraging patients to come in for screenings, which may then lead to scheduled procedures,” she says. “For Dress in Blue Day (March 17, to promote Colorectal Cancer Awareness Month), we encouraged our referral sources and our business community – through TV spots and letters from

“Along with keeping reimbursements healthy, we must continue to monitor costs, while keeping up with technology and supplying high-quality, affordable care.”

– Gina Hoffman, Administrative Director, Ophthalmology and Surgical Institute of Central Pennsylvania

“Mandatory retirement provisions for surgeons who cease to operate, relocate or become disabled are critical in allowing surgeons who utilize the facility to become owners.”

– Mark Dietrich, Member of the National Society of Healthcare Business Consultants
our patient engagement coordinator — to ask employees to wear blue. Participating businesses that sent the center pictures of their employees wearing blue had their photos featured in the TV spots and were eligible for prizes, such as coffee and doughnuts for their staff.”

Being a multispecialty ASC is good for supporting a higher case volume. Still, when adding specialties, Hoffman warns centers to look at which procedures are reimbursable, and whether those reimbursements cover the cost of performing the latest procedures. “We do some general newspaper advertising letting patients know that not only are these procedures available here, but that we can also help them lower their out-of-pocket co-pay.”

According to the Ambulatory Surgery Center Association, a Medicare beneficiary could pay as much as $353 in coinsurance for a cataract extraction procedure performed in a hospital outpatient department, versus a $195 copayment to have the same procedure performed at an ASC.

Meeting financial challenges
While many financial challenges faced by ASCs are industrywide, each center has different areas of focus and opportunities for improvement.

“Keeping up to speed on all the compliance requirements while being able to run an operationally sound and patient-focused ASC is a big challenge,” says Zetter.

Dietrich says, “Payor reimbursement and maintaining profitability are the biggest challenges, especially with limited fee increases and ever-increasing upward pressure on operating costs.”

Hoffmann agrees costs are a concern.

“Along with keeping reimbursements healthy, we must continue to monitor costs, while keeping up with technology and supplying high-quality, affordable care,” says Hoffman.

Despite these challenges, ASCs must continue to focus on providing one-on-one care, says Reighard. “We must always remember that.”

“We’re targeting specific months, such as Colorectal Cancer Awareness Month, and encouraging patients to come in for screenings, which may then lead to scheduled procedures.”

– Amy Reighard, Administrator, Allegheny Regional Endoscopy
BURNED OUT?

Use these strategies to keep your surgeons engaged and productive.

Do your ambulatory surgery center surgeons appear stressed, emotionally drained or physically depleted? Working long hours and dealing with stressful situations — including ownership stake in some cases — take their toll on physicians, all too often leading to burnout.

According to the Medscape Lifestyle Report 2017, 49 percent of surgeons reported experiencing burnout; on a scale of one (low) to seven (high), surgeons rated themselves 4.3 on average. Burnout rates for all physicians have increased 25 percent in just four years, the report noted.

The trend is alarming for ASCs in terms of employee and patient satisfaction and referral sources, as physician burnout is characterized by a lack of empathy for patients, a feeling of decreased personal achievement and negative or cynical attitudes toward patients.

“Physician burnout affects everything,” says Dr. Steven Gabbe, CEO emeritus of The Ohio State University Wexner Medical Center. “If you want to see your organization running most effectively and keeping physicians, you have to address this issue.”

These strategies can help you prevent physician burnout at your center.

**Lessen administrative burdens.** Extensive regulatory and compliance requirements, such as those related to Electronic Medical Records, are reducing the amount of time physicians spend with patients.

“EMRs are seen by physicians as a great source of stress,” says Gabbe. “For every hour physicians spend with patients, they spend two hours with medical records.” And that doesn’t count weekend hours spent catching up.

Part of the problem is that EMRs are designed without an understanding of the end user, says Dr. Carol Bernstein, associate professor of psychiatry at New York University School of Medicine. “There are so many built-in stop points, it makes them impossible to use.”

Using voice recognition services and scribes to record interactions with patients can help ease the burden for physicians. Also, training will help physicians use EMRs efficiently.

**Provide workplace flexibility.** Lack of control over working conditions is one of the biggest contributors to physician burnout. While this can be daunting in balancing efficient facility and OR use, you can try to work in the ideas of the American Medical Association’s STEPS Forward™ (www.stepsforward.com) program. The program is designed to help physicians address common practice challenges. It encourages organizations to address physician burnout by offering workplace flexibility, including:

- Flexible scheduling at the beginning and end of the workday, making it easier for physicians to accommodate child care responsibilities.
Consistently scheduling support staff with the same providers to increase feelings of control.

Get people talking. Another important way to circumvent physician burnout is to facilitate communication between clinicians and staff.

To reduce communication errors, Wexner Medical Center implemented Crew Resource Management, an approach borrowed from the airline industry. Before medical procedures, all team members introduce themselves and define their individual roles. Together, the team confirms that they are providing the right procedure on the right patient with the right resources. The process gives everyone on the team a sense of control, has a positive impact on outcomes and reduces medical errors.

“That communication is essential to relieve burnout,” says Gabbe. Build a better experience. The common theme throughout is to accommodate physicians and surgeons effectively. One way to do that is by creating a more seamless experience for the physicians and surgeons using surgery centers on a regular basis. Ideas include customizing discharge forms to save physicians time explaining their specific instructions and supplying color-coded labels for each physician so they can easily find their patients behind a privacy curtain.

Another way to increase accessibility and tailor the experience for surgeons is to connect with them regarding individual preferences, then use the feedback to prepare materials for their cases. This can help increase efficiency within the surgery center while ensuring physicians feel valued by the facility.

“These actions demonstrate your support for the physicians and surgeons, a key factor in preventing and reducing burnout,” says Gabbe.

Interventions to lessen physician burnout require a commitment of effort and resources. However, addressing system issues, implementing (and monitoring) programs to lessen burnout and regularly checking in with staff are not just good for morale. They also improve patient outcomes, reduce medical errors and lower the costs of replacing good physicians, all of which are good for your bottom line.

Sources:

“EMRs are seen by physicians as a great source of stress.”
– Dr. Steven Gabbe, CEO emeritus of The Ohio State University Wexner Medical Center
ASCs are increasingly relying on data to achieve results, from improving quality to controlling costs to measuring patient satisfaction.

“If an ASC isn’t looking at and using every piece of data to improve its operations, it’s like driving cross country without a GPS or road map; who knows where you’re going to end up?” says David Zetter, founder and lead consultant with Zetter HealthCare in Mechanicsburg, Pennsylvania.

Still, it’s not enough to have the right data. ASCs must manage and analyze their data effectively in order to transform information into actionable insights for operational improvement. The following strategies can help you take a data-driven approach to your ASC’s operations.

Assessing quality
In 2012, the Centers for Medicare and Medicaid Services (CMS) implemented the Ambulatory Surgical Center Quality Reporting (ASCQR) Program, which requires ASCs to report quality of care data for standardized measures to avoid Medicare payment reductions. By publishing ASCQR data, CMS allows consumers to find and compare the quality of care at different ASCs. It also gives ASCs a way to publicly demonstrate their performance on quality measures to patients, physicians and partners.

For national and specialty level information, you may choose to participate in ASCA’s online benchmarking, an annual subscription-based survey that allows for benchmarking across other facilities. From a physician standpoint, the Physician Quality Reporting System (PQRS) is an important tool for data analysis. This resource...
provides participating ASCs the opportunity to assess quality of care by ensuring that patients get the right care at the right time.

“Centers using PQRS can evaluate every piece of data — billing, charges and collections, timing that shows the duration between patient check-in and getting into the OR, duration of procedures and recovery time in the OR,” Zetter says. “Good administrators look at every piece of data to determine where improvements need to be made.”

To measure quality, Zetter also recommends ASCs consult tools that compare centers in terms of revenue, profits, expenses and payor mix. In Pennsylvania, for example, surgery centers are required to report to the Pennsylvania Health Care Cost Containment Council (PHC4), an independent state agency that compiles data on healthcare facilities and reports the results.

Staff at the Ophthalmology and Surgical Institute (OSI) of Central Pennsylvania in Carlisle, Pennsylvania, use data to effectively manage both the operating room and patient satisfaction, says Gina Hoffman, the center’s administrative director.

“Our surveys provide patient feedback on surgeons and anesthesiologists that allows us to react to issues on an individual basis,” says Hoffman. “We also use peer review and patient safety data for improving infection and complication rates. Positive outcomes are always best for an ASC’s bottom line.”

Controlling costs
Two of the biggest costs for ASCs — labor and supplies — require constant monitoring, says Mark Dietrich, a CPA specializing in healthcare industry valuation and a member of the National Society of Healthcare Business Consultants.

“While experienced staff members are valuable resources, longevity and annual pay increases can move key staff salaries to levels that erode the ASC profit margins,” says Dietrich. “Pegging pay increases to financial performance-based factors and metrics, rather than inflation, is an important consideration.”

Surgery centers can also keep equipment and supply costs in line by using effective inventory management, shopping for competitive pricing and enlisting surgeons in the efficient use of supplies, Dietrich says.

To save money on supplies, Hoffman’s center uses Cost Per Weighted Case (CPWC) — a financial indicator that provides insight into the total cost to treat an average patient. Focusing on CPWC data can help ASCs track and use their resources more efficiently.

“We try to get our surgeons to use comparable yet less-expensive supplies for their cases,” Hoffman says. “These supplies can range from eye drops to suture anchors to drapes. We work with our reps to allow for items to be trialed by our surgeons before a purchase is made.”

Still, cost is just one of many data points to consider when it comes to equipment, Zetter says.

“If a center is looking to replace scopes, it needs to look at requirements for training, space, software and storage, as well as maintenance agreements and lease or buy options,” he says. “All of this must be factored into the ROI before making a purchase decision.”

ASC administrator Amy Reighard went through this process when her center, Allegheny Regional Endoscopy, Altoona, Pennsylvania, upgraded its scopes. “We discussed the technology with the vendors and we demoed three scopes, one of which was a new technology that our physicians liked.”

Because the technology was new, however, the center didn’t have the data necessary for evaluating in-field performance, rate of repairs and the availability of loaners, she says. So, Reighard requested that the two remaining vendors provide detailed proposals to be evaluated by the ASC’s physicians and the board. The result was a final purchase decision that pleased everyone.

Maintaining networks
All data, no matter the type, must be managed within your ASC’s network, and that requires a reputable vendor and IT liaison. If your center can’t afford a dedicated IT person who is trained and certified, consider retaining an independent consulting firm with demonstrated expertise in HIPAA regulations, says Dietrich.

It’s also a good idea to have a staff person “who can handle the small things and liaise with the vendor,” says Zetter.

“Even a person who isn’t IT trained and certified can help with things such as printer hookups and contacting the vendor when there are latency issues,” he says. “That way, you free up the administrator.”
Ambulatory surgery centers started as an idea from two physicians. This fundamental ownership ideal remained as the number of centers increased; but that is changing as many hospitals — and some ASC owners — begin to consider joint ventures.

Supporting a change in ownership dynamics, there has been a clear shift in how and where surgeries are performed. Both the Centers for Medicare and Medicaid Services (CMS) and private payors have found that outpatient settings deliver comparable or better quality at a lower cost than inpatient approaches. Each year, CMS has also approved several more procedures to be included on its ASC Approved Procedures List for Medicare patients.

Healthcare finance experts report that these changing payment models, along with outpatient care trends, are driving more hospitals and ASCs to explore the opportunities hospital-physician partnerships can deliver.

**Shifting payment models**

In its final 2017 payment rule for ASCs, CMS increased payment by 1.9 percent, exceeding the 1.2 percent increase in the proposed rule, while hospital outpatient departments received an increase of 1.65 percent. Just as important, CMS added 10 procedures to the ASC approved list, although the Ambulatory Surgery Center Association advocated for dozens more. These changes could help ASCs to offer low-cost, high-quality services to an increased number of patients.

In addition, the Medicare Access and CHIP Reauthorization Act (MACRA) includes the Quality Payment Program (QPP), which further extends the industry shift toward value-based reimbursement. MACRA favors structured measurement and report-
ing, efficiency and quality of care; and because some QPP approaches increase risk, hospitals may be more likely to consider an ASC partnership than to add HOPD procedures or lines of service.

A hospital’s decision to enter into a joint venture can be driven by numerous factors, says James Landman, JD, Ph.D., director of healthcare finance policy, perspectives and analysis for the Healthcare Financial Management Association. Motivations may include expanding geographic reach to improve access to care, building a network of providers that is more attractive to employers and health plans (especially as a leading accountable care organization in their market) and negotiating bundled payments.

Benefits for ASCs

Of the approximately 5,600 Medicare-certified surgery centers in the U.S., as many as 1,700 had a hospital partner in 2016, according to Becker’s Hospital Review.

Whether a joint venture is of value to an ASC depends heavily on market forces and other factors, Landman says. However, one potential advantage is access to hospital-based resources. For example, QPP reporting may require a substantial IT investment that a hospital can better fund or implement.

“The partnership also may be able to increase patient volumes at the ASC and enable the ASC to partner with the hospital in negotiating direct-to-employer contracts, risk-based contracts and other payor contract opportunities,” says Landman.

If your ASC’s out-of-network opportunities are shrinking, a hospital or healthcare system partnership might also provide a source of new patients. New bundled payment systems also reward low-cost, high-quality care, a hallmark of the ASC model and a potential reason to work together to obtain these contracts.

Forming a strong partnership

Financial advantages aside, many ASC physician-owners value the control they have over clinical or business operations, the financial experts say. If control is important for your ownership, emphasize your concern from the start. Some issues are more difficult to overcome, such as noncompete clauses with a healthcare system’s employed physicians, or not-for-profit status of one partner versus the tax status of another.

With proper due diligence, “a joint venture can be a means to strengthen a relationship while maintaining the independence of the parties,” Landman says.

The most important factors in a successful joint venture, according to Landman, are “first, that both parties see positive reasons for the venture that align with their long-term strategies, and second, that they trust one another and are committed to a true collaborative relationship.”

When negotiating, consider the mutual benefits, but also recognize the strengths your center can bring to the table.

6 TIPS FOR SUCCESSFUL JOINT VENTURES

A successful joint venture can help ASCs increase case volume, improve efficiency and strengthen contract negotiations—all of which can positively affect a center’s finances. Still, you’ll want to carefully evaluate any potential partnership to ensure your center will reap the full benefits.

• Enter a joint venture for the right reasons, considering the weight of each advantage and disadvantage.
• Choose credible partners that have a good reputation in your market.
• Establish clear legal and financial plans based on thoughtful negotiation.
• Ensure that joint venture legal documents clearly describe how finances will flow.
• Establish and maintain a culture of trust among all parties.
• Make sure the culture includes transparency, communications and a willingness to share data on costs and quality measures.
Outpatient centers:

**FOCUS ON MILLENNIALS**

Millennials make up the largest part of the population. As healthcare consumers, their views are shaped by the fast-paced and technologically advanced world in which they were raised. Some of the top priorities for this age group are convenience, promptness and paying minimal out-of-pocket expenses.

Because millennials are more concerned with providers meeting their expectations than developing long-term physician-patient relationships,1 outpatient surgery facilities need to strategize with this generation in mind.

**Patient satisfaction expectations**

Millennials expect convenience, prompt treatment and quality care. Outpatient surgery centers have met these standards, surpassing inpatient facilities for years. Patients report a 92 percent satisfaction rate with both the care and service they receive from ASCs.2 To continue this success and grow in the area of patient satisfaction, outpatient centers must keep up with the needs of millennials, as well as with overall patient satisfaction standards.

A visible commitment to infection prevention is a great way to impress patients and improve quality of care. In a recent patient satisfaction survey, 48 percent of all patients said that one of the top reasons their expectations were exceeded was the facility’s display of cleanliness and infection prevention methods.3

In conjunction with the display of cleanliness, there are also other important factors to consider in the outpatient environment. The following categories ranked high in exceeding patient satisfaction: facility accessibility, amenities and quality of products used.3

**Timeliness**

Of the top reasons providers fail to meet patient expectations, wait time to receive care and the inability to receive lab results in the same visit are the top two.3 Outpatient centers already have a positive reputation for timeliness. A study from the NIH measured timeliness by looking at the percentage of cases starting within five minutes of scheduled start time and the percentage of cases in which the actual case duration did not exceed scheduled duration. ASCs began on time in 89 percent of cases, and 77 percent of ASC cases finished within the scheduled time.4

With strong timeliness data already, what can facilities do to stay at the top? Patients have identified the following opportunities for improvement: keeping the patient updated on any sort of delay, giving them the option to wait or reschedule if the provider cannot see them at the originally scheduled time, and providing amenities that make wait times more bearable.3

**Saving more over hospitals**

Millennials are expected to pay the most in out-of-pocket expenses; 60 percent of millennials claim their opinion of a provider is influenced by the cost of services, in comparison to 48 percent of other U.S. adults.1

Though ASCs are saving patients money by providing cost-effective care, there is still concern with high-deductible health plans (HDHPs). HDHPs can cause outpatient facilities to experience slower starts to their year due to patients waiting longer to meet their deductible before moving forward with a procedure. These plans also require higher out-of-pocket payments. ASCs are training their staff to better communicate payment plans to help minimize these concerns.5 Outpatient centers should be proactive in keeping an open line of communication with millennials regarding healthcare plans.

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