

California Orthopaedic Association

Expanding Services in an ASC
Through the Addition of a Recovery Care Center

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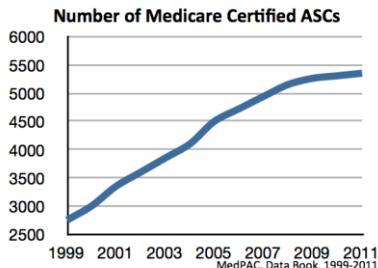
Expanding Services in an ASC Through the Addition of a Recovery Care Center

COA Task Force on Recovery Care Centers

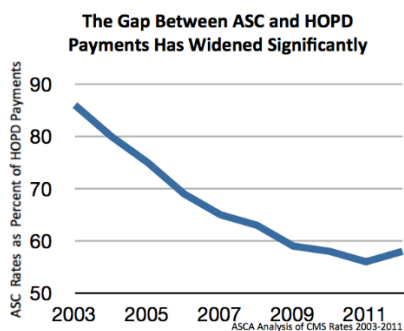
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Introduction

Prior to 1970, all surgeries were performed in hospitals. These procedures were marked with long lengths of stay and high costs. The advent of improved techniques and the desire to reduce the costs and complexities imposed by performing simple surgeries in a hospital led to the development of ambulatory surgery centers (ASCs). The first such center was opened in 1970 in Phoenix, Arizona. The subsequent 40 years witnessed incredible growth in the number of ASCs. In 2006, 35 million visits to ambulatory surgery centers were recorded and by the end of 2011, the number of Medicare certified centers had grown to 5,357.¹



The success of these centers in achieving comparative quality and safety while reducing the cost of care has been well documented.^{2 3} Medicare payments to Ambulatory Surgery Centers are currently only 53% of what Medicare pays for the same procedure in a hospital outpatient department (HOPD).



Medicare and its beneficiaries save \$2.6 billion dollars each year as a result of ASCs and could save an additional \$2.5 billion if just half the current HOPD cases were done in ASCs.

Patients and private insurance companies save similarly. A review of commercial claims found US healthcare costs are reduced by \$38 billion dollars each year due to the availability of ASCs as an alternative for outpatient surgeries. Patients personally, through lower deductibles, realize \$5 billion of those savings. Patients, employers, and insurers, therefore, appropriately remain very interested in ways to safely migrate procedures to ambulatory surgery centers.⁴

Paralleling the growth of ASCs has been a steady increase in the complexity of cases performed in these centers. The ability of ASCs to perform increasingly complex surgeries can be attributed to experience, improved anesthetic techniques, and less invasive techniques. Cases, once considered inpatient only cases, have migrated to the ambulatory surgery center with success and the medical community has continually achieved patient satisfaction, quality outcomes and cost savings.

Total Joint Arthroplasty is representative of procedures that have experienced transition from the inpatient to the ambulatory surgery center setting for select cases. From 2012 to 2015, elective total joint replacements in the outpatient setting increased by nearly 50 percent, and in the next decade outpatient total joint replacement is expected to increase 457% for total knee replacement and 633% for total hip replacements. Sg2 predicts only 3% of the next decade's growth in total joint replacement surgery will take place in an inpatient setting.⁵

While the complexity of cases rose in ASCs, the inpatient average length of stay (ALOS) for Total Joint Arthroplasty has steadily decreased such that now nearly half of these patients stay only one to two days. Similarly, the ALOS for spinal fusions has decreased over time and some procedures, such as select anterior cervical discectomies and lumbar laminectomies, have successfully migrated to ambulatory surgery centers.

Unpublished data from the Spine and Joint Institute at Redlands Community Hospital, Redlands, California, demonstrates an ALOS of 1.5 days for over 1,000 total joint cases annually. The ALOS for all spine cases including moderate to complex cervical and lumbar multilevel decompressions and fusions is 1.4 days for over 450 cases annually. Hence, the limitation currently imposed on ASCs of only an average of 12 hours of skilled post-operative care is preventing a great number of inpatient cases from migrating to the more cost effective ambulatory surgery setting. Bridging this gap by responsibly extending pain management and monitoring beyond the 23:59 allowed in the index ASC, is the focus of this paper.

Orthopedic practices desiring to safely provide the benefits of the ASC to more of their patients can look to two models with a proven history, and one emerging model that may be suitable for practices desiring the option for procedure based interventions during the recovery period.

This paper will consider the following models for recovery post ASC procedures:

- Post Surgical Recovery Care Centers/Medical Hospitality Suites (RCC/MHS)
- Skilled nursing facility (SNF)
- An ASC licensed pain management and recovery care center (PM/RCC).

Post Surgical Recovery Care Centers/Medical Hospitality Suites (RCC/MHS)

Post Surgical Recovery Care Centers

Extended monitoring and pain management in a post-surgical Recovery Care Center (RCC) has been considered by ambulatory surgery centers for nearly two decades.⁶ These centers provide short term nursing care, monitoring and pain control for patients that do not require acute hospitalization. Now, with the potential to transition total joint and spine procedures into the ASC setting, these recovery care facilities have gained more widespread interest.

Despite the growing interest of recovery care centers nationally, only Arizona, Connecticut and Illinois have established licensing standards for recovery care centers.⁷ Colorado licenses recovery care centers as convalescent centers.⁸ RCC regulations for Arizona, Connecticut and Illinois share similar requirements for written policies, medical records, patient's rights, pharmaceutical, and required medical personnel. Required services, prohibited services, length of stay, bed limitation and other criteria vary among the three states. Arizona regulations do not address length of stay; Connecticut provides a maximum of 21 days; Illinois allows a maximum stay of 72 hours. Connecticut has no requirement for laboratory. The Florida House of Representatives passed HB 85 which attempted to create a new licensure category for a Recovery Care Center with a 72 hour stay, but the bill was killed in their Senate Appropriations Committee. It is noteworthy that the Florida Hospital Association's 2017 Legislative Summary reported, "No health care policy legislation that FHA opposed passed."⁹ In California, no such recovery care licensing option is available and efforts to implement licensure requirements for recovery care centers are likely to face intense opposition from the California Hospital Association and other health systems.

Accrediting institutions such as the Accrediting Association for Ambulatory Health Care (AAAHC), the Institute for Medical Quality (IMQ), or the Joint Commission have standard setting programs achieving sufficient federal and state recognition for facilities to successfully meet a broad range of regulations with accreditation by one entity. The AAAHC website lists surgical recovery centers among their accredited organizations under their ASC standards. A search of surgical recovery centers on their database yielded examples of such centers that have been set-up throughout the United States such as the Coronado Surgical Recovery Suites in Henderson, Nevada.¹⁰ While a "recovery care center license" may not be available in California, surgical recovery center accreditation as an ASC by AAAHC, the IMQ, or the Joint Commission as ASCs, may be an option to ensure a consistent application of quality standards for post ASC recovery care.

Medical Hospitality Suites

Medical Hospitality Suites have a long history with plastic surgery ASCs where surgeons cite "better pain control and less worry" when a patient stays at these facilities.¹¹ These medical hotels for other surgical procedures, including orthopedics, have emerged with some success, providing recovery under supervision of licensed nursing and medical personnel in comfortable, patient centric environments. Summit Orthopedics in Minnesota operates, "Care Suites" in the

same building as the ASC for select patients undergoing more intensive surgeries such as spine and total joint replacement procedures. Some opt to partner with an established hotel or lodging facility. The Spine Surgery Center of Eugene, OR has had a 5-year relationship with the bed-and-breakfast Excelsior Inn for extended recovery of patients. This ASC utilizes the hotel accommodation to avoid long travel for patients after surgery and to “keep them nearby for post-op pain control and/or any other post-op problem that might occur.”¹² In yet a third example, Triad Orthopaedic Center (www.tria.com) partnered with Hilton to provide its recovery program.

Until clear licensing standards are established in California, the scope of care provided within the RCC/MHS will need to be clearly defined and consistent with prevailing laws defining the scope of care provided through home health agencies and meet the accreditation standards of nationally recognized accrediting agencies for RCCs.

While the cost effectiveness and flexibility in providing recovery care in hotel like rooms is appealing, every effort should be made to ensure only appropriate patients are selected for this service. In addition, every effort should be made to develop these RCC/MHSs with safety features that equal those found in ASCs, namely:

- Generator back-up power;
- Basic diagnostic and resuscitative equipment;
- Oxygen and suctioning at bedside;
- Licensing requirements for the nursing staff;
- Disaster preparedness plan;
- Fire control plan;
- QA and performance improvement plan;
- A complete, comprehensive patient medical record system;
- Appropriate pharmaceutical services;
- A sanitary environment; and,
- An infection control program.

The presence of licensed home health nurses to staff the RCC/MHS provides an additional level of recognized safety standards within a licensed, regulated scope of practice. The licensed home health agency may be created by the orthopedic practice, which would ensure training, expectations, and patient care that mirrors the ASC, or may be contracted to a qualified, licensed home health agency with specific experience with orthopedics.

Skilled Nursing Facility (SNF)

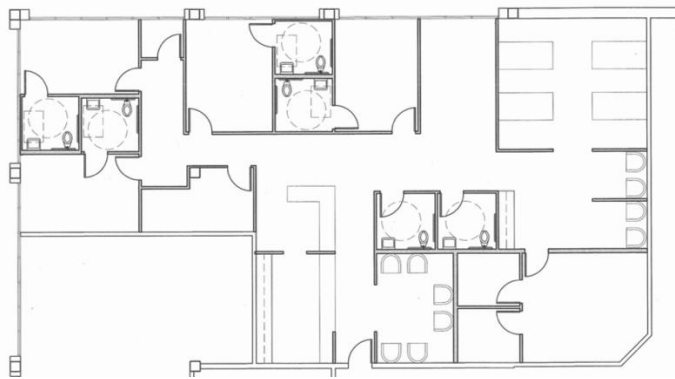
A second option is to develop and license a skilled nursing facility (SNF) to provide post-operative care. Some orthopedic groups in Arizona and Colorado have developed such facilities but not for the narrow purpose of providing expanded pain management and monitoring for their ambulatory surgery cases. The regulatory burden associated with these centers reflects the intent of these facilities to provide extended care for patients with medical and physical conditions requiring nursing evaluation at regular intervals. Medicare requires a 3 day qualifying hospital

stay¹³ which precludes their use that represents the focus of this paper. California criteria for admission to SNF are restrictive. The intent of CCR Title 22 is consistent with good care that could be suitable for post surgical recovery care¹⁴; however, the regulatory requirements intended for patients with higher level of acuity typical associated with SNF patients may prove burdensome for delivering efficient 24-48 hour recovery care for ASC patients.

Pain Management Recovery Care Center licensed as an ASC (PM/RCC)

A third option is to license a second ASC as a pain management and recovery care center (PM/RCC) under the California Health and Safety Code, and accredited by any one of the recognized accrediting bodies. This center could serve to provide pain management and recovery care services with the very same level of safety and competence as the original ASC performing the index procedure and initial 23-hour stay.

An ASC licensed PM/RCC allows the qualified patient to be discharged appropriately from the orthopedic surgical ASC (at or before 23 hours and 59 minutes) and admitted to the PM/RCC ASC. The PM/RCC ASC performs procedures such as epidural and regional blocks and other pain management procedures as well as offers private recovery rooms for patients from the orthopedic ASC to recover in a setting with quality standards assured by a licensed and accredited ASC. Following is a diagram of a PM/RCC currently under development in California where there exists a blending of pain management functionality and a post-surgery recovery care center.



To comply with the ambulatory surgery center requirements of the California Health and Safety Code 1248 and the federal statutes for ASC (42 CFR 416), the PM/RCC ASC must meet the following requirements:

- Compliance with state licensure;
- A governing body responsible for determining, implementing, and monitoring policies governing the ASC's operation;
- Perform surgical services;
- A quality assessment and performance improvement program;

- A transfer agreement with one or more acute care general hospitals, which will admit any patient referred who requires continuing care;
- A disaster preparedness plan;
- An organized medical staff;
- Appropriate nursing service;
- A complete, comprehensive patient medical record system;
- A fire control plan;
- Appropriate pharmaceutical services;
- Lab and radiologic services;
- A sanitary environment;
- An infection control program; and,
- A procedure for patient admission, assessment and discharge.

With the index Orthopedic ASC providing care for 23:59 and the second licensed ASC/RCC providing an additional 23:59 of care, nearly two days of licensed supervised care is available to patients undergoing orthopedic and spine procedures. This two-phase approach provides the quality and cost savings of surgery in the ASC with the patient centric experience of a dedicated pain management and recovery center and successfully bridges the gap for those healthy patients currently requiring 1.5 day length of stay in a hospital setting. This model meets individual regulatory and licensing requirements, is focused on the needs of the orthopedic post-operative patient, and assures the surgeon and patient of quality and safety associated with licensed and accredited facilities.

Compensation

Developing appropriate compensation to assure viability of the RCC/MHS or PM/RCC will be important. These centers are currently ineligible for Medicare Reimbursement except for the recognized pain management procedures performed within the PM/RCC ASC. Viability of the RCC/MHS or PM/RCC ASC facility will, in large part, is dependent on successful contracts with payors for services provided in these centers. The cost savings and patient experience in these settings should drive interest on behalf of both patients and payers leading to greater adoption of these models.

There is evidence of payors recognizing the potential cost savings. New Haven Hotel, a licensed recovery center, successfully obtained a recovery care center contract with Health Net. Said Thomas G. Miller, the vice president of Provider Network Management at Health Net, "I'd rather have a relative at the recovery center than spend a night in the hospital. Patients are not surrounded by people with acute illnesses and the environment is very conducive to getting well."¹⁵

Summary

A large number of healthy patients undergoing hip and knee replacements and spine procedures in inpatient settings could safely migrate to the more cost effective ambulatory surgery center setting if skilled pain management and monitoring can be extended to 48 hours or more, following the ambulatory surgery center procedure.

Options for allowing patients to recover in an outpatient setting are to develop:

1) **An adjacent Recovery Care Center/Medical Hospitality Suite (RCC/MHS)**

The RCC/MHS option is appealing due to the absence of a 23 hour discharge requirement and lower mandatory regulatory burdens associated with this model. However, we believe that it would be important for these centers to maintain high quality standards similar to those required of an accredited ASC. The downside of this model is that you would not be able to bill for any services or procedures performed in the RCC/MHS unless you were able to negotiate reimbursement under a contract or bundled payment arrangement.

2) **An affiliated Skilled Nursing Facility (SNF)**

The size scope and regulatory burdens associated with SNFs make this the least appealing alternative. Also, this is likely to be the most expensive recovery care setting. SNFs may not be open to receiving these patients as they would likely be more short stay patients than typically treated in a SNF and the patient may not meet the requirements for the facility to reimburse for their stay under current Medicare rules.

3) **A Pain Management and Recovery Care Center (PM/RCC)** that is licensed as an accredited ASC. ASC accreditation would ensure high quality care standards. The PM/RCC would need to have in place an agreement with the primary ASC to accept post-surgical patients for extended pain control and monitoring. The center would be an accredited ASC so it could serve other patients in addition to the post-surgical patients. Their accrediting body would determine the staffing needs and other requirements of the facility based on the services performed in the center.

It is our understanding that these RM/RCC centers would need to have their own independent governance structure, but that the RM/RCC could be owned by the same or have some of the same physicians owning the primary ASC. In this model, the PM/RCC could bill for services rendered, but the patient would need to be discharged within 24 hours.

The suitability of a particular model for an orthopedic practice is likely to be dependent on the surgical practices and post operative care preferences of the surgeons. The table below provides a comparison of key components of each model that may be helpful in considering the suitability of each model to your practice.

Comparison of Key Components Each Model			
	Post Surgical Recovery Care Center/Medical Hospitality Suite (RCC/MHS)	Skilled Nursing Facility (SNF)	Pain Management/ Recovery Care Center ASC (PM/RCC)
Cost to Build	\$\$	\$\$\$	\$\$\$
Cost to Operate	\$\$	\$\$\$	\$\$\$
Parenteral Analgesics	Yes	Yes	Yes
Staffing	HHA	In-House	In-House
Bedside Procedures	Minor	Yes	Yes
Regional Blocks	No	No	Yes
Licensure in CA	No	Yes	Yes
Accreditation	No (but recommended)	Yes (mandatory)	Yes (mandatory)
Generator Requirement	Recommended	Yes	Yes
Medical Gas/O2 Requirement	Recommended	Yes	Yes
Physician Ownership	Yes	Yes	Yes
Ability to Bill Private Insurance	Yes	Yes (for stay)	Yes (for procedures rendered)
Ability to Bill Federal Programs	No	Yes (for stay)	Yes (for procedures rendered)
Maximum Length of Stay	By Contract	100 days	23:59
Therapy Services	Yes	Yes	Yes
In-House Dietary Services	No	Yes	No
Catered Dietary	Yes	No	Yes

¹ www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/OAS-CAHPS.html

² US GAO. (2006). *Medicare: payment for ambulatory surgery centers should be based on the hospital outpatient system*. Washington DC: US Government Accountability Office

³ Owens PhD, P., Barrett MS, M., & Raetzman MSPH, S. (2014). Surgical Site Infections following Ambulatory Procedures. *Journal of the American Medical Association*, 311(7) 709-716.

⁴ www.ascassociation.org/advancingsurgicalcare/aboutascs/industryoverview/apositivetrendinhealthcare

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- ⁵ Dyrda, L. (2017, February 10). 16 things to know about outpatient total joint replacement and ASCs. *Becker's ASC Review*.
- ⁶ Breisch, S. L. (1999, June). Profits in Short Stays. *Am. Acad. of Orthopaedic Surgeons Bulletin*.
.http://www2.aaos.org/bulletin/jun99/asc.htm.
- ⁷ Florida House of Representatives Staff Analysis Bill HB 85 Recovery Care Services (2016, January 22).
Storage Name: hoo85e.HHSC
- ⁸ Colorado Board of Health, Chapter XI Convalescent Centers
- ⁹ Florida Hospital Association. (2017). *2017 Legislative Summary*. Florida Hospital Association.
- ¹⁰ www.aaahc.org
- ¹¹ Brooks, A. (1999, February 23). CASES; Recovering, with All the Amenities. *New Your Times*.
- ¹² Pallardy, C., & Vaidya, A. (2014, November 14). 7 ASCs with Recovery Care Relationships. *Becker's ASC Review*
- ¹³ <https://www.medicare.gov/Pubs/pdf/10153.pdf>
- ¹⁴ Title 22 California Code of Regulations
- ¹⁵ Polk, N. (2003, November 16). After Surgery, a Hotel Suited for Healing. *New York Times*