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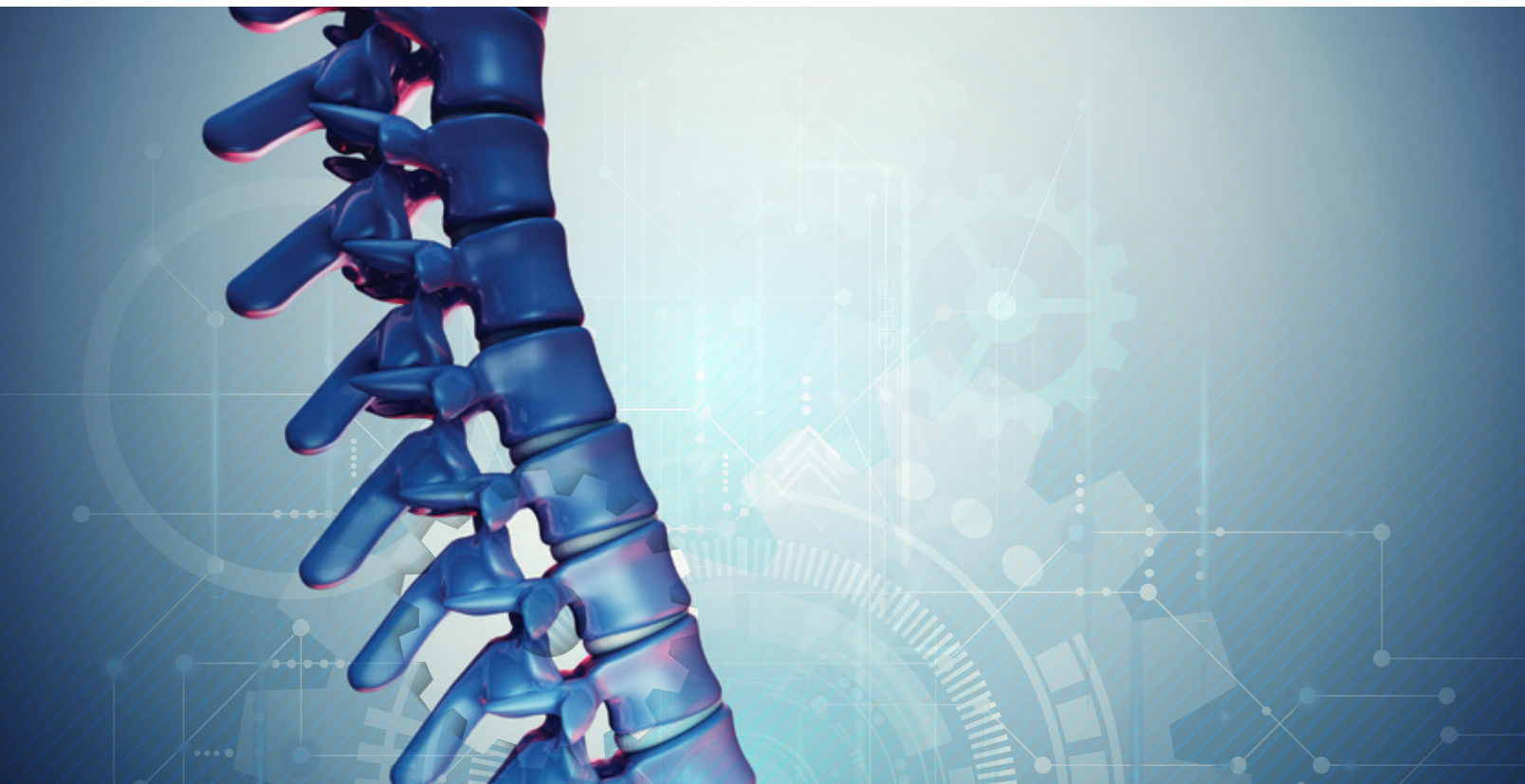


PROVIDING HIGH-ACUITY ORTHOPEDIC AND SPINE CASES

*Strategies for success lie
in pre- and postop care*

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Providing High-Acuity Orthopedic and Spine Cases

Strategies for success lie in pre- and postop care

BY SAHELY MUKERJI

Arthritis and spine- and back-related conditions in adults aged 18 and older will grow from 54 million in 2014 to 63 million by 2020 and 78 million by 2040, according to the Centers for Disease Control and Prevention (CDC).

To keep up with the growing demand for elective spine surgery, researchers believe outpatient settings will handle up to 50 percent of spinal surgery volume within the next few years, according to an article in the July 14, 2014, *Global Spine Journal*.

Traditionally, these cases were done in the inpatient setting with a hospital stay of three to four days. Now, due to less invasive surgery, technological improvements and faster rehabilitation times, these procedures are being

moved to outpatient facilities, such as ASCs, according to an August 22, 2013 (<https://www.ncbi.nlm.nih.gov/pubmed/23964794>) study, and a November 29, 2016 (<https://www.ncbi.nlm.nih.gov/pubmed/27404852>) study by the National Institutes of Health.

“We have intelligently migrated spinal procedures to an ASC, which is a very cost-effective environment,” says Anthony L. Asher, MD, ASCA Board member, director of the Neuroscience Institute at Carolinas HealthCare System and senior partner at Carolina Neurosurgery and Spine Associates in Charlotte, North Carolina. “By ‘intelligent migration’ I mean that the safety and feasibility of performing these procedures was first modeled in hospital environments, before being transferred to the outpatient

setting. In the beginning of our experience, we performed mostly simple procedures, such as lumbar microdiscectomies, in our ASC. As time progressed, we were able to objectively demonstrate the safety of performing more complex procedures, such as cervical and lumbar fusions, in an ASC . . . we are now examining the safety and efficacy of performing increasingly advanced neurosurgical procedures in an ASC, such as basic craniotomies, cranial endoscopy, brain biopsies, Chiari decompressions not requiring durial opening and basic CSF shunting procedures.”

Preop

The key to success, say the physicians who perform these high-acuity orthopedic and spine procedures in ASCs, is careful patient selection.

“Certain cases are appropriate for the ASC setting and others are not,” Asher says. “We have to be particularly careful when screening patients because present regulations require patients to be discharged within a 23-hour window. In that regard, patients having surgery in an ASC need to meet specific criteria related to medical co-morbidities, anticipated pain control needs and the extent of planned surgery.”

To make an ambulatory surgery successful, Asher’s team counsels patients preoperatively and creates realistic expectations about every aspect of their anticipated experience in the ASC.


Sohrab Gollogly, MD, Monterey Spine and Joint and Monterey Peninsula Surgery Center in Monterey, California, also considers managing patient expectations to be a critical part of performing a high-acuity surgery successfully in the inpatient setting.

Before surgery, a nurse educator on Gollogly’s team does one-on-one teaching sessions with each patient. “The nurse educator is the first step of patient education in the preop stage,” he says. “Ninety-nine percent of that session is education and setting expectations.”

Gollogly and his team have developed a preoperative assessment tool to determine who can have a successful

outpatient operation. “It is a 10-point scoring system with six preop questions, BMI and ASA category determination and expected tourniquet time,” he says. He presented a description of this protocol and the results of 100 consecutive hip and knee replacements using it as a screening tool at

the American Academy of Orthopaedic Surgeons (AAOS) annual meeting last year. “This paper found that 100 percent of patients who were selected for outpatient joint replacement using this protocol were able to leave the center within 24 hours and had high patient satisfaction rates and minimal



Convergent Patient Selection Questionnaire

Complete this questionnaire to determine a patient's suitability for a Short Stay Joint Replacement procedure. Medical clearances and secondary screenings by the ASC anesthesiologist should continue per facility protocol.

Question	Circle One
1. Date of Birth: _____ Gender (circle one): M/F	Age: _____
2. Weight: _____ Height: _____	BMI: _____
3. Do you have a medical history of severe pulmonary problems or conditions: Emphysema, Asthma, TB, Sleep Apnea	Yes No
4. Do you have a diagnosis of hypertension?	Yes No
5. Do you have a medical history of any of the following: Angina, Chest Pain, Heart Attack, Irregular Heart Beat, Pacemaker/AICD or Mitral Valve Prolapse or Renal insufficiencies?	Yes No
6. Do you have a medical history of Diabetes?	Yes No
7. Rate your Daily Activity level: a. Able to complete self-care, eating, dressing walking in the home b. All of the above and Wash dishes, climb stairs, and light housework c. All of the above and Vacuuming, laundry, and climbing three or more flights of stairs d. All of the above and Strenuous exercises (e.g. swimming)	Circle One: A B C D
8. Have you been taking Narcotic Medication to manage chronic pain?	Yes No
9. Do you agree or disagree with the statement below? (please indicate in the right side column) Yes / No Have you had a significant outpatient surgical procedure prior to this joint replacement Such as joint arthroscopy, rotator cuff repair, or outpatient spine surgery	Yes No
10. Do you agree or disagree with the statement below? (please indicate in the right side column) It is easy for me to bounce back or recover from stressful situations. Agree / Disagree	Agree Disagree
11. Do you agree or disagree with the statement below? (please indicate in the right side column) I have good relationships with family and friends who will take care of me when I am unwell.	Agree Disagree

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Surgery Location (Circle One): ASC Hospital		Surgeon: _____ T.O.P. 90 Score: Above / Below	
24 Hour Discharge Location (Circle One): Home SNF Hospital Stay		Total: _____	
Procedure (Circle One): UNI TKA THA		Risk Score: Red Yellow Green	

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The Role of the 23-Hour-59-Minute Rule in Higher Acuity Cases



ASCs are allowed to keep patients up to 24 hours after admission unless state law provides a more restrictive time limit.

“The whole issue of 23 hours, 59 minutes is remarkably arbitrary and completely artificial, and it needs to be re-examined,” says Anthony L. Asher, MD, ASCA Board member, director of the Neuroscience Institute at Carolinas Health-Care System and senior partner at Carolina Neurosurgery and Spine Associates in Charlotte, North Carolina. “Why

can’t that period be re-defined as 36 hours, for instance? If we had an intelligent way of expanding the approved observation interval, we would unquestionably be able to expand patient access to ASCs, particularly for those individuals with moderately increased surgical acuity and surgical risk factors.”

One way to help promote case expansion and patient access to ASCs would be to provide payers such as the Centers for Medicare & Medicaid Services (CMS) with substantial data that objectively demonstrates the value of cases performed in ASCs versus hospital settings, he says.

“We cannot perpetually remain in a reactive mode,” Asher says. “We have to proactively determine which procedures we believe are appropriate for treatment in ASCs, then use a variety of quality tools at our disposal, such as clinical registries and payment databases, to compare the safety and value of performing surgeries in different settings.”

Moreover, ASCs should use such data to engage and, hopefully, partner with other stakeholders such as payers. “As we share a mutual interest in improving patient outcomes while allowing for the creation of more sustainable delivery systems, it is my belief that payer groups, faced with reliable data that surgical care could be provided with greater cost efficiency and at least equivalent outcomes in an ASC versus hospitals, should be more willing to consider intelligent modification of existing standards, such as expanding approved stays in an ASC beyond the present 24-hour limit,” he says. “Simply put, if we took patient safety off the table—meaning, show conclusively that patient safety would not be compromised—and demonstrated at least equivalent outcomes to inpatient settings along with enhanced cost effectiveness, then why wouldn’t we expand the use of ASCs? Failing to do so under those circumstances would defy logic.”

ASCs could easily expand their quality data acquisition to include higher acuity procedures and the impact of allowing expanded stays, Asher says. “Such care paradigms can and should be modeled with specific payers to look at the value of doing larger procedures and extending stay—perhaps initially by 6–12 hours—in the ASC. This would allow our outcomes to be transparent and would also create trust through enhanced partnership between relevant health care stakeholders. The stakeholder group could be expanded to include representatives from patient groups, ASCs, the physicians they represent, payers, and even those hospital systems that have already determined the future of surgical care must include ASCs as part of the comprehensive solution.”

We have just begun to realize the potential of ASCs to save the health care system tens of millions of dollars, Asher says. “This potential would unquestionably be enhanced without the existing time constraints. Advanced spine surgeries and orthopedic cases, such as total joint, are complex cases that would benefit from expanding existing uses of ASCs,” he says. “The writing is on the wall for increased utilization of ASCs, but we need to lead the way to that future with data that unequivocally supports such expanded use.”

risk of readmission or uncontrolled pain,” he says.

“We are not looking for unicorns such as 55-year-old marathon runners, but we cannot accept patients who are extremely sick, like an ASA 4, or have multiple medical comorbidities, a history of chronic pain or heavy reliance on opioid pain medication, or rely on anti-coagulants,” he says. “Individual comorbidities could be managed in an ASC but maybe not a combination of comorbidities.”

Kim Jablonski, RN, total joint program director of Ortho and Sports Institute in Appleton, Wisconsin, says her ASC can perform high-acuity procedures on higher-risk patients because it sends those patients to an adjacent skilled nursing facility (SNF) to stay overnight. “We do BMI patients over 40, type 1 diabetics and patients that are anti-coagulated,” she says. “They have surgery and are discharged from our center in four to six hours and admitted to the SNF for two to three nights.” The SNF has a medical director and is attached to the ASC. Patients are directly admitted and transported down the hall to the SNF. “It is a cheaper model for the insurance companies,” she adds. “Our model allows for a one- to three-night stay for total joints, providing the necessary IV antibiotics, pain medications and accelerated therapies. It also allows for higher acuity spine cases that stay overnight for pain control.”

Postop

Asher says his ASC is presently considering extended stay in conjunction with other surgical facilities. “Convalescent centers (CC) represent one of the options, also an apartment setting monitored by individuals with medical backgrounds,” he says. “A vast majority of our patients, however, can safely leave within the window as appropriate for ASCs.”

Asher's ASC does not currently have a lot of provisions for situations when patients need to stay longer than 24 hours, he says. "When these rare situations arise, we document in the medical record the circumstances preventing discharge and state why the patient requires a longer stay. Because our focus is on identifying patients most appropriate for an acute surgical experience lasting less than 24 hours, we do our very best to model those experiences beforehand, based on data that predicts an ability to safely discharge a patient with the prescribed time period."

After the discharge, it is important that we intervene quickly, Asher says. "Our data suggests that within the first two weeks after discharge, pain control and medical complications are the main reasons why patients require hospital admission. If we intervene on time, we can prevent that occurrence. Specifically, we optimize our patients' preop pain control and medical status and we routinely follow up in the first two days postop because those are the intervals that afford us the best opportunities to achieve successful clinical outcomes."

Gollogly says his center experimented with CCs but found that the satisfaction level was not very high. "Our ASC patients did not want to be co-housed with sicker patients," he says.

Patients do the best at home with family members, Gollogly continues. "We call the family members to coach and they reinforce the teaching of our staff and the physical therapy (PT) staff. We typically send them home with PT and home nursing services. How much they use those services depends on how disabled they were preoperatively."

Home health agencies send nurses who can help with medical questions, clarification of medicine doses, pain and nausea management, and dressing care, Gollogly says. "However, most patient needs are social, like getting out of bed, getting a glass of water, etc. The social support makes a difference.



“ *If you have a local community that can care for the patients, the surgeries in the outpatient setting will be successful. That trend is reflected across the country. Patients are going home the same day.”*

—Sohrab Gollogly, MD, Monterey Spine and Joint and Monterey Peninsula Surgery Center

Someone with a good social support—such as an able-bodied family member who can stay with the patient three to five days after surgery—makes for a good high-acuity patient candidate for an ASC.”

Jablonski's ASC is partnering successfully with an SNF and a home care agency. "It is important to find a company that will work with your protocols," she says. "Not every home care agency will do IV medication, like Toradol, or have the PT meet the patient at home. So, it takes cooperation."

The insurance piece can be challenging, she adds. "The SNF has to work on getting contracts in place to ensure they receive adequate reimbursement for higher acuity patients who are discharged from surgery the same day versus the typical patient they see who has had a few days of

hospital recovery," she explains. "We also have bundled pricing agreements in place where we contract for all the surgical services in addition to SNF and home health care services." This, however, could take a while, she cautions. "We have been using SNFs since 2009, and we waited, sometimes for a year or more, for a contract to be put in place. Some insurance carriers follow Medicare guidelines for three-night hospital stay requirements prior to admission to the SNFs. This requires us to work on a waiver where the insurance carrier removes the hospital stay requirement. If we do not receive a waiver, we are unable to accommodate the patient's surgery at our ASC and need to send that patient to a hospital."

Given current trends in health care—like value-based payments and price transparency—it is important to



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deliver maximum value, especially, with the higher acuity patients and more complex cases, Jablonski says. “It is much cheaper to spend two to three nights at an SNF than in a hospital—at least 30 percent cheaper in our market,” she says. “Plus, patients like the security of knowing resources are available to control their pain and that their physical therapy will get started on the right track. Most of our patients want to stay longer because they are being taken care of in a hotel-like environment. Surgeons like it, too, because they can keep tabs on the patients.”

If the primary issue preventing discharge to home is limited to pain control, it would make sense to look

at extended stay, Asher agrees. “Such patients don’t need to be in a hospital, and it would make perfect sense to house them in a CC. Part of the problem, however, is there is presently no good mechanism to reimburse for that service,” he says. “Logically speaking, if an extra day in a hospital costs \$800 to \$900, it surely would make more sense for a patient to stay for half or a full extra day in a modified apartment setting where they would have ready access to an individual with a medical background—an RN or a PA—who’d drop by to check on them. But such an arrangement has to work on both practical and financial levels, in addition to being in the best interest of the patient.”

Conclusion

The state of California has a robust program for performing outpatient total knee arthroplasty (TKA), Gollogly says. “These procedures are performed safely in an ASC for approximately 50 percent of the cost of the same procedure performed as an inpatient,” he says. “The clinical outcomes and patient satisfaction scores are equal to or better than the inpatient environment.”

A retrospective review of 100 consecutive patients undergoing total knee replacement at two ASCs in Carlsbad and Monterey, California, revealed that the average age of patients was 59.2, there were zero hospital admissions within five days, one ER visit for uncontrolled pain, zero infections and more than 99 percent of satisfaction scores, Gollogly says. “The conclusion was that patients that score as having minimal or moderate risk using our preoperative assessment tool are able to tolerate outpatient joint replacement surgery and leave the center within two hours. Retrospectively, they report high levels of satisfaction, good pain control and minimal risk of readmission or ER visits after the procedure.”

Asher’s group has published an article describing a similar experience in patients undergoing cervical fusion. According to that report, individuals who received surgery in an ASC achieved equivalent outcomes compared to a matched cohort treated in an inpatient environment, with considerable associated cost savings.

“In my experience, it does not matter which aspect of joint surgery you look at,” Gollogly says. “There have been many peer-reviewed articles written, if you have a local community that can care for the patients, the surgeries in the outpatient setting will be successful. That trend is reflected across the country. Patients are going home the same day.”