

2021 SENATE INDUSTRY, BUSINESS AND LABOR

SB 2334

2021 SENATE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee Fort Union Room, State Capitol

SB 2334
2/1/2021

relating to the licensure of extended stay centers
--

Chair Klein opened the hearing at 8:59 a.m. Members present: Senators Klein, Larsen, Burckhard, Vedaa, and Kreun. Senator Marcellais absent.

Discussion Topics:

- Need for extended stay centers
- Extended stay centers in relation to hospitals
- Insurance for extended stay centers

Senator Myrdal introduced the bill and testified in favor [9:01].

Scott Meske testified in favor and submitted testimony #4459 [9:05].

Duncan Ackerman, orthopedic surgeon testified in favor and submitted testimony #4415 [9:07].

Courtney Koebele, ND Medical Association testified in favor and submitted testimony #4350.

Jed LaPlante, Center for Special Surgery testified in favor and submitted testimony #4378 [9:33].

Robert Clayburgh, orthopedic surgeon testified in favor and submitted testimony #4399 [9:43].

Megan Hoan, ND Blue Cross Blue Shield testified in neutral [10:00].

Additional written testimony: 4288, 4382, 4383, 4384, 4392

Senator Burckhard moved to adopt Amendment 21.1045.01001 [10:04].

Senator Kreun seconded the motion [10:04].

[10:05]

Senators	Vote
Senator Jerry Klein	Y
Senator Doug Larsen	Y
Senator Randy A. Burckhard	Y
Senator Curt Kreun	Y
Senator Richard Marcellais	A
Senator Shawn Vedaa	Y

Motion passed: 5-0-1

Senator Burckhard moved a DO PASS AS AMENDED [10:06].

Senator Kreun seconded the motion [10:06].

[10:06]

Senators	Vote
Senator Jerry Klein	Y
Senator Doug Larsen	Y
Senator Randy A. Burckhard	Y
Senator Curt Kreun	Y
Senator Richard Marcellais	A
Senator Shawn Vedaa	Y

Motion passed: 5-0-1

Senator Burckhard will carry the bill [10:07].

Chair Klein ended the hearing at 10:07 a.m.

Isabella Grotberg, Committee Clerk

February 1, 2021

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2/1
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PROPOSED AMENDMENTS TO SENATE BILL NO. 2334

- Page 1, line 2, replace "licensure" with "registration"
- Page 1, line 15, replace "**License**" with "**Registration**"
- Page 1, line 16, replace "license" with "certificate of registration"
- Page 1, line 18, replace "license" with "certificate of registration"
- Page 1, line 19, replace "**licenses**" with "**certificate of registration**"
- Page 1, line 20, replace "licensure" with "certificate"
- Page 1, line 22, replace "license" with "certificate"
- Page 1, line 23, replace "**licensure**" with "**registration**"
- Page 1, line 24, replace "licensure" with "registration"
- Page 2, line 1, replace "a facility" with "one or more facilities"
- Page 3, line 4, replace "**license**" with "**certificate of registration**"
- Page 3, line 5, replace "license" with "certificate of registration"
- Page 3, line 15, replace "license" with "certificate of registration"
- Page 3, line 16, replace "license" with "certificate of registration"
- Page 3, line 17, replace "licensed" with "registered"
- Page 3, line 19, replace "licensing" with "registering"
- Page 3, line 23, replace "license" with "certificate of registration"
- Page 3, line 26, after "licensing" insert "or registration"
- Re-number accordingly

REPORT OF STANDING COMMITTEE

SB 2334: Industry, Business and Labor Committee (Sen. Klein, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). SB 2334 was placed on the Sixth order on the calendar.

Page 1, line 2, replace "licensure" with "registration"

Page 1, line 15, replace "License" with "Registration"

Page 1, line 16, replace "license" with "certificate of registration"

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Page 3, line 15, replace "license" with "certificate of registration"

Page 3, line 16, replace "license" with "certificate of registration"

Page 3, line 17, replace "licensed" with "registered"

Page 3, line 19, replace "licensing" with "registering"

Page 3, line 23, replace "license" with "certificate of registration"

Page 3, line 26, after "licensing" insert "or registration"

Renumber accordingly



EXTENDED STAY CENTERS GIVE PATIENTS MORE CHOICE AND REDUCE HEALTHCARE COSTS

SENATE BILL NO. 2334 – EXTENDED STAY CENTERS

SB 2334 creates a new chapter, 23-17.6, of the North Dakota Century Code, relating to the licensure of extended stay centers.

Extended stay centers (ESC) lower costs for patients who may require additional oversight and supervision following a standard medical procedure. Patients electing to have surgery performed by a licensed private practice surgeon are required to be discharged within 24 hours of admittance, regardless of recovery condition progress. High risk patients are transferred to an inpatient medical facility for further observation.

IMPROVED ACCESS TO HEALTHCARE:

Ambulatory surgical centers operate (ASC) more efficiently and can handle larger volumes of patients, meaning patients avoid scheduling backlogs and doctor shortages are offset by greater production from current physicians.

SAFER TREATMENT:

Ambulatory surgical centers outperform in-patient facilities in terms of patient outcomes, including re-admission and infection rates.

HIGHER RISK PATIENTS STILL TREATED AT IN-PATIENT FACILITIES:

Surgeons are always responsible for patient outcomes and are incentivized through performance metrics, insurance oversight, and licensure repercussions to select in-patient facilities to treat higher-risk patients. Extended stay centers allow physicians to choose the best option for their surgical outpatient's, discharge, extended stay center observation, or admittance to a hospital.

AFFORDABLE CARE OPTIONS:

Ambulatory surgical centers, in most cases, lower the total cost of care dramatically. Registered extended stay centers create affordable care options for patients and relieve undue pressure on already overburdened hospitals.

PATIENT OCCUPANCY LIMITATIONS:

The extended stay center would have no more than two recovery beds for each operating room affiliated with the ambulatory surgery center and would not exceed a total of sixteen recovery beds.

ADMITTANCE & LOCATION:

Extended stay center may only accept patients from an ambulatory surgical center and must be separated physically.

LENGTH OF STAY:

All patients would be discharged within 48 hours from the time of admission to the ESC.

INDUSTRY & INNOVATION:

Extended stay centers are a major trend in the healthcare industry across the country – saving significant dollars for patients and the health care industry.

REGISTRATION REQUIREMENTS:

Extended stay centers would meet the minimum standards for licensure, be affiliated with a facility certified by the centers for Medicare and Medicaid services as an ambulatory surgical center. The Extended Stay Center chapter in the Century Code contains structure for licensing and provides the ND Department of Health administrative rule authority to create administrative rules for the licensing and oversight of extended stay centers.

BACKGROUND & DEFINITIONS:

- ASC: "Ambulatory Surgical Center", more often called an outpatient surgical center, an ASC provides general, orthopedic, cardiovascular, and many other surgery services and may provide care for a patient for up to 24 hours, most often measured from the time the patient is admitted into "the back" from the waiting room.
- ESC: "Extended Stay Center", a facility, connected physically and/or through a business relationship to an ASC, which provides care lasting more than 24 hours to patients who need extra time for managing pain or bodily functions, who do not have a caregiver at home, or who may require extended travel time to return home after a surgical procedure.
- Currently in North Dakota: ASCs are limited to 24 hours of care. ESCs will require a new category by law.

Supported by North Dakotans for Open Access Healthcare.

Contact: Duncan Ackerman, M.D. | dackerman@bone-joint.com

Testimony

Senate Bill 2334

Industry, Business, and Labor Committee

Senator Jerry Klein, Chairman

2/1/2021

Chairman Klein, and distinguished members of the IBL Committee, my name is Duncan Ackerman. I am native to North Dakota, born and raised in Minot, and I am an Orthopedic Surgeon who has practiced in North Dakota since completing my residency and fellowship training at The Mayo Clinic in 2009. My family proudly chose to return to our great state to practice medicine and have since been afforded the opportunity to improve the lives of many our friends and neighbors.

I am also an owner / partner in two small businesses. The first, The Bone & Joint Center, is an Orthopedic Surgery clinic that provides a broad scope of musculoskeletal care. There are nine partners in the practice with eight of the partners hailing from North Dakota. The places we grew up include Hillsboro, Bowman, Kenmare, Lansford, Minot, Turtle Lake, and Bismarck. The Bone & Joint Center was established in 1973 and continues to serve the residents of North Dakota. We have permanent offices in Bismarck, Dickinson, and Minot along with outreach locations in Garrison, Turtle Lake, Hazen, Beulah, Williston, Hettinger, Linton, and Wishek.

I am also an owner / partner of Bismarck Surgical Associates (BSA). BSA is an outpatient ambulatory surgery center (ASC). My partners are Orthopedic Surgeons, Anesthesiologists, and an Ophthalmologist. We perform a full array of outpatient procedures from cataract surgery to total joint replacement. ASCs, which were established in 1970, have proven to provide lower cost, high quality care.

The public's demand of transparency has resulted in a shift in health care delivery to lower cost alternatives. The Centers for Medicare and Medicaid Services (CMS) has developed an online tool for

patients to research the difference in cost when comparing surgery at an ASC versus a Hospital Outpatient Department (HOPD). Using national data, an ASC is paid about 56.39% of the HOPD rate for the exact same procedure, saving the Medicare and Medicaid systems more than 43 percent on average. I am an upper extremity specialist, so rotator cuff shoulder surgery is a common procedure in my practice. Utilizing CMS's tool, we can look at and compare the cost difference for arthroscopic rotator cuff repair in an ASC vs. HOPD. In an ASC, the total cost for arthroscopic rotator cuff repair is \$3,918, Medicare pays \$3,134, the patients responsibility is \$783. In comparison, the total cost for the same procedure at a HOPD is \$7,096, Medicare pays \$5,677, the patient's responsibility is \$1,419. The savings are clear, procedures performed in an ASC cost the payor and consumer less than if performed in a HOPD.

Medicare this past year decided to discontinue the Inpatient Only List (IPO) of procedures. The IPO list was a list of procedures that could only be performed in a hospital inpatient setting, including common procedures such as total hip and total shoulder replacement. Medicare would not pay for a procedure on the IPO list to be performed at an ASC. Medicare's decision to discontinue the IPO list proves that CMS values the ASCs as a cost saving alternative to traditional hospital care. This decision will lead to patients having the additional option of having a procedure performed in an ASC, that historically could have only been performed in the hospital.

The Covid-19 Pandemic has also highlighted the need for additional patient choice. In-patient hospital systems were severely challenged by staffing issues, procurement challenges, and patient volumes. Several of my patients rescheduled their surgeries due to the concern of the procedure being done in the hospital environment where patients with Covid-19 were receiving care. In addition, several of my patients were required to be rescheduled because the hospital was at capacity and could not guarantee they would have the staff available to provide appropriate post-operative care. This may seem like a simple inconvenience, but we care for people that have a narrowly defined timeline to heal and return to feeding their families. This is a significant challenge for a farmer or rancher who must recover before

calving or planting, a patient trying to take advantage of already-met deductibles, or a WSI patient who wants to get back to work and off state assistance.

This leads us to discuss a new opportunity for our patients in North Dakota called an Extended Stay Center (ESC). Currently in North Dakota, patients are only allowed to stay in an ASC for up to 24 hours. The creation of the ESC would allow patients to stay up to 48 hours. Extended Stay Centers (ESC) are essentially recovery rooms for patients undergoing a procedure in an ASC. They are there for a patient who might need a little extra time and minor care to recover from surgery. The services included may be for pain management, physical therapy, or management of other bodily functions. Extended stay centers are not complicated, they are not meant to replace the hospital, and they are not a new concept. Other states, for instance Colorado and Arizona, have had convalescent care centers or recovery centers for many years. Reports from their experiences prove these centers are: 1) Patient centered, with very high patient satisfaction, 2) Outcomes driven, with infection and complication rates being extremely low and 3) Cost conscious, with dramatically lower costs to the patient and the health care system. In other states, there have been collaborative joint ventures of an ASC/ESC model and their local health system partner, benefiting the entire regional health care delivery system.

The added advantage of an ESC for our North Dakota patients is related our geographical footprint and population density. Most specialized orthopedic care, like total joint replacement, occurs in our population centers. Adding an ESC would allow our patients that travel a long distance the extra time they may need to recover prior to making the long trek back home. The hospitals, mandated by payors, typically have strict criteria for patients to qualify for a stay longer than 24 hours on some procedures. The ESC can give that patient with long travel distances, limited family support, or minor concerns the extra time needed to feel more comfortable before returning home. The additional time also allows physicians to care for their patients, without the pressure of having to send someone off to the hospital in an ambulance at 23 hours 59 minutes from admission to avoid penalty and burden to every party. The

transfer alone is costly, the insurance companies will be charged for a hospital stay, tests will likely be run, and the patient's continuity of care may be disrupted.

In conclusion the ESC model is not a new idea, it is not a complicated building, and the idea is about being focused on patient care. This model improves patient choice, decreases the overall cost of care, and maintains or improves quality. Please pass SB 2334. I would like to thank Chairman Klein and the distinguished members of this committee for your time and consideration.

I would be happy to take any questions from the Chairman and committee members.

Duncan B. Ackerman, MD



Senate IBL Committee

SB 2334

February 1, 2021

Good morning Chairman Klein and Committee Members. I am Courtney Koebele, the executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

The North Dakota Medical Association supports SB 2334 and urges a do pass from this committee.

Over the past two decades, as surgical techniques improved, surgery centers have moved toward increasingly complex procedures in patients that required longer recovery times. Many surgery centers now keep patients for nearly a full 24 hours after knee or hip replacements. The extended stay model provided for in this bill would allow for a greater percentage of those cases to be done at surgery centers. There is a continuing trend of shifting from inpatient to outpatient procedures, and the extended care center model allows for parallel care in a safe setting.

Extended stay centers could also cut costs for both public and private insurance plans and for patients. The cost of having a surgery done in a surgery center compared to a hospital is lower, resulting in lower co-pays and deductibles for patients, and lower costs for insurance companies.

NDMA respectfully requests a DO PASS on SB 2334. Thank you for your time today. I would be happy to answer any questions.

Testimony in support of SB 2334 – Extended Stay Centers**February 1, 2021**

Good morning Chairman Klein and Members of the Committee:

My name is Jed LaPlante, I am the Administrator of Center for Special Surgery in Fargo, a multi-specialty Ambulatory Surgery Center (ASC). Over the past 10 years of my career, I have worked in two different health systems as a Clinic Director and was the first employee hired to open Center for Special Surgery. In 2017, I obtained my Masters in Healthcare Administration from the University of Minnesota. I am here to testify in support of Senate Bill 2334, allowing the creation of extended stay centers for ambulatory surgery centers.

Cost, Value, Patient Experience:

ASCs perform surgical procedures, on average, at roughly 50-60% the cost of a hospital environment (comparing Medicare fee schedules). Extended Stay Centers may open the door for more patients and their health plans to recognize more savings as ASCs are able to innovate and start new service lines. Higher cost procedures will continue the migration from an inpatient environment to an outpatient/ASC environment in our near future. A 40% discount on a procedure like a cataract extraction provides hundreds of dollars of savings to the patient and health plan for each procedure performed. When you start saving 40% or more on total joint replacement and spine surgery, you recognize thousands of dollars of savings on every single procedure performed. The state of Oregon passed a bill for ESCs in 2018. Two of their state employee benefit systems anticipate to save \$12-\$15 million in a decade with the implementation of ESCs as outpatient surgery volume is expected to double over that same time period. (ASC Focus, March 2018)

Many of the procedures utilizing an ESC will still be done by the same private practice, self-employed physicians that are doing them now. This is simply a change of facility with a mindset that private practice physicians can and should impact the patient's care and experience. This is more about the patient experience than it is about anything else. We believe we have the opportunity to change surgery to feel more like a stay in a hotel, than an institution.

Maintaining a Free Market in North Dakota Healthcare:

Healthcare, over the years, has morphed to where physicians are more often employed than they are a business owner. While both structures can be successful, I do think it's important that we make sure that both options have a fair opportunity to exist in the future, even though I am not a physician. As health systems further desire to employ their physician base rather than contract with private practice groups, it becomes increasingly harder for a physician in private practice to obtain adequate operating room time, a voice regarding implant/technology decisions and the involvement in developing care pathways that make sense for each specialty and each physician. Extended stay centers will surely not replace the role of a hospital in a private practice as there will always be a time and a place for the hospital environment. However, it is another tool for a private practice physician may utilize to maintain independence if a relationship with a key partner deteriorates.

“Inpatient Only List” to be Abandoned by 2024:

The nation is currently trending towards ASC and ESC options, including policies from the federal government. In the Centers for Medicare and Medicaid Services (CMS) final payment rule for 2021, there is guidance from CMS that by the year 2024, there will no longer be a list of procedures that they deem not to be safe in an ambulatory surgery center environment. Earlier I mentioned the migration of inpatient procedures to an outpatient environment. This is not something the private practices in North Dakota created on their own. It's recognition on the federal level that techniques in both surgery and anesthesia have improved, along with technology of implants and instrumentation, that is creating this shift. We believe an Extended Stay Center partnered with an Ambulatory Surgery Center aligns the state of ND with what's to come from Medicare, which for us in Fargo, is the most common medical coverage we see across all of our specialties. Not allowing us to align with what's happening on a federal level will leave ND behind as other states benefit from new and innovative care models. I've used this saying a lot in my time in Fargo as we've worked through performing new procedures, "If we are to wait for Medicare to pave the way, we will forever be behind." We have the chance to get ahead of this now.

Thank you for your time and consideration this morning and I ask the Committee for a DO PASS recommendation on Senate Bill 2334.

Testimony in Support of Senate Bill 2334

The North Dakota Department of Health currently defines an Ambulatory Surgery Center (ASC) as any distinct entity that operates for the purpose of providing surgical services to patients not requiring hospitalization and the expected duration of services do not exceed 24 hours following an admission. An ASC must have a CMS agreement to participate in Medicare and meet the CMS “Conditions for Coverage”.

Of the approximate 57 million surgical procedures performed annually in the U.S. nearly 23 million are performed in ASC settings and 11.5 million performed in Hospital Out Patient Departments (HOPD). There are over 6,000 ASCs in the U.S. and around 13 in North Dakota. The trends over the last 15 years have been for more surgical procedures to migrate into outpatient settings and more from HOPDs to ASCs. Surgical procedures shifting to ASC settings has been driven by the higher patient satisfaction, lower overall complication rates, greater efficiency, and increased perceived value of a procedure performed in an ASC compared to a HOPD. Value is determined by dividing quality by cost. The ASC procedure value is a result of CMS reimbursement rates for the same procedure performed in an ASC that is independent from a hospital to be around 59% of the rate for the same procedure performed in an HOPD. These rates are determined by standardized CMS criteria on an annual basis.

ASCs in North Dakota are disadvantaged with the NDHD rule that a patient must be discharged from the facility within 24 hours of admission. Having the capability to provide care to postsurgical patients for a more extended time would improve patient care and allow an ASC to fulfill its responsibility to adequately manage nonlife-threatening postoperative complications. Serious major postoperative complications that occur at an ASC are currently managed via transferring the patient to a local hospital. Hospital transfers of patients from ASCs are reportable events to CMS, and if frequent might lead an ASC license suspension or revocation. ASCs desire to stringently avoid all transfers of care. Consequently, ASCs have policies regarding preoperative evaluation of patients via a current medical exam within 30 days of surgery and exclusion of patients with medical conditions that have a likelihood of needing a higher level of postoperative care provided only in a hospital. This would include ICU monitoring, prolonged ventilatory support, cardiology, pulmonary, or respiratory care, or advanced imaging such as CT or MRI scans.

However, there are minor postoperative complications which might occur such as postoperative bleeding, prolonged nausea, uncontrolled postoperative pain, or urinary retention which may take longer than 24 hours to resolve, but could be adequately managed with the staffing, equipment, and materials in an ASC, and avoid a transfer to a local hospital. Such a transfer disrupts the patient’s relationship with the surgical staff, anesthesia, and ASC facility, and entails additional costs of ambulance transfer and hospital charges for this additional care. The obligation and responsibility for an ASC to care for a patient until they are safe for discharge home is disrupted by the arbitrary 24-hour constraint. Extending the allowed length of stay to 48 hours would allow an ASC to provide better care to patients and avoid some expensive hospital transfers. It would be expected that ASC patient stays over 24 hours would be infrequent, as an ASC would utilize greater staff and supply resources for more extended care, without any increase in financial reimbursement. ASCs desire to fulfill their patient responsibilities when

they have the resources available. ASCs would prefer to not burden a hospital for a postoperative problem that might only require a bit more time to resolve.

In summary, Senate Bill 2334 would be beneficial for the business community and surgical health care in North Dakota for the following reasons...

- Allow ASCs to complete postoperative complication management within their expertise and facility resources without an arbitrary time constraint.
- Allow an ASC to fulfill its' responsibility for patient care till discharge home.
- Avoid unnecessary hospital transfers, particularly when patients frequently want to avoid a hospital setting. (This has been particularly relevant during the current Corona virus pandemic.)
- To enhance the current and future health care value of ASC procedures for health insurers, employers, patients and their families.

Respectively submitted on Monday, February 1st, 2021

Robert Clayburgh, MD

Orthopedic Surgeon
Valley Bone & Joint Clinic
Grand Forks, ND

Medical Director
North Dakota Surgery Center
Grand Forks, ND

David Schall MD

Valley Bone and Joint

Grand Forks, ND

SB 2334 – Extended Stay Centers

Dear members of the committee,

My name is David Schall MD from Grand Forks. I am currently a private practice Orthopedic Surgeon who has been practicing for over 18 years and I am currently operating and performing procedures at North Dakota Surgery Center in Grand Forks, an Ambulatory Surgery Center (ASC)

I am in favor of this bill and I feel it will directly benefit the citizens of North Dakota, improve their healthcare delivery, and have an indirect benefit by overall lowering healthcare costs.

By the year 2030, it is projected that up to 75% of all total joint replacement performed in the US will be done as an outpatient (staying in the hospital or surgery center less than 24 hours).

I have been performing joint replacements at an ASC for over 2 years. All my patients who are having joint replacements at our ASC are carefully selected, evaluated medically by their primary provider and deemed fit to proceed with their surgery and be discharged within 24 hours. All higher risk patients or those who we do not feel safe going home within 24 hours are all still treated at an in-patient facility (hospital).

There are instances when minor problems occur (such as nausea or urinary retention) and they need to stay longer than 24 hours but less than 48 hours. This would allow us to have patients stay for short periods longer and avoid an unnecessary transfer to an in-patient hospital setting. It will directly benefit the citizens of North Dakota by allowing expanded healthcare options in settings that have been shown to have better patient outcomes, lower infection rates, and higher patient satisfaction, without compromising safety, than in-patient settings.

In the current COVID pandemic, it allows a setting that minimizes patient and families risk to exposure and infection while offering improved access and flexibility with the changing dynamics brought on by the pandemic that larger settings cannot easily provide.

Ambulatory Surgery Centers/Extended Stay Centers markedly reduce the total cost of procedures which can significantly reduce the patients out of pocket costs in an age of high deductibles, as well as passing along significant savings to health insurance companies and workers comp.

In summary, I feel this bill will allow the modernization of health care delivery, especially in the uncertain times we are facing due to the pandemic. It will allow continued improved patient outcomes currently seen at ACS's at a significant cost savings to the patient and health insurance providers without compromising patient safety.

2019

Extended Stay Centers Guideline

Ambulatory Surgery Centers with Extended Stay
Centers: Appropriate Procedures and Patient
Characteristics



Acknowledgments

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Executive Summary

Extended stay centers (ESCs) are a new type of facility that will be licensed in Oregon according to the requirements of House Bill 4020 (2018). ESCs will operate in conjunction with (but as separate entities from) ambulatory surgery centers (ASCs). Patients may stay up to 48 hours (including time in the ASC), rather than the 24 hours currently allowed at an ASC.

HB 4020 also charged the Health Evidence Review Commission (HERC) with developing evidence-based guidelines regarding the patient characteristics and surgical procedures that may be appropriate for ambulatory surgical centers and extended stay centers and reporting a timeline and plan for implementing the guidelines to the Legislative Assembly during the 2019 regular session.

HB 4020 did not change the 24-hour limit on an ASC duration of stay. The requirements for ASC discharge status also have not changed. New Oregon Administrative Rules only require that the patient must be physiologically stable at the time of ESC admission and not in need of intensive monitoring or hospital-level care. The availability of ESCs should not have a major impact on the types of surgical procedures performed in the ASC setting, but ESCs may expand the range of patients eligible for ASC procedures.

The ESCs may be a useful option for patients who:

- Need extra time for managing pain or bodily functions,
- Do not have a caregiver at home, or
- May require extended travel time to return home after a surgical procedure.

Evidence Summary

Because of limited U.S. experience with ESCs or similar settings, no direct evidence exists regarding the effect these facilities may have on the safety and appropriateness of surgeries in an ambulatory setting. Existing data is either noncomparative or focused on patients and procedures that the authors consider appropriate for ambulatory surgery without ESCs or similar facilities.

Given these limitations of the published medical literature, HERC conducted searches on the safety of selected procedures performed in ASCs. The procedures included: knee replacement, hip replacement, mastectomy, bariatric surgery, spinal laminectomy, lumbar fusion, cholecystectomy, hysterectomy, transurethral resection of the prostate (TURP) and neck dissection. There was very low certainty evidence that these select surgical procedures can be safely performed in ASC settings and that ASC surgical outcomes may be similar to the same procedure when performed in a hospital outpatient setting (on the basis of historical controls). The evidence rating reflects a very high risk of bias in these studies related to patient selection and baseline differences in operative risk as well as incomplete methods for ascertaining outcomes. The generalizability of these findings is also limited because many of the studies reported single-center or single-operator experiences.

To develop evidence-based guidelines, more comparative outcome studies of ASC-based procedures vs. hospital-based procedures are needed for procedures that might be considered for ESC use, preferably with randomized assignment and standardized inclusion criteria. As ESCs are implemented, outcome studies comparing ASCs with and without ESCs with other settings would be the gold standard to

develop guidelines for appropriate procedures and patient characteristics. Although such research is unlikely to be funded, the Oregon Health Authority plans to resume collecting discharge data for ASCs and begin collecting discharge data on ESCs in the future. Analysis of these data, linked with other data to capture all outcomes related to patients seen in ESCs, could inform decisions about the need for more research on the impact of these facilities.

Surgical Risk Calculators

Using surgical risk calculators based primarily on hospital data, HERC reviewed hypothetical patient profiles for selected surgical procedures in an attempt to identify procedures and patient characteristics of acceptable risk, for which an ESC would potentially be beneficial in reducing rates of hospital transfer or the severity of complications. The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) Surgical Risk Calculator, as well as several procedure-specific risk calculators, showed that complication rates, hospital readmission rates, and predicted lengths of stay tend to increase with patient age and the presence of medical conditions such as diabetes, hypertension, obesity, and congestive heart failure. It is possible that care for older or more complicated patients in an ESC could reduce hospitalization rates and provide a safe environment to address post-ASC complications. However, in the absence of data comparing ASC and hospital-based procedures, outputs generated from the surgical risk calculators do not allow us to quantify or predict these potential benefits, nor to predict any increased risk attributable to the ASC setting. The surgical risk calculators do not permit determination as to which complications (e.g., infection rates) might be reduced in rate or severity, or which patient conditions might benefit most from ESC availability. The surgical risk calculators appear to be useful for individual patient consultation and decision making (their intended use), but it is not possible to make specific policy decisions based on them.

Policies in Other States

Four other states license recovery care centers that are similar to Oregon ESCs, but no state monitoring or outcomes data was found to be publicly available for review. Accreditation standards for ASCs were reviewed, but there are no criteria specific for ESCs because this type of facility is new and not certified by the Centers for Medicare & Medicaid Services (CMS) for Medicare.

The Oregon Patient Safety Commission (OPSC) monitors adverse events through a voluntary reporting program that includes ASCs. The most common postsurgical adverse event reported for ASCs was unplanned hospital admission within 48 hours, followed by unplanned emergency department visit within 48 hours. The availability of ESCs may be beneficial in reducing these rates, and these rates can be monitored in the future. The current OPSC annual reports are not useful in developing guidelines for ASC-ESC use.

Conclusion

In summary, the evidence and supplemental resources currently available are indirect and insufficient to guide decisions on patient characteristics and surgical procedures that may be appropriate for ASCs and ESCs. HERC developed the following guideline:

In the presence of an ESC, the surgical services provided in an ASC should be for patients not requiring hospitalization and for whom the expected duration of services in the ASC would not

exceed 24 hours after an admission to the ASC. The presence of an ESC should not expand the surgical risk profile or the procedures permissible in an ASC. ESCs should be utilized for patients who need extra time for managing pain or bodily functions, who do not have a caregiver at home, or who may require extended travel time to return home after a surgical procedure.

Background

In 2018, House Bill 4020 was enacted into Oregon Revised Statutes. This bill provides for the licensing of ESCs, a new kind of facility that will be licensed in Oregon. ESCs will operate in conjunction with, but as separate entities from, ASCs. Patients could stay up to 48 hours (including time in an ASC), rather than the 24 hours maximum allowed at an ASC. Certain patients who would currently receive surgery in a hospital setting would have the option of receiving the surgery in an ASC. These patients might receive help with pain management, nausea, or other postsurgical symptoms that might be difficult or uncomfortable to receive in a home setting, but which would not require hospitalization.

House Bill 4020 requires the Health Evidence Review Commission (HERC) to develop “...evidence-based guidelines regarding the patient characteristics and surgical procedures that may be appropriate for ambulatory surgical centers and extended stay centers.” The effort to reduce costs and the improvement of surgical techniques led to the development of ASCs in the 1970s (Steinmann et al., 2018). ASCs are used for less complex surgeries where being without full access to the resources available in a hospital setting does not compromise patient safety (Steinmann et al., 2018). The first ASC opened in 1970 in Phoenix, AZ (Steinmann et al., 2018). Over the years, more types of surgeries have been allowed in ASCs because of improved anesthetic procedures and less invasive surgical techniques (California Orthopedic Association, 2017).

ASCs are only allowed to perform surgeries in cases when the patient is very likely to be discharged in less than 24 hours. Four states allow extended monitoring and pain management to occur in a recovery care center (RCC), which serves in a similar role to an ESC: Arizona, Colorado (licensed as convalescent centers), Connecticut, and Illinois. At least two other states have considered legislation to create RCCs, including Florida (Smernoff, 2017) and Washington (Washington State Senate Committee on Ways & Means, 2016).

Methodological Approach

Because of limited U.S. experience with ESCs or similar settings, no direct evidence exists regarding the effect these facilities may have on the safety and appropriateness of surgeries in such a setting. Existing data is either noncomparative or focused on patients and procedures the authors considered appropriate for ambulatory surgery without ESCs or similar facilities. In addition to reviewing these data, we used accepted surgical risk calculators to analyze surgeries and patient characteristics that could be considered in an ambulatory setting that wouldn’t have been appropriate without an ESC.

A surgery would most likely be considered appropriate if risks for the patient are similar to the patients’ risks described in observational data in ASCs or if the care available in an ASC-ESC combination would be sufficient to address these complications safely and without an emergency hospital transfer. By contrast, a surgery for a patient likely to experience severe complications that would be better addressed in a hospital would not be appropriate. In addition, if there is a significant risk that a stay beyond 48 hours will be needed, the surgery would not be appropriate for that patient in an ASC-ESC setting.

Evidence on Procedures Performed in Ambulatory Surgery Centers

We conducted searches on the safety of procedures performed in ASCs for knee and hip arthroplasty, mastectomy, bariatric surgery, spinal surgeries, cholecystectomy, hysterectomy, neck dissection, and transurethral resection of the prostate (TURP). Studies were included if the study compared outcomes in ASCs to other sites, or if the study assessed outcomes only in ASCs (noncomparative studies). Our search did not identify any studies of hysterectomy, neck dissection, or TURP performed in ASCs.

Across the procedures searched, there is very sparse evidence comparing ASCs to other sites of care. In addition, there is evidence from noncomparative studies (case series) reporting outcomes for surgeries occurring in ASCs; often these case series do not specify whether the surgery occurred in an ASC or an outpatient hospital. Case series are subject to selection bias.

Knee and Hip Arthroplasty

For knee and hip arthroplasty procedures, the search identified the following two studies that compared outcomes by site of care.

Cody et al., 2018

The study by Cody et al. compared outcomes for unicompartmental knee arthroplasty (UKA) performed at either an ASC or as a hospital outpatient procedure (HOP). All patients undergoing this procedure with a single surgeon between 2012 and 2016 were included in the retrospective analysis. Medial and lateral unicondylar procedures were included. The site of the procedure was determined by the patients' preferred date for surgery, operating room availability, and insurance coverage. Anesthesia and procedural characteristics were the same regardless of the site of care. In the overall analysis, there were 288 ASC procedures and 281 HOP procedures. Patient characteristics were similar at both sites; the mean age was 63 years, the mean BMI was around 30, and there were slightly more women than men. The overall 90-day complication rate was 5.3% and did not significantly differ between ASC (4.2%) and HOP (6.4%) ($p = 0.26$). There were no statistically significant differences in the rates of early deep infection, emergency department visits, or hospital admissions at 90 days. The authors concluded that UKA can be safely performed in both ASC and HOP settings.

Browne et al., 2008

The study by Browne et al. is a prospective cohort comparing patients undergoing a variety of procedures at one of six Independent Sector Treatment Centers (ISTCs) or a National Health Service (NHS) hospital in England between 2006 and 2007. The authors included 323 NHS and 187 ISTC knee replacements in their analysis. Patients who were treated at NHS hospitals were more likely to report fair or poor health, to have undergone previous similar surgery, have any comorbidity, and have higher deprivation scores compared to those treated in ISTCs. Overall, 85% of ISTC patients and 87% of NHS patients rated their surgery as successful; after adjusting for baseline differences, there remained no statistically significant difference in patient-reported outcomes for knee replacement at either site. However, the overall rate of complications was greater at NHS facilities compared to ISTCs even after adjustment for baseline risks (adjusted odds ratio [aOR] 0.43, 95% CI 0.27 to 0.69, $p < 0.001$); wound infections (aOR 0.50, 95% CI 0.28 to 0.90, $p = 0.02$), urinary problems (aOR 0.51, 95% CI 0.29 to 0.88,

p = 0.02), and adverse drug reactions (aOR 0.65, 95% CI 0.43 to 0.97, p = 0.02). All complications occurred less often in the ISTC group, but bleeding complications were not significantly different between sites (aOR 0.45, 95% CI 0.14 to 1.4, p = 0.2). The authors cautioned that their risk adjustment model had poor predictive power, and therefore was unlikely to fully account for baseline differences between the ISTC and NHS groups.

The study authors included 291 NHS and 184 ISTC hip replacements in their analysis. Patients who were treated at NHS hospitals were more likely to report fair or poor health, to have undergone previous similar surgery, have any comorbidity, and have higher deprivation scores compared to those treated in ISTCs. Overall, 98% of ISTC patients and 92% of NHS patients rated their surgery as successful. Patients treated in ISTCs had statistically significantly better patient-reported outcomes on the EQ-5D and Oxford hip scale, and these differences remained significant after adjusting for baseline differences. There was no statistically significant difference in the overall rate of complications between patients treated in an ISTC and those treated at an NHS facility (aOR 0.87, 95% CI 0.52 to 1.5), and none of the specific complications varied significantly between the groups.

Our search identified the following five noncomparative studies of knee and hip arthroplasty procedures.

Berend et al., 2018

This is a brief report of the outcomes of outpatient arthroplasty procedures performed at a single ASC in Indianapolis. No methods were described, but the study reported outcomes of 1,230 arthroplasty cases performed in a two-year period. The authors did not provide information on patient characteristics. The procedures were partial knee arthroplasty, total knee arthroplasty, total hip arthroplasty, and unspecified selected revision procedures, although the authors did not provide details on the number of procedures by type. They observed that the overall readmission rate among these patients was 2%, but did not describe any methods for ascertaining the outcome of readmission. The authors observed that patient satisfaction was high: 98% of respondents rated their experience as good or great. However, neither the patient satisfaction survey instrument nor the survey response rate were described.

Parcells et al., 2016

This is a retrospective case series of 51 consecutive patients undergoing total joint arthroplasty in an ASC between 2012 and 2014. All of the procedures were performed by one of three surgeons. Among the included cases, there were 22 total hip arthroplasties, 14 TKAs, and 14 UKAs. Across the three procedures, patients had a mean age ranging from 55 to 61 years, mean BMI of 29 to 32 kg/m², and mean American Society of Anesthesiologists (ASA) classification of 1.9 to 2.2. The mean follow-up period was 15 months. The authors stated that outcomes were ascertained using a uniform patient follow-up protocol, but did not provide additional details. The average operative time was about 130 minutes for all procedures. Average time from admission to discharge ranged from 371 minutes in the UKA group to 426 minutes in the TKA group. Adverse events were mild and predominantly related to nausea and vomiting (31% of patients). All but one of the patients were discharged to their homes within 24 hours of admission; one was discharged to a rehabilitation facility within 24 hours. There were no infections or cardiac or thromboembolic complications at up to 90 days of follow-up.

Berend et al., 2018

This is a retrospective case series describing outcomes for 1,279 patients who underwent 1,427 total hip arthroplasties at an ASC between June 2013 and December 2016. The mean age of the patients was 57 years old, the mean BMI was 30 kg/m², and 54% were men. Patients eligible for ASC procedures had to have “appropriate medical insurance” and had to be functionally independent. Patients with heart failure, chronic obstructive pulmonary disease (COPD), untreated obstructive sleep apnea, hemodialysis, anemia, cerebrovascular accident, or delirium were excluded if these conditions could not be optimized prior to the procedure. At baseline, 3.4% of patients had coronary disease, 14.8% had an arrhythmia, 1.9% had venous thromboembolism, 11.6% had OSA, 8.4% had COPD, 8% had asthma, and 14.7% had urinary frequency. Overall, 87 (5.9%) of patients required overnight 23-hour observation; in 39 cases this was for patient convenience, and the remaining overnight stays were for medical observation of urinary retention, OSA, nausea and vomiting, hypoxemia, or pain. Within 48 hours after the procedure, five patients (0.3%) had major complications, and three required transfer to a hospital (two cases of atrial fibrillation and one case of anemia requiring transfusion). Beyond 48 hours, six patients had unplanned care needs arise (one case each of ileus, urosepsis, diverticulitis, fall, urinary retention, and chest pain), and one additional patient died. At 90 days there were 21 surgical complications (11 wound revisions, 5 incision and drainage procedures, 4 periprosthetic fractures, and 1 dislocation). The authors calculated the overall complication rate per case as 2.2% (32/1,472). When analyzed by the comorbidities present at baseline, patients with coronary disease, COPD, asthma, or urinary frequency all had a statistically significant increase in the risk of requiring overnight observation; the presence of any comorbidity increased the risk of overnight observation (RR 2.34, 95% CI 1.3 to 4.1).

Toy et al., 2018

This is a retrospective case series describing outcomes for 125 consecutive patients undergoing 145 total hip arthroplasty procedures performed in a three-year period by a single surgeon at two ASCs. Patients were ineligible to have their procedure at an ASC if they were over the age of 70, had a BMI greater than 35 kg/m², a history of thromboembolic events, or had undergone cardiac stenting or bypass surgery in the prior six months. The average age of patients was 55 years and the average BMI was 29.7 kg/m². Outcomes were ascertained at follow-up visits at two weeks, six weeks, and three months after the procedure. Overall, 16 patients had overnight stays at the ASC, but 10 of these were preplanned. One patient required transfer to a hospital for blood transfusion. Other complications were also uncommon: there was one case of persistent drainage requiring debridement, one periprosthetic fracture, one superficial wound revision, and one prosthetic hip dislocation that was treated in the emergency department.

Klein et al., 2017

This is a retrospective case series describing 90-day outcomes for 549 consecutive patients undergoing mini-posterior total hip arthroplasty at an ASC between 2008 and 2014. The average age of the patients was 54.4 years and the majority (68%) were men. The average ASA score was 1.6 and the average BMI was 28 kg/m². None of the patients required an overnight ASC stay after their procedure, but three patients (0.5%) were transferred to a hospital (one for pain control, one for unstable hardware on x-ray, and one for an acute exacerbation of polyarticular arthralgias with hypotension and bradycardia). One additional patient was seen in an emergency department for excessive sedation from opioid medications. In addition, the following complications were reported at an average of 630 days of follow-

up: hematoma requiring incision and drainage (6%), infection (0.9%), dislocation (1%), and venous thrombosis (0.5%). The authors observed that the rate of hematoma declined after the first 100 procedures performed.

Mastectomy

For breast procedures, including mastectomy, we identified two studies comparing ASCs to other sites of care.

Trentman et al., 2010

The study by Trentman et al. in 2010 used a natural experiment to compare procedures performed at an ASC to hospital outpatient procedures. In 2005, the authors of the study closed their ASC and began performing procedures at a hospital. The authors compared 92 consecutive patients undergoing breast procedures at the ASC between 2004 and 2005 to 92 consecutive patients who had their procedures performed as hospital outpatients beginning in 2006. All of the patients underwent segmental mastectomy with or without radioactive seed localization, sentinel lymph node biopsy, or axillary dissection. Total mastectomies and bilateral procedures were excluded. All procedures were performed by one of two staff surgeons. The average age of the patients was around 65 years old. Cases performed at the ASC used higher doses of intraoperative fentanyl and were more likely to be managed with propofol and laryngeal mask airways than procedures performed at the hospital. Overall, the preoperative time interval was shorter at the ASC (75 minutes vs. 130 minutes, $p < 0.001$) and the total facility time was also shorter at the ASC (343 minutes vs. 412 minutes, $p < 0.001$). There were no serious perioperative complications in either group, and no patients required hospital admission.

Parikh et al., 2016

The study by Parikh et al. compared the risk of surgical site infection in breast procedures by facility type. The authors performed a retrospective cohort study using data on 110,987 outpatient breast procedures between 2010 and 2014 with complete data in the National Healthcare Safety Network database. This database, maintained by the Centers for Disease Control and Prevention, received records from 139 ASCs and 242 hospitals during the study timeframe. The procedures included in this analysis were mastectomy, lumpectomy, incisional biopsy, and mammoplasty. The primary outcome of interest was any type of surgical site infection within 90 days of the procedure. An unconditional multivariate logistic regression analysis was done to compare the risk of surgical site infection by facility type. The case mix between ASCs and hospitals was adjusted for age, use of anesthesia, ASA class, duration of procedure, gender, wound category, and the year the procedure was done. After adjustment, the age-stratified risk ratio for surgical site infection at ASCs was 0.36 (95% CI 0.25 to 0.50, $p < 0.0001$) for patients age 51 or under, and 0.32 (95% CI 0.21 to 0.49, $p < 0.0001$) for patients older than age 51. In addition to potential inadequate control for confounding, the authors noted that there could have been differential rates of outcome ascertainment based on the facility type.

Bariatric Surgery

Three noncomparative studies were identified for bariatric surgery performed in ASCs.

Billing et al., 2017

This is a retrospective case series describing outcomes for 120 “high acuity” patients undergoing sleeve gastrectomy in a freestanding ASC. These patients were deemed “high acuity” because of age greater than 65 years ($n = 33$), male patients with BMI greater than 55 kg/m^2 ($n = 8$), female patients with BMI greater than 60 kg/m^2 , 72 patients with a history of previous bariatric surgery, and four patients with a history of prior fundoplication. Overall, the mean age of patients was 52 years and the mean BMI was 42.4 kg/m^2 . The mean operative time was 91 minutes. Overall, there were seven complications within 30 days (two portal vein thromboses, two postoperative bleeds, one intra-abdominal abscess, one intraabdominal hematoma, and one infected hematoma). Five patients required readmission within 30 days (4.2%) and an additional patient was transferred from the ASC to a hospital for an active arterial bleed requiring emergent reoperation. All but one of the complications occurred in a patient undergoing conversion of a gastric band to sleeve gastrectomy. The authors observed that these complication rates are similar to those reported for low risk patients.

Sasse et al., 2009

This is a retrospective case series describing outcomes for 38 patients undergoing laparoscopic Roux-en-Y gastric bypass (RYGB) and 210 patients undergoing laparoscopic adjustable gastric banding (LAGB) at an ASC. All of the patients were described as “highly selected,” meaning that they were approved by the ASC surgeon, anesthesiologist, and medical director; had no history of pulmonary hypertension; were ASA class 1 to 3; and had no or well-controlled sleep apnea. In the RYGB group, the mean age was 46 years, 89% were women, and the mean BMI was 44.71 kg/m^2 . In the LAGB group, the mean age was 46 years, 82% were women, and the mean BMI was 43.79 kg/m^2 . The mean operative time was 112.8 minutes in the RYGB group and 72 minutes in the LAGB group. Mean length of stay was 22 hours and 45 minutes in the RYGB group and seven hours and 18 minutes in the LAGB group. The 30-day complication rate was 2.6% in the RYGB group (one case of small bowel obstruction) and 1.9% in the LAGB group (one case of infected port/band and three cases of gastric pouch outlet obstruction). There were no deaths within 30 days in either group.

Watkins et al., 2008

This is prospective case series of 2,411 patients undergoing LAGB, of whom 84% had their surgery performed at an ASC. Overall, the mean age was 44 years, 83% were women, and the mean BMI was 45.7 kg/m^2 . There were 241 total complications (9.9%) including one death. The majority of complications were due to band slippage, port problems, or the need for pouch dilation; other complications included wound infections, pulmonary embolism, gastric edema, and need for band explanation. In reporting these complications, the authors did not separately report the rates of complications for the ASC compared to other sites.

Spinal Surgeries

We identified three comparative studies for spinal surgeries.

Chin et al., 2017

This is a retrospective cohort study comparing outcomes for 30 patients who underwent posterior lumbar fixation using cortical bone trajectory pedicle screws in an outpatient surgical center to 30 patients who underwent an inpatient lumbar fusion with traditional pedicle screws. The study methods

did not describe how the groups were assembled. All of the procedures were performed by a single surgeon. Patients were considered for surgery if they had greater than six months of lumbar pain despite conservative measures and the presence of disk herniation, degenerative disk disease, spinal stenosis, or chronic low back pain with or without radiculopathy or spondylolisthesis. Patients with trauma, fractures, malignancy, infection, unstable comorbidities, prior lumbar fusion, or BMI in excess of 42 kg/m² were excluded. Overall, the average age of patients was 58 years and the average BMI was 29 kg/m²; the average age was 48 in the outpatient group compared to 62 in the inpatient group, but the average BMI was similar in both groups. In the outpatient group at two-year follow-up, visual analog scale (VAS) back pain scores improved from 7.8 preoperatively to 2.5, VAS leg pain scores improved from 4.2 to 0.2, and Oswestry Disability Index (ODI) scores improved from 40.8 to 28.7 (all differences statistically significant at $p < 0.05$). In the inpatient group at two-year follow-up, VAS back pain scores improved from 7.2 preoperatively to 5.9, VAS leg pain scores improved from 5.0 to 1.9, and ODI scores improved from 44.6 to 32.5; in this group, ODI score improvement was the only statistically significant outcome. Complications were not specifically reported, but the mean estimated blood loss in the outpatient group was 152 mL compared to 319 mL in the inpatient group.

Chin et al., 2016

This is a retrospective cohort study comparing outcomes for 40 inpatients and 30 ASC outpatients undergoing lateral lumbar interbody fusion. All of the cases were performed by a single surgeon. Eligible patients had chronic low back pain due to degenerative disk disease or low-grade spondylolisthesis and had not responded to six months of conservative therapy. Patients were also required to have a BMI less than 42 kg/m², be ASA class 1 to 3, and have stable comorbid conditions. Patients with malignancy, infection, major acute trauma, history of pulmonary embolism, or prior lumbar surgery were excluded. The average age in the hospital group was 58 years compared to 60 years in the ASC group. The average BMI in the hospital group was 30.7 kg/m² compared to 28.4 kg/m² in the ASC group. In the ASC group at final follow-up (mean time not given), the VAS score improved from 7.3 to 4.1 ($p = 0.045$) and the ODI improved from 45.21 to 39.1 ($p = 0.368$). In the hospital group, the VAS score improved from 7.8 to 4.8 ($p = 0.004$) and the ODI increased (indicating worsened function) from 48.5 to 55.5 ($p = 0.398$). Operative time was lower in the ASC group (average difference 127 minutes), as was estimated blood loss (average difference 87 mL). The authors observed that complication rates were higher in the hospital group. For both groups, new onset dermatomal numbness was the most common complication, occurring in 20% of the hospital group and 7% of the ASC group; three patients in the hospital group also complained of weakness. The neurological complaints resolved more quickly in the ASC group (average of three months) than in the hospital group (average of six months).

Villavicencio et al., 2013

This is a retrospective cohort study comparing outcomes of transforaminal lumbar interbody fusion for 27 patients treated in an ASC and 25 patients treated in a hospital outpatient department. Patients were deemed eligible for outpatient surgery based on multiple factors including age, comorbid conditions, home support, travel distance, and personal preference. The mean follow-up time after the procedures was 25 months. The mean age of patients was 50 years and there were slightly more men than women. More patients in the hospital outpatient group had undergone previous spinal surgery (48%) than in the ASC group (26%). The surgical procedures also varied at the sites: 72% of hospital procedures used an open approach, and 81% of ASC procedures used a mini-open approach. The mean operative time was

146 minutes at the ASC and 196 minutes at the hospital; the estimated blood loss was 73 mL at the ASC and 179 mL at the hospital. The mean recovery time at the ASC was 4.4 hours compared to 21.5 hours at the hospital. The authors reported similar levels of pain relief and patient satisfaction in both groups. No ASC patients required hospital transfer. Four ASC patients (14%) had a complication (uncontrolled pain, wound infection, constipation, cerebrospinal fluid leak) within seven days of surgery compared to one hospital patient (4%) who had delirium tremens. Over the entire follow-up period, there were nine complication in the ASC group (33%) compared to three complications in the hospital group (12%). The average reimbursement to the ASC was \$18,420, but when implant and recombinant bone morphogenetic protein-2 were included, the average ASC reimbursement increased to \$29,983; the average reimbursement for hospital procedures was not reported.

Our search identified one systematic review and two individual noncomparative studies of spinal surgeries performed in ASCs.

Sivaganesan et al., 2018

This is a review of 39 studies examining the outcomes of various spine procedures performed at ASCs or outpatient surgery centers. The authors did not distinguish between these two sites of care in their analysis. The included studies were mainly retrospective cohort studies and case series. Quality assessment of the included studies was not reported.

- The authors identified 19 studies reporting on outcomes for anterior cervical discectomy and fusion:
 - 15 studies reported morbidity rates ranging from 0% to 5.2%
 - Five studies reported hospital transfer rates ranging from 0% to 6%
 - Nine studies reported readmission rates ranging from 0% to 5.4%
 - Four studies reported patient satisfaction rates ranging from 86% to 100%
- The authors identified 2 studies reporting on outcomes for anterior cervical arthroplasty:
 - Two studies reported morbidity rates ranging from 0% to 10.9%
 - Two studies reported hospital transfer rates of 0%
 - One study reported a readmission rate of 0%
 - One study reported a patient satisfaction rate of 100%
- The authors identified three studies reporting on outcomes for posterior cervical foraminotomy:
 - Three studies reported morbidity rates ranging from 0% to 2.2%
 - Three studies reported hospital transfer rates of 0%
 - One study reported a readmission rate of 0%
 - Three studies reported patient satisfaction rates of 90% to 94%
- The authors identified nine studies reporting on outcomes for lumbar laminectomy or microdiscectomy:
 - Nine studies reported morbidity rates ranging from 0% to 6.9%
 - Eight studies reported hospital transfer rates ranging from 0.6% to 6.6%
 - Two studies reported readmission rates ranging from 0% to 1%
- The authors identified seven studies reporting on outcomes for minimally invasive transforaminal lumbar interbody fusion and direct lateral lumbar fusion:
 - Seven studies reported morbidity rates ranging from 0.5% to 14%
 - Four studies reported hospital transfer rates ranging from 0% to 9.4%
 - Three studies reported readmission rates ranging from 0% to 5.7%

Smith et al., 2016

This is a retrospective case series describing outcomes for 72 consecutive patients undergoing lumbar interbody fusion procedures at a freestanding ASC. Of these patients, 54 had an extreme lateral interbody fusion (XLIF) and 18 had medicalized posterolateral fusion (PLF). The average age of the XLIF group was 50 years, 31% were women, the mean BMI was 28.8 kg/m², and 39% had undergone prior thoracic or lumbar spinal surgery. The average age in the PLF group was 53 years, 67% were women, the mean BMI was 28.2 kg/m², and 17% had undergone previous lumbar surgery. For the XLIF patients, the mean operative time was 86 minutes and the estimate blood loss was 71 mL; these figures were not reported for the PLF group. Two patients in the XLIF group required hospital transfer, one for urinary retention and one for uncontrolled pain. There were also two emergency department visits in the XLIF group, one for postoperative fever and one for testicular torsion. There were no reoperations in the XLIF group. In the PLF group, there were no complications observed and no transfers to the hospital.

Chin et al., 2015

This is a retrospective case series describing outcomes for 16 consecutive patients undergoing open single-level posterior lumbar interbody fusions at a freestanding ASC. Patients were eligible for inclusion if they had chronic disabling low back pain due to degenerative disc or facet disease or grade 1 spondylolisthesis with foraminal stenosis. ASA class 4 patients were excluded. In addition, eligible patients had to live within 30 minutes of a hospital, have a BMI less than 42 kg/m², and a responsible adult to provide care for up to two hours after the procedure. The mean age of included patients was 43 years, 56% were men, and the mean BMI was 28.95 kg/m². The mean operative time was 125 minutes and the mean estimated blood loss was 161 mL. At final follow-up (not specified), the mean VAS score improved from 8.4 to 4.96 ($p = 0.001$) and the mean ODI improved from 52.71 to 37.43 ($p = 0.04$). There was one postoperative complication of pain and incision site tenderness, possibly due to aseptic or infectious discitis.

Cholecystectomy

We identified two comparative studies of cholecystectomy.

Rosero et al., 2017

This is a linked database study that describes the incidence of readmission after ambulatory laparoscopic cholecystectomy. It relies on data from three states (California, Florida, and New York) that are submitted to the State Ambulatory Surgery and Services Database and the State Inpatient Database. Both databases are maintained by AHRQ. Outpatient laparoscopic cholecystectomy cases performed between January 1, 2009 and November 30, 2011 were included. The authors identified 230,745 encounters for ambulatory laparoscopic cholecystectomy across 890 ambulatory facilities (these were not necessarily specified to be ASCs). Patients were predominantly women (75%), middle-aged (approximately half were ages 40-64), and had few comorbidities (77% had a Charlson comorbidity index of zero). Roughly two-thirds of the patients had private insurance, but slightly more than 10% were covered by Medicaid. There were 127 patients (0.6 per 1000 discharges) who required transfer directly from the ambulatory facility to the hospital; these patients were more likely to have acute cholecystitis (15% vs. 9%, $p < 0.0001$). At 30 days postprocedure, 4,675 patients (20.2 per 1,000 discharges) were readmitted to a hospital; 11% of those readmissions occurred within 24 hours of discharge. Surgical complications, pain, nausea, and infection accounted for about two-thirds of the

readmissions. Reoperation was required for 147 patients (0.64 per 1,000 discharges), and endoscopic procedures to relieve bile duct obstruction were required for 903 patients (3.9 per 1,000 discharges). The incidence of inpatient mortality for readmitted patients was 8.5 per 1,000 hospitalizations. Characteristics associated with a greater likelihood of readmission were weekend procedures, older age, male sex, non-Hispanic white ethnicity, and the presence of comorbid conditions (hypertension, heart disease, diabetes, COPD, renal failure, cancer, or liver disease). The use of intraoperative cholangiography was associated with a reduced likelihood of readmission.

Paquette et al., 2008

This is a retrospective cohort study comparing outcomes for laparoscopic cholecystectomies performed at hospital outpatient facilities or ASCs. The authors identified 40,040 outpatient laparoscopic cholecystectomies performed in Florida between 2002 and 2003 using the AHRQ State Ambulatory Surgery Database. Of the 40,040 procedures identified, 38,544 were performed in hospital outpatient facilities and 1,496 were performed in ASCs. Compared to the hospital patients, ASC patients were younger, more likely to be Caucasian, and were less likely to have acute cholecystitis. ASC patients were also significantly less likely to have a history of coronary artery disease, hypertension, pulmonary disease, diabetes, or liver disease. Overall, 95.8% of ASC patients had a Charlson comorbidity index of zero compared to 85.2% of hospital patients. The rate of conversion to open cholecystectomy was not significantly different between the two groups (0.72% at ASCs vs. 0.95% at hospitals). Greater than 99% of patients in both groups were discharged home on the same day of the procedure, but 0.3% of hospital patients were admitted compared to 0% of the ASC patients. After controlling for case mix, the mean procedure charges were lower in ASCs (\$6,028) than in hospitals (\$10,876).

Four noncomparative studies were identified for cholecystectomy performed in ASCs.

Wenner et al., 2006

This is a retrospective case series describing outcomes for 338 patients undergoing laparoscopic cholecystectomy at a single ASC between 1999 and 2003. Most patients were women (80%) and the average age was roughly 44 years. Most patients were ASA class 2 (79%) or ASA class 1 (15%); the remaining patients were ASA class 3. The median operative time was 46 minutes. None of the cases were converted to open procedures. There were no cases of bile duct injury. There were three cases (0.9%) of postoperative bile leak. Six patients (1.78%) required hospital admission for various reasons including pleuritic chest pain, pancreatitis, subhepatic abscess, and three bile leaks. The authors observed that the cost of cholecystectomy at their ASC ranged between \$4,000 and \$6,000 compared to roughly \$16,000 in the local hospital.

Voyles et al., 1999

This is a retrospective case series describing outcomes for the first 100 patients undergoing cholecystectomy in a freestanding ASC. Patients were deemed to be ideal for ASC procedures if they presented for elective cholecystectomy with normal liver function tests, no common bile duct dilation, and age under 65, but these criteria were not strictly applied. All but one of the ASC procedures were successfully completed; one patient was transferred from the ASC to a hospital for an open cholecystectomy when the initial findings at laparoscopy suggested malignancy. The mean operative time was 29.1 minutes. The authors reported that there were no conversions to open procedures, no biliary or bowel complications, and no need for blood transfusions. Most patients (n = 74) were

discharged the same day, and the remaining patients were discharged the next morning. The authors observed that the cost for cholecystectomy at their ASC was \$2,990 compared to more than \$4,000 when performed at the hospital.

Farha et al., 1994

This is a retrospective case series describing outcomes for 55 patients undergoing laparoscopic cholecystectomy in a single freestanding ASC between 1992 and 1993. Patients were eligible if they were undergoing elective cholecystectomy for biliary colic. The mean age of patients was 42 years, and 82% were women. Four of the patients had additional procedures (mainly hernia repairs) done at the time of surgery. The mean operative time was 75 minutes. The mean recovery time was 252 minutes, excluding patients who had additional procedures. Four patients (7%) required overnight admission to a hospital for various reasons (myocardial infarction, need for intravenous antibiotics, bradycardia, and nausea). One additional patient was admitted one week after the procedure for right upper-quadrant pain, but was discharged after an unremarkable work-up. The authors observed that the cost for cholecystectomy at their ASC was \$2,300 compared to more than \$6,500 when performed at the hospital.

Reddick et al., 1992

This is a retrospective case series describing outcomes for 158 patients undergoing laparoscopic cholecystectomy at 24 freestanding surgical centers from June to November 1991. The procedures were performed by one of 36 general surgeons, and participating surgeons had to have performed at least 25 laparoscopic cholecystectomies prior to the beginning of the study. Patients with signs or symptoms of acute cholecystitis were excluded, as were those with previous abdominal surgery, age over 75 years, cardiac or pulmonary disease, or the use of chronic medications that would delay early discharge. Most patients (84%) were under age 55. The mean operative time was 90 minutes. There were no conversions to open procedures. Most patients (60%) were discharged on the day of the procedure; the remainder were discharged after an overnight stay in the ASC. No patients required hospital transfer and there were no readmissions.

Evidence Summary

The paucity of data directly comparing the outcomes of procedures performed at ASCs to procedures performed at hospital outpatient facilities makes it difficult to draw conclusions about the relative safety or efficacy of ASC-based surgical procedures. There is very low-certainty evidence, mainly from noncomparative studies of ASC outcomes, that several surgical procedures can be safely performed in ASC settings and that ASC surgical outcomes may be similar to those of the same procedure when performed in a hospital outpatient setting (on the basis of historical controls). The evidence rating reflects a very high risk of bias in these studies related to patient selection and baseline differences in operative risk, as well as incomplete methods for ascertaining outcomes. The generalizability of these findings is also limited because many of the studies reported single-center or single-operator experiences. Studies that compared hospital outpatient and inpatient procedures were more numerous, but such studies did not directly address the comparative outcomes associated with the use of ASCs and were not summarized for this evidence review.

Surgical Risk Calculators

Currently available surgical risk calculators are based primarily on hospital data (i.e., they are not specific to procedures performed in ASCs), and the inputs do not include the possibility of care in an ESC.

Nevertheless, hypothetical patient profiles were reviewed for selected surgical procedures, including healthy individuals and those with various medical conditions, in an attempt to identify procedures and patient characteristics of excessive risk level, for which the ASC-ESC combination might not be appropriate. Alternatively, situations with acceptable risk might be identified in which an ESC would potentially be beneficial in reducing rates of hospital transfer or the severity of complications.

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) Surgical Risk Calculator <https://riskcalculator.facs.org/RiskCalculator/> was selected as having the most useful outputs, including predicted length of stay and rates of complications, hospital readmission, and return to the operating room. However, for purposes of developing Oregon ESC guidelines, our ability to draw conclusions from the ACS NSQIP calculator was limited by risk-scoring based on hospital procedure data, and by not accounting for geographic variation (e.g., East Coast lengths of stay are generally longer than West Coast). For example, “two days” is the risk calculator-predicted length of stay for healthy patients younger than 65 undergoing total knee or total hip arthroplasty, yet these procedures are now routinely performed in Oregon ASCs where the 24-hour limit applies.

For all of the surgical procedures that were reviewed, complication rates, hospital readmission rates, and predicted lengths of stay tended to increase with patient age and with the presence of medical conditions such as diabetes, hypertension, obesity, and congestive heart failure. It is possible that care for older and sicker patients in an ESC could reduce hospitalization rates and provide a safe environment to address post-ASC complications. For example, in situations where the predicted length of stay is 1.5 days, an ESC admission might appropriately reduce the need for inpatient hospitalization. However, in the absence of data comparing ASC and hospital-based procedures, outputs generated from the surgical risk calculators do not allow us to quantify or predict these potential benefits. Risk calculator results do not allow us to draw conclusions as to which procedures might be safer with ESC care, which complications might be reduced (e.g., infection rates), or which patient conditions might benefit most from ESC availability. Older patients with multiple comorbid conditions are likely not appropriate candidates for ASC procedures, with or without the presence of an ESC. We are unable to develop specific ASC-ESC guidelines based on the use of available surgical risk calculators.

Procedure-specific surgical risk calculators show trends that are similar to those demonstrated in the more general ACS risk calculator. Using the SpineSage calculator for spinal surgeries, for example, as patient age and complexity of medical status increase, and as the “surgical invasiveness” of the procedure increases, the rates of complications (including infections and dural tears) also increase. But these risk calculators do not compare ASC rates with hospital-based rates, and they do not permit determination as to any benefit versus increased risk attributable to the ASC setting. In addition, they do not provide help in deciding whether or not the presence of an ESC would be beneficial in reducing the rate or severity of complications. The surgical risk calculators appear to be useful for individual patient consultation and decision-making (their intended use), but it is not possible to make specific policy decisions based on them.

Table 1 presents the characteristics of five selected general surgical risk calculators:

- American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) Surgical Risk Calculator - <https://riskcalculator.facs.org/RiskCalculator/>
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Surgical Outcome Risk Tool - <http://www.sortsurgery.com/>
- Revised Cardiac Risk Index for Pre-Operative Risk - <https://www.mdcalc.com/revised-cardiac-risk-index-pre-operative-risk>
- Physiological and Operative Severity Score for the enUmeration of Mortality and morbidity (POSSUM) - <https://www.mdcalc.com/possum-operative-morbidity-mortality-risk>
- Surgical Apgar Score for postoperative risk - <https://www.mdcalc.com/surgical-apgar-score-sas-post-operative-risk>

Appendix B contains output from the ACS NSQIP calculator for hypothetical patients undergoing the procedures selected for the evidence review.

Table 1. General Surgical Risk Calculators

Risk Calculator	Intended Use	Inputs	Outputs
ACS NSQIP Surgical Risk Calculator	General preoperative risk prediction	Procedure Age Sex Functional status Procedure urgency ASA class Chronic steroid use Ascites in past 30 days Sepsis within 48 hours Ventilator dependence Disseminated cancer Diabetes Hypertension requiring medications Congestive heart failure (CHF) in past 30 days Dyspnea Smoking within 1 year Severe COPD Dialysis Acute renal failure BMI	Serious complication Any complication Pneumonia Cardiac complication Surgical site infection Urinary tract infection Venous thromboembolism Renal failure Readmission Return to operating room Death Discharge to nursing or rehab facility Predicted length of stay
NCEPOD Surgical Outcome Risk Tool	Preoperative risk prediction for adult inpatients undergoing non-neurological and non-cardiac surgery	Procedure ASA class Procedure urgency Thoracic, gastrointestinal, or vascular surgery Cancer Age	Risk of death within 30 days of surgery
Revised Cardiac Risk Index	Preoperative assessment of cardiac risk	High-risk surgery Ischemic heart disease CHF Cerebrovascular disease Insulin use Creatinine > 2 mg/dL	Risk of major cardiac event (myocardial infarction [MI], pulmonary edema, ventricular fibrillation [VF], cardiac arrest, or complete heart block)
POSSUM for Operative Morbidity and Mortality	Risk estimate for general surgery patients based on history, findings, and intraoperative events	Age Cardiac conditions Respiratory conditions Systolic blood pressure Heart rate Glasgow coma scale Hemoglobin White blood cell count	Predicted morbidity Predicted mortality

Risk Calculator	Intended Use	Inputs	Outputs
		Blood urea nitrogen Sodium Potassium EKG findings Operative severity Number of procedures Estimated blood loss Peritoneal soiling Presence of malignancy Procedure urgency	
Surgical Apgar Score	Postoperative risk assessment for major general or vascular surgery based on intraoperative findings	Estimated blood loss Lowest mean arterial pressure Lowest heart rate	Mortality rate Risk of major complications Postoperative intensive care unit admission

Table 2 presents four surgical risk calculators specific to total hip or knee arthroplasty, bariatric surgery, and spinal procedures.

Table 2. Procedure-Specific Risk Calculators

Risk Calculator	Intended Use	Inputs	Outputs
American Joint Replacement Registry Total Joint Replacement Risk Calculator	Risk prediction for patients over age 65 undergoing total hip or total knee arthroplasty	Height Weight Age Sex Race Buy-in status Alcohol abuse Anemia (preoperative) Cardiac arrhythmia Cerebrovascular disease Chronic liver disease Chronic pulmonary disease Coagulopathy Congestive heart failure Dementia Depression Diabetes Drug abuse Electrolyte disorder Hemiplegia/Paraplegia HIV disease Hypercholesterolemia	Mortality within 90 days Periprosthetic joint infection within 2 years

Risk Calculator	Intended Use	Inputs	Outputs
		Hypertension Hypothyroidism Ischemic heart disease Lymphoma Malignancy Metastatic tumor Obesity* Peptic ulcer disease Peripheral vascular disease Psychoses Pulmonary circulation disease Renal disease Rheumatologic disease Urinary tract infection Valvular disease Weight loss	
Obesity Surgery Mortality Risk Score	Mortality risk prediction for bariatric surgery	BMI Sex Hypertension Risk for pulmonary embolism Age	Perioperative mortality
Bariatric Surgery Mortality Risk Calculator	Mortality risk prediction for bariatric surgery	Age BMI Dyspnea Chronic steroid use Peripheral vascular disease Previous percutaneous coronary intervention Type of bariatric procedure	Risk of mortality at 30 days
SpineSage	Risk for serious complications for various spinal procedures	Age Sex Cerebrovascular disease COPD Asthma Hypertension Rheumatoid arthritis Renal disease Preexisting cancer Syncope or seizure Anemia	Likelihood of major complications, all complications, infection, or dural tear with results stratified by level of surgical invasiveness

Risk Calculator	Intended Use	Inputs	Outputs
		Bleeding disorder Diabetes CHF Revision status Previous cardiac complications BMI Level of surgery Surgical approach	

Policies in Other States

The descriptions below outline some of the requirements for RCCs in the laws and regulations of the four states that license RCCs.

Arizona

Patient Admission

RCCs are for postsurgical and postdiagnostic patients for whom it is reasonable to expect an uncomplicated recovery and not expect intensive care services, coronary care services, or critical care services. RCCs must have written admission and discharge policies that are consistent with this definition.

Staffing

Minimum onsite staffing is one registered nurse and one other nursing staff member when there are patients in the facility. The director of nursing must be a registered nurse who is on site at least 40 hours each week when patients are in the facility.

Facility

RCCs cannot have more than two beds per room.

Length of Stay

The regulations do not address length of stay in RCCs.

Other Requirements

RCCs must adopt a quality management program and evaluate the effectiveness of the quality management program every 12 months.

Sources

Arizona Revised Statutes, Title 36 - Public Health and Safety, Chapter 1 State and Local Boards and Departments of Health, Article 9 Recovery Care Centers, § 36-448. Retrieved from <https://www.azleg.gov/viewdocument/?docName=https%3A%2F%2Fwww.azleg.gov%2Fars%2F36%2F00448-51.htm>

Arizona Administrative Code, Title 9. Health Services, Chapter 10. Department Of Health Services - Health Care Institutions: Licensing, Article 5. Recovery Care Centers. Retrieved from https://apps.azsos.gov/public_services/Title_09/9-10.pdf

Colorado

Patient Admission

Convalescent centers provide postsurgical, postprocedural, and postdiagnostic medical and nursing services to patients when an uncomplicated recovery is anticipated and acute hospitalization is not required. Surgical procedures are limited to those in which the expected combined operating and recovery time does not exceed 24 hours from the time of admission.

Staffing

One registered nurse must be in the center whenever a patient is present.

Facility

The regulations do not address facility requirements.

Length of Stay

The regulations do not specify a maximum length of stay.

Other Requirements

Convalescent centers can only be operated in conjunction with a licensed ASC. The ASC must have a transfer agreement with a local hospital.

Sources

Code of Colorado Regulations. 6 CCR 1011-1 Chap 20. Retrieved from <https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7061&fileName=6%20CCR%201011-1%20Chapter%2020>

Connecticut

Patient Admission

RCCs care for patients after an acute event as a result of illness, injury, or exacerbated disease process and who are in need of a high degree of medical direction, but for whom acute hospitalization is not required. Patients must be expected to have an uncomplicated recovery, and cannot need intensive care services, coronary care services, or critical care services. Patients must fall within one of these categories:

- Emergency department procedures that do not require hospitalization
- Diagnostic or surgical procedures that do not routinely require hospitalization
- Medical, chemical, or radiological treatments that are performed on an outpatient basis
- Medically stable hospitalized patients who require continued health care services to meet the hospital's discharge criteria (Intensity, Severity, and Discharge (ISD-A) Severity of Illness, Intensity of Service Criteria)

- Patients requiring postsurgical care who have had outpatient surgical procedures performed and who need or desire continued care

Staffing

RCCs must have two registered nurses on duty from 7 a.m. to 11 p.m. every day, and one registered nurse and one other patient care staff member at other times.

Facility

RCCs can be attached to or on the grounds of a licensed hospital, or a freestanding facility not on hospital grounds. The maximum size of a nursing unit is 45 beds, and the nurses' station must be less than 150 feet from each patient's door.

Length of Stay

Patients admitted from an ASC are limited to an expected three-day stay. Patients exceeding a three-day period require a progress note written by the attending physician that justifies the extended length of stay, with the maximum total length of stay not exceeding 21 days.

Other Requirements

RCCs must have a transfer agreement with at least one hospital, such that patients are ensured of timely admission to the hospital when a transfer is medically appropriate as determined by a physician. RCCs must have a quality assurance program to evaluate the quality and appropriateness of patient care, measure patient outcomes, and implement improvements to patient care.

Sources

Regulations of Connecticut State Agencies. Sec. 19a-495-571. Retrieved from <https://eregulations.ct.gov/eRegsPortal/Browse/RCSA?id=Title%2019a|19a-495|19a-495-571|19a-495-571>

Illinois

Patient Admission

Postsurgical recovery care centers provide recovery care for patients undergoing surgical procedures that potentially require overnight nursing care, pain control, or observation that would otherwise be provided in a hospital setting. Each RCC must specify the types of surgical procedures that RCC patients can be recovering from when admitted to the RCC. This must include documentation that the expected postoperative stay is less than 48 hours and that the postoperative complication rate is minimal.

Staffing

Minimum staffing is one registered nurse and one licensed nurse. All nursing staff must be certified for cardiopulmonary resuscitation within the first month of employment and have a minimum of two years of experience in the postanesthesia recovery unit or medical/surgical unit of an ASC or acute care hospital.

Facility

The maximum capacity is 20 beds and RCCs are either freestanding or a defined unit of a hospital or ASC.

Length of Stay

The maximum length of stay is 48 hours, although the physician can request an extension from the RCC's medical director for a total stay of 72 hours. If the patient requires additional care after the 72-hour limit, then the patient must be transferred to an appropriate facility.

Other Requirements

RCCs must maintain a contractual relationship with a general acute care hospital, including a transfer agreement. RCCs must be within 15-minutes of travel time from the general acute care hospital. RCCs must develop and implement a quality assessment and improvement program.

Sources

Illinois Compiled Statutes 210 ILCS 3/35. Retrieved from

<http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021000030K35>

Illinois Administrative Code. Title 77: Public Health, Chapter I: Department of Public Health, Subchapter B: Hospitals and Ambulatory Care Facilities, Part 210 Postsurgical Recovery Care Center Demonstration Program Code. Retrieved from <ftp://www.ilga.gov/jcar/admincode/077/07700210sections.html>

Accreditation Standards

Accreditation standards for ASCs are summarized below from the Joint Commission, the Accreditation Association for Ambulatory Health Care and the American Association for Accreditation of Ambulatory Surgery Facilities. The accreditation standards are freely available for only the AAAASF.

Joint Commission

The Joint Commission accredits a wide variety of healthcare facilities, including ASCs. The Joint Commission's [website](#) for ASCs seeking accreditation outlines the process for obtaining accreditation, which includes an onsite survey. The Joint Commission's standards for accreditation include infection prevention, medication management, processes for staffing, and performance improvement. A list of ambulatory care facilities accredited by the Joint Commission can be found using their [online database](#).

Accreditation Association for Ambulatory Health Care

According to its [website](#), the Accreditation Association for Ambulatory Health Care (AAAHC) has more than 6,100 organizations accredited, including ASCs and other outpatient settings. It holds Medicare-deemed status from the Centers for Medicare & Medicaid Services (CMS). According to the AAAHC, the standards for accreditation correspond closely to the CMS Conditions for Coverage for ASCs. These do not require specific patient selection or discharge criteria, but do require that certain policies, processes, procedures and programs be documented and implemented in ASCs. Standards address governance, quality management and improvement, infection prevention, anesthesia care services, surgical and related services, overnight care and services, as well as emergency services.

American Association for Accreditation of Ambulatory Surgery Facilities

The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) has a process for granting accreditation to ambulatory surgery facilities. The AAAASF standards are described in the

[Regular Standards and Checklist for Accreditation of Ambulatory Surgery](#) (last revised in March 2017) and the [Procedural Standards and Checklist for Accreditation of Ambulatory Facilities](#) (last revised January 2018). To receive accreditation, a facility must meet every standard, and facilities are surveyed by AAAASF every three years. In years when surveying by AAAASF is not required, the facility director conducts a self-evaluation survey and submits the survey to the AAAASF.

Many of the AAAASF standards are related to the facility environment and available equipment. There are a variety of standards related to cleanliness and sterilization. Available equipment must include an EKG monitor with pulse readout, standard defibrillator or an automated external defibrillator, pulse oximeter, and positive pressure ventilation device. A transportable “crash” cart must be immediately available, independent of other operating room equipment, and must contain medications and devices for suction, positive pressure ventilation, maintaining an airway, and intravenous access. The operating room and recovery room must have an emergency power source.

A physician must be present when anesthesia, other than local anesthesia, is being administered. Recovering patients must be observed by trained medical personnel in the recovery area. In addition, a physician, certified registered nurse anesthetist (CRNA), physician assistant (PA), or registered nurse (RN) with advanced cardiac life support certification must be immediately available until the patient has met discharge criteria. At least one staff member who is certified in the Pediatric Advanced Life Support Course must be present in the facility when there are pediatric patients recovering from anesthesia.

There must be a written transfer agreement with an accredited or licensed acute care hospital within 30 minutes that is approved by the facility’s medical staff, or the operating surgeon has privileges to admit patients to such a hospital. Every physician, podiatrist, and oral and maxillofacial surgeon must demonstrate that they have held unrestricted hospital privileges in their specialty at an accredited or licensed acute care hospital within 30 minutes of the facility. If the physician, podiatrist, or oral and maxillofacial surgeon does not currently hold admitting privileges at a local hospital, there must be a signed document from a person in the same specialty who has admitting privileges in a hospital within 30 minutes of the facility that indicates their willingness to admit the patient to the hospital.

An accredited facility must have a quality improvement program and peer review process. Any death occurring within 30 days of a surgical procedure performed in an accredited facility must be reported to the AAAASF.

Patient Safety Reporting

The Oregon Patient Safety Commission (OPSC) publishes annual reports on aggregated data submitted for the Patient Safety Reporting Program, and the most recent report summarizes data from 2017 (OPSC, 2018). The OPSC is a non-regulatory, semi-independent state agency. Health care organizations voluntarily submit data on adverse events to the Patient Safety Reporting Program and the OPSC can provide confidential consultation to these health care organizations to review adverse events in order to make improvements to patient safety. Adverse events are defined as an event resulting in unintended harm or creating the potential for harm that is related to any aspect of a patient's care.

The Patient Safety Reporting Program receives data from ASCs, hospitals, nursing facilities, and community pharmacies. Although reporting is voluntary, health care organizations that agree to participate must report all serious adverse events that occur in their facility. Information submitted on

adverse events includes when, how, and why patient harm occurred, as well as strategies for preventing similar events in the future.

In 2017, there were 88 ASCs in Oregon and 63 (72%) were enrolled in the Patient Safety Reporting Program. The number of enrolled ASCs has increased steadily from less than 50 in 2009. A total of 438 adverse events were voluntarily reported in 2017; 126 of these reports were from ASCs. The number of reports from ASCs has remained relatively steady in the past five years. From 2009 to 2017, an average of one death was reported each year, and no deaths were reported in 2017.

Table 3 shows the types of events reported for ASCs in 2017. The most common surgical event was unplanned admission to a hospital within 48 hours of discharge, followed by unplanned emergency department admission within 48 hours, laceration, perforation, puncture or nick, and unanticipated blood transfusion. The health care-associated infections were mostly surgical site infections, although two of the 12 events (17%) involved sepsis. The most common medication errors were incorrect medication followed by incorrect dose. The most frequent stages of origin for medication errors were prescribing/ordering and dispensing. About half of the device or medical/surgical supply errors were from use error, and one-third were from device or supply failure. More than one-half of falls occurred during dressing or undressing, and the others occurred during walking, patient transfer (e.g., chair to bed), or toileting.

Table 3. Number and Percentage of Adverse Events Reported by ASCs by Category

Adverse Event	Number	Percentage
Surgical or other invasive procedure	59	47%
Health care-associated infection	12	10%
Aspiration	11	9%
Medication or other substance	9	7%
Device or supply	9	7%
Fall	9	7%
Care delay	6	5%
Anesthesia	4	3%
Retained object	3	2%
Deep vein thrombosis	3	2%
Other event	1	1%
Total	126	100%

Horizon Scan

We reviewed the last six months of Becker's ASC Review (<https://www.beckersasc.com/print-issues/past-issues.html>) to gain insight into procedures or trends that could influence the ASC/ESC landscape in the next few years. No rigorous inclusion methodology was applied, but we identified the following items as potentially salient:

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- ASCs are increasingly using long-acting local anesthetics (e.g., Exparel) to reduce the need for opioid analgesics
- Many ASCs are investing in robotic surgery systems, particularly for joint replacement procedures
- Gastroesophageal reflux disease procedures (fundoplication, endoluminal fundoplication, magnetic sphincter augmentation) are increasingly being offered at ASCs
- Cardiovascular ASCs are offering peripheral vascular procedures (e.g., vein treatments), and many will begin to provide cardiac catheterization procedures now that this is allowed by CMS
- Private equity investment in ASCs is expected to increase, and a trend toward ASC consolidation under larger management structures is also expected
- Some ASCs are making price transparency (including posting prices on their websites) a feature of their marketing, and some ASCs are using this as a way to encourage direct or cash payments from patients who might otherwise have high out-of-pocket costs through their insurance
- One article highlighted the findings of VMG Health's Intellimarker Ambulatory Surgical Centers Financial & Operational Benchmarking Study in 2018
 - Case volume mix as a percentage of total cases:
 - Gastroenterology: 34%
 - Ophthalmology: 26%
 - Orthopedics: 21%
 - Pain management: 21%
 - Otolaryngology: 12%
 - General surgery: 9%
 - Oral surgery: 9%
 - Urology: 8%
 - Obstetrics and gynecology: 6%
 - Plastic surgery: 5%
 - Podiatry: 6%
 - Net revenue per case:
 - Orthopedics: \$3,458
 - Otolaryngology: \$2,543
 - Podiatry: \$2,688
 - Urology: \$2,483
 - Obstetrics and gynecology: \$2,933
 - General surgery: \$2,235
 - Plastic surgery: \$2,010
 - Ophthalmology: \$1,442
 - Oral surgery: \$950
 - Pain management: \$1,245

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Appendix A. Search Strategies

Knee Arthroplasty

- 1 exp Ambulatory Surgical Procedures/
- 2 exp SURGICENTERS/
- 3 1 or 2
- 4 (ambulator* adj3 (surgic* or surger* or operat* or procedur*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 5 surgicenter*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 6 4 or 5
- 7 3 or 6
- 8 exp Arthroplasty, Replacement, Knee/
- 9 exp Knee Prosthesis/
- 10 (knee* adj5 (replace* or prosth* or arthroplast* or artificial*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 11 8 or 9 or 10
- 12 6 and 11
- 13 exp Hospitals/
- 14 exp Hospital Units/
- 15 exp Personnel, Hospital/
- 16 exp HOSPITALIZATION/
- 17 13 or 14 or 15 or 16
- 18 11 and 17
- 19 ((compar* or vs or versus) adj7 (surgicent* or (ambulator* adj3 (locat* or facil* or center* or servic*))))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 20 (7 or 19) and 11 and 18
- 21 12 or 20

Hip Arthroplasty

- 1 exp Ambulatory Surgical Procedures/

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- 2 exp SURGICENTERS/
- 3 1 or 2
- 4 (ambulator* adj3 (surgic* or surger* or operat* or procedur*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 5 surgicenter*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 6 4 or 5
- 7 3 or 6
- 8 exp Arthroplasty, Replacement, hip/
- 9 exp Hip Prosthesis/
- 10 ((hip or hips or acetabul* or ((femoral* or femur*) adj2 (head* or neck*))) adj5 (replace* or prosth* or arthroplast* or artificial*)).mp.
- 11 8 or 9 or 10
- 12 6 and 11
- 13 exp Hospitals/
- 14 exp Hospital Units/
- 15 exp Personnel, Hospital/
- 16 exp HOSPITALIZATION/
- 17 13 or 14 or 15 or 16
- 18 11 and 17
- 19 ((compar* or vs or versus) adj7 (surgicent* or (ambulator* adj3 (locat* or facil* or center* or servic*))))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 20 (7 or 19) and 11 and 18
- 21 12 or 20

Mastectomy

- 1 exp Ambulatory Surgical Procedures/
- 2 exp SURGICENTERS/
- 3 1 or 2
- 4 (ambulator* adj3 (surgic* or surger* or operat* or procedur*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 5 surgicenter*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 6 4 or 5
- 7 3 or 6
- 8 exp mastectomy/
- 9 (mastectom* or ((breast* or mammary) adj5 (resect* or remov* or excis*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 10 8 or 9
- 11 7 and 10
- 12 exp Hospitals/
- 13 exp Hospital Units/
- 14 exp Personnel, Hospital/
- 15 exp HOSPITALIZATION/
- 16 12 or 13 or 14 or 15
- 17 10 and 16
- 18 ((compar* or vs or versus) adj7 (surgicent* or (ambulator* adj3 (locat* or facil* or center* or servic*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 19 (7 or 18) and 10 and 17
- 20 11 or 19

Bariatric Surgery

- 1 exp Ambulatory Surgical Procedures/
- 2 exp SURGICENTERS/
- 3 1 or 2
- 4 (ambulator* adj3 (surgic* or surger* or operat* or procedur*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 5 surgicenter*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 6 4 or 5
- 7 3 or 6
- 8 exp bariatric surgery/
- 9 (((stomach* or gastr* or intestin* or iliojejun* or jejunoil*) adj3 (bypass* or ((band* or stapl* or sleev* or reduc*) adj3 (surg* or operat* or procedur*)))) or gastroplast* or liposuct* or lipectom* or lipolysis).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 10 8 or 9
- 11 6 and 10
- 12 exp Hospitals/
- 13 exp Hospital Units/
- 14 exp Personnel, Hospital/
- 15 exp HOSPITALIZATION/
- 16 12 or 13 or 14 or 15
- 17 10 and 16
- 18 ((compar* or vs or versus) adj7 (surgicent* or (ambulator* adj3 (locat* or facil* or center* or servic*))))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 19 10 and 17 and (7 or 18)
- 20 11 or 19

Spinal Laminectomy

- 1 exp Ambulatory Surgical Procedures/
- 2 exp SURGICENTERS/

- 3 1 or 2
- 4 (ambulator* adj3 (surgic* or surger* or operat* or procedur*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 5 surgicenter*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 6 4 or 5
- 7 3 or 6
- 8 exp laminectomy/
- 9 ((laminectom* or foraminectom* or (remov* or excis* or (cut* adj (out or away)))) adj7 lamina*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 10 8 or 9
- 11 6 and 10
- 12 exp Hospitals/
- 13 exp Hospital Units/
- 14 exp Personnel, Hospital/
- 15 exp HOSPITALIZATION/
- 16 12 or 13 or 14 or 15
- 17 10 and 16
- 18 ((compar* or vs or versus) adj7 (surgicent* or (ambulator* adj3 (locat* or facil* or center* or servic*))))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 19 (7 or 18) and 10 and 17
- 20 11 or 19

Lumbar Fusion

- 1 exp Ambulatory Surgical Procedures/
- 2 exp SURGICENTERS/
- 3 1 or 2
- 4 (ambulator* adj3 (surgic* or surger* or operat* or procedur*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 5 surgicenter*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 6 4 or 5
- 7 3 or 6
- 8 exp spinal fusion/
- 9 exp spinal diseases/su or exp back injuries/su
- 10 (fuse* or fusion or fusing or fixat*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 11 9 and 10
- 12 8 or 11
- 13 exp lumbar vertebrae/
- 14 exp lumbosacral region/
- 15 13 or 14
- 16 12 and 15
- 17 ((lumbar* or lumbosacr*) adj5 (fuse or fusing or fusion*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 18 16 or 17
- 19 6 and 18
- 20 exp Hospitals/
- 21 exp Hospital Units/
- 22 exp Personnel, Hospital/
- 23 exp HOSPITALIZATION/
- 24 20 or 21 or 22 or 23
- 25 18 and 24

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26 ((compar* or vs or versus) adj7 (surgicent* or (ambulator* adj3 (locat* or facil* or center* or servic*))))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

27 (7 or 26) and 18 and 25

28 19 or 27

Cholecystectomy

- 1 exp Ambulatory Surgical Procedures/
- 2 exp SURGICENTERS/
- 3 1 or 2
- 4 (ambulator* adj3 (surgic* or surger* or operat* or procedur*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 5 surgicenter*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 6 4 or 5
- 7 3 or 6
- 8 exp Cholecystectomy/
- 9 (cholecystectom* or ((remov* or excis* or ((tak* or cut*) adj2 out)) adj2 (gallbladder* or gall bladder*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 10 8 or 9
- 11 6 and 10
- 12 exp Hospitals/
- 13 exp Hospital Units/
- 14 exp Personnel, Hospital/
- 15 exp HOSPITALIZATION/
- 16 12 or 13 or 14 or 15
- 17 10 and 16
- 18 ((compar* or vs or versus) adj7 (surgicent* or (ambulator* adj3 (locat* or facil* or center* or servic*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 19 (7 or 18) and 10 and 17
- 20 11 or 19

Hysterectomy

- 1 exp Ambulatory Surgical Procedures/
- 2 exp SURGICENTERS/
- 3 1 or 2
- 4 (ambulator* adj3 (surgic* or surger* or operat* or procedur*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 5 surgicenter*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 6 4 or 5
- 7 3 or 6
- 8 exp hysterectomy/
- 9 (hysterectom* or ((uterin* or uterus*) adj5 (resect* or remov* or excis*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 10 8 or 9
- 11 6 and 10
- 12 exp Hospitals/
- 13 exp Hospital Units/
- 14 exp Personnel, Hospital/
- 15 exp HOSPITALIZATION/
- 16 12 or 13 or 14 or 15
- 17 10 and 16
- 18 ((compar* or vs or versus) adj7 (surgicent* or (ambulator* adj3 (locat* or facil* or center* or servic*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 19 (7 or 18) and 10 and 17
- 20 11 or 19

Neck Dissection

- 1 exp Ambulatory Surgical Procedures/
- 2 exp SURGICENTERS/

- 3 1 or 2
- 4 (ambulator* adj3 (surgic* or surger* or operat* or procedur*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 5 surgicenter*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 6 4 or 5
- 7 3 or 6
- 8 exp Neck Dissection/
- 9 exp Lymph Node Dissection/
- 10 exp "Head and Neck Neoplasms"/ or exp neck/
- 11 9 and 10
- 12 ((neck* or cervical*) adj3 (dissect* or ((remov* or excis* or ((tak* or cut*) adj2 out)) adj2 (lymph* adj nod*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 13 8 or 11 or 12
- 14 6 and 13
- 15 exp Hospitals/
- 16 exp Hospital Units/
- 17 exp Personnel, Hospital/
- 18 exp HOSPITALIZATION/
- 19 15 or 16 or 17 or 18
- 20 13 and 19
- 21 ((compar* or vs or versus) adj7 (surgicent* or (ambulator* adj3 (locat* or facil* or center* or servic*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 22 (7 or 21) and 13 and 20
- 23 14 or 22

Transurethral Resection of the Prostate

- 1 exp Ambulatory Surgical Procedures/
- 2 exp SURGICENTERS/
- 3 1 or 2

- 4 (ambulator* adj3 (surgic* or surger* or operat* or procedur*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 5 surgicenter*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 6 4 or 5
- 7 3 or 6
- 8 exp Transurethral Resection of Prostate/
- 9 (prostatect* or turp or (prostat* adj5 (resect* or remov* or excis* or transuretha* or urethra*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 10 8 or 9
- 11 6 and 10
- 12 exp Hospitals/
- 13 exp Hospital Units/
- 14 exp Personnel, Hospital/
- 15 exp HOSPITALIZATION/
- 16 12 or 13 or 14 or 15
- 17 10 and 16
- 18 ((compar* or vs or versus) adj7 (surgicent* or (ambulator* adj3 (locat* or facil* or center* or servic*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- 19 (7 or 18) and 10 and 17
- 20 11 or 19

Appendix B. Surgical Risk Calculations

Case #	Procedure (CPT)	Age group	Sex	Functional status	ASA class	Steroid chronic	Diabetes	Hyper-tension requiring meds	CHF (30 days prior)	Dyspnea	Smoke w/in 1 year	BMI	Risk of serious complications*	Re-admission risk	Risk of return to OR	Predicted LOS (days)
1	Total knee arthroplasty (27447)	<65	F	Independent	I-Healthy	No	No	No	No	No	No	22.6	1.4	1.1%	0.5%	2
2		<65	M	Independent	II-Mild sys. disease	No	Oral	Yes	No	No	No	30.7	2.8	2.3%	0.8%	2.5
3		65-74	M	Partially dependent	II	No	Oral	Yes	No	No	No	28.1	4.2	3.0%	0.9%	3
4		65-74	F	Independent	II	No	Oral	Yes	No	No	No	30.7	3.0	2.3%	0.7%	2.5
5		65-74	F	Independent	II	No	No	No	Yes	Mild exertion	No	22.6	4.0	3.1%	0.8%	3
7	Cervical laminectomy, one level (63020)	<65	F	Independent	I	No	No	No	No	No	No	23.3	1.8	2.2%	0.9%	1
8		<65	M	Independent	I	No	Oral	Yes	No	No	No	30.7	1.7	1.7%	1.0%	1
9		65-74	M	Independent	II	No	Oral	Yes	No	No	No	30.7	2.9	2.7%	1.2%	1.5
10		65-74	M	Partially dependent	II	No	Oral	Yes	No	No	No	21.6	3.8	4.0%	1.4%	1.5
11		75-84	F	Independent	II	No	No	No	No	No	No	24.0	2.6	2.7%	1.0%	1.5
12		75-84	M	Independent	II	No	No	Yes	Yes	w/mod. Exertion	No	20.7	5.7	6.1%	1.8%	2
13		<65	M	Independent	II	No	Oral	Yes	No	No	Yes	30.7	2.9	2.9%	1.5%	1.5
14		<65	M	Independent	II	Yes	Oral	Yes	No	No	No	30.7	3.3	4.0%	1.6%	1.5
15	Vaginal hysterectomy with tube(s), ovary(s) (58262)	<65	F	Independent	I	No	No	No	No	No	No	22.6	3.4	1.2%	1.0%	1
16		<65	F	Independent	II	No	Oral	Yes	No	No	No	37.1	6.0	2.5%	1.4%	1
17		75-84	F	Independent	I	No	No	No	No	No	No	22.6	4.4	1.5%	0.9%	1
18		75-84	F	Partially dependent	II	No	No	Yes	No	No	No	22.6	9.0	3.9%	1.5%	1.5
19		<65	F	Independent	II	Yes	Oral	Yes	No	No	No	37.1	9.7	5.0%	2.0%	1.5

Case #	Procedure (CPT)	Age group	Sex	Functional status	ASA class	Steroid chronic	Diabetes	Hyper-tension requiring meds	CHF (30 days prior)	Dyspnea	Smoke w/in 1 year	BMI	Risk of serious complications*	Re-admission risk	Risk of return to OR	Predicted LOS (days)
20	Total abdominal hysterectomy (58150)	3.3<65	F	Independent	I	No	No	No	No	No	No	22.6	3.3	2.4%	1.2%	2
21		<65	F	Independent	II	No	Oral	Yes	No	No	No	30.9	5.5	4.2%	1.6%	2.5
22	Laparoscopic hysterectomy with tubes, ovaries (58571)	<65	F	Independent	I	No	No	No	No	No	No	22.6	2.1	1.3%	0.6%	0.5
23		<65	F	Independent	II	No	Oral	Yes	No	No	No	30.9	3.8	2.5%	0.8%	1
24		65-74	F	Independent	II	No	Oral	Yes	No	No	No	30.9	4.3	2.6%	0.8%	1
25		65-74	F	Partially dependent	II	No	Oral	Yes	No	No	No	30.9	5.7	3.4%	0.9%	1
26		65-74	F	Independent	II	Yes	Oral	Yes	No	No	No	37.1	5.7	3.8%	1.1%	1
27	Lumbar laminectomy, one level (63030)	<65	F	Independent	I	No	No	No	No	No	No	23.3	1.5	1.4%	1.2%	1
28		<65	M	Independent	I	No	Oral	Yes	No	No	No	30.7	1.9	1.7%	1.4%	1
29		75-84	M	Independent	II	No	No	Yes	Yes	Mod exertion	No	20.7	5.6	5.4%	2.0%	1.5
30		65-74	M	Partially dependent	II	No	Oral	Yes	No	No	No	30.7	4.5	3.9%	1.9%	1.5
31	Lumbar fusion (one level) (posterior or posterolateral technique) (22612)	<65	M	Independent	I	No	No	No	No	No	No	21.6	3.5	2.5%	2.2%	2.5
32		<65	M	Independent	II	No	Oral	Yes	No	No	Yes	30.7	6.6	5.0%	3.4%	3
33	Lumbar fusion, posterior interbody technique (IP only) (22630)	<65	M	Independent	I	No	No	No	No	No	No	21.6	2.9	2.0%	1.9%	2.5
34	Cervical lymphadenectomy, complete (neck dissection) (38720)	<65	F	Independent	I	No	No	No	No	No	No	23.3	4.9	2.4%	3.0%	2
35		65-74	F	Independent	II	No	Oral	Yes	No	No	No	30.9	8.7	4.3%	3.9%	2.5

Case #	Procedure (CPT)	Age group	Sex	Functional status	ASA class	Steroid chronic	Diabetes	Hyper-tension requiring meds	CHF (30 days prior)	Dyspnea	Smoke w/in 1 year	BMI	Risk of serious complications*	Re-admission risk	Risk of return to OR	Predicted LOS (days)
36	Modified radical neck dissection (38724)	65-74	F	Independent	II	No	Oral	Yes	No	No	No	30.9	6.0%	2.9%	2.9%	2.5
37	Total hip arthroplasty (27130)	<65	M	Independent	I	No	No	No	No	No	No	21.6	1.7%	1.4%	1.2%	2
38		<65	F	Independent	II	No	Oral	Yes	No	No	No	30.9	2.9%	2.6%	1.4%	2.5
39		65-74	M	Independent	II	Yes	Oral	Yes	No	No	No	30.7	4.5%	3.9%	1.8%	2.5
40	Lap cholecystectomy with common duct exploration (47564)	<65	M	Independent	I	No	No	No	No	No	No	21.6	2.7%	2.7%	1.1%	1.5
41		65-74	M	Independent	II	No	Oral	Yes	No	No	No	30.7	5.3%	5.3%	1.4%	1.5
42		75-84	M	Independent	II	No	No	Yes	Yes	w/mod exertion	No	21.6	8.7%	9.4%	1.7%	2.5
43		<65	F	Partially dependent	II	No	Oral	Yes	No	No	No	30.9	6.0%	7.0%	1.5%	2
44	Sleeve gastrectomy (Bariatric surgery)-43775	<65	F	Independent	II	No	No	No	No	No	No	36.6	1.4%	1.9%	0.6%	1.5
45		<65	M	Independent	III	No	No	No	No	No	No	43.0	2.6%	3.0%	1.0%	2
46		<65	M	Independent	III	No	Oral	Yes	No	No	No	43.0	3.1%	3.8%	1.1%	2
47		<65	F	Independent	III	No	Insulin	Yes	No	No	No	42.9	3.5%	4.8%	1.1%	2
48		<65	M	Partially dependent	III	No	Oral	Yes	No	No	No	43.0	4.3%	5.3%	1.3%	2.5
49	Roux-en-Y gastric bypass (43644)	<65	F	Independent	II	No	No	No	No	No	No	36.6	2.9%	3.6%	1.6%	1.5
50		<65	M	Independent	III	No	No	No	No	No	No	43.0	5.1%	6.0%	2.7%	2
51		<65	M	Independent	III	No	Oral	Yes	No	No	No	43.0	5.8%	7.1%	3.0%	2.5
52		<65	F	Independent	III	No	Insulin	Yes	No	No	No	42.9	6.4%	8.5%	2.8%	2.5
53		<65	M	Partially dependent	III	No	Oral	Yes	No	No	No	43.0	7.6%	9.2%	3.4%	3
54		<65	M	Independent	I	No	No	No	No	No	No	21.6	2.6%	2.1%	1.1%	1
55		<65	M	Independent	II	No	Oral	Yes	No	No	No	30.7	4.5%	3.7%	1.5%	1

Case #	Procedure (CPT)	Age group	Sex	Functional status	ASA class	Steroid chronic	Diabetes	Hyper-tension requiring meds	CHF (30 days prior)	Dyspnea	Smoke w/in 1 year	BMI	Risk of serious complications*	Re-admission risk	Risk of return to OR	Predicted LOS (days)
56	Transurethral resection of prostate-52601	65-74	M	Partially dependent	II	No	Oral	Yes	No	No	No	30.7	6.7%	5.3%	1.7%	1.5
57		75-84	M	Independent	II	No	No	Yes	Yes	w/mod exertion	No	21.6	8.3%	7.4%	1.8%	1.5
58		65-74	M	Independent	II	No	Oral	Yes	No	No	Yes	30.7	5.7%	4.4%	1.7%	1
59	Partial mastectomy with axillary lymphadenectomy-19302	<65	F	Independent	I	No	No	No	No	No	No	22.6	1.5%	0.9%	1.1%	0.5
60		<65	F	Independent	II	No	Oral	Yes	No	No	No	30.9	2.7%	2.0%	1.4%	0.5
61		65-74	F	Partially dependent	II	No	Oral	Yes	No	No	No	30.9	4.2%	2.7%	1.6%	0.5
62		65-74	F	Partially dependent	II	No	No	Yes	Yes	w/mod exertion	No	22.6	6.2%	4.7%	1.9%	1
63		<65	F	Partially dependent	II	No	Insulin	Yes	No	No	No	22.6	4.3%	3.7%	1.8%	0.5
64		65-74	F	Independent	II	Yes	Oral	Yes	No	No	No	3.9	3.9%	2.8%	1.7%	0.5



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Ambulatory Surgery Centers

A Positive Trend in Health Care



Ambulatory surgery centers (ASCs) are health care facilities that offer patients the convenience of having surgeries and procedures performed safely outside the hospital setting. Since their inception more than four decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs. At a time when most developments in health care services and technology typically come with a higher price tag, ASCs stand out as an exception to the rule.

A TRANSFORMATIVE MODEL FOR SURGICAL SERVICES

As our nation struggles with how to improve a troubled and costly health care system, the experience of ASCs is a great example of a successful transformation in health care delivery.

Forty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still performed this way, but not in the US.

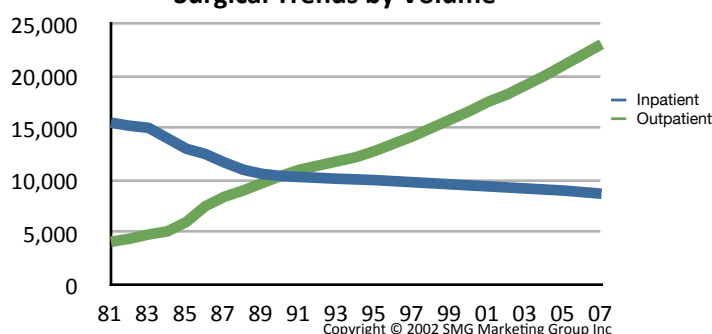
Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling delays, limited operating room availability, slow operating room turnover times, and challenges in obtaining new equipment due to hospital budgets and policies, physicians were looking for a better way—and developed it in ASCs.

Today, physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain increased control over their surgical practices.¹ In the ASC setting, physicians are able to schedule procedures more conveniently, assemble teams of specially trained and highly skilled staff, ensure that the equipment and supplies being used are best suited to their techniques, and design facilities tailored to their specialties and to the specific needs of their patients. Simply stated, physicians are striving for, and have found in ASCs, professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in an ASC (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

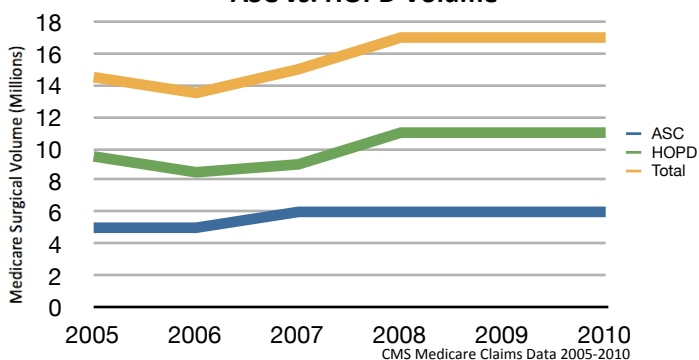
Given the history of their involvement in making ASCs a reality, it is not surprising that physicians continue to have at least some ownership in virtually all (90%) ASCs. But what is more interesting to note is how many ASCs are jointly owned by local hospitals that now increasingly recognize and embrace the value of the ASC model. According to the most recent data available, hospitals have ownership interest in 21% of all ASCs and 3% are owned entirely by hospitals.²

ASCs also add considerable value to the US economy, with a 2009 total nationwide economic impact of \$90 billion, including more than \$5.8 billion in tax payments. Additionally, ASCs employ the equivalent of approximately 117,700 full-time workers.³

Surgical Trends by Volume



ASC vs. HOPD Volume



ASCs PROVIDE CARE AT SIGNIFICANT COST SAVINGS

Not only are ASCs focused on ensuring that patients have the best surgical experience possible, they also provide cost-effective care that save the government, third party payors and patients money. On average, the Medicare program and its beneficiaries share in more than \$2.6 billion in savings each year because the program pays significantly less for procedures performed in ASCs when compared to the rates paid to hospitals for the same procedures. Accordingly, patient co-pays are also significantly lower when care is received in an ASC.

If just half of the eligible surgical procedures moved from hospital outpatient departments to ASCs, Medicare would save an additional \$2.4 billion a year or \$24 billion over the next 10 years. Likewise, Medicaid and other insurers benefit from lower prices for services performed in the ASC setting.

Currently, Medicare pays ASCs 58% of the amount paid to hospital outpatient departments for performing the same services. For example, Medicare pays hospitals \$1,670 for performing an outpatient cataract surgery while paying ASCs only \$964 for performing the same surgery.

This huge payment disparity is a fairly recent phenomenon. In 2003, Medicare paid hospitals only 16% more, on average, than it paid ASCs. Today, Medicare pays hospitals 72% more than ASCs for outpatient surgery. There is no health or fiscal policy basis for providing ASCs with drastically lower payments than hospital outpatient departments.

In addition, patients typically pay less coinsurance for procedures performed in the ASC than for comparable procedures in the hospital setting. For example, a Medicare beneficiary could pay as much as \$496 in coinsurance for a cataract extraction procedure performed in a hospital outpatient department, whereas that same beneficiary's copayment in the ASC would be only \$195.

Without the emergence of ASCs as an option for care, health care expenditures would have been tens of billions of dollars higher over the past four decades. Private insurance companies tend to save similarly, which means employers also incur lower health care costs when employees utilize ASC services. For this reason, both employers and insurers have recently been exploring ways to incentivize the movement of patients and procedures to the ASC setting.

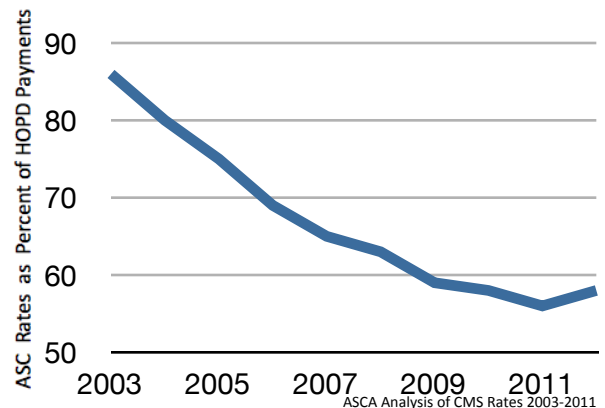
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased by hospitals and converted into hospital outpatient departments. Even if an ASC is not physically located next to a hospital, once it is part of a hospital, it can terminate its ASC license and become a unit of the hospital, entitling the hospital to bill for Medicare services provided in the former ASC at the 72% higher hospital outpatient rates.

**Cost Comparison:
ASC v. Hospital Outpatient Department**

	Patient Cost		Medicare Cost	
	ASC Co-pay	HOPD Co-pay	Total Procedure Cost ASC	Total Procedure Cost HOPD
Cataract	\$193	\$490	\$964	\$1,670
Upper GI Endoscopy	\$68	\$139	\$341	\$591
Colonoscopy	\$76	\$186	\$378	\$655

ASCA Analysis of CMS Rates Effective 1 Jan. 2012

**The Gap Between ASC and HOPD
Payments Has Widened Significantly**

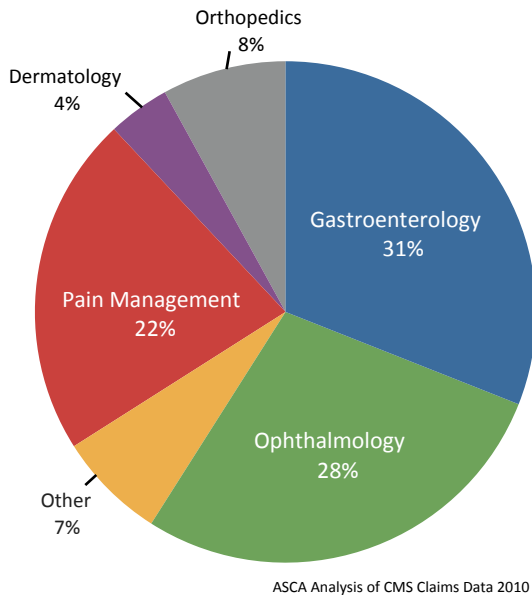


THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

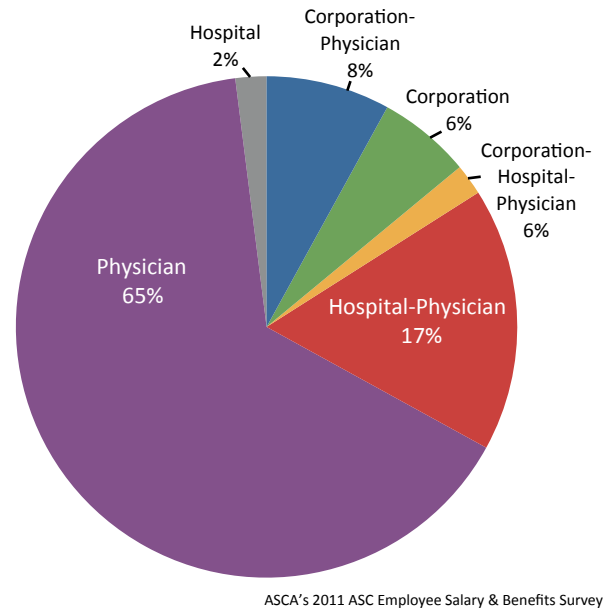
Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price of the planned

surgical procedure and the specific portion for which the patient would be responsible. This will empower health care consumers as they evaluate and compare costs for the same service amongst various health care providers.

Medicare Case Volume by Specialty



ASC Ownership



ASCs = Efficient Quality Care + Convenience + Patient Satisfaction

The ASC health care delivery model enhances patient care by allowing physicians to:

- Focus exclusively on a small number of processes in a single setting, rather than having to rely on a hospital setting that has large-scale demands for space, resources and the attention of management
- Intensify quality control processes since ASCs are focused on a smaller space and a small number of operating rooms, and
- Allow patients to bring concerns directly to the physician operator who has direct knowledge about each patient's case rather than deal with hospital administrators who almost never have detailed knowledge about individual patients or their experiences

Physician ownership also helps reduce frustrating wait-times for patients and allows for maximum specialization and patient-doctor interaction. Unlike large-scale institutions, ASCs

- Provide responsive, non-bureaucratic environments tailored to each individual patient's needs
- Exercise better control over scheduling, so virtually no procedures are delayed or rescheduled due to the kinds of institutional demands that often occur in hospitals (unforeseen emergency room demands)
- Allow physicians to personally guide innovative strategies for governance, leadership and most importantly, quality initiatives

As a result, patients say they have a 92% satisfaction rate with both the care and service they receive from ASCs.⁴ Safe and high quality service, ease of scheduling, greater personal attention and lower costs are among the main reasons cited for the growing popularity of ASCs.

ASCs ARE HIGHLY REGULATED TO ENSURE QUALITY AND SAFETY

ASCs are highly regulated by federal and state entities. The safety and quality of care offered in ASCs is evaluated by independent observers through three processes: state licensure, Medicare certification and voluntary accreditation.

Forty three states and the District of Columbia, currently require ASCs to be licensed in order to operate. The remaining seven states have some form of regulatory requirements for ASCs such as Medicare certification or accreditation by an independent accrediting organization. Each state determines the specific requirements ASCs must meet for licensure and most require rigorous initial and ongoing inspection and reporting.

<

All ASCs serving Medicare beneficiaries must be certified by the Medicare program. In order to be certified, an ASC must comply with standards developed by the federal government for the specific purpose of ensuring the safety of the patient and the quality of the facility, physicians, staff, services and management of the ASC. The ASC must demonstrate compliance with these Medicare standards initially and on an ongoing basis.

In addition to state and federal inspections, many ASCs choose to go through voluntary accreditation by an independent accrediting organization. Accrediting organizations for ASCs include The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) and

the American Osteopathic Association (AOA). ASCs must meet specific standards during on-site inspections by these organizations in order to be accredited. All accrediting organizations also require an ASC to engage in external benchmarking, which allows the facility to compare its performance to the performance of other ASCs.

In addition to requiring certification in order to participate in the Medicare program, federal regulations also limit the scope of surgical procedures reimbursed in ASCs. Even though ASCs and hospital outpatient departments are clinically identical, the Center for Medicare & Medicaid Services (CMS) applies different standards to the two settings.

Reporting Measures

Measure	Data Collection Begins
Patient Burn	Oct 1, 2012
Patient Fall	Oct 1, 2012
Wrong Site, Side, Patient, Procedure	Oct 1, 2012
Hospital Admission	Oct 1, 2012
Prophylactic IV Antibiotic Timing	Oct 1, 2012
Safe Surgery Check List Use	Jan 1, 2012
Volume of Certain Procedures	Jan 1, 2012
Influenza Vaccination Coverage for Health Care Workers	Jan 1, 2013

76 Federal Regulation 74492 - 74517

ASCs: A COMMITMENT TO QUALITY

Quality care has been a hallmark of the ASC health care delivery model since its earliest days. One example of the ASC community's commitment to quality care is the ASC Quality Collaboration, an independent initiative that was established voluntarily by the ASC community to promote quality and safety in ASCs.

The ASC Quality Collaboration is committed to developing meaningful quality measures for the ASC setting. Six of those measures have already been endorsed by the National Quality Forum (NQF). The NQF is a non-profit organization dedicated to improving the quality of health care in America, and the entity the Medicare program consults when seeking appropriate measurements of quality care. More than 20% of all ASCs are already voluntarily reporting the results of the ASC quality measures that NQF has endorsed.

Since 2006, the ASC industry has urged the CMS to establish a uniform quality reporting system to allow all ASCs to publicly demonstrate their performance on quality measures. Starting on October 1, 2012, a new quality reporting system for ASCs will begin and will encompass five of the measures that ASCs are currently reporting voluntarily.

Specific Federal Requirements Governing ASCs

In order to participate in the Medicare program, ASCs are required to meet certain conditions set by the federal government to ensure that the facility is operated in a manner that assures the safety of patients and the quality of services.

ASCs are required to maintain complete, comprehensive and accurate medical records. The content of these records must include a medical history and physical examination relevant to the reason for the surgery and the type of anesthesia planned. In addition, a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and the procedure to be performed. Prior to discharge each patient must be evaluated by a physician for proper anesthesia recovery.

CMS requires ASCs to take steps to ensure that patients do not acquire infections during their care at these facilities. ASCs must establish a program for identifying and preventing infections, maintaining a sanitary environment and reporting outcomes to appropriate authorities. The program must be one of active surveillance and include specific procedures for prevention, early detection, control and investigation of infectious and communicable diseases in accordance with the recommendations of the Centers for Disease Control and Prevention. Thanks to these ongoing efforts, ASCs have very low infection rates.⁵

A registered nurse trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever a patient is in the ASC. To further protect patient safety, ASCs are also required to have an effective means of transferring patients to a hospital for additional care in the event of an emergency. Written guidelines outlining arrangements for ambulance services and transfer of medical information are mandatory. An ASC must have a written transfer agreement with a local hospital, or all physicians performing surgery in the ASC must have admitting privileges at the designated hospital. Although these safeguards are in place, hospital admissions as a result of complications following ambulatory surgery are rare.⁵

Continuous quality improvement is an important means of ensuring that patients are receiving the best care possible. An ASC, with the active participation of its medical staff, is required to conduct an ongoing, comprehensive assessment of the quality of care provided.

The excellent outcomes associated with ambulatory surgery reflect the commitment that the ASC industry has made to quality and safety. One of the many reasons that ASCs continue to be so successful with patients, physicians and insurers is their keen focus on ensuring the quality of the services provided.

Medicare Health and Safety Requirements

Required Standards	ASCs	HOPDs
Compliance with State licensure law	☑	☑
Governing body and management	☑	☑
Surgical services	☑	☑
Quality assessment and performance improvement	☑	☑
Environment	☑	☑
Medical staff	☑	☑
Nursing services	☑	☑
Medical records	☑	☑
Pharmaceutical services	☑	☑
Laboratory and radiologic services	☑	☑
Patient rights	☑	☑
Infection control	☑	☑
Patient admission, assessment and discharge	☑	☑

Source: 42 CFR 416 & 482

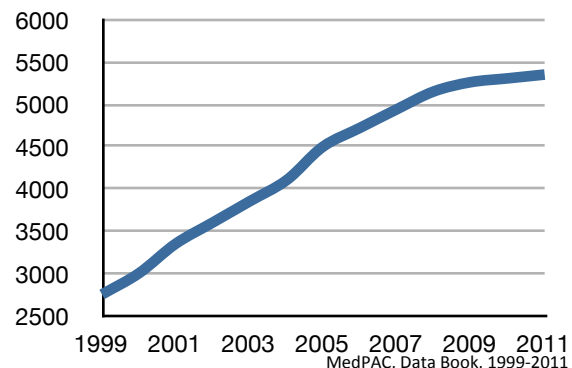
CONTINUED DEMAND FOR ASC FACILITIES

Technological advancement has allowed a growing range of procedures to be performed safely on an outpatient basis (unfortunately, however, Medicare has been slow to recognize these advances and assure that its beneficiaries have access to them). Faster acting and more effective anesthetics and less invasive techniques, such as arthroscopy, have driven this outpatient migration. Procedures that only a few years ago required major incisions, long-acting anesthetics and extended convalescence can now be performed through closed techniques utilizing short-acting anesthetics, and with minimal recovery time. As medical innovation continues to advance, more and more procedures will be able to be performed safely in the outpatient setting.

Over the years, the number of ASCs has grown in response to demand from the key participants in surgical care—patients, physicians and insurers. While this demand has been made possible by technology, it has been driven by patient satisfaction, efficient physician practice, high levels of quality and the cost savings that have benefited all.

However, in a troubling trend, the growth of ASCs has slowed in recent years. If the supply of ASCs does not keep pace with the demand for outpatient surgery that patients require, that care will be provided in the less convenient and more costly hospital outpatient department.¹²

Number of Medicare Certified ASCs



ASCs CONTINUE TO LEAD INNOVATION IN OUTPATIENT SURGICAL CARE

As a leader in the evolution of surgical care that has led to the establishment of affordable and safe outpatient surgery, the ASC industry has shown itself to be ahead of the curve in identifying promising avenues for improving the delivery of health care.

With a solid track record of performance in patient satisfaction, safety, quality and cost management, the ASC industry is already embracing the changes that will allow it to continue to play a leading role in raising the standards of performance in the delivery of outpatient surgical services.

As always, the ASC industry welcomes any opportunity to clarify the services it offers, the regulations and standards governing its operations, and the ways in which it ensures safe, high-quality care for patients.

POLICY CONSIDERATIONS

Given the continued fiscal challenges posed by administering health care programs, policy makers and regulators should continue to focus on fostering innovative methods of health care delivery that offer safe, high-quality care so progressive changes in the nation's health care system can be implemented.

Support should be reserved for those policies that foster competition and promote the utilization of sites of service providing more affordable care, while always maintaining high quality and stringent safety standards. In light of the many benefits ASCs have brought to the nation's health care system, policymakers should develop and implement payment and coverage policies that increase access to, and utilization of, ASCs.

END NOTES

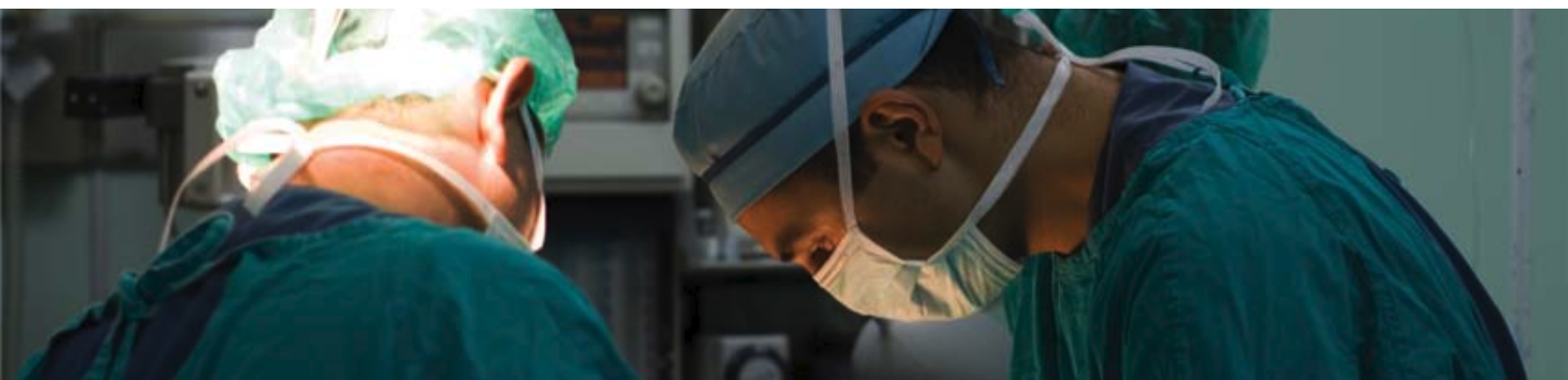
1 "Ambulatory Surgery Centers." Encyclopedia of Surgery. Ed. Anthony J. Senagore. Thomson Gale, 2004.

2 2004 ASC Salary and Benefits Survey, Federated Ambulatory Surgery Association, 2004.

3 Oxford Outcomes ASC Impact Analysis, 2010.

4 Press-Ganey Associates, "Outpatient Pulse Report," 2008.

5 ASCA Outcomes Monitoring Project, 3rd Quarter 2011.



BRIGHTSIDE SURGICAL

401 North 9th Street, Bismarck, ND

701-712-4131

January 31, 2021

To the Honorable Legislators of North Dakota,

I am writing this testimony in support of SB 2334.

Brightside Surgical is an ambulatory surgery center (ASC) located in Bismarck, ND. Our multispecialty physician group and staff provides patient-centered surgical care that focuses on quality, service, and access while ensuring the highest levels of safety. Our center is privately owned, and we have twenty privileged physicians that provide a diverse set of surgical and procedural options to community/region.

We believe Ambulatory surgery centers have clearly provided the residents of North Dakota with quality health care, increased patient satisfaction, decreased cost, and increased choices of where to receive their healthcare. Allowing extended stay centers in North Dakota, under SB 2334, adds a tool for ASCs to expand patient access and options while maintaining the proven record of ASC's for safety, outcomes, and lower costs.

I would respectfully submitted two articles that support our position.

1. ASC – A positive trend in Health Care
2. 2019 Ambulatory Surgery Centers with Extended Stay Centers: Appropriate Procedures and Patient Characteristics

The first article states “With a solid track record of performance in patient satisfaction, safety, quality and cost management, the ASC industry is already embracing the changes that will allow it to continue to play a leading role in raising the standards of performance in the delivery of outpatient surgical services.”

The second article is an executive summary of a bill passed in Oregon that allowed the development of an extended stay centers (ESC). The article demonstrates that this can be done safely and beneficial to the communities.

As a private practice general surgeon for the past 12 years in Bismarck, ND, I have seen the benefits of using an ASC to provide care to my patients. There are numerous examples of scheduling flexibility, decreased cost, high quality outcomes and increased patient satisfaction that I could provide with a firsthand account.

Also, as most physicians know, it is hard to recruit new physicians to ND as well. Possible ownership in an ASC or an ESC is an additional tool that can be used to recruit new physicians to continue to care for our communities.

Thank you for your time and please contact me with any questions,

A handwritten signature in black ink, reading "Brandon Helbling". The signature is fluid and cursive, with the first name "Brandon" and last name "Helbling" clearly distinguishable.

Brandon Helbling, M.D., FACS, FASMBS

President

Brightside Surgical

Testimony in support of SB 2334

Senate Industry, Business and Labor Committee

1/30/2021

Chairman Klein, Committee Members - for the record my name is Scott Osadchuk, I am the director of Bismarck Surgical Associates, an ambulatory surgery center in Bismarck ND. I have been in the medical field since 1990, I worked in the hospital system as staff and management until 2007 then made the switch to ambulatory surgery.

I'm asking for your support for Senate Bill 2334 which allows ambulatory surgical centers the ability to monitor and treat their surgical patients for up to 48 hours following surgery without sending them to a hospital facility; something that is many times a burden, and drives costs up for patients and the healthcare system.

I frequently hear our pre op nursing staff discussing accommodations with our patients from out of town because they do not have a place to stay and live too far away to drive home after surgery. I also hear our physicians say how many of their older patients would like to have surgery at a lower cost center and be less exposed to the illnesses circulating in the local hospitals. These issues are of particular importance during the COVID pandemic and has become a request we hear frequently.

As we all continue to look for more efficient and effective methods to treat patients, SB 2334 allows a real option, and patients will have more freedom of choice and also have more availability to get their elective surgeries completed.

Thank you for your consideration Mr. Chairman, and I respectfully ask the Committee for a DO PASS recommendation on Senate Bill 2334.

2021 HOUSE HUMAN SERVICES

SB 2334

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee Pioneer Room, State Capitol

SB 2334
3/17/2021 AM

Relating to the registration of extended stay centers

Chairman Weisz opened the committee hearing at 9:04 a.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- 24- to 48-hour observation
- Doctor access
- Ambulatory surgery centers
- Facility change

Sen. Janne Myrdal, District 10 (9:05) introduced the bill.

Amanda Parent, Laventure (9:10) introduced Duncan Ackerman, North Dakotans for Open Access Healthcare

Duncan Ackerman, North Dakotans for Open Access Healthcare (9:10) testified in favor and submitted testimony #9783.

Courtney Koebele, Executive Director North Dakota Medical Association (9:33) testified in favor and submitted testimony #9689.

Megan Houn, Director Government Relations Blue Cross & Blue Shield (9:34) testified in favor.

Jed LaPlante, Administrator Center for Special Surgery (9:35) testified in favor and submitted testimony #9728.

Tim Blasl, President North Dakota Hospital Association (9:42) introduced Steven Weiser, President Altru Health.

Steven Weiser, President Altru Health (9:42) testified in opposition and submitted testimony #9761.

Additional written testimony: #9785

Chairman Weisz adjourned at 10:01 a.m.

Tamara Krause, Committee Clerk

Testimony

Senate Bill 2334

House Human Services Committee

Chairman, Representative Robin Weisz

Vice Chairman, Representative Karen Rohr

3/17/2021

Chairman Weisz, Madam Vice Chairman Rohr, and distinguished members of the House Human Services Committee, my name is Duncan Ackerman. I am native to North Dakota, born and raised in Minot, and I am an Orthopedic Surgeon who has practiced in North Dakota since completing my residency and fellowship training at The Mayo Clinic in 2009. My family proudly chose to return to our great state to practice medicine and have since been afforded the opportunity to improve the lives of many our friends and neighbors.

I am also an owner / partner in two small businesses. The first, The Bone & Joint Center, is an Orthopedic Surgery clinic that provides a broad scope of musculoskeletal care. There are nine partners in the practice with eight of the partners hailing from North Dakota. The places we grew up include Hillsboro, Bowman, Kenmare, Lansford, Minot, Turtle Lake, and Bismarck. The Bone & Joint Center was established in 1973 and continues to serve the residents of North Dakota. We have permanent offices in Bismarck, Dickinson, and Minot along with outreach locations in Garrison, Turtle Lake, Hazen, Beulah, Williston, Hettinger, Linton, and Wishek.

I am also an owner / partner of Bismarck Surgical Associates (BSA). BSA is an outpatient ambulatory surgery center (ASC). My partners are Orthopedic Surgeons, Anesthesiologists, and an Ophthalmologist. We perform a full array of outpatient procedures from cataract surgery to total joint replacement. ASCs, which were established in 1970, have proven to provide lower cost, high quality care.

Today I am here representing North Dakotans for Open Access Healthcare.

The public's demand of price transparency has resulted in a shift in health care delivery to lower cost alternatives. The Centers for Medicare and Medicaid Services (CMS) has developed an online tool (<https://www.medicare.gov/procedure-price-lookup/cost>) for patients to research the difference in cost when comparing surgery at an ASC versus a Hospital Outpatient Department (HOPD). Using national data, an ASC is paid about 56.39% of the HOPD rate for the exact same procedure, saving the Medicare and Medicaid systems more than 43 percent on average. I am an upper extremity specialist, so rotator cuff shoulder surgery is a common procedure in my practice. Utilizing CMS's tool, we can look at and compare the cost difference for arthroscopic rotator cuff repair in an ASC vs. HOPD. In an ASC, the total cost for arthroscopic rotator cuff repair is \$3,918, Medicare pays \$3,134, the patient's responsibility is \$783. In comparison, the total cost for the same procedure at a HOPD is \$7,096, Medicare pays \$5,677, the patient's responsibility is \$1,419. The savings are clear, procedures performed in an ASC cost the payor and consumer less than if performed in a 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. Patient and private insurance companies save similarly. A review of commercial claims found US healthcare costs are reduced by \$38 billion 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 care provided at ASCs. (California Orthopedic Association White Paper Expanding Services in an ASC Through the Addition of a Recovery Care Center 2017). (<https://coa.org/newspublications/white-papers/>)

Medicare this past year decided to discontinue the Inpatient Only List (IPO) of procedures. The IPO list was a list of procedures that could only be performed in a hospital inpatient setting, including common

procedures such as total hip and total shoulder replacement. Medicare previously would not pay for a procedure on the IPO list to be performed at an ASC. Medicare's decision to discontinue the IPO list proves that CMS values the ASCs as a cost saving alternative to traditional hospital care. This decision will lead to patients having the additional option of having a procedure performed in an ASC, that historically could have only been performed in the hospital.

The Covid-19 Pandemic has also highlighted the need for additional patient choice. In-patient hospital systems were severely challenged by staffing issues, procurement challenges, and patient volumes. Several of my patients rescheduled their surgeries due to the concern of the procedure being done in the hospital environment where patients with Covid-19 were receiving care. In addition, several of my patients were required to be rescheduled because the hospital was at capacity and could not guarantee they would have the staff available to provide appropriate post-operative care. This may seem like a simple inconvenience, but we care for people that have a narrowly defined timeline to heal and return to feeding their families. This is a significant challenge for a farmer or rancher who must recover before planting or calving, a patient trying to take advantage of already-met deductibles, or a WSI patient who wants to get back to work and off state assistance.

This leads us to discuss a new opportunity for our patients in North Dakota called an Extended Stay Center (ESC). Currently in North Dakota, patients are only allowed to stay in an ASC for up to 24 hours. The creation of the ESC would allow patients to stay up to 48 hours. Extended Stay Centers (ESC) are essentially recovery rooms for patients undergoing a procedure in an ASC. They are there for a patient who might need a little extra time and minor care to recover from surgery. The services included may be for pain management, physical therapy, or management of other bodily functions. Extended stay centers are not complicated, they are not meant to replace the hospital, and they are not a new concept. Other states, for instance Colorado and Arizona, have had convalescent care centers or recovery centers for many years. Reports from their experiences prove these centers are: 1) Patient centered, with very high

patient satisfaction, 2) Outcomes driven, with infection and complication rates being extremely low and 3) Cost conscious, with dramatically lower costs to the patient and the health care system. In other states, there have been collaborative joint ventures of an ASC/ESC model and their local health system partner, benefiting the entire regional health care delivery system. Oregon is the most recent state to pass ESC legislation allowing patients to stay up to 48 hours. This was a collaborative effort between the Oregon Association of Hospitals and Health Systems and the Oregon Ambulatory Surgery Center Association. (<https://olis.leg.state.or.us/liz/2018R1/Measures/Analysis/HB4020>)

The added advantage of an ESC for our North Dakota patients is related to our geographical footprint and population density. Most specialized orthopedic care, like total joint replacement, occurs in our population centers. Adding an ESC would allow our patients that travel a long distance the extra time they may need to recover prior to making the long trek back home. The hospitals, mandated by payors, typically have strict criteria for patients to qualify for a stay longer than 24 hours on some procedures. The ESC can give that patient with long travel distances, limited family support, or minor concerns the extra time needed to feel more comfortable before returning home. The additional time also allows physicians to care for their patients, without the pressure of having to send someone off to the hospital in an ambulance at 23 hours 59 minutes from admission to avoid penalty and burden to every party. The transfer alone is costly, the insurance companies will be charged for a hospital stay, tests will likely be run, and the patient's continuity of care may be disrupted.

In conclusion the ESC model is not a new idea, it is not a complicated building, and the idea is about being focused on patient care. This model improves patient choice, decreases the overall cost of care, and maintains or improves quality. SB 2334 came out of the Senate IBL committee 5-0 DO PASS and passed the full Senate 44-3. I would request the House Human Service Committee vote a DO PASS on SB 2334. I would like to thank Chairman Weisz, Madam Chairman Rohr, and the distinguished members of this committee for your time and consideration.

I would be happy to take any questions from Mr. Chairman and committee members.

Duncan B. Ackerman, MD

North Dakotans for Open Access Healthcare



House Human Services Committee
SB 2334
March 17, 2021

Good morning Chairman Weisz and Committee Members. I am Courtney Koebele, the executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

The North Dakota Medical Association supports SB 2334 and urges a do pass from this committee.

Over the past two decades, as surgical techniques improved, surgery centers have moved toward increasingly complex procedures in patients that required longer recovery times. Many surgery centers now keep patients for nearly a full 24 hours after knee or hip replacements. The extended stay model provided for in this bill would allow for a greater percentage of those cases to be done at surgery centers. There is a continuing trend of shifting from inpatient to outpatient procedures, and the extended care center model allows for parallel care in a safe setting.

Extended stay centers could also cut costs for both public and private insurance plans and for patients. The cost of having a surgery done in a surgery center compared to a hospital is lower, resulting in lower co-pays and deductibles for patients, and lower costs for insurance companies.

NDMA respectfully requests a DO PASS on SB 2334. Thank you for your time today. I would be happy to answer any questions.

Testimony in support of SB 2334 – Extended Stay Centers**March 17, 2021**

Good morning Chairman Weisz and Members of the Committee:

My name is Jed LaPlante, I am the Administrator of Center for Special Surgery in Fargo, a multi-specialty Ambulatory Surgery Center (ASC). Over the past 10 years of my career, I have worked in two different health systems as a Clinic Director and was the first employee hired to open Center for Special Surgery. In 2017, I obtained my Masters in Healthcare Administration from the University of Minnesota. I am here to testify in support of Senate Bill 2334, allowing the creation of extended stay centers.

Cost, Value, Patient Experience:

ASCs perform surgical procedures, on average, at 50-60% the cost of a hospital environment (comparing Medicare fee schedules). Extended Stay Centers may open the door for more patients and their health plans to recognize more savings as ASCs are able to innovate and start new service lines. Higher cost procedures will continue the migration from an inpatient environment to an outpatient/ASC environment in our near future. A 40% discount on a procedure like a cataract extraction provides hundreds of dollars of savings to the patient and health plan for each procedure performed. When you start saving 40% or more on total joint replacement and spine surgery, you recognize thousands of dollars of savings on every single procedure performed. The state of Oregon passed a bill for ESCs in 2018. Two of their state employee benefit systems anticipate to save \$12-\$15 million in a decade with the implementation of ESCs as outpatient surgery volume is expected to double over that same time period. (ASC Focus, March 2018)

Many of the procedures utilizing an ESC will still be done by the same private practice, self-employed physicians that are doing them now. This is simply a change of facility with a mindset that private practice physicians can and should impact the patient's care and experience. This is more about the patient experience than it is about anything else. We believe we have the opportunity to change surgery to feel more like a stay in a hotel, than an institution.

Maintaining a Free Market in North Dakota Healthcare:

Healthcare, over the years, has morphed to where physicians are more often employed than they are a business owner. While both structures can be successful, I do think it's important that we make sure that both options have a fair opportunity to exist in the future. As health systems further desire to employ their physician base rather than contract with private practice groups, it becomes increasingly harder for a physician in private practice to obtain adequate operating room time, a voice regarding implant/technology decisions and the involvement in developing care pathways that make sense for each specialty and each physician. Extended stay centers will surely not replace the role of a hospital in a private practice as there will always be a time and a place for the hospital environment. However, it is another tool for a private practice physician may utilize to maintain independence if a relationship with a key partner deteriorates.

“Inpatient Only List” to be Abandoned by 2024:

In the Centers for Medicare and Medicaid Services (CMS) final payment rule for 2021, there is guidance from CMS that by the year 2024, there will no longer be a list of procedures that they deem not to be safe in an ambulatory surgery center environment. Earlier I mentioned the migration of inpatient procedures to an outpatient environment. This is not something the private practices in North Dakota created on their own. It's recognition on the federal level that techniques in both surgery and anesthesia have improved, along with technology of implants and instrumentation that is creating this shift.

Deep down, I do believe this bill is a benefit to the hospitals in our state, even if it may not feel like that today. There will be a day when Medicare forces certain procedures to the lower cost ambulatory surgery center environment. When that happens, I could see local health systems utilize the ESC to complement their service lines, much like we're describing here today.

We believe an Extended Stay Center partnered with an Ambulatory Surgery Center aligns the state of ND with what's to come from Medicare, which for us in Fargo, is the most common medical coverage we see across all of our specialties. Not allowing us to align with what's happening on a federal level will leave ND behind as other states benefit from new and innovative care models. I've used this saying a lot in my time in Fargo as we've added new procedures and worked to add new service lines, "If we are to wait for Medicare to pave the way, we will forever be behind." We have the chance to get ahead of this now.

Thank you for your time and consideration this morning and I ask the Committee for a DO PASS recommendation on Senate Bill 2334.

2021 SB 2334
House Human Services Committee
Representative Robin Weisz, Chairman
March 17, 2021

Chairman Weisz and members of the House Human Services Committee, I am Steven Weiser, MD, President of Altru Health System in Grand Forks. I appear before you to testify regarding 2021 Senate Bill 2334 and ask that you give this bill a **Do Not Pass** recommendation.

I have been an emergency medicine physician for 26 years, having practiced in Canada before coming to the United States. I have also been in hospital administration for approximately 4 years and President of Altru for over a year. I am familiar with many different types of health care provider facilities, such as general acute care hospitals, specialty hospitals, and ambulatory surgical centers (ASC), but had not heard of the new health care entity this bill would create - an extended stay center (ESC). I understand that the supporters of the bill are asking you to allow these centers, which would provide medical and nursing services to a patient recovering from a surgical procedure performed in an ASC if certain conditions are met.

I want to first say that I recognize the importance of ASCs in our health care system and am not here to diminish that in any way. They play a key role in patient satisfaction and convenience as well as helping to keep health care costs low. An extended stay center, however, is a new and an unknown facility. I have concerns about those unknowns, particularly how they may impact patient safety. I think some background on ASC's is important to understanding those concerns.

As you probably know, federal Medicare participation requirements mandated by the Centers for Medicare & Medicaid Services (CMS) drive much of the structure of our health care system. Medicare defines an ASC as a distinct entity that operates exclusively for the purpose of providing surgical services to patients who will not require hospitalization as a result of the surgery. The Medicare rules specify that an ASC must be certified and meet the Conditions for Coverage (CfCs). And surgeries performed in an ASC must be limited to those that ordinarily would not require the patient to be kept at the ASC for more than 24 hours. In this way, ASCs are appropriately limited to cases where the risk

of complications or serious medical episodes is low. The 24-hour limitation flows from the fact that an ASC does not have the same emergency capabilities as hospitals and patients are at risk if their condition worsens beyond the capability of the ASC.

ASCs are also subject to regulatory oversight by the state. For example, states are allowed to limit the duration of an ASC stay to something less than 24 hours if they choose, but the stay cannot be more than that time period. For example, some states define the duration of an ASC service to be no more than four hours for the procedure and four hours for supervised recovery. Current North Dakota law and administrative regulations require any institution that maintains and operates organized facilities for the diagnosis, treatment, or medical care of two or more persons where care is rendered over a period **exceeding 24 hours**, including outpatient facilities and surgical centers, to secure a hospital license.¹

It is important to understand that ASCs and hospitals are very different in the services they provide patients and the capabilities they have and, so, are also regulated very differently. Because they generally do more simple surgeries, ASCs operate under fewer patient-safety laws and regulations and may provide surgeries that are less complicated and on patients with lower health risks. But where does an ESC fall within that continuum of care? And how will ESCs be regulated? Will they be subjected to something less than full hospital licensing requirements? Who will judge and oversee their quality? Who will determine which procedures are safe to perform in an ESC? What standards of infection control would apply? Will the ESC safety plan for patients who crash essentially be “call an ambulance and transfer to a hospital”?

Because ESCs are only recognized by a few states, regulation of them is very new. Unlike ASCs and hospitals, an ESC is not certified, or even recognized, by CMS and there are no rules of participation that govern them. It is unclear what kind of regulatory process ESCs would be subject to if this bill passes. It is, however, clearly spelled out in the bill that they would not have to be licensed as hospitals are. They would only have to secure “registration” from the ND Department of Health, with the requirements to be determined at a later date in administrative rules.

I do not believe it constitutes good patient care to allow an ESC to expand the surgical risk profile or the procedures permissible in an ASC. I am concerned that allowing ASCs to offer extended services

¹ NDCC 23-16-01; ND Admin. Code 33-07-01.1-01

such as proposed by this bill entices surgeons to perform higher acuity (more difficult and therefore riskier) cases in the ASC. These are cases that should be performed within a hospital - a setting that has the ready resources to address an untoward outcome. An ESC may be appropriate for patients who need extra time for managing pain or bodily functions or who may require extended travel time to return home after a surgical procedure, but they should not be the place of care for a patient who is likely to experience complications. When these patients do crash, they are admitted to a hospital. This lapse of time and the lack of immediately available resources can and has had an untoward outcome for the patient. ASCs were never intended, or equipped to, safely care for patients experiencing serious medical episodes or complications and expanding care with so many unknowns puts patients at risk.

If an ASC wants to keep patients longer than the 24 hours currently allowed under state law and under the CMS definition, why should they not also be required to comply with current hospital level licensure standards? The legislature should not allow ASCs to expand the types of services they perform, or the length of patient recovery needed without proper oversight. If these facilities wish to provide more complex care than can be provided in an ASC, they should seek licensure as a hospital and meet the hospital standards.

Because of limited experience with ESC's, we just do not have data on the effect these facilities may have on the safety and appropriateness of surgeries in such a setting. Existing data is either noncomparative or focused on patients and procedures that are not appropriate for ambulatory surgery without ESCs or similar facilities. The evidence and supplemental resources currently available are simply insufficient to guide decisions on patient characteristics and surgical procedures that may be appropriate for ASCs and ESCs. Maybe this is an area that could be studied to allow consideration of evidence from other states' experience in regulating these new health care entities.

It is for these reasons that I must express my concern that this arrangement does not represent good patient care. Should you wish to proceed, I ask that you instead consider studying and developing an appropriate regulatory framework before authorizing this new type of health care entity. I ask that you give this bill a Do Not Pass recommendation. Thank you.

Respectfully Submitted,

Steven Weiser, MD, President
Altru Health System



EXTENDED STAY CENTERS GIVE PATIENTS MORE CHOICE AND REDUCE HEALTHCARE COSTS

SENATE BILL NO. 2334 – EXTENDED STAY CENTERS

SB 2334 creates a new chapter, 23-17.6, of the North Dakota Century Code, relating to the licensure of extended stay centers.

Extended stay centers (ESC) lower costs for patients who may require additional oversight and supervision following a standard medical procedure. Patients electing to have surgery performed by a licensed private practice surgeon are required to be discharged within 24 hours of admittance, regardless of recovery condition progress. High risk patients are transferred to an inpatient medical facility for further observation.

IMPROVED ACCESS TO HEALTHCARE:

Ambulatory surgical centers operate (ASC) more efficiently and can handle larger volumes of patients, meaning patients avoid scheduling backlogs and doctor shortages are offset by greater production from current physicians.

SAFER TREATMENT:

Ambulatory surgical centers outperform in-patient facilities in terms of patient outcomes, including re-admission and infection rates.

HIGHER RISK PATIENTS STILL TREATED AT IN-PATIENT FACILITIES:

Surgeons are always responsible for patient outcomes and are incentivized through performance metrics, insurance oversight, and licensure repercussions to select in-patient facilities to treat higher-risk patients. Extended stay centers allow physicians to choose the best option for their surgical outpatient's, discharge, extended stay center observation, or admittance to a hospital.

AFFORDABLE CARE OPTIONS:

Ambulatory surgical centers, in most cases, lower the total cost of care dramatically. Registered extended stay centers create affordable care options for patients and relieve undue pressure on already overburdened hospitals.

PATIENT OCCUPANCY LIMITATIONS:

The extended stay center would have no more than two recovery beds for each operating room affiliated with the ambulatory surgery center and would not exceed a total of sixteen recovery beds.

ADMITTANCE & LOCATION:

Extended stay center may only accept patients from an ambulatory surgical center and must be separated physically.

LENGTH OF STAY:

All patients would be discharged within 48 hours from the time of admission to the ESC.

INDUSTRY & INNOVATION:

Extended stay centers are a major trend in the healthcare industry across the country – saving significant dollars for patients and the health care industry.

REGISTRATION REQUIREMENTS:

Extended stay centers would meet the minimum standards for licensure, be affiliated with a facility certified by the centers for Medicare and Medicaid services as an ambulatory surgical center. The Extended Stay Center chapter in the Century Code contains structure for licensing and provides the ND Department of Health administrative rule authority to create administrative rules for the licensing and oversight of extended stay centers.

BACKGROUND & DEFINITIONS:

- ASC: "Ambulatory Surgical Center", more often called an outpatient surgical center, an ASC provides general, orthopedic, cardiovascular, and many other surgery services and may provide care for a patient for up to 24 hours, most often measured from the time the patient is admitted into "the back" from the waiting room.
- ESC: "Extended Stay Center", a facility, connected physically and/or through a business relationship to an ASC, which provides care lasting more than 24 hours to patients who need extra time for managing pain or bodily functions, who do not have a caregiver at home, or who may require extended travel time to return home after a surgical procedure.
- Currently in North Dakota: ASCs are limited to 24 hours of care. ESCs will require a new category by law.

Supported by North Dakotans for Open Access Healthcare.

Contact: Duncan Ackerman, M.D. | dackerman@bone-joint.com

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee Pioneer Room, State Capitol

SB 2334
3/17/2021 PM

Relating to the registration of extended stay centers

Chairman Weisz opened the committee meeting at 3:15 p.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Discharge planning

Rep. Matthew Ruby (3:16) moved **Do Pass**

Rep. Karen Rohr (3:16) second

Representatives	Vote
Representative Robin Weisz	Y
Representative Karen M. Rohr	Y
Representative Mike Beltz	Y
Representative Chuck Damschen	Y
Representative Bill Devlin	Y
Representative Gretchen Dobervich	Y
Representative Clayton Fegley	Y
Representative Dwight Kiefert	Y
Representative Todd Porter	Y
Representative Matthew Ruby	Y
Representative Mary Schneider	Y
Representative Kathy Skroch	N
Representative Bill Tveit	Y
Representative Greg Westlind	Y

Motion Carried Do Pass 13-1-0

Bill Carrier: Rep. Matthew Ruby

Chairman Weisz adjourned at 3:19 p.m.

Tamara Krause, Committee Clerk

REPORT OF STANDING COMMITTEE

SB 2334, as engrossed: **Human Services Committee (Rep. Weisz, Chairman)**
recommends **DO PASS** (13 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING).
Engrossed SB 2334 was placed on the Fourteenth order on the calendar.