Ophthalmology MANAGEMENT
Article

EYE ON OOSS

ASCs Are the Clear Choice For Cataract Surgery

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Delivering safe, quality care in a user-friendly, cost-effective environment

Cataract surgery is one of those rare procedures that goes beyond solving a problem or curing a disease; it literally transforms lives. Sight restoration through cataract surgery markedly improves quality of life and contributes to patient health and safety. The high cost of poor vision is associated with depression, injury, hospital admissions, the necessity for caregivers, and reduced employment.[1] Studies have linked cataract surgery to a significant reduction in the likelihood of hip fractures and auto accidents.[2,3]

About half of Americans will have cataracts by age 75, and more than 3 million cataract surgeries are performed annually in the US. The surgical technique for cataract extraction with intraocular lens implant has become so perfected that the procedure has a 98% or higher success rate, according to the American Society for Cataract and Refractive Surgery.

The remarkable positive impact of cataract surgery and the consistent outcomes it delivers may inure a false sense of security when it comes to this procedure. Much of those positive results aren't guaranteed; they depend greatly on the environment of care and its quality and safety standards.

An Evolving Trend

Over the past five decades, most cataract procedures have shifted from being performed in hospitals to ambulatory surgery centers (ASCs). According to the Ambulatory Surgery Center Association (ASCA), as of June 2020, there were 5,849 Medicare-certified ASCs in the country. Twenty-five percent of single-specialty centers were ophthalmic, and ophthalmology was a component in 46% of multi-specialty ASCs, providing broad access to cataract surgery.

Meanwhile, over the last decade, office-based cataract surgery has emerged and may be gaining traction. The argument for office-based surgery (OBS) focuses largely on convenience factors: ease of scheduling and management of the financial (cash) transactions, along with a more comfortable patient experience due to familiarity with the office environment and staff.[4]

Commitment to Quality

The first ASC opened for business in 1970, and the number of ASCs reached triple digits by the end of that decade. Even as a fledging industry, ASCs' commitment to quality and standards was evident and continues today. Beginning in 1975, ASCs sought accreditation through The Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC). In 1997, the industry launched its first benchmarking initiative, the Outcomes Monitoring Project. In 2002, the Certified Administrator Surgery Center credential was launched. In 2006, the ASC community established the ASC Quality Collaboration to develop ASC quality measures, publicly report data, and support high-quality care in ASCs. In 2018, the Certified Ambulatory Infection Preventionist credential was launched.

Since ASCs emerged, 46 states have established ASC regulations, requiring licensure under state law coupled with initial and ongoing inspection and reporting. Medicare Conditions for Coverage also apply to ASCs participating in the Medicare Program. The amount of ASC regulation and oversight is indicative of the potential health and safety risks associated with patients undergoing surgical diagnostic and therapeutic procedures in ASCs.

I have been privileged to work in and with ophthalmic ASCs since 1984. I have seen the ASC industry establish itself as the gold standard for delivering safe, high-quality care in a user-friendly and cost-effective environment. ASCs have perfected efficiency without compromising quality and safety.

I also have experience with OBS. In 1996, California was the first state to regulate OBS. This regulation was promulgated in response to a consumer issue, specifically the incidences of untoward outcomes and events that occurred in OBS settings. Since then, at least 35 states have issued some type of OBS regulation. Most often, the state requires accreditation in order to satisfy its regulations.

Accreditation is typically a three-year cycle. This means that every three years, the OBS is reassessed. In contrast, ASCs, in addition to accreditation, are subject to annual licensure surveys as well as ongoing oversight and enforcement from Medicare. Medicare inspections can occur anytime and are unannounced.

In a consulting capacity, I routinely assist with start-ups and ongoing compliance efforts in the ASC and OBS setting. The contrast between the two is stark and unsurprising. In my experience, ASCs are more diligent and consistent in maintaining standards, including but not limited to emergency preparedness, environmental standards, staff training and staffing patterns, infection control, quality improvement, medication safety, and documentation.

When I get requests for help from OBS centers facing an upcoming reaccreditation survey, I find more often than not that their accreditation compliance activities ended with the last survey, and they are scrambling to fill the gap. While this does not necessarily impugn the quality of care provided during the interim, at the very least it demonstrates a lack of commitment to maintaining standards associated with quality and safety, which is vital to protecting our elderly cataract patients.

The risks inherent in any elective surgical procedure intensify in elderly cataract patients. A 2015 study published by the Outpatient Ophthalmic Surgery Society (OOSS) found at least 88% of ASC cataract patients had at least two underlying comorbidities, which increase patient risk.

TABLE 1. ASC VS. OBS: CONSIDERATIONS FOR CATARACT SURGERY
Analysis prepared for OOSS based on the evaluation of state laws, CMS ASC Conditions for Coverage, and 2020 AAAHC standards. Data subject to change.

ASC CMS CERTIFIED/AAAHC ACCREDITED	OBS AAAHC Accredited
PATIENT SELECTION	
• Unlimited if the ASC has general anesthesia (GA) capability • Without GA capability, the rare patient that requires GA is excluded	• Limited to patients who can tolerate cataract surgery with only light oral sedation • Additional comorbidities may present risk factors that make the patient an inappropriate candidate for this setting
ASCs can serve a much broader patient population, offering dramatically greater opportunity for surgical volume.	
ANESTHESIA	
• Monitored anesthesia care offers sedation titrated to meet individual patient needs	• Anesthesia limited to light oral sedation
Limited anesthesia options in the OBS limits patient population that can be served.	
ANESTHESIA PROVIDER	
• Qualified anesthesiologist or CRNA, privileged and credentialed by the ASC	• Surgeon is responsible for anesthesia management
Patient risk in the ASC is reduced by the presence of a qualified anesthesia provider. This allows the surgeon to focus on the surgery without distraction and protects the patient with a dedicated provider responsive to patient needs that arise during the procedure. **Patient risk is reduced in an emergency in the ASC because a qualified anesthesia professional is present to manage medical emergencies.**	**Surgeon holds all the risk in the OBS, with sole responsibility for the patient and the procedure.**
REGULATION	
• State license in 47 states • CMS certification • Accreditation (optional)	• License required in 4 states • Accreditation may be state mandated otherwise optional
Broader regulatory demands and ongoing oversight and enforcement in the ASC deliver a higher standard of care with more patient safeguards and less patient risk.	
COMPLIANCE OVERSIGHT AND ENFORCEMENT	
• Annual • Ongoing	• Triannual • Scheduled accreditation resurvey

- Unannounced

Less emphasis on regulation and oversight in the OBS may result in laxity of standards.

EMERGENCY POWER

- Type 1 Emergency Electrical System (EES) provides back-up power to medical equipment, HVAC, OR and path of egress lighting
- No requirement

ASC back up power assures staff and patient safety in an emergency.

LAYOUT TO ADDRESS INFECTION CONTROL PRINCIPLES, PRIVACY, AND CONFIDENTIALITY

- Design standards per state licensure regulations; typically FGI Guidelines for Design and Construction of Healthcare Facilities
- No standard

ASC adherence to state-driven design standards optimizes infection control, privacy, and confidentiality.

RN STAFFING

- Nursing service is under the direction of a qualified RN
- Pre- and post-op assessments are conducted by an RN
- An RN circulator is in the OR
- An ACLS-certified RN is in the ASC whenever a patient is present
- A physician remains present until the patient is discharged
- A healthcare professional, trained in the use of emergency equipment and BLS, is present when patients are present
- At least one qualified practitioner is present or available by phone

RN staffing in the ASC delivers a higher standard of care responsive to the individual needs of elderly patients with complex medical histories and underlying co-morbidities. The ASC adheres to the AORN Guidelines for an RN circulator/patient advocate in the OR.

REIMBURSEMENT

- Eligible for facility fee reimbursement from CMS and other Third Party Payers (TPP)
- Not eligible for a facility fee

OBS is ineligible for CMS facility reimbursement at present. OBS opportunity to negotiate professional reimbursement sufficient to cover facility expenses and generate a profit are variable and unproven.

PROFESSIONAL LIABILITY

- ASC medical staff bylaws establish liability coverage standards for medical staff members
- ASC maintains professional liability insurance as a facility provider
- Anesthesia provider and surgeon have professional liability insurance consistent with ASC Medical Staff Bylaws
- Surgeon maintains professional liability insurance
- OBS exposure may not be contemplated in providers' present malpractice coverage and may lead to further underwriting and premium increases or policy exclusions

ASC mitigates surgeon exposure by spreading risk over ASC, anesthesia provider and surgeon, each covered by its own professional liability policy.

Constant Oversight is Key

After 24 years of consulting, I have reluctantly determined that ongoing oversight and enforcement is necessary to maintain the standard of care. We are all busy. Most of us spend every day dealing with the most raging fire first, often ending the day without making any progress on our "to-do" list. This is the reality for healthcare professionals today. When coupled with human nature and our tendency toward laziness,[5] it can result in selective inattention to that which we deem to be of inferior importance in the moment.

ASCs have adapted to intense scrutiny, preserving a cost-effective and user-friendly environment, while upholding the highest standard of care. Based on my engagements with hundreds of ASC and OBS clients nationally, the choice for cataract surgery is clear: The ASC is the optimal environment for safe, high-quality surgical care, particularly for the cataract patient. Why would you go anywhere else? ■

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Ophthalmology Management, Volume: 25, Issue: February 2021 The Ophthalmic ASC February 2021, page(s): 23-25
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