



GSASC GAZETTE

www.gsasc.org

A Publication of the Georgia Society of Ambulatory Surgery Centers

FALL 2010

PRESIDENT'S MESSAGE

By Stanford R. Plavin, MD
GSASC President



First of all, I appreciate the support and responsiveness that a great many of our constituency has shown over the last few months. There have

been a number of hot button issues that have and will continue to make our Society the choice to represent the ASC community not only in the state of Georgia but also on a greater stage.

As the most recent legislative session ended, there continue to be a number of issues regarding state budgetary constraints. The state is looking at any and all options regarding trying to bridge those gaps.

GSASC was instrumental in achieving a very successful outcome whereby ASCs were exempted from a 1.45% tax

Within the last few months, many of our centers, in the state of Georgia and regionally have experienced very difficult and challenging facility inspections

on their revenue. Phone calls and activism shown by you, the membership, working with our legislative team and the executive office made the difference. We engaged our state congressman and senators and they listened. This will continue to be the way we need to respond.

If being able to save all of you 1.45% is not incentive enough to be or become a member, then the number of upcoming issues and health care reform should certainly do so.

Within the last few months, many of our centers, in the state of Georgia and regionally have experienced very

difficult and challenging facility inspections; both for state and federal surveys. It is our goal at GSASC to engage DCH and work in a collegial and professional manner to ensure their approach to surveys, and our centers ability to be properly prepared and understand what is expected of them, will be outlined completely.

There have been a number of surveys within this state whereby numerous inconsistencies with the process have left our physician owners and partners not only scratching their heads but also extremely frustrated by what is trans-

See President's Message on page 10

Upcoming GSASC Educational Opportunities



ASC Excellence Coding Seminar

Co-sponsored by GSASC

October 19, 2010

Hilton Columbia Center

Columbia, SC

See page 12 for details.



GSASC & SCASCA Joint Semi Annual Conference & Tradeshow

March 10-11, 2011

Intercontinental Hotel

Atlanta, GA

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GSASC Fall Government Affairs Update

By Travis Lindley & Lasa Joiner

New Rule Regarding Facility Licensure, Application, and Activity Fees

Effective August 3, 2010, the Rules and Regulations for General Licensing and Enforcement Requirements, Chapter 111-8-25 require all licensed or registered programs regulated through the Division of Healthcare Facility Regulation (HFR), Department of Community Health to pay licensure activity fees annually beginning with 2010.

The new regulations establish fees related to facilities that are licensed through the DCH Division of Healthcare Facility Regulation (HFR) which

include application fees and annual activity fees. This will apply to ambulatory surgery centers.

In brief, fees will be required for currently licensed or registered programs/facilities newly subject to this rule and must be paid by October 31, 2010 and annually thereafter. Currently licensed or registered facilities will be notified in writing by HFR in September, 2010 regarding the licensure activity fees that they must pay by October 31, 2010. Application fees for new providers will also be assessed.

For updates to the Frequently Asked Questions, see www.dch.georgia.gov,

click on Healthcare Facility Regulation icon tab on left, then the 7/30/2010 Notice To Currently Licensed Facilities And Providers.

Looking Ahead

The GSASC legislative team, Lasa Joiner and Travis Lindley, will continue providing regular updates as the year progresses. Please call them with any questions, they are here to help!

So stay tuned. Please contact Lasa Joiner at 404-299-7700, lasa@gsasc.org or Travis Lindley at 770-435-5586, travis@gsasc.org, with any questions.

SAVE THE DATE!

First Annual GSASC Owners Forum Roundtable Discussion

Friday, October 1st
1 pm until 6 pm

Buckhead Club - Atlanta

Program Speakers:

Scott Becker
McGuire Woods

Milla Perry Jones
USPI and the ASC Coalition

Victor Moldovan
McGuire Woods

Merle Black, PhD
*Emory University, Political Science
Department*

**More info to come in the mail
and by email.**

ASC-GA PAC ELECTION ALERT

The ASC-GA PAC proudly supports the following candidates for their support on key issues of importance to our patients, our practices and our industry.

The Issues: Insurance Reform – Rental Networks & Prompt Pay; CON & Tort Reform; Practice Issues; (E-Prescribing, etc.)

The Candidates: Lieutenant Governor Casey Cagle; Secretary of State Brian Kemp; Sen. Ralph Hudgens for Insurance Commissioner

Candidates for State Senate

Rep. David Casas
Rep. Jill Chambers
Josh Clark
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Senator Bill Heath

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Senator Jeff Mullis
Senator Mitch Seabaugh
Senator David Shafer

Senator Cecil Staton
Senator Doug Stoner
Senator Renee Unterman
Senator Tommie Williams

TAKE ACTION – VOTE!!!

Tuesday, November 2nd, polls are open between 7:00 a.m. and 7:00 p.m. Please watch for your 2010 / 2011 PAC renewal invoices! Our PAC has been fully engaged in this year's elections – supporting our champions as they run for election this November.

Please renew your membership today!

Paid for by the ASC-GA PAC



ASC Industry Responds to CMS Proposed 2011 ASC Rates

Immediately before the 4th of July weekend, the Centers for Medicare and Medicaid Services (CMS) released its proposed 2011 reimbursement for ASCs. 2011 will be the first year that ASCs are governed by the fully implemented APC payment model. ASCs hoping to see an increase were disappointed by CMS's low estimate of inflation that results in no overall increase to ASC rates (a 0% update).

The ASC industry, through the ASC Advocacy Committee is responding strongly to CMS saying that the agency has failed to fully align the ASC and hospital outpatient payment systems, resulting in a major slowdown in growth and new center development. Reports from the industry suggest an even more aggressive slowdown and possible contraction in 2010. The Committee asserts that this slowdown

is bad for patients, bad for the Medicare program as a payor, and bad for the taxpayers who end up paying for services that must remain in the higher cost hospital setting if ASCs cannot expand to keep pace with medical innovation. The industry's lack of growth suggest two things: ASC payments are insufficient to induce the migration from other sites of service; and that no new capacity is being created to provide for new cases that are clinically appropriate for the ASC setting.

As a result the ASC Advocacy Committee is urging CMS to use its authority to update the ASC conversion factor and adopt the hospital Market Basket for purposes of updating ASC rates in 2011, expand the number and criteria CMS uses to add procedures to the ASC list, and adopt other policies from the hospital system that will better

align payments across both settings.

In addition to financial comments, the Advocacy Committee has provided CMS with comments that CMS should implement a voluntary quality reporting option for ASCs that is based on current industry efforts being made through the ASC Quality Collaboration.

Quality reporting will lead the way to stronger evidence of the high quality of care provided in an ASC and lay the foundation for the future Value Based Purchasing program that CMS is required to propose.

The final CMS rule will be published late in the year and become effective January 1, 2011. Industry representatives are meeting with CMS to discuss the ASC industry position and seeking to gain CMS' support of overall increased reimbursement for ASCs.

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ASC Excellence 2010 Coding Seminar this October



The ASC Excellence 2010 Coding Seminar is scheduled for October 19, 2010 in Columbia at the Hilton Columbia Center in Columbia, SC. The seminar is co-sponsored by the Georgia Society of Ambulatory Surgery

Centers and the South Carolina Ambulatory Surgery Center Association.

RAC Audits, 2011 Medicare payment changes, and the tightening healthcare economy make correct coding and billing practices even more crucial to the ASC. Our speaker, Stephanie Ellis will cover all specialties and will provide each attendee with the latest updates and guidelines for billing all types of payers.

This program has the prior approval of the American Academy of Professional Coders (AAPC) for 7 continuing education hours.

For more information please visit our website www.gsasc.org. A registration form can be found on page 12.

ASC Excellence Webinar Series

Past webinars are now available!



Need help preparing for a CMS survey? We have your answer. If you missed the original webinar, you can hear it now with On Demand Replay.

Take advantage of the wisdom and know-how of our expert presenters!

- **Regulatory Surveys - Nightmare to Happy Ending** (*step by step advice for preparing for new CMS surveys)
- **OSHA - Your Other Infection Control Regulator** (reviews OSHA Regulations and frequently cited areas for ASCs)

To purchase the webinar replay visit the GSASC Website at www.gsasc.org and click on the ASC Excellence Webinar Education Series button.

Our next and last webinar of the year is scheduled for October 12, 2010. Sandra Jones CASC, CHCQM, FHFMA, LHRM will present **CMS This Changes Everything: Credentialing and Peer Review**. Be on the look out for emails to register for this webinar!

Congratulations Georgia CASCs!

GSASC would like to recognize the Certified Administrators of Surgery Centers (CASC) who live in Georgia. By meeting the requirements for certification these CASCs have demonstrated their depth of knowledge about the ASC environment from a practice and business standpoint:

- | | |
|----------------------|--------------------|
| • Shirley Anglin | • Patti Hartsfield |
| • N. Phillip Bennett | • Andrew King |
| • Jane Borozan | • Tina King |
| • Sharon Bowen | • Sheila Mays |
| • Gayle Evans | • Michael Piver |
| • Andrea Fann | • Patricia Rush |
| • Richard Farr | • Tami Shea |
| • Cheryl Fielder | • Linda Simmons |
| • Carolyn Goodman | • Evelyn Zahnow |

Welcome New Members!

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*Perimeter Surgery Center
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Savannah Pain Center
Savannah, GA

*Surgery Center of Bone and
Joint Institute*
Jesup, GA

NEW AUXILIARY MEMBERS
Owens & Minor Distribution, Inc.
Kennesaw, GA

**Not a member? Join online
at www.gsasc.org or call the
GSASC office at 888/526-9450
for more information!**

Membership Renewal information for 2011 will mail out in October.

If contact information for your ASC has changed please let us know. Email Meghan@asc-member.org or call the GSASC office at 888/526-9450 to make changes to your membership information.

The GSASC/SCASCA 2010 Joint Conference and Tradeshow was a huge success!

The Joint Conference & Tradeshow held at the Hyatt Regency Savannah in August was a huge success. We had a record number of attendees and a great turnout of exhibitors with everyone enjoying the hotel and the historic Savannah area.

A special thank you goes out to the conference planning committee, Gayle Evans, Belinda Rutledge, Becky Burnett, Karen Blakely, Katie Justice, Mimi Frazier and Pam Hall for their

hard work in planning the conference. Thank you for your efforts to select great topics and speakers to create a spectacular educational schedule.

Conference highlights include Thursday's Keynote Speaker, Charles Marshall, a humorous motivational speaker and sessions throughout the afternoon on infection prevention and disinfection and sterilization.

Thursday ended with the opening of the exhibit hall and reception. Fri-

day's sessions included topics on DEA inspections, accreditation issues & opportunities from the Joint Commission, consultant pharmacists, documentation and staffing.

We hope to see everyone at the March Meeting in Atlanta at the Intercontinental Buckhead!

We would like to thank our speakers and sponsors for the extra support they gave GSASC and SCASCA this year. We couldn't have done it without you!

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**GSASC & SCASCA would like to thank the following
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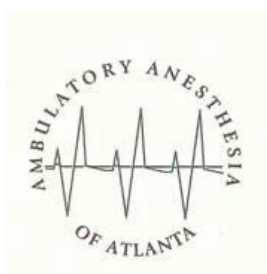


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Implementation of a Disaster Preparedness Plan

By Gayle Evans RN, MBA, CNOR, CASC
Continuum Healthcare Consultants, Inc.

The ambulatory surgery center under CMS CFC 416.41(c) must develop a written disaster preparedness plan that is implemented when there is an unexpected event or circumstance that can potentially pose untoward health or safety issues to anyone in the surgery center. These events include, but are not limited to, natural disasters, failure of water or electrical supply, security breach, biochemical hazards or fire. The governing body is responsible for the implementation and annual evaluation of the effectiveness of the plan.

In developing the plan the surgery center must identify potential hazards that are specific to the location of the center in the community. The standard recommends development of phases to implement the plan.

Hazard Identification

Utilizing a risk assessment tool identifies potential hazards that could affect the facility directly or indirectly in its surrounding service area. The risk assessment tool determines the probability that a potential hazard may be present and could affect the center.

It also evaluates the response of the center if the hazard is present. Risks are prioritized with the risk assessment tool. While we think of emergencies that are routine, fire, cardiac arrest, intruder, etc, performing the risk assessment stretches our thoughts to other areas where the center has the potential of impact. Risks that may be identified through the assessment may include:

- Ice storm during the winter,
- Manufacturing plants that utilized hazardous chemicals,
- Forest fire,
- Loss of water or sewage overflow in the facility,
- Hurricane with a path to be determined.

These examples are “risks” but depending on location of the center in the community may or may not impact the facility directly.

Hazard Mitigation

“Lessening the effect of a potential adverse impact.” This phase identifies activities that may be taken to eliminate or reduce the probability of the

disaster or reduce the severity of the disaster’s outcome on the patients, staff and/or others present on the premises of the surgery center at the time of the disaster or emergency. Identifying the needs of the patients in all phases of care and educating the staff regarding protecting themselves and others in the center should be part of the process. Policy implementation with annual review of their effectiveness is part of “lessening the effect”. Keep it simple but brainstorm and think of all possibilities that will lessen the impact. Using the unexpected ice storm of the winter as an example, consider that power is lost in the community and the emergency generator has exhausted its diesel due to the length of time impacted. Identifying the potential of contamination of sterile items, resetting equipment due to loss of power and battery exhaustion, and medication contamination due to improper storage are just a few of the considerations in this scenario. What do the policies say regarding each of these potential events? Understanding the impact lessens the impact of the hazard. Staff education becomes an important part of this process.

Preparedness

When potential disasters or emergencies are identified based on potential of occurrence how do we respond as an ASC? Identifying both physical needs and activities that must occur to return to normal operations is part of the preparedness phase. If the center does not lose operations how does it prepare if the remainder of the community is impacted. An example of this would be community flooding. If the center is not impacted but the surrounding routes in and out are obstructed, how does the center function to either evacuate or re-focus operations? Again training of the staff as to their roles whether in the center or at home when the event occurs is part of preparedness.

Response

What is the immediate action in planning for the disaster or emergency and what is the long term plan? Again the ice storm may be pending or may be a reality. How does the center respond to the pending event? Take another example of a tornado headed in the direction of the facility. Not only where does everyone move for protection should be determined, but who is responsible for movement of patients, staff and visitors in each area. If the tornado strikes, who is accountable for assessing the outcome and moving evacuation to its resolution. The plan for involvement of the local authorities and the role of the primary contact should be part of the response phase. Training of staff regardless of their role at the time of the event is part of the response phase.

Recovery

Recovering from an ice storm may be simple, a tornado may be impossible. An internal emergency such as contamination of the facility or power loss may be short lived but how does the center return to normal. How does one perform the check and balances to make sure the physical environment is acceptable for all functions of

the center or will functions need to be outsourced? In the recovery phase, the center must identify the “new normal” for the facility. This website is a good reference to check activities that should be completed when starting business again, http://www.cms.gov/SurveyCertEmergPrep/downloads/S&C_EPChecklist_Provider.pdf.

Coordination of the Plan

The disaster preparedness plan should be coordinated with local authorities as appropriate. Likewise, the local authorities must be notified of the capabilities of the center when a disaster occurs in the community. The local authorities then have the responsibility of identifying the role of the center. The communication of the coordination and plan to the local authorities must be documented in the governing body minutes. Again annual review of the center’s role must be completed by the governing body and updated as required.

Testing, Evaluating, and Updating the Plan

Based on the risk assessment evaluation the center should test one of the top disasters that has the higher probability of occurring at least once every year. The plan’s effectiveness must be evaluated upon completion of the drill. A drill that is conducted in concert with State or local authorities would qualify as an annual test. While the drill does not have to test the response to every identified hazard, it is expected to test a significant portion of the plan. For example, a fire drill does not qualify on its own as a sufficient annual drill of the ASC’s plan. The ASC must prepare a written evaluation of each annual drill, identifying problems that arose as well as methods to address those problems. The disaster preparedness plan must be promptly updated to reflect the lessons learned from the drill and the needed changes identified in the evaluation.

What are the key elements reviewed during survey?

ASC’s leadership must show the facility’s emergency preparedness plan summarizing the plan verbally to include how the patients, staff and other visitors are protected at the time of the disaster.

ASC’s leadership must show how staff are informed of the plan, including their roles and responsibilities. During the survey, interviews will be conducted of staff members, including physicians and contract employees working in the center, to determine whether they are aware of the plan and their role.

Coordination with State or local emergency management agencies should be available. The degree, to which State or local authorities require the center to engage in local disaster planning, may vary among localities and States. The ASC must have documentation that it has identified appropriate State and local agencies, and that the ASC has made these agencies aware of the ASC’s interest in coordination.

Documentation of the annual drill will be reviewed during the CMS survey. ASC staff, including physicians, may be asked if they have participated in a drill to test the emergency preparedness plan.

The drill should determine whether the plan performed as expected. If problems during the drill were noted, the evaluation should indicate what changes are needed to address those problems? If the evaluation calls for changes, revise the plan accordingly and then note that the changes were implemented.

For the single specialty center this activity may seem daunting. Performing the risk assessment to identify which disasters are more likely in the community where the center is located is more effective. Think of the disaster drill as the center of a wheel; the spokes are the policies that should be utilized to coordinate activities and bring the center back to the “new normal”. Review those policies, educate staff and perform mock drills. Document the response and observations. The annual disaster preparedness plan has then been tested.

piring in our industry. This is an attack on us and our ability to provide the best and safest care for our patients. It won't be tolerated and your voice must be heard.

I implore you and your colleagues to recruit new members and contribute to a number of initiatives that GSASC is working on in order to protect our centers and our patients.

We just recently had our summer meeting in Savannah which was extremely well attended. The conference committee was able to put together a terrific group of speakers and topics which were well received and enabled those attending to better understand some of the changes and challenges our industry faces.

As a practicing anesthesiologist, I understand patient care; it is our priority to try and maintain the highest quality of healthcare delivery despite the challenges and hurdles that continue to be placed in front of us. We must continue to focus on the patient's well being and being an advocate for them while meeting and exceeding the expectations and bureaucratic challenges and competition that is forever being placed in our path.

It is you, the membership who will be the ones to engage your legislators, it is you, the physician owners that need to step up and be the difference makers. It is really an honor and a privilege to serve and represent you.

I just made it down off my soap box.... Looking forward to seeing many of you at our upcoming Owner's Forum on October 1 in Atlanta and our next meeting in March 2011 in Atlanta as well.

All my best,
Stanford Plavin, MD

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October 19, 2010
Hilton Columbia Center,
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**Ambulatory Surgery
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* This program has the prior approval of the American Academy of Professional Coders (AAPC) for 7.0 continuing education hours.

Quick Registration Form/ ASC Excellence Coding Seminar

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Registration (check one)

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