

**GEORGIA STATE HEALTH PLAN
COMPONENT PLAN**

**AMBULATORY SURGERY
SERVICES**

**HEALTH STRATEGIES COUNCIL
AND
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PREFACE

This Component Plan is a product of the Health Strategies Council and the Georgia Division of Health Planning which are funded through and operated within the authority of O.C.G.A. 31-6-1, et seq.

The purpose of the Plan is to identify and address health issues and recommend goals, objectives and system changes to achieve official state health policies.

This Plan has been produced through an open, public participatory process developed and monitored by the 27-member Governor-appointed Health Strategies Council. The Plan is effective upon approval by the Governor and supersedes all related sections of previous editions of the State Health Plan and any existing related Component Plan.

For purposes of the administration and implementation of the Georgia Certificate of Need (CON) Program, criteria and standards for review (as stated in the Rules, Chapter 272-1, 272-2 and 272-3) are derived from this Component Plan. The Rules, which are published separately from the Plan and which undergo a separate public review process, are an official interpretation of any official Component Plan which the review function has the legal authority to implement. The Rules are reviewed by the Health Strategies Council (prior to their adoption) for their consistency with the Plan. The Rules, as a legal document, represent the final authority for all Certificate of Need review decisions.

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I. INTRODUCTION

A. PLANNING PROCESS

The original Ambulatory Surgery Services section of Georgia's State Health Plan was completed in 1984. This plan dealt specifically with ambulatory surgery centers that were owned and/or operated by hospitals or other entities and did not include offices of private physicians or dentists.

The plan was revised in August 1987 to provide a way for physicians who had been providing outpatient surgery services within their own offices to be classified as "physician-owned, limited-purpose ambulatory surgery centers" so they could receive Medicare facility fee reimbursement for these services. This CON category was exempt from the need criteria established in the 1984 plan. The plan was again revised in 1989 to include use of the most recent Georgia-specific ambulatory surgery rate when computing need instead of the non-specific 30% rate designated in the 1984 plan. This change did not result in any CON rules changes.

The impetus to update the plan again in 1995 evolved from the passage of HB 508, which regulates diagnostic, treatment, and rehabilitation centers that offer ambulatory surgery services, regardless of ownership or setting. The rapid growth of ambulatory surgery in the healthcare industry was also a catalyst behind updating the plan.

On August 18, 1995, Georgia's Health Strategies Council voted to convene a Modified Technical Advisory Committee (TAC) comprised of the Council's Ambulatory/Primary Care Standing Committee. Although this committee was responsible for making ultimate decisions concerning changes to the Ambulatory Surgery Services Component Plan and Certificate of Need Rules, interested parties were invited to participate and provide input and information concerning ambulatory surgery services before any changes were adopted.

The TAC held its first meeting on November 14, 1995, and subsequently formed a Capacity/Utilization/Adverse Impact Subcommittee, which met on November 28 and December 18, 1995, and a Survey Work Group, which met on December 11, 1995. Both the Subcommittee and Workgroup spent many hours researching and discussing many factors related to ambulatory surgery services including the availability of these services in Georgia, trends in the market and regulatory arena as they relate to the changing healthcare environment, and definitions of critical terms including capacity and utilization.

After consideration of regulatory options regarding ambulatory surgery services, the TAC recommended the development of a plan and rules that would **not** include a specific numerical need formula or definition of capacity, but would continue to address the public policy objectives of access and quality. This was based on the following:

- A. The belief that ambulatory surgery services are a low-cost alternative to inpatient surgery services in Georgia.

- B. The belief that ambulatory surgery services should remain under CON regulation, but that the capacity/volume aspects of the need methodology should be eliminated because of the belief that market forces are in place in urban areas to control excess investment. These market forces include 1) a competitive environment, 2) the large number of existing providers, and 3) the growing presence of managed care.
- C. The belief that the public policy objectives of access and quality should continue to be addressed in the plan and regulations.
- D. The belief that healthcare regulation should be compatible with the current healthcare market place so that economic realities (i.e. competition, managed care, and numbers of providers) can co-exist with regulation.

On February 16, 1996, the TAC presented the draft plan and rules to the Health Strategies Council who agreed with the TAC's recommendations. Because the Council recognized that many questions would arise about the proposed regulatory approach, they voted to submit the draft plan and rules for public comment as written because the submission would provide a good opportunity to gauge public response.

The proposed documents were issued for public comment in March 1996 and for a second comment period in June 1996. In both comment periods numerous persons making comments expressed concern about several issues including the absence of a numerical need methodology and the questionable validity of the assumptions about the strength of market forces in Georgia and the impact on ambulatory surgery. In addition there were questions about whether the proposed rules would provide an appropriate basis for the agency to legally defend its CON decisions. In August 1996 the Agency decided not to adopt the rules considering strength of the comments and asked the Council to consider forming a broader based technical advisory committee to further address the issues. The Council asked for assurance that the extensive work by the previous TAC would be taken into account.

This plan is the result of the work of the Agency staff and the Health Strategies Council to develop a numerical need methodology and other need criteria. In addition, it is based on the public's response to the original draft plan and research of current literature, investigation of other state ambulatory surgery plans, and personal interviews with other state health planning analysts.

B. CONCEPTS, PRINCIPLES, CARE CONTINUUM

HB 508 was passed in March 1991 to regulate diagnostic, treatment, and rehabilitation centers, including facilities that offer surgical procedures outside a hospital setting, radiation therapy, biliary lithotripsy, and cardiac catheterization. Passage of this bill was the direct result of recommendations by former Governor Joe Frank Harris' Access to Health Care Commission which intended to 1) provide some control on expenditures for duplicate high cost technology and services, and 2) level the playing field by ensuring the same rules applied to the provision of these services regardless of setting or ownership.

To better reflect ambulatory surgery practices in the state and to accommodate the HB 508 requirements, the following categories of ambulatory surgery facilities fall under Certificate of Need (CON) according to the citations noted below.

1. **Hospital-based multi-specialty facilities:** These facilities are part of a hospital and offer surgical services to patients who do not require inpatient hospitalization. These facilities fall under CON regulation only if they incur expenditures in excess of the current CON threshold pursuant to 272-2-.01(19)(b).
2. **Freestanding, multi-specialty facilities, regardless of cost:** These are freestanding surgical facilities that offer surgical services to patients in at least two specialty areas. These facilities can be owned by hospitals, physicians, or any other business entity. These facilities fall under CON regulation in three ways: 1) as a new healthcare facility pursuant to 272-2-.01(19)(a); 2) if an existing Ambulatory Surgery Facility (ASF) incurs expenditures in excess of the CON threshold pursuant to 272-2-.01(19)(b); or 3) as a Diagnostic, Treatment, or Rehabilitation Center (DTRC) pursuant to 272-2-.01(19)(h).
3. **Freestanding, limited purpose facilities, regardless of cost:** These are freestanding facilities that are owned by hospitals or any other business entity and offer surgical services to patients within a single specialty. These facilities fall under CON regulation in three ways: 1) as a new healthcare facility pursuant to 272-2-.01(19)(a); 2) if an existing Ambulatory Surgery Facility (ASF) incurs expenditures in excess of the CON threshold pursuant to 272-2-.01(19)(b); or 3) as a Diagnostic, Treatment, or Rehabilitation Center (DTRC) pursuant to 272-2-.01(19)(h).
4. **Physician-owned, limited purpose freestanding facilities, over \$1 million:** These are freestanding surgical facilities that are owned by physicians and that incur development costs of over \$1 million. These facilities offer surgical services to patients within a single specialty. These facilities fall under CON regulation as a new institutional health service in or through a Diagnostic, Treatment, or Rehabilitation Center pursuant to 272-2-.02(19)(h).

II. OVERVIEW

A. TRENDS AND ISSUES

1. **Rapid growth:** The transition from inpatient to outpatient surgery services continues to be rapid. Estimates indicate that about 60% of all surgeries performed in the United States today can be performed safely and effectively in an outpatient environment (Earnhart, 1993) and that by the year 2000, 70% of all surgeries will be performed on an outpatient basis (S.M.G., 1994). This transition from inpatient to outpatient surgery is evident in Georgia as well. In 1988 a total of 630,911 surgical procedures were performed in Georgia, 300,033 or 47% of which were performed on an outpatient basis, while in 1996 a total of 799,104 surgical procedures were performed, 505,739 or 63.3 % of which were performed on an outpatient basis.

Nationwide, the number of surgeries performed in freestanding outpatient surgery centers in 1992 rose to 2.87 million -- an 11.1% increase over 1991. This increase followed an even larger 18.6% increase in 1991 over 1990. In 1994, an estimated 1,986 outpatient facilities performed just under 3.5 million surgical procedures (S.M.G., 1994). While the total number of outpatient surgery procedures performed in Georgia has increased 46.6% from 1990 to 1996, the number of surgeries performed in the state's freestanding outpatient surgery centers has not risen as rapidly as those performed in general hospitals (Division of Health Planning). The number of procedures has risen by 52.9% in general hospitals and by only 19.6% in ambulatory surgery facilities.

AMBULATORY SURGERY PROCEDURES

Year	Total procedures	In hospitals	In freestanding
1996	505,739	427,677	78,062
1995	481,809	408,446	73,363
1994	441,555	369,944	71,611
1993	406,544	336,095	70,449
1992	401,845	341,227	60,618
1991	373,901	307,289	66,612
1990	345,048	279,790	65,258

Nationally, the number of freestanding surgery centers has grown also -- up 8% from 1992 to 1993. According to S.M.G. Marketing Group in Chicago, there were 1,832 freestanding outpatient surgery centers nationwide in 1993 compared to 1,696 in 1992. About 200 new centers open each year (Earnhart, 1993).

In Georgia, the number of freestanding facilities and operating rooms has also grown. The table below shows that the total number of facilities grew 100% in the period from 1991 to 1996. The number of Freestanding Ambulatory Surgery Facilities in Georgia grew 52% while the total number of operating rooms grew 60%. Much of the total growth was in Georgia's category of physician-owned Ambulatory Surgery Facilities, where there was a 167% growth in the number of facilities and 182% in the number of operating rooms from 1991-1996. However, the physician-owned facilities are no longer covered by CON unless the cost is over \$1million.

**GROWTH OF FREESTANDING
AMBULATORY SURGERY FACILITIES AND OPERATING ROOMS IN GEORGIA**

Year	Physician-owned		Freestanding		Total	
	Facilities	ORs	Facilities	ORs	Facilities	ORs
1996	48	79	38	112	86	191
1995	46	74	36	107	82	181
1994	43	70	30	89	73	159
1993	33	55	28	81	61	136
1992	25	42	25	70	50	112
1991	18	28	25	70	43	98

2. **Factors Influencing Growth:** Several factors have contributed to this rapid growth in outpatient surgery. These include:

- A. **Consumer Demand:** Outpatient surgery is perceived as more convenient and less threatening than inpatient surgery and has proven to be less costly than inpatient surgery because it eliminates costly hospital inpatient stays.
- B. **Third Party Payers:** Because ambulatory surgery services are a low cost alternative to inpatient surgery services, outpatient surgery services are more attractive to health insurance carriers who bear most of the costs of surgery. Therefore, these carriers offer their members financial incentives to have surgery performed on an outpatient rather than inpatient basis. These incentives include higher reimbursements for outpatient surgery and/or financial penalties if procedures are performed on an inpatient basis. Today, about 25% of healthcare participants (other than HMO participants) receive incentives to elect surgery on an outpatient basis (Grant, 1993). Some health care plans also require outpatient surgery for certain less complicated procedures.
- C. **Medicare Reimbursement:** In January 1992, Medicare added 900 procedures to its original 1,500 procedures covered when performed at an ambulatory surgery center certified by Medicare. This increase has boosted Medicare's share of procedures performed on an outpatient basis to 45% in 1992 from 32% the previous year. The federal government approved 49 additional procedures (but deleted 30) for a net addition of 19 reimbursable procedures in 1994.
- D. **Managed Care Environment:** Today's managed care environment is creating a healthcare market place that encourages the development of outpatient surgery services. Managed care companies and other third party payers recognize that quality care can be provided on an outpatient basis in a more cost-effective manner. Today, 72% of all surgery centers now have contracts with health maintenance organizations, and 75% have contractual agreements with preferred provider organizations (Henderson, *Hospitals Seek*, 1993).

- E. **New Surgical Techniques:** New surgical techniques that require no hospital stay or greatly reduce lengths of stay are boosting the number of outpatient surgical procedures in both hospitals and surgery centers. Technological breakthroughs using new laser applications, endoscopic and arthroscopic surgical instruments, and other less invasive, reasonably priced diagnostic and surgical techniques have contributed greatly to the growth and success of ambulatory surgery services. In coming years, continued improvements in technology and advanced techniques will allow even more procedures to be performed and will move some procedures that historically have been performed in inpatient settings to outpatient.
- F. **Physician Reimbursement:** Increased overhead and declining reimbursement for professional services have encouraged physicians to seek ways to expand office capacity and to make their practices more efficient. Performing outpatient surgery in freestanding facilities or in their own offices is more convenient and cost-effective for physicians because performing surgery in these facilities rather than in hospitals allows physicians to schedule surgeries more easily and to do more surgeries in a significantly shorter time.
- G. **Competition:** The growth of non-hospital affiliated freestanding surgery centers is causing hospitals to position themselves to protect their market share. In the U.S., hospital market share of outpatient surgery dropped from 89% in 1984 to 75% in 1990. Hospitals have reacted to this decline by offering their own outpatient surgery centers. S.M.G.'s hospital market database indicates that more than 80% of U.S. acute care hospitals now offer hospital-based outpatient surgery services.

B. AMBULATORY SURGERY SERVICES IN GEORGIA

Based on data from the 1996 Surgical Services Addendum and Ambulatory Surgery Services Questionnaire for Freestanding Centers, Georgia had 286 operating rooms dedicated exclusively to ambulatory surgery. These dedicated rooms were located in 36 freestanding ambulatory surgery centers with 109 operating rooms, and 154 general hospitals with 171 operating rooms. In addition to these dedicated rooms, Georgia hospitals have 712 shared operating rooms that provide inpatient and outpatient surgery services.

During 1996, 505,739 reported ambulatory surgery procedures were performed in Georgia -- up 5% over 1995. Of these procedures, 427,677 (84.6%) were performed in the hospital-based dedicated and shared operating rooms and 78,062 (15.4%) in the freestanding centers.

Prior to the adoption of this plan, only surgical rooms in the hospital-based ambulatory surgery programs and non-physician-owned, freestanding ambulatory surgery facilities were counted in the CON review process. All freestanding facilities owned by physicians and hospital-based shared rooms were excluded from the inventory.

III. GUIDELINES

A. USE OF GUIDELINES

The following criteria and standards outline the guidelines for the development and delivery of ambulatory surgery services in all settings in the State of Georgia as recommended by the Health Strategies Council.

For Certificate of Need purposes, Ambulatory Surgical Facilities and Diagnostic, Treatment, or Rehabilitation Centers performing ambulatory surgery are classified collectively as Ambulatory Surgery Facilities and would have to be licensed accordingly by the State-licensing agency once a Certificate of Need is issued.

B. DEFINITIONS FOR THE GUIDELINES

1. "Ambulatory surgery" means surgical procedures that include but are not limited to those recognized by Healthcare Financing Administration (HCFA) as reimbursable ambulatory surgery procedures. Ambulatory surgery is provided only to patients who are admitted to a facility which offers ambulatory surgery and which does not admit patients for treatment that normally requires stays that are overnight or exceed 24 hours and which does not provide accommodations for treatment of patients for periods of twenty-four hours or longer.

2. "Ambulatory surgical facility" means a public or private facility, not part of a hospital, which provides surgical performed under general or regional anesthesia in an operating room environment to patients not requiring hospitalization. In addition to operating rooms, an ambulatory surgery facility includes all components of pre and postoperative ambulatory surgery care.

3. "Ambulatory surgery operating room" means an operating room located in a hospital, in an ambulatory surgery facility, or in a DTRC facility that is equipped to perform surgery and is constructed to meet the specifications and standards of the Office of Regulatory Services of the Department of Human Resources.

4. "Ambulatory surgery service" means the provision of ambulatory surgery including pre and post-operative care to patients not requiring hospitalization. An ambulatory surgery service may be provided within any of the following types of healthcare facilities: hospitals, ambulatory surgical facilities or DTRCs.

5. "Ambulatory surgery services patient" means a person who makes a single visit to an operating room during which one or more surgical procedures are performed.

6. "Diagnostic, treatment, or rehabilitation center" (DTRC) means, for purposes of this rule, any professional or business undertaking, whether for profit or not-for-profit, which offers or proposes to offer an ambulatory surgery service in a setting which is not part of a hospital.

7. "Limited purpose ambulatory surgery service" means an ambulatory surgery service providing surgery in only one of the specialty areas as defined in definition number 7 and meets either of the

definitions in numbers 2 or 5.

8. "Multi-specialty ambulatory surgery service" means an ambulatory surgery service offering general surgery; or, general surgery and surgery in one or more of, but not limited to, the following specialties; or, surgery in two or more of, but not limited, to the following specialties: dentistry/oral surgery, gastroenterology, obstetrics/gynecology, ophthalmology, orthopaedics, otolaryngology, pain management/anesthesiology, plastic surgery, podiatry, pulmonary medicine, or urology.

9. "Not requiring hospitalization" means patients who do not require an inpatient admission to an acute care general hospital prior to receiving ambulatory surgery services, who normally would not require a stay that is overnight or exceeds 24 hours, and are not expected to require an inpatient admission after receiving such services.

10. "Operating room environment" means an environment, which meets the minimum physical plant and operation standards specified on January 1, 1991, for ambulatory surgical treatment centers in Section 290-5-33-.10 of the rules of the Department of Human Resources.

11. " Planning Area" means fixed substate regions for reviewable services as defined in this Component plan. (See Appendix A)

C. GUIDELINES

1. APPLICABILITY

Ambulatory surgery is best characterized as any surgical procedure(s) performed on patients who are admitted to a facility which offers ambulatory surgery and which does not admit patients for treatment that normally requires stays that exceed 24 hours and which does not provide accommodations for treatment of patients for periods of twenty-four hours or longer.

Ambulatory surgery services can be either multi-specialty services or limited purpose. A multi-specialty ambulatory surgery service offers general surgery; or, general surgery and surgery in one or more of, but not limited to, the following specialties; or, surgery in two or more of, but not limited, to the following specialties: dentistry/oral surgery, gastroenterology, obstetrics/gynecology, ophthalmology, orthopaedics, otolaryngology, pain management/anesthesiology, plastic surgery, podiatry, pulmonary medicine, or urology.

A limited-purpose ambulatory surgery service offers surgery in only one of the above mentioned specialty areas.

2. AVAILABILITY

Standard 1 - Need The need for an ambulatory surgery service should be determined through application of a numerical need method and an assessment of the aggregate utilization rate of existing services. The agency may allow variance from this standard when the Agency determines that unusual circumstances exist, which justify the action.

- a. The numerical need should be determined through the application of a demographic formula, which includes the number of ambulatory surgery patients in a planning area.
- b. The aggregate utilization rate for ambulatory surgery services in a planning area should equal or exceed industry occupancy standards.

Rationale for Standard 1: Combining both numerical and aggregate utilization in the need methodology accounts for both the number of patients in a planning area with generally accepted indications for ambulatory surgery and optimum utilization of existing services. A major issue in determining need for ambulatory surgery services is the definition of capacity of existing services. An assessment of the literature, including studies and other states' plans and CON regulations, shows some variation in the average number of patients or procedures per ambulatory surgery operating room per day, with a range from 800 up to 1200 patients or procedures per room per year. (*State Plans and Rules: Alabama, North Carolina, Tennessee, and Michigan,*). In Georgia's old plan, capacity is defined as 6 procedures per day, five days per week, 52 weeks per year, with 80% expected use rate which equals 1250 procedures per room per year. In the new plan it is recommended that a definition using the average number of patients instead of procedures be used to determine capacity, considering the number of operating room days per year and the average number of patients per room per day.

Another issue is how to take into account operating rooms in hospitals which are used for both inpatient and outpatient surgery. North Carolina uses a formula for pro-rating shared rooms, which assumes an average operating room time of 90 minutes for ambulatory surgery cases and 145 minutes for inpatient cases. This provides a way to estimate the number of rooms handling ambulatory surgery procedures. Currently, the Agency collects data on the total number of hospital surgery inpatients and outpatients, but does not collect the number of patients by type of room, i.e., shared rooms. Until such data are collected on the 1998 surveys, the Agency should estimate the number of inpatients and outpatients in shared rooms by dividing the number of inpatient and outpatient procedures by the state average number of procedures per patient.

The need method is applied based on fixed geographic planning areas (see definition 11). The Modified Ambulatory Surgery Services Technical Advisory Committee recommended that fixed regions be used rather than continuing to define planning areas through the use of a travel radius. The 13 planning areas in this plan are based on the work of the 1992 General Short-Stay Hospital Technical Advisory Committee and have been used by the Health Strategies Council and the Agency in planning for other health services. The 13 areas are based on the following premises:

- 1.) They represent geographic proportions appropriate for use in planning for community-based services; e.g., services such as ambulatory surgery services; and
- 2.) they reflect population size and patient flow patterns, which support community health service planning.

3. CONTINUITY

Standard 2 - Patient Referral Mechanisms An ambulatory surgery service should have a hospital affiliation agreement and/or the medical director must have admitting privileges or other acceptable documented arrangements to insure the necessary backup for medical complications. The service should have capability to transfer a patient immediately to a hospital with adequate emergency room services. These requirements should be documented in a hospital transfer plan.

Rationale for Standard 2: The ability to transfer ambulatory surgery patients to hospitals in both emergency and non-emergency situations is critical to ensuring optimum patient safety and care. This standard is in keeping with licensure, JCAHO and other appropriate accrediting agency standards. A documented plan for patient transfer helps ensure that necessary services are coordinated and in place when needed.

Standard 3 - Discharge Planning An ambulatory surgery service should have written policies and procedures regarding discharge planning. These should include, where appropriate, designation of responsible personnel, participation by the patient, family, guardian or significant other, documentation of any follow-up services provided and evaluation of their effectiveness.

Rationale for Standard 3: It is important that discharge plans be carefully communicated and coordinated with appropriate healthcare facilities/agencies/providers in the community to ensure an efficient and effective continuum of care as well as optimum patient recovery and safety.

4. QUALITY

Standard 4 - Licensed & Qualified Physicians An ambulatory surgery service should provide a credentialing process, which provides that surgical procedures will be performed only by licensed physicians who have been granted privileges to perform these procedures by the organization's governing body.

Rationale for Standard 4: It is a recognized and accepted medical standard that physicians providing ambulatory surgery services perform only those procedures that are defined within the scope of their license and in accordance with individually granted clinical privileges. Limiting the privileges of a surgeon within an ambulatory surgery center to only those for which he/she is granted by an accredited hospital helps ensure quality of patient care.

Standard 5 - Qualified Anesthesia Personnel An ambulatory surgery service should assure that an anesthesiologist, a physician qualified to administer anesthesia, an oral surgeon, or a certified nurse anesthetist trained in emergency resuscitation procedures is present on the premises at all times a surgical patient is present.

Rationale for Standard 5: The administration of anesthesia carries significant risk. To ensure quality of care and patient safety, qualified personnel who have specialized knowledge, skill and training in the administration of anesthesia should be the only persons who perform this service and should be on hand at all times a surgical patient is present in case an emergency should arise.

Standard 6 - Qualified Support Personnel An ambulatory surgery service should demonstrate that qualified personnel would be available to insure a quality service to meet licensure, certification and/or accreditation requirements.

Rationale for Standard 6: Licensure, certification and/or accreditation criteria establish minimum basic requirements pertaining to the successful operation and management of ambulatory surgery services. Requiring that ambulatory surgery centers meet the criteria established by such organizations helps ensure quality of care and patient safety.

Standard 7 - Care Management and Quality Assurance An ambulatory surgery service should have a policy and plan for reviewing patient care, including criteria for identifying those patients to be reviewed and a mechanism for evaluating the patient review process.

Rationale for Standard 7: Incorporating policies and procedures for patient care management and quality assurance helps ensure quality of care and patient safety.

Standard 8 - Utilization Review An ambulatory surgery service should have written policies

and procedures for utilization review that are consistent with state, federal and accreditation standards and that include review of the medical necessity for the service, quality of patient care, and rates of utilization.

Rationale for Standard 8: Incorporating written policies and procedures for utilization review helps ensure quality of care, patient safety, and appropriate application and utilization of ambulatory surgery services.

Standard 9 - Licensure and Accreditation An ambulatory surgery service should provide evidence of intent to meet (or documentation that they have met as appropriate) the appropriate licensure and accreditation requirements. This includes licensure requirements of the Office of Regulatory Services of the Georgia Department of Human Resources and appropriate accrediting bodies such as the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), and the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (ASF).

Rationale for Standard 9: Licensure and accreditation by these organizations helps ensure quality care and patient safety. Each of these organizations performs on-site visits and establishes standards for many aspects of ambulatory surgery facilities including, but not limited to the following:

1. Patient advocacy
2. Governance
3. Administration
4. Quality of care
5. Quality assurance
6. Medical Records
7. Plant, technology and safety management

Hospital-based ambulatory surgery services that are surveyed and certified by JCAHO have deemed status with Medicare. Both JCAHO and AAAHC have applied for deemed status for certified freestanding ambulatory surgery centers.

5. ACCESSIBILITY

Standard 10 - Comparable Charges An ambulatory surgery service should have charges that are reasonable in comparison to other similar ambulatory surgery services serving the same planning area.

Rationale for Standard 10: Average charges for Ambulatory Surgery procedures can vary significantly from one geographic area to another. Comparing the reasonableness of charges with other services in the same planning area helps ensure reasonable charges within individual communities.

Standard 11 -Financial Accessibility An ambulatory surgery services should foster an environment that assures access to services for those unable to pay regardless of payment source or circumstances.

Rationale for Standard 11: Systematic comparison of the contribution of care for indigent elements of the State's population is an essential component to the planning process. The equitable distribution of indigent care among providers is corollary to the equitable access to ambulatory surgery services and health care services for all citizens without regard to the ability to pay. It is characteristic of rational systems that the burden of the medically indigent to be equitably distributed among all providers.

Assessment of an ambulatory surgery services commitment to assure financial access to services should be multifaceted. The essential elements of the assessment for both past performance and future commitments may include, but are not limited to, the following:

1. Administrative policies and directives related to providing services on a non-discriminatory basis;
2. Informational efforts to patients regarding arrangements for satisfying charges; and
3. Provision of indigent care, charity care and Hill Burton (where appropriate), and bad debt, both percent of adjusted gross revenue and volume (procedures, cases, patient days) of services and both total care and uncompensated care.

6. INFORMATION REQUIREMENTS

Standard 12 - Data Collection An ambulatory surgery service should provide the Agency with requested information and statistical data related to operation and provision of ambulatory surgery services.

Rationale for Standard 12: Uniform data on ambulatory surgery services is important to assess the changing patterns and projected service needs relevant to this service. Such data allow more precise assessment of the level of services being provided as well as of costs, charges, medical techniques and other factors important to health planning.

IV. GOALS, OBJECTIVES AND RECOMMENDED ACTIONS

A. GOAL

To ensure that Georgia citizens have access to cost-effective, efficient, and quality ambulatory surgery services.

B. OBJECTIVES

1. Improve access to cost effective, quality ambulatory surgery services by authorizing these services in sufficient numbers and in locations compatible with needs.
2. Encourage continuity of ambulatory surgery services within communities.
3. Ensure quality and patient safety through compliance with appropriate standards and guidelines.
4. Foster an environment, which assures access to services to individual's unable to pay and regardless to payment source or circumstance.
5. Assess availability, quality and effectiveness of services being provided through Agency information and statistical data.

C. RECOMMENDED ACTIONS

1. Implement Certificate of Need (CON) rules for ambulatory surgery services consistent with this Component Plan and approve CON applications accordingly.
2. Require new or expanding providers to demonstrate plans whereby their services are effectively and efficiently coordinated with other existing healthcare services within the community when appropriate.
3. Require new providers to demonstrate the intent to achieve optimal clinical and physical environment standards established in the most recent licensure, JCAHO, AAAHC, ASF, or other appropriate accrediting agency standards. Require that existing services applying to expand meet the accrediting standards of appropriate agencies.
4. Require new or expanding providers to demonstrate administrative policies showing they provide services on a non-discriminatory basis.
5. Collect data annually, and on an ad hoc basis as needed, to maintain current, accurate information related to availability, quality and effectiveness of services being provided.

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**Georgia State Health Plan
Ambulatory Surgery Services Component Plan**

Appendix A

**Map
Health Planning Areas in Georgia**

GEORGIA

HEALTH PLANNING AREAS (HPAs)

