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➔ INSIDE

Are you wasting time and resources on unnecessary preop tests? Cover

Reducing surgical site infections 76

Helping patients to avoid "surprise bills" for surgery 77

Most 'never' events found during relatively minor cases 78

Novel approach to help reduce patients' pain 79

Should patients stop blood thinners before surgery? 80

SDS Manager: Reasons facilities pursue management companies 81

Surprising source of bacteria in operating room 83

AHC Media

When will physicians stop ordering unnecessary preop tests?

New study: They aren't following guidance from their professional groups

By Joy Daughtery Dickinson

Routine preoperative testing before elective surgery can cause anxiety for patients, delays or cancellations of procedures, expenses, and even potential harm when the results are false-negative or false-positive, says **Girish P. Joshi**, MBBS, MD, FFARCSI, professor of anesthesiology and pain management, University of Texas Southwestern Medical Center, Dallas.

However, several of those tests still are being ordered, despite the fact that professional physician associations consider certain routine tests to be of low value and high cost, and they've tried to discourage their use, according to new research from NYU

Langone Medical Center in New York City, published June 8, 2015, in *JAMA*

Internal Medicine. The study is believed to be the first to look at the long-term national effect of specific professional guidelines across a range of tests and surgery types. Guidance has been issued by the American Society of Anesthesiologists (ASA) and the American College of Cardiologists/American Heart Association (ACC/AHA). (To see the abstract for doi:10.1001/jamainternmed.2015.2081,



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EDITORIAL QUESTIONS
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“Our findings suggest that professional guidance aimed at improving quality and reducing waste has had little effect on physician or hospital practice,” says **Alana E. Sigmund, MD**, the lead investigator and an assistant professor in the Department of Medicine at NYU Langone.

The researchers saw no significant decline in use of the following routine tests before elective surgery:

- plain radiography;
- hematocrit;
- urinalysis;
- cardiac stress testing.

The researchers did see a decline in pre-surgical electrocardiograms (ECGs). (See details of the study included in this issue.) Joshi said, “It is possible that the strict requirements by CMS [the Centers for Medicare and Medicaid Services] and insurance companies for reimbursement for ECG may have reduced this test.”

The study’s senior investigator, **Joseph Ladapo, MD, PhD**, an assistant professor in the Department of Population Health at NYU Langone, said, “While it’s important to ensure patients can safely undergo surgical procedures, many of these procedures are low-risk, and the tests rarely improve patient management.”

The overall rates of routine testing declined across several categories over the 14-year period that was studied. However, after accounting for overall changes in physicians’ ordering

practices, the declines were not statistically significant, the researchers say. They give several reasons.

“Evidence suggests physicians are more likely to follow guidelines that add rather than eliminate a test or procedure,” Ladapo said.

Physicians interviewed by *Same-Day Surgery* agree. “This reflects other physician practices in which it is easier to intervene than ‘hold back,’” Joshi says.

Also agreeing is the president of the American Society of Anesthesiologists, **J.P. Abenstein, MSEE, MD**, associate professor of anesthesiology at Mayo College of Medicine, Rochester, MN. “Adding gives me more information,” Abenstein says. “Eliminating means I have less information. Who would be opposed to more information?”

Ladapo says physicians might not have been aware of the recommendations from national groups, or they might not have believed those recommendations applied to their patients.

Joshi agrees. Even those such as preoperative clinic physicians and surgeons “who are familiar with the guidelines order unnecessary tests with the concern that the anesthesiologist may postpone the surgical procedure due to lack of a certain test, and so it is easier to obtain ALL tests,” he says.

Ladapo also says that reimbursement practices might

EXECUTIVE SUMMARY

Providers continue to order several preoperative tests, even though professional physician associations say certain routine tests are high cost and offer low value.

- The tests rarely improve patient management, according to the study’s senior investigator.
- Protocols are critical. (Editor’s note: One is included with the online issue.)

have had an impact, but that belief is dismissed by Abenstein. “I disagree, in the context of physician anesthesiologists,” he says. “We don’t have an economic self-interest in ordering an additional test.”

Fear of liability might be a different story, he says. “There may be some incentive related to litigation, e.g., ‘if I order a test, and if something goes wrong, this might protect me,’ but no direct reimbursement issues,” Abenstein says.

Joshi agrees that physicians are concerned about their liability. “I believe that the most important reason for anesthesiologists to continue ordering unnecessary tests is fear of litigation and a concern that they may miss something that may come to haunt them just in case things went sour,” he says.

So what can be done? First, we must determine who is ordering unnecessary preop tests, Joshi says. “The problem is that most studies, including this one, are limited, as they do not provide the information that is critical, that is, who — i.e., anesthesiologists, surgeons, or internal medicine/primary care physicians — is ordering the preoperative tests,” he says.

The change should start at training, Ladapo says. “Routine preoperative testing is part of the culture of many residency training programs, and shifting toward medically appropriate testing while physicians are still in training may be one way to break the cycle,” he says.

Protocols are critical, sources say.

Joshi says, “Several anesthesiology practices use a table to standardize the approach to preoperative testing and avoid unnecessary testing.” [See the table that Joshi uses included in the online edition of this month’s newsletter at www.AHCMedia.com. For assistance, contact customer service at

Details of Study

The study from NYU Langone Medical Center in New York City, published June 8, 2015, in *JAMA Internal Medicine*, looked at whether two sets of guidelines released concurrently, in 2002, by the American College of Cardiology/American Heart Association and the American Society of Anesthesiologists, led to changes in preoperative testing patterns. Both organizations made their recommendations about appropriate testing and treatment strategies to discourage preoperative tests ordered “in absence of a specific clinical indication or purpose.”

The NYU Langone researchers analyzed national data from the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey from 1997 through 2010. These two surveys, conducted annually by the Centers for Disease Control and Prevention and the National Center for Health Statistics, examine preoperative visits at office-based physician practices, hospital-based outpatient clinics, and emergency departments in the United States.

The researchers acknowledge that the study was somewhat limited in that it was not able to adjust for surgery type or identify patients who were referred for high-risk surgery. However, they found that the distribution of high-risk surgical procedures after the guideline recommendations saw little change. ■

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Such tables are developed from research, as well as recommendations of the ASA and the National Institute for Health and Care Excellence, London, England (<http://www.nice.org.uk/Guidance/CG3>).

The problem with routine preoperative testing extends beyond elective surgery, Joshi says. “Although this was a study in ambulatory surgical population, the problems are even worse in hospitalized patients,” he says. “It is my observation that in the [public] hospital I practice, there is significant emphasis on reducing unnecessary tests, and we have protocols in place for over a decade” that guide anesthesiologists and surgeons.

Future healthcare changes might resolve the issue, Joshi says. “I am hopeful that once the perioperative services payments are ‘bundled’

and physicians/hospitals receive a fixed amount for a certain surgical procedure, and we have tort reform to prevent frivolous litigation, practices will change,” he says.

Joshi also points to the growing popularity of having a “perioperative surgical home” for patients. In this process, the surgeon decides that the patient needs surgery, and the patient agrees. Then, “the rest of the care is transferred to the anesthesiologist, who would decide the need for tests, and referral to another specialist would prevent unnecessary testing and unnecessary referral,” Joshi says. “This should significantly reduce surgical-related healthcare costs.” (For more on this topic, see “Medicare patients undergo unnecessary tests before cataract surgery, study finds,” SDS, June 2015. Also see story in this issue about one type of preop testing that provides a modest reduction in surgical site infections.) ■

Multifaceted intervention associated with modest decrease in surgical site infections

Implementation of a pre-surgical intervention that included screening for the bacteria *Staphylococcus aureus*, treating patients who were positive for this bacteria, and the administration of antibiotics based on these culture results was associated with a modest reduction in *S. aureus* surgical site infections (SSIs), according to a study in the June 2 issue of *JAMA, The Journal of the American Medical Association*.

S. aureus carriage increases the risk of *S. aureus* SSIs. The risk for these infections might be decreased by screening patients for nasal carriage of *S. aureus* and decolonizing carriers during the preoperative period. Perioperative prevention with agents such as the antibiotic vancomycin might reduce rates of methicillin-resistant *S. aureus* (MRSA) SSIs. Previous studies suggested that a bundled intervention was associated with lower rates of *S. aureus* SSIs among patients having cardiac or orthopedic operations, according to information in the article.

Loreen A. Herwaldt, MD, professor of internal medicine — infectious diseases at the University of Iowa Carver College of Medicine, Iowa City, and colleagues evaluated whether the implementation of an evidence-based bundle is associated with a lower risk of *S. aureus* SSIs in patients undergoing cardiac operations or hip or knee replacement or reconstruction. Twenty hospitals in nine U.S. states participated in this study. Rates of SSIs were collected for a median of 39 months during the pre-intervention period and a median of 21 months during the intervention period.

Patients whose preoperative nasal screens were positive for MRSA or methicillin-susceptible *S. aureus* (MSSA) were asked to apply the antibiotic mupirocin intranasally twice daily for up to five days and to bathe daily with chlorhexidine-gluconate (CHG), an antimicrobial agent, for up to five days before their operations. MRSA carriers received the antibiotics vancomycin and cefazolin or cefuroxime for perioperative prophylaxis. All others received cefazolin or cefuroxime. Patients who were MRSA-negative and MSSA-negative bathed with CHG the night before and morning of their operations. Patients were treated as MRSA-positive if screening results were unknown. (*For more on this topic, see “Want to get a jump start on preventing infections? Have patients do the prep work,” Same-Day Surgery, March 2013.*)

After a three-month phase-in period, bundle adherence remained constant at 83% (full adherence, 39%; partial adherence, 44%). The complex (deep incisional or organ space) *S. aureus* SSI rates decreased significantly among patients in the fully adherent group compared with the pre-intervention period, but rates did not decrease significantly in the partially adherent or nonadherent group.

Overall, 101 complex *S. aureus* SSIs occurred after 28,218 operations during the pre-intervention period and 29 occurred after 14,316 operations during the intervention period (average rate per 10,000 operations, 36 for pre-intervention period vs 21 for intervention period). The rates of complex *S.*

aureus SSIs decreased for hip or knee arthroplasties (difference per 10,000 operations, -17) and for cardiac operations (difference per 10,000 operations, -6).

“Even though the baseline rate of complex *S. aureus* SSI was low (0.36 per 10,000 operations), the full adherence rate was only 39%, and hospitals had implemented some bundle elements before the study began, rates of complex *S. aureus* SSIs decreased significantly,” the researchers wrote. “Given that approximately 400,000 cardiac operations and one million total joint arthroplasties are performed in the United States each year, numerous *S. aureus* SSIs, which can have catastrophic consequences, may be preventable. Moreover, one SSI adds from \$13,000 to \$100,000 to the cost of health care. Thus, implementation of this bundle might reduce patient morbidity and the costs of care substantially.” (*To access the abstract, go to <http://bit.ly/1SW3zTi>.*)

Bundled approaches

In an accompanying editorial, **Preeti N. Malani, MD, MSJ**, professor of internal medicine at the University of Michigan Health System, Ann Arbor, and associate editor, *JAMA*, writes that although this study is a noteworthy addition to a growing body of high-quality infection prevention trials, many questions remain.

“Although *S. aureus* remains the principal pathogen in terms of prevalence and associated morbidity, many other organisms also cause SSIs. As such, decolonization of MSSA and MRSA can be only one aspect of

SSI prevention. Although the current findings demonstrate a decrease in *S. aureus* SSIs, the authors did not find a decrease in gram-negative SSIs or complex SSIs caused by any pathogen. This finding might reflect the overall low rate of infection, but also is a poignant reminder that

additional strategies still are needed.

“Public reporting and nonpayment for preventable complications (including some SSIs) have intensified efforts to eliminate infections — ‘to get to zero.’ The low-hanging fruit for SSI prevention has been picked and incremental decreases are unlikely

to come from simple interventions. Although getting to zero is unlikely to be achievable, efforts that move closer to this elusive goal hold tremendous value for clinicians, hospitals, payers, and, most importantly, patients.”
(To see the editorial, go to <http://bit.ly/1IfCvub>.) ■

Incorrect CPT codes lead to incorrect estimates and sometimes write-offs

(In this second part of a two-part series on price estimates, we discuss factors that can lead to incorrect estimates. In last month's issue, we discussed how two facilities used estimates to dramatically improve collections.)

If a procedure or surgery ends up being slightly different than it was expected to be when a price estimate was provided to a patient, this difference can cause major problems for the patient and the facility.

“Small changes in care can yield big changes in expense to the patient,” says **David Kelly**, MHSA, director of revenue cycle at Mary Rutan Hospital in Bellefontaine, OH. Sometimes a surgical procedure simply takes longer than expected.

To address the problem of incorrect CPT codes, leaders at Novant Health in Winston-Salem, NC, met with leaders in the surgery scheduling department. “They now get the code that the surgeon is authorizing and place it in a field in the system that lets us know what to price,” says **Craig Pergrem**, MBA, senior director of revenue cycle, pre-service, financial counseling, and onsite access.

Patient access leaders worked hard to achieve a collaborative relationship with clinical areas to ensure the

correct CPT codes are obtained. “An informed patient who knows what to expect ahead of time, whether they pay prior to service or not, is better off by not receiving that surprise bill after their service,” says Pergrem.

Reasons for mistakes

Failure to obtain correct procedure and diagnosis codes, or the frequency and dosage for infusion or injectable drugs, are two common reasons for incorrect price estimates given to patients at Salt Lake City, UT-based Huntsman Cancer Hospital. “We end up billing with different codes from the ones we used for estimates,” says **Junko I. Fowles**, CHAA, supervisor of patient access and financial counseling. A colonoscopy is sometimes billed as a diagnostic procedure instead of a screening examination. “Therefore, the patient’s plan processes the claim differently,” says Fowles. Medicare patients might think they are receiving a free screening colonoscopy, but if a polyp is found, the procedure changes to a diagnostic procedure with biopsy. In this situation, the patient has a 20% copayment.

For more than a year, Huntsman Cancer Hospital’s patient access areas have used a price estimate tool for all scheduled services, except transplants and cosmetic services. “We have been

very successful providing accurate service estimates to our patients,” reports Fowles.

These are factors

These two factors sometimes lead to incorrect estimates:

- **Incorrect service location and patient status, whether clinic, outpatient, day surgery, observation, inpatient, or emergency department.**

In terms of the patient’s insurance coverage, “there may be some variation for inpatient or observation services compared to outpatient services,” Fowles explains.

- **Inaccurate insurance payer and benefits information.**

“Our estimates are calculated based on the historical allowed amount data,” explains Fowles. “For some plans, the allowed amount is higher than our billed charges. Therefore, coinsurance is miscalculated.”

If patients end up being billed much higher than the quoted estimated amount, the case is escalated to direct supervisors and managers for resolution.

In this scenario, says Fowles, “each estimate is reviewed case by case. Supervisors or managers may approve additional discounts on the self-pay balance.” ■

Are you prepared to convert to ICD-10?

In preparation for the conversion to ICD-10, the 10th revision of the International Classification of Diseases, you should “review and compare current ICD-9 reimbursement policies for both your commercial and Medicare payers,” according to the Ambulatory Surgery Center Association (ASCA).

“Conditions deemed medically necessary in ICD-9 might not translate to medically necessary

conditions in ICD-10,” ASCA said. The Centers for Medicare and Medicaid Services (CMS) “can provide your facility with many state-specific ICD-10 draft policies pertinent to your Medicare volume.” To access the CMS information, go to <http://go.cms.gov/1M1yA2T>.

Mark Mayo, CASC, executive director of Golf Surgical Center in Des Plaines, IL, says Medicare relies on Local Condition Determinations

(LCDs) that seem to vary in what is covered and in what is required for documentation. “ASCs and HOPDs [hospital outpatient departments] will now also need to obtain new draft policies and coverage lists from many other insurers, such as Blue Cross,” Mayo said.

Oct. 1, 2015, is the new date for healthcare providers, health plans, and health care clearinghouses to transition to ICD-10. ■

How does human behavior lead to surgical errors? Mayo Clinic researchers count the ways

Four to nine factors contributed to each ‘never event’ in invasive procedures, study finds

Researchers at the Mayo Clinic in Rochester, MN, identified 69 never events among 1.5 million invasive procedures performed over five years and detailed why each occurred. Using a system created to investigate military plane crashes, they coded the human behaviors involved to identify any environmental, organizational, job, and individual characteristics that led to the never events. Their discovery: 628 human factors contributed to the errors overall, which is roughly four to nine per event.

Nearly two-thirds of the Mayo never events occurred during relatively minor procedures such as endoscopy, anesthetic blocks, interventional radiology procedures, line placements, and other skin and soft tissue procedures.

The never events included performing the wrong procedure (24), performing surgery on the wrong site or wrong side of the body (22), leaving an object in the patient (18),

or putting in the wrong implant (5). All of the errors analyzed occurred at Mayo, and none were fatal.

The Mayo Rochester campus rate of never events over the period studied was roughly 1 in every 22,000 procedures. Because of inconsistencies in definitions and reporting requirements, it is hard to find accurate comparison data. However, a recent study based upon information in the National Practitioner Data Bank estimated that the rate of such never events in the United States is almost twice that in this report, approximately 1 in 12,000 procedures.

Medical teams are highly motivated and skilled, yet preventing never events entirely remains elusive, says senior author **Juliane Bingener**, MD, a gastroenterologic surgeon at Mayo Clinic. Factors beyond “cowboy-type” behavior were to blame, the study showed, which points to the complexity of preventing never events, she says.

“What it tells you is that multiple things have to happen for an error to happen,” Bingener says. “We need to make sure that the team is vigilant and knows that it is not only OK, but is critical that team members alert each other to potential problems. Speaking up and taking advantage of all the team’s capacity to prevent errors is very important, and adding systems approaches as well.”

For example, to help prevent surgical sponges from being left in patients, Mayo Clinic installed a sponge-counting system and uses that bar code-scanning system and vigilance by the surgical team to track sponges. Other preventive systems include use of The Joint Commission’s Universal Protocol, team briefings and huddles before a surgery starts, a pause before the first incision is made, and debriefings using a safety checklist recommended by the World Health Organization.

To investigate the never events, the researchers used human factors

analysis, a system first developed to investigate military aviation accidents. They grouped errors into four levels that included dozens of factors:

- **“Preconditions for action,”**

such as poor hand-offs, distractions, overconfidence, stress, mental fatigue, and inadequate communication. This category also includes channeled attention on a single issue. In layman’s terms, that phrase means focusing so much on a tree that one cannot see the forest.

- **Unsafe actions,** such as bending or breaking rules or failing to understand. This category includes

perceptual errors such as confirmation bias, in which surgeons or others convinced themselves they were seeing what they thought they should be seeing.

- **Oversight and supervisory factors,** such as inadequate supervision, staffing deficiencies, and planning problems, for example.

- **Organizational influences,** such as problems with organizational culture or operational processes.

In addition to systems approaches and efforts to improve communication, attention should be paid to cognitive capacity, such

as team composition, technology interfaces, time pressures, and individual fatigue, the researchers say.

The stakes are high for patients, physicians, and hospitals, Bingener says.

“The most important piece is the patient perspective,” she says. “You don’t want a patient to have to experience a never event. The breach in trust that happens with that is the most important part.”

The study results are to be published in the journal *Surgery*. The abstract can be accessed at <http://bit.ly/1fhBxSM>. ■

The key to reducing pain in surgery might already be in your hand

Imagine a hand-held electronic device — accessible, portable, and nearly universal — that could reduce pain and discomfort for patients, and allow doctors the freedom to use less powerful and potentially risky medications to complement anesthesia.

Now reach in your pocket, because chances are, you already own one.

According to research, the simple act of texting someone on a mobile phone during a minor surgical procedure done under local anesthetic can significantly reduce a patient’s demand for narcotic pain relief. Make that text buddy a stranger, and the odds that a patient will ask for medications to take the edge off could be as little as one-sixth of those who go under the knife with empty hands. The research was conducted by a team led by **Jeff Hancock**, PhD, communications and information science professor at Cornell in Ithaca, NY, and Cornell student **Jamie Guillory**, PhD, now at RTI

International in Research Triangle Park, NC.

“These findings suggest that the simple act of communicating with a companion or stranger provides an analgesic-sparing effect,” the authors write in the journal *Pain Medicine*. “The data also suggest that text-based communication with a stranger is more effective.”

Building on research that has shown social support before and during medical procedures can reduce anxiety and perceptions of pain, Hancock and his team decided to test whether mobile phones that allow patients to send text messages or play games could bring that support benefit into settings where the company of family members or friends is not possible.

Hancock and Guillory worked with Christopher Woodruff, MD, FRCPC, and Jeffrey Keilman, MD, both from McGill University, at LaSalle Hospital, both located in Montreal. They used an experiment

to track four groups: patients receiving standard mobile phone-free perioperative treatment, those using a mobile phone to play a video game, patients using a mobile phone to text with a close friend or family member, and others invited to text with a research assistant instructed to focus on “getting-to-know-you” conversations. Neither the 98 patient volunteers who took part from January to March 2012, the research assistant texting, nor nine of the 10 treating anesthesiologists (the lone exception being co-author Woodruff) were aware of the nature of the research. Treatment in all cases was left entirely to the discretion of the physicians.

Still, when the research team analyzed the results, they found that patients receiving “standard therapy,” meaning those not using mobile phones during surgery, were almost twice as likely to receive supplemental pain relief as patients who played the game before and during the

procedure. The same patients were more than four times as likely to receive additional analgesic as those texting a companion and, most notably, more than six times as likely to receive additional narcotic relief as patients who engaged in a texting conversation with a stranger.

To verify that latter effect and explore its source, the team took the additional step of analyzing the language of the two groups allowed to text during their surgeries. Hancock and his team found that, while the

text conversations with companions related more to biology, the body, and negative emotions, the texts with a stranger included more words expressing positive emotions, with patients writing more often about self-affirming topics.

The authors say this study provides the first evidence that texting offers this benefit beyond traditional treatment or even “distraction” methods such as playing a video game. The team called for new work to explore exactly what type of

conversations work best and how far this benefit can be developed to assist patients and doctors.

“Our findings suggest that text messaging may be a more effective intervention that requires no specialized equipment or involvement from clinicians,” the authors write. “Even more importantly, text-based communication may allow for the analgesic-sparing benefits of social support to be introduced to other clinical settings where this type of support is not otherwise available.” ■

Heart patients can stop blood thinners when undergoing elective surgery

Patients with atrial fibrillation who stopped taking blood thinners before they had elective surgery had no higher risk of developing blood clots and less risk of major bleeding compared to patients who were given a “bridge” therapy, according to research led by Duke Medicine in Durham, NC.

The findings add much-needed clarity to inconsistent practice guidelines that annually affect an estimated 250,000 patients with atrial fibrillation/flutter who take the blood thinner warfarin, according to the Duke researchers. The study was presented June 22, 2015, at the International Society on Thrombosis and Haemostasis meeting and published in *The New England Journal of Medicine*. (To access the abstract, go to <http://bit.ly/1LshHSb>.)

Atrial fibrillation patients typically are told to halt their warfarin for five days before and after they undergo an elective procedure, because it can cause dangerous bleeding and slow healing. After the procedure and resuming warfarin, it can take five or

more days before the blood thinner reaches its effective target therapeutic level. To continue protecting them from blood clots during this intermission, many doctors prescribe a low-molecular weight heparin, a faster-acting blood thinner, in what is known as a “bridge” therapy.

“Bridging has been controversial because there has been a lack of data demonstrating that it’s necessary, so people don’t know what to do,” said senior author **Thomas L. Ortel**, MD, PhD, chief of the Division of Hematology at Duke and the principal investigator of the study. The study’s Statistical Data Coordinating Center, led by Vic Hasselblad, PhD, and the Clinical Coordinating Center were based at the Duke Clinical Research Institute.

“You can go to five different doctors, and some will bridge and others won’t; it just depends on what they feel they can safely do,” Ortel said. “This trial gives a firm answer to that question.”

The study, named BRIDGE,

enrolled 1,884 patients with atrial fibrillation and atrial flutter. Roughly half received the bridge therapy (dalteparin), and the other half received a placebo while halting their warfarin for up to 13 days around their elective surgeries. Patients were followed for up to 37 days after their procedures.

Among patients who stopped all blood thinners, the incidence of arterial blood clot was 0.4%, compared to 0.3% for patients who received the bridge therapy. Major bleeding events were significantly less common among the non-bridging group, occurring in 1.3% of patients who received no blood thinners, compared to 3.2% of those in the bridging group. “Bridging does not improve the outcome for stroke prevention, but increases the risk of major bleeding complications,” Ortel said. “That’s the counter balance: We’re not doing patients any good, and we are potentially hurting them.”

Ortel noted that the findings are specific to patients with atrial fibrillation who take warfarin and

should not be generalized to other types of patients on the blood thinner. He said the findings also don't cover newer blood thinners. However, the results will be taken into consideration by the organizations

that develop guidelines for doctors on managing atrial fibrillation patients who plan to undergo a procedure or surgery.

"This is the first study to provide high-quality clinical trial data

demonstrating that for patients with atrial fibrillation who need a procedure and who need to come off warfarin, they can simply stop and restart," Ortel said. "They do not need to be bridged." ■

SDS Manager

Management woes in the outpatient surgery field

By **Stephen W. Earnhart, MS**
CEO
Earnhart & Associates
Austin, TX

"There's something happening here. What it is ain't exactly clear ..."

Remember those lyrics from the old song? Oddly, there really is something happening in the surgical industry that isn't restricted to ambulatory surgery centers (ASCs), but includes hospitals as well.

We first noticed it about a year ago with some odd phone calls from past hospital and ASC clients. At first it was just interesting. Now it is almost routine, with several calls per month. It seems, again, *seems*, that folks who have been self-managing their hospital surgical departments and ASCs are throwing up their hands and wanting someone else to manage it for them. At first, we asked "Why?" Management services can be expensive, to say nothing of the sense of "loss of control" that is so critically important to many of these institutions and surgeons. Some of the answers we received and continue to receive are revealing. They are, in order of their frequency:

1. Lack of strong leadership personnel.

Many of the original department heads and ASC administrators have moved on, retired, or "burned out" (their words, not mine).

Replacements are more focused on family issues, time off, vacations, and a general sense of "not being married to the job" and putting in the 60-70 hours per week often necessary. (For more information on that topic, see "How do you successfully manage employees ranging from Millennials to Baby Boomers?" January 2015, SDS Salary Survey Report *supplement*.)

2. Overburdening regulations from the state and federal levels.

With increasing cutbacks in support staff in hospitals and ASCs, the time required to complete paperwork and stay updated on issues surrounding reimbursement, electronic medical records, and compliance issues is often too much for entities to keep up with on a day-to-day basis.

3. Surgeon expectation issues.

Surgeons are expecting and demanding better efficiency and outcomes for their surgical patients, who are increasingly difficult to find. For busy surgeons, the ability to flip-flop two rooms is now the norm, and woe be to the administrator who cannot accommodate them. That ability to placate surgeons is often a higher priority for professional management companies than it is for a single hospital or ASC.

4. No backup.

Related to the first reason, but different in the sense that should a facility lose a key person in the

surgical department, it takes a long time to replace them. Should the unexpected happen, typically (but not always, so make sure you ask!) the management companies have someone they can immediately put into place until a new person they can train steps in.

5. Hassle factor.

Hospital administrators and ASC owner/operators are tired of dealing with the burdensome issues of running the business that they don't have expertise in. They are weary of the late night or early morning phone calls from department heads or ASC administrators with problems they cannot handle. They want someone else to deal with the problems and are willing to pay for that release of duty and obligation.

6. Liability issues.

All seem to want a cognitive intermediary between them and the problem. I don't know how else to put that.

7. Decision-making at the 30,000-foot level.

Most facilities are so self-absorbed they often miss significant events or opportunities that are happening in the industry that they simply don't have access to or are too busy to notice.

8. Cost of supplies and equipment.

Most facilities don't have access to the purchasing power of management

companies, which often purchase for many rather than one or two.

Should you decide to take this route, be careful, as there are many twists and turns ahead of you. There are good and bad things to look for in the local “mom and

pop” and corporate management companies you should be aware of and vet accordingly. There are many issues to look at that we will highlight next month. [Earnhart & Associates is a consulting firm specializing in all aspects of outpatient

surgery development and management. Earnhart & Associates can be contacted at 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.] ■

Paper, storage costs plummet with e-signatures

More than 60,000 pieces of paper each month no longer need to be printed, copied, and stored in offsite record storage locations, due to electronic signatures being implemented in registration areas at Ann & Robert H. Lurie Children’s Hospital of Chicago.

“We are anticipating a great deal of cost savings as a result of this project,” says **Brian M. Stahulak**, MBA, BSN, RN, NEA-BC, administrator of new patient referral.

Registrars no longer need to scan in 30,000 consents each month to the medical record. “This will save a great deal of time for our medical records team,” says Stahulak.

Paper costs are now minimal. “Costs for FTEs dedicated to scanning these documents can now be redirected to more value-added projects,” adds Stahulak. There are also decreased storage costs. Previously, paper consents needed to be stored offsite in a secure location for several years. “E-signature will allow consents to be stored electronically, safely within the patient record,” explains Stahulak.

Leaders at Fairfield, CA-based NorthBay Healthcare are looking at several vendors for electronic verification software. “When you think about a five-page consent form alone, you can easily do the math and figure out that in a year, you’ve made your money back,” says **Lori Eichenberger**, interim senior director

of revenue cycle management.

Ambulatory areas recently implemented electronic signatures at Ann & Robert H. Lurie Children’s Hospital, but facility leaders are not stopping there.

“Patient safety, patient engagement, improved workflows, and cost savings are key drivers,” says Stahulak. “We are continuously looking for ways we can use it for process innovation.” Here are some examples:

- **Electronic signatures are used for consent documents for all hospital-based outpatient centers.**

This system allows parents to sign annual consent documents electronically. “Our previous process was that all consent documents had to be signed on paper, labeled with the patient information, and manually sent to medical records for scanning,” says Stahulak.

Patient consent documents now are automatically saved and stored within the electronic medical record. “This ensures that all patient consent forms are protected and can be utilized by providers immediately,”

says Stahulak.

- **Electronic signatures are available for families using self-check-in kiosks at registration areas.**

“This gives families the opportunity to skip the queue while checking in,” says Stahulak.

Leaders at Memorial Hermann Health System in Houston, TX, have used an internally developed electronic signature tool for years. The department is converting to a revenue cycle system from North Kansas City, MO-based Cerner that includes an electronic signature tool.

“We will be going off our ‘homegrown’ tool in 2016. But we have taken a lot of what we have learned from our existing tool and asked them to build some of that in,” says **Tonie Bayman**, director of revenue and recovery for patient business services.

The “homegrown” tool automatically prints the right forms for each patient. Previously, patient access scanned paper forms and then uploaded those to the patient’s account.

COMING IN FUTURE MONTHS

- Groundbreaking location for surgery
- Potential liability with device reporting
- Predict risk of death from even minor surgery
- Tip on how to save money with your OR staffing

“We have hundreds of forms. There is a lot of risk in counting on a patient access person to remember which one is needed, and a lot of potential for somebody to forget,” says Bayman. Some important forms aren’t used often, such as a form enabling self-pay patients to obtain funds for pharmaceuticals.

Patients appreciate not having to sign the same consents multiple times, because the tool flags which forms already were obtained by patient access.

EXECUTIVE SUMMARY

Healthcare facilities can achieve significant cost savings with electronic signatures, due to less paper use and no need for offsite storage. Registrars at Ann & Robert H. Lurie Children’s Hospital of Chicago no longer have to scan in 30,000 consent forms each month.

- Providers have immediate access to signed consents for admitted patients.
- Consents are stored electronically.
- Forms are no longer printed.

“It is a permanent part of the financial and medical records,” says Bayman. “And if a visually impaired

patient has a hard time reading a form, we can zoom in to enlarge it.” ■

Stuffed animals bring bacteria to OR

Despite efforts to minimize risk of infection after surgery, surgical site infections (SSIs) have not been completely eliminated.

Jonathan Schoenecker, MD, PhD, a pediatric orthopedic surgeon at Monroe Carell Jr. Children’s Hospital at Vanderbilt, in Nashville, TN, and colleagues tested the hypothesis that stuffed animals or other “comfort” items that pediatric patients bring to the operating room might represent a reservoir of bacteria that could contribute to SSIs. The researchers swabbed stuffed animals that were brought into the operating room and quantified bacterial growth.

They report in the *Journal of Pediatric Orthopaedics* that all of the stuffed animals showed bacterial growth. They further demonstrated that a single wash-and-dry cycle in a household washer/dryer, followed by sealing a stuffed animal in a plastic bag for 24 hours, effectively “sterilized” 79% of the items tested.

Although the study does not establish that stuffed animals cause SSIs, the researchers suggest that washing a comfort item one day before elective surgery might be a simple and effective way to reduce

overall bacterial load in the OR.

Another option might be to place the comfort item into a large “zip bag” and keep with the other personal items that are returned to the patient in the recovery area, says **Mark Mayo**, CASC, executive director of Golf

Surgical Center, Des Plaines, IL. “That way these contaminated items are isolated from the procedure room and reduce the potential for cross contamination,” Mayo says.

To access the abstract, go to <http://1.usa.gov/1Bl6tvj>. ■

ASC-8 reporting deadline moved

The Centers for Medicare and Medicaid Services has extended the reporting deadline for quality reporting measure ASC-8 Influenza Vaccination Coverage among Healthcare Personnel until Aug. 15, 2015, the Ambulatory Surgery Center Association (ASCA) says.

To report, facilities must enroll in the National Healthcare Safety Network (NHSN). Facilities that

have not started the enrollment process should do so immediately, according to ASCA. To submit data, ASCs must enroll in NHSN a minimum of eight weeks before the Aug. 15 deadline. ASCA leaders have heard that it can take more than a month to enroll.

For instructions, go to <http://www.cdc.gov/nhsn/ambulatory-surgery/enroll.html>. ■

CNE/CME OBJECTIVES

After reading *Same-Day Surgery*, the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identify how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.



SAME-DAY SURGERY

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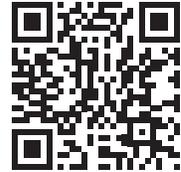
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CNE/CME QUESTIONS

1. In a study of the long-term national effect of specific professional guidelines on preoperative tests, researchers saw no significant decline in which routine test(s)?
 - A. Plain radiography
 - B. Hematocrit
 - C. Urinalysis
 - D. Cardiac stress testing
 - E. All of the above
2. In a study of the implementation of a pre-surgical intervention for *Staphylococcus aureus*, which resulted in a modest reduction in *S aureus* surgical site infections, what steps were taken with patients whose screens were positive?
 - A. These patients were asked to apply the antibiotic mupirocin intranasally twice daily for up to five days.
 - B. These patients were asked to bathe daily with chlorhexidine-gluconate (CHG), an antimicrobial agent, for up to five days before their operations.
 - C. A and B
 - D. Neither A nor B
3. What two factors can lead to incorrect price estimates for patients, according to Junko I. Fowles, CHAA, supervisor of patient access and financial counseling at Huntsman Cancer Hospital?
 - A. Incorrect service location and patient status, whether clinic, outpatient, day surgery, observation, inpatient, or emergency department
 - B. Inaccurate insurance payer and benefits information
 - C. A and B
 - D. Neither A nor B
4. When the Mayo Clinic studied never events among 1.5 million invasive procedures performed over five years, what percentage occurred during relatively minor procedures such as endoscopy, anesthetic blocks, interventional radiology procedures, line placements, and other skin and soft tissue procedures?
 - A. About one-fifth
 - B. Nearly one-third
 - C. About half
 - D. Nearly two-thirds

PREOPERATIVE TESTING IN ADULTS UNDERGOING ELECTIVE SURGERY

ASA Physical Status 1	No tests are necessary
Age	Do not perform routine testing. Follow ASA classification
Pulmonary Function Tests and Chest X-ray	Only if clinical symptoms and signs of significant pulmonary or cardiac disease
Basal Metabolic Profile (BMP) and CBC	Do not to repeat within one month if no change in clinical status
Electrocardiogram (ECG)	Do not repeat within six months if no change in clinical status

	Hemoglobin	CBC Platelets	PT/ PTT	Glucose	BMP	LFT's	Type & Screen	Type & Cross	Drug level	ECG
Age>80 years										X
Cardiovascular Disease	X	X			X					X
Pulmonary disease	X	X								
Diabetes Mellitus	X			X	X					X
Hematologic disorders	X	X	X							
Hepatic Disease	X	X	X		X	X				
Renal Disease	X	X	X		X					X
Drug and Alcohol Abuse	X	X	X		X	X				X
Anticoagulant use	X	X	X							
Anticonvulsants									X	
Digoxin					X				X	X
Diuretic use					X					
EBL >1500 ml	X							X		
EBL 500-1500 ml	X						X			
Malignancy	X	X	X							
Radiation therapy or chemotherapy within 3 months	X	X			X					X
Immunosuppressants	X	X								

Source: Girish P. Joshi, MBBS, MD, FFARCSI, Professor of Anesthesiology and Pain Management, University of Texas Southwestern Medical Center, Dallas.