SAME-DAY SURGERY

THE TRUSTED SOURCE FOR HOSPITALS, SURGERY CENTERS, AND OFFICES FOR MORE THAN THREE DECADES

FEBRUARY 2016 Vol. 40, No. 2; pp. 13-24

INSIDE

AHC Media

Could you save more than $1 million by using SFAs to reduce time?

Increasingly, outpatient surgeons, and the surgery centers and hospitals where they work, are adding surgical first assistants (SFAs) as a tool to shorten their procedure times and add more cases.

"Any time you have consistency of personnel as first assistants, it certainly lowers costs by improving efficiency, turnover, time during case, all those things, and accuracy and safety of cases," says **Todd Albert**, MD, surgeon-in-chief at the Hospital for Special Surgery, New York, NY. The hospital uses physician assistants (PAs) to operate as SFAs, as well as fellows, residents, nurses, and OR techs. SFAs are one tool that allows the Hospital for Special Surgery to operate at full capacity of about 30,000 cases annually, with three new ORs being built, Albert says. Using consistent first assistants allows a surgeon to speed the surgery, he says. "So it lowers infection rate, lowers cost, increases efficiency, and leads to better outcomes," Albert says.

Best cost-saving ideas from your peers

This month's issue, one of our readers' favorites, offers the best cost-saving ideas from outpatient surgery managers. We've talked to facilities that are using surgical first assistants to save time and money. We tell you about a facility that used a simple idea to cut their median supply costs by 4%. We tell you how adjusting your pay period could virtually eliminate overtime. Our columnist Stephen Earnhart shares his best tips for reducing expenses. Our publisher even jumped in with cost savings on infection control resources. Also, we explore one controversial idea for cutting costs: concurrent surgeries. We offer free resources and more! We hope you enjoy this special issue.

Financial Disclosure: Executive Editor Joy Dickinson, Nurse Planner Kay Ball, Physician Reviewer Steven A. Gunderson, DO, and Consulting Editor Mark Mayo report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Stephen W. Earnhart discloses that he is a stockholder and on the board for One Medical Passport.

SAME-DAY SURGERY

Same-Day Surgery®,
ISSN 0190-5066, is published monthly by AHC Media, LLC, One Atlanta Plaza, 950 East Paces Ferry Road NE, Suite 2850, Atlanta, GA 30326

Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices
GST Registration Number: R128870672

POSTMASTER: Send address changes to:
SAME-DAY SURGERY
P.O. Box 550669
Atlanta, GA 30355

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
Customer.Service@AHCMedia.com
AHCMedia.com

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free *AMA Category 1 Credits*™ or Nursing Contact Hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free *AMA Category 1 Credits*™ or Nursing Contact Hours, $469. Outside U.S., add $30 per year, total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer toll-free at (866) 213-0844. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $83 each. (GST registration number R128870672.)
Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

ACCREDITATION: AHC Media, LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 1.75 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #CEP14749, for 1.75 Contact Hours.

AHC Media, LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media, LLC designates this enduring material for a maximum of 1.75 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 24 months after the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

EXECUTIVE EDITOR: Joy Daughtery Dickinson
Joy.Dickinson@AHCMedia.com
DIRECTOR OF CONTINUING EDUCATION AND EDITORIAL: Lee Landenberger.

EDITORIAL QUESTIONS
Questions or comments?
Call **Joy Daughtery Dickinson**
(404) 262-5410

Rockford (IL) Ambulatory Surgery Center uses SFAs primarily to assist its cosmetic surgeons, says **Steven A. Gunderson**, DO, CEO/medical director. "They are exceptionally qualified, do reduce surgery time, in most cases, and best of all, the surgeon is responsible for reimbursement whether it is out of the fee he/she charges the patient or a direct bill to the patient," Gunderson says. When a general surgeon uses an SFA, which happens less frequently, the first assistant bills the insurance company for the fee.

In terms of reducing surgery time, SFAs have been reported to reduce surgery time by more than 14 minutes to almost 23 minutes per case, which translates to approximately 10-16% reduced surgery time.[1] Intralign in Scottsdale, AZ, which employs SFAs to work in hospitals and surgery centers, has found that customers save 15-28% surgical time, reports **Miki Patterson**, PhD, RNFA, ONP, senior director of orthopedics.

Healthcare facilities have reported that the time and staff savings have translated to cost savings ranging from $100,000 to more than $1 million, Patterson says.

First assistant tasks include handing over instruments and supplies, using suction, using retractors to hold the operating site open, or assisting with the actual surgery, she says. "They complement whatever the surgeon needs," Patterson says. "They are able to set up prep and drape, if they have worked with that surgeon prior to that and know their preferences, and they are able to suture wounds closed — this can take 10-30 minutes depending on the incisions — while the surgeon sees the next patient and/or dictates," she says. "An SFA is a licensed clinician, who knows about surgery and anatomy, who works to anticipate what you're going to do. It frees up the surgeon to do other things."

Intralign bills the use of the SFA to the insurance company, as long as the case is considered complex enough to require a first assistant. The American College of Surgeons (ACS) has devised an index of what surgeries need a first assistant. *(That index is available at the web site of the ACS, which offers a disclaimer that the 2013 file might not be up to date. To access that list, go to http://bit.ly/1Pf8I3O.)* Patterson's experience has been that insurance companies will pay for a first assistant on most

EXECUTIVE SUMMARY

Surgeons are using surgical first assistants (SFAs) in hospitals and surgery centers to reduce operating time. Reported time savings with use of an SFA range from 10% to 28%.

- SFAs can include physicians, residents, fellows, nurses, or operating room technicians. You can hire SFAs, use freelance SFAs, or use an outside company to provide them.
- The American College of Surgeons (ACS) and the Association of periOperative Registered Nurses have documents on SFA qualifications. The ACS also has a list of which procedures need an SFA.
- Insurance companies typically will reimburse.
- Ensure you have the volume to support use of SFAs.

cases, as long as they are not simple cases such as procedures on the eyes that don't require an extra set of hands.

Who works as an SFA varies. In some practice settings, one surgeon will ask another surgeon to operate as the first assistant. Many facilities hire a PA or nurse practitioner (NP) to work for the practice. Other facilities hire freelance SFAs to work specific cases. Intralign hires mostly MDs and PAs to work as SFAs, along with a few NPs and registered nurse first assistants (RNFAs).

The ACS has recommendations on who is qualified to serve as a first assistant in a *Statements on Principles* document.[2] While acknowledging that the qualifications of an SFA can vary depending on the operations, surgical specialty, and facility, the ACS says that ideally, the SFA "should be a qualified surgeon or a resident in an approved surgical education program."[2] However, the ACS says that it might be necessary to use nonphysicians, such as surgeon's assistants or PAs with additional surgical training who meet national standards and are credentialed.

The Association of periOperative Registered Nurses (AORN) has a statement on the advanced practice RN (APRN) serving as an SFA.[3] As of Jan. 1, 2016, APRNs who haven't previously worked as a FA are required to do the following: "to acquire the knowledge and skills needed to provide safe, competent, surgical first assistant services by completing a program that covers the content of the *AORN Standards for RN First Assistant Education Program,* which may be a stand-alone program or may be a portion of a graduate or post-graduate program (e.g., additional coursework included in a graduate APRN program)."

Based on a Q&A published in the December 2015 *AORN Journal*, AORN acknowledges that flexibility might be needed to adopt different interpretations or more stringent education requirements/qualifications. The *AORN Position Statement on RN First Assistants* says that effective Jan. 1, 2020, persons entering an RNFA program must have a baccalaureate degree.[4] However, RNFAs who were practicing as SFAs before that date should be permitted to continue working as RNFAs, the organization says.[4] All PAs, MDs, NPs, and RNFAs working as SFAs are licensed by the state in which they work, and they are credentialed by the facilities.

Ensure that you are using a person with the right qualities, Albert emphasizes: "mostly willingness to learn and curiosity, so they'll stay interested."

The most important step to take before hiring or using SFAs? Ensure you need them, Albert says. Ask: Do you have the volume to support it? Are you lacking the assistant's help?

"If a doctor is operating alone, it's not nearly as good a situation as having a qualified FA in there too," he says.

REFERENCES

1. Bohm ER, Dunbar M, David Pitman D. Experience with physician assistants in a Canadian arthroplasty program. *Canadian J Surgery* 2010; 53(2):103-108.
2. American College of Surgeons. *Statement on Principles*. Sept. 18, 2008. Accessed at http://bit.ly/1NQZEo1.
3. Association of periOperative Registered Nurses. *AORN Position Statement on Advanced Practice Registered Nurses in the Perioperative Environment*. 2014. Denver. Accessed at http://bit.ly/1NVF0AT.
4. Association of periOperative Registered Nurses. *AORN Position Statement on RN First Assistants*. Denver. 2013. Accessed at http://bit.ly/1IDOaFs. ■

Want to cut supply costs? Tell surgeons how they compare with their peers

3 surgical departments reduce supply costs 4% over 6-month period

The neurosurgery, orthopedic surgery, and otolaryngology – head and neck surgery (OHNS) departments at UCSF Medical Center in San Francisco had a 4% decrease in median surgical supply costs in six months through a price transparency initiative aimed at surgeons.

From January to June 2015, other services that were not participating in the initiative had a nearly 9% increase in median surgical supply costs, according to the study presented at the most recent annual meeting of the Congress of Neurological Surgeons. *(To access an abstract of the unpublished study, go to http://bit.ly/1Ue7ee5.)*

"To the best of our knowledge,

there are no publications demonstrating cost reduction through a price transparency initiative directed at surgeons, and our work represents one of the first attempts to do this," the authors said.

The premise for the study was that surgeons don't know their OR costs. For example, the researchers say other research shows that orthopedic surgeons incorrectly estimate the cost of their devices, ranging from 1.8% of the actual price up to 24.6 times the actual price.[1] The UCSF Medical Center initiative started with a survey of all attending surgeons, resident surgeons, and OR nurses in which they were questioned about their attitudes regarding cost and value. More than 95% of attendings, residents, and nurses agreed that surgeons can control costs, but only about half (56%) of attending surgeons were aware of ways to cut costs. About one in 10 (12%) attending surgeons knew how their procedure costs compared to their peers.

The researchers used data from electronic records to analyze the time and cost of all surgical procedures at UCSF over a two-year period.

Beginning in January 2015, the researchers gave "surgeon snapshots" with information about median surgical supply costs per case, as well as surgical preparation time and surgical procedure time, to surgeons in the neurosurgery, orthopedic, and OHNS departments at UCSF, said **Corinna C. Zygourakis**, MD, neurosurgery resident physician and fellow at UCSF's Center for Healthcare Value. "These surgeons were compared to surgeons in the remainder of surgical departments at UCSF — cardiothoracic surgery, general surgery, OB-GYN, ophthalmology, urology, vascular surgery, pediatric surgery — who did not receive price transparency snapshots," Zygourakis said in an interview with *Same-Day Surgery.* Each surgical department was eligible for a $50,000 reward, to be used for academic purposes only, if it met a 5% target cost reduction in 2015.

In the first six months, the researchers saw an overall 4% decrease in median case costs for neurosurgery, orthopedics, and OHNS, from $1,391 to $1,335 per case. Combined, the departments have saved more than $310,000 in the first six months of the intervention. The other surgical services had a nearly 9% increase in median case costs, from $704 to $766 over the same time period, Zygourakis said. The different departments have different median case costs at baseline, which is reflected in the difference of $1,391 for the neurosurgery, orthopedic, and OHNS departments versus $704 per case for all other surgical departments.

REFERENCE

1. Okike K, O'Toole RV, Pollak AN, et al. Survey finds few orthopedic surgeons know the costs of the devices they implant. *Health Aff* 2014; 33(1):103-109; doi: 10.1377/hlthaff.2013.0453. ■

Are concurrent surgeries a good tool to save time and money? Experts express caution

Massachusetts General Hospital in Boston has been the focus of controversy over the safety of concurrent surgeries and whether patients have a right to know when surgeons are dividing their attention. One patient safety leader says that the practice is not necessarily improper but should be monitored by management.

The controversy arose with a lengthy story in *The Boston Globe* about a malpractice suit filed by a plaintiff who was paralyzed during spinal surgery. He contends that his injury was due, in part, to the fact that his surgeon was splitting his time between that operating room and another where he was operating on a second patient at the same time (concurrent surgeries). Massachusetts

EXECUTIVE SUMMARY

A controversy at one healthcare facility has raised questions about the safety of concurrent surgeries. The practice is common but should be addressed by managers.

- Concurrent surgeries can be allowed without undermining patient safety.
- The healthcare facility responded with extensive information on its web site.
- Facilities should limit concurrent surgeries to only some surgeons and situations.

General has since limited surgeons from double-booking some complex surgeries.

A hospital spokesman also told the newspaper that while surgeons are "encouraged and expected" to tell patients when they'll be absent for part of the surgery, they are not explicitly required to do so. *(The* Boston Globe *story is available online at http://tinyurl.com/zowtss6.)*

The hospital went to extraordinary lengths to respond to the story. It issued a statement saying, "We are confident that our surgical practices are very safe and among the strongest in the nation. The American College of Surgeons, in fact, called our overlapping surgery policy a best practice and said it exceeds national standards. We have reviewed the complication rates in overlapping and non-overlapping surgeries and found the rates to be the same. We also have reviewed overlapping cases with complications from 2013 and 2014 and found no association between the complications and overlapping. Several studies from other hospitals around the country have shown similar results."

However, Massachusetts General went far beyond the standard statement by creating several pages on its web site devoted to explaining concurrent surgery, the hospital's policies and experience, and medical literature regarding its safety. A link to the material is placed prominently on the hospital's home page. *(The link is http://tinyurl.com/jrn9kob.)*

No tie to malpractice

AHC Media, publisher of *Same-Day Surgery,* contacted The Doctors Company, a malpractice insurer in Napa, CA, to determine how often concurrent surgeries are cited in malpractice cases. **Robin Diamond**, MSN, JD, RN, senior vice president of patient safety and risk management, says the data show no correlation. A review of 7,330 surgery malpractice cases in the company's database from the past eight years found no mention of concurrent surgery as a factor, she says.

Diamond also says the medical literature is scant on any connection between concurrent surgery and malpractice or patient safety. However, she says the lack of data doesn't necessarily mean there is no reason to worry. "Sometimes, until there is a big case or a focus on an issue by regulators, the medical community doesn't shine a light on an issue, and the data is not collected," Diamond says. "I think some of this recent publicity will raise public awareness, and risk managers are going to need to look at the issue more closely."

The issue might become problematic for healthcare facilities as members of the general public become more aware of a practice that is common but largely unknown to them, she says. Patients will not react favorably when they learn that their surgeons leave the operating room during their procedures and divide their attention, she says.

"You leave me anesthetized and go down the hall to work on somebody else? And I'm just lying there waiting for you to come back?" Diamond says. "That's not going to go over well with most people. And, at that point, the question of how it actually affects patient safety can become secondary to the fact that people don't like it and feel threatened by it."

Assess your facility's use

Diamond advises managers to determine how much overlapping surgery occurs in their facilities. The practice is common and has been accepted for so long that it might be happening in a facility without anyone other than the surgical team taking note.

Diamond suggests conducting a failure mode effects analysis (FMEA) to assess the risk. This FMEA will help the manager determine how many surgeons perform concurrent procedures and whether there are any restrictions in place.

There should be policies that limit who can do concurrent surgeries and how much procedures can overlap, Diamond says. Even if concurrent surgery is an accepted practice at your facility, it should not be done by just anyone. Only experienced surgeons should have this option, she says.

"There should be a competency and privileging process for this," Diamond says. "If you are allowing any surgeon to overlap, you are going to get into trouble eventually. The leading hospitals have policies that make sure this is an option only for the surgeons who have proven they can do this without endangering patients."

Surgeons also should be required to justify why concurrent surgeries are necessary. Busy OR schedules can be justification enough, Diamond says, but there should be some reason beyond the surgeon simply wanting to double up and get out of the facility sooner.

Managers should urge full disclosure of concurrent surgery to patients, Diamond says. The policy should be part of the informed consent process, she says.

Documentation also is an issue. Diamond suspects that concurrent surgery often is not documented in the surgery record, possibly only in the OR administrative record. Facility policy should require that concurrent surgeries are documented fully in the OR record, including the surgeon's exit and return times for each

procedure.

Managers also should look at the times of the overlap, Diamond says. "How long are patients waiting, and are they left waiting under anesthesia longer than is reasonable?"

Facility policies on concurrent surgeries often require that a supervising or attending surgeon be immediately available to respond if a patient needs help while his or her surgeon is in a second operating room, but Diamond says those policies often are vague. "Immediately available" can be interpreted as in the next room, down the hall in the doctors' lounge, or even 10 minutes away conducting rounds, Diamond says. Such policies should be included in the risk assessment.

Concurrent surgeries require good patient handoff procedures, Diamond notes. The surgeon's exit and return should be accompanied by a standardized script that notes information such as the patient's vital signs, status of the procedure, when to call the surgeon on standby, and changes since the surgeon's departure.

Diamond also expresses concern that concurrent surgeries might interfere with some safety processes, such as the preop checklist and timeout.

"Is the surgeon doing the preop checklist and timeout on both patients? Or did the rest of the team in the second OR do it without him, and then he shows up later?" she says. "That's a major concern for me, because it is such an important part of the safety process." ■

SDS Manager

In ambulatory surgery programs, money saved equals money earned

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

Some ambulatory surgery managers have a hard time seeing that money saved is money earned. Many hospitals, surgery centers, and surgeons' offices focus so much effort on increasing revenue and not enough on controlling their expenses. Can and should you do both? Of course, but sometimes we all get in a position that one of those options just isn't there for you at that time.

For example, you have cajoled every surgeon you have for more cases; however, with the new year, most patients have not met their deductible, and surgery is down. You cannot get cases that are not there, but what a great way to reduce staffing and save some money by encouraging staff to take winter vacations or use paid time off.

What about payer contracts? Most manages are so unaware about what they are supposed to receive in reimbursement that much of it slips away. You are losing money that you have earned and are not collecting. Now, during these historically slow surgery months, is a great time to review each of your contracts.

It's surprising that few facilities are even aware of one huge expense: the cost of anesthesia drugs and supplies. The last time we analyzed this data, about two years ago, the average cost was around $60 per case for general and around $30 for other.

Check yours, and see where they lay. Again, I guarantee that you will be surprised at how this controllable expense creeps up. Controlling this cost often is as easy as making your providers aware of the price of the various items.

Updating surgeon preference cards is another way to make money by saving money. Many of the outdated cards still contain items that are no longer used but still packaged and/or opened on the back table and Mayo Tray that you are paying for. Custom packs, while convenient for staff, typically are significantly overpriced by the vendors. Again, there are items in packs that the surgeon no longer uses due to different surgical techniques, or there are surgical approaches, such as draping, that no longer apply. It is well worth your time to have someone review the items against the updated preference cards. A savings of even $30 per case adds up quickly!

Check your inventory. Almost every facility has outdated or soon-to-be outdated supplies in your sterile supply room. Making sure stock is rotated appropriately can save money on waste each year.

The historically "slow" surgical months are a great time to change to barcoding your storerooms and items. So many patient chargeable expenses never get billed. In a recent audit we performed, an average of $200 used per case was never billed due to outdated charge sheets or just plain

oversight. Audit yourself to see where you fall. All of these ideas add up to steady income over time. *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates can be reached 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.]* ■

Tip on easy way to reduce overtime

Your staffing costs might be keeping you up at night, but here is one simple tip that can save you significant money: Change the schedule of your pay period from Monday through Friday to Tuesday through Monday.

Pediatric Surgery Centers in Odessa, FL, made this change and has gone from overtime being a commonplace occurrence every pay period to it being an "extremely rare event," says **Carol Trokanski**, RN, BSN, LHRM, CASC, quality manager.

The reason for the savings at the two centers is that Mondays traditionally are slow days for outpatient surgery, but Fridays often end up being long days. On the previous pay schedule, staff worked full days on Mondays, although there were few cases, and some staff members were being paid overtime by Friday. Now, staff pull the cases on Monday and go home. They know Monday will be a short day, and they schedule personal appointments.

"We told people, within our framework, unless we're busy every day of the week, it's an unacceptable fiscal practice" to keep paying overtime, Trokanski says. The managers explained that if the centers are spending money on overtime, there is less money available for quarterly incentive bonuses.

With the change, "people watch their time," Trokanski says. When members of the staff realize they are about to be working overtime, the centers will change their assignments and let salaried staff members take their places.

"It worked for us, and it probably would work for lot of places," Trokanski says. "It's made us more fiscally sound. ■

Art installed, does double duty as decoration and morale booster

How would you like to spend money once, but get more for your buck when you use it for two purposes? One gastroenterology physicians group achieved that goal by decorating the office with art that also motivates employees.

Gapingvoid, a Miami-based consulting firm specializing in change management, conducted preliminary research with staff and patients at the Physicians Group of South Florida, who are physicians in the fields of internal medicine, gastroenterology, and endoscopy with two facilities in the Miami area. The purpose was to determine the daily challenges requiring attention. Art was selected and installed to create a positive and humorous atmosphere for patients, physicians, and staff.

Art was installed with phrases such as "We are family" and "Care in action." After art was installed, increases were reported in the staff's attention to patient care and in positive patient perceptions about the office environment and in their overall experience.

Employees who had difficulty staying motivated at work dropped from 31% to 0%. The art transformed employee priorities, with 66% stating that helping patients was the most fulfilling part of their work, compared with 33% prior to the program. Staff members felt more engaged, part of something larger, and more rewarded. Communication improved, along with positive attitudes among the team and in interaction with patients.

The art also had a positive impact on the patient experience. Of a group of patients surveyed before and after the art was installed, none mentioned the art as their favorite part of their office visit before the program. This figure rose to 50% on their visit after the old artwork was replaced by new imagery.

According to **Jason Radick**, MD, a partner of Physicians Group of South Florida, the new artwork "helped us understand that treating patients effectively means more than prescribing medication. It

means working to create an overall environment that promotes positive, healthy interaction among staff and patients. The art is a reminder to our team to focus on our mission to help people feel better in body and in mind. The results of the program continue to make us a better practice every day."

To view images of the art installation, go to http://1drv.ms/1KSnBaI. ■

Free benchmarking information available for ambulatory surgery

You don't have to go digging through mountains of data to find benchmarking information. As part of our cost-saving issue, *Same-Day Surgery* offers free statistics from the ASC Quality Collaboration.

Data was obtained for patient admissions from July 1, 2015, through Sept. 30, 2015, from the following organizations: Ambulatory Surgery Center Association, Ambulatory Surgical Centers of America, AmSurg, Covenant Surgical Partners, HCA Ambulatory Surgery Division, Regent Surgical Health, Surgical Care Affiliates, Surgery Partners-Symbion, United Surgical Partners International, and Visionary Enterprises.

The most recent data has been collected from 1,404 ambulatory surgery centers (ASCs), including 908 multispecialty ASCs and 496 single-specialty ASCs, representing every state except West Virginia and Vermont. This report presents aggregated performance data for ASC facility-level quality measures developed by the ASC Quality Collaboration:

- patient fall in the ASC: 0.099 per 1,000 admissions;
- patient burns: 0.020 per 1,000 admissions;
- hospital transfer/admission: 1.002 per 1,000 admissions;
- wrong site, side, patient, procedure, implant: 0.027 per 1,000 admissions;
- prophylactic IV antibiotic timing: 99%;
- appropriate surgical site hair removal: 97%;
- normothermia: 94%;
- cataract patients with unplanned anterior vitrectomy: 0.48%. *(For more information, go to http://ascquality.org/qualityreport.cfm.)* ■

Free translator application could be a cost-saving tool

There is a free medical translation iOS app named MediBabble that potentially can avoid the use of third-party translators.

"Also in a multicultural area, patients speaking these languages could be assured they would receive high-quality medical care," which could generate new patients for a healthcare facility, says **Scott Lorenz**, president of Westwind Communications, a medical marketing firm in Plymouth, MI. Lorenz does not represent the company behind MediBabble.

"The patient can hear the translation of the healthcare provider's question and see it on the app at the same time," he says. The patient can respond "yes" or "no" to the questions. "The pre-recorded questions cover practically everything a doctor could ask a patient, including general medical questions, cardiovascular, pulmonary, gastrointestinal, neurologic, and many more," Lorenz says. "The questions include family history, medicines a patient might be taking, and dozens more."

The languages covered by the app from the provider include English, Spanish, Russian, and Chinese-Mandarin. The patient's languages include those languages as well as French, German, Haitian Creole, and Chinese-Cantonese. *(To read more, go to http://medibabble.com. To read about other helpful apps, see these stories in* Same-Day Surgery*: "Three apps that could help improve patient safety," July 2015; "FDA launches drug shortages mobile app," June 2015; and "Nurses text, send images from the OR with new app," April 2015. Do you have a favorite app? Contact Joy Dickinson, Executive Editor, at joy.dickinson@ahcmedia.com.)* ■

Save money on infection control resources

As part of *Same-Day Surgery's (SDS')* special cost-saving issue, AHC Media, *SDS* publisher, is offering a one-time savings on three AHC Media products.

SDS readers can receive 30% off one of the following products (promotional code SDSF30 if buying online at AHCMedia.com) or 50% off a purchase of all three products (use promotional code SDSFA3 online):

• *Hospital Infection Control and Prevention* (national award-winning newsletter with 18 CME/CE hours);

• "Ambulatory Surgery Centers: Infection Control Standards & Safe Injection Practices from CMS" (webinar with 1.5 CE hours);

• *Mastering the CMS Hospital Infection Control Survey* (book).

For more information, see the insert enclosed in this issue, or contact customer service at (800) 699-2421 or customer.service@AHCMedia.com. Reference effort no. 3504 when calling or emailing. ■

Resources for Preventing Surgical Fires Initiative

An estimated 200 to 650 surgical fires occur annually in, on, or around a patient who is undergoing a medical or surgical procedure in the United States, according to ECRI Institute. To combat this issue, The Joint Commission has partnered with the Food and Drug Administration, the Council for Surgical & Perioperative Safety (CSPS), and others in the Preventing Surgical Fires Initiative (PSFI).

The Initiative aims to do the following:

• increase awareness of surgical fires;

• provide prevention tools;

• encourage risk reduction practices.

For more information about PSFI, visit the Initiative's website (http://bit.ly/1YTEo44), which is hosted by CSPS. Among the resources available are a presentation on "Preventing Surgical Fires and Burns in Healthcare Facilities" suitable for Grand Rounds presentations, as well as an online educational program on prevention and management of surgical fires by the Society of American Gastrointestinal and Endoscopic Surgeons. Its "Fundamental Use of Surgical Energy" program deals with operating room safety. To access that program, go to http://bit.ly/1QZEfwD. ■

Free resources for healthcare worker safety

The Occupational Safety and Health Administration (OSHA) has an online resource to help healthcare leaders protect their employees from getting hurt when lifting patients, during exposure to chemicals, and when being exposed to other common hazards of working in healthcare.

Successful strategies to improve patient safety and worker safety "go hand in hand," said **David Michaels**, assistant secretary of labor for OSHA. The site (osha.gov/hospitals) contains fact books, self-assessments, and best practices to guide managers.

The initiative does not include any new requirements for healthcare facilities, but Michaels said that improving safety requires a transformation of the workplace culture in the industry.

"We urge all hospital executives that are ready to protect workers, enhance patient safety, and save money to go to our website, take the self-assessment, compare your hospital with benchmarks from high-performing hospitals," Michaels said. ■

ASCs: Appeal non-compliance with quality reporting

*(*Same-Day Surgery *tweeted about the deadline for the quality reporting program on Dec. 17. Obtain breaking news as it happens by following us on Twitter @SameDaySurgery.)*

Ambulatory surgery centers (ASCs) subject to a reduction in Medicare outpatient payments in calendar year 2016 due to non-compliance with the ASC quality reporting program may appeal by submitting a reconsideration request by March 17, according to the American Hospital Association (AHA), which credits the Centers

for Medicare & Medicaid Services (CMS) with this information.

Eligible ASCs that don't meet all requirements for the ASC Quality Reporting program or don't participate in the program will receive a 2 percentage point reduction of the annual payment update, the AHA said. About 95.9% of ASCs eligible to participate in the program met the criteria to receive a full payment update of negative 0.3% for calendar year 2016, CMS said. The annual payment update status for each ASC eligible for the program can be found at www.qualitynet.org. To submit a reconsideration request, go to http://bit.ly/1OwJmnL. ■

Safety culture is critical in improving surgical results

Study finds non-technical factors significantly influence quality of patient care

To achieve better results for surgical patients, healthcare facilities tend to focus on technical issues such as surgeons' skills and OR equipment. However, a non-technical factor, the so-called "safety culture," might be equally important in delivering high-quality patient care, investigators report in a study published online in the *Journal of the American College of Surgeons* in advance of print publication.

"The non-technical skills of care coordination, teamwork, and ownership over the delivery of care are measured as safety culture," said lead study author **Martin Makary**, MD, MPH, FACS, professor of surgery and health policy & management at Johns Hopkins University School of Medicine, Baltimore. "Anybody who cares for patients knows that a hospital's culture contributes to a patient's outcome, and this study affirmed that observation."

The study is one of the first to evaluate the impact of an organization's teamwork and safety culture on patient outcomes.

Makary defined safety culture as "the organizational characteristics of delivering great care" and the attitude of "how we do things around here." He added, "It's a compilation of burnout, perceptions of management, the connectedness of care, and staff's willingness to speak up when they have a concern."

The study results measured 12 safety culture factors that influenced rates of a specific complication, surgical site infection (SSI) after colon procedures, at seven Minnesota hospitals. SSI rates after surgery at the hospitals ranged from 0-30%, with an average rate of 11.3%, and surgical unit safety culture scores ranged from 16-92 on a percent-positive scale.

Researchers used a cross-sectional sample from the Minnesota Hospital Association to combine safety culture survey data with SSIs after colon operations during 2013. The hospitals were surveyed using the Hospital Survey on Patient Safety Culture, from the Agency for Healthcare Research and Quality. Of the 12 safety culture factors measured, 10 were found to influence the rates of SSI after colon operations:

- overall perceptions of patient safety;
- teamwork across units;
- organizational learning;
- feedback and communication about error;
- management support for patient safety;
- teamwork within units;
- communication openness;
- supervisor/manager expectations of actions promoting safety;
- non-punitive response to error;
- frequency of events reported.

The safety factors not associated with infection rates were handoffs and transitions, as well as staffing.

Feedback and communication after errors (the learning hospital response) had the widest variation among surveyed hospitals, ranging from 21-79% positive, while the smallest variation was in scores for teamwork across units, with a range from 24-49% positive.

The study illustrated the significance of three characteristics of good safety culture, Makary said: an ability and willingness to learn from past mistakes, a high degree of interest in adopting best practices, and an ability to collaborate to benchmark performance.

"The study supports what many surgeons have known for a long time,

COMING IN FUTURE MONTHS

- How to prevent retained surgical items
- New ideas that work from cutting-edge surgery center
- Best practices for geriatric surgical patients
- Surgical tech advances that you need to know about

and that is that the organizational culture matters," Makary said. "While we have traditionally only studied the incremental patient benefits of different medications and surgical interventions, it turns out that organizational culture has a big impact on patient outcomes."

One notable study limitation was that the researchers only investigated one type of surgical outcome. "There are hundreds of outcome variables that can be measured with a safety culture," Makary said. *(Access the abstract at http://bit.ly/221zNB2.)* ■

Voluntary data collected on patients' experiences

Beginning in January 2016, the Centers for Medicare and Medicaid Services (CMS) started voluntary monthly data collection using the Outpatient and Ambulatory Surgery Patient Experience of Care Survey (OAS CAHPS).

The OAS CAHPS survey was developed by the Agency for Healthcare Research and Quality. It includes 37 questions that assess patient experience measures for hospital-based outpatient departments (HOPDs) and freestanding ASCs, as well as patient-reported health outcomes.

The survey measures patients' experiences on important topics when choosing a facility, such as communication and care provided by providers and office staff, preparation for the surgery or procedure, and post-surgical care coordination.

All HOPDs and ASCs are welcome to participate in the Voluntary National Reporting Program. Approved survey vendors, including Press Ganey, will conduct the survey on behalf of HOPDs and ASCs. Data will be submitted to CMS's contractor RTI and posted for participating HOPDs and ASCs to preview before the data are publicly reported. *(For more information, go to http://go.cms.gov/1XotIcW or email AmbSurgSurvey@cms.hhs.gov.)* ■

Hospitals to settle kyphoplasty allegations

Thirty-two hospitals will pay the United States more than $28 million to settle allegations that the facilities submitted false claims to Medicare for minimally-invasive kyphoplasty procedures. The Justice Department has reached settlements with more than 130 hospitals totaling about $105 million in this area.

In many cases, the procedure can be performed safely and effectively as an outpatient procedure. The recent settlements resolve allegations that the hospitals frequently billed Medicare for inpatient kyphoplasty procedures. The settling facilities include:

- The Cleveland (OH) Clinic;
- Citrus Memorial Health System in Inverness, FL;
- Cullman (AL) Regional Medical Center;
- Martin Memorial Medical Center in Stuart, FL;
- MultiCare Tacoma (WA) General Hospital;
- Norwalk (CT) Hospital;
- Princeton (WVa) Community Hospital Association;
- Sacred Heart Medical Center in Spokane, WA;
- Sarasota (FL) Memorial Hospital;
- Spartanburg (SC) Regional Health Services District;
- St. Cloud (MN) Hospital;
- Tampa (FL) General Hospital;
- Five hospitals tied to Community Health Systems, in Franklin, TN: Crestwood Medical Center in Huntsville, AL; St. Joseph's Hospital in Fort Wayne, IN; Carolinas Hospital System in Florence, SC; Mary Black Health System in Spartanburg, SC; and Trinity Medical Center in Birmingham, AL;
- Five hospitals tied to Tenet Health Care Corp. in Dallas: East Cooper Medical Center in Mount Pleasant, SC; North Fulton Hospital in Roswell, GA; Providence Memorial Hospital in El Paso, TX; St. Francis Hospital in Memphis, TN; and Sierra Medical Center in El Paso;
- Five hospitals formerly owned by Health Management Associates in Naples, FL: Biloxi (MS) Regional Medical Center; Davis Regional Medical Center in Statesville, NC; Lancaster (PA) Regional Medical Center; Physicians Regional Medical Center in Naples; and Riley Hospital in Meridian, MS;
- Three hospitals tied to BayCare Health System in Clearwater, FL: Winter Haven (FL) Hospital; St. Joseph's Hospital in Tampa, FL; and St. Anthony's Hospital in St. Petersburg, FL;
- Two hospitals affiliated with Banner Health in Phoenix, AZ: Banner Boswell Medical Center in Sun City, AZ, and Banner Thunderbird Medical Center in Glendale, AZ. ■

SAME-DAY SURGERY

CNE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or log on to AHCMedia.com then select "My Account" to take a post-test. *First-time users must register on the site.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CNE/CME QUESTIONS

1. **What positions work as surgical first assistants?**

   A. Physicians, residents, and fellows
   B. Nurses
   C. Operating room technicians
   D. All of the above

2. **How did several surgery departments at UCSF Medical Center achieve a 4% decrease in median surgical supply costs?**

   A. The researchers provided "surgeon snapshots," with information about median supply costs per case and times.
   B. Costs of each item were posted in the supply room.
   C. Standardization of supplies

3. **In a review of 7,330 surgery malpractice claims in the company's database from the past eight years at The Doctors Company, how strong was the correlation between malpractice claims and concurrent surgery?**

   A. The review found no mention of concurrent surgery as a factor.
   B. Concurrent surgery was cited in 5% of the malpractice cases.
   C. Concurrent surgery was cited in 37% of the malpractice cases.

4. **How did Pediatric Surgery Centers virtually eliminate overtime costs?**

   A. Staff members were required to obtain prior approval to work any overtime.
   B. The pay period was changed from Monday through Friday to Tuesday through Monday.
   C. Staff were told a quarterly bonus could be added.

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;
- identifiy 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 Cost-Saving Issue Specials

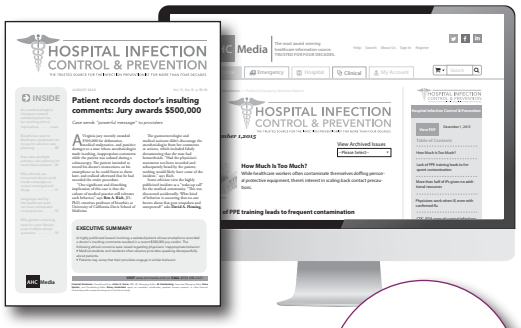
Save 30% off each product below
Use promotional code: **SDSF30**

Save 50% off all 3 products
Use promotional code: **SDSFA3**

AHCMedia.com/HIC

PERIODICAL

Hospital Infection Control & Prevention



For more than four decades *Hospital Infection Control & Prevention* has been the most respected, award-winning source of news and comment on preventing healthcare-associated infections.

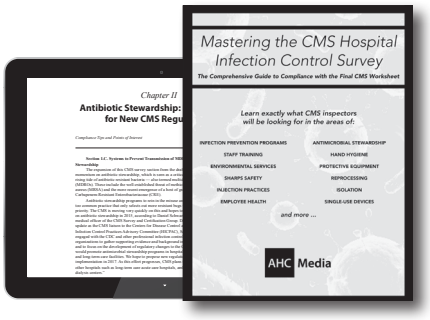
From A to Z – the first cases of AIDS in the early 1980s to the latest Zoonotic infections like SARS, MERS and Ebola – *Hospital Infection Control & Prevention* has provided key insights and take-home tips from both leading authorities and grassroots practitioners.

18 CE/CME

AHCMedia.com/CMS

BOOK

Mastering the CMS Hospital Infection Control Survey



Mastering the CMS Hospital Infection Control Survey Book delivers comprehensive guidance for hospital staff responsible for infection control compliance. It provides tips and insights from experts plus background articles and case studies on the top areas of CMS interest. Learn everything you need to know about hand hygiene, environmental cleaning, patient isolation measures, antibiotic stewardship and much, much more.

AHCMedia.com/Ambulatory

WEBinar

Ambulatory Surgery Centers: Infection Control Standards & Safe Injection Practices from CMS

1.5 CE

CMS issued Conditions for Coverage that every freestanding ambulatory surgery center (ASC) must meet if the ambulatory surgery center receives Medicare and Medicaid reimbursement. The standards apply to all patients treated in the ASC, including worker comp and patients with commercial insurance. This program will cover every tag number in the infection control section. CMS has an infection control work sheet that must be completed, and all staff with direct patient contact should be familiar with this document.

Contact us at Sales@AHCMedia.com or **800-688-2421**

Reference effort # 3504 when calling or emailing.