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APRIL 2016 Vol. 40, No. 4; pp. 37-48

INSIDE

AHC Media

Outpatient surgery field fights back after ban from insurance plans

Under ACA, is ambulatory surgery coverage required?

Distressed. Alarming. Shortsighted. Troubling. These words are being used to describe a new trend of employers offering healthcare coverage that excludes outpatient surgery in all settings: hospitals, surgery centers, and surgeons' offices.

Employers and insurance administrators were turned back by federal regulators last year when they tried to exclude inpatient care coverage from their health insurance plans that they were required to offer under the Affordable Care Act. Now they've targeted outpatient surgery as a new area for exclusion, and their action has gotten the attention of all outpatient surgery providers.

"'Skinny plans,' in short, run contrary to the Affordable Care Act's promise of comprehensive, affordable coverage," said **Richard J. Pollack**, president and chief executive officer of the American Hospital Association (AHA).[1]

"RESTRAINING ACCESS TO CARE WILL DEGRADE THE GENERAL WELLNESS OF THE U.S. POPULATION ..." — FOAD NAHAI, MD, AAAASF

Employers see offering health plans without outpatient surgery benefits as a way to save money but still, they hope, comply with government requirements to offer health insurance. According to a recent article by Kaiser Health News and *The Washingon Post,* these insurance plans have been marketed to lower-wage employers that traditionally didn't offer major medical coverage, such as staffing companies, hotels, and restaurants.[2] It's uncertain how many companies are seeking to

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

EDITORIAL QUESTIONS
Questions or comments?
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exclude outpatient surgery, but last year about one-half of the 1,600 corporations that are members of the American Staffing Association expressed interest in offering no inpatient coverage.[2] More than 30 employers that obtain benefits through EBSO in St. Paul, MN, already have implemented insurance plans that don't include outpatient surgery.[2]

There are questions about whether this exclusion is legal. Regulators turned down the earlier plans that excluded inpatient care because they said large employers must provide "substantial coverage of hospital and physician services." Does that requirement include outpatient surgery? It remains to be seen.

In the meantime, outpatient surgery providers in all settings are responding with forceful words. The AHA says it "has been distressed to learn that some emerging employer-sponsored health plans do not cover outpatient surgeries, including those performed in hospital outpatient departments," wrote AHA Executive Vice President **Tom Nickels** in a letter to the Centers for Medicare & Medicaid Services (CMS) and the Department of the Treasury.[3] The letter urges the agencies to "take swift and decisive action" to protect consumers from the limited-benefit plans that don't include outpatient surgery.

The AHA points to 2013 statistics that show two-thirds of all surgeries done in hospitals were outpatient. "Health plans that do not cover such surgeries put enrollees' physical and financial health at risk; violate the Affordable Care Act's promise of comprehensive, affordable coverage; and hamper efforts to transform the delivery system," Nickels said.[3]

The AHA said that the federal government originally required that employer-sponsored plans had to cover services that would meet a 60% threshold of anticipated healthcare costs.

"We are deeply concerned that some plans have interpreted the new policy to mean that they may exclude critical outpatient surgeries as long as they meet the 60% threshold," the AHA said. "We urge CMS and Treasury to again act to protect consumers from 'skinny' health plans that put their physical and financial health at risk."[3]

The AHA asks that the federal agencies immediately offer guidance that requires employers to cover hospital outpatient surgery. However, the association strongly recommends that the agencies go beyond that step. "We urge CMS to close any remaining loopholes by further defining 'substantial coverage' for purposes of calculating

EXECUTIVE SUMMARY

Some employers and insurance companies are offering healthcare coverage that excludes outpatient surgery in any setting.

- The legality has not been determined.
- The American Hospital Association (AHA) has asked federal regulators to immediately require employers to cover hospital outpatient surgery.
- The AHA also asks the Centers for Medicare and Medicaid Services to define "substantial coverage" in terms of calculating the minimum value threshold in employer health plans.

the minimum value threshold of employer-sponsored health plans," the AHA says. "Plans should be required to provide substantial coverage of a comprehensive range of benefits, including hospital outpatient surgery, among other critical services."[3]

The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) has asked legislators and regulators at the federal and state level to roll back the skinny plans that exclude outpatient surgery. To do otherwise will have serious implications on healthcare quality, said **Foad Nahai**, MD, AAAASF president.

"If physicians and patients migrate back to inpatient care, the delayed treatment resulting from having to wait for the hospital OR to become available would further degrade a patient's condition and force him or her to take additional time off work," Nahai said. "Restraining access to care will degrade the general wellness of the U.S. patient population and result in more expensive inpatient care."[4]

AAAASF Executive Director **Theresa Griffin-Rossi** pointed out that when employees are offered these skinny plans, they aren't eligible for federal subsidies to buy more comprehensive coverage in the online insurance marketplace. "The rationale that these plans offer improved coverage for previously uninsured workers is invalid because the plans render employees ineligible to buy subsidized policies individually on their state's health exchange," Griffin-Rossi said. "While small businesses certainly must find creative ways to manage the potentially devastating costs of providing coverage, doing so in a manner that reduces employee options and increases out-of-pocket expenses, is not an acceptable solution."[4]

Many of those who oppose the skinny plans point to the quality and cost-effectiveness of outpatient surgery. **William Prentice**, chief executive officer of the Ambulatory Surgery Center Association (ASCA), said, "Provisions that give patients access to the top-quality, cost-effective care that ASCs provide should be a part of every plan."

Outpatient surgery offers insurance companies and insured patients lower costs such as lower deductibles and typically includes a 20% copay off of the lower overall charge, says **Mark Mayo**, CASC, executive director of Golf Surgical Center in Des Plaines, IL. "The big issue here is overall cost of care will go up when 'elective' procedures are not covered and develop into more serious and much more expensive inpatient care including inpatient surgery," Mayo says.

In the meantime, outpatient surgery managers are waiting to see what federal regulators will do. **Steven A. Gunderson**, DO, CEO/Medical Director, Rockford (IL) Ambulatory Surgery Center, says, "In the long run, I suspect that this will be determined to be an inappropriate application of the Affordable Care Act."

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First-of-its-kind perioperative surgical home initiative

American Society of Anesthesiologists' initiative demonstrates measurable impact on quality and costs

Most participants in the perioperative surgical home (PSH) learning collaborative reported they enhanced clinical quality, controlled costs, and/or improved patient experiences as a result of their initiatives.

The PSH model is a patient-centered, team-based practice model of coordinated care that guides patients through the entire surgical experience, from the decision to undergo surgery to discharge and return to function. The results were announced by the American Society of Anesthesiologists (ASA) and Premier, a healthcare improvement company based in Charlotte, NC.

One success story was a PSH pilot for adenoidectomy procedures at Nationwide Children's Hospital (NCH) in Columbus, OH, that decreased pharmacy costs by 32% and overall costs by 53%, which saved

EXECUTIVE SUMMARY

Most participants in a perioperative surgical home (PSH) initiative report they have enhanced quality, controlled costs, and/or improved patient experiences.

- A PSH pilot for adenoidectomy procedures at Nationwide Children's Hospital decreased pharmacy costs by 32% and overall costs by 53%, which saved nearly $50,000 across the hospital's first 19 cases.
- Most of the cost savings resulted from reduction in length of stay. This reduction was accomplished through a protocol, standardization of medications and anesthetics, and a YouTube teaching video.

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"The PSH model and learning collaborative helped NCH providers truly work as a team, enabling us to lower costs, while still providing the highest quality of care," says **Vidya Raman**, MD, a pediatric anesthesiologist at NCH. "The benefits of this improved system of care for our patients and their families are well worth the effort associated with implementing this initiative."

Much of the cost savings came from eliminating the overnight stay for most adenoidectomy patients, Raman said in an interview with *Same-Day Surgery*. The pharmacy cost reduction resulted from having a protocol for the procedure from beginning to end, as well as using standardized medications and anesthetics. "It maybe is not the fanciest way, it maybe is not the newest drugs, but we're using ones that have been shown to work and are associated with lower pharmaceutical costs," Raman said.

Previously, adenoidectomy patients were kept for overnight stays due to sleep-disordered breathing, but even that situation was variable, she said. "Some were kept all night, and some were kept for a couple of hours on the floor and discharged," Raman said. "We're trying to standardize even that."

Some of the critical steps for having the procedure be outpatient are pre-identifying patients and making sure they fit the criteria, ensuring the patients don't have a far distance to travel home, and using a standardized cartoon YouTube video that patients can view with their caretakers at the hospital and then access again later if needed. *(See the video at bit.ly/1R7c4Ha.)* The video was done in-house with the media staff. The low-tech video emphasizes points such as when bleeding needs follow-up care. "I think that has helped the family," Raman says.

The staff had to work to obtain the manpower needed to make the video, but the hospital leaders came to realize it would be valuable, because the teaching is standardized, Raman says. The hospital offers traditional discharge instructions as well.

Also, a physician follows up the night of the procedure with a standardized script of questions.

Sometimes surgery managers get "bogged down" with the name "perioperative surgical home," Raman says. "It's basically — call it whatever you want — an initiative to improve the process that's in place," she says. "You're using various metrics, not going about it in a 'hurly-burly' fashion, but in a systematic fashion."

Raman suggests that providers simply can look at patient care from beginning to end and ask, where does it need improvement? "If you have a preop weakness, you can work on that," she says. "If you have postop issues, work on that. You shouldn't shy away from it because you can't do it in its entirely, which is sometimes hard."

The PSH process isn't just for large hospitals with infrastructure and resources, she emphasizes. "People can do this even without those, as long as you have a champion, a vested interest, and a [facility] that's willing to go forth and save money and do good things," Raman says. "It's possible anywhere."

The ASA/Premier PSH collaborative included 44 healthcare organizations that developed, piloted, and evaluated the model from July 2014 through November 2015. Most (73%) of the participants successfully launched one or more PSH pilot programs during the collaborative, with thousands of completed cases across 64 pilots. Many members of the collaborative selected pilots that focused on orthopedics, such as total hip and knee replacements, to help prepare for success in voluntary and mandatory bundled payment programs. Other commonly selected service lines included colorectal, general surgery, and urology.

The results of individual PSH pilot programs varied by institution, depending on variables such as service line chosen and key areas of focus.

In addition to the outcomes data collected by individual organizations, collaborative participants also collectively developed and tested common metrics to assess the impact of the model across the participants. Preliminary analysis of the data for these metrics will be a key area of focus for the next phase of the

PSH learning collaborative, which will launch this month. *(For more information, go to bit.ly/1XPFvCM.)*

Daniel J. Cole, MD, ASA president, said, "The PSH, spearheaded by the ASA, was an opportunity simply to give better care to our patients, while at the same time achieving the goals of the triple aim: better health care, a better quality patient experience, and lower costs."

RESOURCE

- American Society of Anesthesiologists, Perioperative Surgical Home Page. Web: https://www.asahq.org/psh. ■

Advice on resolving count discrepancies in the OR

(In this second part of a two-part series, we discuss how to resolve count discrepancies. In a separate story in this issue, we discuss the importance of standardization and how to address needles. In last month's issue, we discussed some new challenges and solutions for retained surgical items.)

When a member of the OR team notices a count discrepancy, that person must speak up,[1] said **Amber Wood**, MSN, RN, CNOR, CIC, senior perioperative practice specialist at the Association of periOperative Registered Nurses (AORN) and lead author of a newly updated guideline on retained items.

Speaking up is the most important step, Wood said, and that person should be verbally acknowledged by the surgeon.[1] A recently updated guideline from AORN includes a decision tree to guide team members who suspect a discrepancy through the count reconciliation process.[1] *(For information on ordering the updated guideline, see Resource at end of this story.)*

Team members should discuss how many items are missing and what they are, according to AORN.[1] The role of the RN circulator is to ask for assistance and search the room. The role of the surgeon and scrub person is to search the surgical site, as well as the Mayo stand and the back table, AORN says. The circulation and scrub person should do a recount, it says.

If the missing item isn't found, the surgeon should obtain intraoperative images, according to AORN.[1] Your policies should spell out what communication takes place between the operating room and radiology when imaging is performed; specifically, the reason for the imaging should be discussed, The Joint Commission says in a recent *Quick Safety* article on retained objects.[2]

The images should be reviewed by the surgeon and the radiologist at the same time, AORN says, which is a step also recommended by The Joint Commission.[2] The surgeon should verify that the entire surgical site was captured by the image, AORN says. If the item still is missing, the radiologist and surgeon can consider other imaging modes, such as MRI and CT.

If the item remains missing, the RN circulator should document all the steps that were taken to try to find the object, and the surgeon should consult with the patient or patient representative regarding follow-up care, AORN says.

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RESOURCE

- Association of Operating Room Nurses. *2016 Guidelines*. Print edition is $175 for members and $225 for non-members. Web: aornbookstore.org. ■

Standardization is critical to avoid retained items

According to The Joint Commission, having different expectations for counts, depending on the type of procedure being performed, can lead to unintended retained foreign objects (URFOs).[1]

Standardize count policies for all procedures, not just for cases that have an open abdomen or chest, The Joint Commisison says.[1]

NoThing Left Behind, a San Francisco-based national surgical patient safety project to prevent retained surgical items, says that sponges have been retained in surgical wounds of all sizes and almost every operation.

"It's not acceptable anymore for nurses to count sponges out of kick buckets," says **Verna C. Gibbs**, MD, director of NoThing Left Behind.

An article by the Association of periOperative Registered Nurses about the group's updated guideline on retained objects, it uses an illustration of a blue backed plastic hanging sponge holder.[2] Using such a sponge holder is a good standardized practice "so you can see where sponges are at any given time." Gibbs says. *(For instructions, go to bit.ly/1WLwXeX. For a video, go to bit.ly/20XakFv and click on the photo.)*

Outpatient surgery programs also need standardized management practices for small miscellaneous items, Gibbs says. One problem is that healthcare facilities don't usually have a place for these items to be documented in the intraoperative record, she says. "Hospitals are setting up the OR staff for failure," Gibbs says.

She says healthcare facilities should be able to document four classes of items in the intraoperative record: soft goods or sponges, sharps or needles, instruments, and miscellaneous items. "Most only have three places, but not small miscellaneous items," Gibbs says. "That's like saying, 'You don't have to keep track of these.' But they do, and they need a means to keep track of them."

Needles are the most frequently miscounted item, Gibbs says. "Sometimes hundreds of needles are used" in an operation, Gibbs says. Staff often have difficulty in managing them, she says.

Outpatient surgery managers need to work with nurses to improve needle management practices and strengthen policies on how they adjudicate disputes, she says. *(For recommendations on handling needles, go to http://nothingleftbehind.org/Resources.html.)*

Another area in which standardization is important is in the layout of procedural areas, according to The Joint Commission.[1] Scheduling issues, as well as emergency cases, might cause inconsistency in the location of a procedure, the association says. However, teams operate better if they have comparable equipment in similar locations as in past cases, it says.

Surgical technologists and scrub staff members need to have a standardized back table, Gibbs says. "They can't change that any way they want for individual preferences," she says. Standardized layout will help ensure the items on the table are properly accounted for at the end of the procedure. Gibbs says, "They make it hard for each other to do the right thing."

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Shorter surgery check-in saves $11,500 annually

Employees, supervisors, and managers at Seattle Children's Hospital are constantly on the lookout for work that is no longer useful.

"We are good at adding work in. We make sure we are removing as much as we are adding," says **Sarah Thomas**, senior director of access systems. A recent change involved the surgery check-in process.

Patient access staff members verified only certain items for clinic check-ins. However, for surgery check-in, they verified every piece of information on a patient's record.

Registration manager **Sara Dunn** says, "The emphasis on accurate information for invasive procedures compared to outpatient clinic exams was what we had always done — historical due diligence — even if the patient had just been in for a preop appointment days before the surgery."

Cindy Hutchinson-Iverson, a family service coordinator, saw that some of the work was redundant, and she lobbied for change.

"It was a frustrating process, and I could see how stressed families were the day of surgery, so I asked 'Why are we doing this?"' says Hutchinson-Iverson.

For surgery check-ins, staff now verify only the fields that require verification, including patient identifiers. Dunn says, "We are relying on our systems to work for surgery check-ins, just as we know they do for clinic check-ins." Average time for surgery check-ins decreased from six minutes to five minutes. "This calculates to a 0.2 FTE savings," says Dunn.

While just one minute is cut from each surgical registration, says Thomas, "when you multiply the reduced cycle time by hundreds of events in a month, it increases our capacity significantly." The new process saves the department $11,500 annually in per diem coverage. "The great thing about it is it isn't just a cost savings. This is a better experience for our families," says Thomas. "They don't want to sit with us any longer than necessary." ■

You can improve communication with your surgery staff — Here's how

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

"The following sentence is true. The previous sentence is false."

Did you figure it out? Can you? These statements have driven compulsive individuals crazy over the years. It is the "liar's paradox," or *pseudómenos lógos*.

I thought these statements would be a good segue into an exploration of issues related to miscommunication among outpatient surgery staff members and how much of it can be avoided by keeping everyone up to date via staff meetings.

My entire career has been spent in the operating environment, in hospitals and surgery centers. If there is one item of significance that I can point out that sets apart a facility that is great from one that is good, and one that is poor from one that is lousy, it is frequency and quality of staff meetings. Consider these aspects of your meetings:

• Frequency.

How frequent is frequent? There are lots of variables, but the newer the facility, the more staff meetings you need. I am talking about two per day, five days a week.

If you are a dancer or sports person, you are familiar with the term "muscle memory," which basically means that you do a routine frequently enough that it becomes ingrained and you can do it without even thinking about it. If you do it enough, it becomes nature. At staff meetings, if you consistently talk about processes and procedures, staff will follow them automatically.

Established facilities always tell me that they don't need meetings or rarely have anything to report. That's not a valid excuse. There are always new staff, new procedures, new docs, new equipment, etc. There is never a reason not to have a staff meeting at least once a week.

I am a surveyor for Medicare facilities and, therefore, I visit many new facilities waiting to become certified by the Centers for Medicare and Medicaid Services. I have a lot of exposure to staff members. I am always surprised when I ask them for a copy of the minutes of their staff meetings, and they tell me, "Oh, we have been so busy getting ready for these inspections, we have not had time for any." Red flag.

Some facilities have staff meetings broken down by departments. I understand the reasoning, but I have never been in favor of them because it is sort of like the parable of the seven blind men examining different parts of an elephant. No one person ever has the complete information of what is happening at the facility in total – only what pertains to his or her area.

• Content.

I've never had a staff meeting without an agenda. An agenda forces the author to sit and think about what changes have or will occur and what needs to be emphasized or discussed. Minutes are nice, but they should be kept to a minimum so you don't bore everyone. Distribute the agenda with the minutes, or post it on the bulletin board so everyone can read it before the meeting to save time.

Whenever possible, have a guest speaker. This is not a 45-minute talk, but rather a quick 10-minute update from a vendor, surgeon, or official who can convey helpful info about products or new procedures.

This meeting is always a great time for a police officer or firefighter to address the group on safety issues, both within the facility and outside.

• New business.

If you do an agenda, and I hope you do, always include time for new business from the attendees. So often I get complaints from staff members who say that they never have an opportunity to share their ideas or let someone know something they think is significant. Having this agenda item always gives staff members a way to get something off their chest or contribute, and it removes that argument.

The bottom line is that almost all staff enjoy staff meetings. I hear complaints only when there are no meetings. I never get complaints about them. It is a great way to share birthdays, births, and other info about staff members to let them know that their work is more than a job.

• Time.

Keep'em short. No more than 20-30 minutes! Brevity is appreciated by everyone. *(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management.)* ■

BCBSA study shows how consumers save with shift to outpatient care

A new study by the Blue Cross Blue Shield Association (BCBSA) demonstrates how much consumers and payers save when medical procedures shift from an inpatient to an outpatient setting.

The study, "How consumers are saving with the shift to outpatient care," examines four common shoppable procedures — hysterectomy, lumbar/spine surgery, angioplasty, and gallbladder removal — from 2010 to 2014. Shoppable procedures include planned procedures performed on a non-emergency basis that allow patients time to search for providers and select where and when they would like to receive surgery.

Patients who used outpatient procedures saved money in 2014:

- $320 on average for lumbar/spine surgeries;
- $483 for hysterectomies;
- $924 for gallbladder removals;
- $1,062 for angioplasties.

Total average costs for consumers, payers, and employers in 2014 also went down when shifting to the outpatient setting:

- $4,505 per hysterectomy;
- $8,475 per lumbar/spine surgey;
- $11,262 per gallbladder removal;
- $17,530 per angioplasty.

"Performing procedures in the outpatient setting will continue to provide valuable cost savings," said **Maureen Sullivan**, chief strategy officer and senior vice president of strategic services for BCBSA. "These savings will be especially important for members when they need surgical care and will help them save money."

This report also measured the varying shifts from inpatient to outpatient settings for each of the four procedures. Hysterectomy underwent the most dramatic shift during the study period, with the proportion of outpatient procedures increasing from 36% to 64%, while the proportion of outpatient lumbar/spine surgery grew from 61% to 82%. Angioplasty's outpatient share increased modestly from 43% to 50%. Laparoscopic gallbladder removal remained essentially flat at 80%, as it already had shifted to mostly outpatient by 2010.

"For appropriate patients, outpatient surgery has been shown to be safe and effective, achieving similar or better outcomes as inpatient procedures, while allowing patients to spend less time in a medical facility, recover faster, and incur less pain," Sullivan said.

Spine surgery and angioplasty have been shown to be safe and are associated with similar or better outcomes in the outpatient setting. Additionally, outpatient hysterectomy was found to have fewer 30-day complications, lower risk of perioperative morbidity, and less risk of wound complications and other medical complications compared to inpatient, even after adjusting for demographic and operative differences between the two groups.

The Health of America Report, which is a collaboration between BCBSA and Blue Health Intelligence, uses a market-leading claims database to uncover key trends. The results of this recent study can be accessed at bit.ly/1oB0Ymx. ■

American Pain Society publishes guideline for post-surgical pain management

Variety of analgesic meds and techniques as well as non-pharmacological interventions supported

The American Pain Society has released a new evidence-based clinical practice guideline, appearing in *The Journal of Pain,* with 32 recommendations to help clinicians achieve optimal pain management following surgery. According to numerous studies, most surgical patients receive inadequate pain relief, which can heighten the risk for prolonged post-surgical pain, mood disorders, and physical impairment.

Roger Chou, MD, lead author and director of the Pacific Northwest Evidence-based Practice Center in Portland, said the key recommendation in the guideline, based on high-quality evidence, is wider use of a variety of analgesic medications and techniques. "The guideline strongly advises use of

multimodal anesthesia that target different mechanisms of actions in the peripheral and central nervous systems," he said. "Randomized trials have shown that multimodal anesthesia involving simultaneous use of combinations of several medications, acting on different pain receptors or administered through different techniques, are associated with superior pain relief and decreased opioid consumption compared with use of a single medication administered by one technique."

Evidence also indicates that non-pharmacological therapies, such as cognitive behavioral therapies and transcutaneous elective nerve stimulation, can be effective adjuncts to pharmacological therapies, Chou added.

Written by a 23-member expert panel representing anesthesia, pain management, surgery, nursing, and other medical specialties, the guideline is based on the panel's review of more than 6,500 scientific abstracts and primary studies. The guideline's 32 recommendations are rated as strong, moderate, or weak based on scientific evidence cited as high, moderate, or low quality. The recommendations are based on the premise that optimal pain management begins in the preoperative period and should be based on assessment of the patient and development of individual care plans for the surgical procedure involved.

Three other recommendations in the guideline are graded strong with high-quality evidence. They are:

- Adults and children can be given acetaminophen and/or non-steroidal anti-inflammatory drugs as part of multimodal analgesia for management of postoperative pain.
- Clinicians should consider surgical site-specific peripheral regional anesthetic techniques with proven efficacy in adults and children for certain procedures.
- Spinal analgesia is appropriate for major thoracic and abdominal procedures, particularly in patients at risk for cardiac and pulmonary complications or prolonged intestinal distress.

The guideline offers 11 other strong recommendations, based on moderate or weak evidence. They include:

- Clinicians should provide patient and family-centered, individually tailored education to patients and caregivers about treatment options for postoperative pain.
- Oral administration of opioids is preferred to intravenous administration for postoperative analgesia.
- Intravenous patient-controlled analgesia can be used when parenteral administration of analgesics is required.
- Clinicians should consider giving preoperative doses of celecoxib (Celebrex) in appropriate adult patients.
- Gabapentin (Neurotin, Gralise, Horizant) and pregabalin (Lyrica) can be considered for multimodal postoperative analgesia. The medications are associated with lower opioid requirements after surgery.
- Surgical facilities should provide clinicians with access to a pain specialist for patients with inadequately controlled postoperative pain.

The guideline was endorsed by the American Society for Regional Anesthesia. It is available at bit.ly/1n0iWhg. ■

Are flexible resident duty hour policies safe for surgery patients?

Allowing residents the flexibility to work longer shifts than allowed in the United States and to take less time off between shifts to provide continuity of patient care is not associated with a greater risk to patients of early serious postoperative complications or death, according to study results involving 117 U.S. general surgery residency programs and 151 hospitals.

This flexibility also was reported by residents to make it less likely they would need to leave during an operation or hand off an active patient care issue to another provider, notes lead study investigator **Karl Bilimoria**, MD, MS, FACS, a faculty scholar at the American College of Surgeons and director of the Surgical Outcomes and Quality Improvement Center at Northwestern University Feinberg School of Medicine in Chicago.

Bilimoria announced the study results at a recent meeting of the American College of Surgeons.

Compared with current resident duty hour requirements, some of which have been in place for 12 years, implementation of less restrictive work hour policies also showed no significant difference in residents' self-reported satisfaction with their overall well-being and quality of their training. The study is

called the Flexibility in Duty Hour Requirements for Surgical Trainees (FIRST) Trial. *(An abstract and access to the full study are available online at http://tinyurl.com/j362869.)* The FIRST Trial is the first national randomized trial of resident duty hour policies, according to the investigators.

"Making duty hour policies more flexible for surgeons-in-training appears to be safe for patients and acceptable to the trainees," Bilimoria says. "This is the first time we have high-level national prospective evidence to inform resident duty hour policies." Until now, there has been little high-quality data to show the effect of increased work hour restrictions on surgical patient care, he says.

Duty hour policies were revised nationally in 2003 and 2011 by the Accreditation Council for Graduate Medical Education, the accrediting and standards-setting body for about 9,500 U.S. medical residency programs, of which 252 are general surgery programs. Of those 252 programs, 117 participated in the FIRST Trial. Made to address concerns about patient safety and residents' well-being, the initial reform limited residents' work hours to 80 per week, capped overnight shift lengths, and mandated minimum time off between shifts. The more recent changes further shortened the shift length for interns and increased residents' time off work after a 24-hour shift.

Although the reforms from the Accreditation Council for Graduate Medical Education aimed to protect patients against trainees' fatigue-related errors, Bilimoria points out that the newest restrictions increased handoffs.

"In surgery, this more frequent turnover may compromise continuity of patient care, potentially jeopardize patient safety, and decrease the quality of resident education by forcing residents to leave at critical times, such as in the middle of an operation or while stabilizing a critically ill patient," he said. ■

High rate of office visits and cumulative costs prior to colonoscopies for colon cancer screening

Kevin R. Riggs, MD, MPH, instructor at the Johns Hopkins University School of Medicine, Baltimore, and colleagues analyzed billing data to determine the proportion of colonoscopies for colon cancer screening and polyp surveillance that were preceded by office visits.

The study appears in the Feb. 2 issue of *The Journal of the American Medical Association*.[1]

Widely accepted guidelines for colon cancer screening and polyp surveillance and the generally low risk of colonoscopy may obviate the need for many of the gastroenterology office visits before colonoscopy. Open-access endoscopy, which allows patients to be referred for endoscopies without a prior gastroenterology office visit, began in the United States in the 1990s, though recent estimates of the prevalence of the practice have been lacking.

The researchers used a database that contains use and expenditure data for individuals with employer-sponsored private health insurance from several hundred U.S. employers and health plans and includes approximately 43 to 55 million beneficiaries each year from all states. The authors included patients age 50 to 64 years with continuous insurance coverage for 12 months prior to an outpatient colonoscopy performed in the gastroenterology setting that included a diagnosis for screening or polyp surveillance, from 2010 through 2013.

Of 842,849 patients who underwent colonoscopy, 247,542 (29%) had a precolonoscopy office visit. Patients with office visits had a higher Charlson Comorbidity Index (CCI; a score based on health conditions of the patient). Of patients with office visits, 66% had a CCI of 0.

Of the office visits, 77% were associated with a diagnosis of screening or preoperative evaluation. Average payment for office visits was $124. Distributed across all patients, precolonoscopy office visits added an average of $36 per colonoscopy.

COMING IN FUTURE MONTHS

- Tips that work to help patients stop smoking
- Be sure you aren't sending patients home too quickly
- Controversy over outpatient mastectomies
- How to make staff more sensitive to obese patients

"Although the precolonoscopy office visits added a modest $36 per colonoscopy in this population, there are an estimated 7 million screening colonoscopies performed in the United States annually, so the cumulative costs are significant," the authors write. "Identifying which patients benefit from a precolonoscopy office visit and targeting those patients could increase the value of colon cancer screening."

REFERENCE

1. Riggs KR, Segal JB, Shin EJ, et al. Prevalence and cost of office visits prior to colonoscopy for colon cancer screening. *JAMA* 2016; 315(5):514-515. ■

Unnecessary blood tests are common prior to low-risk surgery — high variation among facilities

Depending on which facility patients go to for their low-risk surgical procedure, they may be 2.4 times more or less likely to be sent for unnecessary blood tests. This finding is among those from a study conducted by researchers from the Institute of Clinical Evaluative Sciences (ICES) and the Women's College Hospital Institute for Health Systems Solutions and Virtual Care (WIHV), both in Toronto, Ontario, Canada.

Published in *Anesthesiology,* the study reviewed anonymized patient records for nearly 1 million adults who underwent ophthalmologic surgery or other low-risk surgical procedures in 2008-2013. Researchers found that overall, preoperative laboratory tests, including complete blood count (CBC), blood clotting test, or basic metabolic panel, were conducted prior to roughly 30% of these procedures. In addition, they found high variability in rates among the 119 institutions studied.

Previous studies have shown that for patients undergoing low-risk surgery, routine preoperative blood tests do not improve outcomes and can lead to surgical delays and negative impacts on patient care. As part of the Choosing Wisely campaign, multiple Canadian and American specialty societies, including the Canadian and American societies of anesthesiologists, the American Society for Clinical Pathology, and the American and Canadian surgical societies, have published recommendations stating that unless a patient has clinical indications, preoperative lab tests should be avoided prior to low-risk surgeries.

"Unnecessary but frequently used healthcare interventions like preoperative lab tests represent a significant cost to our already overburdened health care system and can even expose patients to harm," says the study's lead author **Sacha Bhatia**, MD, MBA, FRCPC, Women's College Hospital cardiologist, director of WIHV, and a scientist at ICES. "For example, these tests can lead to surgical delays and more follow-up tests and interventions, which can cause a lot of stress and anxiety for patients and their families. This is despite evidence that these tests do not support better patient care or health outcomes."

Among the study's key findings:

• The most common preoperative blood tests were the basic metabolic panel and CBC, each performed before 25% of procedures. Additionally, blood clotting tests were conducted prior to 5% of the procedures.

• Throughout the five-year study period, the rate of preoperative laboratory tests overall decreased from just more than 30% to just less than 28%.

• There was wide institutional variability in the use of these tests. For CBC tests, one institution showed a rate of 0%, whereas another showed a rate of 98%.

• Patients age 85 or older were three times more likely to undergo these tests, compared to 18- to 25-year-olds.

This study is the first to examine preop lab rates for a broad range of low-risk procedures in multiple institutions across a large patient population and district, and over multiple years. "We see wide variability between hospitals in the rates of unnecessary lab tests for patients undergoing low-risk surgical procedures," says Bhatia. To read the abstract, go to bit.ly/1KIgvLS. ■

SDS offers 2-question survey

We would like your input. All *Same-Day Surgery* readers are invited to take a two-question survey about the newsletter at https://www.surveymonkey.com/r/SDSReaders2016. Thank you. ■

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. **A perioperative surgical home pilot for adenoidectomy procedures at Nationwide Children's Hospital decreased overall costs by 53% by doing which of the following?**

   A. Using a protocol
   B. Standardization of medications and anesthetics
   C. A YouTube teaching video
   D. A, B, and C

2. **When a retained item results in intraoperative imaging, who should review the images, according to the Association of periOperative Registered Nurses and The Joint Commission?**

   A. The surgeon
   B. The radiologist
   C. The surgeon and radiologist

3. **What change did Seattle Children's Hospital make that saved $11,500 annually?**

   A. Staff verify only the fields that require verification rather than every piece of information.
   B. Staff perform registration at the bedside.
   C. Staff begin registration as they walk the patient to preop.

4. **What one factor can avoid miscommunication among outpatient surgery staff members, according to Stephen W. Earnhart, MS, CEO at Earnhart & Associates?**

   A. High quality, regular staff meetings
   B. Daily emails
   C. Bulletin boards with an announcements section

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.