SAME-DAY SURGERY

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INSIDE

RELIAS MEDIA

Renovating and Expanding ASC Requires Comprehensive Design Plan

Technology allows staff to virtually experience proposed changes

More surgeries are moving to ambulatory settings, helping create market pressure for surgery centers to expand.

Growth projections for the ambulatory surgery center (ASC) market suggest the value could reach $40 billion by 2020. As of 2017, the proportion of outpatient surgeries performed in an ASC setting has climbed to more than half, up from 32% in 2005. *(Editor's Note: Read more information about ASC growth at: https://bit.ly/2XLTdwP).*

Market forces on the reimbursement side are driving demand for procedures in ASCs, according to **Deb Sheehan**, ACHE, EDAC, LEED, executive director of firm strategies for CannonDesign in Chicago. She says surgeries are moving from inpatient to outpatient, largely due to pressures on cost reduction and improving outcomes. Also, ASCs are expected to be more efficient, but many facilities are decades-old and unable to support the newest surgical technology. All these factors have led some ASCs to expand through new construction or renovations and expansions that will make room for more surgeries.

"The surgery center industry is maturing; some centers are 20-plus years old," says **Michael Patterson**, FACHE, president and CEO of Mississippi Valley Health in Davenport, IA.

Mississippi Valley Health's surgery center has been undergoing an extensive expansion and renovation. "Ours opened in 1996 ... and things have changed," Patterson says. "We used to have one big open bay with curtains pulled between patients."

The new renovation is nearly doubling (to 29) the number of pre-op and post-op rooms. Instead of curtains, there are walls dividing patients. There will be seven operating rooms in the facility — some brand new, others

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updated, reconfigured, moved, or expanded to accommodate future technology such as robotics, Patterson says.

"We're adding new flooring, new paint, and new cabinets to the ORs one at a time," he explains. "There are three brand-new ORs and four updated ORs." The ASC's renovation, which is ongoing, will increase Patterson's facility space by 16,000 square feet for a total of 40,000 square feet, he says.

One of the chief challenges of adding new space and renovating existing ASC space is maintaining the surgery schedule while construction is underway, says **Jamie Oldfather**, manager of administrative services for the Mississippi Valley Health. "You can't shut down your business for several months," she says. "For me, it was important to not only work with contractors, but to work with staff to know exactly which sections we could phase off so we still had patient flow and staff flow without shutting down too many patient rooms."

A key step when planning a surgery center renovation is to compartmentalize construction to adjacent occupied spaces, using HEPA filters. ASC leaders should be cautious with phasing to make sure they do not create any crossover paths with patient movement, supply movement, and staffing accommodation, Sheehan advises.

"It leaves us with little sequences of construction," she explains. "Maybe we get 500 square feet at a time for the change, which is often the case, to maintain critical flows around construction space."

Keeping construction dust and dirt away from workspace is crucial. ASCs must prevent hazards, but doing so will slow the project, Sheehan notes. "Whenever you have to daisy-chain like that, it elongates the time and cost of construction," she says. "Often, there is some temporary move you end up doing, whether it's displacing supplies or putting up contemporary barriers. That drives up both time and costs."

Despite the challenges, ASCs can expand both their business and space simultaneously. Mississippi Valley Health performed 350 more surgeries in 2018 than in 2017 all while construction was underway on the expansion, Patterson says. "There continues to be patient demand, and you've got to pay for the expansion."

Patterson worked with doctors to adjust procedure schedules. "Physicians were very patient and understanding during all of this," Oldfather explains. "As long as you're

EXECUTIVE SUMMARY

As ambulatory surgery centers (ASCs) increase their market share, they often need to expand and renovate to meet new demands. Designing new space and living with adjacent construction can be challenging.

- New technologies, such as robotics, require greater space than older operating rooms.
- Design firms can work with ASC staff and provide 3D blueprints and models to help employees see how workflow will change.
- A key tactic during construction is to phase and compartmentalize areas, allowing for the ASC to continue its daily business while the expansion is underway.

communicating with all of them upfront, it goes smoothly."

Beyond these measures, there are other tips to help ASC leaders successfully plan and implement a facility expansion:

• Experts, technology help with design phase. A firm with experience in healthcare architecture and design assisted with the planning and design phase, Patterson says of his facility's renovation. "We had multiple meetings for months with the architect and our staff — everyone from the front desk, OR nurses, pre-op team, post-op team, and others," he explains. "We looked at what workflows were through the facility, what works well, and what facility issues were creating problems and not optimizing our patient flow."

The renovation and expansion design was staff-driven and occurred over five to six months. Technology helped make the changes real to staff. "We had the privilege to work with a contracting tool where we could see the existing facility in a virtual world," Oldfather says. "We had architectural drawings and a virtual piece where we could put on virtual goggles and get a feel for the flow of how things would work."

The multidimensional aspect of design made it possible for people to see how workflow would work in the renovated space. "Some people can't look at a blueprint and know what they're looking at," Oldfather says. "They physically have to see it. The virtual tool was a great advantage for us."

The ASC also used a cardboard model of the renovated recovery room, pre-op room, and prep room, she notes. There were beds, stretchers, and chairs in the model recovery room for the staff to see how the furniture would fit into the workflow. "That helped them to see where they wanted the monitor hung and where the oxygen would be located," Oldfather says. "It was a morale booster to see the model. And it was a good thing we did it because we made a couple of changes from what we thought would work."

Staff learned that the space would be tighter than imagined. "We wouldn't have recognized that on the drawing," Oldfather notes.

• Make changes to maintain infection control and sterile processing. "We completely relocated sterile processing," Oldfather says. "We relocated three operating rooms and recovery. We moved the post-op department and pre-op department."

The new sterile processing area was moved to the existing pre-op department, and there would be a sterile corridor for the operating room. This put the new sterile processing room in a more central location.

"It's difficult to put sterile processing on a different floor," Patterson says. "We were adamant about it staying on the same level as the operating room. Everything is in a sterile corridor so no one is going up and down stairs with sterile equipment."

Construction activity and dust create some issues for ASCs as they continue to work. Additional infection control measures must be followed.

"If you are working in the OR or in the sterile processing department and you're cutting and creating dust, there is another set of protocols and barriers to follow," Oldfather says. "Some require plastic tape barriers and some require temporary walls and HEPA filters and a series of requirements that come with the initial assessment."

• Plan everything in phases. "The project was phased; Jamie worked with the general contractor to put together a plan," Patterson recalls. "If you can shut down the place and rebuild it, things can be done much faster. But no one can afford it."

For most ASCs, the renovation and expansion must occur in phases. "It takes longer because we're growing our business while doing a large construction project," Patterson says. "We don't want to sacrifice patient satisfaction, quality, and employee satisfaction. The doctors still need to give care."

The best way to meet all these objectives is to plan construction in various phases that fit in well with operational goals.

• Anticipate staff and space disruptors. "The biggest lesson we learned was to not underestimate the power of change to your team,"

ADDITIONAL CONSIDERATIONS

Mark Mayo, CASC, MS, an ASC administrator in Arlington Heights, IL, offers these tips to remember when renovating a surgical facility:

- Plan so as to avoid contamination of working areas to reduce chances of potential patient infection.
- Ensure areas under construction are no longer linked to the normal ventilation system.
- Fire exit pathways may change, so staff need to know how to exit the building in case of emergency.
- Security of staff, patient records, medications, and supplies.

Patterson says. "We have a very tight-knit clinical team, but when you add square footage, you change the working plan. You cannot underestimate how that could potentially impact operations."

This aspect of construction was a surprise.

"Everyone was involved in the design and all wanted the change. When the new facility opened, the question was, *'What do we do now?'*" Patterson says. "Do not underestimate in your planning the amount of change required; nurses get set in how they care for patients, and now you are asking them to change all of that." The same is true for doctors and other staff, he adds.

The ASC helped staff deal with changes through frequent huddles and fun activities. "When we opened new phases, we had scavenger hunts with prizes to ensure [staff] knew where all emergency equipment was," Patterson says. "They got a tour and could ask questions. We did a lot of that before we opened."

Once the renovated ASC opens, it could take a couple of weeks for employees to develop new workflow habits.

"You can bring online one new area and then shift to another area and bring another one online," Patterson explains. "Each time you bring something online, it's a new dynamic that needs to be dealt with."

Leading staff through the change was a leadership team project. "The entire team was deeply involved in that," he says. ■

5 Key Considerations During Renovation

Focus on efficiency, optimization of resources, and sustainability

When ASCs begin to plan an expansion or major renovation, leaders should consider five key areas of focus for the optimal design and operational efficiency.

The goal is to create a space that works well for staff workflow, patient aesthetics, regulatory compliance, and clinical outcomes. "You need to know how to support the patient population, surgeon, family members, and support people in attendance to make sure there is safe transport to and from the surgery center's pre-op and post-procedure," says **Deb Sheehan**, ACHE, EDAC, LEED, executive director of firm strategies for CannonDesign.

• Optimize efficiency and effectiveness. "The design should optimize movement and flow in the OR and ASC proper," Sheehan says. "With renovations, this is a primary concern, so we start with simulation software and model in a virtual build first."

This model is tested against the supply chain, staff movements, patient intake, recovery, and outbound activities.

"It's a nice way to understand behavior and situational awareness," she says.

The model works well with both new buildings and in cases of repurposed space and incremental expansion. "We're looking at the sweet spot of turn time for throughput, calculating from the volume of services how the movement is," Sheehan adds.

• Optimize clinical outcomes for health and safety. New OR space should be designed to provide access to all necessary information, including an integrated digital display, Sheehan says.

CME/CE OBJECTIVES

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

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

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"We've all seen and heard about some of the errors that occurred with wrong site of surgery," she says. "You need confirmation and validation. In the pre-op condition, the ASC needs to make sure there's a transparency of information."

Design assists with this because it shows where the staff will have access to information on visualization screens in the pre-op phase, in flight boards, and in monitors. "When we get into the OR, it really becomes critical," Sheehan says.

Design also can contribute to optimizing clinical outcomes through designing space to effectively handle congestion and to provide optimal visibility to monitors throughout the surgery center. "It's all about the placement and proximity to make sure there are good visuals to that monitor at all times," Sheehan notes.

• Optimize a positive experience for all users. "Too often, I see designs that are myopically centered around the surgeon or myopically centered around the patient," Sheehan laments. "How do you support the patient population, surgeon, family members, and support people in attendance to make sure there is safe transport to and from the ASC, pre- and-post-procedure?"

Optimal design also includes space for staff respite time. "There often is not enough space for staff to have areas where they can step away during the day," Sheehan says. "While we maximize time in the OR, there needs to be accommodations for lockers and food for clinicians." For patients' family members, there might be suitable accommodations in waiting areas and interactive space in pre-op and post-op rooms. With attention to renovation design, an ASC can create comfortable space in post-op areas so family members can stay with patients, helping them with dressing and ambulation.

With the help of ASC staff, designers can create flexible space and add features, such as natural light where desired or add dimmers to patient room lighting.

• Optimize sustainable practices. ASC owners should remember that as daunting as capital investment seems, this expense is less than operating costs, Sheehan says. Architectural designers cannot control staffing costs, but the design plan can help ASC leaders control energy consumption and minimize surfaces that harbor airborne contamination.

To optimize sustainability, the design plan should outline how to reduce the draw of energy consumption in the buildings, ensuring good stewardship. Maximizing daylight and installing lighting time sensors are two ways to help control energy costs.

"Even though 70% of the operating cost is payroll, we do have an influence on energy draw on systems and can focus efforts on that," Sheehan says. This includes addressing electrical systems, water usage, plumbing and mechanical, ventilation, and building maintenance.

To reduce surface contamination, leaders should consider the type of finish selected for counters, which can affect how easy it is to clean spaces, Sheehan adds.

• Optimize the ability to change over time. Design the space to be adaptable to different case mixes. A surgery center's case mix can evolve and transform. "I'm not designing a room that only can be used for orthopedics, for example," Sheehan says. "You design the layout of the room so that you can schedule universal OR cases in any room."

Look at the size and stature of each room, including flow and layout of equipment. "This is something we do based on planning criteria," Sheehan says. "Don't reduce the size of the room to a specific need because the anticipated case mix can change over time. In a year or five years from now, [case mix changes] may put a different demand on the use of that room than what was anticipated at the time of the opening."

Sizing space for one type of equipment or case is limiting.

"The evolution of case mix moving into the ASC and the innovation happening is driving far more complicated cases into the ASC environment than we ever saw over the past five years. We need to anticipate future changes," Sheehan explains. ■

Want to Engage Physicians More Effectively? Know What They Want

The hiring phase is a pivotal time for leaders to learn about who may come to work for them

When ASC leaders wish to hire or contract with new physicians, there are two issues that arise. First, ASCs and other healthcare settings are facing a nationwide physician shortage that crosses all specialties. Second, there are generational differences in what will motivate a physician to work with an ASC.

"There are a lot of different generations of physicians out there. They all view things from a different perspective," says **Nick Hernandez**, MBA, FACHE, founder and CEO of ABISA, an independent healthcare consultancy in Valrico, FL. "Baby boomers view things differently from Generation X, including in how they view life-work balance."

Another issue concerns team building. "Physicians are not, despite what academic institutions like to claim, taught how to work as members of a team," Hernandez notes. "That's a big issue. Think about doctors going through medical school programs, residency, anatomy, and it's all about who has the best answers."

Doctors learn to compete, not team up. From an ASC administrator's perspective, it is important to learn how to engage, motivate, and retain physicians with a variety of experiences, interests, and priorities. "For example — and this is not just an age thing, it's a generational thing — the older physicians tend to not worry about putting in long hours and doing what it takes to get the job done," Hernandez says. He notes that younger doctors might finish procedures at 4 p.m. and call it a day. Further, he observes younger medical professionals may not work on administrative tasks late into the evening.

One way to view this is that the work ethic varies between generations. Another viewpoint is that older physicians are less efficient with their documentation and administrative work, which means they have to work longer to complete their tasks.

"Younger physicians are actually wickedly productive," Hernandez says. "To stereotype older doctors, they will dictate notes with an old cassette player if you allow them to, and they'll wait and do it at night from their house."

Younger doctors are more technology savvy, which means working with electronic health records is not so problematic for them because they grew up with that kind of technology, Hernandez offers. From an administrator's perspective, younger, more efficient physicians could help save costs.

"If administrators are smart about it, they can run their operations much more efficiently with younger doctors because those are the type of doctors that get in there, get their work done, and go home," Hernandez says.

Also, Hernandez observes that younger physicians tend to depend less on staff.

"Recognizing that from an operational standpoint, the younger generation might be more productive and efficient means that you can tailor your operations and operational expenses accordingly," he says. "And you're likely to have a more profitable surgery center as a result of it."

Beyond generational factors, Hernandez offers other considerations when trying to boost physician engagement:

• Know the difference between how a physician thinks and how an administrator thinks.

"Generally speaking, doctors look at things on a more case-by-case basis," Hernandez says. "They look at one patient at a time, and they're

EXECUTIVE SUMMARY

Surgery centers need to consider generational differences when they develop ways to recruit and retain new physicians.

- For example, baby boomers and Generation X have view the work-life balance differently.
- Younger physicians are better with technology and more efficient in their documentation, which makes them less likely than baby boomer physicians to work late into the evening.
- When hiring new physicians, it is important to learn what motivates a particular physician. Is it the opportunity to become a partner in the surgery center or better hours to allow more leisure and family time?

dealing with this patient, policies, and procedures."

Administrators are the polar opposite, Hernandez notes. "They're not allowed to look at things case by case, patient by patient," he explains. "They have to look at it from a system perspective and the point of interest of all patients their center sees."

Leaders need to plan for the long horizon, looking at what will be beneficial in five years. They are focused on the financial picture, overarching policies, and patient satisfaction results, Hernandez says. Also, physicians are experts of their own specialty, while administrators have to care about all specialties. Studying operations from the center's perspective means a focus on productivity and weighing the considerations of all specialties, not just a focus on one specialty.

"If you understand the perspective of the other person, it's much easier to work with them on projects, policies and procedures, and operating expenses," Hernandez offers. "You understand how the other person looks at things."

When there is a clash between doctors and administrators, bring everyone together to talk. "If there is a clash, it has to do with some kind of fundamental negotiation skills, knowing you won't get everything you need on both sides," Hernandez says.

Administrators must remember that physicians have the say in clinical care. Their role is governance and following policies and procedures.

"You use governance documents and negotiation skills to deal with a clash," Hernandez says. "My hope is that if people on both sides can understand the perspective of where everyone is coming from, then we can minimize the number of clashes and minimize the intensity of the clash."

• Improve physician recruitment process.

"Recruitment is important, whether or not an operator employs physicians," Hernandez says. "I would argue it's applicable no matter how you're structured."

With a shortage of physicians, recruitment is crucial. Still, the issue is more complicated than just offering more money.

"You need to know what kind of doctors you are hiring," Hernandez says. "For some physicians, the pay is important; for others, it's about how much time off they'll have."

When ASCs are involved in physician recruitment, Hernandez says they need to know each candidate's clinical skills.

"At the end of the day, after evaluating clinical skills, this is a business decision. Who is better apt at that than a business person?"

• When interviewing physicians, address the partnership question.

The physician partnership could involve ownership, if that is an option, Hernandez says. Whatever the ASC's arrangements are with doctors, it is important to articulate those expectations up front.

"I recommend that as part of the interview process so the doctor understands where this is going," Hernandez offers. "This is more important now than before."

The prospect of a partnership track could be a point of contention if it is not addressed in the beginning.

"Sometimes, the partnership track could be five years, 10 years, or a longer period of time for a new physician to become a full partner," he says. "But if the new recruit expects to be a partner in two to three years, that's a problem."

ASC leadership can prevent down-the-road issues by addressing exactly what they are looking for and how it will work out in the beginning and later. Failing to make intentions clear could result in a disgruntled a physician who decides to leave the practice soon after the ASC has invested considerable time and money in hiring the new employee, Hernandez warns.

"This happens all the time," he laments. "You have to start all over with recruiting a new physician. It's your fault because you didn't properly screen the type of candidate you wanted and didn't tell him how it would work over time with all of the details."

Along with the partner track discussion, voting rights could be an issue. Succession planning is an especially sticky point in physician retention, one Hernandez has seen cause many problems.

For example, an older physician will tell a newly hired physician that he plans to retire, but then the older physician discovers that the new hire helps lighten the workload. This leads the older physician to think he may continue working for another five or 10 years.

The new physician discovers that the succession is not going to happen as quickly as expected and decides to leave. If older physicians believe they will want to step aside and allow a new physician to take over, they should put the plans in writing so everyone knows the plan, agrees to all the stipulations, and sticks with it, Hernandez advises.

"They need a simple, nonbinding letter of intent for succession planning," he says, noting that administrators and/or business professionals should be involved in these agreements. "It also helps if they have a partnership structure." ■

Surgery Centers Could Improve Quality Assurance Programs With Incentives

Staff-led projects result in better engagement, more passion, and solid outcomes

ASCs that are accredited or that accept Medicare patients need consistent quality assurance/performance improvement (QAPI) programs to ensure all policies and processes align with existing standards and regulations.

The question is: How do centers pull this off while convincing staff to buy in? One answer is to engage every employee in QA by providing financial and social incentives.

While many facilities use QA committees and managers who work on QAPI projects, it is even more effective to involve all employees in these initiatives, according to **Tina J. DiMarino**, MSN, RN, CNOR, CASC, a board member with the Maryland Ambulatory Surgery Association. "What we've done over the years is have every staff member look at their area and think about what they could do to improve the area," says DiMarino, administrator at Mid-Atlantic Surgery Pavilion in Aberdeen, MD.

The result has been original and innovative projects that empower staff. The projects also have impressed accreditation surveyors, DiMarino notes. "When they survey centers, [surveyors] see cookie-cutter studies and on-time start studies that are great if you can affect change with that," she says. But surveyors prefer seeing QAPI projects that make lasting changes, such as correcting processes for maintaining equipment. "Surveyors like seeing the issues you're having at your own center," DiMarino explains. "They love that you did facility review and matched your policies to your processes."

At DiMarino's center, all nurses, techs, front-end, and other staff meet every other year to discuss successful previous QAPI projects and brainstorm new initiatives. The day includes lunch and is meant to be a fun, morale-building activity. By celebrating previous QAPI projects, DiMarino says employees are inspired to work on new projects.

DiMarino encourages employees to choose something they are passionate about that they could improve. If someone says the instruments are not lasting as long as they should, then the employee could start a review of instrument handling and use, DiMarino suggests. One employee led a QA project on recycling, studying how much it would cost the facility and how it would work.

"She looked at everything we had thrown away prior to patient use and found we were filling dumpsters weekly with trash," DiMarino recalls. "We had a company picking up our trash once or twice a week. But after the recycling program launched, the trash pick-ups dropped to once every two weeks."

Not only did the ASC reduce its trash output, this recycling initiative saved the facility money.

Once the group selects some feasible projects, DiMarino says a QA committee, which meets quarterly, considers the ideas. The QA committee and ASC leaders make certain the projects might be feasible and do not affect patient safety or privacy. "We say to the committee, *'Here are the studies we have come up with, here are the ones we're working on for this quarter, and here's the data we are collecting,'"* DiMarino says.

Once the projects begin, DiMarino gives staff sample notification reports, encouraging employees to use these to make the program more robust through documentation. A few items listed on a QA notification report include source of data, assessment of data, changes implemented, and follow-up.

Participants need at least two quarters to collect data and additional time to analyze, assess, and implement corrective actions. "I check in with them monthly during

EXECUTIVE SUMMARY

Quality assurance/performance improvement (QAPI) programs ensure all internal policies and processes mirror appropriate standards and regulations.

- Surgery centers that ask staff to participate in QAPI programs might find more original projects and improve employee morale.
- Recognize employee-led QAPI projects at special staff meetings and provide rewards to winning projects.
- Employees maintain enthusiasm when they feel they are making a positive difference in their workplace.

the project, asking, *'How is it going? Do you need any help?'"* she says. "The hardest part is some employees have a difficult time determining what the performance goal is and ensuring it is quantitative in nature."

When the first results emerge, the QA committee views the data and either gives the go ahead to the project or stops it, often because the early results met the ASC's goals and no further action was required, DiMarino explains. The ASC's doctors receive a full report of all quality improvement findings and any changes that are implemented.

The staff has been very motivated by the QAPI process, and morale is at its peak, DiMarino reports.

"It's a team-building experience that empowers everyone," she explains. "It's not just the nursing staff, but the techs that clean instruments, the receptionist — everyone is involved and treated equally with regard to being a member of the team." At each QAPI meeting, employees listen to each person describe his or her study and findings before voting on the ones they like best. DiMarino hands out gift card awards to the first-, second-, and third-place winners.

Employees are involved in a process that makes them feel as though they are making a difference, DiMarino says.

"Everyone is extremely important, and we strive to ensure they feel that way, as well," she says. "They're making changes and improvements that were their idea." ■

Study: Total Knee Replacement Surgery Patients Who Live Far From Hospital Experience Better Outcomes

Surprising results led one researcher to lobby for practice changes at his facility

Researchers might not always uncover what they expected; however, what they do discover can be even more interesting. This is what happened when investigators studied patients who underwent total knee and hip surgeries at a facility far away from their homes vs. those who underwent such surgeries at a facility close to where they live.

Investigators conducted a study about the relationship between distance away from a medical facility and total knee replacement surgery postoperative events.[1] Researchers used data from 2,892 surgeries. They divided patients into groups based on distance between the medical facility and home: short (less than 10 km), medium (10-40 km), and far (more than 40 km).

The results of their investigation revealed that patients who lived closer to a hospital were seven times more likely than patients who lived far from a hospital to show up in an ED for postoperative pain and swelling. Investigators concluded that total knee arthroplasty was an independent risk factor for more ED visits, a higher rate of hospital readmissions, and less communication with the surgeon after the procedure.

"Originally, we thought those who lived farther away would have less access to healthcare and would end up with more readmissions and problems," says **Bradford Waddell**, MD, assistant attending at the Hospital for Special Surgery (HSS) in New York City who worked on this

EXECUTIVE SUMMARY

Investigators found that total knee surgery patients experience better outcomes when they live farther away from a hospital.

- Researchers observed that patients who lived closer to a hospital were seven times more likely to show up at an ED for treatment after surgery vs. patients who lived far from a hospital.
- These findings suggest that patients are less likely to visit an ED when they experience symptoms of pain and swelling if the clinic or physician's office has closely communicated with patients after surgery.
- Technology can make telecommunication even easier for patients. For instance, doctors could review patients' photos of their surgical site and confirm that it is healing as expected.

research. Patients who lived far away from hospitals were more likely to communicate with their physicians through phone, email, and patient portal use after surgery compared to patients who lived closer.

"What we inferred is those who lived farther away had a lot of pain and swelling and would call to ask, *'Am I OK?'"* Waddell explains. "Those who didn't live far away would just pop into the emergency room."

When patients experience pain and swelling after surgery, they could visit the clinic instead of heading to the ED, or they could call someone to ask about their symptoms. Heading to the ED should be a last resort, intended only when symptoms warrant such a visit. The study's data trend showed a correlation between fewer ED visits and more patient communication with physicians.

Some healthcare institutions treat patients who are covered by alternative reimbursement plans, such as bundled payments, Waddell explains. Bundled payment plans negotiate one payment to cover all of a surgery patient's needs. These agreements require a surgery center to handle (for one lump sum payment) all of a patient's care. The one payment covers everything from the initial visit with the physician through 90 days of care after surgery, including all pre-op visits, the surgical procedure, post-op visits, physical therapy, and any hospitalizations or ED visits.

This means the surgery center will lose money if patients experience poor outcomes and become infected or exhibit symptoms that send them to the hospital. This type of arrangement gives surgery centers a financial incentive to call patients after surgery and to take extra steps to help them prevent postsurgery problems, Waddell adds. From an ASC perspective, these results suggest that follow-up phone calls to patients can help. Surgery centers also might ensure patients understand what type of pain and swelling to expect after surgery so they will not be alarmed unnecessarily when these symptoms appear. The clinic could meet with patients who are worried about symptoms and give them another prescription if they need additional help.

BASED ON THE STUDY'S FINDINGS, ASC LEADERS ALSO MIGHT CONSIDER ENHANCING PATIENT EDUCATION.

Many ASCs already provide follow-up calls and care. Still, based on the study's findings, ASC leaders also might consider enhancing patient education.

"We think we give patients appropriate expectations. But despite rigorous pre-educational classes and joint camp, we had patients hopping into the ER," Waddell says.

Waddell says the results of this study have provided HSS a template for correcting such issues.

"It's changed the way we educate pre-operatively," he says. "We have a nurse navigator now who says, *'Expect to have a lot of pain and swelling. Instead of showing up at the ER where they'll tell you everything is OK, we'd prefer you to give our office a call.'"*

Nurse navigators call within three days, asking patients about their status. Nurses reassure patients and ask them to come into the clinic if they need help.

"We call patients more often, and we keep in better contact with them," Waddell says.

Some patients use electronic medical record portals that allow them to send the clinic a photo of their wound. "I look at three or more wounds a week, on average, through the online patient portal," Waddell says. "Almost always, it's totally normal."

Phone and electronic follow-ups have been more common among ambulatory providers than with hospitals, but that might change, Waddell notes.

"While we're a huge hospital system that doesn't utilize outpatient surgery, we're now using some tricks they use in outpatient surgery," he says.

For ASCs, total knee surgery is a hot topic as it was removed from the list of inpatient of procedures recently, Waddell notes.

"Our study, hopefully, will set up better criteria for knowing who might need that extra motivation to call and be educated or to come into the clinic, as opposed to showing up in the emergency room," Waddell says. ■

REFERENCE

1. Kolodychuk NL, Wong M, Adams T, et al. Travel distance impacts patient access to care following total knee arthroplasty. Abstract presented at the American Academy of Orthopaedic Surgeons (AAOS) Annual Meeting, March 12-16, 2019, Las Vegas. Abstract:P0143.

Use These Tips to Improve Your Negotiation Skills

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Rarely do I ever pay full asking price for any goods or services. This is just a part of how I handle business. Someone might say it is impossible to negotiate the price of everyday items such as food or fuel. But you can! I guarantee that what you are thinking of buying at Whole Foods can be found at a much lower cost at another store or online. The price of gasoline is different at almost every station; you actually are negotiating the price by making an effort to find a station that offers a cheaper option.

Any vendor with which you conduct business, including companies like mine, negotiate the cost of their services. The people who pay full price essentially fund the difference between what you pay and what others negotiate for a lower price. That is business. There is no successful business anywhere that does not understand the concept of paying less for what they offer or purchase.

However, there is one caveat: Before you begin the process of negotiating, you have to be prepared to walk away if you cannot get what you want. Even so, that vendor often will return after a few days when they realize you are serious and must be dealt with and make you another offer. They may not bring you doughnuts, but they will respect you. Remember that vendor representatives have to go to their bosses and explain why they lost you as a client, which never is a good career builder. Saving face is so important in the art of negotiation for many involved. It is important to understand that in some cultures, one must receive something in return for giving something up. If you are a hardcore negotiator who does not care, you run the risk of offending someone with whom you might want or need to have a long-term relationship. Give them something in return.

There are other ways to negotiate, including:

- Ask to not pay shipping and handling on merchandise;
- Suggest a change of the terms (i.e., putting more money down for a lower price or extending the length of a contract for services for a lower price — but, realistically, only if you will use it);
- Listen closely what they are offering. Remember: Selling you something probably is more important to the vendor than you buying it, which can lead to bargains.

Do not be afraid to dangle a carrot with a vendor for a better price. Let them know that if this item, service, purchase, works out, you might be interested in doing more business with them. Surprisingly, some vendors have given me a better price on things in return for "liking" them on Facebook. This is odd, but it is true more often than you would think.

Avoid putting yourself in a corner when you negotiate (i.e., do not threaten an ultimatum). That irritation can remove any chance of finding common ground with vendors. If that happens, you both lose. Vendors in the healthcare industry talk to each other. You do not want your facility to earn the reputation as "easy" or "accepting any offer." Also, be careful of the quick *"Wow, you are really a great negotiator"* tactic and a mediocre decrease in price that comes too easy. It could be that the price was inflated to begin with and you think you are getting a really good deal. In reality, you may be paying the normal price.

Make them sweat or ask them need to secure approval from a higher up. That is when you know you are doing well. Remember that most vendors work on commission. Most commissions are paid at the end of a quarter or the end of the year. Typically, negotiating just before the end of one of those creates more room for flexibility.

Recently, I sat with a group to come up with a situation in which negotiating or finding another path to a better deal did not work. Quite honestly, we could not think of a single good or service that could not be obtained at a different price, location, term, or vendor. Let us know if you have negotiated a better price and how it worked out. ■

(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. Email: searnhart@earnhart.com. Web: www.earnhart.com. Instagram: Earnhart.associates.)

SAME-DAY SURGERY

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **An ambulatory surgery center's expansion should include:**

   a. optimization of the operating room space at a 5:1 ratio of presurgical space.
   b. optimization of the ability to change over time through adaptable space design.
   c. optimization of the waiting room to provide surgical update communication boards.
   d. optimization of the patient experience through presurgical and postsurgical rooms with windows and sofas.

2. **When physicians conduct succession planning, which of the following is a common mistake?**

   a. New doctors say they will take over the surgical practice but change their minds and take jobs with local hospitals instead.
   b. Administrators disagree with the succession plan and torpedo it soon after the new doctor is hired.
   c. The older physician verbally tells the new doctor that he will be stepping down soon and allow the new physician to take over, but then changes his mind and hangs on for years longer.
   d. The surgery center's board votes out the older doctor before the succession has been implemented fully.

3. **According to recent research, certain patients who underwent total knee surgery were more likely to end up visiting the ED after surgery depending on which variable?**

   a. Patients who underwent physical therapy visits three times a week for a month were less likely to end up in the ED.
   b. Patients who were marathon runners for a decade prior to surgery were less likely to end up in the ED.
   c. Patients who lived farther from the hospital were less likely to end up in the ED.
   d. Patients who lived closer to the hospital were less likely to end up in the ED.