# SAME-DAY SURGERY

THE TRUSTED SOURCE FOR HOSPITALS, SURGERY CENTERS, AND OFFICES

JANUARY 2020 Vol. 44, No. 1; p. 1-12


## INSIDE




RELIAS MEDIA


# The Digital Revolution: Telehealth Might Reshape Same-Day Surgical Practice

Technological solutions, including those that make telemedicine easier than ever before, have been transforming the healthcare system, including ambulatory surgery.

"Healthcare, over the last 10 years, has undergone a revolution where our paper charting and administrative processes at the hospital level have been digitized and moved into the computer age," observes **Jonah Stulberg**, MD, PhD, MPH, FACS, clinical director of innovation for Northwestern Feinberg School of Medicine and general surgeon at Northwestern Memorial Hospital in Chicago. "We're on the cusp of a digital revolution that will finally help us realize some of the promise that was built up in the transition to electronic medical records [EMRs]."

"It's a remarkable revolution in technology in the way we do our day-to-day work," says **Heather Evans**, MD, MS, FACS, vice chair, clinical research and applied informatics, and professor of surgery at the Medical University of South Carolina.

"The access we have now to electronic medical records and to apps on our phones is remarkable. We have the ability to record biometric data so easily and submit that data through some of the major EMRs."

The question everyone is asking is how can the current digital tools help quality improvement, Stulberg says. "How do we provide better quality care to our patients?"

Digitization occurred first in the private sector, and hospitals were delayed in making the change to EMRs, he notes.

"As a clinician, you often hear frustration from clinical providers about how the promise of that digitization and the moving to an electronic medical record was supposed to solve all these problems, but instead it added to the burden," Stulberg says.

EMRs have benefited administrative processing, but have not necessarily benefited clinical care. There were some early benefits, such as faster access to lab results. But that is changing as new




**Financial Disclosure:** Consulting Editor **Mark Mayo**, CASC, MS, reports he is a consultant for ASD Management. Nurse Planner **Kay Ball**, PhD, RN, CNOR, CMLSO, FAAN, reports she is a consultant for Ethicon USA and Mobile Instrument Service and Repair. Editor **Jonathan Springston**, Editor **Jill Drachenberg**, Author **Melinda Young**, Author **Stephen W. Earnhart**, RN, CRNA, MA, Physician Editor **Steven A. Gunderson**, DO, FACA, DABA, CASC, RN, CRNA, MA, Editorial Group Manager **Leslie Coplin**, and Accreditations Manager **Amy M. Johnson**, MSN, RN, CPN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

SAME-DAY SURGERY

***Same-Day Surgery*** **(ISSN 0190-5066) is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Same-Day Surgery*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**

**GST Registration Number: R128870672.**

**SUBSCRIBER INFORMATION**
Customer Service: (800) 688-2421
customerservice@reliasmedia.com
ReliasMedia.com

**ACCREDITATION**
Relias LLC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Relias LLC designates this enduring material for a maximum of 1.75 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.75] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 36 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.

**AUTHOR**: Melinda Young
**EDITOR:** Jonathan Springston
**EDITOR**: Jill Drachenberg
**EDITORIAL GROUP MANAGER**: Leslie Coplin
**ACCREDITATIONS MANAGER:** Amy M. Johnson, MSN, RN, CPN



products and technology are allowing clinicians to monitor remotely and diagnose sooner, Stulberg observes.

"One thing I do in my role in innovation is try to find digital and electronic and forward-leaning solutions that make a clinician's job easier," he says. "We should help a clinician work more seamlessly with digital products to deliver higher-quality care."

Surgeons and others are developing new apps that help physicians with their day-to-day workflow, improving their access to necessary information and providing quick educational tips.

One of the chief problems with new technology and apps is determining which products are useful and which are not.

Evans is the chair of the American College of Surgeons' (ACS) health information technology committee, which is working on a toolkit resource surgeons can use to improve their practice.

ACS is not looking at the communication apps that involve monitoring and educating patients, only those designed for surgeons' use.

"We are a group of surgeons who are all interested in not just health information technology in general but in how we can apply it to our daily practice as surgeons," Evans explains. "We're trying to develop some guidance for surgeons to be able to identify apps that are useful and are vetted by a group that understands how these apps work and how they might apply in surgical practice."

The vetting is underway, and the toolkit is expected to be available later this year, she adds. *(See story about surgeon apps, page 4.)*

There are multiple patient apps that track patients' exercise, diet, medication use, vital signs, and heart rates, Stulberg says.

"If a person has an abnormal heartbeat at home, the app automatically notifies the clinician, providing data to the clinical center," he says. "Then, the center reaches out to the patient." This technology eases patient care concerns related to sending patients home sooner than they were in previous decades.

Telehealth also is improving, becoming easier and more effective as the technology advances. It remains a cost-effective way to make presurgery visits and post-surgery visits easier for patients, says **Ryan Spaulding**, PhD, vice chancellor, Institute for Community Engagement, and acting director, Center for Telemedicine and Telehealth at the University of Kansas Medical Center.

"It saves travel distance and time for patients," Spaulding says. "It also creates a fairly routine visit by technology." *(See story on presurgery certification visits via telehealth, page*

## EXECUTIVE SUMMARY

Technology solutions are revolutionizing surgery, making it easier to communicate with patients and monitor their recovery.

- The benefits promised by the introduction of electronic medical records is finally beginning to be realized.
- Apps can track patients' vital signs, exercise, diet, and pain levels.
- There also are apps that provide ready information to surgeons, making their practice more efficient.

*4.)* Telemedicine is an interesting and exciting area of medicine right now, Evans offers.

"A lot of us are focusing on these remote patient monitoring platforms because it's a way to deliver care that is personalized to the patient's situation," she adds.

"For insurance purposes, surgery has to be precertified, and it requires the patient to come into the clinic for a routine visit," Spaulding says. "Those can be done by telemedicine."

One of the biggest improvements in telemedicine involves video calls. These can occur by asking patients to visit a local provider, who sets up a teleconference with the surgery center. Or, these calls can be handled via video conferencing to patients' cellphones, which brings telehealth to their homes.

Telehealth via cellphones still faces funding issues, but once payers start to recognize these in-home, telemedicine visits, the potential benefit to patients is great.

"We want to get into the patient's home for these kinds of consults," Spaulding says. "The way it works now, patients still have to go somewhere else, like a local clinic or hospital, to have a facilitated visit."

These telemedicine visits may become routine if physicians could talk to patients in their homes and cut out the middle facilitator, he adds.

"That's where we would like to go and where it would make the most sense," Spaulding explains. "But right now, reimbursement doesn't cover that, and we want to make sure the fidelity of the visit is high, the video is good, the lighting is good."

Spaulding predicts technological advances in cellphones will drive change in telemedicine: "Eventually, you will see a lot more video consults occur in patients' homes because cellphones and smart devices will make it possible," he offers. "Insurance companies are not there yet, but we're working on it."

Digital tools are available to improve quality improvement and clinical effectiveness in patient care, Stulberg says.

"We are starting to use remote monitoring or digital activity to actually get closer to realization of quality improvement," he reports. "Clinical effectiveness is better than before these technological solutions were available."

For example, one pilot project is about improving opioid prescribing. An app called GetWell Loop prompts patients to answer questions about their medication use after surgery. There is a two-way, automated communication, Stulberg explains. Starting on the first day after surgery, the app's care pathway asks patients how many opioid pills and other medications they have taken. On day five after surgery, the app asks patients about whether they have a fever and drainage.

These data provide clinical feedback that helps physicians make prescribing decisions.

"The big concern is the public. Those who have not undergone surgery cannot understand why surgeons are still prescribing opioids," Stulberg says. "Surgeons say, 'We just operated, and we see the consequences of pain and cutting, and we need to provide pain relief.' But how do you know that patient is getting adequate pain relief and not just going home and suffering?"

The solution was digital monitoring. An app can ask about pain and activity levels, and whether they are getting out of bed, sitting, or walking. It provides this information, along with the opioid use data, to doctors.

Using this information, Stulberg decided to stop giving opioids to patients undergoing robotic inguinal hernia repair, which requires making only a small incision.

"I had data from multiple patients in a row, showing they had never used their opioid medication," Stulberg reports. "Because I knew they weren't using the opioid, I knew I didn't need to provide it to them anymore."

Instead of opioids, robotic inguinal hernia patients take scheduled Tylenol or ibuprofen, and they receive instructions to use ice 20 minutes at a time for the first 48 hours. They also are instructed to move every hour, he says.

"We found stiffness causes a lot of pain," Stulberg says. "For those patients, that was adequate."

The app can be used for additional purposes and surgeries. It also can be set to check on patients over various periods.

Some surgeries might require two weeks follow-up; others would benefit from 60 days.

"The digital solution gives real-time digital feedback that otherwise would be very expensive," Stulberg says. "We are in the process of rolling it out to all surgeries. We will use the data to investigate and see what is helpful for clinicians." ■

## COMING IN FUTURE MONTHS

- Transitional pain nurses can help with post-surgical care
- Check out these billing best practices
- Infection prevention is more than hand hygiene
- Improve patient record documentation

# ACS Reviewing Apps to Help Surgeons With Daily Workflow

Surgeons could find that technology makes their workflow run more efficiently with new apps and digital tools. But which ones work best?

That is a question the American College of Surgeons (ACS) plans to answer by the end of 2020 with a toolkit resource that evaluates and rates various apps geared toward surgeons.

"We're not looking at patient apps; there are a lot of apps out there that are communication apps and require a lot of investment, by the institution, to employ," says **Heather Evans**, MD, MS, FACS, vice chair, clinical research and applied informatics, and professor of surgery at the Medical University of South Carolina.

"We're interested in apps that surgeons can use for education, documentation, or as information and resources," Evans continues. "These are apps that bring together information in a digestible format that would be helpful at the bedside for decision-making or apps that allow you to have access to the latest literature on a topic."

ACS's health information technology committee includes a dozen people, including Evans (committee chair), working on the app evaluation project. A task force of volunteer surgeons also is involved.

"We have just codified our process, and developed a rating system for how we would like to evaluate the apps," Evans says. "We wanted to develop something by surgeons for surgeons that didn't have any bias to it, so we would be able to find the most useful and reliable apps out there, and surgeons could have these in their toolkit."

For example, Evans has heard about an education app that teaches surgeons about pediatric surgery core concepts. It can be a reference for surgeons, providing videos as instructional tools.

"I haven't used it, but one of my committee members took a look at it and thought it was worthwhile," she says. "That's the kind of thing the whole committee will look at." In another example, there are apps that sound as though they might be very useful, but turn out to be disappointing.

"There is an app out there that purports to show you all CPT codes, but, in fact, it's not really searchable," Evans reports. "It's not a terribly useful kind of app if you can't type in the name of the procedure you want to code. You have to know the code to find it or search through a directory."

Apps like this would not make the toolkit list. "We wouldn't want to point surgeons in that direction and waste their time," Evans adds.

Eventually, ACS will invite its members to submit apps for review, but this is down the road, Evans notes. "In the beginning, we are being more deliberate about it because we don't know how many members will create apps," she explains. "We're interested in offering this as a service to surgeons so they can have some kind of guidance." ■

# Telehealth for Preoperation Consults Efficient, Convenient

Surgery centers located in places with patients traveling from rural areas or that draw patients from long distances could make presurgery consultations more efficient and easier through telemedicine.

Many surgery centers already use telemedicine for post-surgery follow-up because it is easy to use the solution to connect briefly with patients to ask them about incisions, pain, redness, and complications, says **Ryan Spaulding**, PhD, vice chancellor, Institute for Community Engagement, and acting director, Center for Telemedicine and Telehealth at the University of Kansas Medical Center.

"We find that a lot of our patients from rural communities are not comfortable driving into the city, so these telehealth visits are satisfying for patients," he reports.

Precertification/preoperation visits are another and newer area that could benefit from telemedicine. For reimbursement, video calls are set up between the surgery center and the patient's local provider or hospital. "Telemedicine in patients' homes is not reimbursed, so that's a barrier to patients using smartphone videos in their homes," Spaulding notes.

For patients who live far away from the surgery center, telemedicine could save them a long drive for a consultation that would last only 15 to 30 minutes.

"We've done the presurgery certification through telemedicine for four years. The farthest site we've contacted is 376 miles away, a

5.25-hour drive," Spaulding says. "It saves a lot of drive time for a routine presurgery visit, and it's well-received by patients and providers."

The telemedicine visits almost always are video conversations. Patients see physicians through video conferencing that is high definition and good quality.

"They can look right at the patient and talk to the patient," Spaulding observes.

For post-surgery telemedicine, physicians can see patients' wounds, burns, or rashes via the video feed. "We did a study with burn patients and looked at still images ... and compared whether you can properly diagnose the level of the burn and how well it's healing," Spaulding recalls. "The study was positive. Both video and still images can be used effectively."

The technology involves either a video system or a computer system. The surgery center and/or surgeon sets up the relationship with the patient's local provider to facilitate the telemedicine visit.

The local provider only has to put the patient in a room where the video conference will take place, Spaulding explains.

Insurers, including Medicare and Medicaid, pay an originating site fee to the place where the patient is sitting during the telemedicine visit. Payers give the surgeon a consult fee and pay the distant site, which is the surgery center or hospital where the surgeon is located during the video call, Spaulding says.

Another consult that can be conducted via telemedicine is the preanesthesia visit.

"Sometimes, patients come to surgery centers because of their airway or maybe their vital signs are [problematic], and they cannot have anesthesia," Spaulding says. "We've worked with an anesthesiologist here to set up a preanesthesia clinic."

Turning these visits into telemedicine sessions would be especially helpful for patients who drive many hours for the clinic visit. Also, this could prevent patients from driving several hours to a clinic, only to hear they could not undergo the procedure.

"We're still trying to get these telemedicine visits set up," Spaulding says. "We have had no consults yet ... but we think it will be fairly easy to do once we work out the logistical and location issues."

During the preanesthesia visit, the anesthesiologist talks with the patient, examines the patient's airway, and ensures it is clear. Then, the patient is ready for anesthesia. Some places already handle these visits via video conferencing.

"It's an exciting use of telemedicine," Spaulding adds. ■

# Lawmakers Consider Proper Approach to Preventing Surprise Medical Bills

There likely will not be a federal law preventing surprise medical bills anytime soon, but some states have moved ahead to protect patients, showing a possible path forward.

Consumer groups and legislators have targeted a common healthcare nightmare: Patients visit a hospital or provider within their insurance network, expecting they will pay a copay and deductible. After receiving treatment and returning home, patients receive an unexpected expensive bill from an out-of-network provider they did not even know had treated them. Since the patient's insurer had not negotiated a set price with that out-of-network provider, the patient is stuck with the full cost of the service — sometimes thousands of dollars. Surprise medical bills affect at least one out of five Americans, and the amount billed to patients often is not related to market rates or the actual cost of services, according to a report from America's Health Insurance Plans (AHIP).[1] Anesthesiologists and radiologists are two of the most common providers to send surprise medical bills, says **Anthony Wright**,

## EXECUTIVE SUMMARY

State and federal lawmakers are trying to enact laws to prevent surprise medical bills.

- Congress is considering a bill called, "Protecting Patients from Surprise Medical Bills Act."
- A recent report shows that California's surprise medical bill legislation has successfully stopped surprise bills and has not caused significant issues for physicians.
- Californians in self-insured plans under the Employee Retirement Income Security Act of 1974 are exempt from state consumer protections and are not covered by the state's surprise medical bills law.

executive director, Health Access California. "One of the common stories we've heard over the years is the patient did the right thing and determined that the hospital or facility was in-network, but one of the doctors was out of network," Wright reports. "For example, a patient goes to an imaging center and gets scanned, never meeting the radiologist who looks at the scan to see if it's positive or negative, and then gets a bill because the radiologist is out of network."

States have turned to legislative remedies to eliminate these surprises and cap what out-of-network providers can charge. The state of Washington recently passed "Out-of-Network Health Care Services — Billing," which went into effect Jan. 1, 2020.[2]

"We think there's a real urgency for this, so we continue to be very active in an effort to try to get federal legislation," Wright says.

Throughout 2019, federal lawmakers introduced various legislation aimed at ending surprise billing.[3] At first, it appeared Congress would move quickly on passing something, but disagreements among lawmakers and private groups about the right approach stalled that progress.[4]

"We do think Congress is coming around," Wright offers. "Many people believe there needs to be action on this issue because surprise medical bills are such an untenable and unfair imposition on consumers."

Meanwhile, in September 2019, Health Access California released a report about how California's surprise medical bills law (AB 72) was working since it was signed into law in 2016. The report revealed that the law is working as intended, and that almost all physicians accepted the average contracted rate benchmark as payment in full, rather than appealing to make a case for higher reimbursement.[5]

Two months earlier, the California Medical Association (CMA) published its position on surprise medical bills that are like California's law in a letter to Congress.[6] The letter claims that California's surprise medical bills legislation is a failure because physicians and insurers are not incentivized to contract and offer an appropriate network of physicians to ensure care access.

The CMA also wrote that insurers are terminating long-standing contracts with physicians or mandating steep rate cuts, diminishing access to care. The Health Access California report disputes that assessment, according to Wright. "We have actual data, not anecdotes," he says.

Wright says his group's report reveals insurers in California have broadened their networks, and that contracting continues to be widespread. Also, 80% to 100% of hospitals and other facilities have no out-of-network billing from the physicians who practice in these facilities.

"The California Medical Association says the bill creates an incentive for insurers to not contract with providers, but the data show that's not the case," Wright explains, adding that the data also show that insurance networks have increased the number of anesthesiology and radiology providers. Further, he argues legislation under consideration in Congress is similar to California's law in how the law would protect patients.

"The bill California passed is specific about physician balance billing, but also includes imaging centers and others," Wright adds. "There is a benchmark rate of 125% of Medicare. If a provider wishes to appeal it, there is a dispute resolution process."

Out of hundreds of thousands of claims, there were 70 appeals, Wright notes. "The law has been working, but several million Californians in self-insured plans under ERISA [the Employee Retirement Income Security Act of 1974] are exempt from California consumer protections," Wright says. "We still need federal action to address that gap."

*(Editor's Note: For further analysis on California law, read this September 2019 report from the USC-Brookings Schaeffer Initiative for Health Policy, which considers data from CMA, Health Access California, and other groups: https://brook.gs/2s3ddQo.)* ■

## REFERENCES


1. America's Health Insurance Plans. *Protecting Patients from Surprise Medical Bills*. February 2019. Available at: http://bit.ly/2On40db. Accessed Nov. 20, 2019.
2. State of Washington. Second Substitute House Bill 1065. Chapter 427, Laws of 2019. 66th Legislature, 2019 Regular Session. Available at: http://bit.ly/344tGBP. Accessed Nov. 20, 2019.
3. Congress.gov. Current legislation search - "surprise medical." Available at: http://bit.ly/2QBl6qr. Accessed Nov. 20, 2019.
4. Springston J. Lawmakers, health groups diverge on surprise billing solutions. Relias Media, June 21, 2019. Available at: http://bit.ly/2raKd8O. Accessed Nov. 20, 2019.
5. Health Access California. *Patients Protected, Providers Paid: Data From Three Years of California's Compromise to Stop Surprise Medical Bills*. September 2019. Available at: http://bit.ly/335L1Js. Accessed Nov. 20, 2019.
6. California Medical Association. CMA position: Support protecting patients from surprise medical bills but oppose the surprise medical billing framework. July 10, 2019. Available at: http://bit.ly/2O5YzjL. Accessed Nov. 20, 2019.

# Program Improves Discharge Instructions, Reduces Same-Day Cancellations

The process improvement project started the way many begin: The surgery center received comments from patients who said they wanted better discharge instructions.

"Patients would go into recovery and not remember things, so we started with a process improvement workshop for discharge instructions," says **Sandy Keating**, RN, clinical director, Surgery Center San Carlos in San Carlos, CA, which is affiliated with Sutter Health's Palo Alto Medical Foundation. "Once patients are medicated, coming out of surgery, they don't remember talking with physicians. We call them the next day, and they might say, 'I wish I could have talked to the doctor,' and we say, 'You did talk to the doctor.'"

Surgery center staff decided to give patients a laminated sheet with discharge and recovery instructions. It includes illustrations, and the language is written at a third-grade reading level. "It also is translated into Chinese and Spanish for our population," Keating notes.

Patients see the laminated copy at the surgery center, and they can take home their own unlaminated copy. The instructions include six panels on both the front and back. *(Editor's Note: See sidebar at right for more about the instructions.)*

The surgery center also targeted same-day cancellations for a process improvement project. "At San Carlos, we have a binder where we document what the cancellations are and the reasons for them," Keating says. "We call people to get more details so that we have information on core issues."

The process improvement committee for the Palo Alto Medical Foundation's six centers focused on this project, tracking surgical and other reasons for cancellations. They started with gastrointestinal (GI) patients, but are expanding to all patients because of such excellent results, Keating reports.

"We created 12 categories of cancellations with standard code inputs, and we are building these into the online program, where we document the cancellation," she explains. "We started calling patients when someone was a no-show, and we would find out the reason. For instance, we found a patient who had a high deductible and couldn't afford to pay for the GI prep solution."

Another patient spoke only Spanish, and did not know to take the prep product because the patient did not see the Spanish instructions. Without calling those patients, they would only have known the patients were no-shows, Keating says.

## DISCHARGE AND RECOVERY INSTRUCTIONS

After many patient complaints, staff at the San Carlos Surgery Center decided to provide patients with a sheet that includes specific discharge and recovery instructions. One side includes instructions related to surgical discharge and recovery:

**• Pain Management**
- Take over-the-counter or prescription medications as directed by your doctor;
- Apply ice or heat, if instructed.

**• Diet Today**
- No alcohol for at least 24 hours;
- Start with a light meal to help prevent nausea and vomiting;
- Stay hydrated and drink fluids.

**• Call Your Doctor**
- Signs of infection;
- Heavy bleeding;
- Ongoing nausea or vomiting.

**• Wound Care**
- Keep surgical dressing clean;
- Follow specific wound care instructions given in recovery;
- Monitor for possible signs of infection (fever 101° F or higher, swelling, heat, drainage, or redness).

The other side of the sheet includes instructions for colonoscopy/endoscopy discharge and recovery:

**• What is Normal**
- Endoscopy: mild sore throat and/or abdominal bloating for one to two days;
- Colonoscopy: cramping or bloating;
- Pass gas to help with bloating and take Tylenol for pain, if needed.

**• After Today**
- Expect a follow-up call from the surgery center on the next business day;
- Biopsy/polyp results will be communicated via phone, mail, or My Health Online within 14 days. ■

"There's always more to the story than just a no-show," he observes. Poor preparation might lead to a patient not following the dietary instructions and being unable to tolerate the prep solution, Keating notes. "They were supposed to change their diet a week ahead, and some didn't read the instructions until the day before," she explains. "Now, we call them a week before the procedure, and send out instructions on My Health."

A quality improvement committee, which meets monthly, identified this as a project that everyone could work on. The surgery team identified what the preparation issues were, and came up with solutions that could be implemented in that surgery center and other ones connected with the healthcare organization.

For example, patients needed clear and simple preoperation instructions. Previously, these instructions were confusing and too long. Some patients were not reading all the way through or did not understand what they were reading. Thus, patients did not complete every task before surgery. "We cut instructions from seven pages to two pages," says **Jannette Gray**, RN, BSN, periop manager, Surgery Center San Carlos. "The instructions' first five bullet points are the most important information for the patient's procedure. We go [into] further details as someone goes through the document."

Not only were instructions lengthy and confusing, another issue was too many types of instructions: online instructions, instructions for medication, and the clinic's lengthy instructions. Patients would report that they read the instructions, but then they would misplace them. That would lead patients to read other (possibly incorrect or misleading) sources of information the day before the procedure. "We worked with our GI doctor to decrease the instructions," Keating says.

Now, there is one instruction sheet, used at all of the system's surgery centers. "Everything you need for that procedure is on one page and the back of it," Gray says. The center also improved its preoperation calls, standardizing and streamlining that process. "We were calling patients seven days ahead and, then, calling one day ahead," Gray says. "But we were missing people in the middle of the week. We changed it to a seven-day call, and then a three-days-out call."

The revised instructions included checkboxes with quick visual cues. For example, one box says the patient should call the center if there are any problems. If patients report problems during the call three days before the procedure, then the procedure can be cancelled and rescheduled, reducing the likelihood of a same-day cancellation, Gray explains. "The day before the procedure, it's too late," she notes.

The project worked well, reducing same-day cancellations. "The four surgery centers that have GI procedures did the project," Keating says. "At one center, the number of same-day cancellations dropped from 6.4% to 2.9% after the improvement."

In sum, before revising the instructions, there were almost four in 10 same-day cancellations because of poor preparation. After piloting the changes, this improved by 70%, Keating reports. ■

# Reach Potential Patients Through Social Media

Every business, including surgery centers, needs to know the social media landscape and how it can help or hurt their image and brand. Through social media, surgery centers can reach their clients with messages that help build trust and interest.

However, this only works if administrators know who they are trying to reach, says **Nick Sideris**, business development manager with Johnson & Johnson Vision in Des Moines, IA.

"We first need to identify target demographics," he says. "Age is the biggest factor." Knowing your patients' average age is important to deciding which social media platforms to use. "If you are after a younger demographic, then use Snapchat or TikTok," Sideris suggests.

People in their teens and early 20s primarily use those social media platforms. If patients are in their late 20s through their 30s, then they use Instagram, he adds.

"Instagram is wildly popular for that demographic," Sideris reports.

Patients older than age 40 might maintain an Instagram account, but most will use Facebook.

"People age 50 and up have been the biggest growing population for Facebook," Sideris says. "Millennials still have Facebook, but they're not as active as they once were. They post most of their activity on Instagram."

Sideris offers a few tips on how to build a helpful social media presence:

• **Create a patient avatar.** Avatars are figures that represent people in video games or internet forums. Sideris suggests surgery centers create an avatar to represent their ideal patient. They can find an image online that illustrates the patient avatar. For instance, they could name the avatar "Sally Smith."

The point is to think of a specific, fictional person when working on educational and messaging content for patients. "When you speak to everyone, you're actually speaking to no one," Sideris says. To make this work, the avatar must fit the characteristics

of a typical patient. "It's more than just age, income, and demographics," he says. "We need to know what are their pains, keeping them up at night."

Give the avatar goals, fears, frustrations, and aspirations. "I tell practices to tape that Sally Smith avatar picture on their walls," Sideris says. "Look at the picture when you're putting together content for social media; pretend you're speaking to Sally, your ideal patient demographic."

Understanding patients' physical problems helps a surgery center gain their trust. "[Patients] assume we have the answers they are looking for," Sideris adds.

**• Develop educational and entertaining content.** Create content that furthers education and really resonates with people, Sideris suggests. For instance, think of the patient's journey in terms of the avatar.

"If you know your avatar really well, you know what journey they take, from never hearing of your surgery practice to choosing your practice for their surgery," Sideris says. "If you know what those stages are, you can create content for each of those stages."

For people who are just beginning their surgery center search, the social media content could include answers to commonly asked questions. The surgery center's social media content could be produced in brief and multiple postings. For instance, each posting could be a short video of the surgeon answering a common question about the procedure, Sideris says.

**• Use social media for branding, awareness.** "Think of Facebook and Instagram as branding tools," Sideris says. When businesses create educational content, social media accounts are in the funnel. "The top of the funnel is awareness, and the next is consideration, where they are educated and want to go deeper into whether it is good for them or not," Sideris explains. "We could create some value tools, lead generation offers, and we can give people something in exchange, like a consumer's guide to the surgery. Ask people to give you their names and emails, and you can send them a five-page PDF report."

Another way to improve branding on social media is to create a quiz, perhaps one that helps a prospective patient gauge if he or she is a good candidate for the surgery, Sideris suggests. On branding, the final part of that funnel is a purchase section, where the prospective patient provides some information — and a little bit of trust.

"Overcoming objections is huge in this section," Sideris says. "They've done their research, and are almost ready to go to your center, but there may be objections they need to overcome."

Objections could involve fear and price. Testimonials and information about the surgery's cost and monthly payment options could answer those objections.

**• Allow posting, but monitor comments.** "Definitely allow posting," Sideris says. "The whole purpose of social media is to be social."

A social media site that includes posts from patients and potential patients creates an enhanced level of awareness and authenticity, he says. These are patients who decided to use the surgery center's services and could be willing to write a brief testimonial about their happy experiences.

"What you notice most is a Facebook ad that is run in a news feed, and people can comment on your ad," he explains. "This is a great thing about social media vs. traditional advertising, where there's a billboard on the side of the road." However, comments can be a problem if they are negative and remain unanswered. "It's super important to keep an eye on those things," Sideris says. "You may catch someone on a bad day, and they say something super negative about you."

Respond positively. If the comment is destructive or off base, then it should be deleted, but surgery centers should not censor comments. That detracts from authenticity.

"You don't want to limit their voices," Sideris adds. "When it comes to reviews of a surgery center, you should check with a HIPAA attorney about how to respond appropriately."

One employee at the surgery center could be put in charge of keeping an eye on the social media sites and checking them at least once a day. Surgery centers also can set up a Google alert with their practice's name. This generates automatic emails whenever something is said somewhere online about the practice.

Also, organizations could hire outside firms to monitor and provide content for their social media accounts, but the money spent on that might be better spent on hiring an outside firm to run ads on social media sites, Sideris says.

"For day-to-day organic posts, it's much better to do it in house," he offers. "The agency might be in New York, and your practice is in California. The subtleties of your local market are not communicated to them."

Plus, an outside agency would not know about day-to-day things, such as a staff member's birthday. "They won't know that information, and wouldn't be able to snap a picture to post on Facebook," Sideris adds.

**• Post creatively.** A lot of practices know they need to post something online, but they are unsure of what to post. "People will sit behind a computer, thinking they need to post, but don't know what to do because they

believe they must create a beautiful masterpiece," Sideris observes.

He suggests turning on a smartphone video and documenting what is going on at the surgery center. For example, if it is Halloween, then someone can take pictures of employees dressed in costumes and ask their social media followers to vote on the best costume. "Or, say it's a super windy day. You could insert a video of a cow flying in a twister," he says. "Use it as a tool to keep people engaged and commenting."

Try sharing a photo of flowers that a patient left as a gift to the center. Post a meme, or reply to a comment with a GIF. Sideris knew a practice that received a comment on an ad that read, "Hey, Joe, that looks like you." The practice answered the comment with a GIF of Leonardo DiCaprio from a movie where he's moving his hands to suggest, "Maybe?"

"They got a ton of comments and likes and shares," Sideris says. "There was engagement because of that." ■

# Surgery Center's QI Program Receives Top Scores From Patients

A large California surgery center achieved 99% scores on a question asking whether patients would recommend the center, partly due to the center's focus on patient education and quality improvement (QI).

"Our net promoter scores are 99%, and our patient response rate is 33%," reports **Tom Wilson**, CEO of Monterey Peninsula Surgery Center – Ryan Ranch in Monterey, CA. "Our system did 17,000 cases in 2018. We had four inspections, 25 readmissions, and 41 ER visits ... we measure quality through the outcomes, and service through net promoter scores."

Monterey Peninsula Surgery Center was involved in a pilot program for total joint surgery, collecting outcomes data for the Centers for Medicare & Medicaid Services (CMS). This information helped CMS decide to allow total joint surgery in ambulatory surgery center (ASC) settings.

The surgery center's success in patient and case outcomes is partly due to its focus on comprehensive patient education, Wilson notes. "We provide an educational program to patients that is mandatory," he says. "They meet with a physical therapist and nurse educator and go over anatomy and the actual procedure. Patients learn which exercises they should be doing ahead of time."

The educator talks with patients about the procedure and recovery process. Patients learn that a coach can help around the house after surgery. "We have people going to their homes and looking for hazards, like throw rugs," Wilson notes.

The program follows strict admission criteria, with 10 items that are predictors of whether someone is a good candidate for total knee or hip or major spine surgery on an outpatient basis. "We select our patients carefully," Wilson says.

The surgery center trains new staff over a six- to eight-week period, including online competency testing and shadowing existing staff, says **Carrie Millsap**, COO at Monterey Peninsula Surgery Center. "We invest a lot of time and money into educating the team, allowing them to grow and be in the operating room," she says. "We make sure they know how to use the equipment properly. We feel this has been very helpful to keeping infections down, and making sure physicians are satisfied with patient care."

Another part of QI involves improving the facilities. "Two years ago, we spent $2 million to expand the operating room, putting in new systems, air filtration, and substerile corridors," Wilson says.

Improving quality and efficiency is an ongoing process, Wilson notes. "Whenever we find a breakdown in our system or a complaint from a patient, it goes to our quality improvement committee," he says.

The QI committee consists of nurses and physicians. They study issues to see if these were related to a policy that could be adjusted to avoid future problems. For example, five years ago, the surgery center saw the need to perform cholecystectomies. "We brought in general surgeons, and asked them what we could do to handle these cases," Wilson says. "They said to train staff, so we brought in surgeons on the weekends with our team for training."

The surgery center also purchased all necessary equipment. Today, they perform hundreds of cholecystectomies per year. "We do so many of these surgeries that we're just as skilled as local hospitals, and it's because we trained our staff and made the investment to do it," Wilson offers.

The center initiated endoscopic spine surgery in the same way, starting with training staff and investing in the equipment, including fiber optics and cameras.

"Now, people in the community can get their back surgery done endoscopically," Wilson adds. ■

# Missed Budgeting Expenses and Opportunities

*By Stephen W. Earnhart, RN, CRNA, MA*
*CEO, Earnhart & Associates, Austin, TX*

Budgeting is never fun. Many *Same-Day Surgery* readers are budgeting for 2020 right now or reworking the numbers because some low-level executive wants the numbers smaller — or eliminated entirely.

While budgeting, consider these tips for saving money, what not to do to make up budget shortfalls, and even advice on spending a little extra here and there:

**• Never agree with a budget you cannot live with.**

Often, we are pressured into accepting a budget into which we put little input; nevertheless, we are expected to achieve those numbers. It is better to argue for a realistic budget now than to explain every month to someone why you did not hit the mark.

**• When totaled, the little things can catch everyone off guard.**

Examples include staff lunch, surgeon car washes, Christmas parties, and birthday cakes. While these sound like small potatoes, the costs always are much higher than expected on an annual basis. Some of these items (e.g., surgeon car washes) may be difficult to justify.

**• The cost of just about everything rises annually.**

A safe forecast for known expenses is to increase them by 7% per category over the previous year.

**• Avoid company credit cards.**

With little or no oversight, these cards are subject to abuse and accidental use, leading to spiraling costs. If possible, avoid these cards.

**• Three separate individuals should be involved in supplies or equipment for your facility.**

The one who orders it, the one who receives it, and the one who pays for it. Too many of us have been burned by rogue employees selling supplies out the back door of the hospital or ASC.

**• Annual bonuses are a waste of money and intent.**

Make the staff bonus worthwhile and distribute it over the year rather than in one lump sum. Twelve small bonuses each year make a much more lasting impression to staff.

**• Usually, outsourcing services is more cost-effective than in-house services.**

Look at outsourcing as an alternative to services no one wants to deal with or for which the cost is too variable. Speaking of which ...

**• The smell of laundry detergent and fabric softener in your facility cheapens the effect of your surgery facility.**

Spend the money on outsourcing linen cleaning. You cannot detect the smell anymore because you have grown accustomed to the odor. However, there is a strong chance patients can smell it.

**• Budget for Wi-Fi in your waiting area.**

It keeps patients and family members busy with social media and less on bugging the receptionist.

**• If it is under your control, do not charge patients for parking.**

Patients have to spend plenty of money on many other services. If staff have to pay for parking, reimburse them.

**• Every vendor should bring lunch for your staff occasionally.** Insist on this one.

**• Stop budgeting for magazines in the waiting room.**

Everyone's nose is in screens they brought from home. Books and magazines only clutter an area that you have to pay someone to clean.

**• Budget for patient gifts.**

These could be a small plant or a garment bag patients can use after discharge. Small tokens like this can improve satisfaction scores.

**• Budget for a gift for your surgeon's office scheduler.**

Rarely are these important individuals noticed for the challenging but vital work they complete. Buy them a small gift with your name, number, and website printed on it that goes on their desk.

**• Do not hire someone to provide one-time services.**

You may be stuck with this person until you get the nerve to fire him or her. Outsource the function.

**• Update your website.**

If there is not a website for your facility, budget for one. These are gateways for patients looking to validate the services you provide.

**• Typically, money spent on physician recruiters is wasted.**

Allocate those funds for something else. ■

*(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

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

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

2. Log on to **ReliasMedia.com** and click on My Account. First-time users must register on the site. Tests are taken after each issue.

3. Pass the online test 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 successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be emailed to you.

## CME/CE QUESTIONS

1. **How can digital apps help improve surgery patients' care?**

   a. Apps can be used to assess patients' homes for fall hazards.
   b. Apps can be used to monitor patients' alcohol intake and substance use.
   c. Apps can track patients' exercise, diet, medication use, vital signs, and heart rates.
   d. Apps can connect with nanotechnology that monitors patients' wound healing.

2. **What is one of the most important benefits of telemedicine for presurgery consults?**

   a. It cuts time spent on consults in half for the surgeon.
   b. It saves the patient from driving long distances for a brief consult.
   c. It reduces the surgery center's carbon footprint.
   d. Telemedicine is reimbursed at a higher rate than in-person consults.

3. **According to a report by the America's Health Insurance Plans, what proportion of Americans are affected by surprise medical bills?**

   a. One in three
   b. One in four
   c. One in five
   d. One in six

4. **Which is a suitable instruction related to surgical discharge and recovery?**

   a. Follow specific wound care instructions given in recovery.
   b. Monitor for fever higher than 99° F.
   c. Call 911 if bloating and cramping occur after colonoscopy.
   d. Avoid walking or standing for 72 hours after knee surgery.