SAME-DAY SURGERY

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INSIDE

RELIAS MEDIA

Health System's Program Reduces Serious Safety Events Everywhere

Healthcare organizations can reduce serious safety events through a focus on high reliability training and education.

This process resulted in an overall 75% reduction in serious safety events over a four-year period at Hartford (CT) HealthCare, according to **Rocco Orlando III**, MD, chief medical officer.

When Hartford began its high reliability work in 2013, the health system educated all aspects of its organization on improving safety. The message was spread throughout the acute care setting of seven hospitals as well as ambulatory settings, including a large medical group, home care, skilled nursing facilities, and ambulatory surgery centers (ASCs), Orlando reports.

"We paid a great deal of attention to the language of high reliability, and made sure it was language that everyone used," he notes. "We didn't want it to be perceived as wisdom that arrives on an airplane; we wanted it to be part of our culture and part of our operating model."

The high reliability model focuses on leadership, staff interactions, and daily management. It takes time to create a culture in which every leader and employee makes safety a priority. "It's been a long journey," Orlando acknowledges. "We began to expand the high reliability education into all aspects of our system."

The definition of high reliability varies according to the employee's workplace setting. For example, the definition of a harm event in an ASC is different than a harm event in a mental health facility, Orlando explains. Formal training into high reliability was possible only after each area defined harm events for their setting.

Another challenge involves ASCs and their governance and structure, Orlando adds. The health system could secure buy-in from most Hartford departments and organizations, but it took additional steps with ASCs. "We had to have conversations with the boards of ASCs and ask them if this made sense and what they thought," Orlando recalls. "Once we had this conversation, there was broad

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recognition that it was a reasonable thing to do and that kind of training was appropriate."

Another challenge with ASCs involved defining the baseline of serious safety events. "They tend to be a safer environment than the acute space. How do you drive the serious safety events numbers still lower?" Orlando asks. "What is that rate if you are not monitoring it? What are the reportable adverse events that occurred?"

Some states require ASCs and other healthcare organizations to report all serious safety events to the department of public health. This reportable information could be used to determine the baseline number of serious safety events. "ASCs are dependent on a physician partnership for that kind of reporting," Orlando says. "One of our assets is we've linked this program to our risk management program, and our risk management director is a driver of decreasing harm."

A high reliability safety organization creates a psychologically safe environment for its employees, says **Stephanie Calcasola**, MSN, RN-BC, CPHQ, vice president, quality and safety, Hartford HealthCare. "The underlying principle is having employees feeling psychologically safe to report events," Calcasola says. "We work to create an environment for self-reporting of adverse events and near misses."

Collecting data on near misses can be vital to an organization because this information reveals problematic areas before a crisis develops. But it takes work and trust to convince staff to report these incidents.

"Helping employees to feel empowered to report is the foundation of any healthcare organization," Calcasola offers. "Hartford is quite mature in that journey of using the principle of transparency as a way to drive change."

Hartford employees consistently report harm events as well as worrisome incidents they prevented from becoming a harm event, Calcasola adds. Data and trends involving near misses can help an organization redesign care or processes. "We can always do better, and make staff psychologically ready to report," Calcasola says.

One tactic surgery centers can employ to improve this culture is to measure self-reporting through surveys to employees, Calcasola suggests. "There are 19 questions in the culture of safety survey," she says. "Our data has shown us that

EXECUTIVE SUMMARY

High reliability training can lead surgery centers and other healthcare organizations to better safety outcomes.

- For one health system, the process resulted in a significant reduction in serious safety events.
- Holding structured time-outs can help prevent errors related to wrong site surgery.
- Ambulatory surgery centers (ASCs) tend to operate with strong safety profiles. A high reliability program's challenge is to find additional ways to make ASCs even safer.

our staff feel very comfortable raising concerns and reporting errors."

Another step in creating a high reliability organization is to perform a root cause analysis of serious safety events. "We look at the way people can improve and how to create an environment of learning," Calcasola says. "Also, every year, we look at what are the risk points in our system of care."

Understanding the risk points helps an organization anticipate future adverse events and prevent serious safety events from occurring. "We can redesign and re-engineer workflows," Calcasola says.

Leaders meet with the people involved in a safety error or near-miss and ask for information that will help everyone understand what occurred. Then, the group can discuss possible solutions and follow the PDSA (Plan, Do, Study, Act) process. "You can test a change and see how it impacts the process," Calcasola says. "You can redesign and measure for the desired outcome."

This process of analyzing problems and improving processes is embedded in Hartford HealthCare's operating model, which also relies on other quality improvement and best practices principles, she notes. "This creates the best foundation to drive out error and create a safety reliability healthcare design," Calcasola says. For example, suppose an eye surgery center experienced a serious safety event in which the wrong lens was implanted in a patient's eye. The center conducts a root cause analysis and finds a series of communication issues related to the preoperative assessment by the ophthalmologist. When the root cause analysis and PDSA process suggest a solution that could prevent this serious safety event from recurring, the suggested changes are disseminated to all the surgery centers that perform eye procedures.

"When we share these events across the whole organization, there's no reason to fix it at [only] one site, but at all sites simultaneously," Orlando explains.

In an operating room, the high reliability path means directing all staff to be attentive to each step of the surgical process. This is important to preventing wrong-site errors.

"There should be a mindfulness of rigor of doing standard work for evaluating a time-out for surgery," Calcasola says. "This means having the team intentionally present, making sure patients are receiving the right procedure on the right site."

When there are mistakes, they often are the result of inadequate focus and mindfulness, she adds. "Mistakes result in human error, an inability to cross-check and peer check, every time and every day," Calcasola explains. "It doesn't matter what surgery or procedure, that is a basic safety rule — to ensure a complete and accurate time-out every time in surgery."

Surgery centers can create a structured time-out process by confirming the right patient is at the right surgery site, and ensuring the operating room contains all the proper equipment to perform the procedure. It also is important to cross-check the patient list to match the recipient to the correct implant. Further, be sure to address the facility's performance quality all along the way.

Training staff on the high reliability journey is a significant commitment, Orlando cautions. "It's not just one hour of training; it is three to four hours of training for all clinical staff," he says. "It is something that can be done with internal resources, if there is someone with the expertise to master the data. But it is more commonly done with experts."

ASCs often work with experts in-house, Orlando notes. "In most ASCs, the good thing is that physicians are likely to be familiar with high reliability," he adds. ■

Asking Caregivers to Stay Overnight Is Part of Patient-Centric Policy

Surgery centers that keep some patients overnight might consider asking caregivers to stay, too. This can help improve caregiver training and reduce the time to discharge, according to the authors of a recent study.[1]

Making it possible for caregivers to stay with patients provides scheduling flexibility and can help resolve transportation issues. For example, some patients might travel hours to a surgery center. Dropping off a patient, driving home, and returning the next morning to pick up the patient could be a hardship for the caregiver, says **Vincent Laudone**, MD, chief of surgery at Josie Robertson Surgery Center, Memorial Sloan Kettering Cancer Center, New York City, and study

co-author. "One of our guiding principles is to be as patient-centric as possible," he says.

For example, Josie Robertson patients often arrive from a tri-state area. "It can be quite a commute, taking three to four hours to get here," Laudone observes. "To have caregivers bring in their family members and then go home, coming back the next morning is not patient-centric."

There is no extra patient fee if a caregiver spends the night. Caregivers can dine for free in the visitor's café, which is open from 7 a.m. to 8 p.m. Caregivers staying overnight does not affect the nurse-to-patient ratio, either. Two or more nurses stay each night, regardless of patient population. "I would suspect it's cost neutral," Laudone says, noting the study did not include a full economic analysis. "The caregiver is occupying the same room as the patient, and the amount of extra food consumed is fairly minimal."

Regarding security, there is only one entrance to the facility, which is guarded by security 24/7. All staff show their ID badges, and guests check in with the guards. Everyone wears badges at all times, and those badges show where people are inside at all times. Floor access is limited to the lobby elevator, and visitors must indicate their floor before entering. Also, patient rooms include individual bathrooms, and the entire building is handicap-accessible.

Josie Robertson Surgery Center, which opened in 2016, was created as a free-standing ASC close to the main hospital to provide any surgeries that did not require more than one-night stay, Laudone says. "It allows us to expand surgeries done on an ambulatory basis to include more complex cancer surgery," he adds. "These include minimally invasive procedures like hysterectomy [or] mastectomy."

The surgery center's case mix includes 65% outpatient and 35% ambulatory extended recovery. Of patients who spend the night, 57% are accompanied by an overnight caregiver, says **Susan Griffin**, FNP/BC, perioperative nurse practitioner at the surgery center and another study coauthor.

There are 12 operating rooms and 28 overnight rooms. The center's surgical services include urology, breast, gastric mixed tumor, gynecology, head and neck, and plastics. It was designed with the goal of considering the needs of caregivers, Griffin says. "Six months after we had our first patient, we were wondering if having the caregiver here overnight would have an impact on patient outcomes," she says. "We wanted to make this a good experience, so we took time to figure it out."

Griffin and colleagues asked these questions:

- What difference would it make to ask caregivers to spend the night with patients?
- Which outcomes could they study?
- Which areas, if any, were caregivers visiting that affect patients' stays and outcomes?

The study revealed no major differences in clinical outcomes between patients who stayed overnight alone and those who stayed overnight with caregivers. However, there were small but statistically significant differences: staying with a caregiver overnight contributed to a shorter length of stay, earlier discharge times, and lower rates of transfer from ambulatory to an inpatient setting.[1]

"The study looked for objective measurements," Laudone says. "We didn't find anything major because most of the benefit is in reducing anxiety, increasing patient and caregiver comfort and knowledge, and, ultimately, providing better care."

Education was another potential benefit. "Having the caregivers there, overnight, allows for more opportunity for the patient and caregiver to learn," Griffin says. For example, mastectomy patients need drainage emptied. "Caregivers need to learn how to strip and empty those drains, and that's something they practice," Griffin notes.

When caregivers spend the night with patients, they empty the drains in a setting where any problems they encounter could be resolved quickly. "Also, there are a lot of medications patients go home with," Griffin adds. When caregivers spend the night

EXECUTIVE SUMMARY

An ASC offers overnight patients the option of staying with a caregiver. It provides convenience and an opportunity to reinforce caregiver and patient education.

- The guiding principle is to be patient-centric.
- A study comparing patient outcomes between those who stayed with caregivers overnight vs. those who did not revealed no major differences in clinical outcomes.
- An advantage was asking caregivers to observe nurses giving patients medication and physical therapists conducting therapy, both of which reinforced patient/caregiver education.

with patients at the surgery center, they can observe nurses giving patients each medication. It helps reinforce the importance of each prescription. Also, this is less overwhelming than the usual experience of receiving a list of medications at discharge. "The caregiver sees medications given out multiple times in the 24-hour period, so it's reinforced," Griffin observes.

Another educational benefit is caregivers can observe patients in physical therapy. "Mastectomy patients get some physical therapy training before they leave the center," Laudone explains. "The caregiver can witness those exercises and become a coach when the patient goes home, assisting the patient with exercises."

Josie Robertson Surgery Center has created an atmosphere that lends itself to both patient and caregiver overnights. Each patient stays in an individual room with a bed and a small sleeper sofa and/or chair. "The whole building is just surgical, so it is a little quieter, Laudone says.

The building contains embedded technology that connects with radio frequency badges that patients, caregivers, and staff wear. Every six feet, there is a sensor in the ceiling. When a post-surgery patient starts walking around the center, the badge provides the patient with feedback on how far they have traveled. This information is sent to nurses and becomes part of their record. "You can walk anywhere in the building, and it monitors what you're doing," Laudone says. "Some patients take it as a challenge and try to walk more than anyone else."

"We encourage people to think of this as an ambulatory facility. In the morning, on each floor, we have a common area where we put out a continental breakfast," Laudone adds. "Patients and caregivers have to get out of bed and go get some food, just like they would in their own homes." ■

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Communication Game Can Teach Staff to Understand Each Other

Surgical mistakes often result from communication problems between physicians, nurses, and other staff. Miscommunication also contributes to lower workplace efficiency and poor staff morale.

Communication tools can help surgery teams improve their communication skills and lead to better outcomes. The challenge is finding a way to teach staff how to improve their skills.

"How do we help the frontline professional teams in healthcare make improvements while providing care?" asks **Marjorie Godfrey**, PhD, MS, BSN, FAAN, co-director of The Dartmouth Institute Microsystem Academy. "We have a disciplined methodology. In some of our work, we found that communication between doctors and nurses was not very good. Research shows that if you want to have excellent patient care and outcomes, teams have to have good relationships."

Communication is a huge challenge and essential for effective teams. Some organizations direct employees to take formal communication courses. "Most people who take our communication course say how it permeates their entire life," says Godfrey, an instructor at The Dartmouth Institute for Health Policy & Clinical Practice. "One woman had a blowout fight with her sister 10 years ago. The woman worked carefully with the [communication] books. Then, she engaged in conversation with her sister and moved things along a bit."

EXECUTIVE SUMMARY

Poor communication can lead to surgical mistakes and other medical errors, so organizations need to find ways to help staff improve their communication and relational skills among colleagues.

- People learn better communication skills more readily when they can practice them.
- Researchers developed a game that uses two communication tools: PEARLS and Ladder of Inference.
- Healthcare workers can learn and practice better communication skills while playing this game: "PEARLS and Ladder."

"There are tons of examples of medical errors caused by miscommunication," observes **Julie K. Johnson**, MSPH, PhD, professor of surgery at Northwestern University. "It's the No. 1 cause of medical errors." *(Read more on this subject at: http://bit.ly/3bOCTmm.)*

Educating staff about effective communication skills works best when employees can practice the skills they are learning, according to Godfrey. "We had exercises in how to do that. Then, in thinking about it, we thought, 'How about we come up with a game?'"

The communication solution is a game called "PEARLS and Ladder," inspired by the children's board game "Chutes and Ladders." The game uses two empathic, nonjudgmental communication tools: PEARLS and Ladder of Inference. PEARLS stands for Partnership, Empathy, Apology/Acknowledgement, Respect, Legitimation, and Support. The Ladder of Inference refers to people de-escalating their negative assumptions and thoughts about an interaction (i.e., take things down the ladder). Instead of assuming someone meant harm, the person talks with their colleague to find out why the other person's response was not as expected.

Godfrey practices these communication skills at work and home. She provides this example of how the Ladder of Inference can work to prevent misunderstandings and arguments: "My husband is a really gabby guy, and goes to the local café in the morning to get coffee, have breakfast, and it goes on forever," Godfrey says. "One time, we were traveling somewhere, and he was going to the café for coffee for me, and I said, 'Please don't have breakfast; I'm leaving in 15 minutes.'"

Forty-five minutes later, and her husband still had not returned with her coffee. "In my old world, I would have jumped all over him," Godfrey says.

Instead, she waited calmly until he walked in the door, and she asked how he was, waiting for him to explain. He told Godfrey that he had traveled to the other side of town to buy her favorite cappuccino.

"This one story reminds me to take a breath and ask questions before jumping to a conclusion," Godfrey observes. "I think he was just showing his love for me, and I could have lost that moment."

The game takes communication skills-building and role-playing to a new level. "Traditionally, there is role-playing, where we sit at a table, and I tell you about a scenario where I was under conflict, and it didn't go so well," Godfrey explains. "If I had used the PEARLS of apology, it might have had a different outcome."

The game's scenarios are healthcare-related, but players can refer to experiences in their own lives as they describe potential solutions. "We found that people will use the PEARLS and Ladder skills as a shorthand way to talk about their communication patterns," Johnson says. "They might say, 'I just needed someone to help me come down the ladder.'"

People testing the communication game say they love it, but they also have offered suggestions that have improved the tool, Johnson notes.

"We've refined the game, and received input on what works well and what can be done differently," she explains.

For instance, the original game did not include situations involving thanking colleagues or acknowledging when someone was helpful. Some game testers, including physicians, nurses, social workers, pharmacists, and others, said they wished the game included more scenarios that were positive so they could practice thanking colleagues and giving staff positive feedback.

"We thought that was a great suggestion," Johnson adds.

The game can be played in about an hour, which makes it feasible for a regularly scheduled meeting or lunch hour. It provides a novel way for healthcare workers to see the problems with their own ways of communicating and interacting with each other.

"In healthcare, people might say harsh things or not respond or listen to people's emotions," Godfrey says. "Game players critique what the person said and discuss it."

Players learn that simply acknowledging a person's emotions can change the dynamic. "One of the scenarios in the game involves a surgeon who is very frustrated because when he was on call, he was called to speak with families that were upset about the care their loved ones were receiving. He never knew what to say to them," Godfrey explains.

The surgeon learned through the PEARLS tool that all he needed to do was show he heard their concerns. He could say, "Anyone who has gone through what you're going through with your loved one would feel the same way."

Those words demonstrated empathy, and it defused the families' anger. "It decreases emotion and anger and does something productive," Godfrey says.

"Communication seems like an easy thing to do, but it trips us up most of the time," Johnson says. "At our center, we teach a master's course in quality and safety. One thing we work on is improving

communication and focusing on the relationship."

When healthcare professionals work on their communication skills, they are working on improving their relationships with their colleagues and patients. "We're at the end stage of finalizing the game board and game pieces," Godfrey says. "It's a new framework for communication and provides people with practice in talking with one another."

As the game was pilot-tested, the interest was so high among some communities, including healthcare professionals around the world, that people suggested the game developers create a family version, Godfrey notes.

"Everyone would like a family version to build more empathic communication and build relationships, instead of tearing them down," she adds. ■

Learn More About How the PEARLS and Ladder Communication Game Works

Healthcare professionals developed a game that can teach people how to improve their communication and interactions with colleagues and patients.

Called PEARLS and Ladder, it is loosely inspired by the children's board game "Chutes and Ladders." Still under development, the game uses two different communication tools: PEARLS and Ladder of Inference. *(Read more about PEARLS at: http://bit.ly/2UXdHUo. For more details about Ladder of Inference, visit: http://bit.ly/2u9amH6.)*

"We've tested PEARLS and Ladder for about a year in various settings, and it's really helping people practice having conversations," says **Julie K. Johnson**, MSPH, PhD, professor of surgery at Northwestern University.

The game helps people learn the best ways to respond during a difficult conversation. It includes a board with color cards that offer various interpersonal scenarios. Four to six people play the game, rolling dice and moving their pieces to spots that direct players to draw cards, Godfrey explains.

The players listen to each person's communication scenario and strategize how to change it into a positive, productive relationship. In one scenario, an employee is working with a colleague on a project, and starts climbing the Ladder of Inference. On the first rung, the colleague does not respond to voicemail messages. "A couple more emails, and you think she's avoiding you. Then you call, and she doesn't return the calls," Johnson says.

The employee concludes the colleague is avoiding her because of a past disagreement. A few rungs up the ladder, the employee makes assumptions, which lead to suspicions that the colleague is trying to sabotage her work. At the top of the ladder, the employee concludes she will seek revenge by not helping the colleague next time. The employee looks for other examples of when the colleague was trying to make her look bad.

In the board game, the employee decides to descend the ladder, taking steps that will lead to better communication and a healthier relationship. This de-escalation includes meeting with the colleague to find out why she did not return the messages. The employee might learn her colleague had not returned the messages because of a family crisis. "What you don't know is she is dealing with her sick mother in the hospital," Johnson says.

Employees need to learn the right skills to go down the ladder, realizing they have made the wrong assumptions or are thinking about things incorrectly, Johnson adds. ■

Study Results Suggest ASCs May Not Be Lowest-Cost Option for All Procedures

Generally, ASCs are perceived as safe, high-quality, low-cost settings for many surgical procedures. Typically, ASC costs are lower than those in the similarly safe and high-quality settings of hospital outpatient departments (HOPDs), which also handle same-day surgeries.

However, the authors of a recent study found there is one striking exception: outpatient joint replacement surgery.[1]

The authors examined total knee replacement surgery and total hip replacement surgery in HOPDs and ASCs that occurred over a four-year period (2014-2017). Researchers focused on commercially insured patients. On average, under Medicare, payments to ASCs for total joint procedures are significantly less than payments to HOPDs.[1]

The authors did not consider outpatient procedures paid by Medicare, as the Centers for Medicare & Medicaid Services (CMS) removed total knee arthroplasty procedures from its inpatient-only list in January 2018, which is outside this study's window. *(Learn more about that CMS decision at: https://go.cms.gov/39ICAaI.)* As of Jan. 1, 2020, total knee arthroplasty procedures are no longer part of Medicare's inpatient only list. *(Learn more at: http://bit.ly/2P42Rs8.)*

"ASCs are growing as alternative surgical sites, so we compared ASC and HOPD prices," says **Kathleen Carey**, PhD, a study co-author and professor of health law, policy, and management at Boston University.

Investigators used data from a large national claims database that showed actual prices paid to providers.[1] "For the same procedure code [in Medicare], ASCs are paid [significantly less than] HOPDs," Carey says. "What I was interested in seeing is whether the commercial sector payments were similar."

Carey and her colleague found that most of the time, the commercial sector payments were similar, except for joint replacements. "That was a very different story," she says.

The authors observed two trends. First, payments to HOPDs for total joint replacements were less than one-third of what ASCs received for each year of the study period. Second, payments to HOPDs rose each year from 2014 to 2017, while payments to ASCs declined over the same period.[1]

> AN ASC MAY HAVE RECEIVED MORE MONEY THAN AN HOPD FOR JOINT REPLACEMENT, BUT THAT GAP IS CLOSING.

Payments to HOPDs for total knee replacement were $6,016 in 2014 vs. $23,244 to ASCs. By 2017, total knee replacement procedure payments to HOPDs had risen to $10,060, and payments to ASCs had declined to $18,234.

Meanwhile, HOPDs received $6,980 for total hip replacements in 2014 vs. $28,485 paid to ASCs. In 2017, HOPDs received $11,139 for hip replacements vs. $18,595 for ASCs.[1]

Notably, the authors acknowledged these figures apply to small patient populations. For total knee replacements in 2014, investigators studied the information of 67 HOPD patients and 68 ASC patients. In 2017, these numbers rose to 223 for HOPDs and 602 for ASCs.[1] For hip replacements, there were 43 HOPD patients vs. 82 ASC patients in 2014. By 2017, it was 206 HOPD patients and 465 ASC patients.

One possible explanation for the higher ASC prices could be related to bundled payments in the HOPD setting, Carey offers.

"Bundled payments is an alternative payment mechanism that's getting a lot of traction, and knee and hip replacements are the most common bundles in the data," she says. "This is not totally an apples-to-apples comparison, although we have no data to support that; it's just speculation."

Carey says she expects there will be further market adjustments in prices paid. Just as the amount paid to HOPDs has risen and the prices paid to ASCs has declined, this type of market adjustment may continue. Researchers have not yet studied similar data for 2018 and 2019, so they do not know how the trend played out more recently.

"We'll look at that soon, and I expect to see the payments to be closer," Carey reports. "I hope to see some convergence of those two lines because things are changing a lot." ■

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Similar Safety Profiles for HOPDs, ASCs Post-Hip Surgery

A group of investigators have observed postsurgery complications for hip arthroscopy are similar for patients treated in both HOPDs and ASCs. Further, there are low complication rates in both settings.[1]

Researchers examined CMS information from the Humana Claims Database, a national repository that contains medical and other data on millions of Americans. The advantage of studying a large database is researchers can find even rare adverse events. These investigators compared postoperative adverse events that occurred between 2007 and 2016 regarding hip arthroscopy procedures in both same-day surgery settings.

"We looked at all people who went through hip arthroplasty in the database," says **Aravind Athiviraham**, MD, a study co-author and associate professor of orthopedic surgery and rehabilitation medicine at the University of Chicago. There were 1,012 hip arthroscopy procedures performed in ASCs and 2,809 performed in HOPDs during the study period.

Investigators reviewed 90-day data for complications that are reportable to CMS. They also reviewed 90-day readmissions, returns to the operating room, seven-day ED visits, and 90-day venous thromboembolism. Reportable complications included myocardial infarction, pneumonia, venous thromboembolism, sepsis, postoperative bleeding, wound infection, and septic arthritis.

Athiviraham and colleagues found ASCs recorded a 90-day, CMS-reportable complication rate of 2.17% vs. 2.95% for HOPDs. Return-to-operating room rates were even smaller (both settings less than 0.2%).

"We found that all of the things we looked at were comparable," Athiviraham says. "It's safe to say the procedure is safe in an ambulatory surgery center setting." Hip arthroscopy is one of the fastest-growing fields in sports medicine, increasing steadily in same-day surgical settings since the 2000s, Athiviraham reports. "The procedure is done almost exclusively in outpatient settings," he says. "Most practices want to know what you bring to the table. If you bring hip arthroscopy, it's a very attractive thing."

The study's chief findings were that the procedure is safe in either same-day surgery setting.

"The bottom line is [surgeons are] doing the right thing in infection control," Athiviraham concludes. ■

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More Recovery Time Can Aid Patients After Hip Surgery

Research suggests some hip fracture surgery patients experience better outcomes after the procedure with a longer post-acute stay Recovery also is easier when these patients do not have to engage in intensive physical therapy initiated immediately after surgery.[1]

Investigators reviewed outcomes and data from Medicare patients in post-acute care settings, including four inpatient rehabilitation and seven skilled nursing facilities, reports **Alison Cogan**, OTR/L, co-author and adjunct assistant

professor of health, human function, and rehabilitation sciences at George Washington University.

These patients needed additional care after surgery. "I can't speak to the settings where surgery was conducted, but they were discharged to post-acute care facilities," Cogan notes.

Cogan and colleagues found discharging many patients before 21 days in a post-acute care setting had elapsed likely transferred burden of care to family and caregivers, home health, and outpatient services. CMS encourages quality care that also is cost-effective. From that perspective, it makes sense to provide more therapy in the early days after surgery, and to discharge patients home faster. But Cogan and colleagues found this approach does not result in the best patient outcomes.

"We need to identify patients who are going to be OK with home discharge and a lower level of support vs. the patients who need to be sent to an inpatient facility for a post-discharge period and who will benefit from more intensive rehabilitation care," Cogan suggests.

The authors examined patients' functional independence measures for mobility and self-care. They grouped patients in different recovery trajectories, including those who recovered quickly and those who took much longer to recover, Cogan explains. "The rate of recovery was strongly associated with how much independence they had with mobility and self-care outcomes at discharge from the post-acute care facility," she adds. "Also, the length of stay was strongly associated with their functional outcomes."

Cogan and colleagues did not see data about patients' functional ability before surgery. However, at admission to post-acute facilities, they were similar in their limitations for self-care, lower body dressing, and getting on and off the toilet, Cogan notes. "Some people improved rapidly; others less so," she says. "We found that the amount of therapy did not seem to change their trajectory."

For instance, some patients were prescribed intense physical therapy, which did not lead to faster improvement, Cogan explains. What did seem to work was giving patients more time to heal instead of jumping into rigorous therapy at the beginning of their post-acute care facility stay, Cogan says.

For this study, patients were divided into groups of high performers, medium performers, and low performers. "People in that middle group who had a longer length of stay were discharged with functional independence. Those on higher-intensive therapy regimens still needed assistance with a number of tasks when they were discharged," Cogan says. "In the inpatient rehab setting, the standard of care is three hours of therapy per day, and the middle group had an average length of stay of 14 days."

Those who stayed 14 days recorded lower functional scores than those who stayed an extra week and participated in less intensive therapy.

Of note, these authors collected data from the 2005-2010 period. Since then, the trend of home discharge has grown, Cogan observes. "It all comes down to cost effectiveness and getting people the right care without doing too much," she says. "There is a trend toward the kinds of surgeries that are discharging people home." ■

REFERENCE

1. Cogan AM, Weaver JA, McHarg M, et al. Association of length of stay, recovery rate, and therapy time per day with functional outcomes after hip fracture surgery. *JAMA Netw Open* 2020;3:e1919672.

SDS Manager

Managing and Mingling Hospital, ASC Cultures

By Stephen W. Earnhart, RN, CRNA, MA
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Fifty years ago, the freestanding surgery center movement was born. It has expanded services and grown each year to unprecedented levels, far and away beyond what was expected.

Little did anyone know the implications of such a move. Hospitals continue outsourcing to ASCs, causing intermingling of services and cultures that challenge both. Surgery centers, conceived by frustrated surgeons wanting a more efficient workplace, decided they could improve the services in their own facilities better than in the traditional hospital environment. However, realizing the errors of

their ways, hospitals have made great strides in the improvement of their services and are eager to joint venture with surgeons in several ways.

This includes developing and managing their own ASCs, buying out existing centers, and developing HOPDs that provide surgical services similar to freestanding ASCs.

Not surprisingly, things do not always go as planned. After 85 hospital/surgeon joint ventures, my company has made striking observations that I would like to share.

As someone who enjoys boating, I have divided these into two lists: "Tailwinds" (issues that make the process easier), and "Headwinds" (issues that make the process harder). The "Tailwinds" are as follows:

• **Need.** There has to be an integration between the two entities for access to services and cost reduction.

Whenever there is a need, a way will be found to make it happen.

• **Public opinion.** The general population is tired of the healthcare burden; they want viable solutions.

Generally, ASCs are about 40% cheaper than hospitals and have the attention of the right people in government (as well as payors).

• **Additional revenue sources.** With additional cuts to surgeons' professional fees, they need another source of income from their ASC.

However, they also often need some service from hospitals, such as referrals from the typically primary care physicians employed by hospitals, to grow and expand services.

• **Retiring surgeons.** Many aging surgeons are ready to sell their equity. Thus, plenty of ASCs are for up for sale. Often, hospitals are the highest bidders.

The remaining four points concern "Headwinds":

• **Information technology (IT).** Hospital-based IT departments remain the greatest obstacle to making ASC industry software work the way it was designed.

ASCs thrive on case-costing and efficiency reports that companies like Surgical Information Systems and HST Pathways provide. Hospitals have their own software packages that need to service many different areas in the system. Thus, hospitals cannot always drill down to the level of detail ASCs need. While there often are interfaces between the two systems, there remains strong resentment from hospital-based IT departments to even consider the bastard child of ASC software.

• **Electronic medical record.** Part of IT, this can be a hard task because ASC-based systems typically do not play well with hospital-based systems. This is a serious obstacle regarding integration of what is needed vs. what is required.

• **Mentality.** ASC advocates can carry an attitude of "We are better than you, and can prove it." Meanwhile, hospitals may retort: "Who cares? We will eventually buy you, and close you."

There is a divide in the overall rigid bureaucracy of some hospitals and the freewheeling mentality of ASCs.

• **Human resources.** It is almost impossible to eliminate ineffective personnel in a hospital. That same protectionism strongly conflicts with the "employee at will" philosophy of most ASCs.

When I started these lists, they grew longer than space available. Many readers have been part of this process on both sides, and likely create similar lists. ■

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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.

COMING IN FUTURE MONTHS

- Minorities experience worse outcomes in surgery settings
- Improve patient record documentation
- Quality plan should include cost-reduction techniques
- Revamp reprocessing education program

SAME-DAY SURGERY

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **Using information from a large national claims database, a recent study revealed which procedures resulted in higher payments to providers in ambulatory surgery centers (ASCs) vs. hospital outpatient departments (HOPDs)?**
   a. Gastrointestinal procedures
   b. Bariatric procedures
   c. Outpatient joint replacement surgery
   d. Spinal surgery

2. **A recent study showed that post-surgery complications for hip arthroscopy are similar for patients treated in both HOPDs and ASCs. The authors reviewed data reportable to the Centers for Medicare & Medicaid Services regarding:**
   a. sepsis, postoperative bleeding, wound infection, and septic arthritis.
   b. sepsis, antibiotic-resistant infections, and high blood pressure.
   c. excessive bleeding, bed sores, and stroke.
   d. high blood pressure, lipodystrophy, stroke, and gangrene.

3. **Surgery centers can take specific steps to ensure there is a structured time-out process. Which is one of the steps?**
   a. Ensure the operating room contains all the right equipment to perform the procedure.
   b. Keep a list of acceptable places for information about implants.
   c. Ask patients to provide a fingertip match on a scanner.
   d. Direct the nurse, physician, and surgical tech to initial the patient's case file.

4. **What does PEARLS stand for?**
   a. Play, Energy, Art, Real, Living, Sunshine
   b. Partnership, Esteem, Affiliation, Responsiveness, Liking, Sympathy
   c. Particular, Enjoyment, Affirmation, Relationship, Look, Support
   d. Partnership, Empathy, Apology/Acknowledgement, Respect, Legitimation, Support