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INSIDE

DECEMBER 2000

VOL. 24, NO. 12 (pages 145-156)

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Will you ID diseases or waste time, money on routine pre-op tests on elderly?

New research opens door for no routine testing with some procedures

Your 80-year-old cataract patient has shown up for the preoperative evaluation on the day of surgery. She has a long history of diseases and medical conditions, but you don't have a lot of time for the interview. She's had some preoperative tests conducted by her internist in recent days, but you don't have the results yet. You're concerned that you might miss something if your rush the assessment because elderly patients often have atypical presentations of diseases.

So what's a same-day surgery manager to do? Order a battery of preoperative tests? Postpone surgery? Go bang his head against a wall?

According to research published this year in *The New England Journal of Medicine,* many physicians routinely order preoperative tests for cataract patients, who usually are older.[1] Those tests include complete blood counts, measurements of serum electrolytes, electrocardiograms, chest radiography, blood-clotting studies, and urinalysis.

Here's the latest PPS news

At press time, the final prospective payment system (PPS) regulation for ambulatory surgery centers was expected to be published in early 2001. Previously, the final rule was to be published this month. Same-day surgery insiders now say they expect the PPS to be implemented in January 2002.

As this issue of *Same-Day Surgery* was readied for publication, the Senate was debating a bill that would offer relief from the Balanced Budget Act and extend the three-year phase-in of the surgery center PPS to four years. (For the current status of S. 1788, *Medicare, Medicaid, and SCHIP Adjustment Act of 1999*, go to this Web site: thomas.loc.gov.)

In news for hospitals, the outpatient PPS (OPPS) for hospitals, which was implemented in August, is expected to result in a 6% to 8% drop in Medicare funding for the average hospital, according to a report from Fitch, an international rating agency in New York City and London.

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EXECUTIVE SUMMARY

Same-day surgery managers often find themselves in a quandary about whether to perform routine preoperative testing on elderly patients. Consider these suggestions:

- Pre-op tests should be conducted for elderly patients with a new or worsening medical problem.
- Elderly patients who have stable cardiac conditions don't need complete cardiac work-ups unless they meet certain conditions.
- A baseline EKG might help you decide whether the patient should be discharged to home.

"Many physicians believed the tests were unnecessary but ordered them anyway because of institutional requirements, legal concerns, or a belief that another physician wanted them performed," says **Oliver D. Schein**, MD, MPH, professor of ophthalmology at the Wilmer Eye Institute at Johns Hopkins University in Baltimore. Schein was the lead author of the research published in *The New England Journal of Medicine*, which indicated that patients who did not have routine preoperative tests before cataract surgery fared as well as patients who did have the tests. Routine pre-op testing before cataract surgery costs the Medicare program $150 million each year, he estimates. And with the number of elderly persons rising, that amount could increase dramatically in coming years.

In response to this research, the Wilmer Eye Institute eliminated routine pre-op testing for cataract patients this year. Other providers who are considering making a change to their pre-op testing guidelines might gain some support next year from the American Society of Anesthesiologists (ASA), which is developing a practice advisory on the topic.

"After reviewing [more than] hundreds of articles, there was no evidence-based data to support that a particular test would have a direct impact on outcome," says **Rebecca S. Twersky**, MD, a member of the ASA task force developing the advisory, and the medical director of the Ambulatory Surgery Unit at Long Island College Hospital in Brooklyn, NY. "The advisory will be based on responses of consultants and ASA members who were surveyed as to their practices."

Lee Fleisher, MD, FACC, associate professor of anesthesiology at Johns Hopkins School of Medi-cine, and clinical director of the OR at Johns Hopkins Hospital, says, "We've almost come to the basic conclusion: There's almost no routine testing for anything, although EKGs are a major issue."

Consider these suggestions

To help you solve the dilemma presented by pre-op testing in the elderly, here are some tips from experts in the field:

• **Consider pre-op tests for cataract and similar procedures only when the history and physical reveals a new or worsening medical condition that warrants such a test.**

The New England Journal of Medicine study involved 19,000 patients at nine medical centers. Researchers randomly assigned cataract procedures to be preceded or not preceded by a standard battery of tests. The researchers recorded any medical complications on the day of surgery or during the following seven days. The most frequent complications in both groups were rises in blood pressure and slowed heart rates. The overall rate of complications was the same in both groups: 31.3 events per 1,000 operations. Researchers observed no benefit of routine preoperative medical testing when analyzing the results by the patient's age, sex, race, or coexisting medical conditions.

So what do these researchers recommend in terms of pre-op tests before cataract procedures? Such tests should be conducted for "anyone with a new or worsening medical problem that under any circumstances, a medical tests would be of benefit to the patient, but not simply because the patient's cataract surgery has been scheduled," Schein says.

The $6 million dollar question is whether the results of the cataract study can be applied to

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similar outpatient procedures. They can, according to Schein. "When one considers outpatient procedures in the elderly, where similar kinds of agents are used, you have monitored anesthetic care, the length of procedures is similar — 20 minutes to one hour — and where anticipated blood loss is minimal, a reasonable extrapolation could be made by reasonable people."

• **Perform a complete cardiac work-up in selective cases.**

The leading cause of death in elective survey is for cardiac complications, says **Jeffrey Leppo**, MD, professor of medicine at the University of Massachusetts in Worcester. Still, elderly patients (typically defined as older than 65 or 70) don't need routine pre-op testing, he adds. "Assuming that patients have stable cardiac conditions, which means they are not Class III or IV angina, don't have congestive heart failure, and don't have significant sustained arrhythmias, they don't require a complete work-up unless they have two of the following three conditions":

— poor functional capacity, which is defined as less than four metabolic equivalent units (METs);

— intermediate-risk factors, which are mild angina pectoris (Canadian Class I or II), prior myocardial infarction by history or pathological Q waves, compensated or prior congestive heart failure, and diabetes mellitus.[2] (Those risk factors are being revised by the guidelines from the Bethesda, MD-based American College of Cardiology and the Dallas-based American Heart Association and will be published in early 2001 in the *Journal of the American College of Cardiology and Circulation*, according to Leppo);

— high-risk surgery, which is defined in the guidelines as vascular surgery and any major abdominal, thoracic, or orthopedic surgery that involves long procedures with high amount of fluid shifts.

"There's a lot of fluid management issues, which impacts mostly orthopedic procedures because of there's a lot of blood loss and transfusion," Leppo says.

• **Consider EKGs.**

EKGs still present a diagnostic dilemma, Fleisher points out. At Johns Hopkins, the anesthesiologists find it useful to have a baseline EKG, even if the EKG was performed years ago. The EKG doesn't help as much with the decision about whether to delay surgery as it helps determine who should safely go home, he says.

"You should only do diagnostic tests that will affect patient management," he acknowledges. "But part of patient management is [asking], 'Is it safe to send them home if they're not medically stable or not in optimal condition?'"

Many providers, including Johns Hopkins, perform routine EKGs at age 65 for men and age 75 for women, but the test is somewhat dependent on risk factors, Fleisher says. "The benefits are that you save the money and inconvenience of getting a new EKG." The risk is that if you take the patients to surgery, connect monitors, and providers see a complication that they didn't expect, they have to decide whether to cancel the case or admit the patient after surgery, he says. "That's the downside."

Identifying 'silent' comorbidities

Therein lies the crux of the debate of eliminating routine pre-op tests for the elderly: Those patients might have nondiagnosed diseases that could have postponed surgery if they had been detected.

There will always be situations in which a particular lab test happens to find an abnormality that subsequently ends up being important, Schein points out. For example, if providers performed a chest X-ray on every cataract patients, it would be possible to find some lung cancer that had previously been undiagnosed. "However, no one would argue that people who undergo cataract surgery should be the only ones who get adequate preventive health care," he says.

Because the incident of undiagnosed medical comorbidities increases with age, some providers

SOURCES

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- **Jeffrey Leppo**, MD, Professor of Medicine, University of Massachusetts, 55 Lake Ave. N., Worcester, MA 01655. Telephone: (508) 856-3711. Fax: (508) 856-1016. E-mail: jeffrey.leppo@umassmed.edu.
- **Oliver D. Schein**, MD, MPH, Professor of Ophthalmology, Wilmer Eye Institute, Johns Hopkins University, 600 N. Wolfe St., 116 Wilmer Building, Baltimore, MD 21287-9019.

A quick tip on when to test

Same-day surgery providers should perform a preoperative evaluation on elderly patients before the day of surgery and stabilize their medical conditions before surgery.

Pre-op testing allows you to involve the internist, organize elderly patients into care, and start medications, "so when they come to surgery that's elective, they're in the best possible outcomes," says **Sheila R. Barnett**, MD, director of education in the anesthesiology department at Beth Israel Deaconess Medical Center in Boston.

"It's not the illness, per se, but how well-controlled it is," Barnett says. ■

think it's important to identify what are essentially "silent" comorbidities. Should you do that with routine pre-op testing?

"You do that with *selective*, pre-op testing," Fleisher emphasizes.

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1. Schein OD, Katz J, Bass EB. The value of routine preoperative medical testing before cataract surgery. *N Engl J Med* 2000; 342:168-175.
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Same-Day Surgery Manager

Use peer comparisons to lower operating cost

By **Stephen W. Earnhart**, MS
President and CEO
Earnhart and Associates
Dallas

It's human nature to compare ourselves to others. There are all manner of comparisons, done rapidly and almost subliminally. We compare our clothes, body type, education, etc.

That comparison is how the fashion industry thrives. We all want to wear Calvin Klein underwear, designer sunglasses, and Armani fragrances. Why? What is this obsession with standardization and lack of originality in our culture? It is based on the fact that the majority of us don't want to stand out from the "accepted" standard. Let's take that same assumption and make it work for us in the operating room!

I have never been much of an advocate for across-the-board standardization in anything. I believe that it brings with it the risk of losing originality and stifling new ideas from not trying different methods. However, when it comes to cost control, there are standards that have been proven effective and efficient that we need to consider in the operating room. We need them to help decrease costs and increase efficiency.

A good example of peer comparisons is not having our cataract patients change their clothes for surgery. Many facilities subject this patient to this unnecessary process because that is the way they have always done it. The operating room staff, or the surgeon for that matter, don't realize that others have been able to effectively and safely eliminate this time-consuming and often embarrassing process for the patient. But rare is the facility or surgeon that would begin this procedure. Chances are, surgeons were exposed to it by someone else and chose to adopt it as their new standard. **(For more on letting patients wear their street clothes for minor procedures, see *Same-Day Surgery*, October 1998, p. 125.)**

Standardize supplies and save money

We need more standardization in the OR to reduce costs and increase efficiency when it comes to light sources, microscopes, intraocular lenses (IOLs), routines, shavers, etc. Because most of our cost per case comes from supplies and equipment, the need for educating our surgeons and staff becomes increasingly important. With the changing reimbursement, it also takes on a new sense of urgency.

Here are some ideas to help standardize cost and equipment. First, pick a procedure to compare. Use a common procedure that is performed by several surgeons at your facility.

For example, consider that you have three cataract surgeons. Label them Dr. A, B, and C. Using their preference cards, price their supply cost. A program such as Microsoft Excel or other

spreadsheet program will help you calculate your results easier. Ideally you want to audit a minimum of 10 cases per surgeon. List each item used in the procedure under the surgeon's name, and price the procedure.

You might have to call your purchasing department to obtain the unit price for each item, but it will be worth the effort. (You probably have several IOLs by different companies, which makes you lose the ability to leverage that collective volume into lower cost per case. How wonderful if they would all use the same lens and vendor!)

Don't forget to include anesthesia supplies and pharmacy items. Add those columns, and come up with the supply cost per case.

Using the operative note, add the length of the procedure for each surgeon. Then find out the resources used per surgeon: how many staff members were in the room, what was the setup time, etc.? Tally the cost per staff member (take their hourly rate and apply it to the minutes in the OR), and do the same for recovery staff. You are trying to quantify the cost per procedure. Clearly the staffing cost will be lower for the surgeon who doesn't require the patient to change clothes.

Make your data meaningful

Total the cost for each physician. Chances are, for most of you, the variance between them will be significant. What does this information do for you? Nothing. Now you have to make it meaningful. Present your findings to your OR committee or your administrator or department head. (You will get points for this effort!)

The ideal situation is to subsequently present it to each of the three physicians. Let them figure out who is who. You don't need to tell them. If they are like most surgeons today, they will want to know why Dr. A is so much higher (or lower) in cost (and/or time) than the others. Many physicians stay with the same format they have always used because they don't know they can do it differently.

When we first started not requiring our cataract patients to change their clothing (10 years ago), many of the surgeons thought that was a terrible thing and refused to allow it on their patients. They wanted to know who was doing that. Once they found out their peers were doing it, that made it easier for them to try it. Peer comparisons, and knowledge that others are doing it as well, are typically going to be required to change standards. Make your life easier, and let the psychology of it work for you.

(Editor's note: Earnhart and Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Earnhart can be reached at 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

Strategy for success in one word? Volume!

MGMA analyzes performance of surgery centers

Surgery centers are indicating higher levels of profits as their caseloads and procedures per case increase, according to a recent report from the Medical Group Management Association (MGMA).

Once a critical mass of case volume is reached at ambulatory surgery centers (ASCs), profits rise correspondingly, according to the report, *Ambulatory Surgery Center Performance Survey 2000*.

"The one word strategy for financial success at ASCs then, is volume," the report says. "After the break-even point is reached, variable costs such as medical/surgical supply expenses and staffing expenses per case can be minimal, depending on the specialties you offer, so the potential for profit rises at an increasing rate."

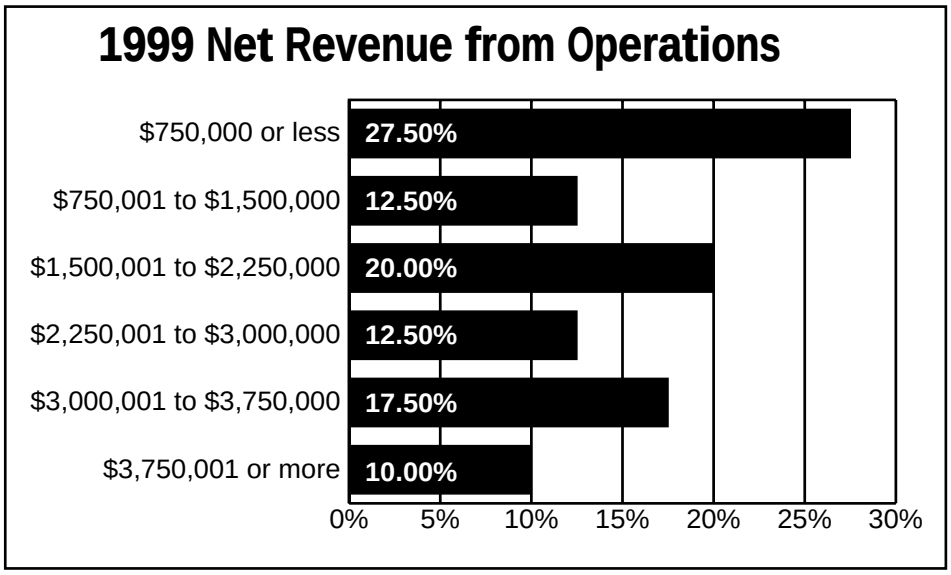
Study to be expanded outside the MGMA

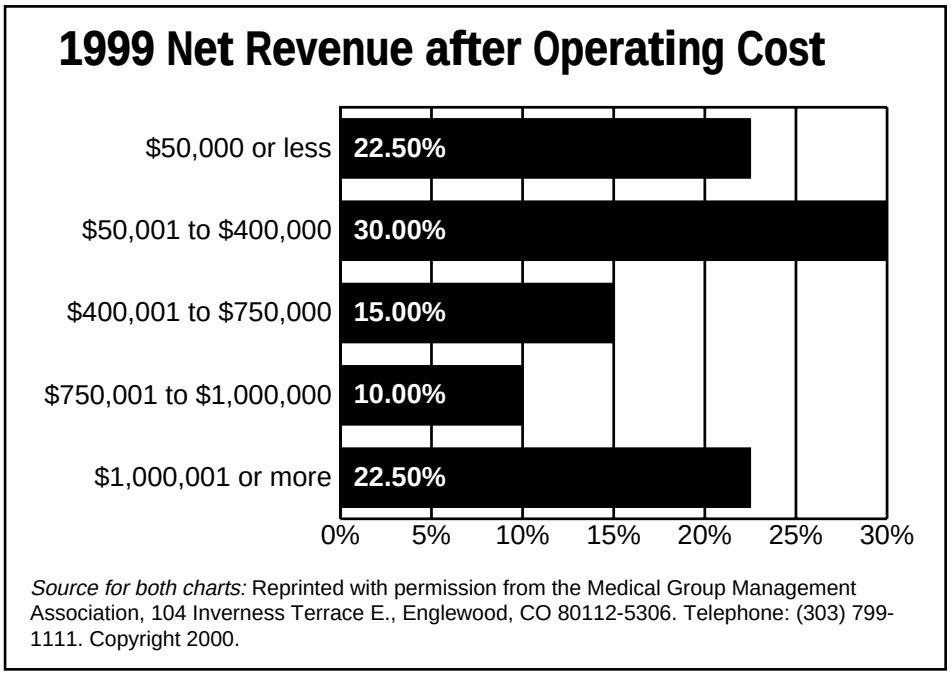
MGMA included 311 members in its survey. The report reflects data from calendar year 1999 or the surgery centers' most recently completed 12-month period. MGMA is planning to expand the study next year by working with outside organizations, including the American Association for Ambulatory Surgery Centers in San Diego.

Here are key findings from the report, which are reprinted with permission of the MGMA:

• Median net income after operating cost is $327,931. **(See "1999 Net Revenue after Operating Cost," p. 150.)** That number dropped to $87,484 at the 25th percentile and rose to more than $950,000 at the 75th percentile.

"These discrepancies are primarily a function





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"1999 Net Revenue from Operations," at left.) Median net income after operating cost as a percent of net revenue from operations is 37.98%.

That percentage is before taxes, Williams points out. "Most of these surgery centers are for-profit," he adds.

Medical and surgical supply costs per case were a median of $192. The median costs in the 1999 report were $171.

"This trend could signify an increased and more accurate deployment of just-in-time inventory techniques at ASCs, and possibly that more and more ASCs are using group purchasing arrangements to facilities better economics of scale," the report says.

Case mix and age of the facility can impact medical supply cost, Williams says.

"As a center operates, they become more astute as to how to reduce medical supply costs," he says.

Case mix can impact cost in that a new procedure, such as pain blocks, may have a significantly lower cost per case than a surgical procedure, Williams points out.

"So when you roll in pain blocks to a normal case mix, on average, your supply cost is going to drop," he adds.

of the volume achieved by ASCs and also by the surgery center's operating capacity and the amount of physical resources it houses," the report says.

The larger facilities are probably multispecialty, says **Bob Williams**, president of the Federated Ambulatory Surgery Association in Alexandria, VA, and senior development executive with Johnson and Johnson Healthcare Services in Superior, CO, points. "The smaller ones could be single specialty, such as ophthalmology, where you have a lot of Medicare," Williams says.

• The report shows that median net revenue from operations is $1,743,256 overall, $747 per case, and $782,578 per operating room. **(See**

• The breakout of total expenses averaged 33.32% for personnel salary and benefits, 29.6% for medical and surgical supplies, and 37.08% for other expenses.

• Net income per case was a median of $241.

• Total expenses per cases were a median of $546.

[The cost of the report (PMM-5590) is $75 for members plus $6.50 shipping and handling and $135 for nonmembers plus $7.50 shipping and handling. To order, contact:

• *Medical Group Management Association, P.O. Box 17603, Denver, CO 80217-0603. Telephone: (877) ASK-MGMA, ext. 888. Fax: (303) 643-4439.]* ■

Domestic abuse victims undergo more surgeries

Help staff ID, aid victims with subtle symptoms

EXECUTIVE SUMMARY

A study shows that women with a history of domestic violence undergo major surgery twice as much as women without a history of domestic violence. Procedures such as exploratory laparoscopies to diagnose unexplained pain are sought more often by victims of domestic violence.

- Make patient safety and confidentiality a focus of your policies.
- Train staff members how to ask questions in a nonthreatening and nonaccusatory tone.
- Establish relationships with community organizations to ensure a smooth referral process.

The patient kept coming to **Debra A. Zillmer**, MD, an orthopedic surgeon in LaCrosse, WI, with persistent tennis elbow. "We tried everything to treat the elbow, but the pain was unrelenting," says Zillmer.

She reviewed the patient's chart and noticed several emergency department visits as well as repeated visits to physicians in the patient's medical history. "At her next visit, I asked her what else was going on in her life," she says. After discovering that the woman was in an abusive situation, Zillmer offered referrals to agencies that could help her. Zillmer says the woman used the resources provided to confront her problems at home, and her elbow pain dramatically improved.

Surgeons and same-day surgery staff do see victims of domestic abuse for procedures that include surgeries to diagnose unexplained pain or treat chronic pain, says **Debra P. Hastings**, CNR, MSRN, a New Hampshire same-day surgery nurse.

Hastings reviewed the medical charts of 110 women older than age 18 who were seen in a primary care practice and found that women who experienced domestic abuse were twice as likely to undergo major surgeries as women with no history of domestic abuse. Hasting's study, co-authored by Glenda Kaufman Kantor, PhD, research professor at the University of New Hampshire in Durham, NH, was presented at the recent National Conference on Health Care and Domestic Violence sponsored by the Family Violence Prevention Fund (FUND) in San Francisco.

"For this study, major surgery was defined as any exploratory laparoscopy, knee surgery, back surgery, abdominal surgery, thoracic surgery, pelvic procedures, or reconstruction," says Hastings.

Minor surgeries included dilation and curettage, dental extractions, and nasal or ophthalmic surgeries. "There were no significant differences in the number of minor surgeries between the group of women with history of domestic abuse vs. women without a history of domestic abuse," she says.

Although most people are aware of the traumatic injuries associated with domestic abuse that are usually seen in emergency departments, most symptoms are more subtle, says Zillmer. "The most important thing that those of us in a surgery setting can do is to be observant," she says. "We have an opportunity to notice signs of abuse on a person's trunk or limbs that may normally be covered by clothing."

The most important role that physicians and same-day surgery program staff members can play is to have a high level of awareness of the subtle symptoms of domestic abuse, Zillmer says.

First contact is crucial

The first contact with a potential victim of domestic abuse is crucial, so it is important that your staff and physicians know how to identify victims and how to refer victims to resources, says **Sherrie Munson**, MSW, department manager of WomanKind, the domestic violence program at Fairview Health System in Minneapolis. **(See story on how to talk to victims, p. 153.)**

Policies and procedures in all Fairview departments, including ambulatory surgery, outline specific questions and suggest how to word the questions so the patient is more open to answer, says Munson.

"We ask all patients about domestic abuse as part of our preadmission procedure, and we tell them that we ask these questions of all patients so they don't become defensive," she says. "We ask if they are now in or have ever been in a relationship where they have been abused, and we ask if they would like to talk to someone if their responses are positive."

Men and women are privately asked the same

SOURCES AND RESOURCES

For more information about same-day surgery staff's role in identification of domestic abuse, contact:

- **Debra A. Zillmer**, MD, Orthopedic Department, Gunderson Lutheran Medical Center, 1836 South Ave., La Crosse, WI 54601. Telephone: (608) 782-7300. E-mail: dzillmer@gundluth.org.
- **Debra P. Hastings**, CNOR, MSRN, One Wild Acres Road, Gilford, NH 03246. Telephone: (603) 524-5995. Fax: (603) 524-3549. E-mail: laser@cyberportal.net.
- **Sherrie Munson**, MSW, Department Manager, WomanKind, Fairview Health System, Fairview University Medical Center, 2450 Riverside Ave., Minneapolis, MN 55454. E-mail: smunson@fairview.org.
- **Lisa James**, Senior Program Specialist, Family Violence Prevention Fund, 383 Rhode Island St., Suite 304, San Francisco, CA 94103-5137. Telephone: (415) 252-8900 ext. 27. Fax: (415) 252-8991.

For resource information about setting up a domestic violence identification and referral program, contact:

- **Family Violence Prevention Fund**, 383 Rhode Island St., Suite 304, San Francisco, CA 94103-5137. Telephone: (888) 792-2873 (Rx-ABUSE) or (415) 252-8900. Fax: (415) 252-8991. Web: www.fvpf.org/health. A number of information packets are free, and FUND also offers training and reference materials for a fee.
- **National Center for Injury Prevention and Control**, Centers for Disease Control and Prevention, Mailstop K65, 4770 Buford Highway N.E., Atlanta, GA 30341-3724. Telephone: (770) 488-1506. Fax: (770) 488-1667. Web: www.cdc.gov/ncipc. A free document titled *Intimate Partner Violence and Sexual Assault: A Guide to Training Materials and Program for Health Care Providers* can be requested by telephone, fax, or e-mail through the Web site.

questions because both groups can experience abuse, Munson points out.

While Fairview has staff dedicated to counseling and referring victims of domestic abuse, smaller surgery programs can set up a program without adding staff, says **Lisa James**, senior program specialist at FUND, an organization that focuses on domestic violence education, prevention, and public policy reform.

Include questions related to domestic violence in all routine preadmission visits, and have a resource folder available for the preadmission nurse, suggests James. The resource folder should have the names of staff members who are identified as domestic violence counselors or liaisons, or names and phone numbers of local community agencies, she says.

Work with local agencies to develop a method of referral and follow-up if the surgery program staff does have a patient who asks for help, she adds.

Your surgery program should train staff about how to ask questions and how to handle referrals and follow-ups. Set up policies that fit your center, suggests James. "Don't set up an complicated procedure that will be hard to follow and staff if you are a small program."

Take advantage of existing resources offered by local agencies as well as organizations such as FUND, James suggests. "FUND offers examples of policies and guidelines, questions to ask, posters, reference cards, and technical assistance for setting up domestic abuse referral programs," she says. **(For contact information, see source box, at left.)**

When developing procedures to respond to reports or evidence of domestic abuse, remember that the safety of the patient is paramount, says Hastings.

"There is no hospital stay to protect them, so we need to make sure we don't send them back into a dangerous situation," she adds.

Ask the patient if he or she feels safe going home, says Zillmer. If the response is negative, suggest some resources that can help the patient find a safe place, she adds.

Physicians or the staff nurses may feel frustrated because they can't fix the problem for their patient themselves, but they play a critical role, says James. "Even if the patient is referred to someone else for help, the physician or same-day surgery nurse may be the first person to ever give the victim an opportunity to ask for help."

Recommended reading

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- Short LM, Johnson D, Osattin A. Recommended components of health care provider training programs on intimate partner violence. *Am J Prev Med* 1998; 14:283-288.
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Be ready to handle domestic abuse victims

Ensure patient safety, meet legal responsibilities

A woman went to see her physician about a health problem that resulted in the physician's recommendation for a dilation and curettage (D&C). During the visit, the woman admitted that she was a victim of domestic abuse and asked for help.

"The patient worked with a crisis counselor to make arrangements to have her D&C, then go to a shelter," says **Debra P. Hastings**, CNR, MSRN, a New Hampshire same-day surgery nurse.

Unfortunately, another same-day surgery nurse, not realizing the patient's special situation, called the patient's home to conduct the pre-op interview and left the message with the husband who had been unaware of the surgery. "The plan fell apart, and the woman had to return to the home following surgery," Hastings says.

Make sure communication is open between community agencies, your physicians, and your staff when domestic abuse is involved, and don't leave messages about surgeries with people other than the patient, she suggests. Hastings conducted a study, co-authored by Glenda Kaufman Kantor, PhD, research professor at the University of New Hampshire in Durham, that looks at the correlation between surgery and domestic violence. The study was presented at the recent meeting of the National Conference on Health Care and Domestic Violence sponsored by the Family Violence Prevention Fund (FUND) in San Francisco.

In addition to keeping communications channels open to ensure patient safety, be sure to teach your staff the right way to ask questions, says **Lisa James**, senior program specialist at FUND, an organization that focuses on domestic violence education, prevention, and public policy reform.

"You should first frame your question so the patient doesn't become defensive," says James. A phrase such as "We see so much violence in our patients lives that we are asking the following questions of everyone" lets the patient know that he or she has not been singled out, she explains. Also, be sure to interview the patient alone, she says. A domestic abuse victim will not be forthcoming if the abusive family member or even another family member is present, she adds.

At Fairview Health System in Minneapolis, MN, staff members tell patients that because the health system is committed to quality health care, screening questions address all aspects of a patient's life, says **Sherrie Munson**, MSW, department manager of WomanKind, the domestic violence program at Fairview Health System.

Once you have established that the questions are part of the standard screening or preadmission procedure, ask specific questions about violence in the patient's life, says James. Ask if the patient is currently in, or has ever been in a relationship that involved physical, emotional, or sexual abuse, she suggests. Follow up by asking if the patient would like to talk to someone about it, she adds.

You can be specific if you notice bruises and evidence of old injuries, says **Debra A. Zillmer**, MD, an orthopedic surgeon in LaCrosse, WI. "When the patient is awake in pre-op, ask what caused the bruises." If the explanation is not consistent with the actual injury or if there are several injuries in different stages of healing, follow up with a statement and question such as, "When I see injuries like this, it is usually because someone has been hurt by another person. Did this happen to you?" she suggests.

Once a patient has told you about an abusive situation, make sure you let the patient know that you understand by saying that you are glad he or she told you and that it is a problem that affects a lot of people, says James. Then offer to provide the names and telephone numbers of a person within your organization or a community agency that can help, she adds.

From an accreditation standpoint, only the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, requires that health care organizations have a procedure to identify potential victims of abuse and refer them to appropriate resources. The Joint Commission standards also require organizations to collect and safeguard evidence and notify authorities in accordance with the laws that govern the health care organizations' area.

Make sure you research your legal responsibility and check with your facility's lawyer, because laws that govern a health care provider's response to domestic abuse reports vary from state to state, says James. Make sure your procedures reflect your state's requirements for reporting and collection of evidence, she adds.

It's important to remember that even the same-day surgery setting should address domestic violence, says Zillmer. "Whenever we can make

contact with patients and tap resources that help them improve their lives, we have accomplished a great deal." ■

Good/bad reimbursement news for pain management

HCFA deletes some procedures from ASC list

Whether your same-day surgery program is home to a comprehensive pain clinic or simply has an anesthesiology staff who incorporate the latest pain management techniques into their overall practice, current changes could affect the financial picture of your pain management service.

The biggest changes will be noticed by freestanding centers, says **Eric Zimmerman**, JD, associate with McDermott, Will, and Emery in Washington, DC, which represents the American Association of Ambulatory Surgery Centers in San Diego.

"When HCFA [the Health Care Financing Administration] published the ambulatory surgery center [ASC] proposed prospective payment system regulation in July 1998, nine pain management procedures were deleted, and another five proposed additions were rejected," he says.

The deleted procedures, CPT codes 64420 to 644623, were injections that were determined to be no-surgical and suitable for administration within a physicians' office setting, he explains.

"There will be no facility fee paid for these injections if they are performed within an ambulatory surgery center if the rules are published as they are today," says Zimmerman. The ASC prospective payment system is expected to be published in early 2001 with implementation likely in January 2002.

"Hospital-based ambulatory surgery programs and pain management programs will most likely notice an increase in the number of pain management patients who require injections since hospitals are permitted to perform the procedures," he says. Although HCFA has determined that those pain management procedures can be performed in a physician's office rather than an ASC, HCFA is under no mandate to develop a list of approved hospital services, he says. That means the physicians who don't want to perform a potentially risky procedure in their offices can decide to use the hospital and they will be reimbursed, explains Zimmerman.

"These injections are inherently risky procedures that can cause convulsions, cardiac arrhythmia, and paralysis," he says. The physician is also invading a sterile space near the brain, so there is also a risk of infection, Zimmerman adds.

"If a physician performs the procedure in an

EXECUTIVE SUMMARY

The Health Care Financing Administration has moved coverage of nine pain management procedures from ambulatory surgery centers (ASCs) to physician offices in the proposed ASC prospective payment system. This change is predicted to create a boon to hospital-based programs, rather than physician offices.

- Physicians are reluctant to provide pain control injections in an office setting. These procedures require monitoring, pulse oximetry, and crash cart capabilities.
- Hospital-based programs face fewer restrictions in the procedures they offer.
- Freestanding programs with mostly workers' compensation patients in the pain management service might feel less effect from the removal of the procedures.

Surgery center rule delayed

continued from cover page

Because other payers are likely to adopt the PPS system, the actual drop could be even higher, the agency warns. Also, hospitals could see a 40% increase in the collection period for Medicare outpatient claims, which could add one to two days in accounts receivable, the report says. The report also addresses the challenges of converting to the outpatient PPS system. "Inaccurate claim submissions will cause a more significant financial impact than the actual decrease in payments due to reduced reimbursement rates, and the most important factor in determining the financial impact is the degree to which hospitals have prepared for the complexities of implementing the new APC system," says **Anil M. Joseph**, an analyst for Fitch.

For a copy of Credit Implications of Medicare Ambulatory Payment Classifications (APCs) visit Fitch's Web site: www.fitchratings.com. **(For more on the hospital OPPS, see story on pain management reimbursement, above.)** ■

SOURCES

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- **Devona J. Slater**, CMCP, President, Auditing for Compliance and Education, 10308 State Line Road, Leawood, KS 66206. Telephone: (913) 648-8572. Fax: (913) 381-1180. Web: www.aceanesthesiapain.com.
- **Eric Zimmerman**, JD, Associate, McDermott, Will and Emery, 600 13th St. N.W., Washington, DC 20005. Telephone: (202) 756-8000. E-mail: ezimmerman@mwe.com.

office, there is a need for a crash cart, pulse oximeter, and other monitoring equipment normally found in an ASC setting," he says.

Reimbursement for pain management services in the hospital outpatient prospective payment system can be helpful to hospital-based programs, says **Devona J. Slater**, CMCP, president of Auditing for Compliance and Education, a consulting firm in Leawood, KS, that specializes in coding and billing compliance issues for anesthesia and pain management. "Bills for pain management procedures are now procedure-driven rather than cost-driven, making the coding process simpler and more accurate." Pain management procedures can still be a revenue generator for hospitals, even though overall reimbursements for pain management were reduced, she adds.

"We have to remember that many pain management procedures are so new that there are not CPT codes to accurately reflect the services that were provided," Slater says. "How the system handles those procedures that do not have codes is yet to be seen." For example, some techniques that were reimbursed for as much as $800 are now reimbursed at levels around $200, but you are allowed to bill for every procedure that is done, she says. "The important thing to remember is to attribute actual costs on the pain center to actual revenue generated by the pain center."

While he still keeps an eye on what is happening with the outpatient prospective payment system, **Gene Hybner**, administrator of Bay Area Surgery in Corpus Christ, TX, doesn't expect that changes will significantly affect his financial picture for the pain management service.

"About 60% of our pain management patients are workers' compensation cases," he explains. "We are lucky in Texas because the state workers' compensation program doesn't differentiate between hospitals and ambulatory surgery centers, so we get paid 85% of the charges we bill for each patient, just like the hospitals receive," he says. Medicare patients represent about 7% of his pain management caseload, and the other 33% are third-party payers or self-pay.

Hybner is proactive when working with third-party payers. "We negotiate payments for pain management upfront with the payers with whom we have contracts, and we encourage them to look at outcomes," he says.

Hybner's staff call all pain patients the day after the procedure to see how they're doing and include the results of the call in the chart. Because

Same-Day Surgery® (ISSN 0190-5066) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Same-Day Surgery**®, P.O. Box 740059, Atlanta, GA 30374.

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Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $399 per year; 10 to 20 additional copies, $299 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

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many pain management patients receive two to three injections over a three- to six-week period, their charts include information from several follow-up calls. A clear picture of how the treatments work emerges from the documentation, he says. ■

Orthopedic information available on the Web

The Web site for the American Association of Orthopedic Surgeons (AAOS), which can be found at **www.aaos.org**, offers research information, patient education materials, and guidelines.

While some sections of the site are available only to members of the association, nonmembers can view free abstracts of articles from the *Journal of the Association of Orthopedic Surgeons*. Full text of the articles can be purchased for $7 per article. Issues of the *AAOS Bulletin* and the *AAOS Report* can be viewed in full. Nonmembers also can view news bulletins from AAOS and other international associations.

Practice guidelines and association publications can be purchased on-line or by fax, telephone, or mail.

The site list current research projects and links to the National Institutes of Health, Federal Drug Administration, Medline, and the National Library of Medicine.

Nonmembers can view patient education materials such as fact sheets and brochures on knee arthroscopy. Managers can check out the orthopedic yellow pages, which provides direct links to appropriate vendors. ■

• March 4-6, 2001 — **The Seventh Annual Same-Day Surgery Conference: Successful Same-Day Surgery in a New Reimbursement Era**, Orlando, FL. Sponsored by American Health Consultants, publisher of *Same-Day Surgery*. To register, contact: Customer Service, American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. Fax: (800) 284-3291. E-mail: customservice@ahcpub.com. ■

CE objectives

After reading this issue, the continuing education participant will be able to:

• Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management (See "Will you ID diseases or waste time, money on routine pre-op tests on elderly?" and "Domestic abuse victims undergo more surgeries," in this issue.)

• Describe how those issues affect nursing service delivery or management of a facility. (See "Be ready to handle domestic abuse victims" and "Strategy for success in one word? Volume!")

• Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. ■

SDS TECHNOLOGY

Technological 'Big Brother' increases efficiency

Real-time patient tracking improves communications, reduces noise, eases anxiety

Although they may feel like characters in a George Orwell novel, some same-day surgery program staff members merely look at a computer display to see where a patient is in the surgical process. Family members see the same information on displays in the waiting room, which gives them updated status reports on their family member's location without taking up staff time.

"We wanted real-time patient tracking in our same-day surgery program to help us improve our efficiency and communicate more effectively," says **Wanda K. Teply**, CRNA, director of perioperative services at Fairview-University Medical Center in Minneapolis.

The product chosen for the health system's freestanding surgery center was the Health Enterprise Navigator System by St. Paul, MN-based NaviCare. **(See contact information, p. 2.)** It offers real-time tracking and display screens that communicate a patient's progress throughout the surgical process.

The system requires little training and relies on each member of the same-day surgery team to push one button to indicate the completion of a task. For example, once the pre-op nurse has completed his or her work with the patient and pushed the button, an icon on the display screen indicates that the patient is waiting on the anesthesiologist. The button can be programmed to indicate whatever data the surgery program wants to communicate, says Teply. The system can indicate when the patient is finished with the admissions process, the pre-op process, the visit with the anesthesiologist, and all other steps of their visit, she adds.

Simple icons on the operating room monitors indicate different parts of the surgical process. For example, a "Mayo stand" in an operating room means that setup for the next case has started and a mop and pail in an operating room indicates clean-up after a case, says Teply. "We also have an icon of a suture line that means closing has started," she adds.

Knowing when a case is nearing completion helps the post-anesthesia care unit staff better organize their time, adds Teply. "They see how many patients will be coming into the unit within a certain time frame, and this helps them determine the best time for breaks."

Improved, easier communication between staff, physicians, and family members results in a more efficient surgery program, says Teply. "Staff members and physicians can simply look at the display screen to see if the patient is ready for the next step. No one has to go find the anesthesiologist, and the physician doesn't have to ask if a patient is ready."

EXECUTIVE SUMMARY

Some same-day surgery programs are using real-time patient-tracking software and monitors throughout the operating rooms, admission area, and waiting rooms to improve communications as well as collect data. The benefits are as follows:

- Fewer telephone calls and pages to locate physicians means a quieter environment and can reduce clerical staff.
- Everyone can communicate more effectively because a glance at the computer monitor shows exactly when a patient is ready for the next step.
- Family members are less anxious.

Because there are fewer phone calls to and from the operating room as people try to find and notify surgeons, anesthesiologists, and other staff, Teply has been able to cut one full-time secretarial position.

The screen in the family waiting area is a simpler version of the detailed screen displayed in the OR areas but does show when a patient moves from one area to another. Icons are not used; instead, a mark is simply placed under the appropriate column headlined pre-op, operating room, or recovery.

"To protect patient confidentially, the patient's full name is not shown, only the first two letters of the last name and the first letter of the first name," says Teply. No other detailed information such as type of procedure or surgeon is included on the waiting room monitor.

Patient's family members appreciate the continuous communication, says Teply. "When you have several waiting areas, it is nice not to have to search for family members to update them, and they don't have to come looking for us."

After the first six months of operating a patient-tracking system, Fairview conducted a survey of family members who used the waiting room monitors, says **Ryan Davenpor**t, hospital spokesman. "Ninety-two percent of the respondents felt the system benefited their stay in all of the categories measured," he says. The survey measured the respondents' opinion on the system's ease of use, relief of anxiety about family members, and usefulness of information.

The Day Surgery Center, a joint venture of United Hospital and St. Paul Children's Hospital in St. Paul, MN, also tracks patients within the same-day surgery program. "We had used a patient-tracking system in our main operating rooms at United Hospital, so we knew it would work well for the same-day surgery center," says **Leiloni Young**, business analyst for the Day Surgery Center. "Our system is linked with the operating rooms at United so surgeons and anesthesiologists working at both facilities can track what is happening with their patients at each location," explains Young. Children's Hospital hasn't used real-time patient-tracking systems in their operating rooms, so there is no program with which to link at that facility, she adds.

Computers that enable updates are in each of the eight operating rooms at the Day Surgery Center. This is one thing Teply wishes her program had done differently at Fairview.

"We placed computers outside the operating rooms to be shared," she explains. "This means that that someone from the surgical team has to come outside the OR to update information or check on the progress of other patients for the surgeon," she explains.

Be sure to pick a system that produces reports you can use for benchmarking and quality improvement, advise Teply and Young.

It is easy to be overwhelmed by the data generated by a patient-tracking program, so

List of Vendors

The following is an abbreviated list of companies offering products that help same-day surgery staff track patients as they move throughout the surgical day:

- **NaviCare Systems**, 4505 White Bear Parkway, Suite 1600, White Bear Lake, MN 55110. Telephone: (877) 628-4227 or (651) 407-6015. Fax: (651) 407-6022. E-mail: info@ navicare.com. NaviCare offers Health Enterprise Navigator System that enables staff members to indicate when patient has completed each step of the surgical process. System also has data-collection and report-writing capabilities. Licensing fees range from $8,000 to $18,000 per procedure room, depending on features chosen. Annual support costs run approximately 15% of licensing fees.
- **Camberley Systems**, 175 Highland Ave., Third Floor, Needham, MA 02194-3034. Telephone: (800) 886-4325 or (781) 444-1424. Fax: (781) 444-2805. Web: www.camberley.com. Camberley Systems offers SurgeOn, a Windows-based product that includes a number of same-day surgery management tools including real-time patient tracking. The basic system costs approximately $25,000.
- **Surgicenter Information Systems**, 71 Bradley Ave., Suite 11, Madison, CT 06443. Telephone: (800) 219-7642, ext. 1 or (203) 318-1300. Fax: (203) 318-0095. E-mail: jfreund1@sissystems.com. Web: sissystems.com. Real-time patient-tracking system that incorporates use of hand-held technology is in development, with product introduction scheduled for mid-2001.

SOURCE

For information on the use of patient tracking systems within a same-day surgery program, contact:

- **Wanda K. Teply**, CRNA, Director of Perioperative Services, Fairview-University Medical Center, 2450 Riverside Ave. MB338, Minneapolis, MN 55454. Telephone: (612) 672-6490. Fax: (612) 672-6470.
- **Leiloni Young**, Business Analyst, Day Surgery Center, 333 N. Smith Ave., St. Paul, MN 55102. Telephone: (651) 220-8462. Fax: (651) 220-5073. E-mail: lyoung@allina.com.

focus on specific areas that are most important to you, says Teply. "You can use these data to support changes you want to make in your processes such as who sets up the room and also to pat the staff on the back for reducing the length of time in the operating room."

Other software vendors offer patient tracking that produces historical reports, but at least two other companies in addition to NaviCare are addressing the need for real-time communication. **(See list of vendors, p. 2.)** ■

Reduce patients' stress with Web site service

Program helps patients stay in touch

Can a same-day surgery program offer assistance to family members who need to update family and friends on a patient's condition? Can it be done without disrupting staff members' jobs or costing the family members a lot of money? Will it increase patient satisfaction with your same-day surgery program?

The answer to all of these questions is yes, says **Diana Torre** director of surgical services at White Plains (NY) Hospital. What was her solution? VisitingOurs.com, which was developed by **David Gottesfeld**, PsyD, a psychologist in New York City. The program enables family members to keep friends and other family members up to date on the patient's progress via the Internet. The idea for VisitingOurs.com came to Gottesfeld after hearing his own patients talk about the stress of having a family member in the hospital for any reason.

"Patients talked about the number of telephone calls they received or had to make and the need to repeat the same story to each person," Gottesfeld explains.

A same-day surgery program that helps patients and their family members deal with the time-consuming, stressful task of updating others gets good feedback from patients, says Torre. A computer terminal that enables patients' family members to log on to the VisitingOurs.com Web site is in the waiting room of the same-day surgery department. "We've had VisitingOurs.com since early summer of 2000, and although we haven't conducted a formal survey, the comments from patients and their family members have been positive," she says.

The advantage of VisitingOurs.com over e-mail is the ease of use, says **Karen Burris-Lombardi**, director of community relations at White Plains. "Even a person with no computer experience can sit at one of the terminals we provide and set up their own page on the site," she says. "The family member is walked through the process, step by step, in simple language."

White Plains offers computer terminals for convenience and also for people who might not have their own computers, says Burris-Lombardi. The computers provided in the

EXECUTIVE SUMMARY

A Web site service can help your patients and their families send updates about the patient's condition to family and friends without taxing your staff's time or your program's budget. VisitingOurs.com offers patients and their families an opportunity to use Web technology without having to spend time or money setting up their own Web page. Benefits to a same-day surgery program include:

- Fewer telephone calls are made to and from the same-day surgery waiting areas.
- Positive comments from patients expressing satisfaction with the same-day surgery program's commitment to customer service.
- Investment in computer equipment is not necessary to offer the service to patients.

waiting room are directly linked to Visiting Ours.com so there is no surfing the Internet or tying up the computer with personal e-mail, she adds.

There is a facility fee charged to the surgery center or hospital that wants to set up a page on the Web site with the facility's logo and information, but there is no charge to the patient, says Gottesfeld. Fees are based on number of admissions and type of facility, he adds, but he declined to give a price range. Facilities that sign up as VisitingOurs.com providers are given an orientation to the program as well as brochures to distribute to patients.

White Plains gives patients VisitingOurs.com brochures at the preadmission visit and through physician offices, says Torre.

"While some facilities do provide computers for family members to use in the waiting rooms, it is not necessary," explains Gottesfeld. He notes that family members can access the Web site from their own computers at their homes or offices and are not limited to using the terminals provided by the facility.

To use VisitingOurs.com, a patient or family member goes to the Web site to check in. A personal identification number (PIN) is issued by the Web page, and an e-mail list of people the patient wants notified with each update can be built. The PIN is the code given to friends and family members to enable them to access the patient's updated information on the Web site. A second PIN is issued to the patient or family member who is designated as the "guardian angel," or the person responsible for updating the patient's information or the e-mail list.

"We are very conscious of patient confidentiality," says Gottesfeld. The PIN that is given to friends only allows them to read the information or send an e-mail back to the patient.

"The guardian angel is the only person who can change the information or control the distribution list," he explains. The e-mail list is not used to send the updated information, he says. Instead, a notification that information has been updated is e-mailed to people on the list to let them know they can use the PIN to see the new information. This prevents a patient's confidential information from being e-mailed to computers that might be used by more than one person who might not have been authorized by the patient to see the information.

Patients' information pages stay active for however long they need it to be, says Gottesfeld. Same-day surgery patients usually set up the page the day before they are scheduled for surgery and use it for several days following surgery, he says.

If the patient or guardian angel forgets to close the page, VisitingOurs.com will contact them if no updates have been made for three weeks. "If there is no response from the guardian angel or patient, the program automatically closes the page," adds Gottesfeld.

Since the computers or brochures describing the program are generally in the waiting rooms, operating room nurses, anesthesiologists, and physicians might not be directly involved with VisitingOurs.com, but all staff members need to be oriented to the program, says Torre.

"The orientation should explain everything the program can do, where the computers are located, and why the organization is offering the service," she says. While admissions or clerical staff members are probably asked the most questions, a patient will sometimes ask about the program when they are talking with the anesthesiologist or pre-op nurse, she adds.

It is also good to designate a specific staff member or two as the VisitingOurs.com resource people, especially when the program is first offered, Torre recommends. "The patient's questions will get answered, but not all staff members will have to become experts if they have a resource person to call upon."

White Plains offers VisitingOurs.com as part of the facility's customer service initiative, explains Torre. "It ties into our overall mission, and that is an important point to make as we introduce the service to both patients and staff members." ■

SOURCE

For more information about VisitingOurs.com, contact:

- **David Gottesfeld**, PsyD, Chief Executive Officer, VisitingOurs.com, 165 W. End Ave., New York, NY 10023. Telephone: (800) 989-8592 or (212) 362-9165. Fax: (212) 362-8168. E-mail: info@visitingours.com. Web site: www.VisitingOurs.com.

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