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FEBRUARY 2001

VOL. 25, NO. 2 (pages 13-24)

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Patients undergoing same-day surgery expect and accept postoperative pain

Post-op pain control techniques are not working — what can you do?

Your patient satisfaction surveys show that your patients are satisfied with your management of their postoperative pain, so you must have an effective pain management service, correct? But wait. Results of a study presented at the annual meeting of the Park Ridge, IL-based American Society of Anesthesiologists show that although patients say they are happy with the pain control offered them after surgery, 85% of the survey participants also report experiencing moderate to extreme pain following their procedure.

How can a patient be happy with pain management and still report pain? The best explanation for this apparent contradiction in experience and opinion is that patients expect pain and don't think any method will relieve it, says **Jeffrey L. Apfelbaum**, MD, director of outpatient surgery at the University of Chicago Hospitals and one of the investigators on the

APCs delayed for surgery centers

A bill that delays implementation of ambulatory payment classifications (APCs) for surgery centers until at least January 2002 is hailed as good news by the freestanding sugery center industry.

The bill frequently is referred to as the "Medicare 'Give-Back' Bill" because it is intended to restore funds cut from the program by the Balanced Budget Act of 1997 (BBA). The legislation, which restores $35 billion in reimbursement cuts, also requires the Health Care Financing Administration (HCFA) to implement APCs over a four-year period. Previously, HCFA planned to implement them over a three-year period.

Also, the bill requires HCFA to begin implementing rates based on a more current survey of facility costs in January 2003. "Given that HCFA cannot implement rebased rates until Jan. 1, 2002, and that it is required to then implement rates based on more current data by Jan. 1, 2003, it is likely that HCFA will decide to scrap entirely the rates first proposed in June 1998 and instead begin work on collecting and processing data to

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EXECUTIVE SUMMARY

Not only is postoperative pain the single biggest fear, but 85% of surgical patients report experiencing moderate to extreme pain following surgery, according to new research.

- As of Jan. 1, 2001, the Joint Commission on the Accreditation of Healthcare Organizations is including pain management standards in accreditation surveys.
- Eight percent of surgical patients in a recent study reported postponement of surgery due to their fear of pain. This postponement increases the likelihood that the patient's surgery will be more complicated once it is scheduled.
- New drugs such as COX-2 inhibitors and new delivery methods such as transdermal pumps are in development.

study. The December 1999 telephone survey included 250 people who had undergone inpatient or outpatient surgery in the previous six years, he says. The experience and response from inpatient or outpatient surgery were similar, he adds.

Why should same-day surgery managers pay attention to a study that shows pain control is not as effective as patient satisfaction surveys indicate? Pain is the single biggest reason patients fear surgery, Apfelbaum says.

"Eight percent of all patients surveyed reported that they had postponed their surgery at least once for fear of the postoperative pain," he adds. The fear also increases the patients' anxiety on the day of surgery, decreases their ability to absorb information you are giving them prior to and after surgery, and affects their entire experience, he explains. All of these conditions affect how well you can care for the patient, and the postponement can make the procedure more difficult, he adds.

Another reason to pay attention to the results is the implementation of pain management standards by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, says **T.J. Gan**, MD, director of clinical research at Duke University Medical Center in Durham, NC, and lead investigator of the study. The new standards, effective Jan. 1, 2001, require same-day surgery programs to recognize pain management as part of the patients' treatment and demonstrate that a process is in place to help patients manage pain. **(For more information on the standards, see *Same-Day Surgery*, March 2000, pain management supplement.)**

"We conducted this study to see if hospitals and surgery centers are ready for the new JCAHO standards," Gan says. "We knew that the number of pain management services had increased, so we assumed we were treating patient's pain more effectively."

The study showed results that were not expected, he says. "We still are not doing a good job of managing pain. In fact, when we compare results of this study to results of a similar study conducted seven years ago, we see that we haven't improved significantly."[1]

No new, effective drugs or methods

There may be several reasons for the lack of improvement, says **Jeffrey A. Katz**, MD, assistant professor of anesthesiology at Northwestern University Medical Center in Chicago.

"We ship more patients out of our facility immediately after surgery as more procedures are performed on a same-day basis," Katz says. That means patients don't have access to intravenous drugs and monitoring by health professionals who might treat pain more aggressively and earlier, he states. "At the same time, we ask patients to increase their activity sooner than we used to expect." While having the patient move around sooner does decrease recovery time, it also in-creases the amount of pain the patient will experience, he explains.

Another reason postoperative pain management has not improved is the lack of new methods that work for patients once they go home, says Katz. "Regional blocks work well, but they only last a maximum of 18 hours with the average time closer to eight to 12 hours." Once the block has worn off, the pain is there and the patient usually has to treat it with oral medication, he adds.

COMING IN FUTURE MONTHS

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Other new methods and medications are being introduced, but current techniques have their drawbacks, says Katz. **(See story on new methods, at right.)** "Most patients don't want narcotics, but narcotics are what we give the vast majority of patients," he says. "Keep in mind that morphine and codeine are the same drugs people used in 4000 BC."

While narcotics can significantly reduce pain, 75% of the patients in the study did not want to use them, says Apfelbaum. "Patients are afraid of the side effects, which can include loss of control, lightheadedness, nausea, itching, and difficulty urinating," he explains.

Ketoraloc is another pain medication that is non-narcotic but also has serious side effects, Apfelbaum says. "Platelet aggregation, bleeding problems, and gastrointestinal upset are side effects that cause me to avoid the drug."

In addition to new medications and delivery systems, there are some simple steps to take to improve a patient's postoperative pain control, says Apfelbaum. He suggests that "making sure that pain is assessed every time a temperature or blood pressure is taken would ensure that we are monitoring pain. Also, including very specific questions about level of pain in all post-op follow-up calls is critical."

Reference

1. Warfield CA, Kahn CH. Acute pain management: Programs in US hospitals and experiences and attitudes among US adults. *Anesthesiology* 1995; 83:1,090-1,094. ■

SOURCES

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- **Jeffrey A. Katz**, MD, Assistant Professor of Anesthesiology, Northwestern University Medical Center, 251 E. Huron St., Chicago, IL 60611. Telephone: (312) 908-3276. E-mail: jkatz@nmff.org.

New methods, medication may increase options

Although there have been few changes in medications or techniques to control postoperative pain for same-day surgery patients in recent years, there are several promising advances in the works, say experts interviewed by *Same-Day Surgery*.

Studies of parecoxib sodium, an investigational parenteral cyclooxygenase-2 (COX-2) specific inhibitor, show positive pain control for post-surgical pain, says **Jeffrey L. Apfelbaum**, MD, director of outpatient surgery at the University of Chicago Hospitals. "The injectable COX-2 inhibitor can be given before, during, or after surgery and will suppress pain for six to 12 hours or more," he says. "This drug does not create side effects such as gastrointestinal upset or bleeding problems seen with Ketoraloc."

Pharmacia Corp. in Peapack, NJ, is the manufacturer of the injectable COX-2 inhibitor that has been submitted for approval by the Food and Drug Administration. The company expects to market the drug by the end of 2001, says **Angela Jerzak**, public relations representative with BSMG Medical & Health Communications in Chicago and spokeswoman for Pharmacia. The drug works by affecting the production of the COX-2 enzyme that is produced by the body at the site of an injury, she says. The enzyme mediates pain, fever, and inflammation, so the COX-2 inhibitor reduces pain by inhibiting the production of the enzyme, she explains. The injectable drug that is being studied works well when given intravenously during surgery, she adds.

In addition to new medications, new ways of delivering medication also are being investigated, says **T.J. Gan**, MD, director of clinical research at Duke University Medical Center in Durham, NC, and associate professor of anesthesiology. "A current study is looking at the use of a credit card-sized mechanism that delivers pain medication through the skin with a simple push of a button," says Gan. Similar to a personal, mobile PCA pump, the transdermal system (ALZA Corp., Mountain View, CA) delivers a set amount of medication, and the patient feels a tingling sensation, he adds. **(For more information, see source box, p. 16.)**

For the past few years, orthopedic surgeons also have been using pain medication pumps that

SOURCES

ALZA Corp. produces two transdermal pain control products, the D-TRANS system and the E-TRANS system. The E-TRANS system is in phase III clinical development. For more information about transdermal pain control, contact:

- **ALZA Corp.**, 1900 Charleston Road, Mountain View, CA 94309-7210. Telephone: (650) 564-5000. Fax: (650) 564-5151. Web: www.alza.com.

go home with patients, says **Jeffrey A. Katz**, MD, assistant professor of anesthesiology at Northwestern University Medical Center in Chicago. **(See story on pain pumps, p. 17.)**

"While there are a number of advantages to delivering the anesthetic directly to the surgical site postoperatively, the disadvantages may include dislodged tubing or additional risk of infection," he points out. ■

Choose the right time and place for education

Patients don't recall info given day of surgery

New technology, stronger medications, and aggressive pain management services are worth nothing in the control of postoperative pain if the patient doesn't follow instructions for at-home pain control.

"There are two main reasons our patients don't take pain medication as directed," says **W. Gray McCall**, CRNA, MHDI, MSN, anesthesia program coordinator at Trover Foundation at Murray State University in Madisonville, KY. "Older patients fear addiction to pain medication, and males don't want to appear weak and unable to handle pain," he explains.

Because patients are wary of taking more pain medication than needed, they often wait until the pain is too severe to control with oral medication, says McCall. Education is key to patient compliance, but pain control teaching may not be occurring at the best time for the patient, McCall adds. "Specific pain control education should begin in the physician's office when the patient is first discussing surgery." The patient is not as anxious at this time and will have time before surgery to absorb the information and ask questions, he says.

"On the morning of surgery, the patient is apprehensive, cold, and usually drowsy from sedation," says McCall. Any teaching done at this time will not be recalled, he says. Post-op teaching with family members present might not be any more effective, he says. "The patient is still feeling the effects of anesthesia, and family members are concentrating on their primary focus of getting the patient home."

Family members also are wary of overdosing the patient, so if instructions say the medication can be given every four to six hours, they generally wait six hours, he says. The extra two hours might be the difference between moderate pain that can be controlled and severe pain that cannot be alleviated by the medication, he adds.

Brochures that spell out directions to take pain medication before pain is severe and instructions to call the physician if the medication doesn't alleviate the pain are helpful if given to patients at the time surgery is scheduled by the surgeon's office, says McCall. "Make sure your brochures or handouts are written in simple-to-understand language and use large print to make them easier to read."

The Internet has proven to be a good way to educate patients on pain control for Beth Israel Deaconess Medical Center in Boston, says **Denise Goldsmith**, RN, MS, MPH, program manager of nursing informatics.

Although Beth Israel has had a Web site (www.bidmc.harvard.edu/ambsurg) with information for same-day surgery patients since 1997, the pain management section was developed in the past year as a result of a nurse's research that

EXECUTIVE SUMMARY

Patient education is a critical component of post-op pain control, but many patients report not receiving pain control information or can't recall details of the information. Paying attention to teaching opportunities outside the same-day surgery setting can increase proper use of at-home medications.

- The ideal teaching time is in the physician's office when surgery is scheduled.
- Use simple language with large print in brochures or handouts that explain post-op pain control.
- Be specific when telling patients to take medications before pain is severe.
- Consider the Internet as another way to disseminate pain management information.

EDUCATIONAL SOURCES ON PAIN

For more information on patient education regarding pain control, contact:

- **W. Gray McCall**, CRNA, MHDI, MSN, Anesthesia Program Coordinator, Trover Foundation, Murray State University, 435 N. Kentucky Ave., Suite A, Madisonville, KY 42431. Telephone: (270) 824-3460. E-mail: anesth@wko.com.
- **Denise M. Goldsmith**, RN, MS, MPH, Program Manager of Nursing Informatics, Beth Israel Deaconess Medical Center, 330 Brookline Ave., Boston, MA 02115. E-mail: dgoldsmi@caregroup.harvard.edu.

Suggestions on how to educate patients about pain control following surgery can be found on these Web sites:

- **www.aspan.org.** This site is sponsored by the American Society of PeriAnesthesia Nurses in Cherry Hill, NJ. Patient information included on the site covers pain management as well as orientation to what happens during different times of the surgical experience.
- **www.pain.com.** Sponsored by the Dannemiller Memorial Educational Foundation in San Antonio, this site provide free, comprehensive information on pain management for health care professionals and patients. A section devoted to perioperative pain was launched in August 2000.

showed patients did not recall receiving pain control instructions or could not recall the details of the instructions, says Goldsmith. **(For more information on Beth Israel's same-day surgery Web site, see *Same-Day Surgery*, April 2000, p. 46.)**

"Before we put time into developing the pain management section, we first surveyed patients to see if the majority had access to the Internet, Goldsmith says. "After discovering that 52% did have access, we developed the pain management section."

Because staff wanted to see if the Web site's pain control information would affect outcome, they didn't make the site available to everyone at first. "We set up a control group and a study group, with the study group having the password to access the pain management section," explains Goldsmith. The control group could access other parts of the Web site that included general pre-op information and directions to the facility, she adds.

Study results show that 85% of patients in both groups accessed the Web site, with no difference between the groups in frequency of access, she adds. A questionnaire was sent home with the 195 patients that comprised both groups on which they rated their pain upon arriving home, on the night of surgery, and on the day following the surgery. Results showed that patients with access to the Web-based pain control information reported significantly lower pain than patients in the control group.

Patients with info suffer less pain

While less than 10% of the group with access to pain information reported discomforting levels of pain upon arriving home, almost 25% of the control group reported discomforting levels of pain. The percentage of patients reporting discomforting pain remained almost 15% higher for the control group on the night of surgery and the day after surgery. More control group patients also reported distressing, horrible, or excruciating pain than patients with access to pain information, says Goldsmith.

The pain control site is now open to all patients, says Goldsmith. "We let patients know about the Web site through brochures that are available in physicians' offices, during the preoperative telephone call, and in our family waiting room." The family waiting room has a personal computer that displays the Web site so family members without access to the Internet at home can get information while they wait, she adds. ■

Put medication directly into the surgical site

Pain pumps keep site anesthetized for 48 hours

Because orthopedic procedures can result in a great deal of postoperative pain, many orthopedic surgeons have looked at delivering pain medication directly to the surgical site, even after the patient leaves the same-day surgery facility.

Pumps that deliver anesthetics through a catheter directly into the surgical site are being used to relieve post-op pain for orthopedic and other surgery patients, says **Stephen Lucie**, MD, an orthopedic surgeon at the Jacksonville Orthopaedic Institute in Jacksonville, FL.

EXECUTIVE SUMMARY

Orthopedic surgeons have been using small pumps that administer anesthetics directly into the surgical site for up to 48 hours. Because the pumps go home with the patient, some orthopedic procedures that previously required a 23-hour stay are now sent home sooner.

- While the additional catheter might increase risk for infection, sources report no increased rates of infection.
- Patients are satisfied with their pain control and require smaller amounts of narcotics to manage the pain.
- Guidelines and policies for use of the pump must be in place before introducing the device into the same-day surgery program.

"I've been using the pump for 18 months on my anterior cruciate ligament [ACL] reconstruction and rotator cuff repair patients," says Lucie. "One advantage is that 100% of my ACL patients are now same-day surgery rather than 50% same-day surgery and 50% 23-hour stay patients," he points out. Patients undergoing rotator cuff repair also are 100% same-day surgery since there is no need to keep them for 23 hours to manage the pain, he adds.

Not only are patients sent home earlier, but the delivery of the anesthetic, usually marcaine, reduces the need for narcotic medications, adds Lucie. The catheter is inserted by the surgeon in the operating room and stays in place for 24-48 hours, he says. "It is usually removed at the patient's first post-op visit to the surgeon or the first post-op visit to the physical therapist." Pumps for Lucie's patients are removed by a nurse or the physical therapist, both of whom have been trained to remove the catheter, he adds.

Some surgeons see the introduction of a catheter into the surgical site as a potential source of infection, but Lucie says he has seen no increase in surgical site infections in his patients as a result of the catheter. Disconnection of the tube is another potential problem, but again, Lucie says it has not been a problem in his practice.

The pumps, which range in price from $125 to more than $300, have not created any reimbursement problems, says **Mary Fischer**, RN, director of outpatient surgery, preadmission, and testing for Borgess Medical Center in Kalamazoo, MI. "As with any supply in same-day surgery, we constantly evaluate reimbursement in order to identify potential problems early, "she says. "We may look at including the cost of the pump in a package price if needed."

The cost savings of the pumps are important, adds Fischer. "We cut down on the amount of pain medication needed, and patient satisfaction is high because they are not dealing with a lot of pain," she points out.

If a same-day surgery manager is looking at adding pain pumps as a pain-control measure, he or she should look at the procedures done most often within one specialty for a pilot, suggests Fischer. "We started using pain pumps only with our ACL patients about two years ago, then expanded its use to patients undergoing shoulder surgery and arthroscopy once we were comfortable with the pump's use and results," she explains.

In addition to pumps that work well for orthopedic patients, there also are pumps that are appropriate for use after some gynecological procedures or hernia repair, she adds.

Patient education starts in the physician's office, and patients are given brochures and telephone numbers in the event they have questions, says Fischer. "We also ask about the pump's performance when the nurse calls the day after surgery," she adds.

Staff education consisted of inservice classes for physicians and operating room staff as well as demonstrations and videos. Because the surgeon fills the pump with the anesthetic, there was no need to cover that topic in the orientation to the device, adds Fischer.

Same-day surgery managers need to prepare

PAIN PUMP VENDORS

These vendors offer pain pumps that are appropriate for same-day surgery procedures:

- **DjOrthopedics LLC**, 2985 Scott St., Vista, CA 92083-8339. Telephone: (800) 336-6559 or (760) 727-1280. Fax: (760) 734-5608. Web: www.donjoy.com.
- **Sgarlato Laboratories**, 656-B N. Santa Cruz Ave., Los Gatos, CA 95030. Telephone: (800) 421-5303 or (408) 399-4638. Fax: (408) 354-4922. Web: www.sgarlatolabs.com.
- **Stryker Instruments**, 4100 E. Milham Ave., Kalamazoo, MI 49001. Telephone: (800) 253-3210 or (616) 323-7700. Fax: (800) 999-3811 or (616) 323-2887. Web: www.strykercorp.com.
- **Breg**, 2611 Commerce Way, Vista, CA 92083. Telephone: (760) 599-5706. Fax: (760) 599-3030. Web: www.breg.com.

SOURCES

For more information on pain pumps, contact:
- **Stephen Lucie**, MD, Jacksonville Orthopaedic Institute, 1325 San Marco Blvd., No. 200, Jacksonville, FL 32207. Telephone: (904) 346-3465.
- **Mary Fischer**, RN, Director of Outpatient Surgery, Preadmission, and Testing, Borgess Medical Center, 1521 Gull Road, Kalamazoo, MI 44001. Telephone: (616) 226-7054.

guidelines and policies regarding the pump before implementing its use, says Fischer.

"Be prepared to change and update these guidelines as you learn more about the device because this is still so new that we are all blazing our own trails," she says. ■

EMTALA regs: Stabilize emergency patients

If a security guard has a stroke in your parking lot, would your staff know how to respond? If a woman goes into labor in your surgery center, do you have a policy to address that scenario?

If your answer is "no," you are not in compliance with new requirements for the Emergency Medical Treatment and Active Labor Act (EMTALA), warns **Charlotte Yeh**, MD, FACEP, medical director for Medicare Policy at the National Heritage Insurance Co. in Hingham, MA. EMTALA regulations have changed dramatically, she says.

The outpatient prospective payment system regulations issued by the Health Care Financing Administration have expanded EMTALA to include hospital outpatient facilities, which now are required to give anyone with a potential emergency condition a medical screening exam. Staff at these remote sites also must stabilize and, if necessary, transfer the patient.

"It's now very clear that EMTALA is not just an ED [emergency department] law," Yeh emphasizes.

The new regulations are effective as of the hospital's first cost reporting following Jan. 10, 2001, says **Eric Zimmerman**, JD, associate with McDermott, Will, & Emery in Washington, DC. Only surgery centers that are provider-based will have to comply with EMTALA requirements, he says.

"A surgery center that is affiliated with a hospital — for example, wholly or partly owned by a hospital but certified as a freestanding ASC — will not need to comply with EMTALA," he says. "Additionally, surgery centers that are Medicare certified as freestanding, and which have no relationship with a hospital, do not need to comply."

Seek legal counsel

EMTALA obligations may vary depending on the type of facility and the hospital with which it is affiliated, Zimmerman says.

"Facilities that think that they may be affected should seek advice from counsel, preferably one who understands the nuances of EMTALA," he suggests. "If the hospital with which they are affiliated has a general counsel, that would be a logical place to start."

In the meantime, here are some suggestions from EMTALA experts:

• **Don't rely on 911.** Calling 911 may not be used as a sole source of response, Yeh stresses. "If someone comes into the lab or surgicenter complaining of chest pain, staff may not simply call 911 and consider their obligation complete," she says. "You may call 911 for support, but you must begin initial stabilization procedures until ambulance personnel arrives."

For remote sites, the regulations specifically state that the home ED must be called for instructions, says **Stephen A. Frew**, JD, president of the Rockford, IL-based Frew Consulting Group, which specializes in EMTALA compliance.

"The ED physician should be giving instructions and assisting in obtaining necessary transfers," he says. "The ED is experienced in these issues, while remote sites are not."

The rule requires that the off-site location have policies and procedures in place to deal with this

EXECUTIVE SUMMARY

As of the first cost-reporting period after Jan. 10, 2001, EMTALA regulations apply to hospital outpatient facilities, unless they are certified as freestanding facilities.
- Staff at hospital surgery centers must provide anyone with a potential emergency condition with a medical screening exam and stabilization and, if necessary, transfer the patient.
- Remote sites cannot delay treatment for an EMTALA-related service by collecting copays.

situation, Frew advises. "These might include: [Provide] immediate lifesaving aid, call 911, and call the home ED for instructions."

If a patient is deteriorating rapidly, movement from the remote site back to the main campus is not appropriate, and if it is in the patient's best interest to be transferred, you must have prearranged transfer agreements with closer hospitals, says Yeh. The off-site location must provide appropriate transportation, equipment, and personnel to transfer the patient to the second closer hospital, she adds.

Consider providing an outside emergency phone for persons having an emergency who arrive at the facility after hours and expect emergency treatment to be available, says **Mark Mayo**, executive director of the Illinois Freestanding Surgery Center Association in St. Charles.

"If you are closed, the patient has no way to call for emergency care," Mayo says.

• **Address billing, signage, and record-keeping practices.** EMTALA regulations state that you may not delay treatment for preauthorization requests or to collect copayments, Yeh says. "This is especially important for outpatient departments, surgicenters, and lab areas where typically you request copays prior to seeing the patient," she adds. "If it's an EMTALA-related service, the remote sites should not be doing copays prior to service."

Anyone who does intake registration and screening or who might receive questions about payment or copays needs to understand the implications of EMTALA, Yeh advises. "They need to ensure that no one is turned away because of the ability to pay."

Under EMTALA, you need to keep records for five years and post nondiscrimination notices in the ED and admitting area, says Yeh. "Now, this applies to all sites, so outpatient sites must have the same record keeping and nondiscrimination notices and the same on-call availability as well."

Increased signage for staff at the off-campus surgery centers is needed to remind them of their obligations, recommends **Larry B. Mellick**, MS, MD, FAAP, FACEP, chair and professor for the department of emergency medicine at the Medical College of Georgia in Augusta. "Additionally, mandatory educational schedules, job aids, and checklists are needed in an area that will be highly vulnerable to oversight," he stresses.

• **Establish individualized protocols for dealing with emergencies.** Your plan has to be commensurate with your facility's ability to provide treatment, explains **Grena Porto**, ARM, CPHRM, director of clinical risk management for VHA, a Berwyn, PA-based alliance of more than 2,000 community-owned health care organizations.

"If the location has physicians and nurses, you'll be required to provide a higher level of screening than a facility that does not have that resource available," she says.

You must have emergency response protocols individualized to your facility's capabilities, says Yeh. "For example, if the site has a physician and nurse, then they are required to do stabilization," she says. "If there is no physician or nurse, then personnel must be trained to place a call to the ED describing the patient's condition and begin to initiate transfer requirements if necessary."

• **Make sure that patient consent for transfer is obtained.** Surgery center staff will need to obtain consent from patients with an emergency medical condition for transfer to another facility, says Porto. "This is not a time when you can rely on implied consent."

When transferring a patient, written documentation is critical, Porto underscores. "If it's an outpatient setting and they do not have a physician there, then you need a policy stating who will initiate the transfer documentation," she explains. ■

SOURCES

For more information about EMTALA regulations and hospital outpatient facilities, contact:

- **Stephen Frew**, JD, Frew Consulting Group, 6072 Brynwood Drive, Rockford, IL 61114. Telephone: (815) 654-2123. Fax: (815) 654-2162. E-mail: sfrew@medlaw.com.
- **Larry B. Mellick**, MS, MD, FAAP, FACEP, Department of Emergency Medicine, Medical College of Georgia, 1120 15th St., AF 2036, Augusta, GA 30912. Telephone: (706) 721-7144. Fax: (706) 721-7718. E-mail: LMELLICK@mail.mcg.edu.
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Same-Day Surgery Manager

Staff incentive plans that make sense

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

I recently had an opportunity to visit with a client on incentive plans for her employees. "What works, what doesn't, and why not?" she wanted to know. Big order.

Incentives should be just that: Provide the staff with an incentive to squeeze out that last smile at the end of the shift when they are dog-tired and their feet are killing them. No hate mail on this, please, but there are those staff members in many centers who don't do that. They still are valuable employees; they just are more focused on their job function and not marketing or promoting increased good will.

Here is a dilemma for you: Should that employee — the one who just does his or her job — be rewarded less than the staff member who goes above and beyond? That employee says, "I was hired to scrub on cases, not be a goodwill ambassador for the center." He or she is right, you know. You could argue that you are not required to provide bonus pay either. But that really isn't fair to the effective staff members who are not the bubbly "cute and perky" types who could miss out on incentive pay.

Conversely, what about the employee who has the same job description as the example here and does everything right and goes out of his or her way to promote the center to physicians or patients? How can you encourage that type of behavior but not at the expense of another?

Some examples of incentive or "bonus" plans out there that have not worked (in our experience) are plans that are too nebulous or too difficult to control, such as plans based upon patient satisfaction, days in accounts receivable, supply cost per cases, etc. Using the first criteria, if your staff have incentive pay based upon patient satisfaction responses, a real risk for not obtaining good data exists.

Most patient satisfaction plans are not effective enough to base staff bonuses on. Most patients only report negative reactions or situations. I am a good example. I fly often and only write an irate letter or make a nasty phone call to the airline when something goes wrong on my itinerary. Like many, I never comment on the flights and connections that go off without a hitch. Therefore, am I a positive and satisfied airplane client or a bad one? How can you tell? If I complained four times in the year 2000 about bad experiences with a certain airline, you would need to know how many times I flew that year to see if I complained 100% of the time or 0.001% of the time. You have no way of knowing. Therefore, unless you can legitimately quantify the response — and you really cannot — it is not fair to your employees to use this as a yardstick.

What about using the administrator or supervisor discretion comments or suggestions as to employee merit and bonus? That should work; after all, they are placed in a position to know who is contributing. My experience is that this is just too subjective. In these situations, the risk is that bonus is based upon personality and popularity. The hard-working employee who has three kids at home and a 45-minute compute back and forth to work maybe just doesn't have the energy for that extra bit of personality at the end of the day.

So, what does work? Again, using my own experience of 18 years in these situations (yours may be different), I think the rational for bonuses need to be understood. You are attempting to elicit certain behavior from individuals and using cash or other rewards as the inducement. While that sounds somewhat clinical and sterile, it is the fact. my idea is to have a pool of funds set aside each month that is a reflection of the profitability or positive variance of the budget. Each employee has a share of that pool. The fewer number of employees in that pool, the larger the share distribution to the shareholders. This system encourages fewer staff and more sharing of the workload and more "cash" availability.

I know that there are a number of centers and departments out there that do not or cannot give "cash" to employees. You don't have to hand out money; use that "pool" to purchase cash equivalents or other goods and services for your staff such as movie tickets, vacations, paid parking, etc. Whatever you do for one, do for all. Some of

APCs delayed for surgery centers

continued from cover page

implement new rates by 2003," explains **Eric Zimmerman**, JD, an associate with McDermott, Will & Emery in Washington, DC, and legal counsel to the American Association of Ambulatory Surgery Centers in San Diego.

Leaders in the freestanding surgery center industry say poor data were used as a basis for APCs.

Kathy Bryant, JD, executive director of the Federated Ambulatory Surgery Association in Alexandria, VA, says, "To us, the solution is to get really good data." [For a copy of the bill, the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)*, HR 4577, go to the Web site: thomas.loc.gov.]

The legislation modifies and delays the provider-based requirements. Under the provider-based rules, if a physician practice meets certain criteria and is owned by a hospital, that practice can be designated as "provider-based" and be paid more under hospital outpatient department rates. Here are the highlights of the changes to the provider-based rules:

• Any facility that was treated as provider-based as of Oct. 1, 2000, shall continue to be treated as such for two years, and the criteria used to determine provider-based status, the prohibition against conferring provider-based status upon joint ventures, the requirements applicable to management contracts, and the prohibition against conferring provider-based status on facilities that furnish services under arrangements shall not apply to facilities treated as provider-based before Oct. 1, 2000, until Sept. 30, 2002.

HCFA is interpreting this legislative two-year moratorium as applying only to entities that:

— have a provider-based determination from HCFA;

— can demonstrate through Medicare payment history that HCFA has treated the entity as provider-based.

"It is not enough that the main provider itself regards the entity as provider-based," according to McDermott, Will & Emery in Washington, DC.[1]

• The legislation provides additional ways in which entities not already treated as provider-based, which must seek a determination under the new regulations, may satisfy the geographic location test required under the regulations.

A subordinate entity may satisfy the geographic location requirement if it is:

— located within 35 miles from the main campus of the hospital;

— owned by a hospital that is a unit of state or local government, is a public or private nonprofit entity that is formally granted governmental powers by a unit of state or local government, or is a private hospital that has a contract with a state or local government to operate off-campus clinics and has a disproportionate share hospital percentage of 11.75 or greater.

"This latter provision appears to be designed to benefit a limited number of providers," McDermott, Will & Emery says.

• The legislation provides that any entity that requests a provider-based status determination between Oct. 1, 2000, and Sept. 30, 2002, shall be treated as provider-based until a determination is made. *[Editor's note: Provider-based information is reprinted with permission of McDermott, Will & Emery in Washington, DC. For further information, contact: Eric Zimmerman, JD. Telephone: (202) 756-8148. E-mail: ezimmerman@mwe.com.)*]

In other news, HCFA announced it will cover cryosurgery in treating prostate cancer patients when radiation has failed. Cryosurgery uses extremely cold temperatures to freeze and destroy cancer cells in the area of the prostate gland. Patients typically spend one night in the hospital.

Reference

1. McDermott, Will & Emery. *Health Law Update* Dec. 20, 2000; 17(9). ■

you also will argue that bonuses should not be expected or given in our business; however, the fact is that your competition is giving them, so you should also.

The bottom line is that all staff members contribute to the success of the department or center. Some employees have different personalities from others.

The "perky" type will always be "perky," while the silent, efficient staff member probably will always be silent and efficient. Money will never change character or personality long term.

If you have an employee who does not live up to the standards of the department or the facility, then cull him or her out of the operations.

Care needs to be taken to screen new hires for positive traits that enhance the overall success of the day-to-day operations. An efficient scrub nurse who does everything well for the patient and the surgeon but has a flat personality is just as effective as the bubbly staff member who opens the car door for the patient and hugs the family member and wishes them luck. Reward them both.

(Readers are invited to submit examples of good and bad incentives. Earnhart can be reached at 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: searnhart@earnhart.com. Web: www.earnhart.com. Earnhart and Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management.) ■

MedPAC fails to endorse coverage of recovery care

Demonstrations could signal need to re-evaluate

Despite a report from the Medicare Payment Advisory Commission (MedPAC) that doesn't support Medicare coverage of extended recovery care, the industry is moving ahead and might even offer a demonstration project, says **Kathy Bryant**, JD, executive director of the Federated Ambulatory Surgery Association (FASA) in Alexandria, VA.

MedPAC's report makes the following recommendation: "At this time, there is insufficient evidence to support a change in Medicare payment policy for postoperative care." However, the report left the door open for future coverage by Medicare: "If, in the future, data from two ongoing demonstration projects [in Illinois and California, which were completed recently] or other sources support coverage of post-surgical recovery care centers, Medicare policy for these facilities should be re-examined." **(For information on ordering the report, see resource box, p. 24.)** MedPAC is an independent federal body that advises Congress on issues affecting the Medicare program.

The California report might have limited value because several of the participants dropped out, Bryant points out.

While FASA would have preferred a positive recommendation from MedPAC, Bryant was reluctant to label the report a "setback." The hearings on the report allowed significant visibility of extended recovery care for a number of high-ranking federal officials, she says. Also, the effort gave several ambulatory surgery officials, including Bryant at FASA, Larry Pickner, MD, president of the San Diego-based American Association for Ambulatory Surgery Centers, and Mark Mayo, executive director of the St. Charles-based Illinois Freestanding Surgery Center Association, the opportunity to join forces and promote recovery care to MedPAC.

Bryant expressed disappointment in the report's comparisons of recovery care and hospital care. "When they said there are no data to compare safety in recovery care and safety in a hospital, we said there are no data to say a hospital is as safe as recovery care," Bryant says.

She points out that it's clear recovery care costs less than a one-night stay in a hospital, "but it's much more difficult to show how the availability of recovery care would affect the hospital industry. We simply don't have access to data on the hospital industry." **(For more information on recovery care costs and other issues, see *Same-Day Surgery*, August 2000, pp. 102-107; September 2000, p. 115.)**

While FASA might sponsor a demonstration

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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RESOURCE

To order a complimentary copy of Report to the Congress — Medicare Payment for Post-surgical Recovery Care Centers, contact:

- **Medicare Payment Advisory Commission**, 1730 K St. N.W., Suite 800 Washington, DC 20006. Telephone: (202) 653-7220. Fax: (202) 653-7238. Web: www.medpac.gov.

project for extended recovery care, Bryant is reluctant to pick any one strategy at this point. "Part of it depends on where we think Medicare is going and what the limitations will be in the future," she says. "With a new administration coming in, it's difficult to determine the best approach to promote recovery care."

The bottom line on whether to offer extended recovery care hasn't changed, Bryant maintains. "Prior to this report, there was no Medicare coverage and no reason to suspect that there would be in the short term," she says. "If you're doing short-term recovery care centers, you have to have a financially viable center without Medicare patients, and that remains the same." ■

Tips on how to manage a successful SDS program

In the current regulatory and reimbursement environment, managing an outpatient surgery program can be overwhelming.

For help on costing surgical procedures, containing costs, and surviving reimbursement changes, among other topics, attend the Seventh Annual Same-Day Surgery Conference March 4-6 in Orlando. The conference is sponsored by American Health Consultants, publisher of *Same-Day Surgery*.

Topics will include advice on reprocessing, antibiotic resistance, hazards in the workplace, achievement of excellence, surgical trends and new technologies, accreditation, risk management, medical errors, the nursing shortage, the outpatient prospective payment system, and motivation of employees. The conference includes opportunities to network with your peers at lunches and a reception, as well as a Downtown Disney excursion.

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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 "Patients undergoing same-day surgery expect and accept postoperative pain.")

• Describe how those issues affect nursing service delivery or management of a facility.

• Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. (See "Choose the right time and place for education" and "Put medication directly into surgical site.") ■