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INSIDE

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After 25 years of growth, the future looks bright — but brace for changes

Challenges include technology, reimbursement, regulations, and staffing

What should outpatient surgery managers be prepared for as we celebrate a quarter-century milestone and look to the future? To put it plain and simple: Expect more growth, with all the joys and headaches that go along with it.

The news isn't good for everyone, however. Many procedures are moving from hospitals to surgery centers to physician offices. Surgery centers should prepare to lose many cases that have served as the "bread and butter" of their caseload, warns **Scott Becker**, JD, CPA, partner with Ross & Hardies in Chicago.

"This may include, for example, gastroenterology cases, [ear, nose, and throat] cases, and pain management cases," he says. **(For more on the move of procedures into physician offices, see *Same-Day Surgery*, November 2000, p. 133.)**

Also, new therapies involving minimally invasive techniques and pharmaceuticals will change the need for surgical intervention, says

OIG report blasts surgery center oversight

If recommendations from a new Office of Inspector General (OIG) report are adopted, ambulatory surgery centers (ASCs) will be required to post their Medicare survey results and their complaint history for all to see.

"I don't understand, because if they already have approved you, it should be enough to put up the approval for patients to see," says **Lawrence Pinkner**, MD, immediate past president of the San Diego-based American Association of Ambulatory Surgery Centers and president of the SurgiCenter of Baltimore. Pinkner expresses doubts about whether surgery centers would comply with a requirement to post complaints made against their facility. "It's like a store putting up a sign: 'Our food is bad, and our clerks are impolite.'"

The OIG report, *Quality Oversight of Ambulatory Surgical Centers: A System in Neglect*, states that the system of quality oversight by the

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EXECUTIVE SUMMARY

Outpatient surgery is expected to continue to grow, with technology advancements continuing to move procedures out of the traditional hospital setting and into freestanding centers and physician offices.

- Surgery centers are predicted to lose some cases and staff.
- The number of surgical hospitals is predicted to grow.
- Hospitals are expected to do more joint venturing with physicians.
- Managers need to stay updated on regulatory, technology, and reimbursement changes.

Eric Zimmerman, JD, MBA, an attorney at McDermott, Will & Emery in Washington, DC. One example is a new gastrointestinal diagnostic tool that is swallowed like a pill, he says.

"Whereas patients used to, and still do to a large extent, need to be treated in a surgical environment to image the [gastrointestinal] tract, they now can receive the same service without surgery," he says. *(Look for more information on this pill in upcoming issues of* Same-Day Surgery*.)*

Technology and reimbursement have influenced the shift of cases to offices, sources says. "Sometimes the staff will go there, too," warns **Kay Ball**, RN, BSN, MSA, CNOR, FAAN, educator/consultant/author in Lewis Center, OH, and past president of the Denver-based Association of periOperative Registered Nurses.

Offices will perform more procedures and perform them more frequently, says **Jennifer Marks**, MPH, acute care product manager at SMG Marketing in Chicago. "We expect continued growth in office-based surgery, although not in the exponential arena," she says. **(See *Projections of Surgical Procedures* on our web site: www.same-daysurgery.com. Click on "toolbox" and look under "projections.")**

On the positive side for freestanding facilities, technology advancements will move more complex procedures into freestanding centers and surgical hospitals, many sources predict.

Becker says, "This includes general surgery cases, neurosurgical lower spine cases, and other cases for which reimbursement will be higher and the technological requirements of the surgery center also will be higher, but achievable."

Expect to see a significant larger number of surgical hospitals, because they allow for profitability from imaging and more complex inpatient and outpatient procedures, he says.

The line between outpatient and inpatient surgery is becoming blurred, several sources point out.

"As more and more ASCs [ambulatory surgery centers] mature into surgical hospitals," says Zimmerman, "the definition of outpatient surgery will continue to change, and the range of services that can be performed on an outpatient basis will continue to grow." **(For more information on surgical hospitals, see "Your facility does what procedures? Surgical hospitals expand limits," *Same-Day Surgery*, March 2002, p. 29.)**

Competition from traditional hospitals won't go away, however, Marks predicts. "We anticipate hospitals will reposition themselves somewhat in marketing their outpatient surgery in order to make more headway in competition with the growth of the surgery center market," he says.

For example, hospitals have started explicitly marketing their outpatient departments, she says. "They're seeking patients who probably would go to an alternative care site," Marks says. "They're not necessarily assuming they will go through the hospital."

Expect to see more joint ventures with hospitals, predicts **Beverly Kirchner**, RN, BSN, CNOR, executive vice president of Surgical Synergies Inc., a St. Louis-based company that develops and manages freestanding surgery centers. "Hospitals are starting to get smart," she says. "Physicians are going to build surgery centers. [Hospitals] can own a piece of the pie or none of it."

Rick Wade, senior vice president of the Chicago-based American Hospital Association, says that technology is one of the primary factors driving hospital-physician partnerships.

"Physicians will find it very attractive as partners, and hospitals will find it a very good long-term move, in terms of stability, to be in partnership with their physicians," he says.

COMING IN FUTURE MONTHS

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- What procedures are expected to grow?
- Necessity of specific pre-op tests
- Where to find ambulatory surgery data

Experts look into their crystal balls

- "Our interpretation, based on everyone facing labor shortages in the health industry in general, is that we're going to have to increase the skill level of staff, particularly clinical staff. Clinical staff will have to be trained to treat outpatients, in terms of their recovery, the types of patients that come in, and the fact that they're treated and released."
  — **Jennifer Marks**, MPH, Acute Care Product Manager at SMG Marketing in Chicago

- "I can see competition for staff increasing very dramatically. We know there is a shortage of nurses. . . . Hospitals are raising salaries to levels we can't possibly compete against. There are still nurses who don't want to work in hospitals, but as hospitals open more and more surgery centers, I can see them stealing staff. . . . Competition is getting bitter over staff."
  — **Lawrence Pinkner**, MD, Immediate Past President of the San Diego-based American Association of Ambulatory Surgery Centers and President of the SurgiCenter of Baltimore

- "The staff will be complemented with robotic technology — not to take a role away from him or her, but to allow an RN to be more available to assess, plan, implement, and evaluate care. The [outpatient] manager probably will become the buying agent, staff manager, scheduler, etc., as new tools help to decrease the stress and time needed for these many activities. For example, buying cooperatives will take care of the product evaluations and ordering, while new patient and staff automatic scheduling systems will manage these aspects. . . . Patients will receive most of their health care information on the Internet, so hospitals and providers will start to use this media more and more. . . . All readers should become very astute in computerized learning."
  — **Kay Ball**, RN, BSN, MSA, CNOR, FAAN, educator/consultant/author in Lewis Center, OH, and past president of the Denver-based Association of periOperative Registered Nurses

- "With increased deeming responsibilities by regulatory bodies, accrediting organizations must become even more sophisticated and sensitive to public demand for quality and safety. . . . It will not be business as usual. . . . In 25 years, I would be surprised if there were any health care practices without some sort of quality oversight."
  — **John Burke**, PhD, Executive Director and CEO, Accreditation Association for Ambulatory Health Care, Wilmette, IL

- "We're looking at alternative methods for [accreditation] evaluation that don't need time on site. For example, we'd look at performance measurement data or self-assessment data, in which organizations assess their own compliance with standards."
  — **Carol Gilhooley**, Director for Accreditation Process Improvement, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL ■

The long-term outlook is strong for hospital-based and hospital-affiliated outpatient surgery, Wade says. In addition to technology, he points to two factors: hospitals' longtime experience with quality oversight and the increasing headaches associated with professional liability, including rising premiums.

"Coverage is going to be an issue for all outpatient surgery," he says. "Freestanding, doctor's office, and hospital-affiliated programs are going to have to have coverage, and the market for that coverage is shrinking, not expanding."

Overall, however, outpatient surgery managers have reason to be optimistic, Zimmerman and others say.

"The same pressures that led the migration of more and more surgeries from hospitals to freestanding facilities in the last 25 years — i.e., (1) increasing cost pressures from employers and third-party payers; (2) the rapid pace of technological advancement; and (3) physician interest in regaining control over patient care — are all still present and strong, and therefore, will continue to push more procedures to the outpatient setting," Zimmerman says.

Driving the growth of the field will be a continued boom in computer technology, endoscopic devices, and communication technology, Ball predicts. "Anything that helps the patients get back to their activities of daily living quicker will be what is accepted," she says.

Stay updated on the current technology by reading journals, newsletters, recommended practices, and benchmarks, because they will discuss practices that will become the standard of care, Ball suggests. "The standard of care will no longer be defined as having most practitioners or facilities doing something one way or another,"

she says. "The standard of care will be what is available that's been shown to be safer. Therefore, the more expensive device may be chosen because it has been shown to be safer."

One side effect of the focus on safety is that surgery centers and hospitals will begin to specialize in different procedures, Ball predicts.

For example, if a surgery center is able to provide safe technology, such as active electrode monitoring (AEM) for gall bladder removals, then they will be the ones who perform the procedures, she says.

"The others who can't afford the safer technology will be forced out of doing specific procedures from the high number of lawsuits they'll experience," Ball predicts. *(See more on AEM in upcoming issues of* Same-Day Surgery.*)*

What's the manager's role

As the same-day surgery field grows, so do managers' responsibilities, such as keeping up with technological changes.

"Managers need to stay current on what is new and innovative in surgery, including surgical instruments, drugs, and surgical techniques," Ball says. For example, managers are being held accountable for devices that have been available, such as AEM, and not been used in the OR, she says.

The Federated Ambulatory Surgery Association in Alexandria, VA, is developing a credentialing program and certification test for outpatient surgery administrators that may be helpful, sources say.

"It's negligence to know that these devices are out there but not being purchased," Ball says. "It requires a considerable amount of time to keep up with regulatory changes."

That's the manager's job, says **Lawrence Pinkner**, MD, immediate president of the San Diego-based American Association of Ambulatory Surgery Centers and president of the SurgiCenter of Baltimore.

"Someone has to know the rules and how they limit what you can possibly do," Pinkner says.

And don't expect federal regulation to lighten up anytime soon, Zimmerman predicts.

"New quality pressures, for example, are likely to lead to a new layer of federal and state regulatory requirements," he adds. "Moreover, as more and more ASCs mature into surgical hospitals, they will be incurring the vast array of additional regulatory requirements applicable to hospitals." ■

Outpatient managers face uncertain reimbursement

With the full impact of ambulatory payment classifications (APCs) still unknown for hospital outpatient surgery departments, ambulatory surgery centers (ASCs) are bracing themselves for an uncertain future.

"We don't know what they'll do to us," says **Lawrence Pinkner**, MD, immediate past president of the San Diego-based American Association of Ambulatory Surgery Centers and president of the SurgiCenter of Baltimore. "Maybe they'll link us to hospitals — not 100%, but maybe 95%." Or there could be a totally different fee schedule for ASCs, he says.

"What we don't expect is a total increase in reimbursement," he says. "It's threatening. Nobody knows what will happen." If Medicare cuts rates, other insurers will follow suit, he says. "That could be death for lots of surgery centers," Pinkner says.

Some surgery centers already are closing because they found out they can't get reimbursed for pass-through items or disposable items. "We're working hard on third payers and say, 'If you pay us for disposables, we could do these procedures and save you a lot of money,'" he says. "Some are changing, but if it doesn't apply, it limits what can move to outpatient venue."

If you make $100-$200 for a procedure, you can't do them, Pinkner maintains.

Eric Zimmerman, JD, MBA, attorney at McDermott, Will, & Emery in Washington, DC, is more optimistic in his outlook. He predicts that reimbursement for freestanding centers will change in the next three to five years, but it probably will be for the better.

"There no doubt will be some winners and losers, i.e., reimbursement will increase for some procedures and drop for others," Zimmerman says. "However, overall, changes on the horizon in Medicare reimbursement will improve stability and predictability in ASC service reimbursement and also an expansion in the number of services that will be covered in the ASC setting."

Pinkner describes reimbursement as the "single biggest burden on managers." However, with the help of tracking software, managers are becoming knowledgeable about their profits, he says. Software can even track the cost by physician, Pinkner says. Good managers will analyze their costs and know when to tell physicians they

can't provide the procedure, he says.

Expect increased managed care contracting with outpatient surgery centers, predicts **Jennifer Marks**, MPH, acute care product manager at SMG Marketing in Chicago.

"Low overhead and this consumer demand for outpatient services appeal to managed care organizations, and surgery centers themselves can offer multiple types of services to patients," Marks says. "It's a combination of it being less costly for managed care and consumers being happier with outpatient service rather than be admitted."

One thing won't change in the years ahead, Zimmerman predicts, and that is the dominance of Medicare. "As the Medicare population swells, so too will the role that Medicare plays in the ASCs, from reimbursement to influence on arrangements," he says. ■

Medicare updates info on pass-through devices

Other policies clarified for surgery centers

The Centers for Medicare & Medicaid Services (CMS) published corrections to the final rule for the hospital outpatient prospective payment system that will result in slightly higher payments for transitional pass-through devices.

The update to the Nov. 30, 2001, rule was published in the March 1, 2002, *Federal Register.*

It can be accessed at www.access.gpo.gov/su_docs/fedreg/a020301c.html under "Centers for Medicare & Medicaid Services."

In other news, CMS has clarified its policy regarding ambulatory surgery centers (ASCs) in the following areas:

• Requirements for ASCs for a separate waiting area and recovery room.

CMS considers a "recovery room" to be an area where patients are brought to recover from procedures and are not yet discharged, according to an agency memo. A "waiting area" is the area set aside for patients and families outside of the areas used to prepare patients for their procedure, the procedure area itself, or recovery from their procedure.

"Each ASC must have a distinct 'waiting area' and distinct 'recovery room' that are not used by patients for other purposes," CMS says. Medicare regulations do not address specific requirements for a pre-op area.

• Length of stay in an ASC for Medicare beneficiaries and nonbeneficiaries.

Overnight stays should be infrequent and only occur in cases where an unanticipated medical emergency requires medical care beyond the capabilities of the ASC, CMS says.

However, Medicare-certified ASCs may transfer non-Medicare patients to overnight care facilities such as skilled nursing facilities, recovery care centers, and other nonhospital, postoperative care facilities (on a routine or nonroutine basis) without jeopardizing their Medicare certification, according to the agency.

• Certification of an ASC without a sterile operating room.

CMS has clarified that ASCs with only a "procedure room" or "treatment room" can be certified as long as the ASC meets the requirements in 42 CFR 416.44. That regulation states that every Medicare-certified ASC must have a functional and sanitary environment for providing surgical services. It also says that each operating room must be designed and equipped so that the type of surgery conducted can be performed in a manner that protects the lives and ensures the safety of individuals in the area. ■

Same-Day Surgery Manager

Flashbacks: Developing a surgery center in the '80s

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

Hindsight is, or should be, 20/20. Age, time, and maturity should produce clarity of thought and distinction of purpose. You would think so, anyway. In this special issue of *Same-Day Surgery*, we are reflective and, I hope, thinking forward from lessons learned in the past.

I vividly remember my very first surgery center, which I became administrator of nearly 20 years

ago. While it seemed so difficult to accomplish back then, retrospectively and comparatively, it was remarkably easy.

I kept a journal of that inaugural event, and I never dreamed for a moment that it would become my career path.

Twenty-some years ago, the regulations, while relatively new, were not as cumbersome as they are now. Not knowing anyone in the industry — or even the industry — I reinvented *everything*. I wrote every single policy, and then sat for hours figuring out the procedures for them. I wasn't quite sure what a quality-of-care plan was, but I figured out that it was something that we needed to measure to ensure the safety of our eventual patients — though at the time, I had difficulty imagining that patients would ever show up. We weren't even on the campus of the hospital.

The genesis of the surgery center was very forward-thinking. At the time, the hospital was 20% outpatient and 80% inpatient. A group of surgeons told the hospital administrator that it was going to build an ambulatory surgery center (ASC) because the hospital was not responding to their needs. Well, I guess some things don't change all that much. The CEO of the hospital told the surgeons that the hospital would join them and make the ASC completely separate from the "bureaucracy" of the hospital.

The hospital then hired a headhunter and found me redesigning the ambulatory surgery services of a small hospital in Massachusetts. It was a good fit, except that I had no idea what I was doing. I wasn't even sure what "HCFA" stood for. (It's now CMS, the Centers for Medicare & Medicaid Services.)

The ASC was to be constructed in a new medical office building off campus. It was my task to design the flow. My background as an orderly, operating room (OR) tech, OR nurse, and certified registered nurse anesthetist certainly helped — but not too much. I needed a strong OR nurse. I looked around and found one. She came on board with me for $8.50 per hour — sans benefits. That was about 15% below market rate, but it was justifiable at the time due to no call, rotation, or weekends. Try that now.

It became apparent that input was needed from the surgeons (investors). Of the 12 who took money out of their pockets for the venture, I was successful in getting three or four to show up for meetings. Again, some things never change. Our total capitalization for the project was about $1.2 million, with the leaseholds and equipment being the bulk of that. The center was a two-OR facility with a treatment room in about 5,000 square feet.

Payer contracting was different than it is now. First, no one knew what I was talking about when I used the term "freestanding." (The term "ambulatory" caused much greater confusion to the patients than it should have — "My feet?") But, be that as it may, a remarkably great reimbursement rate was achieved with the local insurers. I actually got "cost plus" on most of my contracts. No, they didn't last long. Oh, to go back to those wonderful reimbursement days.

The policy and procedure book included only 48 records — and were handwritten. Obviously, we didn't have a computer or word processor, but we managed to get them all typed. Of course, we had to retype them every time we changed them.

We had a truly great medical director: a local respected anesthesiologist who kept the surgeons corralled without getting them angry or resentful. We never would have survived that first year without him. I was the administrator, but he was the rock that stabilized the partnership.

Surviving the first lawsuit

The legal structure was a limited liability partnership in which the hospital assumed full liability for the limited partners: the surgeons. It's not quite that easy today. It was a 60% hospital and 40% surgeon deal that functioned quite well once the surgeons learned that majority ownership doesn't mean that the hospital runs the show.

We were about four months into operations when a patient sued us. She received a dime-sized second-degree burn on her thigh when a bovie pad came undone. It devastated us, but it was settled out of court, and life went on.

We had a 10-minute turnaround time between like cases, and we were consistently within 10 minutes of our start time. We monitored three quality assurance "screens" per month, and our admission rate and infection rates were almost nonexistent.

At the end of the first year, the nurses got a $2.50-an-hour raise. They deserved more, of course, but it wasn't going to happen. We did, however, share the profits with the staff — a first in the ASC industry at the time, I think. They received a percentage of the profit pool.

The payback on the center for the investors was two years. We were experiencing 30% growth per year, and we re-syndicated after two years. The original share price was $12,000 per

1% ownership. The re-syndication price was $42,500 per share. All 10 of the available shares were sold in the first hour of the offering.

The center still is doing well. No one remembers me there except for some of the original surgeons. My name still is on some documents I am sure, but they surely are faded by now.

I'm certain none of us expected the surgery center would do well at that time. There were so many odds against it (I was probably the greatest liability), but we all pulled together. The nurses stayed late almost every night to make the pre- and post-op phone calls and to clean the facility. The front-desk staff (one person) would work her magic on collecting from insurers who still had no idea who we were.

The surgeons would try their best to help us, but it was always best if they just left after their cases. Anesthesia came around after a fashion and had the patients extubated before they came into the recovery area — finally. And I kept thinking this was a great concept and we should do more of them.

Well, here we are, and we're still doing well, aren't we? Our patients are pleased with our services. Our staff are well-compensated and fulfilled. Anesthesia has adjusted into a well-oiled groove, and the surgeons generally are content. The industry is growing and expanding exponentially, and it's creating a new wave of personal and professional opportunities for all of us. It has been a good run.

While I miss the innocence and the challenges of the past, I'm excited about the opportunities of the future. All of us have changed in one way or another. We have raised our families, advanced our careers, and gotten older, but the excitement about this industry continues to grow.

I was interviewed a few weeks ago for an article, and I was asked: "If you could go back in time 25 years, knowing what you know now, what would you have done differently in your choice of careers?" Think about that for a moment or two yourself. Computers, cell phones, dot.coms — there are so many exciting choices we could have made. My response? "I would not have changed a thing — not one single thing."

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Happy employees result in satisfied patients

Recognition programs should be specific

Amazingly, with all of the technological and clinical advances of the past 25 years, the most critical component of a same-day surgery program's success is a motivated, enthusiastic staff.

Unfortunately, almost 14% of the respondents in the 2001 *Same-Day Surgery* reader survey listed low employee morale as the most dissatisfying part of their jobs, which is significantly higher than previous years. Not only is low morale discouraging for managers, but it also results in high turnover rates, dissatisfied physicians and patients, and a real threat to your financial health, according to experts interviewed by *Same-Day Surgery*.

Low employee morale is one indication that your employees are not motivated to take pride in their jobs and assume responsibility for the program, says **Scott Halford**, a Glendale, CO-based consultant who helps organizations with morale, motivation, and workplace performance.

"It is a myth that we can motivate others. Motivation must come from within the person, but we can inspire other people to see possibilities within their lives and their jobs that will motivate them," explains Halford who will talk about motivation at the 2002 meeting of the Association of periOperative Registered Nurses Congress in April. **(For more information, see calendar, p. 59.)**

An important step in building a motivated

EXECUTIVE SUMMARY

Managers can demonstrate appreciation of employees' dedication to increase employee satisfaction and decrease turnover.

- Organizational values should reflect awareness of employees' importance to the program's success.
- Employees should have the proper tools to handle their jobs.
- Specific, appropriate awards should recognize special achievements and commitment.
- Solicit employee input. Follow through on suggestions and report decisions back to staff members, along with reasons.

staff is to hire right, Halford says. "If people don't like the work they are hired to perform, they will never be inclined to do a good job," he says.

Diana Procuniar, RN, CNOR, nurse administrator of the Winter Haven (FL) Ambulatory Surgical Center, says, "I talk to candidates about my philosophy that physicians and patients are our customers and we have to make both groups happy or we go out of business. When I see their heads nodding in agreement and a look of understanding on their faces, I know that they will be right for my program," she says.

Know your priorities

Before you can make sure you hire the right people, examine the values of your organization, Halford suggests. "If your organization is only interested in profits to shareholders, employees will know it and feel left out," he explains.

There are three organizational values that are essential to building a happy work force, says Halford. Surprisingly, pay is not one of the motivating factors for employees, he says. If your pay scale is lower than other facilities, pay is a demotivator, but if your pay is equal or higher than other facilities, it is simply accepted as the paycheck the employee expects, he explains.

Some of the factors that can create a motivated staff are:

- **Fairness.**

Make sure you treat all employees fairly, Halford says.

"If people feel like different rules apply to different people, you'll hear them complaining about the hours they work, the location of the parking lot, uniforms, or any number of other complaints," he says. "These complaints show that people are not focusing on their jobs but on minor irritations that have taken on a greater importance than their jobs."

Fair treatment includes recognition programs with clearly defined parameters that apply to everyone, Halford says. Recognitions such as gift certificates and pizza parties are great if the recognition is sincere and is connected to a real achievement, he says.

For example, perfect attendance is not an achievement worth a special recognition, but a significant decrease in OR turnaround time is a true achievement, he explains.

At Winter Haven Surgical Center, staff recognitions are driven by peer recognitions, Procuniar says. An ongoing employee-of-the-month and employee-of-the-year program recognizes not only the employees being praised, but also those who offer the praise, she says. **(See story on employee recognition program, p. 53.)**

- **Proper tools.**

Another key to maintaining employee morale, especially with increasing volume and reduced staff, is to make sure employees have the tools to handle their jobs, Halford says. With staff costs representing a significant part of any same-day surgery program's expense, it is logical to cut staff during a budget crunch, he points out.

"Just make sure that you have the tools in place that enable the remaining staff to handle the workload," Halford says.

Use the latest, greatest tools to help staff members with their jobs, and be willing to pay overtime if it is needed to get the job done, he says. Computer programs that simplify medical records entries, the proper number of instruments so staff don't have to disinfect or sterilize between every case, and up-to-date equipment that is always working properly are just a few ways to make sure the remaining staff can handle the job, he says.

- **Input.**

Perhaps the most basic way to let employees know that they are appreciated and inspire them to motivate themselves is to ask what they need, Halford says. The most important part of asking, through formal or informal survey methods, is to make sure you follow up on any information employees provide, he adds.

An employee survey at Winter Haven Ambulatory Surgical Center uncovered dissatisfaction with the center's paid time-off policy, Procuniar says.

"We don't have separate vacation, sick, and

SOURCES

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holiday time," she explains. "Everyone accumulates hours of paid time-off each pay period, and it is used for holidays and other time off," she says.

Employees didn't believe the time was comparable to other programs in the area, so Procuniar surveyed other programs, compiled the data, and presented a recommendation to the board.

"The number of hours we increased paid time-off was not as much as employees wanted, but I was able to show employees the data I collected that demonstrated that the new paid time-off policy was fair and comparable to other programs," she says.

Employees who are happy are good workers, Procuniar says.

"Taking time to make sure your employees are satisfied with their jobs pays off in terms of patient satisfaction and low turnover," she adds.

Procuniar speaks from experience because not only does she rarely have employees leave her surgery program, but she also adds, "I'm one of the fortunate same-day surgery managers who has a waiting list of nurses who want to work for me full time." ■

Employee award program based on specific actions

Letting employees know that their efforts are appreciated is an important part of inspiring motivation, says **Diana Procuniar**, RN, CNOR, nurse administrator of the Winter Haven (FL) Ambulatory Surgical Center. It is important to make sure your appreciation programs reward employees for specific, identifiable contributions, or the rewards seem insincere, she adds.

"Our employee-of-the-month and employee-of-the-year nominees are determined by points accumulated from 'kudos forms' we use," Procuniar says.

The simple forms are completed by any staff member who witnesses another staff member who goes out of the way to help finish paperwork, clean a room, or help with a patient, she says. The witnessing employee completes the form with the employee name and the activity for which he or she is being praised. The forms are then posted on Procuniar's door for her to collect, she adds.

The public posting is one way that word spreads about the praise; another is the personal thank-you note from Procuniar. "We also use the kudos to award employee-of-the-month points," she explains.

Employees who fill out the form earn one point, and the employee receiving the praise accumulates two points. Employees also accumulate points from praise included in patient satisfaction surveys, Procuniar explains.

At the end of the month, the employee with the most points is employee of the month. At the end of the year, all employees vote on employee of the year from the 12 employees of the month, she explains.

The employee of the month and the employee of the year receive awards such as restaurant certificates or coupons for free car washes, Procuniar says. "These awards were suggested by staff members, but I'm considering giving up the car wash and offering a free massage or other type of gift certificate," she adds.

While the awards are not extravagant, they are effective, says Procuniar.

"The program does create a sense of pride in doing the job well, because everyone wants to hear us say 'thank you, you did a good job,'" she says. ■

Surfing the Internet is not just for entertainment

E-commerce, on-line education are good waves

In the mid-1970s, scientists and academicians were exploring a concept that involved the connection of different computer networks as a way to share research among large groups of people in different locations. Twenty-five years later, the use of what has become known as the Internet is an everyday occurrence for almost everyone.

"One of the biggest changes made possible by computerization and the Internet is the automation of the medical record," says **Patrick Virnich**, vice president of E-business development at Tyco Healthcare in Norwalk, CT. **(Virnich is scheduled to speak on this topic at the 2002 meeting of the Association of periOperative Registered Nurses. See calendar, p. 59.)**

Some institutions are using wireless devices to

EXECUTIVE SUMMARY

Access to the Internet has become a necessary component of every same-day surgery staff member's job and has produced multiple benefits.

- On-line educational classes reduce costs by eliminating travel and extra staff time away from the job.
- Web site-based information can be provided on a 24-hour/seven-days-a-week basis for patients and physicians.
- Managers can stay up-to-date on regulatory and accreditation changes with web sites that are updated frequently.

capture patient information and transmit directly into the computerized medical record, ensuring accurate, timely updates without requiring a computer at every bedside, he says.

Easy access to these records enables the same-day surgery center to bill accurately and file claims quickly, but the biggest advantage is the ability to analyze data in a variety of ways, Virnich says.

Manually captured data travel in a linear direction. The information is written on paper, it goes to a file, and the file goes to storage, he says. Digital data go into a database that can be manipulated by any area of the organization for use in decision making, he explains.

"You do have to be respectful of patient confidentiality and protect this information in the same way you would protect a paper record, but the data are invaluable for evaluating quality, determining outcomes, and setting patient care standards," he adds.

For example, patient outcomes following a specific procedure can be analyzed to see if a patient's NPO status affects his or her risk level for postoperative nausea.

"Data easily can be captured and analyzed to see if patient care standards should be changed," he explains.

When **Denise Goldsmith**, RN, MPH, director of product development at Framingham, MA-based Clinician Support Technology, worked at Beth Israel Deaconess Medical Center in Boston, she helped design a web site for the same-day surgery program that offered patients specific information about pain control following surgery (www.bidmc.harvard.edu/ambsurg). In follow-up studies, Goldsmith found that patients with access to web-based pain-control information did report a higher level of understanding of pain control and did report less postoperative pain.

"Patients want access to members of their health care team, and they are not satisfied when they can't get the information they need," says Goldsmith. "At the same time, patients are frustrated with the glut of information on the Internet because it is confusing," she adds.

Nurses and physicians have an obligation to help patients find pertinent, accurate information, and the Internet makes that obligation easy to meet, she suggests. She suggests setting up web sites for the same-day surgery program that give patients specific information about their procedures and what to expect during recovery.

Web sites offer new options

Because same-day surgery centers don't have access to patients after they've been discharged, web site-based information that reviews discharge instructions or pain control techniques can answer patient questions, says Goldsmith. **(See story on patient education, p. 55.)** Secure web-based messaging also can help if policies governing the program meet all the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), she adds.

If you use a web-based messaging system to communicate with your patients, be sure you have dedicated staff member for the program, suggests **Vickie Axsom-Brown**, administrator of Medicus Surgery Center in Anderson, SC. Same-day surgery programs that accept patient surveys, physician surveys, or e-mails from patients and physicians have to be ready to respond in a timely manner, and that means checking the correspondence every day, she points out.

In addition to receiving communications, the Internet provides easy access to information that is helpful for same-day surgery managers, Axsom-Brown says. "I regularly check web sites sponsored by a local legislative network, our state medical association, and different professional organizations for alerts and updates on regulations or activities that affect my program," she explains.

When she finds interesting web sites, she posts the web address near computers that staff members regularly use so everyone can see them, she adds.

"I really like the South Carolina Medical Association web site because it regularly includes updates on pending state legislation or regulatory

SOURCES

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updates that might affect my facility," Axsom-Brown explains.

Web sites also can cut the cost of staff and travel time for meetings and conferences, says Axsom-Brown. Continuing education requirements and staff educational requirements that are mandated by accreditation agencies also can be found on line through professional organizations, vendors, and even Medicare, she says. *(Editor's note: American Health Consultants, the publisher of* Same-Day Surgery*, offers* www.ce-web.com *and* www.cmeweb.com.*)*

"On-line courses enable employees to meet educational requirements at times that are convenient to them and to the surgery program," she says. An added benefit is the documentation that on-line courses offer with printout confirmation of test scores and certification forms, she points out.

While many same-day surgery programs are familiar with e-commerce as a way to purchase supplies and equipment, Virnich sees one other area in which vendors can help same-day surgery staffs. ***(See "Hang up the telephone, throw away POs, and join buyers on-line,"* Same-Day Surgery*, June 2001, p. 61.*** *Previously published articles are available on the web site* www.same-daysurgery.com. *Your user name is your subscriber number. Your password is sds in lowercase letters, then your subscriber number again.)*

"There is an opportunity for product suppliers to provide more timely information to the nurse who needs the information immediately," Virnich says.

"He or she doesn't always have time to call the company or wait several days for a representative to return the call," he adds. "A standardized product information library across multiple suppliers would provide more timely information and be more helpful to the nurse," he explains.

"As standards for web-based information evolve, I foresee one point of contact for customers," Virnich says. This central site will address questions on all types of equipment from all types of vendors, and will provide consistent, complete information that truly helps the same-day surgery staff, he adds.

Even with his prediction, Virnich admits that Internet-related technology is changing so quickly that no one really knows what the future holds.

"The development of the Internet was a revolution; now it is an evolution," he says. "It will take time to gain a consensus of opinion on how to handle different activities, and it will be years before we realize the full range of opportunities that exist." ■

Plan ahead to meet patient education needs

Pre-op info in doctors' offices, web sites helpful

The patient arrives at 7 a.m., and you have 30 minutes to gather information for the medical history, make sure the patient understands the procedure to be performed, and answer any

EXECUTIVE SUMMARY

As same-day surgery programs handle more cases and discharge more quickly, nurses must educate patients thoroughly so that they feel comfortable with aftercare and pain control.

- Provide pre-op and pain control information to physicians' office staffs to give patients the opportunity to absorb information. Meet with office staffs to make sure they understand basic pre-op instructions such as arrival times and NPO.
- Start patient education early in the recovery room so the patient and family have time to ask questions.
- Consider a web site to provide pre-op and post-op information for patients who are Internet-active.

questions about what the patient should expect following surgery. Oh, by the way, be sure you present all of this information in such a way that the patient understands now as well as after discharge, when he or she is miles away at home.

Patient education in a same-day surgery program is a challenge because the only contact most patients have with the staff prior to the day of surgery is a brief telephone call a day or so before surgery, says **Nancy Voelker**, RN, MSN, nurse manager of recovery, pre-op, and outpatient recovery for Southeast Missouri Hospital in Cape Girardeau.

Because patients are anxious the morning of surgery, Voelker's program uses a pre-op booklet that discusses some general pre-op instructions and pain management tips, she says.

"We make the booklets available in the physicians' offices, and we hand it to patients if they need to come to us for lab work prior to the day of surgery," she says.

Giving information prior to the day of surgery is helpful because patients have time to think about questions to ask the nurse, says **Ka Russum**, RN, BSN, director of the Lowery A. Woodall Outpatient Surgery Facility at Forrest General Hospital in Hattiesburg, MS. In addition to providing pre-op information booklets to physicians' staffs, her program also takes physician office staff members out to lunch once a month, she says.

"We use the lunches as an informal way to share information in a positive manner," she explains.

For example, if a particular physician's office is having patients arrive too close to surgery times, Russum's staff will bring up the problem as something they need the office staffs' help to resolve, rather than accusing them of sending patients at the wrong time, she says.

Give patients specific info

Almost all same-day surgery programs call patients at least one to two days prior to scheduled surgery, but the telephone calls are most effective if the nurse has specific information about the patient's procedure to offer, Russum says.

"Our nurses give instructions about arrival times, NPO, and skin care prior to surgery that are specific to the patient's procedure," she says.

This increases the likelihood of compliance and reduces the risk of delayed surgery, she adds.

Printed instruction sheets also are valuable teaching tools, Voelker says. Her facility has a wide range of patient education/instruction sheets on almost every type of procedure, she says. The instructions were developed in-house with input from physicians and staff members, she says. The handouts are available on an internal database, so there is no need to store stacks of instructions or dig through dozens of papers when a specific one is needed, she points out. "We just print out the one we need," she explains. **(See sample postoperative instruction sheet for tonsillectomy and/or adenoidectomy on our web site: www.same-daysurgery.com. Click on "toolbox" and look under "patient documentation/patient education.")**

"We start our teaching within the first hour of recovery so that the patient and the family members have time to absorb the information and come up with questions," Voelker says. "You do not teach well if you give patients and their families instructions five minutes before they walk out the door."

Even if you spend as much time educating patients as possible while they are with you, there are always questions and misunderstandings as soon as they get home, so it is important to give patients access to information, says **Mary Ellen Bowers**, RN, MSN, clinical nurse at the Ambulatory Surgical Center at Beth Israel Deaconess Medical Center in Boston. Bowers' facility has had a same-day surgery web site (www.bidmc.harvard.edu/ambsurg) for four years. **(For more information, see story on**

SOURCES

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same-day surgery web sites, below.)

"We include information patients need ahead of time, such as location, parking, arrival times, and what to bring or not to bring," she says. "We also include pain management information that is helpful to patients after surgery."

No matter what techniques you use to streamline patient education and provide comprehensive information, it is important to teach at the patient's level of understanding, Voelker says.

Don't use complicated medical terms, and be willing to offer down-to-earth advice, she says. "For example, we tell parents whose child has difficulty urinating after surgery that the child can be set in a tub of warm water to make urination less difficult," she explains.

The best advice for nurses feeling the pressure of more patient education to present and less time in which to do it is to relax, says Voelker.

"It's an important part of your job, and we should all have a good time with it," she says. ■

Web sites give patients 24-hour information

For four years, the staff at the same-day surgery program at Beth Israel Deaconess Medical Center in Boston have provided patients with pre-op and post-op information through their web site (www.bidmc.harvard.edu/ambsurg), says **Mary Ellen Bowers**, RN, MSN, clinical nurse at the Ambulatory Surgical Center in Boston.

"We developed the site for our Internet-active patients who want access to information at times outside normal office hours for us and for physicians," Bowers explains.

The site contains directions to the facility, instructions on where to park, information about arrival times, and general information for patients on the day of their surgery, she says.

"We also provide information about pain management that patients can look at when they get home," Bowers adds.

This extra information reinforces whatever teaching has been given before discharge, she points out.

While Beth Israel's web site does not allow patients to contact the surgery center through e-mail, Woodall Surgery Center's site does, says **Ka Russum**, RN, BSN, director of the Lowery A. Woodall Outpatient Surgery Facility at Forrest General Hospital in Hattiesburg, MS. (The web site is www.forrestgeneral.com. Click on "Lowery A. Woodall Outpatient Surgery Facility.")

"The e-mails come to me, and I check them every day," she says.

Because the site has been operational for only a short time, Russum is not sure how many e-mails her facility will receive and if it is feasible to have a same-day surgery staff member respond to them.

The web site can be an invaluable adjunct to the patient education process because it is available when the patient needs information, no matter what time of day, Bowers says.

It does, however, need to be marketed, she adds. Bowers suggests brochures in physicians' offices and waiting areas.

"Nurses that make the pre-op telephone calls or follow-up calls ought to ask if patients are Internet-active and direct them to the web site for more information as well," she says. ■

Audio conferences target disasters, disclosure

Have you missed one of American Health Consultants' (AHC) recent audio conferences? If so, two upcoming conference replays offer another opportunity to take advantage of excellent continuing education opportunities for your entire facility.

Disaster Response at Ground Zero: How NYU Downtown Hospital Handled Mass Casualties With All Systems Down, originally held on Jan. 10, takes participants to the heart of the World Trade Center disaster on Sept. 11.

Just a few blocks away from the crash site, NYU Downtown was cut off from crucial life-saving supplies and power, even as hundreds of injured came through the emergency department doors.

HazMat teams on the roof of the hospital had to vacuum all of the debris out of air ducts to maintain air quality and keep generators running. Physicians and nurses had to balance urgent care with proper documentation.

Learn how to prepare your facility for the unthinkable. The replay will be available from 8:30 a.m. ET on Tuesday, April 16, to 5:30 p.m. on Wednesday, April 17. Current AHC subscribers

pay $249, which includes free CME and CE credit. The cost is $299 for nonsubscribers.

On April 23 and 24, **What to Say When Something Goes Wrong: Do the Right Thing When Trouble Strikes** also will be available for replay. This successful audio conference covers the major fears clinicians experience when confronting issues of medical disclosure.

Learn benefits for patient and provider, as well as the risks of litigation and how to avoid costly legal battles. Free CE for your entire facility is included in the $249 fee for AHC subscribers.

To register for either one of these replays, contact American Health Consultants' customer service department at (800) 688-2421 or by e-mail at customerservice@ahcpub.com.

Customer service representatives will provide you with all of the necessary information on dial-in procedure and how to download conference handouts and material on line. ■

(Continued from cover)

Centers for Medicare & Medicaid Services (CMS) is not up to the task. **(See recommendations, p. 59. For information on how to access the report, see box, p. 59.)**

"States have not recertified nearly a third of ASCs in five or more years, and CMS does little to monitor the performance of state agencies and accreditors," the OIG claims.

The OIG points to the explosive growth of surgery centers and the complexity of the procedures performed there. "For these reasons, oversight is more important than ever," the agency says.

This report is not about the quality of care provided in an ASC, but rather how well does Medicare oversee private accrediting bodies and state surveys, maintains **Kathy Bryant**, executive director of the Federated Ambulatory Surgery Association (FASA) in Alexandria, VA. "Right now, 'not very well' is the answer," she says. "However, that doesn't mean that the Medicare conditions of coverage are not being followed by ASCs."

To help address the issue of quality oversight, the OIG recommends that surgery centers display instructions on how to post complaints to Medicare and accrediting groups.

However, there may be a better way than a sign to communicate this information to patients, Bryant says. "One example might be to include [that information] in discharge instructions, which would mean that the patients would have the information when they got home," she says.

In addition, the report says, if CMS makes the survey results more widely available, it also should provide comparative data, such as the average number of deficiencies outstanding at all ASCs.

The Wilmette, IL-based Accreditation Association for Ambulatory Health Care (AAAHC) supports comparative data across the board . . . not just deficiencies, says **John E. Burke**, PhD, executive director and CEO. "Information that is reliable and useful to consumers and presented in an understandable and accessible format would be useful," Burke says.

CMS would need to take great care in ensuring the accuracy and consistency of surveyors, Bryant maintains. Currently there are significant variations among geographic regions in how the state surveyors interpret the Medicare conditions of coverage, she says. "It also varies by surveyors, whether state or private accrediting bodies, and over time," Bryant says. Also, the data would need to be separated by type of ASC, or it would be useless, she says. "A large multispecialty facility might look bad on certain criteria simply because of the cases it does as compared to others," she says.

Pinkner agrees. "You have to differentiate between ambulatory surgery at a hospital, and ASCs that are owned by hospital on campus, and multispecialty surgery centers vs. the small physician's office," he says.

The changes recommended by OIG do have a positive side, points out **Eric Zimmerman,** JD, MBA, attorney with McDermott, Will & Emery in Washington, DC. "If done right, it can be helpful; it can demonstrate the high quality of service provided in ASC and not be overly intrusive," he says. "The question is how they fashion that requirement."

Information that tells the public about the high quality of service in ASCs is generally a good thing, "but you have to balance that helpfulness with the burden of providing that information," he says.

Bryant also expressed concern about the burden, and she points to the requirement for continuous quality improvement.

"In one proposed draft, they were looking at a several paragraph provision where a one paragraph condition now exists," Bryant says. "As they say, the devil is in the details."

Also, the report calls on surgery centers to have systems in place to resolve patients complaints, but according to FASA's outcomes monitoring system, 98.6% of ASCs have such a system**.** The report also called on surgery centers to have systems in place to "respect patients' dignity."

"Part of the reason ASCs have been so successful is that they do provide a more patient-friendly environment and more personal attention than larger, more bureaucratic institutions, so I think ASCs already have had a head start on that one," Zimmerman says. ■

Resources

The report *Quality Oversight of Ambulatory Surgical Centers: A System in Neglect* (OEI-01-00-00450) is available free on the web: oig.hhs.gov/oei/reports/oei-01-00-00450.pdf. *Quality Oversight of Ambulatory Surgical Centers: The Role of Certification and Accreditation — Supplemental Report No. 1* (OEI-01-00-00451) is available free at oig.hhs.gov/oei/reports/oei-01-00-00451.pdf. *Quality Oversight of Ambulatory Surgical Centers: Holding State Agencies and Accreditors Accountable — Supplemental Report 2* (OEI-01-00-00452) is available free at oig.hhs.gov/oei/reports/oei-01-00-00452.pdf. To order a free copy by mail, contact:

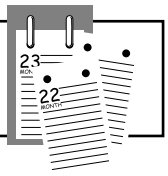
• **Office of Inspector General**, Public Affairs Office, 330 Independence Ave. S.W., Washington, DC 20201. Telephone: (202) 619-1343. Fax: (202) 260 8512. E-mail: eaffairs@os.dhhs.gov.

Recommendations

1. **The Centers for Medicare & Medicaid Services (CMS) should determine an appropriate minimum cycle for surveying ambulatory surgery centers (ASCs) certified by state agencies.**
2. **CMS should update the Medicare Conditions of Coverage for ASCs.** Add sections to address patient rights and continuous quality improvement. Make conditions adjustable to match the levels of surgery performed by different ASCs.
3. **CMS should ensure that state agency certification and accreditation strike an appropriate balance between compliance and continuous quality improvement.** Monitor state agencies and accreditors to ensure that they protect the public from poor performing ASCs while encouraging the rest to go beyond minimal health and safety standards.
4. **CMS should hold state agencies and accreditors fully accountable to the Medicare program for their performance overseeing ASCs.** Use electronic data reporting; federal oversight surveys; and formal, periodic evaluations to monitor and provide feedback to state agencies and accreditors.
5. **CMS should do more to hold state agencies and accreditors accountable to the public for their performance overseeing ASCs.** Take steps to increase public information about state agency certified and accredited ASCs and accessibility of state agencies' and accreditors' complaint processes. Publish public performance information about state agencies and the accreditors.

Source: Office of Inspector General. *Quality Oversight of Ambulatory Surgical Centers: A System in Neglect* (OEI-01-00-00450). 2002; Washington, DC.

CALENDAR



• **Association of periOperative Nurses (AORN) 2002 Congress**, April 21-25, Anaheim, CA.

For more information, contact AORN, 2170 S. Parker Road, Suite 300, Denver, CO 80231-5711. Telephone: (800) 755-2676, ext. 1, or (303) 755-6304, ext. 1. Fax: (303) 750-3212. Web: www.aorn.org/congress. ■

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Editorial Questions

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CE/CME objectives

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

- Identify Medicare policy for ambulatory surgery centers regarding "waiting areas" and "recovery rooms." (See *"Medicare updates info on pass-through devices."*)
- Recognize the important components of an effective employee recognition program that results in motivated employees. (See *"Happy employees result in satisfied patients."*)
- Identify the major benefit of automating medical records. (See *"Surfing the Internet is not just for entertainment."*)
- Recognize one of the advantages of web site-based patient education. (See *"Plan ahead to meet patient education needs."*) ■

CE/CME *questions*

Please save your monthly issues with the CE/ CME questions in order to take the two semester tests in June and December. A Scantron form will be inserted in those issues, but the questions will not be repeated.

13. Can Medicare-certified ambulatory surgery centers have "waiting areas" and "recovery rooms" that are used by patients for other purposes?
    A. yes
    B. no
    C. only if you obtain a waiver from Medicare

14. According to consultant Scott Halford, employee recognition programs are only effective if they:
    A. recognize specific and significant achievements.
    B. result in cash awards to employees.
    C. generate publicity for the same-day surgery program.
    D. eventually award all employees so no one feels left out.

15. There are a number of advantages to automating medical records and using the Internet to access the data, according to Patrick Virnich, vice president of E-business development at Tyco Healthcare. One of the most effective uses of automatic records is they:
    A. keep down the cost of paper forms.
    B. give access to the data to all parts of the organization for use in making informed decisions.
    C. provide a backup in case the paper records are lost.
    D. help same-day surgery programs meet the requirements of the Health Information Protection Act of 1996.

16. According to Mary Ellen Bowers, RN, MSN, clinical nurse at the Ambulatory Surgical Center at Beth Israel Deaconess Medical Center, a web site makes a good addition to a patient education program because it:
    A. attracts Internet-active patients to your program.
    B. makes your program look up to date.
    C. gives patients access to information when it's convenient to them.
    D. helps nurses stay up to date on computer skills.

Then and Now

■ Top outpatient procedures

Then: dilation and curettage, tubal ligation, myringotomy, orthopedics, excision of skin lesion, dental procedures, adenoidectomy and/or tonsillectomy, diagnostic laparoscopy, vasectomy, cystoscopy (1978)

Now: insertion of intraocular lens, phacoemulsification and aspiration of cataract, discission of secondary membrane (after cataract), intracapsular extraction of lens, extracapsular extraction of lens, colonoscopy, esophagogastroduodenoscopy (EGD) with closed biopsy, endoscopy of small intestine, cystoscopy, closed (endoscopic) biopsy of large intestine (2002)

■ Membership of Association of periOperative Registered Nurses (AORN)

Then: 24,662 (1977)

Now: 35,509 (2002)

■ Salary of RN

Then: $396 weekly (1983)

Now: $829 (2001)

■ Salary of physician

Then: $502 weekly (includes physician managers) (1983)

Now: $1,258 (2001)

■ Accreditation cost by Joint Commission on Accreditation of Healthcare Organizations

Then: Ambulatory, three-year cycle: $1,600; Hospital, two-year cycle: $4,500 (1977)

Now: Ambulatory, three-year cycle: $9,500; Hospital, three-year cycle: $23,000 (2001)

■ Number of surveys by Accreditation Association for Ambulatory Health Care

Then: 45 completed, 150 requested (1979)

Now: 1,421 completed (2001)

■ Percentage of hospitals offering outpatient surgery

Then: 4,829 (82.8%) of 5,830 community hospitals (1980)

Now: 3,870 (91.8%) of 4,217 community hospitals (2000)

Sources: Same-Day Surgery in Atlanta; SMG Marketing in Chicago; Association of periOperative Registered Nurses in Denver; Labor Force Statistics Office in Washington, DC; Accreditation Association for Ambulatory Health Care in Wilmette, IL; Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL; American Hospital Association in Chicago.

BIOTERRORISM WATCH

Preparing for and responding to biological, chemical and nuclear disasters

Building a bridge over the abyss: Will bioterrorism help bring disjointed health system together?

Getting in same boat as 'tsunami' of money builds

Diverse and disjointed, the nation's public health and clinical settings have education needs and communication gaps that must be bridged if the system is to improve its response to bioterrorism, a group of consultants recently told the Atlanta-based Centers for Disease Control and Prevention (CDC).

The CDC's national center for infectious diseases is holding a series of meetings to assess the lessons of last year's anthrax attacks and begin to close the long-standing breach between public health and clinical medicine.

The gap may stem from differences between the private and public health care systems, both of which are fragmented and highly variable by geography and urban vs. rural settings, according to a CDC draft summary of the Jan. 7, 2002, consultants' meeting, which was obtained by *Bioterrorism Watch.*

Seeking collaboration

"There was lot of [discussion] about the gap between public health, private practices, and hospitals and how to bridge that gap and make things more collaborative," said **William Scheckler**, MD, a consultant at the meeting and hospital epidemiologist at St. Mary's Hospital in Madison, WI. "[We need] to reduce some of the redundancies in the systems both in terms of preparing and education."

Scheckler also is a member of the CDC Healthcare Infection Control Practices Advisory Committee (HICPAC), which met Feb. 25-26, 2002, in Atlanta.

Scheckler gave a report on the consultants' meeting, telling HICPAC members that the CDC had input from a broad range of bioterrorism groups and clinical specialties. There is a wealth of information scattered among these groups and on numerous web sites, he noted. For example, a dermatology group at the meeting has photographs of skin lesions that could be a good resource in an investigation of cutaneous anthrax.

"When an outbreak occurs, the same questions [arise]: What do people need to know? What is the best way to get out the information?" he said. "There should be one best-practices web page that you can go to."

The CDC currently operates several different clearinghouses for information as well as different public inquiry numbers. The agency now is considering the possibility of centralizing its clearinghouses and public inquiry services, the CDC report states.

"During the anthrax crisis, the CDC public inquiry system was overwhelmed, and therefore the agency set up a new system during the outbreak," the CDC report continues.

In addition, the CDC found that "during the attacks, the amount of information on anthrax increased from virtually nothing to an overwhelming number of e-mails, web sites, printed

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documents, and other materials. Much of this information and work was duplicative."

The consultants suggested that the CDC devise a strategy to centralize information development activities and then distribute the product, rather than having so many individuals working independently. **(See CDC action items, below right.)**

Linking the data base

Regarding public health and clinical partnerships, a relatively simple system of linking health departments with hospital emergency departments (ED) was described by HICPAC member **Alfred DeMaria Jr.**, MD, state epidemiologist at the Massachusetts Department of Public Health in Jamaica Plain.

Under the program, participating hospitals in the Boston area report their daily number of ED visits to the health department. The numbers are compared against emergency visits a week earlier and on the same date a year prior to detect surges that might suggest a bioterrorism event, he said.

The information is easily obtainable by the hospitals and can be submitted electronically to the health department without extra work. That is important because bioterrorism surveillance systems that are labor-intensive will likely falter as vigilance inevitably wanes, DeMaria noted.

The system has provided the secondary gain of improving communication between public health and clinical sectors. The threshold for investigation occurs at two orders of magnitude above baseline, which thus far has occurred with influenza ED visits and those associated with a large trauma event such as a bus crash, he said.

Sometimes, the threshold will be reached simply out of random chance, as ED visits increase for no single reason. "The question is, we don't know how big an event has to happen [to be detected]," DeMaria said.

The CDC is interested in such bioterrorism surveillance systems, and also may seek to apply its existing hospital sentinel networks, including the National Nosocomial Infections Surveillance system, said **Steve Solomon**, MD, chief of special studies activity in the CDC division of healthcare quality promotion.

National concerns about patient safety and bioterrorism have created a "tsunami of money" to address such issues, Solomon told HICPAC members.

"We have a lot of concerns about the surveillance and response needs," he said. "We are seeking a small trickle of that tidal wave of funds."

Ultimately, the CDC may help shape a national system or contribute to a "mosaic" of systems that track surrogate markers such as severity of illness in "real time," he said.

The research and development needs for such a system are in the ballpark of $120 million to $180 million, which may be available in the current climate over the next four or five years, he said. There is considerable interest being expressed from health care-related industries in partnering with the CDC on such efforts.

"They are standing in line," Solomon told HICPAC members. "The phone is ringing off the hook. We are trying to figure out who is the best partner." ■

CDC gets plenty of advice for action

Clarify roles, make info user-friendly

A recent consultants' brainstorming session on education and communication needs for bioterrorism resulted in numerous suggestions to the Centers for Disease Control and Prevention (CDC) in Atlanta. Some of the points of information and recommended items for action included:

- ✔ Strengthen the CDC Health Alert Network e-mail notification system to ensure that all state and local health departments are involved.
- ✔ Make surveillance and reporting as automatic as possible, and do not depend on the clinician to initiate the report quickly.
- ✔ Because the CDC is recognized as an authoritative source for information provided through *Morbidity and Mortality Weekly Report* and press releases, the CDC web site should be changed to make it more user-friendly.
- ✔ Ruling out disease is the most important clinical issue, rather than identifying new cases of disease.
- ✔ Clarify roles when a criminal investigation is going to occur during a public health emergency.
- ✔ Develop a prototype disaster plan for use by communities and make it readily available.
- ✔ The cacophony of information is a problem. For clinicians, an appropriate tool would be a page of bulleted information necessary for the

clinical setting. This should be provided in addition to baseline information.

✔ The CDC smallpox plan is a good model for allowing outside review during the development phase.

✔ Identify additional ways for using communication technology, particularly e-mail, to link local resources together. ■

Was anthrax mailer a bioweapons researcher?

'This has military lab stamped all over it'

Given the difficulty of creating high-quality anthrax in a civilian research lab, the original source of the *Bacillus anthracis* that killed five people last year was likely a U.S. bioweapons facility, the president of the American Society of Microbiology (ASM) tells *Bioterrorism Watch*.

"Given the high quality of the preparation that was used, this has military laboratory stamped all over it," says **Abigail Salyers**, PhD, ASM president and a professor of microbiology at the University of Illinois in Urbana-Champaign.

The U.S. bioweapons program was formally disbanded as part of a global treaty in the early 1970s, but many military labs remained open for "biodefense" research to counter bioterrorism, she says. "These anthrax spore preparations last for decades," Salyers says.

Anthrax mailer is 'criminal, but not stupid'

The atmosphere of a university research lab is too open and freewheeling for someone to produce anthrax undetected, she says. Salyers' personal theory is that someone who worked in a military bioweapons laboratory stole the anthrax, possibly years ago.

"It's anybody's guess as to what is going on here, but I would be astounded if this came out of a university laboratory," she says. "[This person] is crazy, criminal, but not stupid. I can't imagine that anybody who was going to do that would take the trouble and risk of trying to do that in a university laboratory environment."

In a related matter — despite a published report to the contrary — the Federal Bureau of Investigation denies it has narrowed its anthrax investigation to a former scientist in a U.S. bioweapons lab.

A FBI spokeswoman at the agency's national office in Washington, DC, told *Bioterrorism Watch* that the agency has not identified "a prime suspect" in the hundreds of interviews it has conducted in the investigation.

A story that was published in the Feb. 25, 2002, *Washington Times* reported that the FBI's search was focusing on a former U.S. scientist who worked at a government bioweapons laboratory. The government's chief suspect, the article reported, is believed to have worked at the U.S. Army Medical Research Institute of Infectious Diseases at Fort Detrick, MD, which has maintained stores of weapons-grade anthrax. No charges had been filed as this issue of *Bioterrorism Watch* went to press.

Do you know this person?

Salyers described her theory on the case — before the newspaper report was published — when the FBI openly solicited help from the ASM in the investigation. In a message appealing for help from ASM members, **Van Harp**, assistant director of the FBI's Washington, DC, field office, said "a single person" is most likely responsible for the mailings. "It is very likely that one or more of you know this individual," he told ASM members.

A $2.5 million dollar award is offered to anyone providing information that leads to an arrest of the bioterrorist. The FBI profile describes a socially withdrawn person who has "a clear, rational thought process" and is very organized. "The perpetrator might be described as 'standoffish' and likely prefers to work in isolation as opposed to a group/team setting," Harp told the ASM. It is possible the mailer used off-hours in a laboratory or may have even established an improvised, concealed facility to produce the anthrax, the FBI profile noted.

"The person is experienced working in a laboratory," Harp told the ASM. "Based on his or her selection of the Ames strain of *Bacillus anthracis,* one would expect that this individual has or had legitimate access to select biological agents at some time. This person has the technical knowledge and/or expertise to produce a highly refined and deadly product."

Indeed, the Ames strain used in the attacks has been used in bioweapons research both in the United States and worldwide, Salyers says. In

addition, given the elaborate research protocol required, it is unlikely a university laboratorian creating anthrax would go undetected no matter how "standoffish" he or she was.

"I'm just telling you what you have to go through if you were crazy enough to be a bioterrorist," Salyers says. "If a deranged scientist tried to do this in a university laboratory, red flags would be going up all along the way."

Recipe for disaster

The first step — cultivating the bacteria and producing spores — is something that almost any microbiologist could do, she says.

"But you get this slush, and that is not going to hurt anybody," she says. "There are people who will tell you that you can do this the hard way with a mortar and pestle and grind it up in the laboratory. But it is clear that the powder that was in the letters was a much higher quality than that."

The anthrax "slush" must be ground into a fine powder to be capable of getting past human respiratory defenses. "The machinery for doing this is mostly in military research laboratories," Salyers says. In addition, sophisticated treatment of the spores must be done to defeat their general property of clumping and sticking together.

"You would want to treat the spores so that they don't stick together and also so that you get a preparation that is very volatile — goes into the air and stays in the air," she adds.

Regardless of whether the mailer worked in a military lab or other facility, there is growing consensus that the attacks were not the work of foreign terrorists.

"The current thinking among many people is that this is a domestic event that kind of occurred in the slipstream of 9/11," says **William Schaffner**, MD, ASM member and chairman of preventive medicine at the Vanderbilt University School of Medicine in Nashville, TN.

"The [FBI profile] characteristics don't seem terribly surprising. They seem akin to the kind of characteristics that were part of the picture of [the Unabomber] Ted Kaczynski — a disgruntled person who is very bright, and in this instance, has a substantial amount of professional and technological expertise in order to carry this off."

[Editor's note: Those who think they may have information relevant to the case can contact the FBI via telephone at (800) CRIME TV — (800) 274-6388 — or via e-mail: Amerithrax@FBI.gov.] ■

Bioterrorism forensics: The burden of proof

If bug does not fit, you must acquit?

Already asked by federal investigators to assist in finding the anthrax mailer, the American Society of Microbiology (ASM) is taking the next step and discussing the emerging science of bioterrorism forensics.

Despite an impressive array of scientific methods, primarily used in health care epidemiology and outbreak investigations, linking a pathogen to a terrorist will not be easy.

"You want to trace it back to the 'smoking gun,' says **Abigail Salyers**, PhD, ASM president and a professor of microbiology at the University of Illinois in Urbana-Champaign. "We know how to tell what bullet came from what particular gun. But when it is bacteria, viruses, or other microorganisms we really don't have established forensics for that."

To address the issue, the ASM will hold meetings later this year that may result in a booklet on how to use molecular epidemiology techniques to establish a chain of evidence rather than identify the source of an outbreak, she says.

The methods typically used by outbreak investigators include DNA fingerprinting and pulsed-field gel electrophoresis. But using such methods to link a bioterrorist to a biological weapon would be unprecedented, Salyers notes. "Suppose they find somebody [who] might have perpetrated the [anthrax attacks], and they find some spores on that person or the immediate environment."

"Trying to prove that that is the [exact strain] will be unprecedented. It is not just a question of finding the person. It is a question of what are going to be the legally binding types of evidence," Salyers explains.

Another problem in the anthrax attacks is the separation of act and outcome, she says. As opposed to a bomb exploding and leaving an immediate impact, the anthrax mailer had time to dispose of evidence after the mailings.

"You have a perpetration of an act and the consequences of the act separated by nearly a month," she says. "There has been a lot of time for the perpetrator to cover up tracks. This is very different from putting nerve gas into a subway system, where the cause and effect are very close together," Salyers adds. ■

PATIENT SAFETY ALERT™
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Early results of Leapfrog hospital survey promising

Nearly half of institutions contacted provided replies

In mid-2001, a total of 525 hospitals in six regions around the country were invited to complete a web-based patient survey by the Business Roundtable's The Leapfrog Group in Washington, DC.

Now, the first returns are in, and The Leapfrog Group's top official says she is encouraged by what she sees.

"Overall, the results are very promising," said **Suzanne F. Delbanco**, PhD, executive director, during a press briefing held Jan. 17, 2002. "Nearly half of the hospitals that we invited to take the survey submitted responses (241, or nearly 48%). That's an enormous achievement."

53% meet standards

What's even more exciting, she added, is that of the hospitals that responded, 53% already met at least one of Leapfrog's standards for three key safety practices: The use of computerized physician order entry (CPOE); staffing intensive care units (ICU) with intensivists; and evidence-based hospital referral.

By practice, the results broke down as follows:

- Of the responding hospitals, 3.3% have instituted CPOE.
- About 10% of the responding hospitals have fully implemented the intensivist model, and another 18% indicated plans to enlist intensivists by 2004.
- In terms of specific volume recommendations, 12% meet Leapfrog's recommended level of annual experience for coronary artery bypass graft; 31% for coronary angioplasty; 21% for abdominal aortic aneurysm repair; 20% for carotid endarterectomy; 15% for esophageal cancer surgery; and 22% have neonatal ICUs that meet Leapfrog's recommendations.

The six targeted regions include urban hospitals in Atlanta, California, East Tennessee, Minnesota, St. Louis, and Seattle-Tacoma-Everett. Three of the six regions (California, East Tennessee, and Minnesota) reported having at least one hospital with a fully implemented CPOE. Five of the six (California, East Tennessee, Minnesota, St. Louis, and Seattle) have at least one hospital that has fully implemented the ICU physician staffing or intensivist practice.

The greatest impact

The three standards were selected because, according to Leapfrog members, the greatest impact could be made on patient safety in the shortest period of time. If implemented, nearly 60,000 lives could be saved each year and more than half a million serious medication errors could be prevented, the group claims.

"CPOE has been shown to reduce serious medical errors by more than 50%. Staffing intensive care units with intensivists has been shown to reduce the risk of patients dying in the ICU by more than 10%. Appropriate referrals for high-risk procedures and conditions can reduce the risk of a patient dying by at least 30%," Delbanco declared.

Private industry is an integral part of this effort, and companies have their own incentives for participating, noted **Charles R. Lee**, chairman and co-CEO of New York-based Verizon Communications.

"We have two standpoints. First, we care about our employees and our retirees, and their

dependents, and their families," he said.

"The other one is the whole matter of quality. Quality is a never-ending journey. You're never satisfied with the current results; you always want to get better and do better. It's a standard practice in big corporations. We hope that we can, over time, develop relationships with some of the institutions that are involved in the medical profession to move them forward."

Sharing the information

Now that Leapfrog has this survey information, the next step is to share it with specific stakeholders. "Our members are going to share it with their employees, retirees, and dependents, through internal communications like newsletters, benefits materials, and corporate web sites," Delbanco said.

She also noted that Leapfrog, with the help of the Portland, OR-based Foundation for Accountability, has created a consumer test and tool kit that members, health plans, physicians, and others can use and customize to educate consumers. The hospital information is being made available to the public on the group's web site www.leapfroggroup.org.

Delbanco noted that sharing these results fulfills a commitment not only to consumers but also to the hospitals that took the time to complete the survey.

"Sharing this information is only part of what we're doing with hospitals," she added.

"In some cases, our members will offer financial incentives to hospitals to implement the Leapfrog practices, as well as other types of reward and recognition," Delbanco said.

Such strategies are, of course, intended to engender change at the institutional level, which is critical to the success of Leapfrog's efforts. The survey information "is only significant if people change behavior," noted **John Rother**, director of policy and strategy for the Washington, DC-based American Association of Retired Persons (AARP).

"It's only significant if the hospitals respond not only to a request for information but start to implement these changes to save lives." **(Some institutions and health care organizations already have; see article, at right.)**

It's also important for all of us, as patients and family members, to pay attention to the information and make decisions based on it, Rother noted.

"Do not send your parent to a hospital that's refusing to give this kind of information," he warned. "Do not send a family member to a hospital for an operation where we know that another hospital in your area does it better — a lot better. These choices are life and death decisions."

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Putting safety principles into practice

Incentivizing safety efforts

When it comes to safety, theory is nice but results are better. Two panelists at the Leapfrog Group press briefing reported how they have given teeth to safety principles with transformative initiatives.

Michael A. Stocker, MD, MPH, CEO of Empire Blue Cross and Blue Shield in New York City, described an innovative incentive program being undertaken in his area.

"We represent about 100,000 employees and dependents in the New York City area," he said.

Making it worth the effort

"Those hospitals that meet the computerized physician order-entry (CPOE) standard and the enclosed ICU [intensive care unit] standard will receive a 4% bonus on all income that we provide to them if, in fact, they fulfill these standards. We are actually going to send a check quarterly to the CEO to make the point to the hospitals in the area." In the second year, a 3% bonus will be provided, and a 2% bonus will be paid in the third year, he added.

Why is Empire Blue Cross and Blue Shield doing this? "From its inception, what we really

liked about The Leapfrog Group's standards is the fact that they are evidence-based," Stocker noted.

"The evidence is simply overwhelming; one large company estimates that one or two of their employees died because of medical errors every day, including retirees and dependents," he said.

Because the standards are evidence-based, he continued, "Everybody can intuitively understand what it means if you have a volume standard, what enclosed ICUs mean, if you have intensivists [who] are available and [CPOE]. Second, it can be done anywhere. You could do this all across the country, and our hope, of course, is that's what's going to happen."

CPOE implementation

At Cedars-Sinai Health System in Los Angeles, CPOE is about to become a reality. "We've been working on it for about two years, and it's set to go live in May of this year," reported **Michael L. Langberg**, MD, FACP, chief medical officer and senior vice president for medical affairs.

The medical executive committee at Cedars-Sinai passed a motion in January that basically would suspend a physician's ability to practice in the institution if the physician was not certified competent in his or her ability to use the CPOE system by the time it goes live.

"The reason for doing this is not punitive," Langberg explained. "It's a very strong belief in the marriage of a physician order-entry system with clinical decision support. So at the time physicians submit an order to the hospital, they will have available to them all the important information to make the best judgment or choice for their patients.

"Once we establish that standard, all patients and all physicians will have to be involved in that kind of support in real time," he said.

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Safety tool stresses education and action

Tragedy transforms facility into industry model

Two tragic medication errors seven years ago prompted Dana-Farber Cancer Institute in Boston to undertake what CEO **Jim Conway** calls "a journey of change."

That journey has led to industrywide praise and recognition, including the recent awarding to Conway of one of the two inaugural Individual Leadership in Patient Safety Awards from the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance.

Among Conway's most notable accomplishments was the development of a patient safety self-assessment tool that encourages executives to initiate improvements proactively rather than to wait for the occurrence of adverse events to force action.

In early 1995, Dana-Farber discovered that two patients had received massive chemotherapy overdoses. As one of those patients was Betsy Lehman, a well-known health reporter for the *Boston Globe*, the events received extensive media coverage, including 28 front-page stories in the *Globe*. The question on everyone's lips seemed to be, "How could such a bad thing happen at Dana-Farber, and to such an informed patient?"

This led to what Conway calls "a journey of change for our leadership and staff." Naturally, he says, Dana-Farber carried the burden of these events, but that was not enough.

"It was also our responsibility to learn all we could about why our system failed," Conway says. The events, he says, took on significant power, driving health professionals across the country to learn about medical errors.

"It's mentioned in the first sentence of the executive summary of the [Institute of Medicine] report [*To Err Is Human*]," Conway notes. "It was not only a sentinel event, but a seminal event."

The development of the safety tool grew out of the ongoing process of change. "Myself, the chief of nursing, the staff, the directory of pharmacy, the director of risk management, and others have all spoken on the subject extensively," Conway notes.

"We get two common questions from health care leaders. The first is, 'In the absence of high-profile events, how do you create the tension for

change?' The second issue we hear is something like this: 'You would never catch my boss standing in a public forum and talking about *our* stuff!' We have talked a lot about the gap between excellence and perfection," he explains.

It was not surprising then that last November, the Joint Commission asked Conway to give a talk at its annual meeting on leadership and patient safety. "In preparation for that talk, we had conversations with our trustees and executive leadership, as well as with our staff," he says.

"We asked ourselves, 'What are the things we do that work and seem to make sense, and that lead to success?'" Conway then put up a posting on the National Patient Safety Foundation listserv, asking if health care professionals believed their organizations' leaders "got it" when it came to patient safety.

"We got a number of comments from people who said they did, and they told us what they do," Conway reports. "Then we went and looked in the literature. We spoke with people like [the Institute for Healthcare Improvement's] Don Berwick and [Harvard University's] Lucian Leape, and asked what they thought."

Dana-Farber also consulted two other groups: a state coalition of 20 organizations dedicated to improving patient safety, and their patients.

The result was the patient safety tool, which has been given the title, "Strategies for Leadership — Hospital Executives and Their Role in Patient Safety."

It is divided into four basic sections:

- **Personal Education.**

How do you educate yourself? What books and articles have you read? Do you take courses? Do you understand the facts of your organization?

- **Call to Action.**

What are you doing to establish a framework for safety in your facility? What policies and procedures have you put in place?

- **Practicing a Culture of Safety.**

How do you do this every day?

- **Advancing the Field.**

What do you do outside of your institution to support others?

The tool is presented in the form of a questionnaire, with "Y" and "N" boxes next to each of the 42 questions. The American Hospital Association in Chicago has put its imprimatur on the tool and has distributed it to hospital executives. In the cover letter, Conway notes: "To be sure, having a number of checks in the 'Yes' column of the self-assessment is far more significant than having none. But identifying a plan to move some checks from 'No' to 'Yes' could be equally significant."

Clearly, he says, some "Y's" are more important than others, but that can vary from institution to institution.

"The question to ask is, 'How can I move in my organization from No to Yes?' It is an opportunity to step back and reflect," Conway says. "We propose that you not only reflect with yourself, but with a group of other people before checking off the box."

The Dana-Farber program actively involves patients and family members at all levels of institutional planning; this is what helps keep safety at the forefront of all Dana-Farber activities, he adds.

"We have patient and family advisory councils in both adult and pediatric care," he says. "They sit on most of our operational committees — at the board level on our quality committee. [They leave if the board goes into executive session.] We share error rates with patients, and slips and falls. When we go through the Joint Commission survey, they are involved."

Nearly instant feedback

By actively engaging patients and families in the process, Dana-Farber can get almost instant feedback. "We can implement a new system today, and the next day a patient can say, 'The infusion room is too crowded,' or 'The construction project is making the staff uncomfortable,' or 'When I was admitted they couldn't find my records,'" he explains.

"Our patients are experiencing care in ways that none of us do, and to the extent our processes are not working, they can tell us — and quickly. Sure, we do statistical surveys, but the results often come in two or three months later. We want our patients to pick up a phone and give us a call."

Out of a tragedy have come some very good things indeed. Today, Dana-Farber sees nearly three times as many patients as it did in 1995.

"Not only has our volume grown, but our research has grown; the center is vibrant," Conway says. "Our story is the story of how an institution took a tragic situation and used what it learned to leverage the whole organization to a better place."

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