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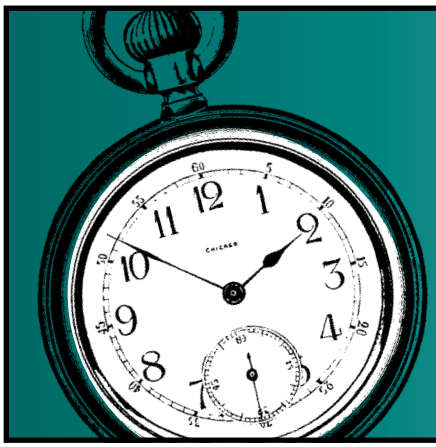

Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 20 Years

INSIDE

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Saving money with surgical scrubs and gowns: How far is too far?

Providers take sides on issue of home laundering

You want to save money with your surgical scrubs and gowns, but not at the risk of higher infection rates. So how far is too far? For example, is it OK for employees to take home surgical scrubs to launder, as long as the scrubs don't have blood or body fluids on them?

One health care facility estimates that home laundering and other major changes in policies and purchases of surgical scrubs and gowns resulted in a one-year savings of $185,000, with no increase in surgical infection rates.

What's prompting such radical moves?

"Economics. No question about it," says **Nathan L. Belkin**, PhD, of Clearwater, FL. Belkin is author of *Association for Professionals in Infection Control and Epidemiology State of the Art Report: Use of Scrubs and Related Apparel in Health Care Facilities.*

Although Belkin acknowledges that his report "dodged" the question of home laundering of surgical scrubs, he is currently researching the issue and consulting with some health care facilities.

"No one that I know of has specifically related the practice to an

EXECUTIVE SUMMARY

Pilferage and loss of surgical scrubs is an issue for same-day surgery providers. One controversial practice allows employees to launder their scrubs at home, as long as no visible blood or body fluid is present.

- Proponents report huge cost savings and say there's no evidence of higher infection rates.
- Opponents raise concerns about safety and standardization. The Association of Operating Room Nurses takes a strong stand against the practice.
- Opponents suggests loss and pilferage can be addressed by increased accountability of commercial laundries, swap systems for distributing scrubs to employees, and vending machines that distribute scrubs.

increase in surgical wound infection rate," Belkin says.

Belkin has found only one published study that discusses the issue of home laundering.[1] That study determined that it was likely that a dog hair from an employee's dog caused colonization of *Malassezia pachydermatis* in an intensive care nursery, he says.

In the Centers for Disease Control and Prevention proposed updated guidelines for prevention of surgical site infection, the issue of home laundering was unresolved, he says.

The Association of Operating Room Nurses (AORN) in Denver has taken a definitive stand on the issue. "We think it's not a good idea," says **Dorothy Fogg**, RN, BSN, MA, perioperative nursing specialist at the Center for Nursing Practice, Health Policy, and Research at AORN.

Following guidelines from the Occupational Safety and Health Administration that bar employees from home laundering scrubs or gowns that are visibly soiled with blood or body fluids isn't enough, Fogg maintains. "You don't know what organisms you may be carrying into your home," she says. "It's not what you see. It's what you don't see that may cause problems. When you don't know it's there, it could be dangerous."

Some experts support home laundering

So what's the consensus among infection control experts? Mixed.

"At this point, I could see more reasons for permitting employees to take home surgical scrubs than not take them home," Belkin says.

For example, many surgeons already wear scrubs from one facility to another, he points out, and employees often wear warm-up jackets and other clothing from home with their scrubs. Furthermore, employees who are participating in the surgical procedure already wear a sterile gown over their scrubs, he says.

"If scrubs are supposed to be worn only in a controlled environment, let's see some evidence as to why that's necessary," Belkin says. "A lot of things we do in life only because we're accustomed to it."

Cost of laundering was a consideration for Brookdale University Medical Center in Brooklyn, NY, says **Robert Garcia**, MT(ASCP), CIC, assistant director of infection control. Brookdale was paying 25 cents a pound to launder scrubs, which weigh between 1½ pounds to 2 pounds, Garcia says. "Do the math," he says.

Brookdale implemented optional home laundering for surgical scrubs that didn't have visible blood or body fluids. This change and other major modifications to policies and purchases of gowns and scrubs resulted in an estimated savings of $185,000 the first year. **(For details on changes, see story, p. 3.)**

Employees were supportive, Garcia says. "They liked to use their own detergents, take care of their own things," he says. "Also, they didn't want to return scrubs, then pick up scrubs. Sometimes, the hospital didn't have all the scrubs they had returned."

Only attending physicians haven't bought into the policy change because they say they don't have time to launder scrubs, he says. For that reason, the policy is optional for physicians and staff.

'What you don't see may cause problems'

Not everyone is a fan of home laundering, however.

Dan Lansford is a technical support specialist at Ecolab in St. Paul, MN. Ecolab develops cleaning, sanitizing, and maintenance products and services for health care and other markets.

"My personal opinion is that it's a bad idea," Lansford says. "Providers have too much opportunity for exposure of children and pets to bloodborne pathogens."

Belkin argues, however, that bloodborne pathogens exist only in blood that hasn't dried.

Another reason Fogg says she supports commercial laundries is that they have laundry formulas that facilitate the microbial kill process for

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linens. "They have controlled water temperatures, controlled concentrations of chemicals, and they all work together give a microbial kill effect," she says.

Home laundry doesn't have the same degree of standardization or safety, Fogg maintains. "We can dump in detergent and bleach, but the reality is, we don't know the temperature of the water, we don't know the concentration of chemicals, we may or may not use sour, and we may or may not use a fabric softening agent," she says. "If sour is used, we need to use an alkalizing agent to bring the pH back to zero. We don't do those things. Nobody knows if we're getting same level of microbial kill."

In addition, employees use different detergents,

Hospital targets scrubs and saves $185,000

Color-coded reusable scrubs replaced disposables

Brookdale University Medical Center in Brooklyn, NY, saved an estimated $185,000 in a one-year period by eliminating the purchase of most disposable scrubs, adding a limited number of color-coded reusable scrubs, and implementing an optional home laundering policy for surgical scrubs.

The approximate savings were:

❒ $60,000 from changes to different colors of scrub suits;

❒ $50,000 from home laundering;

❒ $20,000 from basically eliminating disposable scrub suits.

The remaining savings were from changes to cover gowns, shoe covers, etc.

"We went from originally nine scrub suits per person in different colors to five, because they didn't have to change as often," says **Robert Garcia**, MT(ASCP), CIC, assistant director of infection control. "We went from 12 kinds of gowns to three basic gowns."

Garcia and others determined that the hospital's infection control policies weren't in line with the scientific literature, he says.

"If you look at what the literature shows us over the last several years of studies, there is quite a bit of support of literature that indicates that scrub suits have either minimum additional colonization of bacteria for individuals who wear scrub suits outside OR, as opposed to people who change when they leave or who wear a cover gown over scrub suits," Garcia says. "Even in those studies, no study has shown doing a regimental policy has had the benefit of reducing surgical wound infection, which is ultimately what you want to do."

The hospital decided to allow staff to leave the OR and return in the same scrub suit to perform another procedure, as long as the scrub suit isn't visibly soiled with blood or other body fluids. However, staff members still are required to wear personal protective equipment when, for example, they leave the OR to perform a procedure in another area of the hospital, particularly if the procedure is invasive, Garcia says.

Some employees wearing disposable scrub suits didn't need them, such as housekeepers who were wearing them over their uniforms. "But we're already paying uniform costs, so we eliminated that," Garcia says.

Disposable scrubs were kept for medical students because of their short rotations, he says.

The hospital studied any potential benefits of wearing cover gowns outside the OR. Because some staff preferred to wear them for professional appearance, they were designated as optional.

When making changes to surgical scrubs and gowns, be aware that many employees have a strong preference, particularly if they're involved in performing longer procedures, Garcia says.

To make the right selection of gowns, obtain outside expertise, such as clinical specialists who work for manufacturers, he suggests. Consider fluid penetration, the weight of the material, and the costs when making a selection, Garcia advises. "You need safety, comfort, and [low] cost," he says.

To avoid discord, approach physicians directly, he suggests. "Say, 'we're looking to make changes. I understand you like this gown. Would you be willing to try that one?'"

More than 99% are cooperative, and nine of 10 will change gowns, he says. At Brookdale, "they simply weren't aware of more modern material that gowns are being made of," he says. "Now they're much lighter weight, offer great protection, and costs are generally very good." ■

SOURCES

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so there's no standardization, Fogg points out.

However, the issue of safe laundering isn't addressed completely simply because you use a hospital laundry or commercial facility, Belkin says. For example, some laundries aren't using chlorine bleach, which he believes is a poor practice. Also, some facilities mix garments from different departments, Belkin points out, which he says raises the potential for cross-contamination. "It's not cut-and-dried just because it's laundered commercially," he says.

Same-day surgery providers have no way to monitor the method that employees use to handle and transport scrubs after they're cleaned, Fogg says. Lansford agrees.

"In very general terms, it's a bad idea for a laundry manager to relinquish control of the safe handling of linens from the premises to someone's home," he says.

While acknowledging there are potential problems if employees wash their scrubs at home, these problems can be overcome, Belkin maintains. For example, to avoid the problem of employees wearing dirty scrubs back to the facility, ensure employees have enough outfits so they can wear a different one every day, even if they wash only once a week.

"As long as they're wearing a clean one every day — that's what counts," Belkin says.

While acknowledging that the problem of scrub loss is significant, there are ways to deal with the problem other than home laundering, Fogg maintains.

Build accountability into your commercial laundering system so that you get back the number of scrubs you send out, she suggests. For example, employees could count the number of scrubs that go out and come back, Fogg says.

In terms of pilfering within a facility, consider an exchange system in which employees turn in scrubs to receive an additional set. Also, some vendors offer dispensing machines with ID cards or codes, Fogg says.

"Basically the issue with scrubs in general is the loss through commercial laundry. That's the argument people will make for home laundry: They never get it back," she says. "We think home laundry is the wrong answer to that problem."

Reference

1. Chang HJ, Miller HL. An epidemic of *Malassezia pachydermatis* in an intensive care nursery associated with colonization of health care workers' pet dogs. *N Engl J Med* 1998; 338:706-711. ■

NJ sets benchmark to regulate office anesthesia

Specifies training, equipment, staff requirements

New Jersey set an ambitious goal for the rest of the country when it adopted well-defined, comprehensive regulations governing the administration of office-based anesthesia in 1998.

As greater numbers of surgical procedures that require anesthesia moved from ambulatory surgery centers to surgical suites within physicians' office, patient safety has become a major

EXECUTIVE SUMMARY

Landmark regulation of office-based anesthesia was enacted in New Jersey in 1998. After 15 years of lobbying, the New Jersey State Society of Anesthesia in Princeton Junction was successful in addressing the growing number of patients undergoing surgical procedures in a physician's office.

- Supporters see these regulations as benchmarks for other states looking at the problem.
- States considering similar regulation include New York, Massachusetts, Pennsylvania, Maryland, Connecticut, and Michigan.
- Areas addressed within the regulations include training requirements for personnel administering anesthesia, safety features and maintenance requirements for anesthesia equipment, and incident reporting requirements.

concern for the Princeton Junction-based New Jersey State Society of Anesthesiologists, says **Ervin Moss**, MD, executive medical director of the society.

This concern led to a 15-year battle during which time opponents claimed that regulation of office-based anesthesia would lead to higher health care costs and the closing of some physician practices due to higher overhead costs.

"I don't worry about the cost, I am concerned about patient safety," says Moss. He cites examples of deaths that occurred during procedures performed by a physician who administered anesthesia after viewing a 30-minute educational videotape as well as instances in which a anesthetized patients were given intravenous sedation by the office receptionist.

Although Florida and California have had regulations governing office-based anesthesia for three years, New Jersey's regulations are stricter and better defined, says Moss. "The regulations address standards for training, monitoring equipment, staffing, and credentialing for physicians and staff members administering anesthesia," he adds. **(See story on anesthesia regulations, below.)**

Old equipment a problem

Out-of-date anesthesia machines are a big problem in many physician's offices, explains Moss. Typically, a physician will purchase equipment that a hospital is discarding because it is out-of-date and doesn't contain the most recent

New Jersey regulations focus on patient safety

The regulations for office-based anesthesia adopted by the New Jersey State Board of Medical Examiners in Trenton are basically the same regulations governing ambulatory surgery centers, says **Ervin Moss**, MD, executive medical director of the New Jersey State Society of Anesthesiologists in Princeton Junction. The regulations spell out exactly what is expected of a physician providing anesthesia services within an office setting in these areas:

- **Policies and procedures.**

Practitioners are required to have written policies that address the specific procedures performed in the office, the responsibilities of staff members providing services, infection control practices, procedures to follow during patient's recovery time, and procedures to follow if a patient experiences complications.

- **Incident reports.**

Any incident related to surgery, anesthesia, or special procedures that results in a patient's death, transport to a hospital, or complications has to be reported, in writing, within seven days to the Board of Medical Examiners.

- **Practitioner standards.**

Physicians may only perform services for which they are credentialed to perform in a hospital. Physicians must also have a written agreement with a hospital and licensed ambulance service for transport of patients experiencing complications. Requirements for history and physicals, informed consent, preoperative and postoperative care, and information that is required for the medical record are defined. Personnel authorized to perform general anesthesia, regional anesthesia, conscious sedation, and minor conduction blocks are defined.

- **Equipment.**

Equipment and safety systems required for all locations that provide anesthesia are defined. Examples of equipment required are precordial stethoscope or esophageal stethoscope and a peripheral nerve stimulator, pulse oximeter with appropriate alarms, continuous electrocardiograph with paper recorder, defibrillator, and a respirometer. Locations that provide services to children and infants are required to have emergency equipment and safety devices that are appropriately sized for pediatric patients.

- **Maintenance.**

Service and maintenance records are to be kept on all anesthesia machines, ventilators, and vaporizers. A daily inspection of equipment is to be performed by the physician or a certified registered nurse anesthetist, and prior to each use, an inspection is to be performed and results documented on the anesthesia record.

For a full copy of the regulations, which are free, contact the New Jersey Board of Medical Examiners, 140 E. Front St., Second Floor, Trenton, NJ 08608. Telephone: (609) 826-7100. ■

safety mechanisms, he adds. "The regulations define a safe machine and give physicians six months to update their machines to meet the standards," says Moss.

This doesn't mean that physicians must purchase brand new equipment, explains Moss. "A refurbished machine with all of the up-to-date safety equipment costs about $20,000. When you add the monitors and defibrillator cart, the total comes to $50,000 to save lives," he adds.

Two other key areas addressed by the regulations include credentialing and reporting of untoward events. Basically, a physician may provide any service in the office that he or she is credentialed to provide in a hospital, explains Moss. If the physician is not credentialed on any hospital medical staff, there is an alternate credentialing process described within the regulations.

"A hospital has to report untoward events such as an injury, close call, or death that may be related to anesthesia, but we really don't know what has been happening in physicians' offices," says Moss. For this reason, he counts the mandatory reporting requirements contained in the regulations as one of the major benefits of his society's efforts.

"We will now be able to collect data and evaluate patient safety related to anesthesia within a physician's office," he explains.

Certified nurse anesthetists who provide anesthesia in an office setting must be certified by the American Association of Nurse Anesthetists in Park Ridge, IL, and be supervised by a physician who meets the criteria to administer anesthesia within the office. The New Jersey Association of Nurse Anesthetists is suing the New Jersey Board of Medical Examiners. The certified registered nurse anesthetists claim that their practice is a nursing practice and should not be supervised by an organization that licenses and oversees physicians. They also claim that their training should allow them to perform anesthesia in an office

Proposal encourages office surgery

In Illinois, podiatrists and orthopedists may have a definite financial incentive to offer office-based procedures once a proposal by Chicago-based Blue Cross and Blue Shield of Illinois is enacted.

"We have identified 55 foot and ankle procedures that are already being performed in the office at least 50% of the time, and we have proposed a reimbursement level that recognizes the physician's assumption of additional overhead costs," says **Allan Korn**, MD, vice president and chief medical officer. Physicians choosing to perform any of the 55 procedures in their office rather than a surgery center will receive a $200 bonus, explains Korn.

"Patient safety is our primary concern, so we have asked the Illinois Podiatric Medical Association and the orthopedic surgeons who perform these procedures to review the proposal," says Korn. He points out that his organization's list of procedures identified within the proposal follows Medicare's site of service guidelines.

"To my knowledge, all of these procedures require local anesthetic only, but that is one of the aspects we want local physicians to take a look at during this review process," adds Korn.

The Illinois Freestanding Surgery Center Association in St. Charles, the Illinois Podiatric Medical Association in Chicago, and several groups of orthopedic surgeons have opposed the proposal for a variety of reasons, says **Mark Mayo**, executive director of the surgery center association.

Not only is there a $200 bonus paid to physicians who perform the procedures in their offices, but there is also a $200 penalty for physicians who choose to perform the procedures in an ambulatory surgery center (ASC) or hospital. "This creates a $400 incentive swing for the surgeon to move the case to the office setting," explains Mayo.

Several of the procedures on the Blue Cross list that includes bunionectomies, osteotomies, phalangectomies, tenotomies, and capsulotomies may require more than local anesthetics, says Mayo.

"We are concerned about moving cases from regulated settings such as hospitals and ASCs into unregulated settings such as physicians' offices," says Mayo. The lack of regulation for these settings means a lack of inspection, accreditation, and oversight that ensures patient safety, he adds. ■

SOURCES

For more information about guidelines or regulations regarding office-based anesthesia, contact:

Ervin Moss, MD, Executive Medical Director, New Jersey State Society of Anesthesiologists, 14 Washington Road, Suite 101, Princeton Junction, NJ 08550. Telephone: (973) 744-8158. Fax: (973) 857-7137.

American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068. Telephone: (847) 825-5586. Fax: (847) 825-1692. Web site: http://www.asahq.org.

Society of Ambulatory Anesthesia, 520 N. Northwest Highway, Park Ridge, IL 60068. Telephone: (847) 825-5586. Fax: (847) 825-5658. Web site: http://www.sambahq.org.

For more information about the Blue Cross and Blue Shield proposal, contact:

Allan Korn, MD, Vice President and Chief Medical Officer, Blue Cross and Blue Shield of Illinois, 300 E. Randolph St., Chicago, IL 60601.

Mark Mayo, Executive Director, Illinois Freestanding Surgery Center Association, 2210 Dean St., St. Charles, IL 60175-1059. Telephone: (630) 584-9801. Fax: (630) 584-9805.

without anesthesiologist supervision.

Moss is pleased that the American Society of Anesthesiologists (ASA) in Park Ridge, IL, and the Society of Ambulatory Anesthesia (SAMBA), a subgroup of the ASA, are looking at the issue of office-based anesthesia. The ASA is developing practice guidelines, and SAMBA is providing education to surgeons, anesthesiologists, and patients through its Web site, says **Marc E. Koch** MD, a Whitestone, NY, anesthesiologist who serves as chairman of SAMBA's Committee on Office-based Anesthesia.

"The numbers and types of procedures performed in office settings has grown rapidly and will continue to grow, so it is important for us to look at how practitioners can provide anesthesia safely," says Koch.

The guidelines underscore the fact that there should be one standard of care for all ambulatory anesthetics, whether in a surgery center, doctor's office, or hospital-based ambulatory surgery program, says **Rebecca Twersky**, MD, president of SAMBA and member of the New York State Task Force on Office Surgery and Anesthesia.

SAMBA members are in the preliminary stages of developing protocols for an anesthesia outcomes study. They also are developing an article that will review current literature of office-based anesthesia, state-of-the-art anesthesia technology, legislation regarding office-based anesthesia, and patient safety issues a practitioner should take into account when providing office-based anesthesia.

Moss says that Medicare is forcing more procedures, such as those requiring only local or regional anesthesia, into office settings. He also points out that managed care organizations in New Jersey and other states have also attempted to limit certain surgical procedures to offices. **(See story on insurance incentive, p. 6.)**

For these reasons, Moss adamantly believes that state regulations are the best way to protect patient safety.

"Practice guidelines are helpful but they are not enforceable, and they are offered as advice only," he says. "Regulations are law, and a physician in New Jersey who doesn't follow the regulations is committing a crime. This is the best way to ensure that any patient receiving anesthesia in an office setting will be safe." ■

New Procedures

Baby boomers and lasers team up for financial win

Emphasis on healthy looks produce new market

(Editor's note: In this second part of a four-part series on new procedures in same-day surgery, we target the growth in cosmetic procedures. They're not just for plastic surgeons anymore! In last month's issue, we told you about the expanding interest in pain management procedures. In the next two issues, we'll highlight procedures such as laparoscopic Nissen fundoplication and stereotactic breast biopsy.)

Aging baby boomers and laser technology have come together to make plastic surgery financially attractive for ambulatory surgery programs to include in a menu of services.

"A lot of baby boomers are turning 50, and they are not accepting the wrinkles that their parents accepted," says **Phil Haeck,** MD, a plastic surgeon in Seattle. "These are the people who sat

EXECUTIVE SUMMARY

The growing demand for cosmetic surgery has been fueled by a combination of baby boomers who don't want wrinkles and laser technology that is especially suited for cosmetic surgery. Same-day surgery managers who will add or expand a cosmetic or plastic surgery service need to know:

- New procedures such as endoscopic forehead lifts may not require major equipment investment as existing equipment is simply adapted.
- Lasers are opening doors to new financially attractive procedures such as hair removal.
- Knowing your market is key to adding just the right mix of physicians, procedures, and pricing.

in the sun as teen-agers, and they are now seeing wrinkles," he adds.

Haeck points out that baby boomers generally look at cosmetic surgery as a maintenance issue rather than a vanity issue, which is very different from the older generation.

Most women older than baby boomers will wait until they have a significantly wrinkled look, but younger women are seeking cosmetic surgery for earlier signs of wrinkling, says Haeck.

"In fact, I recently had a mother and daughter come to me for surgery. The mother is in her mid-60s and the daughter is in her mid-40s," he says. "The mother's procedure was more extensive, and there is a dramatic difference in her appearance. The daughter's procedure was less involved, and although the wrinkles were gone, the change in her appearance is subtle," explains Haeck.

The daughter explained to Haeck that she looked at her mother and saw how her face would look in twenty years if she didn't do anything.

Technological advances have played a significant role in cosmetic surgery's growth. Resurfacing lasers have increased physicians' ability to eliminate wrinkles on all parts of the face, says Haeck.

"Before the resurfacing laser, I could perform a facelift and an eyelid lift to give the patient smooth cheeks, but there would still be lines above the lips," he says. "Now, it is rare to perform a facelift or eyelid lift without using a laser for lip lines."

The hottest growth areas for cosmetic lasers is hair removal, says **Carolyn Rogalla**, RN, clinical nurse consultant for Candela Corp., a dermatologic and cosmetic laser company based in Wayland, MA. Rogalla is not only seeing physicians add this service within their offices, but she also is seeing surgery centers dedicate procedure rooms to cosmetic procedures including hair removal. The average charge for laser hair removal is $300, says Rogalla.

"A big advantage in some states is that a physician does not have to operate the laser," says Rogalla. "This makes it possible to use physician time efficiently and generate more income from other staff members," she adds.

Another procedure that has become more popular in recent years is an endoscopic forehead lift. Using the same endoscope typically used by orthopedists, with some adaptive equipment, the plastic surgeon can make three small incisions in the forehead rather than one long incision, says Haeck. "This is much better for the patient because the risk of hair loss is decreased and recovery is easier."

The benefit to the surgery program is less operating room time to perform the procedure, about 1½ hours, so more procedures can be scheduled.

Liposuction is also benefiting from new technology, but it might not be right for every surgeon, says Haeck. "I evaluated ultrasonic liposuction but decided not to offer it because it is inappropriate for my typical patient."

Ultrasonic is most beneficial when the physician has to remove fat from fibrous areas such as the back or male breast; or when the patient is significantly overweight and large volumes of fat must be removed, says Haeck.

Research your market

Knowing your market and your competitors is essential before you add to or establish a cosmetic surgery service, says Rogalla. Evaluate your staff to see if new skills are needed, and check state regulations to see what procedures a physician must perform and what other staff members can perform. If you add new lasers, make sure the vendor trains all staff who will use them, Rogalla adds.

Staffing was not a problem when Dreyer Ambulatory Surgery Center (ASC) in Aurora, IL, added plastic surgery to its service mix. **Jim Kuyper**, RN, administrative director, says, "We perform 7,400 procedures a year in almost all surgical specialties, so our staff is well-trained and flexible."

The one surgical specialty not offered at the ASC until one year ago was plastic surgery. "Our physicians were referring an increasing number of

SOURCES

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patients to a plastic surgeon who was not a member of the group, so we recruited him to perform his surgery at our center," says Kuyper. "Facial procedures such as facelifts and laser resurfacing are the most commonly performed procedures to date, but we are also investigating liposuction and other procedures," adds Kuyper. **(See *Same Day Surgery*, July 1998, supplement p. 2, for a list of the most popular procedures on a national basis.)**

While Kuyper's center already has most of the equipment the plastic surgeon needs, some lasers such as the CO_2 laser used for resurfacing are leased on a single-use basis as needed. Once volume for any particular laser justifies a longer-term lease, it will be evaluated.

"We are pleased with the success of plastic surgery within our center, and we expect demand to continue to grow," says Kuyper.

"Plastic surgery is a natural addition to any ambulatory surgery center because it generally doesn't require extended stays, your income from the procedure isn't limited by managed care, and it is a service demanded by baby boomers," he adds. ■

Want a service unaffected by managed care?

Plastic or cosmetic surgery can be the answer

When your patients come to your surgery center for cosmetic procedures, you don't have to worry about filing insurance and accepting negotiated payments simply because insurance doesn't cover them. This isn't all bad, according to the experts.

"What makes plastic surgery for cosmetic reasons unique within health care is that patients are self-pay," says **Jim Kuyper**, RN, administrative director of Dreyer Ambulatory Surgery Center (ASC) in Aurora, IL. These patients have researched the costs and made arrangements to cover the expense so it is a very straightforward transaction, he adds.

This also means that a same-day surgery manager needs to make sure the price set for the procedure is realistic in terms of recouping the center's expense for operating room time, staff time, equipment, and supply costs, as well as competitive with other prices in the community.

Cost and pricing information for procedures requiring certain equipment also may be available from the equipment's manufacturer, says **Carolyn Rogalla** RN, clinical nurse consultant for Candela Corp., a dermatologic and cosmetic laser company based in Wayland, MA.

"We give examples of pricing to new users of our lasers by telling them what other users in the area are charging," says Rogalla. "When a new laser procedure is introduced within a practice or a surgery center, I suggest that the first price be a little lower than competitors in order to build a client base. As demand for the service grows, the price can be increased to match the standard market rate."

Typical charges for some of the most common plastic surgery procedures, according to the Candela Corp.'s research department, are:

- ✔ liposuction (one site): $1,000 to $3,000;
- ✔ eyelid lifts (both): $1,300 to $3,700;
- ✔ breast augmentation: $1,400 to $5,700;
- ✔ nose reshaping: $1,300 to $2,800;
- ✔ facelift: $1,600 to $4,600;
- ✔ laser resurfacing (not including laser rental): $600 to $1,700.

Dreyer ASC sets prices a little differently, according to Kuyper. "After we've performed three or four cases of a specific procedure, our computer system can assign a cost based on staff time, operating room time, supplies, equipment, and other overhead expenses such as utility costs that must be paid," he says. Kuyper's center uses Temple Surgery Center System software manufactured by Temple Information Systems in Wallingford, CT. Temple has been purchased by Health Information Systems, also in Wallingford, which manufactures a similar software titled AdvantX.

Generally, this procedure generates prices that are competitive in their market, Kuyper says. "Although we don't include the physician's charges in our total, I can work with a patient and a physician to determine the whole package cost to make it easier for the patient to plan financing," he says. ■

Same-Day Surgery Manager

How to keep physicians from leaving your program

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

We all know about the explosive growth of ambulatory surgery centers (ASC). We understand the reasons behind it: lower cost provider, increased efficiencies, ability to joint venture with physicians, ambulatory payment classifications (APCs), etc. But for many, the option of going out and constructing a new surgery center is not an option.

Your surgeons say they can live without a for-profit joint venture, but they are threatening to join the local surgery center because that facility is efficient and you are not. You explain that you are a trauma center and that ambulatory cases sometimes get "bumped" for emergencies — sorry.

Try as you might, you just cannot get the room turnaround time under 30 or 40 minutes. The surgeons scream that the for-profits centers can turn the rooms in under 10 minutes. What do you do?

First, some background. Earnhart & Associates probably has a larger and more extensive data bank on physician satisfaction and other issues related to ambulatory surgery joint ventures than any other organization in the country. When we interview physicians, the overwhelming reason physicians cite for wanting to develop (or join) a for-profit ASC is efficiency of operations. They want cases to start on time and turnaround on time, so they can get out of the hospital as quickly as possible. The surgeons plead to the director, VP, or CEO: "Why can't you do that?" Is it really that difficult to be efficient?

Efficiency of a physician's time is a sign of respect for the job they do. It is a way of the facility saying, "Hey, I understand. Let's get your cases going so you don't have to spend your morning in the doctors' lounge between doing $200 and $300 professional fee reimbursable procedures." That is complete, uncompensated down time for surgeons. They get nothing for the time or the waste of effort. Is it any wonder why they are so disagreeable or unwilling to assist you in cost control or another committee position? Show respect — get respect.

Consider the following approach:

- **Step one.**

Sit down with your staff and find out what you do best. Jot them down. Things such as state-of-the-art equipment, three shifts of operations, full anesthesia coverage, evening hours, Saturday operations, etc., are significant.

- **Step two.**

Write down the things that you might want to improve upon. These usually include turnaround time (find your average time) and start times. (I know, not your fault; it's anesthesia or admitting or someone else, but you are going to have to take the hit for it.) The average number of items in this list is usually 10.

- **Step three.**

Do an honest appraisal of how you can fix or improve items in step two.

- **Step four.**

Interview as many of your surgical staff as possible. Try to get an unbiased person to interview them. Ask things like, "If you were in charge, what would you change around here?" Get their perception of what it is they think you do best. Ask what they think you need to improve. Don't try to argue or debate them. Just write down their comments. Be a very active listener. Don't try to defend yourself or the facility.

- **Step five.**

Go back to steps one and two and compare. I guarantee your list will not be in sync with your surgeons. Perception is reality — face it. If they think your turnaround time is 60 minutes — it is! Live with it, but try to change it.

- **Step six.**

You had better make changes fast. You have

now set expectations in the minds of the surgical staff that you are going to do something. If you do not, you are going to be in worse shape than you are now.

Each facility has different issues, but let's assume that your biggest issues in step four are turnaround and start times.

• **Step seven.**

Start acting on the issues. Analysis your OR staff. If you don't have changes to make in staffing, you aren't being honest with yourself. This is the time to rock the boat! Make changes in management. Put everyone's positions on the line. You have a great deal of money that is going to leave your hospital if your surgeons walk. This exercise is not for the faint of heart.

Tell everyone what you're going to do. Have a definable plan with goals and benchmarks. Start making charts and bar grafts. Have two or three staff meetings per week if necessary (it usually is) to review the goal and redefine where you are. Kick butt!

Some things you might need to consider include time clocks, cross-training, multiple shifts, etc. You are going to lose some of your staff. They are not going to tolerate some of the changes you are going to have to make. So be it.

Next month we will expand this area and discuss ways to fix late start times.

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Trouble ahead with proposed outpatient regs?

Is playing field level under Medicare APC system?

The Baltimore-based Health Care Financing Administration (HCFA) has postponed implementation of new Medicare regulations for outpatient facilities, which gives the outpatient industry time to make a case for higher reimbursement.

However, a bigger question is whether this delay (caused by HCFA's year 2000 computer concerns) would make any difference in a reimbursement system that some experts say could devastate rural and specialty facilities. Do the proposed rules level the playing field between hospital-based and freestanding facilities, or do they give a competitive edge to one side?

Same-Day Surgery asked people associated with the hospital-based outpatient industry and ambulatory surgery centers (ASCs) to analyze these issues and explain the proposed regulations for each and how the ambulatory payment classifications (APCs) might affect outpatient facilities. **(For more on proposed rules, see *SDS,* November 1998, p. 137, and *SDS,* August 1998, p. 101.)**

"I believe we can expect substantial changes from the proposed rule to the final rule," says **Chris Mancill**, technical analyst for the Healthcare Financial Management Association in Washington, DC. The association represents financial managers in hospitals and other health care organizations.

Mancill says the delays in finalizing the rules and implementing a prospective payment system for both hospital-based and freestanding facilities will give the outpatient industry time to respond to the proposed APC rates.

"The proposed rule has payment amounts that hospitals are going to have to have work done on," he says. "Some of the APC amounts will have to be bumped up or increased."

Others doubt HCFA will change APC reimbursement rates in any substantial way because the government's main purpose is to save Medicare billions of dollars.

"Congress passed the outpatient prospective payment system for the purpose of saving money," says **Linda Magno**, interim vice president for policy at the American Hospital Association in Washington, DC.

Outpatient PPS expected to save billions

HCFA predicts that hospital outpatient PPS will save Medicare more than $6.6 billion through 2003. "That's a real reduction relative to what hospitals were going to be paid," Magno says.

Because HCFA has repeatedly extended the comment period, ASC officials have had since June to comment on their proposed regulations. Some say they've needed the extra time in order to make a case for higher rates.

"It gives us the opportunity to now do some good cost analysis and comparison of the APC proposal for ASCs and hospitals," says **Carol Beeler**, regional vice president in surgery division of HealthSouth in West Chester, OH. HealthSouth is a health care company that covers 50 states with

its surgical center and diagnostic divisions, inpatient rehabilitation, outpatient rehabilitation, and medical centers. Beeler also is the president of the Federated Ambulatory Surgery Association in Alexandria, VA.

1994 cost studies were flawed

Even HCFA has admitted to some flaws in its 1994 cost studies on which the APCs are based, Beeler says.

"HCFA is working with us now to develop a good study for 1999," she adds. "What we're looking for is a fair reimbursement system because we have to cover our costs."

Plus, hospitals are being hit from another direction as well; the proposed rules reduce the coinsurance amount Medicare beneficiaries pay to hospital outpatient facilities, Mancill says.

HCFA's new reimbursement methodology fixes the coinsurance payment at 20% of the 1996 national median charge for each APC group with adjustments for inflation for 1999, Mancill explains.

Since beneficiaries presently pay 20% of the outpatient facility's billed charges regardless of Medicare allowance, this can amount to a substantial reduction, he adds. "This doesn't reduce the Medicare charges at all, but it does help beneficiaries."

ASC officials say they are pleased that HCFA decided to postpone implementation of both regulations since the hospital-based outpatient ones were going to be postponed until after the year 2000 computer problem is fixed. Last summer, the ASC industry feared they would have to move to PPS before their hospital competitors, placing them at a competitive disadvantage.

Additionally, the ASC industry's concerns that hospital-based facilities are reimbursed at higher rates were alleviated when the hospital outpatient regulations were published Sept. 8 in the *Federal Register.*

"What we're seeing is [that] the proposed hospital rates would effectively level the playing field between the freestandings and hospitals, so the hospital outpatient departments would take a tremendous hit from their current reimbursements," says **Kevin McHugh**, chief executive officer of Washington Orthopedic Center in Centralia, WA. The single-specialty surgery center has more than 1,000 cases per year.

On the down side, rural surgery centers and others are not being reimbursed enough to cover their costs under the new APCs.

"We've leveled the playing field, but rates have come down so low they don't effectively work for anybody now," he says.

Already, Medicare patients are being shifted from ASCs to hospital-based outpatient surgery centers where the reimbursement is higher. What will happen to these patients, McHugh asks, when the hospital-based centers lose their financial advantage in the Medicare rates?

"We could effectively have a big class of patients that nobody wants; I think that's what HCFA is starting to come to grips with."

Magno says Medicare patients won't be dumped because nonprofit hospitals will take care of them even if it means losing a lot of money.

"Hospitals have been losing money on outpatient services for a number of years; we provide the services anyway," she says.

There's another problem that has been growing in recent years. Both ASCs and hospitals survived with low Medicare reimbursement because of cost

HCFA extends deadlines for comments on PPS

The Health Care Financing Administration (HCFA) has extended the deadline to accept comments on the proposed hospital outpatient and freestanding ambulatory surgery center prospective payment system (PPS) until Jan. 8.

In commenting on the proposed hospital outpatient prospective payment system, which was published in the Sept. 8 *Federal Register*, please refer to file code HCFA-1005-P. In commenting on the proposed surgery center rule, which was published in the June 12 *Federal Register*, please refer to file HCFA-1885-P.

Mail written comments (one original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-1005-P (for the hospital rule) or HCFA-1885-P (for the surgery center rule), P.O. Box 26688, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

- Room 309, Hubert H. Humphrey Building, 200 Independence Ave. S.W., Washington, DC 20201.
- Room C5-09-26, 7500 Security Blvd., Baltimore, MD 21244-1850.

SOURCES

For a summary of the Medicare hospital outpatient prospective payment system proposed rule, contact:

- **Healthcare Financial Management Association's** Knowledge Network Fax-It line at (800) 839-4362. Request item 400057. Members may order it by following the prompt and entering their membership number. Cost for non-members, $30, payable by credit card.

For more information about the Health Care Financing Administration's regulations for ambulatory surgery centers and hospital-based outpatient facilities, contact:

- **Carol Beeler**, Regional Vice President in Surgery Division, HealthSouth, 5254 Woodcliff Court, West Chester, OH 45069. Telephone: (513) 874-5373. Fax: (513) 874-6282. E-mail: carol.beeler@internet.com.
- **Federated Ambulatory Surgery Center**, 700 N. Fairfax St., Suite 306, Alexandria, VA 22314. Telephone: (703) 836-8808. Fax: (703) 549-0976.
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- **Kevin McHugh**, Chief Executive Officer, Washington Orthopedic Center, 1900 Cooks Hill Road, Centralia, WA 98531. Telephone: (360) 736-2889. Fax: (360) 736-3136. E-mail: kmchugh@localaccess.com.

shifting. If Medicare's payment for a procedure is lower than what it costs to provide the service, then someone else — typically commercial payers — makes up the difference by paying more than it costs, Beeler explains. Managed care organizations (MCOs) are putting an end to this trend.

"I think HCFA does not understand the environment . . . today in which managed care uses Medicare's reimbursement rates as the foundation for their reimbursement rates," Beeler says. "In the past, HCFA assumed Medicare was the lowest-cost provider and not the basis for every managed care payer to go by."

The days of cost shifting are long gone; with HCFA again cutting reimbursement rates, health care quality may suffer, Beeler says.

"We want a fair value reimbursement, and the value is cost plus quality," she adds. ■

JCAHO outlines causes of most wrong-site surgery

Operating on the wrong part of a patient's body is an obvious sign that there's a fault in your operating room system. New advice from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, can help you pinpoint the problem.

The mistake usually can be traced to multiple surgeons, multiple procedures, pressure to operate quickly, and unusual body characteristics, according to a recent JCAHO report. Its accreditation committee has reviewed 15 cases of wrong-site surgery in the two years since the sentinel event policy has been in place. A root cause analysis was conducted after each incident, and JCAHO used that information to determine the common characteristics of the incidents.

Wrong-site surgery occurred most commonly in orthopedic procedures, accounting for 10 of the incidents; there also were three urologic and two neurologic procedures. JCAHO reports that these factors apparently contributed to the wrong-site surgeries:

❑ **More than one surgeon was involved.** This could be because multiple surgeries were anticipated, or the patient's case was transferred from one surgeon to another.

❑ **There were multiple surgeries on one visit to the OR.** The risk is greater if multiple surgeries are on both sides of the patient.

❑ **The surgical team was pressed for time.** The pressure to move quickly could be related to an unusual starting time or pressure to hurry through pre-op procedures so the surgeon can start working.

❑ **The patient had unusual characteristics**. Any physical deformity could complicate the preoperative process and the procedure. Extreme obesity,

for instance, can cause the surgical team to alter normal equipment setup and patient positioning.

As might be expected, poor communication is usually behind the wrong-site surgery incidents. The 15 hospitals cited the main causes as miscommunication and faults with pre-op assessment and the procedures used to verify the operative site. The communication problems fell into two broad categories:

- failure to engage the patient or family in the process of identifying the correct surgical site;
- incomplete or inaccurate communication among surgical team members.

The poor communication among team members often took the form of excluding some members, such as the surgical technicians, from the site verification process. In other cases, the team relied solely on the surgeon to verify the correct operative site.

JCAHO cited these other contributing factors:

- failure to review medical records or imaging studies immediately before operating;
- no formal procedure for verifying correct site;
- no final OR check before starting procedure;
- no oral communication in verification process;
- failure to have all relevant information sources in OR;
- not using a checklist;
- atmosphere in which surgical team members felt they were not permitted to point out errors;
- attitude that surgeons should never be questioned.

With those findings in mind, JCAHO makes the following recommendations for preventing wrong-site surgeries:

- Clearly mark the operative site. **(For information on a campaign targeting wrong-site surgery, see *Same-Day Surgery*, September 1998, p. 117.)**
- Involve the patient in marking process to improve its reliability.
- Require each surgical team member to orally verify the correct surgical site.
- Use a checklist that includes any documents mentioning the correct site — including the medical record, X-rays, other imaging studies, informed consent documents, the OR record, and the anesthesia record — and direct observation of the marked operative site on the patient;
- ensure the surgeon personally takes part in obtaining informed consent;
- monitor OR procedures to ensure verification procedures are followed, especially for high-risk ones. ■

ACCREDITATION TIP

Fire drills are a problem — Here's how to ace them

Joint Commission: Every employee, every quarter

Did you receive a poor score regarding fire drills during your last accreditation survey? If so, you weren't alone. The Joint Commission on Accreditation of Healthcare Organizations reports that 13.7% of facilities surveyed between January and July 1997 received a score of 3, 4, or 5 for Environment of Care standard 2.10: Expectations for fire drills. The Accreditation Association for Ambulatory Health Care (AAAHC) also reports that facilities have problems complying with fire drill requirements.

The Joint Commission requires that fire drills be conducted every quarter on every shift and involve every employee. "And some may be a walk-through," says **Ann Kobs**, sentinel event specialist for the Department of Standards at the Joint Commission. "That works fine."

The Joint Commission doesn't require free-standing centers that have less than four people incapacitated at any given point and time to

EXECUTIVE SUMMARY

Two areas where same-day surgery programs may have problems complying with environment of care accreditation standards are fire drills and sterilizer monitoring.

- The Joint Commission on Accreditation of Healthcare Organizations requires fire drills every quarter, every shift, for every employee. The Accreditation Association for Ambulatory Health Care requires one fire drill a year in which the fire alarm boxes are pulled.
- Make sure your physicians and staff know where the fire extinguishers are located, where the fire alarm pull boxes are located, and what they should do in the event of a fire.
- To determine how often sterilizers should be monitored, look to national associations and manufacturer directions.

conduct fire drills, Kobs says.

In comparison, AAAHC requires at least one fire drill a year in which the fire department is notified so that the alarms can be pulled, says **Gerald G. Pousho**, MD, medical director at Washington Outpatient Surgery Center in Freemont, CA, and AAAHC surveyor.

Also, there should be a policy that clearly states who gives the order for evacuation, and at what point that order is given, Pousho says.

What would your physicians do in a fire?

Two of Pousho's favorite questions to ask a same-day surgery employees are: Where is the nearest fire alarm pull box? And where is the nearest fire extinguisher? Kobs says surveyors like to ask physicians what they would do in the event of a fire.

"The answers we've received have been very enlightening," she says. "One was, 'I'd call my secretary.' The second one was, 'Run like hell.'"

All joking aside, many physicians aren't oriented about what to do in the event of a fire, Kobs points out.

Want to earn extra points with your surveyor? Schedule one employee inservice every year in which the fire extinguishers are demonstrated, Pousho says.

"That tells me they're serious about them," he says. "Not only do employees know where they are, but thy know how to use them. That's a good sign."

In regard to another environment of care standard that requires sterilizers to be monitored, neither the Joint Commission nor AAAHC tell you how to monitor them or how often.

Instead, use direction from associations such as the Association for the Advancement of Instrumentation in Arlington, VA; Association for Professionals in Infection Control and Epidemiology in Washington, DC; and the Association of Operating Room Nurses in Denver, Kobs suggests. Also, read your manufacturer's instructions, she adds.

The number of tests on the sterilizer depends on the volume of the surgery program, Pousho says. "If a surgery center is only doing two or three procedures a week that require a sterile technique, then monitoring can be more infrequent."

"But if it's a high-volume program, I'd expect monitoring of the sterilization technique to be at more frequent intervals," he says. ■

New book tells how to apply AORN standards

A new publication scheduled for distribution in March 1999 will help surgical nurses apply the Denver-based Association of Operating Room Nurses' (AORN) standards of practice to non-hospital surgical settings.

"We are not changing our standards. We are giving our members advice and support as they apply the standards to an ever-increasing number of surgical venues outside the hospital operating room," says **Ramona Conner**, RN, MSN, perioperative nursing specialist in the AORN Center for Nursing Practice, Health Policy, and Research.

As nurses find themselves managing surgery centers and office-based surgical services that have none of the additional resources found in a hospital, they have asked AORN for help, explains Conner.

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Subscription rates: U.S.A., one year (12 issues), $449. Approximately 20 nursing contact hours, $509; Outside U.S.A., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $230 per year; 10 or more additional copies, $138 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $77 each. (GST registration number R128870672.)

Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Managing Editor: **Joy Daughtery Dickinson**, (912) 377-8044, (joy.daughtery@medec.com).
Production Editor: **Ann Duncan**.

Editorial Questions

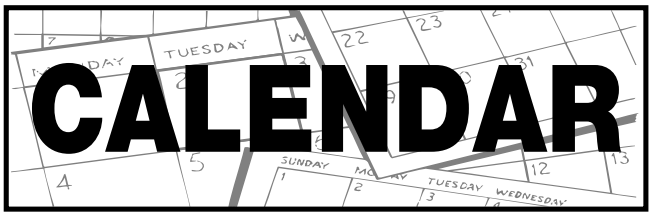
Questions or comments? Call **Joy Daughtery Dickinson** (912) 377-8044.

"This book will address issues such as materials management, infection control, risk management, emergency preparedness, medical records management, and human resources," she says.

The publication will also advise on the application of preoperative, intraoperative, and postoperative standards in a nontraditional setting and will recommend ways for nurses to enforce standards when space is limited or the "surgical suite" is a converted exam room.

"Our members are facing challenges in working in and managing nontraditional surgical settings that not only include freestanding centers and offices, but even mobile operating rooms," Conner says. "Our association is committed to providing the support needed to ensure quality care and patient safety."

The publication will be available in late March 1999. For more information, contact the Association of Operating Room Nurses, 2170 S. Parker Road, Suite 300, Denver, CO 80231-5711. Telephone: (800) 755-2676 or (303) 755-6300. Fax: (303) 750-3462. Web: http://www.AORN.org. ■



• **ASC Update 1999** — March 4-6, San Diego. Sponsored by the American Association of Ambulatory Surgery Centers (AAASC). For more information, contact: AAASC, 401 N. Michigan Ave., Chicago, IL 60611-4267. Telephone: (800) 237-3768. Fax: (312) 321-5150. E-mail: aaasc@sba.com.

• **Same-Day Surgery Conference** -– March 14-16, Atlanta. Sponsored by American Health Consultants, publisher of *Same-Day Surgery*. Contact: Customer Service, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291. E-mail:custserv@ahcpub.com.

• **1999 Society of American Gastrointestinal Endoscopic Surgeons Meeting** — March 24-27, San Antonio. Contact: SAGES, 2716 Ocean Park Blvd., Suite 3000, Santa Monica, CA 90405. Telephone: (310) 314-2404. Fax: (310) 314-2585. E-mail: sagesmail@aol.com. World Wide Web: http://www.sages.org/. ■

CE objectives

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

1. Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. **(See "Baby boomers and lasers team up for a financial win.")**
2. Describe how those issues affect nursing service delivery or management of a facility. **(See "Saving money with surgical scrubs and gowns: How far is too far?" "Hospital targets scrubs and saves $185,000," and "Fire drills are a problem — Here's how to ace them.")**
3. Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. ■