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As nursing shortage stretches out, programs survive with contract nurses

How do you maintain positive clinical outcomes with new staff?

As the nursing shortage lingers on like an unwelcome visitor, some outpatient surgery programs are struggling to keep their surgery schedules running at the same level. In fact, in a recent reader survey conducted by *Same-Day Surgery*, 10% of respondents said the nursing shortage had had a significant impact on quality of care.

The shortage also has impacted cancellation of elective surgeries. In a recent study conducted for the Chicago-based American Hospital Association (AHA), 10% of respondents reported that the nursing shortage has caused such cancellations.[1] **(For information on how the shortage of anesthesiologists is affecting cancellations, see story, p. 123.)**

Programs increasingly are turning to contract nurses to fulfill their staffing needs. The AHA reports that 56% of hospitals are using agency or traveling nurses to fill vacancies.[2]

In the midst of this crisis, staffing effectiveness standards from the Joint Commission on Accreditation of Healthcare Organizations took effect for hospitals only July 1. The new standards help hospitals assess the number, competency, and skill mix of their staff by linking staffing

Are you ready for EMTALA? Audio conference clarifies final regulations

At press time, the final version of the recently proposed changes to the Emergency Treatment and Labor Act (EMTALA) was expected to become effective soon. Issues in the final regulations could include changes to physician on-call requirements, "comes to the emergency department" definitions, later-developed emergencies, nonhospital entities, and prior authorization. With all the confusion surrounding the proposals during the past year, make sure you know what it takes to comply with the final regulations.

(Continued on page 131)

EXECUTIVE SUMMARY

Many outpatient surgery programs are turning to contract nurses to fill vacancies. The Joint Commission on Accreditation of Healthcare Organizations has implemented new standards that require hospitals (only) to measure staffing effectiveness by using indicators, such as on-call or per-diem staff. To ensure positive outcomes:

- Conduct interviews with applicants, and determine length and depth of experience. Obtain references from previous employers, and look for exceptional ratings.
- Put contract nurses on off shifts to avoid resentment among your staff.
- If the contract nurse has a poor performance, you typically can cancel the contract at any time.

effectiveness to clinical outcomes.

The standards rely on clinical and human resource screening indicators. Organizations collect and analyze data on multiple screening indicators that are sensitive to staffing effectiveness. The standards require organizations to choose at least four screening indicators. Two must be clinical/service-related, and two must be human resource-related. One of the human resource indicators that facilities may choose is "on-call or per-diem use."

"It's a tool to assess staffing effectiveness," says **Lucille Skuteris**, RN, MS, associate director of the Standards Interpretation Group at the Joint Commission. "We're not saying, just because there's a high number of on call or per diem, that it's causing negative clinical outcomes."

The Joint Commission frequently receives questions regarding whether contract nurses still have to receive evaluations and whether managers must ensure their competence. The answer is yes to both questions, says Skuteris, who says these requirements can be found in Human Resource Standard 2 (HR 2).

To ensure positive clinical outcomes and good experiences with contract nurses, consider these suggestions:

- **Verify their experience.**

At Strong Memorial Hospital in Rochester, NY, **Deborah G. Spratt**, RN, MPA, CNOR, CNAA, nurse manager, talks to contract nurses who apply to determine their length and depth of experience.

"Sometimes it's hard to see from their paperwork," Spratt says.

As Strong Memorial has opened more operating rooms and more shift coverage on nights and weekends, the hospital added four contract nurse positions and four contract OR techs to the staff of approximately 140.

Spratt looks for nurses who have a CNOR certification and four years of experience. She emphasizes that she doesn't have time to train contract employees, "especially not for the money they make," she says. "They should be able to hit the ground running."

North Suburban Medical Center in Thornton, CO, is filling one of five nurse positions in the ambulatory center with a contract nurse, and two nurses out of 12 in the main OR are contract nurses. "It's very difficult to find experienced OR nurses," says **Lynn Parton**, RN, BSN, CNOR, RNFA, director of surgical services.

To ensure the contract nurses are qualified, Parton conducts a thorough telephone interview. She asks applicants about how they would handle a difficult surgeon or peer, because that shows her how the applicant handles conflict. She also asks applicants to identify their favorite specialty.

"That gives me a clue of what they're really good at," Parton says.

She also obtains references from previous employers. "If I see a profile with evaluations that have exceptional marks, I feel much more confident hiring that person as a 'traveler' than evaluations that are just standard," she says. "I look for exceptional people."

In addition, because her center performs a large amount of orthopedic surgery, Parton looks for experience in that specialty. "I wouldn't take one that didn't list orthopedics as a high skill level," she says.

Parton uses a Performance-Based Delivery

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Shortage of anesthesiologists delays elective procedures

A recent study conducted for the Park Ridge, IL-based American Society of Anesthesiologists indicates that the shortage of anesthesiologists is delaying elective procedures.

More than one-fourth (27%) of hospital administrators surveyed indicated that the wait time for surgical services has increased within the past five years. For hospitals with more than 250 beds, the percentage jumps to 36%.

The impact of the shortage doesn't stop there. According to the study:

- Almost one-half (47%) of the hospitals surveyed have had to limit the number of operating rooms or the available hours of an operating room due to the lack of anesthesia providers.
- Twenty-two percent of administrators said that within the last five years, they have had to limit or eliminate anesthesia services that previously were provided outside of the OR, such as pain management.
- Almost one-half (47%) of the hospital administrators report that they don't have an adequate number of anesthesiologists on staff. Of those, 61% have had to supplement staff with locum tenens anesthesia providers, generally at a very high cost.

The nationwide survey was administered among 327 senior-level administrators from hospitals with more than 100 beds. The survey was conducted by The Tarrance Group in Alexandria, VA, between March 28 and June 17, 2002. The margin of error associated with a sample of this type is ±5%. ■

System (PBDS) to evaluate her applicants. **(See manufacturer information in resource box, below right.)** The PBDS uses methods and tools including videotaped patient scenarios, written scenarios, and audiotaped conversations. The system evaluates a nurse's critical thinking and interpersonal skills. The answers are rated by nurses who compare the answers against model answers from nursing clinical experts.

"There are different situations that an experienced OR nurse would pick up on immediately, such as wrong instrumentation," Parton says. "It gives me a pretty close idea of what they know about surgery."

If applicants fail the test, they are not given contracts. "It weeds out folks who are marginal," she says.

If the applicant has limited experience, he or she is given an action plan to follow that includes education.

• Use contract nurses on off-shifts.

Spratt uses contract nurses on the off-shifts, such as 3-11 p.m., for a variety of reasons. Off-shifts are difficult to fill, she points out. "They were, for us, a godsend," she says of the contract nurses.

She wants many of her full-time employees on the day shift to orient new staff. Also, because contract nurses are paid such high salaries, putting them on off-shifts works as an "equalizer" and minimizes disgruntled staff, Spratt says.

This scheduling frees her to reward her regular staff with Monday through Friday day shifts.

To avoid any problems on the off-shifts, Spratt ensures that she had top-notch supervisors there with whom contract nurses will feel comfortable.

• Learn from your contract nurses.

With some flexibility and open-mindedness,

SOURCES AND RESOURCES

For more information on contract nursing, contact:

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- **Standards Interpretation Group**, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Place, Oakbrook Terrace, IL 60181. Telephone: (630) 792-5900. Web: www.jcaho.org.
- **Deborah G. Spratt**, RN, MPA, CNOR, CNAA, Nurse Manager, Strong Memorial Hospital, 601 Elmwood Ave., Rochester, NY 14642. Telephone: (585) 275-9618. E-mail: Deborah spratt@urmc.rochester.edu.

The Performance Based Delivery System (PBDS) costs a minimum of $50,000 for the product and consulting services. For more information, contact:

- **Performance Management Services**, 13522 Newport Ave., Suite 200, Tustin, CA 92780. Telephone: (714) 731-3414. Fax: (714) 731-4620. E-mail: office@pmsi-pbds.com. Web: www.pmsi-pbds.com.

you may learn some new things from your contract staff, she says.

"They bring in a fresh perspective," says Spratt, who points out that her contract nurses have made some positive suggestions in areas such as instrument pan review. "Sometimes, they have different ways of doing things," which can be good for the department, she says.

If the contract nurse doesn't work out, realize you typically can cancel contracts at any point, Spratt emphasizes.

Spratt says she has had a few contract nurses who weren't satisfactory and was able to terminate them immediately after documenting the problems. "There was one person to whom we said, 'You're not coming back tomorrow, and you're going home today,'" she says. "That person didn't meet our work ethic and our needs."

References

1. First Consulting Group study for the American Hospital Association, January 2002.
2. Joint Commission on Accreditation of Healthcare Organizations. *Nursing Shortage Poses Serious Health Care Risk: Joint Commission Expert Panel Offers Solutions to National Health Care Crisis.* Accessed at www.jcaho.org/News+Room/Press+Kits/Nursing+Shortage+Press+Kit.htm. ■

Some bariatric cases move to outpatient arena

Special supplies, equipment needed for success

When a surgeon wants to offer a new procedure, same-day surgery program managers have to make sure that proper supplies, equipment, and staff are available for the procedure. With bariatric surgery, or weight-loss surgery, managers are in new territory.

"The bariatric patient population has specific needs related to their size that most patients don't have," says **DeNene G. Cofield**, RN, BSN, CNOR, director of surgical services and orthopedic and bariatric service line manager at Medical Center East in Birmingham, AL. "Stretchers, operating tables, wheelchairs, blood pressure cuffs, scales, and gowns all have to be sized and designed to hold larger, heavier patients than normal," she explains. For example, her program stocks gowns sized 1XX to 10XX to make sure that patients don't have to tie two gowns around themselves to be fully covered, she adds.

While most bariatric surgical procedures require at least a one-night stay in the hospital, the laparoscopic gastric bypass and the Lap-Band procedure enable some patients to undergo the procedure as an outpatient or 23-hour stay patient, Cofield says.

In June 2002, the Food and Drug Administration approved the Lap-Band Adjustable Gastric Banding System, manufactured by Inamed Health (formerly Bio-Enterics Corp.) in Santa Barbara, CA. The Lap-Band is not appropriate for all patients and does have some limitations on outcome, she says.

The Lap-Band is put into place laparoscopically, she says. The band is inflated with saline and can be adjusted over time to help patients meet their weight loss goals, she says. The adjustments are made on an outpatient basis, through a portal under the rib cage and the surgeon uses a needle to remove or add saline. Because the band limits how much the stomach can hold, patients lose weight, Cofield explains.

"The weight loss is only half of the amount of weight lost with traditional bariatric surgery," she explains. Some patients who have a body mass index that is higher than a surgeon believes is safe for traditional surgery may choose Lap-Band to lose enough weight to qualify for other surgery, she says.

"We've also had orthopedic surgeons ask for information on our program because they have older patients with knee or other joint problems that are difficult to treat because of the patients' weight," Cofield says. An older patient with

EXECUTIVE SUMMARY

New techniques occasionally are moving bariatric surgery into the same-day surgery arena. Because this patient population has atypical needs, managers must look beyond normal staffing education and supply forms to prepare.

- Offer sensitivity training related to working with morbidly obese patients.
- Appropriately size supplies such as gowns, stretchers, and wheelchairs for bariatric patients.
- Before receiving credentials for laparoscopic gastric bypass or other bariatric procedures, surgeons must demonstrate competence with the open procedure and experience with advanced laparoscopic procedures.

arthritic knees can improve the quality of life and increase the effectiveness of other treatment by reducing weight on the joints, she points out.

Not all bariatric surgeons like the Lap-Band procedure, however. "The Lap-Band trials in the United States have not duplicated the European results, so I'm not convinced of its effectiveness," says **Troy LaMar**, MD, a general surgeon at Arcadia (CA) Methodist Hospital. "With Lap-Band, you are placing a foreign body that can migrate or erode into a patient," he says. The laparoscopic gastric bypass is the procedure that he most often performs for bariatric patients, he says.

"Almost everyone is a candidate for laparoscopic gastric bypass, even patients with previous abdominal surgeries," LaMar says. Ninety percent of the gastric bypasses performed by LaMar and his partners are performed laparoscopically, he adds.

In a gastric bypass procedure, the surgeon creates a pouch that holds about 20 cc by dividing the stomach close to where it attaches to the esophagus. The stomach "pouch" is then connected to the small intestine, LaMar explains.

When credentialing surgeons to perform the laparoscopic gastric bypass, be sure to look for a general surgeon who successfully has performed the open procedure and also has advanced laparoscopic skills, LaMar says. "Surgeons should take courses to obtain formal training on the procedure and should be proctored as well," he adds.

Patient selection for bariatric surgery is important, Cofield says. The National Institutes of Health in Bethesda, MD, defines the ideal patient as between ages 18 and 55 and highly motivated to lose weight, she says. "Patients also undergo a complete physical, a sleep study, and a psychological evaluation," Cofield adds. Patients also attend a nutrition class and a bariatric surgery class prior to the procedure, she says.

"Unlike other surgical procedures, this is not the end of treatment for a disease," Cofield says. "This is the beginning of the treatment, so we want to make sure they are motivated and psychologically prepared for the lifestyle changes they'll be making."

The gastric bypass generally is covered by insurance, Cofield says. The Lap-Band procedure isn't covered at this time, she adds. That has not prevented patients from choosing the $15,000 to $20,000 procedure as a way to lose weight without the longer recovery time of the gastric bypass, she adds.

Before any surgical facility considers adding bariatric surgery, remember that unlike many same-day surgical procedures, this must be part of an overall program, Cofield says. Since the majority of procedures do require an overnight stay at this time, the program must encompass inpatient as well as outpatient surgery, radiology, lab, and nursing, she says. Support groups and nutrition counseling also are important, she adds. Staff need to develop a sensitivity to working with morbidly obese patients, she says.

SOURCES AND RESOURCES

For information about setting up a bariatric surgery program, contact:

- **DeNene G. Cofield**, RN, BSN, CNOR, Director of Surgical Services and Orthopedic and Bariatric Service Line Manager, Medical Center East, 50 Medical Park East, Birmingham, AL 35235. Telephone: (205) 838-3560. E-mail: dgcofield@ehs-inc.com.
- **Troy LaMar**, MD, General Surgeon, Arcadia Methodist Hospital, 622 W. Duarte Road, Suite 301, Arcadia, CA 91007. Telephone: (626) 445-0600. Fax: (626) 574-8654. E-mail: cssweightloss @hotmail.com. Web: www.csscenters.com.

For information about bariatric surgery and related products, contact:

- **Amplestuff**, Department WS, P.O. Box 116, Bearsville, NY 12409-0116. Telephone: (866) 486-1655 or (845) 679-3316. E-mail: amplestuff@aol.com. Web: www.amplestuff.com. Offers gowns and scales for obese patients.
- **American Society for Bariatric Surgery**, 7328 W. University Ave., Suite F, Gainesville, FL 32607. Telephone: (352) 331-4900. Fax: (352) 331-4975. Web: www.asbs.org.
- **Inamed Health** (formerly Bio-Enterics Corp.), 5540 Ekwill St., Santa Barbara, CA 93111. Telephone: (805) 683-6761. Fax: (805) 684-0812. Web: www.inamed.com.
- **National Institutes of Health, National Heart, Blood, and Lung Institute**, Bethesda, MD 20892. Telephone: (301) 496-4000. Web: www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm. Web site contains obesity guidelines for diagnosis and treatment.
- **National Institutes of Health, Weight Control Information Network**, Bethesda, MD 20892. Telephone: (877) 946-4527 or (202) 828-1025. Web: www.niddk.nih.gov/health/nutrit/pubs/gastsurg.htm. Contains information about gastric surgery that can be used for patient education.

"All of our staff members are undergoing sensitivity training because everyone, from patient transport to cafeteria staff to all clinical staff, has contact with our bariatric patients," Cofield says.

The sensitivity training course was designed and is conducted by **Rona Scott**, coordinator of the bariatric surgery program at Medical Center East and a former bariatric surgery patient.

The goal is to make all employees sensitive to the needs of the obese population through a general orientation, Scott says.

"We offer a more in-depth course to nurses and other caregivers so they understand the specific needs of the obese," Scott says. For example, obese patients have specific hygiene issues, they tend to be very hot-natured, and they often suffer from low self-esteem, she says. "We stress that obese patients deserve the same care and respect as other patients, and point out that they should not be openly hesitant to help an obese patient move from the stretcher to the bed, or make comments about a patient's size," Scott points out.

Once employees complete the course, they are given a blue ribbon to wear. Bariatric patients are told that the blue ribbon indicates an employee who can help them with their special needs, she adds.

No bariatric program can succeed if staff members are insensitive to patients' needs, she says. "Our patients need to know that they can ask for information or for help without feeling embarrassed," Cofield says. ■

Same-Day Surgery Manager

What is the physician ownership mentality?

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

If you work in this industry long enough, certain patterns and trends start to gel. One is physician behavior. How is that behavior different in an ambulatory surgery center (ASC) based upon the partnership of the facility? Or is it different at all? And who am I to write about it?

Well, after developing and managing ASCs for 18 years and with more than 4,000 one-on-one surgeon interviews on their thoughts on ASCs (and hospital operating rooms as well), I do believe I am qualified to write my observations. Is the behavior different? Oh, yes — *very* different. The behavior varies depending on whether the physicians are users, investors, members of a physician-only group, physicians in a hospital joint venture, or physicians in a joint venture with a corporate partner.

Space will not allow discussing all the options; so let me focus on the investor vs. user role of physicians in an ASC environment. The fact is that the same surgeon will act completely differently in both roles.

A good example is a surgeon who does an 8 a.m. case at the local not-for-profit hospital, then goes and does a case at another ASC for whatever reason, and then comes back to finish the day at the center where he or she is a financial investor.

The difference in mindset is striking. When physicians are owners:

• **They want to know what things cost.** Informing them is absolutely the very first step in getting them to work with you on controlling costs. You have the opportunity to explain to them what that vendor rep really is costing the center when the surgeon insists upon an exclusive arrangement with someone.

When the surgeons ask what one thing costs — you tell them what *everything* costs. This is when they start to realize that the cost of that new instrument or device actually is coming out of their pockets.

• **They will do without to save money.** Do they really need a second scrub? Can they use the old equipment? Will they buy refurbished equipment? Absolutely. They still will want the best at the hospital, but they will not use it as much as the older one at your center. If you take the time to explain to them that it is more economical to expand your hours of operation than it is to build that new operating room, they will listen.

• **They want the staff well compensated.** After you have finished laughing, continue to read this part. They really don't want to have staff turnover. It is your job to let them know that *one* way to avoid that is to be fair and recognize that good staff are hard to find and expensive — but that recruiting new staff and training them is

about twice as expensive as well-compensated staff.

• **They want staff to share in the financial profits of the center.** If you explain the importance of this, they will listen to you. Every time the owners receive a distribution of profits, staff should as well. The owners know the importance of staff receiving extra for that late afternoon smile or starting their cases early to increase the profitability of their investment.

• **They are willing to be retrained on their own efficiencies.** If you play your cards right, this can be a great management tool. Let your ophthalmologist know that the other cataract surgeons' cases are only 15 minutes and not 60 minutes like his. Show them what equipment their highly cost-effective and efficient peers are using on their cases. Many times the surgeons feel that they cannot do something "out of the norm" because they don't want to go it alone. Making them understand that others are doing it really helps. A good example of this would be not having the cataract patients disrobe for their cases, or not allowing the parents into the room with pediatric cases.

• **They want influence in decisions, but not day-to-day responsibility.** Asking their advice and getting parameters in your managing efforts will go a long way in how the investor treats you. They don't want to micro-manage, but they will do so if they feel as if they have no influence in what you manage.

• **They want flexibility in scheduling.** We find so many administrators who make their jobs much harder than they need to be by not asking the investors to change their cases around to save money and wear and tear on the staff. The angry investor physician who will scream at you for not flip-flopping her room can act completely different if you explain that you wanted to accommodate a new surgeon by giving her an on-time start.

These are just a few examples of the differences. There clearly are more, but understanding the investor mentality will go a long way to making that investment more profitable and your life easier.

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

Final HIPAA privacy rule will be less burdensome

However, 'sweeping operational changes' expected

The final privacy rule for the Health Insurance Portability and Accountability Act (HIPAA) has been published and will be less burdensome than the proposal. "In general, I feel that the Department of Health and Human Services' updates to the HIPAA regulations improve our ability to provide treatment and protect the privacy of our patients information," says **Janice Roach**, executive director of Tri-City Regional Surgery Center in Richland, WA.

The Chicago-based American Hospital Association, however, warns that the rule still requires "sweeping operational changes."

"Because it will affect every department, employee, and business associate of the hospital; it will take intense education of hospital workers and patients," the association warns.[1]

A previous version of the privacy rule was published Dec. 28, 2000, and proposed modifications were published March 27, 2002. The final rule was published Aug. 14, 2002, in the *Federal Register*. **(To order, see resource box, p. 128.)** The deadline for compliance is April 14, 2003, or April 14, 2004, for small health plans.

Here are the areas with major changes:

• **Privacy notice.**

The rule omits the requirement for written consent from patients before disclosing patient information among providers. Instead, patients should

EXECUTIVE SUMMARY

The final privacy rule for the Health Insurance Portability and Accountability Act (HIPAA) has been published. The final rule should be less burdensome than the proposal, but the American Hospital Association still predicts "sweeping operational changes" and intensive education of employees.

- The rule omits the requirement for written consent from patients before disclosing patient information among providers. Instead, patients must acknowledge they have received information.
- The rules for incidental disclosure of patient information are relaxed, so that physicians can talk to patients and other providers without fearing that someone may overhear them.
- Providers must obtain a patient's specific authorization before sending them marketing materials.

be asked to sign or otherwise acknowledge that they have received information about their privacy rights and the providers' information practices. "I am happy about the reduced expectation for the patient consent requirement," Roach says. "It will be easier for us to administrate and also easier for the patients to understand."

The privacy notice must be given during the initial patient encounter and anytime patients request it, she says. "Of course, we make a good-faith attempt to make sure that our patients understand their rights under HIPAA, but not by having to provide them a 20-page legal document," Roach says.

• **Initial use and disclosure.**

The final rule allows uses or disclosure of patient information that are incidental to a use or disclosure that is otherwise permitted. For example, surgery centers may keep patient charts at bedside, physicians can talk to patients in semiprivate rooms, and physicians can confer at nurse's stations without fearing that they violate the rule if a passerby overhears them, according to a statement from the Department of Health and Human Services.[2] The relaxation of the regulations for incidental disclosures actually will make it easier for outpatient surgery providers to take good care of our patients, Roach says. "Medical personnel need to be able to discuss a patient's condition and treatment, without having to constantly worry about breaking the law," she says. "Staff at the [Tri-City Regional] Surgery Center understand the patient's need and right for confidentiality, but this change makes it easier for the nurses and doctors to do their job."

• **Marketing.**

The final rule said providers must obtain a patient's specific authorization before sending them marketing materials.

General newsletters still can be mailed *if* they have general health information and they aren't labeled "information for patients," says **Mark Mayo**, executive director of the Illinois Free-standing Surgery Center Association in St. Charles. Mayo received this advice at the recent HIPAA conference sponsored by the Alexandria, VA-based Federated Ambulatory Surgery Association. "The recommendation is that the mail packet not be too obvious," he says.

The final HIPAA security regulations still are uncertain. "We are still a little nervous about the fact that the final security regulations are not yet finalized, yet we are supposed to ensure the privacy of our patients' information," Roach says. "We expect to make some minor changes to improve security of patient data, but we already have had to begin staff awareness and training." Her awareness includes discussion at monthly staff meetings, she says. Privacy training for all employees is mandatory under HIPAA.

"We are also reviewing our policies and procedures to make sure that we are protecting the privacy of patient information," Roach says. Most covered entities have until April 14, 2003, to comply with the patient privacy rule. Certain small health plans have until April 14, 2004, to comply.

References

1. American Hospital Association. *AHA News Now Special Report — HHS issues final HIPAA Medical Privacy Rule.* Chicago; Aug. 9, 2002.
2. Department of Health and Human Services, Press Office. *Modifications to the Standards for Privacy of Individually Identifiable Health Information — Final Rule.* Washington, DC: Aug. 9, 2002. ■

SOURCES AND RESOURCES

For more information on the final privacy rule, contact:

- **Janice Roach**, Executive Director, Tri-City Regional Surgery Center, 1096 Goethals, Richland, WA 99352. Telephone: (509) 943-9700. E-mail: roachj@kadlecmed.com.

Copies of the *Federal Register* can be found at www.access.gpo.gov/su_docs/fedreg/frcont02.html. Click on "Wednesday, Aug. 14," and look under the "Health and Human Services Department" (HHS). Or you can view the *Federal Register* at many libraries. To order by mail, the cost is $10. Specify the date (Aug. 14, 2002), and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Send your request to:

- New Orders, **Superintendent of Documents**, P.O. Box 371954, Pittsburgh, PA 15250-7954. Credit card orders can be placed by telephone: (202) 512-1800, or by fax: (202) 512-2250.

The HHS' Office for Civil Rights (OCR) will continue to conduct outreach and education targeted to providers affected by the privacy regulation. These efforts include technical assistance materials and responses to frequently asked questions. HHS also will hold national educational conferences in the fall to address issues related to key parts of the privacy regulation. Technical assistance materials will be posted on OCR's privacy rule web site at www.hhs.gov/ocr/ hipaa/.

Multiple ORs per surgeon increase efficiency

Study looks at time, staff, and costs

The use of more than one operating room per surgeon may increase a physician's productivity, decrease the number of hours the same-day surgery program needs to remain open during the day, or enable a surgeon to schedule more cases during the day. But how does the additional operating room affect pre-procedure, procedure, turnover, and discharge times?

This is one of the areas examined by the third Cataract Extraction with Lens Implantation Study by the Wilmette, IL-based Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement (IQI). In addition to studying times, costs, and practices for all 57 participants, IQI presented a section that focused on times and costs of the 34 organizations that use more than one operating room per physician.

In almost all categories, average time for same-day surgery programs using multiple operating rooms per surgeon were one to three minutes lower than same-day surgery programs using one operating room per surgeon, but reported turnover times were higher. Researchers suggest that the average turnover time of 17 minutes for multiple operating rooms vs. 13 minutes for single operating rooms may not be a "true" turnover time because the need for speedy setup and cleanup is not as critical when a single surgeon uses multiple operating rooms.

Using two operating rooms for one surgeon works well, says **Paula M. Dobberstein**, RN, director of nursing at Surgicare Center in Fort Myers, FL. Her program's turnover time was fewer than five minutes, but her surgeons also posted the lowest procedure time at seven minutes, so a quick turnover, even with multiple rooms, is necessary, she says.

A total of six employees are needed to staff the two operating rooms, Dobberstein says. "Two RNs, two scrub techs, one person to keep the autoclaves running, and one person to handle patient preparation and transportation are necessary for the operating rooms," she explains. Even though each employee has a primary responsibility, everyone is cross-trained to other areas for times when a staff member is ill or on vacation, she adds.

Organization and teamwork are the keys to low procedure, turnover, and discharge times, says **Jennifer Hunter**, RN, BSN, administrator and director of nursing at Muncie (IN) Cataract and Laser Center. "We have two operating rooms, but only one surgeon, so we know exactly what is needed during the procedure," she says. "We make sure both rooms are stocked well, with additional supplies pulled ahead of time," she adds.

She was surprised to see that other programs don't have patients arrive as early as the 90 minutes prior to surgery required by her program, Hunter says. "I am going to take a look at our policy, but may not change it because we tend to run ahead of schedule," she explains. "We can easily take the patient into the operating room earlier than planned if they are here and prepped."

Only 14 of the study participants instructed patients to arrive more than 60 minutes prior to scheduled surgery, and five participants require arrival only 30 minutes prior to surgery.

Ten percent of the patients at Minnesota Eye Laser and Surgery Center in Bloomington are moved ahead in the surgery schedule, says **Peggy A. Halvorson**, RN, CNOR, nurse manager of the center. Although patients are asked to arrive one hour before their scheduled procedure, pre-procedure time for the center is close to 40 minutes. Thus, patients are ready for the operating room when there are cancellations or when the surgeon is running ahead of schedule, she says.

"We do have one surgeon who is very fast, so we ask her patients to come in 75 minutes prior to their procedure because we know the surgeon will be ready for them sooner," she adds.

The center has one operating room, and the same surgeon uses the room all day, with different surgeons each day, says Halvorson. Because of increasing volumes, the addition of a second

EXECUTIVE SUMMARY

Data from the third Cataract Extraction with Lens Implantation Study by the Accreditation Association for Ambulatory Health shows that multiple ORs for a single surgeon can reduce time from pre-procedure through discharge by one to three minutes in each area. Other results are:

- The median procedure time was 14 minutes.
- The median discharge time was 22 minutes.
- The median setup time was 11 minutes.
- Six percent of patients required unscheduled follow-up visits for reasons including pain control, vision problems, bruising, and questions about medication, instructions, and prognosis.

SOURCES AND RESOURCE

For more about the cataract study, contact:

- **Paula M. Dobberstein**, RN, Director of Nursing, Surgicare Center, 4101 Evans Ave., Fort Myers, FL 33901. Telephone: (941) 939-3456. Fax: (941) 939-1164.
- **Jennifer Hunter**, RN, BSN, Administrator and Director of Nursing, Muncie Cataract and Laser Center, 3300 W. Purdue Ave., Muncie, IN 47304. Telephone: (765) 289-8251. Fax: (765) 289-8250.
- **Peggy A. Halvorson**, RN, CNOR, Nurse Manager, Minnesota Eye Laser and Surgery Center, 9117 Lyndale Ave., Bloomington, MN 55420. Telephone: (952) 885-2466. Fax: (952) 884-2656. E-mail: pahalvorson@mneye.com.

To order a copy of the 2001 Cataract Extraction with Lens Implantation Study, contact:

- **The Institute for Quality Improvement, Accreditation Association for Ambulatory Health Care**, 3201 Old Glenview Road, Suite 300 Wilmette, IL 60091. Telephone: (847) 853-6060. Fax: (847) 853-9028. Web: www.aaahciqi.org. Copies of the study are available for $50 plus $12 shipping charge for one copy.

operating room has been considered, she says.

"It probably isn't possible because of space constraints, additional equipment needed, and the extra three people I'd have to hire," she says. "Our recovery room can only handle two people, so we'd have to increase it as well."

The IQI study did ask participants to estimate the associated costs of a second operating room for one surgeon, but not all organizations supplied the information.

Of the 23 organizations that did, the range of additional personnel time per procedure to maintain more than one operating room per physician was five minutes to 240 minutes, with the median time at 20 minutes.

Of the 10 same-day surgery programs that estimated the additional equipment and supply cost per procedure, the range was $18 to $600, with a median of $131. The costs can be worthwhile for some programs, Dobberstein suggests. The greatest benefit of multiple operating rooms is physician satisfaction, she says. "The surgeons move from one room to another with no delay or downtime, and productive surgeons are happy surgeons." ■

Medicare proposes 3.5% increase for OPPS

Some day-surgery procedures could jump 10-27%

Although a 3.5% increase has been proposed for 2003 hospital payment rates under the outpatient prospective payment system (OPPS), this amount falls short of compensating hospitals for the costs of providing outpatient care, according to the Chicago-based American Hospital Association (AHA).

The increase would total $530 million more than 2002 payment rates. OPPS payments to rural hospitals would increase 7.6%. The payment rates were based on actual data from OPPS claims, instead of 1996 cost information, as in the past.

For outpatient surgery services, there is some good news, says **Eric Zimmerman**, JD, MBA, attorney with McDermott, Will, & Emery in Washington, DC. The reimbursement for many high-volume procedures would increase 10% to 27%, he says. Zimmerman offers these examples:

- The national unadjusted payment rate for a cataract extraction, intraocular lens (IOL) insertion procedure (CPT 66984) would increase from $1,055 to $1,226.89, a 16% increase.
- The national unadjusted payment rate for a colonoscopy procedure (CPT 45384) would increase from $372 to $435, a 17% increase.
- The national unadjusted payment rate for a cystoscopy procedure (CPT 52000) would increase from $202 to $334, a 27% increase.
- The national unadjusted payment rate for a knee arthroscopy procedure (CPT 29881) would increase from $1,208 to $1,424 for 2003, an 18% increase.

The Centers for Medicare & Medicaid Services (CMS) also plans to cut 95 categories of devices

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services is proposing a 3.5% increase for the outpatient prospective payment system for hospitals in 2003.

- Several outpatient surgery procedures would increase 10-27%, including cataract extraction, intraocular lens insertion; colonoscopy; cystoscopy; and knee arthroscopy.
- Comments are due on the proposal by Oct. 7.
- The Medicare Hospital Outpatient Fair Payment Act of 2002 (H.R. 5234/S. 2547) would require an increase in overall outpatient department payments to 90% of overall costs, from the current 84%.

and about 240 drugs from the pass-through payment system. Under the proposal, these items would be included in their associated ambulatory payment classifications (APCs), and separate APCs would be created for the higher-cost drugs.

At this time, a pro-rata reduction is not included for new technology. However, a pro-rata reduction may be included in the final rule due to drugs awaiting Food and Drug Administration approval that are expected to be costly. Outliers were maintained at the same amount, but the threshold was decreased to allow for more outlier payments.

The AHA supports the Medicare Hospital Outpatient Fair Payment Act of 2002 (H.R. 5234/ S. 2547), which is co-sponsored by Sen. Jeff Bingaman (D-NM) and Sen. Olympia Snowe (R-ME).

The bill would require an increase in overall outpatient department payments to be adjusted to 90% of overall costs, from the current 84%, according to the AHA. It also would extend transitional corridor or "hold harmless'" payments to rural, cancer, and children's hospitals, the association says. *(Editor's note: For the current status of this bill, go to thomas.loc.gov. Search for HR 5234.)*

In the meantime, comments are due on the proposed OPPS rule by Oct. 7. Send written comments (one original and two copies) to: The Centers for Medicare & Medicaid Services, Department of Health and Human Services, ATTN: CMS-1206-P, PO Box 8018, Baltimore, MD 21244-8018. A final rule will be published later in the fall. ■

SOURCE

For more information on the proposal, contact:

- **Eric Zimmerman**, JD, MBA, Attorney, McDermott, Will, & Emery, 600 13th St. N.W., Washington, DC 20005-3096. Telephone: (202) 756-8148. Fax: (202) 756-8087. E-mail: ezimmerman@mwe.com.

(Continued from cover)

To keep you on track, American Health Consultants offers the **EMTALA: Complying with the Final Regulations** audio conference, scheduled for Tuesday, Nov. 12, 2002, 2:30 to 3:30 p.m. ET. The conference will be presented by **Charlotte S. Yeh**, MD, FACEP, and **Nancy J. Brent**, RN, MS, JD.

Yeh is medical director for Medicare policy at National Heritage Insurance Co. in Hingham, MA. Brent is a Chicago-based attorney with extensive experience as a speaker on EMTALA and related health care issues. In June of this year, both speakers presented **EMTALA Update 2002**, one of AHC's most successful audio conferences.

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the audio conference for $299, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. The conference package also includes, handouts, additional reading, a 48-hour replay of the live conference, and a CD recording of the program.

For more information, or to register, call customer service at (800) 688-2421 or (404) 262-5476, or e-mail customerservice@ahc pub.com. When ordering, please reference effort code: **63221**. ■

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Editorial Questions

Questions or comments?
Call **Joy Daughtery Dickinson** at (229) 377-8044.

CE objectives

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

- Identify the requirements from the Joint Commission on Accreditation of Healthcare Organizations concerning evaluations and competence of contract nurses. (See "*As nursing shortage stretches out, programs survive with contract nurses.")*
- Identify the procedural advances that may move more bariatric surgery into the same-day surgery setting. (See "*Some bariatric cases move to outpatient arena.")*
- Identify whether a patient's chart can be kept at bedside under a final federal privacy regulation. (See "*Final HIPAA privacy rule will be less burdensome.")*
- Use national benchmarking information to evaluate your same-day surgery program. (See *"Multiple ORs per surgeon increase efficiency."*) ■

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. According to the Joint Commission on Accreditation of Healthcare Organizations, do contract nurses have to receive evaluations and must managers ensure their competence?
    A. They do require evaluations, but managers aren't required to ensure their competence.
    B. They don't require evaluations, but managers are required to ensure their competence.
    C. They don't require evaluations, and managers aren't required to ensure their competence.
    D. They do require evaluations, and managers are required to ensure their competence.

14. According to DeNene G. Cofield, RN, BSN, CNOR, director of surgical services and orthopedic and bariatric service line manager at Medical Center East, which surgical procedure(s) is/are moving some bariatric surgery patients into a same-day surgery or 23-hour stay setting?
    A. laparoscopic gastric bypass
    B. Roux-en-Y gastric bypass
    D. Lap-Band Adjustable Gastric Banding System
    D. A and B
    E. A and C

15. According to the final privacy rule from the Department of Health and Human Services, can a patient's chart be kept at beside?
    A. yes
    B. no
    C. only when certain criteria are met

16. In the 2001 Cataract Extraction with Lens Implantation Study by the Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement, the median additional personnel time needed per procedure to maintain more than one OR per physician was:
    A. 20 minutes
    B. 30 minutes
    C 45 minutes
    D. 60 minutes

Same-Day Surgery Fax-Back Survey

American Health Consultants is working to create more focused and timely health care information and staff education resources. To help us in that effort, we'd like to know what you're thinking. Please take a moment to complete this short survey. Your thoughts, input, and suggestions will allow us to more accurately respond to your health care information needs. **Please fax your completed form to (800) 284-3291, Attn: Jean Leverett.** The deadline for submission is **Oct. 31, 2002**.

1. What health care regulatory issues concern you most?

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2. What compliance issues does your facility deal with most often?

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3. On which topics is it most difficult to educate your staff? On which topics is it most difficult to find information?

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