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Covering Hospitals, Surgery Centers, and Offices for More than 30 Years

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IN THIS ISSUE

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Surgeon shortage will hit as early as next year — Are you ready?

Researchers predict that by as early as 2010, there could be a shortage of 1,300 general surgeons.[1] That number could grow to 1,875 in 2020, and 6,000 in 2050, says the co-author of the research, **Thomas E. Williams Jr.**, MD, PhD, physician scholar at the Department of Surgery at Ohio State University, Columbus, and retired cardiac surgeon.

"According to simple population calculations, if the number of surgical trainees is not increased and the care model remains constant, there will not be a sufficient number of allopathic-trained general surgeons to care for the American people," researchers said.[1] Williams has co-authored a book titled *The Coming Surgeon Shortage: Who Will Fix our Hearts, your Hip, and Deliver our Grandchildren*? The book is expected to be released late this year.

The number of general surgeons per capita has declined 25% over the past 25 years, according to the American College of Surgeons. Almost 75% of surgeons-in-training are choosing subspecialties that are more lucrative and offer better hours than general surgery, the college says. However, shortages also are developing in orthopedic surgery, urology, obstetrics-gynecology, cardiothoracic surgery, and neurosurgery. Another factor is decreased reimbursement.

The American College of Surgeons is taking notice. The college and others groups have formed a group titled Operation Patient Access: Quality Surgical Care for All, which will focus on the urgent issues facing surgical care. "Operation Patient Access is designed to help policymakers understand that patient access to quality surgical care is at risk

EXECUTIVE SUMMARY

There could be a shortage of 1,300 general surgeons as early as 2010.
- Hospitals should consider employing surgeons. Freestanding centers can play up their lack of emergency surgery and no emergency call/coverage.
- Be as efficient as possible to keep current surgeons satisfied.
- Consider temporary surgeons, but ensure that postoperative care is handled by a qualified provider.

and that we want to work with them to craft workable solutions that address access problems while preserving and improving high-quality surgical care," according to a released statement from the college.[2]

The college's Health Policy Institute issued a new unpublished report that indicates the shortage of general surgeons has raised concerns about access to care for underserved and aging populations in pockets of rural and urban U.S. areas. The study, "Migration of Surgeons," found that surgeons are moving to areas with already established medical communities, which could lead to local shortages, particularly in the Northeastern and Midwestern United States.[3]

David A. Etzioni, MD, MSHS, assistant professor in the Department of Colorectal Surgery, Keck School of Medicine of USC in Los Angeles, says, "The impact of a surgeon shortage on outpatient surgery will depend on a wide range of factors, but it is a given that more outpatient surgical procedures will be performed."

Among the solutions being discussed by Operation Patient Access participants are increasing the number of residency programs, expanding the National Health Services Corps, establishing student loan forgiveness programs, providing more funding for graduate surgical education, reducing liability cost, and implementing alternative payment methods for health care.

The government must take proactive steps to increase the funding for surgery trainees to prevent the shortage and maintain access to high-quality care, Williams said in his study.[1] In the meantime, there are strategies outpatient surgery managers can take now:

- **Change recruiting strategies.**

Hospitals are more likely to employ surgeons in the future, Williams predicts. There will be forgiveness of medical school debt and signing bonuses, he says.

"Business models will be changing over the next 25 years," he says.

Freestanding centers can play up their lack of emergencies, which allows surgeons to live a more scheduled lifestyle, Williams says. Also, surgery centers have no emergency department call/coverage, sources point out.

- **Make sure physicians are happy.**

Are you sure your physicians are happy? Ask them, Etzioni advises.

Medical directors should make sure physicians have what they need for their practice, Williams says. Physicians particularly are drawn to efficient surgery programs, he emphasizes.

In Columbus, OH, some orthopedic surgeons have started performing cases at a specialty hospital, Williams says. One told him that in the same amount of time it takes to do two cases at a local hospital, he can get three cases done at the specialty hospital, "because it's a more efficient delivery system," Williams says. **(For more on this topic, see "Surgeons, staff share what they like about surgery," *Same-Day Surgery,* October 2008, p. 110.)**

- **Do more with less.**

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Find ways to help surgeons streamline their work, Etzioni advises.

"This may include increasing ancillary staff support, allowing surgeons to go back and forth between rooms, shorter room turnover times, etc.," he says.

These recommendations assume that the surgeon already is busy, Etzioni says. "At the national level, I believe that surgeons are going to become increasingly busy," he says. **(Temporary surgeons are one solution to the shortage. See stories, below and on p. 77.)**

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3. American College of Surgeons. New trend data shows access to surgical care at risk in rural and urban areas of the United States, American College of Surgeons Health Policy Institute issues advance findings of study on migration of surgeons. March 24, 2009. Accessed at www.facs.org/news/accessatrisk.html. ■

Temp surgeons creating concerns for managers

General surgeons have become scarcer in hospitals across the country, many of them beaten down by diminishing payments and grueling work hours, and some lured away by specialized surgery niches that offer more money and a better lifestyle.

Hospitals are left with no other choice but to rely more heavily on locum tenens surgeons who are called in as needed, often arriving within hours of the surgery and leaving just as quickly when it is done.

The shorter stays are another part of the trend that concern managers. Previously, locum tenens physicians stayed longer, and the same doctor might visit on a regular basis. Now the statistics show that locum tenens surgeons are more often visiting for just a week or a few days, and then they're gone.

The concept of temporary surgeons is nothing new, and the medical community has long recognized that they can pose some risk to patient safety. But the growing dependence on surgeons-for-hire means that whatever risk has always existed is now growing too, says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of the American Society for Healthcare Risk Management (ASHRM). What once may have seemed an unfortunate but tolerable risk is now becoming more worrisome, she says.

"I think the trend is going to continue to get worse, and we will see more and more problems," she predicts. "We may be seeing the tip of the iceberg now."

The risks are easy for a manager to spot. For starters, the locum tenens surgeon arrives with scant knowledge about the patient and little time to study the case. And then after the surgery, the temporary surgeon leaves the patient in someone else's hands for follow-up care. The whole concept of continuity of care is thrown out the window.

The American College of Surgeons has a *Statement of Principles* that clearly outlines the responsibility of the operating surgeon:[1] "That is to see the patient preoperatively, intraoperatively, and postoperatively," says **Paul Collicott**, MD, FACS, director of the college's division of member services.

David A. Etzioni, MD, MSHS, assistant professor in the Department of Colorectal Surgery, Keck School of Medicine of USC in Los Angeles, says, "We generally assume that if a surgeon provides a surgical service to a patient, that there is a contract of sorts between the patient and physician." The contract implies that the surgeon will be available to care for the patient on a long-term basis, he says. "What if there is a complication that arises that requires ongoing treatment?" he asks. "From a reimbursement point of view, each major surgical procedure has a 'global period,' but in terms of the actual physician-patient relationship, this contract is permanent."

If the locum tenens surgeon is unable to provide postoperative care, then that care should be turned over to the surgeon who was temporarily replaced or a surgeon who can render surgical care equivalent to that provided by the locum tenens surgeon, say experts interviewed by *Same-Day Surgery.* "An orthopedist shouldn't be following up with a cholecystectomy," Collicott says.

Other caveats: The college advises surgeons who do specialized work in urban hospitals not to work in small, rural facilities where the needs are more general. Also, inform patients that the

regular surgeon is not doing the operation, Collicott advises.

Another concern for managers is that the locum tenens surgeon is not part of the facility's culture and community. The surgeon does not know the staff he or she will work with in the OR, and neither is he nor she familiar with the equipment to be used in surgery. That can be important in a crisis, when familiarity with the surroundings and equipment will facilitate a quick response with fewer mistakes.

Perhaps one of the most vexing problems for managers is that the locum tenens surgeon is not party to all of the policies and procedures, inservices, and other education that the manager has deemed so important for everyone else. The traveling surgeon might be required to sign off on certain requirements, and the agency providing the surgeon might certify that he or she meets certain standards, but that is not the same as knowing that the physician has been part of your own facility's learning process, Kicklighter says.

It can be hard enough to have physicians to comply with all your expectations even when they are local, operate at your facility regularly, and are part of the facility's community, she points out. The manager faces a real challenge when the surgeon just flew in, is tired, and the patient needs surgery in a hurry. For example, sources say, how will you ensure that these surgeons know how to handle a fire emergency and are familiar with the procedures to evacuate patients? Do those surgeons even know where the exits are?

"In the world of risk management, the first requirement is adhering to your own policies and procedures. If they don't know what you require, how can you expect them to comply?" Kicklighter says. "These aren't just a few simple rules, after all. We're talking about a whole slew of specific things that are not going to be the same from one [facility] to another."

The risks posed by itinerant surgeons can be mitigated by carefully choosing the agencies and the individual surgeons, she says.

There are other risk exposures to consider also, Kicklighter says. If the facility provides accommodations for locum tenens surgeons, such as a nearby apartment, there can be potential general liability issues there. Similarly, local transportation for the surgeon and security if the facility is in an unsafe area can bring liability. Workers' compensation also is a concern. "If they get stuck [by a needle] in your hospital and don't tell you about it, you aren't able to get a baseline on them or do any follow-up. But then they may come down with something, and years later you're brought in to a lawsuit," Kicklighter says.

Kicklighter also is concerned about how a manager could do a timely and effective investigation after an adverse event when the surgeon has left the community and has little obligation to participate. Also, she questions the ability to conduct a proper disclosure after an adverse event. If the surgeon is gone several days later, once you've investigated, is it right to disclose details to the patient without the surgeon participating in person?

Claims related to the surgery also could be problematic, Kicklighter says. "If a claim is filed several years later, what kind of guarantee do you have that you'll be able to track this doctor down? What kind of leverage do you have to ensure the doctor will be cooperative?" she asks. "I also expect a lot of claims in which there is disagreement about whether the fault lies with the surgeon or the doctor who was left to follow up with the patient after the surgeon leaves town."

Documentation also can be an issue with locum tenens surgeons, she says. With the move toward electronic medical records (EMR), physicians must know how to use the hospital's system. "How are we going to orient the surgeon to this particular hospital's EMR? It's one more thing to teach them when they arrive, and there's no time for it all,"

Overview: Locum Tenens

- Locum tenens surgeons typically work 10-20 days, but temporary providers can work anywhere from three days up to a full year.
- At least 1 in 20 general surgeons works on a temporary basis at least some of the time.
- They can earn $250,000 or more due partly to the fact that they have no overhead.
- A temporary surgeon can cost about $1,500 a day, which includes the staffing agency fee. Additionally, the facility pays for travel and lodging expenses. Sometimes these costs can be passed on during contract negotiations with insurers.
- Providers have to balance the cost against the lost revenue and patient dissatisfaction from a surgeon shortage. Additionally, physician recruitment efforts can take four to six months.

Sources: Fuhrmans V. Surgeon Shortage Pushes Hospitals to Hire Temps. *Wall St Journal*, Jan. 13, 2009. Accessed at online.wsj.com/article/SB123179145452274561.html.

she says. "I'm concerned that we might see a lot of incomplete records."

Arun Ravi, a health care consultant with Frost & Sullivan, a consulting firm in New York City, says there is growing concern about whether traveling surgeons are adequately rested. "We're always concerned about surgeons working long hours and irregular hours, then being asked to perform a complex procedure," he says. "That is a concern, even with local surgeons, and then it becomes a much bigger concern when you have someone flying in from out of town, plus you have no idea what sort of experience they have had in the previous day or two."

Ravi notes, however, that the increasing use of locum tenens surgeons is not all bad. Though it is a solution that comes with its own batch of potential problems, using locum tenens surgeons addresses the shortage of surgeons by allowing hospitals to maintain their surgical revenue. The practice also helps patients avoid traveling to distant locations for surgery.

"This seems to be a pattern of practice that has taken hold in the medical community, for better or worse, so it is up to [facilities] to come up with policies and procedures that address some of the inherent risks," he says. "The most important thing right now is to understand that the use of temporary surgeons is not going to be just an aberration."

Reference

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Consider modifying bylaws to reduce locum tenens risk

Extending temporary privileges to a traveling surgeon can be risky business, says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of the American Society for Healthcare Risk Management (ASHRM) in Chicago.

Even if you use due diligence in selecting the agency providing the surgeon, the very nature of locum tenens surgery might mean that you have to cut corners in some of your typical process for privileging surgeons. The shortcut may be unavoidable, but it could come back to haunt you. For instance, if your facility typically requires that surgeons be credentialed individually and proctored before you grant privileges, a plaintiff's attorney could ask why you saw fit to allow this locum tenens surgeon to operate without proctoring.

"You can make the argument at that point that you had no time for proctoring and had to save the patient's life, but if something goes wrong with that patient, the issue will come up when you're sued," she says.

To avoid inconsistency, which can be used against you later in court, Kicklighter says it might be necessary to modify your medical bylaws to create a special category for the locum tenens doctor. She suggests raising the idea with physician leaders to determine how the bylaws can better accommodate what is becoming a common practice rather than the exception.

"The special category approved by the physician leadership will show that you have considered the need for locum tenens and established under what conditions it is acceptable," she says. "You have that consistency, rather than just making an exception for locum tenens."

An orientation checklist could be useful and could be signed by your locum tenens surgeon, sources suggest. **Arun Ravi**, a health care consultant with Frost & Sullivan, a consulting firm in New York City, offers these other suggestions for mitigating the risk of such surgeons:

- **Put most of your effort into choosing the right locum tenens agency.** Ensure that the agency's standards and credentialing are good enough to satisfy your needs, so that you don't have to start from scratch.
- **Draw up an agreement that each locum tenens surgeon must sign before operating.** This agreement, which is in addition to the standard contracts and documents that bring the doctor to

SOURCES

For more information on risks posed by locum tenens surgeons, contact:

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- **Arun Ravi**, Health Care Consultant, Frost & Sullivan, New York City. Telephone: (877) 463-7678.

your facility, can address any particular concerns you have about policies and procedures unique to your hospital. This agreement can alert the surgeon to any protocols you expect him or her to follow.

• **Require the surgeon to arrive at least 12 hours before the first scheduled procedure, or preferably 24 hours.** This time period will be enough for an orientation and rest.

• **Provide an orientation tour of the facility, with particular attention to the surgical area and the types of equipment that will be used for the procedure.** ■

With 0% surgical infection rate, improvement needed

Some process are identified as 'unreliable'

You might think that with a surgical-site infection (SSI) rate of 0%, you could rest on your laurels, but that's not the attitude of the quality professionals and staff members at Hawaii Medical Center East in Honolulu. Despite achieving such a "perfect" score, they decided to dig deeper and find additional ways to improve.

"Our baseline surgical-site infection rate in 2005 was 0%," recalls **Jennifer Watarai**, director of quality management. "This was attributed to our strong infection control practices. However, when we examined this in detail, we found alarming discrepancies between procedure standards and practice."

What were some of those discrepancies? "Pre-initiative results for administering antibiotics within one hour of incision were only 37%; selecting the recommended antibiotics was 77%; and discontinuing antibiotics within the recommended time frame was only 19%," Watarai reports. "Our medical center chose to work on this initiative since we did not have reliable processes in place to ensure that our surgical patients were receiving antibiotic prophylaxis appropriately. We wanted to do all that we could to minimize the risks of SSIs in our patient population."

An interdisciplinary committee was formed and tasked with leading the improvement efforts, says Watarai. The team included:

• nurse manager of ambulatory care services (ACS) and postoperative care unit (PACU);
• operating room manager;
• chief of surgery (physician champion);
• orthopedic surgeons;
• chief of anesthesiology;
• med-surg nurse manager;
• cardiovascular surgeon (co-chair and physician champion);
• director of quality management (co-chair);
• hospital administrator;
• cardiac catheter lab nurse;
• infection control nurse;
• pharmacists;
• clinical data analyst;
• health information management manager.

The team referenced a number of resources and tools used by other organizations, including:

• SCIP (Surgical Care Improvement Project) pilot package from Ohio KePRO, a Medicare quality improvement organization;
• guidelines for surgical prophylaxis at the University of Louisville (KY) Hospital;
• physicians order for adult preoperative antibiotic for surgical prophylaxis from Southwest General Health Center in Cleveland;
• "timeout" checklist form from Mountain Pacific Quality Health Foundation in Cheyenne, WY.

"Other resources were found at the Institute for Healthcare Improvement: 100,000 Lives Campaign — Preventing Surgical Site Infections web site," she adds. That site can be accessed at www.ihi.org/IHI/Topics/PatientSafety/SurgicalSiteInfections.

The facility adopted a perioperative antibiotic administration process similar to that instituted at Baystate Medical Center in Springfield, MA, where it decreased its SSI rate from 3.8% to 1.4%, notes Watarai. She says that "our objective was to implement reliable processes for appropriate and timely surgical antibiotic prophylaxis to prevent complications of infection from surgery and maintain our 0% surgical-site infection rate."

Watarai says several strategies were used to make sure the staff understood what was expected of them.

"We provided staff education on the SCIP through our medical center's "JCAHO WATCH" newsletter and posters posted in nursing units that highlight revised forms and orders," she says. "We also provided education and feedback on the SCIP to physicians through medical staff department meetings, the medical center's medical staff newsletter, and a poster placed in the OR physician's lounge that highlighted revised forms and orders. Additionally, we developed and implemented SCIP education for surgical residents during their orientation."

The project began with data collection on

SOURCE

For more information, contact:
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patients discharged on July 1, 2005, with project initiation in December 2005. Most of the actions were implemented by July 1, 2007, and efforts have been ongoing.

"We revised and implemented a space for systematic documentation of antibiotic administration on every patient chart, as well as revised existing pre-printed orders according to guidelines for the administration of prophylactic antibiotics," says Watarai. "We included the following in the preoperative checklist: prophylactic antibiotic ordered and sent with patient to OR" to be started in OR, except Vanco, Cipro, and Levo, she says. "White boards are used in the OR suites to document prophylactic antibiotic time, as well as to serve as reminders," Watarai says.

The SCIP team oversees and monitors the process and timeliness of surgical antibiotic prophylaxis and analyzes data, says Watarai. Findings are reported to and feedback is solicited from the OR Committee, Department of Surgery, Department of Anesthesia, Department of Cardiology, Department of EENT, nursing, and the Patient Safety Quality Council on a regular basis.

Here are some of the immediate "next steps" included in the process:

• Pharmacy will flag SCIP patients on the pharmacy computer system to trigger pharmacists to follow SCIP recommendations.

• Pharmacy will implement automated "hard" stops on all surgical prophylactic antibiotics after 24 hours or after 48 hours for coronary artery bypass surgery and other cardiac procedures.

• Revised pre-printed pre- and post-op orders will be posted in the PACU and ACS.

• Revised post-op orders will be placed in an accessible area in PACU.

• The revised post-op orders and pre-op checklist will be bundled with the revised pre-op orders.

• Nurse managers will discard outdated orders and place the revised pre- and post-op orders in their units.

• The SCIP education module for surgical residents' orientation will be updated.

• Two physician champions will personally hand-deliver to each surgeon a packet containing:

— surgeon's individual report card;
— pre-printed ACS pre-op orders;
— pre-printed pre-op orders;
— pre-printed post-op orders;
— information on how to appropriately document infection;
— information that post-op antibiotics are unnecessary;
— educational information on VTE prophylaxis;
— educational information on beta-blockers;

• The chief surgical officer will push to make pre-printed orders mandatory.

"Longer term, a computerized physician order entry system will be implemented with automated options/orders that are in compliance with SCIP guidelines," Watarai adds.

All of the team's goals have been accomplished, she reports. Dramatic improvements were made in administering antibiotics within one hour of incision from 37% to 100%, Watarai says. Selecting the recommended antibiotics went from 77% to 81%, and discontinuing antibiotics within the recommended time frame went from 19% to 63%.

"Most importantly," she concludes, "we were successful in maintaining our SSI rate at 0%." **(For more on this topic, see "Surgery programs reduce infections to zero, or close," *Same-Day Surgery*, June 2009, p. 56.)** ■

Same-Day Surgery Manager

Questions and answers on increasing cash flow

By **Stephen W. Earnhart**, MS
CEO
Earnhart & Associates
Austin, TX

Question: Over the past eight months, we have noticed a huge drop in collections from our patients' copay insurance. We are struggling as a result of this cash flow issue. How are others dealing with this dilemma?

Answer: First, you are not alone. That's some

comfort anyway. There is a difference between patients who do not have insurance (self-pay) and the patient responsibility of their insurance (copay). There is a big difference in how you handle the two. You can negotiate the self-pay patient to collect as much as you think you can get up front. However, with the copay patient, you have to make attempts to collect — part of your deal with the insurance carrier. Your solution is that you absolutely need to collect this money up front before surgery. You have earned it. It is yours. You have a right to expect it.

Question: After your article last month, our team sat down and explored new sources of revenue. We discovered that, on average, our facility fees were about $200 higher than the other surgery center in town. As a result, almost all the plastic surgeons use that center. We are trying to come up with a marketing strategy to entice them to our center as we have lower turnover time, higher patient satisfaction, and a nicer facility than the competing center. Thoughts?

Answer: Your marketing strategy is to lower your cost by $250. During these "interesting times," sometimes the only thing that matters is more money in the surgeons' pockets by lowering fees for his/her patients.

Question: We just opened our new center. While we build our volume, we have excess staff on hand, as we want to accommodate a surgeon that might want to book cases. Our management company is telling us we have to lay off that staff until cases increase. We showed them your article about not focusing on expenses but rather revenue. They laughed at your suggestion and want to know if you are going to pay for our staff. Now what?

Answer: You have a great opportunity to use your excess staff to go out and "market" your center to area surgeons. Don't wait for them to respond to your fliers. Send the staff out in teams and hit every office in your community. Let the surgeon know what you have to offer, but spend the time with their staff that actually book the cases. Send the profits from those cases to me.

Question: Can our center bill do the billing for our anesthesia personnel?

Answer: Of course. You have most the demographic information to do the billing anyway. Your anesthesia staff are probably paying about 6%-8% to someone else to bill for them. Offer to do it for 5%. Based upon your numbers (we talked), that will add about $120,000 to your bottom line. This is a good way to expand your revenue with minimal additional costs.

Question: We are booked solid on Fridays and Mondays in our surgery department, mostly with plastic cases. As a result, we have to turn away higher-revenue cases for those days. We are light on the other days of the week, but the surgeons don't want those blocks because they compete with their block at other locations. The plastic surgeons don't want to give up their time on Friday and Mondays, but their blocks are more flexible. Ugh! We cannot afford to run off the plastics but need to get the other surgeons in. Any ideas that focus on revenue for us?

Answer: Offer your plastic surgeons a 20% reduction in your fees if they will do their cases on Tuesdays, Wednesdays, or Thursdays. Since most aesthetic cases have a narrow profit margin anyway, this change is equivalent to a 20% raise for the surgeons. They will switch, and you will more than make up for that revenue with the other surgeries that will fill that gap.

Question: I need to come up with some additional revenue sources for our facility. Got any ideas? My equipment budget is zero, so it has to be something that doesn't cost me anything.

Answer: Tattoo removal. There are firms out that supply the equipment, and I think the break-even is about eight cases per month. If you have been to the beach lately, you can see why this procedure has potential, for many reasons! **(For more information, see "Permanent isn't forever — Tattoo removals increase," *Same-Day Surgery*, December 2007, p. 141.)**

[Editor's note: What ideas has your outpatient surgery program developed for surviving the economic downturn? Contact Joy Daughtery Dickinson, Editor, at joy.dickinson@ahcmedia.com. Phone: (229) 551-9195. Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 13492 Research Blvd., Suite 120-258, Austin, TX 78750-2254. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.] ■

Hepatitis outbreaks underscore ongoing risk

Recent outbreaks of the hepatitis C virus (HCV) are a wake-up call to boost infection control practices. But they also underscore the prevalence of HCV and the continued occupational risk.

A review of investigations by the Centers for Disease Control and Prevention (CDC) revealed

that health care facilities have contacted more than 60,000 patients and asked them to be tested for hepatitis B due to the failure of health care workers to follow proper infection control practices. There were 33 outbreaks in outpatient clinics, hemodialysis centers, and long-term care facilities, resulting in transmission of HCV or hepatitis C to 450 people.[1] **(See "Centers come under tighter scrutiny for infection control practices," *Same-Day Surgery*, March 2009, p. 21.)**

The outbreak scenarios included cases in which health care workers reused syringes on multiple patients or contaminated multidose vials by reusing a syringe. This spring, Veterans Affairs (VA) centers in Florida, Tennessee, and Georgia began notifying and testing thousands of patients for hepatitis B and C and HIV who had been exposed to endoscopy equipment that was not properly disinfected. **(See "Steps to help ensure proper reprocessing — VA incident gets lawmakers', lawyers' attention," *SDS*, July 2009, p. 68.)**

Infection control lapses raise concern about an overall lack of safety, say safety leaders. "If you've got a facility that's not practicing according to basic standards of safety and infection control, in terms of patient-to-patient transmission, then the chances are probably pretty good that they're not attending to worker safety either," says **Jane Perry**, MA, associate director of the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville.

There have been no recent prevalence studies of health care workers and hepatitis C, although past studies did not show an elevated rate. But a recent CDC analysis of death certificates indicates that health care workers have an occupational risk. Twenty years of data (1984 to 2004) from the National Occupational Mortality Surveillance System found that female health care workers have a 20% greater risk of dying from hepatitis C than women in other occupations. Male health care workers have a 50% elevated risk.[2]

Sara Luckhaupt, MD, medical officer in the surveillance branch of the Division of Surveillance, Hazard Evaluation, and Field Studies at the National Institute for Occupational Safety and Health (NIOSH) in Cincinnati, says, "Our data doesn't link any of these deaths to specific occupational incidents." However, the consistency of the HCV finding was telling, Luckhaupt says. "Since we found the association for both males and females [with HCV], it made us more suspicious that there was an occupational risk," she says.

An estimated 4 million Americans have a chronic hepatitis C infection, but because many of them aren't aware of the infection, HCV has been called "the hidden epidemic."

The National Health and Nutrition Examination Survey (NHANES), which had about 15,000 participants from 1999 to 2002, found peak prevalence in the 40-49 age group. Almost two-thirds (63%) of those who tested positive for HCV RNA said they had never been told they had "any kind of liver condition."[3]

In some settings, the prevalence of HCV might be significantly higher than the national estimate of 1.6%. For example, a VA study of 1,288 veterans in 20 medical centers found a prevalence of 5.4%.[4]

The CDC needs to do more prevalence studies of HCV, including studies of health care workers and their patients, asserts **Robert T. Ball Jr.**, MD, MPH, infectious disease epidemiologist with the South Carolina Department of Health and Environmental Control in Charleston. Health care workers also need to understand the relative risks of bloodborne pathogen exposure, Ball says.

Although studies show a seroconversion rate of about 0.5% after an exposure to HCV, the higher prevalence is a concern, he says. "Anytime a health care worker gets an exposure from a splash or a stick, the overall likelihood of the source having hepatitis C is five times greater than the source having HIV," says Ball.

Tara MacCannell, PhD, health care epidemiologist in the Division of Healthcare Quality and Performance at the CDC, says because there is no vaccine as there is for hepatitis B and no post-exposure prophylaxis as there is for HIV, "we really stress prevention."

The Occupational Safety and Health Administration (OSHA) requires annual training on bloodborne pathogens. Health care-related transmissions underscore the importance of that training, which should include information about HCV.

CDC leaders have vowed to conduct better surveillance of HBV and HCV and to support educational outreach. The Safe Injection Practices Coalition, a group that includes organizations representing nurse anesthetists, infection control professionals, ambulatory surgery centers, and patients, is promoting the One & Only Campaign to emphasize the single use of syringes and needles. **(For more information, see "Infection Prevention Laws on Horizon — Needle Safety Campaign Launched," *SDS Weekly Alert*, Feb. 13, 2009. To subscribe to the free weekly ezine, go to www.ahcpub.com. In the box on the left side of the page, see "Subscribe to one of our free E-newsletters here.")**

Being proactive is critical, says MacCannell. Due to the nature of HCV infection, "it may be years before you detect that there are deficiencies in training or workplace practices," she says.

At the same time, it is critical to include needle safety in the education about safe injection practices, says Ball. "Remind health care workers that their needlestick risk [of contracting HCV] is significant," he adds.

References

1. Thompson N, Perz JF, Moorman AC, et al. Nonhospital health care-associated hepatitis B and C virus transmission: United States, 1998-2008. *Ann Intern Med* 2009; 150:33-39.
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4. Dominitz JA, Boyko EJ, Koepsell TD, et al. Elevated prevalence of hepatitis C infection in users of United States veterans medical centers. *Hepatology* 2005; 41:88-96. ■

Center gets best ideas from its patients

Survey, staff help it reach 98% satisfaction

Do you want to make changes needed to keep your patients happy, but unsure what needs to be changed? Ask them!

At St. John's Clinic: Head & Neck Surgery in Springfield, MO, patients are sent home with a survey and a self-addressed stamped envelope, says **Lynda Dowman-Simon**, RN, the OR manager. The survey asks questions such as "What did you like most?" and "What did you like least?" Also, patients are asked to rate the center on a 1-5 scale on a variety of areas. **[The survey is included with the online version of this newsletter. If you need assistance, contact customer service at customer service@ahcmedia.com or (800) 688-2421.]**

"Whenever I get back, on the 1-5 scale, one that has a low number, 1 or 2, I call and find out what was the problem with that one thing," Dowman-Simon says.

An area at the bottom allows patients the option to write in their names and phone numbers. The survey also includes Dowman-Simon's name and phone number for those patients who prefer to talk by phone. When Dowman-Simon receives a completed survey, she sends a thank-you note and a $25 gift certificate. This reward has resulted in a return rate of approximately 50%.

RESOURCE

The panic button used at St. John's Clinic: Head & Neck Surgery in Springfield, MO, is an earlier version of what is now the ProCare 1000 System from GE Healthcare. The price range is $300-$950 per room. To e-mail for more information, go to www.gehealthcare.com/contact.html.

Many of the suggestions have been small and quickly implemented, such as adding seats to the waiting room and adjusting the room temperature, Dowman-Simon says. One major change was made in response to a parent's suggestion after his 6-year-old son had a reaction to medication and woke up "wild" after surgery, she says. It took five staff members to hold him down, Dowman-Simon recalls. They wanted to bring his dad in the room, to see if a familiar voice would calm him down; however, "we couldn't leave him because he woke up so agitated," she says.

As soon as the medication started to wear off and the child began to calm down, the father was notified. His response was, "Why didn't you get me sooner?"

As a result, the center installed a "panic button" in recovery. "It's within arm's reach," Dowman-Simon says. Now, if a staff member needs help, he or she can push the button, which makes a whistling sound. "We wanted one that would alert people in the surgical suite, but not alarm patients," she said. "We wanted to be sure to have a sound, different from the beep of a call light, that notified the OR we needed help in recovery stat!"

Another consideration was that the sound not be overheard in the waiting room. **(For information on ordering a panic button, see resource box, above.)**

When technicians hear the sound and aren't scrubbed in, they can assist by locating the family and providing information. The center has had to use the panic button only once, when a young girl woke up agitated. It assisted the staff in locating her mother and getting her back to the area quickly.

Changes such as the panic button have helped the center achieve higher than 98% patient satisfaction. "We're real proud of that," Dowman-Simon says. "We produce anxiety, send people home in pain, because they've had surgery, but to produce that kind of satisfaction is quite an homage to our staff. They go the extra mile for our patients. You

can't get those kinds of number without terrific caregivers." ■

Avoiding wrong-site surgery for 5 years isn't long enough

Hospital implements tools for improvement

You would think that going five years without an incident of wrong-site surgery would bring contentment to any surgery program. At Beth Israel Deaconess Medical Center in Boston, however, leaders are constantly trying to improve, so they have incorporated a script, poster, and checklist into their surgery processes.

Donald W. Moorman, MD, associate surgeon in chief, and **Charlotte Guglielmi**, RN, BSN, MA, CNOR, perioperative nurse specialist, spoke about Beth Israel's changes at the recent "Perioperative Safety Symposium: Improving, Enhancing, and Sustaining Positive Patient Outcomes" sponsored by Joint Commission Resources (JCR) and the Council on Surgical and Perioperative Safety (CSPS).

After several episodes of wrong-site surgery in the early part of this decade, Beth Israel leaders implemented a multiyear training program that incorporated an interdisciplinary, team-based format, Moorman says. "We wanted to build work flow into our policies," he said. "Based on that, we've had no wrong-site surgery in over five years or any major adverse event in the OR."

A timeout script was created by the Operational Task Force on Safety, Moorman says. The task force, which meets biweekly, includes Guglielmi, clinical nurses, surgical techs, high-volume attending surgeons and clinical anesthesiologists. Guglielmi says, "There are no solutions unless you engage the people who deal with it every day."

The script, which has been in place about six months, declares the elements of the timeout and who needs to articulate them at the point of care, she says. **[The script is available with the online version of *Same-Day Surgery*. For assistance, contact customerservice at customerservice@ahcmedia.com or (800) 688-2421.]** The script is mirrored in the electronic documentation system, Guglielmi says. **(See timeout screen in the online version of *SDS*.)** If the timeout isn't documented, "a nurse cannot enter an incision time into the system without an override," she adds.

Note that with electronic medical records, some defense attorneys are examining the electronic time entry to be certain that critical data, such as the timeout, are not entered after a problem occurs, sources say.

Another positive change that came out of the task force is that the hospital has posted posters that say, "Attention all team members. Please turn off the radio until the final timeout is completed. Thank you."

The same policy applies for MP3 players, Guglielmi says. **Marsha Maurer**, RN, MS, senior vice president, patient care services, and chief nursing officer at Beth Israel, refers to the timeout as a time of reverence, she says. Everyone should be listening to each other and paying attention, Guglielmi says. "You can't do it if there's a lot of noise around you," she says.

Additionally, a checklist has been developed for time outs based on materials from the World Health Organization, the Centers for Medicare & Medicaid Services, and The Joint Commission. Although the checklist only takes about one minute to complete,

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- Advantages of patient tracking systems
- Ideas that work: Reducing risk of infections
- Computerized discharge home medication order
- Center reduces supplies, saves tens of thousands

some staff members seem to be getting more lax in paying attention, Moorman says.

"We'll be doing observations of scripted timeout, to see if people are actually more engaged and actively participating in a meaningful way to create a patient safety-centered envelope around the procedure," he says. ■

CNE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

5. According to Arun Ravi, how long should a locum tenens surgeon arrive before surgery?

A. At least six hours before the first scheduled procedure, or preferably 12 hours.
B. At least 12 hours before the first scheduled procedure, or preferably 24 hours.
C. At least 24 hours before the first scheduled procedure, or preferably 36 hours.
D. None of the above

6. What does Stephen W. Earnhart, MS, recommend as an additional revenue source with a zero equipment budget?

A. Liposuction
B. Facial plastic procedures
C. Tattoo removal
D. LASIK

7. What did a recently analysis of death certificates by the Centers for Disease Control and Prevention (CDC) indicated about the occupational risk of health care workers regarding hepatitis C?

A. Health care workers have an occupational risk: Female health care workers have a 10% greater risk of dying from hepatitis C than women in other occupations. Male health care workers have a 20% elevated risk.
B. Health care workers have an occupational risk: Female health care workers have a 20% greater risk of dying from hepatitis C than women in other occupations. Male health care workers have a 50% elevated risk.
C. Health care workers do not have an occupational risk.

8. On the patient survey at St. John's Clinic: Head & Neck Surgery, how are patient ratings of 1 or 2 on a 5-point scale handled?

A. The OR manager calls to find out what the problem was with that item.
B. The data are compiled and given to staff quarterly.
C. The data are posted on a bulletin board and in the center's newsletter.
D. Patients are sent a note of apology.

Answers: 5. B; 6. C; 7. B; 8. A.

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Beth Israel Deaconess Medical Center

Time-out Script

A teaching hospital of Harvard Medical School

Time-out occurs after draping unless an explicit exception is documented (i.e. eye)

Scrub person: None of the 4 I's on the Mayo Stand

1. ***Incision:*** **No blade mounted on the knife handle. No tip on the ESU pencil**
2. ***Infiltration:*** **No needle mounted on syringe for local**
3. ***Insertion:*** **No Speculum or Bronchoscope**
4. ***Initiation:*** **None of the above apply to start of procedure**

ALL MEMBERS OF THE TEAM STOP AND PARTICIPATE

WHO	WHAT TO SAY	WHAT TO DO
CIRCULATOR:	Ready to do Time-out	RN at computer with consent in hand.
ALL:	Yes	Stop activities. Turn radios other devices off.
CIRCULATOR:	Patient's name & MRN	Review name and MRN on computer screen & the consent.
ANESTHESIA PROVIDER:	Jane Doe; MRN# 123456	Review the ID Band *
SURGEON:	Confirms patient's name	
CIRCULATOR:	Allergies	View allergies on PIMS screen.
ANESTHESIA PROVIDER:	Lists allergies or declares none	
SURGEON:	Verbally affirms	
CIRCULATOR:	Antibiotics	
ANESTHESIA PROVIDER:	Name of antibiotic and time completed	Verify documentation in AIMS and time of next dose.
SURGEON:	Verbally affirms	
CIRCULATOR:	DVT prophylaxis Declare name of med given or state not applicable. Declare the pneumatic boots have been applied and are activated or state not applicable.	
CIRCULATOR:	Verification of Procedure	Review consent for accuracy.
SURGEON:	Name of procedure including site and side. (i.e. Right ORIF of the Ankle)	
CIRCULATOR:	Site marking	
SURGEON/DESIGNEE: **	Affirms location of mark or state not applicable.	ALL visualize the mark. Remark site if marking removed during prep process.
CIRCULATOR:	Position	
SURGEON:	Affirms that the patient is in the correct position.	
CIRCULATOR:	Implants and instruments or personnel that have been requested are present or declares the plan to secure them.	Calls out to clinical advisor for assistance in solving the named discrepancy.
SURGEON:	Are all of the requested implants and additional personnel requested in the room or in progress?	
SCRUB:	Names implants, instruments or personnel that have been requested are present or declares the plan to secure them.	
CIRCULATOR:	Please confirm the radiological images.	
SURGEON:	Images present and displayed correctly and patient's name and MRN have been verified.	
CIRCULATOR:	Is there anything else we need to disclose.	Records comments if any.
SCRUB:	Declare one of the 4 I's is ready.	Prepares one of the 4 I's.
ALL:	Respond as needed (may include special precautions).	

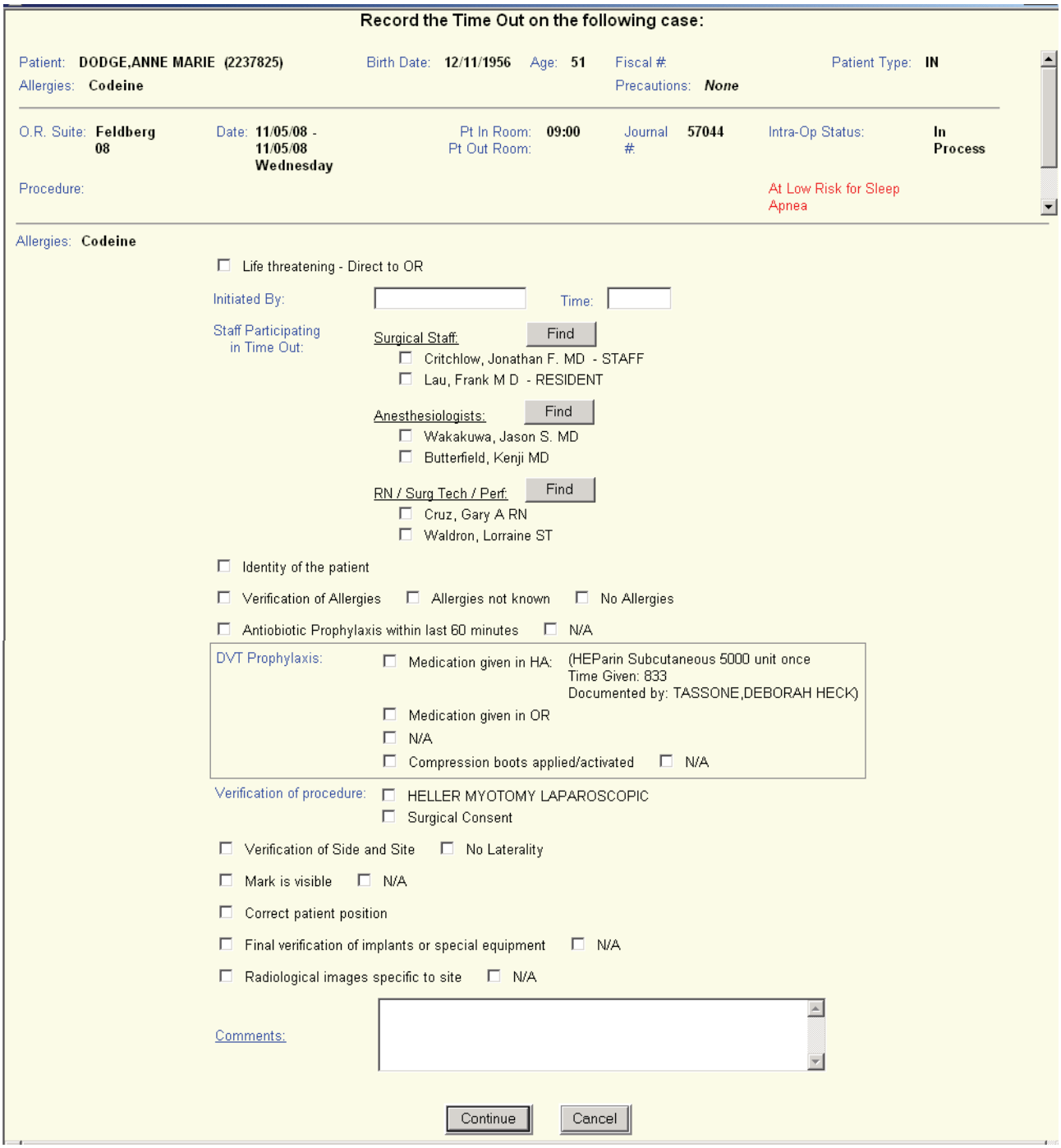
* Anesthesia Provider and Circulating Nurse attest that the verification has occurred if ID not accessible during the Time-out.

** Surgeon/Designee = Licensed Individual Provider who marked the site.

Central line insertions are exempt from Universal Protocol in accordance to outpatient central line guideline.

Source: Beth Israel Deaconess Medical Center, Boston.

BIDME Perioperative Services Revised Timeout Screen



Record the Time Out on the following case:

Patient: **DODGE,ANNE MARIE (2237825)** Birth Date: **12/11/1956** Age: **51** Fiscal #: Patient Type: **IN**
Allergies: **Codeine** Precautions: ***None***

O.R. Suite: **Feldberg 08** Date: **11/05/08 - 11/05/08 Wednesday** Pt In Room: **09:00** Pt Out Room: Journal #: **57044** Intra-Op Status: **In Process**

Procedure: At Low Risk for Sleep Apnea

Allergies: **Codeine**

☐ Life threatening - Direct to OR

Initiated By: Time:

Staff Participating in Time Out:

Surgical Staff: Find
☐ Critchlow, Jonathan F. MD - STAFF
☐ Lau, Frank M D - RESIDENT

Anesthesiologists: Find
☐ Wakakuwa, Jason S. MD
☐ Butterfield, Kenji MD

RN / Surg Tech / Perf: Find
☐ Cruz, Gary A RN
☐ Waldron, Lorraine ST

☐ Identity of the patient

☐ Verification of Allergies ☐ Allergies not known ☐ No Allergies

☐ Antiobiotic Prophylaxis within last 60 minutes ☐ N/A

DVT Prophylaxis:
☐ Medication given in HA: (HEParin Subcutaneous 5000 unit once
Time Given: 833
Documented by: TASSONE,DEBORAH HECK)
☐ Medication given in OR
☐ N/A
☐ Compression boots applied/activated ☐ N/A

Verification of procedure:
☐ HELLER MYOTOMY LAPAROSCOPIC
☐ Surgical Consent

☐ Verification of Side and Site ☐ No Laterality

☐ Mark is visible ☐ N/A

☐ Correct patient position

☐ Final verification of implants or special equipment ☐ N/A

☐ Radiological images specific to site ☐ N/A

Comments:

Continue Cancel

Source: Beth Israel Deaconess Medical Center, Boston.

MERCY
ST. JOHN'S
HEALTH SYSTEM

HEAD & NECK SURGICAL CENTER
PATIENT SURVEY

	very poor	poor	fair	good	very good
1. Information the physician gave you about your surgery	1	2	3	4	5
2. Courtesy/professionalism of person scheduling surgery	1	2	3	4	5
3. Instructions given to you to prepare for surgery	1	2	3	4	5
4. Admission process on the day of your surgery	1	2	3	4	5
5. Instructions given to you for follow-up care after surgery	1	2	3	4	5
6. Courtesy/professionalism of your physician	1	2	3	4	5
7. Courtesy/professionalism of the nursing staff	1	2	3	4	5
8. Courtesy/professionalism of your anesthesiologist	1	2	3	4	5
9. Our concern for your privacy	1	2	3	4	5
10. Overall rating of care received during your surgical visit	1	2	3	4	5
11. Likelihood of recommending this facility to others	1	2	3	4	5

What did you like most about the surgery center? _____

_____

Were there any situations or problems you did not anticipate? _____

_____

How can we improve our service at the surgery center? _____

_____

Do you have any comments for the surgery center staff? _____

_____

_____

IF YOU WOULLD LIKE TO DISCUSS ANY ASPECT OF YOUR STAY AT THE SURGERY CENTER FEEL FREE TO CALL OUR MANAGER, LYNDA SIMON, RN AT 417-820-5089 (MON THRU FRIDAY 8AM-5PM)

_____

Patient name and phone number (*OPTIONAL*)

REVISED: 10-2002 (LDS)

Source: St. John's Clinic: Head & Neck Surgery, Springfield, MO.