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Minimally invasive surgery prevails — but is it as safe as you think it is?

Congressman's death makes providers re-examine procedures

Sometimes in the rush to adopt new surgical approaches that allows less scarring and quicker discharge, an important fact becomes lost: Minimally invasive procedures are serious surgery with inherent risks and potentially deadly postoperative complications. This lesson was brought to the forefront recently with the death of U.S. Rep. John Murtha (D-PA). He reportedly died after undergoing laparoscopic cholecystectomy and developing an infection.[1]

Laparoscopy has its limitations, emphasizes **Michael S. Kavic**, MD, director of education and general surgery at St. Elizabeth Health Center, Youngstown, OH, and associate dean for clinical education, professor of surgery, and vice chair in the Department of Surgery, Northeastern Ohio Universities College of Medicine, Rootstown, OH. Laparoscopy converts three-dimensional reality to a two-dimensional screen, he points out.

"We're taking blood and guts and converting it to bits and bites," he says. "That's a bit of a disadvantage."

In lap chole, the surgeon could be exerting force on an organ outside

EXECUTIVE SUMMARY

The death of U.S. Rep. John Murtha (D-PA), who developed an infection after laparoscopic cholecystectomy, has put attention on the risks of minimally invasive surgery.

- Informed consent should include an understanding of risks, alternatives and their risks, and reasonable expectations. Patients must thoroughly inform physicians about their medical history, including previous surgeries.
- Patient and family education must emphasize that the physician wants to be contacted if there is pain accompanied by post-op complications such as fever.
- Ensure criteria are met for appropriate discharge.
- Physicians must be willing to examine patients with postoperative complications, particularly in the first week or so after surgery.

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the field of view and be unaware of any damage, Kavic says. The risks are multiplied if the patient has had several previous surgeries and there are adhesions around the target organ, he says. One problem that is of particular concern to outpatient surgery providers is that complications might not manifest themselves until one to seven days after surgery, Kavic says.

"The patients can go home feeling halfway decent, and a few days later, they get symptoms — chills and abdominal pain, which are signs of systemic infection," he says.

There are steps that outpatient surgery programs can take to minimize the risks during minimally invasive surgery, according to Kavic and other experts. They include:

• **Thorough informed consent.**

Laparoscopic surgery is usually safe, "but unfortunately it's not 100% safe 100% of the time," Kavic says. Patients must be informed of the risks, the alternatives and their risks, and what should be a reasonable expectation, he adds. Patients must understand this information, Kavic says. Additionally, it's important for patients to inform physicians thoroughly about their medical history, including any previous surgeries, he says.

The issue of previous surgeries is an important one, particularly because many procedures that formerly were performed inpatient are moving to the outpatient arena, says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Healthcare Risk Consultants in Haslett, MI. Patients should be questioned as to whether they had any problem in recovery or whether they developed complications after previous surgeries, he says.

"I think they need to know does the person have any allergies with anesthesia or ever had any problems with anesthesia in the past," he says. "Does the person have any heart-related issue or problems that should be known about and taken into consideration?"

• **Thorough patient education.**

Patients must understand that even with minimally invasive procedures, injuries can occur, Kavic says. "Video game-like surgery doesn't mean it doesn't have risks and complications associated with it," he says. "Patients have to know that."

The discharge instructions should include symptoms of common complications and what patients should do if they experience those symptoms, says **Waldene K. Drake**, RN, MBA, vice president of risk management and patient safety for Cooperative of American Physicians in Los Angeles. "Also on that education sheet, the patient needs to be given a 24-hour number to call or told what symptoms require that they go to an ED," she says.

Patients must be alerted to notify providers if they experience pain associated with any other symptoms such as fever, nausea and vomiting, racing heart rate, and/or shortness of breath, Kavic says.

Convince patients and their families you want to hear from them if anything's not perfect, says **Steven D. Schwaitzberg**, MD, chief of surgery

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at Cambridge (MA) Health Alliance and associate professor of surgery at Harvard Medical School, Boston. Schwaitzberg also is the incoming president-elect of The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES). "Patients, when you talk to them, might not remember a list, or they may lose a piece of paper, but if they know the doctor wants them to call if anything is wrong, that's perhaps the single most important thing they can remember," Schwaitzberg says.

• Use your discharge criteria.

When performing a retrospective examination of surgical complications that show up after discharge, consider whether the patients were sent home appropriately after meeting discharge criteria, Schwaitzberg says.

It's important to not only have a discharge system with criteria, but to use the system, he emphasizes. "Discharge criteria were developed to catch people who are demonstrating objective signs of early complications," Schwaitzberg points out.

Pay attention to post-op checklist

Staff members must pay attention to every line on their postoperative checklist, Drake emphasizes. "These are the standard of care for postoperative nursing care, and if abnormalities are charted but not acted upon, the care is hard to defend, and a complication may not be recognized early enough," she says.

Also pay attention to the patient's complaints, Drake says. "For example, pain can be brushed aside as incisional pain when it may be an early warning of injury to an internal organ or numbness due to nerve injury may be brushed away as a residual to the cuff which was in place during surgery," she says.

• Physicians must examine any patient with post-op problems.

Whoever is taking calls from patients postoperatively, whether they are office managers or nurses, needs to err on the side of patients being examined rather than assume a problem is inconsequential, says **L. Michael (Mike) Brunt**, MD, professor of surgery at Washington University at St. Louis.

Patients who have a significant problem other than pain, such as nausea and vomiting, unable to tolerate anything by the mouth, gas, or fever, and patients who have generalized pain through the abdomen, should be treated differently from patients who simply have pain at the incision site, Brunt says. "The challenge is to differentiate significant issues from those that can be handled over the phone," he says.

Schwaitzberg concurs and says physicians should have a low threshold for examining those patients who call, Schwaitzberg says. "The answer is always the same: Come in, and study them," he says. "Most exams will result in nothing more than reassurance, but the one time you find something, it may be life-saving."

This willingness to examine patients is particularly important in the first week or so after surgery, Schwaitzberg says. Whether the exam is done in the emergency department or the physician's office, "it's important for someone to put their eyes on the patient and make sure there is not an acute surgical problem," he says.

• Staff education.

At your staff meetings, include case studies about procedures that "went wrong," including early warning signs that were missed and the outcome, Drake advises. "Everyone learns from real life cases," she says.

Minimally invasive procedures have become commonplace, Schwaitzberg says, and "familiarity breeds contempt."

"Just because I've done a 1,000 in a row doesn't mean the next one can't be injured," he says. "Vigilance should be part of the DNA of everybody who does invasive procedures."

REFERENCE

1. Neergaard L. Lawmaker's death a reminder of surgery risks. Feb. 9, 2010. ■

Can you survive being out of network?

How to win as David in a Goliath world

It is viable for your facility to be out of network in a world dominated by powerful insurance payers? The answer is a definite . . . maybe.

"It depends on the market, the payers, and the physicians," says **John R. Seitz**, CEO and founder of Ambulatory Surgical Group (ASG), an El Segundo, CA-based company that develops and manages surgery centers without the prerequisite of purchasing equity. "There are still many markets, including California, where the differential between the in-network and out-of-network rates are so significant that you need to really look at it," he says.

EXECUTIVE SUMMARY

While ED managers are intimately involved in the emergency planning processes of their hospitals, they are often unaware of how other EDs and facilities are planning for events that will affect them all. The recently announced National Health Security Strategy seeks to address that problem.

- Pay special attention to the objectives that address

Being out of network causes more work for your staff and some hassle for patients, he says. Additionally, the billing staff need to know how to handle balance billing and any write-off amounts, Seitz adds. "As always, you need to know your cost, know your margins, and understand your contracts," he says.

Payers have attempted to make it difficult for ambulatory surgery centers and other providers to remain out of network, says **Thomas J. Pliura**, MD, JD, PC, physician and attorney at law in Le Roy, IL. "The legality of those steps taken remain to be seen," says Pliura, who noted that several lawsuits are being tried.

Unless you challenge payers, they can make life difficult for out-of-network providers, he says. "They're doing things like asking the doctor to sign a sheet on every patient, if you want to provide surgery in an out-of-network facility," Pliura says. "We could have never envisioned that."

In essence, payers are selling a PPO product to patients, with the perception that patients have a choice to go out of network, he says. However, they charge patients a higher fee for that choice and adopt internal procedures that effectively prohibit patients from going out of network, Pliura says. For example, when patients seek preauthorization, the payer representative will say, "That's not an authorized surgery center," he says. "It's very vague what constitutes an authorized surgery center," Pliura adds.

Payers will scare patients with threats that they will be responsible for larger portions of the bill if they go out of network, regardless of what that provider might have chosen to charge that out-of-network patient for the surgery, he says. And in what Pliura calls "one of the most egregious situations," payers have developed two fee schedules for approved fees, "so in essence, they're setting a fee schedule that is lower for out-of-network facilities than in-network facilities." (**For tips on surviving being out of network, see story, right.**)

While patients might be willing to pay 40% of a bill for the benefit of having a choice in where they go, "in reality, that's just the appearance of choice," Pliura says. "They adopt additional copays and deductibles, adopt a fictional fee schedule that would say: Even if you want to go out of network, in essence, you'll pay the entire fee."

Going out of network is practical if the insurance company pays you based on a reasonable rate, and your state allows you to go out of network under anti-fraud acts, says **Beverly A. Kirchner**, RN, BSN, CNOR, CASC, CEO and president of Genesee Associates, a Highland Village, TX-based company owned by nurses that develops, manages, and consults with hospitals and physicians to develop freestanding surgery centers. Kirchner says there are times you have to go out of network because what some payers offer "is too low to survive." For example, companies that pay 125% of Medicare and less than Medicare on some claims are not worth working with, she says.

When looking at whether you can accept payers' rates, there are several costs to consider, including equipment, malpractice insurance, and utilities, Pliura says. "Every surgery center is different geographically, economically, and in their service area, it depends on what the malpractice rate is and facility costs are," he says.

Many managers are saying that they can't accept Medicaid rates for commercial patients, "and that's where we're headed," Pliura says. "Every surgery center needs to know that number where it becomes financially irresponsible to say, 'I'll accept these rates for this particular procedure across the board,' because at some point, I'm going so low, I'm losing money on every case."

Each provider must face this decision, Pliura says. The question is, "Am I better off? Or I can see fewer patients and make more money than running myself ragged and losing money on patients?" he says.

Out-of-network status will be a part, though probably a smaller part, of the outpatient surgery world for years to come, Seitz says. "You need to know how to contract, how to analyze what you are getting paid, and where the trade-offs are," he says. ■

Pieces of ammunition in the out-of-network war

When considering out-of-network status, beware of rate-limiting plans, says **Beverly A. Kirchner**, RN, BSN, CNOR, CASC, CEO and president of Genesee Associates, a Highland Village,

TX-based company owned by nurses that develops, manages, and consults with hospitals and physicians to develop freestanding surgery centers.

Recently, Kirchner opened a new surgery center in the south and was approached by a payer. The payer said there would be no negotiation, she says. "We decided to wait until we had been open a few months, so we understood our cost and types of cases we were going to perform that might need to be carved out," Kirchner says.

The payer did not inform the center that it had one fee schedule for ambulatory care and that if the center stayed out of network, they would penalize the center by taking 30% off the in-network fee schedule, she says. Subsequently, the payer didn't follow its own policy and instead imposed a 50% penalty on most cases and even more on others, Kirchner says.

"Our attorney informed us we had no leg to stand on in court since we did not have a contract," she says. "When does it become right that a managed care company can tell us what we are worth and what our costs are to provide care? When is it right for a managed care company to not event attempt to negotiate in good faith?"

Beware of the abbreviations MNRP, NAP, and FAC when you see them on a patient's insurance card, says **Catherine A. Meredith**, RN, CASC, vice president of finance for Hanover, MA-based Ambulatory Surgical Centers of America. They are reimbursement rate-limiting plans, she warns. "Insurance companies are selling these plans at lower premiums," she says. "The insurance company is fixing the out-of-network reimbursement to around 110% of Medicare."

Consider these other suggestions:

• Surgeons should review their contracts carefully.

Around the country there are reports of physicians being pressured or threatened to refer in-network. Several insurance companies have clauses in their physician contracts that they must use a participating (par) provider unless the service is not offered, Meredith says. "Physicians were using our center who were out of network with the payer, and the payer sent certified letters threatening to cancel their par status if they continued using our surgery center," she says. "Of course, by the time they enforced that clause, they had reduced out-of-network allowables down to in-network rates."

This problem is difficult to address if the physicians have executed a contract with the payer, Meredith notes. "Many times, the physicians have no idea that this clause exists," she says.

• Get your patients involved.

When doctors are being pressured to refer in network, consider getting your patients involved, suggests **Kathy Bryant**, president of the Ambulatory Surgery Center Association.

"In some cases, you can talk to patients and get them to weigh in with their insurers," she says. "You're clearly in a difficult situation. Most doctors are going to be concerned about going against the insurance company."

Beware of rental or leasing networks in which providers are given access to a payer and its members in return for discounted services.

Managers at the health care facility might think they are going to receive 80% of billed charges, Meredith says. "The 80% comes off the allowable, not the billed charges," she says. In other words, the provider receives 80% of what the primary insurance sends to the rental companies as their reimbursement.

• Address assignment of benefits.

Out-of-network providers should have patients sign an agreement saying all payments go to the center, says **John R. Seitz**, CEO and founder of Ambulatory Surgical Group (ASG), an El Segundo, CA-based company that provides development and management of surgical centers without the prerequisite of purchasing equity.

"This needs to be clearly discussed with the patient," Seitz says. "The surgeon must be completely on board and willing to intervene if necessary."

Kirchner has heard of some facilities that take a predated check for the amount the patient is estimated to owe. The facility cashes the check it if the patient does not bring in the insurance check. "Our attorney tells us this is illegal," Kirchner says. ■

Medical center slashes late starts, long turnovers

In 2008, Heartland Regional Medical Center in St. Joseph, MO, was struggling with late start times, long turnovers, and elective cases that sometimes stretched to 4 a.m. The patients, surgeons, and staff were unhappy, so the administrators determined the root causes of the problems with the help of a surgical oversight committee composed of surgeons, anesthesiologists, and managers.

The successes have been dramatic, according to Press Ganey Associates, which featured the hospital

EXECUTIVE SUMMARY

Heartland Regional Medical Center in St. Joseph, MO, has significantly improved its on-time a.m. starts, turnover time, and block utilization and decreased overtime.

- Physicians and managers are appointed to a surgical oversight committee that meets twice monthly. Physicians with complaints or comments must submit a request sheet first. **(The request sheet is available with the online issue.)**
- Surgical blocks were examined for actual use and actual case duration and adjusted.
- Another committee set guidelines for on-time starts, and penalties were implemented for noncompliance.

in a recent publication.[1]

"We are starting on time," says **Connie M. Stanton**, RN, team leader of post-anesthesia care and same-day-care units. "Our a.m. starts have been at 80% since July 1, 2009." The hospital's wait time before procedure is at the 84th percentile, she reports.

Additionally, the hospital has reduced its turnover time by 11 minutes, says **Tony Claycomb**, RN, team leader of surgery/sterile processing.

Additionally, the hospital has decreased overtime in the same-day care unit (SDCU), surgery, and the postoperative care unit (PACU), Stanton says. "We're getting our work done by 5:30 p.m., which decreases call time," she says.

Members appointed to surgical committee

Step One was revamping the surgical oversight committee, which previously had been made up of voluntary members who were spotty in their attendance.[1] The new committee has appointed members from all surgical specialties, anesthesia, and managers from the OR, PACU, SDCU, and the hospital. They meet twice a month on Tuesdays from 6:30 to 8 a.m.

Now, "we have a surgical oversight committee that is run by physicians who are involved and make crucial decisions for our areas," Stanton reports. "They are assigned physicians that they are to communicate with to keep information flowing."

The committee even included representatives of the surgeons' practices. "We have staff from all the areas involved and staff from areas that support our areas," Stanton says.

To ensure that decisions are made and implemented quickly, the committee developed a "request sheet" for physicians.[1] [**The request sheet is available with the online issue. For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.**] Any physician who has a request or complaint for the committee uses the sheet to explain the issue and present data or additional information to back up their argument. That physician meets with a "pre-meeting" committee that makes a recommendation to the oversight committee. This decision is documented on the original request sheet with an implementation date, and it is returned to the surgeon.

Such actions were critical to the hospital's efforts, Stanton says. "Make changes quickly and monitor success," she advises. (**For the hospital's success on start times and surgical blocks, see stories, below, and on p. 43.**)

REFERENCE

1. Press Ganey Associates. A sense of urgency in the heartland — a hospital rapidly smooths out patient flow, spurring cultural change. *Partners* 2010; 9:22-29. ■

Heartland Memorial addresses start times

Data were the focus when Heartland Regional Medical Center in St. Joseph, MO, decided to address late start times.

Connie Stanton, RN, team leader of Heartland Memorial's post-anesthesia care and same-day-care units, was a leader for the workgroup assigned to improve each day's opening surgery starts. Stanton reviewed data on first starts daily, according to Press Ganey Associates, which featured the hospital in a recent publication.[1] She identified problems and communicated with her team by e-mail.

Keys to improving the start times included identifying all the steps necessary to start on time. (**See steps, p. 43.**) The steps also include penalties for noncompliance, such as the physician losing the 7:30 or 8 a.m. start times for a month after being the cause of 20% of their cases being late starts.

Members of the team also agreed on definitions and responsibilities, and they staggered nursing shifts to handle the morning rush. The guidelines were amended and then implemented by a surgical oversight committee that included surgeons and anesthesiologists.

REFERENCE

1. Press Ganey Associates. A sense of urgency in the

Guidelines for the New Work Flow

- **0730 Case**
  Patient arrival 0500-0530
  Same-Day Surgery Unit (SDCU) completed prep of patient 0630
  Family to waiting room 0645
  Anesthesia evaluation completed 0650-0655
  Circulator in SDCU 0650
  Surgeon in SDCU 0650 (as needed)
  Patient in OR 0700

- **0800 Case**
  Patient arrival 0530-0600
  SDCU nurse completed prep of pt 0700
  Family to waiting room 0715
  Anesthesia evaluation completed 0720-0725
  Circulator in SDCU 0720
  Surgeon in SDCU 0720 (as needed)
  Patient in OR 0730

Source: Heartland Regional Medical Center, St. Joseph, MO.

heartland — a hospital rapidly smooths out patient flow, spurring cultural change. *Partners* 2010; 9:22-29. ■

Hospital targets blocks, staffing

In August 2008, Heartland Regional Medical Center in St. Joseph, MO, began work on its patient flow through the OR with PatientFlow Technology, now called PatientFlow Optimization, and since January 2008, a part of Press Ganey Associates.

A surgical oversight committee looked at the total hours of elective surgery by surgeon, according to Press Ganey Associates, which featured the hospital in a recent publication.[1]

The committee members compared this number to the block schedule to adjust the block times for surgeons who consistently were underusing their blocks and those who needed more time. Also, case duration times were analyzed to make the scheduling more accurate. The committee developed guidelines for the block schedule that included an 80% utilization rate for maintaining the blocks. They also reviewed and adjusted the blocks quarterly.

Next, a staffing workgroup had surgeons review staffing and develop competency skills for each specialty. The workgroup identified the number and types of staffs needed to cover the OR.[1]

Specialties were examined to determine which ones were understaffed and which ones were overstaffed. The OR is training staff to have the correct skills and expertise in the blocks. For example, some RNs are training to become scrub nurses.

"With regard to staffing, we staff in accordance with our block," says **Tony Claycomb**, RN, team leader of surgery/sterile processing. "We had to change a few shifts to accomplish this, but it turned out well for all as staff are productive while they are here and not idle before and after the day's blocks."

The specialty teams have developed an internal peer review process specific to the teams as well as required competencies for each team member to complete to remain on the team, Claycomb says.

REFERENCE

1. Press Ganey Associates. A sense of urgency in the heartland — a hospital rapidly smooths out patient flow, spurring cultural change. *Partners* 2010; 9:22-29. ■

Center shares secrets for boosting referrals

*(**Editor's note:** This is the first of a two-part series on the benefits of a marketing director. In this issue, we tell you about the successes of a former RN who increased referrals while working part-time as the marketing director of a surgery center. In next month's issue, we tell you about the benefits of having a full-time director with a marketing background.)*

How would you like to increase physician referrals, decease the number of physician problems you have to address, and improve your image in the community, all at the same time?

Some surgery centers are finding success in these areas and more, simply by hiring a part-time marketing manager.

At Valley Ambulatory Surgery Center (ASC) in St. Charles, IL, **Diane Lauterer**, RN, marketing director, focuses on educational and promotional activities, in addition to marketing. "This includes recruiting additional surgeons and encouraging existing medical staff to increase utilization of our facility," she says. "I look for new specialties to bring into our center, like pain management and bariatrics, and actively recruit physicians who can

EXECUTIVE SUMMARY

The marketing manager at Valley Ambulatory Surgery Center in St. Charles, IL, has boosted the center's success by focusing on physician referrals, physician office staff, public relations, and marketing.

- She developed a cross-referral pattern between the center's interventional pain physician and orthopedist with local chiropractors through a series of breakfast meetings.
- Her physicians' offices are quieter, so she meets with them to help them grow their business. Luncheon meetings for practice managers focus on challenges and successes such as money-saving ideas, collection strategies, and potential referral opportunities.

provide these services."

Having a designated staff person for marketing is a significant advantage for busy outpatient surgery managers, says **Deborah Lee Crook**, RN, CASC, administrator at Valley ASC. "One advantage as an administrator is that we're so busy with day-to-day things, it's difficult to try to get out to new doctors, and you have someone to focus on that," she says. "Just the little things set you apart from competition such as visits, getting to know their likes and dislikes, and keeping up with our Internet site, to make it useful and informative."

In addition to the web site, Lauterer develops and maintains marketing materials such as brochures and newsletters. She represents the surgery center at community events and serves on several boards, including ones for the chamber of commerce and a free medical clinic where several physicians volunteer their time and services.

The bottom line for Lauterer is increasing case volume, "and my most successful strategy in that arena was in introducing and growing our interventional pain management specialty," she reports.

The center had one interventionalist and needed a referring network. Lauterer determined a large number of chiropractic physicians in their area didn't have an established referral pattern for other specialties when their patients needed more than chiropractic care. "They need an injection to get them past this acute inflammation and spasm state so that they can then receive chiropractic care," she says. "But the chiropractors were either unaware of this option or mistrustful of referring their patients in this manner for fear of losing their patient in the system and never seeing them again."

Lauterer scheduled breakfast seminars for the chiropractors where the pain physician stated his respect for their specialty, educated them on what he offered, and assured them he would return patients to their practice. "I also started inviting our orthopedic surgeon to these seminars so that he could interface and discuss concerns with the chiropractors," she says. "The end result was that a relationship developed between the specialties, and everyone benefitted from it."

Cross-referral pattern set

A cross-referral pattern was established between the chiropractors, interventional pain physician, and orthopedist. "Trust and communication were key, and I needed to work hard to follow up with all parties to establish a communication network that nurtured that trust," Lauterer says. "Case volume rose quickly for the surgery center due to not only the pain cases, but also orthopedics due to their increased referral base."

The breakfasts were held at the center's overnight care facility. Out-of-pocket expenses for catering and table/chair rental were $400, which was split between the surgery center and the pain physician. The center also had sponsorship from an independent radiology group, which benefited by providing information on their MRI and other services to the attendees. That group paid for the design, printing, and mailing of invitations to the chiropractic database. The center held three breakfasts, from 7:30 to 9 a.m., and had 12-15 attendees at each one. (**For information on a successful venture with office managers, see story, p. 45.**)

Lauterer sees her 30-year background as a nurse as a significant benefit in such endeavors because she is familiar with the environment and communicates well with the physicians. "I know their needs and what they are looking for to make them choose an [ambulatory surgery center] over a hospital," she says. "Nurses have an advantage because they have been taking care of patients for years, and it's really the same process working with doctors: We anticipate their problems, identify their problems, and then take care of them. It's like second nature for a nurse."

Crook seconds those thoughts. "They can identify their needs," she says. "They know the language and vocabulary. She worked in a surgery center, knew the environments, and when they talked about instruments or something they're looking to do, she understood."

The ability to connect with physicians is critical, Lauterer believes. "I truly believe it all comes down to relationships, the ability to build them and nurture

them," she says. "That is the single most important characteristic needed in this position." ■

Times tough for docs? Take advantage of the quiet

Marketing director targets office staff

During these difficult economic times, physician offices are quieter. The marketing director at Valley Ambulatory Surgery Center (VASC) in St. Charles, IL, has put this down time to good use.

"That means that we have more opportunity to talk with them and find out what we can do to help them to grow their businesses," says **Diane Lauterer**, RN, who leads the marketing, public relations, and physician referral efforts at her center.

"We are all struggling together, and if we can identify what obstacles our surgeons have in making their surgeries more efficient and their practices growing, it will come back to the surgery center in more case volume," she says. "And we can assist them in growing their referral base by making connections for them in the community and with other medical doctors."

New physicians and staffs are provided lunches and tours of the facility.

"I act as a liaison between physician offices and VASC, and am often called first if there is any problem," Lauterer says.

She also maintains a good rapport with the surgery schedulers and practice managers of the medical staff, and she hosts several functions throughout the year for them. "We have started to have lunch meetings for practice managers in our community every other month where we have roundtable discussions of challenges and successes in our practices, money-saving ideas, collection strategies, etc.," Lauterer says. "Not only do we all benefit from each others experience and knowledge, we also are interfacing across specialties and making relationships with possible referring practices — a win-win opportunity for everyone."

The practice managers' luncheons are organized through the Kane County Medical Managers, which Lauterer helps lead and which is linked to the Kane County Medical Society." Dues are $75 a year. "We also accept some sponsorship for some of our luncheons, but we are very careful with that because it is not our purpose to sell anything to our group," Lauterer says. "However, if we find a company that we would like to know more about, i.e., local phone services that can save us money, EMR vendors, outpatient labs, etc., we invite them in, and they sponsor the event for the privilege." The medical society covers the cost of printing and mailing invitation postcards.

The luncheons are held on Wednesdays from 11:30 a.m. to 1:30 p.m. "We do a lot of fun things at these luncheons also, like raffles where offices donate an item and then are given the opportunity to do a one-minute 'infomercial' on their practice or services to increase awareness and market to their medical referring base," Lauterer says. Typically 24-40 office managers attend. ■

Splash and splatter risk often underestimated

Splashes and splatters can transmit disease effectively, but many institutions don't adequately protect against this risk, says **Susan Y. Parnell**, RN, MSN, MPH, CIC, director of employee health clinical services at the University of Texas Health Science Center in Houston.

"These exposures are grossly underreported," she says. "The risk of HIV and hepatitis B transmission through this route is lower than with a needlestick, but it is still a very significant risk."

Parnell advises managers to review their work practice control policies to determine if they adequately address splash and splatter risk by requiring protective equipment and protective measures when contact with blood and bodily fluids is "reasonably anticipated," as required by the Occupational Safety and Health Administration (OSHA). The work practice control policy should define those circumstances for your facility, so that the frontline worker is not left to guess about each situation, Parnell says. The definitions will vary for each institution, based on variables such as the

EXECUTIVE SUMMARY

The risk of infection from splash and splatter exposure often is not addressed adequately by health care providers. Staff must be educated about the risk and provided with proper protection.

- Managers might need to require the use of protective equipment, not just encourage it.
- Provide proper sizes of safety gear to encourage the best protection.

type of patients treated, procedures performed, and patient volume.

"The next step is a product review. We're all pretty focused on sharps containers and related items, but we need to review the containers for body fluids also to make sure they have tight-fitting lids to prevent spills and splash exposures," Parnell says. "Then you need to review your personal protective equipment. That is where you can gain the most ground in preventing exposures through splash and splatter."

The manager should ensure that all units have an adequate supply of the gear that can prevent bodily fluid exposure: protective glasses and goggles, face shields, hair covers, sleeve covers, long gowns, and gloves, Parnell says. And remember, it's not enough to just have a supply of those items. They have to fit the user, and that might mean keeping a variety of sizes.

"Many, many splashes occur because small nurses are wearing gloves that are too big for them, so they don't have a good grip. They lose control of a container or tubing, and someone gets splashed," Parnell explains.

The work control policy also should specify what equipment is appropriate for different procedures and situations. Parnell says a manager, working closely with the person responsible for employee health, can have great influence in improving policies and procedures to prevent splash and splatter exposure. Become involved with the acquisition of protective equipment also, she suggests. Bring in the frontline employees, and let them review the products you're considering in a "product review fair." This fair can show employees that you aren't simply buying the lowest-bid products and that you want them to have the most effective supplies.

"A lot of what they say won't be new to you, but somebody's going to say something novel, point out a problem that you hadn't realized, or why one product is better than another for your facility. You really need to hear from those frontline nurses," Parnell says. "We can't always buy the most expensive option, but if what they're saying ties directly to the injuries we're seeing in our data, the added cost can be justified, because injuries cost money."

Involving the staff also can reveal other issues that need to be addressed by the manager. For example, Parnell says you might ask nurses to review protective equipment options, and one mentions that "my manager says we use too many of those, so she won't keep them on the unit." That's a managerial problem that must be addressed. **[More on splashes and splatters can be found in the Feb. 26, 2010, issue of the *Same-Day Surgery Weekly Alert*. For a free subscription to the ezine, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]** ■

Same-Day Surgery Manager

Lessons are learned in latest weather crisis

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

What a wonderful winter it has been in America! Snow and ice and everything nice. Stalled cars, streets shut down, schools closed, general chaos tempered with gleeful, giddy, schoolchildren and frustrated parents. Ahh, global warming at its best!

And, pray tell, how did your surgery schedule fare? A couple of canceled cases maybe? Perhaps more than a few? And we all learned . . . what? The country has been hit with multiple storms one right after the next. This was not a "one-day-out-of-the-year" event that inconvenienced us. This already has been a budget-killing year! The "suits" are freaking out in the administrative wing.

But seriously, how did you handle this crisis? It was one, you know, especially to those who had their surgery canceled because they couldn't get out of their driveway or their surgeon's flight from the Bahamas was canceled. At the very least, it was a great disappointment. So what did you do? How did you contact your patients? Your staff? Your surgeons? No answer required, but something to ponder and learn from for the next apocalyptic event.

Did you pay your staff for the time the facility was not doing elective surgery? You could be like the airlines and say it was an "act of God," and you are not responsible. Some did pay staff. I would rather work for those that did myself. I am sure some of your staff — for those who didn't — are dusting off their resumes.

Bottom line: These storms were a good lesson for all of us. Hopefully, your outcome was not

all bad. Historically, most canceled cases become rescheduled cases, and life goes on.

I called some of my facilities during the height of some of the storms, just to see how they were making out. Many had staff stranded at the hospital or surgery center, bored silly. Deciding that being productive was better than just sitting around, many of the facilities redid preference cards, labeled supplies with unit pricing, did inventory, ate all the patient refreshments, blew up latex gloves with surgical air, had wheelchair races, and told ghost stories (my favorite!)

Here are some other tasks they accomplished:

• Shoveling out.

Those staff members that were trapped received pay for their time at the center, and those who couldn't get in were paid for two days or were able to take vacation time. As it should be. Most helped each other find their cars (not as easy as it sounds!) and then dig them out.

• Rescheduling.

Most facilities were accommodating to their canceled cases by extending their hours of operations and even running an elective Saturday schedule to catch up. There were rare complaints.

• Planning ahead.

I know that most of us will be much better prepared when this type of event happens again. Be it snow, blizzards, mudslides, fire, or pestilence, we will be armed with experience on our side. Take serious note of what worked and what didn't during all the chaos that February brought us and, as the Boy Scouts say, "Be prepared!" *[Earnhart & Associates is a 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. Tweet address: Earnhart_EAI.]* ■

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 **June** 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.

Billing, coding issues for outpatient surgery

If you don't bill and code correctly, you could be leaving money on the table, in addition to being noncompliant, warns **Stephanie Ellis**, RN, CPC, president, Ellis Medical Consulting in Brentwood, TN. Ellis spoke at a recent coding seminar held by the Ambulatory Surgery Center Association.

Focus on these particular areas, Ellis advises:

• Transforaminal injections.

Transforaminal injections are a target area of the Office of Inspector General due to their increased billings to Medicare, Ellis says. "Medical necessity must be proven to give these injections," she says. "Be sure that for patients receiving multiple transforaminal injections over time, there is documentation of improvement from these injections in the medical record."

• Billing noncovered CPT codes for ASC services with CPT codes for covered services.

Some providers use billing codes that don't properly describe the procedure performed, Ellis says.

• Billing for new procedures that do not have existing CPT codes with codes for procedures that do not fit.

"Carefully check out advice on coding for new technology or equipment you get from salespeople and equipment reps," Ellis warns. "If they give you flawed advice and you code incorrectly, you are still responsible."

• Place of service errors on claim forms.

Remind physicians using your facility to use POS 24 as the place of service on their claims for procedures performed at the ASC facility, rather than POS 11 for their office, Ellis advises, "If surgical procedures are performed at their office, they are reimbursed at a higher rate than when they are performed at the ASC, which can be a fraud issue," she says. ■

COMING IN FUTURE MONTHS

- Avoiding fatal mistakes with medication
- Employee issues that put you in legal trouble
- How-tos of price transparency
- Plan for making your surgery program stand out

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.

13. Going out of network is practical under what circumstances, says Beverly A. Kirchner, RN, BSN, CNOR, CASC, CEO and president of Genesee Associates?
A. If the insurance company pays you based on a reasonable rate.
B. If your state allows you to go out of network under anti-fraud acts.
C. A and B
D. Under no circumstances is it practical to go out of network.

14. Why should you beware of the abbreviations MNRP, NAP, and FAC when you see them on a patient's insurance card, according to Catherine A. Meredith, RN, CASC, vice president of finance for Hanover, MA-based Ambulatory Surgical Centers of America?
A. They are reimbursement rate-limiting plans.
B. The insurance company is fixing the out-of-network reimbursement at around 150% of Medicare.
C. Patients don't know what the abbreviations stand for and won't understand their plans.
D. None of the above.

15. Heartland Regional Medical Center significantly improved its on-time a.m. starts, turnover time, and block utilization and decreased overtime. What was involved in the first step of revamping the surgical oversight committee?
A. Asking for volunteers.
B. Appointing members from all specialties, anesthesia, and managers from the OR, PACU, same-day surgery unit, and the hospital.
C. Changing the meeting schedule to once a week.
D. Changing the meeting schedule to once a month.

16. According to Susan Y. Parnell, RN, MSN, MPH, CIC, what are the definitions for when splash and splatter exposures should be "reasonably anticipated?"
A. Any time a patient's wound is open or blood is exposed.
B. Only during surgery.
C. The definitions will vary for each institution based on variables such as the type of patients treated, procedures performed, and patient volume.
D. Only during trauma care.

Answers: 13. C; 14. A; 15. B; 16. C.

SURGICAL OVERSIGHT REQUEST FORM

DATE OF REQUEST: _____

REQUESTOR: _____

REQUEST/CONCERN: ***(Please indicate specific dates, times, day, block etc.)***

_____

_____

_____

- - - - Balance of form to be completed by Surgical Oversight Committee member - - - -

SUPPORTING DATA: _____

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DATA SUPPORTED RECOMMENDATION(S) PRESENTED TO SURGICAL OVERSIGHT:

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_____

DATE REVIEWED BY SURGICAL OVERSIGHT: _____

SURGICAL OVERSIGHT DECISION: _____

_____

_____

DECISION EFFECTIVE DATE: _____

Source: Heartland Regional Medical Center, St. Joseph, MO.