Same-Day Surgery®

35th Anniversary

Covering Hospitals, Surgery Centers, and Offices for More than 35 Years

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IN THIS ISSUE

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Are you prepared for high BMI patients or just focused on their gown sizes?

The answer spells the difference between never events and good care

As the number of people in the general population with high body mass index (BMI) rises, outpatient surgery providers are seeing growing numbers of these patients. The question arises, are providers treating them appropriately? No, according to the National Association to Advance Fat Acceptance (NAAFA).

"In the midst of our nation's frenzy to fight fat, there is an alarming increase in bias against fat patients among healthcare providers," the NAAFA said recently in a release announcing "Guidelines for Healthcare Providers who Treat Fat Patients." *(See excerpt, p. 3. The full guidelines are available at http://bit.ly/rAJ0Ef.)*

Pat Lyons, RN, MA, who worked with the NAAFA to develop the guidelines, says, "Standard medical practice often operates from the basic assumption that high weight causes all medical problems and that no problem can be successfully treated without focusing on weight loss." Lyons also previously served as the female project director of the WomanCare Plus Research Project at the

Same-Day Surgery kicks off 35th anniversary year

This month's issue marks the 35th anniversary issue of *Same-Day Surgery*. We are honored to have been with you since the beginning. As you have changed, so have we. We're now on twitter (@SameDaySurgery) and send out information weekly via e-mail. (Sign up at http://bit.ly/s9ZFFE.)

We kick off this 35th anniversary celebration by marking a growing trend: patients with increasingly higher body mass indexes (BMIs). We tell you about recently released guidelines from a national group that can help providers better care. During our anniversary year, we'll explore other the new thresholds that outpatient providers are crossing including surgery on an increasingly elderly population. We'll also examine how you can use new trends, such as social media, to your benefit. We'll discuss how transparency is changing your job. In this month's issue, we include our annual salary survey results.

We look forward to serving you for the next 35 years!

University of California, Berkeley, which collected data from African American and white women on barriers to gynecological cancer screening related to BMI.

"Many assume they are not doing their job if they don't counsel fat people to lose weight, so after a lifetime of this kind of medical treatment, fat patients may be even more frightened about surgery than other people," Lyons says. These patients might need extra support and reassurance, she says. "They may not believe surgeons really know what they are doing with big bodies," Lyons says.

Such concerns might be understandable. One of the major co-morbidities associated with obesity is obstructive sleep apnea (OSA). In addition to respiratory support, obese patients might have unique positioning needs. The special needs of obese patients came to the attention of one California hospital after it experienced two sentinel events within six months involving patients with a high body mass index (BMI). *(See story, p. 3.)*

Lyons suggest you ask yourself, "Are the surgeons well-trained and experienced in doing procedures on patients of all sizes of large, and I mean above 300 pounds too?"

Managers need to ensure that members of their staff aren't discriminating against patients based on their size. Michigan prohibits discrimination against overweight persons, and several cities, including Washington, DC, and San Francisco, have enacted anti-discrimination ordinances.

The newly released guidelines offer assistance. For example, they suggest providers "engage in health-centered, non-weight focused language (i.e., avoid the term obese.)"

This advice is seconded by **Rebecca Puhl**, PhD, director of research at the Rudd Center for Food Policy & Obesity at Yale University, New Haven, CT. "There are many straightforward strategies that providers can use to reduce weight bias toward their obese patients," Puhl says. "This can start with challenging one's own assumptions and stereotypes about body weight, and using sensitive language with patients in patient-provider communication to ensure that they are not blaming or stigmatizing their patients."

The NAAFA guidelines also suggest it might be necessary to provide size diversity training to your staff. (See Resource at end of this article.) "Weight bias toward obese patients can occur in a number of ways, ranging from stigmatizing or prejudiced comments from providers, fat jokes made by medical staff, and denial of treatment or medical services or procedures," Puhl says.

She points to a recent column in a surgery publication, "meant to be humorous," that included derogatory fat jokes toward overweight patients. It included such statements as "You should worry about performing surgery on the super-sized if there is a comma in your patient's body weight," and doctors should worry about operating on patients "who have more chins than a Chinese phone book."

Puhl said, "It made national headlines. He [the author] later apologized, but this is a clear example of how socially acceptable weight bias has become, even

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among health providers whose job it is to care for obese patients." *(For more on the article, go to http://abcn.ws/ryVBuX.)*

Your surgery staff, lab technicians, and other staff need to be well-trained that X-ray equipment might not be adequate, Lyons says. When that situation occurs, staff members should use non-judgmental language and attitudes, she advises. Lyons offers this example: "I'm sorry, our X-ray machine is too small to meet your needs," rather than, "You are too big for our equipment."

In addition to your staff, ensure your facility is prepared. "Once someone gets to outpatient, be sure gowns, BP cuffs, wheelchairs, gurneys, or other transport equipment is substantial for both safety and comfort," Lyons advises. Also consider weight capacity and width of patient chairs, special support for wall-mounted toilets, the weight and lift capacity of OR/procedure tables, and patient safety straps on OR tables and gurneys, experts suggest.

Address at-home support, Lyons suggests. Wound care issues might arise if a person can't see or reach the surgical site, she explains. They might need bathing aids or other support.

Lyons says the attitude starts with your surgeons. She says to ask yourself, "To what extent are they focused on the whole patient, versus only the specific body part needing surgery, and addressing any special needs related to weight in a non-judgmental way?"

RESOURCES

• "Health at Every Size" principles are available from the National Association to Advance Fat Acceptance at http:///www.naafaonline.com/dev2/education/haes.html.

• The Rudd Center for Food Policy & Obesity at Yale University, New Haven, CT, has educational resources available to help managers increase awareness and understanding of weigh bias in the healthcare setting. Their video is required training at some bariatric surgery centers. Web: http://www.yaleruddcenter.org/what_we_do.aspx?id=196. ■

BMI questionnaire may avoid never event

As obesity rates climb in the United States, perioperative professionals must be prepared to care for patients with a high body mass index (BMI) and to prevent the surgery-related complications seen in this patient population. High-BMI protocols, including strategies centered on interdepartmental communication, respiratory care,

"Guidelines for Healthcare Providers Who Treat Fat Patients" (Excerpt)

Medical Procedures

• Ensure your patients have access to durable medical equipment (DME) that meets their size needs.

• Have several sizes of blood pressure cuffs readily available. Using a small blood pressure cuff on a bigger arm can produce false readings.

• Have longer needles and tourniquets available in order to draw blood from your patients.

• Utilize appropriate equipment for OB/GYN exams (i.e., longer specula).

• Your lavatory should have a seat that is split in front, to enable patients to more easily hold urine specimen cups in place. A urine specimen collection device with a handle or a "hat" is preferable.

• Closely monitor breathing with sedation if there is increases incidence of sleep apnea and airway problems.

Accommodations

• Provide several sturdy armless chairs, couches, or benches in your waiting room. Chairs with arms often cannot accommodate a fat patient.

• There should be 6 to 8 inches of space between chairs.

• Sofas should be firm and high enough to ensure that your patients can rise with ease. Exceptionally low and soft sofas can be difficult.

• Be mindful of the information you provide in your waiting rooms and on the walls. Ensure it reflects diversity, including size, to promote a safe and inclusive environment for all your patients.

Source: National Association to Advance Fat Acceptance, Foster City, CA. Web: www.naafa.org.

equipment, and staff education can reduce the risk of surgical complications for obese patients, according to a report in a recent issue of AORN Journal.[1]

The effects of a high BMI on perioperative safety were brought to the forefront at John Muir Medical Center in Concord, CA, when two sentinel events occurred during a six-month period. At the time these sentinel events occurred, perioperative administrators did not have a mechanism for advance notification when elective, nonbariatric surgical procedures were scheduled for patients who were obese. The bariatric patients already had a clinical nurse specialist attending to their needs.

"The problem was with patients not having bariatric surgery who may have an equal or exceeding BMI, but they fell out of the oversight," says **Diane Graham**, MS, RN, CNS, CNOR, clinical nurse specialist in surgical services at John Muir. For nonbariatric patients, additional preparations for respiratory support and positioning needs were required on short notice, Graham says.

In the article, Graham and colleagues describe the work of a High BMI Task Force to create and implement a system that would improve surgical results for obese patients. The hospital implemented revised checklists noting the patient's BMI. When a patient appears for preop education and has a BMI above 35, a High BMI Questionnaire is now used.

"It's directed at determining whether a patient might have difficulty breathing postop," Graham says. "They might have a sleep apnea problem. If they have that, in postop recovery area, they will be needing a positive pressure machine or ventilator." *[A copy of that questionnaire is included with the online version of* Same-Day Surgery *at www.same-daysurgery.com. Select "Access your newsletters." If you need assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]*

Chart audit results confirmed the quality improvement project, was successful; 92% of 50 charts showed inclusion of the BMI on the surgery schedule, and 94% showed inclusion of the BMI on the preoperative checklist. No serious positioning incidents or intubation emergencies have occurred in patients with a high BMI since Jan. 1, 2009, Graham says.

A first step is to assess your patient population to determine how many of your patients have a high BMI, Graham suggested in an interview with Same-Day Surgery. "Given the fact that we know nationally that the BMI of patients is increasing… regardless of your population, you can be pretty assured you will be getting these patients more frequently."

The bottom line is to "be proactive to protect your patients in the positioning and respiratory sense, so you're not taken unaware when you have those patients come in," Graham says. "It's better to be proactive, rather than respond to injuries."

She points to the two sentinel events at her facility. "I don't want other people to have that kind of occurrence to discover they have deficits in their positioning or respiratory care of the patient," Graham says. *(See story about white paper on the potential role of endoscopic bariatric therapies in treating obesity and obesity-related diseases, below.)*

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Societies explore role of endoscopy for obesity

The American Society for Gastrointestinal Endoscopy (ASGE) and the American Society for Metabolic & Bariatric Surgery (ASMBS) have issued a white paper on the potential role of endoscopic bariatric therapies (EBTs) in treating obesity and obesity-related diseases like Type 2 diabetes.

The white paper titled, "A Pathway to Endoscopic Bariatric Therapies," appears in the November issue of GIE: Gastrointestinal Endoscopy, the peer-reviewed scientific journal of the ASGE.

"The two societies formed a joint task force to identify opportunities where endoscopic treatments may play a role in improving patient outcomes and reducing costs," said **Gregory G. Ginsberg**, MD, FASGE, ASGE president and chair of the ASGE/ASMBS Task Force on EBT. "The white paper establishes the criteria for success as new technologies and procedures are developed."

According to the white paper, several EBTs are in different stages of development and include a wide variety of methods to induce weight loss and reduce obesity-related diseases and conditions.

EBTs are performed entirely through the gastrointestinal tract using thin flexible endoscopes and might offer patients an outpatient alternative to bariatric procedures including laparoscopic gastric bypass, adjustable gastric banding, and sleeve gastrectomy.

Bipan Chand, MD, chairman of the ASMBS Emerging Technology and Procedure Committee and co-chair of the ASGE/ASMBS Task Force, says, "Endoscopic therapy has the potential to be applied across the continuum of obesity and metabolic disease. However, it is generally expected that endoscopic modalities achieve weight loss superior to that produced by medical and intensive lifestyle interventions, have a favorable risk/benefit profile, and have scientific evidence to support its use."

The white paper addresses endoscopic bariatric therapy treatment classification, potential indications, and efficacy including: primary efficacy endpoints such as weight loss, definitions for weight loss, comparison of weight loss between therapies, threshold for weight loss, and study design. It also addresses secondary efficacy endpoints such as reduction in obesity-related co-morbidities, changes in quality of life, safety, durability, repeatability, adoption of EBTs in the context of global patient care, endoscopy unit considerations, training and credentialing, cost effectiveness, and government and industry relations.

According to the Centers for Disease Control and Prevention (CDC), about one-third of U.S. adults (33.8%) are obese. Medical costs associated with obesity are about $147 billion or 10% of all medical spending, double what it was a decade ago.[1] The ASMBS estimates there are 17 million people in the United States with morbid obesity (BMI of 40 or more, or a BMI of 35 or more with an obesity-related disease).

Obesity is a disease that contributes to more than 30 other obesity related diseases and conditions that include Type 2 diabetes, hypertension, heart disease, sleep apnea and certain cancers.

Bariatric surgery has been shown to be the most effective and long lasting treatment for obesity and many related conditions.[2] Studies have shown patients might lose 30 to 50% of their excess weight six months after surgery and 77% of their excess weight as early as one year after surgery.[3] The Agency for Healthcare Research and Quality (AHRQ) reported significant improvements in the safety of bariatric surgery over the last several years due in large part to improved laparoscopic techniques and the advent of bariatric surgical centers of excellence. The overall risk of death from bariatric surgery is about 0.1%[4] and the risk of major complications is about 4%.[5]

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Same-Day Surgery Manager

Revamping surgery in the outpatient area

By **Stephen W. Earnhart**, MS
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By every standard, outpatient surgery is growing. The recession took a bite out of it, with many patients delaying elective surgery until they obtained new positions and health insurance. However, by and large, most facilities are seeing resurgence in cases again in the hospital outpatient departments (HOPDs) and freestanding centers.

Plastic surgery is booming, helping patients "groom" themselves for new jobs and an older workforce wanting to compete against their younger-appearing competition. It is working.

The split between inpatient and outpatient cases is widening as technology, treatment modalities, advances in anesthetic agents, and patients wanting to be home sooner grows. Most inpatient surgical cases in the acute care setting are patients who are spending only one night in the hospital for pain control or for surgeons insecure about sending them home the same day. It is clearly only a matter of time before these cases will become surgery center procedures only, with no HOPD reimbursement at all.

Many single specialty surgery centers are borderline underperforming. GI, ophthalmic, and pain centers are struggling as their reimbursement has significantly changed over the past several years. Intended as single specialty-only centers from inception, it has been difficult to retool these centers due to smaller operating rooms, lack of expansion space, and hoarding of ownership over the years, which meant not allowing new surgeons into the partnership. Eventually these cases will become office procedures only, with no facility reimbursement at all.

While the freestanding industry is seeing a 1.6% bump in Medicare facility fees and the hospital-based cases are seeing a 1.9% increase, it will not make a material difference to either in the long run. It is folly to expand hospital surgical environments to accommodate surgical cases that will not be profitable. With many underperforming surgery centers closing across the country and inexpensive operating rooms empty in others, it is time to revamp these services in a manner that works for all.

To most surgeons who work in a surgery center environment, the thought of taking cases back into the hospital system of perceived bureaucracy is abhorrent to them. For hospitals, trying to appease surgeons who are accustomed to 10-minute turnaround times and running their centers like a business, it is a "no-win" scenario for most hospital CEOs.

However, there is an obvious solution for the outpatient surgery industry: having hospitals absorb these closed surgery centers and buy out underperforming surgery centers with far less cash than would be needed to build hospital operating rooms.

Involving the surgeons to run these new off-site extensions of acute care hospitals is critical to the success of the ventures. While the surgeons would not be able to be investors in the sites, they still could be profitable by managing the centers in a similar fashion as they were accustomed to in the past.

With the budget changes and with healthcare costs out of control, the time is here to think out the current arrangement. *[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. Twitter: @SurgeryInc.]* ■

Mandatory reporting for adverse events jumps

More states are mandating adverse event reporting, and this trend could have a significant impact on healthcare providers, says **Kathryn Schulke**, BSN, a principal with the law firm of Booz Allen Hamilton in Rockville, MD. Twenty-seven states and the District of Columbia have passed legislation requiring adverse event reporting, she says.

One risk is that the reporting systems can provide a false impression of patient safety at a facility, Schulke says. "Many of the adverse events that must be reported cannot be validated by an outside entity," she says. "A fall is an adverse event, but a fall that is caught is a near miss. So if you have a lot of falls and don't honor the reporting, you look like a provider with fewer falls than a hospital that is enthusiastic about reporting all falls and near misses."

Schulke expects that the number of states requiring adverse event reporting will continue to rise, and she also says the legislation is likely to be expanded to include facility-acquired conditions. Physician reporting of adverse events also might be made available, she says. *(For a list of the states that require adverse event reporting and information on each state's reporting system, go to http://tinyurl.com/3tjqyd4. The page opens with California's rules, and other states can be selected on the right side.)*

EXECUTIVE SUMMARY:

Mandatory adverse event reporting is becoming more common at the state level. These laws might affect reimbursement for providers and have other effects.

- The reported information is protected from use in malpractice litigation.
- Hospital-acquire conditions probably will be included in reporting requirements.
- The federal government is offering $500 million in aid for patient safety improvements.

State officials say that they protect the information transmitted to state agencies concerning adverse events and that the information cannot be used against provider in a lawsuit; thus, reporting is not a direct liability threat, they maintain. Mandatory adverse event reporting can cause other headaches, however. Third-party payers are increasingly hesitant to pay for poor care, and reporting an adverse event might result in non-payment for all of the care rendered, even if the adverse event was relatively small and benign, Schulke says. The reports also could be detrimental to facilities amidst the push for more value-based purchasing.

"There is not 100% alignment between the events that must be reported under mandatory adverse event reporting and what is reported for value-based purchasing," but there is enough alignment that it should leave behooves managers and chief medical officers to take an aggressive approach to reducing errors, Schulke says. "Not only are they going to be reported, but in the very near future they are going to affect reimbursement," she says.

Managers should start by determining whether their facility or system is a poor performer in comparison to national averages or error rates in their communities, Schulke says. Then you have to drill down and look at those individual units where those numbers are not good, she says. The manager needs to "narrow down where the risk is and then address that risk with specific solutions."

The good news is that there is substantial federal funding available for reducing adverse events and improving patient safety, Schulke notes. The Center for Medicare and Medicaid Innovation (CMMI) announced it will provide $500 million in funding to selected local and statewide entities to coordinate the implementation of projects under the Partnership for Patients initiative. *(See the story below for more information on that program.)*

"To my knowledge, this is the first time that the government has had this large of an effort to fund and help hospitals make patient safety improvements," Schulke says. It's virtually free of charge to the facility if you agree to work on seven out of a list of 10 areas of harm, she says. ■

CMMI offering funds for safety improvements

Based on the Institute for Healthcare Improvement's (IHI) model, the Partnership for Patients is a recently announced public-private partnership aimed at reducing injuries and complications by 40% and hospital readmissions by 20% over three years.

The Center for Medicare and Medicaid Innovation (CMMI) seeks to contract with large health systems, statewide associations, and other entities to support efforts to achieve the goals of the Partnership for Patients: improving the quality of care and patient safety while lowering costs.

Providers seeking to become "patient safety hospital engagement contractors" will be required to design intensive programs to teach and support hospitals in making care safer, conduct training for facilities and care providers, provide technical assistance for facilities and care providers, and establish and implement a system to track and monitor facility progress in meeting quality improvement goals.

The Hospital Engagement Campaign funding is the first round of $500 million made available by CMMI under the Partnership for Patients. More information and application materials for the Hospital Engagement Campaign solicitation are available online at http://tinyurl.com/3by6fgb. ■

Keep patients happy when delays occur

Avoid finger-pointing

During morning surgery rush times, registrars at Indiana University Health North Hospital in Carmel began monitoring the actual time patients were arriving in a database.

"We learned that even though surgery times are staggered, and the patients are told to come in 15 minutes prior to surgery, they were actually arriving closer together," says **Brian Sauders**, manager of patient access services.

The earliest scheduled patients would arrive slightly before the department opened, while the later scheduled patients would arrive well before they were instructed to arrive. "Rather than having evenly staggered arrivals, it was more like a bottleneck," says Sauders. "If 10 patients were scheduled to arrive, we would actually see closer to 20."

Armed with this information, Sauders set out to base patient access staffing on actual volumes. "We have limited FTEs, so we couldn't just add more people," says Sauders. "Instead, we utilize registration team members from different areas of the

hospital. If the ED isn't really busy, we'll pull somebody to come help."

Although ED registrars aren't necessarily familiar with the specifics of the surgical registration process, they keep things moving by checking in patients or keeping them continually informed.

Keep patients in loop

"We don't have a lot of patients waiting an extended amount of time, but if we do for some reason, we keep them in the loop," says Sauders. "It may be that we are chasing down an order for the patient." If that's the case, patient access staff members take these steps:

- They make a point of using the patient's physician's name when talking to the waiting patient, such as stating, "We spoke to Dr. Johnson."

"That helps them to understand that we are truly doing what we say we are," Sauders says, because patients feel more comfortable knowing that access staff actually spoke to their physician.

- They identify specific stumbling blocks to a frustrated patient, such as the fact that the order mistakenly was faxed to a different location.

"In that case, we tell them that we're going to find the order. But we also let them know that we cannot complete what we have to do without that order," Sauders says.

Staff members explain that not completing the registration, and consequently the service, without the order helps to meet safety standards and is in the patient's best interest. "When explained in that manner to the patient, they have a higher level of assurance that we are here to provide the best service to them," says Sauders.

- They resist the temptation to point fingers.

"One thing we do not do is start bashing the other service line," Sauders says, adding that members of the patient access staff instead convey to patients that they work closely with their physician and the department the patient is going to.

- If a patient is adamant that his or her physician faxed something that wasn't received by registrars, they don't argue about it.

Instead, the patient is reassured that members of the patient access staff work closely with the patient's physician, with comments such as, "They are really good about getting us those orders. Let us just check and follow up with them," says Sauders.

"We never place blame," he says. "We can't put ourselves in a light that the patient is in bad hands or that anyone is incompetent. We want to assure them that they are in the right place."

The department's wait time logs indicate that 98% of patients are seen within 10 minutes, and 92% of those are seen within five minutes. "A check-in person out front is our air traffic controller," says Sauders. "We are constantly guiding our patients. We know who has the patient now and which patient needs to be next."

If patients complains about a wait, members of the patient access staff call them at home to apologize. "People are often surprised by that," says Sauders. "They generally compliment the staff. This is a great way to get feedback, because we don't have any formal surveys for patient access." ■

Resident training and informed consent

According to a study that appears in Archives of Surgery, between 85% and 94% of patients were willing to sign forms permitting medical residents to assist surgeons, but many will not consent to giving residents a major role during surgery.[1] Fewer patients consented when the form offered more detailed information about the education level or role of the student.

For the study titled, "Training surgeons and the informed consent process," researchers compiled data from 316 questionnaires completed by patients from a tertiary-level U.S. Army hospital and referral center. The study population consisted of all patients who were scheduled for an elective surgical procedure and who had arrived at the general surgical clinic for their final preoperative evaluation.

Most of the patients (91.2%) that were polled said that their care involving residents in a teaching hospital would be "equivalent to or better than that of a private hospital." When asked whether they would allow a student to participate in a surgical procedure, 85.0% agreed to an intern, and 94.0% agreed to a resident.

The percentage of patients who consented to the residents' role went down when patients were "given specific, realistic scenarios involving trainee participation." For example, only 57.6% consented when a junior resident would be assisting a staff surgeon, and when a staff surgeon would be assisting the resident, only 32.1% of those patients polled gave consent. That percentage dropped even further to 25.6%

when a staff surgeon would be observing the resident and dropped to 18.2% when the resident would be performing the procedure without the staff surgeon present.

It is not common for patients to be made aware of a resident's role in surgical procedures, but those questioned in the study "overwhelmingly" thought they should be informed and said that the information could "change their decision of whether to consent."

The authors of the study determined that policy makers should consider the variation in willingness of patients to be treated by physicians in training.

"We believe that broad calls for routine mandated disclosure should be carefully planned and analyzed prior to implementation to avoid any adverse effects on surgical training," the researchers say.

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Which is better: open, laparoscopic, or robotic?

Another question: Does it matter?

Abstract & Commentary

By **Frank W. Ling**, MD, Clinical Professor, Departments of Obstetrics and Gynecology, Vanderbilt University School of Medicine, and Meharry Medical College, Nashville, TN, is Associate Editor for *OB/GYN Clinical Alert*, also published by *Same-Day Surgery*'s publisher AHC Media.

Synopsis: This commentary challenges the urologic medical community to get past its "collective obsession with technology" and try to figure out why some surgeons have better outcomes, irrespective of the surgical approach taken.

Source: Vickers AJ. Great meaningless questions in urology: Which is better, open, laparoscopic, or robotic radical prostatectomy? *Urology* 2011;77:1025-1026.

The author informs us that the winner of the 2010 Tour de France was Alberto Contador, riding a Specialized SL3 racing bike. The U.S. rider Chris Horner finished 12 minutes behind riding a Trek, Madone. The best rookie finisher, Daniel Loyd, rode a Cervelo S3, and finished more than four hours behind the leaders. The author opines that "no self-respecting urologist" would use this information to claim that the Trek is a faster bike than the Cervelo or that Loyd would have won the race had he ridden a Specialized.

The reader also is told that surgical complication rates among high-volume surgeons who perform radical prostatectomies range from < 5% to > 50%. He also cites in one study that functional outcomes differ by up to 40% with regard to erectile and urinary function. The author points out that the difference between surgeons and their performance dwarfs the inherent differences of the surgical approach. As in the Tour de France, where the focus should not be the bicycle, in urology, the focus should not be on the surgical approach when performing radical prostatectomies.

Comparative publications analyzing complications and success rates are unable to control for pathologists' skills, patient population characteristics, and/or definitions of "success" or "complication." He compares this to asking the three cyclists to go on a 100-mile ride, with the best bike being the one ridden by the first person to get to the finish line, irrespective of the route taken, weather, etc.

The analogy is carried further: The cycle judged to be the best cannot be the one that finishes first because of variables such as the experience of the rider. As with cycling, a skilled, experienced surgeon is different from a novice surgeon, and both are different from the "average" surgeon. In fact, the term "average" raises the statistical issue of results. Vickers points out that depending on how the results are collected and reported, surgical outcomes numerically might look similar, but, as far as patient outcome is concerned, might be very different.

The author concludes that Lance Armstrong said, "It's not about the bike." He asserts that some doctors seem to be saying, "No, but it is all about the robot." Studying how to get the best results should be the goal, but this will require "far greater investment of time, resources, and scientific ingenuity than retrospective analyses of surgical databases."

Commentary

Admittedly, you probably don't get this journal. Even if you did, you probably wouldn't think of this article (it's an opinion piece, not a research study)

as something worth reading or reviewing since it's about radical prostatectomy. When's the last time any of us even discussed the prostate with our patients? So why are you being asked to read about it? It's because if you squint your eyes a little, and allow the words to morph a bit, suddenly you're seeing someone discussing open, laparoscopic, or robotic hysterectomy, oophorectomy, lysis of adhesions, incontinence surgery, prolapse surgery, cancer surgery, etc.

We're being challenged by the author, and he doesn't even know he's doing it! He suggests that urologists as a group get past its "obsession with technology" and try to identify factors that lead to some surgeons getting better results than others, irrespective of the surgical approach used.

Let's relate what the urologists are facing and compare the issues with other fields.

First, I like that the author is a PhD in the Department of Epidemiology and Biostatistics at Memorial Sloan-Kettering Cancer Center. He isn't someone who does any of these procedures. In essence, there is less chance that he has a bias regarding one procedure or another. He also is unlikely to have a conflict of interest relating to an instrument company or another product being used during the surgery. We should be watchful for who is writing the articles that we read, particularly when it's involving surgical approaches and technique. Does someone have an ax to grind?

Second, I love the analogy. It makes sense and gives us a fresh perspective on how we look at surgical literature. Their issues of radical prostatectomy are similar to ours related to benign, malignant, and urogynecologic procedures. Unless you actually believe that one of the "cycles" is better than others, you can see how we gynecologic surgeons need to focus on our patients and how to get them the best results.

Third, what defines "success?" In the case of radical prostatectomy, the urologists are trying to avoid recurrence and maintain intact sexual and urinary function. As our gynecologic oncologists look at endometrial and ovarian cancers, they similarly are looking at recurrence, but also at areas in which benign surgeons focus a lot of attention. When we perform benign surgery, is our goal a shortened convalescence? Shorter anesthesia time? Greater patient satisfaction? Improved cosmesis? Fewer complications? Greater physician satisfaction? Can our urogynecologists define success for sacral colpopexy as any case that doesn't require a laparotomy? What about a five-year success rate? What would the world class cyclists define as "successful?"

Fourth, aren't there factors in the equation beyond just the surgeon's decision-making and skills? What about the patient who has done her "research" and knows the surgical approach that she feels is appropriate for her case? What about the role of the hospital and its administration who might be publicly extolling the virtues of a newly acquired (and very expensive) piece of equipment? How long a learning curve for new technology is acceptable? Is it the same for everyone? For a surgeon to gain needed experience, how long is it reasonable for patients who might not need the new technology to be treated with it?

Finally, you might notice that the cyclist wears a jersey boldly displaying the sponsor's name. I don't think any of us has seen any surgeons with similar commercialized garb entering the operating room (I know I haven't ... have you?). Whether the influence of industry on us is subtle or overt, each of us is responsible for being as candid as possible with our patients regarding all surgical approach options … including no surgery at all. Informed consent requires that of us. We should expect that of ourselves. We should expect that of each other. Until definitive information is available (and, honestly, we might never get it), overzealous rushing to a new technology is probably no worse than an unswerving aversion to it.

I'm taking us far beyond our usual comfort zone by literally stealing the thrust of this thoughtful piece of writing in the urology literature and asking us to do the same: Let's get past our fascination with the latest technology and try to determine how to best serve our patients by getting the best outcomes. Sometimes newer is, indeed, better. Sometimes, it isn't. ■

AAAHC Institute releases benchmarking studies

Four reports issued by the AAAHC Institute for Quality Improvement, a subsidiary of the Accreditation Association for Ambulatory Health Care (AAAHC), offer insights into some of the most common outpatient procedures, including cataract surgery, colonoscopy, low back injection, and knee arthroscopy. Highlights of the studies include:

• Cataract extraction with lens insertion.

— Procedure times.

The median pre-procedure time (defined as patient check-in to start of the procedure) was 81 minutes (range 30 to 157 minutes). Organizations with the

shortest pre-procedure times use processes that include standardized charting and sufficient staffing.

Average procedure times (defined as the time the procedure starts; i.e., incision, to the time the procedure has ended; i.e., dressing on) ranged from 5 to 38 minutes (median 14 minutes). Average procedure times were lowest for those that used IV plus peribulbar block for anesthesia (12 minutes) and greatest for those that used IV plus retrobulbar block (19 minutes).

The median discharge time (defined as end of the procedure until patient meets discharge criteria) was 13 minutes (range 6 to 31). Organizations with the shortest discharge times attributed practices such as streamlining paperwork and adequate staffing.

— Patient outcomes.

Ninety-six percent of patients were able to schedule their procedures as soon as they wanted. Ninety-nine percent said they had adequate understanding of the procedure. Ninety-nine percent said they were comfortable before the procedure and after discharge.

Eighty percent were contacted by their health care providers to assess outcomes within 14 days of the procedure. Ninety-five percent reported their vision was better post-surgery; and 95% returned to activities of daily living within one week of the procedure. Ninety-nine percent would recommend the procedure to friends or relatives with cataracts.

• Colonoscopy.

— Procedure times.

The median pre-procedure time was 60 minutes (range 14 to 130). Organizations with the shortest times use processes such as preparing paperwork before the patient arrives, PRN staffing and scheduling efficiencies.

Average procedure times ranged from 7 to 42 minutes (median 18).

The median discharge time was 39 minutes (range 10 – 71 minutes). Organizations with the shortest times attributed their results to the use of sedatives that allow patients to recover quickly, and sufficient recovery room staff.

— Patient outcomes.

Ninety-six percent of patients were able to schedule their procedures as soon as they wanted.

Seventy-four percent reported little or no discomfort during pre-procedure bowel preparation. Ninety-six percent reported little or no discomfort during the procedure.

Ninety-nine percent said they received written discharge instructions.

Ninety-nine percent said they would recommend the procedure to a friend.

• Knee Arthroscopy.

— Procedure times.

Median pre-procedure time was 90 minutes (range 60 to 164). Organizations with the shortest times attributed their results to preparing prior to the day of surgery and sufficient staffing.

Average procedure times ranged from 7 to 55 minutes (median 26).

Median discharge time was 68 minutes (range 40 to 132). Organizations with the shortest times attributed their results to educating patients preoperatively and short-acting anesthesia combined with local anesthetics.

— Patient outcomes.

Ninety-one percent said they were able to schedule their procedures as soon as they wanted.

Ninety-nine percent said they experienced little or no discomfort during the procedure, and ninety-eight percent said they were comfortable post-discharge.

One hundred percent said they had adequate understanding of the procedure and had received written discharge instructions.

Ninety-seven percent had begun walking (with or without crutches). ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

- Anesthesia contracting: Where is it heading?
- Future of electronic medical records
- Tips for increasing colorectal screenings
- Suggestions for reducing staffing costs

CNE/CME OBJECTIVES

- **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.

CNE/CME QUESTIONS

1. Guidelines for Healthcare Providers Who Treat Fat Patients" from the National Association to Advance Fat Acceptance (NAAFA) suggest you avoid using which word?
   A. Fat
   B. Obese
   C. High body mass index (BMI)
   D. None of the above.

2. "Guidelines for Healthcare Providers Who Treat Fat Patients" suggest which of the following?
   A. Provide several sturdy armless chairs, couches, or benches in your waiting room.
   B. Six to 8 inches of space between chairs.
   C. Both A and B
   D. Neither A nor B

3. To address registration bottlenecks during morning surgery rush times at Indiana University Health North Hospital, what did the hospital do?
   A. Utilize registration team members from different areas of the hospital.
   B. Tell patients to arrive 45 minutes early.
   C. Register patients by phone the previous evening.
   D. Have patients register online the morning of surgery.

4. According to AAAHC Institute benchmarking data on colonoscopy, what process(es) is/are used by organizations with the shortest procedure times?
   A. Preparing paperwork before the patient arrives,
   B. PRN staffing
   C. Scheduling efficiencies
   D. All of the above

Same-Day Surgery®
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Covering Hospitals, Surgery Centers, and Offices for More than 35 Years

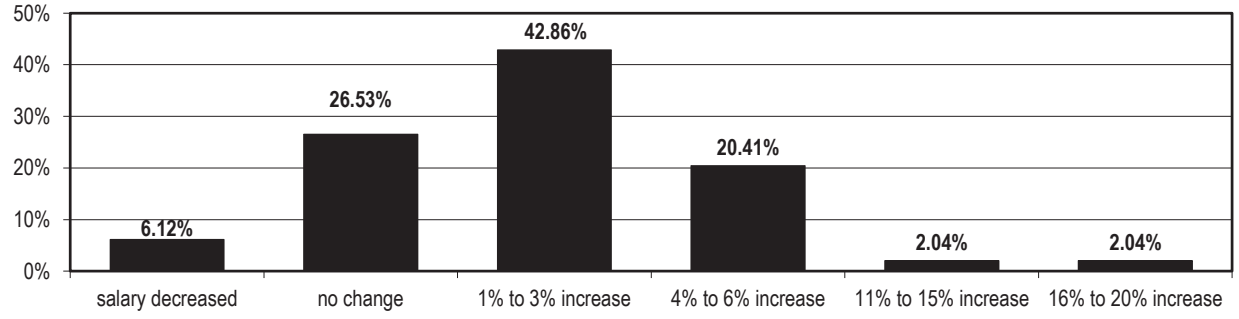
Faced with flat and decreasing salaries, look for other ways to recruit and retain

With outpatient surgery salaries flat across much of much of the nation, outpatient surgery managers are finding that they need to enticing benefits and a positive work culture to recruit and retain staff.

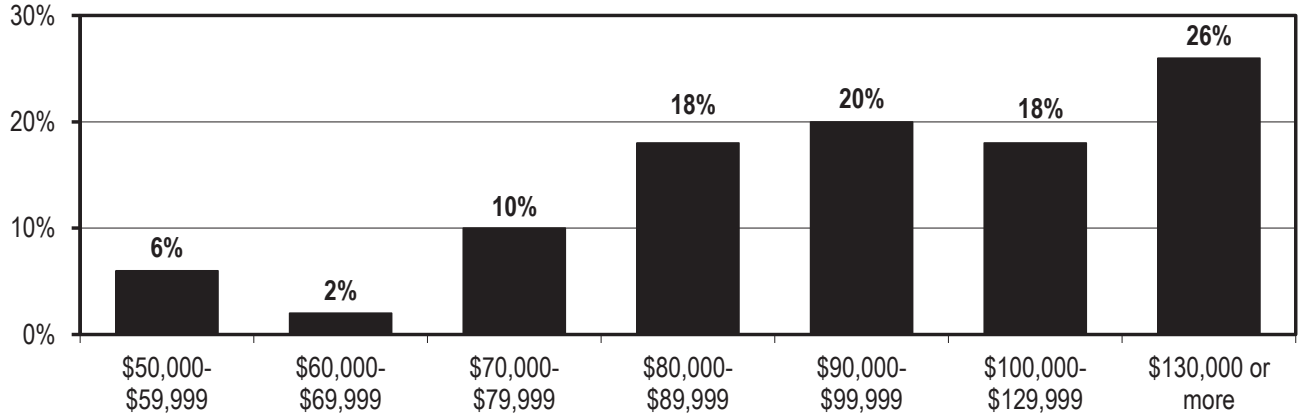
The 2011 Salary Survey results indicated that 26.5% of respondents received no increase in salary, and 6.1% received a decrease. These figures compare with 38.1% receiving no increase in salary in 2010, and 3.2% receiving a decrease that year. *(See graphics: "In the Last Year, How Has Your Salary Changed," below, and "What is Your Annual Gross Income From your Primary Healthcare Position, p. 2.) Same-Day Surgery* sent the 2011 Salary Survey to 480 subscribers with the September 2011 issue. Fifty subscribers responded, for a response rate of 10.4%.

So what can you do when you can't hand your employees a nice, big raise? You could consider additional ways for employees to earn money. At WellStar Health System in Marietta, GA, named one of best the 100 best places to work in the country by Working Mother magazine, nurses earn additional money as they advance up the clinical or management track or by becoming board certified in a specialty. Additionally, WellStar offers bonus performance pay plan for all

In the Last Year, How Has Your Salary Changed?



What is Your Annual Gross Income from Your Primary Healthcare Position?



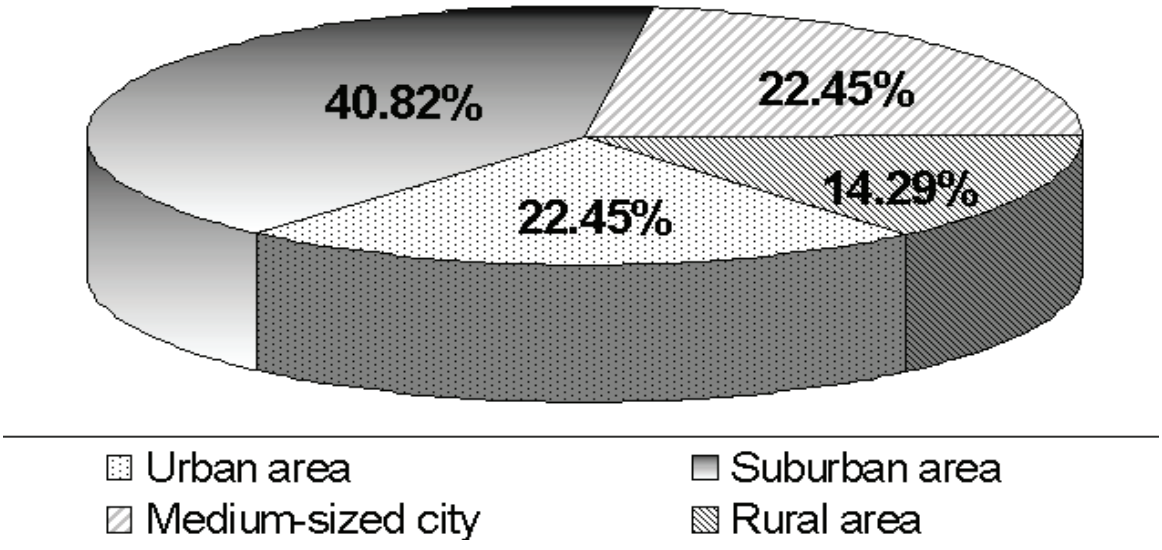
employees tied to organizational performance, says **Karen Mathews**, CWLP, director of work life services.

Also, WellStar employees are allowed tuition reimbursement for graduate degree assistance, as well as undergraduate degree courses and high school diplomas/GED. Even part-time employees can be eligible. *(To see how your degree lines up with your peers, see graphic, "What is your highest degree?" p. 4.)*

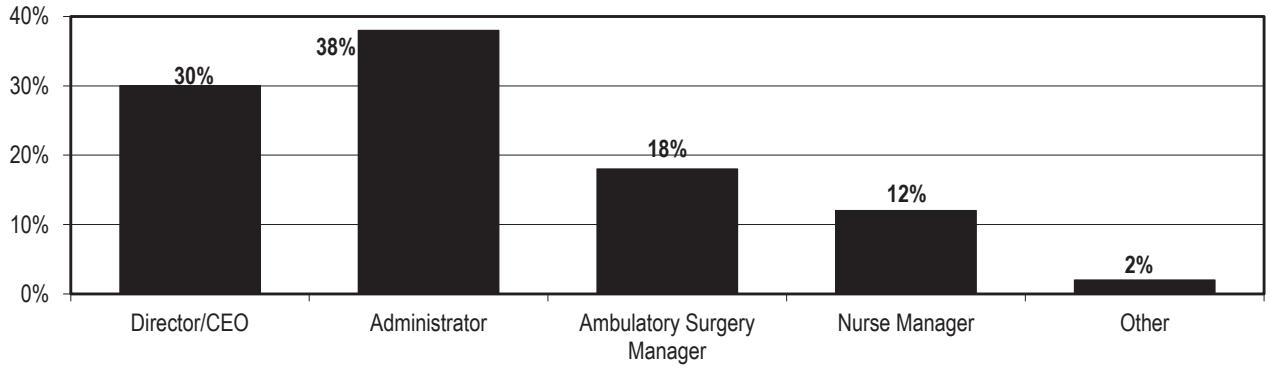
The Methodist Hospital in Houston, TX, named to *Fortune* magazine's "100 Best Companies to Work For" list six years in a row, offers a generous tuition reimbursement program. Another bonus? Flexible work schedules that employees can fit around their classes, says **Janet Gilmore**, MSN, RN, interim vice-president of perioperative services.

WellStar offers a FlexWorks program and policy. More than 75% of the workforce

Which Best Describes the Ownership or Control of Your Employer?



How Many People Do You Supervise?



uses flexible work such as job shares, daily flexing, remote self-scheduling, compressed work weeks, and part-time and full-time teleworking. And the perks don't stop there. "Benefits-eligible employees have a bank of 80 hours a year for back up care for a child elderly relative anywhere in the country," Mathews says. "Cost to the employee is only $2 an hour for center-based care and $4 an hour for at-home care." The system allows has a full concierge services program free to employees to run errands, complete car maintenance, pick up dry cleaning, and more *(For more on the concierge program, see "Want to keep employees happy? Offer flexible schedules, concierges to run errands,"* Same-Day Surgery*, February 2011, 2010 Salary Survey Results supplement.)* Methodist Hospital offers referral services for vendors to perform personal services such as roofing and painting, even in other cities where employees might own property. "They can do a lot of legwork for you and let you be the nurse," Gilmore says.

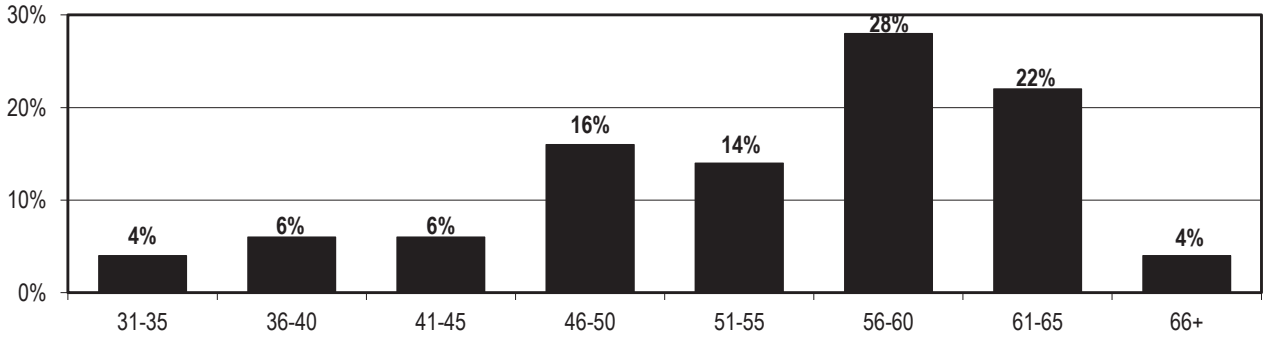
What's as important as salary and benefits?

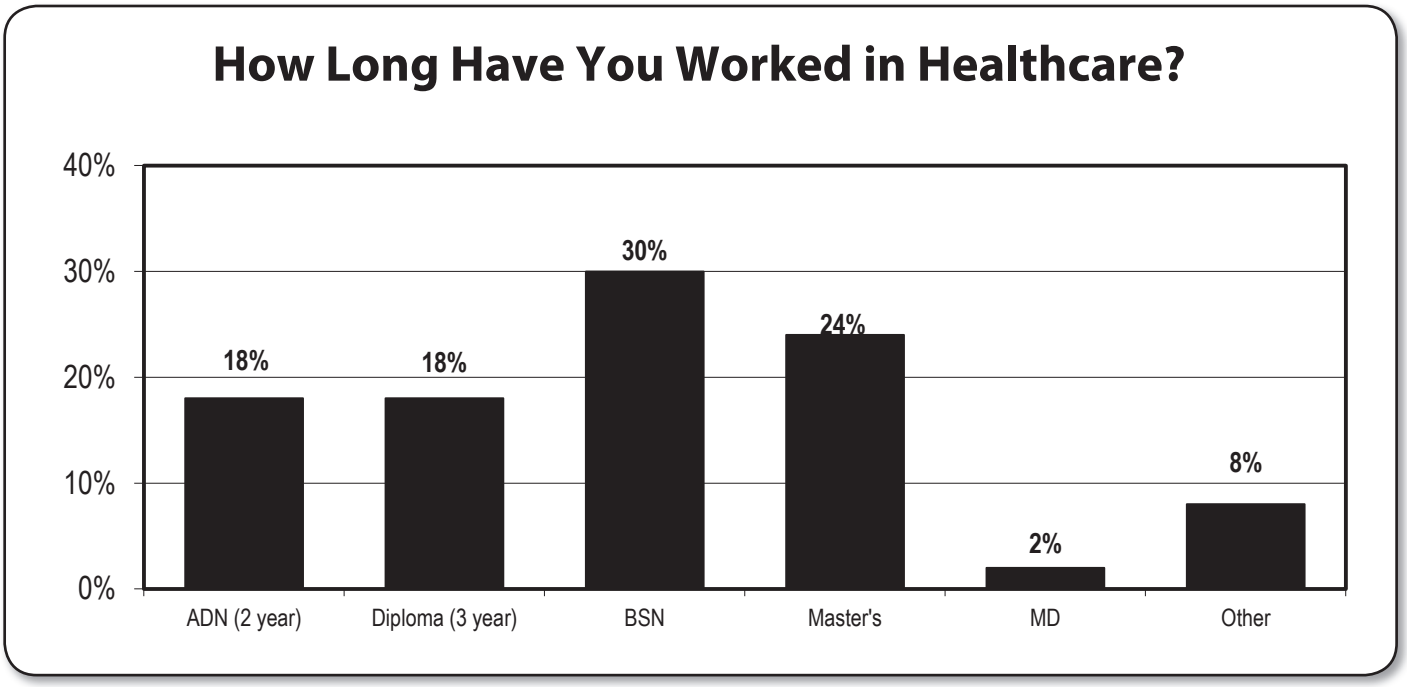
There are some things that are at least as important as salary and benefits, according to sources interviewed by *Same-Day Surgery*. One of those, they say, is workplace culture.

Methodist Hospital offers a research institute with a large laboratory where nurses can practice skills, such as robotic surgery. Other state-of-the-art equipment includes vein finder for starting IVs and blotter scanners for determining if patients need to be catheterized. "We have lots of bells and whistles to help us in our practice," Gilmore says.

Methodist was voted no. 10 on the *Fortune*

How Many Hours a Week Do You Work?





list for work-life balance. The benefit include a wellness program with a state-of-the- art gym; programs for stress reduction, weight loss, and tobacco cessation; and reduced fees for on-site massage therapists. Additionally, the hospital holds parties to mark national awards such as the Fortune designation and achieving magnet designation, which the hospital just achieved for the third time. "We're celebrating successes," Gilmore says.

WellStar uses intentional strategies to focus on the work culture. "We conduct team engagement action planning sessions regularly," Mathews says. Every leader is expected to develop relationships with their team and team members, she says. "Know what they are thinking, Mathews suggests. "Ask their opinions," she says. Offer them responsibility, and then empower them so they can success, Mathews says. "Have their back," she says. "Celebrate them often, and never take them for granted."

It's critical to build a culture of trust and engagement, Mathews says. "Team members in healthcare work long and often stressful hours," she says. They need to know "they are valued, their opinions count, that someone cares about them as a person, and that their life is more than their job," Mathews says. "When team members experience compassionate care, understanding, and professional support, they extend it to their patients." *(For more results of the salary, see these graphics: On p. 2, "Where is your facility located?" On p. 3, " What is your current title?" On p. 3, " What is your age?")* ■