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Are you throwing away money with unnecessary routine preop tests?

By **Joy Daughtery Dickinson**, Executive Editor

Are you performing unnecessary preoperative tests? If so, you're wasting expensive staff time required to conduct them and analyze them, as well as supplies needed to conduct them. In addition, you're experiencing potentially unnecessary surgical delays due to false positives. Additionally, patients are wasting time, possibly away from work. All of these costs add up, especially in these tight economic times.

So why is unnecessary testing done? "One of answers, I hear frequently, hear they have a need to practice defensive medicine," says **Jeffrey L. Apfelbaum**, MD, chair of the American Society of Anesthesiologists' (ASA's) Committee on Standards and Practice Parameters, professor and chair of the Department of Anesthesia and Critical Care at the University of Chicago, and member of the Executive Committee of Pritzker School of Medicine and medical staff of the University of Chicago Hospitals in Chicago. "Having information available is one way to do so," Apfelbaum says.

His opinion is echoed by **Michael N. Abrams**, MA, co-founder and managing partner of Numerof & Associates Inc. (NAI), a St. Louis, MO-based strategic

This month: Best cost-saving tips from your peers

This month's issue is one of the most awaited issues of the year: our annual cost containment issue. We offer extensive information, including real-life examples, on how to save money by reducing routine preop tests. We tell you how another facility reduced surgical site infections and other costly problems with two cost-effective tools. This month's issue also includes a story on how one surgery center is targeting increases in medical premiums with a wellness program. Another shares how an annual meeting with its bank paved the way for several cost savings, including a 3% reduction in its loan interest rates. Our columnist Stephen W. Earnhart offers some cost-saving tips, but he also suggests where you should stop these efforts. Finally, we offer you a collection of free sources on sleep apnea, bloodborne pathogens, reprocessing, privacy training, and an OR medication safety.

We hope you enjoy this special issue of Same-Day Surgery.

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management consulting firm focused on organizations in rapidly changing industries, including healthcare. "There are other hypothesized factors as well, including: to provide early detection of potentially serious medical conditions; to detect underlying health conditions that, even though rare, could result in complications during or after the scheduled procedure; and to provide peace of mind to the patient/family by reporting that all screening tests were normal."

Electronic records may change the parameters of preoperative testing, because testing at its foundation is about lowering risk, says **T. Forcht Dagi**, chairman of the Committee on Perioperative Care for the American College of Surgeons. "As we get better at deploying electronic health records, and as we have interchange of data across entire medical systems, it will be easier to know what tests the patient has had and what the results were," Dagi says.

Currently, when a surgeon is doing an operation that needs a chest X-ray, the patient might say he had one done one month ago. When the surgeon asks the result, the patient might say he isn't certain, but he thinks it was OK. "It's easier to get another X-ray then chase down the original results," Dagi says.

So how do you know which preoperative tests to perform? Look to recent developments and research for direction:

• A study published in the September issue of the Annals of Surgery said that preoperative testing is overused in patients undergoing low-risk, ambulatory surgery.

After adjusting for patient and procedure characteristics, neither testing nor abnormal results were associated with postoperative complications in 73,596 patients undergoing elective hernia repair.[1]

In the study, 63.8% of patients underwent testing, and at least one abnormal test was recorded in 61.6% of patients. In patients with no comorbidities, as defined by the National Surgical Quality Improvement Program, and no clear indication for testing, 54% received at least one test, the researchers said. In addition, 15.3% of tested patients had their lab tests done on the same day as their operations. In this group, surgery was done despite abnormal results in 61.6% of same-day tests. Major complications (reintubation, pulmonary embolus, stroke, renal failure, coma, cardiac arrest, myocardial infarction, septic shock, bleeding, or death) occurred in 0.3% of

EXECUTIVE SUMMARY

Unnecessary preoperative tests waste expensive staff time required to conduct them and analyze them, as well as supplies needed to conduct them. Also, surgery may be delayed due to false positives.

- A recent study found no connection between preop testing for low-risk, ambulatory surgery patients that resulted in abnormal test results with postop complications.
- The American Society of Anesthesiologists' "Practice Advisory for Preanesthesia Evaluation" says preop tests should not be ordered routinely.
- Global payments are likely to include preop tests as the Affordable Care Act (ACA) is fully implemented.
- A care path that includes preop tests might offer even more savings.

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patients.

On the basis of high rates of testing in healthy patients, the use of preoperative tests should be dictated by physician and/or facility preference, as well as patient condition, the researchers say.

• In 2012, the American Society of Anesthesiologists Committee on Standards and Practice Parameters updated the society's "Practice Advisory for Preanesthesia Evaluation."[2]

The advisory says that preop tests should not be routinely ordered. "Preoperative tests may be ordered, required, or performed *on a selective basis* for purposes of guiding or optimizing perioperative management," the advisory says.

There is insufficient evidence for ordering routine preop tests based on clinical characteristics, the advisory says. "However, consideration of selected clinical characteristics may assist the anesthesiologist when deciding to order, require, or perform preoperative tests," it says. Specific tests and their timing should be based on the individual patient and can be based upon information such as the medical record, patient interview, physical examination, and the type and invasiveness of the planned procedure, the advisory states.

The need for selective testing is emphasized by Apfelbaum. "Selecting tests, after you considered information you gathered using medical skills, likely will assist the anesthesiologist in making decisions that will be useful in the preoperative assessment or perioperative management of patient," he says. "That's the take-home message."

• The Agency for Healthcare Research and Quality of the Department of Health and Human Services has a current project on preop testing for patients undergoing elective or ambulatory surgery requiring anesthesia.

This project is providing "excellent guidance," according to Abrams *(The guidance can be accessed at http://1.usa.gov/UzN6UP.)*

The guidance, which still is in development, says, "[I]t is important look not only at the benefits and harms of preoperative testing in general but also at specific patient and intervention factors that might change the balance between the benefits and harms — namely, the risk of the surgical procedure, the type of anesthesia planned, the indication for surgery, comorbidities, and other patient characteristics."

While the current fee-for service payment model provides little incentive to eliminate preop testing, that model is changing quickly, Abrams emphasizes. Bundled pricing typically includes such testing in a comprehensive price. While the "global surgery package" defined by Medicare doesn't include diagnostic tests and imaging, global payments are likely to evolve to include them as the Affordable Care Act (ACA) is fully implemented, Abrams says. "Savings from using only appropriate testing will make the transition much easier," he says.

For example, Dagi says, if a patient is having a very minor procedure, and the risk of bleeding is very low, and the patient has no history of difficulty with blood clotting and no history of hemorrhage, and the patient is not taking any medications that might affect the ability to coagulate, then under those circumstances you may be able to skip some of preop coagulation tests that would be required for major surgery.

Would care paths be a better approach?

Abrams suggests that providers go beyond simply targeting preoperative testing and instead look at using care paths to reduce costs.

"Significant savings can be realized through minimizing personnel time spent doing tests, assessments, treatments, and procedures so that increased efficiency improves throughput time and staff workload," he says. "The time and effort spent following up on false positive tests must also be considered"

To determine how much you can save, look at your data on staff practice variances, Abrams suggests. "The data elements include such items as test utilization, false positive test rates and associated case cancellation rates, supply use, OR time and staff utilization, complication rates and reimbursement denials," he says.

Effectively using care paths can bring all surgeons up to the level of the best performer's results, or better, Abrams says.

"Since adherence to care paths has been demonstrated to improve outcomes, reduce complications, and improve patient/family satisfaction, care paths contribute to reduced staff time and facility resources to care for post-procedure complications and may secondarily improve patient loyalty and community reputation," he says. *(See story about how Abrams helped a surgery center eliminate unnecessary tests with a care path for diagnostic evaluation of prostate cancer, p. 16. For information on how to get physicians on board with reducing preop testing, see story, p.16. To see how researchers reduced patient charges for common preop tests, see story, p. 16. For more on preoperative testing, see "Is there reason for routine pre-op tests? New research raises question,"* Same-Day Surgery*, May 2009, p. 41.)*

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RESOURCE

The DVD-based Manual for Anesthesia Department Organization and Management (MADOM) is free for members of the American Society of Anesthesiologists and $100 plus shipping and handling for non-members. To order, go to http://bit.ly/XK6SxD. ■

Get physicians on board to reduce preop testing

So if you're convinced that unnecessary preop testing needs to be eliminated, how do you accomplish this feat?

"Eliminating unnecessary preop test ordering and other costly behaviors that a thorough assessment of current practices will reveal involves change management for the entire facility staff, including its physicians," says **Michael N. Abrams**, MA, co-founder and managing partner of Numerof & Associates Inc. (NAI) in St. Louis, MO. "Providers will be critical for most changes needed, however, since they control much of what is ordered and carried out for the procedures done in the facility."

While getting physicians on board might seem like a daunting task, Abrams points out that physicians, as a group, have attributes that help facilitate acceptance of change. He lists the following: "a desire to provide the highest quality care for their patients, a competitive spirit concerning the quality of their outcomes compared to peers, and a requirement for data to be provided to support change."

Flexibility is an important factor, Abrams says. "Although the smooth, consistent functioning of the entire team that accompanies use of care paths is appreciated, most physicians need to know that variation based on their assessment of individual patients will be allowed — subject to review for appropriateness, of course," he says. ■

Reducing preop tests as part of a care path

Path targeted diagnostic evaluation of prostate cancer

When one surgery center's care path for diagnostic evaluation of prostate cancer showed routine use of three diagnostic tests, **Michael N. Abrams**, MA, co-founder and managing partner of Numerof & Associates Inc. (NAI) in St. Louis, MO, took a deeper look.

"The care path under review had indicated that all patients should receive a bone scan, CT scan of the abdomen, and a PET scan," Abrams says. "In this particular instance, the issue came down to differential diagnosis, and reserving such tests for those specific patients whose cases warranted these tests."

The American Urological Association has established clinical practice guidelines for the evaluation of a patient with prostate cancer, which depend on the status of both the patient and status of the cancer. "Preoperative care pathways, therefore, will include the urologist's assessment of the patient as a candidate for surgery depending both on the stage of malignancy and also the anesthesiologist's needs to provide safety during the operation," Abrams says.

Before you consider surgery, the patient must be a good surgical candidate and have a life expectancy of at least 10 years, he says. "The malignancy should be localized to the prostate, so that surgery can provide a high likelihood of clinical success and cure," Abrams says.

According to best practice pathways, men with a presenting prostate-specific antigen (PSA) under 10, and a Gleason score (representing tumor aggressiveness) below 8 have a very low risk of metastatic disease, and no further imaging or testing is indicated, he says. "However, men who are at high risk of harboring extra-prostatic cancer are those with PSA greater than 10 or have a Gleason score equal to or greater than 8," Abrams says. "These men are at a high risk of metastasis and should have further studies including a bone scan and CT scan of the abdomen and pelvis."

If there are still concerns about tumor spread after these studies, then more extensive tests could include PET or Prostascint scanning, he says. "However, these tests would not routinely be given to all prostate cancer patients," Abrams says.

Because the cancer cannot be cured once it is beyond the borders of the prostate gland, these tests determine whether surgery would be curative and should proceed, he explains.

"Once the decision for surgery has been made, immediate pre-operative testing follows standard collaborative guidelines established by both the surgeon and anesthesia, including appropriate blood tests, EKG, etc.," Abrams says. Other consultants, such as cardiology or oncology, also provide input, he says.

At the time of admission and surgery, use cost-efficient programs in choosing antibiotics and in efficient use of hospital resources, Abrams advises. "By establishing evidence-based pathways from the preoperative area to the surgical suite, to post-operative care, patients can oftentimes be discharged after just an overnight stay or even as outpatients," he says. "This can save thousands of dollars per patient and millions of dollars to the healthcare system." *(For more information on cost containment in urology, see select references, below.)*

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Anesthesiologist model of care saves money

Patient charges cut for hip, knee replacements

Using a comprehensive preoperative triage system directed by anesthesiologists, researchers at the Ochsner Medical Center in New Orleans has shown marked reductions in patient charges for common medical tests without sacrificing quality of care and successful outcomes. Their findings were presented at the recent Anesthesiology annual meeting of the American Society of Anesthesiologists.

Patient charges for the seven most common medical tests were reduced by $18,187 for every 100 patients with mild disease and $20,664 for every 100 patients with moderate disease.

Lead study author **Sharon Carrillo**, MD, MS, and her group used methods of coordinated care in the surgical setting in which facilities "join together like a concerned family to oversee a patient's surgical experience" and create substantive savings in healthcare. "Our premise is that dedicated anesthesiologists likely have more insight into surgical stresses and test requirements than primary care physicians who, with surgeons, still predominantly 'clear' most patients in U.S. clinical practice," said Carrillo.

In the study of nearly 1,400 patients, anesthesiologists at Ochsner reviewed available medical records, ordered tests, and requested appropriate consults for total knee and total hip replacement surgeries. Among several other cost-saving practices, the study authors replaced costlier comprehensive metabolic profile tests with a basic metabolic profile, obtained EKG tests only for healthy patients over 65, and avoided duplicate X-rays by administering them only when called for because of symptoms or previous examination findings.

Interestingly for the Ochsner researchers, their findings were observed during a period in which an external auditor determined that major complications associated with total knee and total hip surgeries at the institution were decreasing.

"We believe that we have successfully reduced the cost passed on to patients without sacrificing successful outcomes," said Carrillo. "Our goal is to expand the triage process to other surgical groups in hopes of further cost containment and improved patient satisfaction at our institution." ■

Training and checklist cut postop complications

Training sessions focus on communications

Two simple cost-effective methods — communications team training and a surgical checklist — have been shown in a study to reduce postoperative complications,[1] which are the most expensive medical errors, averaging $14,500 per case.[2]

Investigators have found that when surgical teams completed communications training and used a surgical procedure checklist before, during, and after high-risk operations, patients experienced fewer adverse events such as infections and blood clots. The study was conducted at the University of Connecticut Health Center, Farmington, and Saint Francis Hospital and Medical Center, Hartford, CT.

While this study builds on previous research about

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A "Journal of American College of Surgeons" study reports that surgical site infections, blood clots, and urinary tract infections were measurably reduced when surgical teams use two easily accessible, cost-effective tools.

- Communications training included three sessions on topics such as differences between introverts and extroverts, effective dialogue among all operating room personnel, and how to use a surgical checklist.
- The team used the one-page Association of periOperative Registered Nurses Comprehensive Surgical Checklist before, during, and after high-risk operations.

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the benefits of using checklists, it is the first to look at how communications training can help surgical teams have productive conversations around patient care while using the checklist, explained **Lindsay Bliss**, MD, lead study author and general surgery resident at the University of Connecticut.

The drop in postoperative complications has implications for national healthcare spending because Medicare and other health insurance providers are starting to decline reimbursement for complications that result from the clinicians' errors, especially just a month after the patient's procedure.

"Every adverse outcome results in more expense," Bliss said. "It means a longer stay in the hospital and more treatment. Communicating and using a checklist do not just add extra minutes on to the procedure. There is an ethical and financial obligation tied to both tools."

Occasionally unforeseen circumstances can occur during surgery. Sometimes surgical equipment isn't on hand, or the patient requires more blood than expected, which delays the procedure and requires dispensing more anesthesia while a team member hurries to obtain needed supplies. Also, surgical team members might have inconsistent information about priorities for the procedure, Bliss said.

"Everyone brings to the team a different aspect of patient care that they think is the most important," she said. "But the team has to understand all aspects of patient care and agree on what's important."

For the study, Bliss' colleagues compared three groups of surgical procedures to determine whether communications training coupled with a standardized checklist could bring surgical teams into agreement and reduce patients' complications. The communications training included three sessions on topics such as differences between introverts and extroverts, effective dialogue among all operating room personnel, and how to use a surgical checklist.

The communication training was given by internal professional development staff at Saint Francis. The curriculum was primarily developed internally by one of the trainers as well as members of the research team. Key principles were from the text "Crucial Conversations: Tools for Talking when Stakes are High" (McGraw Hill).[3]

Although surgical checklists have existed for a while, they are not universally used. Bliss' team used the one-page Association of periOperative Registered Nurses (AORN) Comprehensive Surgical Checklist developed in April 2010. (The checklist can be accessed at http://bit.ly/TRV12G.) It includes protocols mandated by the World Health Organization (WHO), The Joint Commission, and the Centers for Medicare and Medicaid Services (CMS), and it has been endorsed by the American College of Surgeons (ACS) and other surgical organizations.

For one group of procedures, the surgical team selected operations from the ACS National Surgical Quality Improvement Program (ACS NSQIP) database. These operations occurred between January 2007 and June 2010 and served as the baseline group, because these surgical teams had not gone through the communications training or used a checklist. Bliss said pulling this information from the ACS NSQIP database allowed the researchers to access standardized clinical and demographic data on the patients, along with information about 30-day surgical outcomes.

These procedures were compared with two other groups of surgical procedures that occurred between December 2010 and March 2011. In one group, 246 procedures involved surgical teams who had undergone communications training, while the other group included 73 procedures involving surgical teams who had not only gone through the same communications training, but also used the checklist.

Study results showed that the communications training coupled with the checklist curbed complications within 30 days of the procedures. Complications included surgical site infections (SSIs), vein blood clots, lung blood clots, and urinary tract infections (UTIs). When surgical teams had no communications training and did not use checklist, more than 23% of the procedures resulted in complications within 30 days. About 16% of procedures by surgical teams who only participated in communications training led to complications within 30 days, and only 8.2% of the procedures had a 30-day complication when the surgical teams used the communications training and the checklist.

Even small steps such as making sure everyone on the team introduced themselves before the procedure helped reduce complications. Bliss said. "The theory is that this brings a sense of accountability and

makes sure that everyone's voice can be heard," she explained. "No one on the surgical team is a nameless, faceless body. The checklist makes sure everyone is advocating for the patient."

She pointed out that the checklist is free and available online. "The cost of a photocopy in exchange for reducing patient morbidity is a fabulous return on investment," Bliss said.

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Outpatient surgery center targets worker wellness

Outcomes-based incentives for employer-sponsored workplace wellness programs are expected to become more common as a result of provisions in the Affordable Care Act that encourage their use, but some employers aren't waiting.

Texas Health Surgery Center Denton has added a wellness program that includes health risk assessments, biometric screenings, and a wellness portal for employees to monitor and improve health and wellness credits.[1] Employees who participate are given reduced health insurance premiums.

The center worked with two companies on its wellness activities. Cooper Consulting Partners in Dallas helped design the wellness plan and worked one-on-one with high-risk employees. The Vitality Group in Chicago provided tools to employees to manage their health.

Monthly webinars have been added to cover healthy living topics. Recent topics have included strength straining and flexibility. "In addition, we have had several speakers come to speak to our employees this year to provide education on fitting exercise into your busy life, nutritional eating, financial health, etc." says **Lynne Parris**, RN, BSN, director of clinical and surgical services. Some of the speakers have been provided by United Healthcare as part of the center's benefits package.

Reduced costs for gym memberships are provided through the agreement with Vitality and through United Healthcare. A fitness center is located on the Texas Health Presbyterian Hospital Denton campus. "Our employees can join this fitness center and make payments via payroll deduction," Parris says.

Additionally, the center is surveying employees to gauge interest in a 10-week exercise class program. "Options we have provided are fitness classes such as Zumba, yoga, or bootcamp," Parris says. "Our goal is to have an instructor come to our employees twice a week after hours and lead a private class."

Staffers can monitor their exercise level by wearing Fitbugs (ttps://usa.fitbug.com/sales) to track their steps and calories burned. The Fitbugs link to a coaching website that provides personal weekly targets. The Fitbugs were $40, and the surgery center paid for 50% of the cost.

This summer, the center started an eight-week "Lost and Found Challenge" to encourage five health habits: eating breakfast, drinking at least 32 ounces of water daily, exercise at least 15 minutes per day, eat five servings of fruits and vegetables a day, and participate in one "bonus activity." "The idea is to do three of the five daily habits each day and have three scheduled weigh-ins during the challenge … the end result being to start healthy habits that continue on beyond the end of the challenge," Parris says..

Several employees participated in a 5K race this summer. As a group, staff participated with five other facilities managed by Texas Health Partners in a contest named "Battle of the Bulge" and came in third place. The winning facility received $250 from the other facilities to go toward the charity of its choosing as well as a monetary award to celebrate with staff.

With the emphasis on wellness, one employee has quit using tobacco products. Healthy employees can reduce sick days, which are disruptive to the staff, sources point out.

Parris says, "Our ultimate goal is to help our employees manage their health and in turn, hopefully, see a leveling off of medical premium increases."

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RESOURCE

The American College of Occupational and Environmental Medicine has a new training program on worksite wellness designed for employers, human resource professionals, benefits managers, and occupational health professionals. The program presents a step-by-step approach on how to implement a successful worksite wellness program. The program is titled "Worksite Wellness: The Healthy Worker Advantage." For more information, go to http://www.acoem.org/courses.aspx. ■

Want to save money? Meet with your bank

Would you like to realize dramatic cost savings, including cutting your interest rates in half? Meet with your bank once a year, suggests **Joan Shearer**, CASC, administrator of Lawrence (KS) Surgery Center.

Shearer sets up the annual meetings that include herself, her office manager, one of the bank's vice presidents, and one of the bank's service managers.

The group discusses current loans and interest rates, among other topics. "We continue to reduce our interest rate on loans, which is a significant cost savings for us," Shearer says. A couple of years ago, the interest rate was 7%, Shearer says. "Now we're down to between 3.5 and 4%."

The annual meeting also provides an opportunity to review bank fees and how those fees can be reduced, she says.

This meeting also has opened the door for a change in how the center processes checks. It now has an electronic check processor, so staff members don't have to travel to the bank. "It helps with our turnaround on cash," Shearer says. The amount of investment for the processor was insignificant, she says, and the cash now appears in the account within an hour, as opposed to the next day, she says.

At the annual bank meeting, Shearer also discusses future capital needs and how the bank can structure a loan for big ticket items. "It gives them a heads up," she says. For example, the center managers alerted the bank that they are preparing to purchase new scopes and probably will finance those purchases. "The bank is examining what kinds of loans they have and what would be a good option," she says. They bank also is examining the option of combining loans, Shearer says.

"We do our strategic planning for the year: our plans, their services, and how we can work together to reduce our expenses," she says. ■

PA facilities implement wrong-site best practices

More than 30% of Pennsylvania healthcare facilities have successfully implemented 21 potential recommendations for preventing wrong-site surgery, according to the Pennsylvania Patient Safety Authority (PPSA). Such efforts go a low way toward avoiding potentially costly lawsuits.

The PPSA recently sent 417 Pennsylvania facilities with operating rooms its 21 potential recommendations to prevent wrong-site surgery and asked the facilities to describe barriers for implementing the recommendations that would prevent them from meeting the standard or standards for the goal. *(For more information and to see the 21 potential recommendations, go to http://bit.ly/UGH9DT.)* The PPSA survey divided the 21 potential recommendations into five groups, with a total of six goals and eight proposed measurement standards for the groups. For each of the six goals, the PPSA asked facilities to describe barriers for successful implementation. Seventy facilities responded to the survey. Two-thirds of the responses were from hospitals, and one-third were from ambulatory surgical facilities, says **John Clarke**, MD, clinical director of the PPSA.

"Overall, the surveyed Pennsylvania healthcare facilities felt they could successfully implement the potential recommendations for preventing wrong-site surgery," Clarke says. "Less than 20% of surveyed healthcare facilities identified some barriers to implementation, but all of the barriers could be modified or overcome through education, policy changes, or culture changes."

Pennsylvania healthcare facilities responding to the survey gave their reasons for successful implementation of the 21 potential recommendations to prevent wrong-site surgery. "Education, audits, leadership, and empowerment of nurses to 'stop the line' were some of the strategies facilities cited they have used to successfully implement wrong-site surgery best practices," Clarke says. "Elaboration of these strategies includes leadership buy-in from surgery departments and respectful interactions with staff."

Clarke added that 27 facilities commented about the feasibility and potential cost impact of implementing the potential recommendations associated with each of the eight standards. "Most respondents — 20 out of 27 — had no concerns, indicating that the potential recommendations were in place or that they thought implementation was feasible at minimal cost," Clarke said. "Seven expressed primarily cost concerns."

Concerns about potential cost impact include: personnel time to verify and reconcile information, resources to monitor compliance, personnel time for redundant checking of information, resources needed to implement the evidence-based best practices, resources and time for education, resources to upgrade electronic and paper documents, possible increased staffing, OR delays and loss of business, and physician availability on-site or remotely for a second verifica-

tion of intraoperative images. Physician behavior and accessing accurate information before the patient's arrival in the preoperative holding area were cited by surveyed Pennsylvania healthcare facilities as common barriers, Clarke adds.

The PPSA's program to prevent wrong-site surgery began in December 2007 after research revealed that Pennsylvania healthcare facilities were submitting about two and one-half wrong-site surgery reports per week. Since the prevention program began, wrong-site surgeries in Pennsylvania have decreased by 37% from an average of 19 reports per quarter to an average of 12 reports per quarter.

In April 2012, the PPSA began another wrong-site surgery initiative with 28 Pennsylvania healthcare facilities that have made the commitment to reduce and eliminate wrong-site surgeries.

SOURCE

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Same-Day Surgery Manager

Unconventional cost control and reduction measures

By **Stephen W. Earnhart**, MS
CEO
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Houston, TX

At some point, after reducing cost so much, we are going to realize that the best option is to not do surgery at all. Think of the savings!

As healthcare providers, over the years — the decades — we have been cutting and cutting and cutting so insurance companies can profit and profit and profit. Surgical reimbursement under accountable care organizations (ACOs) will be driven by YOU reducing cost. Really? I have nothing else to do? I guess we drove past controlling it sometime ago. I never got the memo.

What more can we reduce?

• **Hospitals.** Man, it is tough. You have so many masters to serve. Emergency trauma cases, major unexpected complicated findings in exploratory surgery, student nurse programs, interns, robotic surgery programs, huge overhead and contribution margins, and a system that inherently has not had to deal with cost reduction on the scale that you are going to be facing now.

Hospital managers are going to have to look at their issues realistically and understand they have to start providing different levels of care. You just cannot, absolutely cannot, continue to provide inpatient and outpatient surgical services under one roof or location. You must have a lower cost environment for the uncomplicated, predicable levels of surgical services. Comes again back to the development of off-site surgical hospital outpatient departments (HOPDs) with different staffing ratios, management, and organizational structure. These are tough decisions for upper management and hospital boards.

Hearing anything on tort reform? Wonder if that would cut healthcare costs? (Sarcasm.)

• **Surgery centers.** Fifty to 60% of your expense is personnel and supplies. I know I frequently beat up on our vendors to cut their cost and even their commissions, but I have to admit, I think they are down to bone. Most are in the same boat as we are. When we are in cost-cutting mode, we don't buy as much, and it hurts them just as much as us. While there might be a tad more to cut there, it probably is not worth the effort. You need to just control it.

Personnel cost, in hospitals and surgery centers, still is high. Because half of my clients are hospital-based, I recognize that it is much easier to justify their higher personnel levels than surgery centers. They have too much uncertainty with higher acuity cases, labor and delivery, call, and unpredictability.

We still are overstaffed. Like it or not, most of you will admit it only to yourselves, but you know you can make reductions.

But let's say you cut staff by one or two nurses. Is that going to slow your turnover time? What about when our surgeons become employees of the hospital? They aren't going to really care about turnover time anyway, will they? Ka-ching, ka-ching!

What if you cut one or two front desk staff? Will that slow down your registration time and delay cases?

What if we tell our surgeons that no more free lunch's on the days they have a full block of cases? What if we stop giving our busiest surgeons the ability to flip-flop rooms? Do we save money if they leave and go someplace else?

What if we stop buying new equipment and technology? Will that affect our quality of care?

What if we slow down payment to vendors and capture that prized 0.01% interest for an extra two weeks? Will the credit holds and case-on-delivery sup-

ply shipments not cost us more?

What if we eliminate patient nourishment in recovery? Can they wait until they get home, or will that cause more problems with the patient's recovery?

How much can we save if we eliminate those postop phone calls? There are valuable nursing hours spent on that. But will you lose your cost savings when one patient has a postoperative problem that isn't caught?

How much did you spend on your holiday party? Do you consider that a waste of money? What about morale and the cost of replacing staff?

What if we eliminate sending staff to conferences? Or buying subscriptions to industry journals and newsletters? Don't those actually save us money in helping us learn how to save money?

What if we have the staff clean the facility each day and save on housekeeping costs? Won't that increase infections?

What if we go back to paper and get rid of the cost of computers and software? Will we actually save money in the long run by doing that?

What if we lose our passion? What if it is burned out of us? What if no matter what we do, it is not enough? That is the hardest cut of all, my friends. *[Editor's note: Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates' address is 238 S. Egret Bay Blvd., Suite 285, Houston, TX 77573-2682. Phone: (512) 297.7575. Fax: (512) 233.2979. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.]* ■

CMS corrects list of ASC payable procedures

The Centers for Medicare and Medicaid Services (CMS) failed to include three codes in the list of ASC payable procedures released Nov. 1, according to the Ambulatory Surgery Center Association (ASCA). They are:

- 0303T, Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation when performed and intra-operative interrogation and programming when performed; electrode only.
- 0307T, Removal of intracardiac ischemia monitoring device.
- 0308T, Insertion of ocular telescope prosthesis including removal of crystalline lens. Healthcare Common Procedure Coding System (HCPCS) code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens) was deleted June 30, 2012, and replaced with CPT code 0308T effective July 1, 2012.

CMS has updated the list to include these codes, and the ASCA has updated the 2013 Medicare Rate Calculator and the 2013 Separately Payable Procedures list to reflect this change. For more information, go to http://www.ascassociation.org/FederalRegulations/Medicare/Payments. ■

New toolkit developed on sleep apnea

AAAHC Institute develops first in series for professionals

A new toolkit for healthcare professionals was created to enhance safety for patients who have obstructive sleep apnea and are undergoing outpatient surgery. Now available online, the "Ambulatory Surgery and Obstructive Sleep Apnea (OSA)" toolkit was created by the AAAHC Institute for Quality Improvement, a not-for-profit subsidiary of the Accreditation Association for Ambulatory Health Care.

"Since these patients may face complications, the information covers considerations for management of all stages of a patient's condition in ambulatory surgery from screening to post-discharge," said Naomi Kuznets, senior director and general manager, AAAHC Institute for Quality Improvement. "The toolkit is a helpful resource in an easy-to-read format."

Information in the OSA toolkit includes preoperative, intraoperative, and postoperative considerations for optimum patient care and a screening tool for OSA risk. A helpful acronym, STOP-BANG, includes the most common symptoms of OSA: **s**noring, **t**iredness, **o**bserved apnea, **p**ressure, **b**ody mass index, **a**ge, **n**eck circumference, and **g**ender.

Guidelines for safe anesthesia and recovery treatment are also explained. The toolkits are available online at http://bit.ly/V2u3AZ. AAAHC-accredited ASCs will receive a laminated copy by mail.

Additional toolkits are being developed, including one on deep vein thrombosis (DVT) assessment and another on fall prevention. ■

CDC tools help ensure every injection is safe

The Centers for Disease Control and Prevention (CDC) and the Safe Injection Practices Coalition

have released new materials to make it easier for clinicians and others working in healthcare to learn and train others about following safe injection practices. *(To access the materials, go to http://bit.ly/WvjCrj.)*

Healthcare providers or training managers who need to keep staff current on bloodborne pathogens training can use a new presentation: "Safe Injection Practices: Protection Yourself and Your Patients – A Bloodborne Pathogens Training Activity." (To access the presentation, go to http://bit.ly/UbicBj.) This training was created to remind providers that measures they take to protect themselves from bloodborne pathogens and other exposures also protect patients from healthcare-associated infections.

Providers who want to understand how to properly use single-dose vials will benefit from viewing a new animated video. This "How to do it Right" video highlights the importance of using single-dose vials one time for one patient by following the story of Joe, a patient who ended up in the hospital with an infection as a result of unsafe injection practices. *(To view the video, go to http://bit.ly/UtsADn.)*

Healthcare facilities, clinicians, and others interested in communicating about safe medical injections are encouraged to use the new digital press kit. This resource puts the most recent information all in one place. Materials include a fact sheet about the impact of unsafe medical injections; an infographic showing the problem, as well as key prevention steps and consequences of not following them; a podcast for clinicians; key subject matter expert bios and quotes; and information about the One & Only Campaign, which is meant to raise awareness among providers and patients about safe injection practices. *(Access the digital press kit at http://bit.ly/TF2j4t.)* ■

Online tool let you ID reprocessing cost savings

A new tool that calculates the financial and environmental impact of reprocessing is available from Phoenix, AZ-based Ascent, a division of Stryker Corp.

The first-of-its-kind calculator, available on the Ascent website, estimates the cost savings and waste reduction potential for a facility if it focuses on reprocessing as a best practice. The tool is designed to help healthcare facilities understand the potential results reprocessing can deliver based on their size and program utilization. *(To access the tool, go to http://sustainability.stryker.com and on the left side of the page, select "Calculate Your Savings.")*

With a reprocessed device costing about half that of its equivalent single-use original equipment manufacturer (OEM) device, reprocessing offers significant cost savings, Ascent says. The calculator illustrates that a hospital with 250 staffed beds that implements a reprocessing program in the operating room (OR) and electro-physiology (EP) lab could save as much as $1 million and divert roughly 8,000 pounds of waste from landfills each year with a strategic and organizational commitment to reprocessing.

Reprocessing programs are employed by more than half of the U.S. News & World Report "Honor Roll" hospitals. Hospitals that already are implementing reprocessing programs can use the calculator to understand the potential for additional savings. For a hospital that is only reprocessing in the OR, for example, the calculator can estimate how much more could be saved if the program were expanded to include the EP lab, non-invasive devices, or open/unused or expired devices.

Savings and waste estimates are based on averages achieved by actual Ascent reprocessing customers who have identified reprocessing as a targeted program and achieve the highest savings among hospitals that reprocess. ■

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

- Generate volume with employer-based health plans & workers' comp plans
- 'Home-grown' medical tourism
- Center shares radical idea for paying your surgeons
- How to attract geriatric patients

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. In 2012, the American Society of Anesthesiologists Committee on Standards and Practice Parameters updated the society's "Practice Advisory for Preanesthesia Evaluation" to say which of the following?
   A. Preoperative tests may be ordered, required, or performed *on a selective basis* for purposes of guiding or optimizing perioperative management.
   B. Consideration of selected clinical characteristics may assist the anesthesiologist when deciding to order, require, or perform preoperative tests.
   C. Both of the above
   D. Neither of the above.

2. What was found to reduce adverse events such as infections and blood clots in a study was conducted at the University of Connecticut Health Center, Farmington, and Saint Francis Hospital and Medical Center, Hartford, CT?
   A. When surgical teams completed communications training
   B. When surgical teams used a surgical procedure checklist before, during, and after high-risk operations.
   C. A and B
   D. None of the above

3. When Texas Health Surgery Center Denton added a wellness program that includes health risk assessments, biometric screenings, and a wellness portal for employees to monitor and improve health and wellness credits, what were the benefits offered to employees?
   A. Reduced health insurance premiums
   B. Time off to exercise or attend weight loss programs
   C. Extra vacation time
   D. Cash awards

4. When managers at Lawrence (KS) Surgery Center held their annual meeting with their bank, the results was an electronic check processor. What was the advantage of this technology?
   A. The cash now appears in the account within an hour.
   B. The cash now appears in the account within a half-day.
   C. The cash now appears in the account within a day.