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INSIDE

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Moms want to direct their maternity care, and hospitals are listening

Bells-and-whistles maternity services emerge as big marketing tool

A generation ago, mothers-to-be entered the hospital with little information and very little say in how the birth of their children would proceed. The care they received was designed to meet the needs of doctors and nurses, not families.

But over the last 30 years, things have changed dramatically. Maternity units boast beds or sleeper chairs for dads. There are refrigerators in the rooms and special celebratory meals for new parents. At the Rose Medical Center in Denver, one premier part of the labor ward includes private chefs for patients.

Hospitals are going all out to cater to new moms, and use their maternity services as a big selling point for their facilities.

One of the places where this trend is most evident is Northside Hospital in Atlanta. A 450-bed community hospital, it had 13,500 deliveries last year. The hospital is in the midst of a $36 million renovation that will include a women's center **(for more on women's centers, see related story, p. 51)** with 36 labor / delivery / recover (LDR) rooms and 108 private post-partum rooms.

Consumers want high-tech/high-touch facilities

According to **Eileen Hayes**, CHE, director of planning at the hospital, the additional facilities are just one marketing tool for the maternity services.

"First, we serve very well-educated consumers, and they want facilities that are high tech *and* high touch," she explains. "But patients also don't want to be treated like they are sick. They want an environment that acknowledges that."

The new rooms have many of the family care center concepts that are popular in major hospitals — from places for dads or partners to sleep, to more home-like décor. Northside has also provided new moms with some options that other hospitals don't.

"A lot of places like the rooming-in concept and encourage the moms to keep their babies with them," says Hayes. "But there is no nursery for

them to send their baby to if they want some rest."

Having a nursery also helps to accommodate pediatricians, who can examine all the babies at the same time.

Another part of the program is to have a low patient-to-nurse ratio, which Hayes says will be at 5:1 when the new facility is completed.

The high-tech part of the program includes a special care nursery that has more space for the family at the bedside and more privacy.

"Some people call us a baby factory because we deliver so many babies," she says. "But we try to focus on one-to-one care. And, so far, our patient satisfaction scores show we are doing a good job."

Patient satisfaction surveys' design helped

The project, which started in 1990 as a way to build on Northside's bread-and-butter maternity business, was designed around comments and suggestions from patient satisfaction surveys and focus groups, as well as on the clinical aspects of care that physicians and nurses demanded. Nursing staff, in particular, have been directly involved in the process, explains Hayes. Getting their input from the start helped them buy-in to changes and become some of the biggest cheerleaders of the project. Over 130 people from the 3,000 member staff at the hospital were involved.

There have been some glitches, however. The construction of the five-floor, 150,000-square-foot facility caused a parking nightmare. Hayes went to management with an unusual request: valet parking for patients for the duration of construction. Although there was a cost associated with it, by her third approach to management she convinced the holders of the purse strings that providing this service would help to alleviate the problems that patients — particularly moms in labor — would face in getting where they needed to go.

The payback for the millions spent will be loyal customers, Hayes says. "Women are health care decision makers; if we can provide high-quality service to them when they have a baby, then we keep them for a lifetime. They will send their children and husbands here."

Smaller markets, same trends

Salinas, CA, located on the central coast, is a much smaller market than Atlanta. But there too, the trend toward patient-centered maternity care is evident.

Natividad Medical Center, which had just under 1,500 deliveries in 1998, completed a move to a new facility in February. The 163 beds include eight labor / delivery / recover / post-partum (LDRP) rooms, and capacity for 16 more mothers in the infant unit. There are also 15 beds in neonatal intensive care.

The hospital, associated with the University of California-San Francisco residency program in family practice, also has a level-two nursery, which treats seriously ill babies.

Here, too, staff proudly talk about the elements of care they have developed with mothers in mind. **Shirley Algire**, RN, assistant director of nursing, points to the three physicians on duty at all times. "That means no waiting," she says.

Virginia Matthews, RN, MBA, assistant hospital administrator of nursing services, likes to talk about the affiliated family center which provides day care services for patients' children, and access to ancillary services, such as the Women, Infants, and Children's (WIC) program. "It's a real one-stop shop."

Algire says that just putting in a rocking chair and new décor won't cut it any more with knowledgeable patients.

"That's all old hat. What patients want — and what they asked for when we started our building program — is LDRPs. We only planned to have three or four, but then we decided to convert all our rooms."

Matthews says just having a new facility is an improvement, offering increased space, greater

comfort, and more privacy.

"Our gut feeling, even this early, is that it has improved patient satisfaction," she says.

The decisions on what to include in a new maternity wing were made, as at Northside, with the assistance of patient satisfaction surveys and focus groups. Natividad also looked at past patient complaints to see what was missing from the facilities, and keeps abreast of what other local hospitals are doing through peer networking.

"We have to stay abreast of what is going on in the industry and in the community," says Matthews.

Even in a hospital with limited funds, she adds there is a strong argument to be made for making some of these expensive changes.

"It keeps us state-of-the-art, current, and competitive," says Matthews. "The fact that we are a teaching hospital may make it a little easier for us to sell the idea to management. But we still have to make a case for the changes with a good business plan."

So far, the new maternity program is working well. Open for just four months, the number of births at the center is already up from 120 per month last year to 129 in its first month of operation.

Cherie Stock, director of marketing and public relations, has marketed the new services using television, newspapers, and health forums. Like her peers at Northside, she sees the emphasis of catering to women as part of a larger trend that acknowledges their greater role in making health care decisions.

Stock sees that trend continuing. "You have all these baby boomer women hitting menopause at the same time. That makes them talk about hormone replacement therapy. You have women talking about wellness issues and breast cancer. Women are hungry for more information and demanding more from their care. We aren't our mothers. We will be influencing what is a hot topic in health care and what is not for a long time to come." ■

Women's centers target a market, meet a need

Can improve emotional well-being and cure rates

Anyone who knows someone who has developed breast cancer knows how important it is to the mental well-being of the patient to get a diagnosis and start treatment quickly. But for many women in that dire situation, there is a delay of weeks or even months between the first inkling of a problem and any subsequent surgery. At the Milford-Whitinsville Regional Hospital Women's Pavilion in Milford, MA, that's no longer the case.

By creating a women's center that puts oncology, radiology, and reconstructive surgery under one room, the hospital has been able to cut the time between a positive mammogram and a biopsy to as little as one day. This not only improves the emotional well being of patients, but may also improve cure rates, says medical director **Barbara Ciak**, MD.

"There may not be a huge clinical difference in most cases. We don't know the cell doubling rate in all cases. But we do know that premenopausal women have more aggressive cancers; we can see people waiting months between biopsy and surgery, which can have an adverse effect on outcomes," she says.

As an added bonus, patient satisfaction increases. In a recent state study of patient satisfaction, the Women's Pavilion ranked third of all Massachusetts hospitals. Ciak has played steward to a program that promotes cooperation between specialists who, in the past, have not worked well together.

Ciak says she believes the success of the Pavilion stems from people "buying into doing things faster. Doctors realize they will stay popular and busy if they cater to patient demands. This is a demand of these particular patients."

The Women's Pavilion is a multimillion-dollar project that Ciak shepherded from inception to its current form. It started with a committee of oncologists, radiologists, and surgeons — groups that she has seen work poorly together in the past.

"I tried this before, and radiology and surgeons' meetings became turf battles. But this time, we set clear boundaries from the start. If they don't want to play, they don't have to stay."

Patient satisfaction exit interviews help ensure that the Pavilion — which offers breast care, as well as obstetrical, gynecological, fertility, and headache care — continues to offer what patients want. What those interviews have found is that patients have more interest in getting a call from physicians when lab reports are back **than in a pleasant ambiance**. Quick lab results and on-time physicians are more important than having fax machines

SOURCES

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and modem hookups in the waiting room.

But Ciak admits that letting patients call all the shots can be costly and unproductive.

"Women's centers can have things included that aren't medically necessary, but attract patients. It's up to physicians to help cut to the chase on what is state-of-the art and necessary."

For example, she says, there is a lot of new machinery available that can offer more than one technique. "We may choose one over the other, but if a patient says they want something because a friend had it, we have to put a stop to it. Don't do ultrasounds if they aren't necessary. Stick to the standard of care."

The center has four surgeons, two medical oncologists, two radiation therapists, perinatology, plastic surgery, and two neurologists for the headache clinics. All the choices of what to offer — and that will continue to change over time — come from meetings between the initial committee members, says Ciak, as well as from looking at other women's centers.

The Faulkner Breast Center in Boston was one model Ciak used.

"They had a lot of plastics and other services in one place so that patients didn't have to run from one place to another," she explains. "They also wanted to include gynecological subspecialties, so I latched onto that. You have to sit back and look at what women deal with and what disorders are frequent in perimenopausal and menopausal women."

One new addition is a clinician in teen female medicine with a specialty in eating disorders. "We have players picked out, but getting money is slower than I had hoped," she notes.

Women's centers vary greatly from place to place, says Ciak. Northside Hospital in Atlanta is building a 150,000-square-foot center that will feature everything from breast care to fertility assistance. There will be special care nurseries, a shop for women's health care products, health education facilities, and places for support group meetings.

At Natividad Medical Center in Salinas, CA, the emphasis is on providing high-tech maternity and gynecological care.

The hospital has an exclusive agreement with the purveyor of a minimally invasive system for treating abnormal uterine bleeding. This allows for faster recovery and helps some patients avoid hysterectomies. In addition, Natividad's center offers many social services to its patient population — largely Hispanic, often poor. Along with educational facilities, there is access to social services programs such as WIC and drop-in child care for patients. The hospital even offers an English as a Second Language class in its family center.

This is a trend that will continue, says Ciak.

"Women in the family generate most medical decisions," she says. "Every facility should look at its demographics and see if it is tapping the right percentage of OB/GYN care. If you aren't, think of doing something like this. You don't have to hire new people or spend millions of dollars on a new women's center. Just get the physicians you have to buy into it. Get people to agree to work together and think of the patient first." ■

Helping your staff can help your community

Child care is just one aspect of NOVA program

Editor's Note: In February, the American Hospital Association (AHA) of Washington, DC, presented five hospitals with its NOVA award, honoring their "innovative, collaborative projects designed to improve the health status of their communities." Over the next several months, Patient-Focused Care and Satisfaction *will look at the winning organizations and the programs they created which so impressed the AHA. The first installment appeared in the April 1999 issue on p. 37.*

Pittsburg, KS, has been economically stressed for decades. One in four children in the town of 20,000 live at or below the federal poverty level, and a third of residents are illiterate.

More than half of families in the town are

headed by single parents who often work two jobs to provide for their children. The result of these factors often was students not ready to learn when they entered schools.

Usually, the children lacked immunizations, had unaddressed vision or hearing problems, and persistent behavioral problems. Employers, including the 140-bed Mt. Carmel Hospital, were concerned that parents were often distracted, sometimes unproductive, and many seemed overwhelmed with their personal responsibilities.

Meetings spawned a resource center

To deal with these linked problems, medical center personnel started meeting with representatives of the local school district and Pittsburg State University.

The result was a Family Resource Center that provides day care for 220 children, including a significant number of the children of Mt. Carmel employees. It provides drop-in care for patients' children, and includes a preschool program for 90 students. Social service organizations have representatives available on site, and a doctor is available twice a week to see patients. Once a week, the center is the site of a free clinic staffed with local physicians for those without health insurance.

Monica Murnan, executive director of the center, says the awareness that community health was a hot topic certainly fueled the hospital's participation in the project, as did the child care needs of staff and patients.

"We got together and formed a not-for-profit organization with the school district, the hospital, and Pittsburg State University as sponsoring organizations," Murnan explains.

Over two years, the players worked together to find space and develop programs. Since August 1997, the Family Resource Center has provided child care, health care, preschool, family counseling, adult education, and parent resources, says Murnan.

The preschool caters to all preschoolers with disabilities in the area.

"That was the philosophy from the beginning — to create a place for all kids," she says. "We knew there were services out there — like Head Start for economically disadvantaged children — but they were specific resources for specific groups. We joined together so we could lose some of those barriers."

Although there is no specific data available yet on the successes of the program, Murnan says there are some indications that they are doing the right thing. Firstly, there is positive feedback from parents, the school district, and the community. And the National Association for Education of Young Children is due to accredit the program. "If we can meet their research-based standards, we know we are having an impact."

Community program benefits hospital

Eighteen of the children in day care belong to hospital staff, she says. The center also provides drop-in care for patients' children and family-related services that those families may need.

For instance, says Murnan, if a social worker says a patient doesn't have a telephone, the center might use its network of resources to help set up phone service. There is also emergency drop-in care available for patients who might have medical emergencies.

A physician, a nurse practitioner, and two nurses handle the medical aspects of the center. "There is a lot of preventive care, school physicals, and immunizations done," she says.

Services usually are not free. For patients with insurance, the health clinic can bill directly — either Medicaid or private pay. There is also access to the hospital charity write-off to provide free or discounted care.

The child care services are considered among the more expensive in the area — $65 to $75 per week. However, the center is a vendor for state social and health services, and thus has some of its students subsidized by state money.

Groups' cooperation was surprisingly easy

Getting diverse groups — from the medical community and educators to social services organizations — to work together was something Murnan was concerned about when she started the project.

"But the funny thing is [that] it was easy, compared to finding a location and the money we needed. We have the three largest employers and 14 other services and organizations from our area all working well together. I think that's because we had a well-laid-out plan focused on children and proactive measures.

"The heads of these organizations signed on immediately," she continues. "That showed the rest of the community that if they felt it was a

SOURCE

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good idea, it must be worth trying."

Perhaps one reason why there was so much cooperation was because Murnan made her requests in terms that made the employers and organizations see how the project could help them.

"There can be fewer lone wolves out there when federal budgets are declining. If we come together, we can be stronger."

Finding the money was difficult, she admits. "There were some territorial issues — about who we should go to and who should do the talking. But they have been limited. You just have to be clear, persistent, and sure [that] you follow through on your plans. Then, people eventually buy into a project."

"If you have a dream . . . it can happen"

One key to success has been having a plan that states what the center is trying to achieve, how it will get there, and who will do it. But Murnan also keeps a wish list on hand.

"If you have a dream, write it down," she advises. "Note how you will get there, when it will happen, and who will be standing with you. Then it can happen."

While much of the Family Resource Center's program seems to be outside of the traditional sphere of hospitals, Murnan thinks there are benefits that are already accruing.

First, it is a service Mt. Carmel can offer to both patients and staff. "What money can't you measure in recruitment and retention of employees? That is worth something," she says.

Second, community health initiatives are gaining favor. Lastly, early childhood education is something that all the research shows works and can prevent educational, behavioral, social, and health problems later in life.

"Early Head Start is a part-year, part-time program. We get $9,000 per child for a full-day, all-year program; but we only spend $2,200 per child. And we are still going to be accredited," Murnan says. We know we are doing something good, and doing it economically and efficiently. This is something worth trying." ■

CDC: Antibiotic-resistant bugs on rise in ICUs

MRSA, VRE continue to climb in sentinel ICUs

Data from Centers for Disease Control and Prevention sentinel hospitals reveal a "concerning and continuing increase" in antibiotic-resistant nosocomial infections in intensive care units.[1] Your facility's infection control practices may play a role. **(See related story, p. 55.)**

Posted on the Internet, the surveillance report summarizes the rates of antimicrobial resistance among selected pathogens identified from ICU patients with nosocomial infections in the CDC National Nosocomial Infections Surveillance (NNIS) system. The CDC compared the percentage increase in resistant rates for the period of January-November 1998 with the average rate of resistance for each pathogen over the previous five years (1993-1997).

The highest percentage increases in resistance for 1998 vs. 1993-1997 were for vancomycin-resistant enterococci (55%), methicillin-resistant *Staphylococcus aureus* (31%), and quinolone resistance in *Pseudomonas aeruginosa* (89%).

The pathogens were selected for their public health importance or because they are known to be common causes of nosocomial infections (i.e., VRE, MRSA), explains **Scott Fridkin**, MD, medical epidemiologist for nosocomial infection surveillance activity in the CDC hospital infections program. The CDC released the analysis in part to respond to frequent inquiries about national antibiotic resistance rates.

"It is really an attempt to coordinate our response to the public and to the infection control community on resistance," he says. "It is the best possible comparable rates we can come up with because we are focusing on a specific patient population. It is not a representative sample of all of the patients in the U.S."

The combination of prudent use of antibiotics and infection control measures with drug-resistant infections has been much emphasized in guidelines and studies over the last few years, but Fridkin says one cannot simply conclude the measures are not working based on the NNIS data. The analysis did not attempt to factor in the level and variety of infection control guidelines and antibiotic controls used in the NNIS hospitals and ICUs.

"What it does say, though, is that in this patient

population — the ICU patient — the problem of resistance is continuing despite some warnings and revised recommendations," he says.

Similarly, the data are not risk-adjusted, and should be used with caution in interfacility comparisons, the CDC reminds. However, infection control professionals can make "a reasonable comparison" in looking at the CDC rates of resistance and those found in their own ICUs, Fridkin notes. Plans call for an update of the analysis every six months, so increases and declines in antibiotic-resistant infections can be tracked on an ongoing basis. In some cases, the level of overall resistance is so high that simply holding the status quo will be little cause for celebration. For example, while methicillin resistance in coagulase-negative staphylococci increased only 2% in 1998 compared with the prior five-year average, a striking 85.7% of the 2,553 isolates causing infections were resistant. In comparison, *P. aeruginosa* infections resistant to third-generation cephalosporins also increased only marginally (1%) in the two comparative periods, but a much lower percentage (21%) of the 1,931 isolates were resistant.

"Are we going in the right or wrong direction?" Fridkin says. "For all of these, they are still moving up. That is the point you can take away."

Reference

1. Centers for Disease Control and Prevention. Selected antimicrobial resistant pathogens associated with nosocomial infections in intensive care unit patients, comparison of resistant rates from January-November 1998 with 1993-1997. National Nosocomial Infections Surveillance System. ■

Hand washing may suffer in understaffed settings

Keeping patients from picking up an infection during their hospital stay is a concern to everyone involved with patient care — and it can start with something as basic as washing your hands.

Recently, researchers attempted to identify predictors of noncompliance with hand washing during routine patient care in a 1,300-bed teaching hospital in Geneva, Switzerland. They examined the activities of 520 nurses, 158 physicians, 166 nursing assistants, and 199 other types of health care workers caring for 964 (70%) of the beds in December 1994. Five trained observers noted the number of opportunities for hand washing that presented themselves after each patient contact; between care of a dirty body site and a clean one; after contact with body fluid; before and after care of an intravenous site, a wound, the respiratory and urinary tract, as well as after glove removal; and after any activity involving indirect patient contact or hospital maintenance. They also noted how often hands were actually cleansed. The hospital guidelines recommended that hands be washed with soap and water or be disinfected before and after patient contact. They also should be washed after removing gloves and after contact with a potential reservoir of microorganisms such as body fluids and substances, mucous membranes, broken skin, or inanimate objects that are likely to be contaminated.

Average compliance was only 48% of the 2,834 observed opportunities for hand washing, with physicians being least compliant (30%) and nurses being most compliant (52%). Compliance was better on weekends (59%) than during weekdays (46%) and worst in intensive care units (36%), with medical and surgical wards being 47% to 52% compliant.**(See related story, p.54.)**

Similarly, hands were least likely to be cleansed after procedures involving a high risk of contamination (38%) than after other procedures (49% to 52%) and when the intensity of patient care was high (37% for more than 60 opportunities for hand washing compared with 58% for less than 20 opportunities). The researchers concluded that the moderate compliance with hand washing might be explained by the intensity of care, suggesting that understaffing may lower the quality of patient care. An editorial accompanying the publication of the survey's results called for expanded study of the possible role of alcohol-based, bedside hand rinses and gels, which could reduce the time required for hand washing and make it more feasible for caregivers with high workloads to wash their hands more frequently.

*Comment by **J. Peter Donnelly**, PhD, clinical microbiologist, University Hospital Nijemen, the Netherlands.*

With nosocomial infections complicating as many as one in 10 hospital admissions, the problem is not negligible. Since the days of Ignaz Semmelweis, the medical community has been confronted with the simple truth: "clean hands = fewer infections." Why then did only half of the health care workers follow this simple rule? The answer may well lie in the fact that they are all too busy. This is almost certainly true for those

nurses who have to care for patients' clean and dirty body sites and are most likely to wash hands once they have finished rather than in between each and every step in the patient's care. [The researchers] point out that it takes eight to 10 seconds to wash the hands and might take one minute to go from the patient to the sink, wash their hands, and return to their patient. Nearly half of the observed opportunities to wash hands occurred when patient care was at high intensity (21 to 40 hand washing opportunities per hour), occupying a prohibitively large amount of the working hour. This is reinforced by the better compliance observed on weekends when hospitals run a less intensive service and the extremely poor compliance seen during the care of critically ill patients, thus confirming the perception that health care workers are often too busy to wash their hands as recommended.

An organizational issue

There is a relationship between the intensity of patient care and noncompliance with hand hygiene recommendations, meaning hand washing is not only a matter for the individual but also for the organization. Reducing workloads would, therefore, seem a necessary part of the solution to the problem of failure to wash the hands. In an accompanying editorial, the writer emphasized that hospital administrators should strive to create an organizational atmosphere in which adherence to recommended hand hygiene practices is considered an integral part of providing high-quality care. Strangely, [the writer] did not mention improving staff / patient ratios, not even for nurses who are perceived to be the most likely to cross-infect patients because of the nature of their contact with patients. Rather, he suggested that a record of adherence to hand hygiene recommendations should form a part of the annual personnel evaluation. Clearly, it is intolerable that hand washing is still neglected to almost the same extent as it was in Semmelweiss' day, and it is time for hospitals to get serious about improving hand hygiene. But if there really is not enough time to comply with hand hygiene, it is hard to see a solution while there continues to be a drive toward maximizing productivity by employing fewer people to care for more patients in a shorter period of time.

Suggested readings

1. Pittet D, Mourouga P, Perneger TV, et al. Compliance with hand washing in a teaching hospital. *Ann Intern Med* 1999; 130:126-130.

2. Boyce JM. Editorial. *Ann Intern Med* 1999; 130:153-155. ■

Non-immunized nurses spark deadly flu outbreak

Importance of HCW vaccination emphasized

An outbreak of influenza A in a long-term care facility that resulted in two deaths and three hospitalizations was sparked by flu infections in unvaccinated health care workers, the Centers for Disease Control and Prevention reports.

Because influenza infections can be severe in debilitated populations and because vaccine effectiveness is lower among residents (30% to 40%) than in healthy adults (70% to 90%), the CDC recommends that health care workers and others caring for high-risk patients receive influenza vaccine annually. Health care workers and family members should be educated about the potentially serious consequences of influenza illness for high-risk people and the need to limit contact with these people. When health care workers and family members are ill, they should avoid contact with high-risk people.

More than 10% of staff, residents are infected

The first cases in the Santa Clara, CA, facility occurred during Dec. 21 to Dec. 28, 1998, among five unvaccinated nurses who worked in two adjacent units in the same building. From Dec. 29, 1998, through Jan. 17, 1999, additional cases developed among residents and staff from those two units. Overall, 34 (11%) of 309 staff members and 25 (13%) of 192 residents were infected. Three residents were hospitalized and two died, including one who was not vaccinated because of a history of egg allergy.

Residents in the facility are assigned to different buildings according to the level of care required. The most debilitated residents, most of whom are bedridden and require complete care, resided in the building where the outbreak began. During the fall, residents in all four buildings received influenza vaccination unless contraindicated. Of the 1,200 staff members offered vaccine, only some 200 (17%) were vaccinated at the facility, though some may have been vaccinated by outside providers. Forty-nine of the 50

residents in the two initially affected units had been vaccinated before the outbreak, compared with 12 (26%) of the 47 staff members in those units. Outbreak-control measures included cohorting ill residents under droplet precautions and administering amantadine for prophylaxis and treatments. Unvaccinated staff were offered amantadine prophylaxis and influenza vaccine. Ill staff were discouraged from coming to work, and ill visitors were asked to postpone their visits. Influenza outbreaks can occur among highly vaccinated long-term care populations even in years when the vaccine is well-matched to circulating virus strains, the CDC noted.

Long-term care facilities should conduct surveillance to identify clusters of respiratory illness and should alert state or local health departments when clusters are identified. Early detection of influenza outbreaks and timely initiation of control measures, such as cohorting of ill residents, use of droplet precautions, and use of antiviral medications for prophylaxis or treatment can limit the spread of disease. Amantadine and rimantadine are 70% to 90% effective in preventing influenza A infections and can reduce severity and duration of symptoms from influenza A when administered within 48 hours of onset. However, these medications are not effective against influenza type B viruses. Chronic care facilities should know which laboratories in their area perform rapid influenza A testing and should develop a plan to rapidly detect influenza A outbreaks and to administer antiviral medications if influenza is detected.

Reference

1. Centers for Disease Control and Prevention. Update: Influenza activity — United States, 1998-1999 season. *MMWR* 1999; 48:177-181. ■

Here's two new services for your outpatient program

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

At Earnhart & Associates, we are always looking for new ideas and procedures to enhance our bottom line — as we should. However, sometimes the ideas dry up, and we need to become a bit more creative.

Let's look at some new things we have been doing and see if they might work for you.

• **A surgery center within a surgery center: The esthetic plastic surgery center.**

Plastic surgeons, for the most part, shun the average surgery center because they think it doesn't meet the needs of their clientele's image. (I said, "average." Your center is perfect and beautiful; this is directed to other people's centers.)

Unfortunately they are often right. As much as we like to think that our center is pleasing to the eye, if you look closely, most do not live up to the average operating suite in most plastic surgeons' offices.

In my travels and meetings, I have been in many of these. They are ornate, lavish, and tastefully done. They are complete with *The New Yorker* magazine, attractive receptionists, and multicolor brochures. From somewhere there is a light source, although I can rarely find a lamp or overhead fluorescent lighting. And the music; where do they get this soothing music? And where the heck is the radio?

Now, those of us who have been in the industry for more than three months know that much of what the administrator does in dealing with plastic surgeons is to try to negotiate a reasonable facility fee from them that at least covers the cost of the sutures they use. Not an easy task. Obviously, the surgeons want the facility fee as low as possible, so their global fees are competitive with their peers. That will probably always be an issue; however, the cash upfront reimbursement is looking more attractive. To attract more esthetic procedures to our facilities, we have been creating a new image for these patients.

Creating an attractive atmosphere

Essentially, we are creating a new entrance to the surgery center — a distinctly different entrance from the main door. Often, this will be off on another part of the building or a different corridor. The signage will read "Esthetic Surgery Center" and will have, usually, the name of the surgeon operating that day on the door. Depending upon the number of plastic surgeons you have, this may or may not work for you.

Once the patient enters that door, there is a small, but highly appointed waiting area. The size is usually 120 square feet. There is a window for the receptionist to register the patient. You can use your own select staff member here, or you can

have the surgeon bring over their own. Beyond the door, there is a single changing area that can double as the phase-two recovery area. Again, you need to evaluate the numbers of patients you are going to accommodate during the day. From this point, the patients share the general population operating rooms and phase-one recovery.

Will it work for you? I don't know. Clearly, before you would consider the expense, which isn't that much, you would want a commitment from the surgeons on potential new volume.

• **Kidney stone lithotripsy or fragmenting of kidney stone (CPT code 50590).**

This procedure is on the list to be approved for Medicare reimbursement for surgery centers by the Health Care Financing Administration with the implementation of the new ambulatory payment classifications (APCs). This procedure holds a lot of promise for new and existing facilities. The proposed reimbursement from Medicare is $2,107. We'll have to wait and see if that holds up.

In the meantime, strong consideration should be given, especially for new construction, for adding this service. For the majority of facilities, a mobile machine will be required — a fixed site probably doesn't make much sense. However, there is new equipment out there now that doesn't require a truck.

Most providers use the mobile 18-wheeler truck, which requires a specially constructed "pad" in the parking lot for the large truck to pull up and make water and electrical connection. The average price for the construction of the pad, overhang, hookups, construction of a door into the surgery center, etc., is about $25,000 (assuming you have no other construction issues). The services — there are several in the United States — usually have the staff and all the equipment to perform the procedures and usually schedule time once or twice a month, depending upon your schedule and number of patients.

The fee for the truck, machine, staff, and supplies can exceed $1,000 per patient — but there is very little incremental cost involved beyond that fee. This is also a great way to get the urologist involved in the facility. Keep your eye on this new opportunity. To research companies, perform a search for "mobile lithotripsy" on the Internet.

(Editor's note: Earnhart can be reached at Earnhart & Associates, 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: surgery@onramp.net. World Wide Web: http://www.earnhart.com.) ■

HHS launches Web repository for guidelines

74 cardiac-related protocols are just a click away

There's a new cardiac resource on the Internet — a repository for more than 500 evidence-based clinical practice guidelines that have been developed by the Agency for Health Care Policy and Research (AHCPR) in partnership with the American Medical Association and the American Association of Health Plans.

The National Guideline Clearinghouse at www.guideline.gov contains thousands of clinical practice guidelines created by medical and professional societies, managed care organizations, hospitals, state and federal agencies, and others. When our editors searched for "cardiac" at the site, the engine came up with 74 related guidelines.

Hard to find evidence-based guidelines

Until now, guideline users have often had difficulty gaining access to a full range, then had difficulty identifying which were based on evidence. There has been no efficient way of making comparisons to select the guideline that best meets your needs. The clearinghouse responds to that by identifying and featuring evidence-based guidelines and presenting them with standardized abstracts and tables that allow for comparison of guidelines on similar topics.

The tables provide information on the major areas of agreement and disagreement among guidelines, which will help users make informed selections.

"It is well known that variation in health care results partly from uncertainty and a lack of evidence for clinical treatment," says **John M. Eisenberg**, MD, AHCPR administrator. He says this clearinghouse should help reduce variation and improve health care quality.

The agency will continue to receive guideline submissions, and organizations wishing to submit should contact Vivian Coates, ECRI, NGC Project Director, 5200 Butler Pike, Plymouth Meeting, PA 19462-1298. For questions about guideline submissions, contact Jean Slutsky, NGC Project Officer, (301) 594-4042; e-mail to jslutsky@ahcpr.gov. ■

Run 6-month angiogram routinely after PTCA?

Study concludes yes, but controversy continues

There is ongoing controversy as to whether repeat coronary angiography should be routinely performed after successful percutaneous transluminal coronary angioplasty (PTCA). Do the costs outweigh its subsequent benefits?

A recently reported German study demonstrates that patients who undergo a follow-up angiogram six months after their angioplasty have a significantly lower subsequent risk of death and other adverse events than patients who do not undergo the follow-up procedure.

400-patient study reports low mortality rate

Investigators identified 400 patients who underwent successful single-vessel PTCA without adverse cardiac events, defining "success" as a decrease in stenosis of more than 20%. All procedures were performed at a center that routinely schedules patients for angiography six months after successful angioplasty. About 80% of the patients had complied with this recommendation, and their mortality rate was 7% over a 10-year follow-up period. The rate of three serious adverse events combined — death, infarction, or bypass surgery — was 24%. The rates were significantly worse among patients who did not undergo angiography — 19% and 38%, respectively.

Repeated angiography helps survival

The researchers' conclusion: "A routinely performed angiographic control six months after successful PTCA is associated with a significantly higher rate of repeat PTCA but, most important, is correlated with a significantly lower mortality rate during the 10-year follow-up period."

"Angiographic follow-up was the most important predictor of long-term survival," the team reported.[1] There was a 2.7-fold increase in mortality rate in patients without angiographic follow-up.

AHC offers health care Y2K reference resource

American Health Consultants has published the *Hospital Manager's Y2K Crisis Manual,* a compilation of resources for non-technical hospital managers. This 150-page reference manual includes information, in nontechnical language, on the problems your facility will face, potential fixes, and possible consequences, including:

- Will your computers and software work in 2000?
- What does Y2K mean for patient care?
- What will happen to your medical devices?
- How can you make sure your vendors are Y2K compliant?
- Are you at legal risk due to Y2K?
- Are you prepared if Y2K delays HCFA payments?

The *Hospital Manager's Y2K Crisis Manual* is available now for $149. For more information, contact American Health Consultants' customer service at (800) 688-2421, or go on-line at www.ahcpub.com. ■

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Patients who underwent angiography were 2.5 times more likely to undergo repeat angioplasty than patients who did not have the follow-up examination, perhaps explaining the survival advantage in the angiography group.

In an accompanying editorial, experts point out that much has changed since the study cohort underwent angioplasty in the mid-1980s. Both techniques and the hardware of angioplasty have improved, and intracoronary stenting has changed the scenario significantly, and those factors must be taken into account.

Reference

1. Rupprecht HJ, Espinola-Klein C, Brennecke R, et al. Impact of routine angiographic follow-up after angioplasty. *Am Heart J* 1998; 136:576-577,613-619. ■

Nurses face yet another order: Cultural competence

Ethnic sensitivity assumes priority among payers

Be careful. The direction in which your patient's bed may be facing could determine whether your ICU wins high or low scores in patient-family satisfaction.

Federal and state health care officials are pushing providers to become more culturally sensitive in dealing with ethnic and cultural diversities among patients. Private health maintenance organizations and some large employers that pay for health insurance are asking for proof of heightened cultural competence from contracting medical providers.

In September, the Health Care Financing Administration proposed new regulations mandating states establish cultural competence guidelines for health plans that contract with the government under Medicaid. In turn, payers are likely to raise the issue in patient satisfaction questionnaires and hospital accreditation assessments.

"The Joint Commission on Accreditation of Healthcare Organizations is also looking into the subject," says **Elaine Waidley**, RN, MSN, a health care consultant and president of EKW & Associates in Laguna Beach, CA. The commission recently began including cultural competence factors in completing their site surveys for accreditation renewals.

The enormous diversity of patient populations in the health care system has given rise to a new mandate, says Waidley. Nurses, physicians, and allied health professionals need to understand how they affect their patients culturally during the patient-provider encounter, she adds.

Waidley is scheduled to present a six-hour workshop on cultural diversity at this month's National Teaching Institute and Critical Care Exposition in New Orleans. The event is part of an annual conference sponsored by the American Association of Critical Care Nurses based in Aliso Viejo, CA.

Despite a growing awareness of cultural diversity, many hospitals have not taken adequate steps to ensure that staff competencies get translated into appropriate actions, Waidley says. "There is still a ways to go in doing these things."

In the ICU, where family input is usually welcome, nurses have a great opportunity to seek out cultural information about the patient. In the Muslim culture, for example, a patient's family is likely to prefer that the hospital bed be pointed so the patient faces an easterly direction.

Ask about religious preferences ahead of time

The preference may seem silly to Westerners, but it conforms to Muslim religious beliefs, Waidley says. Ask the family ahead of time, she advises. And incorporate the topic in each patient's care plan. Most requests, unless they interfere with medical necessity, will be easy to grant.

Diversity concerns don't only apply to ethnic differences, the consultant says. The same sensitivity on the part of caregivers should apply to any group that is considered outside the mainstream such as the homeless. ■