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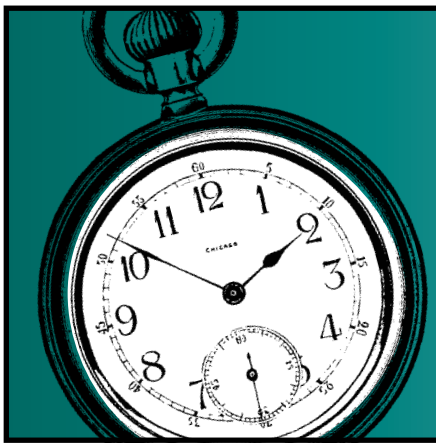

Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 20 Years

INSIDE

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American Health Consultants® is A Medical Economics Company

Don't miss out! Tattoo removal, short recovery cosmetic cases in demand

Reach new patients with innovative community programs

Attracting new patients to your surgery program is a constant challenge for day surgery program managers. Not only is it important to identify the market segment you want to reach, but you must also figure out which services are important to these new patients. Once you've identified the services, you need promote your services and get paid.

While participation in community programs can always generate publicity, two facilities have gone beyond traditional health fairs and festival sponsorships. The day-surgery programs at Abbott Northwestern Hospital in Minneapolis and Provena St. Joseph Medical Center in Joliet, IL, have teamed up with other community organizations to offer former gang members a free program for the removal of their gang tattoos. The program encompasses not only laser removal of the tattoos, but also counseling, job placement, and mentoring services. The actual removal of the gang tattoo is essential for the program's success, says **Lupe Salazar**,

EXECUTIVE SUMMARY

Finding ways to promote your program and reach new patients is an increasing challenge for day surgery managers who don't have advertising or publicity budgets large enough to compete with other same-day surgery programs. Community programs are a good way to reach the general public, but it's difficult to find a surgery-based service that fits a community need.

- Laser tattoo removal programs for former gang members have given two facilities a chance to contribute to the community and enhance the visibility of their laser surgery services.
- Other programs use short recovery cosmetic procedures to attract younger, nontraditional patients.
- Benefits include little or no capital investment, ability to use existing staff, paying patients, and younger and predominately female patients who are or will be the health care decision makers of their households.

CBET, laser safety officer at Provena St. Joseph.

"We see young people who find out they are going to have a child and they want to move out of the gang culture. Unfortunately, the tattoo may keep them from getting a job or moving away from the influence of the gang," he explains.

Abbott Northwestern has 80 people undergoing treatment for tattoo removal, says **Paul K. Plumb**, manager of laser services. "Since the program began in 1996, we've had 200 youth enter the program, and we've seen a dropout rate of about 25%," Plumb says. The approximately 70 youth who have not yet begun treatment are still undergoing the first steps of the program, which include mentoring and self-development counseling with employees of the local parks department. **(See story on setting up a tattoo removal program, p. 91.)**

Because young people congregate in parks, the parks department police get to know youth who are involved with or in proximity to gangs and become key in identifying potential program participants, says Plumb.

The price for removing a tattoo can be as high as $3,000 or $500 for each of four to six treatments necessary for removal. "Our tattoo removal program gives former gang members access to a procedure that they normally could not afford," Salazar explains.

While most of the clients Salazar sees are in their late teens to early 20s, the program also has some clients who are in their 30s and 40s. "Our older clients are parents of teen-agers who want to remove evidence of their own gang involvement so their children won't think being in a gang is OK," he explains.

Salazar's facility purchased the laser used for tattoo removal specifically to participate in the community program, which is run by the police department, YMCA, and local Boys and Girls Clubs. The facility performs about 10 tattoo removals per month through this program.

The MedLite laser, manufactured by Continuum Biomedical in Livermore, CA, cost $50,000. Funds for the laser came from the day-surgery program budget, but having the laser also has attracted paying patients, Salazar says. Media coverage of the program has increased awareness of the technology that is available to remove tattoos. This publicity has created a new patient base of young people for the day-surgery program, Salazar says.

"We see young women in their 20s who want to remove tattoos that fit the image of a college kid but not a professional woman," he says.

While most tattoo removals can be done in a physician's office, Salazar says his program has some surgeons who prefer the convenience of the day-surgery program's laser.

"Not all plastic surgeons want to invest in a laser for tattoo removal, so our laser is available to them," he says. "We also have some surgeons who may have a laser in their office, but they will schedule tattoo removals in our facility on days they have a number of surgical cases scheduled in our operating rooms. Our laser enables them to schedule tattoo removals between their larger cases."

Plumb's laser center sees a number of people in their 20s and 30s for tattoo removal. His program also receives calls from people considering a tattoo. "They want to know how much it costs to remove a tattoo before they get one," he says. "We don't know how many change their minds after hearing the $3,000 price tag and the warning that we can only guarantee removal of 80% to 85% of the tattoo."

Tattoo removal is one way to reach a young, affluent market with cosmetic surgery. The general public has heard and read about "lunchtime surgeries" that take place in a physician's office with the patient returning to work after the lunch hour.

"I don't like the term 'lunch-hour surgery,'" says **Harlan Pollock,** MD, public education chair of the American Society of Plastic and Reconstructive Surgeons in Arlington Heights, IL. "There are a number of cosmetic procedures that require short recovery times, but you must not foster unrealistic expectations by implying that cosmetic surgery can be performed and recovered from in one or two hours."

The time it takes to perform the surgery is not

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the key to defining short recovery procedures. It is more important to look at what activities the patient has scheduled after surgery, says **John B. Harris** MD, head of the plastic surgery section of the Mayo Clinic in Jacksonville, FL. "If a patient wants to return to work after surgery, he or she cannot be taking pain medication," he explains.

Many procedures that fall into this category, such as Botox injections or chemical peels, are performed in physicians' offices rather than day-surgery programs, says Harris. Surgeries that a day-surgery program staff might encounter, he says, include:

❒ **small liposuction procedures of the hips or abdomen** in which the local anesthetic used for liposuction will prevent pain;

❒ **removal of extra skin on the eyelid.**

"The eyelid surgery would be for removal of skin only, not blepharoplasty or removal of fat. Blepharoplasty would require bandages and pain medication," he adds.

The best way to appeal to women in their early 30s to 50s who are interested in cosmetic surgery is to offer surgery times late in the week for procedures that have recovery times of three to four days, says Harris. This enables the patient to undergo surgery on Thursday, then go back to work on Monday, missing only one or two days of work and having no visible signs of surgery, he adds.

The procedures most likely to have short recovery times are minor breast augmentation, minor breast reduction, and limited liposuction, says Pollock. Facial surgeries do not fall into this category because there is a lot of bruising, explains Harris.

One advantage of adding cosmetic surgery to a day-surgery program's service offering: Most centers have the equipment. However, they may need to add liposuction equipment or some lasers, he says.

"If a day-surgery program needs to add equipment, I would recommend evaluating leases because the technology is changing so quickly," says Pollock. "I would not purchase a laser until it had been on the market for a while. This gives the surgery staff time to make sure it does what is needed and to make sure it isn't updated every few months."

Staffing requirements don't change as a result of cosmetic surgery, but you may want to take a look at the environment experienced by the patient, says Harris. "It is important to remember that these patients are not sick, so their perception of their experience is different," he explains. A calm, soothing environment that extends from the waiting area to the operating suite to the recovery area becomes a priority, Harris emphasizes.

It's also important to have separate waiting rooms for patients choosing elective surgery and staff education that emphasizes the need that cosmetic patients are not made to feel self-conscious about their surgery, explains Harris. **(See SDS Manager column, *Same-Day Surgery*, April 1999, p. 46.)**

Most cosmetic patients pay on the basis of cash only with payment up front. However, cosmetic surgery programs also can enhance managed care negotiations, says Harris.

"As managed care companies try to attract more subscribers to their plans, they want to add other services that make them stand out from other companies," he says. "Although they won't pay for cosmetic surgery, they will negotiate discounts for their members as a way of adding value to their health plan." ■

Follow steps for success with tattoo removal

Sticking to your area of expertise, building your funding base, and partnering with other organizations are keys to a successful gang tattoo removal program, according to **Paul K. Plumb**, manager of laser services at Abbott Northwestern Hospital in Minneapolis.

Get fundraising and volunteer recruitment in place before the program begins, he advises. The hospital's fundraising department helped him obtain a grant to underwrite some of the costs associated with the program, but he says that garnering community support is important for ongoing funds. "The majority of the grant funds were used to underwrite the cost of a full-time [Minneapolis] Parks and Recreation Department employee to coordinate the program," he explains. "The [direct] costs associated with the actual laser treatment are minimal."

Abbott Northwestern absorbs much of the cost of gloves, injectable anesthetics, and antibiotic cream used for those having tattoos removed. However, Plumb uses grant funds and donations to pay for the replacement of the laser lens. "The cost of the lens is $300, and it is usually replaced

two or three times each year," he explains.

Plan on continuous volunteer recruitment to keep the program going, Plumb advises. Articles in employee and physician newsletters as well as posters throughout the hospital have been the most effective recruitment tools, he adds.

Abbott Northwestern has provided tattoo removal since the beginning of the TRY Program (Tattoo Removal for Youth) in 1996. Co-sponsored by the hospital, the Minneapolis Police Department, and the Minneapolis Parks and Recreation Department, the program began in 1996 after a 1½ year planning process.

The program attracts people younger than 25 who want to move away from gang involvement, finish school, and find jobs. "The real carrot to attract involvement is the tattoo removal," says Plumb. "But before the youth even gets to us for removal of the tattoo, he or she has to undergo a counseling and self-development program."

In fact, the former gang members may be in the program several months before the first tattoo removal treatment is performed, says Plumb. The steps that the youth undergo before tattoo removal are:

1. **Mentoring and self-development counseling sessions with parks and recreation department employees.** These sessions help program members set goals such as finishing school, obtaining job training, finding a job, and keeping a job. "This is an important step for these youths because many of them come from homes in which they've not been taught how to set goals," says Plumb.

2. **Community service.** Each person must complete four hours of community service each month he or she is in the program. Parks and recreation employees help program participants find places to serve. Plumb has seen youth volunteering time at libraries, parks programs, hospitals, and other places.

3. **Tattoo treatment.** After the program participant has performed the first month of community service, stayed in school, or gotten a job, he or she is eligible for the first treatment. A parks department employee meets the youth at the day-surgery program to verify school attendance, job attendance, and community service before the first treatment is administered. The parks department employee verifies the criteria every visit before the treatment.

An important extra service provided is an extensive health history and physical that is performed before the first treatment, says Plumb. "Most of these youth have no regular access to health care, and this is the first physical they've received," he says. "This gives us a chance to identify other health services they may need."

The actual treatment lasts about 10 to 15 minutes, but eight to 10 treatments may be needed, says Plumb. "Amateur tattoos using India ink are relatively easy to remove, but as time has gone by, we are seeing more professionally applied tattoos for cult and gang members."

Participants may stay in the program as long as two years to complete the counseling and tattoo removal, says Plumb. "We remove all tattoos, starting with the most visible, then moving to those that may be hidden by clothes."

Appointments for the treatments are handled by the surgery staff at two outpatient centers, one within the hospital and one satellite center in a nearby suburb. The suburban center sees the tattoo patients after 4 p.m. when the surgery center is closed, but the center at Northwestern sees patients during the day.

"We originally set up a secure, separate waiting room because we feared trouble with other gang members, but security is not the problem we anticipated," says Plumb. There is still a separate waiting area, but that is more for the comfort of the youth who might be unaccustomed to a surgery setting than for security reasons, he adds.

SOURCES

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- **Lupe Salazar**, Laser Safety Officer, Provena St. Joseph Medical Center, 333 N. Madison St., Joliet, IL 60434. Telephone: (800) 407-4454 or (815) 741-7662. Fax: (815) 741-7205.
- **Paul K. Plumb**, Manager of Laser Services, Abbott Northwestern Hospital, Allina Health System, 800 E. 28th St., No. 13403. Minneapolis, MN 55407. Telephone: (612) 863-8974. Fax: (612) 863-8876. E-mail: plumbp@allina.com.
- **Harlan Pollock**, MD, 8305 Walnut Hill Lane, Suite 210, Dallas, TX 75231. Telephone: (214) 363-2575. E-mail: hp@drpollock.com.
- **John B. Harris**, MD, Head of Plastic Surgery Section, Mayo Clinic Jacksonville, 4500 San Pablo Road, Jacksonville, FL 32224. Telephone: (904) 953-2073. Fax: (904) 953-7368.

Staffing for the program is all volunteer, says Plumb. Medical personnel needed for the treatments include a surgeon, a nurse practitioner, a surgical technician, and, occasionally, a social worker, says Plumb. A plastic surgeon volunteers time at the Northwestern site, and a dermatologist performs the procedure at the satellite center, he says. ■

Publication addresses alternative medicine

Now available from American Health Consultants, publisher of *Same-Day Surgery*, is *Alternative Medicine Alert*, a monthly evidence-based, clinically relevant resource for health care providers.

Alternative Medicine Alert presents the facts — good and bad — about alternative therapies including dietary supplements, homeopathy, vitamins, Chinese medicine, herbal remedies, manipulation, and other approaches that "complement" traditional allopathic medicine. *AMA* sorts through available literature and provides a practical, factual forum for determining safety, efficacy, and effectiveness of commonly used alternative therapies.

For more information, contact Customer Service, American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. Web: www.ahcpub.com. ■

Check patients' herb use before same-day surgery

Enhancing your immune system, getting a good night's sleep, and reducing your anxiety level are just three of the benefits promised to people who use herbs. But while consumers hear about the benefits of herbs, they usually haven't heard about the potential dangers if surgeons and anesthesiologists don't know about their use prior to surgery.

The American Society of Anesthesiologists (ASA) in Park Ridge, IL, has issued a warning for patients to tell physicians about the use of herbal medications before surgery. The ASA recommends that a patient stop taking herbal medications two to three weeks before surgery, and if there is not enough time to stop taking the medication, the patient should bring the product in its original container to the hospital or surgery center.

"Seeing the original container gives the pharmacist, surgeon, and anesthesiologist a better chance to identify other ingredients that might produce an interaction with drugs during or after surgery," explains **Jessie A. Leak**, MD. Leak is an associate professor of the department of anesthesia at M.D. Anderson Cancer Center in Houston and a researcher who specializes in the study of herbal medication.

One in three Americans use a botanical or herbal product, and 60% of these do not regularly disclose the use to their physicians, according to Leak. "We are very concerned about the possible effect of some herbal medications on a patient's outcome," she says. "Consumers don't realize that 'natural' does not equal safe for everyone in every situation."

Because herbal medications and vitamin supplements can be purchased over the counter, pharmacists don't have the opportunity to spot potential interaction with prescription medication. Some of those interactions can be dangerous if the patient undergoes surgery, Leak says. **(See potential interactions, p. 94.)**

Some botanicals produce their effect by thinning the blood to increase circulation. If a patient taking one of these botanicals is also taking a

EXECUTIVE SUMMARY

As the use of botanicals, oxygen, vitamin supplements, and other alternative treatments increase, the importance of knowing what a patient is taking also increases.

- While many products are promoted as "natural," the American Society of Anesthesiologists (ASA) in Park Ridge, IL, warns that some botanicals may cause complications if the anesthesiologist or surgeon is unaware of their use.
- Basing their warning on anecdotal information as well as limited research, the ASA recommends stopping the use of herbs prior to surgery since reports show that complications can occur.
- Minimize the risk of botanical-related complications by including specific questions related to herb use on preadmission forms, requesting pharmacy consults if staff members are unfamiliar with an herb or if multiple medications are used with herbs, and discontinuing patient's use of herbs two to three weeks prior to surgery.

Popular botanicals may cause interactions

More than $5 billion will be spent on herbal products this year, and seven out of 10 people using these products will not tell their physicians, according to the American Society of Anesthesiologists (ASA) in Park Ridge, IL.

While many people may benefit from herbal medications, also called botanicals, the patient who is undergoing surgery must disclose the use of botanicals to his or her physicians prior to surgery, says **Jessie A. Leak**, MD, associate professor of the department of anesthesia at M.D. Anderson Cancer Center in Houston, and a researcher who specializes in the study of herbal medication.

Potential interactions with drugs used for anesthesia as well as prescription medications the patient is already using can occur if the surgeon and anesthesiologist are unaware of the herbal medication's use, Leak advises.

"There have not been enough studies of botanicals in the United States for us to state that there definitely will or won't be a reaction during surgery, but most anesthesiologists and surgeons will err on the side of caution," she says. "We definitely need more botanical research, but based on anecdotal stories and the personal experiences of ASA members, we do recommend discontinuing some herbal medications at least two to three weeks prior to surgery."

Some of the more common herbal medications and their potential complications they could cause during surgery, according to Leak, are:

- **Ginseng.**
  Ginseng is used to enhance energy levels. If combined with stimulants used by anesthesiologists, it can cause tachycardia and high blood pressure. It can also decrease the effect of warfarin, causing the blood to thicken and develop clots.
- **Ephedra.**
  Ephedra is included in over-the-counter diet aids. It interacts with inhalants used for anesthesia to affect blood pressure. If used with monoamine oxidase inhibitors or oxytocin, the patient can experience high blood pressure and irregular heart rate during surgery.
- **Feverfew.**
  Feverfew is often used to treat migraines. It inhibits platelet activity that can increase bleeding during surgery.
- **Garlic.**
  Garlic is used to lower lipids and as an antioxidant. It inhibits platelet activity, especially if the patient is already taking warfarin.
- **Valerian.**
  Valerian is a mild sedative effect to help sleep. It causes a potential increase in the effect of barbiturates used in anesthesia, which causes a deeper effect of anesthesia.
- **Ginkgo biloba.**
  Ginkgo biloba is a circulatory stimulant. It decreases platelet activity and clotting ability.
- **St. John's Wort.**
  St. John's Wort is used to treat anxiety and depression. It may prolong the effects of some narcotics and anesthetics.
- **Licorice.**
  Licorice treats symptoms of gastritis and duodenal ulcers. It can cause edema and chronic liver problems and increase the risk of renal insufficiency.
- **Echinacea.**
  Echinacea is used to enhance to immune system. It may cause hepatoxicity and cause liver damage.
- **Ginger.**
  Ginger treats nausea. It can increase bleeding time.
- **Goldenseal.**
  Goldenseal is a diuretic and laxative. It can worsen edema and increase blood pressure. ■

drug such as warfarin, the result is excessive bleeding during surgery, says Leak.

Even without warfarin, the patient's blood may take longer to clot, she says. "If the surgeon knows about the use of the botanical, the patient can discontinue its use several weeks prior to surgery to reduce the risk of bleeding."

Finding out if patients are using herbal medications or vitamin supplements is not a simple task because many are afraid to reveal the use to their physicians, says **Paulette Swanson**, RN, education coordinator at Lakeview Hospital in Stillwater, MN. "Patients tell us that they don't reveal their use of herbal medications because physicians don't ask or because they feel guilty," she says. Patients feel guilt because they don't want their physicians to think they don't trust the physician's ability to care for them, she adds.

"To help patients feel comfortable discussing their use of alternative medicine, we have to initiate the conversation in a nonthreatening manner," says Swanson. The day-surgery program at her hospital uses a patient admission assessment form that specifically prompts the nurse to ask about alternative medicines as part of the question asking about prescription and over-the-counter

SOURCES

For more information about herbal medications and surgery, contact:

- **Jessie A. Leak**, MD, Associate Professor, Department of Anesthesia, M.D. Anderson Cancer Center, 11515 Holcombe Blvd., Box 042, Houston, TX 77030. Telephone: (713) 792-6911. Fax: (713) 794-4590.
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medications. **(See assessment form, inserted in this issue.)**

"Because the nurse is already asking the patient for different types of information, the patient is comfortable giving information about herbal medications," explains Swanson. "If a nurse identifies a patient that is taking more than five medications [including prescription, over-the-counter, herbs, oxygen, or vitamin supplements], a pharmacy consult is requested," she says. "A pharmacy consult is also arranged if the nurse is not familiar with the herb identified by the patient or if the patient doesn't know why he or she is taking the herb."

Sometimes, just knowing the name of the botanical isn't enough to enable a physician or pharmacist to evaluate potential interactions, says Leak. "Botanicals are not regulated as a drug by the Food and Drug Administration. They are included in the same category as food," she says.

This classification results in less stringent requirements for the production of botanicals. For example, consider echinacea, which is used to enhance the immune system. Echinacea from one manufacturer may not contain the same amount of echinacea mixed with other ingredients as a second manufacturer, she explains.

If you want to ask patients about use of herbal medications or other alternative medicine treatments, be careful how you address the patient, warns Swanson. Staff cannot be judgmental or skeptical, and can't offer advice regarding the effectiveness of treatments, she says. "It is also important that your surgery staff is aware of potential interactions."

Most importantly, says Swanson, "You must convey the idea that it is OK to integrate alternative medicine with traditional medicine in order to make the patient feel comfortable enough to give you the information. Not only do we have to ask the patient about herbs, but we have to make them want to answer."

Suggested reading

O'Hara MA, Kiefer D, Farrell K, et al. A review of 12 commonly used medicinal herbs. *Arch Fam Med* 1998; 7:523-536. ■

Same-Day Surgery Manager

Physician exodus (surgicaleth departus)

By **Stephen W. Earnhart**
President and CEO
Earnhart and Associates
Dallas

We have talked much over the past several years about the opportunities available to surgeons outside the walls of the hospital. The trend is actually increasing as more physicians get on the bandwagon and join their peers in surgery centers or the corporate world.

We oversee many joint ventures between surgeons and hospitals on ambulatory surgery center (ASC) projects in which both parties are present at the meetings. While the process is dynamic and constructive, I am continuously amazed by the aggressiveness of the physician partners at these meetings. Gone are the days of accepting promises by hospital administration. The physicians are looking for answers and results, and they are not resting until they find the right response or someone who will give them the results.

Many physicians tell us that they are fighting for their careers and survival in this industry of decreasing reimbursement, increasing complexity, and decreasing personal reward and satisfaction. They tell us that past loyalty to the organization (hospital) is exactly that — in the past. Their desire for increased efficiency, competitive pricing, lower costs, and equity participation goes

beyond personal relationships with hospitals or issues of loyalty. As a result, hospitals lost 12% of the ambulatory surgery market share — in just one year between 1997 and 1998, according to SMG Marketing Group in Chicago.

Can anything be done to stem this exodus? Actually, quite a bit. My firm has seen most of the ways that physicians and hospitals deal with this issue. Some of the ideas and strategies hospitals have employed in the past just don't work at all, while others only inflame the parties and make the situation worse.

The real risk hospitals face when trying to prevent physicians from moving forward on an ASC project, either individually or with an outside group, is bringing it down to a "personal issue" and not a business issue. That often can backfire on the hospital on issues and programs other that just the ASC programs. Others strategies, however, can be quite effective.

How can you, from a senior-level management position, prevent your surgeons from walking out and opening their own surgery center? What will it take to partner with them instead of their doing it with someone else? Bottom line: Listen! You need find out what the issues are. Could this project be done as partners? What is the root problem? Can it be fixed?

If you want good, honest data, you need one-on-one, face-to-face, personal and private interviews with each of your surgeons (or the leaders in the groups). Develop a comprehensive interview sheet so your interviews are consistent and measurable. Have internal marketing people or someone within the system (who your physicians trust) conduct the interviews. If you don't have that, get another impartial party to do it. But get to the issues. Quickly.

So many times we get called in when it is too late. Contracts have been signed, and commitments have already been made to others that are binding. The overwhelming response from physicians is: "Why didn't they listen to us? We gave them the opportunity to work with us, and they turned it down."

The greatest compliment you can pay most people is to nonjudgmentally listen to their thoughts and ideas. I guarantee your surgeons have the answers to your questions.

Once you have the data — do something with it. We cannot recommend strongly enough: Develop a steering committee made up of your physicians. If you, as an organization, cannot do something with your physicians on a joint venture basis because of bond issues, board problems, certificate of need restraints, etc., let that steering committee be the author of such news to the rest of the staff. Most hospitals constantly think that only they can come to those decisions and deliver the results. Let your physicians be part of the discovery process. The absolute worst thing you can do is nothing.

Send newsletters to the physicians each month that update them on the progress of the ASC project. Let them know there is activity going on and that the project has not died or stopped.

Slip a copy of this article to your boss or senior management if you think this is an issue at your facility. The sooner you act, the better chance you have of working it out.

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

Extra! Extra! Free data available on the Web

Technology is changing health care data industry

You've always heard there's no such thing as a free lunch. So you probably wouldn't expect a vendor to give your facility something valuable for nothing. But in one particular case, you'd be wrong: Data that you need for your benchmarking efforts are increasingly becoming available for free or at least for much less than you're used to paying.

One company that's betting on this idea is Market Insights, a six-year-old firm based in San Francisco. In March, Market Insights began offering free hospital benchmarking data on its Web site (www.marketinsights.com) through a tool called the National Hospital Almanac. Click on "free data" and you can select up to six hospitals for side-by-side comparisons of such information as:

❒ **staffing** (by job type);

❒ **financials** (common income statement and balance sheet information);

❒ **inpatient costs, charges, length of stay, mortality, and complications** (by DRG, product line, and department);

❒ **outpatient costs, charges, and reimbursement**

(by ambulatory surgery and APC service line).

Rick Louie, founder and director of business development for Market Insights, is the first to point out that you have to pay $1,200 a year to get access to the company's most recent data. Much of the free data on Market Insights' Web site dates from 1996.

But depending on what you're looking for, the free data might just do the trick. If that information is not enough, of course, the company stands ready to provide customized reports from its database, 80% of which comes from the public domain such as the Health Care Financing Administration (HCFA), and 20% of which comes from client data. Market Insights has five years worth of such data on every hospital in the country.

"I'm amazed at everything I can get through the Internet now that I would have had to pay for five or 10 years ago," Louie says. "Today's technology is pushing data down to a commodity level."

William Cleverley, founder of The Center for Healthcare Industry Performance Studies (CHIPS) in Columbus, OH, agrees that data are becoming a commodity and says that CHIPS also offers some limited 1997 data free on its Web site. If you're willing to pay, you can get much more data on the subscriber Web site for $495 a year.

He says that Market Insights' offering is of some concern to companies like CHIPS who deal mostly with publicly available data. "If you can get something for free, why pay for it? We have a lot of the same data elements they have," Cleverley says. "If you can give something away for free but it entices them back, then you may try and do it. If we all begin to do that, we'll strangle each other. I think there's going to be some bloodletting at some point in time. You're going to see many of these companies consolidating with one another or else going out of business."

So, how will data companies survive? Cleverley says the survivors will redesign formats or introduce new products to make their services unique. CHIPS has already begun that process with new services such as a report that will identify the potential impact of the new ambulatory payment classifications (APCs) under HCFA's proposed prospective payment system on a hospital's profitability. CHIPS also recently began offering a balanced scorecard review that offers customized reports that identify areas to improve financial performance.

Cleverley says CHIPS will continue to increase the analysis it offers. "A lot of users have too much data and too little time to interpret them."

Another key issue in the changing data industry is technology, particularly the new capabilities the World Wide Web brings, says **Dennis Dunn**, senior scientist with the Sachs Group in Evanston, IL. "Everybody's being forced to make the investment to come up with Web-based delivery methods of their information and analysis," he says.

While this may be creating extra work for the data companies, it's making life easier for benchmarkers. "This can only benefit planners," Dunn says. "Data will be more widely available, and the pressure will keep the cost down. It's so much easier to comparison-shop on the Web. That is particularly true for public data offerings. People used to charge hundreds of dollars for a report that you can now get on Market Insights' Web site for free. It's simply not going to be possible for a company to offer a $1,000 provider comparison report."

Dunn cautions that the type of free data you might find on the Web — even Sachs offers some on its site — is probably not enough for serious benchmarking. "It might be useful for people who are making the first baby steps into benchmarking or for occasional data users who need quick information, like who is the biggest player in a certain market," he says. "But people with

SOURCES

For more information on finding benchmarking data on the Internet, contact:

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- **William Cleverley**, Founder, CHIPS, 1550 Old Henderson Road, Suite S-277, Columbus, OH 43220. Telephone: (800) 859-2447. Web site: www.CHIPSonline.com.
- **Dennis Dunn**, Senior Scientist, Sachs Group, 1800 Sherman Ave., Suite 609, Evanston, IL 60201. Telephone: (847) 475-7526. Web site: www.sachs.com.
- **John Morrow**, Senior Vice President, HCIA, 300 E. Lombard St., Baltimore, MD 21202. Telephone: (410) 895-7539. Web site: www.HCIA.com.
- **Myla Wagner**, Director of Marketing, MECON, 200 Porter Drive, Suite 210, San Ramon, CA 94583. Telephone: (800) 356-3266, ext. 4005. Web site: www.MECON.com.

serious market size will need more."

He also warns planners not to believe everything they find on the Web. "Taking information at face value can be very dangerous," Dunn says. "This is typically information that is being submitted to fiscal intermediaries, some of whom clean the data a lot and some of whom don't. The quality really varies."

John Morrow, senior vice president for Baltimore-based HCIA Inc. agrees that planners should check out a company's reputation before putting stock in its data offerings. He says many of the public data sets that come from HCFA are not reliable enough to merit HCIA's trust.

"There are probably a dozen places you can go on the Internet and get some data, and I'm not sure I would trust any of it," Morrow says. "If I'm a business person making business decisions based on data, I'd better really have a strong conviction about the source of the data, the efficacy, and the utilization of that data. We as Americans are consumed with statistics, and we'll believe almost anything we hear."

Morrow says HCIA also offers some free data in the hopes that clients will be willing to spend more for the extra value the company offers. "HCIA pretty much started this industry in 1985," he says. "Now our business is centered around value-added services. The real insight is in the findings, not the data."

Eleanor Anderson-Miles, former director of corporate communications for MECON Associates in San Ramon, CA, says the key issue for all data companies in the current market is providing information on how to use the data. "Statistics don't mean anything if you don't know what they represent," she says.

Since January, MECON's customers have enjoyed an absolute Web-based technology that allows them to access the company's data warehouse through the Web. MECON is introducing technology that enables clients to go to the Web site and find benchmarking partners. "We will have discussion boards for people working on the same issues and a way to spotlight best practices like never before," Anderson-Miles says. ■

Multiply number of noncompliant items by 5

Estimates on products' Y2K compliance were off

The number of medical products that are not year 2000 (Y2K) compliant is almost five times what was previously believed, according to Joel C. Willemssen, director of the Civil Agencies Information Systems Accounting and Information Management Division of the Washington, DC-based General Accounting Office (GAO). Willemssen recently testified before the Senate's Special Committee on the Year 2000 Technology Problem.

As of June 1, the Federal Y2K Biomedical Equipment Clearinghouse listed 427 manufacturers referring users to their Web sites. When GAO officials studied the manufacturers' sites, they determined about 4,445 medical products, or 12.5%, are considered noncompliant by the manufacturer, he said.

That number is almost five times the number of individual noncompliant products (897) that manufacturers reported to the federal clearinghouse, he said. Noncompliant products reported by manufacturers on their Web sites include a bedside monitor and laboratory information systems, according to Willemssen. In many cases, the manufacturer provides solutions to correct the problem, such as software upgrades and manual calculations, he said.

And that's not all of the bad news, according to Willemssen. Several hospital engineers have tested their own biomedical equipment. "Several of these engineers informed us that their testing identified some noncompliant equipment that the manufacturers had previously certified as compliant," he said. The equipment found to be noncompliant had display problems and were not critical care/life support equipment. They included a cardiac catheterization unit, a pulse oximeter, medical imaging equipment, and ultrasound equipment, Willemssen added.

In response, the Food and Drug Administration (FDA) plans to review manufacturers' test results supporting their compliance certifications for a sample of critical devices. The FDA has developed a list of about 70 such devices. To view a list of the devices, go to Web page: www.fda.gov/cdrh/yr2000/cdrh/phrds/phrds.html. By putting a device on the list, the FDA is not implying that all devices of this type are not Y2K-compliant. Also, if they aren't compliant, the devices wouldn't necessarily pose a significant risk to patients.

Instead, FDA officials emphasize that these devices could pose a risk to patients if they aren't

Y2K compliant. The list of critical devices includes the following, listed with section number in Title 21 of the Code of Federal Regulations where the device type is described:

- gas machine for anesthesia or analgesia, 868.5160;
- infusion pump, 880.5725;
- laparoscopic insufflator, 884.1730.

This list can help same-day surgery facilities prioritize devices that should be assessed and brought into compliance.

According to Willemssen, health care providers have been slow to respond. Fewer than one-third of the hospitals responding to the Washington, DC-based Office of the Inspector General stated their biomedical equipment was currently compliant, and only 6% of the hospitals responding to a survey from the Chicago-based American Hospital Association stated their biomedical equipment was compliant, he said.

(Editor's note: The FDA clearinghouse can be found on the Web at http://www.fda.gov/cdrh/yr2000/year2000.html.) ■

Joint Commission targets surgery

Five areas identified for core measures

The Joint Commission on Accreditation of Healthcare Organizations has identified surgical procedures and complications as one of five areas for which core performance measures will be developed. The other four areas are acute myocardial infarction, congestive heart failure, pneumonia, and pregnancy and related conditions.

"Now that those five areas have been identified, the Joint Commission will convene clinical panels in each area and determine specific measures," says **Ceil Stern**, director of accreditation and licensure for the Princeton-based New Jersey Hospital Association.

A nationwide Core Measurement Implementation Task Force has been put in place by Dennis O'Leary, president of the Joint Commission. The task force was a response to a letter O'Leary received in January from 17 state hospital associations that raised concerns about the Oryx initiative, the Joint Commission's new electronic reporting system.

"We have an active role in the process now," Stern says. The group met in late March for the first time and has met periodically since that time, in person and by phone. "We in the field bear the burden of implementing performance measures, so we need to be included when the Joint Commission develops policies that are going to impact us," Stern says. "I do think the Joint Commission has responded appropriately to our letter in terms of convening the task force." ■

Clinical guidelines on the Web

Trying to find clinical practice guidelines is easier now that the National Guidelines Clearinghouse (NGC) has an on-line site.

The National Guidelines Clearinghouse is a resource for evidence-based clinical practice guidelines, explains **Jean Slutsky**, NGC project

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officer. The site is sponsored by the Agency for Health Care Policy and Research (AHCPR) in Rockville, MD, the American Medical Association in Chicago, and the American Association of Health Plans in Washington, DC.

Visitors to www.guideline.gov can browse through treatment and intervention guidelines as well as information on equipment and supplies. Topics of interest to day-surgery managers include:

- anesthesia guidelines;
- cataract guidelines;
- adult and pediatric eye evaluation guidelines;
- cardiovascular perioperative guidelines for non-cardiac surgery.

There is no charge to view or list guidelines.

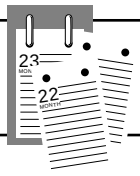
The typical time between submission of a guideline and inclusion on the Web site is three months, Slutsky says. Abstracts for every guideline submitted are written by the NGC staff to conform to a specific format that enables visitors to compare guidelines of one organization to another.

New guidelines appear Tuesday mornings. The new guidelines are listed in the "What's New" section of the site, says Slutsky. She says, "We estimate that we'll have about 700 guidelines on the Web site this fall."

For more information, contact www.guidelines.gov. or send your request to Jean Slutsky, AHCPR, 6010 Executive Blvd., Suite 300, Rockville, MD 20852.

For information on how to submit guidelines for the Web site, go to www.guidelines.gov, choose "about NGC", choose "content overview," and choose "content development and inclusion criteria." ■

CALENDAR



• **Joint Commission Freestanding Ambulatory Care Accreditation: Standards and Survey Process** — Sept. 16-17, Nashville, TN. Sponsored by THA — An Association of Hospitals and Health Systems and the Joint Commission on Accreditation of Healthcare Organizations. Contact: Education Services, THA — An Association of Hospitals and Health Systems, 500 Interstate Blvd. S., Nashville, TN 37210. Telephone: (800) 258-9541 or (615) 256-8240. ■

CE objectives

After reading this issue, the continuing education participant will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. **(See "Don't miss out! Tattoo removal, short recovery cosmetic cases in demand," p. 89 and "Joint Commission targets surgery," p. 99.)**
- Describe how those issues affect nursing service delivery or management of a facility. **(See "Popular botanicals may cause interactions," p. 94.)**
- Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. **(See "Clinical guidelines on the Web," p. 99.)** ■