Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 25 Years

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

MAY 2004
VOL. 28, NO. 5 • (pages 49-60)

Hospitals and surgery centers throw punches at national, state, local level

Regulations and legislation target physician-owned facilities

County commissioners in Sheridan, WY, are seeking a moratorium on ambulatory surgery centers (ASCs) after the hospital and physicians planned competing facilities. Communities in Kansas and Oklahoma have passed similar moratoriums.

Economic credentialing actions have been taken by hospitals in Ohio, Idaho, Arkansas, and elsewhere against physician owners of competing facilities, says **David Shapiro**, MD, president of the Johnson City, TN-based American Association of Ambulatory Surgery Centers (AAASC).

A group of doctors who say they were blocked from building an outpatient surgery center is suing a Lancaster County, SC, hospital for $15 million.

And the list goes on. **(For more examples, see box, p. 51.)**

What's going on?

"I think that the actions are part of a concerted effort by hospitals to impose restrictions on ASC development and generally make physician investment in ASCs less appealing," says **Eric Zimmerman**, JD, partner with McDermott, Will & Emery (MWE) in Washington, DC.

According to sources interviewed by *Same-Day Surgery*, hospitals have

EXECUTIVE SUMMARY

As physician-owned facilities, particularly specialty hospitals, are targeted by hospital groups and others for legislative and regulatory restrictions, ambulatory surgery centers (ASCs) are caught in the crossfire.

- Some hospital leaders say physician-owned facilities drain the best-paying, least complex patients from hospitals and threaten their survival.
- ASC leaders contend restrictions are unnecessary, and they are organizing statewide and educating lawmakers.
- Future restrictions are predicted, but ASC leaders say health care providers need to work together to meet future growth.

increasingly become concerned about competition from specialty hospitals, including surgical hospitals. This concern has caused hospital associations at the national and state level to seek legislative and regulatory relief against physician-owned facilities, which sometimes includes ASCs.

Congress recently imposed an 18-month moratorium against new specialty hospitals and limited expansion of existing ones retroactively beginning Nov. 18, 2003. **(See *SDS*, January 2004, p. 4.)**

The moratorium on specialty hospital development is counterproductive, anticompetitive, restricts patient choice, and harms the nation's health care system, according to **Michael J. Lipomi**, MSHA, president of the San Diego-based American Surgical Hospital Association.

"The moratorium itself is based on misinformation provided by hospitals, health care systems, and their associations to protect and preserve their monopolistic strangle hold on the health care system to the detriment of the patients," he explains. The United States needs a system that encourages competition and innovation, Lipomi says. "Specialization improves patient care, lowers costs, and increases quality and patient satisfaction," he adds.

Surgery center leaders are swift to criticize the regulatory and legislative restrictions that include ASCs.

"It's a huge, unnecessary threat to high-quality, efficient, patient-preferred surgery centers," says **Craig Jeffries**, Esq., executive director of AAASC. In fact, several states, including Massachusetts, are underserviced by ASCs because of the state regulatory burdens to development, he maintains.

Additionally, the response of hospitals is unnecessary because the growth of outpatient surgery provided in hospitals exceeds the growth in ASCs, says **Kathy Bryant**, executive director of Federated Ambulatory Surgery Association in Alexandria, VA. ASC leaders also point to many successful hospital-ASC joint ventures.

Where will it end? In a worst-case scenario, ASCs potentially could lose their safe harbor protection under the anti-kickback law, Shapiro warns.

Michael Romansky, JD, partner in the health law department of MWE, says there is only a small chance of those safe harbors being lost, but he adds that this was the same prognosis he gave when assessing the hospital industry's prospects for obtaining a moratorium on surgical hospital development.[1]

For its part, leaders of the American Hospital Association (AHA) in Washington, DC, insist that they are not targeting ASCs.

"In terms of what AHA has been doing, our legislative agenda in that respect has been focused on the specialty hospitals," says **Ellen Pryga**, director of policy. However, AHA has brought together state hospital associations to discuss issues that are common, including a meeting on specialty hospitals in fall 2003. She says that ASCs were discussed briefly.

Same-Day Surgery® (ISSN 0190-5066) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Same-Day Surgery**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $519. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $415 per year; 10 to 20 additional copies, $311 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

This continuing education offering is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing. Provider Number CEP 10864. Approximately 20 nursing contact hours. Thomson American Health Consultants (AHC) designates this continuing medical education (CME) activity for up to 20 hours in Category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

AHC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide CME for physicians. This CME activity was planned and produced in accordance with the ACCME Essentials. It is in effect for 36 months from the date of the publication.

This CME activity is intended for outpatient surgeons and other clinicians.

Statement of Financial Disclosure: Ball (board member) discloses that she is a consultant with Steris Corp., Encision, Encision-AMT, and Megadyne. Twersky (board member) discloses that she is on the speaker's bureau for Stuart/Zeneca Pharmaceuticals, Roche Laboratories, Anaquest, Abbot, Marrion Merrill Dow Inc., and GlaxoSmithKline. Pence (board member) discloses that he is a stockholder with FWI Healthcare. Burke, Derby, Earnhart, Edwards, Geier, Jeffries, Overholt, and Schwaitzberg have not reported any financial relationships to disclose.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

This publication does not receive commercial support.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).

Editorial Group Head: **Valerie Loner**, (404) 262-5475, (valerie.loner@thomson.com).

Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@thomson.com).

Senior Production Editor: **Ann Duncan**.

Editorial Questions

Questions or comments? Call **Joy Daughtery Dickinson** at (229) 551-9195.

State Legislation — Physician Ownership, 2003-04

State	Status	Covers ASCs	Covers Hospitals	Notes
California	Effective 1/01/04	Yes	No	Workers' comp only; notify patient & pre-authorization
California	Pending	Yes	No	Would repeal above law
Colorado	Not Enacted	No	Specialty	Prohibits referrals
Indiana	Not Enacted	Yes	Specialty	Prohibits referrals
Louisiana	Not Enacted	No	All	Prohibits referrals
Minnesota	Pending	Yes	No	Written notice to patients of economic interest; patient must sign
Mississippi	Not Enacted	No	Specialty	One-year ban on CONs
New Hampshire	Pending	No	All	No referring investor more than 15%
Ohio	Not Enacted	No	All inpatient	Two-year ban on new; disclosure to patient
Tennessee	Pending	Yes	Yes	Pathology /cytology services only

Source: Federated Ambulatory Surgery Association, Alexandria, VA.

The problem is that some physician-owned facilities, particularly specialty hospitals, have the less complex, better-insured patients, Pryga says.

"When they're uninsured, or covered by Medicaid, or not paid well under Medicaid, or a more complex patient, they go to community or full-service hospitals," she says. The better-paying patient and the better-paying procedures are the ones that help hospitals cover the ones that don't have coverage, are Medicaid-reimbursed, or are not fully reimbursed, Pryga points out.

"When it comes to overall viability of including broad range of services and access to the entire community, the proliferation that are very narrowly focused on specific populations and specific procedures, and pulling out only those populations and procedures put the ability to maintain services for entire community at risk," she adds.

The AHA stance is reinforced by the Federation of American Hospitals in Washington, DC. "The [federation] board has talked about surgery centers and given attention to oppose incidents where there are referrals by physicians to facilities where they have an ownership interest," says **Richard Coorsh**, spokesman. "We believe it increases an unlevel playing field that ultimately is detrimental to patients and other consumers."

ASC leaders are not taking legislative and regulatory threats lightly. They are hiring lobbyists at the state and national level, educating state and congressional lawmakers, and better organizing their state associations.

When the Colorado Health and Hospital Association in Greenwood Village began formulating a bill against physician referral to "limited service hospitals," including surgical hospitals, it spurred the Colorado Ambulatory Surgery Association to become more active, says **Rebecca Craig**, RN, CNOR, CASC, president of the association and administrator of Harmony Surgery Center in Fort Collins.

"We were afraid that the next thing on the agenda would be for them to say that for physicians to own surgery centers is a conflict of interest," she points out.

The group organized and hired a lobbyist, who was successful in tabling the bill. Now another bill is being developed to prohibit ASCs from obtaining a convalescent care license, which allows extended recovery care with no time limit in Colorado. The ambulatory surgery group is educating state legislators with statistics and benchmarks and providing them tours of ASCs to demonstrate the quality of care.

"I think [ASCs] will continue to grow in the state of Colorado, due to the quality product we have to offer," Craig says. "I think that will speak for itself. But of course, we're going to have to continue to fight for the ability to do that."

In terms of future scrutiny, ASC leaders don't expect much more to come from the Medicare Payment Advisory Commission (MedPAC), despite the fact that at MedPac's January hearing, a commissioner asked whether physician investment in ASCs should be scrutinized. **(See**

SDS, **March 2004, p. 34.)**

"They may discuss it some more, but my guess is that it's not an important policy discussion," Jeffries says.

In fact, MedPAC's recent report to Congress did not address physician ownership of ASCs.

In the meantime, hospitals and ASCs need to work together to meet the surgical demands of tomorrow's patients, Bryant maintains. "One study is predicting 15% growth in ophthalmic surgery by 2010, and by 2020 a 47% growth, which is incredible,"[2] she says. "If those kinds of estimates are true, we needs lots of growth to meet those needs."

Physicians, hospitals, and ASCs should have discussions on how to meet increasing demands, Bryant notes. "Hospitals are going to need ORs to meet growing inpatient demands," she says. "I think, based on the procedures we can do in ASCs, the overall population will benefit."

However, in the short term, don't expect hospital groups to stop pursuing legislative and regulatory restrictions against physician-owned facilities.

"I think the issues that we're all dealing with are intensifying not diminishing," Pryga says. "I would guess [future restrictions are] probably a safe bet."

References

1. Conn J. Hospitals moving aggressively against surgery centers: AAASC. *MP Stat*, March 4, 2004. Web: www.modernphysician.com.

2. Etzioni DA, Liu JH, Maggard MA. The aging population and its impact on the surgery work force. *Ann Surg* 2003; 238:170-177. ■

Stuffed animals, 'cruises' alleviate surgical anxiety

Orientations produce calmer children and parents

One same-day surgery program offers a "cruise." Another program offers one-on-one tours and talks. Although the approach is different, the goal is the same: Prepare children for their same-day surgery experience by explaining the unknown and making the whole experience less scary.

Offering an orientation for children is important because parents don't always know how to explain surgery to their children, even if they know what to expect, says **Emily Fazio**, CCLS, a child life specialist in day surgery at Children's Healthcare of Atlanta at Egleston. Fazio even has had parents mislead their children by telling them they are going to get ice cream as they head to the hospital.

EXECUTIVE SUMMARY

One way to alleviate children's pre-surgery anxiety is to orient children and their parents prior to the day of surgery.

- Answer questions directly and honestly.
- Let children touch items such as oxygen masks and stethoscopes.
- Use balloons or stuffed animals to personalize the child's experience.
- Use photographs or a video to show the child the operating room.

Fazio's orientation program usually is a meeting between Fazio, the patient, and the patient's parents. "I like to talk with patients one-on-one rather than large groups because each patient is undergoing a different procedure, and a difference in age of patients also means different concerns," she points out.

If there are two children of similar age and maturity level undergoing the same procedure and she can make the parents' wait a little shorter by combining the orientation meetings, she does talk with more than one family at a time. "I conduct the orientation at the same time the patients and parents come into our preoperative clinic," explains Fazio. "This is usually a few days to no more than a week before their surgery."

Timing is important because younger children, such as 3- or 4-year-olds, don't retain the information any longer than a week, she says.

"I walk them around the area, let them see where they will come on the day of surgery, and show them all of the areas they will see, except the operating room," Fazio continues.

She explains to the children that the operating room is a sterile area to make sure no germs are in the room during surgery. She subsequently shows them pictures of the operating room and the equipment that they will see.

The children at Children's Surgery Center in Columbus, OH, also are not allowed in the operating room during their tour, but they take a virtual tour of the operating room on-line at a computer in the surgery center, says **Annette R. Svagerko**, RN, CNOR, OR, clinical coordinator at the center.

"Because our center has a nautical theme with

a reception desk designed as a boat and fish and other aquatic designs throughout the center, we call our orientation tour a cruise," she explains. "Each child on the cruise receives a stuffed animal that they can bring back on the day of the surgery as a comfort item."

It is important to show children some of the unfamiliar things that they will see on the day of surgery and let them touch them and get accustomed to them, says Svagerko. "We let them put the anesthesia mask on their face so they won't be frightened by it, and we let them choose how the mask will smell," she explains.

Same-day surgery nurses put a small amount of scented oil on the inside of the mask so that the smell is more pleasant, she says. "The children can pick from a variety of scents such as peppermint, evergreen, bubble gum, or strawberry," she adds. *(Editor's note: The manufacturer is LorAnn Oils, Lansing, MI. Web: www.lorannoils.com.)*

Telling the children what will happen doesn't mean just talking about clinical issues, points out Svagerko. "Not only do they try on the anesthesia mask, but we also let them experience the pulse oximeter, the blood pressure cuff, the stethoscope, and the otoscope." While giving the children an opportunity to see and touch these clinical items ahead of time is important, you have to remember that they are children, she says.

"We also show them a Mylar balloon and explain to them that their name will be on one of the balloons and it will be attached to their bed," she says. "They know that, along with the stuffed animal we give them, they will have their own balloon and their own place on the day of surgery, and this also reassures them."

Children ask different questions based upon their ages, with younger children wanting to know if it will hurt and older children more interested in when they can return to normal activities, Fazio adds. **(For suggestions on how to answer common questions, see tips, below.)**

How you can answer those tough questions from kids

Kids not only say the darndest things, as television personality Art Linkletter says, but they also ask some tough, specific questions when facing a day of same-day surgery.

"You have to answer questions honestly, but be sure you think about your answers from the children's perspective," says **Emily Fazio**, CCLS, a child life specialist in day surgery at Children's Healthcare of Atlanta at Egleston.

For example, at Children's Healthcare, staff members never say, "We are going to put you to sleep," she notes. "Most children have heard that phrase used to describe killing a sick pet, and we don't want to make them associate anesthesia used for their surgery with that experience," Fazio points out. "Instead, say that the doctor has some medicine that will help the child sleep."

Here are some other common questions from children:

- **What will happen if I wake up during surgery?**

"I explain that there are a lot of people in the room with them, and there is one person who is always there to make sure the children have enough medicine to stay asleep," Fazio says. "It's important to reassure the child that everyone in the room is going to make sure they stay safe and don't hurt."

- **Is it going to hurt?**

"I explain that they won't hurt during surgery, because the medicine they will be given helps them sleep so deeply that they won't feel it, and that we also give them pain medicine," Fazio says.

Be honest about possible aches or pains after surgery, Fazio adds. Be sure to describe any soreness the child may feel and explain that parents will have medicine to help with the pain, she says.

Fazio's same-day surgery program also helps minimize pain with simple techniques such as topical anesthetics used at any sites in which a needle might be placed for intravenous lines, she adds.

"We minimize the use of needles by using only mask induction," says **Annette R. Svagerko**, RN, CNOR, OR clinical coordinator at Children's Surgery Center in Columbus, OH. "We rarely have to draw blood, and we start IVs after the child is asleep," she adds.

- **When can I play again?**

The best way to talk to children about post-surgical recovery is to first find out what they like to do, Fazio says. "Ask about hobbies, sports, games they play with friends, then talk about their time after surgery in those terms," she says.

Don't say that they can't do something for several days; instead phrase the information positively by saying that they can ride their bike again in three days, or whatever time period is appropriate, Fazio says.

While it is almost always preferable to phrase the information positively, there are instances when a negative for an adult is a positive for a child, she points out.

"Boys always love to hear that they can't take a bath or shower for a few days," she says. "Their moms, however, always jump in with the statement that they can sponge bathe them." ■

SOURCES

For more information, contact:

- **Emily Fazio**, CCLS, Child Life Specialist, Patient and Family Support Services, Children's Healthcare of Atlanta at Egleston, 1405 Clifton Road, Atlanta, GA 30322. Phone: (404) 315-3771. E-mail: Emily.fazio@choa.org.
- **Annette R. Svagerko**, RN, CNOR, OR Clinical Services Coordinator, Children's Surgery Center, 660 Children's Drive, Columbus, OH 43205. Phone: (614) 722-2920. E-mail: svagerka@chi.osu.edu.

"The most important thing to remember is to be honest," she says.

Make sure, also, that the nurses calling the day before surgery do a good job of preparing the parents, Fazio suggests. In addition to giving instructions on what the child can and cannot drink or eat prior to surgery, be sure to remind parents of the process, she says. Tell them what to expect in the waiting room, in recovery, and at discharge, she explains. Let them know how long they can expect to be at the facility and how their child will feel at discharge, she adds.

"If the parents are comfortable that they know what will happen, they are calmer and can reassure the child," she adds. ■

Powdered gloves increase surgical complication risk

Adhesions, granulomas, decreased resistance linked

Same-day surgery managers and infection control experts have long been aware of the risk of latex gloves to patients with latex allergies, but the risks posed by the powder in gloves to all patients now is being addressed by surgery programs.

"There is substantial data and compelling evidence of the risks to surgical patients from powdered gloves, so our entire facility, including same-day surgery, went powder-free several years ago," says **Victoria Steelman**, RN, PhD, CNOR, advanced practice nurse at the University of Iowa Hospital and Clinics in Iowa City. "We've known that powder increased the exposure of employees to latex proteins, so protection of employees and patients of latex allergies is one reason to go powder free."

Reduction of the risk for post-surgical complications for patients is another good reason, she adds. These risks include adhesions, granulomas, aggravated inflammation, cytotoxic complications, clots, delayed healing, and fever, says **Wava Truscott**, PhD, director of scientific affairs and clinical education for Kimberly-Clark in Roswell, GA.

While patients undergoing lengthy, complicated procedures that are typically inpatient procedures are at highest risk, research does show that same-day surgery patients are at risk as well, she says. **(For access to research summaries and names of specific articles, see resource box, p. 55.)**

The use of trocars in minimally invasive surgeries for gynecological patients can deposit granules of powder from gloves into the incision just as ophthalmologic instruments can deposit powder into eyes during procedures, says Truscott.

It's not just powder particles left on instruments or gloves that can cause problems, either, points out Steelman. Before going powder free, Steelman's facility conducted air-sampling studies in different areas to determine the level of powder particles.

"Even in areas outside the surgical suite, we found particles that exposed people not wearing gloves to latex proteins," she says. Although staff members were rinsing gloves and washing hands after taking gloves off, the powder particles were escaping into the air and contaminating the environment, she adds.

Powder-free gloves are more expensive than traditional gloves, with the additional expense varying according to volume ordered and discount programs in which a same-day surgery program participates.

Prices for powder-free surgical gloves range

EXECUTIVE SUMMARY

Research has shown that several post-surgical complications can occur when powder particles from surgical and exam gloves fall into an open incision or are accidentally placed in the body with an instrument on which the particles have attached themselves.

- Make your case for a switch to powder free with solid, evidence-based research.
- Obtain administrative support before proceeding.
- Offer more than one option for the new glove.
- Emphasize patient and staff safety as the reason for the switch.

SOURCES AND RESOURCE

For more information, contact:

- **Nancy Flannagan**, RN, CNOR, QI Coordinator, Surgical Services, Piedmont Hospital, 1968 Peachtree Road N.W., Atlanta, GA 30309.
- **Victoria Steelman**, RN, PhD, CNOR, Advanced Practice Nurse, University of Iowa Hospital and Clinics, 200 Hawkins Drive, Iowa City, IA 52242. Phone: (319) 356-4751. Fax: (319) 357-8234. E-mail: Victoria-steelman@uiowa.edu.
- **Wava Truscott**, PhD, Director, Scientific Affairs and Clinical Education, Professional Health Care, Kimberly-Clark, 1400 Holcomb Bridge Road, Roswell, GA 30076. Phone: (770) 587-8447. Fax: (770) 587-7764. E-mail: wtruscott@kcc.com.

For more information about the risks associated with powdered gloves and current research on the topic, go to www.kchealthcare.com, click on "Knowledge Network," then choose "Article Reprints." Volumes 1, 2, and 3 of *FirstHAND* address issues surrounding powder and powder-free gloves. Free copies of *FirstHAND* also are available by calling (800) 524-3577.

from 75 cents to $1.20 on average per pair, as compared to traditional surgical gloves with powder that range from 30 cents to 50 cents on average per pair, according to a Kimberly-Clark spokesperson.

The extra cost is attributed to the process through which a glove undergoes to become powder free, says Truscott.

"All gloves start with powder on them in the manufacturing process," she says. The powder is necessary to remove the gloves from the forms on which they are made. "Once made, powder-free gloves go through multiple rinsing cycles then are turned inside out, and the rinsing process is repeated," Truscott explains.

Although the gloves may cost more than traditional gloves, the switch to powder-free gloves at Steelman's facility was a break-even proposition.

"Once we looked at the time and supplies required for our staff to rinse their hands and gloves every time they donned or removed gloves, the cost difference was minimal," she points out.

Nancy Flannagan, RN, CNOR, quality improvement coordinator for surgical services at Piedmont Hospital in Atlanta, says, "When you reduce the risk of expenses associated with adhesions or allergic reactions in post-surgical patients, as well as employee health costs associated with employees' allergic reactions, it just makes sense in both financial and patient care concerns to go powder free."

Staff health problems minimized

While concerned about the risk of post-surgical complications, Flannagan points out that reduction of the spread of latex protein through the powder is a great benefit of going powder free.

"We have a number of surgeons and staff members with latex allergies, and we realized that even if they had the option of latex-free gloves, the powder from latex gloves was in the air and the areas in which they worked," says Flannagan. "It's not practical to think that a same-day surgery program can go completely latex free, but we can minimize the exposure to latex protein by going powder free."

Asking staff members and surgeons to switch to a glove that they traditionally have not used is not easy, admits Steelman. Before you switch to powder-free gloves, be sure you have administrative support for the move, she suggests.

Use evidence-based practices that are supported by research, and collect relevant information on your own same-day surgery program, such as post-surgical complications that are related to powder and numbers of staff members, patients, and surgeons allergic to latex, to make your case, she recommends.

"We standardized the glove we used throughout the entire hospital, not just the surgical areas," Steelman points out. "By using one vendor, we were able to choose a high-quality glove at a reasonable price," she says.

Be ready, however, to offer an alternative choice to surgeons or staff members, Steelman suggests. "At the beginning of our conversion to powder free, we also choose another glove that would serve as our optional glove," she says. "It, too, was powder-free but did have a different feel from our standard glove.

"The second glove made it possible for the same-day surgery manager to give surgeons some choices without compromising the facility's commitment to powder free," Steelman explains.

Staff education prior to the switch to powder free included posters produced in-house and placed in locker rooms and other employee areas, she says.

"The posters explained that the switch to powder-free gloves improved patient and employee safety and were part of the hospital's overall commitment to high-quality care," Steelman says. ■

Same-Day Surgery Manager

Staffing is tough: Can you make everyone happy?

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

Wouldn't it be nice *not* to have to deal with staffing issues? Really, what do people expect of us? We try hard to accommodate everyone, but it seems like often we come up short.

If there is one question that comes up more than any other in this industry, it always is somehow related to staffing. Always. Don't assume you know the answer to just about anything that deals with people and resultant payroll.

Personnel (labor) cost and supply expense account for about 50% of a facility's budget. A benchmark that I often see is that somehow — I have no idea why there is a correlation — supply cost and personnel cost tend to be about the same percentage of net revenue. That is a large chunk of change that needs to be accounted for each month.

Also, because of the high degree of cost, staffing always is on the mind of investors. "Why do we need so much staff?" they ask. "Why is everyone sitting around doing nothing?" It goes on and on.

Is there an answer? I think partially there is.

For the most part, surgery centers and hospital surgical departments are fairly predictable in their needs. Granted, new centers just beginning operations still are experiencing scheduling gaps, but they eventually will stabilize the peaks and valleys in the surgical posting. So, as many investors often ask, "Why do we have staff sitting around doing nothing? Why aren't staff sent home when surgery is complete?"

We all know that staff retention is critical to efficient operations. Training new staff members is expensive (assuming you can find them). If that reason is not enough, your surgeons — yes, the very ones who complain about too much staff — are all over you for giving them "the new one." Every one of us has to keep staff employed, even if we don't need them for 40 hours per week, just so we don't lose them. I've done it myself — many times.

It is easier than cutting staff hours and getting them upset with you or losing them to another location. If we all wimp out like me, then we are going to deal with investor ire and get that dreaded look of "does he know what he is doing" at each board meeting.

There must be a way to satisfy all parties. There is, and it is relatively painless.

You need to plan out your staffing needs. You realistically cannot alter your entire staff overnight. The majority of investors I am used to dealing with basically want a plan and a timeline of when they can expect to see a change. Give it to them. Now, if you are blessed and no one is looking at your staffing costs, then you have achieved nirvana and may float onto your next life experience and ignore the rest of this column.

For the rest of you, you need a mixture of full-time and per-diem staff. I'm referring to staff who work the full hours each week and per-diem staff who go home when surgery is complete.

What is the mix of full to per diem? Everyone is different, but I think a healthy mix is 50/50. That ratio gives you the opportunity to get creative with your staffing budget and benefit costs. How do you get there? Well, it takes time, and it isn't the easiest undertaking you will face.

Start by replacing new staff with per diem. If you have a full-time staff opening, try filling it with two per-diem members. As current staff members leave, replace them with part-timers as well.

It is risky; I agree. You get a breathing body in front of you who wants a full-time job with benefits or forget it, and it is hard to turn him or her away.

That is exactly why you need a game plan and support from your investors. They need to understand the downside risk of not being able to attract new staff. If they cannot support you, then you need to have a very serious discussion of how they expect you to reduce staffing hours.

The process literally can take years to get to the point that you are not dependent upon fully benefited, full-time staff members. But every plan needs to begin somewhere. Sitting down with your investor group and getting realistic expectations and a time frame is the first step.

By the way, the surgeon investors who scream the loudest to reduce staffing expense always will be the ones who complain that they don't have enough staff in their rooms. Notice that?

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management.

Contact Earnhart at 8303 MoPac, Suite C–146. Austin, TX 78759. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

HIPAA Q & A

[Editor's note: This column addresses specific questions related to Health Insurance Portability and Accountability Act (HIPAA) implementation. If you have questions, please send them to Sheryl Jackson, Same-Day Surgery, *Thomson American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com.]*

Question: Does the security rule prohibit transmission of protected health information (PHI) by e-mail?

Answer: No. The security rule requires covered entities to address the security of electronic transmission of PHI, says **Robert W. Markette Jr.**, an Indianapolis attorney. Depending upon a covered entity's perception of the threat, the same-day surgery program may decide to implement encryption or some other security feature, he says. However, encryption is not a required standard. "In the comments to the security rule, the Department of Health and Human Services (HHS) stated that one of the reasons it was not requiring encryption was due to the prevalent use of e-mail by rural providers to communicate with patients," says Markette. These comments from HHS recognize that PHI will be transmitted by e-mail, he says.

Question: Are health organizations responsible for the protection of unsolicited e-mails sent by patients?

Answer: When same-day surgery programs come into possession of electronic PHI, such as e-mail from patients or physicians, the organization must protect it, Markette says. "However, the agency is not responsible for the security of the information as it is transmitted from patient or physician to the entity," he adds. ■

SOURCE

For more information, contact:

- **Robert W. Markette Jr.**, Attorney, Gilliland & Caudill, 3905 Vincennes Road, Suite 204, Indianapolis, IN 46268. Phone: (800) 894-1243 or (317) 704-2400. Fax: (317) 704-2410. E-mail: rwm@gilliland.com.

Key words, eye contact boost satisfaction scores

Staff education, involvement key to score increases

Making sure your patient satisfaction program is top-notch takes more than just sending out surveys, according to winners of a national patient satisfaction improvement award offered by Press Ganey Associates in South Bend, IN.

"I knew that the only way we could go was up when I looked at how our satisfaction scores compared to other ambulatory surgery programs," says **Marilyn Bergman**, RN, clinical manager of ambulatory surgery for Providence Alaska Medical Center in Anchorage. "We were between the third and sixth percentile in rankings, so I knew we could put some programs in place to increase our scores," she says.

The first thing Bergman did was to educate her staff. "Staff members were shocked because we do provide excellent care, and they had no idea that our patient satisfaction scores were so low because they had never seen them before," she says. In addition to sharing the data, Bergman also shared the questions on the survey and the meanings of the different rankings.

"After our initial sessions of education on the meaning of the patient satisfaction scores, we set goals for improvement," she explains. "We wanted to improve to the 25th percentile by the first year, and we actually ended up reaching that goal in six months, and we reached the 50th percentile at the end of the first year."

Recent results are close to the second year goal of 75%. "We don't always meet our goal every month or every quarter, but we are pleased with our efforts to improve," she adds.

Several activities contributed to Providence's success, Bergman notes. "We did some scripting to make sure that patients understood why we were doing some things a certain way," she says.

The scripting didn't require nurses to memorize speeches or specific sentences, but it did identify key words to include when explaining things to patients or their family members. "For example,

EXECUTIVE SUMMARY

Same-day surgery managers who have successfully increased their patient satisfaction scores say success in patient satisfaction requires several activities that involve the entire staff.

- Script key words that help patients understand that staff actions do relate to concern for safety, privacy, and comfort.
- Identify areas upon which patients place a high value, and target those areas with educational efforts.
- Keep staff members involved by making sure they know scores on an ongoing basis and they understand meaning of scores.

when we close the curtain on the patient's cubicle, we say 'I'm closing this curtain to give you some privacy,'" says Bergman.

Staff member repeat the phrase "I am doing this to protect your privacy" or a version of that phrase throughout the patient's stay, she says. "When the patient receives the survey in the mail several weeks later, he or she is more likely to answer the question related to our concern for the patient's privacy in a positive manner because we constantly described our reason for our actions."

Identification of key words and actions was also effective at the same-day surgery program at St. Edwards Mercy Health Network in Fort Smith, AR, which saw patient satisfaction scores climb almost six points in 15 months from a starting average of 86.05 to an average score of 91.65.

"We choose five areas that greatly affected patients' perception of our service and came up with ways to improve our attention to those areas," says **Michelle Gasaway**, RN, clinical nurse manager of the ambulatory surgery department at St. Edwards. For example, acknowledgement of the patient is important, so employees know to make eye contact with people, even if they are coming up to a desk to ask for directions or for information that the employee may not have.

"It's very easy to avoid interruptions by avoiding eye contact, but we make the eye contact, even if it means going elsewhere or making phone calls to help the patient or family member," she says.

In addition to acknowledgement, her staff identified other key areas of customer service: introduction by name, explanation of time that the patient or family member can expect for each step of surgery and recovery, explanation of delays, and use of the words "thank you." Gasaway's staff also uses phrases such as, "I'm raising this side rail for your safety" or "I'm doing this to increase your privacy." Staff members who volunteered to serve on a patient satisfaction team developed the phrases and laminated cards that list the five fundamentals of good customer service for each employee.

One of the responsibilities of team members is to take time to observe the patient's experience. "Too often, we get caught up in doing our job, and we don't look objectively at what is happening to the patient," Gasaway explains.

Now, patient satisfaction team members take time to sit in waiting areas and go to different areas, such as lab, radiology, or business office, related to same-day surgery and observe the patient's experience, she says. "This doesn't take a lot of time, and each staff member who observes a different area becomes more aware of his or her own area," Gasaway adds.

"This increased awareness enables all of us to be more proactive and take steps to correct long wait times before patients complain," she notes. Because her program involves lab, radiology, and other areas of the hospital to which ambulatory patients go, staff members feel comfortable pointing out to other employees that they didn't hear an explanation of the long wait given to the patient, Gasaway says. "Staff members also make suggestions about the way they handle scheduling of lab work and other tests to avoid long waits."

Have a process to immediately address patients' concerns, Bergman adds. Nurses in her program know to ask a patient if there is a problem if they notice behavior that suggests dissatisfaction, she points out. "Many times it is a matter of apologizing for a delay and thanking the person for their patience, but nurses also can give coupons to the hospital coffee shop for family members to use, or some other simple thing. If necessary, nurses contact a supervisor who immediately talks with the patient or family member to resolve the problem."

SOURCES

For more information, contact:

- **Marilyn Bergman**, RN, Clinical Manager, Ambulatory Services, Providence Alaska Medical Center, 7529 E. Sixth Ave., Anchorage, AK 99504. Phone: (907) 562-2211. E-mail: mbergman@provak.org.
- **Michelle Gasaway**, RN, Clinical Nurse Manager, Ambulatory Surgery, St. Edwards Mercy Outpatient Surgery Center, 7301 Rogers Ave., Fort Smith, AR 72917. Phone: (479) 314-1792. E-mail: mgasaway@ftsm.mercy.net.

Bulletin boards in staff areas are used to post current patient satisfaction scores, Gasaway adds. "The actual report is very complicated, so it is summarized so that staff members can easily see the areas of improvement and decline, she says.

"When we see that we are not doing as well in areas that are rated most important by patients, we take a look at what we are doing and add new key words or emphasize the area such as concern about pain, delays, or privacy," Gasaway explains. "Sometimes, we do see a drop in one area if we've been concentrating on other areas, so it is a constant process of review, evaluation, and changes to our approach." ■

Hospitals receive payment updates from CMS

Effective April 1, 2004, hospitals receive special payments for four additional services under updates from the Centers for Medicare & Medicaid Services (CMS). These are temporary until sufficient cost data are available to develop an appropriate price, according to CMS. The services are:

• Health care common procedure coding system (HCPCS) code C9712, insert pH capsule, GERD. This is insertion of a special device for measuring acid levels associated with gastroesophageal reflux disease. The payment is $450.

• HCPCS C9713, noncontact laser vap prosta. This is a procedure using a laser device that vaporizes the prostate and controls bleeding. The payment is $3,750.

• HCPCS C9714 Breast inters rad tx, immed. This is immediate placement of a balloon catheter in the breast for interstitial radiation therapy following a partial mastectomy. The payment is $2,750.

• HCPCS C9715 Breast inters rad tx, delay. This is delayed placement of a balloon catheter in the breast for interstitial radiation therapy following a partial mastectomy. The payment is $3,250.

For more information, go to www.cms.hhs.gov/manuals/pm_trans/R132CP.pdf. ■

CE/CME instructions

Physicians and nurses participate in this CE/ CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the June 2004 issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. ■

COMING IN FUTURE MONTHS

- Another procedure moves outpatient and makes a profit
- Newly released benchmarks: How do you measure up?
- Outpatient surgery as spectator event
- How to practice for the new JCAHO survey process
- Tips for reducing costs, maximizing profit

CE/CME objectives

After reading this issue you will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management.
- Describe how those issues affect clinical service delivery or management of a facility. (See *"Powdered gloves increase surgical complication risk"* and *"HIPAA Q&A."*)
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *"Stuffed animals, 'cruises' alleviate surgical anxiety"* and *"Key words, eye contact boost satisfaction scores."*)

CE/CME *questions*

17. During the orientation tour, what decision does the same-day surgery staff at Children's Surgery Center let children make so that they feel more comfortable about the anesthesia when they come in for surgery, according to Annette R. Svagerko, RN, CNOR, OR clinical coordinator?
    A. whether they have a pulse oximeter
    B. whether a family member is in surgery with them
    C. what scented oil will be placed on their anesthesia masks
    D. what color mask they will wear

18. What is one way to avoid complaints from staff members and surgeons when switching to powder-free gloves, according to Victoria Steelman, RN, PhD, CNOR, advance practice nurse at the University of Iowa Hospital and Clinics?
    A. Don't tell anyone you are switching.
    B. Keep powdered gloves available even after the switch.
    C. Offer more than one choice of powder-free glove.
    D. Cite the financial benefits of the switch.

19. Which of the following actions is not one of the key aspects of good customer service, according to Michelle Gasaway, RN, clinical nurse manager of the ambulatory surgery department at St. Edwards Mercy Health Network?
    A. eye contact with patients and family members
    B. explanation of time frame for surgery and recovery
    C. apology for delays
    D. detailed information on billing procedure

20. According to attorney Robert W. Markette Jr., in what way is a same-day surgery program responsible for unsolicited e-mails with a patient's protected health information under HIPAA?
    A. Once received, it must be protected.
    B. The same-day surgery center should block unsolicited e-mails.
    C. The same-day surgery center should install technology to ensure safe transmission of unsolicited e-mails.
    D. The unsolicited e-mail should be returned to the sender as soon as the same-day surgery program sees the content.

CE/CME answers

17. C 18. C 19. D 20. A