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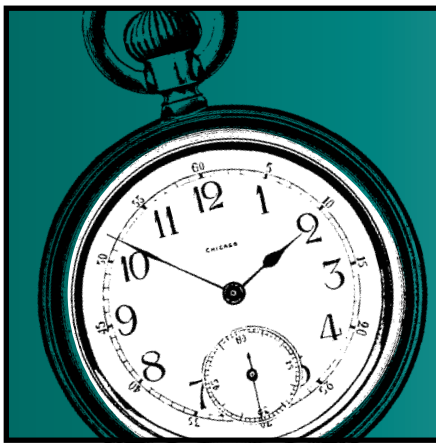

Same-Day Surgery®

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INSIDE

MAY 2000

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Were you expecting the worst with outpatient PPS? You can relax

Among provisions: Laparoscopies, new method IOLs to be reimbursed

Overall, same-day surgery managers can breath a sigh of relief regarding the final outpatient prospective payment system (PPS) rule for hospitals. Compared to the proposed rule, the final rule offers more money, reimburses for more outpatient services and devices, including laparoscopies and new technology intraocular lenses (IOLs), and provides a "transitional corridor" for those programs that suffer losses.

The payment system is based on 451 ambulatory payment classifications (APCs). The regulations were published in the April 7 *Federal Register*. **(For information on how to access the rule, see resource box, p. 51.)** The regulations also are available on the Health Care Financing Administration (HCFA) Web site (www.hcfa.gov). A 60-day comment period applies only to the regulatory changes in the final rule that resulted from the 1999 budget law. **(For information on submitting comments, see box, p. 50.)** The final rule is effective July 1, 2000.

Same-day surgery programs and other hospital outpatient units will bill for services using HCFA common procedural classification system (HCPCS) codes, not APCs, using the same claims forms they use now.

EXECUTIVE SUMMARY

The Health Care Financing Administration (HCFA) has published the final rule on the hospital outpatient prospective payment system (PPS), which is based on ambulatory payment classifications. The rule goes into effect in July. Hospitals were expecting a 5.7% reduction in outpatient payments. Instead, they will receive a 4.6% increase over current outpatient payments.

- For hospitals that will suffer losses, HCFA has built financial buffers into the system.
- HCFA will pay for outlier cases.
- The ambulatory surgery center PPS rule is expected to be published in November 2000 and take effect in April 2001.

"Although to receive payment under the new system, hospitals will have to more fully code the services they furnish; they will not have to know to which APC the service is assigned in order to determine the payment amount," HCFA says. HCFA published the payment rates applicable to each HCPCS codes in the final rule.

The regulation gives hospitals a 4.6% increase over current outpatient payments. Hospitals were expecting a 5.7% reduction in outpatient payments under the Balanced Budget Act (BBA) of 1997.

"It depends on the actual mix of services in individual hospitals, but for any given service, a lot of hospitals should do better than payments they were receiving before," says **Chantal Worzala**, PhD, an analyst with the Washington, DC-based Medicare Payment Advisory Commission, which advises Congress on health care financial issues.

Kevin Quinn, senior health economist at Abt Associates, a health care research and consulting firm in Washington, DC, describes the final rule as "a very hospital-friendly PPS." Originally, the PPS was intended to bundle a number of services into the payment. However, the final rule is an unbundled approach, he says. "So hospitals will be able to bill for every individual lab test, every individual X-ray, every CAT scan. It really puts a lot less financial risk on hospitals than they would have seen if HCFA really had done outpatient DRGs," says Quinn, referring to diagnostic related groups, which form the inpatient PPS.

However, not everyone is happy with the final rule. Overall, the increased payments still put hospitals in a hole compared with where they were prior to the Balanced Budget Act (BBA), according to the Chicago-based American Hospital Association (AHA). Before the BBA was passed in 1997, Medicare paid hospitals about 92 cents for every dollar of outpatient services performed, the AHA says. The BBA cut that amount to about 82 cents on the dollar and threatened to lower it. The 1999 Balanced Budget Refinement Act stopped the decrease. With the new PPS regulation, the amount of payment will go to about 86-87 cents for every dollar of outpatient services. And that amount will decrease as transitional corridor payments are phased out, AHA officials point out.

To Send Comments

Providers have 60 days after the April 7 publication of the final rule to submit comments. Refer to file code HCFA-1005-FC. Mail written comments (one original and three copies) to:

Health Care Financing Administration
Department of Health and Human Services
Attention: HCFA-1005-FC
P.O. Box 8013
Baltimore, MD 21244-8013

During a transition period until 2004, Medicare will pay hospitals a portion of any losses they would otherwise incur resulting from receiving smaller payments than under prior law. For rural hospitals with 100 or fewer beds, these losses will be fully replaced.

"But the big question is how well the corridor system will work," says **Eric Zimmerman**, JD, an associate with the law firm of McDermott, Will, and Emery in Washington, DC. Zimmerman points out that the payments will be made retroactively when hospitals submit the paperwork. "It will be interesting to see how well carriers will implement that and how soon providers will get their money," he says.

Additionally, AHA officials are concerned there isn't enough time to implement the system accurately. Specifically, the association is concerned that providers will have difficulty obtaining software for the new rules and training staff.

Same-day surgery experts, however, express relief about the final rule because many procedures previously labeled as "inpatient only" in the proposed regulation have been moved to outpatient APCs, including laparoscopic cholecystectomy. **(See list of added procedures, p. 52.)** In the final rule, HCFA said, "We acknowledge that emerging new technologies and innovative medical practice are blurring the difference between the need for inpatient care and the sufficiency of outpatient care for many procedures, although we are concerned that some of the procedures that commenters claim to be performing on an outpatient basis may actually have been

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performed with overnight postoperative care furnished in observation units." In the final rule, HCFA declined to pay for observation services. **(See story on other bad news, p. 52.)**

Having a procedure on the APC list doesn't mean that HCFA requires that procedure to be performed on an outpatient basis, the agency clarified. ". . . Regardless of how a procedure is classified for purposes of payment, we expect, as we stated in the proposed rule, that in every case, the surgeon and the hospital will assess the risk of a procedure or service to the individual patient, taking site of service into account, and will act in that patient's best interest."

HCFA emphasized that it expects "only the simplest and least resource-intensive procedures of each type to be performed in the outpatient setting." The agency plans to annually update the list of procedures in the outpatient PPS. "If hospitals find that surgeons are discharging patients successfully on the day of surgery, they should bring this to our attention, as well, because hospitals may become aware of this trend before our payment data disclose it," HCFA said.

Medicare will make payments for certain new medical devices and drugs for up to three years. These are called "transitional pass-throughs." For same-day surgery providers and others who have high-cost cases, Medicare will make outlier payments. When the cost exceeds the PPS payment by more than 2.5 times, HCFA will pay 75% of the cost above the 2.5 threshold.

HCFA also is making special transitional payments for new technology items and services. Transurethral destruction of prostate tissues by microwave thermotherapy and wound closer by adhesive are two procedures designated as new technology services. In the final rule, HCFA also explains how to submit requests for coverage of new technology services as they arise.

Intraocular lenses (IOLs) also received special treatment in the final rule. Medicare will pay for implanted medical devices, including new technology IOLs, under APCs, rather than under a medical equipment fee schedule. "We previously thought it would only apply in the ASC setting," Zimmerman says. In the final rule, payment rate for cataract procedures with IOL insert — $1,287.33 — equals the payment for cataract procedures without the IOL insert. "Proper coding in the future should result in better differentiated costs between these groups," HCFA says.

HCFA received about 2,000 comments on its proposal to package corneal tissue acquisition costs into the APC payment for corneal transplant procedures. In response, HCFA hasn't packaged the payment for the tissue acquisition costs with the APC payment for corneal transplant procedures. "Instead, we will make separate payment,

SOURCES AND RESOURCES

For more information on the hospital outpatient prospective payment system, contact:

- **Kathy Bryant**, JD, Executive Director, Federated Ambulatory Surgery Association, 700 N. Fairfax St., Suite 306, Alexandria, VA 22314. Phone: 703-836-8808. Fax: 703-549-0976. E-mail: fasa@fasa.org.
- **Kevin Quinn**, Senior Health Economist, Abt Associates, Suite 610, 1110 Vermont Ave. N.W., Washington, DC 20005. Telephone: (202) 263-1750. Fax: (202) 263-1802. E-mail: kevin_quinn @abtassoc.com.
- **Chantal Worzala**, PhD, Analyst, Medicare Payment Advisory Commission, 1730 K St. N.W., Suite 800, Washington, DC 20006. Telephone: (202) 653-7200.
- **Eric Zimmerman**, JD, Associate, McDermott, Will, and Emery, 600 13th St. N.W., Washington, DC, 20005. Telephone: (202) 756-8000. E-mail: ezimmerman@mwe.com.

At the Health Care Financing Administration, contact:

- For general information: **Janet Wellham** at (410) 786-4510, or **Chuck Braver** at (410) 786-6719.
- For information related to the classification of services into ambulatory payment classification groups, contact: **Kitty Ahern** at (410) 786-4515.

The hospital outpatient prospective payment system rule is available on the Health Care Financing Administration Web site (www.hcfa.gov). To order copies of the *Federal Register* containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date of the issue requested (April 7) and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is $8. You can view the *Federal Register* at many public and academic libraries. This document also is available on-line at www.access.gpo.gov/su_docs/ aces/aces140. html.

based on the hospital's reasonable costs incurred to acquire corneal tissue," the agency said.

Although the final PPS rule for surgery centers hasn't been released, HCFA has indicated it will have a consistent corneal tissue policy for hospitals and surgery centers, according to the Fairfax, VA-based American Society of Cataract and Refractive Surgery. The final outpatient PPS rule for free-standing surgery centers should be published in November of this year, with implementation in April 2001.

For their part, freestanding ambulatory surgery centers (ASCs) see the final hospital rule as good news for them as well. "I think it's good for ASCs, because both will be paid on a prospective basis," says **Kathy Bryant**, JD, executive director of the Federated Ambulatory Surgery Association in Alexandria, VA. "It will be a more level playing field for the competitors," she says.

Hospitals need to keep that level playing field is mind, because with this final rule, HCFA is killing cost-based reimbursement, Quinn points out. "Hospitals with high cost are going to be in trouble, and hospitals with low cost are going to be in good shape. To the extent other payers will copy Medicare, and sooner or later almost all of them will, this final rule underscores the point that hospitals are going to have to intensify their efforts to be cost-efficient." **(For information on how one same-day surgery program lowered its cost, see story, p. 53.)** ■

Procedures Added to APC Reimbursement

- ❒ Laparoscopies, including cholecystectomies
- ❒ Planned tracheostomies
- ❒ Diagnostic thoracoscopies
- ❒ Some insertion/removal/replacement of pacemakers
- ❒ Pulse generators, electrodes and cardioverter-defibrillators
- ❒ Embolectomies and thrombectomies
- ❒ Transluminal balloon angioplasty and peripheral atherectomy
- ❒ Transcatheter therapies
- ❒ Bone marrow transplantation
- ❒ Gastrostomies
- ❒ Percutaneous nephrostolithotomy
- ❒ Ovarian biopsies
- ❒ Surgeries on the orbit

Here's the bad news from hospital PPS rule

The publication of the final hospital outpatient prospective payment system (PPS) rule wasn't all good news, according to same-day surgery experts. Some procedures retained their "inpatient only" label and won't be covered under the new outpatient system. **(See list, below.)**

The list of noncovered procedures is fairly extensive, says **Robert T. Langston**, partner with KPMG in Costa Mesa, CA. "It's somewhat problematic," he says, pointing out that same-day surgery providers are known for using cutting-edge technologies.

In the final rule, published in the April 7 *Federal Register*, the Health Care Financing Administration (HCFA) explained why some procedures are not covered. "Our medical advisors and staff, as well as consulting physicians, believe these procedures are too invasive [for example, thoracotomies], too extensive [for example, breast reconstruction with myocutaneous flaps], or too risky by virtue of proximity to major organs [for example, repairs of spinal fluid leaks and carinal reconstruction] to be performed on an outpatient basis."

Procedures that Won't Be Paid Under APCs

- ❒ Breast reconstruction using myocutaneous flaps
- ❒ Radical resections of tumors of the mandible
- ❒ Open treatment of certain craniofacial fractures
- ❒ Osteotomies of the femur and tibia
- ❒ Sinus endoscopy with repair of cerebrospinal fluid leaks
- ❒ Carinal reconstruction
- ❒ Surgical thoracoscopies
- ❒ Pacemaker procedures by thoracotomy
- ❒ Certain thromboendarterectomies
- ❒ Excision of mediastinal cysts and tumors
- ❒ Excisions of stomach tumors
- ❒ Enterostomies
- ❒ Hepatotomies
- ❒ Ureterotomies and ureteral endoscopies through ureterotomies
- ❒ Transcranial approaches to the orbit
- ❒ Laminectomies

Also in the "bad news" category: Same-day surgery managers face a July 1 implementation date. Hospital-based surgery centers need to immediately obtain a determination from HCFA that they're indeed provider-based, says **Eric Zimmerman**, JD, an associate with the law firm of McDermott, Will, and Emery in Washington, DC.

"Our message to our clients is to investigate this immediately because there will be a backlog at their intermediary in processing requests," Zimmerman says.

Usually it's more lucrative for providers to have this designation than to be reimbursed as a freestanding surgery center, he says.

Langston suggests managers look closely at the new payment rates in order to prepare. "People need to think, from an operational standpoint, what service they're providing and whether APC rates will compensate them in the same way as tiered payments, and if there's a loss, how will they adjust from an operational strategy and a business planning perspective," he advises. ■

SOURCES

For more information, contact:

- **Robert T. Langston**, Partner, KPMG, 650 Town Center Drive, Suite 1000, Costa Mesa, CA 92626. Telephone: (714) 850-4371. Fax: (714) 850-4488. E-mail: rlangston@kpmg,com.

For information related to the determination of provider-based status, contact:

- **George Morey**, Health Care Financing Administration. Telephone: (410) 786-4653.

Surgery center reduces cost of cataract with IOL

Rockford (IL) Ambulatory Surgery Center reduced its cost for cataract phacoemulsification with intraocular lens (CPT 66984) from $741 to $557 by working with ophthalmologists and staff to perform the procedure more efficiently.

Such cost savings can pay off under the proposed outpatient prospective payment system for surgery centers. Under the proposed ambulatory payment classifications for ambulatory surgery centers (ASCs), the reimbursement will be $863 for CPT 66984. An efficient ASC will expend $890 in cost to perform this procedure, according to *Ambulatory Surgery Guidelines*, published by Seattle-based Milliman & Robertson. **(For ordering information, see resource box, p. 54.)**

And reimbursement already has dropped for that procedure: from $1,083 to $889 for Rockford, according to **George Arends**, MD, assistant medical director. However, the center started its cost-savings efforts before the reimbursement dropped, Arends adds. Cataracts have always had high costs, in comparison to other outpatient procedures, due to equipment and medications, he says.

"So we're trying to get costs in line and bring them down so we can continue to do the procedures for our surgeons," he says. "You can't do a case if you lose more than you make on the case."

The center took these steps to reduce its costs:

- **Anonymously compared surgeons' costs.** The managers compiled each surgeon's cost, then individual surgeons were shown their costs compared to their peers, who were listed anonymously. "We asked if there was some way they could consider making changes to their medications or make a lens change to become more in line with the less expensive and more efficient cataract surgeons," Arends says.

The response? "Not uniformly good," he says. "However, when you present them with the opportunity to work with the surgery center or work at the hospital because we can't afford to keep them anymore, they all changed."

- **Went to less expensive supplies, equipment,**

EXECUTIVE SUMMARY

Rockford (IL) Ambulatory Surgery Center shares its success in reducing its cost for cataract phacoemulsification with intraocular lens from $741 to $557.

- Managers showed physicians their costs anonymously and explained the necessity of reducing costs in order for the center to stay financially viable.
- Physicians agreed to use significantly less costly supplies, equipment, and medications.
- The center maintains a stable staff and offers them the opportunity to share cost-saving ideas.
- The surgeon OR time is 12-18 minutes a case, and 25 minutes elapse from the time a patient is wheeled into the room until the time the patient is wheeled out. Patients recover in 30 minutes or less.

SOURCE AND RESOURCE

For information on reducing your costs for cataracts with intraocular lens, contact:

- **George Arends**, MD, Assistant Medical Director, Rockford Ambulatory Surgery Center, 1016 Featherstone Road, Rockford, IL 61107. Fax: (815) 226-9990. E-mail: georgea515@aol. com.

For information on obtaining *Ambulatory Surgery Guidelines (Healthcare Management Guidelines: Vol. 3),* which cost $460 plus $10 shipping and handling, contact:

- **Milliman & Robertson**, HMG Client Services Desk, 401 Second Ave. S., Suite 400, Seattle, WA 98104. Telephone: (888) 464-4746. Web site: www.milliman-hmg.com.

and medication. All the surgeons have accepted a reusable phacoemulsification machine that uses reusable tubing. The AMODiplomax machine is manufactured by Irvin, CA-based Allergan. The machine that was used previously had a pack cost of $60 to $85 per case, Arends says. That amount has been reduced to $8 per case, he says.

Rockford also was able to negotiate a better lens price by buying in bulk from Allergan. "We try to keep the lens cost below $50 a lens," Arends says. With the cooperation of the surgeons, Rockford changed the viscoelastic it used and now pays less than $30 a case, which is down from $53 to $85 a case.

• **Maintained a stable staff who share in the profits.** Rockford has two circulating nurses and one scrub tech for cataract procedures. A stable, dedicated staff probably has been the most significant factor in reducing costs, Arends maintains. "They know their jobs. They don't have to break in someone new."

The staff work from 7:30 a.m. to 3 p.m., with only a half-hour break for lunch, he says. Having a staff who enjoy their work is key, Arends adds. "If they don't enjoy it, you don't go fast and you don't make money." The staff are members of a profit-sharing program and are given the opportunity to recommend cost savings, he says.

• **Achieved efficiency in the OR.** At Rock-ford, surgeon OR time is 12-18 minutes a case, and 25 minutes elapse from the time a patient is wheeled into the room until the next patient is wheeled in. There is essentially no turnover time between cases. The center had eye-operation carts fitted with a footboard on which all the monitoring devices are located. The monitors are attached to patients in the preoperative area. "When they leave pre-op, they come directly to the OR with the monitors in place, so they're set to go," Arends says. The nurses don't need additional time to reattach monitors or reposition patients from one bed to another, he points out. You need cooperation from your surgeons, Arends says. "If your surgeons dash off every five minutes to make a phone call, it won't work."

Efficiency is the key, Arends emphasizes. "You can have cost savings in your medications and materials you use, but all in all, your biggest cost is personnel cost."

At Rockford, patients are in recovery 15-30 minutes and go home. "If you keep operating and recovery time down, that's where you save money," he adds. ■

Joint Commission warns about OR sentinel events

First came the report from the Washington, DC-based Institute of Medicine that estimated medical errors kill at least 44,000 people in U.S. hospitals each year and possibly as many as 98,000. Next, the Chicago-based

EXECUTIVE SUMMARY

The Joint Commission on Accreditation of Healthcare Organizations has issued a *Sentinel Event Alert* on operative and postoperative complications. Same-day surgery managers say you can address some of the root causes of those complications by taking these steps:

- Have managers audited weekly to ensure that policies for proper procedure verification are followed.
- Have more than one person conduct the preoperative assessment to obtain complete information. Don't send the patient to the OR until all items, including the history and physical, are on the chart. Have a staff member double-check the preoperative checklist.
- Don't offer credentials to surgeons simply because they have those credentials at another facility. Verify all of the surgeon's information, including the type and length of training.

The Joint Commission defines sentinel event

What constitutes a sentinel event? That question is one of the most common ones the Joint Commission receives, according to **Richard Croteau**, MD, executive director of strategic initiatives at the agency.

"If an unexpected serious adverse outcome is primarily the result of the natural procession of patient's illness or underlying condition, we would not consider that a sentinel event," Croteau says. "On other hand, if related to the treatment of that condition, such as surgical procedures, we would consider that a sentinel event." A "serious adverse outcome" means patient death or major permanent loss of function, he adds. ■

American Hospital Association (AHA) added its stamp to the current emphasis on patient safety. The AHA Web site (www.aha.org) now offers a section on reducing medication errors that includes resources and safety strategies from hospitals. At press time, the AHA also planned to post a model event reporting system for medical errors on the Web site.

Topping off the growing emphasis on patient safety, the Joint Commission on Accreditation of Healthcare Organizations has issued a *Sentinel Event Alert* on operative and postoperative complications. **(For information on how to access the *Alert*, see the resource box, p. 57. For definition of a sentinel event, see box, above.)**

Nonemergency procedures in 90% of cases

Since the agency began tracking sentinel events about four years ago, it has reviewed 64 cases related to operative and postoperative complications.[1] The agency reports 84% of the complications resulted in patient deaths, and 16% resulted in serious injury. Ninety percent of the cases involved nonemergency procedures. **(For details of the complications, see box, p. 56.)**

In its alert, the Joint Commission listed root causes of the operative and postoperative complications, as well as risk reduction strategies that can prevent such complications. **(See story on risk-reduction strategies, p. 57.)** Here are the root causes that apply to the same-day surgery setting, along with tips from your peers on how these areas can be addressed:

• **Inadequate communication among caregivers.** "Most of the time when a problem occurs, it's a miscommunication between physicians and other people, or even between staff members," says **Vicki Sullivan**, RN, CNOR, administrative director of Quad City Ambulatory Surgery Center in Moline, IL. For example, a physician might misunderstand the order of the surgical procedures. To avoid that problem, Quad City posts the schedule, and staff ensure the surgical permit is posted as the patient is presented to the physician.

• **Failure to follow established procedures.** Don't assume that your staff are following your facility's procedures; instead, find out for yourself, SDS managers advise. At Southeastern Surgery Center in Tallahassee, FL, managers are required to spend about one hour per week auditing their departments to ensure that the policies for proper procedure verification are being followed, says **Susan Kizirian**, MBA, executive director. The managers make sure that the caregivers are verifying the correct patient, correct surgical site, and correct procedure.

"What I tell each manager is that when staff tell you they're sick and tired of it, you're doing your job," she says.

• **Necessary personnel not available when needed.** While most same-day surgery programs interviewed for this story said their staffing is adequate, several added that the emphasis on cost-containment in outpatient surgery can lead to staffing problems at some facilities.

"I definitely can see how that can happen, because dollars always count and that's the first place someone always wants to cut: staff dollars," Sullivan says. However, staffing isn't the most effective place to cut for financial savings, she emphasizes. "If you don't have adequate staff, then you'll have corners being cut and inappropriate people working in some spots."

• **Incomplete preoperative assessment.** Have two or three people perform the preoperative assessment to ensure you obtain all the critical information, Sullivan suggests. "Sometimes, patients don't want to burden a doctor. They feel intimidated by a doctor, but then they talk to a nurse who's friendly and open, and they'll tell her things they don't want to bother the doctor with," she says. "So sometimes nurses pick up a lot more than the physicians do."

This tactic works especially well with older patients because they often enjoy talking with

nurses and provide additional information, Sullivan adds.

And just as a pilot goes through a checklist before flying a plane, your staff should go through a checklist to ensure all the critical items, including the history and physical, are on the chart before the patient goes to the OR, Kizirian emphasizes. "The reason those items are on a pre-op checklist is because they're critical to ensuring patients have good outcomes."

At Southeastern Surgery Center, the pre-op nurse checks off the items on the list, and the circulating nurse double-checks the list before the patient goes to the OR.

• **Deficiencies in credentialing and privileging.** Simply reading about deficiencies in credentialing and privileging is enough to raise the blood pressure of many same-day surgery managers. **Ann Geier**, RN, MS, CNOR, chief operating officer of Medicus Surgery Center in Anderson, SC, says, "With liability of credentialing and privileges, nothing like that should happen anywhere."

At Medicus, physicians who have privileges at the hospital still undergo an extensive check before they are credentialed to perform procedures at the surgery center, she says. "We verify training, what type of training they received, where they trained."

Medical schools and residency program must verify whether the surgeons were taught the surgical procedures in their programs. If not, the center contacts the program that performed the training. "In this day and age, it behooves everyone to have that in place," Geier advises.

And same-day surgery programs face additional issues, Kizirian points out. How many hands-on procedures must surgeons perform before they can do procedures alone? How long a class do they have to attend? How many times must they be precepted before they can perform the procedure alone? "This will continue to be an issue due to technology and new ways of doing procedures," Kizirian says. **(For more on credentialing for new technology, see *Same-Day Surgery*, March 2000, p. 25.)**

• **Inconsistent postoperative monitoring procedures.** Provide training and use a postoperative checklist to ensure patients aren't discharged until they meet all criteria, including postoperative education, Kizirian advises.

Inconsistent post-op monitoring can be related to a staffing deficiency, Sullivan points out. "If you don't have enough people to take care of your patients, problems go unnoticed and aren't addressed."

• **Failure to question inappropriate orders.** Empower your staff so they are comfortable questioning orders that appear inappropriate, Sullivan emphasizes. Because Quad City performs the same procedures routinely, an out-of-the-ordinary order stands out, she says. "Employees are quite

Joint Commission *Sentinel Event Alert*

Operative and postoperative complications

- The Joint Commission reviewed 64 cases of operative and postoperative complications.
- All of the cases occurred in acute care hospitals.
- Cases directly related to medication errors or to administration of anesthesia were not included.
- 58% of the complications occurred during the postoperative procedure period, 23% during the intraoperative procedures, 13% during post-anesthesia recovery, and 6% during anesthesia induction.
- The types of procedures most frequently associated with these reported complications included interventional imaging and/or endoscopy, tube or catheter insertion, open abdominal surgery, head and neck surgery, orthopedic surgery, and thoracic surgery.
- The most frequent complications by type of procedure included:
  - — naso-gastric/feeding tube insertion into the trachea or a bronchus;
  - — massive fluid overload from absorption of irrigation fluids during genito-urinary/gynecological procedures;
  - — open orthopedic procedures associated with acute respiratory failure, including cardiac arrest in the operating room;
  - — endoscopic procedures (including nongastrointestinal procedures) with perforation of adjacent organs; liver lacerations among the most frequent complications of abdominal and thoracic endoscopic surgery;
  - — central venous catheter insertion into an artery;
  - — imaging-directed percutaneous biopsy or tube placement resulting in liver laceration, peritonitis, or respiratory arrest while temporarily off prescribed oxygen;
  - — burns from electrocautery used with a flammable prep solution.

Source: Joint Commission on Accreditation of Healthcare Organizations. Operative and post-operative complications: Lessons for the future. *Sentinel Event Alert* 2000; 12. Web site: www.jcaho.org.

comfortable questioning that. They've been empowered to make those professional judgmental decisions."

Be sure to educate new staff persons about questioning orders, Kizirian emphasizes. "We cover the types of orders they're given and we say, 'If it doesn't make sense to you, ask.'"

In the same-day surgery setting, staff need to understand that a wide variety of adverse events can happen at any time, Sullivan emphasizes. "Those who think, 'It will never happen to me,' are the scary ones. You do have to be prepared for all those things."

Reference

1. Joint Commission on Accreditation of Healthcare Organizations. Operative and post-operative complications: Lessons for the future. *Sentinel Event Alert* 2000; 12. Web site: www.jcaho.org. ■

SOURCES AND RESOURCE

For more information on reducing errors in same-day surgery, contact:

- **Richard Croteau**, MD, Executive Director, Strategic Initiatives, Joint Commission on Accreditation of Healthcare Organizations. E-mail: rcroteau@jcaho.org.
- **Ann Geier**, RN, MS, CNOR, Chief Operating Officer, Medicus Surgery Center, P.O. Box 1886, 107 Professional Court, Anderson, SC 29622-1886. Telephone: (864) 716-7911. Fax: (864) 716-7965. E-mail: ageier@mindspring.com.
- **Susan Kizirian**, MBA, Executive Director, Southeastern Surgery Center, 2000 Center Point Blvd., Tallahassee, FL 32308. Telephone: (850) 309-0500. E-mail: exdir@seuc.com.
- **Vicki Sullivan**, RN, CNOR, Administrative Director, Quad City Ambulatory Surgery Center, 520 Valley View Drive, Moline, IL 61265. Telephone: (309) 762-1952. Fax: (309) 762-3642. E-mail: vsullivan@qcora.com.

The *Sentinel Event Alert* issued by the Joint Commission on Accreditation of Healthcare Organizations can be found on the agency's Web site at www.jcaho.org. Click on "for health care organizations and professionals," then "sentinel events," then "sentinel event alert," and select the Feb. 4, 2000, bulletin titled "Operative and Post-Operative Complications: Lessons for the Future." To obtain the latest copy of *Sentinel Event Alert* by fax, call the Joint Commission's fax on demand line at (630) 792-3885. Press 4.

Seven steps to reducing surgery complications

When the Joint Commission on Accreditation of Healthcare Organization distributed a *Sentinel Event Alert* on operative and postoperative complications, the agency also listed several risk-reduction strategies that can prevent such complications. Here are the strategies that relate to the outpatient surgery setting, along with advice from same-day surgery managers on how to apply these in your facility:

• **Improving staff orientation and training.**

Have orientation and training guidelines with a list of items to cover so that important aspects of the process aren't omitted, suggests **Vicki Sullivan**, RN, CNOR, administrative director of Quad City Ambulatory Surgery Center in Moline, IL. However, be flexible because staff differ in their previous training and in their ability to absorb new information, she says. Mentors also are critical, Sullivan says. "They can pass on so much of the culture that your center has developed, so new people know what is expected of them and how they approach outpatient surgery differently, and they have the feeling they are responsible and accountable for their work."

Orientation should include education on how to handle high-risk events, says **Susan Kizirian**, MBA, executive director of Southeastern Surgery Center in Tallahassee, FL. Not only does her center review high-risk events at orientation, they are covered annually with all staff members, she says. Additionally, staff bring up safety issues at weekly meetings, she says. "That can't be overdone."

• **Educating and counseling physicians.**

Physicians don't always know the routine standards procedures as well as the staff, Sullivan says. "So sometimes you have to educate physicians by saying, 'This is the way we do it in our center. This is what works for us.'"

• **Standardizing procedures across settings of care.**

Hospitals and their affiliated surgery centers should standardize their procedures, same-day surgery experts agree. "The more they can standardize, particularly if you're sharing personnel, the more they can be accurate in your assessment and care," Kizirian says. This standardization is especially critical when "once-in-a-blue-moon" adverse events happen, she emphasizes. "Otherwise, you put someone in

the situation of asking, 'What do I do now?'"

Nonaffiliated freestanding centers and hospitals programs should standardize within their individual programs, says **Ann Geier**, RN, MS, CNOR, chief operating officer of Medicus Surgery Center in Anderson, SC. For example, "If you perform IV conscious sedation in your OR and in GI lab, are you operating with the same standards of care? You should be," she says.

• **Revising credentialing and privileging procedures.**

These issues are critical for managers to review, just as orientation and training should be reviewed, Kizirian says. "Because the information that we have is constantly being expanded, because technology is constantly changing, privileges and credentialing need to be updated."

• **Clearly defining expected channels of communication.**

Train your staff so they are comfortable knowing how the communication process works in your program, Kizirian emphasizes. "Caregivers have to know who to communicate what to at what point in the process," she says. For example, who do they talk to when they need to question an inappropriate order?

• **Revising the competency evaluation process.**

"Because information and technology are changing, the skill levels we have have to change," she says. "We have to revise evaluations as the way we provide service changes."

Same-day surgery centers often are challenged in this area because they don't have large staff development departments or nurse specialists in staff development, Geier says. "We have to develop our own competency evaluations." Medicus managers collaborate with hospital same-day surgery nurses, she says. "We do a yearly competency process, and every year I wish it could be better."

Quad City handles competencies through required inservices on topics such as infection control and malignant hypothermia, Sullivan says.

• **Monitoring consistency of compliance with procedures.**

Same-day surgery programs have an advantage when it comes to ensuring staff are complying with procedures, Sullivan says. "When you're in a smaller environment, you know if someone's not doing as they're expected. Everyone is visible, it's all open," she says. "Communication is so direct, and feedback from patients is so direct — usually within the next day. So if someone hasn't followed the customary standard, you soon become alerted to that."

Ensure that staff don't fall back and follow previous procedures after the procedures are changed, advises **Mark Mayo**, facility director of Valley Ambulatory Surgery Center in St. Charles, IL.

"Nurse managers need to observe, note what they see, make necessary changes, and then follow through to make sure positive changes are made and carried through weeks or months later," he says. ■

Core measures include surgical site infection

Joint Commission ponders problem

The thorny issue of post-discharge surveillance for surgical site infections (SSIs) threatens to undermine the accuracy of data reported on SSIs as a core quality measure to the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL. The Joint Commission is aware of the problem, but it is not immediately clear how it is going to be corrected so that facilities with the best post-discharge surveillance don't appear to have the highest infection rates.

Under its ORYX initiative, introduced in 1997 to integrate outcomes and other performance measurements into the accreditation process, the Joint Commission is moving to a continuous data-driven accreditation process. The ORYX initiative was designed to be implemented in phases, with the use of nationally standardized core performance measures as a planned component. As approved by the Joint Commission and its advisory panels in February, 25 core measures are planned under the following five areas: acute myocardial infarction, heart failure, pneumonia, pregnancy and related conditions, and surgical procedures and complications. The fifth category includes SSIs within 30 days of the procedure and timing of antibiotic prophylaxis prior to surgery. **(See box, p. 59.)** Acute care hospitals that serve patient populations whose conditions correspond to two or more of the core measure areas will be required to choose two measure sets from among the initial five by Sept. 1, 2001, according to the Joint Commission.

But difficult questions about the method and intensity of post-discharge surveillance used by hospitals tracking SSIs need to be resolved if the core measures are to be accurate and effective,

says **Bryan Simmons**, MD, a member of the Joint Commission advisory committee on the SSI core measure.

"[The committee] talked about surveillance intensity, that hospitals that do a worse job at surveillance will actually look better than hospitals that do a better job, particularly with post-discharge surveillance. But it was felt that we could not mandate that," he says. The panel reached an impasse when discussion turned to the resources needed and the unresolved issues of what type of post-discharge surveillance should be required (i.e., send cards or phone patients, contact surgeon, etc.). "[Committee discussions indicated] that this would be time-consuming and costly and still would not be exactly comparable because there is no one method of post-discharge surveillance that the [Centers for Disease Control] or anybody else has recommended," Simmons says.

As a result, the advisory committee did not recommend a post-discharge surveillance component to the Joint Commission as part of the SSI core measure, though Simmons warned that those with the best surveillance programs could fall victim to misperceptions. "It was elected not to do this, but with full knowledge — at least by me, and I expressed this to the others there — that this may result in the hospitals doing the best job of post-discharge surveillance looking the worst," he says. "The data look like 30% to 70% of infections that occur after surgical procedures are first detected after discharge from the hospital. So [even] if it's only 30%, your rate will look 30% worse, everything else being equal."

The Joint Commission is aware of the problem and likely will take action to correct it as the SSI core measure specifications are finalized, says **Jerod M. Loeb**, PhD, vice president for research and performance measurement at the Joint Commission. "In view of the short lengths of stay today, I think of necessity it is almost without doubt that [the SSI core measure] is going to include some form of post-discharge surveillance," he says. "At this juncture, the specifics of that form of post-discharge surveillance — i.e., phone call, card, letter, or whatever — is unclear. All of [that] will be clarified as the measures have their specifications developed."

(Editor's note: Copies of the Joint Commission's core measures and related documents can be found on the Web at www.jcaho.org/permeas/coremeas/cm_pub.html.) ■

Joint Commission Defines Surgical Core Measures

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has developed a surgical complication core measure that includes surgical site infection within 30 days. Specific criteria are summarized as follows:

- ❒ **Performance measure name:** Surgical site infection (SSI) within 30 days (for selected surgical procedures).
- ❒ **Description:** Patients undergoing selected surgical procedures that develop a SSI within 30 days of the procedure.
- ❒ **Focus of measure:** Reducing the incidence of SSIs.
- ❒ **Rationale:** SSIs affect 2% to 5% of the 16 million patients undergoing surgical procedures each year in acute care hospitals. There are well-studied risk factors for infections. These infections lead to a significant increase in morbidity and mortality accounting for 24% of all nosocomial infections, second only to urinary tract infection in overall frequency.
- ❒ **Type of measure:** Outcome.
- ❒ **Numerator statement:** Patients undergoing selected surgical procedures (utilizing ICD-9-CM codes) who develop SSIs within 30 days after the procedure (incision).
- — **Included populations:** Patients meeting the Centers for Disease Control and Prevention National Nosocomial Infections Surveillance definition of SSIs.
- — **Excluded populations:** Patients undergoing procedure (utilizing ICD-9-CM codes) are not included on the list.
- ❒ **Denominator statement:** Patients undergoing selected surgical procedures (utilizing ICD-9-CM codes).
- — **Included populations:** Patients undergoing one of the selected procedures (utilizing ICD-9-CM codes). List of proposed procedures: appendectomy, cardiac surgery (open chest procedures on valves or septum of heart), CABG with both chest and leg incision, CABG with only chest incision, cholecystectomy, colon surgery, open reduction of fracture, vascular surgery, abdominal hysterectomy, mastectomy, hip prosthesis, knee prosthesis, laminectomy, spinal fusion, ventricular shunt, craniotomy, head and neck surgery (entry into oropharynx).

Same-Day Surgery Manager

Benchmarking is more than managers realize

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

I'm a firm believer in "benchmarking" the costs, services, patient satisfaction, etc., in our facilities. We need to realize that there is more to benchmarking than knowing that the average supply cost is $200 per case for most ambulatory surgery cases. While having that information is great and will go a long way in helping control or identify opportunity, clearly, information is missing.

For example, what if your surgery center does a significant number of gastrointestinal or urology cases? If you compare yourself to the $200 cost, you could be falsely satisfied that your supply cost per case is acceptable. Using this example, you would expect the $200 cost to be significantly lower, perhaps as much as $75 per case. Conversely, what if you are performing many high-end cases such as anterior cruciate ligament repairs or laparoscopic cholecystecomy? Chances are your supply cost will be significantly higher.

Using $200 as a benchmark, are you outside the envelope in supply costs? Maybe not, but how can you be sure? One parameter does not a benchmark make. Try to describe a pencil to someone who has never seen one. It is not enough to say, "It is long." How long? How wide? What is it made of? What is its function? Clearly one parameter won't cut it. You need more information before you can truly "benchmark."

This may be the time that you throw your hands in the air and say "enough is enough!" Many of us have had it with analysis of cost and reimbursement. But hold on. Benchmarking is actually fun, and you can get immediate results! You also can involve people at your facility that "don't really do anything but you cannot fire them" to do most of the data collection.

Why is benchmarking fun? Because now you can, with irrefutable proof, go to your physicians or manager and point to the charts and graphs and say, "See, I told you we were *(pick one)*: doing great, about to go under, the most expensive, the least expensive, the best, the worst."

Or you can take the information, clear your throat, and say, "Yes, very good, thank you. I need to study this before I comment on it." *(Get rid of any witnesses, and keep it quiet.)*

Benchmarks you want to study include more than supply cost. You want to monitor your personnel costs as well. How many personnel do you have on an arthroscopy of the knee? Do you use RN first assistants? Who pays for them? How many items do you have in your packets? What is the cost of them? Do you use critical pathways? What is your pre-incision time? Post-incision time? The list goes on and on.

These are just some of benchmarks you need to audit. Probably one of the best results of the benchmark will be how you compare with your peers and competition. Seek out that information through networking and other opportunities.

The bottom line is you're probably not doing yourself justice if you narrow your benchmarks to just a few parameters. Be the leader in developing new benchmarking in areas such as average patient waiting time, average days in accounts receivable, and other areas.

Benchmarking for the sake of benchmarking doesn't make much sense if you don't use it constructively. We all know that most of us use the information to validate staffing levels, contractual pricing with purchasing agents, bonuses, etc. Share the information with your medical staff, personnel, in your newsletter, or on your Web site to tout your accomplishments. You have worked hard to get the recognition. Now take advantage of it!

How often should you benchmark? I recommend it be done on a rotating but continuous schedule. It doesn't make much sense to check your supply cost each month, but you might want to check your turnaround time one quarter, your start time the next, etc. The Earnhart Survey Group, in our October 1999 survey, reported that the majority of facilities "benchmark" once a year, and slightly less than that number do it on a six-month basis. How often do you?

(Editor's note: Earnhart and Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Earnhart can be reached at 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: surgery @onramp.net. Web: www.earnhart.com.) ■

How do surgeons judge a day-surgery program?

On-time starts, quick turnover time important

Can a beautiful building, convenient parking, good location, and high patient satisfaction survey results guarantee success? Not if your surgeons aren't happy with your equipment, staff, and turnover times, say experts interviewed by *Same-Day Surgery*.

How do you find out what your surgeons value and how they rate your day-surgery program as a place to do business? Simply ask them, says **Cheryl E. Dendy**, RN, administrative director of St. John Surgery Center in St. Claire Shores, MI. "We want our center to be recognized for best practices, and the best way to find out what our surgeons really think about our service to them is to survey," she says. A formal written survey was mailed to each of the physicians who use Dendy's facility asking them to rank the center's performance in a variety of areas that include equipment and supplies, scheduling, preoperative testing, staff, anesthesia services, and advisory committees. **(See survey techniques, p. 62.)**

The survey had a response rate of 28%, and results have been positive. Between 90% and 100% of the respondents agree or strongly agree with statements regarding well-maintained operating rooms, equipment, and supplies, as well as availability of equipment and supplies, says Dendy.

Surgeons also expressed high levels of satisfaction with the preoperative testing process that includes timely testing, quick turnaround of lab tests, and no surgery delays due to delayed testing. "One reason our pre-op testing process is efficient is that our nurses are cross-trained to perform EKG tests," says Dendy. This avoids delays in testing when a physician adds an EKG to the pre-op orders at the last minute.

An efficient pace within the operating rooms is very important to surgeons, says **William J. Mazzei**, MD, medical director of perioperative services at the University of California-San Diego Medical Center. Mazzei uses a combination of informal and formal discussions to evaluate surgeon satisfaction. **(See survey techniques, p. 62.)**

Mazzei has found that the most important issues concerning a same-day surgery program, from a surgeon's point of view, are:

- cases that start on time;
- minimum amount of turnover between cases;
- pleasant work environment in which the physician's needs during surgery are anticipated and met;
- comfortable, safe environment for the patient and family members.

Because Mazzei's responsibilities include inpatient and outpatient surgery, he has an opportunity to observe differences in expectations of surgeons who work primarily in one setting or the other. The one area in which there is a difference is the expectation in inpatient surgery that the same staff will work with a particular physician all of the time, says Mazzei.

"I don't know if it is because same-day surgery tends to be less complex and doesn't require a specialized team, or if it is because most same-day surgery staffs are small and physicians tend to know the whole staff, but same-day surgery physicians don't place as much importance on having the same nurses each procedure," he explains.

Dendy's clinical staff rated high marks on skills, knowledge, and responsiveness to needs from her physicians, but the surveys did identify several opportunities for improvement. One opportunity was in the scheduling area, says Dendy.

Only 50% to 60% of the respondents agreed with the statements that block time was distributed fairly and adjusted appropriately. Written comments on the surveys expressed a desire from many physicians that block time be freed up sooner than the current one week in advance, she says.

"Finding a way to free that time so other physicians can take advantage of it without disrupting the schedules of physicians that have the time block will be a challenge, but we are looking at ways to handle it," she says. "We currently have four operating rooms and have submitted a certificate of need application to add a fifth room, but approval will take time."

Surgeons want to post their cases in a timely manner, says Mazzei. "Most of our physicians want to schedule a case within a week."

Surveys are good ways to document what is important to your physicians, says Dendy. Even when you have a vocal medical staff, surveys provide hard data that might be needed to make changes, she adds. "The best thing about this survey is that it gives physicians a chance to make comments that will be read." The physicians at her center have complained before, but their complaints have fallen on deaf ears, she says. "Now I

SOURCES

For more information about determining physician satisfaction, contact:

- **Cheryl E. Dendy**, RN, Administrative Director, St. John Surgery Center, 21000 Twelve Mile Road, St. Claire Shores, MI 48081. Telephone: (810) 447-5015. Fax: (810) 447-5012. E-mail: cheryl.dendy@stjohn.org.
- **William J. Mazzei**, MD, Medical Director of Perioperative Services, University of California-San Diego Medical Center, No. 8770, 200 W. Arbor Drive, San Diego, CA 92103-8770. Telephone: (619) 543-5720. Fax: (619) 543-5424. E-mail: wmazzei@ucsd.edu.

Vendors provide survey tools

While some same-day surgery programs may have access to staff and resources to conduct a formal physician survey in-house, many managers may want to use outside research firms to handle the data collection and report generation. The following firms offer survey tools that can be used to measure physician satisfaction:

✔ **Press, Ganey Associates**

Offers a standard survey tool that can be customized to reflect the needs of your same-day surgery program. Pricing varies according to level of customization of the survey tool and reports. For more information, contact: Emily Ripperger, Press, Ganey Associates, 404 Columbia Place, South Bend, IN 46601. Telephone: (800) 232-8032 or (219) 232-8032. Fax: (219) 246-4924. E-mail: eripperger@pressganey.com. Web: www.pressganey.com.

✔ **Parkside Associates**

Offers a physician survey tool that can be customized. Price depends on the customization needs of the same-day surgery program, but for most same-day surgery programs, the cost should be less than $5,000, says **Jerry Siebert**, president of the organization. Contact: Parkside Associates, 205 W. Touhy Ave., Suite 204, Park Ridge, IL 60068. Telephone: (847) 698-9866. Fax: (847) 698-6875. Web: www.parksideassociates.com.

✔ **OR Benchmarks**

Offers a physician survey tool that measures surgeon satisfaction. Cost is $2,490 and includes distribution of the survey, data collection, and generation of reports. For information, contact: Judy Dahle, RN, MS, director, OR Benchmarks, P.O. Box 5303, Santa Fe, NM 87502-5303. Telephone: (877) 877-4031. Fax: (505) 982-7766. Web: www.orbenchmarks.com. ■

have written proof that these are things that affect our satisfaction ratings."

The information is presented to various groups, including the president of the hospital and the hospital board, she explains. "If we can take action on one of the suggestions made to improve our service to surgeons, we will further improve our relationship with our physicians." ■

Survey techniques vary among facilities

Finding out what your physicians think about the service you provide to them is simply a matter of asking them for feedback, but how you obtain that feedback can differ according to your program's culture and your physicians' personalities. "My surgery center clinical staff and physicians are very accustomed to benchmarking projects and studies, so it was easy for us to decide to use a written survey," says **Cheryl E. Dendy**, RN, administrative director of St. John Surgery Center in St. Claire Shores, MI.

Dendy uses an outside company to produce, distribute and report the results of her physician survey **(see survey vendors, at left),** but says day-surgery programs with the resources of a larger institution may be able to handle it internally by using marketing, research, or information systems staff.

Don't forget to reassure physicians that their responses will be confidential, suggests Dendy. "Because we are a small facility, the physicians feel that an outside company provides more confidentiality. This confidentiality may prompt some surgeons to be more open with criticism or suggestions," she adds. Written surveys are the primary tools to collect data on physician satisfaction for Dendy's same-day surgery center, but she also holds informal conversations with physicians on a day-to-day basis.

Informal or "curbside chats" are good ways to get information, says **William J. Mazzei**, MD, medical director of perioperative services at the University of California-San Diego Medical Center. To make sure doctors feel comfortable talking to you on the spur of the moment,go in the operating rooms frequently, he says. "If a surgery program director is a nurse, then he or she should circulate through the rooms and be visible. If the director is an anesthesiologist, he or she should be sure to

work with all of the physicians, not just a few."

A common way to gather information is to listen to the "complaint-o-meter," says Mazzei. But if you only listen to the surgeons who feel strongly enough to complain, you'll miss an opportunity for input from other surgeons who have suggestions for improvement, he adds.

To make sure that all physicians have a chance to be heard, administrative managers in Mazzei's same-day surgery program schedule one-on-one interviews with physicians on a regular basis. "We set a specific time and place to meet so that part of the interview is formal, but the conversation is informal," he says. "We ask very general questions about problems the physicians may have encountered, and we always ask how can we improve our service to them or their patients."

Information from these interviews is collected and reviewed by the management team to determine if there is a need for following up on trends and taking action to improve service, he adds. ■

Patients define value of pre-op information

(This is the second part of a two-part series on communicating with patients preoperatively on the Internet. Last month, we told you what information to offer, how to present it, what support you need, and what a Web site can't do for you. This month, we tell you how to ensure the information you give patients is valuable.)

Including pre-op information on your surgery program's Web site might seem like the answer to improving communications with your patients, but how do you know what patients really want to hear in their pre-op teaching?

Beth Israel Deaconess Medical Center in Boston uses e-mail messages, patient satisfaction survey forms, and comments to nurses to evaluate information in the pre-op information section of its Web site, says **Denise M. Goldsmith**, RN, MS, MPH, program manager of nursing informatics. "We started the Web site with the general information we already had in our handouts, but we'll get messages such as 'I didn't realize I would urinate so often,' so we collect the information and add it to the Web site as appropriate."

Bay Care Health System in Green Bay, WI, also uses feedback from same-day surgery patients to update information on the pre-op information Web site, says **Tammy Krueger**, BSN, LNC, executive director of Bay Care Ambulatory Services.

Procedural information is considered important by patients, but mundane items such as directions to the facility, information about parking, and location of the admissions' area within the building are probably the most valuable, says Krueger. "I also can't emphasize [enough] the value of maps and written directions that patients can print out and hold in their hands." Maps and directions to the facility are the most frequently mentioned benefit of the Web site, she adds.

The same-day surgery staff at the University of Texas Medical Branch at Galveston don't have a pre-op information Web site. However, they wanted to find out what information patients valued, so they asked them. In a study that surveyed 100 patients undergoing same-day surgery, staff contacted patients on the day of surgery to ask if they were willing to participate in the study, then interviewed the participants at the surgical follow-up visit that occurred five to 10 days after

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Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Editorial Group Head: **Valerie Loner**, (404) 262-5475, (valerie.loner@medec.com).
Managing Editor: **Joy Daughtery Dickinson**, (912) 377-8044, (joy.dickinson@medec.com).
Production Editor: **Ann Duncan**.

Editorial Questions

Questions or comments? Call **Joy Daughtery Dickinson** at (912) 377-8044.

SOURCE

For more information about pre-op information's value to patients, contact:

- **Mary Jane Bernier**, RN, PhD, Assistant Clinical Professor, School of Nursing, University of Texas Medical Branch at Galveston, 301 University Blvd., Galveston, TX 77555-1020. Telephone: (409) 772-8249. Fax: (409) 772-8323. E-mail: mbernier@utmb.edu.

surgery. "Basically, we wanted to find out what pre-op teaching information the patient could recall and what information was most valuable," explains **Mary Jane Bernier**, RN, PhD, assistant clinical professor of the School of Nursing at the University of Texas and co-investigator of the study. "Our survey tool was patterned after a similar tool used to measure patient and nurse perceptions of pre-op teaching in an inpatient setting," she says.[1] "Even with our modifications to apply the tool to an outpatient setting, the results were similar."

When asked procedural questions such as, "Before surgery did the nurse review the type of surgery you were having?" 92% of the patients recalled receiving the information. Only 87% recalled receiving information related to their role in surgery, such as not eating before surgery or asking for assistance after surgery, adds Bernier.

When asked to describe the value of pre-op information, patients identified information regarding their role as most valuable, followed by procedural information, then psychosocial information such as addressing concerns and worries.

The most surprising finding was that men tended to value psychosocial information more than women, says Bernier. "We assumed women would have more concerns and worries that they would want to discuss with a nurse, but we discovered that men considered this more valuable."

Skills to help during recovery were recalled by 55% of patients interviewed. "When we asked if nurses helped them practice deep breathing or if they were told to expect different sensations such as lightheadedness, they said they didn't recall but would have valued that information," she says.

Reference

1. Yount B, Schossler J. A description of patient and nursing perceptions of preoperative teaching. *Journal of Post Anesthesia Nursing* 1991; 6:17-25. ■

CE objectives

After reading this issue of *Same-Day Surgery*, the continuing education participant will be able to:

• Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. **(See, "How do surgeons judge a day-surgery program?")**

• Describe how those issues affect nursing service delivery or management of a facility. **(See, "Were you expecting the worst with outpatient PPS? You can relax.")**

• Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. **(See, "Surgery center reduces cost of cataract with IOL," and "Joint Commission *Sentinel Event Alert*.")** ■