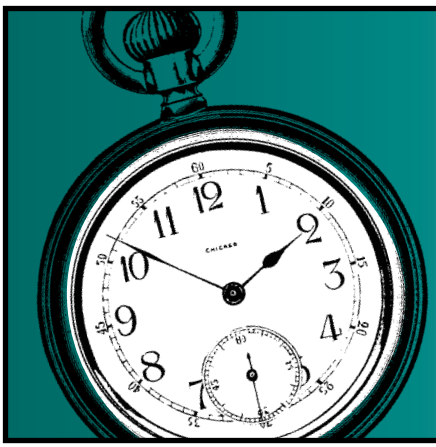

Same-Day Surgery®

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IN THIS ISSUE

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If surgery patients call back following discharge, do staff know their limits?

Nonphysicians must know expected and normal reactions

An outpatient surgery patient called back after discharge with complaints that indicated significant internal bleeding, but the staff member who answered the phone didn't recognize the signs and didn't refer the person to emergency care or a physician. By the next day, the patient had died.

Another patient called back after discharge with symptoms indicating a heart- or aneurysm-related problem. No one who responded to the patient, including a physician, recognized the symptoms or referred the patient to emergency care. He went to an emergency department the next day and died.

"We have seen lawsuits because staff incorrectly assessed the situation over the phone and gave advice that led to injury of or a bad outcome for the patient," says **Waldene K. Drake**, RN, MBA, vice president of risk management for Cooperative of American Physicians — Mutual Protection Trust in Los Angeles.

Stephen Trosty, JD, MHA, CPHRM, director of risk management and CME for American Physicians Assurance Corp. in East Lansing, MI, says, "It's the exception, but it becomes important that someone taking

EXECUTIVE SUMMARY

Postoperative patient calls can create liability for same-day surgery programs and the staff members who respond to the calls.

- Ensure the discharge instructions tell patients what to expect and who to contact about which complications.
- Staff education, policies and procedures, and job descriptions for staff and physicians should spell out who answers what types of questions.
- Nonphysicians should discuss only the discharge instructions. Patients who are experiencing serious bleeding, heart-related problems, or aneurysm-related problems should be directed to seek emergency care.

the call can make an evaluation about whether this is an expected or normal reaction."

Tell patients they can call the surgery center, as well as the physician, after surgery, Drake and others suggests. "A licensed nurse could reinforce the discharge instructions and precautions," she says.

Patients who are discharged early in the day may be unable to reach their physicians that day, because their surgeons still may be operating, says **Linda Kirk**, RN, MPA, director of ambulatory perioperative services at Spectrum Health Hospital in Grand Rapids, MI.

"If the issue is medication, and the surgeon needs to talk to them, we connect them if the surgeon's here," Kirk says. "If they're not available, we get them in contact with appropriate medical care."

One downside of taking calls from patients is that same-day surgery programs generally are not open at night or on weekends. Programs can have an after-hours call service, but physicians need to be available for backup, Drake says.

In most states, outpatient surgery programs do have an obligation to respond in emergency situations, Trosty warns. "If a call comes in, say it's from a person having a critical or emergency situation, and the surgery center or hospital doesn't advise the person to go to the ED, there is potential liability there," he says.

Start with good discharge instructions

To avoid liability and poor outcomes concerning post-op patient calls, follow these steps:

- **Send the patient home with detailed discharge instructions that include the physician's contact information.**

"The key for this whole issue is that the facility has good discharge instructions that are reviewed with the patient and/or responsible adult that will be with the patient at home," Drake says.

In the case of a bad patient outcome, discharge instructions play an important part and help provide a defense for a surgeon or facility, she says. "Thus, written/printed discharge instructions should have both general postoperative instructions and instructions specific to the procedure the patient had," Drake advises. "They should include when/what the patient may eat; activity level on discharge and for successive days; possible symptoms of complications; when/who they should call if there is a problem/question; minor symptoms/complications that they may expect during the immediate postoperative period; precautions they should take; and when they should make an appointment to see the doctor for a postoperative checkup."

Also, ensure handouts include space to write in any specific instructions from the surgeon, sources advise.

Document in the medical record who gave the

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patient/caregivers the discharge instructions, their apparent level of understanding, and a copy of the instructions or a reference to a standard (for example, *No. 14 At-Home Care After Cataract Surgery)*, Drake says.

Before discharge instructions are handed to patients, it should be clearly spelled out when the patient should call the facility and when the patient should call the physician, say sources interviewed by *Same-Day Surgery*. Kirk says.

"We let them know they can call us back with any issues or questions," she says. "It it's a medical concern following the day of surgery, we suggest they call physicians directly." These directions are written on the discharge instructions, with the physician's name and office number as well as contact information for the surgery center.

Verify contact information with the surgeons to ensure calls from patients will be answered, sources suggest.

Education should start in the physician's office when the surgery is scheduled, Kirk maintains. "Education and instruction of patients and family need to start early, not the day of or after surgery," she says.

Also, if the surgeon moves to a new office, ensure the contact information is changed on the handouts, sources advise.

• Specify what types of questions can be answered by nonphysicians.

Give staff specific directives on what issues are appropriate to be handled by nonphysicians, what responses to give, and which ones must be handed off to physicians, Trosty says. Your policies and procedures also should specify the appropriate way to handle patient calls, he says.

Look to your state's licensing laws to determine what questions can be answered by nonphysicians, Trosty suggests. "Usually, the rule of thumb is that anything that has to do with the practice of medicine, anything to do with diagnosing or providing emergency treatment should be for the physician," he says.

Job descriptions should clearly spell out whose responsibility it is to answer what types of questions, Trosty notes. "That includes the physicians," he adds.

Nurses should limit their answers to the discharge instructions that the patient was given, Drake says.

"They may answer questions and give advice in line with their experience and training or within standardized protocols set by physicians in the facility," she explains. "However, they do have responsibility, and perhaps liability, for their assessment and advice should it be wrong."

Some calls, such as ones from patients who have lost their postoperative education sheet or who aren't sure when to return to activities of daily living, don't need to be forwarded to a physician, Trosty emphasizes.

Staff must be able to differentiate between these calls vs. patients who are not responding normally or who have something that went wrong in surgery.

"If a nonphysician is answering questions and is inappropriately answering questions, liability will rest there on the facility," he says.

• Know when to refer the patient to the physician or emergency care.

The discharge instructions should outline when and for what conditions patient should seek help or call, sources says. Some problems, such as mild or moderate pain, are expected after surgery, Trosty says.

"You need to be able to determine whether the pain is at a level expected, or it is far greater pain that is indicative of another problem," he says.

If patients indicate serious bleeding, heart-related problems, or aneurysm-related problems, direct them to seek emergency care, Trosty says.

Follow up and track patient complications

Two critical aspects to have in place for postoperative patient calls are follow-up with any patient who communicates potential complications and an occurrence reporting system, says **Janice Williams**, RN, BSN, regulatory manager of The Surgery Center of Nacogdoches (TX).

"If a nurse has asked the patient to contact a doctor, the nurse calls the patient back or follows up at the hospital [where most of the center's physicians are on staff], or she follows up with the emergency department to see if the patient actually contacted the doctor," Williams says. Typically, this confirmation occurs within 24 hours of the patient's initial call, and it is documented, she says.

For all patient problems that require follow-up with the physician, the nurse fills out an occurrence report, Williams says. On the report, the nurse gives a brief actual description of the problem and specifies the type of error, if it involved medications or falls.

"We track and trend to see if too many patients are having nausea and vomiting, or too much drainage," for example, she says. ■

SOURCES

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At The Surgery Center of Nacogdoches (TX), "Nurses help the patient understand the doctor's discharge instructions and questions about pain management," says **Janice Williams**, RN, BSN, regulatory manager.

If the patient reports fever, drainage, nausea/vomiting, inability to urinate, or similar complications, the patient is referred to the physician or the emergency department, she notes.

"Nurses also encourage the patient to call the doctor if the patient feels he or she is not progressing as he or she should," Williams says.

The night answering service or recorded message should inform patients to dial 911 if it is an emergency, sources suggest. Patients who are not experiencing an emergency should be directed to contact their surgeon, they say.

The safest approach for postoperative patient calls is to refer serious questions to physicians as long as the physicians take the calls, Trosty points out.

"If doctors don't take the calls or don't call back in a timely manner, and this is a question that could indicate a potential emergency problem, [outpatient surgery staff] need to indicate to people to go to the nearest ED to seek care, at least," he says. **(For information on following up on patient calls, see box, p. 15.)** ■

Scope repair costs cut by $12,000 in one center

Training, handling procedures improve scope care

Determining the best way to sterilize and repair a flexible endoscope's damage after it's been used to check an airplane gas tank for leaks is not a problem that most same-day surgery managers encounter. Staff members and physicians understand more about the fragile nature of scopes than they did 15 years ago, when this incident occurred at a hospital-based outpatient surgery program.

Today, the gastroenterologist would never consider using a scope to check his airplane, nor would the staff allow it.

The fact remains, however, that scope repair can represent a substantial portion of an outpatient surgery program's budget.

After determining that her center's repair cost of $12.33 per procedure was out of line with similar facilities by comparing her costs to the repair costs of endoscopy centers in her area that she surveyed, **Helen Rolf**, RN, BSN, nurse manager at Green Spring Station Endoscopy in Lutherville, MD, initiated an effort to address the cost. "The average cost of repair for other facilities in our area was $7.08 per procedure," she says.

"The toughest part of getting starting was obtaining good data to identify our problem," Rolf admits. Her contact with other ambulatory centers that offered endoscopy led to the formation of an informal peer group of nurse managers

EXECUTIVE SUMMARY

Staff at Green Spring Station Endoscopy in Lutherville, MD, have cut scope repair costs by more than $12,000 per year by paying attention to how they handle and care for the fragile equipment.

- Staff members viewed a dissected scope to increase awareness of the equipment's fragility.
- The scope storage cabinet was lined with foam covered with easy-to-clean vinyl to prevent unnecessary bumps against the walls.
- Scopes are no longer stacked on top of each other, and basins are used to transport the scopes from procedure rooms to the reprocessing room.
- The gastrointestinal techs' method of performing leak tests is evaluated upon hiring by the scope repair vendor to make sure leak testing is performed appropriately to prevent damage to the scope.

who share benchmark data on a quarterly basis, she explains.

"It does take time to set up a peer group, but I am glad that I got us started because it gives us good benchmarking data that is related specifically to endoscopy," Rolf adds. **(For information on the peer group, see resource box, p. 18.)**

"We perform over 6,000 procedures each year, so over $12 per procedure for repairs is significant," she points out. One year later, her repair costs have dropped to $10.26 per procedure and still are dropping, Rolf says. While still above the $7.08 per procedure average repair cost for her benchmarking group, this decrease in repair costs represents a savings of more than $12,000 in the first year.

There were several reasons for the high cost of repair, Rolf notes. "First, we changed the way we practiced and went from having two or three GI [gastrointestinal] techs handle the scopes to having many different people handle the scopes," she says.

This change occurred when the same-day surgery program began using certified registered nurse anesthetists (CRNAs). "With the surgeon, the CRNA, an RN, and the tech in the room for each procedure, it became crowded," Rolf explains. To alleviate the crowding, the GI tech no longer stays for each procedure, and the CRNA or the RN assumes some of the room turnaround responsibilities, including changing the scope between procedures, she says.

One of the first steps Rolf took to address the problem was to evaluate repair vendors. "I had always used the original manufacturer to repair the scopes, but I began to investigate other companies," she notes. "I actually visited plants and compared the services that each company could provide."

After checking out different companies, including the manufacturer she had always used, Rolf chose another vendor because a key part of the vendor's service was education.

Endoscopes do not look fragile from the exterior,

Ongoing education keeps awareness up, costs down

Dissecting an endoscope to see what the interior components looked like was fun for the staff at Green Spring Station Endoscopy in Lutherville, MD. More importantly, it was educational and the perfect first step in the same-day surgery program's effort to improve handling and care of scopes to reduce the cost of repair.

"We knew we had to keep our educational programs interesting in order to keep everyone aware of how to handle scopes safely," says **Helen Rolf**, RN, BSN, nurse manager of the program. Education continued after the initial presentation with reports on repair costs at each staff meeting.

"I also have our repair vendor return damaged parts to me, and I place them on the bulletin board or take them to staff meetings and ask employees to guess how much the repair to that part cost," says Rolf. "They come to me with estimates that vary widely, and they are usually blown away when I tell them the actual cost."

Rolf says that this simple activity keeps everyone aware of scope damage and makes it is easier for everyone to remember safe handling procedures.

You also can reduce the amount of downtime associated with repairs for wear and tear by making sure you have the proper number of scopes for your program, says **Keicha R. Schipa**, senior territory manager of Integrated Medical Systems, a medical equipment repair company in Birmingham, AL. "Data from our company's experience show that the optimum use of a scope is between 0.75 and 1.25 uses per day," she explains. "This means that you should have 20 scopes if you perform 600 procedures each month."

By making sure you have enough scopes, you reduce the damage on each scope and give yourself enough time to perform the proper maintenance, Schipa points out.

Because overuse of scopes increases the amount of damage on the equipment, Rolf also has her GI techs monitoring use of each scope to make sure they are used equally. "Physicians want to use the newest scopes, but it is important to share the wear and tear among all the scopes," she says. The scope utilization tracking information is shared with staff and physicians.

Rolf's repair vendor also provides monthly reports on repair costs and types of damage to scopes that Green Spring Station experiences. "These reports help me identify the types of educational programs we need to address handling problems we have and to make the programs timely," she explains.

Educational assistance and help in identifying your specific needs is an important service that your scope repair vendor should offer, Rolf adds.

"In addition to doing your normal due diligence as you check out vendors, be sure to look for someone who can help you solve some of your problems as well as repair your scopes," she says. **(For a partial list of scope repair vendors, see resource box, p. 18.)** ■

SOURCE/RESOURCES

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For information on how to establish a nurse manager peer group or benchmarking data that the group collects, contact Helen Rolf by e-mail. (**See above.)**

For more about scope repair programs, contact:

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- **Pentax Medical**, 102 Chestnut Ridge Road, Montvale, NJ 07645. Phone: (800) 431-5880 or (201) 571-2300. Web: www.pentaxmedical.com.
- **Endoscopy Support Services**, 3 Fallsview Lane, Brewster, NY 10509. Phone: (800) 349-3636 or (845) 277-1700. Web: www.endoscopy.com.
- **Precision Endoscopy of America**, 10969 McCormick Road, Hunt Valley, MD 21031. Phone: (800) 285-5959 or (410) 527-9596. Web: www.precisionendoscopy.com.

and because few people have seen the inside, it is difficult for staff members to understand how delicate they are, Rolf notes.

"The first educational meeting we had for all of our staff members was our vendor showing us a dissected scope and explaining how the glass light fibers and the scope tip with the computer chip can easily be broken if the scope is mishandled," she says.

The demonstration was an important first step because the handling safety procedures that were implemented made sense to staff members and they had seen how simple actions such as coiling the scope too tightly could damage the parts inside the scope, she points out.

"We lined the cabinet in which we store scopes with a foam covering so the scopes wouldn't bump against the walls, and we emphasized careful handling in the procedure rooms and during transport of the scopes," Rolf adds.

Some of the new procedures included laying the scopes on the table with the knobs facing up rather than down to avoid loosening the knobs and coiling the scope lightly rather than tightly when carrying it to avoid damaging the light fibers, she says. "We also do not stack scopes, and we even got each scope a basin to use when transporting it from the procedure room to the reprocessing room," Rolf notes.

Also, staff ensure that forceps are never near the scope on the table, she says. "This avoids accidental punctures in the rubber tubing," Rolf explains.

Staff education did not stop with one meeting, she says. "Our efforts to keep staff members aware of the need to handle scopes carefully continues with staff meetings and ongoing educational programs," Rolf says. "The key is to keep it interesting, just like we did with the first presentation," she adds. **(For tips on scope educational efforts, see article, p. 17.)**

Keicha R. Schipa, senior territory manager of Integrated Medical Systems, a medical equipment repair company in Birmingham, AL, says 70% of scope repairs that are performed are due to care and handling problems, as opposed to 30% of repairs due to normal wear and tear.

"This means that 70% of the repairs that same-day surgery programs are experiencing are preventable," she says.

One of the most common mistakes made in the care of scopes is improper leak testing, says Schipa. "Leak testing is a detailed process that requires time to ensure that fluid is not getting into the scope," she points out. "Most centers do not test effectively because they don't test after every case; they don't insufflate before putting the scope into water; they don't test long enough; or they don't purge the tube of air properly."

Not only does improper leak testing lead to more repairs of the scope, but it also presents a patient safety concern because a scope that leaks contains contaminated water that could expose the patient to infection, she adds.

Improper leak testing was one of the problems identified at Green Spring Station Endoscopy, so leak testing competencies now are performed for all new GI techs, Rolf explains.

Physicians also spent a morning with the scope repair vendor learning how their techniques could damage scopes, she says. While staff might not feel comfortable challenging a physician's scope handling technique directly, Rolf does say that nurses have been known to point out, "Helen would not be happy to see you do that with the scope." ■

Failing SDS program? Address multiple causes

Staff and labor costs, underutilization key problems

There usually is more than one reason a same-day surgery program doesn't show a profit, and at Brookside Ambulatory Surgery Center in Battle Creek, MI, management had to address multiple issues to turn the center from a program that had accounts receivable of 80 days, operating rooms that were used 20% of the time, and staff costs that represented 50% of overhead expenses.

"The center had been open for five years, and the partners had never seen any profit," says **Luke M. Lambert**, chief executive officer of Ambulatory Surgery Centers of America, a Norwell, MA-based company that owns or manages same-day surgery programs and a speaker on this topic at the most recent annual meeting of the Federated Ambulatory Surgery Association.

When Lambert's company first looked at the center's information, it saw several items that needed to be addressed immediately, he says.

"The facility was underutilized, with operating rooms scheduled only 20% of the time, but the facility stayed open five days a week," he points out. "This meant a lot of downtime for staff members, most of whom were full-time employees instead of part-time or per-diem employees who could be sent home if there was no work**."(For tips on how to increase utilization, see story, p. 20.)**

Even with the underutilization, the center paid a significant amount of overtime, Lambert says.

"Physicians would start cases late in the day to avoid conflicts with office time and patients' work days, and that required employees to stay longer hours, which meant overtime pay," he explains. "We pointed out the cost to physicians and eliminated start times that would mean staff members staying late for procedures and recovery."

Other centers set a time to start the last case of the day, sources say. For example, they dictate "no cases after 2 p.m." or "no cases that won't end by 3 p.m." Other facilities have a split shift with some nurses coming in for early cases, 6 a.m. to 12:30 p.m., for example, and others coming in later, such as 9 a.m. to 3 p.m., sources say.

Supply costs also can cause problems. At Brookside, these costs were extremely high because the center's cash-flow problems meant bills were paid late so vendors would give no discounts, Lambert notes. "Once we finished our audit, we discovered that the center owed $1.3 million to vendors, a fact that the physician owners and the center staff didn't know," he says.

One of the reasons for the late payments to vendors was the length of time that it took the center to collect its fees, Lambert explains. "The center was using an outside billing company that charged high fees and didn't provide good service, so we brought the billing process back to the center," he says.

The variety of reasons for Brookside's problems are not uncommon, says **Michael Sawyer**, administrator of Santa Barbara (CA) Surgical Center. While the basic problem may be the same among faltering centers, you do have to evaluate solutions based on each center's geographic, financial, competitive, and physician issues, says Sawyer, who also serves as regional director for Regent Surgical Health, a Westchester, IL-based company that manages and owns surgery centers.

Cash flow was a problem for the Santa Barbara center, he says. They were using an outside billing company, but they chose not to bring the job in-house, Sawyer says. "It takes time to hire and train people to handle billing, and we did not want to put off correcting our cash-flow problem," he adds.

The previous billing company had been billing only two times each month. "We switched to a company that agreed to bill daily, so we get our money faster," Sawyer says. "The new billing company began working immediately on collecting outstanding debts as well, so I could concentrate

EXECUTIVE SUMMARY

To engineer a turnaround of a failing same-day surgery program, several problem areas must be addressed.

- Keep labor costs down by using a combination of full-time and per-diem or part-time employees so that staffing can be adjusted when the program is not as busy.
- Collect monies due to you in a timely manner by billing properly and collecting copays at the time of service.
- Avoid high supply costs by participating in group purchasing organizations that give you access to discounted supplies.
- Looking at block-time policies and times made available to nonowner surgeons made it possible for one facility to increase its cases from 250 to 350 per month.

on other areas we needed to correct."

The center also began collecting copayments at the facility, which was not done previously, he adds.

Supply costs are another area that usually needs to be targeted immediately, Lambert says. "Once we found out that vendors were owed over $1 million, we immediately contacted all of them to explain that the center was under new management and we were committed to paying all debts," he notes.

They set a timeframe with each vendor, making a substantial first payment, Lambert explains.

"After the first payment, we made regular monthly payments, and within nine months, we were current with all vendors," he continues.

Once they could prove that they paid their bills, they joined a group purchasing organization that provided discounts on supplies, he adds.

Another supply cost that Sawyer eliminated was service contracts. The previous management purchased every equipment maintenance contract available, he says.

"I believe that it is less expensive to buy equipment that has a good reputation or with which you've had good experience in the past and to pay for repairs as you go along," Sawyer notes. "Even with maintenance contracts, you will have downtime that you have to cover, but if you have enough scopes, for example, you can cover the time that one scope is out for repair."

Staffing costs also are straightforward, but addressing some issues can be tough, admits Lambert. "We were able to reduce labor costs from being 50% of our net revenue to 18% by making sure we had the right mix of full-time, part-time, and per-diem employees," he says.

Santa Barbara is relatively isolated, so the staff members that were hired for the center came from the local hospital, and all of the staff members came with the hospital mentality, Sawyer explains. Because the Santa Barbara center was the first same-day surgery center in the area, staff members and management assumed that full-time employees would work best, he says.

Unfortunately, the center didn't have the caseload to support full-time employees, and employees didn't have the flexibility to work shorter hours when needed. "They felt entitled to their hours," Sawyer says.

Also, they needed staff members who were willing to cross-train and didn't say that something "wasn't their job," he adds. "We needed everyone to believe that the success of the center depended on everyone pitching in to do whatever needed doing," Sawyer says.

New staff members were hired. "Today, the staff are composed of more per-diem members than full-time members, but they are all people who like working in the same-day surgery environment," he adds.

(Editor's note: Do you have a success story to share? Contact Joy Daughtery Dickinson, Senior Managing Editor, at joy.dickinson@thomson.com.) ■

SOURCES

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Increase cases from 250 to 350 per month

Use new rules, welcome mat for surgeons

In addition to the problems of high staff costs, outstanding debts, and overpriced supplies, outpatient surgery programs that are not performing well often have underutilized procedure and operating rooms, according to experts interviewed by *Same-Day Surgery*.

Underutilization of a center can be addressed in several ways, says **Luke M. Lambert**, chief executive officer of Ambulatory Surgery Centers of America, a Norwell, MA-based company that owns or manages same-day surgery programs. By looking at block-time policies and times made available to nonowner surgeons, Brookside Ambulatory Surgery Center in Battle Creek, MI, saw an increase from 250 cases per month to 350 per month, he adds.

At Brookside, every physician partner had blocks of time, but not all of them used their time, he points out. This created a problem for same-day surgery scheduling staff and other physicians

because there was no process for releasing block time to another physician, he says.

"There were other surgeons who wanted to use the center but couldn't get OR time, so we have a new policy that basically says physicians must use their block time or lose it," Lambert says.

If a physician has not filled the block of time for a certain day two or three days prior to that day, then the time will be released to other physicians, he explains.

"We will also cut the amount of time blocked for a certain physician if he or she has a trend of not using the full time," Lambert says. "For example, if the surgeon typically only used two hours of a four-hour block on a certain day, we'll cut that surgeon's block to two hours."

A major shift in outlook for the physician owners was Lambert's suggestion that the red carpet be rolled out for noninvesting physicians who wanted to use the center. "We ask a noninvesting surgeon what days and times would be convenient for his or her practice," says Lambert. "This means that some investors have to shift when they perform their surgery, but once they realized that this meant the center would become profitable, they were agreeable," he says.

In California, Santa Barbara Surgical Center's management also had to focus on physician behavior as they tried to increase the caseload per month. "This center probably had too many physician investors, with about 22 surgeons, because the financial incentive to use the center wasn't significant," admits **Michael Sawyer**, administrator of the Santa Barbara center.

"We had to talk with the physicians and explain that they needed to bring their patients to the center, not only to increase caseload, but also to present the image of a busy, successful facility," he explains. "People want to be associated with winners, so if a surgery center looks like it's getting ready to close its doors, noninvesting physicians won't bring their patients."

As more of the physician owners began using the center, other surgeons began to bring patients as well, Sawyer says. "The caseload at the center now averages 370 to 380 cases per month, but we are aiming for 400 cases per month," he adds.

Before you talk with your physicians, be sure that you know if all of their patients are good for your business, Lambert suggests. "On the first day we were in the center, we began case costing for all procedures," he says. "We discovered that we were losing an average of $450 per case for one plastic surgeon's patients."

Because plastic surgeons quote a package price for their patients that includes the facility fee, the center set the fee for the doctor without really knowing how much the cases cost because they had not been collecting the information, Lambert says. "We met with the physician and explained that we needed to set a more accurate facility fee for his patients," he adds.

Now, the surgeon is choosier about the patients he brings to the center. "We do well with short cases, but longer cases are better handled in the hospital," he explains.

"We were able to go to the physician with specific information as a result of our case costing," Lambert points out. They used the same information to go to their managed care payers to renegotiate fees with them, he says.

For this reason, Lambert suggests, "find out what everything is costing your program before you start making changes, so you can be sure that the changes you make will fix the problem." ■

Same-Day Surgery Manager

How you can address clutter in your facility

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

The average surgical corridor looks like the ending scenes in a disaster movie where all the actors claim, "We can rebuild it — and make it better than it was."

Look around your facility, and you will see what I'm talking about: a mess. Over the months and years, our eyes have filtered it out. We minimize the optical clutter, but it still is there.

I have been conducting a number of patient interviews during the past few months, and one question I ask is, "What was your first impression of the facility?" Almost 90% say, "It seemed cluttered." Clutter also can lead to thoughts that we are disorganized and unprofessional. Then you have the rash of news articles about surgery on

the wrong body part, and it reinforces some of the subliminal panic our patients face in that long ride down the hall to their operating room.

Not only do patients complain about the clutter, but surgeons do as well. I spend more time with surgeons now that I'm in the business world then I ever did when I was in the operating room. Believe me — they notice and comment on this issue. The ones who are building a new facility always say that they want the corridors "clean and uncluttered" in the new center. That statement is significant because that means that they are willing to pay more money out of their pockets to store this stuff.

Remarkably, there is a cure for most of the hospitals and surgery centers out there. Start here:

1. Begin with the surgical corridor. It is the one that receives the most attention. Label each piece of equipment or box with the name of the department that it belongs to such as anesthesia, lab, X-ray, postanesthesia care unit, OR, etc.

2. Notify those departments that it needs to be removed in the next three days. If (and when) you get hassled, you might want to add the follow, "per order of the Fire Department." It usually works.

3. After everyone else has removed their junk, focus on yours. Most of the remaining stuff deals with linen, partially empty boxes, monitors of various applications, and similar items. Move whatever you can into the equipment storage room (if you are lucky enough to have one). Just shove the stuff around; you *always* can find more room in there. Patients and physicians rarely go in there, and they never complain about it anyway.

4. What is left can be consolidated into fewer boxes. Go to a hardware store or even better, a store that specializes in containers and organizational materials for homes and offices. Buy brightly colored boxes and storage bags. For some reason, anything sitting around in a brightly colored box appears to belong there and is not considered junk or clutter.

5. When all else fails, take another linen cart (with cover) and put all the remaining stuff in there. Use a piece of paper to label what is behind the curtain.

6. For the emergency items you might need, have a file cabinet or shelving unit (painted red) in the corridor with those items. It might sound silly, especially in light of all the other minutia we face each day, to address clutter. But like a blister on your heel, you know it is there and have to deal with it.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Do you have additional questions? Contact Earnhart at 3112 Windsor Road, Suite A-242, Austin, TX 78703. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

HIPAA Q & A

Question: What are the deadlines for compliance with the HIPAA security rule?

Answer: For all covered entities, other than small health plans, the compliance deadline is April 20, 2005, says **Robert W. Markette Jr.**, an Indianapolis attorney. "Contrary to a popular rumor, there is not an exception for small health care providers," he says.

Question: What happens to noncompliant providers on April 20, 2005?

Answer: "At least for the near future, CMS [the Centers for Medicare & Medicaid Services] is sticking to its stated policy of assisting noncompliant providers to become compliant, rather than imposing large fines," Markette says.

However, the possibility of leniency from CMS should not lead you to feel complacent about security rule compliance, he notes. "You should make every effort to be in compliance or be well on your way to compliance, because CMS is far more likely to be lenient if it can see documentation of the efforts you are making to comply, how far along you are, and how far you have left to go," notes Markette. "In the event of a complaint, a CMS investigator will not be interested to hear that you have read the rule, but have done little else."

In addition to potential penalties from the government, there are other possible consequences of a HIPAA violation that fall outside of federal jurisdiction, he says. For instance, it's possible for HIPAA violations to become the basis for civil lawsuits, Markette adds. "Providers who are subject to state licensure surveys may also encounter a state surveyor who erroneously cites a covered entity for a HIPAA violation," he says. "This could affect a provider's license even without a violation."

Finally, a HIPAA violation presents the potential for negative publicity, Markette says. "With the current focus in America on individual privacy, a provider who is found to have violated

SOURCE

For more information on the security rule, contact:

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the HIPAA security rule may be perceived as insensitive to the concerns of patient privacy," he explains. This perception could have a negative effect on patient confidence and, therefore, business, he adds.

Question: Where should I start when putting together my compliance plan?

Answer: First, appoint a security officer, says Markette. The HIPAA security rule, like the privacy rule, requires the covered entity to designate someone as responsible for the entity's compliance with the HIPAA security regulation, he explains. This person is known as the security officer. "The security officer does not need to be an information security expert or hold any special certifications, but the person should be familiar with the HIPAA privacy and security rules and be able to manage a project and complete it in a timely fashion," Markette adds. "Larger organizations should consider a security compliance team to assist the security officer."

The security rule allows this kind of assistance, but the security officer retains responsibility for your organization's compliance efforts, he says. "The team should include managers from each department or persons designated by the managers," he notes. It is important the team remembers that the security officer retains final control, and the security officer should be able to put pressure on the team to meet deadlines, Markette adds.

Next, the security officer must familiarize himself or herself with the security rule, he notes. "A good place to start is the rule itself, and the CMS web site [www.cms.hhs.gov] provides a number of resources including CMS' recently published overview of the security rule — *Security 101 for Covered Entities,"* he says. **(See article, above right.)**

Reading the rule serves two purposes, notes Markette. "You will learn the more specific requirements of the rule as set forth in the 19 standards and 36 implementation specifications, and you also will see that you already have implemented a number of the rule's requirements as you implemented programs to comply with the privacy rule," he adds. ■

CMS releases first of 7 security white papers

The Centers for Medicare & Medicaid Services (CMS) has released one of seven guidance papers on the Health Insurance Portability and Accountability Act (HIPAA) security rule. *Security 101 for Covered Entities* offers a basic overview of the security rule and covers topics such as what administrative simplification means, who the rule covers, and who must comply. The papers are meant to assist providers in understanding the HIPAA security rule — not provide sure-fire compliance methods. Topics for future papers include administrative, physical, and technical safeguards; policies and procedures; documentation requirements; basics of risk analysis and risk management; and implementation for the small provider.

To access the paper, go to www.cms.hhs.gov/hipaa/hipaa2/education and scroll down to "Security Educational Material." Click on "Security 101" to download the document. ■

Correction

In the January 2005 *SDS Accreditation Update*, a quote related to the Accreditation Association for Ambulatory Health Care's (AAAHC) revision to the standard related to fire drills was attributed in error to a Joint Commission on Accreditation of Healthcare Organizations representative. The comments should have been attributed to the AAAHC representative. In the same supplement's executive summary, the statement about the AAAHC requirement on who should be immediately available until patient discharge should have read "physician or dentist."

We apologize for the errors. ■

COMING IN FUTURE MONTHS

- Improve your patient registration process
- Achieve thorough completion of claims
- 14 facilities share outpatient surgery benchmarks
- HIPAA: Direction on risk analysis
- MedPAC's latest reimbursement proposals

CE/CME objectives

After reading this issue of *Same-Day Surgery,* 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 *If surgery patients call back following discharge, do staff know their limits?* and *Failing SDS program? Address multiple causes* in this issue.)
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *Scope repair costs cut by $12,000 in one center* and *Increase cases from 250 to 350 per month.)*

CE/CME answers

5. D **6. D** **7. C** **8. D**

CE/CME *questions*

5. What should be documented in the medical record, according to Waldene K. Drake, RN, MBA, vice president of risk management of Cooperative of American Physicians — Mutual Protection Trust?
   A. Who gave the patient/caregivers the discharge instructions
   B. Their apparent level of understanding
   C. A copy of the instructions or a reference to a standard (for example, *No. 14 At-Home Care After Cataract Surgery)*
   D. All of the above
6. What percentage of scope repairs is preventable, according to Keicha R. Schipa, senior territory manager of Integrated Medical Systems?
   A. 30%
   B. 40%
   C. 55%
   D. 70%
7. What is one supply cost that can be eliminated to save money, according to Michael Sawyer, administrator of Santa Barbara Surgical Center?
   A. Multiple sets of instruments for some procedures
   B. Different equipment for different surgeons
   C. Service and maintenance contracts
   D. A and B
8. Why is it important to have a process to release unused block time to other surgeons, according to Luke M. Lambert, CEO of Ambulatory Surgery Centers of America?
   A. It makes staff scheduling easier to plan.
   B. It is an accreditation requirement for most organizations.
   C. It improves turnaround time for all ORs.
   D. It prevents underutilization by allowing other surgeons to use the time.

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 2005 issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■