Same-Day Surgery®

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

THOMSON™
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

MARCH 2005
VOL. 29, NO. 3 • (pages 25-36)

As obesity rates rise, providers ask: How obese is too obese for outpatient?

Difficulties can be a 'setup for disaster. . . a perfect storm'

The obesity rate has risen dramatically, from 13% of men and 17% of women in 1980 to 28% of men and 34% of women in 1999-2000.[1] Increasingly, outpatient surgery providers are faced with the question: Can we handle these people as outpatients?

"The answer is many times obese patients can be taken care of in an outpatient setting, especially within the walls of a hospital-like facility," says **F. Dean Griffen**, MD, FACS, chair of the committee on patient safety and professional liability at the Chicago-based American College of Surgeons, and general surgeon at Highland Clinic in Shreveport, LA.

"Marked individualization is required, especially if the patient is in a freestanding facility, such as a doctor's office or surgery center, because the frustration of transport by ambulance or whatever arrangements that have been made with that hospital of choice can be stressful at best, and may not be totally safe," he explains.

Obesity in and of itself should not be a contraindication to day surgery in any facility, Griffen emphasizes. However, obese patients are more likely to have comorbidities including diabetes mellitus, sleep apnea, asthma, hypertension, heart disease, venous statis ulcers, and gastro-esophageal reflux disease.

The most irresponsible behavior is to send a morbidly obese patient home who has sleep apnea, says **Rebecca S. Twersky**, MD, medical

EXECUTIVE SUMMARY

Many obese patients can be handled as outpatients if care is individualized and the facility and staff are prepared.

- Male obesity is more problematic because men usually carry weight in their midsection, which increases risk.
- Assess patients for comorbidities and the condition of those comorbidities.
- Consider the type of anesthesia, the total dose, and the aftereffects.

director of the Ambulatory Surgery Unit at Long Island College Hospital and professor of anesthesiology at State University of New York Downstate, both in Brooklyn. "There have been deaths," she says. **(See *Same-Day Surgery*, November 2003, "Should patients with obstructive sleep apnea be handled as outpatients?" p. 121, and "Sleep apnea patients require special handling," p. 124.)**

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

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $495. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

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

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

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

Statement of Financial Disclosure: Ball (editorial board member) discloses that she is a consultant and stockholder with Steris Corp. and is on the speaker's bureau for the Association of periOperative Registered Nurses. Schwaitzberg (board member) discloses that he is a stockholder in Starion Instruments. Twersky (board member) discloses that she conducts research and is on the speaker's bureau for Stuart/Zeneca Pharmaceuticals, Roche Laboratories, Anaquest, Abbot, Marrion Merrill Dow, and GlaxoSmithkline. Burke, Derby (board members), and Earnhart (board member and columnist) have no relationships to disclose.

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

This publication does not receive commercial support.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Glen Harris**, (404) 262-5475, (valerie.loner@thomson.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@thomson.com).
Senior Production Editor: **Ann Duncan**.

THOMSON
AMERICAN HEALTH CONSULTANTS

Editorial Questions

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

In one recent study, anesthesiologists were surveyed on which patients they were willing to include in their selection criteria for ambulatory surgery.[2] More than 75% who responded said that sleep apnea patients with postoperative narcotics, as well as morbidly obese patients with comorbidities and no patient escort, were unsuitable for ambulatory anesthesia. More than 75% said they would include patients with morbid obesity without comorbidities and patients with sleep apnea without use of narcotics.

Another issue is the mobility of the patients at home and how well they can care for themselves, says **Janey S.A. Pratt**, MD, FACS, bariatric surgeon at MGH Weight Center, assistant surgeon in the division of general surgery at Massachusetts General Hospital, and instructor of surgery at Harvard Medical School, all in Boston.

In terms of the operation, obese patients often are difficult to intubate, Griffen says. "It creates a setup for disaster. It's like a perfect storm," he adds.

These indeed are high-risk patients, explains **Ramona Conner**, RN, MSN, CNOR, perioperative nursing specialist at the Center for Nursing Practice at the Association of periOperative Registered Nurses in Denver. "Very often they don't have just one or two comorbidities," she says. "They often have a complex array of physical problems."

The most important key is individualized care, Conner says.

Twersky says she doesn't believe outpatient surgery should be performed on patients with a body mass index (BMI) of more than 35 with significant comorbidities (sleep apnea, cardiac, endocrine, and/or respiratory) for general anesthesia.

"It is critical to assess the patient for comorbidities and the condition of those comorbidities," she continues. "If patients have sleep apnea and require general anesthesia, is the facility prepared to monitor the patient for an extended period of time, e.g., 23 hours?"

Another comorbidity that should be on the assessment radar is malnutrition, Pratt says. "Believe it or not, the obese tend to be fairly malnourished," she notes. Typically, these patients have a long history of dieting, Pratt says. Often, they're on high-protein or low-fat diets, she says. "When you cut out a major food group, that's the best way to get malnourished," Pratt adds.

In addition to comorbidities, consider these areas when determining whether obese patients

can undergo outpatient surgery:

• **Body type.**

Men who are obese frequently are more problematic than women because they carry more weight in their midsection, Griffen explains. "This increases pulmonary issues," he says. "There's more risk of pneumonia and more risk of aspiration."

In comparison, women often carry weight in their hips and thighs, he says. "A woman who weighs 280 pounds who has all her added weight below the waist is a much safer anesthesia risk and safer outpatient than a man with a beer gut," Griffen explains.

• **Anesthesia.**

Consider the extent of the procedure, the type of anesthetic, and the anesthetic risk, sources advise. Breast biopsy or similar procedures can be rationalized more easily for obese patients and can be performed much more safely than procedures that require a deeper level of sedation, such as gallbladder, Griffen notes. At issue is the total dose and the aftereffects, he says.

If you are performing general or deep intravenous sedation, you need a trained anesthesia provider on site, Pratt emphasizes. Regional anesthetics are more variable in the obese population, she says.

"If you're doing a spinal for knee surgery, for example, you may want to be in a facility with a trained [anesthesia provider] who feels comfortable managing the airway because the regional may not last as long or may not be as good as with a thin person, so the patient may end up needing anesthesia in the middle of the procedure," Pratt says.

An office may not have an anesthesia machine or vaporizers, Twersky points out. "Patients who will require significant postoperative opioids for pain also present with risks for postoperative respiratory depression and respiratory arrest, so it's not over just when the surgery is over," she says.

• **Facility preparation.**

Outpatient facilities must be prepared to handle obese patients by having large gowns, operating room beds and stretchers that are weighted correctly for patients, appropriately sized equipment — such as anesthesia monitors with extra large cuffs, a difficult-airway cart, scales that can handle large weights, and sometimes, longer instruments, sources says.

Pratt is aware of day surgery units that don't have doorways large enough for large stretchers to go through, she says. When those facilities have a very unhealthy or unambulatory obese patient, they have to perform surgery in the main OR, not the day unit, Pratt notes.

• **Staff training.**

Ask some physical therapists to train your staff on how to move overweight patients, she suggests. To avoid inappropriate behavior or prejudice toward obese patients, train staff so they obtain a sense of what it's like to be overweight, Pratt advises.

"This is so they understand that people aren't overweight of their own volition; it's a disease," she says. "It's not laziness or just because they overeat. They probably were born with it."

Massachusetts General brought in former gastric bypass patients to share things that were said them before they lost weight, and then they described how they were treated differently after the surgery. Also, nurses did role-playing in which they played the part of obese patients who were being told how to wipe themselves after having bowel movements. "Even being aware of that difficulty is very important for nurses to know about patients, especially one who has had abdominal surgery," Pratt says.

The hospital had its staff wear "obesity empathy suits" that weighed 40 pounds and changed a person's anatomy to resemble an obese person. "You wear this for a while, and it gives you a true sense of what it's like to be overweight," Pratt says. "The nurses thought it was incredibly useful in terms of understanding obesity from a personal perspective."

So what's the bottom line for ambulatory surgery providers? Be prepared.

"It's perfectly OK to handle obese patients as outpatients, especially in a hospital, especially if

SOURCES

For more on handling obese patients, contact:

- **Ramona Conner,** RN, MSN, CNOR, Perioperative Nursing Specialist, Center for Nursing Practice, Association of periOperative Registered Nurses, Denver. E-mail: consult@aorn.org.
- **F. Dean Griffen**, MD, FACS, General Surgeon, Highland Clinic, 1455 E. Bert Kouns, Shreveport, LA 71105. Phone: (318) 798-4546.
- **Janey S.A. Pratt**, MD, FACS, Bariatric Surgeon, MGH Weight Center; Assistant Surgeon, Division of General Surgery, Massachusetts General Hospital; Instructor of Surgery, Harvard Medical School, Boston. E-mail: jpratt@partners.org.

they are individualized in terms of keeping with their body habitus — weight below the waist, keeping with their comorbidities: diabetes and esophageal reflux, and the extent of surgery planned," Griffen says.

"I don't think we should categorically say that big people can't have outpatient surgery, because they can. But we need to be alert to these possibilities with them, especially extubation considerations with anesthesia, that dictate most should be done in a hospital setting," he notes. Hospitals have broader options for the post-anesthesia period, including ventilator care, admission, and safe transport on a gurney to a room, Griffen says.

"With the increasing prevalence of obesity in the U.S.," Twersky adds, "it is critical that both the anesthesiologist and surgeon be honest in assessing the risks of the procedure and the patient, and if the outpatient facility can handle not only the intraoperative care, but the postoperative care as well."

References

1. Centers for Disease Control and Prevention. National Center for Health Statistics. *National Health and Nutrition Examination Survey.* Web: www.cdc.gov/nchs/data/nhanes/databriefs/adultweight.pdf#search='National%20Health%20and%20Nutrition%20Surveys%20Data%20obesity'.
2. Friedman Z, Chung F, Wong DT. Ambulatory surgery adult patient selection criteria — a survey of Canadian anesthesiologists. *Can J Anaesth* 2004; 51:437-443. ■

Low-cost ideas boost your community image

With many outpatient surgery programs having few, if any, funds available for public relations, there is a strong need for free or low-cost ways to improve your community image. Many programs are finding out that by giving back to their community, they also can reach potential patients and improve staff morale in the process.

Here is a sampling of ideas gathered from outpatient surgery providers:

• Bicycle and skate helmet and safety program.

For the past few years, a Ride Cool bike and skate helmet and safety program has been sponsored by Northeast Missouri Ambulatory Surgery Center (ASC) in Hannibal and other health care providers. The surgery center and providers set up several booths on a Saturday, and young people have their bicycle washed, receive safety inspections, and receive water bottles and first aid kits. Also, the ASC distributes helmets that it purchases at a discount rate from Bell Sports in Rantoul, IL, with money from a local philanthropic organization.

"We'll handle 600 helmets on a particular Saturday," notes **Brian Shelton**, MBA, CAFC, regional operations manager at Health Inventures, a development management company for surgery and diagnostic imaging centers, including Northeast Missouri ASC, based in Broomfield, CO.

The program includes fit checks for helmets. It is advertised through local newspaper and radio announcements and fliers at Northeast Missouri ASC and the local hospital.

The advantage to the center is the safety awareness being created in the community with children and parents, Shelton says. "It demonstrates community involvement," he says. "We give back. It gives the message: 'We don't just operate on you; we're more than that.'"

• Business expo.

Staff members from Northeast Missouri man a booth at the community's annual business expo. "At that booth, we give out literature about the surgery center and health and wellness information," Shelton says. Specifically, the center partners with the American Cancer Society to distribute literature about colorectal cancer and to provide a free at-home test kit. Over a three-year period, the center has seen about 15 positive results to the cancer screening, Shelton says.

• Fire Department Kids Education Program.

Northeast Missouri ASC contributes financially to the local fire department so the firefighters can distribute safety literature to the community. The literature includes an explanation of how to safely exit a building that is on fire. The center distributes this information to pediatric patients, Shelton says.

EXECUTIVE SUMMARY

Outpatient surgery programs can have free or low-cost public relations initiatives by participating in community projects.

- Set up a committee to ensure the surgery program isn't overextended in terms of financial resources or staff time.
- Survey staff to find out which programs they're interested in.
- Focus on projects that tie in with your program's mission.

• Local advertising through high schools and clubs.

Mentor (OH) Surgery Center advertises in its local high school sports programs. "For $25 to $50, you put an ad in a program that they pass out to everyone at athletic events," says **David Weir**, CASC, administrator at Mentor Surgery Center. "It's a minimal advertising expense compared to newsprint, and a lot of people see your name."

Also, because one staff person and several staff spouses belong to a local branch of The Benevolent and Protective Order of the Elks of the USA, the center advertises in the program for the group's annual awards ceremony. "It gives a sense of community outside of work, as well as at work," Weir adds.

• Gifts to local people who are ill.

Mentor employees provided two wagons full of gifts at Easter for two terminally ill children through the local branch of the Phoenix-based Make-a-Wish Foundation of America. Staff members were given the names and ages of the children and contributed gifts, gift certificates, wagons, and balloons. **(For information on participating in the Make-a-Wish Foundation, see resource box, above right. For information on providing surgery to needy people from overseas, see story, below right.)**

• Membership in local civic organizations.

Several members of Health Inventures' surgery centers are members of local civic organizations, including the chamber of commerce. The centers typically pay their membership fees.

Indirectly, it's a promotion of the surgery center, but it's not advertising, Shelton says. It shows the center's staff members are good community citizens, he says. "We're giving back as much as patients and the community give to us," Shelton explains. "They support us, so we try to support the community they're living in through these activities."

If you're looking at boosting your community involvement, first plan a budget, sources say.

"The more you get involved, the more requests you get," Shelton says. Often, financial commitments are involved. "If you're not careful, it could lead to many, many requests for other contributions, which could become unmanageable," he adds.

Time commitments also are an issue, he says. "We have 35 employees," Shelton says. "There's only so much they can do in their off time."

Salina (KS) Surgical Hospital formed a committee to find out which staff members were interested in which community projects, Weir says of his sister facility.

Keep in mind administrators and staff might not be interested in the same types of projects, sources say.

Staff at Salina Surgical Hospital established a budget and pooled ideas and contacts to start the service projects rolling, Weir says. "You can start small and see how it goes."

Also, focus on a handful of key organizations or initiatives that fit well with your center's mission. For instance, a cancer awareness campaign made sense for Northeast Missouri because many patients come for cancer procedures, Shelton says. "If they see us support it, it lends to our credibility and respect in the community," he says. ■

SOURCES/RESOURCE

For more information on boosting your image in the community, contact:

- **Brian Shelton**, MBA, CAFC, Regional Operations Manager, Health Inventures, Hannibal, MO. Phone: (573) 406-1450. E-mail: Bshelton@healthinventures.com.
- **David Weir**, CASC, Administrator, Mentor Surgery Center, 9485 Mentor Ave., Suite One, Mentor, OH 44060. Phone: (440) 205-5725. E-mail: dweir@healthinventures.com.
- For information on participating in the Make-a-Wish Foundation of America, call (866) 880-1382, Monday through Friday, 7 a.m. to 4 p.m. Mountain Time. Web: www.wish.org.

Surgery center provides free hernia operation

When a woman living near Lima, OH, started a service to provide free surgery to needy people overseas, she found a willing partner at nearby West Central Ohio Surgery and Endoscopy Center in Lima.

The organization, called Children's Medical Missions, sent a photo of a 10-year-old African boy needing a hernia operation to the center. She told the center a little about the child, and they decided to offer the surgery.

Children's Medical Missions arranged transportation and sent a chaperone to ensure the child was prepared preoperatively by having enough food and sufficient clothing. The center and physicians donated all expenses for the operation.

The child spoke French, so the center arranged for a boy in the community from Africa to interpret. "When he got here, we found out he was from the same country," says **Cheryl Swenar**, BSN, RN, CASC, administrator. "They didn't speak the same dialect, but they could communicate in French."

The case was handled as part of the regular surgery schedule. Children's Medical Missions arranged for a host family to provide a place for the child to recover.

In addition to free publicity through a local newspaper article, the advantage of providing the free surgery was "being able to help somebody — a child who probably never would have any hope," Swenar says. "Hernias can strangulate, cause the bowel to die, then without medical help, he would die." **(For information on donating equipment and supplies overseas, see resource box, at left. For information on outpatient surgery providers who provide charity to U.S. residents, see *Same-Day Surgery*, March 2002, p. 39.)** ■

SOURCES/RESOURCES

For information on providing surgery in the United States to needy people from overseas, contact:

- **Children's Medical Missions**, c/o Tami Shobe, 15595 Waynesfield Road, Waynesfield, OH 45896. E-mail: tamishobe@hotmail.com. Web: www.medical-missions.org.
- **Cheryl Swenar**, BSN, RN, CASC, Administrator, West Central Ohio Surgery and Endoscopy Center, 770 W. High St., Suite 100, Lima, OH 45801. Phone: (419) 226-8701. Phone: (419) 568-2893. E-mail: cswenar@healthinventures.com.
- **Recovered Medical Equipment for the Developing World (REMEDY)** is a group of health care professionals promoting the recovery of open-but-unused surgical supplies. A free teaching packet includes a video, CD containing inventory and shipping database template, in-service teaching manual, staff handouts, case cart collection bags to start a program, box label templates for the recovered supplies, and brochures/posters. To obtain the packet, go to www.remedyinc.org. Under "Quick Links," click on "Start a REMEDY Program."

  In the Hand Carry Program, associate REMEDY programs give students, medical care providers, and families supplies to take with them when traveling abroad. To participate, send an e-mail to REMEDY@Yale.edu, and they will put you in touch with a REMEDY recovery hospital in your area.

  AIRe-mail, the Agencies for International Relief e-mail program, links donors and recipients of medical equipment and supplies through e-mail notices to its member organizations. It is a joint project of REMEDY and the Office of International Health of the Yale School of Management. To participate, send an e-mail to REMEDY@Yale.edu, and they will make the information on donations available to AIRe-mail members.

HIPAA Q & A

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

Question: After my security officer is designated and familiar with the HIPAA security rule, what are my next steps toward compliance?

Answer: Identify what activities your organization already has implemented as part of your normal operating procedure that show compliance with the security rule, advises **Robert W. Markette Jr.**, an Indianapolis attorney.

"For example, the rule requires covered entities to implement policies and procedures to create retrievable duplicate copies of electronic protected health information [EPHI], also known as backup copies," he points out. "It is extremely unlikely that providers who use computers to maintain patient information and billing information are not regularly making backup copies of the data."

By comparing what your organization already is doing to what the rule requires, you will discover that you already have implemented parts of the rule, Markette says.

"For these standards and specifications, compliance with the security rule then will become a matter of evaluating whether the procedures are reasonable and either modifying them accordingly or simply inserting them into your HIPAA security rule policies and procedures binder," he says.

The next step is to inventory EPHI, Markette adds. "This should not take a lot of effort, because you should have an inventory of protected health information [PHI] that was generated as part of

RESOURCE

To find a draft of the *Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act Security Rule*, go to csrc.nist.gov. Under "CSD Publications," choose "drafts," then scroll down to May 12, 2004, publication No. 800-66. For other tools specific to risk analysis, go to csrc.nist.gov, then enter "risk analysis" in search box to see list of articles and tools available.

your privacy rule compliance efforts," he notes.

You can determine the locations of EPHI by simply reviewing the PHI inventory and determining which locations meet the definition of electronic media under the security rule, Markette says. "This inventory will make the risk analysis easier," he adds.

Question: What steps are necessary for a proper risk analysis, according to HIPAA?

Answer: Although the security rule requires you to perform a risk analysis, it does not provide you with any guidance on how to perform one, admits Markette. "There are numerous strategies and methods for performing a risk analysis, including publications from the National Institute for Standards and Technology," he says. **(See resource box, above.)** "Regardless of the particular tool you choose, the key concept in risk analysis is identifying potential risks and quantifying the likelihood that the risk materializes."

Identifying potential risks will involve thinking about ways your information systems could be harmed, explains Markette. Start with broad categories, such as natural disasters and incidents caused by people, then subdivide these categories, he suggests. "For example, under incidents caused by people, you may have two subcategories: intentional and unintentional," Markette says. These categories could be further divided into employee and nonemployee.

"You should try to identify all potential risks, even remote risks," he adds. "Then in the next step of the risk analysis, you will determine the likelihood of the potential risks coming to pass."

Identifying the likelihood of the identified risks coming to pass will not be a mathematically precise endeavor, Markette admits. "The security rule requires you to implement policies and procedures aimed at protecting against reasonably anticipated risks of your electronic protected health information. You do not have to sit down and decide that a potential risk has a 43.5% chance of happening and, therefore, it is reasonably anticipated."

Identify all potential risks and group them into categories such as highly unlikely, unlikely, likely, or highly likely to occur, he suggests. For example, a highly unlikely risk would be a hurricane in Montana or, for providers without Internet access, a hacker breaking into the system, he says. "On the other hand, an employee's actions leading to a security incident might be categorized as very likely," he adds. "The object is to identify the risks against which you should take precautions."

Once you have completed your risk analysis, you will have a framework for reviewing your current security policies and for designing new policies and procedures that reduce the risk to your EPHI, Markette says.

Question: Is a risk analysis and review of security rule compliance a one-time activity?

Answer: HIPAA security rule compliance is not a one-time effort, he emphasizes. "The security rule specifically requires you to periodically evaluate your security rule efforts but does not state how often you need to perform this evaluation," Markette says.

He recommends a review on an annual basis at a minimum. "As your organization grows and changes, the potential threats to EPHI security may change, and that means that your policies and procedures also will need to change," he adds. ■

Same-Day Surgery Manager

How are OR managers spending their time?

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

Have you ever tracked how you spend your time? While boring, it can be useful information to have.

Supply cost and personnel cost make up the majority of your expense items. I always have been a huge advocate of cutting back on staffing when and where you can. Since it often is difficult in the hectic pace of the operating room,

OR Managers' Use of Time

Issues	Hours per Week	Satisfaction Level
Employee Issues/HR	4	8
Physician Relations	4	6
Billing-Related	9	1
Conflict Resolution	5	9
Contracting (Any Type)	3	8
Physical Plant Issues	2	7
Instrument Issues	6	3
Meetings	4	3
Budgeting	4	2
Patient Contact	3	9
Family Member of Patient	5	9
E-mail (Any Type)	3	5
Walking Around	4	8
Meeting with Vendors	4	6

every tool you can use to identify areas that you might consider outsourcing or eliminating is important.

We all know the expense of employee turnaround. Understanding what your staff are doing and the level of satisfaction associated with certain tasks can make a manager's job easier in assigning certain responsibilities to individuals.

I thought that it would be interesting to see what some of my operating room associates do with their time. We set up a task sheet to track this information. I designed it to be very simple to use and with only a few parameters such as what we wanted to track, how much time was spent on it per week (you could do it daily, but it's probably not as effective because it would become too time-consuming), and the level of satisfaction they got out of the issue.

In the box, above, are the results of 25 OR managers that tracked it for a month. A satisfaction score of "10" means it was a very satisfying time spent on the issue and the effort was worth the time, and a score of "1" was just one level above walking out the door. This is not very scientific, but revealing.

Since most of the managers work a 60-hour week, the total on this is fairly accurate. The obvious conclusion is that most managers enjoy interaction with just about anyone (even the dreaded vendors!) but abhor issues related to instruments, budgets and meetings, and surgical billing. Also note that most people spend lots of time on billing issues. We concluded that billing issues and the time spent on them is not a good thing. Outsource the billing — it is cheaper anyway!

(For more information on outsourcing your billing, see *Same-Day Surgery*, July 2004, p. 75, and *SDS*, August 2004, p. 88.)

I did find this to be a useful study — informal as it was — to help identify ways we could function better by recognizing those time-consuming areas and perhaps reassigning personnel who might obtain a higher satisfaction level from the task; hence, it could be done faster and perhaps better.

Try this with your staff members and see what you find out. You may need to change it to meet the needs of your techs and clinical staff. At your staff meeting, ask what issues should be included. Please e-mail me your responses to searnhart@earnhart.com. I would be very curious to see how they are different. Please specify whether you are an ambulatory surgery center, physician's office, or based in a hospital.

[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.] ■

How your program can save on educational costs

Like many outpatient surgery programs, Mount Nittany Surgical Center in State College, PA, has a limited budget and always is trying to stretch its educational dollars as far as possible.

"We rotate who goes to seminars, etc., and then require the attendees to review the information they gathered with the rest of our staff," notes **Roger Pence**, administrative director of Mount Nittany and president of FWI Healthcare, an Edgarton, OH-based consulting firm for primarily ambulatory health care providers.

"This ensures the attendees pay attention at the meeting and increase their knowledge of the subject by reviewing and discussing it with others, and it enables nonattendees to learn about the topic also."

In addition, Mount Nittany videotapes manufacturer's representatives who explain how to use new equipment and products, Pence says. "If

someone is sick or a new hire started, they, too, can benefit from the recorded presentation," he says. "Some reps even append their presentation by adding updated information or responses to frequently asked questions."

Another way to save on education is to work with noncompeting facilities in your area and share the expense, suggests **Jerry W. Henderson**, RN, MBA, CNOR, CASC, executive director of SurgiCenter of Baltimore in Owings Mills, MD. Also, you can work with your state surgery center association or hospital association to offer low-cost seminars, sources say.

When you do send employees out of town to conferences or other educational opportunities, use a credit card that offers a payback. "We have a Bank One Visa that gives back 1% on certain items and 3% on other items," says Henderson, who uses the card for supplies also. "That isn't much, but it does add up over time," she adds.

[Editor's note: Do you have a cost-saving tip to share with your peers? Contact Joy Daughtery Dickinson, senior managing editor, at (229) 551-9195 or joy.dickinson@thomson.com.] ■

4 patient safety centers target ambulatory surgery

All 6 programs will target hospitals

Six states have enacted legislation supporting creation of state patient safety centers, and four of those states (Florida, Massachusetts, Oregon, and Pennsylvania) will focus on ambulatory surgery centers. All six, which also include Maryland and New York, will focus on hospitals.

A recent report from the National Academy for State Health Policy in Portland, ME, examined the models in use in the six states.

The effort grew out of the 1999 Institute of Medicine (IOM) report that documented 98,000 deaths per year in the United States due to medical errors, says report author **Jill Rosenthal**, project manager at the National Academy of State Health Policy**.** "The IOM recommended two types of reporting systems: state mandatory reporting for serious adverse events and a voluntary system for near misses," she says. "The safety centers are a way of implementing the voluntary reporting."

The report says that all six patient safety centers studied are legislatively authorized or endorsed in some manner. That authorization distinguishes them from other state or public/private patient safety programs or coalitions.

Four of the centers are housed within their state governments, while two are outside of but still have legislatively authorized affiliations with the state governments. Financial support for patient safety centers comes primarily from fees, grants, and appropriations.

SOURCE/RESOURCE

For more information on the report, contact:

- **Jill Rosenthal,** Project Manager, National Academy of State Health Policy, Portland, ME**.** Phone: (207) 874-6524. E-mail: jrosenthal@nashp.org.
- To access a free copy of the report or find links for the state patient safety centers, go to the National Academy of State Health Policy's web site (www.nashp.org). Under "Quality and Patient Safety," click on "New: State Patient Safety Centers," then "State Patient Safety Centers: A new approach to promote patient safety."

A similar goal

Although patient safety centers may have different governing structures, operations, and activities, they are similar in their mission statements: All six have statements on improving, ensuring, or promoting patient safety. The most universal function, common to all six centers surveyed, is to educate providers about best practices to improve patient safety, Rosenthal says. Other common roles include identifying causes of patient safety problems, fostering a culture of safety, developing collaborative relationships among patient safety stakeholders, and educating consumers about patient safety.

Five of the six states with centers have separate mandatory reporting systems for serious adverse events, and those systems are housed in state regulatory agencies. Several centers have access to the data in those systems and will assist with their analysis. Three of the states chose to develop within their patient safety centers a voluntary reporting system for less serious errors, intended to complement the mandatory systems already in place.

The types of data and methods of collection and analysis used by the centers vary. Rosenthal says some interesting and unique activities of patient safety centers include:

• Florida will examine ways to reward providers who implement evidence-based medical practices and will recommend core competencies in patient safety for health professional curricula.

• Massachusetts has developed a patient safety ombudsman program to work with patients, families, and consumers on patient safety-related problems and also plans to address health system and individual practitioner accountability.

• Pennsylvania's statute includes a provision for a discount in medical malpractice liability insurance premiums for facilities that can demonstrate a reduction in serious events following adoption of center recommendations.

What will the public see?

All of the patient safety centers plan to make some information available to the public. If the centers have reporting systems, they will publicly report only data patterns using aggregate de-identified data that do not name facilities. Maryland and Oregon also will provide information on which facilities are participating in the reporting systems. Only New York provides facility — and provider-specific outcome information (which is contained within its physician profiling system) and outcome measure reports.

The impact of state patient safety centers remains to be seen, Rosenthal notes. "Despite the lack of rigorous indicators, patient safety centers ultimately will have to demonstrate gains in patient safety," she adds. "If they are unable to do this, pressure will no doubt build from regulators, purchasers, and the public for more draconian measures." ■

66% of consumers talk to surgeons to reduce risk

Survey targets views on medical errors

On the fifth anniversary of the Institute of Medicine's 1999 report on the high number of medical errors in this country, 66% of consumers surveyed said that they have talked to a surgeon about details of a proposed surgery to reduce the risk of experiencing a medical error when seeking treatment.

Consumers said the discussions included items such as exactly what the surgeon will do, how long it will take, and the recovery process.

RESOURCE

To view a summary of the survey report, go to the web site of the Henry J. Kaiser Family Foundation (www.kff.org). Under "New and Noteworthy," click on "National Survey on Consumers' Experiences with Patient Safety and Quality Information."

The consumer survey was conducted by the Kaiser Family Foundation, the U.S. Agency for Healthcare Research and Quality, and the Harvard School of Public Health. The survey found that 35% of people said they have seen information comparing the quality of health plans, hospitals, or doctors in the past year, up from 27% in 2000.

Some 19% of all Americans said they have used comparative quality information about health plans, hospitals, or other providers to make decisions about their care, up from 12% in 2000. More specifically, 14% of consumers said they have used quality information to choose health plans, 8% to choose hospitals, and 6% to choose doctors.

Consumers said that information on how many times a hospital has performed a particular surgery or test (65%) and information on how many patients die after having surgery (57%) tells them "a lot."

The survey found that 40% of respondents believe the quality of health care has gotten worse in the past five years, while 17% say it has gotten better and 38% think it has stayed the same. Nearly half of U.S. residents (48%) said they are concerned about the safety of the medical care that they and their families receive, and 55% said they are dissatisfied with the quality of U.S. health care, up from 44% who gave that opinion in a survey conducted four years ago. ■

MedPAC to recommend extension of moratorium

Specialty hospitals would be restrained until 2007

The Medicare Payment Advisory Commission (MedPAC) will recommend to Congress that the moratorium on development of specialty hospitals, including surgical hospitals, be extended by 20 months to Jan. 1, 2007. The moratorium in the Medicare Bill affects facilities participating in

Medicare and prohibits physicians' referral of patients to specialty hospitals in which they have an ownership interest, as well as development of new specialty hospitals.

The current 18-month moratorium was scheduled to expire in June.

"We are in total disbelief as to the recommendation for an extension of the moratorium," says **Michael J. Lipomi**, MSHA, legislative co-chair of the San Diego-based American Surgical Hospital Association. "Certainly, projects that are planning on starting following the sunset of the current moratorium would be devastated by a decision to extend the moratorium."

The industry as a whole will be damaged, he maintains. "One, when there is no growth in an industry, it loses momentum and it affects the short- and long-term value," Lipomi says.

Secondly, the ability to respond to market changes is critical in any industry, he notes. "The moratorium places a restriction on this and, as such, adds risk and detracts from future values."

Finally, the aging of physician investors is a great concern for surgical hospitals, Lipomi says.

"According to the restrictions imposed by the moratorium, aging, retired, or practicing physicians who move out of the area cannot be replaced by adding new investor physicians," he points out.

"We now need to go out and buy back physician investors at a premium in order to make room for new investors." The physician selling has a great deal of bargaining power and often gets a greatly inflated price for selling his or her investment, which puts the facility at a disadvantage, Lipomi notes.

MedPAC also will recommend changes to the Medicare inpatient prospective payment system that could reduce incentives for patient selection. These changes include establishing rates for diagnosis-related groups [DRGs] that more accurately reflect the costs of caring for patients of varying severity of illness and resource consumption.

MedPAC also will recommend refinements to the relative values of existing DRGs, implementation of case-mix measurements, and changes in the outlier policies.

"We agree that some revision to DRGs needs to be done in order for more appropriate and representative payments to be made," Lipomi says.

MedPAC's recommendations, which will be finalized in March, are the result of a yearlong study on the impact of specialty hospitals on community hospitals. The study found that specialty hospitals:

- do not have lower costs per case than community hospitals;
- concentrate on certain DRGs and treat relatively low-severity patients within them;
- tend to treat lower shares of Medicaid patients.

Lipomi is hopeful that the recommendations will not be approved. "I am confident that the Congress of the United States of America will see through the smoke and mirrors offered by the established, old-fashioned general hospital establishment and offer America new, innovative, and cost-effective alternatives in health care," he says. "Our nation is calling out for innovation and patient choice, and specialty hospitals answer their call."

Also, MedPAC will recommend allowing hospitals to offer incentives to physicians to encourage physician and hospital cooperation to lower costs and improve care. MedPAC reported that such gainsharing arrangements, which are currently prohibited under federal law, could help improve hospital-physician relationships.

In other news, MedPAC voted to recommend a payment update of marketbasket minus 0.4 percentage points for hospital outpatient services in 2006.

The reduction would apply to all hospitals paid under the Medicare prospective payment system, even though the Medicare Modernization Act specified a full update for hospitals that share data on 10 key quality indicators for fiscal years 2005 through 2007. ■

SOURCE

For more information on surgical hospitals, contact:

- **Michael Lipomi**, MSHA, CEO, Stanislaus Surgical Hospital, 1421 Oakdale Road, Modesto, CA 95355.

COMING IN FUTURE MONTHS

- ■ Tips on how to meet new patient safety goals
- ■ Credentialing: What surveyors want to find in files
- ■ OR reduces sharps injuries: We'll tell you how
- ■ Updated and amended accreditation standards
- ■ Are you prepared for random unannounced surveys?

CE/CME objectives

After reading this issue of *Same-Day Surgery*, the CE/CME participant will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. (See *66% of consumers talk to surgeons to reduce risk* in this issue.)
- Describe how those issues affect clinical service delivery or management of a facility. (See *Low-cost ideas boost your community image* and *How your program can save on educational costs.)*
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *HIPAA Q&A.)*

CE/CME answers

9. A **10. D** **11. B** **12. D**

CE/CME *questions*

9. What type of advertising did Mentor Surgery Center find cost-effective?
   A. Advertisements in high school sports programs
   B. Radio advertisements
   C. Newspaper advertisements
   D. Television advertisements

10. When performing your risk analysis to meet requirements for the HIPAA security rule, how does Robert W. Markette Jr. suggest you subdivide the larger category of threats posed by people?
   A. Financial and nonfinancial
   B. Likely and unlikely
   C. Physician and nonphysician
   D. Intentional and unintentional

11. How does Mount Nittany Surgical Center stretch its educational dollars?
   A. Travel to seminars and conference is based on length of employment.
   B. They rotate who goes to seminars and conferences and require the attendees to review the information they gathered with the rest of staff.
   C. Travel to seminars and conferences is based on who has used lowest amount of vacation time.
   D. Employees bring back cost-saving ideas from seminars, conferences, and site visits.

12. In a consumer survey by the Kaiser Family Foundation, AHRQ, and Harvard School of Public Health, what quality information did consumers say tells them "a lot."
   A. How long employees have worked in the field and how long they have worked at the facility
   B. How long the managers have worked in the field and how long they have worked at the facility
   C. The facility's length of stay by procedure and by patient age
   D. How many times a hospital has performed a particular surgery or test (65%) and information on how many patients die after having surgery (57%) tells them "a lot."

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 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** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. ■