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Surgery centers say to payers: We are not going to take it any more!

Exclusion from contracts, low and late payments push centers to action

How would you like to go from receiving no payment increases from one of your payers to receiving rate increases of 3% to 11% four years in a row? Sound impossible? Not for ambulatory surgery centers (ASCs) in Ohio, which became proactive in educating their workers' compensation board after receiving no payment increases for three years in a row.

ASCs across the country are reporting similar strategies as they go on the offensive after years of complaining that they are being blocked out of payer contracts, receiving delayed payments, and/or being given payments even lower than Medicare and Medicaid.

"We want to get rid of the ASC list, thereby putting the decision about where surgery is performed in the hands of physicians and patients," says **Lisa Spoden**, PhD, executive director of the Ohio Association of Ambulatory Surgery Centers in Columbus and the Kentucky Ambulatory

EXECUTIVE SUMMARY

Surgery centers are going on the offensive after complaining of being blocked out of contracts, having delayed payments, and receiving payments that are less than Medicare and Medicaid.

- One surgery center gave an educational presentation to a state workers' compensation board and succeeded in having 35 procedures added to the ASC list, plus received four consecutive years of 3% to 11% payment increases.
- Maintain ongoing discussions with payers to highlight problems on both sides and explain your special needs. Invite payers to visit your center.
- Remind payers of any applicable state laws covering payment turnaround, meet with them to explore delays, and if necessary, meet with your state department of insurance.

Surgery Center Association in Frankfurt.

Surgery centers are focusing their lobbying efforts on Medicare because that system has the most antiquated list, she says.

"So many payers use Medicare as baseline for what they approve in procedures and what they pay," Spoden adds. "That has been a stumbling block for us, because Medicare is so behind in the procedure list they approve for ASCs."

And that's not the only problem, say sources contacted by *Same-Day Surgery.* Some ASCs say they're unable to obtain contracts with payers, says **Rob Schwartz**, executive director at the Colorado Ambulatory Surgery Center Association in Denver.

"We have members who have expressed concerns that they're locked out — that the answers they're getting from carriers is that they're making business decisions," Schwartz says. "Some choose not to elaborate or explain beyond that."

Another concern is payers are developing pricing for ASC procedures that displaces them from serving individuals with that payer, even in situations in which they're paid as "out-of-network" providers, says **Craig Jeffries**, executive director of the American Association of Ambulatory Surgery Centers in Johnson City, TN. Still other facilities are having difficulty getting payments from payers, Spoden says.

To successfully address problems with payers, take these steps:

• **Educate payers.**

Members of the Ohio Association of ASCs realized payers didn't understand the difference between hospital outpatient surgery departments, freestanding ASCs, and physician offices that performed surgery, Spoden explains.

In response, the association provided information, advocacy, and education. For example, the Ohio association shared benchmarking data with payers to show high levels of patient satisfaction and low infection rates when compared with inpatient facilities, she says.

A computerized presentation with graphics provided basic information on what surgery centers are and what they do. The presentation, given to seven payers, discussed patient satisfaction rates and technological advances. The association representatives met with the state workers' compensation board to discuss what procedures should receive reimbursement in surgery centers.

"We used some well-written, well-documented writings from physicians proving the efficiency of the cases," Spoden notes. That educational effort led to 35 new procedures being added to the list of procedures reimbursed under workers' compensation, she says. "They continue to add each year a number of procedures," Spoden adds.

• **Establish an ongoing dialogue with payers.**

It's important for ASCs and payers to understand how each works, she says. An ongoing dialogue can help ASCs understand where claims may be getting delayed and where the information

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pipeline is disconnected between the centers and the payer, Spoden says. "It also helped to identify who our ASC experts are, and when they have questions, they can come to the association and we'll help them understand a particular procedure or answer their questions," she says. "We tried to have regular dialogue to benefit insurers, ASCs, and ultimately, our patients."

While the Ohio association initially established a working group with the workers' compensation board, they are trying to do the same with other payers. The association wants to try to explain the centers' position in different areas, including the benefit of performing multiple procedures at one time, why implants need to be paid above the established rate, and why some patients need longer than two to three hours to recover properly, Spoden says.

Another important piece of the dialogue with payers is having them tour your facility, Spoden emphasizes. "It gets payers out to see how things are done in an ASC, and they come away with a better understanding of why it's a great site for patient care," she says.

• Ensure your state's laws for payment are followed.

Some states have regulations that set a payment turnaround time for all medical providers, Spoden says. "If you're having problems with a particular payer, advise the payer of the statutes," she suggests.

If you don't receive a positive response, meet with them and discuss the problems, Spoden says. Examine where the delays are, and determine if there is anything the surgery center can do to speed payment, she suggests. Also share where you see payer problems that need to be addressed, Spoden advises.

"If you're getting nowhere, go to your [state] department of insurance and talk about the problems you're experiencing," she says. Her association has taken that step, and centers are reporting better payment turnaround, Spoden says. **(Filing suit is usually a last resort. See story, below.)**

If you have problems with payers saying they never received claims, consider filing electronically so you can set up your system to notify you when the information is delivered. If you send paper claims, have the insurance company sign when they receive the claims, Spoden suggests.

When you initially approach payers, emphasize that it's a partnership and you want the same outcomes, Spoden suggests. "Our goal is to provide good quality outcomes and be cost-effective for them, save insurance and purchasers of insurance — the companies that have workers — money and yet have fair payment to ASCs," she says. "That's the bottom line of ASCs." ■

SOURCES

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Some centers resort to taking legal action

Many insurance companies that aren't paying the full patient bills sent to them from ambulatory surgery centers (ASCs) seem to have taken the stance, "let 'em sue us," says **Thomas J. Pliura**, MD, JD, physician and attorney at law in Le Roy, IL. So that's exactly what some surgery centers are doing, he says.

One lawsuit has been filed in Illinois, and another is pending, Pliura adds. One center has submitted $900,000 in billed charges to a payer and has received $57,000 from the payer.

"It puts the patients legally on the hook for the bill, but [payers] are taking advantage of the fact that the health care providers will very rarely pursue claims directly against the patients," he says. "The companies know that the centers don't do so because that will give them a bad name and fear their business might suffer if other patients learn about the lawsuits."

The legal way around this dilemma is to file directly against the insurance company on behalf of the patient, using the patient assignment as a legal tool, Pliura explains.

In the lawsuit that's been filed, the centers allege failure to pay a contractual obligation, federal and state antitrust violations, restraint of trade violations, and violation of the Consumer Fraud and Deceptive Practice Act, he adds.

"We also believe it is illegal for an insurance company to enter into a separate agreement with a hospital to try and keep a competing surgery center out of a particular market," he adds. "It seems several insurance companies are now attempting to squeeze out facilities that refuse to become contracted facilities with the particular companies by entering into agreements with hospitals, etc., to keep the noncontracted facilities out of the market."

Patients pay extra money to their payer to have the privilege of using noncontracted providers, he says. "Insurance companies are taking the higher PPO [preferred provider organization] payments from the patients, yet they are secretly prohibiting patients from utilizing noncontracted providers," Pliura notes. In essence, these companies are trying to exclude noncontracted providers and make the patients use only "contracted" providers, even though the patients have been paying extra money to buy a policy that allows them to go out of network, he says.

"Insurance companies across the country seem to have taken the stance they will simply ignore health care payment obligations," Pliura says. Many insurance companies are deciding arbitrarily to simply make a token payment — even if the facility does not have a contract with the insurance company — and assume the surgery center will accept the payment as full payment for the bill, he says. "This is ridiculous, in my opinion, but rarely do the surgery centers take the time to pursue the matter," Pliura says.

As an increasing number of ASCs begin to experience this "squeezing down," these facilities will begin to pursue claims against the insurance companies directly, he predicts.

Some consumer groups are concerned that a health care monopoly is developing that drives up cost, says **Rob Schwartz**, executive director of the Colorado Ambulatory Surgery Center Association in Denver. There have been discussions about approaching the state attorney general, he says.

"Any actions that target surgery centers and attempt to lock them out is wrong and anti-consumer," Schwartz adds. ■

SOURCE

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Hospital cuts sharps injuries in the OR

Managers make rounds, note compliance

Never let up. That is what Greenville (SC) Hospital System learned about reducing sharps injuries in the operating room. It takes a sustained effort to keep rates down.

The three-hospital system has been on the forefront of sharps safety by implementing safety devices in 1991, about 10 years before the Needlestick Safety and Prevention Act provided a national mandate. When other hospitals were evaluating safety products, Greenville Hospital System was monitoring compliance.

But one challenge remained. The operating room still had consistently high rates of blood and body fluid exposure. "Because the safety devices have reduced injury in other areas, the OR stands out," says **Connie Steed**, RN, CIC, director of infection control.

So an action team created a new objective: "Decrease OR health care worker exposures by implementing a hands-free neutral zone during surgery and ensuring the appropriate use of safety devices and personal protection equipment."

Easier said than done.

The hospital placed an emphasis on maintaining a neutral zone for the passing of sharps. They no longer should be passed directly between a surgical technician or nurse and the surgeon.

"It took more than a year to get compliance," says clinical nurse specialist **Sue Seitz**, RN, MSN, CNOR. "We faced several barriers. We educated [physicians and OR staff] about the neutral zone policy; we educated about hepatitis C and the devastating effects it can have. Despite the education, there was not any behavioral change."

Monitoring behavior in the OR and providing feedback on sharps injuries eventually made the difference, she points out.

Rounds focus on safety hazards

Seitz continually relayed information to the OR staff and physicians about who was being stuck, how were they being stuck, how it could have been prevented, and what it was costing the hospital.

Infection control staff made rounds in the OR and noted safety hazards. For example, they recommended that fewer people hover around the

OR table, which meant some students needed to step back a few paces and provide more room for safe maneuvering.

Nurse managers made rounds and reminded staff about the neutral zone. They used "award" and "alarm" sheets to give feedback about compliance. The sheets also were shared with managers and made part of the employee's record.

Meanwhile, the hospital system's vice president of medical affairs offered his strong commitment, which was the key to surgeon support of the changes. The hospital brought in Marc Davis, MD, a former surgeon who has become a national champion of sharps safety in the OR, to speak to medical staff.

The hospital initially gave surgeons four options for the neutral zone: a magnetic pad, a folded towel, an emesis basin, or relay trays. "We set up a display for our surgeons outside of their lounge so they could see examples of what they could expect [from surgical technicians]," says Seitz.

From 2002 to 2003, the OR exposures declined from 5.55 to 3.73 per 1,000 procedures. By 2003, the rate climbed again, to 4.72. **Margaret Baker**, RN, the hospital system's exposure control nurse, tracked the quarterly rates and investigated why the exposures went up. Nurse managers told her they had slacked off on rounds.

The rounds started up again, and Seitz reminded the OR staff to keep up the neutral zone. The rate dropped to 4.21 in 2004.

"We are still on the right track," Baker says.

Suture needles remain a challenge

Challenges remain in the OR, as they do for hospitals around the country. Surgeons have resisted using blunt sutures and say the devices change their technique and affect patient care.

"Two or three years ago, I talked to the surgical groups to facilitate interest," she notes. "We had a lot of surgeons volunteer to try it. Some of them tried it and didn't like it."

Nationally, suture needles are the second greatest source of sharps injuries, accounting for 18% of injuries, says **Jane Perry**, MA, director of communications for the International Healthcare Worker Safety Center at the University of Virginia Health System in Charlottesville.

The center collects sharps injury data from hospitals participating in its EPINet network. The EPINet database, established in 1993, includes more than 25,000 sharps exposure incidents.

"Our data show that sharp-tip suture needles continue to be a significant source of injury to health care workers, but there's been very little change in the injury rate for this device over the last 10 years because safer technology and techniques haven't been widely adopted," she says.

A 1997 study by the Centers for Disease Control and Prevention showed blunt suture needles were effective in reducing sharps injuries in gynecologic surgery without affecting outcomes, Perry notes.[1]

"I think manufacturers of blunt suture needles need to do a better job of promoting this technology as a safety measure for surgeons and those who work with them," she says. "Surgeons need to be educated about what this technology is and how it can be used."

Greenville Health System will continue to educate surgeons about blunt suture needles and other safer technologies. "We're not going to give up," Steed explains.

Here are some of the lessons that were learned at Greenville about reducing sharps injuries in the OR:

- **Track your rate, not your numbers.**

If your sharps injuries go up, you need to know whether your procedures or patient population went up as well.

- **Collect your data monthly, but analyze it quarterly.**

On a month-by-month basis, you may have a lot of fluctuation that can be confusing, says Baker.

- **Look at sharps injuries by occupation.**

For example, Greenville Health Systems noticed sharps injuries were going up among medical residents, which prompted a closer look at that group.

- **Your past performance is your best benchmark.**

If you compare your rates to those of other facilities, you may not know if you're calculating your injuries in the same manner.

"Some hospitals don't [include nonemployees, such as surgeons], so it looks like they have lower rates," Baker adds. "We decided not to compare ourselves with others."

Reference

1. Centers for Disease Control and Prevention. Evaluation of blunt suture needles in preventing percutaneous injuries among health care workers during gynecologic surgical procedures — New York City, March 1993-June 1994. *JAMA* 1997; 277:451-452. ■

Same-Day Surgery Manager

How to improve your surgeon utilization

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

Getting surgeons to operate out of your ORs shouldn't be an issue. Surgery is up everywhere, and while 200 new surgery centers are under construction right now, there is not a glut of places where surgeons can operate.

So why is surgeon utilization an issue? Fact: Old habits are hard to break.

I work with inpatient and outpatient surgery issues — in the hospital setting as well as the freestanding ambulatory surgery center (ASC) arena.

The problem is about the same in both areas: The surgeons don't operate where we think they should. We build surgery centers, add new operating rooms in the hospital, and buy all the expensive equipment they request, but where are they? There are exceptions (always).

You would think that after the time and expense in setting up their own ASC, they would be motivated to perform virtually all their procedures in their own shop. Au contraire! While we have some very hungry, entrepreneurial surgeon investors who are using their investment well, there still are those who drag their feet and hang on to what's familiar.

Likewise, many hospitals have gone out of their way to ensure they keep the surgeons there by giving them what they want, such as new equipment, larger operating rooms, dedicated staff, and rapid turnover time.

After dealing with this issue for almost 17 years, I have some insight that might help you understand why, or at the very least, let you know that you are not alone in your puzzlement. Many of the surgical specialists rely heavily on referrals from others for their surgical volume.

Usually those referrals come from family practitioners and internist. Those referrers often are very loyal to the hospital and become upset when a surgeon leaves the hospital and works at a surgery center.

They think taking cases out of the hospital can hurt the bottom line of the hospital and hence cause the hospital to cut back on programs that might cut into their referrals (that come from the hospital). Thus, it often is not easy for surgeons to completely stop using the hospital for their cases.

They often will have to appease their source of cases by doing a certain amount of surgery at the local hospital.

You also have pressure on the surgeon from their own partners who, naturally, want to enhance their investment in the surgery center by having everyone do all their cases there.

Then you have the surgeons who have no interest in a surgery center at all but flip between two or three hospitals to perform their cases. Again, it usually is because of where the referrals are coming from that dictates where surgeons will do their surgery. For what it is worth, most surgeons would love to consolidate their surgical volume in one location, but that just isn't going to happen for most of them.

Much attention is focused on ASCs; however, the bulk of surgery still is performed in the community hospital setting. The hospital managers are shaking their head in puzzlement as well.

Many senior partners in specialty groups are very loyal to the hospital and try to show it by using it as much as possible. It often is difficult for these large practices to keep everyone supporting the hospital when investment opportunities abound elsewhere.

With some surgeons going between two and three hospitals and another couple of ASCs to do their surgery, everyone loses. The hospitals are gaining momentum in capitalizing on their reputation, their referral networks, and the development of their own internal and/or external surgical programs. Getting the surgeons to use them, even after the hospitals have provided just about everything the surgeons have requested, still is a challenge.

There are ways that you can steer more cases to your location. Just asking and making the surgeons feel guilty usually isn't enough. They need something that will justify their going against the wishes of their referrers or senior partners — something that will make it worthwhile to jeopardize that long-term relationship. Money is not always the answer.

The primary reason that surgeons will start surgery centers is because of time efficiency. If

you can give them back time by being incredibly efficient in start times, turnover times, and posting time, you have a good shot at getting more of their cases. Many successful hospitals have started their own programs to do just that.

The surgeons then can go back to their referrers (the internists, family practice groups, senior partner, etc.) and tell them, "If the hospital can give me 10 minutes turnaround times, good start times, and let me post the cases in a reasonable timeframe, then I would do more work there." Those reasons alone can justify the surgeon taking his/her cases elsewhere. We need to give them a reason, excuse, and justification to break old habits.

(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.) ■

Improve collections with info and communication

Let patients know up front what costs will be

(Editor's note: This is the first of a two-part series on improving business office efficiency to reduce accounts receivables and improve cash flow. This month, we look at policies and communications with patients designed to improve collections. Next month, we will look at how to staff your business office and how to make sure staff members use their time wisely.)

Imagine managing your household budget with paychecks that were two, three, or four months late. How would you pay your mortgage, buy your groceries, or feed your family?

Many same-day surgery managers find themselves in similar situations with unpaid claims that reach more than 128 days in accounts receivables. Fortunately, there are many little things that can be done before the claims become so old, say experts interviewed by *Same-Day Surgery*.

"We reduced our average accounts receivables days from 128 to 38 after I took this position," says **Steven Wright**, business office manager for Physicians Surgery Center in Daly City, CA. The dramatic turnaround came after Wright evaluated all of the systems in place to gather, document, and submit information for patient claims, he says.

EXECUTIVE SUMMARY

Improving cash flow depends upon the efficiency of business office personnel as they gather information to prepare claims as well as the diligence of the financial manager in monitoring accounts receivables and identifying potential problems.

- Review accounts receivable reports daily to catch problems before they develop.
- Start collecting information at the time of the physician's referral.
- Use form letters to communicate financial responsibilities to patients before the day of surgery.
- Strictly follow policies requiring copays and other monies owed by the patient on the day of surgery.

An efficient business office enables you to start the collections process before the patient is ever seen in the surgery suite, Wright says. "The business office staff should begin collecting information at the time of the physician's referral.

"In a perfect world, we would gather complete insurance information; verify coverage, copays, and deductibles; and receive complete contact information for each patient at the time of referral for every case," he says.

Because this isn't a perfect world, Wright's staff members collect as much information as possible from the physician's office staff, then call the insurance companies to verify coverage and other requirements, he says. "Once we have the estimate of payment from the insurance company, we complete a form that is sent to the patient explaining the expected cost of the procedure and the expected payment from insurance. We state the amount of money that the patient will pay out of pocket and tell them that we will collect this on the day of surgery.

They also give the names and phone numbers of the business office personnel who can answer questions or make payment arrangements for the patients so staff can address any problems prior to the day of surgery, he adds. **[To see copies of the forms used by Physicians Surgery Center to communicate with patients, go to www.same-day-surgery.com and click on "toolbox." The new forms are listed under the "billing" headline. Your subscriber number on your mailing label is your user name, and your password is sds (lowercase) plus your subscriber number (no spaces).]**

In addition to making sure the patient understands his or her financial obligation, getting the correct information up front saves time required to submit corrected claims, says **Pam Hooper**, RN, administrator of Spring Hill Surgery Center in Little Rock, AR. Recognizing that information can be overlooked when staff members become rushed, Hooper had copy machines placed at the desks of admission personnel so they don't have to gather insurance cards and other items that may need to be copied for the record, then go to another area in the office to make the copies, she says.

"This not only speeds up the process of collecting information, but we also never leave the patient sitting by themselves, wondering why they're waiting," she adds.

In addition, you have to make sure that verification of insurance occurs in a timely and complete manner, Hooper explains. A recent performance improvement project at Spring Hill looked at the problems that result from inadequate insurance verification. "We always verify primary insurance, but we found that we often don't follow up on secondary insurance verification," she says.

Knowing how secondary insurance will pay and under what circumstances can be another way the surgery center can improve collections and cash flow, she points out.

Stick by your policies

Be sure that if you say that your policy is to collect the coinsurance or deductible on the day of surgery, you are ready to do so, Wright says. "You can always be ready to accept a partial payment if you set up a payment plan, but you have to show that you do follow your own policies," he says.

Laurie Nichols, a consultant with Credit Control Co., a Little Rock-based medical collections agency, says, "I don't see a lot of surgery programs that say, 'No. We can't do your surgery.'"

When you don't collect anything up front, you run the risk of not collecting anything from the patient, she says.

"It's important that you tell the patients before the day of surgery what they are expected to pay; and if they show up for surgery with no payment or arrangements to pay, be prepared to reschedule," Nichols says. "Physicians don't want to turn a patient away, but financially, it is a risk for the surgery center and the physician if patients believe they don't have to pay."

One center regularly turns patients away, and there is never a patient relations problem because the center communicates its policies well before the patient arrives for surgery, Nichols explains.

When you do send a letter explaining the cost of surgery, how much insurance will pay, and what you expect the patient to pay, be sure you use words such as "estimate," Wright recommends.

"There are too many variables that can affect the length of surgery, and therefore, the cost of the procedure," he says. "Include a statement that your figures are only estimates and the final charges will be determined after the surgery is complete."

In all of your communication with patients, be sure to include a direct line to a business office employee who can answer questions and handle problems, Wright suggests. Don't make your patients navigate a complicated voice mail system, only to have to leave a message, he says.

Also, return calls within 24 hours, Wright adds. "This is not only common courtesy, but it establishes a good relationship that will improve your chances of collecting monies you are owed," he explains.

Another key to successfully managing your claims payments is to review your accounts receivable information regularly, Wright says.

"I check the age of my accounts every day so that I can stay focused on accounts receivables even when I have a lot of other things going on," he adds. "If there's a systemic problem, I can spot it at 45 days and take steps to correct it before it becomes a big problem." ■

SOURCES

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Key Performance Indicator (Cases Per Year)

	1,999 or Fewer Cases/Year	2,000 to 2,999 Cases/Year	3,000 to 4,999 Cases/Year	5,000 or More Cases/Year
	Median	Median	Median	Median
Total Gross Charges	$2,991,663	$5,528,041	$7,620,059	$11,761,196
Total Medical Revenue	$1,457,473	$2,546,211	$4,111,633	$5,780,141
Total Medical Revenue Per Case	$1,146.80	$997.11	$988.05	$808.88
Total Employed Support Staff	7.01	15.13	21.75	32
Medical and Surgical Supply Cost Per Case	$213.18	$234.32	$184.16	$177.75
Total Operating Cost Per Case	$985.03	$822.95	$772.13	$582.65

Source: Ambulatory Surgery Center Performance Survey: 2004 Report Based on 2003 Data. Medical Group Management Association, Englewood, CO.

Largest centers report lowest operating costs

Surgery centers performing 5,000 or more cases per year showed operating costs of $582.65 per case in 2004, compared with operating costs of $985.03 per case for centers that performed 1,999 or fewer cases per year, according to a new report from the Medical Group Management Association (MGMA) in Englewood, CO. **(See chart, above.)**

Medical and surgical supply costs per case ranged from $177.75 for the centers performing 5,000 or more cases per year to $234.32 for centers performing 2,000 to 2,999 cases per year, according to the *Ambulatory Surgery Center Performance Report: 2004 Report Based on 2003 Data*.

Total medical revenues per case ranged from $808.88 for the largest centers to $1,146.80 for the smallest centers, the report said. The survey received 148 responses out of 823 facilities that were sent the questionnaire, for a response rate of 18%. Facility ownership of respondents was:

- owned by group practice of multiple physicians, 36.49%;
- joint venture of several organizations, 33.11%;
- owned by multiple physicians in different medical practices, 22.97%;
- owned by one physician, 3.38%;
- owned by hospital or health system, 2.03%;
- other, 2.03%.

The *Ambulatory Surgery Center Performance Report* provides a summary of the financial performance and productivity of ambulatory surgery centers, including productivity measures of cases (patients) and procedures, case volume and total operating costs. This year's report includes geographic sections, which provide area-specific information broken down by Eastern, Midwest, Southern, and Western areas. The report includes separate reporting for orthopedic, gastroenterology, and ophthalmology specialty data.

To obtain a full copy of the report, go to the MGMA web site: www.mgma.com. Click on "store" and search for the title. The cost of the item for nonmembers is $355 plus $7.50 for standard shipping. ■

You can save money with supplies and equipment

Two of your surgeons want you to purchase an expensive piece of technology, but you're wary because you're unsure how much they will use it. What should you do?

"Try to lease the new 'Whizz-bang Whatchamacallit' one or two surgeons want, before buying," says **Roger Pence**, administrative director of Mount Nittany and president of FWI Healthcare, an Edgarton, OH-based consulting firm primarily for ambulatory health care providers. "Then you can determine their real volumes before committing to a capital purchase," he adds. **(For more tips on what to do before buying new technology, see *Same-Day Surgery*, September 2003, p. 106.)**

RESOURCE

For more information, contact:

- **Cadmet**, P.O. Box 24, Malvern, PA 19355. Phone: (800) 543-7282 or (610) 640-1234. Fax: (610) 695-0290. E-mail: salesusa@cadmet.com. Web: www.cadmet.com.

What should you do if you bought the latest technology, but the physician no longer has a need for it? "Sell it!" Pence says. "Unless your storeroom is cavernous and you plan on creating an antique medical equipment museum, get rid of what you don't need or use." If you still are paying for it, selling it will reduce your expense and depreciation, he adds. "If it's paid for, you may put some money back into the pot and free up storage space," Pence says.

Consider these other suggestions for savings:

• Explore using non-name brands.

SurgiCenter of Baltimore found a Sony printer paper for the EVIS system that goes with their Olympus Endoscopy System that is clinically comparable but costs less than the Olympus paper, according to says **Rose Lambie**, RN, MEd, CNOR, director of surgical services at the center. The managers also found less expensive 300 watt Zenon light bulbs for the system by going through another company, she says.

The printer paper and light bulbs come from Cadmet, a Malvern, PA-based distributor of video/digital printing supplies and medical equipment. **(For information, see resource box, above.)**

The Sony print paper (product # UPC 5510) costs them $158 for 200 sheets, compared to $125 for 100 sheets for the brand-name product, Lambie says. The 300 watt Zenon bulb price (product # UPC 57000) costs them $350 vs. $514.80 for the name brand, she says.

• Order supplies weekly or biweekly.

At Mount Nittany Surgical Center in State College, PA, managers review the schedule for the upcoming cases, look at the amount of supplies on hand, and order accordingly, Pence says. "The physicians are aware of this process and are very conservative with the amount of supplies used," he says.

The system seems to work better than having a certain amount of supplies shipped each time, says Pence. "This also decreases the amount of storage space needed for the supplies and allows for better control over the cost of supplies," he notes.

The ASC should have minimal variety of drugs and supplies and nearly no duplicates, Pence suggests. This step reduces inventory and dollars.

"We periodically review the cost of each supply item our center uses to ensure it is as low as possible," Pence says.

• Consign your inventory.

Almost all inventory should be consigned, he says. "Why tie up the ASC's dollars?" With consignment, the consigned items are paid for as they are used. "The manufacturer/supplier carries the inventory overhead," Pence says.

The same principal applies to just-in-time supply deliveries, he adds. ■

Cataract study documents benefits of preparation

The fifth in a series of Cataract Extraction with Lens Insertion best practices studies recently released by the Accreditation Association for Ambulatory Health Care Institute for Quality Improvement (AAAHC Institute) shows that more intensive staffing and patient education can reduce the amount of time patients spend in the facility.

Seventy-one ambulatory surgery organizations participated in the study, and annual cataract extraction volume for these organizations ranged from 200 to 8,777 procedures.

Organizations that experienced the shortest pre-procedure times were those where the pre-op team reviewed procedures with patients well before the day of the procedure so the time devoted to the admission process was greatly reduced.

Other findings include:

- The median actual procedure time was 14 minutes. Those organizations with the shortest procedure times attributed the abbreviated time to standardized instruments, procedures, supplies, and equipment.
- New data gathered this year found that 47, or more than half the organizations included in the study, reported that they use more than one operating room per surgeon.
- More than two-thirds of the organizations studied standardize instrumentation for all of their physicians who perform this surgery.

[Editor's note: For more on this study, contact the AAAHC Institute at (847) 853-6060 or send a fax to (847) 853-9028. To purchase copies, go to www.aaahc.org, choose "education programs and products," then select "products." The cost of the study for organizations that did not participate is $50.] ■

Reader Question

Should staff wash their OR attire at home?

Are fleece jackets appropriate for the OR?

Question: I am looking for data to support washing warm-up jackets at home. We all have the same problem: If we send them to our laundry service, they never come back. Also, please give me any information on the type of material that can be worn in the OR. I have staff members who want to wear fleece jackets. I just can't agree to this, but I need documentation. Thank you for any help you can provide. — **Pam Neiderer**, RN, BSN, Team Leader, Clinical Services, Surgical Center of York (PA).

Answer: The Association of periOperative Registered Nurses (AORN) does not recommend home laundering surgical attire, including warm-up jackets, says **Ramona Conner**, RN, MSN, CNOR, perioperative nursing specialist at the Center for Nursing Practice of AORN in Denver. The "Recommended Practices for Surgical Attire" in *AORN Standards, Recommended Practices, & Guidelines* (2005), p. 299, states, "Laundering of surgical attire in home laundries is not recommended." AORN recommends that all reusable surgical attire be laundered in a facility-approved and monitored commercial laundry. Commercial laundries are required to follow strict guidelines that are often not found in home laundries including:

- proper and controlled water temperatures;
- use of detergents;
- use of oxidizing agents (e.g., chlorine bleach) in specified and monitored concentrations;
- repeated changes of water;
- dryer or iron and press drying temperatures.

Although AORN does not recommended home laundering, AORN is aware that some facilities require personnel to home launder surgical attire. If health care workers are required to home launder attire, steps should be taken to protect the home environment from possible contamination. Laundering practices similar to the commercial guidelines are recommended. These steps include:

- using an automatic washer and hot-air dryer;
- using water temperatures of 110º F to 125º F;
- using chlorine bleach;
- using detergent according to manufacturer's instructions;
- laundering surgical attire in a separate load with no other items;
- laundering surgical attire as the last load after all other items have been laundered;
- washing hands immediately after placing laundry in the washing machine;
- keeping laundry items completely submerged during the entire wash and rinse cycle;
- avoiding placing hands or arms in the laundry or rinse water to keep items submerged;
- thoroughly cleaning the door and lid of the washing machine before removing the laundered attire;
- using the highest drying setting possible that is safe for the material;
- promptly removing attire when dry.

Fleece warm-up jackets are not acceptable in the perioperative setting. The fabric used for surgical attire, which includes warm-up jackets and hats, should be nonlinting multiuse fabric. Fleece tends to lint or may harbor lint from other fabrics. Polyester, acrylic, and wool can be carriers of *Staphylococcus aureus* and *Pseudomonas aeruginosa* bacterial strains, two major pathogens commonly involved in health care-associated infections. Perioperative nurses and managers should consider this when evaluating scrubs or warm-up jackets to be used in perioperative settings. Appropriate surgical attire should be made of low-linting cotton blend fabric to minimize bacterial shedding and transmission, and provide comfort, safety, and a professional appearance. ■

SOURCE

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COMING IN FUTURE MONTHS

- ■ New technology helps mark surgical sites
- ■ Make waiting fun for patients' family and friends
- ■ Best practices in patient satisfaction
- ■ How to improve OR efficiency

CE/CME objectives

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. (See *Surgery centers say to payers: We are not going to take it any more!* in this issue.)
- Describe how those issues affect clinical service delivery or management of a facility. (See *Hospital cuts sharps injuries in the OR*.)
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *Improve collections with info and communication* and *Be aware of fuel sources, ignition to reduce fire risk.)*

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. ■

CE/CME *questions*

13. According to Lisa Spoden, PhD, executive director of the Ohio Association of Ambulatory Surgery Centers, if you're having problems with a particular payer and payment turnaround time, you should advise the payer of the statutes, meet with them and discuss the problems, and then, if you're not successful, you should:
    A. Sue them.
    B. Meet with your state department of insurance.
    C. Have your state or national association contact them.
    D. None of the above

14. According to clinical nurse specialist Sue Seitz, RN, MSN, CNOR, Greenville Hospital System finally obtained compliance with a neutral zone for the passing of sharps by doing what?
    A. Monitoring behavior in the OR and providing feedback on sharps injuries
    B. Providing education
    C. Putting up posters about reducing sharps injuries
    D. Playing games to educate staff about the neutral zone

15. How much information does Steve Wright, business office manager for Physicians Surgery Center, suggest that same-day surgery managers include in pre-op communications with patients?
    A. Only instructions needed to prepare the patient for actual surgery
    B. An estimate of the cost of the surgery and what insurance will cover
    C. An explanation of the patient's financial responsibility on the day of surgery
    D. B and C

16. What is one way that same-day surgery managers can reduce the risk of fire in the operating room, according to Richard J. Greco, MD, a plastic surgeon?
    A. Evaluate need for oxygen for every procedure.
    B. Only allow certain staff members to set up equipment.
    C. Limit the number of heat-producing items on the surgical field.
    D. Require male patients to shave mustaches and beards.

CE/CME answers

13. B **14. A** **15. D** **16. A**

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Be aware of fuel sources, ignition to reduce fire risk

How safe are your drapes, and do you really need to use oxygen?

Even though surgical-fire prevention is discussed by staff, sometimes, it takes a fire to make you realize how little you and your staff understand the risks of fire in an operating room.

At least, that's what **Richard J. Greco**, MD, a Savannah, GA-based plastic surgeon discovered when a fire occurred in his office-based surgery program. "My fire occurred many years ago, and there was not a lot of information on the causes and risks of intraoperative fires," he notes.

After his experience, Greco began to research the risks and discovered that although inpatient surgery programs paid attention to potential risks during lengthy procedures, surgery centers and office-based surgery programs did not take the risks as seriously because procedures performed in these locations were shorter and less complicated, he says.

"Fires have been reported in cases as small as the excision of a skin lesion," Greco warns. "If there is oxygen in use and there is a source of ignition such as a Bovie and there is something to burn, such as a drape, you can have a fire."

In recent years, two surgery centers in Illinois experienced fires and both involved hand-held Bovies that were not completely discharged, says **Jay Kiokemeister**, DO, president of the Illinois Freestanding Surgery Association.

"There were no injuries, but in one center, the Bovie was dropped into a trash receptacle that caught fire, creating the need to evacuate the center and causing significant damage to the building," he says. The other center experienced minor damage and did not evacuate the building because the Bovie was dropped into a heavily padded, plastic sharps container that did not burn as quickly, Kiokemeister adds.

"It is very easy to get busy and become rushed in a same-day surgery setting, but these fires point to the need to make sure employees are reminded on an ongoing basis to follow proper procedures with all equipment," he says. **(For more information about surgical fire prevention, see *Same-Day Surgery*, August 2003, p. 90.)**

Look carefully at your actions during surgery and evaluate what you can change to reduce the risks, Greco suggests. The staff of Effingham (IL) Surgery Center have looked carefully at potential causes of fires in the operating room. "We used a failure mode effect and analysis [FMEA] to identify the potential risks for surgical fire and to look at how we could minimize those risks," says **Leanne Bales**, RN, CNOR, administrator of the center. **(For more information on FMEA, see *SDS Accreditation Update*, July 2003, p. 1.)**

"I like the FMEA approach to potential problems because it is a proactive way to make changes and it gets staff members involved in the process," she notes. The five nurses who worked on the FMEA for fire in the operating room presented their findings to the staff in training sessions that included fire hats for the presenters and fireball jawbreakers for audience members who could answer questions about surgical fire risks, Bales says.

One key to reducing the risk of fire is to recognize the potential for one to happen, she adds.

Awareness of the increased risk of fire when oxygen is in use is key, Greco explains. In fact, he suggests surgeons evaluate their need for oxygen prior to any procedure.

When patients are sedated without an anesthesiologist in an office-based program, surgeons

tend to give oxygen routinely because it does ensure the patient maintains a good oxygen saturation rate, Greco says.

However, this is not always necessary, he adds. "If a surgeon uses pulse oximetry to monitor the patient during the procedure and administers oxygen only when necessary, the potential risk of fire is minimized because you've removed a combustible gas from the operating room," Greco explains.

If oxygen is used, use the lowest concentration necessary and use it in the open as opposed to allowing it to pool under surgical drapes, he recommends. "If it has to be administered under drapes, be sure you vent or suction the extra oxygen from under the drape," he says.

Finally, if you must use oxygen and you will be using an ignition source such as a laser or Bovie, be sure to turn off the oxygen and allow it to dissipate before turning on the laser or Bovie, Greco suggests. "There is no magic number for the amount of time you must wait for oxygen to dissipate, but any delay before activating a Bovie or laser will reduce the risk of ignition," he says.

The oxygen-use policy at Effingham Surgery Center requires the oxygen to be turned off one minute prior to activating a device such as a cautery, Bales says. "If the cautery is used on the face or neck area, the oxygen must stay off one minute after the cautery is turned off," she adds.

Operating room staff need to remember that they may smell smoke before they see fire because fluids used to prepare the surgical area may pool under the drapes and ignite where they can't be seen, Bales says. "Even if the flame is not hidden, in an oxygen-rich environment, a blue-flame may not be easily seen before drapes catch fire," she points out.

Once a fire is ignited, it needs fuel to burn, so you also need to look at drapes carefully, Bales adds. "Price is important when you evaluate drapes, but you also need to remember that some drapes burn more quickly than others. Vendors do have information on how quickly their drapes burn, but we don't take anyone's word," she says.

When evaluating drapes, Bales and her staff conduct their own burn test by placing a cautery against the drape and timing how quickly the drape catches fire and burns. While the test is designed to simulate real situations, staff members have water and fire extinguishers handy to extinguish fire quickly, she says. "We've found that you don't have to buy the most expensive drape to improve safety, but you do have to know what you're buying," she adds.

SOURCES

For more information about surgical fires, contact:

- **Leanne Bales**, RN, CNOR, Administrator, Effingham Surgery Center, 904 W. Temple Ave., Effingham, IL 62401. Phone: (217) 342-1234. E-mail: lbales@effinghamsurgerycenter.com.
- **Richard J. Greco**, MD, FACS. The Georgia Institute for Plastic Surgery, 5361 Reynolds St., Savannah, GA 31410. Phone: (912) 355-8000. Fax: (912) 355-8403. E-mail: plastxdoc@aol.com.
- **Jay Kiokemeister**, DO, President, Illinois Surgery Center Association. E-mail: jfcookie@comcast.net.

Pay attention to the manufacturers' recommendation for number of layers of drapes, Bales says.

"If you use too many layers, you give fire a chance to smolder and build into a more severe fire before you smell the smoke or see the flame," she explains.

Hair is also good fuel for fire, so staff members at Effingham Surgery Center use a water-based petroleum jelly to coat patients' mustaches, beards, pubic areas, and eyebrows, Bales adds.

"A single piece of hair can fuel a fire, so this is a simple precaution that can reduce risk of injury to a patient," she explains.

Another simple procedure that will reduce the risk of fire is for a nurse to tell the surgeon where the foot pedal has been placed, Bales says. This prevents accidental triggering of devices such as lasers, she says.

To avoid accidentally triggering other devices such as disposable cauteries, Bales has her staff remove the wire at the end of the instrument. "If the cautery is dropped into a container and the button is activated, the wire will get hot and cause a fire," she says. Removal of the wire prevents this situation from happening, she adds.

Make sure your staff are prepared in case of fire, Bales notes. "We have developed policies designed to help staff handle fire quickly so we can avoid injury to the patient and staff," she says. **(For tips on how staff members should handle fire, see story, p. 3.)**

The most important part of fire prevention is to make sure the topic is part of day-to-day activities, Greco stresses. "Talk about fire prevention, discuss the issue of oxygen with anesthesiologists before procedures, and actively think about what the risks might be and how they can be reduced," he says. ■

Make sure your staff are ready if fire breaks out

Have supplies and information at hand

Although it is important to focus upon fire prevention in the operating room, don't forget to look at your staff's readiness to fight fire and treat a patient if a fire does occur, recommends **Leanne Bales**, RN, CNOR, administrator of Effingham (IL) Surgery Center.

"If you don't act quickly when you first detect a fire, you risk harm to the patient and staff members," she points out. The first step is to turn off oxygen immediately, Bales says. "Even if the fire doesn't begin near the airway, the oxygen will support combustion," she explains.

The most basic supply to keep immediately available is a bowl of water or saline, Bales says. "We make sure this bowl is restocked after every case because it can be enough to put out the initial fire," she adds.

If you do have to douse part of the drapes when there is a spark that starts to burn them, be sure to remove all drapes and re-drape the patient, Bales recommends.

"This is the only way to make sure that no other sparks have occurred under the drapes where you can't see them," she says.

Be sure your employees have a system that easily alerts other staff members that a fire has occurred. "In addition to pull boxes, we have a wireless system that requires the push of one button to send a message to a panel in our post-op area that indicates the location of a fire," Bales notes.

"Our post-op nurses are the most likely group that can leave the area to offer assistance and to make sure the appropriate emergency response plans are activated." If there are patients in recovery, a nurse stays with them while others go to help, she adds.

The one-button system is preferable to having to pick up a telephone and dial a number to trigger the alarm because it saves time, Bales says.

Also place instructions on how to care for a burn patient in the operating room, she suggests.

"Although we have the telephone numbers for the local hospital burn unit and the helicopter or ambulance service in a central area in the surgery center, in an emergency, the operating room staff who are caring for the patient needs the information immediately," Bales says.

One guide that the managers compiled from various sources includes this information along with care instructions regarding fluid control, pain control, and wound care prior to transport will make sure that the staff has the information needed to care for the patient, she adds. ■

AAAASF revisions simplify some requirements

Organization addresses needs of varied specialties

The 2005 standards revisions for The American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) in Gurnee, IL, simplify the requirements for the increasing number of office-based surgery practices seeking accreditation.

"Our association began by serving plastic surgery practices, but we've grown to include a variety of specialties such as pain management, urology, and podiatry, so we need to make sure that our standards are generic enough to be applicable to these practices while still demanding the same quality of care," explains **James A. Yates**, MD, a plastic surgeon in Camp Hill, PA, who serves as AAAASF's president.

"This increase in the variety of specialties is the major reason for a change that allows highly trained physicians with an American Board of Medical Specialty certification in a nonsurgical specialty to serve as facility directors in AAAASF-accredited facilities," he adds.

Direct observation requirement

A revision to standard 310-020 requires that a recovering patient be under direct observation until discharged from monitored patient care.

"The old standard would allow video monitoring, but we believe that it is safer to have a physician, recovery room nurse, or other clinical staff member with the patient," Yates says.

AAAASF-accredited facilities are required to have staff members with advanced cardiac life support (ACLS) training on site, and physicians are responsible for the patient until the patient physically leaves the facility, he adds.

"This means that you are responsible for the patient even when he or she is waiting in your

SOURCES

For more information about American Association for the Accreditation of Ambulatory Surgery Facilities' (AAAASF) standards changes, contact:

- **James A. Yates**, MD, Plastic Surgery Center, 205 Grandview Ave., Corporate Place, Suite 401, Camp Hill, PA 17011-1714. Phone: (717) 763-7814. Fax: (717) 763-4918. E-mail: jay5plas@msn.com.

For information about accreditation by AAAASF, contact:

- **American Association for the Accreditation of Ambulatory Surgery Facilities**, 5101 Washington St., Suite No. 2F, P.O. Box 9500 Gurnee, IL 60031. Phone: (888) 545-5222 or (847) 775-1970. Fax: (847) 775-1985. Web: www.aaaasf.org.

reception area for a family member to pick them up," Yates explains.

"We also changed the wording for standard 800-002 to indicate that narcotics and controlled substances must be adequately secured, not portable, and under supervision," he explains. This replaces the requirement that narcotics be double-locked, Yates says. "We could not find any scientific evidence or reason that a double-lock system is more secure or is necessary," he adds.

One change in standards that will make it easier for physicians in some areas to gain accreditation for their office-based surgery practices is related to hospital privileges.

"We had required that a physician have hospital-admitting privileges in case a patient needed admission directly from the physician's office," Yates continues.

This presents a problem in some areas in which hospitals don't grant privileges to certain specialties or restrict admitting privileges to physicians that are part of specific health networks, he explains.

If a physician does not have admitting privileges but does have an agreement with another physician with privileges who will accept the transfer of patient care and admit the patient to the hospital, the physician's facility will meet the requirements of the standard, Yates adds.

AAAASF surveys facilities under three categories that have different requirements based upon the type of anesthesia used. Facilities are surveyed as Class A, B, or C. Class A facilities use only local or topical anesthesia, Class B facilities use local or topical in addition to regional anesthesia and analgesia, excluding propofol, without the use of intubation, and Class C facilities use the more complex anesthesia including propofol, epidural, spinal, and laryngeal intubation, says Yates.

"We have many organizations that are using propofol or may want to use it but don't utilize epidural, spinal, or laryngeal intubation anesthesia, but they have had to meet all the requirements for a C facility," he explains.

A new category, C-M, will allow facilities that use propofol but not the other types of C-class anesthesia to meet the standard without having the equipment and supplies required for the other types of C-class anesthesia.

"This is a category that many plastic surgeons will move toward because it gives them the flexibility to use propofol without investing in equipment and supplies that they won't use," Yates adds. ■

AAAHC accreditation conferences coming up

The Wilmette, IL-based Accreditation Association for Ambulatory Health Care's (AAAHC) 2005 Achieving Accreditation conferences will focus on 2005 standards changes, including the completely revised Chapter 5: Quality Management and Improvement.

Designed to help organizations prepare for accreditation or re-accreditation, this interactive 1½ day program provides in-depth information regarding AAAHC standards and the survey process.

The conferences are led by AAAHC surveyors and will be held in Denver, June 24-25 and in Baltimore, Sept. 23-24.

The conference fee is $560 for the first registrant from a nonaccredited organization and $515 for the first registrant from an accredited organization, with discounted registration for additional attendees from the same organization.

For questions or more information, contact AAAHC at (847) 853-6060, or register by going to the web site at www.aaahc.org, click on "Education Programs and Products," then select "Education Programs." ■