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IN THIS ISSUE

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Do you benefit from these surgeries? *Consumer Reports* says maybe not

Magazine tells patients to check out safer alternatives

Warning: *Consumer Reports* is telling your patients that they may not need surgery. The popular magazine recently posted an article that says there are 12 procedures that may be overperformed, and it goes as far as referring to bloodletting and lobotomy as examples of popular procedures that later proved ineffective or dangerous. (To view the article, go to www.consumerreports.org/mg/free-highlights/manage-your-health/needless_surgeries.htm.) Knee debridement and lavage also is given as an example. The article credits the Rand Corp. in Santa Monica, CA, as the research source for its list of procedures that may not be necessary.

Consumer Reports says overuse of surgeries typically occurs when surgeons don't keep up with the research, rush to perform new approaches before their safety and effectiveness has been documented, and when they recommend a procedure that hasn't been proven without describing other options.

"It is true that a number of medical procedures previously thought helpful have been shown to be of little or no use," says **Thomas G. Stovall**, MD, clinical professor of obstetrics/gynecology at the University of Tennessee,

HHS: ASC list will include all procedures except for those with risks, overnight stays

Michael O. Leavitt, secretary of the Department of Health and Human Services (HHS), has announced that HHS will propose including all outpatient surgical procedures on the list of approved procedures for ambulatory surgery centers (ASCs), except for those that department officials think would pose a significant safety risk in a center and those that would require an overnight stay.

*(See **HHS list**, page 16)*

EXECUTIVE SUMMARY

Consumer Reports is telling patients that there are surgical procedures that may be overused because some surgeons aren't keeping up with research, they are rushing to perform new approaches, and they are recommending procedures that haven't been proven.

- Sometimes there isn't adequate scientific information or proper studies before a procedure is introduced, one surgery source admits.
- Some of the information in the report in misleading and/or incomplete, sources say.

Memphis. "This generally comes about secondary to a lack of scientific information or the lack of proper study being done before a procedure is introduced."

Even with the rigid clinical studies required to approve a new drug, members of the medical community have seen instances where new or unusual side effects occur after the drug is released, he points out. "With surgical procedures and other medical devices, these controls are lacking."

Here are some of the specific procedures for which *Consumer Reports* issued warnings:

• **Surgical weight loss.** The number of people having bariatric surgery quadrupled between 1998 and 2002, the article reports. While acknowledging that the procedure appears to cause a significant amount of long-term weight loss in the severely obese, it goes on to say the operations are "highly invasive." It warns of potential complications and says that one of every 200-300 patients dies. It recommends weight-loss surgery as a "last resort" for the extremely obese, those who have weight-related medical conditions, and those who have unsuccessfully tried to lose weight with other methods.

The article mixes fact with fiction, says **Neil Hutcher**, MD, president of the American Society for Bariatric Surgery. "These are isolated facts taken out of context and out of the reality of the situation," he adds.

For example, there is no medical treatment for morbid obesity, Hutcher emphasizes. "I would be happy to debate anybody, anytime that bariatric surgery is the most rehabilitative treatment in modern medicine today," he says. "In one treatment, you can cure diabetes, heart disease, hypertension, obstructive sleep apnea, hyperlipidemia, control arthritis, control spastic incontinent bladder, and make the patient feel better about himself or herself."

Additionally, most patients suffering from morbid obesity are desperately ill, he says. "The trivialization of what a morbidly obese person goes through, the fact that they seek surgery — is totally misleading and not accurately represented," he says.

• **Prostatectomy.** While *Consumer Reports* acknowledges that prostatectomy appears to cut the opportunity for recurrence of prostate cancer

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slightly better than radiation therapy does, it goes on to warn of complications such as impotence and incontinence.

Durado Brooks, MD, MPH, director of prostate and colorectal cancer at the American Cancer Society, argues against the tone of the article. "It made it sounds as if surgeons are knowingly operating on people who do not need surgery," he says. "That is not the case."

The article is incomplete, Brooks says. "It's not as easy as this makes it sounds to determine whether or not surgery is the best route."

Clearly, there are some men undergoing surgical removal of prostate gland or radiation treatment who will not benefit from the procedures, he says. "But selecting which men will benefit and clearly identifying those men that don't need active treatment is a challenge," Brooks says. "We simply don't have accurate enough testing methods to make that determination with absolutely certainly."

Men need to know their options other than surgery for addressing prostate cancer, he urges. "They need to be educating themselves about all of these options and potential complications and side effects related to treatment and making a decision based on their personal preferences," Brooks says.

• **Hysterectomy.** While hysterectomy is absolutely needed in some circumstances, less invasive treatments are appropriate in other cases, according to *Consumer Reports.* Hysterectomy poses unusual surgical hazards, such as reduced sexual pleasure, the magazine says. It also says conditions that most often cause pelvic pain or abnormal bleeding, such as endometriosis, can be treated less aggressively. For example, surgeons can remove just the fibroids or use endometrial ablation, it says.

Stovall offers this viewpoint: "For many patients, hysterectomy is the appropriate procedure and an answer to the patient's problem. The patient should talk with her doctor, ask questions, and determine if there are other alternatives that she is willing to try, he says. "No single treatment or procedure is right for any patient and any time."

• **Enlarged prostate procedures.** Transurethral resection of the prostate (TURP) is very effective but causes infertility and retrograde ejaculation in most men, the article says. Additionally, it causes complications, including serious bleeding, in about 10% of patients, *Consumer Reports* says. It discusses simpler treatments for prostate enlargement but says all of them are usually unnecessary, as 30% of men usually get better without them.

J. Brantley Thrasher, MD, spokesman for the American Urological Association and chairman of the department of urology at the University of Kansas, says he doesn't basically disagree with the points in the article. However, from before the time there were alpha-blockers and finasteride (Proscar), "TURP has been the gold standard," he says. "For every treatment that a reader sees or hears about, it has to be compared to the effectiveness of TURP."

Thrasher acknowledges that the procedure has several side effects, and he says that a thorough history and physical is critical in determining the best course of treatment. He also points out that urethral stricture has similar symptoms to an enlarged prostate and should be ruled out before surgery. "Once that's done, I like to treat patients most of time from less invasive to more invasive, along that spectrum," he says. Most patients would rather take a pill than undergo any type of surgery, regardless of how invasive it is, Thrasher emphasizes.

• **Lumbar laminectomies and cervical discectomy.** *Consumer Reports* points out that operations for low back pain have increased from about 190,000 annually in the 1980s to more than 300,000 per year today. "Many of those operations are probably unnecessary," the magazine says. The most common cause of low back pain is a minor problem that usually goes away within about a month, the article says. Even pain from a herniated disk resolves itself within six weeks about 90% of the time, the magazine says. Additionally, the benefits from having surgery apparently are temporary most of the time, it says. It quotes one long-term study as saying that people who waited had no more back pain than those who had surgery.[1]

Consumer Reports says surgery should be considered only under certain conditions, such as when other treatments, such as spinal steroid injections, have failed. **Stuart Weinstein**, MD, president of the American Academy of Orthopedic Surgeons, takes issue with the report. "I think it's very difficult to say that because the numbers of surgeries increased, it's unnecessary," he says.

However, Weinstein does say that surgery is indicated only rarely in acute situations. "With back pain, there is a logical order of nonoperative therapies and diagnostics before surgery," he says. **(See more procedures that *Consumer Reports* warns readers about on p. 16.)**

Reference

1. Weber H. Lumbar disc herniation. A controlled, prospective study with ten years of observation. *Spine* 1983; 8:131-40. ■

3 more procedures article warns against

In an article highlighting risks of several surgical procedures, *Consumer Reports* discussed the risks of angioplasty, including death in 2% to 6% of patients, and it questioned the long-term safety of drug-coated stents. The article advised patients to consider angioplasty plus stenting only in certain conditions, such as when tests show more than 70% blockage.

The issue of when to perform angioplasty is very complicated, says **Lloyd W. Klein**, MD, FACC, director of Clinical Cardiology Associates at Gottlieb Memorial Hospital, Melrose Park, IL, and professor of medicine at Rush Medical College in Chicago. "There isn't a very simple answer to this that will fit into a sound byte," he says.

Klein agreed with a source quoted in the *Consumer Reports* article to some extent.

"Interventional cardiologists, and cardiologists in general, are overutilizing the procedure and applying drug-eluting stents more aggressively in applying to different patients than what long-term studies allow us to conclude," he says. However, he described the article's viewpoint that interventional procedures should never be done unless medical therapy tries and fails as being "overly conservative."

The article also said that patients may be better off without these procedures:

- **Wisdom tooth extraction.** The magazine says there's little evidence to support the concern that routinely removing impacted wisdom teeth can prevent future problems. The article says the procedure causes postoperative pain and swelling, and also permanent nerve damage in about 1% of patients. Get a second opinion if the tooth isn't causing you any difficulty, *Consumer Reports* suggests.
- **Circumcision.** While acknowledging some medical benefits from circumcision, *Consumer Reports* mentioned the risks and says there's no clear justification from a medical standpoint. ■

HHS list

(Continued from cover)

"The letter is extremely significant as it is the first time that a senior HHS official has indicated support for the MedPAC [Medicare Payment Advisory Commission] recommendation to significantly expand the list, saving the program and its beneficiaries money," says **Kathy Bryant**, executive vice president of the Federated Ambulatory Surgery Association (FASA). "The letter from Secretary Leavitt indicates that CMS [the Centers for Medicare & Medicaid Services] is finally going to try to expand fully Medicare beneficiaries access to ASCs."

The change would come as part of the implementation of a new ASC payment system in 2008. Also, Leavitt announced that HHS will update the current ASC procedures list by July 1, 2007. The announcements came in a letter from Leavitt to Sen. Mike Crapo (R-ID), a sponsor of The Ambulatory Surgical Center Payment Modernization Act. That act would expand Medicare coverage for ASC services and revamp the ASC payment system. It would set the ASC reimbursement rate at 75% of the hospital outpatient department (HOPD) rate. Generally, ASCs would be paid in the same manner and for the same things as HOPDs, except ASCs would not be paid for outliers, graduate medical education, or capital. **(For more information, see "New payment system to be proposed for ambulatory surgery centers," *Same Day Surgery*, November 2005, p. 121.)**

Although the Leavitt letter indicates that the ASC list will be expanded significantly, it is not clear that it will go as far as the MedPAC recommendation, Bryant says. "For example, it does not indicate that CMS will use a list of what is not paid for in an ASC rather than what is," she says.

This process change is beneficial, Bryant points out. In addition the legislation also includes specifics on payment reform, she says. "Thus, FASA still believes the legislation is critical."

Leavitt is on target with his policy recommendation to expand beneficiary access to services within ASCs, says **Craig Jeffries**, Esq., executive director of the American Association of Ambulatory Surgery Centers (AAASC). "This recommendation is consistent with an earlier MedPAC recommendation to eliminate the ASC procedure list and reinforces a goal of Sen. Crapo's legislation — The Ambulatory Surgical Center Payment Modernization Act — to empower patients and their physicians to exercise a wider choice on where to have surgery," Jeffries says.

The big question is what will the department find to be a significant risk or require an overnight stay, says **Don May**, vice president for policy for the American Hospital Association in Washington,

DC. "It's unclear what the final ASC list will look at until we see proposals from CMS," he says. "It's just as likely more could be taken off the list than added, but it's hard to tell." **(For more information on ASC payments, see "ASC payments to be cut to hospitals' level," below.)** ■

ASC payments to be cut to hospitals' level

Decision is one year earlier than expected

Beginning Jan. 1, 2007, ambulatory surgery center (ASC) payments that are higher than hospital outpatient department (HOPD) payments for the same procedures will be reduced to the hospital rate, based on the budget reconciliation bill awaiting final Congressional approval at press time. This change will affect 280 procedures and amounts to $300 million over five years, according to the American Hospital Association, which says it is quoting Congressional Budget Office figures.

Procedures that will have their reimbursement reduced include dilate esophagus (43450), biopsy of prostate (21393), and sigmoidoscopy and biopsy (45331), according to the American Association of Ambulatory Surgery Centers (AAASC). **(See list of some of top procedures by volume and percent change, p. 18.** To see the entire list of procedures, go to www.aaasc.org/advocacy/documents/Impact of2005Legislationfinal1205.xls.) No change in payment occurs for the 2,267 procedures paid more in the HOPD than in the ASC, according to the Federated Ambulatory Surgery Association (FASA).

EXECUTIVE SUMMARY

As of Jan. 1, 2007, surgery center payment rates that are higher than hospital rates for the same procedures will be cut to the hospital payment level.

- This change affects 280 procedures, including after cataract laser surgery, injection paravertebral l/s add-on, dilate esophagus, biopsy of prostate, and sigmoidoscopy and biopsy.
- House-Senate conferees rejected a ban on physician-owned specialty hospitals. Instead, the Centers for Medicare & Medicaid Services can extend the moratorium for up to eight months to allow time for evaluation and action.

Officials with the ambulatory surgery center associations, including FASA, were quick to voice their negative reactions. "FASA finds it distressing that Congress adopted an almost 3-year-old recommendation without revisiting the issue," says **Kathy Bryant**, executive vice president.

When the Medicare Payment Advisory Commission (MedPAC) first proposed this system in 2003, ASCs responded with an aggressive campaign designed to show that reducing these procedures only made sense if also addressing the extremely low rates for other procedures, Bryant says. In 2003, Congress was convinced and instead required the Centers for Medicare & Medicaid Services (CMS) to develop a new payment system that would address issues across all procedures, she says. "Then out of the blue, this provision was added to the reconciliation bill," Bryant says. "Even ASC supporters in Congress were not consulted in advance."

The cap on ASC rates is notable for two reasons, says **Craig Jeffries**, Esq., AAASC executive director. "First, it underscores the vulnerability of the ASC industry to U.S. budget-driven changes in ASC payment," he explains. "And second, it reinforces that as an industry and as an organization, we have a great deal of work to do to improve our political strength that will help insulate us from arbitrary, last-minute actions by Congress."

AAASC already was aware that as of January 2008, CMS' new payment system would not pay ASC higher rates than hospitals for the same procedures. Congress' decision to make this change a year earlier is disappointing and will have at least a nominally adverse impact on most ASCs, AAAASC officials said in a release posted on the association's web site.

The change is part of the Deficit Reduction Budget Reconciliation Conference Report. There will be no changes for the procedures paid more in the HOPD than in the ASC. HOPD payments are expected to change in 2007, so some of the ASC procedures may not be affected, according to FASA. The newly passed bill also freezes physician fees in 2006. Current law would have reduced payment by 4.4%.

Moratorium extended for surgical hospitals

In other news, House-Senate conferees rejected part of the report that would have banned physician-owned specialty hospitals, including surgical hospitals. Instead, the conferees agreed that CMS should extend the moratorium for up to

Budget Reconciliation Provision on ASC Payments, Impact by Procedure Volume[1]

HCPCS Code	Short Descriptor	ASC Payment Group	2006 Payment Amount	APC	HOPD Payment Rate	Percent Reduction from ASC Payment	Difference in Base Rate Amount[2]	2003 Frequency in Case File (Volume)
66821	After cataract laser surgery	2	$446	0247	$290	-34.98%	-$156	269,108
62311	Inject spine l/s (cd)	1	$333	0207	$331.91	-0.33%	-$1.09	165,656
64476	Inj paravertebral l/s add-on	1	$333	0206	$309.48	-7.06%	-$23.52	47,115
64483	Inj foramen epidural l/s	1	$333	0207	$331.91	-0.33%	-$1.09	44,238
G0121	Colon ca scrn; not high risk	2	$446	0158	$441.10	-1.10%	-$4.90	37,447

1. This chart shows the impact of the policy change as if it were effect in 2006. The policy is not effective until 2007, but the American Association of Ambulatory Surgery Centers (AAASC) was unable to estimate changes in the HOPD payment amounts for the next fiscal year. The HOPD payment amounts are expected to increase by the change in the hospital market basket, and the relative weights of some procedures are likely to increase or decrease.
2. Difference in the unadjusted base payment amount for ASC and HOPD services.

Source: American Association of Ambulatory Surgery Centers, Johnson City, TN.

Budget Reconciliation Provision on ASC Payments, Impact by Percentage Change[1]

HCPCS Code	Short Descriptor	ASC Payment Group	2006 Payment Amount	APC	HOPD Payment Rate	Percent Reduction from ASC Payment	Difference in Base Rate Amount[2]	2003 Frequency in Case File (Volume)
13121	Repair of wound or lesion	3	$510	0024	$101.10	-80.18%	-$408.90	1,848
13132	Repair of wound or lesion	3	$510	0024	$101.10	-80.18%	-$408.90	4,796
13151	Repair of wound or lesion	3	$510	0024	$101.10	-80.18%	-$408.90	1,485
51772	Urethra pressure profile	1	$333	0164	$71.59	-78.50%	-$261.41	1,324
51785	Anal urinary muscle study	1	$333	0164	$71.59	-78.50%	-$261.41	2,162

1. This chart shows the impact of the policy change as if it were effect in 2006. The policy is not effective until 2007, but the American Association of Ambulatory Surgery Centers (AAASC) was unable to estimate changes in the HOPD payment amounts for the next fiscal year. The HOPD payment amounts are expected to increase by the change in the hospital market basket, and the relative weights of some procedures are likely to increase or decrease.
2. Difference in the unadjusted base payment amount for ASC and HOPD services.

Source: American Association of Ambulatory Surgery Centers, Johnson City, TN.

eight months to allow the agency to evaluate issues involving specialty hospitals and take action to address those issues.

At press time, the specialty hospital language was expected to be final, says **Molly Gutierrez**, executive director of the American Surgical Hospital Association. "The language that has been drafted and that we've seen thus far is a small victory for existing specialty hospitals," Gutierrez says. "Obviously we're discouraged/concerned about the continued moratorium, but we believe CMS will look at specialty hospitals as was addressed in the legislation and determine the industry is valuable as it is."

According to the American Surgical Hospital Association, CMS is to develop a strategic plan regarding specialty hospitals focusing on the following topics:

— proportionality of investment return (making sure that return on investment is not directly determined by the number of surgeries an investor brings to the facility);

— bona fide investment;

— annual disclosure of investment information;

— provision of Medicaid services;

— provision of charity care;

— a method of appropriately enforcing such strategic plan.

CMS is to issue an interim report to Congress in three months and must file a report describing its recommendations for a specialty hospital strategic plan within six months.

According to the American Surgical Hospital Association, this agreement is an expansion of an

effort already initiated by CMS administrator Mark McClellan. The expectation is that CMS will implement any required action or seek additional legislative authority within the first six months of 2006, according to the association. "Therefore, our battle is not yet over! In fact, we are simply experiencing a 'half-time' break," association officials said in a release posted on its web site.

A representative of the American Hospital Association (AHA) praised the bill. "It acknowledges Congress' concern about physician-owned limited-service hospitals that are not known for providing uncompensated care for indigent populations," says **Don May**, vice president for policy for the AHA in Washington, DC. "They're not known for being on the bus route, for being easy to get to for poor populations, and they put the entire health care system, in the communities that they're in, in a precarious situation."

CMS is conducting an analysis of these facilities, May says. "Are some of these even so-called hospitals? Or are they ASCs with two beds and one inpatient a week?" he asks.

Gutierrez notes that surgical hospitals are well established and "going strong" as actual hospitals with many inpatient procedures. "They do inpatient procedures and follow hospitals' licensure requirements," she says. ■

Technology reassures families in waiting rooms

Software tracks patients

(Editor's note: This is the second of a two-part series that looks at improving communications with family members of patients. Last month we learned about nurse liaisons that are responsible for updating family members. This month we will evaluate different technological ways to keep family members updated.)

Good communications with family members on the day of surgery is essential for reduction of anxiety in the waiting room, say experts interviewed by *Same-Day Surgery*. Some facilities are using technology to keep family members updated on the progress of their loved one.

"We have an electronic board in our waiting room that lists patient case numbers and indicates by color, where the patient is located," says **Lorraine Osborne**, RN, CPN(C), perioperative clinical educator at Kingston (Ontario) General Hospital in Canada. "If the patient is in the operating room, the color of the bar containing the information is green, then when the patient moves to recovery, the color changes to yellow," she explains. **(For information on vendors, see resource box, p. 20.)**

EXECUTIVE SUMMARY

Some programs are turning to technology to keep families informed on the day of surgery.

- Software programs that offer patient-tracking capability inside the OR also can be used to inform families in the waiting areas.
- Protect patient privacy by limiting information shown in public areas and by coding the patient's identity on the public screen.
- Make the process of finding information easy by choosing a self-scrolling screen rather than asking family members to input information on a keyboard.

Just watch the screen

Finding information is easy for family members because they don't have to do anything but watch the screen, Osborne points out. "The information continuously scrolls, so a family member just needs to look for the case number used to identify the patient," she says.

While her Canadian facility does not have to meet privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), a patient's privacy is protected because the screen in the waiting area contains only case numbers and the surgeon's name, says Osborne. "The case number is given to the family member on a small card so no one else knows the name of the patient," she adds.

The outpatient surgery staff members at Yale-New Haven (CT) Hospital also rely upon a patient tracking system that includes a component for family viewing in the waiting room, says **Jeanie Cacopardo**, RN, BSN, perioperative educator. The screens that are in the operating rooms or the surgical areas that are not open to the public contain more information about each patient, including names and type of procedure, but the family view screens only contain a code to identify the patient and location, she explains. As a patient moves from pre-op to the operating room,

staff members enter "leave" or "take" to indicate that the patient has left one area and been taken by the staff of another area, Cacopardo says.

"Most of the commands simply require the staff person to click on the information and drag it to the proper area, so it is not time-consuming," she adds. "Not only are we constantly aware of where the patient is located, but family members can see what is happening."

Family members love being able to immediately obtain information about the patient, says **Babette Edwards**, surgical services systems manager at Multicare Health System in Tacoma, WA. "They feel more involved and they are less anxious about the length of time they wait," Edwards says. "This helps our staff members and our volunteers who are in the waiting room, because they can immediately help a family member by checking their screens."

This system is more efficient than volunteers or staff members having to leave the waiting room to find someone who knows where the patient is located, then relaying the information back to the family member, she explains.

Edwards' facility opened a new surgical hospital last year that handles inpatient and outpatient procedures. "While most patient tracking systems with a family view feature can be run on a computer monitor, we opted to install larger screens that sit up on pillars so that they can easily be seen by people in the waiting room," she says. "There are two 21-inch screens in the waiting room with one facing in one direction and the other screen facing the opposite direction, so that no matter where in the waiting room you sit, you can see the screen," she says. The two screens scroll the color-coded case numbers continuously, she adds.

Avoiding initial confusion

Even if you have staff members or volunteers in the waiting room, it is a good idea to post instructions near the screen, suggests Cacopardo. "Some people see the slowly scrolling information, the numbers, and the different colors and find it confusing when they first look at the screen," she admits. "If you have posted instructions that include a reminder to look for the case number they've been given and explain the meaning of the different colors, they find it much easier to remember what they are waiting to see."

No matter how well your communications technology works, remember that your primary goal is to keep family members informed and less anxious, says Cacopardo. "If the patient is undergoing a long procedure, or if you've encountered a situation that will make the procedure last longer than the family member was told to expect, a nurse needs to go to the waiting room to reassure the family," she points out. "An electronic board, no matter how well it works, cannot offer the reassurance that a nurse can offer." ■

SOURCES/RESOURCES

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- **Hill-Rom**, 1069 State Route 46 E., Batesville, IN 47006. Hill-Rom offers NaviCare, a patient tracking system that can be customized to a facility's needs. While the price of the product is determined by an outpatient surgery program's specific requirements, the cost for the NaviCare software application, configuration, implementation, and annual support for a procedural area that does 5,000 cases per year would be about $150,000. For information about NaviCare, call (800) 445-3730 or (919) 854-3351 or go to www.navicare.com.
- **Per-Se Technologies**, 1145 Sanctuary Parkway, Suite 200, Alpharetta, GA 30004. Per-Se Technologies offers two products that add communication and patient tracking options to the ORSOS One-Call system that the company offers. The products, Big Board Module and PathFinder, are priced according to facility size and needs, but generally the Big Board expansion module for the ORSOS system costs between $20,000 and $50,000, and PathFinder costs $150,000 and up for software and service. For more information on these products, call (877) 737-3773 or go to www.per-se.com.

Same-Day Surgery Manager

Nurse manager retires, and other quandaries

By **Stephen W. Earnhart**, MS
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In this month's issue, I address some of your most pressing questions, including whether to replace a retiring nurse manager, motivation of long-time staff, use of a urology table for other procedures, whether to have separate staff and physician lounges, use of cell phones, and the most profitable specialty.

Question: The nurse manager of our surgery center is retiring next month after 20 years of great service to our center. We were informed today that the board is not going to replace her but rather have her functions absorbed by the administrator and the business office manager. Can they do that? I always heard that you must have a nurse manager in charge of clinical issues.

Answer: Not only can they, but it sounds like it is a good business decision your board has made. Your nurse manager was hired when you opened 20 years ago and when your administrator was not an RN. With your current RN administrator who was hired seven years ago, it sounds like your current administration can carry her current load and still maintain a credible presence to the clinical staff.

Question: I am finding it increasingly difficult to motivate many of my staff members into being cost- and time-efficient and effective. These are seasoned nurses and have been here for decades. What can I do to fire them up again?

Answer: It sounds like you have tried everything. Call it burnout or whatever you want, but sometimes you just cannot get staff to do what is required of them. It might be best to sit down with them on a one-on-one basis and plan their retirement.

Question: One of our surgeons is pushing us to bring a new urologist into our facility. The cost of the equipment is more than $240,000, and we cannot use the room for any other procedures. The urologist is trying to convince us that the "urology table" can be used for other specialties and it should not be considered just a "uro room." Have you ever heard of a "urology room" being able to be used for other specialties?

Answer: The equipment you are referring to is the split-tail, fixed-imaging operating table. It is for urology use only. While some might have found another use for that table, most of us have not. I believe you are correct in your thoughts that you can only use it for urological procedures.

Question: We are adding an extension to our facility, and the staff wants to separate the surgeon and staff lounges. Administration wants to have only one lounge in the facility. They said it will foster a feeling of closeness between the staff and the surgeons and that is a good idea to keep us all in one room. We think they are just being cheap. What do you think?

Answer: I agree with your administration: Keeping the staff and surgeons in one lounge does promote a greater sense of working together, and it helps to keep communications open.

Question: In one of your columns a few months ago, you said that cell phones should not be allowed in the operating room or the facility. I have young children and a sick mother and I need to be available immediately if they need me.

Answer: I had stated that the best policy is that cell phones stay off during working hours but be used during breaks and meals. You can give the number of the facility to caregivers or your children rather than your cell phone number. Another change you might consider is to leave the number of your workplace in your message should someone call you in an emergency.

Question: What specialty typically makes the most profit in a surgery center? We have a contest going here.

Answer: Based upon my experience: ophthalmology. Did I win?

Feel free to send your questions to me at the e-mail address below. All e-mails are handled as quickly as possible and with 100% anonymity.

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

Monitor utilization to ID nonproductive surgeons

Deadweight. Deadwood. Nonproductive. None of these adjectives are very flattering, and surgery center managers avoid using these terms to describe members of their medical staff; however, the reality for physician-owned surgery centers is that none can afford to have surgeons on staff who don't bring cases to the center.

This issue isn't just a financial one, says **Henry H. Bloom**, president of The Bloom Organization, a consulting and development firm for surgery centers. "I've managed centers in which this situation exists, and I've found that if investing partners are receiving distributions from surgery center profits but are using other facilities for their procedures, resentment among the partners is bred, and other partners begin to think about performing procedures at other facilities," he says. A general feeling of, "Why should someone else benefit from my commitment to the center when they have no loyalty?" does not create a good work environment for anyone in the facility, he adds.

From a regulatory perspective, you have to stay aware of anti-kickback laws that protect physician owners when they perform at least one-third of their surgical procedures in a facility in which they own, says **Joshua McKaye**, Esq., an attorney with McDermott Will in Miami. Safe harbor laws that define protections for physicians can be invoked as a reason for a physician partner to increase use of the center or opt to sell his or her shares back to the corporation, he says.

At Santa Barbara (CA) Surgery Center, "We don't use any safe harbor, or anti-kickback laws, as negotiating points with our physicians who are not productive," says **Michael Sawyer**, administrator. Because his participation agreements are based on level of investment rather than numbers of cases, Sawyer does not believe that the safe harbor argument is the best for his center.

"What we do focus upon up front is the likelihood and the good intention of the surgeon to use the center," he says.

Make sure that the surgeon's specialty, location, and patient base make him or her a good candidate not only as an investor, but also as a surgeon practicing in the center, Sawyer explains. "You will encounter some situations in which a surgeon plans to use the center, but as the facility is developed, plans change and it may not accommodate the surgeon's needs."

For example, Santa Barbara has one investor who is an ophthalmologist who specializes in retina procedures. "Three years ago, we planned to accommodate his needs, but we didn't know that the equipment would be so expensive and the reimbursement would drop to a level that it is not feasible to offer the service," Sawyer says.

The best way to deal with nonproductive surgeons is to craft your partnership agreement carefully, says McKaye. "I recommend that the governing document address the issue of deadweight physicians by contractually identifying events that can trigger a buyout of the physician's investment," he says. "A failure to perform one-third of procedures at the center, or even a majority vote of other partners when a partner fails to attend meetings or meet other obligations of the contract, such as quality assurance activities, can be two triggers."

Peer pressure among the physician owners can be very effective, says Bloom. "These physicians are all involved in the community, are usually friends or members of the same country club, and don't want to be seen a disruptive to a business venture," he explains. "If one partner is not meeting the contractual obligations, the other partners can vote that by not meeting the obligations, the nonproductive partner is not good for the business."

If the partnership agreement is specific about expectations and consequences of not meeting obligations, then approaching a nonproductive physician is straightforward, Kaye says. Buying out the physician's share of the business at a fair market price is the most common resolution, he adds.

Before reaching the point of buying out a physician's share of the surgery center, be sure you are monitoring utilization on at a least a weekly basis so you can identify problems early, Sawyer suggests. "If you see a drop in utilization, talk to the

EXECUTIVE SUMMARY

It is important to monitor physician utilization to keep a center financially healthy.

- Monitor utilization on a daily and weekly basis to identify problems early.
- Speak to physicians to discover reasons for lower utilization.
- Offer to evaluate pricing, payer contracts, and equipment to meet surgeons' needs.
- Educate surgeons' office staff members to make sure they understand benefits to patients as well as physicians to schedule procedures at your facility.

surgeon to discover the reason."

Many times you'll discover a need to educate the surgeon's office staff to address the problem, Sawyer adds. **(For tips on educating office staff members, see article, below.)**

If a surgeon is approaching retirement and scaling back on cases, be sure you talk to him or her about encouraging a new partner or the surgeon who will take over the practice to use the center, says Sawyer. Even if your partnership agreement requires that the retired physician sell back shares of the business, the new surgeon may be eligible as an investor and definitely will be able to practice at the center as a part of the medical staff, he adds.

The key to keeping physicians from becoming nonproductive is to communicate on an ongoing basis, says Sawyer. "I carve out one or two afternoons each week to visit our physicians to make sure everything is going well for them," he says. "I also use the time to update them on the center's activities."

Sometimes Sawyer uses this time to ward off problems and complaints. Recently, he knew that they had a very busy Friday schedule. "So I told a few of our key physicians that were scheduled that morning that the good news was our busy schedule, which was good for our bottom line, but that the bad news was that some operating rooms might not turn over as quickly," he recalls.

He told them that the staff would be doing their best to accommodate their schedules. "The physicians were all surprised that I came to their offices to tell them to expect the busy schedule, but none were unprepared for a busier-than-usual Friday at the center, so there were no complaints that day," Sawyer says. ■

Educate office staff to improve utilization

Surgeons may be the investing partners in your surgery center, but in many cases, it may be office staff who determine at which facility a procedure is scheduled. If you notice that a surgeon's utilization of your center is dropping, consider education for office staff to address the downturn, says **Michael Sawyer**, administrator of Santa Barbara (CA) Surgery Center.

"Some physicians rely upon their office scheduler, who may think that it is more convenient to schedule some outpatient procedures at the hospital on a day the surgeon is at the hospital for inpatient procedures," he points out. "By educating the scheduler as to the cost benefit to the patient whose overall financial responsibility will be lower in an outpatient center, as well as to the physician who is both an investor and has the equipment and staff ready at the center, we can usually get more procedures moved to the center."

Sometimes it is simply a matter of educating the surgeon's staff as to the expanded list of procedures that Medicare will reimburse in an outpatient surgery center or to the ability of the center to act as an out-of-network facility for some payers, he says. When the stated reasons for not scheduling procedures at your center are availability of operating room time, payer issues, or need for different equipment, be ready to make changes to accommodate the surgeon, suggests Sawyer. "It's important to make an effort to identify the reason for the downturn in the surgeon's utilization and to address it if possible." ■

CE/CME instructions

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

COMING IN FUTURE MONTHS

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CE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

5. When does *Consumer Reports* say that overuse of surgeries typically occur?

A. When surgeons don't keep up with the research, rush to perform new approaches, and when they recommend a procedure that hasn't been proven
B. When physicians have financial arrangements with equipment companies
C. When physicians hear about procedures at surgical conferences and consider those presentations to demonstrate adequate safety and research
D. When physicians feel pressured to perform minimally invasive procedures to facilitate earlier discharge

6. HHS will propose including all outpatient surgical procedures on the list of approved procedures for ASCs, except for which ones, according to Secretary Michael O. Leavitt?

A. Those that are paid more in a hospital setting
B. Those that require more than a 72-hour stay
C. Those that department officials think would pose a significant safety risk in a center and those that would require an overnight stay
D. Only those that department officials think would post a significant safety risk in a center

7. How can an outpatient surgery manager ensure that electronic message boards that convey information about a patient's progress through surgery do not violate privacy, according to Lorraine Osborne, RN, CPN(C)?

A. Place screen with information in a room separate from waiting area.
B. Make sure staff members are with family members when they access information.
C. List cases by codes, not names of patients, and give codes only to appropriate family members.
D. Only provide information for patients who have agreed to have this information made public.

8. According to Joshua McKaye, Esq., what is the best way to deal with nonproductive surgeons?

A. Decrease amount of operating time available to them.
B. Purchase whatever equipment they say they need.
C. Offer to cut prices for their patients.
D. Craft your original partnership agreement carefully to address nonproductivity.

Answers: 5. A; 6. C; 7. C; 8. D.