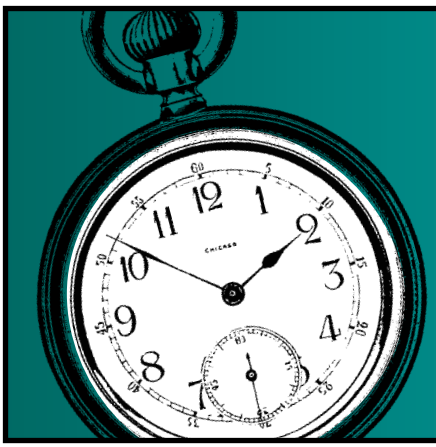

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IN THIS ISSUE

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Identity theft cases jump radically, outpatient surgery is at risk

Recent cases show need for you to address problem proactively

A patient goes in to a hospital for preoperative testing and ends up with more than $8,000 charged to fake accounts in his name at stores across his state.[1]

• Another patient takes his son to the emergency department at the same hospital and ends up with a $24,000 debt at Home Depot for an account falsely opened in his name.[2]

• Another hospital notifies 25,000 patients that their identities may have been stolen after two contract employees are arrested on charges of stealing personal information from surgery and emergency patients and charging thousands of dollars on fake credit cards.[3] Police says dozens of patients have come forward and said they were victims of identity theft at that facility. **(See details of these three cases, p. 27.)**

Identity theft at health care facilities is a growing trend. "We've seen a tenfold increase at medical billing companies where suspects come from the billing companies and are hired by the hospital through an

EXECUTIVE SUMMARY

Identity theft is increasing in health care, and outpatient surgery program may be particularly vulnerable because staff copy records for so many other parties. Consider these suggestions:

- Avoid using complete Social Security numbers as patient identifiers when possible.
- Communicate your expectations on confidentiality to your staff. Establish policies on physicians taking records off-site.
- Perform background checks on employees and contract workers. Limit employee access to Social Security numbers.
- Determine how to safely store patients' valuables during surgery.
- In the case of identity theft, follow federal and state laws and notify police.

outside agency," reports Sgt. **Pete Grimm** of the Redondo Beach, CA, police. In one case of identity theft, a thief was able to obtain a second mortgage on the victim's house, Grimm says.

Some health care facilities have reported break-ins in which the only thing stolen was medical records, says **Waldene K. Drake**, RN, MBA, vice president of risk management and patient safety at Cooperative of American Physicians-Mutual Protection Trust (CAP-MPT) in Los Angeles. For that reason, have good close-up procedures at the day's end, "maybe having two persons close up so there is no question that all was locked up appropriately," she advises.

Consider having medical records and files protected by alarms and motion detectors, sources suggest.

Outpatient surgery programs may be particularly vulnerable to identity theft because staff may be copying patient records for anesthesiologists, insurers, peer review organizations, and primary care physicians, says **Stephen Trosty**, JD, MHA, CPHRM, director of risk management and continuing medical education at American Physicians Assurance Corp. in East Lansing, MI. "The reality of it is, there isn't any 100% foolproof method to totally avoid it," he admits.

However, outpatient surgery managers can take steps to help prevent private information from being stolen. Consider these suggestions:

• **Determine whether it is necessary to obtain Social Security numbers from patients.**

When possible, avoid putting patient's Social Security numbers in their paperwork or on their wristbands, Trosty suggests.

Determine if you must use Social Security numbers as patient identifiers, Trosty suggests. In some instances, the answer still may be yes, he says, "but that's changing," he adds. "As that changes, health care entities need to keep up with those changes."

Many insurers are moving away from using Social Security numbers as identifiers because of the increase in identity theft, he points out. However, it may be necessary to continue to obtain those numbers for Medicare and Medicaid patients because governments typically use those numbers as patient identifiers, Trosty says. One option for other patients, and one that usually satisfies insurers, is to use the last four digits of a Social Security number, he adds.

• **Ensure background checks are performed on employees and contract workers.**

Perform background checks on your new hires, and if you contract for an outside service, ensure that the service is conducting these checks, Trosty says. **(For more information on background checks, see *Same-Day Surgery,* January 2006: "In light of 2 criminal cases, how do you ensure employees don't abuse patients?" p. 1; and "Take these steps to cut liability risk," p. 4.)**

"Ideally, you'd like to see if they're taking bonds on employees," Trosty says. "Some may not." There are two advantages to their having bonded employees, he says. First, if there is identity theft, money is

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3 cases of identity theft involve surgery, emergency deparments

1. A patient goes in to a hospital for preoperative testing and ends up with more than $8,000 charged to fake accounts in his name at stores across his state.[1]

In this case, a hospital spokesperson initially said there was no conclusive evidence that any hospital employee misused the surgical patient's personal information, according to a media report.[1] However, the report said:

—The arrest warrant said the person was able to obtain a credit card with information stolen by someone who worked at the hospital.

— The warrant said the employee stole patient information including names, birth dates, and Social Security numbers.

— That employee passed the information to the person who was arrested, who passed the information to an unidentified person in another state.

— The unidentified person would make up fraudulent operators' licenses and identification cards in the names of the patients, according to the warrants.

— The warrant identified that the hospital employee was fired from the hospital for violation of policy.[1]

2. A man takes his son to the emergency department at the same hospital and ends up with a $24,000 debt at Home Depot for an account falsely opened in his name.[2]

According to the media report:

— The person's name, date of birth, and Social Security number were used to open the Home Depot account.

— A third patient at the same facility, who had cancer and later died, also was a victim of identity theft.

— Police have arrested an employee of the hospital's affiliated medical school who had access to hospital records.

— She pleaded guilty to identity theft charges.[2]

According to police, all of the victims were in one department for tests.[1]

3. A hospital notifies 25,000 patients that their identities may have been stolen after two contract employees are arrested on charges of stealing personal information from surgery and emergency patients and charging thousands of dollars on fake credit cards.[3]

According to a media report:

— Both were employees of a photocopying company that the hospital hired to copy patients' medical records. The women also copies records for patients and attorneys.

— The photocopying firm says they are planning on conducting stronger background checks; however, the two arrested had no previous records.

— The hospital is offering credit monitoring and support for the affected former patients.

— The hospital is changing to electronic records, which will eliminate the need to contract for copying services.[3]

While a hospital spokesperson was quoted as saying only a very small number of patients were affected,[3] Sgt. **Pete Grimm** of the Redondo Beach, CA, police, says dozens of patients have come forward and said they were victims of identity theft at that facility.

References

1. Backus L. Hospital identity theft, Jan. 31, 2005. Accessed at www.zwire.com/site/news.cfm?newsid=3141153&BRD=1641&PAG=461&dept_id=10110&rfi=6.

2. Cohn A. Police connect hospital to identity theft cases. WTNH, May 25, 2005. Accessed at www.wtnh.com/Global/story.asp?S=3394079&nav=3YeXaJU3.

3. Kaiser South Bay Patients' Information Stolen. KCAL. Accessed at cbs2.com/topstories/local_story_005205257.html. ■

available to uncover the crime and offer restitution, Trosty says. Additionally, to be bonded, employees have to undergo a background criminal check, he says. "If you say, 'We only want to use bonded employees,' it provides financial protection if needed, but it's also an indirect way to find out if employees are clear."

• Limit access to patient records.

Ensure access to particular information in a record, such as a Social Security number, is on a need-to-know basis, Trosty says. To ensure that access is limited, install appropriate passwords and firewall protections in your electronic systems, he advises.

• Establish policies about removing medical records from your facility.

"One of our doctors called to say she had several charts in her possession and laid them down somewhere traveling from a store to the hospital, and they were lost," Drake says.

• Adequately secure patients' valuables during surgery.

Ensure that patients' wallets, which often have identification cards, and other valuable aren't stolen during surgery, Trosty advises. While some facilities put valuable items under the gurney or stretcher, you may want to insist that patients bring a relative or friend to hold their valuables during surgery to avoid them being taken, he says.

• In the case of identity theft, notify

RESOURCE

For more information on how to prevent identity theft, contact:

- **Federal Trade Commission**. Web: www.ftc.gov. Click on "consumers" and then "identity theft." Move your cursor to "business" on the left side of the page and then click on "Assisting Victims," "Dealing with a Data Breach," "Business Publications," and "Resources."

appropriate parties.

Some state laws require you to notify patients if you know of identity theft, Drake says. "A loss of patient information probably also should be reported to the police," she adds.

Also there are requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to correct the violation of privacy, take action against employees who violate HIPAA, and notify patients, sources say.

• Communicate expectations to employees.

Ensure employees and contracted employees are clearly taught about the confidentiality of patient records and the criminal intent charges that can occur, Trosty advises. "If someone is really determined to do identity theft, it won't prevent it, but you can show that, as part of your orientation or inservice, you reiterated the legality of that," he says.

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1. Backus L. Hospital identity theft, Jan. 31, 2005. Accessed at www.zwire.com/site/news.cfm?newsid=3141153&BRD=1641&PAG=461&dept_id=10110&rfi=6.
2. Cohn A. Police connect hospital to identity theft cases. WTNH, May 25, 2005. Accessed at www.wtnh.com/Global/story.asp?S=3394079&nav=3YeXaJU3.
3. Kaiser South Bay patients' information stolen. KCAL. Accessed at cbs2.com/topstories/local_story_005205257.html. ■

AORN addresses environment and safety

Tissue banking recommended practice enhanced

Reuse of single-use devices, environmental responsibility, and development of a patient safety culture are three of the new or significantly revised guidance statements to be included in the *2006 Standards, Recommended Practices and Guidelines* published by the Association of periOperative Registered Nurses (AORN).

The Reuse of Single-Use Devices guidance statement was updated significantly to reflect new Food and Drug Administration (FDA) requirements, including quality system regulations, says **Ramona L. Conner**, RN, MSN, CNOR, perioperative nursing specialist in the Center for Nursing Practice at AORN in Denver. "The statement addresses management, purchasing, documentation, and control of the process."

A beneficial portion of the guidance statement is a table that provides a cross-reference to relevant FDA regulations that apply to reuse of single-use devices, says Conner. **(See table, p. 29.)** "This table is very handy for people who are struggling to stay on top of regulatory changes and requirements," she explains. This table also is helpful for outpatient surgery managers as a guide to questions to ask of their reprocessor, Conner adds.

Reuse of single use devices also ties into a new guidance statement that addresses environmental responsibility, says **Jane Kusler-Jensen**, RN, MBA, CNOR, director of surgical services for Aurora BayCare Medical Center in Green Bay, WI. "The main concern is that we maintain the same quality when we reprocess; but if we can reprocess an arthroscopic shaver without compromising quality and use it five times instead of only once, we've cut down on the number of shavers in the waste," she explains.

AORN has had a recommended practice for environmental responsibility, but it was seldom

EXECUTIVE SUMMARY

The *2006 Standards, Recommended Practices, and Guidelines* for the Association of periOperative Registered Nurses addresses some key issues.

- A guidance statement for reuse of single-use devices provides a table that cross-references Food and Drug Administration guidelines to make requirements easier to understand.
- An environmental responsibility guidance statement includes links to resources that help managers identify ways to eliminate mercury, dispose of hazardous waste, and construct facilities for maximum efficiency.
- The importance of developing a patient safety culture that encourages the reporting of near misses is stressed in the new patient safety guidance statement.

Table 1

QUALITY SYSTEM REGULATION[1]	
Area Addressed	Code of Federal Regulations
Management responsibility	21 CFR, Part 820.20, 22, 25
Design controls	21 CFR, Part 820.30
Document controls	21 CFR, Part 820.40
Purchasing controls	21 CFR, Part 820.50
Product identification and traceability	21 CFR, Part 820.60, 65 [4]
Production and process validation	21 CFR, Part 820.70, 72, 75
Acceptance activities such as inspections, tests, or other verification activities	21 CFR, Part 820.80, 86
Nonconforming product control	21 CFR, Part 820.90
Corrective and preventive action	21 CFR, Part 820.100
Labeling and packaging controls	21 CFR, Part 820.120, 130
Handling, storage, distribution, and installation controls	21 CFR, Part 820.120, 140, 150, 160
Records including device master record, device history record, quality system record, and complaint files controls	21 CFR, Part 820.180, 181, 184, 186, 198
Servicing controls	21 CFR, Part 820.200
Use of statistical techniques to establish, control, and verify the acceptability of process capability and product characteristics	21 CFR, Part 820.250

1. *"Quality system regulation," CFR 21 Part 820, US Food and Drug Administration,* http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm?CFRPart=820*(accessed 3 Oct 2005).*

referred to and it did not provide a great deal of guidance, reports Conner. "We have added new information and upgraded the recommended practice to a guidance statement that does offer advice on how a surgery manager can create a green environment within his or her program." The guidance statement addresses the elimination of mercury, managing hazardous waste, disposal of chemicals, and recycling, she points out.

"There is so much information available for outpatient surgery managers about every aspect of environmental responsibility that we have also included web sites that have additional information," says Conner. "We have even found resources that focus on the environmentally conscious design and construction of health care facilities." **(For one web site included in the guidance statement, see resource box, p. 30.)**

Safe disposal of hazardous waste is one environmental responsibility that all outpatient surgery program staffs face, and it often can be a costly task, says **Ann Geier**, RN, MS, CNOR, CASC, vice president of operation for Ambulatory Surgical Centers of America in Norwell, MA. "I believe that everyone went overboard by red-bagging all waste, but now we look carefully at what is hazardous waste and what is regular trash," she says. It is too costly for centers to throw noncontaminated trash into red bags because most trash removal companies charge

SOURCES/RESOURCES

For more information on changes to guidance statements and recommended practices of the Association of periOperative Nurses Association, contact:

- **Ramona L. Conner**, RN, MSN, CNOR, Perioperative Nursing Specialist, Center for Nursing Practice, Association of periOperative Nurses Association, 2170 S. Parker Road, Suite 300, Denver, CO 80231. Telephone: (800) 755-2676 or (303) 755-6304. E-mail: rconner@aorn.org.
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- **For more information about developing an environmentally-friendly operating room**, go to www.noharm.org. This web site offers tips on how health care organizations can better handle waste disposal, elimination of mercury, disposal of chemicals, and construction for more efficiency.
- **To order a copy of the *2006 Standards, Recommended Practices and Guidelines***, go to www.aorn.org. Choose "products" on top navigational bar, then click on "2006 Standards" under the "Feature of the Month" section. Cost is $55 for members and $69 for nonmembers, plus $7 for shipping.

by the weight or the number of containers, she explains. **(For tips on how one center reduced waste disposal costs, see "Good studies take all shapes and sizes," *Same-Day Surgery*, October 2005, p. 116.)**

Avoid retribution for staff who report errors

Another new guidance statement calls for the development of a patient safety culture throughout the perioperative process, says Conner.

"It is in everyone's best interest to encourage staff members to report errors and near misses so that process changes can be implemented to prevent errors in the future," Conner says. A true patient safety culture that enables staff members to discuss close calls when there is no adverse outcome can be attained only if there is no fear of retribution, she points out.

Kusler-Jensen suggests, "You have to look at the situation — not the person — when there is an error. There will always be a chance for human error, but if you standardize your processes and have backup safety measures built into the processes, you reduce the opportunity for human error to harm the patient."

If there is a close call or an adverse outcome, look first at the process to see where the breakdown occurred, Kusler-Jensen recommends. If staff members understand that they can report near misses without automatically being accused of causing the error, then you will have a chance to learn about potential problems before they occur, she says. "We put the best processes into place that we can, but we will always encounter situations that we might not have considered," Kusler-Jensen says. "A patient safety culture gives everyone permission to point out what might need to be evaluated."

Tissue banking to reflect regs, standards

In addition to these new guidance statements, AORN's *2006 Standards and Practices* also will include a significantly updated recommended practice for tissue banking, says Conner. New FDA regulations, as well as accreditation standards for organizations accredited by the Joint Commission for the Accreditation of Healthcare Organizations, were effective in 2005, and the recommended practice reflects the more stringent requirements of these two organizations, she explains. The recommended practice addresses the specific requirements for storage of tissue, but the biggest change is related to documentation and tracking of the tissue, she says.

Kusler-Jensen says, "I believe that we have a good tracking system in place, but we will need to fine-tune it to make sure that we are recording maintenance of temperature throughout the whole process of receiving tissue. Everyone's concern is what happened during the shipping process, she says. For example, does it come to you by FedEx? How long did it sit on a loading dock? Was the proper temperature maintained throughout the time it left the tissue bank and arrived at your facility? "These are all questions that your documentation should address to ensure that the tissue is safe for your patient," Kusler-Jensen says. ■

Minimal sedation cuts costs, improves outcomes

Choose patients carefully and have a 'hand holder'

Thinking "outside the box" enabled the manager and medical director of the Elmira (NY) ASC to not only cut the cost of their procedure for patients, but also to make the patients' recovery more comfortable and quicker.

Elmira won a 2005 Innovations in Quality Improvement Award from the Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement for its solution to an anesthesia coverage challenge.

"Anesthesia coverage for our facility was 'iffy,'" says **Tom Friedrich**, administrator of the surgery center. "Because we only handle ophthalmology procedures, the anesthesiology group that provided coverage was losing money on the procedures they handled due to the Medicare reimbursement level." In addition, the anesthesiology group had concerns about being able to guarantee staff to cover the center, he adds.

"The anesthesiology contract was due for renewal, and we were told that they could not continue to provide coverage unless we subsidized their reimbursement," says Friedrich. "We renewed the contract for a short time with the subsidy in place as we studied our other options."

The other option that was chosen after careful evaluation was to eliminate the need for anesthesiologists by using only minimal sedation in the center. "Over 70% of our procedures are cataract surgeries," Friedrich reports. After reviewing studies and recommendations for reducing risks of anesthesia, the center's managers decided to pilot a project in which they used diazepam, an oral sedative, instead of intravenous (IV) sedation.

"Initially, some of our nurses were reluctant to make the change, and we did give them the option of not participating in the pilot project," he notes. Reasons for the reluctance included a concern that an anesthesiologist would not be available as a medical crisis manager, he says. Friedrich addressed this concern by making sure that a nurse trained in advanced cardiac life support is always on-site when there is a surgical patient in the facility.

"The surgeon prescribes the sedative, and nurses in the pre-op area administer it," he says. Monitoring and discharge protocols for conscious sedation that existed when anesthesiologists were on-site are still in place, with nurses monitoring the patient, he adds. Note that requirements for monitoring differ from state to state, Friedrich suggests.

Richard Rosenberg, MD, medical director of the center says, "I piloted the project, but soon all of the surgeons were using minimal sedation on all of their patients." The most difficult and surprising aspect of the change is that you are treating a patient who is awake, Rosenberg says. "Once a surgeon gets over the psychological aspect of talking to your patient during surgery, there are many benefits to minimal sedation," he says. "Patients are not asleep or lethargic, so they can look up or down as you need."

Physicians also can improve the patient-physician bond by talking through the procedure and explaining what they are doing, and what the patients may hear, Rosenberg says. Patients stay calmer during the procedure when they know what to expect, he adds.

EXECUTIVE SUMMARY

When faced with a requirement to subsidize anesthesiologists $100 per hour to ensure anesthesia coverage for their ophthalmology surgery center, administrators at Elmira (NY) ASC looked for safe options for intravenous sedation. After choosing to use minimal sedation on all patients, the surgery center staff noticed more than financial benefits.

- The patient-physician bond is strengthened by the physician's communication with the patient during the procedure.
- Patients can "help" physicians by looking up or down as needed.
- A staff member who holds the patient's hand has resulted in calmer, less anxious patients.

Hand-holder calms patients

Because the staff and physicians did not know what to expect in terms of patient anxiety when they first tried minimal sedation, a new position in the operating room was created to address anxiety.

"The most important part of this switch to minimal sedation is the hand-holder," says Friedrich. An employee with good interpersonal skills sits next to the patient and holds his or her hand, he says. The hand-holder will talk to the patient and explain what is happening, especially if the patient is showing signs of anxiety by squeezing the employee's

SOURCE

For more information about switching to minimal sedation, contact:

- **Tom Friedrich**, Administrator, Elmira ASC, 207 Madison Ave., Elmira, NY 14901. Telephone: (607) 734-2984. E-mail: tfriedrich@stny.rr.com.

hand a little more tightly, Friedrich adds. "We started with only registered nurses as hand-holders, but now we're letting surgical techs with the skills and knowledge needed to explain things to the patient fill the position as well," he says.

"When you use minimal sedation, it requires more communication with the patient throughout the procedure, but the combination of the surgeon and the hand-holder has produced very good feedback from our patients," says Friedrich. Knowing that someone will be sitting with them during the procedure to explain everything and just to be with them reduces patients' preoperative anxiety, he says. "When you reduce anxiety, the patient is more comfortable during both the procedure and the recovery," he adds. **(For another approach to reducing preoperative anxiety, see first study, this page.)**

The cost-savings to switch to minimal sedation is not related to drug costs, points out Friedrich. "The cost of the drugs for IV sedation compared to minimal sedation is similar, but we are not having to subsidize the anesthesiologists $100 per hour as their contract specified," he says.

There are other benefits, Friedrich says. "Our patients are not exposed to the risks of anesthesia, so we don't have the potential for medical complications related to anesthesia, especially with our older patients," he points out.

Cancellation rates dropped after the switch to minimal sedation because it is easier to obtain medical clearance for patients, Friedrich points out. "Patients also appreciate the fact that they don't have to make a separate visit to their primary care physician for medical clearance because our surgeons perform the pre-op evaluation," he says.

When performing the pre-op evaluation, you do have to be aware that some patients might not be appropriate candidates for minimal sedation, points out Rosenberg. "Patients who are claustrophobic may not be able to tolerate being awake during the procedure, and patients who are in the early stages of senility and can't control their anxiety are not appropriate candidates for minimal sedation," he explains. "You can also get a sense of how cooperative the patient might be during the procedure and if they are prone to panic during your pre-op exam."

Patients who are not appropriate for minimal sedation have their procedures scheduled at the hospital, says Rosenberg. "We've scheduled just a handful of patients for the hospital since we switched to minimal sedation, and we are actually able to schedule more at the freestanding facility because we can see patients with medical conditions that made them high risk ambulatory patients when we were administering anesthesia." ■

Saadat H, Caldwel-Andrews A, Drummond-Lewis J, et al. **Effect of hypnosis on preoperative anxiety in adult ambulatory patients.** *Anesthesiology* 2005; 103:A619.

Researchers at the Yale School of Medicine have shown that hypnosis can reduce preoperative anxiety for adults undergoing ambulatory surgery.

Participants in the study were split into two groups prior to their surgery. Within the preoperative holding area, one group of patients received empathic attention from a staff member who listened to the patient and offered support, and the other group of patients underwent a 45-minute hypnotic session with the suggestion of relaxation and well being by an anesthesiologist trained in hypnosis.

Prior to the hypnosis, anxiety levels of both groups of patients were similar. Following intervention, participants in the hypnosis group reported significantly lower levels of anxiety.

Calmer surgery patients are important because reports have shown pre-surgery anxiety to be linked to greater postoperative pain, increased need for painkillers, and longer recovery times, according to the researchers. ▼

Gordon NA, Koch ME. **Duration of anesthesia as an indicator of morbidity and mortality in office-based facial plastic surgery.** *Arch Facial Plast Surg* 2006; 8:47-53.

The length of time patients spend under anesthesia during outpatient facial plastic surgery

procedures is not linked to their risk of injury or death, according to a study in the January issue of the *Archives of Facial Plastic Surgery*.

In a study of 1,200 patients who underwent facial plastic surgery between July 1995 and February 2005, study authors found that 1,032, or 86%, were under anesthesia for more than 240 minutes. Participants who were in the longer anesthesia group underwent multiple facial procedures, while patients in the shorter anesthesia group had only rhinoplasty.

Each participant was monitored the day after surgery. No deaths were reported in the study, and the rate of complications was similar for patients in both groups. The authors report that there were no complications that are typically attributed to longer anesthesia times, including intractable postoperative nausea, vomiting, and pain.

The authors conclude that regulatory bodies that are creating surgical guidelines should have a detailed understanding of the specific risks associated with different types of surgery in order to avoid generalization and nondata-driven regulation. ■

Research help available to study pain

Web-based program provides tools, protocols

Between 50% and 80% of the 609 patients in a pain study conducted by the e-Pain Research Group in Montreal, had misconceptions about the pain they could expect after surgery and about the proper way to use medications to control pain.

Three of the six procedures studied were outpatient procedures: hernia repair, laparoscopic cholecystectomy, and knee arthroscopy. Patients who underwent these procedures also reported using herbs, acupuncture, massage, and physiotherapy to alleviate some of their pain.

The study was the first step in the development of the e-Pain Collaborative Network, a worldwide, web-based association of nurses, surgeons, and anesthesiologists who want to gain a better understanding of the pain levels in their own organization and protocols that can impact those levels.

"Our goal is to give surgery programs low-cost access to well-designed and structured protocols with pre-validated questionnaires that are ready to use," says **Jennifer Cogan**, MD, an anesthesiologist at the Montreal Heart Institute and one of the founders of the e-Pain Research Group. Not every surgical program has access to research resources that can develop tools that are needed to gather accurate data and compare that data with other organizations in order to benchmark progress, she says. "Our collaborative will not only allow participants to evaluate their own data, but also access the data collected across the network."

While the data collection tools and protocols used in the initial study were underwritten by grants, there will be a reasonable participation fee set to maintain the database on an ongoing basis, says Cogan. "I do not expect it to exceed $1,000 per year."

Other costs for participation are small

Other costs for participation are small, points out **Ann Robinson**, RN, CCRP, a research specialist at Boreal Primum, a health care research company based in Montreal. "Staff costs to conduct initial interviews and follow-up calls and to enter data are the primary costs," she says. A participant can choose from three levels of participation, she points out. Phase I measures postoperative pain levels on the day of surgery only. Phase II measures levels on the day of surgery and three months after surgery with questions related to quality of life and ability to handle activities of daily living. Phase III is the most comprehensive follow-up with information taken on the day of surgery, three months after surgery with questions about quality of life, and a description of medication or other pain control methods used, she says.

While collection of the data and comparison of data from organization to organization is beneficial to participants, e-Pain network members also

SOURCES

For more information about the e-Pain Collaborative Network, contact:

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will be expected to share their research findings through publication in clinical journals, says Robinson. "The best way for us to improve our understanding of postoperative pain is to share the data," she says. Because many clinicians outside the academic arena don't understand the process for publication, e-Pain network members will have access to people who can guide them through the process, she explains.

All of the data collection tools and protocols will be available on the web site (www.borealprimum.com), says Robinson. Data will be collected and evaluated through the same web site, she adds.

Pain is hard to evaluate, because it is different for each patient, Robinson admits. "We also see that some patients expect pain, so they don't let us know about it because they don't want to complain," she says. Studies conducted through the e-Pain network will enable clinicians to develop better treatment protocols and better patient education so that patients will know what may be normal, she adds.

With pain management becoming the focus of many organizations' improvement efforts, this is a good time for an association to research pain, says Robinson. "There have been so many options for pain control developed that it is important that we evaluate their use and find ways to prevent acute post-surgical pain from becoming chronic pain." ■

Operating costs vary widely in MGMA survey

Per-case costs range up to $1,430

In ambulatory surgery survey results recently released by the Medical Group Management Association (MGMA) with the American Association of Ambulatory Surgery Centers (AAASC), total operating cost per case varied from $343.49 for single specialty — gastroenterology centers to $1,430.88 for orthopedic surgery centers. **(For excerpted results, including multispecialty centers, see chart, below.)**

In addition to detailed cost data sorted by single specialty and multispecialty centers, the report sorts results by number of cases performed at centers.

The report is "a fantastic tool for improving the business of running your center," says **Craig Jeffries**, executive director of AAASC. "Each ASC has different needs/problems, and the report gives them a tool that helps address their unique issue."

Out of 1,117 surveys that were mailed, there were 166 responses, for a gross response rate of 15.87%. The respondents included 83 physicians, 74 joint ventures of several organizations, five hospital/integrated delivery systems, and one ASC management company.

Readers interested in purchasing Ambulatory Survey Center Performance Survey should call toll-free (877) 275-6462, ext. 888, or go to www.mgma.com. Click on "Store" and then "New releases." The cost of the report is $210 for MGMA members and $365 for nonmembers, plus $7.50 for shipping and handling. ■

Key Performance Indicators for Multispecialty/Single Specialty

	Multispecialty	Single Specialty — Gastroenterology	Single Specialty — Ophthalmology	Single Specialty — Orthopedic Surgery
	Mean	Mean	Mean	Mean
Total Gross Charges	$13,102,357	$7,489,709	$5,539,231	$8,828,930
Total Medical Revenue	$5,885,312	$3,811,428	$2,482,821	$4,364,437
Total Medical Revenue Per Case	$1,405.89	$629.76	$868.58	$2,141.01
Total Employed Support Staff	28.15	20.46	12.52	16.76
Medical and Surgical Supply Cost Per Case	$238.92	$47.61	$221.26	$481.97
Total Operating Cost Per Case	$939.18	$343.49	$599.93	$1,430.88

Source: Ambulatory Surgery Center Performance Survey, Medical Group Management Association, Denver.

Same-Day Surgery Manager

Should you shop for a better deal?

Management companies, mergers, and other issues

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

Question: Our facility is managed by an outside management company. We pay them 9% of net collected revenue, plus they have 15% of the equity in the center. This seems high. Is it?

Answer: I cannot comment on their agreement with you since I don't know the details. There are other firms out that that charge about half that amount and do not require equity. Maybe you should shop around for a better deal.

Question: Our hospital is about to merge with another system. They are going to turn our hospital operating rooms into only outpatient surgery suites and joint venture them with the docs that are here. It seems to make sense to us (the nursing staff). However, this place is huge, and we just don't see how it can be done. Have you heard of such a thing before?

Answer: It's more common that you might think. The long-term return on such a venture typically is more profitable than the current business. You are right to support the concept with your staff.

Question: I am getting burned out on the paperwork that we as nurses go through today. Is there an opportunity with your firm to be a consultant?

Answer: As a consultant, I am getting burned out on all the travel and would like to stay home at night and be with my family. (The grass is not always greener!)

Question: We are expanding our operating room here at _____ hospital. I am charged with the task of how many operating rooms we need to add. Is there any rule of thumb that I could use that would help me?

Answer: Yes. On average, inpatient surgical suites typically handle about 800 cases per operating room per year. Outpatient cases usually average between 1,200 and 1,500 cases per operating room per year.

Question: Who makes the best medical director for any operating room environment: a member of the anesthesia department or a surgeon?

Answer: I think a member of the anesthesia department has a broader picture of the needs of the department or facility. They are typically in the operating rooms daily or at least more often than the average surgeon, and they are usually considered more balanced in their treatment of the surgical staff. Often there are jealousies or friction between two surgeons when one is acting as the cop (which is often what a good medical director needs to be) in a facility. In my experience, anesthesia is generally more accepted in that role. ■

On-line report available for our subscribers

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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. ■

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.

9. What is one way to avoid identity theft with non-Medicare and non-Medicaid patients, and also satisfy insurers, according to Stephen Trosty, JD, MHA, CPHRM?
A. Use the last four digits of a Social Security number.
B. Use the Social Security number backward.
C. Don't use any numbers from the patient's Social Security number.
D. Use the entire Social Security number, but don't enter it electronically.

10. What is the key to successfully developing a patient safety culture, according to Ramona L. Conner, RN, MSN, CNOR?
A. Designate monitors for all operating rooms specifically to identify patient safety issues.
B. Ensure that safety guidelines are posted on bulletin boards.
C. Notify physicians of safety requirements.
D. Make sure your employees are encouraged to report errors and near misses without fear of retribution.

11. What is the biggest hurdle surgeons must overcome when switching from intravenous sedation to minimal sedation for their patients, according to Richard Rosenberg, MD?
A. Documentation of medication used.
B. Pre-op evaluations.
C. Operating on a patient who is awake.
D. Obtaining insurance company approval for the procedure.

12. What are the benefits of participation in the e-Pain Collaborative Network include, according to anesthesiologist Jennifer Cogan, MD?
A. Access to well-designed, validated data collection tools.
B. Additional information to provide to insurance companies.
C. Lists of medications that work well for pain management.
D. Job descriptions for staff members who are involved in the project.

Answers: 9. A; 10. D; 11. C; 12. A.