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IN THIS ISSUE

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When you have pregnant staff, protect them and their fetuses from harm

Don't put yourself at risk for sex discrimination — Follow suggestions

Several of your staff are in the first trimester of pregnancy. You're thrilled for them, but you want to make sure they aren't exposed to chemicals or radiation that might impair the fetus. One staff member brings in a note from her OB/GYN saying to follow guidelines for pregnant staff in the OR, but you can't find any state or federal guidelines.

You wonder if you should change any of their job responsibilities or schedules, but you don't want to be accused of discriminating. Discrimination against women on the basis of pregnancy is sex discrimination and is illegal under the federal Civil Rights Act and some state laws, according to a pregnancy guide published by the Washington Department of Labor and Industries in Olympia.[1] Subjecting a pregnant woman to an unwanted transfer is an example of discrimination.[1]

You decide to get your administration, employee health staff, and human resources department involved, but other members of your

EXECUTIVE SUMMARY

Managers can be proactive in protecting their pregnant staff from reproductive risks and protecting themselves from sex discrimination accusations.

- Schedule short breaks for pregnant women at least every two hours, and provide a place where women can rest.
- Pregnant staff should wear wraparound aprons to avoid radiation exposure. Make sure portable X-rays meet specifications for shielding and protection. Fetal monitoring badges can be worn under aprons.
- Waste anesthetic gases are not a danger with recovery systems, sources say.
- Pregnant women should avoid exposure to HIV infection, including contact with items possibly contaminated with blood of an infected patient.
- Pregnant women who are not immune to chickenpox and rubella should avoid people with those diseases.

leadership team dismiss your concerns and imply that you're crazy for pursuing the issue.

And the concerns don't end there. One surgical manager recently sounded this alarm on a listserv: *What are we doing for the nurse who doesn't realize she is pregnant? And when she learns the happy news, does she spend the next seven months terrified for her unborn because of exposures she unwittingly allowed?*

There are many areas of potential reproductive risks in outpatient surgery, according to sources interviewed by *Same-Day Surgery*. A generic list for all workplaces from the Washington Department of Labor and Industries says risks include heavy lifting, working more than 40 hours per week, certain chemicals, radiation, anesthetic gases, some infectious diseases, stress and fatigue, and standing for long periods of time. Prolonged standing can be associated with preterm birth, says **Barbara Grajewski**, PhD, senior epidemiologist at the National Institute for Occupational Safety and Health in Cincinnati, OH. Additionally, an organizational atmosphere of high strain, or "high demand but low control over how fast and what you do, has been linked to some adverse reproductive health outcomes," Grajewski says. Schedule short breaks at least every two hours, and provide a place where women can rest on their breaks, suggests the Washington Department of Labor and Industries.

Don't wait until you have a pregnant worker to put healthy policies and practices into place, the Washington agency advises. Consider these suggestions submitted by experts in the field:

- **Protect staff from radiation.**

When it comes to procedures involving radiation, "if there is any question about being pregnant, staff should always go the safest route: Wear a wraparound apron," says **Kathie Bailey**, LVN, CST, materials manager at Lakeview Surgery Center in West Des Moines, IA. At Lakeview, female staff sign a form letter for declaring pregnancy that addresses the health risks. **[Editor's note: A copy of this form is available with the on-line version of *Same-Day Surgery*. If you're accessing your on-line account for the first time, go to www.ahcpub.com. Click on the "Activate Your Subscription" tab in the left-hand column. Then follow the easy steps under "Account Activation." If you already have an on-line subscription, to go www.ahcpub.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose "Same-Day Surgery," and then click "Sign on" from the left-hand column to log in. Once you're signed in, select "2006" and then select the May 2006 issue. For assistance, call Customer Service at (800) 688-2421.]**

Lakeview has a variety of lead aprons available, Bailey says. "The younger females prefer wraparound, full-protection gowns." The advantage of the wraparound aprons is that if staff members have their backs to the field, they are protected, sources say.

However, pregnant women should be aware that lead aprons may be uncomfortable and can cause

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upper back and neck problems, cautions **Laura Welch**, MD, adjunct professor of environmental and occupational health at George Washington University in Washington, DC, and director of Silver Spring, MD-based Occupational and Environmental Medicine at the Center to Protect Workers Rights, which focuses on the construction industry.

Grajewski advises outpatient surgery managers to ensure that all machines that emit radiation, including portable X-rays, are within specifications for shielding and protection, "and make sure there's not undue scattering of radiation happening, especially with portable units."

Nina Johnson, RN, CNOR, OR coordinator at Mankato (MN) Surgery Center, says her big worry is for the nurse who doesn't realize she is pregnant. "My nurses know when one of us is 'trying to become pregnant' because that nurse starts wearing the maternity lead [apron] before she knows for sure," Johnson says. "Once pregnancy is confirmed, we monitor with the additional fetal radiology exposure badge."

• Monitor exposure limits for radiation.

At Lakeview, employees who are pregnant have the option of signing a declaration of pregnancy. Once signed, that form is placed in the employee's file, and exposure limits are monitored, Bailey says. If an employee does not declare her pregnancy, then no occupational exposure limits can be placed, according to Lakeview's policy. Pregnant employees may ask for a fetal monitoring badge to be worn under an X-ray apron, the policy says.

• Waste anesthetic gases not a danger with recovery systems.

The American Society of Anesthesiologists says that there is no evidence that trace concentrations of waste anesthetic gases causes adverse health effects of people working where scavenging of waste anesthetic gases is carried out.[2] "It is safe to try to become pregnant or work when pregnant in these locations," the ASA says.[2]

Waste anesthetic gases are one of the most well-studied reproductive toxicants, Welch reports. With anesthetic recovery systems, there no release of anesthesia into the staff members' breathing zone, she says. While many studies focused on specific older anesthetic agents such as nitrous oxide, Welch isn't comfortable saying the newer ones are safe. "Use best available practices, and control any exposure," urges Welch, referring to anesthetic recovery systems.

• Avoid exposure of pregnant staff to some infectious diseases.

RESOURCES

A publication and video/DVD titled *Waste Anesthetic Gases: Information for Management in Anesthetizing Areas and the Postanesthesia Care Unit (PACU)* is available from the American Society of Anesthesiologists. To access the free publication, go to www.asahq.org/publicationsAndServices/wasteanes.pdf. The video/DVD version is available for $10 plus $6 for shipping. Contact:

- **American Society of Anesthesiologists**, 520 N. Northwest Highway, Park Ridge, IL 60068. Telephone: (847) 825-5586, ext. 134. Fax: (847) 825-1692.

For more information on reproductive risks in outpatient surgery, contact:

- **National Institute for Occupational Safety and Health**, Cincinnati. Telephone: (800) 356-4674. Web: www.cdc.gov/niosh/topics/repro.
- **The MSDSSearch National MSDS Repository** provides free access to more than 2.5 million material safety data sheets. Web: www.msdsearch.com/msdssearch.htm.

According to the March of Dimes, women should avoid all possible sources of HIV infection before and throughout pregnancy, including contact with needles, razors, or other items possibly contaminated with the blood of an infected person.[3]

Also, pregnant women who are not immune to chickenpox should avoid anyone with the disease and anyone who has had contact with someone with the disease, according to the March of Dimes.[4] An infected person is contagious before he or she develops the disease, the association says.

If a pregnant woman is not immune to rubella, she should avoid anyone who has this illness, according to the March of Dimes.[5] There is no effective treatment for rubella during pregnancy, and there is no effective way to prevent rubella in a susceptible woman who is exposed to the illness, the association says.

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Will centers make money with the move to APCs?

Start analyzing now to prepare for change

As surgery centers begin to analyze how a new reimbursement system, if passed, would affect their income and bottom line, they are finding that future changes will be a mixed bag.

The Department of Health and Human Services (HHS) previously 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. The change would come as part of the implementation of a new ASC payment system in 2008.

In other action, a bill was proposed that 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 with transition provisions so that payments for specific procedures would not decrease.

Generally, ASCs would be paid in the same manner and for the same things as HOPDs, including implants. However, ASCs would not be paid for outliers, graduate medical education, or capital. **(For more information, see "HHS: ASC list will include all procedures except for those with risks, overnight stays," *Same-Day Surgery,* February 2006, p. 13.)**

On one hand, some specialties may experience significant reimbursement decreases. On the other hand, cases that previously were performed at a loss or were borderline may actually be profitable with new APC rates, says **Caryl A. Serbin**, RN, BSN, LHRM, president and founder of Surgery Consultants of America and Serbin Surgery Center Billing, both in Fort Myers, FL.

"An increased number of groups lead to more equitable reimbursement in most cases," she says. Instead of nine payment groups for surgery center procedures, they will be reimbursed under hundreds of ambulatory payment classifications (APCs). Serbin spoke on preparing for the new reimbursement system at the most recent annual meeting of the American Association of Ambulatory Surgery Centers.

The current nine payments groups aren't very logical because so many different types of procedures are put into the same group and reimbursed at the same rate, Serbin says. "This is one of those rare times that what the hospital is doing makes more sense," she says. "We don't want to follow all that they do, but we'd like to follow right behind them" with this.

To analyze the effect of a new system, which takes effect in 2008, consider the following suggestions:

• Determine future direction for cases that wouldn't be profitable.

For those cases whose profit appears threatened under the new reimbursement system, work with your physicians, suggests **Mike Pankey**, RN, MBA, administrator at Ambulatory Surgery Center of Spartanburg (SC). "We're trying to get them to get their costs down so we can continue to do the procedures," he says. For those procedures that won't be able to become profitable, Pankey is working to move those cases to the hospital that is in a joint venture with the center. "I hate to lose cases, but if I do 100 cases where I've lost money on every case, I can't continue to do that," he says.

Surgery centers can't bill for some outliers that hospitals can, Pankey says. "Hospitals are seeing an increase of approximately 3% a year, so the distance between hospital reimbursement and ASC reimbursement is now increasing," he says. Pankey points out that ASC reimbursement is flat

EXECUTIVE SUMMARY

Surgery center managers need to examine the impact of a proposed new reimbursement system, which probably will pay 75% of the hospital outpatient department (HOPD) rates.

- Gastrointestinal, pain management, and ophthalmology would be hit hard. Be sure you can cover your direct costs. Ear, nose, and throat cases would benefit.
- Begin discussions with your managed care payers concerning how your contracts will change.
- You may need to adjust your fee schedules to 350% of Medicare rates.

SOURCES

For more information on preparing for the upcoming reimbursement system for surgery centers, contact:

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until 2008 due to a freeze on Medicare rates.

"We want to market to new physicians where [proposed] changes have brought some procedures into the positive area for us and expand our services in those areas, and we want to minimize those areas where we may be losing money in cases," he says. **(See information on impact for specialties, this page.)**

• Determine impact with managed care.

Serbin is putting together spreadsheets for every managed care contract to determine where they are paying in comparison to 75% of the HOPD rate. "On paper, it looks like significant increases for many procedures we're doing," she reports.

One of the biggest changes will be the types of cases her centers can perform, Serbin says. "It will in the long run allow us to do more procedures, including ones we always knew we should do, such as lap chole, which weren't cost-effective to do in an ASC," she explains.

Orthopedics is another example, Serbin notes. She and other managers have been upset about how they've been reimbursed in terms of supplies and overall time. With the proposed system, "it's going to end up making it a fairer payment system for us," Serbin says. If surgery centers are able to charge for implants and other orthopedic items, as hospitals are, this will help some surgery centers to receive more reimbursement per cases, sources say.

While you can begin discussions with managed care companies about the new system, they are ill-prepared to deal with it now, Serbin warns. "There's no commitment one way or another," she says.

Centers that currently are reimbursed based on group rates will see a huge impact that will make their rates more equitable when the system changes, Serbin reports. If you have contracts that will continue into 2008, you must open the dialogue with payers, she says. Be sure you know your case cost prior to beginning negotiations, Serbin advises. "Say, 'We suspect a new system is coming. How will you handle it?'" she suggests. "Put language in there that says, 'When we have a change, you will follow Medicare guidelines.'"

The centers reimbursed on a percentage of charges won't see an impact, Serbin points out. "If you're in a percentage of billed charges, you don't want to have that conversation," she says. "You're better off, and you hope they will ignore it."

Pankey uses a physician-hospital organization to contract with managed care organizations. "I'm meeting with my rep to make sure she's aware of the changes coming and having her get in touch with payers regarding any changes to contracts," he says.

• Update your fee schedule.

Similar to her analysis of managed care rates, Serbin is beginning to look at how HOPD rates are paid, what expenses are grouped, and how she might begin to make a fee schedule based on these items. While surgery centers currently seek 350%-500% of Medicare rates, this range will have to be adjusted under HOPD rates, probably to a 350% markup of HOPD rates, she predicts, "Five hundred percent would be way too high," Serbin says.

Pankey says he hopes his contracts will hold up in under the new system, "but if Medicare goes down, the contract goes down," he says. "You can't just look at Medicare. You have to look at the whole payer mix and fee schedule." ■

Change to HOPD rates to impact specialties

Surgery center managers should determine how the new reimbursement system, scheduled to take effect in 2008, will affect their current case mix, suggests **Caryl A. Serbin**, RN, BSN, LHRM, president and founder of Surgery Consultants of America and Serbin Surgery Center Billing, both in Fort Myers, FL.

The new system is proposed to reimburse at 75% of the hospital outpatient department (HOPD) rate. To determine the impact, Serbin created a spreadsheet with some of the higher volume procedures

for the centers she manages. Then she looked at the rate change. Serbin determined, for example, that most ear, nose, and throat (ENT) procedures would increase, and her centers perform a significant number of ENT cases. "That's a specialty we want to continue to market to," Serbin says.

On the flip side, Serbin has to identify specialties that wouldn't be so fortunate, she says. "Ones that stands out the most, in terms of potential cuts, are GI [gastrointestinal procedures] and pain management," Serbin says. "If I were a center that did only GI and pain management, I'd be concerned, but there's not as much impact on multispecialty."

To determine the impact, you obviously have to know what your costs are, says **Mike Pankey**, RN, MBA, administrator at Ambulatory Surgery Center of Spartanburg (SC). "The general rule of business is that if you're covering your direct cost related to a case, you should continue to do it," he says. "If you can't cover your direct cost, you can't make it up in volume."

Pankey has been performing cost analysis on different specialties and determining how ambulatory payment classifications (APCs), the foundation of the new reimbursement system, would affect his center's reimbursement. In addition to pain management and GI, ophthalmology is an area of concern. "We do a lot of it, and it will be hit hard," he says. His center has been experiencing a 1% profit margin in terms of direct and indirect costs for those procedures, Pankey says. "We may not be able to cover our indirect costs, but we probably still can cover our direct costs," he says.

Serbin has determined the percentage of increases and decreases to be as follows:

• **Ear, nose, and throat (ENT).** Proposed rate ranges from a 30% increase (from $717 to $930.71) for tonsillectomy/adenoidectomy, ages 12 and older [Current Procedural Terminology (CPT) 42821] to an 82% increase (from $510 to $930.71) for tonsillectomy/adenoidectomy, younger than 12 years (CPT 42820);

• **Orthopedics.** Proposed rate ranges from an 11% decrease (from $1,339 to $1,197.73) for arthroscopy, wrist, release carpal ligament (CPT 29848) to a 265% increase (from $510 to $1,862.50) for arthroscopy, shoulder, decompression/acromio (CPT 29826) and a 265% increase (at the same dollar amounts) for arthroscopically aided anterior cruciate ligament repair (CPT 29888);

• **Urology.** Proposed rate ranges from a 60% decrease (from $446 to $177.54) for biopsy of prostate (CPT 55700) to a 145% increase (from $630 to $1,541.72) for prostatectomy [transurethral resection of the prostate (TURP), CPT 52601].

• **Podiatry.** Proposed rate ranges from a 14% decrease (from $1,339 to $1,154.03) for endoscopic plantar fasciotomy (CPT 29893) to a 159% increase (from $446 to $1,154.03) for bunion surgery, Keller type (CPT 28292).

• **Gynecology.** Proposed rate ranges from a 62% increase (from $446 to $723.40) for dilation and curettage [D&C (CPT 58120)] to a 258% increase (from $510 to $1,827.13) for laparoscopy with fulguration of oviducts by device (CPT 58671).

• **General surgery.** Proposed range ranges from a 21% increase (from $995 to $1,199.89) for repair recurrent inguinal hernia, any age (CPT 49520) to a 190% increase (from $630 to $1,827.13) for laparoscopy with repair inguinal hernia, initial (CPT 49650).

• **Gastrointestinal.** Proposed rate ranges from a 44% decrease (from $333 to $185.84) for flexible sigmoidoscopy, with biopsy (CPT 45331) to a 4% increase (from $333 to $345) for esophagogastroduodenoscopy [EGD (CPT 43235)];

• **Ophthalmology.** Proposed rate ranges from a 51% decrease (from $446 to $217.50) for after cataract laser surgery (CPT 66821) to a 138% increase (from $717 to $1,706.47) for repair of detached retina (CPT 67107).

• **Pain management.** Proposed rate ranges from a 30% decrease (from $333 to $232.11) for sacroiliac joint injection (27096, CPT G0260) to a 25% decrease for several procedures. ■

MedPAC recommends 2007 payment update

One system would lose $1.1 million in revenue

In the Medicare Payment Advisory Commission's (MedPAC's) March 2006 report, the commission recommends a 2007 update for hospitals of market basket minus half of the commission's expectation for production growth for outpatient and inpatient services.[1] The commission's productivity factor is 0.9% for 2007 deliberations. It's a 10-year average of the Bureau of Labor Statistics' estimate of economywide productivity growth.

MedPAC is an independent federal body that advises Congress on issues affecting the Medicare program.

"If approved, the proposed FY07 rate reductions will impact Clarian in real dollars," said

Dan Evans, CEO of Indianapolis-based Clarian Health Partners, which owns or is affiliated with 15 hospitals and health centers throughout Indiana and has more than 1.3 million outpatient visits annually.[2]

Evans testified at the House Ways and Means Committee's Health Subcommittee hearing on testimony regarding the report's recommendations. "From 2007 to 2009, we project that the reductions would cumulatively amount to $8.3 million in lost inpatient revenue and $1.1 million in lost outpatient revenue," he said.[2]

MedPAC recommended that these updates should be combined with a quality incentive payment policy for hospitals. The commission has said that a pay-for-performance program should:

- reward providers based on improving care and exceeding certain benchmarks;
- be funded by setting aside, initially, a small portion of payments;
- distribute all payments that are set aside to providers achieving the quality criteria;
- establish a process for continual evaluation of measures.[3]

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JCAHO changes focus on disaster preparedness

Use of volunteers, review of plans clearly defined

Same-day surgery managers and staff members will have more direction and some flexibility if they face a disaster that requires the use of health care volunteers or if they choose to stay open during a pandemic situation with new standards in the Joint Commission on Accreditation of Healthcare Organizations' hospital, ambulatory care, and office-based surgery standards that are effective July 1, 2006.

EXECUTIVE SUMMARY

On July 1, 2006, new and revised Joint Commission on the Accreditation of Healthcare Organizations' standards will go into effect. While most organizations already are performing many of the activities required to comply with these standards, some facilities may have to formalize their process to ensure compliance, according to **Michael Kulczycki**, executive director of the Ambulatory Accreditation Program at the Joint Commission.

- Specific criteria for the use of licensed and nonlicensed health care personnel as volunteers during disasters are addressed.
- Organizations must perform an evaluation of every disaster drill to identify areas of improvement.
- Storage conditions of medication must be documented even if the medication is obtained through outside pharmacies or anesthesiologists.

"Changes to the standards that relate to disaster situations have been in the works for several years, but the disasters of the past two summers have illustrated the challenges faced by health care organizations and the need to define different roles and expectations," says **Michael Kulczycki**, executive director of the Ambulatory Accreditation Program at the Joint Commission.

One of the challenges faced by health care organizations that needed extra help and health care workers from other parts of the country that wanted to volunteer was the requirement that providers be credentialed by the organization for which they were volunteering, says Kulczycki. New standards for both nonlicensed independent contractors and licensed independent contractors allow organizations to grant disaster responsibilities or disaster privileges, in the case of physicians, to those who want to volunteer. "Volunteers who are members of the Medical Reserve Corps or the Emergency System for Advance Registration of Volunteer Health Professionals are already preregistered and credentialed to assist in a professional capacity in a disaster, but not all health care workers are members of these or similar organizations," he points out.

The new standards (H.R. 1.2.5 and H.R. 4.3.5) allow organizations to assign emergency responsibilities or privileges to volunteers who show verification of their licensure, certification, or registration

to practice their profession until the immediate situation is under control and primary source verification of credentials can begin, says Kulczycki. Primary source verification must be completed within 72 hours of the time the volunteer appeared for assignment, or the organization must document reasons for not completing this step in this timeframe, he adds.

Not only does this standard more clearly define the process that organizations should follow to use volunteers in a disaster, but it provides some flexibility so that a volunteer can immediately begin helping, says Kulczycki. The standard also specifies that disaster privileges can be granted only when the disaster plan is implemented and the organization cannot meet immediate patient needs without volunteer assistance, he adds. Another component of the standard requires the organization to have a written protocol that may include observation, mentoring, and clinical record review of volunteers to ensure that the volunteer is competent to handle the assigned duties and to assure patient safety, Kulczycki explains.

Lou Warmijak, administrator of Kissimmee (FL) Surgery Center, says it would be rare for a surgery center that performs elective procedures to continue operating during a disaster, "but I can see that in some situations we might be opened as a triage center or other type of health facility," he says. "We've not experienced the long-term recovery period following a disaster that Louisiana and Mississippi health care organizations have experienced, so we have not had to deal with professionals offering to volunteer." Warmijak points out that the flexibility of the disaster volunteer standards is helpful for everyone because staff members at his and other surgery centers owned by his general partner are able to volunteer through the larger organization for work in disaster areas.

Evaluate all disaster drills

Other Joint Commission standards changes that relate to disaster preparedness for ambulatory care organizations require that organizations not only develop a disaster plan that addresses a variety of situations, but also that the organization conduct a variety of disaster drills and that the organization conducts an evaluation of these drills, says Kulczycki. Prior standards manuals did not clearly state the expectation that organizations critique each drill to identify deficiencies and implement changes to improve the plan, he explains.

SOURCES

For more information on accreditation standards or emergency preparedness, contact:

- **Michael Kulczycki**, Executive Director, Ambulatory Accreditation Program, Joint Commission on the Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5290. E-mail: kulczycki@jcaho.org.
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The evaluating of each drill does not need to be in writing, but it must be in practice, says Kulczycki. "If a surveyor asks a staff member what happens after a disaster drill, the surveyor wants to hear that a multidisciplinary team looks at how the plan was implemented and if everything went as planned," he says. "I expect that most same-day surgery programs already perform an evaluation, but some may have to formalize the process and include a variety of staff members in the evaluation."

Warmijak's experiences with hurricanes in the past couple of years have changed the way his facility plans and prepares for disasters, he says. "It's very hard to completely prepare for a disaster when you're sitting behind a desk with electricity working," Warmijak points out. "It wasn't until we experienced a storm that cut power for many days that we discovered flaws in our plan." **(For tips learned during the hurricane, see p. 57.)**

Testing of emergency plans for office-based surgery programs does not require as much evaluation because the staff size is not as large as a surgery center, Kulczycki says. "Office-based surgery staffs do have to test their plans and do have to address realistic scenarios," he says.

One editorial change to the office-based surgery manual's infection control standard specifies that if an office-based program chooses to treat patients during a pandemic situation, the program must have a plan to segregate infectious patients from noninfectious patients, says Kulczycki. The previous standard's wording did not make it clear that an organization does not have to treat patients if there is a pandemic-type situation but if the organization chooses to do so, there must be a plan, he explains.

With medication management being such an important issue for patient safety, a requirement that the organization develop a policy that addresses medication storage between the receipt of medication and the administration of the medication is a key addition to the ambulatory care and the office-based surgery standards, says Kulczycki. "If a same-day surgery program is using compounded drugs from outside the organization, they must get assurance that the medication was stored and transported safely," he says.

Don't forget your anesthesiologists either, especially if you contract with another organization for anesthesiology services, suggests Kulczycki. If you allow the anesthesiologist to bring in medications, make sure you can identify how the medication was stored and at what temperature, if that is a safety factor," he says. ■

Hurricanes point out disaster plan weaknesses

As administrator of Kissimmee (FL) Surgery Center, **Lou Warmijak** knows that weather-related disaster plans must be in place and must be comprehensive. But, as he learned during the 2004 hurricane season, there are always situations for which you cannot plan.

Because hurricanes and other storms frequently mean a loss of power, his center does have generator power backup; but if the building is not occupied, the generator is not run, explains Warmijak. "That's not a problem if we are out of the building for a day, but when no one is in the building for several days in high humidity weather, sterile supplies or any supplies that must be maintained at a certain temperature, are no longer usable," he points out.

When his staff returned to the center after many days of no power following Hurricane Frances, they found that all of the sterile supplies were contaminated. They could not begin rescheduling surgery cases until supplies were obtained, says Warmijak. "We now leave the generator on unless there is a high risk of building damage during which a running generator creates a dangerous situation for emergency personnel who might enter the building."

If a decision is made to take the generator off line, supplies are secured as best as possible, says Warmijak. "We also have a procedure to obtain new supplies as quickly as possible so we don't lose surgery days," he adds.

Up-to-date inventory lists show which supplies were lost, and vendors who can deliver in a short time have been identified. Although hurricanes are dramatic, there always is some time to prepare for them, Warmijak says. "We also make sure our emergency plans and drills cover events that don't give us time for preparation," he says. "Microburst storms with a lot of lightning and tornadoes are common weather events in central Florida, and they happen with no warning."

Less likely to occur, but included in his plans, are vehicles that crash into the building because the facility is located on a busy highway, Warmijak explains. "Weather events will be most likely to occur, but we have to have a plan for the unexpected as well," he adds. ■

Same-Day Surgery Manager

Expanding your OR space, and other managers' issues

Tips for tackling staffing, profit-sharing

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

Question: We need to expand our freestanding center by one more operating room. We have a storage room that is about 300 square feet that we are using for storage. Can we use this?

Answer: Probably not. Although exemptions can be obtained, for your needs you need a full-service operating room that is going to be required to be 420 square feet. In addition to that, you also will need three additional beds (usually one pre-op and two post-op). However, there is the possibility to convert to a special procedures room, which may require fewer than 400 square feet. Check your state regs and meet with an architect who understands surgery centers.

Question: Our hospital is expanding, and the administrators have asked me to help them plan how many operating rooms we will need. I heard you speak last year, and you said that on average, you can do about 1,000 to 1,500 cases per operating room. Can I use that figure for our planning purposes?"

Answer: The short answer is No. That figure you heard me give was for a typical surgery center, not a hospital with more complex procedures. A good rule of thumb for a hospital is closer to 800 cases (patients, not procedures) per year per operating room.

However, for planning purposes, you probably are better off counting your historic surgical minutes rather than cases. Add them up and divide by the average number of minutes per your work day, and then divide by the number of operating rooms. You should look at about a 75% utilization rate. If you get too much above that percentage, you lose the ability to "flip-flop" cases. When in doubt, add an operating room. Surgery is up everywhere.

Question: You gave a staffing pattern in one of your articles last year that I completely disagree with. I cannot staff my center with the number of people that you said could be done. My surgeons scream if they do not have the help that they want. Do you actually have any experience in an operating room? If you did, you would understand that surgeons want as much staff as they can get!

Answer: I actually do have experience in the operating room, first as a scrub tech for about seven years, then as an OR nurse for a several others, and then as a certified registered nurse anesthetist (CRNA) for nine years. After that, I had seven years as an administrator in several surgery centers.

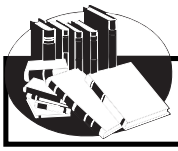
Note for readers: I called this manager and found out that her surgeons had tried to start a surgery center last year and the hospital fought their certificate of need to the point where the surgeons had to abandon their plans for their own center. A phone call to the medical director of the hospital revealed that surgeons were upset with the hospital and were using as many resources as they could. The medical director told me that their supply cost had more than doubled since the surgeons' plans were curtailed. I stand behind my staffing plan.

Question: I want to give my staff a profit-sharing plan. Once a quarter, the surgeon investors in our surgery center get their "check" that is their profit from the previous quarter. Some of the staff members complain that they are a big reason for the surgeons' profits, and they want to know why they cannot share in the profits. Do you have an easy suggestion as to how that can happen?

Answer: Sure. Get your board of directors to take a percentage of their profits. I suggest 3% and put it in a staffing pool that you divide among the staff once a quarter. When the surgeons get their check, the staff gets theirs as well.

Footnote: The board agreed to 2% for the staff. That amount ended up being about $38,000 per year to be split among the 15 staff members.

(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.) ■



JOURNAL REVIEW

Study identifies top 10 herbals used by patients

Surgeons not aware of potential side effects

Cosmetic surgery patients use herbal and supplemental medicines at a higher rate than the general public, but physicians are not always aware of the use or of the effect of the supplement on perioperative care, according to a recent study published in *Plastic and Reconstructive Surgery*.[1]

The study surveyed 100 cosmetic surgery patients, plus 100 randomly selected adults from the same geographic area, to assess use of herbal and supplemental medicines. An additional survey of 20 plastic surgeons was conducted to assess physicians' awareness of herbal medicines and supplements, knowledge of perioperative complications associated with the medicines, and recommendations they make to discontinue medicines preoperatively.

Of the cosmetic patients, 55% reported using herbal medicines and supplements, with 100% of those patients taking at least two medicines. This group of patients reported taking at least one of their medicines every day. Of the participants in the general population survey, 24% reported

using herbal medicines and supplements, with only 33% reporting use two remedies, and only 50% reporting use of at least one herbal medicine every day.

Physicians were aware of 54% of the herbal medicines and supplements identified in their survey, but they only knew of the side effects of one herbal medicine, ephedra. Only 30% of the physicians identified chondroitin, the most frequently used herbal medicine used by patients in the survey, as associated with bleeding. The side effects of other herbal medicines were not correctly identified by any survey participants. Physicians reported that they did not recommend stopping 85% of the herbal medicines listed in the survey preoperatively or perioperatively.

Because the prevalence of herbal medicines and supplements is growing, and information on their side effects is necessary to ensure patient safety, study authors compiled a list of the 10 most frequently used herbal medicines and supplements by cosmetic surgery patients, the most common uses, and potential surgical complications. The herbal medicines/supplements and their potential complications are:

- chondroitin — surgical bleeding;
- ephedra — hypertension and cardiac instability with anesthetics;
- echinacea — potential barbiturate and halothane toxicity, allergic reaction, and immunosuppression;
- glucosamine – hypoglycemia;
- ginkgo biloba — postoperative sedation and perioperative bleeding;
- goldenseal — volume depletion, postoperative sedation, and photosensitization;
- milk thistle — volume depletion;
- ginseng — perioperative bleeding;
- kava — postoperative sedation;
- garlic — perioperative bleeding.

Reference

1. Heller, JBS, Gabbay, JS, Ghadjar, K, et al. Top-10 list of herbal and supplemental medicines used by cosmetic patients: What the plastic surgeon needs to know. *Plast Reconstr Surg* 2006; 117:436-445. ■

Checklists ID supplements and verify safety steps

Pre-op and post-op forms for charts save time

Preoperative and postoperative safety checklists, as well as forms that collect information about the patient's medications and dietary or herbal supplements, are important tools for outpatient surgery programs focusing on patient safety.

The American Academy of Orthopaedic Surgeons offers free checklists as well as safety reports for ambulatory and office-based surgery programs.

The "Dietary Supplement Intake Form" lists 38 herbal medicines and vitamin supplements for patients to review. The form has space for the patient to indicate the dose, how often each week the supplement is taken, and the reason for taking the supplement. Blank spaces at the bottom of the form also give room for the patient to fill in any other supplements that might not be included on the list.

In addition to the dietary supplement form, a preoperative checklist prompts the surgeon to ensure that information such as the history and physical, lab work, electrocardiogram, patient risks, list of all medications, and the dietary supplement

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

- How to use volunteers effectively
- Tips on putting together an effective H&P form
- Latest research: Cognitive function after surgery
- Nuclear medicine facilities in surgery centers
- Staffing tips from your peers

form are included in the chart prior to beginning surgery. The preoperative checklist also prompts the surgeon to verify site identification and patient identification as well as other safety activities.

To reach these forms and reports, go to www.aaos.org. Under the "special projects" headline, choose "patient safety," then choose "safety checklists" on the left navigational bar. ■

New organization helps office surgery programs

A new, for-profit subsidiary created by the American Association for Accreditation of Ambulatory Surgery Facilities will help office-based surgery programs improve their efficiency and comply with requirements of different regulatory bodies and accreditation organizations.

A web-based product that helps facilities with compliance is available through the subsidiary, Surgery Facilities Resources (SFR). Group purchasing arrangements as well as international accreditation is being explored. A system to identify qualified consultants that can help new facilities in the design, construction, and accreditation phases also is being pursued, according to **Jeff Pearcy**, executive vice president of SFR.

To request more information about the organization, go to www.surgeryfacility.org and complete the on-line request form for information. ■

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.

17. Which of the following are reproductive risks, according to the Washington Department of Labor and Industries?
A. Heavy lifting
B. Working more than 40 hours per week
C. Stress and fatigue
D. Standing for long periods of time
E. All of the above

18. Which specialties are predicted to lose a significant amount of money under the proposed reimbursement system for APCs, according to Caryl A. Serbin, RN, BSN, LHRM?
A. Gastrointestinal procedures and pain management
B. Orthopedics
C. Ear, nose, and throat
D. Gynecology

19. What must occur after each disaster drill, according to new standards for ambulatory care and office-based surgery that go into effect on July 1, 2006, according to Michael Kulczycki?
A. Written reports evaluating the drill must be developed.
B. The program's safety officer must review results of the drill.
C. An evaluation by a multidisciplinary team must be conducted.
D. There's no change from previous standards requirements.

Answers: 17. E; 18. A; 19. C

FORM LETTER FOR DECLARING PREGNANCY

This form letter is provided for your convenience. To make your written declaration of pregnancy, you may fill in the blanks in this form letter, you may use a form letter the licensee has provided to you, or you may write your own letter.

DECLARATION OF PREGNANCY

To: _____

In accordance with the IDPH rules 641-40.22, "Dose to an Embryo/Fetus," I am declaring that I am pregnant. I believe I became pregnant in _____ (only the month and year need be provided).

I understand the radiation dose to my embryo/fetus during my entire pregnancy will not be allowed to exceed 500 millirem (5 millisievert) (unless that dose has already been exceeded between the time of conception and submitting this letter). I also understand that meeting the lower dose limit may require a change in job or job responsibilities during my pregnancy.

_____
(Your signature)

_____
(Your name printed)

_____
(Date)

Source: Iowa Department of Public Health, Instruction Concerning Prenatal Radiation Exposure. Accessed at http://www.idph.state.ia.us/eh/common/pdf/radiological_health/prenatalexposure.pdf.