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IN THIS ISSUE

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When you go through an unannounced survey, will you sink or soar?

Joint Commission process receives high marks from those who prepare

Since the Joint Commission on Accreditation of Healthcare Organizations launched its unannounced surveys in January, more than 1,370 organizations have gone through the new process. For hospitals that had been surveyed at press time, the average number of requirements for improvement (RFIs) increased to 7.4 in 2006 compared with 5.8 in 2005, and the average RFIs for ambulatory care facilities increased to 6.7, compared to 5.8 in 2005.

While smaller surgery centers (those doing fewer than 1,500 cases per year) receive a five-day notice to ensure the center will be in operation during the survey, most outpatient surgery programs don't know the Joint Commission surveyors are coming until that information, along with surveyor biographies and photos, is posted on the agency's extranet web site at 7 a.m. Eastern Time. (Go to www.JointCommission.org, and go to the "Jayco Login" section. After logging in, click on the "notification of scheduled events" link.)

To ensure your program receives top marks and avoids RFIs, consider

EXECUTIVE SUMMARY

The Joint Commission on Accreditation of Healthcare Organizations has been doing unannounced surveys since January, and a few simple steps can help you sail through the change smoothly.

- Check the web site daily to find out if surveyors are arriving that day. Have a system in place to communicate their imminent arrival to managers and staff. Use a last-minute checklist. **(See checklist, p. 63.)**
- Several people should know how to check identification of surveyors.
- Have updated key documents on hand. **(See list, p. 64.)**
- Have someone accompany surveyors on patient tracers.
- Review videos/DVD on tracer process. Hold as many mock patient tracers as possible, and conduct them when your census is high.

these suggestions from outpatient surgery programs that have been through the unannounced survey process this year:

• Have a system to communicate that surveyors are on-site, and use a last-minute checklist.

Staff at Baylor All Saints Medical Center at Fort Worth (TX) paged managers the morning of Jan. 16 to let them know the surveyors were coming that day, says **Beverly Joanne Kennemur**, RN, manager of same-day surgery. Other facilities use telephone trees, and one facility put everyone on alert by announcing, "We welcome the Joint Commission surveyors" on its public announcement system.

Advance notice does help, she advises. Baylor All Saints had developed a last-minute checklist, which was posted in the same-day surgery department, Kennemur says. **(See checklist, p. 63.)** "The staff knew to look at the checklist, to go over it, and to make sure we had followed all those guidelines," she says. In 20 minutes or fewer, all the steps were completed, she recalls.

• Have staff educated about how to handle surveyors' arrival.

The issue of identifying surveyors has taken on additional importance in light of recent reports of more impostors attempting to gain access to hospitals in California and Wisconsin by posing as Joint Commission surveyors. **(For information on previous impostors, see these stories in the June 2005 issue of *Same-Day Surgery:* "Impostors could target hospitals for terrorism," p. 64; "What to expect from a Joint Commission surveyor," p. 65; "You must use vigilance when checking visitors' IDs, p. 66; and "Impostors show up, but flee when challenged," p. 67.)**

Ensure that several people in your program know how to confirm surveyors' identification, says **Michael Kulczycki**, MBA, executive director of ambulatory care accreditation. Staff should ask surveyors for identification. Their identification can be confirmed by signing in on the agency's extranet web site or by contacting the Joint Commission by phone or fax. (Staff should look up the numbers themselves to ensure they are correct, rather than obtain them from the surveyors.) In some cases, surveyors have had to show staff how to sign on at the web site and check the identification, he says. The front desk receptionist should have that information available and should know to take the surveyors to a conference room so they can review materials and create an agenda while the organization's leaders determine which of them are on site to help during the survey, Kulczycki says.

"If the administrator is not there, keep in mind that the survey is not designed around the administrator or Joint Commission coordinator," he says. "Sixty percent of the total survey time for a typical ambulatory surgery center, which is two days [total], is spent talking to frontline staff." In smaller surgery centers that have six to 12 staff people, the surveyor is likely to talk to every single staff person, Kulczycki adds.

• Be ready to provide key documents.

The biggest issue for programs going through unannounced surveys is the amount of time it

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Last-Minute Joint Commission Clean-Up List

CHARTS
- ☐ Every page in the chart should have a patient sticker.

PEOPLE
- ☐ Everyone is wearing their ID badge.
- ☐ Be polite. Answer only the question that is asked.

ENVIRONMENT
- ☐ No food or drink in patient care areas.
- ☐ Make sure everything is on the same side of the hallway.
- ☐ Make sure no fire exits/doors/extinguishers are blocked.
- ☐ Linen cart is covered.
- ☐ Check Clean Room. Make sure only clean equipment is stored, there is nothing on the floor, there are no outer storage boxes, and there is an 18-inch clearance from the ceiling.
- ☐ Check Dirty Room. Make sure only dirty equipment is stored, there is nothing on the floor, there are no outer storage boxes, and there is an 18-inch clearance from the ceiling.
- ☐ Only cleaning supplies under all of the sinks.
- ☐ Containers closed. Remove expired items in the patient nutrition fridge.
- ☐ Secure ALL medications. ALL medications are in a locked med cart or locked med room.
- ☐ All oxygen tanks are secured.

Source: Baylor All Saints Medical Center at Fort Worth (TX).

takes managers and staff to get organized the morning of the surveyors' arrival, says Kulczycki. There is a list of documents that are important to keep on hand to provide to surveyors right away, he says. **(See list, p. 64.)**

"Except for the daily or weekly scheduled procedures, everything is pretty static," Kulczycki says. Ensure these documents are updated with information such as new services when they are added, he adds.

• Assist surveyors by assigning someone to accompany them on tracers.

While it's not required or expected that a staff person accompany surveyors on patient tracers, it is helpful for the agency and the surveyed program, Kulczycki says. For example, the staff person can ensure that the surveyor is talking to staff who aren't immediately involved in patient care, so that process isn't interrupted, he says. Another benefit is that the staff person can help keep the surveyor on time after the surveyor has stated the amount of time that he or she wants to allot to the tracer process. Another benefit is that if the surveyor requests policies or procedures, the staff person can arrange to have that information pulled so it is available by the time the tracer is completed, he says.

The person accompanying the surveyors should carry a memo pad and note not only what the surveyors want, but also what they find and what they say, suggests **Mark Mayo**, executive director of the Illinois Freestanding Surgery Center Association in St. Charles. "This will help you identify and fix a problem, maybe before the surveyors leave, and will help you with a plan of correction," he says.

• Practice tracers during peak times.

SOURCES/RESOURCE

For more information on the unannounced surveys, contact:
- **Beverly Joanne Kennemur**, RN, Manager, Same-Day Surgery, Baylor All Saints Medical Center at Fort Worth, 1400 Eighth Ave., Fort Worth, TX 76104. Phone: (817) 922-2068.
- **Brenda Loguidice**, RN, MBA, CNOR, Manager, Perioperative Services, Holyoke Medical Center, 575 Beech St., Holyoke, MA 01040. Phone: (413) 534-2500. E-mail: Brenda_Loguidice@holyokehealth.com.

For resources on the unannounced surveys, including a video, go to www.jacho.org and click on "unannounced surveys" on the left side of the page.

Items to Have Available for Surveyors

- ☐ Organizational Chart
- ☐ List of Sites (If Applicable)
- ☐ List of Departments or Services
- ☐ List of All Patients (e.g., Scheduled Procedures) During Days of Survey
- ☐ Key Contact Who can Assist Surveyors in Planning Patient Tracers
- ☐ Performance Improvement Data
- ☐ Infection Control Data
- ☐ Quality Control for Waived Testing
- ☐ Environment of Care Plans
- ☐ Environment of Care Meeting Minutes
- ☐ Statement of Conditions (If Applicable)
- ☐ Leadership Meeting Minutes

Source: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

When programs conduct mock tracers in preparation for the unannounced survey, their natural tendency is to schedule it for a slow day, Kulczycki says. "What is the likelihood that a surveyor will show up on a slow day?" he points out. "You want to test your processes when you're running at your peak, not during a slow time."

Use a wide range of staff to conduct the mock tracers, Kulczycki suggests. For example, your front office staff can examine procedures in the postoperative area that they're less familiar with, and your clinical staff can look at admitting procedures, he says. "This will help with testing your compliance with your requirements and looking for process errors where you can improve," Kulczycki says.

The same-day surgery department at Baylor All Saints prepared by watching a tracer video and doing mock tracers with staff, Kennemur says. **(For unannounced survey resources, see sources/ resource box on p. 63.)** "If they don't know an answer, we tell them to refer to their supervisor or manager," she says. At the actual survey, one patient was traced through the department to radiology, Kennemur says. "They were watching how they identified the patient, how they received reports," she says. "They wanted to know how we knew the doctor was on staff and what their privileges were."

At Holyoke (MA) Medical Center, fewer than seven mock tracers were done as preparation for the survey, says **Brenda Loguidice**, RN, MBA, CNOR, manager of perioperative services. Does she recommend that number for other facilities? "I'd say to do as many as they could, to tell you the truth," Loguidice says. **(For more information on patient tracers, see story, below.)** ■

You can't bluff your way through patient tracers

Here are actual issues explored by surveyors

Don't think that your staff can fake their way through answers during the patient tracer section of an unannounced survey by the Joint Commission on Accreditation of Healthcare Organizations, says **Nancy Hammes**, patient care director in day surgery at Franciscan Skemp La Crosse (WI) Campus. Franciscan Skemp went through one of the Joint Commission's new unannounced survey process earlier this year.

"The nurse we got [as a surveyor] was, I think, with the Joint Commission the longest of any nurse they had," she recalls. "She was like an encyclopedia. You couldn't bluff your way through."

The physician surveyor wanted to know how they got patients ready, she says. For AM admit patients, he wanted to know how the day surgery staff communicated with the surgery staff and what they documented, Hammes reports. The surveyor looked at the patient chart, she says. "They went through every page and asked every question."

For same-day discharges, the surveyors wanted to know the discharge criteria. They challenged staff with hypothetical situations such as a patient ready for discharge who complained about having a headache or a patient whose prior medication may not have been reconciled. "They wanted to see documentation that you took the initiative by speaking to that patient or got the order from the physician so someone follows through on the medication they came in with but not one that necessarily the physician wrote to continue," Hammes says.

At Holyoke (MA) Medical Center's unannounced survey earlier this year, surveyors wanted to know how staff identified patients and surgical sites, and what else was included in the timeout procedure, says **Brenda Loguidice**, RN, MBA, CNOR, manager of perioperative

SOURCES

For more information on patient tracers, contact:
- **Nancy Hammes**, Patient Care Director, Day Surgery, Franciscan Skemp La Crosse Campus, 700 West Ave. S., La Crosse, WI 54601. Phone: (608) 795-0940, ext. 22441. E-mail: hammes.nancy@mayo.edu.
- **Dee Weigel**, RN, Quality Nurse, Algonquin Road Surgery Center, 2550 Algonquin Road, Lake In the Hills, IL 60156.

services. While reviewing timeouts, the surveyors went into the OR and "watched every one of them," she says.

This approach was a dramatic contrast with previous surveys. Previously, surveyors sometimes came to outpatient surgery facilities at 4 p.m. when all the procedures were completed and the staff had gone home, Loguidice says.

At the accreditation survey for Algonquin Road Surgery Center in Lake In The Hills, IL, the surveyor asked recovery room nurses how they determined pain in patients and how they used pain scales, says **Dee Weigel**, RN, quality nurse. He asked the front desk staff what they would do if a patient presented them with a living will, she says. "He asked several questions back in the OR and sterile processing about how they do sterile processing, what the process is, and he talked to them at length about their lead aprons and how we test them for holes," she says.

The surveyor also was interested in testing of the medical equipment and asked about their putting all their medical equipment into risk categories.

No more scrambling and hiding

The unannounced surveys with patient tracers are a dramatic change from past surveys, says Loguidice. "In the past, direct care people would scramble and hide when the Joint Commission came, but now they are the focus, which is really good," she says. Her staff weren't intimidated, she says. "They were proud to be able to say, 'This is what I do for my patient.'"

Loguidice says she has worked in nursing for 30 years, "and this is the first time I really felt that the Joint Commission was really making an impact on the day-to-day nursing care of the patient." ■

Surgical site infection rate drops to zero in months

Antibiotics and no razors contribute

(Editor's note: This is the first of a two-part series that looks at effective strategies to reduce surgical site infection rates. This month, we look at the importance of reducing the use of razors, using prophylactic antibiotics, and keeping the patient warm. Next month, experts talk about glucose management, environmental control, and new products.)

Between 2% and 5% of patients undergoing surgical procedures will develop a surgical site infection that results in additional costs that range from $2,734 to $26,019 for each infection, according to the Centers for Disease Control's National Nosocomial Infections Surveillance system.

The surgical site infection rate at Porter Hospital in Middlebury, VT, was 2.6% when the ambulatory surgery staff initiated a program to address infection in October 2004. "Today, our surgical site infection rate is zero," says **Ann Beauregard**, RN, RN, performance improvement manager. Most of the hospital's surgical procedures are outpatient, with orthopedics, general surgery, and gynecological surgery representing the greatest volume, she says.

The performance improvement team started the project with reports from infection control nurses that tracked the type of surgical wound, timing of prophylactic antibiotic if used, surgeon, type of prep for surgery, start time for procedure,

EXECUTIVE SUMMARY

When the outpatient surgery staff at Porter Hospital in Middlebury, VT, decided to tackle a performance improvement project to reduce surgical site infections, they did not expect to achieve a 0% infection rate so quickly. In less than one year, the staff implemented changes that reduced the infection rate to zero.
- Razors were eliminated from the OR, and clippers are used only when needed.
- Appropriate prophylactic antibiotics are administered in a timely manner for procedures that warrant their use.
- Patients are kept warm to keep oxygen-rich blood flowing to the incision site to promote faster healing.

and length of procedure, she says. "We gathered our data and information from a wide range of literature to develop recommendations for change," she says.

Cynthia Spry, RN, MA, MSN, CNOR, clinical consultant at Advance Sterilization Products in Irvine, CA, says, "The good news for surgery managers is that we have a lot more information about prevention of surgical site infections, and we have more emphasis on the importance of reducing these infections."

With regulatory agencies such as the Centers for Medicare & Medicaid Services and accreditation agencies such as the Joint Commission on the Accreditation of Healthcare Organizations focusing on patient safety and prevention of infection, outpatient surgery managers have a lot more clout when they approach administration and physicians about the need to address infection rates, she says.

"We've known since the 1960s that shaving patients prior to surgery increased the risk of infection, but there are still people reluctant to change," points out Spry. As more surgical programs focus on infection prevention, practices are changing to only shave the patient if necessary and, when necessary, shave immediately before the procedure and never use a dry razor, she says.

One of the first changes at Porter Hospital was the elimination of razors in the operating room, says Beauregard. "We use clippers if we need to remove hair from the incision site," she says.

Antibiotics effective when used correctly

The use of prophylactic antibiotics is also very important to reducing surgical site infections, says Spry. "It is important to use the right antibiotic at the right time and to realize that not all procedures require a prophylactic antibiotic," she says.

"Procedures such laparoscopic cholecystectomies, laparoscopic hysterectomies, and urinary procedures all require prophylactic antibiotics," says Beauregard. Procedures that are not abdominal such as knee arthroscopies generally don't require antibiotics, she points out.

Melinda Rogers, RN, CNOR, clinical development specialist for surgical services at Northside Hospital in Atlanta, says, "We have used prophylactic antibiotics for all recommended procedures for over two years."

Because her hospital participates in the Surgical Care Improvement Project (SCIP), and reduction of surgical site infections is one focus of the project, Rogers uses SCIP resources for guidance on use of prophylactic antibiotics. "The tools available on the SCIP web site are helpful as you identify which procedures are appropriate for prophylactic antibiotics and which antibiotics are best for each situation," she says. **(For information on the web site tools, see resource box, below.)**

Broad-spectrum antibiotics should not be used because they are less effective against specific bacteria present in different procedures, and all prophylactic antibiotics should be discontinued

SOURCES/RESOURCES

For more information about surgical site infection control, contact:

- **Ann Beauregard**, RN, Performance Improvement Manager, Porter Hospital, 115 Porter Drive, Middlebury, VT 05753. Telephone: (802) 388-5645. E-mail: abeauregard@portermedical.org.
- **Melinda Rogers**, RN, CNOR, Clinical Development Specialist, Northside Hospital, 1000 Johnson Ferry Road, Atlanta, GA 30342. Telephone: (404) 851-6065. E-mail: melinda.rogers@northside.com.
- **Cynthia Spry**, RN, MSN, CNOR, Clinical Consultant, Advanced Sterilization Products. Telephone: (212) 627-4787. E-mail: cspry @aspus.jnj.com.

For tools, research, and recommendation for surgical site infection control, contact:

- **Institute for Health Improvement (IHI)**, 20 University Road, Seventh Floor, Cambridge, MA 02138. Telephone: (866) 787-0831 or (617) 301-4800. Fax: (617) 301-4848. Web: www.ihi.org. The IHI web site has a variety of tools to use in monitoring infections, developing surgical site infection control programs, and implementing programs. Click on "topics" on the left navigational bar. Choose "patient safety" then choose "surgical site infections."
- **The Surgical Care Improvement Project** (SCIP) is a national collaborative effort between the Centers for Medicare and Medicaid Services, hospitals, and quality improvement organizations. At this time, the project is collecting data only from hospital-based inpatient programs but the tools, research, and recommendations are available to all surgery managers at www.medqic.org. Click on the SCIP logo on the right-hand side of the home page, then choose "infections" on the left navigational bar. A list of resources, tools, strategies, and other information related to surgical site infection prevention will be displayed.

within 24 hours of initial use because it should not be necessary at that point, Spry says.

One of the keys to proper antibiotic administration is allowing enough time for the antibiotic to get to the cell level, says Beauregard. "You need to administer the antibiotic 30-60 minutes prior to the first cut," she says.

Studies of their procedures showed that hysterectomy patients who were scheduled as the first procedure in the morning were often receiving the antibiotic fewer than 30 minutes prior to the incision, Beauregard notes. "We found that nurses were taking vital signs, checking patient history, and handling their other responsibilities prior to administering the antibiotic."

While this process did not affect patients scheduled later in the day, the patients who were scheduled first often went into the operating room more quickly because there were no cases before them that went a little longer than planned or necessitated cleaning of the room, Beauregard points out. "The first patients were moved into the operating room before the antibiotic got into their system," she explains. To address this issue, nurses began administering the antibiotic before they finished their other tasks, says Beauregard. "This gives the medication the extra time needed to get into the patient's system," she says.

Avoid hypothermia

Controlling the temperature of the room and the patient is also important to prevent infection, says Spry. Keep patients warm to prevent hypothermia, she says.

"Hypothermia reduces oxygen to the wound site and increases the buildup of collagen," she says. "Both of these conditions delay the wound healing process."

While patients have always appreciated warm blankets, studies have shown that keeping the patient's core temperature and the surgical site warm not only make the patient more comfortable, but also keep infection rates down, says Spry.[1] "Prewarm the patient in holding areas with warm blankets and make sure your operating rooms are not cold," she says. The rooms should be kept at a temperature that makes it possible to maintain the patient's normal core temperature, she adds.

At Porter Hospital, anesthesiologists warm fluids, and the patient's temperature in the operating room and in the recovery area are monitored, says Beauregard. After evaluating different methods of monitoring a patient's temperature, Beauregard's staff has chosen to use a temporal scanner thermometer because they found it to be easier to use and more accurate than other types of thermometers. "We chose the Exergen TA [McKesson Medical-Surgical, Richmond, VA] and we use it exclusively in the PACU and will be phasing out use of other thermometers throughout the entire hospital," she adds.

Other tips to keep patients warm include keeping them covered until you have to expose the surgical site, says Spry. "Also, when you are prepping the surgical area, expose only as much area as necessary," she adds.

Because you know that any amount of cold will reduce oxygen to the wound site, be sure to keep the patient well oxygenated during the procedure, suggests Spry. "Oxygen will speed healing and reduce the risk of infection," she says.

This is a good time for outpatient surgery managers to focus upon reduction of surgical site infection, points out Spry. "There is more research available on tactics that work, and there are protocols available for everyone's use," she says. **(See resource box, p. 66.)** "There are many different ways that surgery managers can approach this issue, and none of them require a lot of money — just attention to processes."

Reference

1. Kurz A, Sessler DI, Lenhardt R. Perioperative normothermia to reduce the incidence of surgical-wound infection and shorten hospitalization. Study of wound infection and temperature group. *N Engl J Med* 1996; 334:1,209-1,215. ■

Study compares business practices, technology use

Cataracts and colonoscopy are focus

[Editor's note: This is the first part of a two-part series that looks at results of a nonclinical benchmarking study conducted by the Institute for Quality Improvement (IQI). This month, we look at patient scheduling practices, staff costs, use of electronic medical records, and patient satisfaction results. Next month, we look at effective billing and collections practices.]

Billing data, supply costs, staff costs, and patient satisfaction are top issues for all outpatient surgery managers, but benchmark studies that address these areas don't always focus on similar

EXECUTIVE SUMMARY

The recent Ambulatory Surgery Non-Clinical Study by the Institute for Quality Improvement (IQI) focused on cataract extraction with lens implantation and colonoscopy.

- The same percentage of colonoscopy patients was satisfied with their overall procedure as the percentage of cataract patients: 98%.
- While most participants use some form of information technology, 40% of colonoscopy organizations reported using an electronic medical records system as compared to 12% of cataract organizations.

procedures so that comparisons can be made easily. This specific comparison of information is now available to facilities that perform cataract extractions with lens implantation and colonoscopy.

Detailed nonclinical info provided

For more than five years, the IQI, a subsidiary of the Accreditation Association for Ambulatory Health Care (AAAHC), has collected clinical benchmarking data that focus on specific procedures, including cataract extraction with lens insertion and colonoscopy.

"We've always included some nonclinical information in our studies, but not the level of detail that this study, which focuses on cataract extraction with lens insertion and colonoscopy, includes," says **Naomi Kuznets**, PhD, director of the institute. "The difference between this study and other studies that address these issues is that it reflects real-time, rather than retrospective, data, and it focuses on a specific CPT code so that we know we are comparing apples to apples."

These two procedures were chosen because, with approximately 2.5 million cataract extractions and more than 1.1 million colonoscopies each year, they are the two most frequently scheduled procedures in an outpatient setting, explains Kuznets. While the procedures and the facilities at which they are performed differ, a report that compares results from the two groups is available as well as individual reports on each of the two procedures **(See resource box, p. 69, for ordering information).**

Cataract patients tended to wait less time for their procedure than colonoscopy patients, with 29% of cataract patients not having to wait past their appointment time compared to 40% of colonoscopy patients who had to wait. "Outpatient programs that handle cataract surgeries have this procedure down to a science," Kuznets points out. This procedure has been in a competitive market for many years, she says. "Colonoscopy is a newer procedure in the outpatient center arena, so these staffs are still learning some of the tactics that ophthalmology programs learned in past years," Kuznets says. **(For other statistics from the benchmark study, see p. 69.)**

Schedule carefully to cut wait times

Cataract patients spend less time in the facility for a variety of reasons, says **Linda Pavletich**, RN, BSN, CASC, LHRM, administrator of St. John's Surgery Center in Fort Myers, FL. Her patients spend about 90 minutes in the facility, well below the median facility time of 128 minutes reported by all cataract study participants.

"We have two operating rooms and 10 surgeons on staff, so we offer block times for the surgeons," she says. Because each surgeon gets one day each week for his or her operating time, the center has the same two surgeons all day, she says. This setup makes it easy to move quickly from case to case because you don't have to prepare a case differently for a different surgeon in the room, she adds.

In addition to the block scheduling, most of the pre-admission information is handled well before the patient arrives, and pre-op calls by nurses are made the day before the procedure, explains Pavletich. **(For tips from other cataract study participants, see p. 69.)**

EMRs used by colonoscopy facilities

One advantage that colonoscopy study participants have over cataract study participants is the use of electronic medical records (EMRs), says Kuznets. While almost all participants report the use of an information technology system with an electronic billing component, 40% of colonoscopy study participants report an electronic medical record component. Only 12% of cataract organizations report that feature, Kuznets says.

In addition to the electronic medical record, 47% of the colonoscopy study organizations reported that their scheduling systems decreased the time required when the procedure was scheduled and when it occurred, she adds. These technological features enable colonoscopy organizations to continue

SOURCES/RESOURCE

For more information about the Ambulatory Surgery Non-Clinical Study Report, contact:

- **Naomi Kuznets**, PhD, Director, AAAHC Institute for Quality Improvement, 5200 Old Orchard Road, Suite 200, Skokie, IL 60076. E-mail: nkuznets@aaahc.org.
- **Linda Pavletich**, RN, BSN, CASC, LHRM, Administrator, St. John's Surgery Center, 8901 Conference Drive, Fort Myers, FL 33919. Telephone: (239) 481-8833. Fax: (239) 481-7898. E-mail: stjohnsurgery@earthlink.net.

To order a copy of this study, contact the Institute for Quality Improvement by phone at (847) 853-6060 or fax at (847) 853-9028. Copies of the study also can be purchased by going to aaahciqi.org and clicking on "publications." The cost of the study for organizations that did not participate is $100 for a CD-ROM ($125 for a hard copy) for each of the reports on colonoscopy and cataract extraction, or $150 for a CD-ROM ($175 for a hard copy) for the combined report. Shipping and handling charges start at $12.

to streamline their activities and improve waiting and facility times, she says. **(For tips from colonoscopy study participants, see article, below.)**

The biggest surprise in the comparison of the two studies came in the patient satisfaction area, says Kuznets. "The assumption is that colonoscopy patients would be less satisfied with the overall experience because of the nature of the procedure, but we found that 98% of both groups of patients were satisfied with their overall experience," she says.

"Because patient satisfaction levels do depend on patient expectations prior to the procedure, we assume that patient expectations of the colonoscopy experience are so negative that they are pleasantly surprised and very satisfied to find that it isn't as bad as they thought it would be!" Kuznets adds. ■

Results compare cataract, colonoscopy study groups

Results of the recent Ambulatory Surgery Non-Clinical Study for Cataract Extraction with Lens Insertion and Colonoscopy include the following statistics:

- **Salaries.** Cataract organizations paid RNs a median annual salary including benefits of $53,400, while the median annual salary for RNs in colonoscopy organizations was $55,000. Median salary plus benefits for LPNs for cataract organizations was $39,000, and for colonoscopy organizations was $38,000. Surgical techs were paid a median salary and benefits of $36,700 in cataract facilities and $39,000 in colonoscopy facilities.
- **Accounts receivables.** The percentage of claims that were more than 90 days due was 5% for colonoscopy organizations and 4% for cataract organizations. Denial of claims as a result of incomplete claims or inaccurate information was low for both types of organizations: less than 1%.
- **Purchasing.** Sixty percent of cataract organizations and 67% of colonoscopy organizations participated in purchasing groups. While 64% of cataract and 67% of colonoscopy organizations in the study had inventory tracking systems, 33% of the cataract organizations used an electronic system, while only 19% of the colonoscopy organizations had an electronic system. Two-thirds of participants in both studies used reusable supplies. ■

Staff costs affected by mix of staff, tenure

Supply costs also examined in benchmark study

Reaction to the results of the "staff costs" category of the Ambulatory Surgery Non-Clinical Study for Cataract Extraction with Lens Insertion was mixed, with the organization that reported the lowest cost expressing surprise and the organization posting the highest cost not planning any changes. The study was conducted by the Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement.

Staff costs for the procedure ranged from $26 to $220, with a median of $110. "I was surprised that we posted the lowest staff cost in the study because we use an all RN staff," says **Kathleen Donigan**, administrator of the Michigan Center for Outpatient Ocular Surgery in Fraser. "My physicians are constantly asking me about mixing LPNs or surgical techs in with the RNs to hold costs down, so this study confirms my belief that a highly experienced, well-trained staff can be cost efficient, even with RN salaries," she says.

"I use a combination of full-time and part-time staff members in the operating room, but everyone is cross-trained to work in the clinic so I can move them to another part of the center if the surgery department is slow," says Donigan.

Cross-training also is one way that the Northeastern Eye Institute Ambulatory Surgery Center in Scranton, PA, keeps staff costs down as the third lowest reported staff cost in the study, says **Mary Ann Labas**, RN, supervisor. All of the RNs and technicians know how to sterilize instruments, she says.

"My pre-op staff is trained to work in recovery, and scrub nurses are trained to operate lasers," she says. The surgical technicians also type, so they can help secretaries with administrative tasks as well, Labas adds. "This flexibility lets us move people around to make the best use of their time."

Labas does have a mix of surgical techs, LPNs, RNs, per diem, full-time, and part-time staff. "It's important to have a mix of staff so you can schedule based on caseload," she adds.

At St. John's Surgery Center in Fort Myers, FL, **Linda Pavletich**, RN, BSN, CASC, LHRM, administrator, was not at all surprised that they posted the highest staff costs. "We have 25 people on staff and our turnover is very low, so I have people who have been here a long time," she says. "I have six RNs who have been here 10 years or longer, and with that tenure, you will be paying more for an experienced nurse as opposed to a younger, less experienced nurse."

Her staff is a mixture of part-time and full-time staff, so she does have the flexibility to send people home when the schedule slows, says Pavletich. "We work as late as necessary to complete the procedures schedule for the day, so some days we start at 6:30 a.m. and finish at 2 p.m.; other days we start at 6:30 a.m. and finish at 7 p.m.," she says. "In our case, the experienced staff is necessary to handle the 4,500 cataract extractions we perform each year, so I don't plan any changes."

Although her staff costs per procedure were the highest, Pavletich's supply cost per procedure were the second lowest in the study at just more than $100 per case.

They have standardized all of their supplies so they can buy in volume to cut costs, she says. "We are not part of a buying group because we've found that it is easier for us to get the best price by negotiating our own price based on our volume and our needs," she adds. "For everyday supplies such as intravenous catheters, we use a local supplier to save on shipping costs."

Median supply costs: $310

Supply costs per case reported in the study ranged from $95 to $1,347, with a median of $310. In addition to standardization, Pavletich is able to keep her cost below the median by having two staff members who handle inventory. "I have one person responsible for the bulk supplies and one person responsible for specialty supplies such as lenses," she explains.

With only 25 people on staff, communication with the staff members responsible for ordering is easy, so they can stay on top of unusual needs or expected changes in scheduling, she says. Her staff members order one month's supplies at a time.

"We did belong to a buying group for a while, but we've found that we get a better price negotiating for ourselves," says Donigan. "We order every week so that we keep as little inventory as necessary in the center."

Not only does this system save on space needed for storage, but it also keeps them from accumulating supplies they don't use, she adds. In fact, 26 of the 33 organizations that participated in the cataract study order on a weekly basis. Available storage space for study participants ranged from 30 to 3,000 square feet within the facility, with a median of 441 square feet.

Most organizations in the cataract study use an inventory tracking system to monitor inventory and make usage projections for the future. ■

SOURCES

For more tips from participants in the Ambulatory Surgery Non-Clinical Study for Cataract Extraction with Lens Insertion, contact:

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Same-Day Surgery Manager

Want to be cost-efficient? Consider these ideas

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

Do you ever compare yourself with others? Do you compare how you look and what you weigh? What about how much you make and what kind of car you drive? What about other things, like your supply cost per case? What are other people paying for the same stuff you buy? Nothing riles us quicker than thinking we have been taken advantage of in some aspect of life.

Well, prepare to compare!

Average supply cost for outpatient surgery knee arthroscopy performed in an ambulatory surgery center (ASC) by an investing surgeon is $375. If you are hospital-based, I can bet you are upset about that one! Chances are yours are almost three times that amount. What about supply cost for cataracts? Including the intraocular lens (IOL), it is about $350 in an ASC via an investing surgeon.

A reader from Chicago sent me an e-mail the other day: "What to you think is the best way to reduce turnaround time in our not-for-profit hospital? We cannot pay bonuses to the staff like the for-profit surgery centers."

Answer: Au contraire. Of course you can bonus your staff in the hospital market. It is so simple I am shocked that not every hospital does it. Simply send your OR teams home when they have finished their elective cases — with full pay! Rotate your staff so it is fair.

Why hospitals continue to reinforce disincentives for productivity confounds me! Why have staff stay the full day to get a full day's pay, rather than given them incentives to finish their cases early (and giving them full pay)?

An ASC from Texas asks, "How much should we be subsidizing anesthesia to provide coverage to our center? They say that they do not make money on our Medicare cases. The current group wants $1,000 per day — even if we do no cases!"

Answer: No one should subsidize anesthesia services. Like all businesses, we make more money on some things than we do on others. Anesthesia does very well on the non-Medicare cases, and that should balance the equation.

A reader in California asks: "What for-profit ASCs have profit sharing for their staff?"

Answer: The smart ones.

Other areas of cost-efficiency for you to consider:

- A well-run, for-profit ASC should never incur overtime.
- Being hospital based is no excuse for being inefficient in time management. So many of the managers I deal with keep saying that. Stop hiding behind that self-imposed barrier.
- Your administrator or department head always should work longer hours than their staff.
- Any nursing position that deals with surgeon complaints should make more than those that do not.
- IOLs for cataracts can cost as low as $45 per lens.
- The ophthalmologist who performs cataract procedures in your ASC also should perform

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. **The semester ends with this 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

- Where can you find outpatient surgery policies on the web?
- How to solve compliance problems with safety goals
- Policies and procedures on body piercing
- Where to find quality data for outpatient surgery programs

their YAG laser procedures there as well.

• Your operating rooms should never function above 78% of time utilization. Otherwise you lose the ability to "flip-flop" rooms for a more rapid turnover.

(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.) ■

Surgery providers warned of TASS outbreak

An increased incidence of toxic anterior segment syndrome (TASS) following outpatient cataract surgery has been reported recently, according to an alert issued by the American Society of Cataract and Refractive Surgery and the American Academy of Ophthalmology.

TASS is an acute, sterile anterior segment inflammation following uneventful cataract and anterior segment surgery. Most patients with TASS will develop symptoms within 12 to 24 hours of the surgery.

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.

21. What is true of the requirements for improvements (RFIs) since the Joint Commission on Accreditation of Healthcare Organizations launched its unannounced surveys in January?
A. The number of RFIs have increased for hospitals and ambulatory care facilities.
B. The number of RFIs have decreased for hospitals and ambulatory care facilities.
C. The number of RFIs have stayed the same for hospitals and ambulatory care facilities.

22. Why is it important to keep patients warm in the outpatient surgery area, according to Cynthia Spry, RN, MA, MSN, CNOR?
A. To keep them comfortable.
B. To make it easier for the anesthesiologist to anesthetize them.
C. To prevent hypothermia, which slows healing and increase risk of infection.
D. To keep staff comfortable.

23. What is one reason that her cataract patients rarely have to wait past their scheduled appointment, according to Linda Pavletich, RN, BSN, CASC?
A. The number of procedures is limited throughout the day.
B. Patients are never given a set appointment time, just a 15-minute range.
C. Block scheduling means that nurses are setting up for the same surgeon throughout the day.
D. Procedures are canceled if there are delays.

24. According to Stephen W. Earnhart, MS, what is the best way to reduce turnaround time in a not-for-profit hospital?
A. Pay bonuses to the staff.
B. Post turnaround times for each case with the names of the people who worked that case.
C. Schedule inservices on the topic of turnaround times.
D. Send your OR teams home with full pay when they have finished their elective cases.

Answers: 21. A; 22. C; 23. C; 24. D.

Surgeons are encouraged to closely monitor patients with increased postoperative inflammation and to report suspicious outbreaks to Nick Mamalis, MD, at the University of Utah's Ocular Research Center at nick.mamalis@hsc.utah.edu or (801) 581-6586. Surgeons also can call the Centers for Disease Control and Prevention's Division of Health Care Quality Promotion at (800) 893-0485. ■