Same-Day Surgery®

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IN THIS ISSUE

- How to handle requests for new products 135
- Issues related to older patients. 138
- Physiology of elderly surgical patients. 139
- Tips to improve care of elderly. 140
- ***SDS Manager:*** Credentialing surgeons at an ASC, plus more answers to your questions 142
- How can you get patients to comply with fasting? 143
- Outpatient anesthesia systems evaluated 143

- **Inserted in this issue:**
  — 2006 *SDS* index of stories
  — Evaluation form for CE/CME subscribers

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How do you save money on implants, stay within legal, ethical boundaries?

$345,000 settlement, national investigation gets managers' attention

In light of a $345,000 out-of-court settlement and a national investigation of implant manufacturers, outpatient surgery managers are looking intensely at spiraling implant costs and their own purchasing agreements and wondering, what exactly is considered illegal or unethical behavior when purchasing implants?

A surgery center and its artificial joint supplier are repaying the Medicare system $345,000 in a whistle-blower case that left both accused of violating the Stark anti-kickback statute.[1] **Spencer Greendyke**, MD, the physician whistle-blower, worked from 1999 to 2004 for the facility that was the surgery center's primary owner and served on its board of directors, according to the U.S. Attorney's office. From 2002 to 2003, the physicians accepted payments from Stryker Corp. as an incentive to use its orthopedic products, according to a court complaint. Stryker listed the payments as rent for space to be used for trade shows and programs, but the space was never used by Stryker, according to the lawsuit. When Greendyke used non-Stryker products in knee replacements, he had to go to a different facility where they weren't banned, the lawsuit says. Stryker's

CMS final OPPS rule doesn't link inpatient quality, outpatient updates

Medicare additions, deletions to ASC list announced

In the final 2007 rule for the hospital outpatient prospective payment system (OPPS), officials with the Centers for Medicare & Medicaid Services (CMS) decided against linking inpatient quality reporting to the outpatient payment update. Instead, CMS officials will develop outpatient quality measures and require hospitals to report them starting in 2009.

(See OPPS rule, page 136)

arrangement "led to an inflated price for the products sold by Stryker within the region," according to the lawsuit. Under the False Claims Act, Greendyke can receive up to 25% of the damages.

Additionally, the U.S. Department of Justice is investigating the orthopedic implants industry for possible criminal violations of antitrust and other laws.[2]

And outpatient surgery managers face another challenge concerning implants. "Implant prices overall have skyrocketed, over a 100% increase over the last 10 years or so," says **Judy Schanel**, CHE, vice president for the neurosciences, orthopedic, trauma, and rehabilitation services lines at Moses Cone Health System in Greensboro, NC. "Reimbursement hasn't nearly been that high," she adds. Additionally, an increasing number of private payers refuse to reimburse surgery centers for their implant costs because they claim the cost is included in the procedure fee.

All of these legal and financial developments have brought attention to purchasing arrangements for implants. One strategy that has proven successful for many providers is the capping of implant prices. The University of Pittsburgh Medical Center has saved millions on its implant prices, compared with the retail prices, with this approach, says **William C. Welch**, MD, FACS, chief of neurosurgery and director of neurosurgical spine services at the University of Pittsburgh Medical Center. Welch also is Peter E. Sheptak professor of neurological surgery in the departments of neurological surgery, orthopedic surgery, and rehabilitation science and technology at the University of Pittsburgh School of Medicine.

With this approach, a facility sets maximum prices and informs manufacturers that they will pay only that amount, Welch says. At the University of Pittsburgh, the process started with the physicians meeting as a group with the purchasing department staff and examining costs of the most common surgeries, he says. Purchasing staff suggested prices to the physicians, and they decided what seemed reasonable. "We said, as a group, that an

EXECUTIVE SUMMARY

One surgery center and its artificial joint supplier have agreed to repay Medicare $345,000 in a case that accused them of violating the Stark anti-kickback statute when payments allegedly were offered for exclusively providing that brand of implants. Additionally, the U.S. Department of Justice is investigating orthopedic implant companies for criminal violations.

- The capping of implant prices has proven successful for many providers, including one that says this one change has saved them millions when comparing their prices with retail prices.
- Gainsharing for providers and physicians has been proposed in national legislation, and the Centers for Medicare & Medicaid Services is setting up a project to evaluate gainsharing.
- Any vendor relationship should benefit the patient, according to guidelines from the Academy of Orthopaedic Surgeons.

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Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@ahcmedia.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@ahcmedia.com).
Senior Production Editor: **Nancy McCreary**.

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Editorial Questions
Questions or comments?
Call **Joy Daughtery Dickinson** at (229) 551-9195.

implant for single-level cervical fusion [for example] would be paid at a fixed rate, no matter what implant was used," Welch says.

When using this approach, consider the entire implant system, he advises. "So in the case of an intracervical plate, you need a plate and four screws," Welch says. "Screws can have radically different costs, and plates can have radically different costs."

What was the vendor reaction? "They were displeased," he says. However, they understand that capping prices is the nature of the business, Welch adds.

Downsides of capped prices

When capping prices, keep in mind that there should be exceptions for highly specialized products, Welch says. "This system was not designed to cover every possible scenario, but cover the vast majority of surgical procedures we perform," he says.

The system is not without a downside, he warns. "Once you have a capitation system or a cap in place, there's a strong disincentive for companies to offer the latest technologies," Welch says. "All surgeons like to use the most advanced system, and we don't routinely have access to the most advanced system because of the cost structure." By using an older system, physicians may encounter a slightly increased degree of difficulty or increased time with a procedure, he adds.

Moses Cone Health System also has found success with capping prices, Schanel says. It took a long time to determine fair prices, she recalls. Managers looked at the lowest price that some vendors were charging, Schanel says. "We told the others that if they wanted to keep supplying us, they had to meet those prices." Her strategy had the backing of her CEO, board of trustees, and physicians, Schanel says. "That needs to happen, because physicians and vendors will go everywhere [to perform surgery]," she emphasizes.

Still, the process was difficult, Schanel acknowledges. Surgeons received a significant amount of pressure from vendor representatives to use their implants, she says. "The orthopedic surgeons said, 'Just leave us out of this,'" Schanel says. Neurosurgeons told vendors the same thing, she adds.

The hospital officials set a deadline for the vendors and said that if they hadn't signed a contract, they wouldn't schedule any more cases using that product. "We didn't get much beyond a week of that deadline, and vendors starting realizing that physicians were no longer scheduling cases with them, and they agreed to the price," Schanel says.

Lawmakers and regulators look at gainsharing

The concept of gainsharing in which cost savings on implants and other supplies are shared between physicians and facilities also has gotten a significant amount of attention. A specialty hospital bill (S1002) that is under consideration by the Senate Finance

Value analysis program helps keep down costs

With implant and other costs spiraling upward and reimbursement falling behind, outpatient surgery managers are always searching for ways to keep down these costs. One idea that has proven success is the establishment of a value analysis program for purchases.

Beaumont Hospital in Royal Oak, MI, has an aggressive value analysis program for its orthopedic purchases, says **Allynn Petersen**, RN, administrator of surgery. Orthopedic surgeons frequently can be "swept off their feet" by vendors selling the newest systems, she says. At Beaumont, a person with biomedical engineering experience serves as the director of value analysis and examines these new systems to see how they are different from older systems, Petersen says. He analyzes the components and also performs literature searches, she adds.

The surgeons are very receptive to this analysis, Petersen says. "I think they respect him, and I think they like that he does some of homework for them," she says. "He's actually able to help them sort out the differences."

Additionally, hospital staff educate the surgeons on costs, she says. This educational process, together with the value analysis, helps them, Petersen says. "They come to strong conclusions," she says. "They'll say, 'Don't use it then.'"

In other cases, the value analysis indicates that the product is valuable. In that case, the hospital sets a price limit and lets the surgeon select the vendor. "It's similar to what we pay for something else, unless it can be proven that it's a definite step up." *[Editor's note: Do you have an idea for keeping down costs in your outpatient surgery program? Contact Joy Daughtery Dickinson, Senior Managing Editor,* Same-Day Surgery. *Phone: (229) 551-9195. Fax: (229) 551-0539. E-mail: joy.dickinson@ahcmedia.com.]* ■

SOURCE

For more information on implants, contact:
- **Judy Schanel**, CHE, Vice President for Neurosciences, Orthopedic, Trauma and Rehabilitation Services Lines, Moses Cone Health System, 1200 N. Elm St., Greensboro, NC 27401-1020. Phone: (336) 832-8243.

Committee includes a section that would allow gainsharing between providers and doctors through safe harbors under the Stark anti-kickback law. Additionally, the Centers for Medicare & Medicaid Services (CMS) has announced a three-year gainsharing demonstration project that will focus on inpatient hospital resources. (For more information, go to www.cms.hhs.gov/apps/media/press/release.asp?counter=1957.)

The American Academy of Orthopaedic Surgeons has issued a position paper on gainsharing. One foundation of those guidelines is that any vendor relationships should be able to withstand public scrutiny, says **E. Anthony Rankin**, MD, second vice president of the academy and chief of orthopedic surgery at Providence Hospital in Washington, DC. "All relationships with industry reps should be legitimate and disclosed to patients," he says.

Use conflict of interest forms to have physicians disclose their relationships with manufacturers, such as conducting research or serving on their advisory board, Petersen advises. Those physicians having relationships with vendors should not participate in decision making, she says. Have these forms signed annually, Schanel advises. "You're reminded on an annual basis of your responsibility," she says.

While the concept of gainsharing in general violates fraud and abuse laws, the Office of Inspector General of the Department of Health and Human Services has signaled through several advisory opinions that if the proper safeguards are in place, they will not seek sanctions against providers and physicians for participating in gainsharing, Rankin says. The concept of gainsharing to reduce costs and improve financial performance is good, he says. "But the fact of the matter is, they violate fraud and abuse laws, so when one enters into that, it has to be clearly established that the safe harbors are addressed," he says. *(To access the advisory opinions. Go to oig.hhs.gov. Click on "Fraud Prevention and Detection" and then "Advisory Opinions." For the date 02/25/05, click on "Advisory Opinion 05-06" and "Advisory Opinion 05-05." For the date 02/17/05, click on "Advisory Opinion 05-04," "Advisory Opinion 05-03," "Advisory Opinion 05-02," and "Advisory Opinion 05-01.")*

Another critical part of the gainsharing guidelines is that any vendor relationship should benefit the patient, Rankin says.

"Patient care is the primary purpose of our profession, so we have to keep the patient as the central focus," he says. "If we keep patients at the center of decision making, and [conflicts of interest] are kept transparent for patients, it is less of an issue." **(For more tips on how to control implant costs, see story, p. 135.)**

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2. Lee VD, Swiatek J. U.S. probe targeting 3 orthopedics firms in state. The Indianapolis Star. Accessed at www.indystar.com/apps/pbcs.dll/article?AID=/20060627/BUSINESS/606270449&SearchID=73249133274363. ■

OPPS rule

(Continued from cover)

Rick Pollack, executive vice president of the American Hospital Association (AHA), said in a prepared statement that the AHA is pleased that CMS will develop quality measures specifically for the outpatient setting and has given hospitals enough time to implement a reporting system for hospital outpatient services. "We had concerns with CMS' earlier proposal because connecting outpatient payments to inpatient measures is an 'apples to oranges' comparison that would undermine hospitals' efforts to make useful and reliable quality data available to the public," he said. **(For more information on the proposed rule, see "HOPDs rate updated, tied to quality measures," *Same-Day Surgery*, September 2006, p. 100.)**

CMS is adding 21 procedures to the list of those that are reimbursed in ambulatory surgery centers (ASCs) for 2007. Two of the procedures are for surgical services furnished to maintain vascular access fistulas and grafts for hemodialysis patients. **(See additions, p. 137.)** Additionally, CMS is adjusting the payment group for 10 CPT codes. **(See changes, p. 137.)** Also, due to revisions by the American Medical Association to the 2007 CPT codes, CMS is adding an additional 25 codes to the ASC list and deleting 22 codes. **(See**

deletions, p. 138.)

In addition, beginning Jan. 1, Medicare beneficiaries will be required to pay a 25% copayment for screening colonoscopies (CPT G0105 and G0121), according to the Federated Ambulatory Surgery Association (FASA). Previously, beneficiaries paid a 20% copayment, FASA says. Only the copayment is increased, the organization says.

In other parts of the final rule:

• CMS is implementing in a provision of the Deficit Reduction Act that requires that Medicare payment for surgical procedures performed in ASCs not exceed the Medicare payment for the same procedures when they are performed in a hospital outpatient department. This change means that the payments for 275 procedures will be capped at the hospital outpatient department (HOPD) rates, which cuts the rates of 269 procedures on the ASC list beginning Jan. 1, 2007, according to FASA. These reductions can be viewed at www.fasa.org/asclist/cuts.pdf.

CMS reports that adding the procedures to the ASC list and capping payment for 275 procedures on the ASC list will result in savings of about $15 million to the Medicare program in 2007.

• The rule contains a 3.4% payment rate update for hospitals. After taking into account other factors that affect the level of payments, CMS officials estimate that hospitals will receive an overall average increase of 3%.

• CMS will continue to pay separately for brachytherapy sources, but it will base payment on the source-specific median costs for brachytherapy sources, as seen in hospital outpatient claims data. Payment will be on a per-unit source basis rather than on a per-day basis.

• CMS will reduce the payment for ambulatory payment classifications (APCs) with significant costs for implanted devices when a device is replaced without cost under warranty or recall. CMS will reduce the beneficiary coinsurance proportionately.

• The rule will begin the transition from the current policies for administering hospital outpatient claims using fiscal intermediaries and carriers to the new Medicare Administrative Contractors (MACs). Under the rule, hospitals will file their claims with the intermediary with jurisdiction over the hospital's geographic location until a MAC replaces the intermediary. CMS is adopting a policy that all providers and suppliers generally be assigned to a MAC based on geographic location. However, a large qualified

Payment Changes

CPT Code	Descriptor	Change
19298	Place breast rad tube/caths	From Group 1 to Group 9
22522	Percut vertebroplasty addl	From Group 1 to Group 9
36475	Endovenous rf, 1st vein	From Group 3 to Group 9
36476	Endovenous rf, vein add-on	From Group 3 to Group 9
36478	Endovenous laser, 1st vein	From Group 3 to Group 9
36479	Endovenous laser, vein add-on	From Group 3 to Group 9
46947	Hemorrhoidoplexy by stapling	From Group 3 to Group 7
58353	Endometr ablate, thermal	From Group 4 to Group 7
58563	Hysteroscopy, ablation	From Group 4 to Group 9
58565	Hysteroscopy, sterilization	From Group 4 to Group 9

Additions to ASC List

HCPCS	Short Descriptor	Payment Group	CPT	Short Descriptor	ASC Payment Group
13153	Repair wound/lesion add-on	3	13102	Repair wound/lesion add-on	1
19295	Place breast clip, percut	1	13122	Repair wound/lesion add-on	1
31620	Endobronchial us add-on	1	13133	Repair wound/lesion add-on	1
43257	Upper gi scope w/thrml txmnt	3	19297	Place breast cath for rad	9
57267	Insert mesh/pelvic flr add-on	7	21356	Treat cheek bone fracture	3
61795	Brain surgery using computer	1	22520	Percutaneous vertebroplasty, thor	9
G0392	AV fistula or graft arterial	9	22521	Percutaneous vertebroplasty, lumb	9
G0393	AV fistula or graft venous	9	22522	Percutaneous vertebroplasty, add'l	9
0176T	Aqua canal dilat w/o retent	9	36818	AV fuse, upper arm, cephalic	3
0177T	Acq canal dilat w retent	9	43761	Reposition gastrostomy tube	1
			46946	Ligation of hemorrhoids	1

provider chain will be allowed to file all claims with the MAC that has jurisdiction over the chain's home office.

The final OPPS rule does not affect changes to the ASC payment system that will take effect on Jan. 1, 2008. The ASC payment system final rule is expected to be published in spring 2007, CMS says. ■

Deletions Medicare ASC List

PHCPCS	Short Descriptor
67350	Biopsy eye muscle
57820	D&C of residual cervix
56720	Incision of hymen
54820	Exploration of epididymis
55859	Percut/needle insert, pros
49085	Remove abdomen foreign body
31700	Insertion of airway catheter
28030	Removal of foot nerve
27315	Partial removal, thigh nerve
27320	Partial removal, thigh nerve
26504	Hand tendon reconstruction
25611	Treat fracture radius/ulna
25620	Treat fracture radius/ulna
21300	Treatment of skull fracture
19140	Removal of breast tissue
19160	Partial mastectomy
19162	P-mastectomy w/ln removal
19180	Removal of breast
19182	Removal of breast
15831	Excise excessive skin tissue
15000	Wound prep, 1st 100 sq cm
15001	Wound prep, addl 100 sq cm
67350	
57820	
56720	

Source for all charts: Centers for Medicare & Medicaid Services, Baltimore.

RESOURCES

- **For information on ambulatory surgery center payment issues**, contact Dana Burley at the Centers for Medicare & Medicaid Services (CMS). Phone: (410) 786-0378.
- **For information on hospital outpatient payment issues**, contact Alberta Dwivedi at CMS. Phone: (410) 786-0378.
- **To access the final payment rule for the 2007 hospital outpatient prospective payment system**, go to www.cms.hhs.gov/center/hospital.asp and click on "CMS-1506-FC."

Programs face challenge with older patients

Physiological, psychological, emotional needs differ

With individuals who are ages 65 and older undergoing almost one-third of the 25 million surgical procedures performed annually, and with people ages 85 and older representing the fastest growing segment of our population,[1] it is important that any surgical program pay close attention to the special needs of older patients. Because you send patients home within hours of their procedures, it is especially important for outpatient surgery staff to be aware of these special needs, according to experts interviewed by *Same-Day Surgery*.

"Perioperative nurses must become geriatric specialists in order to fully meet the needs of this burgeoning population," says **Patricia Stein**, RN, MAOL, CNOR, nurse education specialist for perioperative services at Palomar Pomerado Health System in Escondido, CA. "An elderly surgical patient has less 'bounce back' after surgery, and there is less wiggle room for error of any kind," she says.

Know effects of medications

While perioperative care for all patients requires thoroughness and attention to detail, it is particularly important to pay close attention to your

EXECUTIVE SUMMARY

As more procedures are moved to the outpatient setting and as our population ages, outpatient surgery programs are seeing more patients ages 65 and older. Along with their age, these patients bring a set of needs that greatly differs from the typical young, healthy outpatient surgery patient.

- Assessment must include a thorough listing and analysis of the effect of multiple medications on post-surgical recovery and potential complications during surgery.
- Evaluate the patient's mental status and ability to understand and follow discharge instructions.
- Require that a responsible adult is available not only to transport the patient home, but also to listen to discharge instructions and be with the patient during recovery at home.

assessment of an older patient, says **Jim B. Wilkerson**, RN, BSN, CCRN, outpatient surgery supervisor at Pomerado Hospital in Poway, CA. "Older patients are often on a number of medications, and you must be aware of how those medications, as well as their own physiological changes, might affect surgery," he says.

Elderly are individuals

The definition of elderly or older may differ for various outpatient programs, but generally it is defined as age 65, says **Jackie Close**, RN, MSN, certified nurse specialist in gerontology at Palomar Pomerado Health System. "Age 65 is used only because it has been set by the government as the age for retirement and therefore the beginning of 'old age,' but 65 is nothing more than an arbitrary number with no scientific data to support the decision," she says. Nurses must consider individual differences and characteristics when planning and implementing care for the older adult, such as overall health, activity level, and cognitive function, Close recommends.

One example of a difference between a younger patient and an older patient is skin resilience, Wilkerson points out. "A patient that might have been on steroids for a long time will have fragile skin," he says. This fragile skin means that the patient might bruise easily from a blood draw or have skin torn by adhesive bandages, he adds. "Also, be sure to ask if the patient is bruised or suffering from skin breakdown anywhere on their body so you can pad and position the patient to prevent further pressure on these injured areas," he suggests. **(For other tips on caring for older surgical patients, see story p. 140.)**

Even starting an intravenous line should be done with special care, recommends Stein. An everyday elastic tourniquet can injure fragile skin, so consider using a blood pressure cuff instead of

(Continued on page 141)

Physiological changes affect reaction to surgery

No one enjoys undergoing surgery or approaches surgery without some anxiety, but older patients have physiological reasons that may increase their apprehension and confusion about surgery, according to **Patricia Stein**, RN, MAOL, CNOR, nurse education specialist for perioperative services at Palomar Pomerado Health System in Escondido, CA.

• Impaired senses.

Not only are vision and hearing affected by age, but also by medications, anxiety, and the noises and activity in strange surroundings. "These impaired senses will affect the ability of the older patient to grasp what is being said or to read through of all of the papers that he or she is required to sign," says Stein. "The patient is taking in as much as possible so don't push the patient to hurry or quickly sign papers."

One way to make it simpler for older patients to comprehend is to make all preprinted material easy to read, says Stein. "Consider large-print font for preoperative consents," she suggests.

• Body temperature.

"Thermoregulation is impaired so the older patient will not shiver until their temperature drops lower than a younger patient who has better temperature regulating ability," Stein says. Expect that the older patient will get colder sooner and take longer to bring their temperature back up, she says. "This alone will slow the metabolism of the medications that the patient is receiving preoperatively and intraoperatively."

Nurses should keep the patient warm, even if they have not complained about cold, says Stein. "Consider preoperative warming systems that prewarm the patient prior to the move into surgery," she suggests.

• Musculoskeletal changes.

Changes in the older patient's musculoskeletal system that decrease the range of motion for patient limbs and proprioception affect balance, especially if preoperative medications are administered, says Stein.

• Vascular and cardiac functions.

"A decrease in elasticity of both the arteries, and the muscles and nerves that surround them, affect vascular and cardiac functions," Stein says. "Contractility and irritability will be affected, medications given will take longer to take effect, and impaired kidney and renal function will affect drug clearance, especially of lipid-soluble medications like propofol," she says.

• Risk of infection.

"The elderly patient has a weaker immune system because of fewer T-cell production and maturation," explains Stein. "For this reason, exquisite attention to strict principles of asepsis must be followed," she states. ■

Tips for caring for older surgical patients

Knowing the physiological differences between your older patients and your younger patients is a good start to providing care that addresses their needs, but some of the things you can do to help the patient don't involve clinical skills, says **Jim B. Wilkerson**, RN, BSN, CCRN, outpatient surgery supervisor at Pomerado Hospital in Poway, CA.

Don't just assess the patient. Consider the caregiver's health and ability to provide post-surgical care as well, Wilkerson says. Sometimes the surgical patient is actually the caregiver for a spouse who may be medically fragile, he explains. "Ask about the current home situation, and make sure that needs such as transportation to a physician's office for follow-up visits are possible," Wilkerson says. If there is a concern, help the patient find home care services or another family member who can help, he suggests.

Discuss financial issues

During the preoperative visits and assessments, be sure that patients understand their insurance, their responsibilities for copayments, and any other financial obligations. "Older patients live on a fixed income, so they are more concerned about being able to make payments," says Wilkerson. "It's not like a younger patient who might just work overtime or take a part-time job to cover extra expenses." Have resources in the community or within your hospital that you can call upon to provide extra help for the patient, he suggests.

Because it is likely that the patient is on a variety of medications, tell the patient to bring in the bottles so that an accurate list of them can be made at the preoperative visit, suggests **Patricia Stein**, RN, MAOL, CNOR, nurse education specialist for perioperative services at Palomar Pomerado Health System in Escondido, CA. "Determine which ones are to be taken preoperatively and which ones should be withheld, especially medications that affect clotting, glucose control, or blood pressure," she says.

Use 'Mr.' and 'Mrs.'

You should respect the dignity of the patient, using proper pronouns when addressing him or her, she says. "For example, use 'Mrs. Smith' rather than 'Hazel' when speaking to the patient," Stein says. Make eye contact when talking to the patient but with sensitivity to cultural differences for which eye contact may not be positively received, she says. "Allow the patient to speak for him or herself rather than depend upon a relative or friend for answers," Stein adds.

"It will be difficult for the patient to tolerate a vigorous bowel prep if you are performing an endoscopic or bowel procedure or to be NPO for an extensive length of time," points out Stein. If possible, schedule an elderly patient's surgery or procedure so that it is completed early in the day, she suggests. At the same time, recognize that getting to the hospital at 5:30 in the morning for a first case may be difficult, Stein adds.

Secure all prostheses especially hearing aids, false teeth, and glasses prior to surgery, but make them available to the patient as soon as is safe, says Stein. Making sure that the patient can see and hear and look normal makes them more comfortable as they recover and prepare for discharge, she adds.

"Allow the patient to hug and kiss their loved ones goodbye prior to the move into the operating room," says Stein. Although surgery is a routine procedure for the busy staff of an outpatient program, undergoing a surgical procedure is not easy for the patient or family, she adds.

Increase staff sensitivity

Helping your staff members develop sensitivity to an older patient's needs is a matter of education, says Stein. "Invite a clinical nurse specialist or other nurse professional who is knowledgeable about caring for the older patient speak to the staff at an inservice," she suggests.

Help staff members develop empathy for older patients by letting them experience the same challenges, recommends Stein. For example, have a staff member put on earmuffs to simulate difficulty with hearing, remove glasses or put them on to simulate difficulty seeing, and add an ice pack to bring down the temperature of the body, she says. Other ideas include hobbling on one leg to help with understanding impaired mobility and then having that person obtain several instructions at once in quick consecutive order from many caregivers, she adds.

"It is important that we show genuine concern and empathy for our older patients," says Wilkerson. "Outpatient surgery is so technical and fast-paced that we get used to an assembly-line pace of work, but when we are dealing with older patients who have faced a life full of challenges, we need to slow down and ask them, 'How can I make this better for you?'" ■

(Continued from page 139)

a tourniquet to apply a more even, less pinching device to properly obtain access, she suggests.

Assess cognitive status

Another key difference between older patient and a younger patient is mental status, Stein says.

"There is a decrease in short-term memory, and patients are at risk for postoperative dementia and confusion," she says. Add these cerebral function changes to the effects of multiple medications for a variety of medical conditions, and you must be especially careful that the patient understands what will happen during their time in the surgery program and after discharge, she points out. **(To read about other physiological changes, see story p. 139.)**

Patients also experience sensory changes that they may not want to admit, says Wilkerson. "A patient may not be able to see clearly enough to read discharge instructions or may not clearly hear or comprehend the instructions you give verbally, but they will nod and react as if they do," he says. To ensure comprehension, Wilkerson suggests that nurses ask the patient to point to or read something, such as the phone number of the physician to call if there are problems. Asking the patient to repeat information back to the nurse is also effective, he adds.

Give instructions to caregiver

Requiring a family member, friend, or other responsible adult who will be with the patient when he or she goes home to listen to the discharge instructions also is critical, Wilkerson says. "We require the responsible adult to sign the discharge forms because the patient is still under the effects of anesthesia and won't know what is being signed," he says. "Older patients often don't remember being told anything about care at home, so it is important for another adult to be there to hear the instructions and remind the patient that the nurse explained everything before discharge."

An important point to explain to the adult caregiver is an older person's susceptibility to delirium following anesthesia, says Wilkerson. It doesn't occur with every patient, but it is not uncommon for a patient to become delirious, confused, and even combative in the middle of the night following surgery," he says. Because this can be very frightening to a caregiver, be sure that you explain the possibility of this occurring so that they are not surprised, he adds.

Because the first step in caring for an older surgical patient is the initial assessment, Close suggests, "allow yourself extra time for the interview and assessment. We must not hurry our older patients because when we don't listen, we miss out on very valuable information that could impact their surgical experience."

Reference

1. Muravchick S. Geriatric anesthesia — Are you ready? American Society of Anesthesiologists. 2006. Web: www.asahq.org/clinical/geriatrics/geron.html. ■

SOURCES/RESOURCES

For more information about caring for older surgical patients, contact:

- **Patricia Stein**, RN, MAOL, CNOR, Nurse Education Specialist for Perioperative Services, Palomar Pomerado Health System, 555 E. Valley Parkway, Escondido, CA 92025. E-mail: sanger1956@yahoo.com.
- **Jim B. Wilkerson**, RN, BSN, CCRN, Outpatient Surgery Supervisor, Pomerado Hospital, Poway, CA. Telephone: (858) 613-4000. E-mail: Jim.Wilkerson@pph.org.

For more information about older patients, see:

- **www.GeroNurseOnline.org.** This is the official geriatric nursing site of the American Nurses Association and contains information and links to a wide range of information about nursing care for older patients. Choose "resources" on the top navigational bar, then select "assessment tools" on the right navigational bar to access tools that can be used to assess pain or dementia, and conduct an overall assessment of the elderly in a health care setting.
- **www.emedicine.com.** Site offers a tool to help nurses assess a patient's mental status. Select "resource centers" from top navigational bar, then choose "dementia." On left navigational bar, scroll down to "eTools" and select "Mini Mental Status Tool."
- **American Society of Anesthesiologists.** Go to www.asahq.org, select "Clinical Information" on left navigational bar, then choose "Syllabus on Geriatric Anesthesia" on right navigational bar. Articles discuss effects of anesthesia on elderly patients, differences in respiratory and cardiovascular systems of elderly, and information on different anesthetics and medications.

Same-Day Surgery Manager

Q&A: Do surgeons have to be credentialed at ASC?

Also: turnaround, preop tests, hoarding supplies

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

Question: We have a new surgery center, and I have the job (I am being punished) of taking care of the credentialing of the surgeons. I have a couple of questions. I have been told that if the surgeons have credentials at the local hospital, then they need not be re-credentialed at the surgery center. Further, I have been told that the CRNAs (certified registered nurse anesthetists) do not need to be credentialed since they are "certified." This is actually a great relief to me as several of the surgeons have told me that they would not fill out the paperwork again. I am correct, right?

Answer: I am about to ruin your day. First, your surgeons have credentials at the local hospital, but that has nothing to do with your facility (even if is partly owned by the hospital in a joint venture arrangement). You absolutely, categorically, unequivocally, must credential them at your center. I can certainly understand why they do not want to go through the hassle of the credentialing process again, but they must. It's part of the responsibility of using the facility.

As far as the CRNAs go, just being certified does not exclude them from needing to be credentialed as well. Looks like a bad day for you.

Question: I am a surgeon at the [name withheld] surgery center in Louisiana. I am also an investor in this facility. We have a medical director that is one of the ENT surgeons who started this place about a year ago. I just found out that he is being paid by the surgery center $95,000 for this role. It was my understanding that the medical director of a surgery center gets paid no more than $25,000. Could you please provide me with the literature that states that amount to be paid?

Answer: Actually, there is no such literature. The medical director is paid, essentially, whatever the board of directors says he or she is entitled to receive. There are many medical directors of surgery centers that receive from nothing up to $200,000 (maybe higher) for the service they provide. *[Editor's note: For more information on medical director salaries, see the ASC Employee Salary & Benefits Survey report from the Federated Ambulatory Surgery Association (FASA). The cost is $35 for FASA members and $125 for nonmembers. To order the publication, go to www.fasa.org/Publicationsorder form.doc or call FASA at (703) 836-8808.]*

Question: What is the average hospital-based ASC [ambulatory surgery center] turnaround time that you are seeing out there?

Answer: For hospital-based ASCs that like to follow procedures, it seems as if the average is about 45 minutes from the time the first patient leaves the room until the next patient goes in. While that number still is high, it is better than it was a couple of years ago.

Question: Our hospital requires extensive preop testing for ambulatory patients. I found out this requirement when my relative had surgery here last month. In addition to all the lab and EKG work, he also had to have a chest X-ray even though he is a nonsmoking 28-year-old male. The self-pay part of the bill was more than $350! Why does the hospital require all this expensive testing?

Answer: Actually, the pre-op testing is usually required by the department of anesthesia, not the hospital, so be aware of the culprit. Most facilities have pared back on what is required for essentially healthy individuals requiring surgery. Some stay with the old. It wouldn't hurt to go to your chief and explain to him what you told me. Let me know if you get anywhere.

Question: I understand that you are an RN and past administrator of surgery centers. So let me ask you, why does the staff hoard supplies and implants over and above par inventory levels? Are they really that afraid of the surgeons?

Answer: Shakespeare said, "Cowards die many times before their deaths. The valiant never taste of death but once." Well, I have a string of tombstones as far as the eye can see. I can tell you from experience that none of us want to tell the surgeon who has a sleeping patient on the table that we don't have something they need.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact

Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

JOURNAL REVIEW

Tell patients reason for pre-op fasting

In a recent study, only 22% of patients surveyed correctly understood the reason for fasting before outpatient surgery.[1] Patients who didn't understand the reason were nearly five times more likely to underrate the importance of compliance.

Of the 100 patients surveyed, 2% said they did not comply by fasting, and 4% said they would consider misrepresenting whether they had fasted if it was inconvenient for them to postpone the surgery.

"The results of this study suggest a need to better inform day surgery patients about the reason for preoperative fasting," the authors conclude. "A better understanding of the need for preoperative fasting may lead to improved compliance and patient safety.

However, there is another way of looking at the results. "That even though patients don't understand pre-op — or even post-op — instructions, compliance is generally high, with little sequela for complications," says **Rebecca S. Twersky**, MD, MPH, medical director of the Ambulatory Surgery Unit at Long Island College Hospital and professor of anesthesiology at State University of New York Downstate, both in Brooklyn.

Reference

1. Walker H, Thorn C, Omundsen M. Patients' understanding of preoperative fasting. *Anaesth Intensive Care* 2006; 34:358-361. ■

ECRI evaluates anesthesia systems

ECRI, a nonprofit health services research agency, has evaluated two anesthesia systems designed for the outpatient surgery setting.[1]

The two systems evaluated were the Datex-Ohmeda S/5 Aespire 7100 and the Draeger Medical Fabius Tiro. ECRI evaluated the systems for their ability to meet the typical patient's needs, the adequacy of the systems' safety

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

- Most organized surgery managers share tips
- Challenges for ASC competency programs
- Cost-effective method to track inventory, maintain equipment
- Improve staffing efficiency with HR administrator
- Innovative staffing solutions from outpatient surgery managers

features, the comprehensive of their pre-use checks, and their ease of use.

"The two systems we evaluate in the current study offer performance similar to that of the inpatient units, without many of the (often expensive) features that would likely go unused in an ambulatory surgery setting," the authors conclude.

In July 2006, ECRI evaluated six systems designed for inpatient surgery that also could be used in outpatient surgery.

Reference

1. ECRI. Anesthesia systems for ambulatory surgery settings. *Health Devices* 2006; 35:316-329. ■

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. Which of the following statements is true of gainsharing?
A. Gainsharing is illegal in all circumstances, according to the Office of Inspector General.
B. While the concept of gainsharing in general violates fraud and abuse laws, the Office of Inspector General has signaled through several advisory opinions that if the proper safeguards are in place, they will not seek sanctions.
C. Gainsharing is legal in all circumstances, according to the Office of Inspector General.

22. Which of the following is true of the final hospital outpatient prospective payment system rule for 2007?
A. CMS officials will connect outpatient payment rate updates to inpatient quality measures.
B. CMS officials will develop outpatient quality measures and require hospitals to report them starting in 2009.
C. There will be no outpatient quality measure in the foreseeable future.

23. What is one way to start an intravenous line on an elderly patient without injuring their fragile skin, according to Patricia Stein, RN, MAOL, CNOR, nurse education specialist for perioperative services at Palomar Pomerado Health System?
A. Use a standard tourniquet
B. Use a blood pressure cuff to apply pressure
C. Use different locations for each IV
D. Use smallest IV tube

24. According to Stephen W. Earnhart, MS, CEO of Earnhart & Associates in Austin, is it necessary for a freestanding surgery center to re-credential physicians if they have credentials at the local hospital?
A. Yes
B. No

Answers: 21. B; 22. B; 23. B; 24. A.

2006 Index

Accreditation
- AAAASF revisions simplify some requirements, APR *SDS Accreditation Update*:3
- Credentialing & QI post challenges for office programs, OCT *SDS Accreditation Update*:1
- Delays, postoperative complications rank high in percentage of sentinel events, JAN *SDS Accreditation Update:*1
- Emergency preparedness standards, others change — AAAHC clarifies number, type of emergency drills, JAN *SDS Accreditation Update:*2
- Fixed performance areas listed for random surveys, JAN *SDS Accreditation Update:*1
- How one agency meets privileging standards, *SDS Accreditation Update:*3
- Items to Have Available for Surveyors, JUN:64
- JCAHO changes focus on disaster preparedness — Use of volunteers, review of plans clearly defined, MAY:55
- JCAHO tips to avoid medication errors, APR *SDS Accreditation Update:*4
- JCAHO to publish separate ASC standards, JUL *SDS Accreditation Update*:4
- JCR offers do-no-use abbreviation kit, JAN *SDS Accreditation Update*:4
- Joint Commission updates look-/sound-alike list, OCT *SDS Accreditation Update:*4
- Last-Minute Joint Commission Clean-Up List, JUN:63
- New JCAHO standard requires flu vaccine, AUG:90
- New patient safety goals added for next year, AUG:89
- Patient safety issues need your attention — Surveyors want to see staff follow policies, OCT *SDS Accreditation Update*:3
- Random unannounced surveys end in 2007, APR:48
- Rapid response teams are not just for inpatient units, APR *SDS Accreditation Update:*1
- Surveyors want to see follow up to studies — Med labels, credentialing, staff training important, OCT:115
- Surveyors want up-to-date info, details in documents, JUL *SDS Accreditation Update:*3
- Three National Patient Safety Goals present compliance challenge in outpatient surgery, JUL *SDS Accreditation Update*:1
- When you go through an unannounced survey, will you sink or soar? JUN:61
- You can't bluff your way through patient tracers, JUN:64

Alternative Medicine
- *Journal Review:* Study identifies top 10 herbals used by patients — Surgeons not aware of potential side effects, MAY:58
- *SDS Studies:* Effect of hypnosis on preoperative anxiety in adult ambulatory patients, MAR:322

Anesthesia/Pain management
- Clinical guideline on nausea posted on-line, NOV:130
- ECRI evaluates anesthesia systems, DEC:143
- Minimal sedation cuts costs, improves outcomes, MAR:31
- Research help available to study pain — Web-based program provides tools, protocols, MAR:33
- *SDS Journal Review:* Tell patients reason for pre-op fasting, DEC:143
- *SDS Studies:* Duration of anesthesia as an indicator of morbidity and mortality in office-based facial plastic surgery, MAR:32
- What do you need for sleep apnea patients? New guidelines address outpatient cases, JAN:10

Cost Containment (Also see *Finances* and *Medicare)*
- How do you save money on implants, stay within legal, ethical boundaries? DEC:133
- *SDS Manager:* Want to be cost-efficient? Consider these ideas, JUN:71
- You can save a lot of money buying from on-line auctions, but is it a good idea? APR:37

Disaster Preparedness and Response
- Emergency preparedness standards, others change — AAAHC clarifies number, type of emergency drills, JAN *SDS Accreditation Update:*2
- Hurricanes point out disaster plan weaknesses, MAY:57
- JCAHO changes focus on disaster preparedness — Use of volunteers, review of plans clearly defined, MAY:55

When looking for information on a specific topic, back issues of *Same-Day Surgery* newsletter may be useful. If you haven't activated your on-line subscription yet so that you can view back issues, go to www.same-daysurgery.com. On the left side of the page, click on "activate your subscription." You will need your subscriber number from your mailing label. Or contact our customer service department. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: customerservice@ahcmedia.com.

Documentation/Tools
Checklists ID supplements and verify safety steps — Pre-op and post-op forms for charts save times, MAY:59
HHS Pandemic Influenza Plan, Supplement 3 Healthcare Planning — Nonhospital Health Care Facilities, OCT:111
ISMP, FDA provide free toolkit to reduce errors, OCT:120
Items to Have Available for Surveyors, JUN:64
Last-Minute Joint Commission Clean-Up List, JUN:63
Research help available to study pain — Web-based program provides tools, protocols, MAR:33
Sample Bylaw: Economic Credentialing, JUL:76

Equipment/Supplies (Also see *Laparoscopy/endoscopy/colonoscopy* and *Technology)*
Argon plasma coagulation minimizes risk of injury, APR:42
CMS approves $50 added fee for new IOL, APR:46
CMS clarifies payment for implants, prosthetics, JUL:81
How do you save money on implants, stay within legal, ethical boundaries? DEC:133
Payment and Billing for Items/Services That Are Not ASC Facility Services, JUL:81
Think twice before buying from [on-line] auctions, APR:40
Value analysis program helps keep down costs, DEC:135
You can save a lot of money buying from on-line auctions, but is it a good idea? APR:37

Finances (Also see *Medicare* and *Reimbursement)*
Upfront efforts result in better collections, JUL:78

Freestanding Centers (Also see ***Medicare* and *Surgical Hospitals)***
AHA deplores migration to outpatient centers, SEP:103
ASC payments to be cut to hospitals' level, FEB:17
Center given moratorium after abuse allegations, AUG:92
Change to HOPD rates to impact specialties, MAY:53
JCAHO to publish separate ASC standards, JUL *SDS Accreditation Update:*4
Some surgeons can open centers or work at the local hospital, but not both, JUL:73
Will centers make money with the move to APCs? MAY:52

Hospital-Based Programs
AHA deplores migration to outpatient centers, SEP:103
CMS final OPPS rule doesn't link inpatient quality, outpatient updates, DEC:133
HOPD rate updated, tied to quality measures, SEP:100
Hospital, docs responsible in impairment case — Doctor fired, then given glowing recommendation, AUG:91
MedPAC recommends 2007 payment update — One system would lose $1.1 million in revenue, MAY:54
Some surgeons can open centers or work at the local hospital, but not both, JUL:73
Surgical site infection rate drops to zero in months, JUN:65

Infection Control
AAMI incorporates several practices into one [on steam sterilization], AUG:88
AORN addresses environment and safety [reuse of single-use devices], MAR:29
Are you prepared for a pandemic? Leading facilities share how to gear up, OCT:109
CDC issues updated TB prevention guidelines, APR *Patient Safety Alert:*2
CDC to conduct survey on outpatient surgery, APR:47
Don't be one of the horror stories — Learn proper use of flash sterilization, AUG:85
Educate your staff, and hold pandemic drills, OCT:113
Educating staff is critical piece [of flash sterilization], AUG:88
Environmental control, education cut infections, JUL:76
Health care workers may imperil patients by snubbing influenza vaccinations, JAN *Patient Safety Alert*:1
HHS Pandemic Influenza Plan, Supplement 3 Healthcare Planning — Nonhospital Health Care Facilities, OCT:111
How to limit spread of respiratory illnesses, OCT:112
New JCAHO standard requires flu vaccine, AUG:90
Surgery providers warned of TASS outbreak, JUN:72
Surgical site infection rate drops to zero in months, JUN:65

Laparoscopy/Endoscopy/Colonoscopy
Blue Cross sued over payment policy — Payments to increase for non-hospital endoscopies, AUG:94
Staff costs affected by mix of staff, tenure — Supply costs also examined in benchmark [colonscopy] study, JUN:69
Study compares business practices, technology use — Cataracts and colonoscopy are focus, JUN:67

Management (Also see *Cost Containment, Disaster Preparedness and Response, Finances, Patient Satisfaction/Public Relations, Quality Improvement/Quality Assurance/Benchmarks, Regulation, Salary/Career, Staffing/Staff Satisfaction,* and *Surgeons*
AHA deplores migration to outpatient centers, SEP:103
AORN addresses environment and safety [reuse of single-use devices, environmental responsibility, patient safety, and tissue banking], MAR:29
Educate office staff to improve [physician] utilization, FEB:23
Liposuction, exercise, and nutrition = good outcomes, NOV:128
Monitor utilization to ID nonproductive surgeons, FEB:22
Operating costs vary widely in MGMA survey, MAR:34
SDS Manager: A tale of two managers — Where is the grass greener? NOV:129
SDS Manager: Want to be cost-efficient? Consider these ideas, JUN:71
SDS Manager Q&A: Do surgeons have to be credentialed at ASC? Also: turnaround, pre-op tests, hoarding supplies, DEC:142
SDS Manager Q&A: Expanding your OR space and others managers' issues — Tips for tackling staffing, profit-sharing, MAY:57
SDS Manager Q&A: Nurse manager retires and other quandaries, FEB:21
SDS Manager Q&A: Questions about bonuses, moving GI procedures — CRNA administrators, lap bands are OK? AUG:95
SDS Manager Q&A: Should you shop for a better deal? Management companies, mergers, and other issues, MAR:35
SDS Manager Q&A: Staff and physician woes, plus question on OR size, JUL:80
SDS Manager Q&A: Time to celebrate reimbursement changes? Q&A:

Expansion, investors, and late staff, OCT:117
SDS Manager Q&A: When to cut the cord with a management company — Also: Moving up, moonlighting, and other issues, APR:45
Staff costs affected by mix of staff, tenure — Supply costs also examined in benchmark study, JUN:69
Study compares business practices, technology use, JUN:67

Medicare
ASC payments to be cut to hospitals' level, FEB:17
Bariatric surgery available to more Medicare patients, APR:46
Change to HOPD rates to impact specialties, MAY:53
CMS adds 14 procedures, but cuts other payments, SEP:100
CMS adds 32 codes, cuts 10 from ASC list, JAN:12
CMS approves $50 added fee for new IOL, APR:46
CMS clarifies payment for implants, prosthetics, JUL:81
CMS final OPPS rule doesn't link inpatient quality, outpatient updates, DEC:133
CMS posts data on ASC payments, OCT:118
HHS: ASC list will include all procedures except for those with risks, overnight stays, FEB:13
Highlights: MedPAC Report on Health Care Spending, SEP:104
HOPD rate updated, tied to quality measures, SEP:100
MedPAC recommends 2007 payment update — One system would lose $1.1 million in revenue, MAY:54
Panel: Insurers favor more costly back pain treatments — CMS doubles rate for less invasive procedure, APR:43
Under proposed rule, ASCs would be paid 62% of the hospital OPD rate, SEP:97
Will centers make money with the move to APCs? MAY:52

New Procedures and Programs (Also see *Laparoscopy/Endoscopy/Colonoscopy* and *Surgeons)*
Bariatric surgery available to more Medicare patients, APR:46
New treatments for the back cut costs, NOV:127
Panel: Insurers favor more costly back pain treatments — CMS doubles rate for less invasive procedure, APR:43
Streams of water balloons offer back pain relief, NOV:125
You must screen patients carefully [for back pain treatments], NOV:126

Nurses (Also see *Patient Education/ Consent)*
AORN addresses environment and safety, MAR:29
Boost patient satisfaction: Keep families informed — Liaisons keep everyone up-to-date and informed, JAN:5
Clinical guideline on nausea posted on-line, NOV:130
Massachusetts considering patients-per-nurse limits, JUL *Patient Safety Alert*:1
Nurse liaison must communicate well, JAN:7

Patient Education/Consent
Do you hear me? Do you understand me? Patients don't always process instructions correctly, SEP:101
Environmental control, education cut infections, JUL:76
Has the patient given informed consent? Surgery staff is last line of defense, NOV:121
Nagging questions on informed consent, NOV:123
SDS Journal Review: Tell patients reason for pre-op fasting, DEC:143

Patient Safety (Also see *Infection Control* and *Risk Management)*
Alert addresses medication errors, APR *SDS Accreditation Update*:2
AORN addresses environment and safety, MAR:29
CDC issues updated TB prevention guidelines, APR *Patient Safety Alert*:2
Do you benefit from these surgeries? *Consumer Reports* says maybe not — Magazine tells patients to check out safer alternatives, FEB:13
Drugs can cause problems during cataract surgery, OCT:118
Health care disparities narrow for many, APR *Patient Safety Alert*:2
Health care workers may imperil patients by snubbing influenza vaccinations, JAN *Patient Safety Alert:*1
Hospital reports critical results within one hour, OCT *Patient Safety Alert:*1
ISMP, FDA provide free toolkit to reduce errors, OCT:120
Massachusetts considering patients-per-nurse limits, JUL *Patient Safety Alert:*1
New patient safety goals added for next year, AUG:89
Patient safety issues need your attention — Surveyors want to see staff follow policies, OCT *SDS Accreditation Update*:3
Physiological changes [of elderly] affect reaction to surgery, DEC:139
Programs face challenge with older patients, DEC:138
Rapid response teams are not just for inpatient units, APR *SDS Accreditation Update*:1
SDS Journal Review: Ergonomics research offers patient safety tips, OCT:119
SDS Journal Review: Tell patients reason for pre-op fasting, DEC:143
Study: Quality, patient safety improving at a modest pace, APR *Patient Safety Alert*:1
Three National Patient Safety Goals present compliance challenge in outpatient surgery, JUL *SDS Accreditation Update*:1
Tips for caring for older surgical patients, DEC:140
To tape or not to tape: How do you handle jewelry? OCT:114
What do you need for sleep apnea patients? New guidelines address outpatient cases, JAN:10

Patient/Family Satisfaction/Public Relations
Boost patient satisfaction: Keep families informed — Liaisons keep everyone up-to-date and informed, JAN:5
Center finds way to make holidays more meaningful, NOV:131
Nurse liaison must communicate well, JAN:7
Patients happy with liposuction procedure, SEP:106
SDS Manager: Want to make patients, staff, and surgeons happy? SEP:105
SDS Studies: Effect of hypnosis on preoperative anxiety in adult ambulatory patients, MAR:32
Technology reassures families in waiting rooms, FEB:19
Ticket to satisfaction: Personal movie players, APR:40

Quality Assurance/Quality Improvement/Benchmarks
CMS final OPPS rule doesn't link inpatient quality, outpatient updates, DEC:133
Credentialing & QI post challenges for office programs, OCT *SDS Accreditation Update*:1
Staff costs affected by mix of staff, tenure — Supply costs also examined in benchmark study, JUN:69

Study: Quality, patient safety improving at a modest pace, APR *Patient Safety Alert*:1

Reimbursement (Also see *Medicare)*
Blue Cross sued over payment policy — Payments to increase for non-hospital endoscopies, AUG:94
Panel: Insurers favor more costly back pain treatments — CMS doubles rate for less invasive procedure, APR:43

Risk Management/Medical Errors (Also see *Infection Control* and *Patient Safety)*
3 cases of identity theft involve surgery, emergency departments, MAR:27
3 more procedures article warns against, FEB:16
Adopt a written anti-harassment policy, JAN:8
Argon plasma coagulation minimizes risk of injury, APR:42
Center given moratorium after abuse allegations, AUG:92
Don't simply ignore repeated offenses — Facilities address inappropriate conduct, harassment, JAN:8
Hospital, docs responsible in impairment case — Doctor fired, then given glowing recommendation, AUG:91
How do you save money on implants, stay within legal, ethical boundaries? DEC:133
Identity theft cases jump radically, outpatient surgery is at risk — MAR:25
In light of 2 criminal cases, how do you ensure employees don't abuse patients? JAN:1
ISMP warning: Providers confuse Carpuject syringes, AUG:93
JCAHO tips to avoid medication errors, APR *SDS Accreditation Update*:4
JCR offers do-no-use abbreviation kit, JAN *SDS Accreditation Update:*4
Joint Commission updates look-/sound-alike list, OCT *SDS Accreditation Update*:4
Surgeons less likely to disclose errors, NOV:124
Take these steps to cut liability risk — When staff act suspicious, take action, JAN:4
Think twice before buying from [on-line] auctions, APR:40
You can save a lot of money buying from on-line auctions, but is it a good idea? APR:37
When you have pregnant staff, protect them and their fetuses from harm. Don't put yourself at risk for sex discrimination — Follow suggestions, MAY:49

Salary/Career
Avoid hiring woes by keeping your current good employees, NOV *Salary Survey* Supplement:1

Staff Education
Educate your staff, and hold pandemic drills, OCT:113
Educate office staff to improve [physician] utilization, FEB:23
Educating staff is critical piece [of flash sterilization], AUG:88
Environmental control, education cut infections, JUL:76

Staffing/Staff Satisfaction
Adopt a written anti-harassment policy, JAN:8
Avoid hiring woes by keeping your current good employees, NOV:*Salary Survey* Supplement
Boost patient satisfaction: Keep families informed — Liaisons keep everyone up-to-date and informed, JAN:5
Boost your staff's morale with these ideas, JAN:9
Don't simply ignore repeated offenses — Facilities address inappropriate conduct, harassment, JAN:8
Health care workers may imperil patients by snubbing influenza vaccinations, JAN *Patient Safety Alert*:1
In light of 2 criminal cases, how do you ensure employees don't abuse patients? JAN:1
Massachusetts considering patients-per-nurse limits, JUL *Patient Safety Alert*:1
Nurse liaison must communicate well, JAN:7
SDS Manager Q&A: Expanding your OR space, and others managers' issues — Tips for tackling staffing, profit-sharing, MAY:57
SDS Manager: Want to make patients, staff, and surgeons happy? SEP:105
Tackling staffing, profit-sharing, MAY:57
Take these steps to cut liability risk — When staff act suspicious, take action, JAN:4
Volunteers add extra touch in outpatient surgery, JUL:82
When you have pregnant staff, protect them and their fetuses from harm. Don't put yourself at risk for sex discrimination — Follow suggestions, MAY:49

Surgeons and Office-Based Surgery
(Also see *New Procedures and Programs)*
3 more procedures article warns against, FEB:16
Adopt a written anti-harassment policy, JAN:8
Credentialing & QI post challenges for office programs, OCT *SDS Accreditation Update*:1
Don't simply ignore repeated offenses — Facilities address inappropriate conduct, harassment, JAN:8
Educate office staff to improve [physician] utilization, FEB:23
Hospital, docs responsible in impairment case — Doctor fired, then given glowing recommendation, AUG:91
How one agency meets privileging standards, *SDS Accreditation Update*:3
Journal Review: Study identifies top 10 herbals used by patients — Surgeons not aware of potential side effects, MAY:58
Monitor utilization to ID nonproductive surgeons, FEB:22
New organization helps office surgery programs, MAY:60
On-line or on paper — peer review is key, OCT *SDS Accreditation Update*:3
SDS Manager: Want to make patients, staff, and surgeons happy? SEP:105
Some surgeons can open centers or work at the local hospital, but not both, JUL:73
Surgeons less likely to disclose errors, NOV:124

Surgical Hospitals
Final report issued on specialty hospitals, SEP:101
Surgical hospitals finally have good news, JUL:82

Technology
Study compares business practices, technology use, JUN:67
Technology reassures families in waiting rooms, FEB:19