Same-Day Surgery®

30th Anniversary

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IN THIS ISSUE

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JUNE 2007
VOL. 31, NO. 6 • (pages 65-76)

Media and lawsuits put spotlight on awareness in outpatient surgery

With emphasis on cutting time and costs, how can you prevent it?

With National Public Radio, *Oprah,* and other media outlets covering patient awareness during anesthesia, many outpatient surgery providers report an increasing number of questions about the issue from their patients.

Prepare for even more. This fall, a movie titled *Awake* will be released in which a man is awake but paralyzed during surgery. The movie is billed as doing for surgery what the movie *Jaws* did for swimming in the ocean, says **Richard J. Pollard**, MD, chief of neuroanesthesia at Southeast Anesthesiology Consultants in Charlotte, NC. Pollard recently presented an audio conference titled *Awake During Surgery: A Patient's and Surgeon's Nightmare,* which was sponsored by AHC Media, publisher of *Same-Day Surgery.* **(For information on ordering the CD, which includes tips for preventing awareness, see resource box, p. 67.)** Pollard and his peers just published a study on awareness in *Anesthesiology.*[1]

Recent cases of awareness have received national attention:

• One laparoscopic cholecystectomy patient received a large settlement after she reported being aware during surgery and hearing the surgeon

EXECUTIVE SUMMARY

A movie to be released this year about patient awareness — along with some well-publicized lawsuits — is bringing more attention to patient awareness.

- Rushing anesthesia providers can interfere with their ability to perform a through preoperative evaluation of factors that contribute to awareness, such as a patient's increased anesthetic requirement.
- Speeding patient extubation by five minutes per case may save 30-50 minutes a day, but it increases the potential for awareness and malpractice liability.
- Brain monitors can be one tool that helps avoid awareness.

call her a "fat whale," according to Pollard.

• In West Virginia, a Baptist minister had surgery to diagnose abdominal pain. The anesthesia providers gave him muscle relaxants but failed to give him general anesthesia until 16 minutes after the first cut. He was not told about the anesthesia incident, and he doubted his memories. After the procedure, he was unable to sleep, he was afraid of being left alone, and he complained of people trying to bury him alive. Two weeks after the surgery, he committed suicide. A lawsuit has been filed by the family. **[For more information about this case, see the April 20, 2007, issue of *Same-Day Surgery Weekly Alert.* If you are interested in receiving this free e-mail publication for subscribers, contact customer service at customer service@ahcmedia.com or call (800) 688-2421.]**

"This is outcome that can have a horrible devastating effect on your patient," Pollard says. "Even having it happen one time is too many."

There's an increased willingness to report awareness, he says. "So we will quite possibly see more of these patients on the front pages and come to the point we will meet them in the courtroom," Pollard says.

His views are backed by the American Society of Anesthesiologist closed claims database, which indicates an increased number of claims for awareness. In addition, 78% of those cases received payment, Pollard says. The size of damages is increasing, with the highest award at $850,000, he says.

What causes awareness?

According to Pollard, the causes of awareness include:

• **The patient receives too light anesthesia.** In Pollard's study, every patient who experienced intraoperative awareness had a low dose of the anesthetic agent, he says.[1]

• **Anesthesia machines malfunction or are misused.** "If your machine is not working, if it's not being meticulously maintained, if you haven't been able to give enough drug to patients because of breaks or errors with your machinery, the patient is not going to get enough anesthesia and is not going to be asleep during surgery," Pollard says.

• **The patient has increased anesthetic requirements.** Anesthetic requirements may be increased by factors such as whether they drink alcohol or take medications, Pollard says. To address this potential problem, ask the patient about medications, previous operations, and previous problems, he advises. A thorough evaluation before surgery is critical, Pollard says, "but that can bring us into conflict with people who want us to move fast."

Due to the need to reduce dosages of medications, other patients at risk for anesthesia awareness include cardiac surgery (2%-4% of patients at risk for awareness), obstetric surgery (0.4%-1% of patients at risk for awareness), and trauma surgery (11%-43% of patients at risk for awareness), Pollard says.

Other trends may be contributing to the problem of anesthesia awareness, including total IV

Same-Day Surgery® (ISSN 0190-5066) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Same-Day Surgery**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $495. Add $9.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

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Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@ahcmedia.com).
Senior Production Editor: **Nancy McCreary**.

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

RESOURCE

A CD copy of the audio conference "Awake During Surgery: A Patient's and A Surgeon's Nightmare" is available for $299 including slides, from AHC Media, the publisher of *Same-Day Surgery*. To order, call (800) 688-2421 and ask for priority code **11T07162**. Or order online: www.ahcmediainteractive.com.

anesthesia, Pollard says. "There's been a trend in anesthesia to move away from inhalational agents to keep patients asleep more to shorter acting, easy-to-give medications through the IV," he says. Unfortunately, some of these medications do not provide amnesia, Pollard says. Also, muscle relaxants can hide a patient's response to surgery, he says.

Being alert to causes of awareness

When looking at ways to avoid awareness, keep in mind that muscle relaxants have no amnestic affect, sources says.

Michael Rieker, DNP, CRNA, director of the Nurse Anesthesia Program at Wake Forest University Baptist Medical Center in Winston-Salem, NC, says, "In cases where muscle relaxants are used heavily or patients are on beta-blockers or other antihypertensives, some signs of awareness may be masked by these medications."

Also keep in mind that benzodiazepines have a drip half-life of only 1½ hours, Pollard says. "If the case is two hours, three hours, or longer, and you have only a single dose of benzodiazepines on board, the protective affects of that agent may be gone," he warns. All six cases of awareness in his study used midazolam, he reports. **(For a discussion of whether brain monitors can reduce the potential for awareness, see story, right.)**

Awareness may continue to be a problem as long as there is an emphasis on decreasing costs, sources say. This trend can lead to less anesthesia being administered, Pollard warns.

Outpatient surgery may be particularly at risk for awareness because of time issues, sources say. Rieker says, "Any time an anesthesia practitioner is rushed, there is the potential for them to miss an important piece of the patient's history." Most of the components of assessing awareness risk are fairly straightforward, such as history of legal or illegal drug use, or previous awareness under anesthesia, Rieker says. "If the anesthetist is rushed to the point of not determining such basic components of the preoperative assessment, awareness will not be the only complication plaguing the institution," he warns.

If the anesthetist feels compelled to run a "light" anesthetic to speed wake-up or avoid nausea, or to discontinue the anesthetic early, these actions could contribute to awareness, sources say. Speeding patient extubation by five minutes may save 30-50 minutes if you are performing six to 10 cases per day. "However, the tragedy of patient awareness, not to mention the potential malpractice liability, vastly overshadows the benefit of saving this time," Rieker says. "Economics are important, but with awareness occurring in 100 patients every day in the United States, cutting corners in the anesthetic is not a tenable risk."

Reference

1. Pollard RJ, Coyle JP, Gilbert RL, et al. Intraoperative awareness in a regional medical system. *Anesthesiology* 2007; 106:269-274. ■

Should you use a brain monitor?

So what's the answer to avoiding patient awareness under anesthesia?

Not necessarily brain monitors, says **Richard J. Pollard**, MD, chief of neuroanesthesia at Southeast Anesthesiology Consultants in Charlotte, NC.

"We have very low incidence of recall, and we don't use brain monitors of any variety," he says. Pollard's research indicated an incidence rate of 0.0068%.[1] **(For Pollard's specific concerns about brain monitors, see CD copy of the audio conference "Awake During Surgery: A Patient's and A Surgeon's Nightmare." Ordering information is in resource box, above left.)**

Others see benefits in the monitors. **Michael Rieker**, DNP, CRNA, director of the Nurse Anesthesia Program at Wake Forest University Baptist Medical Center in Winston-Salem, NC, says, "Smaller same-day surgery centers may defer purchase of anesthetic agent monitors due to budgetary constraints, but these monitors can be a very useful tool in ensuring that the patient is receiving the intended amount of anesthetic." However, even Rieker warns that you shouldn't put your trust

completely in such monitors. "Unfortunately, there are many false-positives and false-negatives in the readings provided by the monitors we have," he says. "If an awareness monitor can fool you on even *one* patient, then you cannot put your total trust in it on *any* patient. " Instead, these monitors provide a bit of additional information that should be used to augment, verify, or dispute what the practitioner already has determined, he maintains. "Without the required degree of vigilance, insight, and clinical assessment acumen, awareness can occur with or without an electronic monitor," Rieker says.

Others who support the monitors include **Donald M. Mathews**, MD, associate chairman for academic affairs at the Department of Anesthesiology, St. Vincent's Hospital Manhattan (NY) and assistant professor of clinical anesthesiology at New York Medical College in Valhalla. "I personally use the monitors in all my patients who receive general anesthesia because I believe the information that I obtain allows me to make better decisions as I care for my patients," Mathews says. "A secondary benefit, and not the primary reason I use these monitors, is that I hope to decrease the chance of one of my patients experiencing awareness."

Reference

1. Pollard RJ, Coyle JP, Gilbert RL, et al. Intraoperative awareness in a regional medical system. *Anesthesiology* 2007; 106:269-274. ■

Insurance company ordered to pay for surgery

Insurer claimed gynecomastia case was cosmetic

An insurance company has been ordered to reimburse a father for his teenage son's gynecomastia surgery after it had refused on the grounds that it was a cosmetic procedure.[1]

The decision went all the way to the New York Supreme Court's Appellate Division.

Group Health Inc. (GHI) was ordered to pay for the surgery because it was 'medically necessary' for the boy to lead a normal life, the court says. GHI was ordered to pay $5,000 to the father, who had already paid for the surgery that cost $7,500.

"This would be one of the few cases of gynecomastia that has been covered in the last few years," says **Larry Pinkner**, MD, plastic surgeon and owner of SurgiCenter of Baltimore and past president of the American Association of Ambulatory Surgery Centers.

EXECUTIVE SUMMARY

Group Health Inc. has been ordered to reimburse a father $5,000 for his teen son's gynecomastia surgery after the insurer refused to pay on the grounds that it was a cosmetic procedure. To be successful in overcoming insurance objections to coverage of reconstructive procedures:

- Send documentation, including photos and letters from other physicians, indicating the extent of the patient's condition.
- Have the patient or family talk to their employer's human resources representative.
- Considering publicizing the case through media stories or legal action.

The father sued GHI in 2004, when the boy was 17. According to legal documents, the teen was teased by his peers and refused to attend an out-of-state university because he was afraid that students in his dormitory would ridicule him.[1] In an unanimous decision, the appellate division judges rejected the insurer's argument that the plaintiff did not suffer emotional turmoil. The judges said, in fact, that ''the patient suffers 'depression' and 'emotional distress' from this condition.'' The judge in the original case, Manhattan Civil Court Judge Barbara Jaffe, said in 2004 that the boy was unable to function as a normal teen because of the condition. She said it was ''an objective, tangible and unusual source of turmoil, more akin to a clubfoot or cleft palate than to a large nose, heavy acne or diminutive breasts on an adolescent female, all of which are relatively common.''[1]

This case illustrates a long-standing debate between surgeons and the insurance industry over what exactly is "cosmetic" and what is "reconstructive." For **Walter L. Erhardt Jr.**, MD, FACS, past president of the American Society of Plastic Surgeons and chair of the society's Public Education Committee, the distinction is clear: "Cosmetic surgery is designed so that you're taking something in the realm of what a prudent person would say is normal and you try to improve on it because the patient wants to do it electively," Reconstructive surgery is taking something the prudent observer would say is not within the realm of normal and you try to get it closer to normal."

Within the last five years, Erhardt has seen a significant change by insurance companies on

what procedures they are willing to cover.

The simplest way to avoid having to review a procedure is simply to exclude it, "and that seems to be the approach that's become more and more popular with the insurance industry," Erhardt says. "Gynecomastia is certainly one area where we have seen this." Pinkner says gynecomastia is almost always in the vague language of "reconstructive surgery is to restore function, and because there is no function of the male breast, surgery is cosmetic.

Reduction mammoplasty is another example of a procedure that often won't be covered by insurance companies, sources say. Insurance company reps will say, "I'm not telling you it's not appropriate or not medically indicated; I'm just telling you that based on our contract, this is not a covered procedure," Erhardt says. "It's becoming harder and harder for all of us in health care to provide appropriate health care to our patients when we have to deal with the insurance industry."

Consider these suggestions:

• Approach the insurance company armed with information.

As a first step, tell the insurance company exactly why the procedure is medically necessary, suggests **Robert Aicher**, Esq., general counsel for American Society for Aesthetic Plastic Surgery. The insurance company may require a second opinion and perhaps an examination by a physician selected by them, "but with perseverance, the process can be successful," Aicher says.

Consider sending a photograph that shows the condition of the patient, Pinkner suggests. In the case of gynecomastia surgery, a photograph can address the concern of the insurance company that a boy has breasts because he is obese. Also, the insurance company may request letters from pediatricians or other physicians that explains the patient's problems and how long the patient has had the condition.

• Have the patient or a family member become an advocate.

When a medically indicated procedure is rejected for payment, have the patients or their family members talk to their company's human resource representative, Erhardt advises.

"It's unfortunate, but it's one of those things where the squeaky wheel gets the grease," he says. Erhardt has seen insurance companies reverse their decision when this tactic is used.

• If turned down, consider publicizing the case through the media or through legal actions.

Erhardt says, "In the past, I've known insurance companies to back down when publicity comes to a case." He commends the father in this case. "So many times, it's like the patient, David, going against the insurance company, Goliath," Erhardt says.

This case is a triumphant one, Aicher says. "That father is a great example of the level of energy and perseverance often required to establish medical necessity and should be an inspiration to others in similar situations," he says.

Reference

1. Associated Press. Insurer must pay for boy breast surgery. Accessed at www.nytimes.com/aponline/us/AP-Boys-Breast-Reduction.html?ex=1176436800&en=bff55e2a176fc3e7&ei=5070&emc=eta1. ■

Same-Day Surgery Manager

Renew relationships with those who left you

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

Who hasn't had a significant surgeon leave your facility for greener pastures? What about that staff member whom you spend so much time with, who you develop into a world-class employee who seemed to master every task, only to see him or her lured or driven away to a competitor?

All of us in the industry have accumulated losses like these over the years. We whined and mentally cursed them, but we also felt sorry for our losses and experienced a deep sense of betrayal by their departure. Time, glorious time, normally has softened those losses. But has it really? Many of us wish we could get those key employees or surgeons back *(where they belong)* into our facilities after they *(learned their lesson)* realize that the grass is not always greener *(or it is only growing over a septic system)* and they want to *(come crawling back)* rejoin the team from whence

they left. Pride often prevents their return. Some of them feel as if they might have burned a bridge when they left.

The market is as tight as I have ever seen for attracting new staff and surgeons. There are so many options available to both groups that you really need to get innovative to remain competitive. Here are some suggestions on getting back that surgeon who left you:

1. Make a list of surgeons and staff that have left your facility over the past five years.

2. Put a negative (-) mark beside those who you danced in the street when they left. Put a plus (+) sign in front of the ones you were sorry to see go and wished you had back.

3. Take the "+" list and jot down the reason (or what they told you was the reason) they left. Get others on your staff to get their input, as you might not have all the facts.

4. Send each of the "+" list a card (to their home address) telling them that you and the staff miss them. If the reason they left has been resolved or eliminated, state that as well. For example: "Dear Dr. Brown. Several of us were sitting around the other day and reminiscing about how much fun we used to have when you did your cases here. We know that you were upset that we couldn't give you the block schedule that you had requested several years ago, but we have since expanded our facility and can now accommodate your requests. I would like to call you in a few days to discuss this with you. Thanks again for all the great times we had at _____ (facility)."

5. Wait a few days after you think the physicians have received their letters, and then call. Ask them to come back and do just one case so the staff have an opportunity to see them again and for them to see the improvements you have made.

6. Now do the same for staff members that have left. It is essentially the same format except that you might want to explain your new pay scale, flex hours, the fact that the supervisor who worked with them has retired, etc. In other words, often even minor changes can attract staff back to you. Many times when someone has left a job, they realize they made a mistake and would like to return to their old job but are embarrassed to do so. Give them an opening by contacting them first. You might be pleasantly surprised by their response. If you try this response, contact us to let us know how it works.

(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.) ■

You must prepare now for new payment system

Centers must make a 'monster effort'

Are you ready for the biggest change for ambulatory surgery centers in 20 years? The impact of other changes, such as preparing for Y2K, are dwarfed in comparison to the new payment system coming for ambulatory surgery centers, says **Judith L. English**, vice president of business operations at Surgery Consultants of America and Surgery Center Billing in Fort Myers, FL.

"I take a look at other changes, and it's going to be a monster effort on everyone's part" to get ready, English says.

Amazingly, some surgery centers managers are just now hearing about these dramatic changes, says **Craig Jeffries**, Esq., executive director of the American Association of Ambulatory Surgery Centers (AAASC).

At a recent seminar held by AAASC to educate members on preparing for payment changes, about 25 of 150 attendees seemed to fall into that category, says Jeffries, who spoke at the seminar. "My takeaway from that is that the administrator or physician owner is aware, or maybe the executive of the hospital who is overseeing the ASC, but it not necessarily at the level of learning and preparing for others who might need to be involved," he says. This lack of preparedness may be highest among administrators of single-specialty ASCs, and some specialties will be dramatically affected by the payment changes, Jeffries warns.

"Surgeons, anesthesiologists or medical directors, administrators, and directors of nursing — all those functional areas should begin to have a very clear understanding of the range of changes," he says. Additionally, the person who handles contract management needs to be prepared, Jeffries says.

The Centers for Medicare & Medicaid Services is expected to issue a proposed payment rule by August 2007, but it probably will be published by

early summer, Jeffries reports. The final rule is expected to be published by Dec. 1, 2007, he adds.

One quirk about the budgeting process this year is that that the budgeting process normally starts in August or September, but the payment changes won't be finalized by then, says **Caryl A. Serbin**, RN, BSN, LHRM, president of Surgery Consultants of America, who also spoke at the AAASC seminar. "The budget process in 2007 is going to be later," she says. "That's going to be the challenge."

As soon as the new rates are approved, those rates need to be added to the center's budget projections so that the impact on the bottom line can be assessed, Serbin says. Don't expect to take a lot of vacation time from the publication date through March, Serbin and English say. "There's going to be a lot of work to put the changes into place," Serbin says.

For now, you can examine what has been proposed for 2008. **(See "Under proposed rule, ASCs would be paid 62% of the hospital OPD rate," *Same-Day Surgery*, September 2006, p. 97.)** Make a spreadsheet looking at procedure codes that your center is doing, and look at how the reimbursement is supposed to change to determine the effect on your bottom line, Serbin suggests. However, keep in mind that this is just "preconceived notions," English says. For example, consider a multispecialty center that does a significant number of gastrointestinal (GI) cases. "You may say, 'I'm not going to increase the amount of GI, but if they come back and change GI [reimbursement] at the last minute due to lobbying, this may change your budget and what you're going to do; it may change the purchase of equipment," English says. "There's going to be a last-minute rush to do it right, we believe."

Put your costs under the microscope, Serbin advises. "First and foremost, determine if there is a way to decrease man-hours," she says. Multitasking will be essential for your staff, Serbin says.

Also take a close look at your medical supply costs. **(See upcoming issues of *Same-Day Surgery* for case studies of facilities that cut their supply costs by up to 25%.)** Negotiate with vendors, Serbin suggests. "From what I see, vendors are doing a good job of becoming educated about the system change, and they're trying to respond with some alternatives," she says. "I really don't feel like we're in this alone." **(For more suggestions on how to prepare, see story, right.)** ■

Going back to fundamentals will help you be prepared

In general, surgery centers will need to get back to basics in terms of cost accounting, budgeting, and contract management, in order to prepare for the new Medicare payment system, says **Craig Jeffries**, Esq., executive director of the American Association of Ambulatory Surgery Centers (AAASC).

"Those basic business issues are an important upgrade that many ASCs will need to focus on," Jeffries says. "Many surgery centers, especially single specialty, have not focused as much on fundamental business principles as they'll need to due to changes coming down."

Consider these suggestions:

• Determine new opportunities.

Get aggressive about your marketing plan, suggests **Caryl A. Serbin**, RN, BSN, LHRM, president of Surgery Consultants of America. Look at what specialties are doing well under the proposed plan, such as retinas and orthopedics, she says. "We're encouraging administrators to look at what procedure codes are paying and what the new opportunities are in markets," Serbin says. "They may have never wanted to approach retina surgeons, but now is that opportunity."

Single specialty centers that offer procedures that won't fare as well under the new payment plan, such as pain management, should consider joining forces with a specialty that will be better reimbursed, such as ortho, she advises.

• Start negotiating your managed care contracts early.

Look at your existing contracts and/or those tied to Medicare and begin the process of renegotiating, Jeffries advises. **(See how one surgery center saved $100,000, p. 72.)**

A lot of ASC managers thought the managed care organizations would know what they will be reimbursing at this point, Serbin says. "There's a lot of disappointment in that." The bottom line is, they don't, Serbin says. **Judith L. English**, vice president of business operations at Surgery Consultants of America and Surgery Center Billing in Fort Myers, FL, says, "It's as if they have their heads in the sand like ostriches."

Look at each contract individually, Serbin advises. "Fifteen contracts can be written 15 different ways," she warns. This might be a good time to have your attorney review the wording, Serbin advises.

• **Perform case costing.**

The centers that Serbin works with are taking one specialty a month, examining the costs for a number of procedure codes within each, and then discussing with Serbin and English what to do with that information, she says.

In terms of your fee schedule, make sure your fees still are going to give you the same percentage of profits that you're accustomed to or that you will require, Serbin advises. "Some will be going down, and some will be going up," she says.

Another area that managers are examining is the 100 plus procedures that had their reimbursement decreased in 2007, English says. **(For more information, see "ASC payments to be cut to hospitals' level," *Same-Day Surgery*, February 2006, p. 17.)** "They need to make sure those cases are not costing more than what they're being reimbursed for," English says.

Ensure your coders understand that there will be 500 more ASC codes in 2008, Serbin warns. "They'll be seeing some different things being done, different types of cases," she says.

• **Assess service contracts.**

Look at your contracts for housekeeping, information systems, and maintenance, Serbin suggests. "There's a lot of hidden dollars in maintenance contracts," she says. While you must have those contracts, determine if there can be some shared risk that might lower your dollar amount, Serbin says. If you've been open several years, you can estimate the benefit of the contracts. In other words, determine what you have spent, she says. "There may be some way to renegotiate that would be more beneficial for the surgery center," Serbin says.

• **Put money in the bank.**

Realize that your payments will not be accurate when the change takes effect, so you must audit 100% of them for accuracy, English warns. Also, they will be late, she advises.

"Be prepared that for the first three months after this takes place, you probably won't have reimbursement," she says. "You'd better have money put up ahead." Serbin suggests your center put away a cushion of several months. ■

Careful management of contracts saves $100K

Look at auto renew contracts

(Editor's note: This is the second of a two-part article that looks at key reasons for failure in outpatient surgery programs. Last month, we looked at human resource issues, and this month we examine key revenue areas that must be addressed to help a struggling program.)

Save $100,000 in one year? It takes time and effort, but the key to achieving this cost-saving milestone for Calumet Surgery Center in Munster, IN, was careful attention to contracts that automatically renewed themselves.

If you sign an automatic renewable contract, be sure to pay attention to the dates, warns **Denise Cheek**, RN, administrator. One of the first steps taken as her surgery center worked to pull itself out of financial trouble was to review managed care contracts carefully.

"Many of our contracts were signed a long time ago with minimum price adjustments identified and automatic renewals," she says. "When we compared the reimbursement to the actual costs of providing care to these patients, it was obvious that we would continue losing a lot of money if we continued the contracts."

It is not unusual for outpatient surgery programs to routinely lose money on managed care contracts, says **Thomas Mallon**, CEO of Regent Surgery Health, a Westchester, IL-based developer and manager of ambulatory surgery programs. Although it's easy to believe that the only way to succeed is to have contracts with managed care providers in your area, it is possible to find yourself stuck in a bad contract, he says. "The most common mistake a surgery center administrator makes is to sign a two- to three-year contract that offers no provision for early cancellation," he says. In these cases, the surgery center is stuck with the contract even if taking those patients means losing money on every case, he says.

Because she did not have a provision for early cancellation in most of the contracts, Cheek had to carefully identify all of the renewal dates along with the time period required for notice of cancellation. "You have to make sure you set up reminders and alerts for each contract because the terms of cancellation are different with each contract," she explains. Terms for notification of cancellation or for renegotiation are very specific and must be followed exactly to protect your program, Cheek adds.

The same care also must be taken with contracts for equipment leases, maintenance, or other

professional services, suggests Cheek. "We also had a lot of long-term contracts with vendors that were automatically renewed each year, often with no review by anyone in our facility," she says.

Know your real costs and income

The best way to avoid bad contracts is to know your costs and your market, suggests Mallon. "Every market is different, so you must do your research to discover which managed care companies cover the most people in your area, and then you need to know what your true costs are before you begin negotiations," he says.

When reviewing contracts, be sure you have the best data possible, recommends Mallon. You might see a surgeon in your operating rooms every day, and you know that his patients fill large blocks of time; he may not necessarily be bringing in a lot of money for your program, he says.

"You cannot judge the revenue produced by a surgeon by looking at how much operating time he or she schedules," points out Mallon. "You may have a very busy orthopedic surgeon who uses costly implants for which you receive a low reimbursement."

Evaluate your surgeon's productivity by actual revenue rather than by number of cases, suggests Mallon. Your reports should show the type of cases performed and the revenue generated, he says. "Many times administrators are surprised to find that their largest producers are not their high-volume surgeons," he says.

If you do have a surgeon that routinely schedules high-cost, low-reimbursement procedures in your center, see if some of those procedures can be moved to the hospital setting, suggests Mallon. With different reimbursement rates for hospitals vs. ambulatory surgery centers, it may make more sense to perform the procedure in the hospital, he says. He adds, "The surgeon may be scheduling his or her procedures at your center for convenience or because it is easier to get operating room time without knowing the financial implications." ■

Reduce anxiety in children, parents for better outcomes

Tours, explanations are good preparation

No one likes to undergo surgery, and children are especially vulnerable to anxiety prior to surgery. A recent study demonstrates that presurgical intervention designed to reduce the fears of children and parents does have a positive impact on the child's surgical experience and recovery.[1]

Researchers at Yale-New Haven (CT) Children's Hospital placed 408 children and their parents in four groups. The control group received the standard of care, a second group allowed parental presence during induction of anesthesia, a third group received family-centered behavioral preparation, and the fourth group received oral midazolam. The group receiving family-center preparation showed significantly lower anxiety in the holding area and during anesthesia induction, exhibited less emergence delirium after surgery, required significantly less analgesia in the recovery room, and was discharged from recovery earlier than the other groups.

Although staff members at Children's Surgery Center in Columbus, OH, was not part of the research study, they understand the importance of preparing patients and their families for the day of surgery early, says **Sandy Hagood**, RN, nurse manager of perianesthesia at Children's Surgery Center. "We start explaining what to expect in our pre-op phone call prior to the day of surgery," she says. "We explain how much time they can expect to spend in the waiting room and the pre-op area, and we talk about where they will wait for their child during surgery."

Because anxiety increases the longer a person waits, the staff at Children's tracks how long someone has been waiting and checks with them every 30 minutes to let them know what is happening

EXECUTIVE SUMMARY

Researchers at Yale-New Haven (CT) Children's Hospital compared different levels of preparation for surgery for children and parents to determine what behavioral interventions would reduce anxiety and how reduction of anxiety would affect outcomes. Study results and the experiences of pediatric surgery programs show that family-centered preparation has a positive effect on the overall surgical experience.

- Be aware of how long someone is waiting, and explain lengthy waits.
- Supply portable DVD players as diversion while waiting.
- Separate parents and children on tour to help them prepare for being separated on the surgery day.
- Reassure parents that children will not be alone.

and to reassure them that they haven't been forgotten, she adds.

The "Surgical Safari" is one way that the staff at the Ghesquiere Family Center for Children's Surgery at Royal Oak, MI-based Beaumont Hospital address fears and concerns of patients and their parents. The educational class is held on Saturdays. "We have a video for parents and children to view, then we conduct tours of all the areas they will see on their surgery day, including the operating rooms," Hagood reports.

To reinforce the point at which parents and children are separated on the day of surgery, staff members take the parents into one operating room to talk with them, and other staff members take the children into another operating room. "We don't want to confuse the children by letting them think their parents will come into the operating room with them," explains **Amanda Nash**, RN, nurse manager of the center.

In the operating room with the parents, staff members explain that their children will never be alone and that the anesthesiologists for the center are specially trained to work with children, says **Nancy Strzyzewski**, RN, CPAN, nurse clinician and educator for the center. The children are reassured that they will not hurt because the "medicine the doctors give them will make them sleep and feel no pain," she says. "We also let them try on the oxygen masks and explain that they can take their mask home to show their friends."

On the day of surgery, different activities are planned to distract children and reduce their anxiety, says **Allynn Petersen**, RN, CNOR, administrator of the center. "We only have one television in the waiting area to control some of the noise and confusion, but we have portable DVD players for the children and a selection of movies that are appropriate for all ages," she says.

In the few months since the center's opening in January 2007, staff members have found some changes that were needed. "I didn't think about this before our opening, but we perform a lot of retinal surgical procedures for children who were premature, so they are blind," says Nash. "All of our diversions relied on sight initially, but we are adding storybook CDs and music, as well as portable CD players," she explains. The hospital's recreational therapy department also has helped the surgery center staff find tactile toys that are interesting to the children with no or low vision, she adds.

Reference

1. Kain ZN, Caldwell-Andrews AA, Mayes LC, et al. Family-centered preparation for surgery improves perioperative outcomes in children: A randomized controlled trial. *Anesthesiology* 106:65-74. ■

Removing organs through the rectum?

Gallbladder through vagina opens possibilities

In the future, minimally invasive surgery may be performed though the rectum, with an incision made in the large intestine, according to surgeons at New York–Presbyterian Hospital and Columbia University Medical Center who recently removed a woman's gall bladder through her vagina.

As part of a clinical trial, surgeons used a technique called natural orifice translumental endoscopic surgery (NOTES) to insert an endoscope through the patient's vaginal wall and into her body cavity. NOTES has been used at the hospitals for appendectomy, abdominal exploration, and biopsy. This surgery went a step further: into the patient's abdominal cavity.

The gallbladder was removed through the vagina, which then was sutured. "Internal incisions, such as in the vaginal wall, are less painful and may allow for quicker recovery than incisions in the abdominal wall," says **Marc Bessler**, MD, FACS, who led the surgery. Bessler is director of laparoscopic surgery and director of the Center for Obesity Surgery at New York — Presbyterian and Columbia and assistant professor of surgery at Columbia University College of Physicians and Surgeons, all in New York City.

This technique allows surgeons to make smaller and fewer skin incisions, Bessler says. Furthermore, doctors in France have announced they removed gall bladders through the vagina without any abdominal incisions, according to an April 29 story from The Associated Press (AP). The surgical staff pierced the patient's abdomen with a needle about one-tenth of an inch wide, the AP reports. The needle, which included a video camera system, was used to inflate the abdomen, the story said. Doctors in India say they have performed appendectomies through the mouth, according to the AP. *(Editor's note: For more information, go to www.noscar.org.)* Sources say avoiding cuts through a patient's abdominal wall avoids cutting a large number of nerves, which take time to heal, and may reduce recovery time. ■

Surgical hospitals must treat emergency patients

CMS: Calling 911 can't be a substitute

In the aftermath of reports that some surgical hospitals called 911 when patients developed complications, the Centers for Medicare & Medicaid Services (CMS) has issued a Survey & Certification letter clarifying that all hospitals are required to appraise medical emergencies, provide initial treatment, and provide referral when appropriate, regardless of whether the hospital has an emergency department.

A hospital is not in compliance with the Medicare conditions of participation (CoPs) if it relies on 911 services as a substitute for the hospital's ability to provide emergency services, according to CMS. The guidance does not apply to critical access hospitals (CAHs).

Additionally, CMS has issued its proposed hospital inpatient payment rule for 2008. Under the proposal, 745 new severity-adjusted diagnosis related groups (DRGs) would replace the current 538 DRGs. Under the proposal, surgical hospitals and other hospitals that treat fewer severely ill patients would probably see decreases in reimbursement. The Physician Hospitals of America (PHA) association, which represents specialty hospitals, supports the proposal. "PHA agrees that hospitals providing services to more complex patients should be reimbursed in a manner that reflects the nature of that care," the association said in a prepared statement. "We continue to support CMS' efforts to make hospital payments more rational."

The proposal also has new requirements for disclosure of physician ownership for specialty hospitals. They include:

• Physician-owned hospitals must disclose the physician ownership, with the physicians' names provided upon request.

• Physicians who have ownership in a hospital must disclose that ownership to patients they refer them to the hospital.

• Physician-owned hospitals must notify all patients in writing if a physician is not at the hospital 24 hours a day, seven days a week. They must describe how they will handle emergencies if no physician is on site.

PHA's response is that all hospitals, regardless of ownership, should disclose the financial arrangements between themselves and physicians, says **Molly Gutierrez**, executive director. Also, all hospitals should have to disclose whether they have 24/7 physician coverage, she says.

The proposed rule can be accessed at www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-P.pdf. ■

Company refuses FDA request for recall

On May 2, the Food and Drug Administration (FDA) issued a formal request that Shelhigh in Union, NJ, recall all of its medical devices, including hospital inventories, because of sterility concerns. Shelhigh has responded that it will not initiate a recall.

"This is the first formal request by the FDA for Shelhigh to recall its products; and since the FDA

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

- Foolproof method for reducing medication errors
- Nonsurgeons performing surgery — What can you do?
- New checklist helps you communicate with patients
- How to handle a terrible surgical outcome
- Surgery center is first of its kind

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?
A. Muscle relaxants have no amnestic affect.
B. Muscle relaxants have some amnestic affect.
C. Muscle relaxants have a full amnestic affect.

22. In preparation for changes in payment to surgery centers, what contracts should you assess, according to Caryl A. Serbin, RN, BSN, LHRM?
A. Housekeeping
B. Information systems
C. Maintenance
D. All of the above
E. None of the above

23. What item in a managed care or vendor contract is important to note to prevent being stuck with a bad contract for longer than you want, according to Denise Cheek, RN?
A. Contact information for the contract manager
B. Description of preapproval process
C. Special provisions for after-hours service
D. Dates for automatic renewals

24. How does the staff at Ghesquiere Family Center for Children's Surgery prepare children and parents to be separated on the day of surgery, according to Amanda Nash, RN?
A. Video presentation
B. Brochure
C. Separation into parent group and children's group during tour
D. Fact sheet given to parents by physician

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

allegations are unfounded, Shelhigh has no intention to initiate a product recall," says **Shlomo Gabbay**, MD, founder of Shelhigh.

FDA investigators and U.S. marshals seized all implantable medical devices from Shelhigh on April 17 after finding significant deficiencies in the company's manufacturing processes. The agency recommends that doctors and hospitals consider using alternative products.

The products include surgical patches as well as pediatric heart valves and conduits, dural patches, annuloplasty rings, and arterial grafts. Brand names include No-React Tissue Repair Patch/UroPatch, No-React EnCuff Patch, and Gold perforated patches.

FDA has prepared a document for physicians (www.fda.gov/cdrh/safety/041807-shelhigh.html) that advises them to monitor patients with a Shelhigh implant for infections.

If you have questions, contact the Office of Surveillance and Biometrics (HFZ-510), Rockville, MD. Phone: (240) 276-3357. Fax: (240) 276-3356. E-mail: phann@ cdrh.fda.gov. ■