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Inserted in this issue: Evaluation form for CNE/CME subscribers, 2007 Index

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IN THIS ISSUE

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DECEMBER 2007
VOL. 31, NO. 12 • (pages 137-148)

2008 rates for some ASC procedures lower than in Medicare proposed rule

Ambulatory surgery centers (ASCs) still will be paid generally 65% of the hospital outpatient department (HOPD) payment in 2008, as was proposed in August, but the actual payment rates will vary from the ones proposed because the relative weights used are different than those proposed, according to the Federated Ambulatory Surgery Association (FASA).

"We are disappointed that payments for some of the procedures that are most commonly performed in ASCs, like cataract surgeries and colonoscopies, have even lower payments in the final rule than they had in the proposed rule," says **Kathy Bryant**, president of FASA. "I don't think the issue is really whether or not ASCs are generally being reimbursed at 65%, but the total payments they are receiving."

Because the methodology to determine this percentage was finalized on Aug. 2, 2007, FASA leaders didn't expect the Centers for Medicare & Medicaid Services (CMS) to change this rule, Bryant says. "We remain convinced that CMS had the authority to at least pay ASCs 73.06% of HOPD rates and that by failing to do so, CMS is hindering its beneficiaries access to cost-efficient, high-quality surgical care."

Craig Jeffries, executive director of the American Association of Ambulatory Surgery Centers, says, "We are disappointed that CMS did not further address changes recommended by the ASC industry and

EXECUTIVE SUMMARY

The 2008 final payment rules for ambulatory surgery centers will pay generally 65% of the hospital outpatient department payment (HOPD).

- The actual payment rates will vary because the final rule changed the relative weights used, so payments for cataract, colonoscopies, and other surgeries will be lower than proposed.
- Congressional legislation has been introduced in the House and Senate that would increase the percentage to 75% of the HOPD rate.

will aggressively work with Congress over the next 60 days to provide relief based on elements of the ASC legislation."

The Congressional legislation would pay ASCs 75% of the HOPD rate. A bill has been introduced in the Senate to change the ASC payment system and the method that CMS uses to determine what procedures Medicare reimbursement in an ASC, according to FASA. This legislation is similar to HR 1823 introduced in the U.S. House of Representatives earlier this year. This legislation, named the Ambulatory Surgical Center Medicare Payment Modernization Act of 2007, authorizes ASCs to receive Medicare payments for any surgical service unless Health and Human Services identifies a specific risk concerning a certain procedure being performed in an ASC or an overnight stay is required. "Under the new process, CMS includes all surgical procedures on the ASC list unless a procedure meets one of the several criteria that would justify exclusion," FASA says.

Disappointment, even with 834 additions

The final payment rule adds 834 procedures to procedures that can be performed in ASCs and deletes 17 procedures.

Bryant says, "We are disappointed that some of the procedures we believe should be added to the list weren't added."

The additions include laparoscopic cholecystectomy. **[For a list of additions and deletions, go to www.fasa.org/new/#paymentrates2008. At the bottom of the page, click on "ASC List Additions Effective January 1, 2008 (As compared to 2007 ASC List)" and "ASC List Deletions Effective January 1, 2008 (As compared to 2007 ASC List)."]**

The nationally determined ASC rates will continue to be adjusted to reflect differences in local costs using local wage indexes, FASA says. The final rule says 50% of the national rate will be adjusted by the local wage index. Currently, only 34.45% of the rate is adjusted by the local wage index. At press time, FASA planned to post an online calculator that will provide the local payment rate for each procedure on the ASC list when an ASC inserts its local wage index. **(Go to www.fasa.org/new/#paymentrates2008.)**

CMS has announced that there will be two exceptions to the 65% level of payment. One exception is device-intensive procedures, or procedures that require the use of a device that costs more than 50% of the total ambulatory payment classification (APC) reimbursement, FASA says. For these procedures, the ASC will be paid the same amount as an HOPD for the device, and only the remainder of the APC reimbursement will be discounted to 65% of the HOPD rate, the association says.

A second exception is procedures often performed in physician offices. For 365 of the procedures that CMS added to the ASC list for 2008, payments will be less than 65% of the HOPD payments under the proposed rates, FASA says. These lower payments result from a new limit CMS is imposing on procedures that are

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 $12.95 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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CMS releases final details of 2008 ASC payments

The 2008 payment system from the Centers for Medicare & Medicaid Services (CMS) gives ambulatory surgery centers (ASCs) additional payments for radiology, devices, and drugs or biologics used in procedures, according to the Federated Ambulatory Surgery Association (FASA).

ASCs will be able to receive payment for radiology services if the following three conditions are met:

- The service would be separately payable in a hospital outpatient department (HOPD).
- The service is required for successful performance of a procedure.
- The service is performed immediately preceding, during, or immediately following a surgical procedure in the ASC.

ASCs will be paid at a rate determined using the usual ASC methodology or the physician office practice expense, FASA says. "The limitation that this only applies if hospitals are paid separately is a significant one," FASA says. "For example, because fluoroscopy is not paid separately in HOPDs, ASCs will not be paid separately either."

As is the case now, separate payments won't be made for most devices or supplies, including screws and anchors used in orthopedic procedures, regardless of the cost of these devices and supplies, FASA says. There is one exception for devices with "pass-through status," which is for certain new technology that costs significantly more than the previous technology used in the same procedure, the association says. For these devices, additional payment will be made so that Medicare beneficiaries can have access to this new technology, FASA says. In the final rule, CMS applied the same rules for additional payment for new technology to ASCs as it applies to hospitals, the association says. Medicare contractors (previously called Medicare carriers) will set the prices.

Medicare will continue to pay ASCs an additional payment for new technology intraocular lenses (NTIOL), FASA says. However, CMS will establish the additional amount paid for each NTIOL individually rather than pay an additional $50 for all NTIOLs, the association says. The payment for the regular IOL is included in the APC payment.

Payment for prosthetics and durable medical equipment would depend on whether those devices are implantable, FASA says. "For implantable prosthetics and durable medical equipment, payment beyond the base payment rate will not be provided," FASA says. The costs of these items are included in the rate for the relevant ambulatory payment classifications (APCs). "Only ASCs qualified as Medicare suppliers will be reimbursed for prosthetics and other durable medical equipment that is not implanted," FASA says.

In general, CMS applied the same policy to drugs and biologics in ASCs as it applies to HOPDs, FASA says. Beginning in 2008, when HOPDs are paid separately for a drug or biologic, ASCs also will be paid separately, the association says. "This policy will apply to the costs associated with acquiring corneal tissue," FASA says. "ASCs will also be paid separately for brachytherapy sources." The rate for drugs and biologics will be the same for ASCs and HOPDs.

Regarding multiple procedures, ASCs will be paid 100% for the primary procedure (the procedure with the highest reimbursement rate) and 50% for each additional procedure, even when some of the procedures are in the same APC. "For 158 procedures, ASCs will be paid 100% of the procedure rate, even when those procedures are done in the same surgical session as another procedure," FASA says.

ASC payments will be adjusted each year to reflect changes in technology and resources for the procedures, FASA says. "CMS makes such adjustments as a regular part of the annual rule making process for HOPDs," the association points out. CMS will begin by recalculating the relative weights for HOPDs; these relative weights will be adjusted again to ensure that changes are budget-neutral in the ASC setting. "As a result, each year the relative values of some procedures will go up and some will go down," FASA says.

ASCs will continue to bill Medicare using a CMS-1500 claim form and use CPT codes to describe procedures performed, according to FASA. ■

performed in physician offices more than 50% of the time, the association says. For these procedures, CMS will limit the ASC payment to the lesser of the following:

- The payment rate determined using the usual 65% methodology;
- The amount Medicare pays physicians for the cost of their practice expense when these procedures are performed in the physicians' offices.

Limiting ASCs to the physician office payment can bring significantly lower payments than ASCs would receive if these procedures were reimbursed at 65% of the HOPD rates, according to FASA. **(To see a list of procedures that are exceptions to the 65% payment, go to www.fasa.org/new/#paymentrates2008. Under "Exceptions to 65% Device Intensive Procedures," click on "Device Intensive Procedures Effective January 1, 2008" and "Procedures Often Performed in Physician**

Offices Subject to Payment Limit.")

CMS maintained the four-year transition to the new rates that was proposed. **(See graphic in *Same-Day Surgery*, September 2007, p. 102.)** In 2008, as part of this transition, 75% of the payment for ASC procedures will be based on the 2007 rate, and 25% will be based on what Medicare would have paid without the transition.

There will be no 2008 adjustment for ASCs because inflation increases were frozen for surgery center until 2009.

There will be no annual inflation update for 2009, FASA says. "This does not mean that 2009 rates will equal 2008 rates," the association points out. The annual changes in procedures' relative values may cause some rates to go up and to go down, it says. Also, because of the four-year phase-in, the 2009 rates will be different, FASA says. In 2010 and beyond, the ASC conversion factor will increase by an amount equal to the consumer price index for urban consumers, it says. "FASA had argued that the inflation update for ASCs should be the same as the update for hospitals — the hospital market basket — but CMS rejected this argument and left the ASC annual update as it is under the existing system, thus proving the importance of advancing ASC legislation in Congress," FASA says. The proposed legislation links the ASC and HOPD payment systems in an ongoing manner in terms of annual updates.

The final rule was to be published in the Nov. 27 *Federal Register*. **(For information on the proposed rule, see "It's a step in the right direction, but new payment system falls short, leaders say," *SDS*, September 2007, p. 101.)** ■

HOPD payments to increase 3.8%

In a final payment rule for hospital outpatient departments (HOPDs), the Centers for Medicare & Medicaid Services (CMS) predicts that HOPD payment would increase by 3.8%, considering market basket update and other factors.

Additionally, hospitals will be required to report seven quality measures to receive the full market basket update in calendar year 2009, including "timing of antibiotic prophylaxis" and "selection of prophylactic antibiotic — first- or second-generation cephalosporin." Also, several services, including intraoperative services, will be incorporated into the payment for the main procedure.

The final rule was published in the Nov. 27 *Federal Register*. **(For information on the proposed rule, see "It's a step in the right direction, but new payment system falls short, leaders say," *SDS*, September 2007, p. 101.)** ■

Same-Day Surgery Manager

What annoys you? Readers respond

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

Last month I wrote about my annoyances in the surgical environment, and I obviously touched a nerve for many of you. I received 45 emails with issues that upset you and our staff as well:

- **Cell phones.** As with me, cell phones were at the top of your list as well, but yours dealt with patients who were on them. Facilities have signs that ask you to turn them off when you enter the hospital or the surgery center. Many of your complaints dealt more with patients (be fair: and/or family members) who were checking in and would hold up the "just one minute" finger. They keep yapping away, which holds up the check-in process. More sympathy for you I could not have.
- **Children.** All children aren't irritating — just the ones that are running around the waiting room with no parents to keep them in check. I must admit it is news to me that this issue is ongoing for some centers.
- **Overhead paging.** Several responded that muffled or garbled paging systems are a strong source of agitation to many. Some members of the staff have figured out that if you lift the corner of the ceiling tile next to the speaker, there is a wire that plugs into the unit that can unplugged. Less caffeine also helps.
- **Parking spots that cannot fit an American car.** This complaint I can understand. Those narrow

little strips of white paint that make it impossible to get out of your car without proof of insurance drive me nuts, too. I asked a real estate developer about it. She said that the average parking space costs about $12,500 to build, that they were indeed minimum standards in width, and everyone wants to get as many spaces in as small an area as possible.

• **Locker size.** Four complaints about the size of the lockers in the change areas. It's hard not to agree with that.

Related to above: Why does the women's locker room has the same number of lockers as the men's, but the female staff members outnumber the men by three to one? Good news: Most new facilities being built today are addressing that issue.

• **Anesthesia cleanup.** (I think we all know where this is going.) I suggest a number of you get serious about cleaning up after yourselves. Some of the complaints hinted at physical dismemberment.

• **Dirty dishes in lounge.** It should be clear by now that most of the staff do not clean up after themselves and never will, no matter how insulting your messages. It is time to give up and buy disposable.

• **Time clocks.** Unprintable responses from facilities that require staff to punch in.

Thanks for sharing your annoyances. I'm interested in hearing how you've addressed these issues. Send me your ideas. *(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.)* ■

Permanent isn't forever — Tattoo removals increase

Lifestyle changes prompt laser treatment

Failed relationships, evenings better forgotten, and a desire to go against society norms are just a few of memories evoked by tattoos that a growing number choose to remove.

In 2006, 43,000 Americans underwent laser removal treatments for their tattoos, according to the Millennium Research Group, a Toronto-based research firm that specializes in medical technology. Also in 2006, almost 3.7 million people, or 20% of people with tattoos, researched removal methods, according to the Millennium Research Group.[1]

EXECUTIVE SUMMARY

As the popularity of tattoos continues to rise, so do the requests for removals, according to surgeons.

- Laser is the preferred method for removal, with different lasers affecting different colors of ink.
- A new ink that is more easily and more completely removed by laser will be on the market in December 2007. Surgeons expect the ease of removal will increase the number of people seeking tattoo removals when they tire of the design.
- Educate patients about the risks of tattoo removal: pain, potential for hypersensitivity reaction, and incomplete removal of current inks.

Although tattoos have increased in popularity and the number of people getting tattoos continues to grow, there also is a steady flow of people seeking removal, says **Brian Zelickson**, MD, medical director of the Abbott Northwestern Hospital Laser Center in Edina, MN. "Ages of people seeking removal treatments are all across the board, with the majority of patients in their 30s and 40s," he says. "Reasons for removing the tattoos include marriage, new jobs, and discontent with the tattoo."

Roy G. Geronemus, MD, director of the Laser & Skin Surgery Center of New York, is seeing an increase in the number of patients asking for tattoo removal. While he sees patients of all ages, several parents have brought their minor children in for tattoo removal recently, he says. Although tattoo artists are not supposed to work on children, fake identification is often used to obtain the tattoo, he explains. Because the child is not able to sign a surgical consent, the parents must do so, but the child must agree to the procedure, he says. If the child does not want the tattoo removed, the parents and child are asked to come back when they can all agree to the procedure, he adds.

"I also see a number of young women who are new mothers and don't want their children to see tattoos on their mothers as they grow up," says Geronemus. There are also young professionals and others who decide that a tattoo from college is no longer acceptable and cannot be hidden by clothing, he adds. All of these situations lead to a steady, increasing stream of patients, Geronemus says.

"I don't anticipate the number of patients asking for tattoo removal to decrease any time soon," he says. "I've seen reports that as many as 25%-30% of all college freshman have a tattoo." Many of these students will finish college, enter the work

SOURCES/RESOURCE

For more information about tattoo removal, contact:
- **Roy G. Geronemus**, MD, Director, Laser & Skin Surgery Center of New York, 317 E. 34th St., New York, NY 10016. Phone: (212) 686-7306. Web: www.laserskinsurgery.com.
- **Brian Zelickson**, MD, Medical Director, Abbott Northwestern Hospital Laser Center, 4100 W. 50th St., Edina, MN 55424. Phone: (952) 929-8888.

For information on Freedom-2 tattoo ink, go to the company's web site at www.freedom2ink.com.

world, start their families, then realize that tattoos are not part of their new lives, Geronemus says.

When Zelickson was interviewed in 2004 by *Same-Day Surgery* on the topic of tattoo removal, dermabrasion and surgical excision were two techniques used in addition to laser treatments. "Now, dermabrasion is rarely used, and only a small number of patients opt for surgical excision," he says. "Laser removal is the most common and, in most cases, the most effective."

The most common lasers used for tattoo removal are the Q-switched ruby laser, which works well on green but not red inks, and the Q-switched neodymium YAG and the Q-switched alexandrite lasers, which remove green but not red inks, Geronemus says.

New ink simplifies removal

There is a new tattoo ink that at press time is scheduled for release this month that will change the way that people think about tattoos, says Geronemus.

"Freedom-2 Inc. [of New York City] are designed to be easily removed by laser," he says. While the ink is permanent and will not fade, if the patient decides that he or she no longer wants the tattoo, it can be easily, safely, and completely removed, he adds. Current inks are hard to remove in some cases, with bright colors and blacks presenting the greatest challenges, says Zelickson. "A professional tattoo can require between eight and 12 treatments for removal, and some ink may not be completely removed," he explains. Tattoo removal is not covered by insurance, so the $100 to $400 cost per treatment, depending on the size and color of the tattoo, can be significant, he adds.

An ink that can easily be removed will change the way people think about tattoos, points out Geronemus. "Today, people get a tattoo thinking that it is permanent, but inks that promote easy removal may make tattoos more of a fashion accessory that can be changed often," he says. The increased ease of removal will create more business for outpatient surgery providers who offer tattoo removal, he adds.

Even with easily removed inks, it is important to educate patients up front, says Geronemus. "Patients need to understand that results may not be exactly what they want," he says. "It is important for the physician to honest about what may and may not be removable."

There are some risks with any surgical procedure, including laser tattoo removal, Zelickson points out. "In rare cases, a delayed hypersensitivity may result in the area becoming inflamed and itchy, with symptoms spreading," he says.

The more common risk is the property of inks that contain iron oxide to turn black when the laser is applied, says Zelickson. "Because this is a risk, I try one pulse on the ink; then if it turns black, we stop," he says.

Although tattoo removal can be a simple laser procedure, be sure you have a clean environment and adequate anesthesia, suggests Zelickson. "We use ice or cold packs, topical anesthesia, and local lidocaine injections if necessary," he says. "The level of anesthesia is determined by the size and color of the tattoo, as well as the patient's tolerance of pain."

Reference

1. Millennium Research Group. *U.S. Markets for Aesthetic Lasers 2007*. Toronto; 2007. ■

Improve pain control, cut SSIs with one product

Study shows pain pump's positive effect

Extra help in reducing surgical site infections (SSIs) can come from an unlikely source: a pain management pump. In a study presented at the Interscience Conference on Antimicrobial Agents and Chemotherapy in Chicago, researchers presented information showing a decrease in surgical site infections for patients using an in-the-wound pain control pump.[1]

Although the study looked at 289 inpatients receiving colorectal surgery, the results are

EXECUTIVE SUMMARY

Reducing surgical site infection (SSI) rates requires a program that addresses a multitude of issues. A new study identifies the latest weapon in the fight against SSIs.

- Patients using an in-the-wound pain pumps with a silver-coated catheter experienced an infection rate of less than half the number of infections for patients in the group receiving traditional narcotic pain control.
- Effective pain control improves early ambulation, which increases blood flow to the wound and tissue regeneration, both factors that reduce the risk of infection.

significant for outpatient surgery programs because the use of in-the-wound pain management pumps is common for many outpatient procedures, says **Jay Singh**, MD, director of surgical residency at Piedmont Hospital and professor of surgery at Emory University, both in Atlanta. **(For more information about pain pumps, see "Place anesthetic in wound during recovery to cut pain," *Same-Day Surgery*, December 2003, p. 135.)** While outpatient procedures are generally considered to be "clean," the fact that patients are discharged to home on the day of surgery increases the need to consider every opportunity to reduce SSIs, he says.

Singh was the lead investigator of the study that compared the rate of SSIs in patients receiving an On-Q PainBuster with ON-Q SilverSoaker Antimicrobial Catheter [I-Flow Corp., Lake Forest, CA] to the rate of SSIs in patients receiving traditional narcotic pain management via patient-controlled analgesic or epidural. In the study, patients receiving pain management through the pain pump had a significantly lower SSI rate; the SSI rate for the pain pump patients was 6.6%, compared to a rate of 14.6% for patients receiving traditional pain management.

Deciding to evaluate the pain pump as a reason for lower SSIs was the result of secondary observations during previous studies that evaluated the device's affect on hospital length of stay and effectiveness of pain management, says Singh. "We knew that SSIs were the cause of longer lengths of stay, but we were surprised to see a connection between the pain pump and fewer SSIs," he says.

There are several reasons that the in-the-wound pain pumps reduce the risk of infections, says Singh. "Most people's first reaction is that inserting a catheter into the wound is another way to introduce bacteria," he says. "In reality, we discovered that the pain pump reduced pain to the point that patients were ready to move around earlier." Ambulation increased blood flow to the wound, which increased the speed of tissue regeneration, Singh says. A wound that heals quickly is less likely to become infected, he points out.

Narcotics also are known to negatively affect the immune system, and the anesthetic used in a pain pump actually boosts immune systems, says Singh. Without a suppressed immune system, the patient is less vulnerable to infection, he adds.

Another factor that contributed to the significant reduction in SSIs in the pain pump group is the silver soaker system patented by I-Flow Corp., says Singh.

"Silver is known to have antimicrobial properties, but we did not test a pain pump that does not use a silver-coated catheter, so we can't know for sure if this was a significant factor," he says. A follow-up study that compares silver vs. nonsilver catheters is logical, Singh adds.

In outpatient surgery settings, the most likely procedures for in-the-wound pain pumps would be inguinal hernias, laparoscopic hysterectomies, and mastectomies, says Singh. "Orthopedic procedures such as knees, shoulders, and any procedure using graft material are also ideal for pain pumps," he says. "It is especially important to avoid infecting any hardware that is implanted because an infection can require removal of the implant."

Surgeons at the Surgery Center of Santa Rosa (CA) have used pain pumps since September 2004, says **Michele Eichner**, RN, director of nursing for the center. "We started with a general surgeon who used the pump for hernias and a hand surgeon, but now the pump is predominately used by some of our orthopedists," she says.

Results of the SSI study may help Eichner promote increased use of the pump. "Of the 12 orthopedists on staff at the center, only seven use the pump," says Eichner. "The other five orthopedists are concerned about infection from the catheter inserted in the wound."

Although she has pointed out that in-the-wound pain pumps have been used for years at the center with no incidence of surgical site infections, the physicians' minds have not changed, she says. A formal study, with documented results, may provide more ammunition, she adds.

The catheter takes only a couple of minutes to place, so the overall time of surgery is not affected, Singh says. "The pump contains a three- to five-day

supply of anesthetic, then the patient returns to the physician's office for removal," he says. In reality, the catheter is simple to remove, and a patient can do so at home, Singh says. "Most surgeons, however, want to see the patient to evaluate the wound," he adds.

There is not a lot of staff education required to use the pain pump, says Eichner. "There is a small amount of assembly in the operating room, and you do have to document insertion of the pump and the medication, but it is not difficult," she says.

Patient education occurs in the recovery room, and patients are not uncomfortable with the idea of the catheter, says Eichner. "The idea of improved pain control is very attractive to all patients," she adds.

SOURCES/RESOURCES

For more information about pain pumps and reduction of surgical site infections, contact:

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- **Michele Eichner**, RN, Director of Nursing, Surgery Center of Santa Rosa, 1111 Sonoma Ave., Lower Level, Santa Rosa, CA 95405. Telephone: (707) 578-4100. E-mail: michele.eichner@scasurgery.com.

The following companies offer in-the-wound pain control pumps:

- **Breg**, 2611 Commerce Way, Vista, CA 92083. Telephone: (800) 321-0607 or (760) 599-3000. Fax: (800) 329-2734. Web: www.breg.com. E-mail: info@breg.com.
- **dj Orthopedics**, 2985 Scott St., Vista, CA 92081. Telephone: (800) 321-9549 or (760) 727-1280. Fax: (760) 734-3595. Web: www.djortho.com. E-mail: info@djorth.com.
- **I-Flow Corp.**, 20202 Windrow Drive, Lake Forest, CA 92630. Telephone: (800) 448-3569 or (949) 206-2700. Fax: (949) 206-2600. Web: www.iflo.com. E-mail: information@iflo.com.
- **Sgarlato Laboratories**, 130-C Knowles Drive, Los Gatos, CA 95032. Telephone: (800) 421-5303 or (408) 374-9901. Fax: (408) 374-9924. Web: www.sgarlatolabs.com. E-mail: pcervantes@sgarlatolabs.com.
- **Stryker Instruments**, 4100 E. Milham Ave., Kalamazoo, MI 49001. Telephone: (800) 253-3210 or (269) 323-7700. Web: www.strykercorp.com. E-mail: medicalcustomerservice@med.strykercorp.com.

The ON-Q pump is reimbursed by most insurance companies and Medicare to treat post-surgical pain under the hospital outpatient prospective payment system (OPPS), but Eichner participates in a program in which her vendor, I-Flow Corp., handles all insurance claims. "I just order the pumps I need, then send the documentation to the company and they handle everything," she says. "It's a very efficient way to offer a good service to patients at no cost."

Reference

1. Singh J, Hum M, Liberman H, et al. Multicenter infection surveillance study comparing two types of postoperative pain management, surgical site using ON-Q SilverSoaker and local anesthetics vs. systemic narcotics following colorectal procedures. Presented at 47th Annual Interscience Conference on Antimicrobial Agents and Chemotherapy. Chicago. Sept. 9, 2007. ■

Education videos, games, food at patient's fingertips

Bedside communication system boosts efficiency

Televisions are standard equipment in recovery areas to help patients and their family members pass time and reduce anxiety. New technology now gives the same television the capability to improve patient education, give patients control over their environment, and improve use of nurses' time.

A standard television, a small control box, a remote control, and pillow speaker phones are all that is needed to turn bedside communications systems into an interactive patient education and patient communications tool.

Bedside patient communications systems are making their way into outpatient surgery programs. "We began installation of our system a year ago, but it has only been in the past couple of months that the system has been installed in our outpatient surgery center," says **Barbara Hertzler**, chief operating officer and executive vice president of St. Joseph Mercy Oakland Hospital in Pontiac, MI. "Our system gives patients access to the Internet and to e-mail from their bedside, but this service appears to be used more by inpatients than by outpatients," she says. Information on the system, GetWellNetwork in Bethesda, MD, can be accessed at www.getwellnetwork.com.

EXECUTIVE SUMMARY

A patient bedside communication system can increase responsiveness and cut staff time related to patient education by almost 50%. The system gives access to patient education materials, the Internet, ancillary departments, and entertainment such as TV shows, movies, and games.

- Make sure system can be easily updated and customized to fit your facility's needs.
- Set aside one room for staff training to give staff time to play with the system.
- Design an easy-to-understand menu for the system.

Bedside communications systems typically include access to entertainment including movies, local television, games, patient education videos, Internet, ancillary services such as housekeeping or food services and, in some cases, the ability to complete surveys or research clinical material, provided by the facility, says Hertzler. "We've also downloaded information on our health care team with staff photos and biographies so that patients know who is providing their care," she says. Other items that can be added to a system to personalize it include an orientation to the facility, including locations of gift shops, ATMs, cafeterias, and other local information, Hertzler adds.

Nurses appreciate a bedside communication system because it frees their time to focus on patient care activities, says **Dennis Roth**, RN, MSN, surgicenter educator at Luther Midelfort Hospital in Eau Claire, WI. "We have 35 patient rooms in our surgicenter, and we have an interactive communications system in each room," he says. Patient education is a key use of the system by nurses. Information on the system, Skylight Healthcare System in San Diego, can be accessed at www.skylight.com.

The staff have access to teaching videos through the system, so a nurse accesses the menu and selects the video that is appropriate for the patient, he says. The nurse does not have to stay in the room while the patient watches the video, but instead returns after the video is over to answer questions and review key material if necessary, he explains.

"There are several benefits to using this system for patient education," says Roth. The previous education process required nurses to spend time locating the proper patient education video, taking it to the patient's room, rewinding tapes, and setting the video to the proper place to start, he says. "Now, everything is in the patient's room, so there is less time and labor involved to find the video on the system and play it," Roth says. Once the patients and families are taught how to use the system, the video can be watched as many times as they want, he says.

Time studies conducted at Luther Midelfort showed that nurses typically spent between 12 and 15 minutes to find and set up videos for patients prior to the bedside communications system. "We have not conducted a follow-up study for the new system yet, but I would estimate that we've cut the time required by seven to eight minutes," he adds. This time savings is significant when you consider that the nurses at Roth's center show about 600 videos per month, he points out.

This process also eliminates the conflicts that arose when multiple patients needed to view the same video at the same time, says Roth. "We'd have multiple copies of some videos, but there were times when patients had to wait until another patient finished viewing the information," he says.

Give patients control over environment

While Hertzler knew that the entertainment and patient education portions of the system would be well used in the outpatient surgery center, she is surprised at how often patients use the environmental control aspect of the system.

"Patients can contact ancillary departments such as maintenance, food services, and housekeeping from their bedside," she explains. "Inpatients use this service often, but I didn't expect outpatients to use it as often as they do." Patients can send a message to other departments if they need extra blankets or pillows, if the temperature in their room is too cold or too hot, or if they want something to eat or drink, she explains.

The environmental control feature takes nurses out of the "middleman" position, Hertzler says. "One of nurses' biggest complaints is the time it takes to get in touch with other departments with patient requests," she says. Not only does it save time for nurses when the patient makes the contact, but it reduces conflicts between departments, she says. "When nurses are constantly calling other departments to ask for food, blankets, or change in room temperature, it puts the nurses in a confrontational position, especially if they have to call several times," she explains.

SOURCES

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Patients and family members like the ability to contact ancillary departments directly because it gives them more control over their experience, says Roth. "They don't feel dependent on others to make their requests," he says.

Installing a patient bedside communication system does require an investment of money and time, points out Hertzler. The actual cost depends on the size and age of your facility, which determines the extent of your need for new wires and cables, and whether you are going to upgrade your current televisions. "We did purchase all new televisions, but it isn't necessary for everyone," she says.

On average, hospitals invest less than $1,000 a year per bed to license the GetWellNetwork system, according to a GetWellNetwork spokesperson. This figure can vary fairly dramatically depending on the number of patient rooms, the type of infrastructure already in place, and the amount of content the hospital wishes to add to the system.

One tip that Hertzler offers for anyone considering a bedside communications system is to make sure you accurately assess your buildings. "We did not do the best infrastructure assessment, and it resulted in time and expense that we didn't anticipate," she says. Older buildings do require additional wiring because their existing capability may not support the technology, Hertzler adds.

Be sure to make sure that the system is easy to navigate, suggests Roth. The menu should be easy to understand and should require just a few clicks of the remote or a keystroke on the keyboard, he says. "Also, make sure that it is simple to add patient education videos to the system," Roth says. At the same time, the menu should be easy to update to reflect new videos, he says.

Staff training on the system was simple, says Roth. "The training session took between 15 and 20 minutes with staff members going into an unoccupied patient room to learn how to use the system," he says. "Because nurses tend to be kinesthetic learners, we always had one room available for training when we first implemented the system."

After nurses received their initial orientation to the system, they were able to go into the rooms to play with the system on their own, he points out. "Being able to play with the remote and move through the menus ourselves was the most effective part of the training," he adds.

A bedside patient communication system improves overall customer service, Hertzler says. "We are able to immediately address patient concerns and educational needs, and patients have the ability to control their own environment," she says. ■

Children with recent colds linked to respiratory events

Children undergoing general anesthesia for surgery or other procedures are more likely to have adverse respiratory events if they recently had a cold or other upper respiratory infection (URI).[1]

The November issue of *Anesthesiology* presents the first large study to look at how recent URIs affect the risk of adverse respiratory events in children receiving anesthesia using the laryngeal mask airway (LMA). The overall risk is low and serious complications are rare when anesthesia is delivered with this method. However, the results suggest that waiting two weeks after a URI may make anesthesia even safer.

"Our results will help anesthesiologists in planning the anesthesia management of children with recent upper respiratory tract infection," says **Walid Habre**, MD, PhD, one of the study authors and senior lecturer and head of the Pediatric Anesthesia Unit at Geneva (Switzerland) Children's Hospital, University Hospital.

Over five months, researchers asked parents of children undergoing surgery to provide information on recent URIs, such as colds, sinusitis, or tonsillitis. All of the children were given general anesthesia via an LMA for their procedures.

According to the parents, 27% of children had had a URI in the previous two weeks. Children with recent URIs were about twice as likely to

develop certain adverse respiratory events. Overall, 20% of children had episodes of desaturation requiring oxygen administration in the recovery room. Although these events were more frequent in children with recent URIs, they were no more severe. Children with URIs also had a greater rate of laryngospasm. Children with recent URIs were also at almost double the risk of problems with coughing after their procedure.

All respiratory events were more common in younger children and in children undergoing surgery on the ear, nose, and throat. Adverse events also were more frequent when more than one attempt was needed to insert the LMA device in the mouth.

The risks of proceeding with surgery are not well known due to limited evidence on how long one must wait after a URI for the risk to drop to normal. The researchers emphasize that the overall risk is low and that all of the events in the study were easily managed, with no lasting effects.

"Our study may help parents to better understand why anesthesiologists may prefer to postpone anesthesia for at least two weeks in children with recent URI, in order to decrease the incidence of perioperative respiratory adverse events," Habre says.

Reference

1. Von Ungern-Sternberg BS, Boda K, Schwab C, et al. Laryngeal mask airway is associated with an increased incidence of adverse respiratory events in children with recent upper respiratory tract infections. *Anesthesiology* 2007; 107:714-719. ■

Surgery center growth expected to continue

The growth rate of ambulatory surgery centers (ASCs) in the United States is exceeding that of hospitals and is expected to keep climbing, according to a report from the Health Industry Distributors Association (HIDA) in Alexandria, VA.

"Since 2000, analysts report the number of surgery centers has grown more than 9% each year compared to nearly zero growth for inpatient hospitals," said **Adam Korengold**, HIDA's director of research, in a prepared statement.

HIDA's 2006-2007 market report includes the top distributed products for ASCs plus national health care and Medicare spending data in ambulatory surgery centers (ASCs). The report also examines the developing ASC market, which accounted for about $11.2 billion of U.S. health care spending in recent years.

"A number of trends are emerging with these centers as health care in the United States evolves," said Korengold. "Among these trends is a new emphasis on private funding of surgery centers and the consolidation of surgery center chains."

The cost of the report is $40 for members and $595 for nonmembers. To order the report, go to www.hida.org and search for "Ambulatory Surgery Center Market Report." ■

Tracer methodology covered in video

A video that is tailored to the specific needs of office-based and ambulatory programs explains The Joint Commission's focus on continuous performance improvement with survey

CNE/CME instructions

Physicians and nurses participate in this CNE/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

- Using information technology to increase profits
- Patients given electronic access to medical records
- Get updated on changes to accreditation standards
- Address surgeons talking on the phone during cases

CNE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

21. What is/are the exception(s) for the surgery center payments set at 65% of the hospital outpatient department rate?
A. Device-intensive procedures
B. Procedures often performed in physician offices.
C. Both A and B.
D. Neither A nor B.

22. What were the results of a study that compared the rate of surgical site infections (SSIs) in patients receiving an On-Q PainBuster with ON-Q SilverSoaker Antimicrobial Catheter to the rate of SSIs in patients receiving traditional narcotic pain management via patient-controlled analgesic or epidural?
A. Surgical site infections were higher in patients using the pain pump.
B. There was no difference in infection rates of the two groups.
C. The pain pump patients' infection rate was less than half of the other group's infection rate.
D. Study results have not yet been reported.

23. Why does Roy G. Geronemus, MD, believe that the number of people seeking tattoo removal treatments will continue to increase?
A. The number of young people with tattoos.
B. New ink that is more easily removed.
C. Insurance coverage.
D. A and B

24. How much time does Dennis Roth, RN, MSN, estimate that nurses save per patient when showing patients education videos with the bedside communications system?
A. 3-5 minutes
B. 7-8 minutes
C. 9-11 minutes
D. 12-15 minutes

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

techniques such as the tracer methodology.

The 58-minute video can be used for staff education to point out the reasons for the Joint Commission's changes, the importance of periodic performance reviews, and the reason for priority focus process. To view a complimentary clip of the video, go to www.jcrinc.com. Choose "Education" on the top navigational bar, then select "Videos/DVDs" on the left navigational bar. Scroll down to "The Shared Visions — New Pathways: The Joint Commission's Redesigned Accreditation Process (Ambulatory Care and Office Based Surgery)."

Cost of the video is $275 with shipping costs starting at $18.95. Orders can be placed online at www.jcrinc.com or by telephone at (877) 223-6866. ■

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