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INSIDE

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Bundled Same-day Total Joint Program Focuses on Quality, Outcomes

Several years ago, several high-volume North Carolina surgeons decided there had to be a better way to handle total joint surgeries than the status quo. Total joint surgeons in their region were among the top 10 nationally in volume. Yet, some didn't believe their goals and objectives were aligned with the hospital systems where these surgeries took place. The solution: an ambulatory total joint surgery program that has succeeded beyond their early expectations.

The move to an outpatient setting largely was a clinical decision, says **Steve Lucey**, MD, co-founder and president of Delta Joint Management, LLC, in Greensboro, NC. Lucey runs his private practice, Sports Medicine & Joint Replacement Center in Greensboro, which is an affiliate of Wake Forest Baptist Health.

"We noticed total joints were heading to outpatient because of better pain management, no drains, and other clinical pieces," Lucey recalls.

It helped that a new, state-of-the-art, 60,000 square-foot ambulatory surgery center (ASC) with 13 operating rooms and two procedure rooms was under construction in the area. "We went to the Surgical Center of Greensboro facility and said, 'We can bring you total joints,'" he adds.

"We've been very pleased with bringing total joints into the facility," says **Jennifer Graham**, RNFA, CASC, CNOR, the CEO of Surgical Center of Greensboro, LLC. "This is a service we can provide within the community from an outpatient standpoint, and we have received great feedback from patients."

The new ASC facility, which opened Aug. 31, 2017, contains 10 overnight beds to handle patients who need an extended recovery, including total joint patients. In its previous two locations, there were nine overnight beds, and the surgery rooms were small (less than 400 square feet). The new facility is one of the largest in the United States, and its operating rooms, accommodating

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AUTHOR: Melinda Young
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

total joints, are 625 square feet, large enough to comfortably handle the larger equipment and instrumentation, Graham says.

"We made sure the flow of patients was streamlined and accommodating," Graham says. "This has been a great opportunity and learning experience for staff, and it's a new service line to focus on, a new challenge."

Lucey and three additional surgeons handled about 95% of the community's total joint volume. They joined forces through Delta Joint Management and each contributed to starting the new organization.

"We've had the good fortune of designing everything in the ASC for the total joint center, including two larger rooms and committed capital expenditures for total joint equipment," Lucey explains. "And we partnered with the surgery center to educate the staff, creating pathways, protocols, and inclusion criteria."

Delta Joint Management also developed a bundled payment model that greatly simplifies charges for patients, lowers costs, and spreads risk among providers. The organization negotiated a contract with North Carolina Blue Cross/Blue Shield to handle their privately insured population's total joint surgical and after-care needs.

The program has saved North Carolina Blue Cross/Blue Shield more than $1 million. It's also reduced out-of-pocket and copay expenses for patients, cutting their costs by at least half, Lucey says.

The overall surgery cost is 20% less than the typical rate, which saves the insurer thousands of dollars on each case. Patients typically pay 10-20% as coinsurance on the bundled cost of the surgery. This means their out-of-pocket costs are considerably lower than if they underwent surgery elsewhere, Lucey explains. It also gives patients peace of mind. Once they've paid their copay, there are no surprise expenses. "So, when they show up at the doctor's office or therapist ... there are no more bills or copays," Lucey says. "The fact that they don't get billed — they love it."

Within 15 months of opening the total joint program, it's expanded to 11 surgeons from all the private practices in Greensboro. More than 150 patients underwent total joint surgery, and none experienced infections or needed hospitalization.

The program could serve as a nationwide model as more ASCs and physicians turn to same-day total joint services.

"We have had so many people calling and asking about this model," Lucey says. "So, we've shared our story."

The program's success hinges on patient experience, and anecdotal evidence suggests that has been very positive.

"For patients and doctors and even the surgery center, this has been a fantastic experience," says **Frank Rowan**, MD, an orthopedic surgeon with Southeastern Orthopaedic Specialists and a partner with Delta Joint Management.

Surgeons nationwide have contacted Delta Joint Management to learn more about how the program works, Rowan notes.

"By 2025, I think 50% of total joints will be outpatient," Rowan predicts. "It will expand and be in some ways very rapid."

The bundled payment aspect to the ambulatory total joint program also might spread. In the nation's evolving healthcare market, shifting some or most risk to providers helps ensure accountability, efficiency, and quality of care. It also keeps costs lower for patients.

Surgeons take on the risk of complications post-surgery, although there are risk ceilings for especially serious events, such as a heart attack, says **Donna Garvey**, CMPE, practice administrator of Sports Medicine & Joint Replacement and executive director of Delta Joint Management.

"If a catastrophic complication occurs where costs exceed the agreed-upon limit, then the bundle is busted, and the episode returns to a classic fee-for-service model," Garvey explains. "This protects the business model, which is advantageous for all parties. Having said that, we haven't had any busted bundles."

Delta Joint Management handles risk through patient inclusion assessments, patient education, communication between physicians and all post-surgery providers, including case managers, and tracking patient data to watch for complications. "We're not having many complications," Garvey says. "The most common thing we're seeing is a need for some additional physical therapy."

Patients receive a good clinical experience at a lower cost, and physicians enjoy a positive collaboration with the ASC, Graham says. "From the doctor side, I feel like we're continuing to work together to improve patient outcomes." ■

A Closer Look at How Delta Partners Built Their Total Joint Program

Key components to success with a bundled total joint same-day surgery program include a thorough risk assessment, pathways and protocols to ensure standardization, strong buy-in and communication with all providers and partners, and an emphasis on patient education.

Delta Joint Management, LLC of Greensboro, NC, operates a bundled total joint ambulatory surgery program that is working very well, says **Steve Lucey**, MD, co-founder and president of Delta Joint Management.

"We're taking good care of patients, educating and standardizing, and our infection rate is zero," Lucey says. "Our hospitalization rate is zero. Our DVT rate is zero. Our re-operation rate is 1.6%, compared with a national average of 3.5 to 5%."

Bundling all pre-surgery, surgical, and post-surgery services into one contract is expensive; however, surgeons eventually will realize profits, Lucey says. "We believe in the business model because it's a great one for everyone."

When physicians take on 90 days of financial risk, they have to focus on preventing all hospitalizations, post-surgery infections, and other complications. The first step on this tightrope walk is a patient risk assessment. The program facilitators have to choose their patients wisely and appropriately. For instance, Delta Joint Management contracts only with private payers, which means patients are younger than 65 years of age, when they would be eligible for Medicare. But the biggest help is a risk assessment tool that identifies patients with potential surgical and post-surgery complications.

Additional steps in making a bundled total joint program successful include contracting with payers, standardization, data collection and assessment, and case management. Lucey and others involved in the program explain how the program was developed and how it works:

• **Find the right physician partners.** "The four of us who formed Delta performed 1,800 total joints at the hospital each year," says **Frank Rowan**, MD, an orthopedic surgeon and a partner with Delta Joint Management. "We were honing our skills to get the surgery down to a standardized procedure. We were minimizing blood loss, following protocols."

Rowan, Lucey, and their colleagues developed a keen sense of knowing which patients would be discharged quickly. These were the patients who might be candidates for surgery in an ASC with a 23 hour and 59 minute maximum stay.

As the total joint program grows, the four original partners have added more surgeons to their group, but these doctors must meet certain criteria. Surgeons must perform at least 70 hip and knee surgeries each year, they must rank well below the national average in surgery complication rates, and they must agree to follow the protocols and standardized practices/orders.

The group seeks high-volume surgeons because of research that shows low-volume surgeons tend to log higher complication rates, Rowan says. Standardized practices also are very important. "It's highly standardized," Rowan notes. "If you want to be one of our surgeons, you have to use the standardized orders we came up with."

There is no room in the group for physicians who want to go their own

way, Rowan adds. Also, physician partners must demonstrate excellent outcomes, Lucey says.

• **Contract with insurers.** "The huge part was getting four doctors from different practices together," Lucey says. "We were competitors."

Once that happened, the second big milestone was landing a contract.

"We went directly to payers and said, 'We'll save you 20% off your spend if you give us the check and we control it from there,'" Lucey says. "We believe that all decisions are clinical and patient care is the focus. However, each decision has financial implications as well. Therefore, who better than the physician to control the bundle?"

The physicians were convinced they could manage risk properly, and North Carolina Blue Cross/Blue Shield agreed, signing a contract with them. "We signed the first physician-controlled, outpatient total joint, private-pay, 90-day bundle in the country," Lucey says.

Recently, Delta Joint Management signed a second contract with Aetna, and the company is working on reaching agreements with additional payers.

"A huge part of what we do is a paradigm shift, where physicians are in charge of the bundle," Lucey explains. "This is a business mentality that is very unique. I take risk as the patient walks through my door."

Since the risk includes what happens after the patient leaves and for 90 days, surgeons are incentivized to focus on quality of care and preventing complications and infections. Despite the bundled payment's cost savings for payers, Delta Joint Management pays providers the same as what they would make without a bundled payment, he adds. "We're doing a double whammy of value, increasing the numerator and decreasing the denominator, improving outcomes and decreasing cost," Lucey says. "The only loser is the inpatient hospital system."

• **Create pathways.** In a bundled payment environment, standardization and best practice protocols are crucial to successful outcomes. Creating inclusion criteria was part of this model, but it was important to the Delta partners to research the literature and develop pathways and protocols.

"The pathways start when patients show up, continue through their stay, and follow up with how many days they receive of home healthcare and physical therapy visits," Lucey explains. "There's also a pre-op order set that everyone uses."

The key to success is standardization, Lucey adds.

"The four of us have set up best practices. We use the same pain protocol, the same number of pills, the same type of pills, and we continually perfect that," Lucey notes. "We've decreased use of opioid-based medications."

Standardization is a big plus from the ASC's perspective, says **Jennifer Graham**, RNFA, CASC, CNOR, the CEO of Surgical Center of Greensboro, LLC.

"For our team, instead of having 15 different doctors and 15 different sets of orders, we have one standardized pathway for every patient," Graham explains. "For my team, that enables them to become engrained in how this program is running, and it continues to improve patient care."

Delta Joint Management also created protocols for each downstream provider, says **Donna Garvey**, CMPE, executive director of Delta Joint Management. "We brought in a physical therapist to help us determine what we were going to do from the standpoint of developing protocols for their care," Garvey says. "What was the criteria they'd have to follow in order to get patients to the right goals?"

Surgeons worked with physical therapists to determine how many visits were needed and the best pathway for handling visits. "All downstream providers understand that if a patient is not reaching goals as needed, then it is their responsibility to reconnect with the surgeon," Garvey says.

Physical therapists have agreed to the arrangement, which they helped develop. "Surgeons met with physical therapists and asked how many visits were needed for a proper recovery from total joint surgery, and they asked what would be the fair compensation for a visit," Lucey recalls. "That's how we determined how much they would get."

The protocol includes an expected range of physical therapy visits for each patient. If a patient reaches goals in fewer visits, then the physical therapy organization can end the visits, but receive the same payment. If the patient needs more visits, then the physical therapist organization must provide them and not expect more payment.

"If the patient reaches goals in eight or 20 visits, the physical therapy company receives the same payment," Garvey says, noting that additional therapy must be approved by the surgeon. "So far, the only time we've seen this is when the patient has needed a manipulation, which is a normal potential outcome for recovery [after a total knee procedure]. If [patients] need a manipulation, then they are authorized for six additional visits."

• **Use case management.** Case management starts with inclusion

criteria, putting a patient in the system, and setting up a plan of care, Lucey says. Each surgeon works with a case manager for assistance.

"We hired case managers to run the show," he says. "The case management layer includes the informatics software, and there is a financial layer."

Each patient is assigned an electronic plan of care. It prompts the case manager to call the patient after surgery. Case managers are in constant communication with downstream providers, Garvey notes. Case managers were trained to handle bundled payment cases through their work with a bundled payment program for Medicare patients. "The Medicare program is what led us to see a lot of excessive spending going on when physicians were not necessarily involved in the management of patients during the 90 days of care after surgery," Garvey says.

For instance, Delta saw how patients were spending excessive time in skilled nursing facilities (SNFs) when they did not need that level of care, Garvey explains. Instead, under the ambulatory bundled total joint program, patients are sent home within 24 hours of surgery and receive assistance from case managers. These managers are registered nurses with rehabilitation experience, and they follow patients closely after patients return home, Rowan notes.

"Patients love it," he reports. "I've had three patients where we did inpatient hips on one side and outpatient hips on the other, and every one of them said they won't go back to the hospital for their surgery."

• **Educate ASC staff.** "We have off-site education for our teammates and doctors and in-house total joint education for teammates," Graham says. "We've been working diligently to get a core group of teammates trained to facilitate a total joint team, and we continue to cross-train other teammates in the program." ■

Risk Assessment Crucial Part of Bundled Total Joint Program

A bundled payment ambulatory total joint program can improve quality of care and produce positive financial benefits to all involved, but only if risk is assessed and mitigated. The key is a smart inclusion criteria and risk assessment process.

"One of the prime motivators of anything in the world is dollars, and this is a significant cost savings to patients and insurers," says **Frank Rowan**, MD, a partner with Delta Joint Management. "We're financially viable, but we have to be very careful about managing risk. If someone gets an infected total joint, that's a very expensive proposition, and we're at risk for that. When you're at full risk for this, you are extra careful."

A major step toward managing risk is to establish thorough inclusion/exclusion criteria and conduct a risk assessment of each potential patient. Not every patient is a good candidate for ambulatory total joint surgery. A bundled total joint program is financially responsible for patient outcomes, so it would be very costly (and risky) to select patients with health complications.

"The key to determining whether a patient is a good candidate is the risk stratification tool that Dr. Rowan helped to design," says **Donna Garvey**, CMPE, executive director of Delta Joint Management. "[Patients] have to answer a series of questions so we can establish whether they are a lower- or higher-risk patient based on their answers to these questions. We will not put them in a situation where they would be at risk, so his questions ensure we have good outcomes."

The risk tool identifies potential red flags.

"Certain problems are absolutely no-nos," Rowan says. "If someone is taking more than 10 mg of oxycodone a day, then there's a high probability you won't be able to discharge that person within 24 hours."

Likewise, patients with A1c blood glucose of 7.5 or greater carry an elevated risk. The same is true for morbidly obese patients, whose body mass index (BMI) is more than 40 kg/m^2. These individuals exhibit an infection rate that is twice as high as other patients, Rowan notes. Smoking, excessive drinking, and psychiatric problems also would not meet the inclusion criteria because these behaviors make it difficult to discharge a patient in fewer than 24 hours, he adds.

"You have to stop smoking first, and use alcohol no more than a couple of ounces a day," Rowan says. "For patients, good behavior is part of it; the patient has to cooperate."

When patients question the smoking prohibition, Rowan notes how much they'd save in copays by undergoing surgery in the outpatient setting. "How often in your lifetime as a smoker has someone offered to give you a couple thousand dollars to

quit smoking?" The patient's ability to be safe at home also is important. "One of our inclusion criteria is that you must have a family member who is at your side for the 48 hours minimum," Rowan says. Patients who do not have a family member or friend who can be with them for two days could hire a nurse to fill that role. Although patients must pay for this service out of pocket, it would be less costly than if patients were to undergo surgery in a hospital, Rowan says. "Hiring some help could save a patient $2,000 in copays." ■

Managing Clinical, Financial Risk With Proper Data Tracking

A healthcare organization likely could not manage financial risk well without access to accurate and complete case and financial data. Delta Joint Management has developed a database for collecting, sharing, and analyzing patient data and outcomes.

"The dashboard tracks patients from time of surgery to receiving bundled payment to each downstream provider and care they receive," says **Donna Garvey**, CMPE, executive director of Delta Joint Management.

Data on pre-op visits, surgery, post-op visits, therapy, patient's plan of care, dates, questions and answers, outcomes, and other items are collected. The patient's outcomes reports are given at post-surgery dates of two weeks, six weeks, and 12 weeks, says **Steve Lucey**, MD, founder and president of Delta Joint Management. The database's dashboard shows a patient list, date of surgery, when their 90 days benchmark expires, when payments were received, and who the downstream providers are for each case, Garvey says.

"It's a file of the different contracts we have with the different payers," she says.

Easy access to data and data analysis is so important to the work that Delta Joint Management has been working with information technology experts to expand the database and dashboard. After the total joint program opened in 2017, its volume expanded quickly. Garvey realized that the software wouldn't provide all the necessary information.

"So, we decided to build our own software," she says. "We developed a team of people, including a software developer, to create a tool that contains clinical and financial management information."

Once the software is complete, Delta Joint Management will license it. "The way my dashboard will improve is [the software] also will have a patient portal access, as well as downstream provider access," Garvey says. "This will allow me to know information from the case manager side of things, and patients can report on how they're doing."

Through the portal, patients can let their providers know how they're progressing. Patients also can log in and confirm when they started physical therapy and finished it. "This will help with reporting, claims information, and outcomes information," Garvey notes.

The database also provides quarterly reconciliation.

"At the end of the quarter, we look at any leakage claims or how claims are going through," Garvey adds. "We see if there is anything happening with patients that we were not aware of." ■

Electronic Distractions Can Be Costly to Surgeons, ASCs

More than a decade into America's love affair with ubiquitous smartphones and tablets, the evidence is mounting that these addictive distractions can lead to deaths, depression in teens, and mistakes by doctors and other healthcare professionals.

"Many times, that distraction takes away from the task at hand, especially in the operating room," says **Peter Papadakos**, MD, FCCP, FCCM, FAARC, director of critical care medicine and professor of anesthesiology, surgery, neurosurgery, and neurology at the University of Rochester Medical Center in Rochester, NY.

In 2017, Papadakos published a book titled, *Distracted Doctoring: Returning to Patient-Centered Care in the Digital Age*, with co-author Stephen Bertman, PhD. Papadakos also is scheduled to speak on this topic at the OR Excellence Conference, which is set to take place Oct. 3-5, 2018, in Ft. Lauderdale, FL.

An example of an extreme case of distracted doctoring involves a 2011 case in which a Dallas anesthesiologist was looking at his iPad and failed to notice his patient's low blood oxygen levels. The patient died, and a subsequent malpractice lawsuit alleged the anesthesiologist's electronic distractions led to the patient's death. *(http://bit.ly/2L6FdaJ)*

"There have been a number of distracted incidences occurring, and my main point is we need to educate people on distracted doctoring and electronic etiquette," Papadakos says.

Healthcare providers also must learn appropriate ways to interact with patients when electronic charts are present. "You go into the doctor's office, and he's crazily typing on the computer console with his back to you because he needs to fill out federally required nonsense," Papadakos says.

Healthcare professionals can be more fixated on the electronic chart than on the patient, he adds. "Unfortunately, with the electronic medical record, medical errors have increased, physician burnout has increased, and costs have gone up," Papadakos laments.

Four problems caused by electronic distractions in healthcare include worsening patient care and vigilance, a breakdown in the bonds between providers and patients, creation of medical legal liability, and higher healthcare costs. Medical liability results from the recent discovery that plaintiff lawyers can investigate a provider's electronic footprint and use whatever the provider did online during that day as evidence for a malpractice suit, Papadakos explains.

"To be exact, they look into your pattern of use: how many hours you are online during the day and even at night because they can add that you were fatigued and addicted," he says. "Your posts and emails are not private."

If healthcare professionals exhibit a strange electronic presence that includes racist, hateful, or other negative comments about patients or families, that will come back to haunt them, Papadakos adds.

For instance, in the case of the Dallas anesthesiologist whose patient died, a deposition showed that a lawyer asked him about two Facebook posts from previous cases. In one post, the physician mentioned a patient's lice. In the second post, the doctor had photographed the patient's monitor.

Electronic distractions can increase healthcare costs when employees are slower in OR turnovers because those employees constantly check their phones. Or, these distractions might affect housekeeping and the flow of patients in a facility, Papadakos offers.

"In a hospital, you walk around and see staff buried in their gizmos," he observes. "We've become addicted to these devices through dopamine from the bings, pop-up stimulation, and alerts."

Smartphone and social media addictions are nationwide issues that affect all areas of life. But the problem in healthcare is that distracted doctoring affects and includes everyone in the organization — not just doctors, Papadakos says.

Additionally, there's the overwhelming, lingering threat that lawyers will gain access to cellphone records. For example, a lawyer in a malpractice case could easily discover what a physician was doing on the morning of a surgery and use this in court: "Dr. Smith, according to your phone records, you sent 5,000 texts while in the OR, and you weren't paying attention to the patient," or "Dr. Smith, you were watching Netflix on your phone," or "You texted that the patient who had a massive heart attack under your care was a jerk."

If ASC leaders educate physicians and staff about this risk, it might result in better outcomes. "This is much more threatening than having a supervisor take your phone away, and that's how we educate people,"

Papadakos explains. The solution from an ASC perspective is to restrict Wi-Fi, perhaps allowing connections in certain areas. Or, ASCs could prohibit staff from using their phones or tablets. Administrators could mandate that family members who need to contact a staffer regarding an emergency could call the operating room or main phone. Most of the time, staff will miss trivial things.

"I work with younger staff, and they have day care and nannies, and the texts they receive continuously are: 'Baby had a bottle,' 'just changed the diaper,'" Papadakos reports.

The chief obstacle to prohibiting cellphones is staff backlash. "People have a fear of not being connected," Papadakos notes. Another solution is to educate employees about the legal and medical risks they incur when they're addicted to electronic devices and cannot put those away while at work.

Organizations can mandate classes in electronic etiquette, which might include teaching staff how to approach a physician or colleague to say, "I'm supposed to warn you that you're on your phone, and it will disrupt patient care. Please put your phone away," Papadakos offers.

ASCs can develop their own multidisciplinary guidelines on how to curb electronic distractions. For example, Beth Israel Deaconess Medical Center's department of anesthesia, critical care, and pain medicine created guidelines for electronic device use, which include: placing electronic devices (other than hospital pagers) on silent or vibrate to minimize interruptions of patient care; limiting electronic device use to when patients are stable; prohibiting participation in electronic games, social media, videos, online shopping, magazines, and non-medical books during OR time; postponing private phone conversations; and minimizing hospital-related internet usage.

However an ASC handles electronic distractions, Papadakos stresses that the important thing is to begin this conversation. ■

Use a Safety Survey to Assess ASC's Strengths, Weaknesses

ASCs can prevent errors and improve quality through completing an annual culture of safety survey.

Poor communication and lax adherence to standards can result in operating room mistakes. However, it's not just the lack of communication between staff and surgeons, but between different physicians, says **Kecia Norling**, RN, MBA, CNOR, CASC, administrator at Northwest Ambulatory Surgery Center in Portland, OR.

Even asking a newer surgeon to question a more experienced surgeon can be uncomfortable, Norling notes. "It's a really interesting dynamic, and it's one that needs to be addressed more frequently," she says. "We talk about it all the time at our surgery center."

For instance, Norling's ASC made a medical error that likely resulted from poor communication between staff and the surgeon, she recalls. "Communication wasn't as strong as needed, and the staff did not feel comfortable speaking up to the surgeon."

One preventive action would be to continually remind the surgery team that their work is important and they have permission to speak up if they see a problem, Norling offers. "Tell the team you are dependent upon their doing their best work and that it takes the entire team and all of their input to oversee any issues. If surgeons said, 'I depend on you to help me do my job well,' then people might be comfortable speaking up."

After the ASC's adverse event, the facility used that example in a physician meeting, emphasizing the need to learn from the mistake.

"We talked about culture, which is a non-punitive way to discuss it," Norling says. "It's not [an individual's] fault, we just need to look at our own processes, starting with administering a culture of safety through a safety survey. A lot of ASCs don't know what their culture is, so they can do a survey through the Agency for Healthcare Research & Quality (AHRQ)." *(Editor's note: The AHRQ checklist is available at: http://bit.ly/2wKXoQ7.)*

Administrators can download the checklist and administer it to all surgeons and staff to get an idea of the ASC's baseline on operating room safety, Norling advises. The survey's findings might be an eye-opener. For instance, studies have shown that while seven out of 10 surgeons will say physicians maintain a positive tone throughout operations, only 34% of other staff believes this is true, Norling notes. An ASC's weaknesses are revealed through the survey. This gives a facility the opportunity to develop plans to fix its problems by forming a committee that focuses on

a culture of safety. "Determine which areas you are going to work on and do this continuously, not just a one and done," Norling says. "Then, do the survey each year and adjust goals for that year; it's never-ending, constantly tweaking it and improving it."

Below are some best practice strategies for using the survey and creating a culture of safety:

• Develop measurable goals. The AHRQ culture of safety survey asks specific questions that can help an ASC pinpoint its weaknesses. For instance, the first section relates to the employee's experience working in the facility. Each statement is answered by a checkmark in one of these five categories: Never, Rarely, Sometimes, Most of the Time, Always. Here are a few examples of statements:

- Important patient care information is clearly communicated across areas in this facility;
- We feel comfortable asking questions when something doesn't feel right;
- We have enough staff to handle the workload;
- Our ideas and suggestions are valued in this facility;
- There is enough time between procedures to properly prepare for the next one;
- We feel rushed when taking care of patients.

If an ASC's survey shows that a significant percentage of staff answered that they never or rarely have enough staff and enough time between procedures to properly prepare for the next one, or that they always or most of the time feel rushed when taking care of patients, then the ASC could develop a measurable goal related to staffing and spacing patients.

"Or, say our survey shows that our staff does not feel like their input matters when decisions are made, then that would be a place to start," Norling says.

When physicians answer the same questions differently, an ASC director will begin to understand how there's a difference in what leadership perceives and what employees see. "Typically, there are surprises," she says. "Even the best teams will say, 'Wow, I wasn't aware of that, and we can work on that.'"

• Determine priorities for improvement. After writing measurable goals, based on the survey's results, an ASC culture of safety committee should determine two or three areas for improvement over the next year. "These are areas where you can make the most change, based on where you had the lowest scores," Norling suggests. "Then, you decide how you're going to implement that change, measure it, and follow up."

For example, Northwest Ambulatory Surgery Center has been conducting culture of safety surveys for four-plus years, giving the ASC comparison data. "We can compare one year to the next, and we can compare our culture of safety results with data from our corporate partner and other ASCs," Norling explains.

Based on these metrics, the ASC found that its staff didn't feel included in the survey results. They might have missed the staff meeting during which the culture of safety results were discussed. Because of this feedback, the ASC created binders containing the survey results in each department. Each binder holds the current year's results, as well as comparisons with previous years and the results from other ASCs within the corporate organization. "Every person has to sign off when they read the results," Norling says. "Then, we sit and have a meeting to discuss what we want to work on with them. For example, one area was better communication between teams."

• Specify solutions to issues raised in the survey. In its second section, the culture of safety survey focuses on teamwork and training, asking staff to rate the organization on items such as: when someone in this facility gets really busy, others help; staff feels pressured to perform tasks on which they haven't been trained; the facility allows disrespectful behavior; and staff members work together as an effective team.

Through these teamwork questions, an ASC might learn that one area of the organization feels that another area is not pulling its weight and vice versa. "They don't understand their different roles, seeing someone at a desk and just sitting because they've finished a phone call with a patient," Norling says. "But the operating room person walking by doesn't know this." For example, there can be frustration between the post-anesthesia care unit (PACU) or pre-op team and operating room (OR) team. "People can feel disrespected and like they couldn't perform their jobs because of the other team," Norling says.

This means the organization needs better team involvement and improved communication between departments. Maybe the OR should allow pre-op enough time to admit the patient, giving the patient a good experience through that, and the pre-op team should ensure the patient is returned to the OR when the surgeon expects the patient, Norling offers. "Typically, these come down to small communication issues." Sometimes, the solution involves new technology. For instance, Northwest Ambulatory Surgery Center maintains an electronic board that informs staff when a patient is ready.

• **Remind employees of goals and outcomes.** An ASC administrator might say, "The patient safety surveys are coming up next month. Let's talk about everything we've done this past year."

"Link what you're doing and label it so when [staff members] see that question come up on the survey, they can say, 'Yes, we addressed that this past year,'" Norling says.

This process of reminding employees must include all staff, including those who work in the business office. "Our business office didn't have enough information about everything we were doing around patient safety because we were leaving them out," Norling says. "So, that's an area we've really worked on this year — making sure the business office knows everything we're doing." For instance, business office staff might not be aware of how OR staff handle a time out before surgery as part of the surgical checklist. It's up to the administrator to explain this process to them.

• **Make difficult changes when needed.** When ASC leaders dig into a culture of safety survey's findings, they might discover a problem that relates to one person's actions or personality. This issue must be addressed, although it can be challenging.

"We had a surgeon who was a good surgeon but had a challenging personality," Norling recalls. "So, the OR staff felt frustrated with him; his paperwork frequently wasn't complete, and we viewed this as a possible weakness that could increase the probability of an adverse outcome."

The solution was to address the issue with the surgeon directly, letting him know the staff's concerns. "We changed the way he scheduled patients," Norling adds. "Instead of sending us a fax, we had his office use our software system through which the office could schedule directly into our software system, and that helped his office be more accurate."

ASC leaders encouraged staff members to speak up if they saw any issues during surgery. "We showed staff we were listening to them and heard them," Norling says. "It was a win-win for everyone." ■

State ASC Associations Can Help With Networking

Networking is one way ASC nurses and other staff can grow as professionals in the ever-changing field.

Ambulatory surgery is expanding rapidly within the current overall trend of the healthcare industry, which is increasingly moving toward outpatient services, says **Kim Van De Ven**, RN, BSN, MBA, chief nursing officer at Banner Surgery Centers, Banner Health System, in Phoenix and the president-elect and conference chair of the Arizona Ambulatory Surgery Center Association (AASCA).

"Every year after [the AASCA] conference, people have asked for networking opportunities to go deep, diving into the day-to-day life of a center," she says. "Now, we have a committee that came up with questions and topics for discussions with surgery center professionals." During the group's latest conference in June, AASCA's board members facilitated discussions with surgery center professionals. Each group of professionals were grouped according to a color code by their facility's specialty area. These areas included eye, multispecialty, pain, plastics, and gastrointestinal. Groups were formed to put people with similar challenges and interests together.

The goal was for administrators, clinical managers, chief nursing officers, and others to learn, network, and get to know each other. Organizers hope participants can use these sessions to create strategies they could use in their own facilities.

After the small group networking sessions, there was an open forum for questions, most of which were general. The session included time for asking attendees what type of quality studies they've conducted and how the results of those studies affected their quality metrics. Additionally, attendees shared best practices.

"What is your staffing, and how do you maintain appropriate staffing levels when the ebb and flow of a center is on some days zero cases and others there could be 30 cases?" Van De Ven says. "What have people found that works to maintain staffing and decrease turnovers during the ebb and flow of surgery center census?"

The prospect of a focus on networking excited AASCA's board members, Van De Ven notes. "They [were] excited to have the opportunity to learn and help facilitate networking. They always want to be involved." ■

Overheard Peer Comments Might Raise Awareness at Your Facility

By Stephen W. Earnhart, RN, CRNA, MA
CEO
Earnhart & Associates
Austin, TX

If you think you are alone in your issues, thoughts, and questions, you are not. The following are some random comments overheard from your peers in both hospitals and ASCs. Admittedly, some of these are amusing asides; however, others might provide some food for thought at your facility. Maybe you find yourself asking (or answering) similar questions. Or perhaps you'll ask similar questions of your staff or take time to better scrutinize certain aspects of your facility. Hopefully, asking more questions and raising awareness around important issues will result in improved operations at your facilities.

• When are surgery centers going to be required to maintain an electronic medical record? It seems like no one really knows, and now I have heard from some vendor that we may never be required to foot that bill and can stay on paper.

• It seems like the corporate surgery center companies are buying all the surgery centers they can. I wonder what they know that I don't?

• Is Trump is going to reduce the paperwork on running a surgery center?

• I wonder why anesthesia staff never clean up after their cases and leaves it for my staff.

• With spine and total joints procedures moving to surgery centers, are we (hospitals) going to get stuck with just old people and high-risk cases?

• My staff wants another raise. Seems like this happens a couple of times a year. I wonder when I get one?

• I have no idea how to handle mobile phones with cameras in my area. It seems like it is out of control, and nothing makes sense in trying to regulate it.

• There was another miscount on the narc sheet yesterday.

• The state is holding reimbursement on all Medicaid payments again. I wonder if we can hold off on performing surgery on Medicaid patients?

• Our lease is running out in two years, and the landlord is playing hardball.

• Looks like someone is stealing supplies.

• Housekeeping is not cleaning in the corners of the rooms — again.

• The surgeons don't like the free meal we gave them today and now want to order what they want from their phones.

• Three out of the four 7 a.m. cases are delayed because surgeons are late — again.

• It is so tempting to just scream at patients' families when they ask why it is taking so long. ■

(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates can be reached at 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. Email: searnhart@earnhart.com. Web: www.earnhart.com.)

CME/CE OBJECTIVES

After reading *Same-Day Surgery,* the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identify how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

COMING IN FUTURE MONTHS

- Tips for tabletop disaster drills
- Advice on protecting ASC in a lawsuit
- Improve behavior, outcomes of anesthesia team
- Watch out for Amazon effect in healthcare

SAME-DAY SURGERY

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Log on to AHCMedia.com then select My Account to take a post-test. *First-time users must register on the site.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CME/CE QUESTIONS

1. **Delta Joint Management's bundled payment ambulatory total joint program shifts financial risk to providers to ensure accountability, efficiency, and quality of care. How does it work?**

   a. Surgeons charge payers and patients no more than 10% above their actual costs.
   b. Surgeons negotiate a bundled payment that covers patients' surgery and 90 days of post-surgery physical therapy and other care, although there is a risk ceiling for very serious events.
   c. Payers establish a bundled payment that gives health systems a set number of dollars to spend on surgeries or any other possible solution to patients' medical problems.
   d. None of the above

2. **A surgeon-led bundled total joint program in an ambulatory setting has produced positive results, including cost savings, zero hospitalization rate, zero DVT rate, and what percentage of a re-operation rate?**

   a. 1.6%
   b. 2.9%
   c. 3.5%
   d. 5.8%

3. **Which of the following would be a good guideline to prevent distracted doctoring/electronic distractions in the surgery center?**

   a. Keep electronic devices (other than hospital pagers) on silent or vibrate to minimize interruptions of patient care.
   b. Limit electronic device use to when patients are stable.
   c. Prohibit participation in electronic games, social media, videos, online shopping, magazines, and non-medical books during OR time.
   d. All of the above

4. **When conducting a culture of safety survey, which of the following would *not* be a good statement for obtaining staff feedback about the facility's safety culture?**

   a. When someone in this facility gets busy, others help.
   b. When someone uses the staff refrigerator, he or she should clean it out.
   c. Staff feels pressured to perform tasks on which they haven't received training.
   d. Our facility allows disrespectful behavior by those working here.