Faster procedures benefit patients and bottom line

Shortening the time it takes for an outpatient procedure may increase volume, OR utilization, and hence revenue—but that is not the point, say the nation’s top performers in a recent survey of procedure times.

Rather, the purpose is to enhance patient safety and satisfaction. For example, less time in the waiting room means less fear and frustration. A shorter procedure time means less time under anesthesia, which in turn means less time in recovery and a better understanding of postdischarge instructions.

The Accreditation Association for Ambulatory Health Care Institute for Quality Improvement (AAAHC Institute) tracks selected procedure times in a semianual survey. Overall, ambulatory surgery centers (ASCs) have been shortening the length of patient visits, but there will always be room for improvement, according to AAAHC Institute Senior Director Naomi Kuznets, PhD.

“ASCs always strive to do better,” she says. “These results show improvement for certain organizations, which is always laudable. I don’t think there is ever a stopping point for these studies.”

The AAAHC Institute uses procedure times as benchmarks for quality, Kuznets explains, “because they reflect processes not dictated by clinical guidelines and are, for the most part, within the control of the organization.”

The latest results, due out shortly before press time, cover the period from July 1, 2012, to December 31, 2012.

The previous study, conducted between January 1, 2012, and June 30, 2012, covered colonoscopy, knee arthroscopy, pain management by low-back injections, and cataract surgery. High-scoring ASCs in the first 2 categories agree that advance planning, teamwork, and sincere concern for patient welfare were the keys to excellence.

Quick, but careful

In the January through June colonoscopy survey, 61 ASCs submitted data on 2,086 cases. The median preprocedure time was 62 minutes, with a range of 12 to 97 minutes. The procedure itself took from 9 to 27 minutes, with a median of 18 minutes. The interval to discharge ranged from 13 to 62 minutes, with a median of 36 minutes. Total facility time for participants ranged from 57 to 166 minutes, with a median of 121 minutes.

At the Ambulatory Endoscopy Center of Central Florida (AECCF) in Longwood, the average discharge time was 12.6 minutes (rounded to 13), making the center a top performer in that category. The AECCF is a freestanding, physician-owned center with 2 procedure rooms. The center’s 4 gastroenterologists perform about 300 colonoscopies per month.

Endoscopy manager Angela Corallo, RN, attributes the rapid recovery time in part to sedation management by the certified registered nurse anesthetist (CRNA), who decreases the sedation before the end of the procedure but still maintains an adequate level of comfort for the patient.

One of the first tasks in determining the discharge time, she recalls, was defining it. The AAAHC Institute defines discharge criteria for colonoscopy as the period from
when the physician removes the scope to the time the patient is medically ready to leave. “That is not the actual time they leave,” she notes.

No patient is released before 30 minutes have elapsed postprocedure. Patients must be alert and oriented, they must have discussed the results with the physician, and their driver must have arrived.

The center identified 2 ways to shorten that period: keep medication levels to the minimum necessary for patient comfort, and start planning for a smooth recovery well before the patient arrives in recovery. The third factor, which makes it all possible, is a team that is able to communicate and coordinate actions.

“Our major emphasis is on keeping the patients safe and comfortable. All of the following processes revolve around these concepts,” Corallo says.

**Step by step**

The road to a rapid discharge begins with a well-organized admission.

The receptionist is the first staff member to interact with the arriving colonoscopy patient, and her role is crucial.

“She is the start of the patient’s experience with us, and she could make that experience unpleasant if she does not handle the patient properly,” Corallo says.

Upon arrival, patients often are hungry, irritable, in need of a bathroom, embarrassed, or nervous about the procedure. At the AECCF, a nurse is available to provide immediate assistance and explain what will happen. The AECCF prides itself on having adequate staff, with long experience and low turnover.

The admitting nurse takes vital signs and then reviews medications, consents, and medical history for accuracy. After the patient changes into a gown and is on a stretcher, the nurse starts an IV line with fluids to relieve dehydration; this, too, helps speed recovery.

The contract anesthesiologist then evaluates the patient, followed by the CRNA,
who will administer and monitor the sedation. Next, the physician meets with
the patient to review concerns and expectations. After the patient is fully se-
dated, there is a time-out to verify the procedure and patient’s identity, and then
the procedure begins. Shortly before it ends, the dose is decreased, allowing
recovery to begin sooner. The physician routinely removes air from the colon at
the end of the procedure, which also helps decrease recovery time.

The CRNA and a float nurse accompany the patient to the recovery room. The
CRNA remains until the patient is stable.

There, the advantage of a quicker recovery is evident: the patient spends less
time sedated, has less chance of nausea, and is more alert when the physician
comes in to discuss the results.

“What happens upon admission affects everything that happens afterward,”
Corallo says. Patients who know what to expect and are comfortable will have a
better recovery.

At the front end
At Mountain Laurel Surgery Center in Honesdale, Pennsylvania, the average pre-
colonoscopy time was 12 minutes, making the center a top performer in that cat-
egory. In the just-released second study, Mountain Laurel was again named a top
performer.

The freestanding, physician-owned center has 3 gastroenterologists and 2 proce-
dure rooms where about 60 colonoscopies per week are performed.

Director of nursing Patricia Williams, RN, says close coordination with the phy-
sicians makes the short wait times possible. Within 30 days of a scheduled colonos-
copy, the physician’s office staff interviews the patient. ASC nurses contact the pa-
tient 2 or 3 days before the procedure to review all medications and conditions and
to determine if there have been any changes.

By the time the patient arrives at the ASC, the information is on hand, and only
a quick review is necessary. The physician then reviews the consent form with the
patient. The anesthesiologist or CRNA interviews the patient before moving the
patient to the procedure room.

The rapid, efficient processing not only saves time but also minimizes anxiety,
Williams explains. “We try to work with our patients when they come in for the
procedure,” she says. “Because of that, most of the anxiety has dissipated. They
know what to expect.”

She notes that younger patients, usually present for diagnostic colonoscopies,
tend to be the most anxious on arrival but respond well to the attention they re-
ceive.

“They say it’s the way we present ourselves that helps them calm down,” Wil-
liams says. “One of the younger patients recently told me, ‘It’s so nice to come
here, compared to someplace else.’ ”

Propofol safety
Both AECCF and Mountain Laurel administer propofol during colonoscopies, but
AECCF combines it with midazolam (Versed) and fentanyl. Ondansetron (Zofran)
is also available in case of nausea.

Because propofol has been known to produce sudden adverse side-effects,
the Institute for Safe Medication Practices (ISMP) and other experts strongly
recommend having trained anesthesia personnel—that is, an anesthesiologist or
CRNA—administer the drug, even if the drug is intended for sedation only.

much supervision can the physician provide if he or she is focused on the procedure itself?”

Both ASCs follow that guideline. CRNAs are present during procedures to administer the drugs and monitor the patient’s respiratory function. Anesthesiologists are available on site.

Propofol is the sedative of choice for colonoscopies because it is fast acting with a short-term effect, which is ideal for a brief procedure. “Patients wake up sooner with no side-effects and are more alert,” Williams explains.

Because of current shortages, some ASCs, such as AECCF, augment propofol with other drugs. According to the American Society of Health-System Pharmacists’ Current Drug Shortages Bulletin of February 5, 2013, 2 major suppliers, Hospira and American Pharmaceutical Partners, have propofol on back order. Hospira cites manufacturing delays, and APP is unable to meet growing demand.

Efficient arthroscopy
Knee arthroscopy calls for patient stays of up to 4 hours, but the principle is the same: careful planning and medication management can make the patient’s visit shorter and easier.

Staff nurse Shannon Waring, RN, oversees benchmarking studies at Los Alamitos (California) Surgery Center. Even before the AAAHC study, she was in the habit of monitoring procedure times.

In the first 2012 study, Los Alamitos ranked number 3 in average preprocedure time, at 45 minutes. “That’s where we excelled,” Waring says.

For the January through June knee study, 33 organizations reported data on 796 cases. The preprocedure time range was 24 to 115 minutes, with a median of 90 minutes. The median procedure time was 27 minutes, with a range of 17 to 42 minutes. Discharge times averaged 48 to 113 minutes, with a median time of 71 minutes. Total time spent in the facility ranged from 119 to 246 minutes, with a median of 192.

Los Alamitos, an independent ASC with 3 ORs owned by a group of physicians, performs about 1,600 knee arthroscopies annually.

The surgeons and ASC staff work closely to coordinate patient scheduling and preparation, according to Waring.

“We have frequent meetings, with OR technologists, RNs, and sometimes anesthesiologists,” she says. “We work closely with our surgeons.”

The ASC is strict about OR start times. “If you are scheduled at 7:30 am, we start surgery at 7:30 am.” RNs and surgical technologists arrive an hour before start time to make sure instrument trays are ready. The nurses are cross-trained so they can move from preop to the OR to the postanesthesia care unit as necessary.

Paperwork is completed the day before surgery in a phone call to the patient. When patients arrive, they sign the paperwork, and then an RN leads them to the dressing room.

“People don’t really wait in our waiting room,” Waring notes. “We bring the patients right back.”

The RN checks vital signs, starts the IV, adds antibiotics, and checks the consent form. Then the anesthesiologist comes in and reviews the patient’s history. Following surgery, the same nurse and anesthesiologist accompany the patient to the recovery area.

Recovery time for knee arthroscopy with general anesthesia is 1 hour. After the patient awakens, the surgeon meets with him or her to clarify discharge instructions.
Planning and teamwork
Waring says the key to keeping preprocedure time short is to have all of the required documentation completed the day before. The surgeon’s office collects the information and sends the completed forms to the ASC.

“We have a good working relationship with our surgeons,” she notes.
ASC employees meet regularly with their counterparts in the physicians’ offices to compare notes and head off potential problems.

But these clinicians do not just talk among themselves; they also make it a point to communicate with patients. That, Waring says, is another secret to their success.

“We focus on the patient and the patient’s experience. We have a common goal.”
Regardless of the type of procedure, that philosophy applies. The top performers agree that planning and effective communication make for speed but never haste.

It means making patients feel cared for, not rushed. As Waring observes, “Just because you’re efficient doesn’t mean you have to compromise in the way you’re caring for someone.”

—Paula DeJohn

Have a question on the OR revenue cycle?

Keith Siddel will respond to questions in the column. Send your questions to editor@ormanager.com
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