SOCIETY FOR AMBULATORY ANESTHESIA
Outpatient • Office Based • Non-Operating Room
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Nuts and Bolts of a 23-Hour Stay

Staffing, equipment, and logistical considerations

National Medical Director, HCA Ambulatory Surgery Division

Diplomate of the American Board of Anesthesiology

Diplomate of the American Board of Preventive Medicine (Clinical Informatics)

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Why 23-hour stay?

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- Provide an option between typical ASC care and hospital care
- Better experience for patient (safety, convenience, cost)
- Expand opportunities for ASCs
- Create capacity in acute care facilities

Requires thoughtful approach for patient and procedure selection, staffing competencies and the unique logistical requirements of functioning in an environment typically designed for day-only care

Caveat if you are considering adding this service – heavily dependent on state law, regulations, payer characteristics, politics, staff availability, etc.

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23-Hour Stays – All about workflows

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ASC workflows are designed for patients going home in a few hours with

Modifications are required for stays exceeding a few hours – adding staffing hours is necessary but insufficient to provide safe patient care

Trouble – while rare – can occur by failing to account for workflow changes that differ from normal day only care – e.g., the lack of readily available backup help, available items at the bedside or easily accessible, location of telephones, medications, etc.

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Staffing

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Fundamental staffing questions – number, ratio, skills

- Number of staff to provide routine and crisis care AT NIGHT (no help)
- Minimum staff of 2 – is this enough? Depends!
- Skills needed
  - RN for basic patient care (monitoring, med administration, pain management, wound management, etc.)
  - Some debate on 2nd caregiver skills – mostly another RN (interchangeable)
  - Labor costs & staffing shortages leading to discussion of alternatives
  - RN + LVN, RN + MA/EMT/paramedic, RN plus "warm body"
  - Constrained by state/federal law, accreditors, practice acts, etc.

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Staffing questions for your ASC

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Are overnight staff possess skills and competencies needed without onsite backup?

- Routine and emergency care
- Physical therapy or other special needs (e.g., joint replacement)

If using outside staff for nights are they familiar with the ASC?

Effect of overnight staffing needs on morale, availability for day shifts, etc.

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Staffing – physician care

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Which physician is in charge of overnight care?

- Surgeon, anesthesiologist, primary care
- Non-procedure related issues (i.e., "medical care")
- Who is available for consultation – e.g., anesthesiologist who performed case or on-call physician at hospital?
  - Must be member of medical staff
- What if consultation is needed? Transfer?

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Staffing – Regulatory and accreditation issues

State specific requirements (e.g., licensure for overnight stays, room size, use of PACU, diversion risk prevention, nursing board requirements, etc.)

- When does the 23-hour period begin? Admission or induction of anesthesia?

AAAHC Medicare Deemed Status – Chapter 20

Joint Commission – no specific chapter/standards applicable - essentially all elements applicable for other procedural care apply

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Equipment and logistical issues

- Mostly related to workflow design and staffing levels, skills and services
- For example, If only 2 staff present are items available at bedside?
  - Communication devices – is staff tethered to wired phone at nursing station? What happens during crisis if both caregivers are involved in resuscitation or other high intensity event?
  - Medication management (procurement, wasting/witnessing if only one licensed clinician, etc.)
- Visitors? How are they managed?
- Patient meals?
- SECURITY – many ASCs are in areas with little foot traffic after hours
  - Does the staff feel safe?

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Is it all worth it?

Benefits include potential expansion of case volume and market share

- Cases requiring extended stay plus "halo" volume

May be offset by lack of reimbursement, increased costs, staff morale, etc.

Outmigration from hospital may cannibalize health system revenue?

Alternative is standard ASC care with "recovery center"

- Licensed facility
- Hotel arrangement

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Discussion

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