

DTIC FILE COPY

2

AD-A222 193

A STUDY TO DETERMINE
THE MOST EFFICIENT PROVISION
OF SURGICAL CARE AT
DARNALL ARMY COMMUNITY HOSPITAL

A Graduate Research Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree

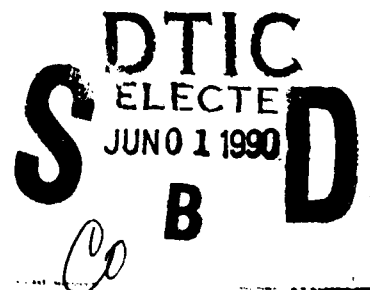
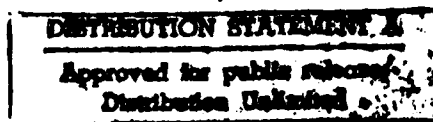
of

Master in Health Care Administration

by

Major Gale S. Pollock, AN

September 1987



90 044

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION N/A			1b. RESTRICTIVE MARKINGS N/A		
2a. SECURITY CLASSIFICATION AUTHORITY N/A			3. DISTRIBUTION / AVAILABILITY OF REPORT Unclassified/Unlimited		
2b. DECLASSIFICATION / DOWNGRADING SCHEDULE N/A					
4. PERFORMING ORGANIZATION REPORT NUMBER(S) 74-89			5. MONITORING ORGANIZATION REPORT NUMBER(S)		
6a. NAME OF PERFORMING ORGANIZATION Darnall Army Comm. Hospital		6b. OFFICE SYMBOL (If applicable) N/A		7a. NAME OF MONITORING ORGANIZATION US Army-Baylor University Graduate Program in Health Care Administration	
6c. ADDRESS (City, State, and ZIP Code) Fort Hood, TX			7b. ADDRESS (City, State, and ZIP Code) AHS San Antonio, TX 78234-6100		
8a. NAME OF FUNDING / SPONSORING ORGANIZATION N/A		8b. OFFICE SYMBOL (If applicable) N/A		9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER N/A	
8c. ADDRESS (City, State, and ZIP Code) N/A			10. SOURCE OF FUNDING NUMBERS		
			PROGRAM ELEMENT NO.	PROJECT NO.	TASK NO.
11. TITLE (Include Security Classification) A STUDY TO DETERMINE THE MOST EFFICIENT PROVISION OF SURGICAL CARE AT DARNALL ARMY COMMUNITY HOSPITAL					
12. PERSONAL AUTHOR(S) POLLOCK, GALE S.					
13a. TYPE OF REPORT FINAL		13b. TIME COVERED FROM 7-86 TO 7-87		14. DATE OF REPORT (Year, Month, Day) 87/9	
15. PAGE COUNT 121					
16. SUPPLEMENTARY NOTATION					
17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number) Same Day Surgery (SDS), Darnall Army Community Hospital (DACH)		
FIELD	GROUP	SUB-GROUP			
19. ABSTRACT (Continue on reverse if necessary and identify by block number) ➤ This study was performed to determine the most efficient method to provide surgical care at Darnall Army Community Hospital which would allow maximal utilization of personnel and facilities without decreasing the quality of care provided. The paper concluded by recommending that Darnall go on a same day surgery program with the Chief of Surgery deciding on cases needing overnight care. <i>re: a Medical Services multi-Care, (187)</i>					
20. DISTRIBUTION / AVAILABILITY OF ABSTRACT <input checked="" type="checkbox"/> UNCLASSIFIED/UNLIMITED <input type="checkbox"/> SAME AS RPT. <input type="checkbox"/> DTIC USERS				21. ABSTRACT SECURITY CLASSIFICATION N/A	
22a. NAME OF RESPONSIBLE INDIVIDUAL Major Leahy				22b. TELEPHONE (Include Area Code) (512) 221-2324/6345	
				22c. OFFICE SYMBOL	

TABLE OF CONTENTS

ACKNOWLEDGMENTS.....	4
LIST OF TABLES.....	5
CHAPTER	
I. INTRODUCTION.....	6
Historical Perspective.....	6
Conditions Which Prompted the Study.....	7
Problem Statement.....	8
Objectives of the Study.....	8
Criteria.....	8
Assumptions.....	9
Limitations.....	9
Review of Literature.....	10
Definition of Same Day Surgery.....	10
Growth of Same Day Surgery.....	11
Advantages of Same Day Surgery.....	12
Disadvantages of Same Day Surgery.....	16
Potential for Same Day Surgery.....	17
Market Analysis.....	20
Research Methodology.....	21
II. DISCUSSION.....	24
Analysis of Surgical Workload.....	24
Analysis of Nursing Workload.....	25
Cost Comparison.....	28
Interest in a Same Day Surgery Center.....	31
Comparison of Civilian Facilities.....	33
Alternatives.....	34
III. CONCLUSION AND RECOMMENDATIONS.....	38
Conclusion.....	38
Recommendations.....	38
APPENDIX	
A. DEFINITIONS.....	40
B. SAME DAY SURGERY UTILIZATION PATTERNS.....	44
C. IDENTIFICATION OF SURGICAL BACKLOG BY THE DEPARTMENT OF SURGERY.....	47

D.	-DARNALL ARMY COMMUNITY HOSPITAL CATCHMENT AREA.....	54
E.	JCAH STANDARDS.....	56
F.	DARNALL SAME DAY SURGERY POLICY.....	67
G.	INPATIENT OPERATING ROOM PROCEDURES THAT MET DARNALL SDS CRITERIA.....	72
H.	HEALTH SERVICES COMMAND SAME DAY SURGERY POLICY.....	74
I.	INPATIENT OPERATING ROOM PROCEDURES THAT MET HSC SDS CRITERIA.....	91
J.	SINGLE SOLDIER ESTIMATES.....	95
K.	WORKLOAD MANAGEMENT SYSTEM FOR NURSING, WORKSHEETS AND STAFFING GUIDES.....	97
L.	NURSING WORKLOAD ANALYSIS.....	106
M.	MAP OF DARNALL ARMY COMMUNITY HOSPITAL.....	111
	BIBLIOGRAPHY.....	115

ACKNOWLEDGMENTS

I sincerely doubt any project of this magnitude is accomplished without support from loved ones and professional colleagues. This project has not been an exception. I am truly thankful to Doug McAllaster for his patience and his never faltering encouragement to meet milestones, Rob Dahlander for his enthusiasm for clear writing, Ellen Synovek for her tireless efforts to teach me the various workload programs in the hospital, and finally COL Johnny Conner for never verbally doubting this project would come to an end. To the unmentioned supporters through this year, many many thanks and may God bless all of you!



Accession For	
NTIS GRA&I	<input checked="" type="checkbox"/>
DTIC TAB	<input type="checkbox"/>
Unannounced	<input type="checkbox"/>
Justification	
By	
Distribution/	
Availability Codes	
Dist	Avail and/or Special
A-1	

LIST OF TABLES

TABLE 1-Most Commonly Performed Ambulatory Surgery Procedures.....	18
TABLE 2-Calculation of Inpatient Nursing Care Requirements.....	26
TABLE 3-Calculation of Same Day Nursing Care Requirements.....	27
TABLE 4-Percent of Care Provided by Ward.....	28
TABLE 5-Six Month Average Length of Stay (ALOS).....	29
TABLE 6-Cost Comparison.....	30
TABLE 7-Comparison of Alternatives.....	37

I. INTRODUCTION

Historical Perspective

Darnall Army Community Hospital (DACH) established its Same Day Surgery Center (SDSC) in 1983. It was established for several reasons: 1) to decrease the surgical backlog, 2) to lower costs involved with providing surgical care, and 3) to ease the workload for the nursing department which was experiencing a decrease in authorizations (Synovek, Personal interview, 6 October 1986).

Utilization of the SDSC was initially satisfactory to both clinicians and administrators of the medical treatment facility (MTF). They had anticipated that the SDSC workload would gradually increase as the staff and the patient population became educated to the concept of same day surgery. Although utilization increased in 1984 and 1985, it decreased in 1986 (Appendix B). This decrease in utilization was attributed to personnel turnover among key hospital leaders who supported SDS at Darnall. This turnover included members of the Department of Surgery, the Chief of Surgery, the Deputy Commander for Clinical Services, and the Hospital Commander. Interest in Same Day Surgery waned.

Conditions Which Prompted This Study

This study was undertaken to determine if SDS is part of the problem or a potential solution to the problems which preceded its implementation. The conditions which prompted its initiation in 1983 still exist. Did the SDSC fail to correct the three adverse conditions cited above due to improper implementation? If so, the Commander needs to know how the SDSC can be modified to enhance its contribution to DACH. If not, he needs conclusive evidence that SDS will not work at Fort Hood so he can utilize the SDSC's assets in another fashion. The demand for surgical care is increasing as is the surgical backlog. Surgical care at Darnall must be provided in the most productive manner.

Second, the number of nursing and ancillary personnel assigned to the hospital did not increase when more physicians were assigned. Thus, there is an imbalance between the number of physicians and the number of nursing and ancillary personnel.

Third, there are more surgeons assigned to Darnall than can utilize the inpatient operating rooms efficiently.

Fourth, the SDSC at Darnall failed to meet the Joint Commission on the Accreditation of Hospitals (JCAH) standards of care because a professional nurse was not assigned to the recovery room of the SDSC. This

emphasizes the necessity of examining staffing patterns for the SDSC recovery room.

Problem Statement

To determine the most efficient method to provide surgical care at Darnall Army Community Hospital which would allow maximal utilization of personnel and facilities without decreasing the quality of care provided.

Objectives of the Study

The objectives of the study included: 1) to assess interest in Same Day Surgery shown by Darnall's surgical care providers; 2) to identify surgical procedures provided at Darnall which are appropriate for a SDSC; 3) to compare costs between traditional inpatient surgical care and SDS; 4) to calculate the difference in nursing workload between the traditional inpatient surgical care and same day surgical care; and 5) to compare the system for Same Day surgery at Darnall to those at local civilian facilities.

Criteria

There are four criteria against which alternatives will be measured. First, the Health Services Command (HSC) policy guidelines for surgical care will be

followed. Second, to maintain quality care, the standards of documentation, established by the Joint Commission on the Accreditation of Hospitals will be met in 100% of surgical admissions. These standards include: a) a complete pre-operative medical history and physical exam, b) pre-operative lab work identical to that required for the same procedure performed on an inpatient basis, and c) a documented pre-anesthetic interview. Third, productivity must be increased by correcting the workload imbalance between the physicians and nursing care providers. Fourth, surgical care must be provided in the most cost effective manner.

Assumptions

The demand for surgery exceeded the availability of surgical care. This is demonstrated by the surgical backlogs (Appendix C). The demand for surgery corresponds directly to the population supported by Darnall Army Community Hospital.

In order to support the population effectively, the facility must operate at one hundred percent capacity. However, the demand will continue to exceed capability.

Limitations

The study involved only the first six months in 1986. The available CHAMPUS data was for the entire

catchment area. The Fort Hood catchment area includes seventy-seven counties in Texas (Appendix D). It was felt unreasonable to expect that all beneficiaries would travel to Darnall for their surgical care. For this reason, specific computations on total cost savings to the CHAMPUS program were not done.

The housing office at Fort Hood does not maintain a roster of the single, active duty members who reside in the barracks, the non-commissioned bachelor quarters, or the bachelor officer quarters. Estimates of the single soldier population were derived from local demographic data.

Review of Literature

Definition of Same Day Surgery

In 1986, Wetchler (p.121) defined a Same Day Surgery Center as a unit which

"... will permit the patient to have an operation in comfortable, safe and sterile surroundings, and to go home the same day. Surgical, anesthesia, and recovery room procedures identical to those used for inpatient surgery are carried out, except that following recovery the patient is sent home instead of to a hospital bed."

Same Day Surgery Centers are not new. Surgery has been performed outside the hospital for many years. However, ambulatory surgery centers have come to be established in the United States only in the past twenty years (O'Donovan, 1976). Several types of ambulatory

surgery centers have developed. The most common include hospital-based nonmedicated units, hospital-based defined units, and freestanding units (Appendix A). In 1971, the American Medical Association endorsed the practice of same day surgery (Detmer, 1982).

Growth of Same Day Surgery

Ambulatory surgery is presently one of the most rapidly growing areas of the American health care delivery system. This growth was stimulated by the Health Planning and Resources Act of 1974 (PL-93-641), which promoted ambulatory care (Detmer, 1982).

The American Health Consultants held two seminars, one in November 1980 and a second in April 1981, to discuss the development and growth of SDSC programs throughout the United States. According to data collected by the American Hospital Association, there was a nationwide increase of 77% in same day surgery between 1970 and 1983. This increase is anticipated to continue due to cost containment pressures, government legislation affecting hospital reimbursement and changes in consumer behavior (American Hospital Association, 1984).

Changes in reimbursement requirements have also contributed to the growth of SDS. When Medicare and other third party payers paid billed charges, there was

little financial pressure to promote SDSC. Medicare has specified over 100 procedures for which outpatient surgery is appropriate and for which hospitals will not be reimbursed if provided as inpatient care (Katz, 1983). Private health insurers have also mandated that certain procedures be performed on an outpatient basis in order to be reimbursed. Financial incentives are offered in the form of higher payment percentages by the insurer if procedures are done as same day surgery.

Three major factors, other than financial, have been identified which allowed for this growth in ambulatory surgery. First, improved anesthetics act quickly and wear off faster than their predecessors. Second, improved technology allows for superior control of bleeding. Third, early post operative ambulation reduces pulmonary and vascular complications (Schowalter, 1977).

Advantages of Same Day Surgery

Many authors have addressed the advantages of SDS. These advantages are presented from the perspective of the health care facility, the nursing staff, the patients, and quality of care.

There are several reasons for hospitals to provide ambulatory surgery, beyond the compelling facts of reimbursement. Some hospitals have identified

10

ambulatory surgery as a means to cope with overcrowding and high costs of twenty-four hour nursing staff (Schowalter, 1977). According to Kropt (1984) ambulatory surgery reduces waiting time for surgery and decreases the demands on the staff due to a decrease in occupancy. The actual savings to the medical treatment facility will be in three main areas. First, the ability to close the ward at night and on weekends and so economize in the salaries of nursing staff. Second, a reduced need for "hotel" facilities, including meals, lighting and power, laundry, etc., required for the use of inpatients. Third, the shorter time spent by each patient in the hospital permits more patients to be treated in the facility, providing that operating theaters are available (Burn, 1983). Additionally, length of stay is decreased as post operative complications secondary to nosocomial infections decrease (Egdahl, 1984; and Pineault, 1985). The primary emphasis has been on the advantages of decreased postoperative infection, conservation of bed days, and the freeing of nurses and other personnel for the more critically ill patient.

Advantages for the nursing staff are acknowledged by the nurses and the facilities which employ them. Nursing organizations have developed and improved their teaching plans for those patients who undergo same day

surgery (Mauldin, 1983). In addition, same day surgery centers have provided nurses the opportunity to follow a patient throughout his operative experience: from admission, to the operating theater, and to the recovery area. These same nurses have coordinated discharge planning and provided telephonic follow-up twenty four hours later. This provides job enrichment and contributes to job satisfaction. An additional advantage for the nursing staff is the fact that ambulatory surgery allows for a Monday through Friday schedule with no evening or night responsibility.

The public is becoming aware of the advantages of same day surgery. These advantages include less interruption of the patient's routine, reduced anxiety and greater comfort and convenience for both the patient and the health care providers (Brownlee, 1977). In 1982, Detmer identified savings in both time and money, being spared the emotional stress of hospitalization, avoidance of the forced dependence of an inpatient as improvements for the surgical patients.

Many patients identified the pleasure of recovering at home, and some discussed the ability to return to work more quickly (Detmer, 1982). Other patients stated that the benefits of recovering at home included a faster recovery, feeling better mentally, less disruption of family routine and reduced cost (For Your

Good Health, 1986). The convenience of day surgery, particularly for mothers, has enabled women to receive surgical treatment that otherwise would have been difficult to arrange (Burn, 1983).

Quality of care is another advantage of same day surgery. Safety in same day surgery has been well documented by reports of individual practitioners and from large centers. Kambouris (1986) reported to the 28th Annual Assembly of the Midwest Surgical Association that of 13,433 patients undergoing surgery in free standing ambulatory centers, the incidence of infection and hemorrhage was extremely low, only 16 patients had to be hospitalized. Ryan (1984) reported 10 per cent complications, mainly urinary retention, among 53 patients who underwent herniorrhaphy on an ambulatory basis with three patients hospitalized for medical reasons. In contrast, 36 percent of matched hospitalized patients who underwent the same operations developed complications, 30 per cent of them being urinary retention. The decrease in infection contributes to a cost saving for the hospital and increased safety for the patient.

In an effort to insure high quality of care for patients choosing the same day surgery option, the Joint Commission on the Accreditation of Hospitals developed specific standards for ambulatory surgery programs

(Appendix E). Administrators must also remember that the pattern of patient care and design of facilities must reflect the needs of the patient and the constraints of the resources available rather than the convenience of the staff or the hospital.

Disadvantages of Same Day Surgery

Everyone does not view SDS as the panacea for correcting the problems in the health care system. The reported disadvantages of SDS include: 1) an increase in the workload for the nursing personnel; 2) potential for a decreased quality of care; 3) resistance to revision if problems are discovered; and 4) hidden costs and dissatisfiers for the patients.

One opposing view is that as the healthy patients are removed from the hospital environment, demands on the nursing staff will increase. This increased demand would result because the average patient would be more severely ill.

Not all physicians agree with these new alternatives. R.D. Reinecke (1985) voiced concern that substandard care would be result from same day surgical care. Reinecke stated this change was "a return to the barbershop, a dangerous and unacceptable situation" (Reinecke, Outpatient Surgery, p. 26).

Pineault (1985) addressed the need for ongoing

evaluation to insure that changes are made if needed. A specific concern of Pineault was menisectomy. Presently menisectomies are considered an appropriate procedure for same day surgery. Menisectomy often requires heavy splints or casting which results in longer recovery periods. Individuals who had undergone menisectomy in an ambulatory setting were much less satisfied than patients who underwent the procedure in a traditional inpatient facility.

Hidden costs of early return to home by the patients were addressed by Berk (1986). These include the loss of time if both adults are employed and that most studies have not included the cost of care provided by relatives (Paulshock, 1982). Other dissatisfiers identified were an absence of explanation of procedures, long registration procedures, and discourteous staff.

Potential for Same Day Surgery

As resource constraints have increased, discussion of Same Day Surgery Centers has increased. J. Burn (1983) proposed that same day surgery become the standard of care for all suitable surgeries and that every hospital provide ambulatory surgical care. The U.S. General Accounting Office has recommended that every hospital analyze same day surgery's potential for cost savings (Government Accounting Office, 1985). In

1983, Blue Cross concluded that ambulatory surgery is the most important tool now available for curbing rising health care costs.

Dr. Ward, (1983) a British physician, addressed the need for hospitals to develop alternatives to traditional modes of care to conserve resources and meet the needs of an ever growing and graying population. He believes that money and manpower used for inpatient surgical care could be used more productively to meet other health care needs without compromising the quality of surgical care.

Table 1 is a comparison of surgical procedures accomplished in hospital ambulatory surgery centers and free-standing ambulatory centers which was released by Nathanson in 1986.

Table 1.

Most Commonly Performed Ambulatory Surgery Procedures

Hospitals	Independent FASC's
D & C	D & C
Diagnostic cystoscopy	Cataract extraction
Myringotomy	Arthroscopy
Biopsy of breast tissue	Laparoscopy
Skin lesions	Myringotomy
Diagnostic laparoscopy	Plastic surgery
Cataract extraction	Skin lesions
Release of carpal tunnel	Tonsillectomy/ adenoidectomy

Potential use of ambulatory surgery has been

evaluated at several facilities. Bashin evaluated anesthetics administered to adult inpatients at University Hospital in Seattle, a tertiary referral center. He found that 422 of 1559, or twenty-seven percent, were administered for surgical procedures appropriate for same day surgery on patients who were American Society of Anesthesiologists (ASA) Physical Status I or II (Appendix A).

Siu et al (1986) reviewed the medical records of 1132 hospitalized adults in a random trial to access avoidable admissions. They judged 40 percent of these admissions avoidable if ambulatory surgery was available. Their decisions were based on a list of suitable ambulatory procedures developed and tested by Restuccia and colleagues at Boston University (Siu et al, 1986).

Pineault (1985) evaluated patient satisfaction, clinical outcomes and cost of the episode of care. He found that fifty-four percent of the patients felt their stay at the hospital for same day surgery was too short. However, half of the patients who felt that way claimed they would repeat the experience in the SDSC.

In 1982, Detmer reported that the satisfaction levels of 900 surgical patients in Arizona were similar whether patients were treated in free standing ambulatory centers, hospital ambulatory surgery centers,

or inpatient hospital units but were lower when patients were treated in outpatient hospital settings.

Ambulatory surgery units, both hospital based and free standing, consistently outperformed both hospital inpatient and outpatient services in staff friendliness, attention to patient needs, pleasantness of environment, and perceived quality of care.

Market analysis

Marketing has gained importance in the development of community awareness of SDSC's as alternative for care (Inguanzo, 1985). Special interest groups have formed to change the perceptions of the community. These groups have encouraged the patient and families to participate in medical care decision making.

Market analysis has been performed in the civilian community to determine who is likely to use a SDSC. Inguanzo (1985) found that households which: are supported by two incomes; earn total incomes of \$40,000 per year or more; contain two or more children under age eighteen; are familiar with HMO's and preferred provider agreements; and are headed by college graduates are the most likely to utilize SDSC's. The segment of the population showing the least disposition toward SDS included people living in the South; people with less than high school level education; households with annual

incomes under \$15,000; and people aged 65 and older.

Analysis of established SDSC's has also been accomplished. When market analysis of community needs, operating room schedules, bed occupancy, physician interest, medical specialty needs, developing programs, and available space was done prior to implementation, the SDSC evidenced growth and success (American Health Consultants, 1983).

Research Methodology

The requirements established in the preceding sections were accomplished in several steps. First, a review of the literature was completed. This review focused on current trends and developments in Same Day Surgery and included admission and discharge policies, nursing concerns, and resource management. Previous studies completed by Baylor students (McNeil, 1981; Jennings, Lenniville, McNeil, 1982; Koehler, 1982; Ledford, 1982) and standing operating procedures for Darnall and Walter Reed were obtained and reviewed.

Second, interviews of key personnel were accomplished. These interviews provided various perspectives on the problem of under utilization of surgical resources and alternatives to increase and improve the quantity of surgical care.

Third, workload data was obtained from the

Resource Management Division, OCHAMPUS, and PASBA. The operating room register was used to develop a data base for all surgeries performed from 1 January through 30 June 1986. The data base included: nursing unit to which the patient was assigned; specific surgical department involved in the care; type of procedure; whether the patient was an active duty soldier, a retiree or a family member; whether the procedure was routine or emergency; and date of procedure. When the data base was developed, a field named "quantity" was included to allow for mathematical calculations.

The research process examined which surgical procedures were considered appropriate for same day surgery and which procedures continue to require inpatient care postoperatively. Both Darnall Army Community Hospital and Health Services Command have policies that state which procedures are appropriate for same day surgery. Health Services Command's policy for same day surgery was reviewed to determine the difference, if any, between those policies. These recommended procedures were then compared to the actual procedures completed at Darnall. The number and the percentage of cases which were appropriate for same day and for inpatient care were calculated with both of these policies. Initial analysis was with Darnall's current policy for same day surgery to determine if

20
this policy had been utilized.

A major factor, mandated by HSC in April, was that single soldiers who live in the barracks or other bachelor quarters are not eligible for same day care. This required the development of estimates of the number of soldiers affected. Specific reports were not available at Fort Hood with these statistics. The estimates were generated based on the percentage of single soldiers to total population.

The average length of stay and the average cost for care for inpatient surgical care were calculated. The cost for same day surgery was also developed.

The effects on nursing workload were calculated using the Workload Management System for Nursing. Alternations in staffing patterns were projected based on potential same day surgery utilization.

Visits to St. David's Community Hospital in Austin, Hillcrest Baptist Medical Center in Waco, and Scott & White Medical Center in Temple were done during January 1987. These visits allowed the opportunity to evaluate alternative styles of patient flow patterns and staffing management.

II. Discussion

The literature review suggested that a Same Day Surgery Center has great potential for contributing to productivity and efficiency in hospitals. The contribution potential for the SDSC at Darnall was analyzed from several perspectives to determine whether it could correct existing problems. The first perspective was that of the surgical workload at Darnall. The second was the comparison of nursing requirements between traditional inpatient care and same day surgical care. Third, the differences in cost were determined. Fourth, key hospital personnel were interviewed to assess interest in same day surgical care and to identify factors that limit SDS at DACH. Finally, civilian same day surgery programs were examined.

Analysis of Surgical Workload

Evaluation of the inpatient operating theaters demonstrated that at least forty-two percent of the surgery could have been performed as SDS. During the period of analysis, January through June 1986, 1551 procedures were performed in the inpatient operating rooms. Of these procedures, seventy-seven percent (1200) were scheduled, elective procedures. Emergency procedures do not fit the criteria required for same day

11

surgery and were eliminated from the analysis. These 1200 non-emergency inpatient procedures were evaluated in three ways: 1) Using Darnall's policy (Appendix F) forty-two percent (509) were appropriate procedures for same day surgery (Appendix G); 2) When the procedures accomplished as inpatient were compared with the HSC procedure guidance (Appendix H) for same day surgery, fifty-seven percent (688) could have been completed in a same day setting (Appendix I); 3) When HSC guidelines for procedure and elimination of single soldiers in barracks (Appendix J) were applied, the number of eligible procedures was forty-eight percent (576). Consequently, about half of all inpatient procedures done at DACH during the first half of calendar year 1986 could have been performed in the SDSC.

The evaluation of the care provided in the Same Day Surgery Center revealed that all procedures accomplished there met the policy guidelines for both Darnall and Health Services Command. However, utilization was below full capacity.

Analysis of Nursing Workload

In an effort to determine the effect of the same day surgery eligible patient load on the nursing staff, the Workload Management System for Nursing (WMSN) was utilized. This analysis revealed that the nursing

workload would decrease by about fifty percent on the three major surgical wards if eligible SDS patients were not admitted as inpatients.

The WMSN requires that a prospective analysis of the patient's needs for the next twenty four hours be completed by a professional nurse. These nursing care tasks are listed as critical indicators and a point value is assigned to each. The sum of the point values determines the patient acuity category (Appendix K). Table 2 identifies the point values for a typical same day surgical eligible inpatient on both the admission day and the first post operative day. These point totals make a patient a category II for each hospital day.

Table 2.

CALCULATION OF INPATIENT NURSING CARE REQUIREMENTS

DAY OF ADMISSION	FIRST POSTOPERATIVE DAY
1 Vital signs QID or less	6 Post-op Vital Signs
2 Self Care	2 Intake & Output q4hr
12 New Admission	2 Self Care
(assessment and orientation)	4 KVO
4 Preoperative teaching	2 Medications q3hr
	2 Assist OOB, walk
	& return x 1
19 Category II	4 Patient/family teaching
	22 Category II

Documentation of the categories is reported to the

Department of Nursing and reflects current staffing requirements. The WMSN includes a staffing table. The number of patients in each category determine the number of nursing hours required to provide care. The total hour requirement then provides the basis for staffing to meet patient needs (Appendix L).

The patient category averages, and hence, staffing requirements, change if eligible patients receive care in a Same Day Surgery setting. A SDSC patient is a category II. This is illustrated in Table 3.

Table 3.

CALCULATION OF SAME DAY NURSING CARE REQUIREMENTS

DAY OF SURGERY

- 1 Vital signs QID or less
 - 2 Self Care
 - 12 New Admission (assessment and orientation)
 - 4 Preoperative teaching
 - 6 Post-op Vital Signs
 - 4 Patient/family teaching
-

29 Category II

There are 4.79 surgical patients per day eligible for same day surgery. If these patients were cared for in a Same Day setting, the nursing care requirements would decrease on the inpatient nursing units. Table 4 reflects the percentage of surgical care provided by each ward during the six month period.

Table 4.

Percent of Care Provided by Ward

3S	34.92%
3E/4E (pediatrics)	6.67%
4W	28.17%
5W	28.09%
ICU	.30%

3S and 5W are dedicated to the care of surgical patients. Their decrease in surgical patient load would be 50 percent and 38 percent, respectively, if the eligible patients received SDS instead of inpatient care. 4W, an orthopedic ward would have a potential decrease in patient load of 58 percent. The effect on staffing was calculated for these three wards based on the nursing care required for an admission and first post-operative day. The total staff savings for personnel when this change is in place is estimated to be one professional nurse, two 91C (practical nurses), and two 91A (corpsmen). Because the nursing requirements for SDS patients are less than inpatient nursing requirements, the use of Same Day Surgery would rectify most of the physician : nurse staffing imbalance.

Cost Comparison

The cost of inpatient surgery at Darnall during the period of analysis was \$1,094,621.69. The average

cost per bed day was \$501.43. As seen in Table 5, the average length of stay (ALOS) for this period was 3.79 days.

TABLE 5.

SIX MONTH AVERAGE LENGTH OF STAY (ALOS)

MONTH	ALOS
JAN 86	3.89
FEB 86	4.33
MAR 86	3.86
APR 86	3.7
MAY 86	3.4
JUN 86	3.56

Six Month ALOS = 3.79

The following cost comparison was calculated based on the estimate developed earlier, that 576 patients were eligible for SDS. Darnall used approximately 2,183 inpatient bed days for care which could have been provided in the SDSC.

The total costs for this six month period in the SDSC were \$206,045.87. The ALOS for a SDS patient is one day. With a case load of 296 for this period, the average cost per day was \$696.10.

With the elimination of 2.79 bed days for these 576 patients, the cost savings for these procedures can be seen in Table 6. Table 6 also exhibits the loss of Medical Care Composite Units (MCCU) which would result from the transition to SDS. Supply dollars are allocated based on the accumulation of MCCU's. Each

MCCU is worth \$18.83. Ten MCCU's are awarded for each inpatient admission or SDS admission. One MCCU accumulates for each subsequent hospital day. The lost MCCU's from fully utilizing the SDSC are 1,607.04.

Table 6.

Cost Comparison

A. Bed Days

Eligible patients* x savings in bed days = Saved bed days

$$576 \times 3.79 = 2,183.04$$

Saved bed days x cost per bed day = Cost saved

$$2,183.04 \times \$501.43 = \$1,094,641.75$$

Eligible patients* x SDS average cost per day = SDS cost

$$576 \times \$696.10 = \$400,953.60$$

Inpatient cost - SDS cost = Total cost savings

$$\$1,094,641.75 - \$400,953.60 = \$693,688.15$$

B. Medical Care Composite Unit Loss

$$576^* \times 2.79^{**} = 1,607.04 \text{ bed days} =$$

$$1,607.04 \text{ MCCU's lost}$$

$$1,607.04 \times \$18.83 = \$30,260.56 \text{ lost in supply dollars}$$

* 576 patients are eligible to receive care in SDS.
 ** ALOS for period is 3.79 when care is provided as inpatient. ALOS for SDSC is one day.

The cost comparison shows that even with a loss of supply dollars, the SDSC is more economical than inpatient surgical care.

Interest in a Same Day Surgery Center

The assessment of interest in SDS was accomplished through interviews with the anesthesia nursing staff, the operating room nursing staff, the Chief of the Operating Room, the physician director of the SDSC, and the Chief Nurse of the hospital.

The mission statement for the SDSC required a nurse anesthetist to provide the nursing care and supervision in the recovery room. Therefore the number of general anesthetics was limited because of the dual role of the nurse anesthetists. The nursing anesthesia section did not have its full strength of authorizations and accomplishment of both missions was difficult. The anesthesia staff nurses felt this was a severely limiting factor in the provision of care in the SDSC. The anesthetists felt that if they were not responsible for the post anesthesia care, their staff could support the SDSC functioning at its maximum capacity.

The operating room nurses and technicians felt that there was not adequate space to allow the families to be with the patients after their discharge from the recovery room. It was not unusual for families to stand by the patients bed in the hallway in the SDSC. This lack of space caused a lack of privacy and an unacceptable level of noise in the recovery area. This was another limiting factor in the utilization of the

SDSC.

The Chief of the Operating Room was not amenable to "late starts". A "late start" allows the physician to schedule a procedure in a SDSC to start his surgical day. When the surgery is completed in the SDSC, the surgeon then moves to the operating room established for the inpatient procedures. With a "late start", the operating room would continue operation into the evening shift. The mission, and therefore the staffing of the operating room section, does not allow for evening shift personnel. This inflexibility added to the difficulties of increasing utilization of the SDSC.

The physician director of the SDSC stated that physician resistance to utilization was in two areas. First, the documentation requirements were identical for SDS and inpatient surgical care. The time constraints were not. The policy established by the Deputy Commander for Clinical Services required that the medical record of the SDSC patient be completed within twenty-four hours; when the care was provided on an inpatient basis, the documentation did not require completion until 72 hours after discharge. The second area of resistance was the geographic separation of the SDSC from the inpatient operating area. The SDSC is located adjacent to the Surgical Clinic on the ground floor. The inpatient operating room is on the second

floor (Appendix M). This geographic separation was felt to cause a waste of physician time in traveling from one area to another to write discharge notes or to see the patients.

The Chief Nurse had originally not been in favor of utilizing a professional nurse overhire to provide post anesthesia recovery care as that care had been tasked to the anesthesia department in the mission statement. However, as the anesthesia department decreased in staff from 13 to 7, she felt the mission could not be accomplished without the addition of a professional nurse. This also brought the SDSC into compliance with JCAH criteria for accreditation, i.e. that a professional nurse must be in the recovery area at all times.

Comparison of Civilian Facilities

Comparison of the three civilian facilities visited allowed for the selection of advantages from each of these systems. The importance of patient privacy and convenience of a "private" area for recovery was emphasized by the staff of all three facilities. It was also best if these areas had toilet facilities close at hand. Although the patients must ambulate prior to discharge, they are definitely not capable of walks down the hall or around the

corner. The private rooms also allowed for patients to feel as though they were special and provided the family members who accompany the patient a place to be away from the other patients and families. The patients also were being taught to accept more responsibility for their health care.

The nursing staff in all of these facilities enjoy the process of taking a patient through their entire day, from admission to discharge. The staffs feel comfortable with the education provided to these individuals and believe it contributes to the overall success of the programs.

The facility administrators are also happy with these programs as it costs the hospital significantly less to care for these patients in a same day setting than in the traditional manner of surgical care.

Alternatives

Four alternatives were identified. These were evaluated against the following criteria: 1) Productivity is increased by correcting the workload imbalance between the physicians and non-physician health care providers; 2) The HSC policy guidelines for SDS procedures would be followed; 3) JCAH standards for documentation would be met in 100% of surgical records; and, 4) The care would be provided in a more cost

effective manner. Table 7 is a comparison of these four alternatives.

The first alternative is to do nothing and maintain the status quo. This fails to meet three of four criteria. Because the imbalance of nursing staff to physicians is not corrected if the status quo is maintained, productivity of the SDSC continues to decrease. During the period of analysis, the JCAH requirements for records were met. As identified in the discussion, provision of care in a same day surgery setting is less expensive than that same care provided in an inpatient setting. Finally, maintenance of the present system continues to ignore the policy guidelines of Health Services Command. The positive benefits are that there is no need to overcome resistance to SDS, nor is there change for the staff to cope with.

A second alternative was to close the Same Day Surgery Center. This alternative does not meet the established criteria. The closing of the SDSC will not correct the imbalance of nursing staff to physicians. It would decrease the workload on both groups, but it would concurrently decrease productivity. The elimination of sixty surgical procedures per month would compound the existing problems of inadequate operating time for the surgical care providers and

would further decrease the provision of needed care to DACH constituents. The cost of providing care would increase as all care would be provided on an inpatient basis. Again, this alternative fails to follow the HSC guidelines.

The third alternative is to provide all care requiring general anesthesia on an inpatient basis and all surgical care requiring local anesthesia as SDS. This choice does not meet the criteria. This alternative, instead of correcting the imbalance between nursing staff and the physician staff, increases the demands on the inpatient care providers. The location of some of the surgical care would change, but productivity would not be increased. Costs would not decrease as more patients would receive their care in the more expensive inpatient area. Again, this alternative fails to follow the HSC guidelines for the provision of selected surgical care as same day surgery.

The fourth alternative was to provide all surgical care at Darnall according to the HSC policy. This meets all of the criteria. This alternative shifts about fifty percent of care presently provided on an inpatient basis to a same day surgery basis. It increases productivity by providing surgical time without the concurrent increased demand on the ward nursing staff. It provides care in the most cost

effective manner. The cost to the facility is less when the patient is provided same day rather than inpatient care.

Table 7.

	<u>Comparison of Alternatives</u>			
ALTERNATIVES:	1	2	3	4
CRITERIA:				
Increase productivity by correcting imbalance among providers	NO	NO	NO	YES
Follow HSC guidelines	NO	NO	NO	YES
Meet JCAH standards	YES	YES	YES	YES
Increase cost efficiency	NO	NO	Y/N	YES

III. CONCLUSION AND RECOMMENDATIONS

Conclusion

The most efficient method of providing surgical care at Darnall Army Community Hospital which allowed for maximal utilization of personnel and facilities without a decrease in the quality of care provided would be to implement alternative four to provide all surgical care according to HSC policy. Providing surgical care for all eligible patients on a Same Day basis would make the hospital a more productive and cost efficient facility.

Acceptance of this alternative would substantially improve the adverse conditions cited in the introduction. Productivity would be greatly improved as the physician to nursing personnel imbalance would be corrected. With this correction, the surgical backlog would be reduced. In addition, the hospital would achieve substantial cost savings.

Recommendations

This researcher recommends that Darnall Army Community Hospital implement the fourth alternative. Certainly such a large change in policy requires a major system change and will cause a period of turmoil for the organization. However, it is in long term best interest for the patients that Darnall serves. Maximal

provision of Same Day Surgery will allow the hospital to provide more care to its patient population through good management of scarce resources, i.e. facilities, personnel and monies.

The Commander must set a policy that requires all patients who meet the criteria for same day surgery to have their surgery done as outpatients. Only the Chief of Surgery grants exceptions to this policy. This snifts about fifty percent of surgical care provided by Darnall from traditional inpatient care to the Same Day Surgery mode.

This shift prevents the SDSC from being the site of all same day surgery. A two room operating theater is not adequate for this number of surgeries. The SDSC operating rooms could be used for all procedures which require local anesthesia or intravenous sedation. The SDSC recovery area can support these patients without difficulty. The numbers of patients and families involved in same day surgery under this alternative will also prevent the SDSC from being the focus for admission and discharge. Space will not allow for it.

The main operating theater will be necessary to provide this volume of care. The main recovery area, adjacent to the operating theater, would be the site of initial recovery from general anesthesia.

The transition to same day surgery will have a

profound effect on the surgical wards. There are presently three wards dedicated to surgical patients. The decrease in workload for these areas would allow for the combination of workcenters. The combination of 3S and 5W would be the best choice. The decrease in workload will not be as large on 4W, the orthopedic ward, because this area supports the highest number of active duty soldiers. 4W patients are often excluded from same day surgery as they are single and reside in government quarters.

The decrease of inpatient workload and combination of units results in availability of nursing staff to support a same day surgery patient area outside of the current SDSC. It facilitates continuity of care by having the same staff complete the pre-operative counseling, admit the patient, be available for patient and family education, assist the family with discharge, and complete telephonic follow-up twenty four hours post operatively. The personnel requirements remain less than for a ward which must be open twenty four hours a day, seven days a week.

In utilization of former ward space for the SDSC, patient satisfaction should be enhanced. The rooms on the ward have toilet facilities. Private or semiprivate rooms also provide the space necessary to allow families to stay with the patients before and

after the procedure.

The concern of providing surgical time for the increasing number of surgeons is addressed by this change in policy. Physician concern over the geographic separation of the surgical care areas should be decreased through the provision of all general anesthetics in one area. This change provides the surgeon with easier access to the recovering patient.

Darnall has an opportunity to stay ahead of other military care facilities and continue to be the trend setter for the MEDDAC's. It is an excellent facility with innovative and hard working military and civilian personnel. By maximizing utilization of resources and anticipating the impact of DRG based reimbursement, Darnall can maintain its philosophy of excellence.

APPENDIX A

Appendix A

Definitions

American Society of Anesthesiologists (ASA) Category 1-- Patients who are in good health and have no systemic disease.

American Society of Anesthesiologists (ASA) Category 2-- Patients in moderately good health with well controlled systemic disease.

Free standing ambulatory center (FASC)--is physically separate from other health care facilities.

Hospital based, Defined unit--is the most common, it is a dedicated unit within the hospital structure.

Hospital based, Non-dedicated unit--The patient never occupies a hospital bed in a defined unit; rather, the surgery is done under general anesthesia and the patient is discharged directly from the recovery room when his or her condition warrants it.

Inpatient surgery--The traditional process of admitting a patient to the hospital for a stay of at least one night and performing surgery during that hospitalization.

Level 1 Surgical Care--Minor ambulatory surgery (formerly outpatient surgery). This includes operations performed on nonhospitalized patients with immediate discharge of the patients.

Level 2 Surgical Care--Major ambulatory surgery (formerly ambulatory surgery). This includes operations performed on nonhospitalized patients, under any type of anesthesia, in which a period of postoperative care and/or observation is used.

Level 3 Surgical Care--Inpatient surgery. This includes operations performed on hospitalized patients.

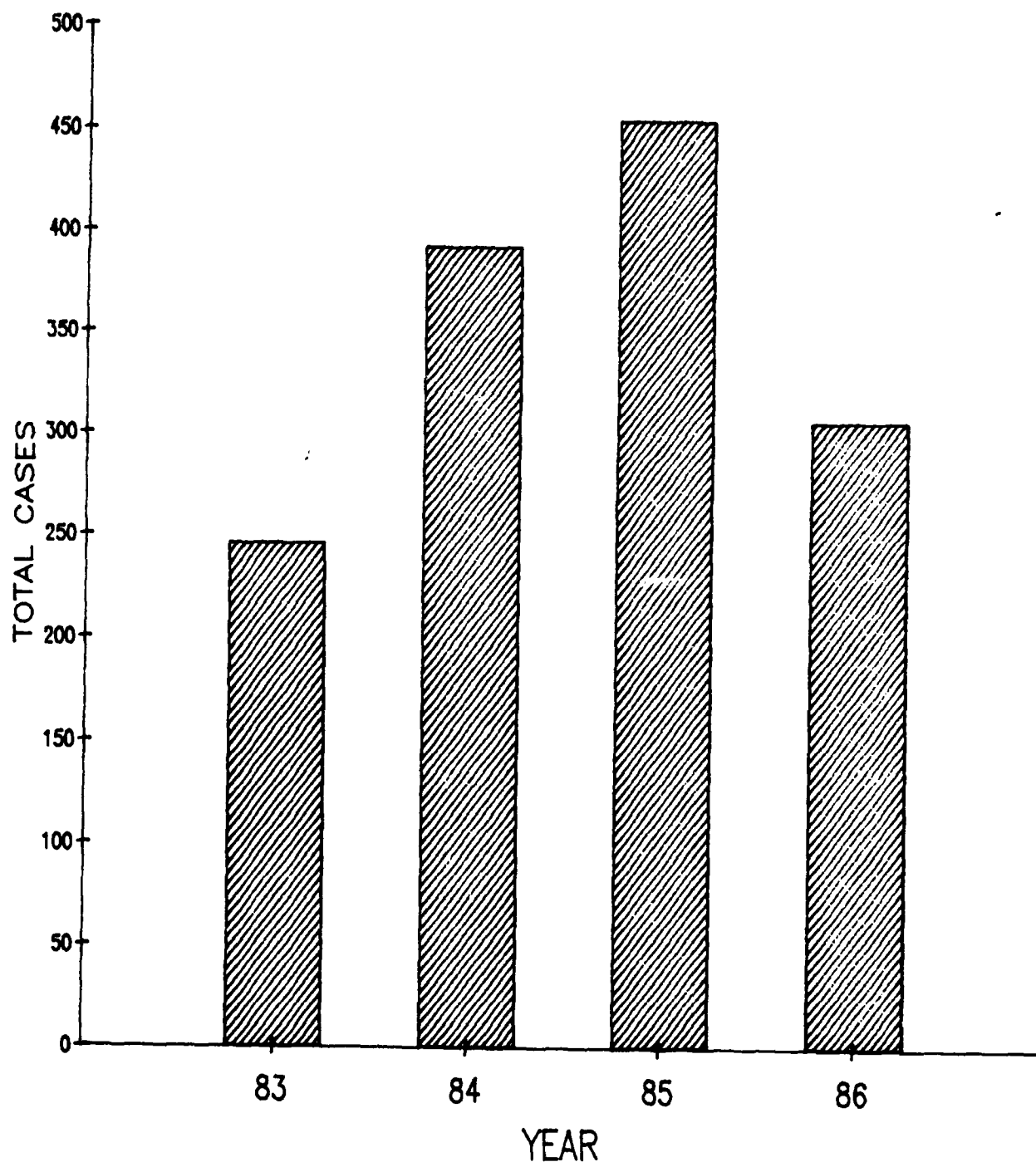
One day surgery--The process by which the patient is admitted in the morning of the operation and discharged that afternoon.

Same day surgery--procedures that are more complex than office procedures done under local anesthesia, but are less complex than major procedures that require prolonged postoperative monitoring and hospital care in order to guarantee the patient a safe recovery and desirable outcome.

APPENDIX B

APPENDIX B

SAME DAY SURGICAL CENTER
HISTORICAL WORKLOAD
JANUARY - JUNE



APPENDIX C

APPENDIX C

Identification of Surgical Backlog by the Department of Surgery

HSXI-HOS-SU

4 February 1986

SUBJECT: Minutes of Department of Surgery Meeting

used for comparison and no significant mortality was noted. Problem is resolved as individual practitioner has retired from military service.

b. Data input:

- (1) All surgical services.
- (2) Surgical backlog.
- (3) Staffing.
- (4) Operating Room utilization.
- (5) Same Day Surgery Center utilization.
- (6) Increased administrative requirements.
- (7) Incidents.
- (8) Potential compensable event.
- (9) Positive occurrence screening - None reported this month.
- (10) Audits.
- (11) Referrals from other committees and departments.

c. New problems:

- (1) SU 860201 -
 - (a) Personnel shortages.
 - (b) Increased workload per health care provider causes increased stress and demand which can lead to errors in judgment and longer waiting times for appointments and surgery.
 - (c) Will compare workload reported to staffing.
 - (d) Chief of Surgery and Administrative Officer will evaluate TRIPAS and UCA reports.
 - (e) Followup monthly.
- (2) SU 860202 -
 - (a) Backlog of appointments in surgery.
 - (b) Longer waiting periods and increased complaints.
 - (c) Monitor appointment backlogs.

HSXI-HOS-SU

4 February 1986

SUBJECT: Minutes of Department of Surgery Meeting

- (d) Chief of Surgery.
 - (e) Monthly followup.
 - (3) SU 860203 -
 - (a) Backlog of elective surgery.
 - (b) Delay in patient obtaining surgery. Increased cost to the patient and inconvenience if performed on CHAMPUS. Patients may be inconvenienced by referral to other military MTF.
 - (c) Will monitor backlogs on monthly basis.
 - (d) Chief of Surgery.
 - (e) Review monthly.
 - (4) SU 860204 -
 - (a) Increased administrative requirements.
 - (b) Decreased availability of staff to provide health care to all eligible health care beneficiaries.
 - (c) Document increased hours to complete administrative functions.
 - (d) All service chiefs and Chief of Surgery.
 - (e) Monitor monthly.
8. The next meeting will be held at 1500 hours 4 March 1986.
9. The meeting adjourned at 1610.

Encl



HENRY A. MAYER, JR.
Colonel, Medical Corps
Chief, Department of Surgery

Nancy M. Gann
Nancy M. Gann
Recorder

HSXI-HOS-SU
SUBJECT: Minutes of Department of Surgery Meeting

4 March 1986

(3) 860201 - Personnel Shortages.

Still consistent with what was initially reported. The only significant change is going to be in Optometry upcoming with CPT Felton going to the CAS³ Course. We are working that problem at this time to see if we can get some help from the divisions. We think we are going to be able to continue the optometry service without any interruptions, just a little bit of inconvenience.

(4) 860202 - Backlog of Appointments in Surgery.

There are still no significant changes in the backlogs. COL Mayer said that he needs to have a report from each service the third Monday of each month before Quality Assurance meeting that Thursday and will get a DF out to the chiefs as to what he will need.

(5) 860203 - Backlog of Elective Surgery.

No significant changes. It is continued as an ongoing problem and will be monitored on a monthly basis. This will also be reported as above to COL Mayer.

(6) 860204 - Increased Administrative Requirements.

There has been no relief. This is an ongoing problem. CPT Green is trying to give some relief, but there is no anticipation of significant change in the administrative duties required of each individual. CPT Green is scheduled for PCS 31 Mar 86 and no replacement has been found.

b. Data input:

- (1) All surgical services.
- (2) Surgical backlog.
- (3) Staffing.
- (4) Operating Room utilization.
- (5) Same Day Surgery Center utilization.
- (6) Increased administrative requirements.
- (7) Incidents.
- (8) Potential compensable event.
- (9) Positive occurrence screening.
- (10) Audits.
- (11) Referrals from other committees and departments.

HSXI-HOS-SU

1 April 1986

SUBJECT: Minutes of Department of Surgery Meeting

information could be disseminated plus permission would have to be granted by HSC before any services could be cut.

(4) 860202 - Backlog of Appointments in Surgery.

ENT Clinic Visits: ENT - 13 AD, 35 RFU, 600 New/Dep.
Audiology - 59 AD, 40 Dep.
Speech Pathology - 20 (all).

Ophthalmology Clinic Visits - 497 (all patients; not including appointments already in computer).

Orthopedic Service Clinic Visits: 6 to 8 months return; 2 to 3 months for AD/New.

General Surgery Service Clinic Visits: 205 Dep/Ret; no AD waiting.

GU Service Clinic Visits - 6 weeks (to to 8 months for people awaiting vasectomies in clinic). CPT Waxman said the service now has a resident and has reapportioned some of the surgery time to take care of the backlog in vasectomies.

OB-GYN Department Clinic Visits - COL Mayer asked MAJ Smith to submit his clinic's backlog to be included in the minutes.- 11 months; 7 months - Pap smears

(5) 860203 - Backlog of Elective Surgery.

ENT: 101 cases (4 months).

Ophthalmology: 9 patients.

Orthopedic: 6 weeks.

General Surgery: 5 weeks.

GU: 8 patients.

OB-GYN Department: 2 weeks.

(6) 860204 - Increased Administrative Requirements.

Administrative requirements are increasing. The Department of Surgery is totally without an Administrative Officer, as CPT Kelly Green has become an MI officer and is no longer with the hospital. COL Mayer said he was considering bringing SFC Babic from the Orthopedic Clinic in as NCOIC of the department. COL Mayer congratulated everyone on keeping their charts up.

HSXI-HOS-SU

6 May 1986

SUBJECT: Minutes of Department of Surgery Meeting

(4) SU 860202 - Backlog of Appointments in Surgery.

(a) The backlog of appointments in surgery continues to grow. COL Mayer anticipates this to be a continuing problem on through the summer well into the fall, and thinks this may never be corrected at the present rate.

(b) Waiting Times for Clinic Appointments:

General Surgery - 5 months.

Urology - 0.

Gynecology - 12 months.

Obstetrics - 0.

Orthopedic - 8 to 12 months.

Podiatry - 1 month.

Ophthalmology - 12 months.

Optometry - 0.

ENT - 12 months.

Audiology - 2 months.

(5) SU 860203 - Backlog of Elective Surgery.

(a) The backlogs of elective surgery is in the same status as the backlog of appointments in surgery. The department is trying to get some contracts out to help alleviate some of the problems. MAJ Smith is working on a contract for his OB-GYN care. COL Mayer is working on a contract for Podiatry and a contract for the Brace Shop. Contracts are being looked at but nobody has approved them yet.

(b) Waiting Times for Elective Surgery.

General Surgery - 2 to 3 months.

Urology - 2 to 3 months.

Gynecology -

Orthopedic - 2 to 3 months.

Podiatry - 1 month.

Ophthalmology - 2 weeks.

ENT - 2 to 3 months.

HSXI-HOS-SU

3 June 1986

SUBJECT: Minutes of Department of Surgery Meeting

(3) SU 860201 - Personnel Shortages.

(a) Personnel shortages will continue. Notification has been received that there will be only 4 Orthopedic surgeons instead of 5 assigned. There will be 5 General Surgeons, 10 obstetricians, 2 otorhinolaryngologists, 2 urologists (3 for a short time), 3 oral surgeons, 2 anesthesiologists, 8 nurse anesthetists, 2 ophthalmologists in late August or early September, and 2 podiatrists will be here by July. MAJ Allen will be on board by the end of the month in Optometry. LTC Stevens said a physical therapist would be coming in January 1987 and 1 in February. A student had been promised, but it would probably be the summer of 1987 before Physical Therapy would be back up to strength. LTC Mills, Chief of Occupational Therapy, will be leaving in early October and his replacement will be here in late September.

(b) The shortage of 91 Deltas will continue and although that is a nursing problem, it plays an important role in the number of operating room nurses available. LTC Sims mentioned that in the new TDA, the operating room nurses are below the authorization but in the old TDA, they are right at strength. The new TDA is effective 1 October. COL Mayer stated that MILPERCEN now controls the assignments and that if COL Courcy did not get the supplement from FORSCOM, ward nurses may be a problem. There will be a shortage of officer and enlisted personnel during the months of June, July, and the first half of August.

(4) SU 860202 - Backlog of Appointments in Surgery.

(a) The backlog of surgical appointments continues. COL Mayer invited the chiefs to pick up a printout sheet of the backlogs from SFC Babic or CPT Birdsall.

(b) Waiting Times for Clinic Appointments:

General Surgery - 6 months.

Urology - 5 weeks.

Gynecology - 12 to 13 months.

Obstetrics - 0.

Orthopedic - 12+ months.

Podiatry - 1 month.

Ophthalmology - 12+ months.

Optometry - 4 weeks.

ENT - 9 months.

Audiology - HEAs - 14; AUDs - 49.

Speech Therapy - 11 evaluations booked.

HSXI-HOS-SU

3 June 1986

SUBJECT: Minutes of Department of Surgery Meeting

(5) SU 860203 - Backlog of Elective Surgery.

(a) The backlogs of elective surgery continues.

(b) Waiting Times for Elective Surgery:

General Surgery - 6 weeks.

Urology - 5 weeks.

Gynecology - Less than 2 weeks.

Orthopedic - 2 to 3 months.

Podiatry - 5 weeks.

Ophthalmology - 0.

ENT - 2 to 3 months.

(6) SU 860204 - Increased Administrative Requirements.

There is no change in administrative requirements. COL Mayer reported that in the past month, he had visited two civilian hospitals and their administrative requirements had also increased. MEDICARE has new stipulations and if they are not met, MEDICARE will not pay the patient's bill.

(7) SU 860301 - Utilization of Same Day Surgery Center.

The problem of underutilization still exists. Better utilization should occur in August or September after physician replacements come in.

(8) SU 860302 - Shortage of TDY Funds for Physicians and for Continuing Medical Education for Everybody.

Funding is still in a holding pattern and is going to become extremely critical. The department is operating with a deficit. Three hundred thirty one million dollars will be withdrawn from the Department of the Army on the 16th of June unless there is legislation to alleviate that from the Gramm-Rudman bill. HSC's cut is approximately fifty one million and they will let us know what our share will be.

(9) SU 860401 - Survey of Practitioners Complying With Attending Notes on Charts.

The survey has been completed and will be re-audited in six months (2 December 1986).

(10) SU 860501 - Nissen Study on Nissen Fundoplication.

APPENDIX D

Darnall Army Community Hospital Catchment Area

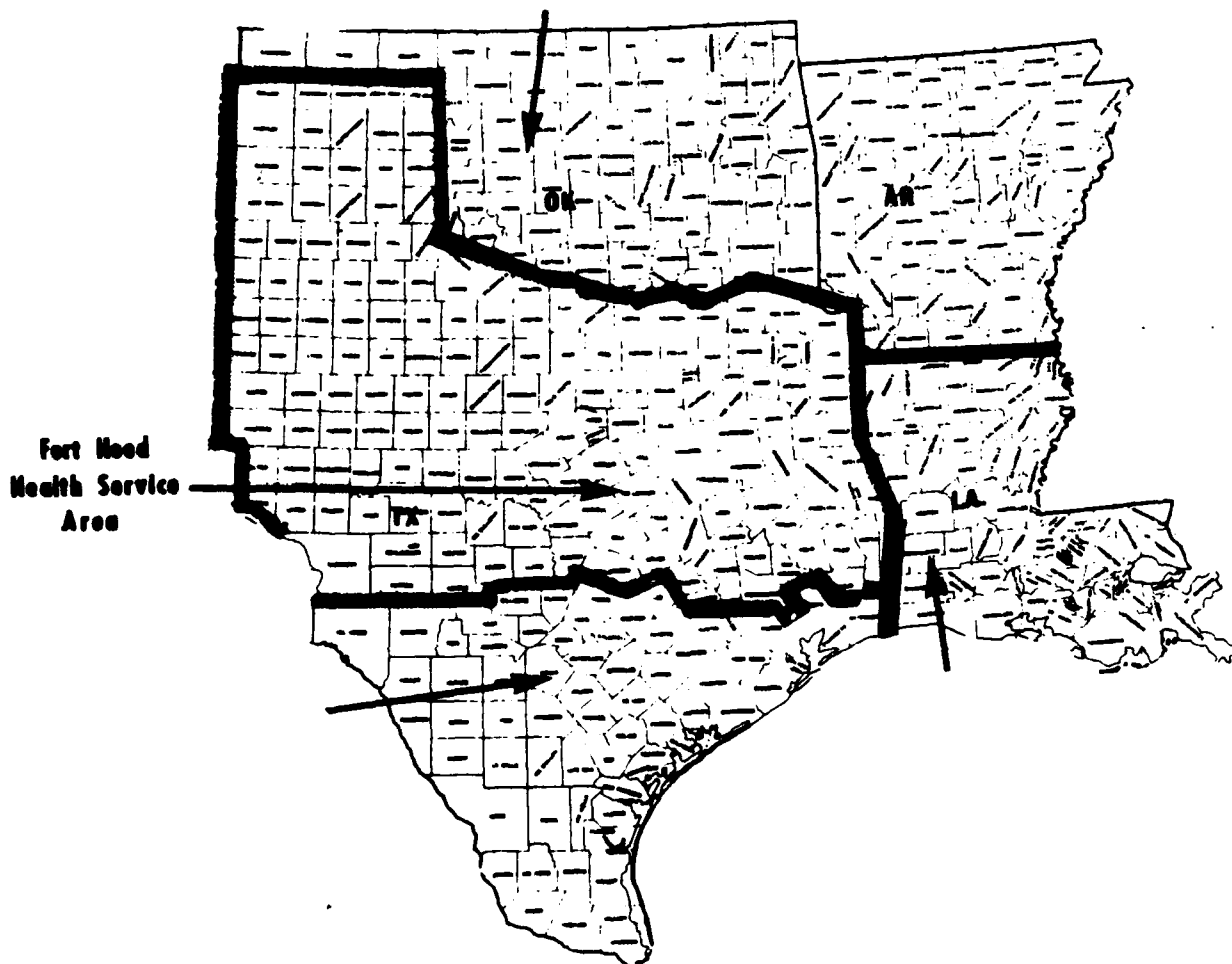
2-2. FORT HOOD HEALTH SERVICE AREA.

a. Area Responsibility:

US Army Medical Department Activity (W2M5AA), Fort Hood, TX 76544

US Army Dental Activity (W2M5DC), Fort Hood, TX 76544

b. Geographical Area: TEXAS counties of Anderson, Andrews, Angelina, Archer, Armstrong, Bailey, Baylor, Bell, Borden, Bosque, Bowie, Brazos, Brisco, Brown, Burleson, Burnet, Callahan, Camp, Carson, Cass, Castro, Cherokee, Childress, Clay, Cochran, Coleman, Collin, Collingsworth, Coke, Comanche, Concho, Cooke, Coryell, Cottle, Crane, Crockett, Crosby, Dallam, Dallas, Dawson, Deaf Smith, Delta, Denton, Dickens, Donley, Eastland, Ector, Ellis, Erath, Falls, Fannin, Fisher, Floyd, Foard, Franklin, Freestone, Gaines, Garza, Glasscock, Gray, Grayson, Gregg, Grimes, Hale, Hall, Hamilton, Hansford, Hardeman, Hardin, Harrison, Hartley, Haskell, Hemphill, Henderson, Hill, Hockley, Hood, Howard, Houston, Hunt, Hutchinson, Irion, Jack, Jasper, Johnson, Jones, Kaufman, Kent, Kimble, King, Knox, Lamar, Lamb, Lampasas, Leon, Limestone, Lipscomb, Llano, Lubbock, Lynn, Madison, Marion, Martin, Mason, McCullough, McLennan, Menard, Midland, Milam, Mills, Mitchell, Montague, Montgomery, Moore, Morris, Motley, Nacogdoches, Navarro, Newton, Nolan, Ochiltree, Oldham, Palo Pinto, Panola, Parker, Parmer, Polk, Potter, Rains, Randall, Reagan, Red River, Roberts, Robertson, Rockwall, Runnels, Rusk, Sabine, San Augustine, San Jacinto, San Saba, Schleicher, Scurry, Shackelford, Shelby, Sherman, Smith, Somervell, Stephens, Sterling, Stonewall, Sutton, Swisher, Tarrant, Taylor, Terry, Throckmartin, Titus, Tom Green, Trinity, Tyler, Upshur, Upton, Van Zandt, Walker, Washington, Wheeler, Wichita, Wilbarger, Williamson, Wise, Wood, Yoakum, Young.



APPENDIX E

APPENDIX E
JCAH STANDARDS

Hospital-Sponsored Ambulatory Care Services (HO)

Standard

Circle One

- HO.1** Hospital-sponsored ambulatory care services, whether provided through a formally organized department/service of the hospital, or through other organized departments/services of the hospital, or through a combination thereof, are provided safely and effectively and in a manner designed to assure the quality of care, and are evaluated for compliance with all pertinent requirements of this and other chapters of this *Manual*.*

1 2 3 4 5 NA

Required Characteristics

- HO.1.1** Ambulatory care services provided by or under the sponsorship of the hospital are properly directed and appropriately integrated with other departments/services of the hospital.
- HO.1.2** Staffing is commensurate with the anticipated needs of patients and the scope of services offered.*
- HO.1.3** The relationship of all ambulatory care services provided under the sponsorship of the hospital is specified in the hospital's overall organizational plan.
- HO.1.4** The objectives and scope of ambulatory care services, including any criteria used to determine eligibility for hospital-sponsored ambulatory care services, are defined in writing.
- HO.1.5** Hospital-sponsored ambulatory care meets the same standards of quality that apply to inpatient care provided by the hospital.*

1 2 3 4 5 NA

1 2 3 4 5 NA

1 2 3 4 5 NA

1 2 3 4 5 NA

1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

- HO.1.6** Procedures, including operative procedures, that require the use of special equipment, personnel, facilities, and/or services (eg, procedures associated with radiology, pathology and medical laboratory services, and the operating suite) are performed only when appropriate resources are available.* Circle One
- 1 2 3 4 5 NA
- HO.1.7** When any ambulatory care services are provided under the aegis of the hospital through sources outside the hospital by individuals who are not hospital employees, the sources*
- HO.1.7.1 are approved, as appropriate, by the medical staff through its designated mechanism and by the administration: 1 2 3 4 5 NA
- HO.1.7.2 provide designated services on a specified basis: 1 2 3 4 5 NA
- HO.1.7.3 meet pertinent safety requirements: 1 2 3 4 5 NA
- HO.1.7.4 abide by the pertinent rules and regulations of the hospital and the medical staff: 1 2 3 4 5 NA
- HO.1.7.5 document the quality control measures to be implemented; and 1 2 3 4 5 NA
- HO.1.7.6 meet the applicable requirements of this chapter and related chapters of this *Manual*. 1 2 3 4 5 NA
- HO.1.8** Although many acceptable methods exist for administering hospital-sponsored ambulatory care services, responsibility for the direction of ambulatory care services provided under the sponsorship of the hospital is vested in one or more individuals whose qualifications, authority, and duties are defined and approved by the chief executive officer.* 1 2 3 4 5 NA
- HO.1.8.1 When all ambulatory care services are subsumed under one organized department/service, there is one director. 1 2 3 4 5 NA
- HO.1.8.2 The director(s) has the authority and responsibility for carrying out established policies and for providing overall direction in the continuing provision of ambulatory care services.* 1 2 3 4 5 NA
- HO.1.8.3 The director(s) takes all reasonable steps to assure that the quality, safety, and appropriateness of ambulatory care services are monitored and evaluated and that appropriate actions based on findings are taken.* 1 2 3 4 5 NA
- HO.1.8.4 The relationship of the director(s) of the ambulatory care services to the medical staff and to the administration is defined. 1 2 3 4 5 NA
- HO.1.9** Responsibility for medical direction of the ambulatory care services provided is defined in writing and is vested in one or more physician members of the medical staff.* 1 2 3 4 5 NA
- HO.1.9.1 Alternatively, responsibility may be assigned to a medical staff committee, the chairman of which provides medical direction under the committee's guidance. 1 2 3 4 5 NA
- HO.1.9.2 A physician who is responsible for the general direction or supervision of the medical aspects of the ambulatory care services may also serve as the overall director. 1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

HO.1.9.3 When administrative direction is not the responsibility of a qualified physician, direction is provided by another qualified individual who is responsible to the chief executive officer or his or her designee.	Circle One 1 2 3 4 5 NA
HO.1.10 The method of providing medical staff coverage for ambulatory care services is defined in writing.*	1 2 3 4 5 NA
HO.1.10.1 Acceptable methods of providing medical staff coverage include	
HO.1.10.1.1 the use of house staff under adequate medical staff supervision:	1 2 3 4 5 NA
HO.1.10.1.2 the use of contract individuals and groups who, unless otherwise provided by law, are members of the medical staff; or	1 2 3 4 5 NA
HO.1.10.1.3 the assumption of such coverage by appropriate medical staff members through a designated mechanism.	1 2 3 4 5 NA
HO.1.10.2 Routine clinical specialty consultation is available as required.	1 2 3 4 5 NA
HO.1.10.3 Requirements for medical staff membership and the delineation of clinical privileges are specified in Standards MS.1 and MS.4 of the "Medical Staff" chapter of this <i>Manual</i> .*	
HO.1.11 Registered nurses who are qualified by relevant education and experience and by current competence supervise the provision of ambulatory nursing care.*	1 2 3 4 5 NA
HO.1.11.1 Sufficient nursing services personnel are available to provide the nursing care required.*	1 2 3 4 5 NA
HO.1.12 The duties and responsibilities of other staff disciplines and their relationship to physicians and nurses are defined in writing and are provided in accordance with the applicable requirements of Standard MS.1 of the "Medical Staff" chapter and Standard GB.1 of the "Governing Body" chapter of this <i>Manual</i> .*	1 2 3 4 5 NA

Standard

HO.2 Personnel are prepared for their responsibilities in the provision of ambulatory care through appropriate education and training programs.	1 2 3 4 5 NA
--	--------------

Required Characteristics

HO.2.1 Individuals who provide ambulatory patient care participate on a regular basis in relevant educational programs or activities.	1 2 3 4 5 NA
HO.2.1.1 Such programs or activities include in-service programs for registered nurses, licensed practical nurses, and vocational nurses.	1 2 3 4 5 NA
HO.2.1.2 The hospital administration encourages personnel who provide ambulatory care services to participate in relevant ambulatory care education programs outside the hospital.	1 2 3 4 5 NA
HO.2.1.3 Ambulatory care services personnel are eligible to participate in education programs to the same extent as other hospital personnel.	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

HO.2.1.4 The extent of participation in education and training programs is realistically related to the size of the staff and to the scope and complexity of the ambulatory care services provided.	Circle One 1 2 3 4 5 NA
HO.2.1.5 Education programs for ambulatory care services personnel are based, at least in part, on findings from the monitoring and evaluation of the ambulatory care services provided and include safety and infection control requirements described elsewhere in this <i>Manual</i> .	1 2 3 4 5 NA
HO.2.1.6 Cardiopulmonary resuscitation training is conducted as often as necessary for all appropriate professional personnel who work in the ambulatory care setting.	1 2 3 4 5 NA
HO.2.1.7 The extent of participation in education and training programs is documented.	1 2 3 4 5 NA
Standard	
HO.3 The provision of ambulatory care services is guided by written policies and procedures.*	1 2 3 4 5 NA
Required Characteristics	
HO.3.1 There are written policies and procedures that specify the scope and conduct of patient care to be provided in hospital-sponsored ambulatory care settings.*	1 2 3 4 5 NA
HO.3.2 The policies and procedures are approved, as appropriate, by the medical staff through its designated mechanism, the nursing staff, the hospital administration, and other pertinent departments/services.	1 2 3 4 5 NA
HO.3.3 The policies and procedures are reviewed at least annually, revised as necessary, dated, and enforced.	1 2 3 4 5 NA
HO.3.4 The policies and procedures relate to at least the following:*	
HO.3.4.1 The patient appointment system.	1 2 3 4 5 NA
HO.3.4.2 The mechanism used to inform a patient of the practitioner(s) responsible for the patient's care.	1 2 3 4 5 NA
HO.3.4.3 The ambulatory care patient medical record.	1 2 3 4 5 NA
HO.3.4.3.1 This policy/procedure includes reference to the confidentiality of patient information and to the safeguarding of records, the release of information to authorized individuals, and any required consent for treatment.	1 2 3 4 5 NA
HO.3.4.3.2 Refer also to the requirements contained in the "Medical Record Services" chapter of this <i>Manual</i> .	
HO.3.4.4 The scope of treatment allowed in specific patient care areas, including general and specific elective procedures that may not be performed by medical staff members in the provision of ambulatory care services.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

Circle One

- HO.3.4.4.1 The limits of the use of anesthetic agents and the surgical procedures that may be performed in such areas are also defined.* 1 2 3 4 5 NA
- HO.3.4.4.2 These limits are approved, as appropriate, by the medical staff through its designated mechanism and by the administration. 1 2 3 4 5 NA
- HO.3.4.5 Who, other than physicians, may perform specified procedures, under what circumstances, and under what degree of supervision.* 1 2 3 4 5 NA
- HO.3.4.6 The mechanism for the provision of care to an unemancipated minor not accompanied by a parent or a guardian. 1 2 3 4 5 NA
- HO.3.4.7 The location, storage, and procurement of medications, supplies, and equipment.* 1 2 3 4 5 NA
- HO.3.4.8 The dispensing of medication in accordance with legal requirements and requirements of the "Pharmaceutical Services" chapter of this *Manual*. 1 2 3 4 5 NA
- HO.3.4.9 Responsibility for maintaining the integrity of the emergency drug supply. 1 2 3 4 5 NA
- HO.3.4.10 Infection control measures.* 1 2 3 4 5 NA
- HO.3.4.11 Pertinent safety practices.* 1 2 3 4 5 NA
- HO.3.4.12 Any required reporting of communicable diseases to the appropriate authority. 1 2 3 4 5 NA
- HO.3.4.13 The role of the ambulatory care department/service in the hospital's internal and external disaster plans. 1 2 3 4 5 NA
- HO.3.4.14 The use of standing orders, as appropriate. 1 2 3 4 5 NA
- HO.3.4.15 The handling and safekeeping of patients' valuables, as in the case of a patient undergoing anesthesia for surgery. 1 2 3 4 5 NA
- HO.3.5 When surgical services are provided in an ambulatory care setting, the policies and procedures are consistent with those applicable to inpatient surgery, anesthesia, and postoperative recovery.* 1 2 3 4 5 NA
- HO.3.6 When surgical services are provided in an ambulatory care setting, in addition to the policies and procedures stated in HO.3.4.1 through HO.3.4.15, the policies and procedures address the following:*
- HO.3.6.1 The types of elective operative procedures that may be performed and the locations where they may be performed. 1 2 3 4 5 NA
- HO.3.6.2 The scope of anesthesia services that may be provided and the locations where such anesthesia services may be administered. 1 2 3 4 5 NA
- HO.3.6.3 Preoperative and postoperative transportation. 1 2 3 4 5 NA
- HO.3.6.4 An established method of intervention when the designated preoperative patient workup and preparation are incomplete. 1 2 3 4 5 NA
- HO.3.6.4.1 Surgery is performed only after an appropriate history, physical examination, and any required laboratory and x-ray examinations have been completed and the preoperative diagnosis has been recorded.* 1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

Circle One

- HO.3.6.5 Postoperative care, including patient care guidelines for post-anesthesia recovery and the role of family members in assisting in patient care.* 1 2 3 4 5 NA
- HO.3.6.5.1 Any patient who has received other than local anesthesia is examined before discharge and is accompanied home by a designated person. 1 2 3 4 5 NA
- HO.3.6.5.1.1 The examination is performed by a physician or, when appropriate, by a qualified oral surgeon. 1 2 3 4 5 NA
- HO.3.6.5.2 Written instructions for follow-up care are given to the patient or family member responsible for the patient and include directions for obtaining an appropriate physician or qualified oral surgeon for postoperative problems. 1 2 3 4 5 NA
- HO.3.6.5.3 Whenever feasible, a family member is available to pediatric patients during the preoperative and postoperative periods. 1 2 3 4 5 NA

Standard

- HO.4 Facilities used for the provision of ambulatory care services are designed and equipped to assure the safe and effective care of patients.* 1 2 3 4 5 NA

Required Characteristics

- HO.4.1 Ambulatory care areas are readily accessible to patients, including handicapped individuals. 1 2 3 4 5 NA
- HO.4.1.1 Wheelchairs and other ambulation aids, as appropriate, are readily available to the entrance and do not obstruct entry. 1 2 3 4 5 NA 1
- HO.4.2 A convenient waiting area, telephone, drinking fountain, and lavatory are available to patients seeking ambulatory care and to individuals accompanying them. 1 2 3 4 5 NA
- HO.4.3 The design of ambulatory care service areas facilitates the visual and auditory privacy of patients without compromising patient care. 1 2 3 4 5 NA
- HO.4.4 The location of the patient registration areas in relation to waiting areas assures that patient privacy and confidentiality of information are maintained. 1 2 3 4 5 NA
- HO.4.5 Radiology services and pathology and medical laboratory services are available as required.* 1 2 3 4 5 NA
- HO.4.6 When indicated, special examination rooms, such as rooms for gynecological, ophthalmologic, orthopedic, or pediatric patients, are provided. 1 2 3 4 5 NA
- HO.4.7 When general anesthesia is administered in ambulatory care areas, the anesthesia area meets applicable requirements of the "Anesthesia Services" chapter of this *Manual*.* 1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

HO.4.7.1 When a flammable anesthetic agent is used in the performance of ambulatory surgery, or when anesthetic agents (other than local) are administered in a building that houses patients overnight, the anesthesia and operating area meets the same requirements for electrical safety as stated in Standard PL.11. Required Characteristics PL.11.6 through PL.11.8.3. of the "Plant, Technology, and Safety Management" chapter of this *Manual*.*

Circle One

1 2 3 4 5 NA

HO.4.7.2 When only nonflammable anesthetic agents are administered in a building that does not house patients overnight (e.g. in a separate satellite surgical facility), or when the anesthesia and operating area meets National Fire Protection Association (NFPA) requirements for a mixed occupancy, the anesthesia and operating area meets at least the requirements cited in Chapter 4, "Inhalation Anesthetics in Ambulatory Care Facilities," in NFPA 99, *Standard for Health Care Facilities*, 1984.*

1 2 3 4 5 NA

HO.4.7.3 Any room designated for the performance of ambulatory surgery under other than local anesthesia is so located that it does not directly connect with a corridor used for general through traffic.

1 2 3 4 5 NA

HO.4.7.3.1 There is a means of communication for securing assistance in an emergency.

1 2 3 4 5 NA

HO.4.8 Equipment and supplies are suitable for the sizes of patients treated.

1 2 3 4 5 NA

HO.4.9 Specified equipment is checked on a scheduled basis in accordance with the hospital's preventive maintenance program and the requirements of the "Plant, Technology, and Safety Management" chapter of this *Manual*.*

1 2 3 4 5 NA

HO.4.10 Emergency drug carts and emergency drug storage areas are checked at least daily when ambulatory care services are provided and after each use to assure that all items are immediately available in usable condition.

1 2 3 4 5 NA

HO.4.10.1 This requirement may be met by a system designed to assure the continued integrity of the contents between periods of use.

HO.4.10.2 Uniformity in the arrangement of supplies is recommended.

HO.4.11 Refrigerated storage for biologicals and all other supplies requiring such storage is provided.

1 2 3 4 5 NA

Standard

HO.5 A medical record is maintained for every patient who receives ambulatory care services.*

1 2 3 4 5 NA

Required Characteristics

HO.5.1 Prior pertinent medical record information is available to the attending practitioner and other authorized individuals.*

1 2 3 4 5 NA

HO.5.2 The following information is documented in each patient's medical record and, at the time of each ambulatory care visit, any required updating of such information is accomplished and any pertinent new information is entered:*

1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

Circle One

- | | |
|--|--------------|
| HO.5.2.1 Patient identification: | 1 2 3 4 5 NA |
| HO.5.2.2 Relevant history of the illness or injury, and physical findings:* | 1 2 3 4 5 NA |
| HO.5.2.3 Diagnostic and therapeutic orders:* | 1 2 3 4 5 NA |
| HO.5.2.4 Clinical observations, including the results of treatment:* | 1 2 3 4 5 NA |
| HO.5.2.5 Reports of procedures, tests, and results:* | 1 2 3 4 5 NA |
| HO.5.2.6 Diagnostic impression:* | 1 2 3 4 5 NA |
| HO.5.2.7 Patient disposition and any pertinent instructions given to the patient and/or family for follow-up care: | 1 2 3 4 5 NA |
| HO.5.2.8 Immunization record: | 1 2 3 4 5 NA |
| HO.5.2.9 Any allergy history: | 1 2 3 4 5 NA |
| HO.5.2.10 Growth charts for pediatric patients; and | 1 2 3 4 5 NA |
| HO.5.2.11 Referral information to and from outside agencies. | 1 2 3 4 5 NA |
| HO.5.3 A summary list of significant past surgical procedures, past and current diagnoses or problems, and currently and recently used medications is legibly recorded in the same location in each patient record.* | 1 2 3 4 5 NA |
| HO.5.4 An accurate and complete description of the techniques and findings of every operative procedure performed is dictated or written immediately following surgery and is authenticated by the individual who performed the procedure.* | 1 2 3 4 5 NA |
| HO.5.5 Refer to the "Medical Record Services" chapter of this <i>Manual</i> for other requirements related to the ambulatory care patient medical record.* | |

Standard

- | | |
|--|--------------|
| HO.6 Appropriate quality control mechanisms are established.* | 1 2 3 4 5 NA |
|--|--------------|

Required Characteristics

- | | |
|---|--------------|
| HO.6.1 At least the following quality control mechanisms are established: | |
| HO.6.1.1 The coordination of a scheduling and staffing plan that facilitates accessibility and continuity of care and minimizes patient waiting time. | 1 2 3 4 5 NA |
| HO.6.1.2 A system for follow-up on broken appointments, when indicated, as well as an evaluation of the effectiveness of the system. | 1 2 3 4 5 NA |
| HO.6.1.3 A timely review, interpretation, and reporting, as appropriate, of diagnostic radiographic studies, laboratory tests, and electrocardiograms, to be available to the practitioner requesting such services in the provision of ambulatory care.* | 1 2 3 4 5 NA |
| HO.6.1.3.1 Reports on a patient scheduled for surgery are made available to the practitioner responsible for the patient before surgery is performed.* | 1 2 3 4 5 NA |

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

HO.6.1.3.2 A mechanism is established for notifying and recalling patients who require repeat or additional studies or for whom further consultation is appropriate.*	Circle One 1 2 3 4 5 NA
HO.6.1.4 A means of assuring that ambulatory surgical patients treated in the facility under other than local anesthesia receive the same preoperative and postoperative evaluations as patients undergoing the same surgical procedures on an inpatient basis.*	1 2 3 4 5 NA
HO.6.1.5 A systematic review and evaluation of surgical patients who require hospitalization following ambulatory surgery.*	1 2 3 4 5 NA
HO.6.1.6 The examination of surgical specimens by a pathologist.*	1 2 3 4 5 NA
HO.6.1.6.1 Refer to related requirements contained in the "Pathology and Medical Laboratory Services" chapter of this <i>Manual</i> .*	
HO.6.1.7 When authorized and appropriate, the provision, to the private practitioner or medical facility responsible for follow-up care, of a copy of the record or summary of ambulatory care services.	1 2 3 4 5 NA
HO.6.1.8 The maintenance and evaluation of patient drug profiles, whenever possible.	1 2 3 4 5 NA
HO.6.1.9 Inclusion, in the medical staff's review functions, of drug usage evaluation of ambulatory care patients who receive medications.*	1 2 3 4 5 NA
HO.6.1.10 Inclusion, in the medical staff's review functions, of blood usage review of ambulatory care patients who receive blood transfusions.*	1 2 3 4 5 NA
HO.6.1.11 When the facility provides radiation therapy for ambulatory care patients, compliance with the requirements of the "Radiation Oncology Services" chapter of this <i>Manual</i> .	1 2 3 4 5 NA
HO.6.1.12 A means of communicating in the language of the predominant population groups served.	1 2 3 4 5 NA

Standard

HO.7 As part of the hospital's quality assurance program, the quality and appropriateness of patient care provided by the ambulatory care department/service are monitored and evaluated, and identified problems are resolved.*	1 2 3 4 5 NA
--	--------------

Required Characteristics

HO.7.1 The ambulatory care department/service has a planned and systematic process for the monitoring and evaluation of the quality and appropriateness of patient care and for resolving identified problems.*	1 2 3 4 5 NA
HO.7.1.1 The physician director of the ambulatory care department/service is responsible for assuring that the process is implemented.*	1 2 3 4 5 NA
HO.7.2 The quality and appropriateness of patient care are monitored and evaluated in all major clinical functions of the ambulatory care department/service.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

HO.7.2.1 Such monitoring and evaluation are accomplished through the following means:	Circle One
HO.7.2.1.1 Routine collection in the ambulatory care department/service, or through the hospital's quality assurance program, of information about important aspects of ambulatory care:* and	1 2 3 4 5 NA
HO.7.2.1.2 Periodic assessment by the ambulatory care department/service of the collected information in order to identify important problems in patient care and opportunities to improve care.*	1 2 3 4 5 NA
HO.7.2.1.2.1 In HO.7.2.1.1 and HO.7.2.1.2, the ambulatory care department/service agrees on objective criteria that reflect current knowledge and clinical experience.*	1 2 3 4 5 NA
HO.7.2.1.2.1.1 These criteria are used by the ambulatory care department/service or by the hospital's quality assurance program in the monitoring and evaluation of patient care.*	1 2 3 4 5 NA
HO.7.3 When important problems in patient care or opportunities to improve care are identified,	
HO.7.3.1 actions are taken:*	1 2 3 4 5 NA
HO.7.3.2 the effectiveness of the actions taken is evaluated.*	1 2 3 4 5 NA
HO.7.4 The findings from and conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported.*	1 2 3 4 5 NA
HO.7.5 The actions taken to resolve problems and improve patient care, and information about the impact of the actions taken, are documented and, as appropriate, are reported.*	1 2 3 4 5 NA
HO.7.6 As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities in the ambulatory care department/service is evaluated.*	1 2 3 4 5 NA
HO.7.7 When an outside source(s) provides ambulatory care services, or when there is no designated ambulatory care department/service, the quality and appropriateness of patient care provided are monitored and evaluated, and identified problems are resolved.*	1 2 3 4 5 NA
HO.7.7.1 The medical staff is responsible for assuring that a planned and systematic process for such monitoring, evaluation, and problem-solving activities is implemented.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

Note: For other requirements related to the provision of ambulatory care services, refer to the following chapters of this Manual: "Anesthesia Services," "Diagnostic Radiology Services," "Dietetic Services," "Infection Control," "Medical Record Services," "Medical Staff," "Nursing Services," "Pathology and Medical Laboratory Services," "Pharmaceutical Services," "Plant, Technology, and Safety Management," "Quality Assurance," "Radiation Oncology Services," "Rehabilitation Services," "Respiratory Care Services," and "Social Work Services."

APPENDIX F

APPENDIX F

Darnall Same Day Surgery Policy

The 1983 accreditation manual for hospitals lists the types of elective operative procedures that may be performed and the locations in which they may be carried out.

General

SDSC surgery requires strict adherence to guidelines to guarantee maximum utilization of time and personnel and safety for the patient. Briefly, procedures of short duration requiring no post-operative hospitalization will be performed on patients whose physical condition warrants outpatient care. The patient's well being extending beyond his/her discharge from the area must be protected and to assure this, the selection criteria guidelines, preoperative preparation and admission and discharge procedures must be followed diligently. It shall be the responsibility of the medical director of the SDSC, or his designee, to screen each patient prior to the procedure to insure that the above guidelines are followed and it will remain his responsibility to cancel non acceptable cases.

1. Below is a list of surgical procedures considered acceptable for SDSC. This list is not complete. Exclusion of a procedure from this list does not necessarily exclude it from being performed in the SDSC. Appropriate procedures may be added to this list by each surgical specialty after having been approved by the medical director of the SDSC and the chief of the requesting surgical service.

Otolaryngology

1. Myringotomy (with or without insertion of PE Tubes)
2. Removal of PE tubes
3. Septorhinoplasties
4. Nasal polypectomies
5. Maxillary antrostomies and antral windows
6. Closed reduction and fixation of nasal fractures
7. Small scar revisions of head and neck
8. Diagnostic and therapeutic endoscopies
9. Closed reduction of zygomatic arch (towel clip technique)
10. Frenotomy
11. Excision aural polyp
12. Biopsy of tongue

Plastic

1. Augmentation mammoplasty
2. Rhinoplasty
3. Minor Scar revisions
4. Suture removal on children
5. Minor procedures on children
6. Otoplasty
7. Cheiloplasty
8. Dermabrasion
9. Blepharoplasty

Oral Surgery

1. Complicated exodontia (adult and pediatric)
2. Surgical removal of odontogenic and nonodontogenic lesions
3. Closed reduction of facial fractures

Orthopedic

1. Closed reduction of simple fractures
2. Percutaneous pin fixation of fracture
3. Carpal tunnel release
4. Extensor tendon release
5. Tenosynovectomy, finger
6. Muscle biopsies
7. Shoulder, hip and knee manipulation
8. Cast change
9. Pin and wire removal
10. Removal foreign body in muscle, simple
11. Bunionectomy
12. Synovial biopsy
13. Diagnostic arthroscopy
14. Fasciotomy, palmar for DePuytrere's contracture
15. Ganglion excision
16. Tenotomy
17. Excision Morton's neuroma
18. Arthroscopic meniscectomy
19. Digital neuroorrhaphy

Genitourinary

1. Circumcision
2. Orchiopexy
3. Vasectomy

Thoracic

1. Rigid bronchoscopy
2. Rigid esophagoscopy
3. Esophageal dilation (primarily in children)
4. Removal of sternal wires or other appliances in ASA Class I and II
5. Debridement of chest wall sites not requiring hospitalization

Obstetrics and Gynecology

1. Elective sterilization
2. Diagnostic minilaparotomies
3. D&C
4. EUA
5. Removal of IUD
6. Diagnostic laparoscopies
7. Biopsy of perineum
8. Hymenectomy
9. Vaginal dilatation
10. Hysteroscopy

Neurosurgery

1. Carpal tunnel release
2. Skull biopsies
3. Excision Morton's neuroma
4. Ulnar nerve transposition

Ophthalmology

1. Strabismus surgery
2. EUA

3. Lacrimal duct probing
4. Cyclocryotherapy
5. Retinal cryopexy
6. Photocoagulation
7. Minor lid procedures
8. Blepharoplasty
9. Chalazion removal
10. Ptosis procedures
11. Pterygium removal
12. Cataract removal

General Surgery

1. Hernia repair (adult and pediatrics)
2. Excisional biopsies
3. Gastroscopy (pediatric)
4. Superficial and integumentary lesions
5. Sigmoidoscopy (pediatric)
6. Orchiopexy
7. Frenulectomy
8. Anal and rectal biopsies
9. Node biopsies
10. Examination under anesthesia
11. Breast biopsy (2 stage procedure)
12. Breast biopsy (needle localization)
13. Rectal polypectomy
14. Excision sebaceous cyst
15. Drainage of simple hematomas
16. Esophagoscopy
17. Gastroscopy
18. Fistulotomy, subcutaneous
19. Fistulectomy
20. Hemorrhoidectomy, simple ligature
21. Aspirational biopsies
22. Pilonidal cyst

2. Surgical Procedures Not Considered Suitable for the Same Day Surgery Center

A. Patients who have known infections should not be operated on in the Same Day Surgery Center. However, if an infection is found during surgery, the patient requires an isolated recovery area.

B. Patients requiring emergency surgery are not likely to meet the criteria for patient selection. Adding a patient for emergency surgery will disrupt the organization of the elective schedule possibly forcing cancellation of scheduled outpatient procedures. An exception to policy may be granted for certain "emergency cases" provided that the case meets our selection criteria; the patient has been NPO and operating space is available. An example of a case which fits into this category would be a closed reduction of fracture.

C. Any surgical procedure which requires major intervention in the abdomen or thorax will not be considered.

D. Any procedure requiring more than a 4-hour stay in the recovery room.

APPENDIX G

APPENDIX G

Inpatient OR Procedures that Met Darnall SDS CriteriaOtolaryngology

1. Myringotomy (with or without insertion of PE Tubes)	7
3. Septorhinoplasties	7
5. Maxillary antrostomies and antral windows	5

Oral Surgery

1. Complicated exodontia	7
--------------------------	---

Orthopedic

1. Closed reduction of simple fractures	2
3. Carpal tunnel release	17
9. Pin and wire removal	12
11. Bunionectomy	27
13. Diagnostic arthroscopy	65
15. Ganglion excision	7
17. Excision Morton's neuroma	1

Genitourinary

1. Circumcision	17
2. Orchiopexy	6

Obstetrics and Gynecology

1. Elective sterilization	20
3. D&C	25
6. Diagnostic laparoscopies	64

Ophthalmology

1. Strabismus surgery	34
2. EUA	1
3. Lacrimal duct probing	6
7. Minor lid procedures	1
8. Blepharoplasty	2
12. Cataract removal	32

General Surgery

1. Hernia repair (adult and pediatric)	108
2. Excisional biopsies	9
13. Rectal polypectomy	2
15. Drainage of simple hematoma	1
20. Hemorrhoidectomy, simple ligature	14
22. Pilonidal cyst	10

TOTAL

= 509

APPENDIX H

REPLY TO
ATTENTION OF

Health Services Command Same Day Surgery Policy
DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, DC 20310-2100
HQDA Ltr 40-86-6

DASG-PSZ(M)(2 Dec 86)

31 December 1986

Expires 31 December 1988

SUBJECT: Same Day Surgery

SEE DISTRIBUTION

1. Reference.

- a. Department of Defense Instruction 6025.8 (Same Day Surgery).
- b. ICD-9-M (International Classification of Diseases, 9th Revision Clinical Modification, Volume 3).
- c. AR 40-3 (Medical, Dental, and Veterinary Care).
- d. AR 40-66 (Medical Record and Quality Assurance Administration).

2. This letter directs the implementation of same day surgery programs in Army medical treatment facilities (AMTFs)(Reference 1a above). Army policy is to encourage maximum use of same day surgery in AMTFs where it is cost effective to do so.

3. Commanders of AMTFs with appropriate facilities and resources will establish same day surgery programs consistent with the guidelines contained herein. Joint Commission on Accreditation of Hospitals (JCAH) standards and requirements will be incorporated into local plans. The attached list of suggested procedures will be used to assist in the selection of procedures which may be appropriate for inclusion in local programs. This list may be modified as dictated by local circumstances and clinical judgment. Program documentation must address as a minimum the areas listed below:

a. Patient selection criteria: The criteria for Class I and Class II patients as defined by the American Society of Anesthesiology will be used. Patients considered to be good candidates for same day surgery are those who--

(1) Are in general good health or have a systemic condition under good control.

(2) Have no organic psychiatric problems.

(3) Require the operation for a localized and not a systemic disturbance.

(4) Require surgical care that is more appropriately rendered on an inpatient rather than an outpatient basis in the surgical clinic.

(5) Will receive post-operative care in a recovery room and normally will be discharged from the hospital the same day.

(6) Have a responsible adult available at quarters to assist with unplanned medical followup care for 2 to 3 days following same day discharge.

b. Credentialing and quality assurance: Health providers conducting same day surgery will be credentialed in accordance with existing requirements. Since the clinical success of a same day surgery program depends on experienced judgment to select patients least likely to have delayed post-operative complications, and precise operative technique to prevent such complications, specific attention will be directed during the credentialing process to these elements of provider competence. Ongoing reviews of quality care will incorporate the medical records of those undergoing same day surgery, in order to give particular attention to events that may only be documented in the outpatient record.

c. Preoperative testing/operating and recovery room protocols, staffing, and organization: Local programs will formally address preoperative testing procedures. Specific protocols for same day surgery will be developed where they are not currently a part of existing operating and recovery room protocols. Staffing and organization requirements as needed will be coordinated and accomplished through appropriate command channels before initiation of same day surgery procedures.


d. Admission and admission procedures: The admission of same day surgery patients will be supplemented to provide for special requirements for same day surgery patients.

e. Medical records documentation, coding, and formats: Medical records documentation in same day surgery cases will be governed by the provisions of chapter 7, AR 40-66. The timely and proper completion of the documentation of same day surgery procedures like other hospital cases cannot be over emphasized. The coding of same day surgery procedures will be consistent with ICD-9-CM.

4. This letter becomes effective upon receipt. The provisions contained herein will be incorporated into the next revision to AR 40-3. Inspectors general will make same day surgery programs and this letter a topic of interest during annual inspections or staff assistance visits. Comments and recommendations for changes should be directed to HQDA(SGPS-CP), 5111 Leesburg Pike, Falls Church, VA 22041-3258.

DASG-PSZ
SUBJECT: Same Day Surgery

BY THE ORDER OF THE SECRETARY OF THE ARMY:


R. L. DILLWORTH
Brigadier General, USA
The Adjutant General

Encl
Suggested Procedures for
Same Day Surgery.

DISTRIBUTION:

HQDA (DAAR-ZA)

HQDA (DACS-ZA)

HQDA (DAPE-ZA)

HQDA (DAPE-ZA)

HQDA (DASG-ZA)

NGB-ZA

COMMANDER IN CHIEF

US ARMY, EUROPE AND SEVENTH ARMY

COMMANDERS

US ARMY FORCES COMMAND

US ARMY HEALTH SERVICES COMMAND

US ARMY TRAINING AND DOCTRINE COMMAND

EIGHTH US ARMY

US ARMY, JAPAN

US ARMY WESTERN COMMAND

SUPERINTENDENT

US MILITARY ACADEMY

CF:

SEVENTH MEDICAL COMMAND

EIGHTEENTH MEDICAL COMMAND

SUGGESTED PROCEDURES FOR SAME DAY SURGERY

ICD-9-CM CODETITLE

1. OPERATIONS ON THE NERVOUS SYSTEM (01-05)
 - 04.2 Destruction of Cranial and Peripheral Nerves
 - 04.3 Suture of Cranial and Peripheral Nerves
 - 04.6 Transposition of Cranial and Peripheral Nerves
 - 04.79 Other Neuroplasty
2. OPERATIONS ON THE ENDOCRINE SYSTEM (06-07)
 - 06.7 Excision of Thyroglossal Duct or Tract
3. OPERATIONS ON THE EYE (08-16)
 - 08.09 Other Incision of Eyelid
 - 08.20 Removal of Lesion of Eyelid, Not Otherwise Specified
 - 08.3 Repair of Blepharoptosis and Lid Retraction
 - 08.49 Other Repair of Entropion or Ectropion
 - 08.52 Blepharorrhaphy
 - 08.59 Other Adjustment of Lid Position
 - 08.63 Reconstruction of Eyelid with Hair Follicle Graft (Eyebrows and Eyelids)
 - 08.70 Reconstruction of Eyelid, NOS (Blepharoplasty)
 - 08.71 Reconstruction of Eyelid, Involving Lid Margin, Partial Thickness
 - 08.89 Other Eyelid Repair
 - 08.99 Other Operations on Eyelids
 - 09.0 Incision of Lacrimal Gland
 - 09.20 Excision of Lacrimal Gland, Not Otherwise Specified
 - 09.3 Other Operations on Lacrimal Gland
 - 09.49 Other Manipulation of Lacrimal Passage
 - 09.51 Incision of Lacrimal Punctum (Splitting of Lacrimal Papillae)
 - 09.53 Incision of Lacrimal Sac
 - 09.59 Other Incision of Lacrimal Passages
 - 09.6 Excision of Lacrimal Sac and Passage
 - 09.72 Other Repair of Punctum
 - 09.73 Repair of Canaliculus
 - 09.99 Other Operations on Lacrimal System

ICD-9-CM CODE

TITLE

10.0	Removal of Embedded Foreign Body from Conjunctiva by Incision
10.1	Other Incision of Conjunctiva
10.31	Excision of Lesion or Tissue of Conjunctiva
10.33	Curettage-Other Destructive Procedures on Conjunctiva
10.44	Mucosal Graft (Other Graft to Conjunctiva)
10.49	Other Conjunctivoplasty
10.5	Lysis of Adhesions of Conjunctiva and Eyelid
10.6	Repair of Laceration of Conjunctiva
10.99	Other Operations on Conjunctiva
11.0	Magnetic Removal of Embedded Foreign Body from Cornea
11.1	Incision of Cornea
11.31	Transportation of Pterygium
11.32	Excision of Pterygium with Corneal Graft
11.39	Other Excision of Pterygium
11.49	Other Removal or Destruction of Corneal Lesion
11.51	Suture of Corneal Laceration
11.60	Corneal Transplant, Not Otherwise Specified
11.61	Corneal Transplant, Lamellar Keratoplasty with Autograft
11.62	Other Lamellar Keratoplasty
11.63	Penetrating Keratoplasty with Autograft
11.64	Other Penetrating Keratoplasty, Perforating Keratoplasty (with Homograft)
11.69	Other Corneal Transplant
11.79	Other Reconstructive Surgery on Cornea
11.91	Tattooing of Cornea
11.92	Removal of Artificial Implant from Cornea
11.99	Other Operations on Cornea
12.01	Removal of Intraocular Foreign Body from Anterior Segment of Eye with Use of Magnet
12.11	Transfixion of Iris, Iridotomy
12.12	Other Iridotomy, Sphincterotomy of Iris
12.14	Other Iridectomy, Optical Iridectomy
12.31	Lysis of Goniosynechiae
12.32	Lysis of Other Anterior Synechiae
12.39	Other Iridoplasty

ICD-9-CM CODE

TITLE

12.40	Removal of Lesion of Anterior Segment of Eye
12.41	Destruction of Lesion of Iris, Nonexcisional
12.42	Iridocystectomy (Peripheral) Excision of Lesion of Iris
12.43	Destruction of Lesion of Ciliary Body Nonexcisional
12.44	Excision of Lesion of Ciliary Body
12.47	Diminution of Ciliary Body, NOS
12.51	Goniotomy (Goniotomy without Goniotomy)
12.54	Trabeculotomy (ab externo)
12.55	Cyclotomy, Cyclodialysis, Ciliotomy
12.59	Other Facilitation of Intraocular Circulation
12.63	Iridocleisis and Iridotaxis
12.65	Sclerectomy
12.69	Iridosclerotomy, Other Fistulizing Procedure
12.79	Other Glaucoma Procedures
12.81	Suture of Sclera
12.84	Excision or Destruction of Lesion of Sclera
12.89	Other Operations on Sclera
12.99	Other Operations on Anterior Chamber
13.01	Removal of Foreign Body from Lens with Use of Magnet
13.02	Removal of Foreign Body from Lens without Use of Magnet
13.19	Other Intracapsular Extraction of Lens
13.41	Phacoemulsification and Aspiration of Cataract
13.51	Extracapsular Extraction of Lens by Temporal Inferior Route (Capsulectomy)
13.59	Other Extracapsular Extraction of Lens
13.65	Excision of Secondary Membrane (After Cataract) (Capsulectomy)
13.69	Other Cataract Extraction
13.70	Insertion of Pseudophakos, Not Otherwise Specified
13.8	Removal of Implanted Lens
13.9	Other Operations on Lens
14.59	Other Repair of Retinal Detachment
14.75	Injection of Vitreous Substitute (See "Excludes")
14.79	Other Operations on Vitreous
15.11	Recession of One Extraocular Muscle
15.13	Resection of One Extraocular Muscle

ICD-9-CM CODE

TITLE

15.2 Other Operations on One Extraocular Muscle
 15.22 Shortening Procedures on One Extraocular Muscle
 15.3 Operations on Two More Extraocular Muscles Involving Temporary Detachment from Globe, One or Both Eyes
 15.4 Other Operations on Two or More Extraocular Muscles, One or Both Eyes
 15.5 Transposition of Extraocular Muscle
 15.7 Repair of Injury of Extraocular Muscle
 15.9 Other Operations on Extraocular Muscles and Tendons
 16.1 Removal of Penetrating Foreign Body from Eye

4. OPERATIONS ON THE EAR (18-20)

18.29 Excision or Destruction of Other Lesion of External Ear
 18.5 Surgical Correction of Prominent Ear
 18.6 Reconstruction of External Auditory Canal
 18.71 Reconstruction of Auricle of Ear
 18.79 Other Plastic Repair of External Ear
 18.9 Other Operations on External Ear
 19.3 Other Operations on Ossicular Chain
 19.4 Myringoplasty
 20.09 Other Myringotomy
 20.01 Myringotomy with Insertion of Tube (Insertion of Tympanotomy Tube)
 20.1 Removal of Tympanostomy Tube
 20.51 Excision of Lesion of Middle Ear (Excision of Cholesteatoma)
 20.59 Other Excision of Middle Ear (Removal of Outer Attic Wall)

5. OPERATIONS ON THE NOSE, MOUTH, AND PHARYNX (21-29)

21.30 Excision or Destruction of Lesion of Nose
 21.31 Polypectomy
 21.61 Turbinectomy by Diathermy or Cryosurgery
 21.62 Fracture of the Turbinates
 21.69 Other Turbinectomy
 21.71 Closed Reduction of Nasal Fracture
 21.8 Repair and Plastic Operations on the Nose (Excludes 2183, Total Reconstruction)
 21.99 Other Operations on Nose

ICD-9-CM CODE

TITLE

22.2	Intranasal Antrotomy
22.39	Other External Maxillary Antrotomy
22.60	Sinusectomy, Not Otherwise Specified
22.71	Closure of Nasal Sinus Fistula (Repair of Oro-Antral Fistula)
22.79	Other Repair of Nasal Sinus
23.01	Extraction of Deciduous Tooth
23.09	Extraction of Other Tooth
23.10	Other Surgical Extraction of Tooth
23.11	Removal of Residual Root
23.2	Restoration of Tooth by Filling
23.49	Other Dental Restoration
24.5	Alveoloplasty
24.91	Vestibuloplasty
25.01	Needle Biopsy of Tongue
25.02	Other Biopsy of Tongue
25.09	Other Diagnostic Procedures of Tongue
25.91	Lingual Frenotomy
26.0	Incision of Salivary Gland or Duct
26.99	Other Operations on Salivary Gland or Duct
27.24	Biopsy of Mouth, Unspecified Structure
27.56	Other Skin Graft to Lip and Mouth
27.59	Other Plastic Repair of Mouth
28.2	Tonsillectomy without Adenoidectomy
28.3	Tonsillectomy with Adenoidectomy
28.6	Adenoidectomy without Tonsillectomy
29.2	Excision of Branchial Cleft Cyst or Vestige (Only If Non-Infected)
6.	OPERATIONS ON THE RESPIRATORY SYSTEM (30-34)
30.09	Other Excision or Destruction of Lesion or Tissue of Larynx
31.0	Injection of Larynx
31.42	Laryngoscopy and other Tracheoscopy
33.24	Other Bronchoscopy
33.26	Percutaneous (Needle) Biopsy of Lung

ICD-9-CM CODETITLE

34.24
34.91

Pleural Biopsy
Thoracentesis

7. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (35-39)

37.85 Replacement of Cardiac Pacemaker Pulse Generator
38.50 Ligation and Stripping of Varicose Veins, Unspecified Site
38.59 Stripping Varicose Veins (Lower Limb)
38.92 Umbilical Vein Catheterization
38.93 Other Venous Catheterization
39.30 Suture of Unspecified Blood Vessel

8. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEM (40-41)

40.11 Biopsy of Lymphatic Structure
40.29 Simple Excision of other Lymphatic Structure
41.31 Biopsy of Bone Marrow

9. OPERATIONS ON THE DIGESTIVE SYSTEM (42-54)

42.24 Biopsy of Esophagus
44.12 Gastroscopy Through Artificial Stoma
44.13 Other Gastroscopy
45.22 Endoscopy of Large Intestine through Stoma (Artificial)
45.24 Other Endoscopy of Large Intestine
48.25 Other Biopsy of Rectum
48.32 Other Electrocoagulation of Rectal Lesion or Tissue
48.35 Local Excision of Rectal Lesion or Tissue
48.81 Incision of Perirectal Tissue
49.10 Incision or Excision of Anal Fistula
49.11 Anal Fistulotomy
49.12 Anal Fistulectomy
49.23 Biopsy of Anus
49.3 Local Excision or Destruction of other Lesion or Tissue of Anus
49.46 Excision of Hemorrhoids (Banding only)
49.51 Left Lateral Anal Sphincterotomy

ICD-9-CM CODE

TITLE

49.52
49.59
50.11
53.00
53.10
53.20
53.30
53.4
53.41
53.49
53.59
54.21
54.22
54.97
54.98
54.99

Posterior Anal Sphincterotomy
Other Anal Sphincterotomy
Percutaneous (Needle) Biopsy of Liver
Unilateral Repair of Inguinal Hernia, Not Otherwise Specified
Bilateral Repair of Inguinal Hernia, NOS
Unilateral Repair of Femoral Hernia
Bilateral Repair of Femoral Hernia
Repair of Umbilical Hernia
Repair of Umbilical Hernia With Prosthesis
Other Umbilical Herniorrhaphy
Repair of other Hernia or Anterior Abdominal Wall
Laparoscopy
Biopsy of Abdominal Wall or Umbilicus
Injection of Locally-Acting Therapeutic Substance
Peritoneal Dialysis
Other Operations of Abdominal Region

1-7

10. OPERATIONS ON THE URINARY SYSTEM (55-59)

55.01
55.11
55.22
56.1
56.31
56.99
57.32
57.33
57.34
57.49
58.1
58.23
58.45
58.5
58.6

Nephrotomy
Pyelotomy
Pyeloscopy
Ureteral Meatotomy
Ureteroscopy
Other Operations on Ureter
Other Cystoscopy
Transurethral Biopsy of Bladder
Other Biopsy of Bladder
Other Transurethral Excision or Destruction of Lesion or Tissue of Bladder
Urethral Meatotomy
Biopsy of Urethra
Repair of Hypospadias and Epispadias
Release of Urethral Stricture
Dilation of Urethra

ICD-9-CM CODE

TITLE

11. OPERATIONS ON THE MALE GENITAL SYSTEM (60-64)

60.11	Needle Biopsy of Prostate
60.12	Other Biopsy of Prostate
61.2	Excision of Hydrocele (of Tunica Vaginalis)
62.11	Percutaneous Biopsy of Testis
62.12	Other Biopsy of Testis
62.3	Unilateral Orchiectomy
62.30	Unilateral Removal of Ovotestis
62.41	Removal of Both Testes at Same Operative Episode
62.42	Removal of Remaining Testis
62.5	Orchiopexy
63.30	Excision of Other Lesion or Tissue of Spermatic Cord and Epididymis (for Excision of Lesion)
63.1	Excision of Varicocele and Hydrocele of Spermatic Cord
63.59	Repair of Hydrocele of Cord
63.73	Vasectomy
64.0	Circumcision
64.11	Biopsy of Penis
64.41	Suture of Laceration of Penis
64.42	Release of Chordee
64.44	Reconstruction
64.49	Other Repair of Penis
64.93	Division of Penile Adhesions
64.98	Irrigation, Corpus Cavernosum
64.99	Other Operations on Male Genital Organs

12. OPERATIONS ON THE FEMALE GENITAL SYSTEM (65-71)

66.2	Bilateral Endoscopic Destruction or Occlusion of Fallopian Tubes
69.01	D&C for Termination of Pregnancy
69.02	D&C Following Delivery or Abortion
69.09	Other D&C (Diagnostic)
69.51	Aspiration Curettage of Uterus for Termination of Pregnancy

ICD-9-CM CODETITLE

69.59	Other Aspiration Curettage of Uterus
69.97	Removal of Other Penetrating Foreign Body from Cervix
70.14	Other Vaginotomy (Removal of Foreign Body by Incision)
70.31	Excision of Hymen
70.33	Excision or Destruction of Lesion of Vagina
70.91	Other Operations on Vagina
71.11	Biopsy of Vulva
71.3	Other Local Excision or Destruction of Vulva and Perineum
71.71	Perineorrhaphy
71.72	Closure of Perineal Fistula
71.79	Other Repair of Vulva and Perineum
13. OBSTETRICAL PROCEDURES (72-75)	
14. OPERATIONS ON THE MUSCULO-SKELETAL SYSTEM (76-84)	
76.01	Removal of sequestrum
76.09	Other Incision of Facial Bone
76.61	Closed Osteoplasty of Mandibular Ramus (Ramisection, Condylotomy)
76.62	Open Osteoplasty of Mandibular Ramus (Ramisection, Condylotomy)
76.67	Reduction Genioplasty
76.68	Augmentation Genioplasty
76.69	Other Facial Bone Repair
76.71	Closed Reduction of Malar and Zygomatic Fracture
76.73	Closed Reduction of Maxillary Fracture
76.75	Closed Reduction of Mandibular Fracture
76.78	Other Closed Reduction of Facial Fracture
77.20	Wedge Osteotomy Unspecified Site
77.30	Other Division of Bone, Osteotomy
77.54	Excision of Bunionette
77.59	Other Bunionectomy
77.60	Local Excision of Lesion or Tissue of Bone, Unspecified Site
77.68	Excision of Metatarsal Head or Phalanx
77.80	Other Partial Osteotomy, Unspecified Site (Hand and Foot only)
77.90	Total Osteotomy, Unspecified Site (Hand and Foot only)

78.50	Internal Fixation of Bone Without Fracture Reduction
78.60	Removal of Internal Fixation Device, Unspecified Site (Superficial Only)
79.02	Closed Reduction of Fracture of Radius and Ulna Without Internal Fixation
79.03	Closed reduction of Fracture (Carpals and Metacarpals) Without Internal Fixation
79.04	Closed Reduction of Fracture Without Internal Fixation (Phalanges of Hand)
79.06	Closed Reduction of Fracture of Tibia and Fibula Without Internal Fixation
79.07	Closed Reduction of Fracture without Internal Fixation (Tarsals and Metatarsals)
79.12	Closed Reduction of Fracture with Internal Fixation Radius and Ulna
79.13	Closed Reduction of Fracture with Internal Fixation Carpals and Metacarpals
79.14	Closed Reduction of Fracture with Internal Fixation Phalanges of Hand
79.17	Closed Reduction of Fracture with Internal Fixation Tarsals and Metatarsals
79.18	Closed Reduction of Fracture with Internal Fixation Phalanges of Foot
79.2	Open Reduction of Fracture without Internal Fixation, (Hand and Foot only)
79.3	Open Reduction of Fracture with Internal Fixation, (Hand and Foot only)
79.7	Closed Reduction of Dislocation of Unspecified Site (Wrist, Hand, Ankle and Foot only)
80.10	Other Arthroscopy, Unspecified Site
80.20	Arthroscopy, Unspecified Site
80.30	Biopsy of Joint Structure, Unspecified Site
80.40	Division of Joint Capsule, Ligament, or Cartilage, (Arthroscopic, Hand and Foot only)
80.6	Excision of Semilunar Cartilage of Knee
80.70	Syndectomy, Unspecified Site
80.80	Other Local Excision or Destruction of Lesion of Joint, (Arthroscopic only)
80.90	Other Excision of Joint, Unspecified Site (Arthroscopic only)
81.11	Ankle Fusion
81.20	Arthrodesis of Unspecified Joint (Hand and Foot Only)
81.79	Other Repair of Hand and Finger
81.96	Other Repair of Joint
82.0	Incision of Muscle, Tendon, Fascia, and Bursa of Hand
82.1	Division of Muscle, Tendon, Fascia on Hand
82.2	Excision of Lesion of Muscle, Tendon, and Fascia of Hand
82.3	Other Excision of Soft Tissue of Hand
82.4	Suture of Muscle, Tendon, and Fascia of Hand
82.7	Plastic Operation on Hand with Graft or Implant
82.8	Other Plastic Operations on Hand
82.84	Repair of Mallet Finger

ICD-9-CM CODETITLE

82.85	Other Tenodesis of Hand
82.86	Other Tenoplasty of Hand
82.89	Other Plastic Operations on Hand
82.89	Other Plastic Operations on Hand
82.9	Other Operations on Muscle, Tendon, and Fascia of Hand
83.0	Incision of Muscle, Tendon, Fascia, and Bursa
83.13	Other Tenotomy (Transection of Tendon)
83.14	Fasciotomy
83.19	Other Division of Soft Tissue
83.2	Diagnostic Procedures on Muscle, Tendon, Fascia, and Bursa, Including Hand
83.3	Excision of Lesion of Muscle, Tendon, Fascia, and Bursa
83.4	Other Excision of Muscle, Tendon, and Fascia, (Except Scaleneotomy)
83.6	Suture of Muscle, Tendon, and Fascia
83.61	Suture of Tendon Sheath
83.62	Delayed Suture of Tendon
83.64	Other Suture of Tendon
83.8	Other Plastic Operations on Muscle, Tendon, and Fascia
83.9	Other Operations on Muscle, Tendon, Fascia, and Bursa
84.01	Amputation and Disarticulation of Finger
84.11	Amputation of Toe
84.3	Revision of Amputation Stump
15.	OPERATIONS ON THE INTEGUMENTARY SYSTEM (85-86)
85.0	Mastectomy
85.11	Percutaneous (Needle) Biopsy of Breast
85.12	Other Biopsy of Breast
85.20	Excision or Destruction of Breast Tissue
85.21	Local Excision of Lesion of Breast
85.24	Excision of Ectopic Breast Tissue (Excision of Supernumerary Breast)
85.50	Augmentation Mammoplasty, Not Otherwise Specified
85.51	Unilateral Injection Into Breast for Augmentation
85.52	Injection into Breast for Augmentation (Bilateral)
85.53	Unilateral Breast Implant

ICD-9-CM CODE

TITLE

85.54	Bilateral Breast Implant
85.60	Mastopexy
85.81	Suture of Laceration of Breast
85.82	Split-Thickness Graft to Breast
85.83	Full-Thickness graft to breast
85.89	Other Mamoplasty
86.04	Other Incision with Drainage of Skin and Subcutaneous tissue (Drainage)
86.05	Incision with Removal of Foreign Body from Skin and Subcutaneous Tissue (Removal of Foreign Body)
86.09	Other Incision of Skin and Subcutaneous Tissue
86.11	Biopsy of Skin and Subcutaneous Tissue
86.21	Excision of Pilonidal Cyst or Sinus
86.22	Debridement of Wound, Infection, or Burn
86.23	Removal of Nail, Nailbed, or Nail Fold
86.24	Chemosurgery of Skin
86.25	Dermabrasion
86.3	Other Local Excision or Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue
86.59	Suture of Skin and Subcutaneous Tissue of Other Sites
86.60	Free Skin Graft, Not Otherwise Specified
86.62	Other Skin Graft to Hand
86.75	Revision of Pedicle or Flap Graft
86.81	Repair for Facial Weakness
86.82	Facial Rhytidectomy
86.84	Relaxation of Scar or Web Contracture of Skin
86.85	Correction of Syndactyly
86.89	Other Repair and Reconstruction of Skin and Subcutaneous Tissue
86.99	Other Operations on Skin and Subcutaneous Tissue
16.	MISCELLANEOUS DIAGNOSTIC AND THERAPEUTIC PROCEDURES (87-99)
87.54	Other Cholangiogram
87.52	Intravenous Cholangiogram
87.59	Cholecystogram

ICD-9-CM CODETITLE

88.45	Arteriography of Renal Arteries
89.29	Calibration of Urethra
93.26	Manual Rupture of Joint Adhesions
93.53	Application of other Cast
93.54	Application of Splint
96.03	Insertion of Esophageal Obturator Airway
96.16	Other Vaginal Dilatation
96.23	Dilatation of Anal Sphincter
96.24	Dilatation and Manipulation of Enterostomy Stoma
97.71	Removal of Intrauterine Contraceptive Device
97.88	Removal of External Immobilization Device
98.0	Removal of Intraluminal Foreign Body from Digestive System without Incision
98.1	Removal of Intraluminal Foreign Body from Other Sites without Incision
98.2	Removal of other Foreign Body without Incision
98.06	Tamponade, Insertion of Sengstaken Tube
98.16	Removal of Intraluminal Foreign Body from Uterus without Incision
98.17	Removal of Intraluminal Foreign Body from Vagina without Incision
99.62	Other Electric Countershock of Heart

APPENDIX I

APPENDIX I

Inpatient OR Procedures that Met HSC SDS Criteria

<u>ICD-9-CM CODE</u>	<u>NUMBER</u>
1. OPERATIONS ON THE NERVOUS SYSTEM (01-05)	
04.6	17
2. OPERATIONS ON THE ENDOCRINE SYSTEM (06-07)	
	0
3. OPERATIONS ON THE EYE (08-16)	
08.20	1
08.52	2
09.49	7
13.51	32
15.3	33
15.11	1
4. OPERATIONS ON THE EAR (18-20)	
20.01	7
5. OPERATIONS ON THE NOSE, MOUTH AND PHARYNX (21-29)	
21.31	2
21.71	1
21.8	7
21.99	1
22.2	5
22.71	1
23.10	10
24.91	3
27.24	2
28.3	14
6. OPERATIONS ON THE RESPIRATORY SYSTEM (30-34)	
30.09	8
7. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (35-39)	
38.59	1
8. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEM (40-41)	
40.11	9
40.29	2
9. OPERATIONS ON THE DIGESTIVE SYSTEM (42-54)	
48.35	2
49.12	1
49.46	14
49.51	4
53.00	90
53.4	11
53.49	5
54.21	64

9. OPERATIONS ON THE DIGESTIVE SYSTEM (42-54)

48.35	2
49.12	1
49.46	14
49.51	4
53.00	90
53.4	11
53.49	5
54.21	64
54.99	1

10. OPERATIONS ON THE URINARY SYSTEM (55-59)

56.3	7
56.31	1
57.32	13
57.33	9
58.6	1

11. OPERATIONS ON THE MALE GENITAL SYSTEM (60-64)

60.12	1
61.3	3
62.11	2
62.3	6
63.1	1
64.0	17

12. OPERATIONS ON THE FEMALE GENITAL SYSTEM (65-71)

66.2	21
67.2	25
69.09	25
70.79	1
71.71	2
71.72	1

14. OPERATIONS ON THE MUSCULO-SKELETAL SYSTEM (76-84)

77.3	5
77.5	2
77.59	28
77.8	5
78.6	12
79.0	1
79.02	2
79.3	2
80.20	65
80.9	2
80.1	1
80.70	1
80.80	3
81.20	1
81.1	1
81.96	5
82.3	7
82.1	1
82.2	6
82.7	2
83.1	1
83.8	2
83.9	3
84.11	1

15. OPERATIONS ON THE INTEGUMENTARY SYSTEM (85-86)

86.09	4
86.3	11
86.8	6
86.21	13

APPENDIX J

APPENDIX J

Single Soldier Estimates

According to Mr. John Sweitzer, (Real Property Office, Fort Hood, Texas) there are 38,387 active duty soldiers assigned to Fort Hood. Forty nine percent of these soldiers are single.

There are 7,553 single soldiers residing in post housing. This means that 5773 of 38,378, or nineteen percent are not eligible for same day surgery.

Active duty surgical care compromised forty seven percent of the total surgical care at Darnall during the period January-June 1986. The estimated number of ineligible soldiers is therefore 112 of 688.

APPENDIX K

CRITICAL INDICATORS		ACTIVITY CODE													99
TREATMENTS/PROCEDURES/MEDICATIONS		A17-A23													
c = more > 15 and < 30 Minutes Total															
2)	Start IV or NG or Foley or EKG	70													70
2)	OR care or enemas or eye washes/tears	71													71
2)	Simple dressing or tube care, Foley care (exclude trach)	72													72
2)	S&A or S&G or Gulae or vein HCT x 6	73													73
2)	Lap studies x 6: APB or blood culture x 3	74													74
2)	Medications q3h - q6h (up to 12 trials) (exclude IV)	75													75
2)	Irrigations or instillations x 4 or less	76													76
2)	Restraints (2 or 4 point or pose)	77													77
2)	Assist OOB to chair/wheelchair x 3	78													78
2)	Assist OOB, walk & return x 1	79													79
2)	Infant circumciser or phototherapy	80													80
2)	Accompany patient off ward > 15 minutes and < 30 minutes	81													81
2)	Other activities requiring > 15 minutes and < 30 minutes	82													82
2)	Isolation (gown and glove x 6)	83													83
Cameles > 30 minutes and < 1 Hour Total		A24-A26													
4)	Chest tube insertion or lumbar puncture	90													90
4)	Thoracentesis or paracentesis	91													91
4)	Complex dressing change (30 minutes to complete)	92													92
4)	Straight catheterization x 4 or more	93													93
4)	Medication q2h or more (greater than 12 trials) (exclude IV)	94													94
4)	Race of motion exercises x 3	95													95
4)	Accompany patient off ward > 30 minutes	96													96
4)	Other activities requiring > 30 minutes and < 1 hour	97													97
Special Procedures > 1 Hour and < 4 hrs															
8)	Each hour requiring continuous staff attendance/assistance	100													100
12)	New Admission (assessment and orientation)	101													101
4)	Transfer (in-house)	102													102
RESPIRATORY THERAPY		A27-A30													
2)	Oxygen therapy or nebulizer	110													110
2)	Incentive spirometer or C&DS q4h	111													111
2)	IPPB or maximal blow x 2	112													112
4)	IPPB or maximal q4h or x 4	113													113
6)	IPPB or maximal q6h or x 6	114													114
8)	Crude test or mist test	115													115
2)	Chest pulmonary therapy bid or x 2	116													116
4)	Chest pulmonary therapy q4h or x 4	117													117
6)	Chest pulmonary therapy q6h or x 6	118													118
2)	Suctioning q4h or x 6	119													119
4)	Suctioning q2h or x 12	120													120
10)	Ventilator	121													121
4)	Tracheostomy care x 3	122													122
TEACHING & EMOTIONAL SUPPORT (Must be documented)		A31-A35													
2)	Group teaching	130													130
4)	Preoperative teaching	131													131
4)	Special structured teaching (diabetic, cardiac, etc.)	132													132
EMOTIONAL SUPPORT (in excess of 30 min a 24 hours)															
4)	Patient/family support (anxiety, denial, loneliness, etc.)	133													133
4)	Lifestyle modification (diet, behavior, image, etc.)	134													134
8)	Sensory deprivation (deaf, blind, etc.)	135													135
10)	Maximum points for emotional support	136													136
CONTINUOUS		A36-A39													
96)	Patient requiring 1:1 coverage all shifts	140													140
146)	Patient requiring greater than 1:1 coverage all shifts	141													141
0-12 I _____ 04-05 IV _____		SUBTOTAL													
12-21 II _____ 06-14 V _____		TOTAL													
22-63 III _____ 146-000 VI _____		CATEGORY													

.. NURSING CARE HOUR REQUIREMENTS

PATIENTS	CATEGORY					
	I	II	III	IV	V	VI
1	2	5	11	18	27	45
2	3	10	21	36	54	91
3	5	15	32	53	81	136
4	6	20	43	71	108	182
5	8	25	54	89	135	227
6	10	29	64	107	161	272
7	11	34	75	125	188	319
8	13	39	86	142	215	363
9	14	44	96	160	242	409
10	16	49	107	178	269	454
11	18	54	118	196	296	499
12	19	59	128	214	323	545
13	21	64	139	231	350	590
14	22	69	150	249	377	636
15	24	74	161	267	404	681
16	26	78	171	285	430	726
17	27	83	182	303	457	772
18	29	88	193	320	484	817
19	30	93	203	338	511	863
20	32	98	214	356	538	909
21	34	103	225	374	565	953
22	35	108	235	392	592	999
23	37	113	246	409	619	1044
24	38	118	257	427	646	1090
25	40	123	268	445	673	1135
26	42	127	278	463	699	1180
27	43	132	289	481	726	1226
28	45	137	300	498	753	1271
29	46	142	310	516	780	1317
30	48	147	321	534	807	1362

NURSING CARE HOUR REQUIREMENTS

PATIENTS	CATEGORY					
	I	II	III	IV	V	VI
31	50	152				
32	51	157				
33	53	162				
34	54	167				
35	56	172				
36	58	176				
37	59	181				
38	61	186				
39	62	191				
40	64	196				
41	66	201				
42	67	206				
43	69	211				
44	70	216				
45	72	221				
46	74	225				
47	75	230				
48	77	235				
49	78	240				
50	80	245				
51	82	250				
52	83	255				
53	85	260				
54	86	265				
55	88	270				
56	90	274				
57	91	279				
58	93	284				
59	94	289				
60	96	294				

NURSING CARE HOUR REQUIREMENTS

PATIENTS	CATEGORY					
	I	II	III	IV	V	VI
61	98	299				
62	99	304				
63	101	309				
64	102	314				
65	104	319				
66	106	323				
67	107	328				
68	109	333				
69	110	338				
70	112	343				
71	114	348				
72	115	353				
73	117	358				
74	118	363				
75	120	368				
76	122	372				
77	123	377				
78	125	382				
79	126	387				
80	128	392				
81	130	397				
82	131	402				
83	133	407				
84	134	412				
85	136	417				
86	138	421				
87	139	426				
88	141	431				
89	142	436				
90	144	441				

MEDICAL SURGICAL
PERSONNEL REQUIREMENTS CHART

TOTAL HOURS	TOTAL 24 HOUR STAFF	DAYS			EVENINGS			NIGHTS		
		RN	91C	91A	RN	91C	91A	RN	91C	91A
0-48	6	1	1	0	1	0	1	1	0	1
49-56	7	1	1	1	1	1	0	1	0	1
57-64	8	1	1	2	1	1	0	1	0	1
65-72	9	2	1	1	1	1	1	1	0	1
73-80	10	2	1	2	1	1	1	1	0	1
81-88	11	2	1	2	2	1	1	1	0	1
89-96	12	2	2	2	2	1	1	1	0	1
97-104	13	2	2	2	2	1	1	1	1	1
105-112	14	2	2	2	2	1	2	1	1	1
113-120	15	3	2	2	2	1	2	1	1	1
121-128	16	3	2	3	2	1	2	1	1	1
129-136	17	3	2	3	2	2	2	1	1	1
137-144	18	3	2	3	3	2	2	1	1	1
145-152	19	3	2	3	3	2	2	2	1	1
153-160	20	4	2	3	3	2	2	2	1	1
161-168	21	4	3	3	3	2	2	2	1	1
169-176	22	4	3	3	3	2	3	2	1	1
177-184	23	4	3	3	3	2	3	2	1	2
185-192	24	4	3	4	3	2	3	2	1	2
193-200	25	4	3	4	4	2	3	2	1	2
201-208	26	5	3	4	4	2	3	2	1	2
209-216	27	5	3	4	4	3	3	2	1	2
217-224	28	5	4	4	4	3	3	2	1	2
225-232	29	5	4	4	4	3	3	2	2	2
233-240	30	6	4	4	4	3	3	2	2	2

MEDICAL SURGICAL
PERSONNEL REQUIREMENTS CHART

TOTAL HOURS	TOTAL 24 HOUR STAFF	DAYS			EVENINGS			NIGHTS		
		RN	91C	91A	RN	91C	91A	RN	91C	91A
241-248	31	6	4	4	4	3	4	2	2	2
249-256	32	6	4	5	4	3	4	2	2	2
257-264	33	6	4	5	4	3	4	3	2	2
265-272	34	6	5	5	4	3	4	3	2	2
273-280	35	6	5	5	5	3	4	3	2	2
281-288	36	7	5	5	5	3	4	3	2	2
289-296	37	7	5	5	5	4	4	3	2	2
297-304	38	7	5	5	6	4	4	3	2	2
305-312	39	7	5	5	6	4	4	3	2	3
313-320	40	8	5	5	6	4	4	3	2	3
321-328	41	8	5	6	6	4	4	3	2	3
329-336	42	8	5	6	6	4	5	3	2	3
337-344	43	8	5	6	6	4	5	4	2	3
345-352	44	8	6	6	6	4	5	4	2	
353-360	45	8	6	6	6	5	5	4	2	
361-368	46	8	6	7	6	5	5	4	2	3
369-376	47	8	6	7	7	5	5	4	2	3
377-384	48	9	6	7	7	5	5	4	2	3
385-392	49	9	6	7	7	5	5	4	3	3
393-400	50	9	7	7	7	5	5	4	3	3
401-408	51	9	7	7	7	5	6	4	3	3
409-416	52	10	7	7	7	5	6	4	3	3
417-424	53	10	7	7	7	3	6	4	3	4
425-432	54	10	7	6	7	5	6	4	3	4
433-440	55	10	7	8	8	5	6	4	3	4

MEDICAL SURGICAL
PERSONNEL REQUIREMENTS CHART

TOTAL HOURS	TOTAL 24 HOUR STAFF	DAYS			EVENINGS			NIGHTS		
		RN	91C	91A	RN	91C	91A	RN	91C	91A
441-448	56	10	8	8	8	5	6	4	3	4
449-456	57	10	8	8	8	6	6	4	3	4
457-464	58	11	8	8	8	6	6	4	3	4
465-472	59	11	8	8	8	6	7	4	3	4
473-480	60	11	8	8	8	6	7	5	3	4
481-488	61	11	8	9	8	6	7	5	3	4
489-496	62	11	8	9	9	6	7	5	3	4
497-504	63	11	8	9	9	6	7	5	4	4
505-512	64	12	8	9	9	6	7	5	4	4
513-520	65	12	9	9	9	6	7	5	4	4
521-528	66	12	9	9	9	7	7	5	4	4
529-536	67	12	9	10	9	7	7	5	4	4
537-544	68	12	9	10	10	7	7	5	4	4
545-552	69	12	9	10	10	7	7	6	4	4
553-560	70	13	9	10	10	7	7	6	4	4
561-568	71	13	9	10	10	7	8	6	4	4
569-576	72	13	9	10	10	7	8	6	4	5
577-584	73	14	9	10	10	7	8	6	4	5
585-592	74	14	10	10	10	7	8	6	4	5
593-600	75	14	10	10	10	8	8	6	4	5

APPENDIX L

APPENDIX I

Nursing Workload AnalysisDaily Averages of Categories I-IV

Month	Ward	I	II	III	IV
JAN	3S	4	19	12	1
	4E	0	0	9	3
	4W	2	16	9	0
	5W	1	7	11	0
FEB	3S	1	11	7	0
	4E	0	0	9	3
	4W	2	17	7	0
	5W	1	8	13	0
MAR	3S	1	8	12	2
	4E	0	1	9	3
	4W	3	16	9	0
	5W	1	9	9	0
APR	3S	1	8	17	1
	4E	0	0	9	2
	4W	3	14	7	1
	5W	5	9	5	0
MAY	3S	1	10	8	0
	4E	0	1	6	3
	4W	2	11	7	0
	5W	4	9	4	0
JUN	3S	3	8	6	0
	4E	0	0	6	3
	4W	5	9	6	0
	5W	5	8	3	0

6 MONTH AVERAGE

3S	1.83	10.67	10.33	.67
4W	2.8	13.83	7.5	.16
5W	2.83	8.33	7.5	0

Patient Categories

		I	II	III	IV
6 MONTH AVERAGE	3S	1.83	10.67	10.33	.67
NURSING CARE HR REQUIREMENT A	3	54	118	18=193	
REVISED AVERAGE	3S	1.83	6.67	10.33	.67
NURSING CARE HR REQUIREMENT B	3	34	118	18=173	

STAFFING REQUIREMENTS A=25	RN	91C	91A
DAYS	4	3	4
EVENINGS	4	2	3
NIGHTS	2	1	2

STAFFING REQUIREMENTS B=22			
DAYS	4	3	3
EVENINGS	3	2	3
NIGHTS	2	1	1

SAVINGS: 1 PROFESSIONAL NURSE
2 91A

PATIENT CATEGORIES

		I	II	III	IV
6 MONTH AVERAGE	4W	2.8	13.83	7.5	.16
NURSING CARE HR REQUIREMENT A		5	69	86	18=178
REVISED AVERAGE	4W	2.8	9.93	7.5	.16
NURSING CARE HR REQUIREMENT B		5	49	86	18=158

STAFFING REQUIREMENTS A=23	RN	91C	91A
DAYS	4	3	3
EVENINGS	3	2	3
NIGHTS	2	1	2

STAFFING REQUIREMENTS B=20			
DAYS	4	2	3
EVENINGS	3	2	2
NIGHTS	2	1	1

SAVINGS: 1 91C
2 91A

PATIENT CATEGORIES

	I	II	III	IV
6 MONTH AVERAGE 5W	2.83	8.33	7.5	0
NURSING CARE HR REQUIREMENT A	5	44	86	0=135
REVISED AVERAGE 5W	2.83	6.33	7.5	0
NURSING CARE HR REQUIREMENT B	5	34	86	0=125

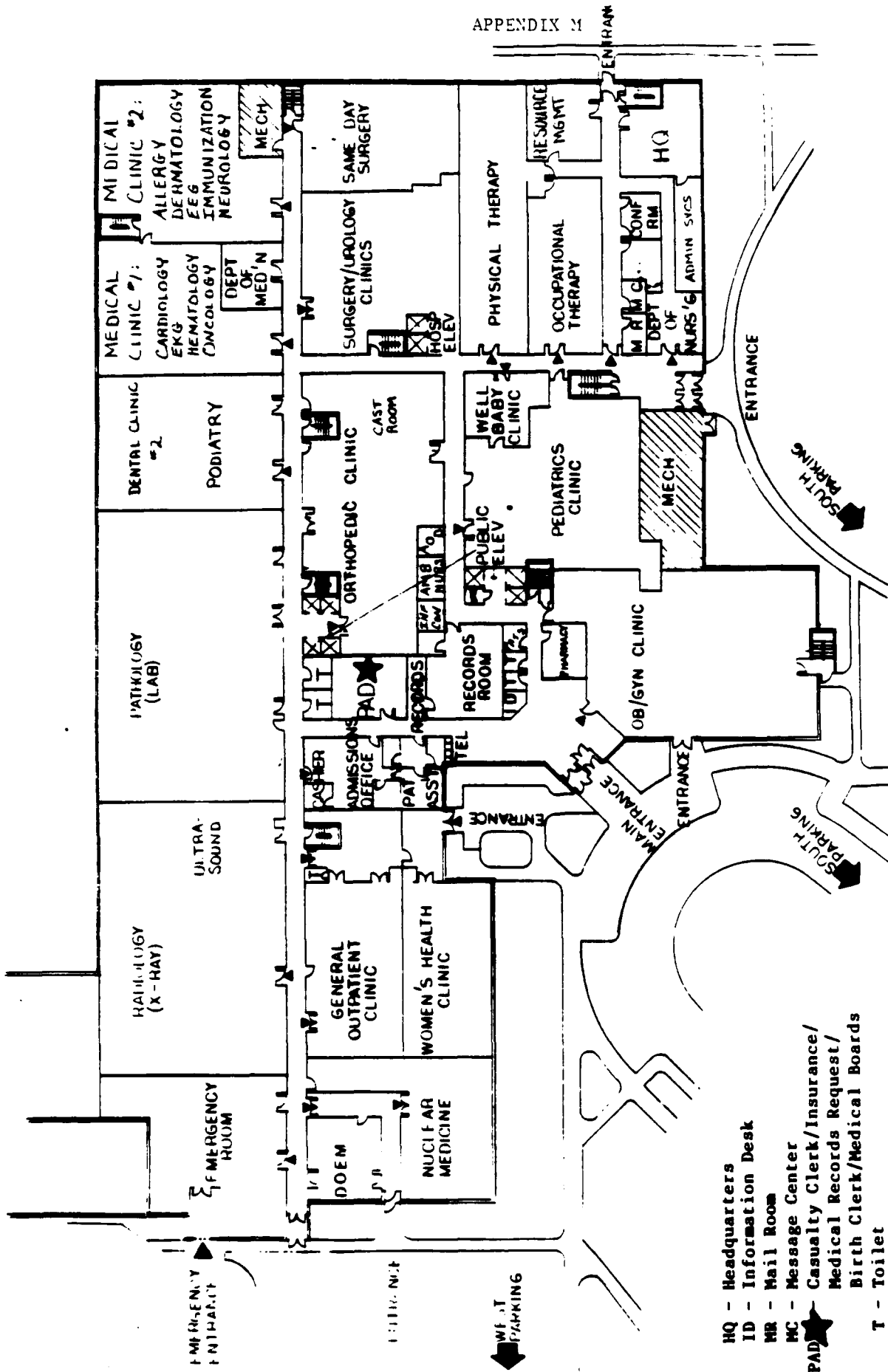
	RN	91C	91A
STAFFING REQUIREMENTS A=17			
DAYS	3	2	3
EVENINGS	2	2	2
NIGHTS	1	1	1

STAFFING REQUIREMENTS B=16			
DAYS	3	2	3
EVENINGS	2	1	2
NIGHTS	1	1	1

SAVINGS: 1 91C

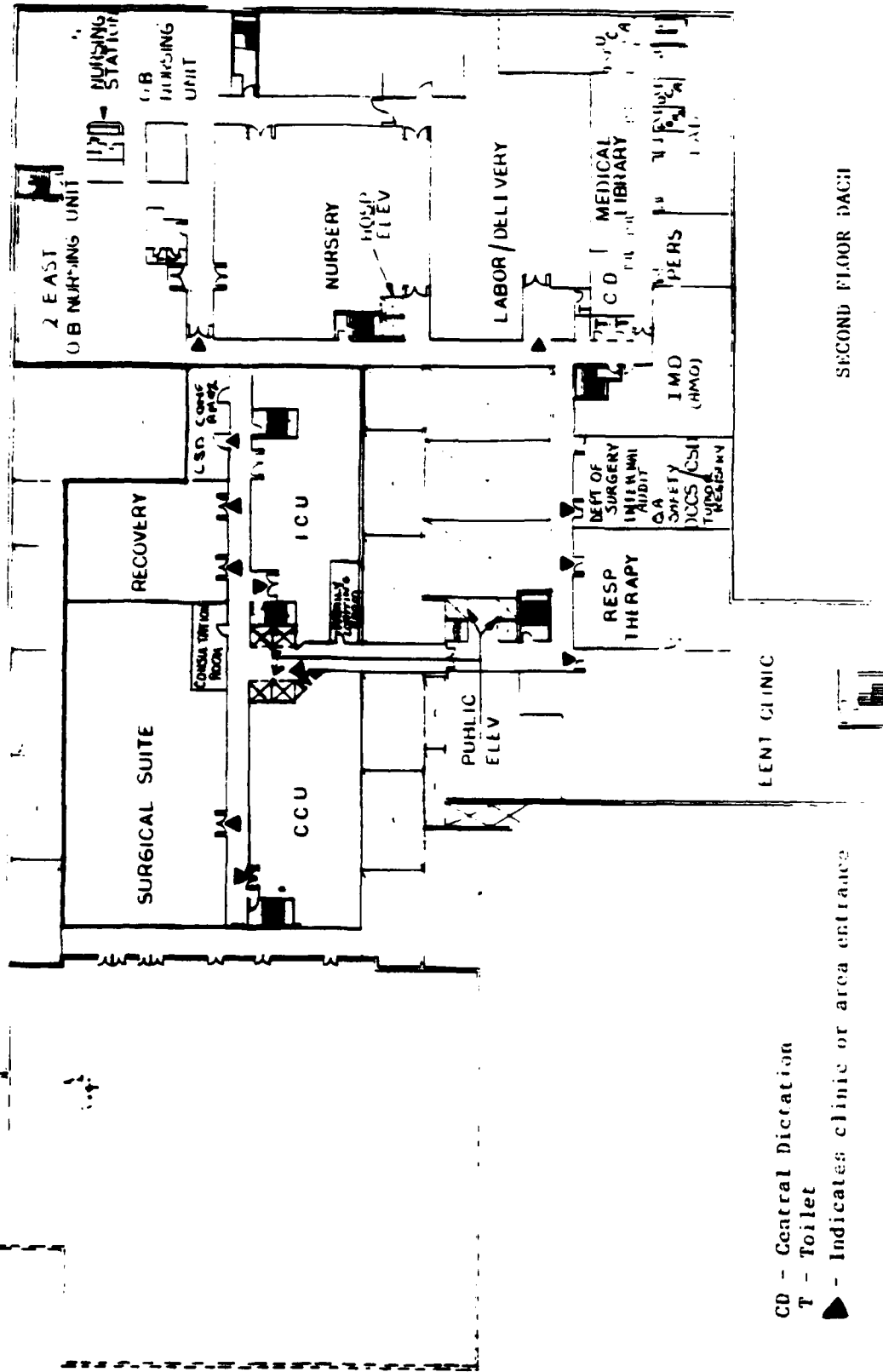
TOTAL STAFF SAVINGS: 1 PROFESSIONAL NURSE
 2 91 C's
 4 91 A's

APPENDIX M



FIRST FLOOR DACH

- HQ - Headquarters
- ID - Information Desk
- MR - Mail Room
- MC - Message Center
- PAD - Casualty Clerk/Insurance/
Medical Records Request/
Birth Clerk/Medical Boards
- T - Toilet
- ▲ - Indicates clinic or area entrance
- - Toilet facilities available in each clinic



CD - Central Dictation

T - Toilet

▴ - Indicates clinic or area entrance

BIBLIOGRAPHY

BIBLIOGRAPHY

Articles and Periodicals

- Ancona-Berk, V.A., & Chalmers, T.C. (1986). An analysis of the costs of ambulatory and inpatient care. American Journal of Public Health, 76(9), 1102-1104.
- Anderson, R. & Zimbra, C. (1986). Same day surgery: Coordinating the admission process. Nursing Management, 17(12), 23-25.
- Bashein, G., & Glauber D.T. (1984). [Letter to the editor]. The New England Journal of Medicine, 310(13), 855.
- Berry, F.A. (1984). Outpatient anesthesia should not be limited to ASA Class I patients. Anesthesiology, 60(6), 620.
- Brownlee, R.C. Jr. (1977). The case for day-care surgery. Pediatrics, 60(4 Pt 2), 650-651.
- Brubaker, K.M., & McGowan, M.B. (1986). Open hospital beds open new opportunities. Nursing Management, 17(11), 39-41.
- Burn, J.M. (1983). Responsible use of resources: Day surgery. [letter]. British Medical Journal, 286(6363), 723-724.
- Davis, J.E. (1984). The need to redefine levels of surgical care. JAMA, 251(19), 2527-2528.

- Detmer D.E., & Buchanan-Davidson, D.J. (1982).
Ambulatory surgery. Surgical Clinics of North America,
62(4), 685-704.
- Egdahl, R.H. (1983). Ways for surgeons to increase the
efficiency of their use of hospitals. New England
Journal of Medicine, 309(13), 1184-1187.
- Egdahl, R. H. (1983). [Letter to the editor]. The New
England Journal of Medicine. 310(13), 857.
- Inguanzo, J.M., & Harju, M. (1985). What's the market
for ambulatory surgery?. Hospitals, 59(15), 55-57.
- Katz, C. (1983). Free-standing treatment centers--
Another member of the competition. Postgraduate
Medicine, 74(2), 291-294.
- Kambouris, A.A. (1986). Ambulatory surgery: Its impact
on general surgical practice. The American Surgeon.
52(7), 347-350.
- Loder, R.E. (1982). The anaesthetist and the day-
surgery unit. Anaesthesia. 37, 10037-1039.
- Mortensen, M. & McMullin, C. (1986). Discharge score
for surgical outpatients. American Journal of
Nursing, 86(12), 1347-1349.
- Muller, C. (1986). Outpatient surgery: Are we
satisfied?. American Journal of Public Health, 76(9),
1086-1087.
- Nathanson, S. & Riffer, J. (1986). Hospitals not ready
for outpatient surgery PPS. Hospitals, 60(22), 81.

- Omphroy, C.A. and Corboy, J.M. (1985). Outpatient surgery [letter]. Archives of Ophthalmology, 103, 889.
- Paulshock, B.Z. (1982). [Letter to the editor]. The New England Journal of Medicine, 306(13), 813-814.
- Pineault, R. Contandriopoulos, A.P., Valois M. Bastian, M.L., & Lance, J.M. (1985). Randomized clinical trial of one-day surgery. Patient satisfaction, clinical outcomes and cost. Medical Care, 23(2), 171-182.
- Reinecke, R.D. (1985). Outpatient surgery: Back to the barbershop? Archives of Ophthalmology, 103, 26-27.
- Riffer, J. (1986). Technology and outpatient care shape surgery. Hospitals, 60(2), 86, 88.
- Roth, R.A., Gruendemann, B.J. (1986). Use of AORN recommended practices. AORN Journal, 43(5), 991-999.
- Schowalter, J.E. (1977). We won't leave you. Pediatrics, 60(4), 651-652.
- Shannon, K. (1985). Alternate delivery wrap up. Special section: Ambulatory surgery. Hospitals, 59(10), 54-6, 61-62.
- Siu, A.L., Sonnenberg, M.D., Manning, W.G., Goldberg, G.A., Bloomfield, E.S., Newhouse, J.P., & Brook, R.H. (1986). Inappropriate use of hospitals in a randomized trial of health insurance plans. The New England Journal of Medicine, 315(20), 1259-1266.

Staff. FASA statistics reveal top 10 procedures. Same-Day Surgery, April 1981, 47-49.

Staff. JCAH outlines records requirements for ambulatory surgery. Hospitals, 59(18), 118.

Staff. Outpatient surgery plan gets mixed reviews. Hospitals, 59(18), 117.

Ward, C. (1983). Responsible use of day surgery. British Medical Journal, 286(6363), 492-493.

Wetchler, B.V. 1986. Ambulatory surgery: The future is now. Journal of the Association of Nurse Anesthetists. 54(2), 121-125.

Yankauer, A. (1983). Lessons in surgery for the third World. American Journal of Public Health, 73(12), 1359-1360.

Books

American Health Consultants. (1981). Successful Management of Ambulatory Surgery Programs. Proceedings of the First National Conference, "Same Day Surgery-1980", and selected sessions from the Second National Conference, "Same Day Surgery-1981". Atlanta, GA: Author.

Brown, B.R. (1978). Outpatient Anesthesia. Philadelphia: F.A. Davis.

Field, P.A., & Morse, J.M. (1985). Nursing Research: The Application of Qualitative Approaches. Rockville, Maryland: Aspen Systems.

- Good, R.C. (1982). Guide to Ambulatory Surgery. New York: Grune & Stratton.
- Joint Commission on the Accreditation of Hospitals. (1986). AMH/87: Accreditation manual for hospitals. Chicago, IL: Author.
- Kassity, K.J. (1982). Manual of Ambulatory Surgery. New York: Springer--Verlag.
- Kroft, R. & Greenberg, J.A. (1984). Case studies of market and medical staff analysis. Strategic Analysis for Hospital Management. Rockville, MD: Aspen Systems. (pp. 232-257).
- Mauldin, B. C. (1983). Ambulatory Surgery: A Guide to Perioperative Nursing Care. New York: Grune & Stratton.
- O'Donovan, T.R. (1976), Ambulatory Surgical Centers Development and Management. Germantown, MD: Aspen Systems. (pp. 5-6)
- Treece, E.W., & Treece, J.W. (1973). Elements of Research in Nursing. Saint Louis: C.V. Mosby.
- Wolcott, M.W. (1981). The surgical ambulatory care unit--Planning, organization, and management. In M.W. Wolcott (Ed.) Ambulatory surgery and the basics of emergency surgical care. Philadelphia: J.B. Lippincott.
- Wong, H. (1985). Socio-economic factbook for surgery. Salt Lake City: American College of Surgeons.

Government Publications

U.S. General Accounting Office. (1985). Implementing outpatient surgery programs in military hospitals can reduce DOD's health care costs. (GAO/HRD-85-23). Washington, DC: Author.

Health Services Command. (1986, July). The workload management system for nursing: Patient acuity system. San Antonio, TX: Author.

Pamphlets

Harbison, R.J. (Fall 1986). For Your Good Health. Abington, PA: Abington Memorial Hospital.

Unpublished Research Reports

McNeill, J. (1981). Considerations for an Ambulatory Surgery Program.

McNeill, J. (1981). A marketing analysis for an ambulatory surgical clinic at Darnall Army Community Hospital, Fort Hood, Texas.

McNeill, J. (1982). A marketing analysis to determine the consumer demand for ambulatory surgery at Darnall Army Community Hospital, Fort Hood, Texas.

Koehler, H.C. (1982). A study to determine the best approach for conducting a formal ambulatory surgery program at William Beaumont Army Medical Center. El Paso, Texas.

Ledford, G.L. (1982). Opening the ambulatory surgery center at Darnall Army Community Hospital: An application of the program evaluation and review technique (PERT). Fort Hood, Texas.

Jennings, B.L. (1982). Ambulatory Surgery Program Proposal.

Lenneville, M.W. (1981). Marketing of a military ambulatory surgical center.