CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

THE SHORT STAY SURGICAL CENTER
AN ANALYSIS

A thesis submitted in partial satisfaction of the requirements for the degree of Master of Health Science in

Health Services Administration

by

Bruce Francis Weber

June, 1974
The thesis of Bruce Francis Weber is approved:

Committee Chairman

California State University, Northridge

June, 1974
DEDICATION

To my parents. Their guidance, understanding, and counsel was, and is, indispensable.

And to Alma. Her patience gave me strength.
ACKNOWLEDGMENTS

My sincere thanks and appreciation to all those people who have helped in any way with the preparation of this paper. I especially wish to thank the employees, staff and administration of West Valley Community Hospital for their cooperation and assistance.

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ABSTRACT

THE SHORT STAY SURGICAL CENTER
AN ANALYSIS
by
Bruce Francis Weber
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The Short Stay Surgical Center at West Valley Hospital in
Encino, California, was incorporated into the hospital's services
package in an effort to provide efficient care along with maximum
cost savings to the patient and insurance company. The center is
also an attempt at providing a service that alleviates the anxiety
of the surgical patient who has to wait several days for surgery,
and at the same time utilization of the Short Stay Surgical Center
frees hospital beds for those patients who really need them.

This study investigates the operation of the Short Stay
Surgical Center (SSC) at West Valley Hospital. The analysis is
conducted from the standpoint of, and is limited to, the organization
and function of the center, the SSC patient, and selected financial
characteristics. The categories involved in this process are: type
of patient, patient origins, type and number of services provided,
cost of services, methods of reimbursement, and cost/charge relationship by service.

It was found that the Short Stay Surgical Center functions efficiently, treats primarily females 18–35 years of age, who usually pay cash, and that the center provides the hospital with good profits. In this respect, the center is viable and provides a necessary service for the community.
Chapter I

INTRODUCTION

The patient who has to wait several days or even weeks before undergoing surgery may find the waiting period filled with anxiety. He has time to consider the income he has lost while away from the job, the cost of the surgery, the inconvenience to his family and close friends while he is away from his home, and the pain and suffering he may have to go through. For the pediatric patient, separation from family for any significant amount of time may be somewhat traumatic.

The modern hospital has attempted to alleviate this situation somewhat through the establishment of outpatient departments. These departments are designed to procure treatment for certain patients whose care does not require an overnight stay in the hospital. This includes the surgical patient. Hospitals are becoming more specialized in the services they provide, and there is an increasing trend toward ambulatory care. This theoretically frees hospital beds for the more demanding patient, whose care is usually quite costly.

Although the outpatient is spared the cost of a hospital room and board charge, he is not without his problems. Miss Bette
Clemons, Head Nurse Coordinator for the Certified Hospital Admissions Program, Maricopa Foundation for Medical Care, Phoenix, Arizona, indicates that:

"Hospital efficiency is geared to the hospitalized patient. Outpatients requiring surgery never quite fit into the flow of hospital life."

Definitions

The following terms are used throughout this paper and are defined as follows:

Outpatient: a person who receives treatment at a hospital and is then released without an overnight stay in the hospital.

Inpatient: a person who receives treatment at a hospital and spends one or more nights in the hospital.

Minor Surgery: surgery of such a nature that it can be performed and not require the patient to stay overnight in the hospital unless complications occur.

Major Surgery: surgery of such a nature that its performance usually requires the patient to stay overnight in the hospital, even without complications.

Ambulatory Care: medical care delivered on an outpatient basis.

Short Stay Surgical Center: that portion of West Valley Hospital, Encino, California, that is specifically designed to accommodate the outpatient surgical candidate. It is assumed that all qualifying requirements for such a unit have been met. The Short Stay Surgical Center is integrated. That is, it is part of the West Valley Hospital system of services.
"Surgicenter": an autonomous center for the accommodation of the outpatient surgical candidate, located in Phoenix, Arizona. In this study, autonomous and independent are synonymous. That is, an autonomous unit is one located completely separate and apart from any hospital or other building.

MEDLARS: a computerized medical and health information system at the University of California, Los Angeles (UCLA).

Problem Statement

Hospitals are geared to provide major surgical and other services for the acutely ill patient requiring inpatient care. Outpatient departments are designed to provide services not requiring inpatient care for the ambulatory patient. The problem is that continuity of care is often lacking for the outpatient who requires minor surgery.

In the attempt to alleviate the frustrations of the patient requiring only minor surgery by introducing ambulatory patient care, there is an apparent loss of efficiency in some areas such as admissions, which produces a different type of frustration. Yet this type of patient should not have to suffer any inadequacies simply because he is not a major surgery candidate. If the outpatient surgery candidate received care in an autonomous facility or clearly delineated subsystem of the hospital services system, the outpatient would be spared the anxiety of "competing" for service in a system designed primarily for inpatient care.
The Surgicenter, in Phoenix, Arizona, is an attempt to solve this problem. The Surgicenter is autonomous, that is, completely separate from any other facility. The owner/inventors of the Surgicenter, John L. Ford, M.D. and Wallace A. Reed, M.D., indicate that there are several responsibilities which they hope to discharge with the Surgicenter concept. These responsibilities apply to ambulatory services in general. They are: "to make the ambulatory patient a matter of greater concern; to streamline the delivery of his medical services; to reduce the cost of his care; to work for a broadening of his insurance coverage."²

West Valley Hospital, a 153-bed general medical-surgical facility in Encino, California, has instituted its own answer to the problems of the minor surgery candidate. It is called the Short Stay Surgical Center (SSC).

Like the Phoenix Surgicenter, West Valley Hospital's SSC patients enjoy the economic advantages of less extensive laboratory, staff, and X-ray requirements, along with the elimination of the room and board charge. The psychological advantages, such as a shortened waiting period and reduced anxiety, are also similar. Unlike the Phoenix Surgicenter, however, the Short Stay Surgical Center at West Valley Hospital is not autonomous. It is an integrated part of the hospital's system and thus provides the patient with the added assurance that all hospital emergency services are available should he need them. The unit has been in operation since February, 1973.
Purpose

The purpose of this study is to analyze the operation of the Short Stay Surgical Center (SSC) at West Valley Hospital and to provide a data base for administration of the center.

The analysis of the SSC will provide data on three important aspects of operation as follows:

1. Patient characteristics, including age, sex, type of insurance coverage and religion.

2. Utilization of services, including type of surgery and number of patients in each category.

3. Selected financial characteristics, including reimbursement methods with number of patients and revenue per each method, cost/charge relationship for each service, and profit contribution per unit.

Categorical information is presented with the use of tables and illustrations for review and analysis. Figures are rounded at .5, and the format reference for all material in this study is William Giles Campbell, *Form and Style in Thesis Writing* (3d ed.; Boston: Houghton Mifflin Company, 1969).

Limitations

The study concerns itself only with West Valley Hospital's Short Stay Surgical Center, its patients and selected financial characteristics. The surgeon and anesthesiologist fees are not included in the hospital charges. Therefore, a complete cost/charge relationship cannot be presented at this time.
Methodology

Financial information was obtained through a review of payroll and expense schedules and after consultation with appropriate personnel in the controller's office. Patient information was obtained through a review of the Short Stay Surgical Center (SSC) records and the admitting documents for SSC patients. Medical Records and SSC admitting personnel were also consulted.

The investigation covers a period of six months from September, 1973 to and including February, 1974.

LITERATURE REVIEW

There are, literally, no articles on the Short Stay Surgical Center at West Valley Hospital. However, there are several articles on short-stay surgical departments, ambulatory surgery, and outpatient surgery. Many of the articles under these headings are not germane because they are limited to one specialty such as plastic surgery, pediatric surgery, or the effects of various types of anesthesia. Various other articles do deal with minor outpatient surgery, in either incorporated or individual units, and include the subject of major surgery on an outpatient basis.

A MEDLARS bibliography on short stay surgical departments was requested from the Reference Division, Biomedical Library, University of California at Los Angeles (UCLA). The files were searched for 27 months from January, 1972 through March, 1974, and covered 2,300 journals in the MEDLARS system. Twenty-four citations
were retrieved, see Appendix A. Following is a resume presentation of three of the more pertinent articles.

1) Burton S. Epstein, M.D. is Professor and Vice Chairman of the Department of Anesthesiology at George Washington University Medical Center, and Associate Director of Operating Rooms at George Washington University Hospital. He, along with his associates Charles S. Coakley, M.D. and Marie-Louise Levy, M.D., has written an article entitled "Outpatient Surgery: Guidelines for Organization of Unit and for Selection of Patient and Surgical Procedure." The article appeared in Hospitals Magazine September 1, 1973.

This is an excellent article based on actual experience, the data for which were collected at the George Washington University Medical Center, the University of California at Los Angeles, and the Surgicenter, an autonomous unit in Phoenix, Arizona.

The authors indicate three reasons for the development of outpatient surgery units:

"...reduction of medical care costs, increase in the availability of hospital beds for those who need them, and the opportunity to offer patients the same quality care administered to inpatients without such associated hazards as the disruption of the family unit and cross infection."

These reasons can apply to outpatient surgery in general and in fact do appear in various forms in many of the articles on this subject.

Doctor Epstein indicates that it is feasible for an outpatient surgery service to be included in an existing hospital organization. He advises separation of secretarial, waiting room, operating room,
and recovery room operations from inpatient functions of the same
nature in order to achieve efficiency in the use of these areas,
although he does suggest close proximity to the similar inpatient
services.

The outpatient set-up should consist of a receptionist area,
waiting room, dressing rooms, lockers, bathrooms, and recovery area.
The surgery schedule is coordinated with available space and personnel,
with the general anesthesia patients being scheduled early. As in
inpatient surgery, the surgeon selects the patient and schedules the
surgery.

"The prime consideration in selecting a patient is the
anticipated recovery period, during which minimal or no
post operative complications should be expected." 4

The article further indicates that the patient should agree
to short stay, be in good health, and that any systemic disease
should be under control. The operative procedure itself should be
short, 15 to 90 minutes, and involve minimal bleeding with minor
physiologic dysfunction.

In a section dealing with preparation of the patient, the
authors trace the patient flow from preoperative evaluation to the
recovery room.

Most preoperative evaluations are done in advance of ad-
mission, usually in the doctor's office. It is advisable to de-
termine if the patient has any abnormal conditions before admission.
Blood and urinalysis testing is essential, with additional tests
determined by the patient's age and physical status. The surgeon
explains all patient instructions.
The anesthesiologist is responsible for determining the most appropriate type of anesthesia for the qualified patient.

At the George Washington University Medical Center, the patient arrives 45 minutes before surgery. The receptionist confirms completion of all permits, lab, history and physical, and insurance information. The patient then enters the locker room to change and check all valuables, and is interviewed by the anesthesiologist at that time. The patient then walks to the operating room, or is taken by stretcher if he has been premedicated. When the patient awakens after surgery, he is asked to sit in the stretcher, then in a chair, to drink fluids, and finally to walk with and without assistance. The anesthesiologist determines the time of discharge -- when the patient can safely leave the hospital with a responsible adult.

With over 14,000 outpatient anesthetics administered, there have been no deaths, and only 1% of the outpatient surgical population required inpatient hospitalization.

"In conclusion, physicians experienced in outpatient surgery advocate its use because: 1) Patient response is enthusiastic. 2) The cost to the patient or insurance carrier usually is half that of inpatient surgery and recovery. 3) Hospital beds are available for those who need hospitalization. 4) There is less disruption of the family unit and less exposure to contamination. 5) The risk of serious complications is negligible."

2) Susan M. Rockwell, R. N. is Associate Editor of R. N. Magazine, in which her article entitled "Surgicenter: The One-day Surgical Facility" appeared in the March, 1972 issue. (See Appendix B for selected readings on the Surgicenter and outpatient surgery).
Miss Rockwell toured the Surgicenter in Phoenix, Arizona, and produced an excellent article dealing with the one-day life of one of its patients, while eliciting pertinent comments on the Surgicenter's function from its founders and operators, John L. Ford, M.D. and Wallace A. Reed, M.D.

When a surgeon decides to use the Surgicenter, one simple phone call will enable him to reserve operating room time, bed space, and even an anesthesiologist if needed.

When the patient arrives, the receptionist conducts the initial interview, obtaining necessary personal and billing information and the $15.00 deposit. The patient then goes to the post-anesthesia recovery (PAR) room where he is greeted by the PAR nurse, who then performs the initial medical interview, checking height, blood pressure, pulse, blood, weight, urine specimen (which the patient has brought with him), and does a finger prick for hematocrit. The anesthesiologist then does the admit evaluation. All information is recorded in triplicate directly into the patient's chart and billing record.

The patient then is issued disposable slippers and gown. Storing his personal items under his stretcher, he awaits the arrival of his physician. If the patient is a child (1.5% are), the mother is asked to stay during pre and post op periods.

The anesthesiologist again speaks with the patient, and administers a light anesthetic. The patient usually awakens 5 to 15 minutes after surgery, and follows a progressive recovery routine.
in the postanesthesia recovery (PAR) room. The anesthesiologist discharges the patient and dictates the discharge summary. The patient leaves the Surgicenter only with a responsible person, and receives a follow-up phone call from the PAR nurse within 1 or 2 days.

The charge for most procedures is $95.00, which includes most tests but not the professional charges. The center treats 12 to 25 patients per day.

Surgicenter itself consists of 3 operating rooms, 1 cystoscopy room, and one 12-bed postanesthesia recovery (PAR) room. There are 6 nurses in the operating area and 3 in the PAR room, with one nurse circulating in each room. Two male assistants perform all remaining necessary functions.

By eliminating some hospital features, the Surgicenter was planned to keep costs down. Doctor Reed indicates that:

"Since explosive anesthetics aren't used, conductive flooring and special wiring weren't necessary. Use of disposable linens erased the need for a laundry. Lab studies are confined to those done with DIP-STIX eliminating the need for a laboratory full of expensive equipment. Any elaborate diagnostic studies are taken care of by the physician before the patient arrives."6

Another factor of low cost is the regular operating schedule of the facility, from 7:00 a.m. to 4:30 p.m. Monday through Friday only.

Miss Rockwell closes her article by noting that the Surgicenter is helping patients profit physically and financially from the advances in medicine.
3) This final selection deals with major outpatient surgery, the next logical step for outpatient surgery. The article indicates that such a step is possible because such a system does, in fact, now exist.

The article, "Major Outpatient Surgery," in the November 24, 1974 issue of The Lancet, explains in detail the operation of a unit for the management of major surgical operations on an outpatient basis. The article is based on the operation of the system at the General Surgery Unit, Western General Hospital; Department of Clinical Surgery, University of Edinburgh; and Community Nursing Service, Edinburgh Northern Division.

The system has been in actual operation since 1969. The lubrication for the system is a close cooperation between hospital staff, general practitioner, and the district nurse, see Appendix C for a full commentary on the system and its operation.

Such a system, transferring responsibility for post-operative care from the hospital to general practice, and based on close liaison between hospital and community health services, is bound to have repercussions.

The article indicates that the hospital nurse feels the rise in work-load, since most of the less dependent patients have been removed from the hospital, and care has increasingly focussed on the elderly, more dependent patient. Hospital stay lengthens with a fall in the turnover of patients.

The surgeon also feels the effects of the change. He is required to make a detailed analysis of the patients he intends to
recommend for major surgery on an outpatient basis. This involves much more paperwork, and is acceptable to the surgeon only when he has time for such work.

A much greater proportion of major procedures has a definite effect on staffing and materials management. The recovery room and intensive care facilities also are affected.

Finally, the laboratory and radiology departments experience increased demand from the outpatient department and from the ward where more critically ill patients are treated.

The article does point out, however, that such a system is not the cure for the long inpatient waiting line. But the advantages to the healthy surgical patient are part of the intrinsic merits that make the plan for major outpatient surgery viable.

"Thus outpatient surgery as a system should not be viewed as a means of reducing the hospital costs or of lightening the surgical load. It does neither. It will be quite unacceptable to the majority of surgeons unless its consequences are appreciated and it is accompanied by a greater concentration of resources where they are needed for the care of the seriously ill patient. In other words, there must be simultaneous and complementary development of community and hospital services."7

SUMMARY

The institution of the outpatient surgical department by many hospitals is an attempt to alleviate the anxiety producing and somewhat frustrating waiting period for the minor surgical candidate, especially the pediatric candidate. The Surgicenter in Phoenix is one example of an independent outpatient surgical care center.
The Short Stay Surgical Care Center in West Valley Hospital, Encino, California, is an integrated outpatient surgical care center.

The literature review indicates that, in theory and practice the outpatient surgery department is a viable concept, regardless of whether the system is integrated or autonomous. Implications for outpatient major surgery do exist.

This study investigates the operation and function of the Short Stay Surgical Center based upon actual operating data accumulated for the second six-month period of operation.
Chapter II

THE SHORT STAY SURGICAL CENTER

The health care needs of the community must be provided for as efficiently and economically as possible. An ambulatory surgical care center is one attempt at providing such care. If the unit is integrated, as is West Valley Hospital's Short Stay Surgical Center, then the economics of fuller utilization of the rest of the hospital facilities are expected.

In this chapter the organization and function of the unit at West Valley Hospital will be described.

ORGANIZATION

The Short Stay Surgical Center provides individualized care to those patients who qualify for admission to the unit. The physician decides whether or not the patient is a candidate for short stay surgery. Usually the decision is based on the general health of the patient, his ability to recover quickly from light anesthesia and the type of surgery involved. There are 129 surgical procedures that qualify for short stay, see Appendix D. The major surgical categories are: Ear, Endoscopy, Nose and Throat, Eye, General Surgery, Gynecology (GYN), Neurosurgery, Orthopedic,
Plastic Surgery, Urology, Dental, and some special charge procedures such as face lifting. The procedures involved are usually too extensive to be performed in the physician's office, yet do not require an overnight stay in the hospital. As anesthesia and surgical techniques become more sophisticated, the list will expand.

In an unpublished report by Ms. J. Zanicchi, Short Stay Surgical Center Admitting Secretary, the philosophy of the unit is presented, along with statistical information. She reports:

"The purpose of the Short Stay Surgical Center is to eliminate the overnight stay, cut medical costs to the benefit of both the patient and the insurance company, assure the ambulatory surgical patient that his surgical condition is minor, thereby reducing anxiety. It provides the hospital facility with the ability to utilize space and serve more patients in the unit due to a rapid recovery and discharge of the patient."8

Ms. Zanicchi indicates that insurance companies approve of the 30 to 50% reduction in medical care costs for the qualified patient. She reports that insurance companies are making payments provided that the procedure is surgical and cannot be performed in the physician's office. Expenses related to certain conditions such as pregnancy are reimbursable to the extent of specific policy coverages.

Consistent with the economic philosophy of reducing cost to the patient, the integrated unit at West Valley Hospital utilizes the hospital operating room and staff, and has at its disposal all in-patient facilities. The unit itself is not designed as an emergency center, but it does have its own emergency equipment, see Appendix E, and access to the emergency systems of the hospital.
The Short Stay Surgical Center is organized so that the patient has contact only with those persons who are directly involved with his care. Such personnel are identified by light blue uniforms. Ms. Zanicchi further reports:

"Since its opening day on February 12, 1973 to September 30, 1973, 850 patients have been treated in the Short Stay Surgical Center, 10% of which were children under 10 years of age. Of the 850 patients 17 were transferred to the floor (5 of which were at patient request)."

The unit itself is organized to provide maximum convenience to the patient. It is deliberately designed to eliminate the usual sterile hospital atmosphere because the patient is not ill in the true sense of the word. In fact, the patient must be physically healthy to be considered a short stay candidate. As a further convenience, the unit is open from Monday through Friday, 6:00 a.m. to 6:00 p.m.

FUNCTION

The Short Stay Surgical Center functions on a 12 hour day. Surgical procedures are done from 7:30 a.m. to 3:30 p.m. only, with the last patient being discharged by 6:00 p.m. when the unit closes. All patients are preadmitted within 72 hours prior to surgery, between 9:00 a.m. and 12 noon and again between 1:00 p.m. and 4:00 p.m., see Appendix F for the Manual of Operations.

Patient history and physical examinations are required before the anesthetic is administered. The patient is advised to arrive
at least one and one-half hours prior to surgery, with no oral in-
take for the previous eight hours.

Procedures are booked on an hourly schedule, with one hour
procedures starting at 7:30 a.m., but no earlier than 11:00 a.m.,
see Appendix C for patient admission instructions.

An anesthesiologist is available on the premises until
all patients have been discharged. Patients are discharged to the
care of a responsible person after they have reached a stable con-
dition. All physician, surgeon and anesthesiologist charges are
separate from the hospital charges, see Chapter IV.

Census Comparisons

The Short Stay Surgical Center (SSC) census generally has
followed the trend of the inpatient hospital census, but has ex-
perienced greater fluctuation. It can be seen on the comparative
census graph, Illustration 2.1, that normal seasonal fluctuation
has occurred in both census recordings; a slight elevation for
October and November, preceding the Christmas season, with a drop
during December, and a gradual increase through January and February.

The average hospital census over the six months in
question was 69 patients per month, with a high of 73 patients and
a low of 58 patients. The SSC census during that period averaged
91 patients, with a high of 116 patients and a low of 73 patients.
It is obvious that the Short Stay Surgical Center is experiencing
a high utilization rate as compared to the inpatient facilities at
West Valley Hospital.
ILLUSTRATION 2.1

SSC AND HOSPITAL INPATIENT CENSUS WITH AVERAGE
SUMMARY

The Short Stay Surgical Center at West Valley Hospital provides a relatively high degree of personalized care to the patients who qualify for admission. The unit is highly organized and functions efficiently, providing economies connected with the utilization of hospital resources. Utilization of the service is generally high as compared to inpatient utilization, which would indicate a high degree of physician and patient acceptance of the relatively new service.
Chapter III

THE SHORT STAY SURGICAL PATIENT

Of critical importance to the operation of any business are its customers. Without them, there is no income or profit. In this respect, hospitals are just like any other business. They exist to serve the doctors and patients. The patients, in paying their bills, provide one of the major sources - if not the only source - of dollar income. Without the patient, hospitals could not function.

There are many reasons for adding a new service to a hospital routine. Of great importance are patient convenience and economy. Patient utilization of a new service reflects the degree of acceptance of that service by both doctors and patients. In this respect, the service must be tailored to the needs of the patients involved.

The analysis of patient utilization provides data on patients by age, sex, type of services received, method payment, religious affiliation and patient origin. This data enables administration to identify the equipment, personnel and physical needs of the new service.
Chapter III describes patient origins, characteristics, and general utilization patterns.

PATIENT ORIGINS

Patient origin data delineates the hospital's service area, and the socio-economic characteristics of the service area.

Data on patient origin within a radius of 0 to 22 miles from West Valley Hospital is presented in three tables. The first table, 3.1, pg. 23, is an alphabetical listing by city, the second, 3.2, pg. 24, is a rank-order by number of patients, and the third, 3.3, pg. 25, is a rank-order by distance from the hospital. Only those cities with 10 or more patients are listed. There are data on 422 patients, or 77% of the total 545 patients receiving service during the period covered by the study.

The tables illustrate that there are 14 cities out of 68 that have 10 or more patients originating from them. There are 5 cities with 10 to 19 patients, representing 36% of the cities, and 4 cities in the 30-39 patient category, adding another 29%, together covering 197 (47%) patients (65 and 132 patients, respectively).

There are 12 cities in the 0 to 10 mile range, or 86% of the 14 cities, covering a total of 383 (91%) patients. Canoga Park and Van Nuys are the largest contributors with 66 patients each.

As indicated, there are 14 out of 68 cities contributing 10 or more patients. In the remaining 54 cities, classified as "Other", 
### TABLE 3.1

Patient Origins---Alphabetical by City

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Patients</th>
<th>% of Patients</th>
<th>Miles from Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canoga Park</td>
<td>66</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Chatsworth</td>
<td>10</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Encino</td>
<td>25</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Hollywood - North</td>
<td>38</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>27</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Northridge</td>
<td>33</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Reseda</td>
<td>31</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Sepulveda</td>
<td>14</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Sherman Oaks</td>
<td>30</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Simi</td>
<td>12</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Studio City</td>
<td>10</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Tarzana</td>
<td>19</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Van Nuys</td>
<td>66</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Woodland Hills</td>
<td>41</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>422</strong></td>
<td><strong>100</strong></td>
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</table>
TABLE 3.2
Patient Origins--Rank Order by Patients

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<th>Area</th>
<th>Number of Patients</th>
<th>% of Patients</th>
<th>Miles from Hospital</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Studio City</td>
<td>10</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Simi</td>
<td>12</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Sepulveda</td>
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<td>5</td>
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<tr>
<td>Tarzana</td>
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</tr>
<tr>
<td>Encino</td>
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</tr>
<tr>
<td>Los Angeles</td>
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</tr>
<tr>
<td>Sherman Oaks</td>
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</tr>
<tr>
<td>Reseda</td>
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</tr>
<tr>
<td>Northridge</td>
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<td>7</td>
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<tr>
<td>Hollywood - North</td>
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<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Woodland Hills</td>
<td>41</td>
<td>10</td>
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<tr>
<td>Canoga Park</td>
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<td>Van Nuys</td>
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<td><strong>Total</strong></td>
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### TABLE 3.3

Patient Origins--Rank Order by Distance

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<th>% of Patients</th>
<th>Miles from Hospital</th>
</tr>
</thead>
<tbody>
<tr>
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<td>25</td>
<td>6</td>
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<tr>
<td>Sherman Oaks</td>
<td>30</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Tarzana</td>
<td>19</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Van Nuys</td>
<td>66</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Reseda</td>
<td>31</td>
<td>7</td>
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</tr>
<tr>
<td>Studio City</td>
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<td>4</td>
</tr>
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<td>14</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
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<td>38</td>
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<td>Woodland Hills</td>
<td>41</td>
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<td>7</td>
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<tr>
<td>Canoga Park</td>
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<td>8</td>
</tr>
<tr>
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<td>10</td>
<td>2</td>
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</tr>
<tr>
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<td>3</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>422</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>
there are 6 cities without mileage information. These cities represent only 9 patients, or 1.65% of the total patients.

Table 3.4, pg. 27, indicates that 530 patients (97%) came from within 60 miles of the hospital.

In summary, the major portion of the Short Stay Surgical Center service area has been shown to be within a 22 mile radius of the hospital, with Van Nuys and Canoga Park the largest contributing cities with 66 patients each.

PATIENT CHARACTERISTICS

The patient characteristics included in this study are: age, sex, type of insurance coverage*, utilization by type of surgery (which will be discussed in the next section of this chapter), and the number of patients in the four major religious categories as listed on the admitting form which are: Catholic, Jewish, Protestant, and None. Patient racial characteristics are not available. Patient characteristics are summarized in Table 3.5, pg. 28.

Table 3.5 shows that the patients are predominantly female (82%). Of these females, those 18-35 years of age have the highest utilization record. There are 272 females in the 18-35 years age bracket which is 92% of all females and 54% of the total 545 patients.

*As noted on the admitting form: (C) designates MediCal, (M) MediCare, (B) Blue Cross, (O) Cash, and (X) Other.
**TABLE 3.4**

Number of Cities by Miles and Patients

<table>
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<th>Number of Patients</th>
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### TABLE 3.5

**Patient Characteristics by Month and Category**

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<td></td>
<td>545</td>
<td>127</td>
<td>106</td>
<td>91</td>
<td>86</td>
</tr>
</tbody>
</table>
Highest utilization rates are experienced during October and November. The most frequent mode of payment is cash—321 patients (59%), followed by MediCal—124 patients (23%).

As for religious preference the predominant religion is Catholic. The four major religious categories cover 410 patients, or 75% of the total, and are broken down as follows: Catholic (C)—127 patients, 23%; Jewish (J)—106 patients, 19%; Protestant (P)—91 patients, 17%; and None (N)—86 patients, 16%. The remaining 21 categories are classified as "Other".

In summary, the typical Short Stay Surgical Center patient is an 18–35 year old Catholic female who usually pays cash.

UTILIZATION

Utilization of a service is one indication of the need for that service and indicates also the boundaries of the service. In the case of an ambulatory surgical center, it is important to know which specialty of surgical medicine is more prominent in its use of the facilities. One would expect a corresponding pattern of service utilization which is borne out by the data from the Short Stay Surgical Center at West Valley Hospital. As shown, in Table 3.6, pg. 30, most patients are female and the predominant type of surgery is "female" surgery, usually performed by a gynecologist.

Of the eight surgical categories, therapeutic abortion (TAB) is the most frequently performed procedure, followed by the general surgery category, and then gynecological (GYN) surgery. The remaining 5 categories are extremely low in utilization, almost to the
TABLE 3.6

Utilization by Service and Age-Sex Characteristics

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<th></th>
<th>Tot</th>
<th>Surg</th>
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<td>110</td>
<td>4</td>
<td>14</td>
</tr>
</tbody>
</table>

30.
point of being insignificant. The three major categories of surgery represent 87% of the total surgeries performed during the six month period in question: 198 TAB's--36%, 147 General Surgeries (all specialties)--27%, and 130 GYN surgeries--24%.

For a specific breakdown of the types of surgery performed, and to illustrate the trends more clearly, consider the 190 total surgeries performed in September and October, 1973. Of these, 79 (42%) are therapeutic abortions (TAB), 52 (27%) are dilatation and curettage (D&C), and there are 31 (16%) "Other" individual surgeries. The remaining 28 surgeries are divided as follows: cystoscopy--8, bilateral inguinal hernia--7, breast biopsy--4, right inguinal hernia--3, bilateral blepharoplasty--2, excision bartholin cyst--2, and strabotomy, O.U.--2.

The three major categories--TAB, D&C, and "Other"--represent 85% of the 190 surgeries. Female surgery is predominate in the pattern of service utilization.

Of the total surgical population of 545, only 17, or 3%, were admitted as inpatients. This includes those patients who attended the Short Stay Surgical Center for lab work only before major surgery, those patients who requested to be transferred to the inpatient services, and finally those patients who experienced complications during surgery or recovery. This 3% figure seems insignificant when compared to other outpatient surgical facilities that average approximately 1% admission to inpatient facilities just from surgical or recovery complication.
In summary, therapeutic abortions (TAB) and dilitation and cutterage (D&C) are predominant in the pattern of utilization of the Short Stay Surgical Center. This corresponds with the patient characteristics data which has shown that females are the most frequent users of the service.

SUMMARY

Important in any planning process, patient origins reveal the hospital service area, which gives an indication of the total population that might be served by the hospital.

Canoga Park and Van Nuys are the largest contributing cities, each with 66 patients. There are 14 major contributors out of a total of 68 cities involved. These 14 cities range from 0 to 22 miles from the hospital, and cover 422 (77%) patients. It is noted that 530 patients (97%) come from within 60 miles of the hospital. The target city of Encino contributed 25 patients in the six month period from September, 1973 to and including February, 1974.

Only 3% of the total outpatient surgical population were admitted to inpatient services for medical and other reasons.

With a generally high utilization rate as compared with that of inpatient services, the Short Stay Surgical Center shows definite trends toward surgical procedures on females in the 18 - 35 year old category. Of the 190 surgical procedures surveyed for September and October, 1973, almost 70% were in the categories of dilitation and cutterage (D&C) and therapeutic abortion (TAB).
An exact correlation between the age/sex and type of surgery classifications has not been established because of the predominance of female surgery in the pattern of utilization.
Chapter IV

FINANCIAL CHARACTERISTICS

Since dollar income is important in the operation of any business, including the hospital business, it is important to know the source of the income. In hospitals, the patient, like the customer, is the primary source of income. But it is important to know whether the patient pays by cash, or the hospital is reimbursed on his behalf by state or federal programs such as MediCal and MediCare, or from the patient's own "private" insurance company.

Chapter IV describes the method of reimbursement from the Short Stay Surgical Center patient, the revenue per each reimbursement method, and the charge/cost relationship for the service.

REIMBURSEMENT METHOD

Hospitals deal with both direct and indirect methods of reimbursement. Direct reimbursement is a cash payment to the hospital by the patient in the form of a deposit upon admission, or a payment upon discharge. The indirect method is payment made to the hospital by an intermediary source, usually after the service has been provided. The most common third party payers are the Federal...
MediCare Program, the State MediCal Program, Blue Cross, or any other insurance coverage the patient may have.

Table 4.1, pg. 36, is a simple listing of the various sources of reimbursement that the hospital has utilized for its short stay patients, and the number of patients in each category.

Cash payment is the most frequently used method of reimbursement with 312 patients (59%), followed by MediCal with 124 patients (23%), then private insurance with 73 patients (13%), and finally Blue Cross with 27 patients (5%). There are no MediCare patients.

Table 4.2, pg. 37, is a listing of the percentage of total each reimbursement method is of the total for that month.

REVENUE PER REIMBURSEMENT METHOD

Table 4.3, pg. 38, is a listing of the dollar amounts of gross revenue from each reimbursement method. The total dollar amount of revenue for each month is shown in the table at the bottom of each column for that month. Gross revenue figures for the entire six month period are shown in the "Total" column at the left of the table. The Cash and MediCal reimbursement methods produce the highest amount of dollar revenue.

Table 4.4, pg. 39, is a statement of percentage of revenue and revenue dollar amounts per each reimbursement method over the entire six month period. The gross revenue figure is at the bottom of the right hand column "Revenue Dollar Amount".
### TABLE 4.1

NUMBER OF PATIENTS PER REIMBURSEMENT METHOD

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid (C)</td>
<td>26</td>
<td>27</td>
<td>40</td>
<td>21</td>
<td>6</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Medicare (M)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Blue Cross (B)</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>Cash (O)</td>
<td>53</td>
<td>69</td>
<td>57</td>
<td>40</td>
<td>49</td>
<td>53</td>
<td>321</td>
</tr>
<tr>
<td>Other (X)</td>
<td>4</td>
<td>5</td>
<td>14</td>
<td>17</td>
<td>14</td>
<td>19</td>
<td>73</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>105</td>
<td>116</td>
<td>82</td>
<td>73</td>
<td>84</td>
<td>545</td>
</tr>
</tbody>
</table>
# TABLE 4.2

PERCENTAGE REIMBURSEMENT METHOD (in %)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MediCal (C)</td>
<td>31</td>
<td>25</td>
<td>35</td>
<td>25</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>MediCare (M)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Blue Cross (B)</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Cash (O)</td>
<td>62</td>
<td>66</td>
<td>49</td>
<td>49</td>
<td>67</td>
<td>63</td>
</tr>
<tr>
<td>Other (X)</td>
<td>5</td>
<td>5</td>
<td>12</td>
<td>21</td>
<td>19</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
## Table 4.3
Dollar Revenue per Reimbursement Method (in $)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MediCal</td>
<td>949</td>
<td>1383</td>
<td>1670</td>
<td>945</td>
<td>249</td>
<td>176</td>
</tr>
<tr>
<td>MediCare</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Blue Cross</td>
<td>61</td>
<td>221</td>
<td>191</td>
<td>189</td>
<td>186</td>
<td>316</td>
</tr>
<tr>
<td>Cash</td>
<td>1897</td>
<td>3650</td>
<td>2337</td>
<td>1852</td>
<td>2080</td>
<td>2211</td>
</tr>
<tr>
<td>Other</td>
<td>153</td>
<td>276</td>
<td>572</td>
<td>749</td>
<td>590</td>
<td>807</td>
</tr>
<tr>
<td>Total</td>
<td>3060</td>
<td>5530</td>
<td>4770</td>
<td>3780</td>
<td>3105</td>
<td>3510</td>
</tr>
</tbody>
</table>
**TABLE 4.4**

**GROSS REVENUE BY REIMBURSEMENT METHOD**

<table>
<thead>
<tr>
<th>Reimbursement Method</th>
<th>Number of Patients</th>
<th>Percent of Total</th>
<th>Revenue Dollar Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MediCal (C)</td>
<td>124</td>
<td>23%</td>
<td>$5464</td>
</tr>
<tr>
<td>MediCare (M)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Blue Cross (B)</td>
<td>27</td>
<td>5</td>
<td>1188</td>
</tr>
<tr>
<td>Cash (O)</td>
<td>321</td>
<td>59</td>
<td>14015</td>
</tr>
<tr>
<td>Other (X)</td>
<td>73</td>
<td>13</td>
<td>3088</td>
</tr>
<tr>
<td>Total</td>
<td>545</td>
<td>100</td>
<td>23755</td>
</tr>
</tbody>
</table>
Cash payments of $14,015, from both deposits and payments, represents the most popular reimbursement method as it is almost 60% of the $23,755 gross revenue.

CHARGE/COST RELATIONSHIP

The charge/cost relationship for the Short Stay Surgical Center at West Valley Hospital is very basic, and yet quite interesting. There are only 2 admitting clerks, 1 Registered Nurse, and 1 Licensed Vocational Nurse assigned to the Short Stay Surgical Center (plus assigned personnel as needed) on a permanent basis. Since the center is integrated within the hospital itself, the hospital operating and recovery rooms, and their personnel are utilized for short stay patients. There is no meal charge, and no room and board charge. There are no other expense allocations made. Therefore, the only expenses involved in operating the center are payroll and supplies. Table 4.5, pg. 41, illustrates the revenue from charges and the cost of operation relationship. It should be noted that there is a $95.00 surgery charge which applies regardless of the specialty area the surgery involves. Therefore, no category of revenue by surgical service is possible. Table 4.5 shows a net profit of $13,574.

The Short Stay Surgical Center at West Valley Hospital requires, as part of its admitting procedure, a deposit of $150. This is broken down as follows: laboratory--$10; holding room--$45; and surgery--$95. This usually covers the amount of the hospital portion
TABLE 4.5

CHARGE/COST RELATIONSHIP WITH STATEMENT OF PROFIT OR (LOSS) (in $)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payroll</td>
<td>1884</td>
<td>1598</td>
<td>1386</td>
<td>1361</td>
<td>1332</td>
<td>1477</td>
<td>9038</td>
</tr>
<tr>
<td>Supplies</td>
<td>232</td>
<td>272</td>
<td>338</td>
<td>71</td>
<td>111</td>
<td>119</td>
<td>1143</td>
</tr>
<tr>
<td>Other Allocated Expenses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gross Expense</td>
<td>2116</td>
<td>1870</td>
<td>1724</td>
<td>1432</td>
<td>1443</td>
<td>1596</td>
<td>10181</td>
</tr>
<tr>
<td>Gross Revenue</td>
<td>3060</td>
<td>5530</td>
<td>4770</td>
<td>3780</td>
<td>3105</td>
<td>3510</td>
<td>23755</td>
</tr>
<tr>
<td>Total Profit or (Loss)</td>
<td>944</td>
<td>3660</td>
<td>3046</td>
<td>2348</td>
<td>1662</td>
<td>1914</td>
<td>13574</td>
</tr>
</tbody>
</table>
of the bill, but does not include professional fees for the surgeon or anesthesiologist. As noted earlier, there is a policy of allocating only payroll and supplies expense to the Short Stay Surgical Center. Together, these practices establish a relationship between revenues, expenses, and profit contributions. Table 4.6, pg. 43 carries this illustration one step further by picturing the contribution to profit on a gross and per unit basis. The total relationship is further exposed by performing this analysis on the high census month of November, 1973, and again on the low census month of January, 1974, and the total for the six month period.

Table 4.6 shows that the overall contribution to profit of each procedure for the six month period averages $25, or $13,574 for the 545 procedures. This per unit figure quite naturally drops to $23, or $1,622 total for the low census month, and jumps to $26, or $3,046 for the high census month. These figures are obtained by dividing the number of patient days (when one patient spends one night in the hospital, one patient day is generated) into the dollar amount involved, and then subtracting the expenses from revenues to obtain the contribution figure.

Break-even Analysis

The relationship between revenues and expenses has been illustrated, along with the contribution to profits that this relationship produces. There remains only one question. How many procedures, according to this preestablished relationship are necessary to perform on a monthly basis to produce zero profit, that is to break even.
<table>
<thead>
<tr>
<th></th>
<th>November 1973</th>
<th>January 1974</th>
<th>6 Month Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Days (#)</strong></td>
<td>116</td>
<td>73</td>
<td>545</td>
</tr>
<tr>
<td><strong>Gross Expense ($)</strong></td>
<td>1724</td>
<td>1443</td>
<td>10181</td>
</tr>
<tr>
<td><strong>Gross Revenue ($)</strong></td>
<td>4770</td>
<td>3105</td>
<td>23755</td>
</tr>
<tr>
<td><strong>Gross Contribution ($)</strong></td>
<td>3046</td>
<td>1662</td>
<td>13574</td>
</tr>
<tr>
<td><strong>Expense per Unit ($)</strong></td>
<td>15</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td><strong>Revenue per Unit ($)</strong></td>
<td>41</td>
<td>43</td>
<td>44</td>
</tr>
<tr>
<td><strong>Contribution per unit ($)</strong></td>
<td>26</td>
<td>23</td>
<td>25</td>
</tr>
</tbody>
</table>
The equation to be used for break-even analysis is as follows: "Sales equal Variable Expenses plus Fixed Expenses plus Net Profit." This equation deals with the relationship between revenues and expenses. Let \( X \) equal the number of procedures needed to break even.

Translating this formula into terms that fit this particular situation, we have Sales Price per Unit equal Supplies Expense per Unit plus Payroll Expense per Month plus Net Profit, which will be zero. Therefore,

\[
150X = 2X + 1506 + 0
\]

\[
148X = 1506
\]

\[
X = 10
\]

This shows that in this particular situation, with the relationship between revenues and expenses as defined, and only for the six months in question, only 10 procedures per month needed to be performed to obtain zero profit, that is, to break even. The Short Stay Surgical Center averaged 91 cases per month.

**SUMMARY**

The Short Stay Surgical Center at West Valley Hospital appears to be doing well from a financial standpoint. The primary source of patient revenue is in the form of cash.

Because of its integrated relationship with the hospital, costs that would otherwise be allocated to the center are not allocated, primarily because those costs would normally be in operation
to serve the hospital inpatients. The overall effect of such a policy is to leave only the cost centers of payroll and supplies to relate to the Short Stay Surgical Center. Table 4.5, pg. 41, indicates that there is a net profit for the six month period of $13,574, and Table 4.6, pg. 43, shows a service unit contribution to profit of $25 under these conditions.

There is a $150 deposit required, which incorporate a $95 surgery charge, a $45 holding room charge, and a $10 laboratory charge. Under these conditions, break-even analysis indicates that the center, which averaged 91 cases per month, needed to handle only 10 cases per month to break even. This type of break-even analysis may be unrealistic because of the policy of allocating only supply and payroll expenses to the operation of the Short Stay Surgical Center.
Chapter V

SUMMARY

The otherwise healthy minor surgery candidate is a natural for surgery on an outpatient basis. This means that the patient would be discharged within a few hours after surgery. Theoretically this type of surgery has many advantages such as money savings to the patient, as well as anxiety reduction. The question is, can such surgery be performed on an outpatient basis rendering all these advantages, and providing the same quality of care as inpatient surgery.

West Valley Hospital has developed an integrated Short Stay Surgical Center (SSC). The center has been in operation since February of 1973, and has handled over 1000 patients.

This study analyzed the operation of the unit at West Valley Hospital. The study focused on an analysis of the operation and function of the Short Stay Surgical Center, the characteristics of the Short Stay Surgical Center patient, and selected financial characteristics, including the cost/charge relationship for the services provided. Data were obtained from: a review of the Short Stay Surgical admitting documents, and in some cases patient charts; and interviews with personnel in the Short Stay Surgical Center, Medical Records Department, and the Controller's office.
The Short Stay Surgical Center (SSC) operates on a 12 hour per day basis, Monday through Friday, and is organized to provide maximum conveniences to the patient. The unit utilizes the hospital inpatient surgery suites, recovery room, and appropriate personnel. SSC personnel include only 1 Registered Nurse, 1 Licensed Vocational Nurse, and 2 admitting clerks.

The patient is asked to arrive at least one and one-half hours before surgery so that the appropriate interviews and tests can be conducted. All patients are discharged by 6:00 p.m.

The results are that the center at West Valley Hospital provides highly personalized service, with the good organization and efficient functioning that results in dollar savings to the patient.

The patients themselves come to the unit from 68 different cities. There were 14 cities that provided 77% of the total patients during the period of this study, September, 1973, to and including February, 1974. The 14 cities ranged from 0 to 22 miles distance from the hospital. If the range is extended to 60 miles, 97% of the patients would be accounted for. The cities of Canoga Park and Van Nuys were the largest contributors with 66 patients each, and Encino itself contributed 25 patients.

The patients are predominantly Catholic females 18 to 35 years of age. The predominant procedures performed were therapeutic abortion (TAB) and dilatation and curettage (D&C), together totaling almost 70% of the procedures performed during a two month period September and October, 1973.
The Short Stay Surgical Center (SSC) averaged 91 patients per month which is a relatively high utilization when compared with the inpatient average of 68 patients per month. Seventeen (3%) of the 545 SSC patients were admitted to the hospital. This appears high since the average is usually around 1%, but it has not been determined exactly how many of these patients were admitted as a result of complications during or after surgery, and how many were admitted for other reasons.

The center appears to be financially stable. The primary source of revenue is cash. The only costs allocated to the Short Stay Surgical Center are payroll and supplies. Under these conditions, there accumulated a net profit for the six month period of $13,574, and a per unit contribution to profit of approximately $25.

The deposit required includes a $95 surgery charge, a $45 holding room charge, and a $10 laboratory charge, totaling $150. Considering the deposit as a sale price, and with the revenue/expense relationship defined, a break-even analysis, indicating only 10 patients per month were needed to produce zero profit, proved unrealistic because of the expense allocation policy. Illustration 5.1, pg. 49, is a summary of revenue and expense per month.

CONCLUSIONS

The analysis of data obtained indicates that the operation of the Short Stay Surgical Center at West Valley Hospital appears to be a viable process, in terms of cost of services, and it should be retained as part of the total service package offered by the hospital. It is
MONTHLY REVENUE AND EXPENSE
further concluded that the center provides a necessary service, of equal quality as compared to inpatient services, for the people of the surrounding communities.

RECOMMENDATIONS

1) Since the Short Stay Surgical Center does provide the hospital with a profit, the deposit fee of $150 need not be raised at this time.

2) In order to establish guidelines for the operation of the center, an appropriate break-even analysis should be performed.

3) Patient racial origins should be incorporated as a matter of routine admission information to aid future analysis of patient utilization.

4) The Short Stay Surgical Center charges and any additional professional fees should be combined for a future study to determine if the patient's total cost is competitive with similar services elsewhere.
FOOTNOTES


4 Ibid., p. 82.

5 Ibid., p. 84.


8 J. Zanicchi, (unpublished report on the Short Stay Surgical Center at West Valley Hospital, Encino, California, 1973), 1.

9 Ibid., p. 4.

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APPENDIX A

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APPENDIX B

SELECTED READINGS


APPENDIX C

MAJOR OUTPATIENT SURGERY
THE SYSTEM

The essentials are summarized as follows. A patient is selected for outpatient surgery on first referral to the consultant's clinic. Indeed outpatient management is sometimes suggested by the general practitioner when he refers the case. After medical assessment a range of investigations including urinalysis, full blood count, blood-urea, chest X-ray, and, in selected patients, electrocardiogram is arranged. The patient returns to a special screening clinic where history, physical examination, and the results of the tests are checked, and, if all is well, a suitable date for operation can be given to the patient at this visit.

The Queen's Institute of District Nursing (since May, 1973, the Community Nursing Service) is notified in advance. A district nursing sister visits the patient's home before the operation to discuss the arrangements. This visit has the important extra function of providing a check on the suitability of the home environment. The patient is also asked to get in touch with his or her own doctor before operation.

THE OPERATION

The fasting patient reports to the day-bed area at 8:30 a.m. and is seen by the surgeon on arrival. The major outpatient operations are placed at the beginning of the list, the remainder of which is made up of minor cases.

Most operations (67%) have been performed by the consultant-in-charge, the remainder under his supervision.

On the afternoon of operation, if there are no complications, the outpatient secretary telephones the general practitioner and the Community Nursing Service to confirm arrangements. The patient is discharged home by ambulance in the late afternoon, and thereafter is visited by the district nursing sister. On the first and second postoperative days the district nursing sister visits morning and evening or morning, afternoon, and evening, depending on the patient's needs. These visits are continued daily.

The patient on discharge is supplied with six 5 mg. tablets of phenaacine (Narphen) sublingual and a letter to the district nurse advising her of the nature of the operation, any special aftercare, the time for removal of sutures, and the follow-up appointment for 2 weeks thence. A copy of the operation note, complete with
advice on postoperative care, dictated and typed on the day of operation, is sent directly to the practitioner and the Community Nursing Service.

After operation the general practitioner is responsible for all medical care, although surgical advice and hospital facilities are readily available if required. Questionnaires completed by the doctor and district nurse are returned to the hospital. Patients are reviewed in the outpatient department 2-3 weeks after operation. A district nursing liaison officer visits the hospital twice weekly to exchange information and discuss any problems.
APPENDIX D

SURGICAL PROCEDURES AVAILABLE
EAR, NOSE AND THROAT

Adenoidectomy and Myringotomy
Antral puncture, with or without irrigation
Arch bars, removal
Closed reduction nose or zygoma
Inferior turinate fracture
Laryngoscopy
Myringotomy with or without tubes
Ostoscopy, with or without removal of foreign body
Nasal Polypectomy
Septal reconstruction, SMR
Ethmoidectomy
Rhinoplasty
Stapedectomy
Tympanoplasty
Wiring of fracture- jaw

ENDOSCOPY

Bronchoscopy
Cystoscopy
Cystoscopy and Retrograde
Esophagoscopy
Laryngoscopy
Protoscopy

EYE

Cataract
Chalazion
Discission
Ectropian and Entropian
Eye exam
Eye muscle operation
Iridectomy
Lacrimal duct probing
Prolapsed iris, excision
Pterygium
Insertion of glass tube into lacrimal duct
Reconstruction of lacrimal duct

GENERAL SURGERY

Baker's cyst, excision
Breast masses, excision biopsy only
Cervical node biopsy
Foreign body, removal of
Frenulectomy-tongue
GENERAL SURGERY cont'd.

Hemorrhoidectomy
Thrombotic hemorrhoidectomy
I & D abscess
Inguinal herniorrhaphy and femoral
Lipoma, excision
Muscle biopsy
Excision of draining sinus tract
Pilonidal cystectomy
Rectal polypectomy
Sebaceous cyst, excision
Skin lesions, excision (granuloma)
Thyroglossal duct cyst
Umbilical herniorrhaphy
Varicose vein ligation, with or without stripping
Fistulectomy

GYN

Bartholin cystectomy
Cervical amputation (Stermdorf)
Cryotherapy (alone)
Cryotherapy with biopsy and/or D&C
Culdoscentesis
Culdoscopy
D&C
Exam under anesthesia
Hymenotomy
Hysterosalpingogram
Laparascopy-diagnostic or sterilization
Cervical cone-hymenectomy
Perinorrhaphy
Removal IUD
Therapeutic abortion

NEUROSURGICAL

Carpal tunnel
Alcohol injection of nerve and coagulation of nerves for control of pain
Intercostal neurectomy
Excision of neuroma
Morton's neuroma
Ulna nerve release

ORTHOPEDIC

Arthroscopy
ORTHOPEDIC cont'd.

Closed reduction fracture, with x-rays
Bunion operation
Bursae, removal of (olecranon)
Carpal tunnel decompression
Closed reduction, without x-rays
Finger or toe nails, removal
Ganglion
Hammertoes with tenotomies and resection of bones
Hand surgery
Hardware, hip, removal
Kidney cannula, revision
Manipulation of joints
Manipulation of joints with x-rays
Metatarsal heads, excision
Morton's neuroma
Nerve repair
Phalangeotomy
Plantar wart, excision
Plate or screws, except hip, removal
Repair of medial ligament, knee
Stitches, removal
Tendon repair
Tenosynovectomy
Tenotomy, hand or foot
Open reduction fractures, without x-rays
Open reduction fractures, with x-rays
Cast change with x-rays
Excision of foreign body - granuloma
Exostosis, excision
Release of tendon sheath
Ulnar nerve repair

PLASTIC SURGERY

Augmentation mammoplasty
Blepharoplasty
Dermabrasion
Otoplasty
Rhinoplasty
Small scars, excision
Small tattoo, excision

UROLOGICAL

Circumcision
Cystoscopy
Cystoscopy and Retrograde
Dorsal slit
UROLOGICAL cont'd.

Meatotomy
Prostate, biopsy
Urethral dilation
Vasectomy

SPECIAL CHARGES

Cryotherapy, alone
Impacted wisdom teeth, removal
Modified face lift
Modified face lift combined with blepharoplasty
Cardioversion

DENTAL

Peridontal
Filling and Crowns
Extractions
APPENDIX E

SSC EMERGENCY SUPPLIES
DRUGS: EMERGENCY

- Adrenalin 1:1,000 (6 amps)
- Adrenalin 1:1,000 (1 vial)
- Aramine (3 10cc vials)
- Atropine (1 vial)
- Benadryl (2 50mgm. amps)
- Calcium Chloride (1 vial)
- Calcium Gluconate (1 vial)
- Cedilanid-D (4 amps)
- Decadron (1 vial)
- Digoxin (4 amps)
- Dilantin (1 vial)
- Ephedrine Sulphate (2 amps)
- Inderal (4 amps)
- Isuprel (4 amps)
- Lasix (4 amps)
- Levophed (4 amps)
- Lidocaine 2% (4 pre-loaded syringes)
- Novocaine 1% (1 vial)
- Phenobarbital (2 amps)
- Potassium Chloride (1 vial)
- Pronestyl (1 vial)
- Quinidine (1 vial)
- Solu-Cortef (2 vials)
- Tensilon (1 amp)
- Valium 10mgm. (2 amps)
- Vasoxyl (2 amps)
- Water for injection (1 vial)

I.V. Solution & Supplies
- 500 cc. 5% D/W
- 500 cc. 5% D/Saline
- Scalp Vein Needles (19, 21 & 23 g.)
- Intra-Cath's (S,M,L)
- Angio-Cath's
- Dual Injection Site
- 4-Way Adaptor
- "Y" Blood Tubing
- Blood Pump (2)
- I.V. Tubings
- Tourniquet

EQUIPMENT AND SUPPLIES

- Chest Board (1)
- Demand Valve (1)
- Syringes (all sizes)
- Needles (all sizes)
- Tape (all types and sizes)
- Oral-Pharyngeal Airways (all sizes)
- "S" Resusitation Airway
- Suction Catheters
- Levine Tubes (2 #16)
- Tonsil Tip Suction
- Defibrillator (1)
- Trach Tray (1)
APPENDIX F

MANUAL OF OPERATIONS
1. **HOURS OF OPERATION** - 6:00 A.M. to 6:00 P.M. Monday through Friday.

2. **SURGICAL PROCEDURES** - 7:30 A.M. to 3:30 P.M.

3. All patients are to be discharged from the Unit by 6:00 P.M. when the Unit will be closed.

4. All patients are to be preadmitted and have their preadmission laboratory work within 72 hours prior to surgery. Preadmission hours are 9:00 A.M. to 12:00 P.M. and 1:00 P.M. to 4:00 P.M., Monday through Friday.

5. All patients are to be thoroughly screened medically and are to be physically Class I or Class II under stable control. Those patients 50 years of age and over shall have the results of an electrocardiogram and chest x-ray performed within one month of the admission recorded on the chart. Those patients on diuretics will be required to have a preoperative potassium study.

6. All patients' laboratory work will be limited to a hemoglobin, white count and dipstick urinalysis. A differential will be performed if the blood white count is in excess of 10,000 or less than 5,000. A microscopic will be done if the stick urinalysis is abnormal. No extra laboratory procedures will be provided or ordered while the patient is in the Unit except as the result of an emergency problem. Procedures other than the above routine will be charged on an individual basis, whether done by the Lab or other departments.

7. Tissue pathology examination will be performed at an extra charge.

8. Procedures applicable to the SSC will be limited to those on the attached sheet. Unlisted procedures will be performed at the discretion of the Co-Chiefs of the SS Unit.

9. No routine X-ray examination will be performed while the patient is admitted to the Unit.

10. A pertinent history and physical examination will be required before the administration of an anesthetic. This will include: (1) Chief Complaint and Present Illness (2) Systemic Conditions (3) Allergies (4) Current medications. Physical Examinations will include: (1) An ENT examination (2) A cardiovascular examination (3) A pulmonary examination (4) An examination of the affected area.
11. The patients will arrive for admission a minimum of one and a half hours prior to surgery and will be required to be NPO for a minimum of eight hours prior to that.

12. Procedures will be booked and charged on an "hourly" rate.

13. Single "hourly" procedures will be booked starting at 7:30 A.M.

14. Two and three "hourly" scheduled procedures will be booked at 1:00 P.M. and 12 Noon and no earlier than 11:00 A.M.

15. All medications, including premedications, narcotics, sedatives, tranquilizers, but not limited to these, are to be given by or with the approval of the Anesthesiologist in charge.

16. An Anesthesiologist will be available on the premises until the last patient has been discharged from the SS Unit.

17. Patients requiring admission to the general hospital shall revert to the full fee schedules as of the time of transfer.

18. No food services will be provided for patients or visitors in the Unit except for vending machine service.

19. Personnel will be identified as members of the SS Unit staff by a distinctive uniform.

20. All charges made by physicians, surgeons and anesthesiologists are entirely independent of the hospital charges and are a matter for the patient and his physician.
APPENDIX G

PATIENT PREADMISSION FORM