GEORGIA VISION INSTITUTE REPORTS ON THE ADVANTAGES OF ORAL SEDATION FOR CATARACT SURGERY

Holly Fields, COA, COE

Brandon Meacham

Practice administrator Brandon Meacham, MBA, PPMC, CST tells how his ASC trialed different anesthesia modalities to determine best practices in improving patient comfort and reducing costs.

HF: How did you identify there was an issue with anesthesia workflows?

BM: Our surgery volume was increasing, and we were using PRN LPNs just to have extra hands to start IVs. We pulled people from other duties if there was a hard stick, since this was our only source of anesthesia, and we'd be at a standstill or have to skip the patient until we could get help.

HF: Tell us about your anesthesia "study."

BM: MKO melts are sublingual tablets consisting of Midazolam 3mg, Ketamine HCl 25mg, and Ondansetron 2mg. We would give the tablet to patients right after the consent process and it would kick in around 15 minutes later.

Other specialties were using Valium a lot. So, we started with 5mg of Valium and bumped up to a 10mg dose, given at least 30 mins before surgery. This seemed to be the sweet spot for most people.

The results for the MKO and the Valium were very similar with both beating out IV on patient discomfort level, anxiety level, and whether they felt adequately sedated. The Valium beat the MKO and IV with our older patient base: the caretakers really appreciated the patient not being completely "out of it" and being a fall risk for the rest of the day.

HF: What was the difference in cost per patient for each sedation method?

BM: We figured around $24/patient to do an IV based on just supplies and medication. MKOs were at $18.50/patient but outweighed the cost due to efficiency and painlessness. The Valium was only around $0.14/patient!

Averaging around 3,000 patients a year, IVs (not counting time, cost, and extra supplies for multiple sticks) would total around $72,000. MKO would be about $55,000, and Valium around $300.

HF: How did the study findings affect your staffing and workflows?

BM: We no longer had the need for PRN LPNs and were able to hire medical assistants to do a lot more of the pre-op work. The RNs would give patients the oral medicine. Around the time of the study, we were doing 15-18 cases a day; afterward, 22-24 cases a day.

HF: Any other pearls of wisdom for administrators looking to make this type of surgery-related shift?

BM: The key is having a "let's try it" attitude. Give your staff the ability to be vocal and change how you're talking about anesthesia. We tell patients, "We want you completely aware, able to communicate with us if something hurts, and able to follow instructions. We just want to take the edge off." *AE*

Holly Fields COA, COE (holly.fields@bannerhealth.com), is the Senior Director/Department Administrator of Ophthalmology at Banner University Medical Group in Tucson, AZ.

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FAST FACTS

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