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INSIDE

AHC Media

Growing number of elderly brings issues with LOS, readmissions

(Editor's note: In this first part of a two-part series on elderly patients, we discuss problems that cause delirium in and unanticipated hospitalization of seniors. In next month's issue, we discuss more specifics about the problems, as well as solutions from experts in the field.)

An elderly lumpectomy patient was supposed to change her gauze, but instead, she removed the sterile strips holding the wound closed. She had to return to the surgeon.[1] Another elderly ambulatory surgery patient was supposed to take four opioid pills a day, but she misunderstood and took four pills in an hour. She ended up in the emergency department.[1]

Reports are growing of such incidents. The number of elderly patients in outpatient surgery is increasing, and so are the complications, lengths of stay (LOS), and hospital readmissions, according to two just-published studies.

In a study published in the August issue of the *Journal of the American*

EXECUTIVE SUMMARY

The number of elderly patients in outpatient surgery is increasing, and so are the complications, lengths of stays, and hospital readmissions, according to two recent studies.

- Verify if patients are able to take care of themselves at home, and find out if they have support.
- You can use the Hospital Elder Life Program, known as HELP, to prevent delirium from occurring in high-risk patients.
- Consider geriatric consultations at the facility prior to surgery. Also consider having clinicians with expertise in geriatrics co-manage the patients.

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EDITORIAL QUESTIONS
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Geriatrics Society (doi: 10.1111/jgs.13537), age was shown to be an independent risk factor for ambulatory surgical complications, which was not previously known. The study examined data from 53,667 patients who underwent ambulatory surgery in academic medical centers. The information was obtained for 2012 from the American College of Surgeons National Surgical Quality Improvement Project database. This database extracts information from more than 400 participating community and academic hospitals. Data are collected for acute care hospitals and freestanding surgery centers.

Over 30 days, seniors were 54% more likely to be readmitted to the hospital compared to patients younger than 65 years, after accounting for differences in other medical problems, the study reports.

"It's not because they are sicker; it's because they are older and have trouble understanding their discharge instructions and medication dosing, which often are not clearly explained," said **Gildasio De Oliveira Jr.**, MD, lead author of the study, assistant professor at the Center for Healthcare Studies at Northwestern University Feinberg School of Medicine, and a physician at Northwestern Memorial Hospital, both in Chicago, in a released statement.

The study suggested an answer: "Interventions to improve transitions of care for older adults after ambulatory surgery are needed." The need for such interventions is likely to increase as economic pressures to reduce healthcare costs lead to even more complex surgeries in an ambulatory setting, the authors said. About 9 million ambulatory surgeries annually are performed on patients 65 and older.

Sharon K. Inouye, MD, MPH, professor of medicine at Harvard Medical School and director of the Aging Brain Center at Institute for Aging Research, Hebrew SeniorLife, both in Boston, says, "In the outpatient setting, we know outpatient surgery is dramatically increasing, and more and more patients who are more and more frail are undergoing surgery as day surgery." Delirium is seen frequently, and that's the reason patients end up getting admitted, Inouye says. "It's not uncommon after, for example, cataract, urologic, even procedures considered minor, such as ortho procedures, that we are seeing increasing numbers of delirium patients."

Inouye was an author of a study in *JAMA Surgery* which found that among patients 70 years or older having elective surgery, major complications contributed significantly to a prolonged length of stay (doi:10.1001/jamasurg.2015.2606).

The study included patients who underwent elective major orthopedic, vascular, or abdominal surgical procedures at two large academic medical centers. Of the 566 participants, 47 (8%) developed major complications and 135 (24%) developed delirium. The researchers found that delirium alone contributed significantly to all adverse outcomes. Delirium exerted the highest attributable risk of adverse outcomes compared with all other adverse events.

The authors wrote, "Delirium is not consistently considered a major postoperative complication. However, given its prevalence and clinical effect, delirium should be considered a leading postoperative complication for predicting adverse

hospital outcomes."

Delirium contributed significantly to several adverse accounts, including LOS and readmissions. That report is backed up by some just-released statistics from the Pennsylvania Patient Safety Authority in Harrisburg. According to an article in the September *Pennsylvania Patient Safety Advisory*, more than 400 events of patients experiencing delirium in hospitals were reported over a 10-year period, and 64 of those incidents resulted in patient harm. *(To access the article, go to http://bit.ly/1RbTTC9.)*

Michelle Feil, MSN, RN, CPPS, Patient Safety Authority analyst, said in a released statement, "The Authority has seen a nearly seven-fold increase in the number of delirium-associated patient safety events reported over the past decade, with an average of sixteen events reported per quarter in 2014, compared with two and a half per quarter in 2005. This increase could represent an increase in the number of these events that are occurring. But it is probably also the result of heightened awareness and improved recognition of delirium."

Falls were the most common type of event, followed by reports of adverse drug events.

Some of the common risk factors for developing delirium were age 65 or older, male gender, pre-existing cognitive impairment, depression, and severe illness. Other common factors that can increase the chances of a patient experiencing delirium include surgery requiring sedation, sudden or severe illness or medical condition (stroke, infection, or substance withdrawal, for example), certain medications (sedatives and narcotics, for example); and environmental factors, such as sleep deprivation, Feil said.

Evidence-based guidelines and risk reduction strategies help identify and prevent delirium in patients, Feil said.

Problems and solutions

Another issue with elderly patients is that they might have difficulty understanding medication doses. According to Northwestern University, 44% of seniors have low health literacy.[1]

Medications should be given in large-print written format and reviewed verbally with the patient and the caregiver, Inouye says. "Any new medications should be reviewed in detail, along with their side effects and potential interactions," she says. Provide printed information on the new medications, Inouye advises. "The primary care physician or next facility assuming care should be notified about all medication changes that have been made," she says.

With a patient at high risk for delirium, determine if any medications need to be changed or avoided, Inouye advises. "Certain meds are at a very high risk of causing delirium in older patients," she says. The Beers Critical Medications list spells out medications to avoid with elderly patients who are at very high risk for precipitating delirium. It can be accessed for free at http://bit.ly/1or0n0a.

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Alarm sounded: Recurrent problems in reprocessing

Warning that continuing infection control lapses are endangering patients, the CDC and the FDA recently issued a joint alert calling for healthcare facilities to review policies and practices in cleaning and processing reusable medical devices.

"Recent infection control lapses due to non-compliance with recommended reprocessing procedures highlight a critical gap in patient safety," the agencies said in a health advisory issued Sept. 11.[1] "Healthcare facilities (e.g., hospitals, ambulatory surgical centers, clinics, and doctors' offices) that utilize reusable medical devices are urged to immediately review current reprocessing practices at their facility to ensure they are complying with all steps as directed by the device manufacturers, and have in place appropriate policies and procedures that are consistent with current standards and guidelines."

The agencies cited recent reports of patients being notified that they might be at increased risk for infection due to lapses in basic cleaning, disinfection, and sterilization of medical devices. These events involved failures to follow manufacturers' reprocessing instructions for critical (e.g., surgical instruments) and semi-critical items (e.g., endoscopes). (*Editor's note: A story in the October 2015 issue of* Same-Day Surgery, *"Scopes still contaminated after cleaning, study shows," explained how bacteria can survive on endoscopes, despite a multi-step cleaning and disinfecting process.)*

The advisory did not cite specific incidents, but the problem is chronic

EXECUTIVE SUMMARY

The CDC and the FDA recently issued a joint alert calling for healthcare facilities to review policies and practices in cleaning and processing reusable medical devices.

- The Bellevue Clinic and Surgery Center of Seattle Children's Hospital notified up to 12,000 patients this year they could be at risk for infection because of improperly cleaned surgical instruments going back to 2010.
- Arrange for a healthcare professional with expertise in device reprocessing to immediately assess your procedures. Ensure that reprocessing allows enough time for personnel to follow all steps recommended by the device manufacturers.

and is in evidence frequently in the media as healthcare facilities reach out to patients and warn them of possible exposures. There have been outbreaks of carbapenem-resistant Enterobacteriaceae linked to duodenoscopes, which are notoriously difficult to clean and disinfect.

In a follow-up statement, the CDC and FDA rescinded the following recommendation: If healthcare facilities contract maintenance and repair of these devices to third-party vendors, healthcare facilities should verify that these vendors are approved or certified by the manufacturer to provide those services. "We are making this change because there are currently no formal standardized programs or processes through which all manufacturers certify third-party vendors," the agencies said in the statement. "We are also further clarifying that healthcare facilities which hire contractors to perform device reprocessing should verify that the contractor has an appropriate training program (i.e., consistent with what would be required in the healthcare facility) and that the training program includes the specific devices used by the healthcare facility." *(View the update at http://1.usa.gov/1JPcaPs.)*

The FDA ordered the three manufacturers of duodenoscopes marketed in the United States to conduct post-market surveillance studies to better understand how the devices are reprocessed. The manufacturers — Olympus America, Fujifilm Medical Systems, U.S.A., and Hoya Corp. (Pentax Life Care Division) — were given 30 days to submit post-market surveillance plans to the FDA. These proposals must detail their plans to conduct studies to evaluate, among other things, how well healthcare personnel are following instructions to clean and disinfect duodenoscopes between patients and to better understand the rate of contamination of clinically used duodenoscopes.

The Joint Commission recently said that standards related to "infections with equipment/devices/supplies" are among those with the highest noncompliance for the first half of 2015 for ambulatory facilities, hospitals, and office-based surgeons. *(For the entire list, go to http://bit.ly/1U6QRUN.)*

Recent examples of questionable practices cited by the CDC in published reports[2] include the following:

- The Bellevue Clinic and Surgery Center of Seattle Children's Hospital notified some 10,000 patients this year they could be at risk for infection because of improperly cleaned surgical instruments going back to 2010.
- Last year, Pennsylvania authorities found that a surgery center failed to perform high-level disinfection of sigmoidoscope biopsy ports and to sterilize various forceps.

The CDC and FDA recommend that healthcare facilities arrange for a healthcare professional with expertise in device reprocessing to immediately assess their reprocessing procedures. This assessment should ensure that reprocessing is done correctly, including allowing enough time for reprocessing personnel to follow all steps recommended by the device manufacturers. In addition, other key recommended actions and interventions include the following:

- **Training.**

Healthcare facilities should provide training to all personnel who reprocess medical devices. Training should be required and provided, upon hire or prior to provision of services at the facility, at least once a year thereafter, and when new devices or protocols are introduced (including changes in the manufacturer's instructions for use during the device's life cycle).

Personnel should be required to demonstrate competency with device reprocessing (i.e., trainer observes correct technique) prior to being allowed to perform reprocessing independently. Healthcare facilities should maintain current documentation of trainings and competencies.

Copies of manufacturers' instructions for operating and reprocessing each type of reusable device should be readily available to staff and inspectors. This file should include instructions for use of chemical disinfectants.

- **Audits and feedback.**

Healthcare facilities should regularly audit (monitor and document) adherence to cleaning, disinfection, sterilization, and device storage procedures. Audits should be conducted in all areas of the facility where reprocessing occurs. Healthcare facilities should provide feedback from audits to personnel regarding their adherence to cleaning, disinfection, and sterilization procedures. Audits should assess all reprocessing steps, including:

— performing prompt cleaning after use, prior to disinfection or sterilization procedures;

— using disinfectants in accordance with manufacturers' instructions (e.g., dilution, contact time, storage, shelf-life);

— monitoring sterilizer performance (e.g., use of chemical and biological indicators, read-outs of sterilizer cycle parameters, appropriate record-keeping);

— monitoring automated endoscope reprocessor performance (e.g., printout of flow rate, time, and temperature; use of chemical indicators for monitoring high-level disinfectant concentration).

• Infection control policies and procedures.

Healthcare facilities should allow adequate time for reprocessing to ensure adherence to all steps recommended by the device manufacturer, including drying, proper storage, and transport of reprocessed devices. Considerations should be made regarding scheduling of procedures and supply of devices to ensure adequate time is allotted for reprocessing.

Facilities should have protocols to ensure that healthcare personnel can readily identify devices that have been properly reprocessed and are ready for patient use (e.g., tagging system, storage in a designated area).

Facilities should have policies and procedures outlining facility response in the event of a recognized reprocessing error or failure. Healthcare personnel should assess the cause of the error or failure and the exposure event in order to determine the potential risk of infection. The procedure should include how patients who might have been exposed to an improperly reprocessed medical device would be identified, notified, and followed.

Individuals responsible for infection prevention and reprocessing at the healthcare facility should be consulted whenever new devices will be purchased or introduced to ensure that infection control considerations are included in the purchasing decision as well as subsequent implementation of appropriate reprocessing policies and procedures and to ensure that the recommended reprocessing equipment is available at the healthcare facility.

Facilities should maintain documentation of reprocessing activities, including maintenance records for reprocessing equipment (e.g., autoclaves, automated endoscope reprocessors, medical washers and washer-disinfectors, water treatment systems), sterilization records (physical, chemical, and biological indicator results), and records verifying high-level disinfectants were tested and replaced appropriately.

Healthcare facilities should follow manufacturer recommendations for maintenance and repair of medical devices that are used to perform reprocessing functions as well as medical devices that are reprocessed. *(See story in this issue with recommendations for bronchoscope reprocessing.)*

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2. Lowes R. Dirty reusable instruments also plague outpatient settings, CDC warns. *Medscape Medical News*. Sept. 11, 2015; accessed at http://www.medscape.com/viewarticle/850894. ■

Recommendations for bronchoscope reprocessing

The FDA has issued safety recommendations for healthcare facilities that reprocess flexible bronchoscopes, the American Hospital Association (AHA) recently reported.

The FDA said facilities and staff should strictly adhere to the manufacturer's reprocessing instructions and immediately remove from service any bronchoscope that fails a leak test or shows visible signs of damage. The agency also said facilities should do the following:

• Follow the manufacturer's recommendations for preventive maintenance and repair;

• Implement a comprehensive reprocessing quality control program;

• Store bronchoscopes in a manner that will minimize the likelihood of contamination.

You can access the recommendations at http://1.usa.gov/1KHaPvI. ■

Problem of surgery on the wrong site and retained objects won't go away

Wrong-site surgery errors persist even after years of concerted efforts to avoid them, and some of the standard prevention policies and procedures might not be effective enough. Some facilities are finding other ways to prevent this never event and other errors.

Wrong-site errors occur in about one in 100,000 surgeries, according to a study in the August issue of *JAMA Surgery* (doi:10.1001/jamasurg.2015.0301). Also, surgeons leave a sponge or other item in the patient's body in one out of every 10,000 procedures.

The researchers found that poor communication among medical staff was the root cause of many wrong-site and retained object errors. Another study, however, from the Veterans Health Administration found that surgeons respond well and correct their behavior when told stories of how other physicians made wrong-site errors. *(Access the abstract at http://1.usa.gov/1O0bj4H.)*

The medical community has relied largely on the Universal Protocol, including time-outs before surgery starts to confirm the procedure, to avoid wrong-site errors. Those strategies are being augmented as more weak points are identified in the surgical process, says **Coleen A. Smith**, RN, MBA, CPHQ, director of high reliability initiatives with the Joint Commission Center for Transforming Healthcare in Oakbrook Terrace, IL. For example, the Center recently began emphasizing the registration step for surgery as a potential weakness in preventing wrong-site procedures.

"That was conspicuously absent in the Universal Protocol," Smith says. "When we asked why the Universal Protocol wasn't working as well as we wanted, we realized we had left a big portion of the process out."

Orthopedic cases dominate the voluntary reports of wrong-site errors, Smith says. Wrong-digit or wrong-side errors are among the most common, along with spinal surgery at the wrong level.

Managers are finding other ways that can help. One hospital in California has found that having immediate access to X-ray images can reduce the incidence of this error. Surgical teams at Saddleback Memorial Medical Center in Laguna Hills, CA, routinely have the patient's X-ray images available in the OR so they can confirm laterality before proceeding, explains Lead Clinical Risk Manager **Danielle Gleason Tarricone**, RN, JD, CPHRM.

"A few area hospitals had laterality issues with kidney removals, so based on lessons learned from those hospitals, we now require that images be posted in the OR and confirmed as part of our time-out process," she says. "It's an additional check to the site being marked."

Saddleback Memorial has not experienced any wrong-site surgeries involving laterality, and Tarricone says she attributes that success partly to the X-ray policy. She notes that marking the operative site has been widely adopted specifically to avoid wrong-site errors, yet the strategy is not foolproof.

Now that clinicians have been trained to look for that site marking, they also have to be reminded that it might be wrong, Tarricone says. "We heard through the rumor mill that in ... local cases, the wrong side was marked from the get-go. The physician put in the wrong consent order, said left, marked left, but then when they pulled the film, it was right," she says. "We felt that having the X-ray posted would help us catch the problem even if the wrong site was marked on the patient. It's another safeguard against human error."

Regional blocks also pose a risk for laterality errors, because the anesthesia provider relies on the surgeon's site marking, Tarricone notes. Saddleback Memorial is implementing a policy that requires the anesthesia provider to mark the correct site, in addition to the surgeon's mark.

"Often these two marks will be very close together, but it's another verification," Tarricone says. "Two people are talking to the patient about where the procedure is going to

EXECUTIVE SUMMARY

Wrong-site surgery errors continue to happen at an unacceptable rate, along with retained foreign objects. Facilities and providers must look for new strategies to avoid these errors.

- Clinicians should be reminded that site marking is not foolproof.
- Having X-rays posted in the OR can help avoid laterality errors.
- A postop debrief can help avoid retained objects.

be, and two people are marking it, so that's another layer of confirmation."

End-of-case debrief

For the past year, surgical teams at Saddleback Memorial also have used an "end-of-case debrief" to reduce the incidence of retained objects, Tarricone notes.

This new policy came about when OR nurses explained that it was impractical to count every single item used in surgery because there are so many. A single tray for one part of a procedure might contain dozens of pieces, but only a few might be used, for example.

Counting every item is not standard procedure even when a facility requires counting, so Tarricone and her colleagues devised the end-of-case debrief to help account for the items not usually counted.

One question that is asked during the debrief: "Is everything in the surgical field accounted for in its entirety?"

"It's one of the last steps before the patient leaves the OR," Tarricone says. "The patient might already be closed, but it's a last check to make sure everything that should be out of the patient is accounted for."

If the count is off or the end-of-case debrief raises concerns, all OR staff members are empowered to demand an X-ray before the patient leaves the OR. When a postoperative X-ray is ordered, the radiologist is notified of what item is unaccounted for and what it looks like, to speed recognition, Tarricone notes. "If for any reason the surgeon is refusing to put that order in, the staff member goes quickly up the chain of command and gets that X-ray performed before the patient leaves the OR," she says.

Physicians did not eagerly embrace the end-of-case debrief, Tarricone notes. Time is money in the OR, and surgeons always have somewhere else to be, so they want out of the room as soon as their work is done. That desire makes them reluctant to accept a policy that requires them to stay in the OR even a few minutes longer, she explains.

Physicians who do not participate in the end-of-case debrief are reported to the medical staff for a behavior issue, she says. Smith also notes that hospital culture remains one of the biggest challenges in preventing never events. Staff members sometimes report that their efforts to conduct a time-out or properly mark the patient are rebuffed by surgeons, she says.

"We still think that there are situations where there are hierarchy and intimidation issues," Smith says. "That's where organizations are still struggling. It's one of the hardest things to get right." ■

SDS Manager

A blurred line between hospitals and surgery centers

By ***Stephen W. Earnhart****, MS*
CEO
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The line between hospitals and freestanding ambulatory surgery centers (ASCs) is becoming more and more blurred.

The national trend of doing total joint replacements in freestanding surgery centers is expanding. Medicare is allowing spinal procedures to be performed in ASCs, but not joint replacements — yet.

With Blue Cross citing that the cost of a total knee or hip replacement, in the hospital, can be as high as $69,000 without complications, the pressure to bundle these procedures with the surgeon, the facility, anesthesia, and rehab is a compelling argument. This argument is especially convincing now that many freestanding ASCs are doing just that at a significant savings to payers.

Adding to that shift: The number of hip procedures has doubled and knee replacements tripled in the past 10 years. It is no wonder that there will be changes in the very near future on where these procedures will be performed. Both of these procedures are typically age-related, and 10,000 people turn 65 years old every day, which is a trend that will continue for the next 20 years.

On a side note, we have found that of the non-Medicare eligible patient procedures performed in an ASC, we need to deduct these procedures by 20% for acuity. This estimate means that if your surgeon has 100 total joints they replace in a year and they have a payer mix of 28% Medicare, then the total potential joint replacements they can do in your ASC is 58 per year. (The Medicare deduction is 28%, so 100 - 28 = 72. Then the 20% deduction for acuity from 72 is 14. Then 72 - 14 = 58.) Still, it's a very attractive market. While the supply and implant cost is high, if you can control your costs, you would do well to explore this market.

By bundling your costs, ASCs have a distinct financial advantage over most hospitals, especially because

ASCs can bundle the surgeon fee into the mix.

Spinal surgery, which CMS saw the light on this year by allowing many of the more common procedures to be done in an ASC, has the same option. Depending upon the need for the procedure, typically the acuity is not as limiting on the patients who are healthy enough to have surgery performed in an ASC. The number is closer to 5% vs. 20% for total joints. Again, significant savings can be achieved by bundling.

Many not-for-profit (NFP) hospitals have their own freestanding surgery centers, but they cannot partner with the local surgeons due to Stark and other federal regulations. Therefore, they are at a distinct disadvantage in bundling the surgeon fee into the mix. Even if they could, with the lower cost of the facility fee for a for-profit ASC vs. an NFP hospital, the overwhelming portion of the facility fee for the NFP hospital would dramatically decrease the amount of the bundle that the surgeon would receive.

This issue of bundling, associated fees, and when and where these procedures will be performed is going to continue for many years. The solution? Very simple. Blend the for-profit ASCs with the NFP hospitals. We have been doing it for years.

When hospitals realize that they are going to continue to lose market share across the spectrum of surgical procedures, we will see more and more joint ventures between these two parties. The problem is that both cannot have 51% ownership! *[Earnhart & Associates in Austin, TX, is a consulting firm specializing in all aspects of outpatient surgery development and management. Web: www.earnhart.com.]* ■

Retirement system saves $7 million: Coverage adjusted for hospital colonoscopies

The California Public Employees' Retirement System (CalPERS) saved $7 million on spending for colonoscopy two years after it implemented a reference payment initiative that offered full insurance coverage at low-priced facilities but required substantial cost sharing if patients picked a high-priced alternative, according to an article published online by *JAMA Internal Medicine*.

Some employers are experimenting with payment methods that seek to counter high healthcare prices while upholding consumer access to valuable services. Employers, insurers, and consumers face varying prices for the same procedures within the same local communities, including screening tests such as colonoscopy.

James C. Robinson, PhD, of the University of California–Berkley, and coauthors obtained data on 21,644 CalPERS enrollees who underwent colonoscopy in the three years prior to implementation of the reference payment initiative in 2012 and data on 13,551 patients in the two years after implementation. Data for a control group were obtained on 258,616 Anthem Blue Cross enrollees who underwent colonoscopy and who were not subject to reference payment initiatives during the five-year period.

Under its reference payment initiative, CalPERS paid the facility's negotiated price, without consumer cost sharing, if the patient selected an ambulatory surgery center. However, it limited its payment contribution to $1,500 for patients who selected hospital-based outpatient departments. Patients were exempt from the initiative if their physician presented a clinical case for services at a hospital-based outpatient department or if a patient lived more than 30 miles from an ambulatory surgery center, according to background information in the study.

The authors report that use of low-priced facilities for CalPERS members increased from 68.6% in 2009 to 90.5% in 2013 after the reference payment was implemented. The average price paid for colonoscopy in the CalPERS population increased from $1,587 in 2009 to $1,716 in 2011 and then decreased to $1,508 in 2013 for patients subject to the reference payment.

"As reported in this study, the implementation of reference payments for colonoscopy accelerated the shift in patient choice toward lower-priced facilities," the authors said. "This led to substantial reduction in the mean price paid for the procedure, without any observed reduction in safety. In the first two years after implementation, CalPERS saved $7 million (28%) compared with what it would have spent on colonoscopy in the absence of a reference payment initiative."

The abstract of this research is available for review at http://bit.ly/1FpUdeO. ■

Evidence for a preadmit showering regimen

A standardized preadmission shower regimen results in maximum skin surface concentrations of chlorhexidine gluconate that can inhibit or kill surgical wound pathogens, according to a study just published online in *JAMA Surgery*.[1]

The showers included 118 mL of aqueous chlorhexidine gluconate, 4%, per shower, with a 1-minute pause before rinsing. There were a minimum of two sequential showers.

"This showering regimen corrects deficiencies present in current nonstandardized preadmission shower protocols for patients undergoing elective surgery," the authors said.

A randomized prospective analysis in 120 volunteers was conducted at an academic tertiary care medical center from June 1, 2014, to Sept. 30, 2014. The volunteers were randomized to two chlorhexidine gluconate, 4%, showering groups (two versus three showers), containing 60 participants each, and three subgroups (no pause, 1-minute pause, or 2-minute pause before rinsing), containing 20 participants each.

Skin surface concentrations of chlorhexidine gluconate were analyzed using colorimetric assay at five anatomic sites. Access the study at http://bit.ly/1O3W8pg.

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Until Nov. 16, ASCs can suppress certain public data

ASCs may choose through Nov. 16 to have 2013 and 2014 data for five claims-based measures suppressed from the Hospital Compare website, the American Hospital Association (AHA) reported. The five measures are ASC-1, Patient burn; ASC-2, Patient fall; ASC-3, Wrong site, wrong side, wrong patient, wrong procedure, wrong implant; ASC-4, Hospital transfer/admission; and ASC-5, Prophylactic IV antibiotic timing.

The ASC Association advises centers to look for results that could have been skewed by clerical errors such as typos or transposed codes.

CMS cited ASC concerns with implementing associated billing process changes. "Recognizing concerns from the ASC community that some facilities encountered difficulties in expediting these changes for the initial implementation years resulting in reporting issues, CMS has determined that ASCs may choose to suppress data for CY 2013, CY 2014, or both years from being displayed on the Hospital Compare website," the agency said. "Thus, only ASC-6 and 7 data submitted for CY 2012 via the QualityNet Secure Portal will be publicly reported in October 2015." Those measures are ASC-6: Safe Surgery Checklist use; and ASC-7: ASC facility volume data on selected ASC surgical procedures.

ASCs should email requests to suppress the data to ASCPublicReporting@hsag.com, and they should note the following:

- facility name;
- CMS Certification Number;
- National Provider Identifier;
- whether to suppress the data for calendar year 2013, 2014, or both.

For questions, you may contact the program's support contractor by calling (866) 800-8756 or go to the web site https://cms-ocsq.custhelp.com. ■

The Joint Commission posts changes for 2016, alters office-based requirements

The Joint Commission has approved the 2016 accreditation and certification decision rules for all accreditation and certification programs.

These decision rules are effective for surveys and reviews beginning Jan. 1, 2016.

The changes include:

- separate decision rules for organizations seeking initial accreditation and organizations seeking reaccreditation;
- revisions to "Contingent Accreditation" and "Accreditation with Follow-up Survey" designations so that organizations will have two opportunities to come into

compliance with the standards;

• a revision that addresses instances in which organizations fail their Medicare follow-up survey;

• new Evidence of Standards Compliance (ESC) and Measures of Success (MOS) to clarify that failure to successfully address all Requirements for Improvement might require the second submission of an ESC or MOS.

New decision categories

The Joint Commission also added three new decision categories:

• Medicare Survey;

• Condition-Level Deficiency, to clarify that a Medicare follow-up survey will occur if organizations have any condition-level deficiencies;

• Not Certified, to address failure to submit payment for review fees or annual fees.

Offices' LS chapter cut

In other news, effective immediately, the Life Safety chapter is no longer applicable for office-based surgery practices accredited by The Joint Commission.

The removal of the Life Safety chapter aligns with revised eligibility criteria for office-based surgery practices that became effective Jan. 1, 2015.

The revised criteria limit office-based surgery practices to a business occupancy, which is an occupancy having three or fewer patients at the same time who are rendered incapable of self-preservation in an emergency or are undergoing general anesthesia. The Life Safety chapter applies to facilities classified as ambulatory health care occupancy, which means having at least four patients at the same time who are rendered incapable of self-preservation in an emergency or are undergoing general anesthesia. ■

$9.5M settlement in lawsuit over out-of-network centers

On behalf of out-of-network California ASCs, a Los Angeles law firm has filed a motion for preliminary approval to settle a class action complaint it filed more than six years ago.

The complaint alleges that United Healthcare Services and

United States Postal Service

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- Changes to surgery recovery care
- Could your surgeon be a whistleblower?
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- Handling bad behavior in the OR

OptumInsight (together, United), formerly known as Ingenix, improperly calculated the reasonable and customary amounts for out-of-network ASCs, which resulted in underpayments of millions, according to the firm of Hooper, Lundy and Bookman (HLB). United has agreed to settle the case for $9.5 million.

The parties estimate that there are about 250 ASCs that could participate in the settlement. Assuming that the court preliminarily approves the settlement, notice of the settlement and instructions outlining how to participate in the settlement process will be sent to all potential class members, HLB said.

This case challenged the defendants' calculations of reasonable and customary amounts under employer-provided healthcare benefit plans and health insurance policies that are governed by the Employee Retirement Income Security Act (ERISA). For more information about this case or the settlement, email dtooch@health-law.com. ■

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David R. Fournier Publisher & CEO — Date 09/10/2015

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PS Form **3526,** October 1999 *(Reverse)*

CNE/CME OBJECTIVES

After reading *Same-Day Surgery,* the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identifiy how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

HVAC task force gives guidance

An HVAC task force has issued interim guidance to help facilities maintain appropriate temperature and humidity control in ORs and sterile processing departments as it works for consensus on conflicting standards.

Organizations first should form a multidisciplinary team to review HVAC operating practice and perform a risk assessment of the affected area(s), the guidance states. "The team should enter the values/parameters they will follow on a day-to-day basis into their organization's HVAC system policy, along with appropriate corrective measures to mitigate risk and restore the HVAC system to the desired parameters when conditions fall outside of those values," the guidance states. "The team should identify medical products and devices that require tightly controlled storage conditions and move those products to a location where the humidity and temperature are maintained within the manufacturer-prescribed parameters (e.g., a temperature and humidity controlled cabinet)."

The task force plans to explain the conflicting standards to accreditors and state agencies and ask them to work with organizations to establish a plan for resolving variance. ■

SAME-DAY SURGERY

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CNE/CME QUESTIONS

1. **Which of the following is true of the age of ambulatory surgical patients, based on a study published in the August issue of the *Journal of the American Geriatrics Society*?**

   A. Age was unrelated to ambulatory surgical complications.
   B. Age was shown to be an independent risk factor for ambulatory surgical complications.

2. **According to a joint advisory issued by the CDC and the FDA, healthcare facilities should maintain documentation of reprocessing activities, including which of the following?**

   A. Maintenance records for reprocessing equipment
   B. Sterilization records
   C. Verifying high-level disinfectants were tested and replaced appropriately
   D. All of the above

3. **The FDA has issued safety recommendations for healthcare facilities that reprocess flexible bronchoscopes and said facilities should do which of the following?**

   A. Follow the manufacturer's recommendations for preventive maintenance and repair.
   B. Implement a comprehensive reprocessing quality control program.
   C. Store bronchoscopes in a manner that will minimize the likelihood of contamination.
   D. All of the above

4. **Which of the following is true of the end-of-case debrief at Saddleback Memorial Medical Center?**

   A. Only nurses attend.
   B. It is intended to ensure that every single item has been counted.
   C. Any team member can decide that an X-ray is needed before the patient leaves the OR.
   D. The debrief must be performed before the patient is closed.