SAME-DAY SURGERY

THE TRUSTED SOURCE FOR HOSPITALS, SURGERY CENTERS, AND OFFICES FOR MORE THAN THREE DECADES

DECEMBER 2016

Vol. 40, No. 12; pp. 133-144

INSIDE

AHC Media

Healthcare Providers Paid $3.5B to Feds Over False Claims Act Cases

$1M paid by nurse anesthesia group

When a Georgia-based nurse anesthesia group paid more than $1 million in August in a civil settlement related to violations of the Federal Anti-Kickback Statute and Medicaid policies, the organization, which operates in ambulatory surgery centers, joined a long list of healthcare companies that have run afoul of the False Claims Act.

In fiscal year 2015, the Department of Justice collected more than $3.5 billion in settlements and judgments related to the False Claims Act. It was the fourth continuous year that these settlements topped $3.5 billion. Total recoveries since January 2009 to the end of last year were $26.4 billion, according to the DOJ.

""I'M ALWAYS AMAZED THAT PEOPLE CONTINUE TO GET THIS THING WRONG OR THAT THEY CHOOSE NOT TO BELIEVE THAT THE FEDERAL LAWS APPLY TO THEM," . — THOMAS PLIURA, MD, JD, A PHYSICIAN AND ATTORNEY AT LAW AT THOMAS PLIURA LAW FIRM

Most of the settlements come from healthcare organizations. In 2015, nearly four out of five organizations with settlements were healthcare related, according to a False Claims Act Settlements 2000-2015 chart.

Federal law is very clear that companies that receive federal money are not permitted to give or receive kick-backs based on referrals.

"I'm always amazed that people continue to get this thing wrong or that they choose not to believe that the federal laws apply to them," says **Thomas Pliura**, MD, JD, a physician and attorney at law at Thomas Pliura law firm in Le Roy, IL. "In this case, a group of nurse anesthetists were directly or indirectly providing monetary benefits to a company for

Financial Disclosure: Jill Drachenberg executive editor, Mark Mayo, consulting editor, Physician Reviewer Steven A. Gunderson, DO, Dana Spector associate managing editor, Melinda Young writer, Lee Landenberger director, and nurse planner Kay Ball report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Columnist Stephen W. Earnhart discloses that he is a stockholder and on the board for One Medical Passport.

SAME-DAY SURGERY

Same-Day Surgery®,
ISSN 0190-5066, is published monthly by AHC Media, LLC,
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326

Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices
GST Registration Number: R128870672

POSTMASTER: Send address changes to:
SAME-DAY SURGERY
P.O. Box 550669
Atlanta, GA 30355

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
Customer.Service@AHCMedia.com
AHCMedia.com

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free *AMA Category 1 Credits*™ or Nursing Contact Hours, $519. Add $19.99 for shipping & handling. Online only, single user: 1 year with free *AMA Category 1 Credits*™ or Nursing Contact Hours, $469. Outside U.S., add $30 per year, total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site-licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at Groups@AHCMedia.com or (866) 213-0844. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $83 each. (GST registration number R128870672.) Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

ACCREDITATION: Relias Learning, LLC, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.75] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

AHC Media, LLC, is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media, LLC, designates this enduring material for a maximum of 1.75 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 24 months after the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

EXECUTIVE EDITOR: Dana Spector
Dana.Spector@AHCMedia.com
DIRECTOR OF CONTINUING EDUCATION AND EDITORIAL: Lee Landenberger.

EDITORIAL QUESTIONS
Questions or comments?
Call **Dana Spector**
(404) 262-5470

referral of patients covered by the Medicare and Medicaid program."

The nurse anesthesia group provided free anesthesia drugs to surgery centers, which is an improper inducement to steer referrals back to the anesthesia provider, Pliura says.

"It's just like I could not pay you for a dollar for every patient you referred to me, and I couldn't buy you gas for your car, and I would be prohibited from sending you steaks every week or giving you free tickets to a ball game," Pliura explains.

Sweet Dreams Nurse Anesthesia Group of Swainsboro, GA, reached a civil settlement in August 2016, agreeing to pay the United States $1.034 million and the state of Georgia $12,079, according to the Department of Justice, U.S. Attorney's Office, Middle District of Georgia.

The settlement was to resolve allegations that Sweet Dreams violated the False Claims Act and the Georgia False Medicaid Claims Act by paying unlawful kickbacks to healthcare providers with the intention of inducing referrals of Medicaid and Medicare patients, the DOJ said.

"Sweet Dreams Nurse Anesthesia (SDNA) vigorously denies any wrongdoing," according to the company's statement about the settlement.

"SDNA entered into the settlement agreement as a business decision in order to avoid the cost and expense of litigating the matters to vindication," SDNA officials said. "Given the complexity of the issues, SDNA legal fees alone would have exceeded the settlement amount."

DOJ officials investigated the anesthesia group for nearly two years in response to a lawsuit by Adam Nauss, under the whistleblower provisions of the False Claims Act and the False Medicaid Claims Act. Nauss will receive a share of the settlement.

"A disgruntled ex-affiliate of SDNA filed the whistleblower action with numerous meritless claims," SDNA officials said.

Federal officials also said the nurse anesthesia group's affiliate allegedly agree to fund the construction of an ambulatory surgery center (ASC) in Marietta, GA, in exchange for contracts for Sweet Dreams' selection as the exclusive anesthesia provider at that facility and a number of other podiatry-based ambulatory surgery centers that are affiliated with the Marietta ASC.

"The giving of a kickback by one provider to induce referrals from another negatively impacts patient choice and fair competition among providers," said U.S. Attorney **G.F. Peterman** in a news statement.

"For that reason, Medicare and Medicaid prohibit taxpayer money from being used to pay for services that arise out of arrangements that violate the Anti-Kickback Statute," Peterman said. "By diligently enforcing the Anti-Kickback Statute in this district, our office protects the integrity of many federal programs and ensures that when a healthcare provider in Middle Georgia refers a patient to another provider, the referral is based on what is best for the patient rather than the provider's own self-interest."

"During the course of SDNA's investigation and full cooperation with the government, however, two issues arose," SDNA officials said.

Those two issues were:

1. "A program where SDNA would purchase Propofol for use in ASCs where SDNA would bill applicable third-party payors for the Propofol when allowed by the applicable payor policies, and
2. "A failed joint venture to own and operate an ASC."

The case is complicated – not a black and white issue, SNDA officials said.

"With regard to the Propofol Program, there was a short period of time where SDNA, due to administrative glitches, did not invoice the ASCs for the minimal Propofol costs for the use in surgery on Medicare patients (i.e., Propofol used in cases where it was bundled into ASC payment)."

Also, the failed ASC joint venture was a situation in which SDNA acted under the advice of previous legal counsel with respect to the venture.

"Unfortunately, SDNA's joint venture partner failed to uphold their end of the bargain. The government alleged that the JV partner's failure was a kickback," SDNA officials explained. "Note that SDNA is currently in active litigation/arbitration with the joint venture partner."

DOJ and Georgia justice officials made no comment about whether or not they were investigating the ambulatory surgery centers that received allegedly illegal incentives, but typically they would be subject to penalties, as well, Pliura notes.

Providers often think they can find a way to get around the law, and this type of thinking can get them in trouble if they fail to seek proper legal advice before taking some kind of unusual action, he says.

"You'd be surprised at how many providers call me and say, 'Dr. Pliura, here's what I want to accomplish,' and what I say is, "What that sounds like, smells like, is the fragrance of a violation of anti-kickback laws,'" Pliura says. "I say, 'Do you want to find a way around anti-kickback laws that prohibit you from paying for referrals?' and there's a pause on the phone."

Pliura steers providers away from such deals by pointing out that the penalties cannot only involve millions of dollars, but also result in prison sentences. *(See descriptions of federal laws about healthcare fraud, in this issue.)*

It's far better to ask for legal clarification before attempting something new that could be a problem, Pliura suggests.

"Call a reputable law firm that deals with federal anti-kickback or Stark laws," he says.

The goal is to request from the federal government an advisory opinion ruling in which you lay out the proposal completely, telling the federal government what is planned, and asking the government whether or not it is legal, Pliura says.

"They'll give you an opinion and say whether or not it violates the laws," he says.

The government also might say that it would violate the law, but under certain conditions would be acceptable, he adds. "So you have the 'good housekeeping' approval certificate, so long as you laid your soul bare to the federal government ahead of time."

Pliura has obtained these advisory opinion rulings multiple times, and they've worked well – although they can take a year or longer, he says.

"For example, we had a primary care group that was exempt from federal Stark law from investing in a surgery center," Pliura says. "Normally, it would be improper for a primary care provider to own interest in a surgery center and refer cases to their surgeons because it's a conflict of interest. But there are certain exemptions, and you can lay out all of that through an advisory opinion process." ■

RESOURCES

- Comparison of the Anti-Kickback Statute and Stark Law. Accessed at http://bit.ly/2eUHB6X.
- False Claims Act Settlements 2000-2015. Accessed at http://bit.ly/2fEl4wr.

SOURCE

- **Thomas Pliura**, MD, JD, Physician and Attorney at Law, Thomas Pliura law firm, Le Roy, IL. Email: tom.pliura@illinoisastc.com.

Here are Three Laws All ASCs Should Know

You need to know what to avoid

Every physician and ambulatory surgery center should know how to avoid violating federal statutes that protect taxpayer money from unscrupulous or unknowledgeable healthcare providers. Here are three laws every ASC and doctor should know:

- The Anti-Kickback Statute (42 USC § 1320a-7b(b)): this criminal statute prohibits the exchange of anything of value to reward or induce referrals or generate business that involves federal healthcare business and funding, such as Medicaid and Medicare patients and reimbursements.

Convictions can result in fines up to $25,000 and imprisonment for up to five years, as well as mandatory exclusion from federal healthcare programs.

Civil penalties can result in a civil monetary penalty of $50,000 per violation and a civil assessment of up to three times the amount of the kickback.

- The False Claims Act: Individuals have the right to bring qui tam actions alleging violations

of the Anti-Kickback Statute. So when someone sues on behalf of the federal government and succeeds, the person who sued receives a percentage of the recovery.

- The Stark Law (42 USC § 1395nn): A physician is prohibited from referring Medicare patients for designated health services to an entity with which the physician or an immediate family member has a financial relationship. They also are prohibited from submitting claims to Medicare for those services that result from a prohibited referral.

Penalties include an overpayment or refund obligation, a False Claims Act liability, civil monetary penalties, and a potential civil monetary penalty of $15,000 for each service and a civil assessment of up to three times the amount claimed. ■

SOURCE

- Department of Health and Human Services

Worried About Staff Burnout? Here are Prevention Strategies

First: Cross-train nurses

Surgery centers, like most healthcare organizations, have to deal with staff burnout and stress. But there are healthy strategies that help staff deal with work stress, and there institutional policies that might reduce burnout.

For instance, it's important to cross train staff and vary schedules with both fulltime and part-time nurses, says **Kristine Kilgore**, RN, BSN, administrative director at Surgical Care Center of Michigan, an ophthalmology center in Grand Rapids, MI. Kilgore recently spoke about staff burnout at the Becker's ASC 23rd annual meeting, held Oct. 27-29, in Chicago.

"I have a good mix of fulltime and part-time," Kilgore says. "On lighter days, I say to the fulltime staff, 'Would you like to go home early today?'"

Part-time nurses are very happy because they won't lose hours and the fulltime nurses often are thrilled to be able to leave early, she says. "One person told me, 'You wouldn't believe what I got done! I got the house cleaned and I made a full dinner for the family.'"

Kilgore doesn't worry about whether the fulltime employee's hours dip below fulltime hours, and she doesn't make them use their vacation time. Instead, she sees this as a positive for her, as well as for them.

"I look at it that they are helping me out by going home early," she explains.

Another strategy is to focus on wellness and holistic solutions to stress, notes **Adrienne Schultz**, RN, HN-BC, assistant vice president, patient care services, Cancer Treatment Centers of America in Zion, IL. The organization, which sees 5,000 patients annually, has a 73-bed inpatient facility, as well as outpatient services, ambulatory surgery and clinics. Schultz also spoke about stress at the Becker's ASC 23rd annual meeting. *(See story on creating a "renewal room," in this issue.)*

"One of the most exciting things we've done is an initiative to support holistic nursing," Schultz says. "I'm a board certified holistic nurse, so we've sponsored cohorts of nurses – about 20 at a time – to undergo training in holistic nursing."

The benefits of this additional training are huge, she says. "It benefits both patients and stakeholders."

The Cancer Treatment Centers of America will have had four cohorts of nurses going through holistic nursing training by the end of this month. The organization has dedicated resources to the training because it fits in well with its vision. Holistic nursing can benefit both the nurses, who learn more about self-care, and patients, Schultz says.

Physician burnout also can be an issue for ambulatory surgery centers, although not every site has this worry, Kilgore notes.

"For our organization, physician burnout is not as much of an issue because the physicians are owners of the company," she explains. "So they set the agenda and the pace. They determine how many cases they can do in a half day."

Kilgore is more concerned about the staff: "Last week we had a physician in the morning do 16 cases, and then a physician came in the afternoon to do 22 cases. They might think 22 cases is not that big of a deal, but for the staff it's 16 plus 22."

Full schedules and a fast pace can contribute to stress and burnout, but there are ways to buffer staff from their impact. Kilgore and Schultz offer these ideas for reducing staff stress:

- **Make sure new employees can handle the workload**: Everyone hired at the Surgical Care Center of Michigan is trained based on what they need given their own experience and education, Kilgore says.

"I tailor it to what the person

needs," she says. "I start with pre-op because it's the most consistent, depending on the doctor, and the last part is circulating because it's the hardest thing to learn and you need to learn each doctor's preferences."

One critical step in hiring new staff is to have them spend a day job-shadowing, Kilgore says.

"This is to make sure they're even interested in the work," she explains. "They come in for a half day and shadow a nurse to see pre-op, circulating, and recovery."

The goal is to make sure the job is a right fit for that particular nurse. "This is a fast-pace environment, and it's not for everyone."

- **Offer access to wellness activities**: Larger organizations can provide employee assistance programs, along with wellness activities, including gym membership discounts and staff exercise sessions, Schultz says.

"We have exercise sessions that people can sign up for and that are available at all different times to accommodate all of our stakeholders," Schultz says. "We also have an onsite yoga room that people can go to during their lunch time, and there are open, instructor-led sessions."

- **Cross-train nurses**: Registered nurses at the Surgical Care Center of Michigan are trained to work in each area of the surgery center.

"They can work in the pre-op area, take care of patients to get them ready, and they also can circulate and also recover patients," Kilgore says. "I make sure they go to each area throughout the month."

A nurse might work in the pre-op area for one week and then work in the recover area.

"They are learning ophthalmology, one specialty," Kilgore notes. "They are not having to learn 20 different specialties."

- **Stagger shifts and include nurses for the breaks**: "The pre-op nurses are staggered, starting at 6:30 a.m., 6:45, 7, 7:15 – every 15 minutes, depending on how many nurses I need," she says. "It's usually three to five people."

At 7, the circulators start to arrive, and the nurses in recovery arrive at 8 or 8:30 a.m. The surgeons start at 8 a.m., except on the busiest of mornings when they'll begin at 7 or 7:30, Kilgore says.

"The surgeons have a four-hour block and go until noon, and the afternoon surgeon starts at 12:30 p.m.," she says. "Then I bring in a nurse that does all the breaks for the nursing staff, and I have an extra scrub tech to turn rooms over."

The biggest challenge is finding a good scrub tech, Kilgore says. "It takes a long time to train a good scrub tech."

The last staff will arrive at 8:30 or 9 a.m. and be one of the recovery people, relieving the last late person and following up on the last patients, she adds.

- **Attend to employees' emotional health**: At the Cancer Treatment Centers of America, employees can attend a panel session to discuss an issue that concerns them, Schultz says.

"About once a month, our folks come to speak on a panel about a particular instance or issue they need to share with others," she explains. "This is multidisciplinary with nurses, physicians, pharmacists, and others who want to debrief or talk about something very personal for them or to share how they handled it."

For instance, one session involved a long-term patient who had died. Some employees had gotten very close to the patient and wanted to share their feelings about the loss, Schultz says.

"We have one topic per event, and usually different people can share at the event," she adds.

The sessions are held in a large meeting room, which sometimes has standing room only. Attendees can bring their lunch with them, as the meeting takes place at lunch time.

"People want to share," Schultz says. "They want that ability to garner input and support from their co-workers."

- **Create nice surprises**: "The day the physician had 22 patients, starting at 12:30, he said 'I'd like to get a treat for the nurses in the afternoon – I know it's going to be a long day,'" Kilgore says. "Those little things are huge, and it comes from me or the surgeons."

Other nice surprises will be a catered lunch for staff after a particularly busy week or month, she says.

"I try to acknowledge everyone," she says. "I'll do a nurses' week and bring in lunch or breakfast."

- **Recognize employees**: "Our company does an employee recognition day – usually on a Friday in June," Kilgore says. "We feel it's important to recognize every employee, so we close the surgery center early."

After closing the center at noon on a Friday, all surgery center employees head across the street to a botanical garden called the Frederik Meijer Gardens. They have a holiday luncheon. Employees from the surgery center are joined by staff from the company's various clinics, as well.

"We have over 300 employees, and it's fun because everyone gets to see everyone," Kilgore says. "Also, we have fun activities planned that change each year."

For example, one activity was a game show led by the management team.

- **Keep staff aware of how they're doing**: Merit reviews typically occur at the end of the year, but these reviews should not have any surprises for employees, Kilgore says.

"Hopefully, if there are issues, you are not waiting until the year end to go over them," she explains. "If something is identified by a staff member or an

anesthesia provider or a physician, I try to raise it when it occurs so at the review time it's not a surprise."

Giving employees real-time assessment makes it easier to discuss issues with them at the annual review. "You know their strengths and weaknesses," Kilgore says.

"I always ask employees what their goals are for the next year," she adds. "I ask, 'What do you want to accomplish in a year,' and sometimes you find out interesting things from them.'"

- **Take employees' suggestions seriously**: Kilgore learned when talking with nurses during one evaluation that they wanted to be trained to use one new surgical device. It was a laser that required a certified trainer to come in and show staff how to use it, and couple of nurses said that the next time there was a class, they'd like to have the trainer train four nurses at a time, she recalls.

"I had no idea they were even interested," she says. "What I've learned over time is to listen to my staff. People might think they're just complaining, and there is some complaining, but sometimes you pick up little pearls that could work."

Listening to staff also can prevent misunderstandings. For example, Kilgore brought in an ancillary employee to help the RNs. The idea was to ease some of their burden, but some nurses were worried that they were going to be replaced by LPNs.

"I said, 'No, I've listened to what you say, and you need help, so I'm bringing in someone to help you,'" she says. "It's a balancing act." ■

Renewal Room Gives Staff Quick Peace of Mind

Calm, cool colors, massage chair, making everyone comfortable

The Cancer Treatment Centers of America in Zion, IL, has made wellness and a holistic approach to staff and patients so much a part of its culture that its created what it calls several "renewal rooms."

These small sanctuaries are relaxing spaces with calm, cool colors, softened lighting, a massage chair, a mini-waterfall, jars of essential oils, a bookshelf, and additional soothing features.

"It's a space where the rules are, 'Do not bring in a phone or pager – no electronic distractions,'" says **Adrienne Schultz**, RN, HN-BC, assistant vice president of patient care services at the Cancer Treatment Centers of America.

"We took a small space that was originally used for storage and repurposed it to allow for a space for our stakeholders to take a few minutes to focus, relax, and renew themselves," Schultz says. "We provided a massage chair, aromatherapy, an opportunity to do some journaling, music therapy, and whatever the stakeholder feels will help them relax."

The center's staff can enter the room whenever a busy or stressful day wears them down. Employees generally spend 10 to 15 minutes in the room.

"A few minutes of self-care allows them to center and help their patients," Schultz says.

The original room was so successful – used 422 times in the first three months – that the center studied overall pre- and post-use anxiety among nurses who went into the renewal room. Anxiety was measured based on the Likert scale.

"We saw a dramatic decrease in their anxiety levels," Schultz reports. "Ninety percent of the people who went into the room used three of the relaxation techniques; the most commonly used were aromatherapy, massage therapy, and music therapy."

In fact, it was such a success, the organization decided to open additional renewal rooms, putting a new one on each floor of its inpatient tower, which opened last fall.

"We're trying to educate all of our teams about self-care," Schultz explains. "It's something they don't really teach you in school, and to us, here, it's a really important part of being fully present for your patient – taking care of yourself, including getting appropriate lunch breaks."

The center's employees have expressed gratitude for the renewal room and for the organization's commitment to expanding it into the new building's space, she notes.

"When you design a building and look at the square footage and floor layout, the square footage is at a premium," Schultz says. "We were very intentional about building that renewal room into the space, and they're grateful we afforded that for them."

When the first renewal room opened, they tried using a sign-up sheet to schedule time, but quickly found that this didn't work well, she notes.

"As a practitioner, you can't schedule when you'll feel overwhelmed," Schultz says.

So the schedule was abandoned and it's open on a first-come, first-serve basis. If the room is occupied, a door slider indicates that it's in use.

"We've never had an issue where it was needed and wasn't available," Schultz says. ■

Adopt Latest Standards for Cleaning Flexible Endoscopes

SGNA, AMMI, others have guidance

The Society of Gastroenterology Nurses and Associates (SGNA) Inc. of Chicago, recently published revised infection prevention standards pertaining to flexible endoscopes, which should be a reminder to surgery centers that they need to assess their own practices and make changes as needed.

"The flexible endoscope is in the spotlight," notes **Susan Klacik**, CRCST, CIT, FCS, president of Klacik Consulting in Canfield, OH. "There is a lot of good and new information on these endoscopes. All the research is coming out with evidence showing there's a lot of work we need to do. So be aware of new standards."

In the last couple of years, SGNA has joined other organizations in issuing new standards, including the Association for the Advancement of Medical Instrumentation (AAMI)

SGNA's 31-page standards, published this fall, are called the "Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes." They outline nine steps in endoscope reprocessing, from pre-cleaning to visual inspection to storage.[1] '

Earlier in 2016, the Association of periOperative Registered Nurses (AORN) of Denver, published "Guideline for Cleaning and Processing Flexible Endoscopes and Endoscope Accessories."

Also, AAMI published "ST91: 2015, Comprehensive guide to flexible and semi-rigid endoscope processing in healthcare facilities," addresses national concern about infections caused by carbapenem-resistant *Enterobacteriaceae* (CRE) from coast-to-coast.

Surgery centers need to continually emphasize infection control prevention.[1]

Research shows that for staff to achieve competency in cleaning flexible endoscopes, training is crucial, Klacik says.

"They must have documented competency to process these scopes, which are challenging to clean," she says. "They are a good breeding ground for bacteria."

Some of the new standards talk about adding a new step to the reprocessing of flexible endoscopes to verify the scope is cleaned before subjecting it to the high-level disinfection or sterilization step. This step is to use a magnifying glass on the external part of the scope and a cleaning verification method to measure the levels of organic soil and microbial contamination for external scope and internal channels, Klacik says.

"Another hot topic is the storage time," she says. "Previously, AORN's best practices were to have a five-day storage; now they've changed that and are recommending performing a risk assessment to see how long scopes can be stored in each facility before they become contaminated."

The time it takes for a stored endoscope to become contaminated can vary based on how it's stored, how it's been handled, and other variables, she adds.

To conduct a risk assessment, refer to the AAMI ST91 standards, which have a table for risk assessment, Klacik suggests. "The risk assessment says, according to this we look at several variables, such as the patient population, frequency of use, and testing protocols."

Surgery centers should put the risk assessment's findings in their policies so if the assessment determines that the endoscopes could hang safely for five days, then the policy should limit it to five days of storage.

"Each site determines its own expiration date of flexible endoscopes, and this concurs with AORN, who also says to do a risk assessment," Klacik says.

Prior to use with a patient, the scope needs to be visually inspected to make certain it's visibly clean and ready for the patient. The visual inspection should ensure there are no cracks, discoloration, and retained debris. If it's not clean, then manual cleaning steps need to be taken.[1]

"Inspecting the scope before use and finding an unclean scope requires the scope to undergo complete reprocessing, including disinfection or sterilization," Klacik says.

When reprocessing the devices, sites should follow the manufacturer's instructions, including how many flushes are necessary, the type of brush to use, and all of the critical steps, she notes. "They have to be documented each time they're processed, and it's important the scope is traceable to each patient."

Also, depending on the surgery center's size, there might be one staff member dedicated to reprocessing the scopes and documenting the reprocessing. Some places have automatic endoscope processors.

"The best practice is an automated endoscope reprocessor that we call an AER," Klacik says. "When you and I process scopes, we do it dif-

ferently, and the way I process one at 8 a.m. is different than 2 p.m. Processing automation is much more standardized and consistent."

The latest guidelines also address how the scopes should be transported after use. "They need to be contained in a leak-proof, puncture-proof container alone," Klacik says. "They must have lids and have to be identified as biohazardous."

After the scopes have been cleaned, they should be transported from being cleaned to storage and then to patient use in a manner to prevent contamination, thus they should be covered, Klacik adds. ■

REFERENCE

1. Herrin A, Loyola M, Bocian S et al. Standards of infection prevention in reprocessing flexible gastrointestinal endoscopes. *Gastroenterol Nurs.* 2016;39(5):404-418.

SDS Manager

Questions from Readers About Competing for New Staff, Medicare Certification

By Stephen W. Earnhart, MS
CEO
Earnhart & Associates
Austin, TX

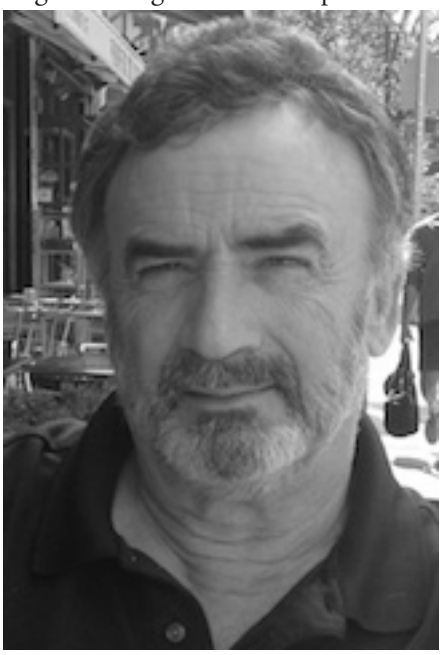
One of the most requested columns I do is take real-time questions from staff members in hospitals and ASC facilities and put my responses to them here – for all to read. I get many so many emails after each time I do this from readers who say, "That is exactly what we are going through!" or, "We have the same questions!" That encourages me to do more! As always, feel free to email me any questions you have – if it has wide appeal, I will add it to the list to share with others. And, as always, your questions are 100% confidential!

Question from RN in freestanding ASC: "I was just hired to run a new start up surgery center. I was surprised to hear that the ASC, while licensed as such in Texas, is not going to be Medicare Certified. The facility I came from required Medicare certification. Did I make a mistake by changing to a surgery center that is not certified? Will it hurt my license?"

Answer: Medicare Certification (CMS) is not required to do surgery in Texas (or any other state). You can do surgery without the expense and oversight of CMS with just a state license, much of which has the same requirements of CMS. However, you cannot treat federal patients, Medicare, Medicaid, CHAMPUS (Civilian Health and Medical Programs for Uniformed Services), and others without it. Also, some insurance payors will not contract with you if you do not go that route. Some surgery patients, such as ophthalmic patients have a high payor mix of Medicare patients and they require certification. Others, such as plastic procedures, have a very little Medicare population and they do not feel taking the next step is necessary."

Question from Hospital Surgical Department Head in South Carolina: "We have been competing for staff in our small town against a very successful freestanding surgery center that our orthopedic group established several years ago. Our greatest obstacle in attracting staff back to the hospital is the profit sharing that the competing facility offers. As a not-for-profit hospital system, we cannot offer profit sharing like these 'profit mills.' It is an unfair advantage."

Answer: Well, without getting too political, remember that as a not-for-profit organization, you do not pay taxes on your revenue and the ASC does. Your competitor could say the same about you having an unfair advantage. BUT! You can offer non-financial incentives to your staff as well. There are many more qualified authorities, who could offer examples, than I, but here's one of my examples: hospitals can provide an incentive to staff to reduce start time delays and room turn-over time by sending them home – with pay – when their room cases are complete. Paid time off is a huge advantage to staff. The process is



too complex to get into here, but you can figure out the details.

Question from RN in physician practice that has a surgery center in same building: "We are a pain management practice that is building a surgery center across the hall from our practice. Most of the staff of the practice will eventually work in the surgery center when we are not working on the practice side. Our doctor says that we will have to 'clock out' of the practice side and 'clock into' the surgery center when we work at either one. This sounds like a way to avoid paying overtime!"

Answer: From a licensing and Medicare standpoint, your pain management practice you're your surgery center, although across the hall, are two totally different businesses that require separate booking, staffing, etc. Compare it to working in one hospital and moonlighting in another. You have to follow the same protocols."

Question from a medical director in a freestanding surgery center: "I just became the medical director in this new surgery center. I am not used to this! I was a very busy anesthesiologist for a large hospital and I took this job to slow down and take it easy. I am shocked by the furor of activity in this place. The staff does not take breaks and works through lunch. The surgeon wheels their patients into the operating room and actually help turn over the cases. One day the nurses will work in PACU and the next day circulate the rooms. I had no ideal of the intensity of activity and was not anticipating this when I took this job. They do more cases by noon than we did at the hospital by 6 pm. I truly see the attraction to independent surgeons. Wow!"

Answer: One thing most hospitals do not understand is that, for the most part, freestanding surgery centers are established for time efficiency – not profit. However, that efficiency does generate profit if done properly. Non-employed surgeons only get paid when they do surgery. The time they wait for their patient to be taken into the room or wait for the room to be turned over between cases, is down time for them that they do not get paid – unlike the hospital staff. Inefficient utilization of time hurts everyone."

[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates can be reached at 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979.
Email: searnhart@earnhart.com
Web: www.earnhart.com.] ■

Research Suggests Importance of Assessing Patients' Frailty, Pre-Surgery

Frailty is under-recognized

A new study finds that patients who are referred for surgery are often frail or at risk of frailty, suggesting frailty is under-recognized, and more surgical patients could be screened for the condition.[1]

Published in October 2016, in *The Annals of Thoracic Surgery*, the study included a cohort of thoracic surgical patients, ages 60 and older. Frailty was screened using an adapted version of Fried's phenotypic frailty criteria, including weakness – grip strength, slow gait on 15-foot walk, unintentional weight loss, self-reported exhaustion, and self-reported low physical activity.[1]

Of the 125 participants who completed screening, 57% were pre-frail and 12% were frail. Exhaustion was their most common symptom.[1]

"We know that frailty has poor surgical outcomes, but there is less research about whether we can change somebody's frailty status in a way that impacts surgical outcomes," says **Angela Beckert**, MD, assistant professor of medicine at the Medical College of Wisconsin in Milwaukee, and the first author on the study.

While the solution is elusive, the first step is to identify the magnitude of the problem, says **Mark K. Ferguson**, MD, professor, department of surgery and The Cancer Research Center; head of the thoracic surgery service, and director of the residency program in cardiothoracic surgery at the University of Chicago medicine and biological sciences in Chicago. Ferguson is a co-author of the study.

Investigators wanted to learn how many patients are pre-frail or frail, so they started a screening study. Everyone who came into Ferguson's clinic, who was a potential candidate for surgery, was assessed for frailty.

"In our thoracic surgery population, the most common sign of frailty was fatigue," Ferguson says. "If you take an orthopedic surgical population, the most common element contributing to frailty is decreased gait speed."

Physicians who observe fatigue or a slow gait in a patient

might want to screen the patient for frailty prior to surgery.

It doesn't take long to identify possible signs of frailty, Beckert notes. "Patients who are weak or walk really slowly will have a difficult time getting on the examination table. They're not very active, so any complaint would trigger someone to think, 'Maybe I should do a more formal assessment of their frailty status.'"

For instance, a physician might notice that the patient took 10 seconds or longer to walk a few steps in the exam room. For a non-frail patient, this might have taken a couple of seconds. "If you observe the patient doing that, then you have a pretty good idea of whether they need to be screened additionally."

The literature on frailty shows that frail patients are more likely to have adverse effects and surgical complications that could result in hospitalization or increased hospitalization, and they are more likely to die from surgery, Beckert says.

Knowing a patient's frailty status can be very useful to surgeons.

"They can use the findings to possibly alter the surgery plan," Ferguson says. "For example, I treat lung cancer, and we could remove a small amount of lung tissue or a large amount of lung tissue; the larger might be the standard of care, but the smaller might be better for a frail patient if we're concerned about them having risk with the bigger operation."

Many older patients are pre-frail or frail, and these patients also might be the ones who most need medical attention and surgery, Beckert says. "Age alone isn't a reason to withhold surgery from someone because some will do well with it."

But if the patient is identified as frail then there might need to be a conversation with the patient and family about what they might expect from the surgery and what their options are, Beckert says.

Another benefit to screening patients for frailty would be that it gives surgery sites information that can be used to provide more intensive resources in the post-operative period and to help prepare families for complications.

For instance, families could be warned that the patient might have post-operative delirium, which is common in older and frailer people, Ferguson says.

"They might have an increased vulnerability to stress, usually physiological stress, and surgery is a huge physiological stress," he explains. "Frail patients are more likely to have readmissions and a decreased quality of life in the post-op period."

Future research could produce answers to why some patients become frail and others do not. There might be genetic markers and morphologic measures that will help identify frailty more accurately than screening tests, he says.

"If we identify somebody who is at increased risk because of frailty, there might be ways to intervene to reverse frailty characteristics, including exercise and nutrition, strength training, training for stamina, endurance, and balance training to prevent falls," Ferguson says.

It might be possible to help a patient improve his or her physical strength well enough to improve chances of surgical success, he adds.

"Maybe in a few weeks – where it might not be too much of a delay – someone could get into better shape before surgery," Ferguson says. ■

REFERENCE

1. Beckert AK, Huisingh-Scheetz M, Thompson K, et al. Screening for frailty in thoracic surgical patients. *Ann Thorac Surg.* 2016;S0003-4975(16)31146-8. Epub ahead of print.

CMS Publishes Final Rule About New Medicare Payment Methodology

Eligible clinicians have two options

CMS recently has published its final rule about the new Medicare payment methodology for physician services under Medicare Part B or the Quality Payment Program (QPP).

Enacted in 2015, the QPP is part of the Medicare Access and CHIP Reauthorization Act. The effective date is Jan. 1, 2017 for reporting the first year of QPP, while payments will begin in 2019. CMS will accept comments on the final rule through 5 p.m. on Dec. 19, 2016 at http://www.regulations.gov.

The final rule repeals the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule and replaces it with the QPP. The goal is to reward high-quality patient care by eligible clini-

cians and groups through two options: the Advanced Alternative Payment Model (APM) and the Merit-based Incentive Payment System (MIPS).

Eligible clinicians, who have more than 20% of their Medicare patients in models that qualify as Advanced APMs or who receive 25% or more of their Medicare-covered professional service payments in 2017, can qualify as Advanced APMs and can select the APM track to earn a 5% Medicare incentive payment in 2019. Those who decide to not report data under MIPS in 2017 will receive a negative 4% payment adjustment for that year.

Clinicians eligible for MIPS will need to report for at least 90 continuous days in 2017.

MIPS, a new program for some Medicare-enrolled practitioners, consolidates components of the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Record Incentive Program for Eligible Professionals. MIPS will continue CMS' focus on quality, cost, and use of certified electronic health record technology.

Acknowledging that technology, infrastructure, physician support systems, and clinical practices will change in the near future, CMS said that the QPP will "evolve over multiple years in order to achieve our national goals."

QPP specifically aims to do the following:

1. Support care improvement by focusing on better patient outcomes, decreased provider burden, and preservation of independent clinical practice;
2. Promote adoption of alternative payment models that align incentives across healthcare stakeholders, and
3. Advance existing efforts of delivery system reform.[1]

"We solicited and reviewed over 4,000 comments and had over 100,000 physicians and other stakeholders attend our outreach sessions," CMS said.

Based on feedback, CMS established six strategic objectives, as follows:

4. To improve beneficiary outcomes and engage patients through patient-centered APM and MIPS policies;
5. To enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools;
6. To increase the availability and adoption of robust Advanced APMs;
7. To promote program understanding and maximize participation through customized communication, education, outreach, and support that meet the needs of diverse physician practices and patients;
8. To improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders, and
9. To ensure operational excellence in program implementation and ongoing development.

MIPS measures quality of care through evidence-based clinical quality measures, selected by eligible clinicians, CMS says.

Also, MIPS accounts for activities that physicians identify, including practice-driven quality improvement.

The final rule also notes that services rendered for outpatients in community settings, including surgery centers, are reimbursed through Part A and are exempt from the Quality Payment Program.

This results in beneficiaries who are less acute and low cost to the Medicare program being excluded in the QPP attribution, CMS noted.

For more information about the final rule, contact Molly MacHarris (about MIPS) at (410) 786-4461 or James P. Sharp (about APMs) at 410-786-7388. ■

REFERENCE

1. Medicare program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule and Criteria for Physician-Focused Payment Models. Federal Register. Nov. 4, 2016. http://bit.ly/2ezYCAt.

COMING IN FUTURE MONTHS

- Complying with nondiscrimination requirements
- Achieving optimal surgical experience strategies
- Federal drug disposal update
- Quality improvement best practices

CE/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;
- identify how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

SAME-DAY SURGERY

CE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or log on to AHCMedia.com then select "My Account" to take a post-test. *First-time users must register on the site.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE/CME QUESTIONS

1. Which of the following best describes the federal Anti-Kickback Statute?

a. A physician is prohibited from referring Medicare patients for designated health services to an entity with which the physician or an immediate family member has a financial relationship
b. Individuals have the right to bring qui tam actions alleging violations
c. The statute prohibits the exchange of anything of value to reward or induce referrals or generate business that involves federal healthcare business and funding
d. All of the above

2. Which of the following is a good way to prevent staff nurse burnout?

a. Offer access to wellness activities
b. Cross-train nurses
c. Stagger shifts and include nurses over the breaks
d. All of the above

3. According to the latest industry standards, how should flexible endoscopes be transported?

a. They should be handled only by specially-trained endoscope technicians
b. They should be carried by nurses who are wearing latex gloves and masks
c. They need to be contained in a leak-proof, puncture-proof container alone, and they have to be identified as biohazardous.
d. All of the above

4. The Quality Payment Program will do all except which of the following?

a. Pay providers 50% bonuses for meeting standards
b. Support care improvement by focusing on better patient outcomes, decreased provider burden, and preservation of independent clinical practice
c. Promote adoption of alternative payment models that align incentives across healthcare stakeholders
d. Advance existing efforts of delivery system reform