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INSIDE

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In the Year of the Rooster, Best ASC Strategy Is Focus On Self

Cutting costs, improving productivity are some strategies

Ambulatory surgery centers (ASCs), like all other healthcare organizations, might wonder what will happen in 2017 as a new Congress and President Donald Trump promise sweeping changes to the Affordable Care Act (ACA). It's impossible to build into budgets the possibility of disruption and change. But ASCs can avoid behaving like roosters and chickens that run straight into peril and uncertainty.

Instead, it might be time to focus on what can be controlled by working to improve the organization's productivity and efficiency.

"I think in healthcare, situations occur out of your control, but the bottom line is looking after your patients and your facilities," says **Terri Mahoney**, RN, CNOR, CASC, administrator of Bluffton Okatie Surgery Center in Bluffton, SC.

> "YOU ALWAYS LOOK AT PRODUCTIVITY, QUALITY, AND PATIENT SAFETY, NO MATTER WHAT'S HAPPENING LEGISLATIVELY."

"You always look at productivity, quality, and patient safety, no matter what's happening legislatively," Mahoney says. *(See story on how a small ASC avoids growing pains, page 28.)*

"Both the regulatory environment and the insurance/payer environment keep us on our toes all the time with new regulations that require us to revamp something," says **Janie Kinsey**, RN, CASC, administrator at Saint Luke's Surgicenter–Lee's Summit in Lee's Summit, MO.

Surgery centers do what they can to cut costs and improve productivity to

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prepare for any type of regulatory or insurance environment.

"Productivity starts with participation and ownership by staff," says **Alfonso del Granado**, administrator of Ashton Center for Day Surgery in Hoffman Estates, IL.

Also, there's no point in worrying about time wasted on regulations today that might not exist tomorrow, such as standards that might no longer be required if lawmakers repeal some or all of ACA and other healthcare regulations, notes **Lianne McDowell**, administrator at South Portland Surgical Center in Tualatin, OR. *(See story on efficiency strategies, page 29.)*

The first step to improving productivity is to study metrics, trends, and to listen to employees. *(See story on productivity metrics, page 31.)*

Staff buy-in on changes can help improve staff satisfaction. Del Granado learned this lesson as a child growing up in South America, where he would see shopkeepers operate their businesses from 6 a.m. to 10 p.m. and, yet, seem happy and satisfied with their work. Though their hours were long, they were able to work at their own pace for themselves. This sense of ownership can be imparted to employees if they're given some autonomy in how they perform their work, del Granado says.

"I found that staff were being micromanaged remotely and were not given any kind of decision-making authority outside the normal scope of practice," del Granado says. "So we changed that culture a little bit, making it a number-one priority to reduce employee turnover, increase satisfaction, and decrease staffing hours."

The strategy worked, increasing patient satisfaction from 93% to 98%, decreasing employee turnover, and increasing efficiency, he says.

"We were 23% more productive when compared with the baseline metric," del Granado says. "Ownership sounds like a buzzword, but there's an underlying feeling that you're in charge of your destiny, and it definitely increases satisfaction."

There is a downside to productivity if it's not handled in a way that reflects what employees need and want. For instance, the productivity numbers (cases worked per hour), were very high when Kinsey started working at Saint Luke's Surgicenter.

"Our productivity numbers looked really good," Kinsey says. "But we were expecting maybe too much from our employees."

Ashton Center for Day Surgery also found that very high productivity rates were hard on staff. "We pulled back on the productivity," del Granado says.

"Even though the staff was very happy and patients were satisfied, we could see it was taking a toll on the

EXECUTIVE SUMMARY

Healthcare is undergoing another major change across the nation, creating uncertainty and disruption. However, ambulatory surgery centers (ASCs) should follow experts' advice and focus on improving quality, cost-cutting, efficiency, and productivity.

- A first step is to improve operational efficiency.
- Realign the organization's goals.
- Increase consistency and make smart supply decisions.

staff," he explains. "Some were getting a little frazzled, and there was a safety component."

Also, when a surgery center demands too much from employees, there is the risk of a high turnover rate and burnout. This especially can be true when the productivity demands remain high even when the surgery center adds new and more complex surgeries, Kinsey notes.

"We've had higher acuity level patients and procedures," Kinsey says. "We started a total joint program, an overnight stay program, [and] a hysterectomy program."

When workflow demands become more complex, staffing levels should be re-evaluated.

"So what we did was hire adequate staff, and they began spending less time complaining about how busy we were and more time getting the work done," Kinsey says. "We were able to do more cases with those extra people, and everyone was happier."

Kinsey and del Granado suggest the following additional strategies for improving productivity and efficiency, while maintaining quality:

• **Add operational efficiency.** Each organization operates differently, but sometimes it's necessary to re-evaluate habits and workflow to see how things can improve.

For instance, Saint Luke's Surgicenter directed staff to make pre-op phone calls at the end of the day. It was a low priority, Kinsey notes.

But this often resulted in last-minute calls that would reveal that a particular patient could not come in for surgery the next day. That surgery spot would be wasted.

So the center hired someone whose job was to make the pre-op calls a week or two in advance of the surgery. The caller could identify patients who might have difficulty meeting their appointments, and find a replacement for that time slot, Kinsey says.

"That decreased our last-minute cancellations and even decreased delays because we'd have updated information about patients before they got here," she says. "The caller would look at patients' charts and notice if their lab work was done."

The surgery center now conducts many different assessments ahead of time.

"We get a feel for the whole patient and it's tied into our being better prepared when patients show up for surgery," Kinsey says.

• **Realign your goals.** "The goal is to not keep the staff busy, but to take care of patients efficiently, methodically, and safely with the highest degree of satisfaction," del Granado says. "Focus on that, and you'll find yourself realigning your priorities a little bit."

An example of this focus is to look at the staff schedule and ask a slightly different question: "How many nurses does this patient need?" he suggests. "It's a slight shift of perception that makes a significant difference by staffing based on the patient's needs instead of keeping nurses occupied."

Nurses can idle and still perform duties above average if managers do not worry about slow periods and control their schedules through micromanaging.

"Recently, I had a discussion with someone who was pointing out that this Monday I had someone sitting idle for two hours," del Granado recalls.

"I pointed out that the person researched a clinical question during that time, but they also should look at the person's productivity over a week, month, and quarter," he adds. "That person might have had two hours of idle time, but also produced three times the normal output for a nurse over time."

• **Allow for staff scheduling autonomy.** Within the goals of increasing patient satisfaction and decreasing employee turnover, it's possible to allow employees to organize their days, del Granado says.

"It can seem contradictory to have staff work harder but in fewer hours, but we managed to do it," he says. "We decreased staff hours by 42%."

Employees were given the autonomy to take their 15-minute breaks to watch a screen or just stand by themselves in some corner. "We gave them some freedom, saying that if they could do their work more efficiently, then they could take more breaks," del Granado says.

"If they can keep a good pace for the rest of the day, and we have set an expectation and goal for them, then we can let them figure out how to get to that goal," he adds. "Whereas before, an employee would say, 'Why rush? I'm going to be here for eight hours anyway.' Well, now they can rush and take a little break."

Employees who work according to scheduled hours still do so, but there is more flexibility for many workers. For example, the techs who open the center to prepare for the day's surgeries can negotiate to take turns, with one tech opening the room for all others earlier in the day, and another tech to arrive later to catch more sleep, del Granado explains.

"The goal is to get it ready by 7 a.m., but we give them autonomy on how to spend their time, and this gives them the feeling that they're in charge of their own destiny and it increases [staff] satisfaction," del Granado adds.

• **Increase consistency.** "We had been inconsistent with our anesthesia providers changing every day," Kinsey says. "There was no standard protocol for what was an acceptable patient

and what wasn't."

So the surgery center asked the anesthesia providers to assign one person to the center so decisions would be more consistent. Everyone would know what the assigned anesthesiologist's expectations were and what that person expected in regard to standards for surgery through the physical status classification system (PSCS), she adds.

"Now, we have the same doctor who interprets the standards the same way every time, and it makes for more consistency," Kinsey says.

• **Make smart supply changes.** Sometimes a small change can make a big difference to a center's bottom line. For example, staff at Saint Luke's Surgicenter–Lee's Summit ordered supplies for scheduled surgeries and shipped overnight, Kinsey says.

"They were ordering for the next day instead of the next week," she explains. "That change seems small, but if you place 25 orders a week and spend $150 in overnight charges when you can reduce that by half, then you can save a significant amount of money."

The solution was to plan ahead and order for the week ahead, allowing for far cheaper shipping costs. The change was painful for a few weeks, but it worked, cutting the center's shipping costs in half, Kinsey says.

"Supply costs have gone crazy over the last few years, and it's something we're all facing," she adds. "Any way you can manage those is good, and it's smart not spending extra money on shipping."

• **Put patients first.** "We put patient care first," Kinsey says.

"For instance, some cases that do overnight care will give patients frozen meals, warmed up in the microwave, and that's fine, widely accepted," she says. "But we go an extra step and order from Outback Steakhouse, and that makes patients feel very well cared-for." ■

Small ASC Doubles, But Experiences Few Growing Pains

Focus on staff for success

As an ASC grows, a key strategy to its success is focusing on staff, staying sensitive to their need for work-life balance, and keeping lines of communication open.

"Traditionally for us, we have focused on [staff] caregivers, trying to realize they have a life outside of work," says **Terri Mahoney**, RN, CNOR, CASC, administrator at Bluffton Okatie Surgery Center in Bluffton, SC.

"If we can be understanding and accommodating, within reason, then we will keep some high-quality providers where, maybe if we were not quite so flexible, we would not have that ability," Mahoney says.

During Bluffton Okatie Surgery Center's early years, it was challenging to find qualified nurses and other employees who were interested in part-time work. "So we had to think outside the box," Mahoney says.

"How could we attract people and receive a commitment from them, when our case volume fluctuates so much and we're not as consistent as most people need?" she asks.

The answer was to inject blatant honesty into the interview process.

"We had to be really honest with people during the interview process about what we're offering," Mahoney says. "Usually, I would start the conversation with how this is our volume, and these are our procedures, and these are the days we work."

Mahoney would tell prospective employees that the schedule would fluctuate, and she'd ask about their financial expectations.

"People appreciated the fact that we were open with them and that they could make an informed decision," she says.

As a result, the ASC attracted semi-retired nurses with great clinical experience. It helped that Bluffton is on the coast of South Carolina, near Hilton Head Island and Savannah, GA. Some of the PRN nurses lived in neighboring retirement communities, and they were not interested in full-time work.

To keep the staff content, the ASC offered them scheduling flexibility. If a nurse needed a summer month off for a long vacation, the surgery center could make this work.

"When you have a large PRN population of employees, you have a little more flexibility on your staffing," Mahoney says. "When working with a semi-retired population, it's not unusual for them to love to travel and take frequent time off, and we were able to accommodate that."

But this strategy did not work for the long-term as the ASC was growing, including a major expansion in the past year. The ASC has shifted

from a corporate ownership structure to a joint venture that includes physician owners. Bluffton Okatie Surgery Center's focus turned to finding and hiring qualified full-time staff, nearly doubling its staff to 16.

This was a different challenge that required competing for staff within an hour radius of Bluffton. "There are a lot of healthcare facilities close to us for a relatively small community," Mahoney says.

Staffing flexibility remains an important way to keep employees happy, although employee requests are a bit different than before. For example, Mahoney says an ASC employee recently wanted to leave her shift a couple of hours early so she could see her child perform in a school play. She told Mahoney a couple of days in advance, and Mahoney filled in for her.

"When we can help them, we try really hard to do that," she says. "We can't always accommodate things, but we try to make it a priority."

Additionally, Mahoney says the center tries to create an open atmosphere at staff meetings. Mahoney will review both successful situations and unsuccessful ones, and ask staff for feedback.

"When we sit down as a staff, it's very informal," she says. "Usually, I'll ask people for ideas, or we'll talk about a situation that occurred that wasn't ideal."

The employees who were involved in the situation tell everyone what happened, which creates an atmosphere in which other employees feel more open to discussion and making suggestions, Mahoney says.

"This way, the conversation is not a negative one; it's a learning experience where we want to make sure it doesn't happen again, so we ask people to tell us some ideas of how to avoid it," she says. "That's the atmosphere — not a punitive thing."

Staff meetings are an opportunity for an ASC to keep employees aware of changes. During Bluffton Okatie Surgery Center's recent expansion, the staff meetings served as an important way to keep staff involved and informed about the expansion and any resulting culture changes, Mahoney notes.

The ASC's staff also responds very positively to any gestures physicians make, such as buying them the occasional lunch, she says.

"What has had such a great impact on our staff is that one of our physicians — on a fairly regular occasion and at least once a week — brings in doughnuts," Mahoney says. "He started doing it himself, and it's had an amazing impact on the staff; it shows them that he appreciates them and goes out of his way for them." ■

EXECUTIVE SUMMARY

Staff satisfaction and cooperation is crucial to running a surgery center that's focused on quality and productivity. There are some strategies to achieve success — even as a center is growing by leaps and bounds.

- Keep communication lines open.
- Provide scheduling flexibility to enhance staff's need for work-life balance.
- Physician recognition through lunches, doughnuts can boost staff morale.

With a Smart Focus, ASC Leader Spins Gold from Inventory Changes

Site saves $77,000 in inventory costs

To illustrate just how a few smart changes can reap real dollar rewards, an ASC administrator explained how a materials manager convinced surgeons to cut in half the costs of shoe/boot covers.

"One pair of shoe/boot covers costs about $6 a pair and another one was about $3 a pair," says **Lianne McDowell**, CASC, administrator of South Portland Surgical Center in Tualatin, OR.

The materials manager went into the surgeons' locker room and placed the two different boot cover options and their corresponding prices on benches so physicians easily could see that one was 50% cheaper.

The surgeons were surprised to see the difference in cost and opted to try the cheaper ones, she adds.

That change, along with a number of other tactics, resulted in a $77,000 inventory cost savings from the peak inventory cost, McDowell says.

"Our case volumes have gone up, but our dollars on the shelf have gone down," she adds.

McDowell describes the following techniques for cutting materials costs at an ASC:

• Put the right people in the right roles. "You have good people,

and then you have some people who are roadblocks to what you are trying to attain," McDowell says. "It's about getting the right people in the right places."

There are some positions, like a materials manager or an office manager, where it's difficult to find experienced professionals who also fit well with the organization's culture. Administrators should search for a current staff member who could perform other roles well.

"I look at how people function and do their jobs, and sometimes look at their habits and skills," McDowell says.

The ASC needed a part-time materials manager, and McDowell noticed that a radiographer handled supplies in a smart, efficient way. The employee noticed how some supplies were expired, and he questioned the efficiency of the waste.

"He showed signs of being frugal, and we liked that," she explains. "So it became an opportunity to offer him this job, and it was a fabulous move."

The radiographer spent about half his time on materials-managing work and brought down the center's inventory costs by 30%, she adds.

"He took the time and had the creativity of meeting with reps and looking for cost savings," McDowell says.

In another example, McDowell identified a clinical employee who communicated well and who could be a good fit for the business office. The employee agreed to the change and became a great fit for the role, McDowell says.

"She built spreadsheets, showing who was in network and who was out of network," McDowell says.

"IN OUR SURGERY CENTER, IT DOESN'T MATTER WHAT YOUR POSITION IS BECAUSE WHEN THE CASE COMES OUT AND THE PATIENT COMES OUT, THE TEAM PITCHES IN AND EVERYONE CLEANS UP THE GARBAGE, WIPES DOWN, AND MOPS THE PLACE."

The extra work on spreadsheets paid off as schedulers could see how the ASC would benefit their patients without costing them more than if they were referring patients to the hospital, she adds.

• **Develop materials-sharing relationships with other ASCs.** South Portland Surgical Center has formed mutually beneficial relationships with other ASCs so that if one center needs an item, it can borrow from the other, McDowell says.

Likewise, the ASC can agree to split orders for products that have to be bought in bulk amounts, reducing costs and waste.

"Sometimes you have to buy in packs of three, so maybe one center orders them and sells one of them to another center, doing cost-sharing," she says. "We're actually competitors, but we've come to see each other as building relationships." Be sure to confirm whether laws or rules prohibit sale of such items.

• **Use reprocessed items to reduce expenses.** Some items, such as blades, shavers, and manifolds, can be sterilized and reprocessed instead of disposed, McDowell says.

"It's cheaper reprocessing manifolds than buying new ones, and you go through a lot of them," she says.

Any device marketed as disposable must be reprocessed by an FDA-qualified reprocessing company. If items are reusable, then hospital staff must make certain they reprocess the device according to the manufacturer's written instructions.

• **Work as a team.** "In our surgery center, it doesn't matter what your position is because when the case comes out and the patient comes out, the team pitches in and everyone cleans up the garbage, wipes down, and mops the place," McDowell says.

"We have good nurses, kind people, compassionate people who understand that we're here to accomplish this goal because that's what the surgeons and owners and non-owners need," she explains. "We pay our staff well and treat them well with lunches, gift cards, and thank-you items and fun treats — whether it's a barbecue day with an ice cream truck, or just ordering pizza on a busy day." ■

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A focus on smarter inventory purchases and changing physician habits can reap significant savings for an ASC.

- Show doctors the difference in cost between two supply items.
- Find people with the right skills to put in charge of handling materials and office management.
- Reprocess rather than dispose of costly materials, if possible.

Study Data Before Making Workflow or Productivity Changes

Collect, analyze, adjust

ASCs and their staff develop certain processes and workflow habits over years. Managers and employees often do not imagine they could change these ingrained processes.

This is why a good way to start a project of improving efficiency and productivity is by collecting metrics on current operations.

An ASC can begin by collecting data on how employees currently perform their jobs, suggests **Alfonso del Granado**, administrator of Ashton Center for Day Surgery in Hoffman Estates, IL.

This is how Granado collected metrics: "I analyzed all of the staffing done for the previous year and a half," he says. "I looked at what kind of staff were being used, what position, and for what purposes."

Del Granado also collected national benchmark information, including staff hours per patient, to use for comparison before observing employees as they worked, which wasn't easy. Del Granado says he had to observe surreptitiously and misdirect their attention. If workers knew he was observing them, they might change their workflow or behavior, and that would muddy the data.

"You have to be sneaky about it," he says. "I would walk around with a clipboard and facility checklist, like I'm looking at lights and walls."

Along with data collected through workflow observations, del Granado asked for employees' input.

> "THE PROBLEM WITH A LOT OF ADMINISTRATORS IS THEY WALK INTO THE ROOM AND START DICTATING. IN MY CASE, IT WAS OBSERVING AND ASKING QUESTIONS."

"The problem with a lot of administrators is they walk into the room and start dictating," he says. "In my case, it was observing and asking questions."

Through questions and communicating an openness to creative solutions, del Granado was able to get staff to think outside of their normal workflow.

"As a tech or nurse, you're focused on a specific task to get the patient ready for a procedure, but nobody stops to look around and say, 'Huh, there's a hole coming up,'" he explains. "Our nurses came up with many solutions."

For example, one solution was for the center to use zone defense in staffing. Previously, every nurse was assigned a schedule that was considered fair as it gave each person a certain number of patients to follow. During a day's ebb and flow, nurses would run from one place to the next, with patients in pre-op, recovery, and post-op areas, and data showed this wasted time.

"We were adding time to the nurses' work by having them move from one place to another," del Granado says. "So we assigned nurses to zones, and whichever patient was in that zone belonged to that nurse."

Another issue del Granado observed related to slow turnover rates among one surgeon's patients. The physician complained that the turnover took too long, and the staff working with that physician complained that the physician was never ready when his patients were ready.

The solution? It was simply a matter of paging the surgeon when patients were ready, del Granado says.

"Inevitably, you'll have lag time because one patient arrives late or doesn't come for the appointed procedures, and now there's a gap or a hole in the schedule, and these are accumulative," he says.

The process improved as a result of information-gathering and thinking of outside-the-box solutions. ■

EXECUTIVE SUMMARY

The first step to improving efficiency and productivity is to collect metrics and employee workflow habits.

- Surgery center administrators can surreptitiously observe employees' habits on the job.
- Create an open environment so staff can share creative solutions and ideas.
- Assign staff to zones to save time and improve efficiency.

Create Sound Financial Plan to Carry ASC Through 2017

All about strategic planning

Strategic planning is a little-recognized talent that surgery centers should develop if they hope to achieve their goals and prepare for future growth.

After developing a strategic plan, it becomes the pilot, steering every major future decision.

"Most strategic plans are three-year plans," says **Colin C. Rorrie, Jr.**, PhD, FASAE, CAE, president of CCR & Associates in Dallas.

"It should be focused with a mission and three to four key values," Rorrie says. "Keep the mission short and focused with 10 words or less; you should be able to remember it."

Once the strategic plan is in place, ASCs should ask before each major decision or change, "How does this relate to our strategic plan? Does it really help to implement the mission?"

The next step is to write three or four values that drive the ASC. These can be things such as collaboration and cooperation, and they're each divided into two or three key goals, with two or three objectives per goal, and two or three strategies per objective.

"Once you put that together and it's approved by the board of the ASC and senior staff, working together, I recommend outside assistance," Rorrie says. "Have a third party help you work on the plan."

Outside experts can help an organization stay on top of regulatory and industry changes.

"How do you make sure you are constantly looking forward?" Rorrie asks. "Every time there's a board meeting of ASC leadership, a progress report on implementation of the strategic plan should be on the board meeting agenda."

Then, ask the following questions:

- "How is the implementation working out?"
- "Are we on target to implement those objectives and strategies?"
- "If we're not on target, what is the issue and what can we do to get back on track?"
- "What changes have occurred over the year since the strategic plan was established?"
- "What is the effect on your ASC?"
- "Do you need to make any changes in your current strategic plan, based on the environmental assessment that has been completed?"

It's also wise to ask staff to attend a meeting with leadership to present their assessment of the environment in which the ASC is operating, Rorrie says.

The following are some additional ways to create a useful strategic plan:

• Continuously update the plan. "We recommend the strategic plan be a constant, living document, continuously updating — not an evergreen process," Rorrie says. "It's not a static document you develop in 2015 and then in 2017, you say, 'It's been three years — let's update it.'"

Instead, it might need to be altered each time the ASC adds a new service or when the market changes, such as new ASC competitors opening in the same service area.

"You update it based on the environment and then identify the key priorities to be budgeted for in the next year's plan," Rorrie says.

• Match budget to strategic plan priorities. "The budget developed by an ASC should reflect the key priorities identified in the strategic plan for the coming year," Rorrie says. "If you put a committee together to work on a particular activity, then the charges and specific things to work on should tie back to the strategic plan."

For instance, there are legacy committees that have been around for years, such as a bylaws committee, but no one can say exactly what they're doing. With a strategic plan, the answer should be clear: that the committee's work ties back to the strategic plan, Rorrie says. "The plan drives the budget for the ASC, and it

EXECUTIVE SUMMARY

Every ASC should create a strategic plan that becomes the guidepost to every major decision.

- Make it a three-year plan and keep the mission statement to one sentence, easily memorized.
- Create several values for the mission statement and divide each value into a few key goals.
- Each goal should feature two or three objectives, and each objective should feature two or three strategies.

drives the committees and the work they're doing."

Performance objectives, deadlines, and finance goals all are tied to the strategic plan.

"The performance objectives the administrator is held accountable for ties back to the strategic plan of the organization," Rorrie explains. "Those are the ways we really emphasize making the strategic plan the driving document of the ASC, and it remains relevant by being on the board agenda for every board meeting."

• Detail components of the strategic plan. The mission statement can be as simple as providing quality patient care or providing cost-effective, high-quality patient care. It should be simple enough to repeat to someone in an elevator.

"It should be something everyone in the ambulatory surgery center can remember," Rorrie says.

From there, the goal is to write several value statements that reflect the ASC's culture. These typically are single-word points, accompanied by definitions. Examples might be "quality," "collaboration," and "teamwork."

"We tell people to limit these to four to six, so it's not a laundry list of things," Rorrie says. "If a particular action is being proposed, the first thing you do is say, 'How does this help us implement our mission statement, and does it reflect the values of the ASC?'"

The goals, which follow the values, are broad-based statements that, usually, are not measurable. They have a future focus to them and are unlikely to change during the three-year strategic plan. "So you might have one in the area of finance that says the ASC will remain fiscally viable," Rorrie says. "This is the foundation for your strategic plan."

The next step is to move from the broad-based, non-measurable goal into a more strategic and measurable objective to implement that goal. Based on a goal of remaining fiscally viable, the objective might be to budget for a surplus each year to build the reserves.

"When we start working on objectives and strategies, we implement smart methodology," Rorrie says. "With objectives, we're getting into the specific things we need to do to achieve that goal."

"IF A PARTICULAR ACTION IS BEING PROPOSED, THE FIRST THING YOU DO IS SAY, 'HOW DOES THIS HELP US IMPLEMENT OUR MISSION STATEMENT, AND DOES IT REFLECT THE VALUES OF THE ASC?'"

Objectives should be:

- specific,
- measurable,
- achievable,
- relevant, and
- timely.

"So to budget for a surplus each year — is that specific? Yes. Then is it measurable? Yes. Then is it achievable?" Rorrie says.

If all five adjectives apply, then it stays as an objective. For each objective, the next step is to write strategies for implementing them.

"Strategies are what you're going to do," Rorrie explains. "If we want to budget for a surplus each year, then what are we specifically going to do to make sure we have a surplus? Are we going to make sure our revenue exceeds what our expenses are going to be?"

A strategy could be to plan to raise rates by X percent for certain procedures, which will help the ASC ensure that revenue exceeds expenses.

"You start with the goal of remaining fiscally viable. Then, you implement the objective of budgeting for a surplus each year, and use a strategy to increase rates by X percent in order to help achieve the objective statement of budgeting for a surplus," Rorrie says.

• Leave some space for future details. Although it's important to create concrete strategies, it's not necessary to provide every single detail in advance.

For instance, if an ASC expects to raise rates that year, it's OK to indicate in the strategic plan that the rates will increase, but to leave the amount undetermined.

"We suggest people put a place holder in there and write, 'raise rates by X percent,'" Rorrie says. "Oftentimes, the thing that happens is people want to put a figure in there of 'Let's raise it by 10%,' but we might need to do a background analysis and have the finance staff take a look at it to see what would be the right percentage to increase our rates so we don't wind up with something that is too expensive or too little."

Strategic plan experts know that some details require advice and more data.

"Sometimes, in order to fully develop an objective or strategy and to make the right decision, it will require you to do some background work," Rorrie says. ■

Revisit Staff's Hand Hygiene to Address Infection Control

May 5 is World Hand Hygiene Day

Take May 5 — World Hand Hygiene Day — to make sure infection control and hand hygiene rules and practices are up to date, incorporating both regulatory and advisory guidelines. Hand hygiene is the most important action to prevent healthcare-acquired infections, and, yet, it also is poorly performed, according to the World Health Organization (WHO) and others.[1]

Last year, WHO released guidance and a video, recommending a six-step hand hygiene technique.

The CDC created a Clean Hands Count campaign, using the hashtag #CleanHandsCount. The CDC's recommendation for hand hygiene for surgery involves surgical hand antisepsis, including removing debris from underneath fingernails, using a nail cleaner under running water. The CDC also addresses fingernail care, stating that germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing. The CDC joins other organizations in recommending that healthcare providers do not wear artificial fingernails or extensions when directly contacting patients at high risk, including in operating rooms. Also, the guidelines suggest keeping natural nail tips less than one-quarter of an inch long.

That advice is a little less strict than what some associations recommend, says **Sandy Berreth**, RN, MS, CASC, administrator of Foothills Surgery Center at Sansum Clinic in Santa Barbara, CA.

For example, the Association for Professionals in Infection Control and Epidemiology (APIC) says freshly applied nail polish does not increase germs. APIC also says that chipped nail polish may harbor bacteria, and people with artificial nails are more likely to harbor higher bacterial counts, so artificial nails should not be worn.

A surveyor exploring an ASC might note any fingernail color on direct patient caregivers, including scrub nurses, RNs, and medical assistants, Berreth says.

"That is considered a breach, although some understand the rules better and will say that if you have fingernail polish that is well-maintained and short fingernails, it is OK," she says. "Every surveyor looks at it differently, with some that are very strict."

The Association of periOperative Registered Nurses' (AORN) answer sheet that addresses nail polish in the operating room contains an analysis that says a multidisciplinary team that includes perioperative RNs, physicians, and infection preventionists should make the determination of whether fingernail polish is worn. AORN states that further research is needed to determine whether nail polish affects hand contamination or patient outcomes. The organization has a similar answer for whether ultraviolet-cured nail polish and enhancements may be worn.

AORN says artificial nails should not be worn in the perioperative environment, and this includes any substance or device added to natural nails.

As ASCs revisit hand hygiene policies, they will need to back up policies with evidence from associations and literature.

"We have to realize that people want to follow a policy, but in order for a policy to be carried out, you have to show the evidence — have every policy backed by a standard," Berreth says. "I like to make sure when I develop a policy that I have someone much greater than I who says, 'This is how we should do it to protect our patients.'" ■

EXECUTIVE SUMMARY

World Hand Hygiene Day is coming up. It's a good reminder to make sure the organization's infection control and hand hygiene rules and practices are up to date.

- Follow the World Health Organization's six-step hand hygiene technique.
- Operating room staff should avoid all artificial nails and extenders and keep natural nail tips short.
- While some guidelines permit fresh nail polish, many surveyors will not approve.

REFERENCE

1. World Health Organization (WHO) Five Moments Hand Hygiene. Jackson Health System and Public Health Trust (slide presentation); 2016. Available at: http://bit.ly/2jFSJX8.

Message to Surgery Industry: Here Are the Things I Notice

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

I have worked in the surgery industry for four decades and during that time, I have noticed things that perhaps others have not. The following are some of my observations, with which you may or may not agree.

1. Your facility is overstaffed by at least 10%. Hospitals have a better way to shield this fact due to emergency cases, involved cases that run over, and poor personnel management. ASCs just tend to get away with it because no one is actually looking.

2. Your inventory is way too large. Most facilities have overstocked inventory because their vendors need to dump supplies to make their quota and bonuses, staff doesn't want surgeons mad at them if they don't have exactly what they want, and no one is actually looking at it because they don't know how to gauge it.

3. Most of your staff is insensitive to patient needs, and rude when questioned by patients. Don't believe it? Sit in your waiting room for 30 minutes and observe.

4. Most of your professional staff is underpaid. Compare what your nurses do to the duties and pay of others outside. The poor wages mostly are due to incompetent administration that cannot see beyond the numbers.

5. Your waiting rooms are third-world environments. This is the first exposure your patients and families see when they enter your facility. You are setting up for a bad patient experience right from the start.

6. Anesthesia will not help you in cost control. They have no incentive.

7. If you charge your patients to park while they use your facility, you are cheap and gouging them. Would you go to Starbucks to get a latte if you had to pay to park to get it?

8. Surgeons make no money between room turnover or waiting for delayed cases. This is the biggest reason there are 6,200 alternatives for them instead of you.

9. Most "pre-op" testing is revenue-based and not in the patients' interest or for their protection.

10. Hospitals offer no time incentives for their staff to turn over rooms quickly and start cases on time. Sending staff home with pay when their rooms are finished is a start.

11. Requiring patients to come to your facility two hours before surgery is ridiculous. This just highlights your inefficiency.

12. Only 30% of facilities have updated policies and procedures. Why? Because the odds are that you will get away with it.

13. Eighty percent of you do not capture all your patient charges.

14. Ninety percent of you don't even know it.

15. Most ASC medical directors don't know what is required of them.

16. Elimination of the Affordable Care Act will have virtually no effect on your job.

17. About 99% of facilities do not offer enough supply or equipment storage space. This problem results in cluttered hallways and sterile corridors that make you look "trashy" to patients wheeled into the operating or recovery room. Second impressions also are negative.

18. Most surgeons don't care about your personal issues. Save them for Facebook.

19. All staff resent surgeons talking about their new homes or cars or boats, while they struggle with day care costs and day-to-day expenses. A good surgeon is a quiet surgeon. ■

(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.
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Web: www.earnhart.com.)

COMING IN FUTURE MONTHS

- Getting the most out of value-based purchasing programs
- Improve profits with benchmarking help
- Update on ASC mergers and acquisitions
- Best practices in handling high deductible plans

SAME-DAY SURGERY

CME/CE 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.

CME/CE QUESTIONS

1. **Which of the following is a good strategy for reducing inventory/supply costs at an ambulatory surgery center?**

   a. Put a smart, cost details-oriented person in the role of materials manager.
   b. Reprocess some supplies instead of disposing of them.
   c. Develop supply-sharing relationships with other ASCs.
   d. All of the above

2. **After creating a strategic plan, an ASC's board should analyze its implementation on a regular basis. Which of these questions would not be appropriate to ask during this analysis?**

   a. How is the implementation working out?
   b. Are we on target to implement those objectives and strategies?
   c. Which employees should we fire?
   d. If we're not on target, what is the issue and what can we do to get back on track?

3. **Related to hand hygiene, which rule/guideline do organizations agree should be followed by operating room nurses?**

   a. Do not wear nail polish.
   b. Do not wear fake nails or nail extenders.
   c. Do not use scented soaps.
   d. Do not keep nails too short.

4. **When writing objectives for an ASC's strategic plan, which of the following items would help create the best objectives?**

   a. Write objectives with one-paragraph case examples for each.
   b. Provide hyperlinked references for each objective.
   c. Keep objectives specific, measurable, achievable, relevant, and timely.
   d. None of the above

SDS ACCREDITATION UPDATE

Covering Compliance with TJC, AAAHC, AAAASF, and Medicare Standards

Ready for That Survey? Here are Some Helpful Tips

Know state, federal regulations well

Here's what everyone about to be surveyed has in common: Fear.

"Because of that fear factor, staff and administrators fear the process instead of looking forward to the process," says **Sandy Berreth**, RN, MS, CASC, administrator of Foothills Surgery Center at Sansum Clinic in Santa Barbara, CA. Berreth speaks about regulatory and accreditation issues at national conferences and has served as a surveyor for the Accreditation Association for Ambulatory Health Care (AAAHC).

"I tell people that if you know what you are doing, you don't have to fear any surveyor," she says. "Whether it's a federal surveyor, state surveyor, or organizational surveyor like The Joint Commission, we're there to follow the rulebook."

Surveyors follow specific guidelines in Appendix L of the Medicare Conditions for Coverage for ASCs as found in 42 CFR 416. To fly through the survey, all an ASC needs to do is read, understand, and adhere to the guidelines, Berreth says.

"The key is to not try to cram it in a month before your application is due at your accrediting body," she says. "If you do that, you'll find yourself hyperventilating and having palpitations, and that's not good for anybody — not good for you, and especially not good for your staff."

Berreth offers the following suggestions for how to prepare for a survey:

> "IN THE ENVIRONMENT OF TODAY'S PRESCRIPTION OPIOID EPIDEMIC, EVERYONE IS LOOKING FOR SOMEONE TO BLAME."

• **Create a survey readiness team.** A survey readiness team can make sure certain processes and documentation are compliant. They can be on constant lookout for issues, and can conduct a walk-through to make sure documentation and processes have met the standards, Berreth says.

"You don't have to do the walk-through monthly; quarterly is fine, or every six months" she says. "But if you do it annually, you miss a lot, so I recommend bi-annual at least."

The walk-through should note whether staff and physicians are following the guidelines. It might reveal another strategy to emphasize to everyone who walks through the surgery center that the ASC makes accreditation and standards a high priority, she adds. It also helps to rely on the team approach as surveyors usually ask direct staff, not just administrators, why they follow certain practices.

• **Pay attention to organizational details.** Surgery centers struggle with organizational practices, Berreth notes. This includes administrative functions such as holding board and committee meetings that, on a regular basis, address required standards such as a comprehensive review of the infection control program.

"What happens is organizations are not prepared and try to prepare in a small amount of time, and they do that badly," she explains. "The staff is not prepared for questions surveyors ask."

The way to prevent that deer-in-headlights look when asked a question during a survey is to know the standards and to keep them current, Berreth says.

Standards are the rules organizations follow. If the standards are not current, then it's like playing a game without a rule book.

• Learn the right way to handle credentials. Organizations sometimes over-credential, or they think it's much harder than it needs to be, Berreth says.

"Credentialing is one of the hot topics organizations are trying to get better and better at," she adds.

ASCs sometimes handle credentialing incorrectly, leaving room to improve their process through consistency. For example, one best practice in handling credentialing is to create a schedule that puts everyone on the same cycle, she suggests. Also, ASCs must show they understand the difference between credentialing (verifying and assessing qualifications, such as training) of a provider and privileging (periodic peer review of clinical performance and adherence to standards of care).

• Evaluate the delineation of privileges (DOPs). "Delineation of privileges needs to be extremely well evaluated, especially at reappointment time," Berreth says.

"You need an active list of what surgeons are doing," she adds. "One of the things I have found that works is to not be specific, to always be general."

For example, if a surgery center has Medicare procedures and CMS accreditation, then the center's scope of practice should include every Medicare CPT code, and physicians reserve the right to perform any of the coded applicable procedures. The DOP will say what a specific doctor can do, listing the CPT codes. The physician must review the list and verify that he or she can carry out each of these items.

"Then the list goes to the medical advisory/executive committee, and their peers can agree he can do these," Berreth explains. "Then those privileges are granted."

Organizations must understand that they have to request the DOP, then proceed through the process and document that the physician can perform each listed procedure.

"Organizations have DOPs, but they don't have them marked as to what procedures the physician is actually requesting to be done," Berreth says.

Also, to add new surgeries to the DOP, surgeons must work with administrators, who write a letter or email to the center's board, stating that the physician would like to conduct a new procedure and has completed the required training to do so, she explains.

"Then, the peer board members can say, 'Yes, that's fine,' and they'll grant those privileges based on the information," Berreth says. "Then the administrator can print out the emails, put those with the surgeon's delineation of privileges, adding this one procedure."

The process has to be followed, and while it's not difficult, it does have to happen, she adds.

• Complete infection control worksheet. "This is not a big thing to surgery centers, but it is to surveyors — the infection control worksheet that CMS has out," Berreth says.

"Every surveyor looks at that document a little differently," she says. "We as surveyors are going to walk into an organization, and we'll base our infection control survey on interpretation of CMS worksheet guidelines."

If a surgery center only bases its infection control on federal rules, there is a risk of being out of compliance with a particular state regulation, or with an association's guidelines, or the healthcare organization's own rules.

One example involves rules about nail polish and gels. The conservative approach by the Association of periOperative Registered Nurses (AORN), and also recommended by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA), allows only nail polish. Nail extensions, gels, and artificial nails should not be worn in the operating room because of infection risks, Berreth says.

"On the Centers for Disease Control infection control worksheet, it says that artificial nails or gels are not worn by anyone providing direct patient care," she says. "A gel is a new type of nail polish that is thicker and UV cured."

It's a hot topic for nurses, who are constantly washing their hands and using alcohol rubs. Nurses often think of nail polish as a way to protect their nails, she adds.

Another infection control issue involves wearing masks in the operating room.

Doctors and nurses sometimes take down their masks and leave them hanging around their necks as they walk into other areas. This is something that a surveyor would note, Berreth says.

"When you are breathing into the mask, the mask is filtering bacteria," she explains.

But when a nurse or doctor pulls off the mask and walks up to someone, there is the potential of spreading bacteria, so the healthcare provider should always dispose of the used mask and re-mask, she adds.

"It's the same thing with slinging a stethoscope around the neck," Berreth says. "It drives surveyors crazy when they see that three of your nurses have stethoscopes around their necks."

Remember to institute disinfection policies for these kinds of items, she advises.

Reusing syringes that are attached to IVs also is a habit that would land an organization in trouble with a surveyor, Berreth says. Infectious disease experts now know that there is a problem with back-up fluid that makes this reuse unacceptable. ■

HFAP Changes Standards After Updated Life Safety Code Rules

ASCs must meet environmental safety standards, but they do not always put the most knowledgeable people in charge of this task, which could result in a big mistake.

"The number one problem is when healthcare organizations do not read the standards, or if they read them, they do not understand what is required," says **Brad Keyes**, CHSP, an engineering advisor with the AAAHC of Skokie, IL, and the Healthcare Facilities Accreditation Program (HFAP) of Chicago.

"It's their responsibility to make sure that someone in their organization is knowledgeable on that, and there is no shame or dishonor in asking questions," Keyes says. "Everyone should have some mentor they could go to to ask a question."

Some ASCs will contract with experts to conduct their environmental regulatory compliance on a weekly or monthly basis. Others might hire someone they know who has mechanical skills, even if that person does not have the necessary regulatory knowledge and competence, Keyes says.

"I've seen where an organization knows someone with a retired husband who can do some things, and everyone thinks he is doing a good job until the survey and he says, 'I didn't know I was supposed to do that,'" Keyes explains. "If a person is not working in the life safety industry, sometimes these changes and requirements can be confusing or puzzling."

Keyes wrote the updated life safety industry standards for HFAP, basing them on the new 2012 Life Safety Code, published in a final version in 2016 by CMS.

CMS had not updated the life safety code since its 2000 edition, so a revised version was no surprise, Keyes notes.

"The National Fire Protection Association [NFPA] publicizes life safety code updates every three years, so there have been four editions since the 2000 edition," Keyes says. "There were a lot of people lobbying CMS to adopt the new life safety codes in 2011, so they did their due diligence."

The HFAP environment standards outline what ASCs can do to meet the new rules. The HFAP Accreditation Requirements for Ambulatory Surgical Centers is 33 pages, which includes columns for standard/element, explanation, scoring procedure, and score.

"A big part of code is interpretations," Keyes says. "In many cases, we have to interpret the life safety code to learn how to apply it, and we've done all of that work over the years."

Keyes spent about a month going through the book and updating the standards.

One of the major changes is that fire pumps can be tested monthly, instead of weekly. Another change is that water flow switches in the sprinkler system now are tested semi-annually, instead of quarterly. This relaxation of requirements is a trend in the updated rules, he notes.

"More changes of the life safety code reduce the amount of work rather than add to the work," Keyes says.

The following are some of the other significant changes in the code and standards:

• **Side-hinged fire doors.** All side-hinged, fire-rated doors must be inspected and tested on an annual basis. This requirement is entirely new, and in some healthcare facilities, it is a big change as they might feature 400-plus such doors, Keyes explains.

"In general, the technical committee that writes the standards realized that in the past, healthcare organizations have abused fire doors and did not have a plan to inspect and replace them," he explains. "So, previously, the fire doors would be damaged and wouldn't close and operate properly, and many healthcare organizations did not have a program to inspect them."

The new rule was created to hold organizations accountable for the safety of their fire doors.

• **All NFPA 99 rules apply.** CMS adopted the 2012 edition of NFPA 99, something it hasn't done previously, Keyes says.

"In the past, some healthcare facilities did not have to comply with NFPA 99, and some of these changes will be a bit of a surprise to them," he says. "One of the biggest surprises in requirements is that healthcare organizations have to do a risk assessment to categorize, from one to four, the level of risk of a particular mechanical or electrical system."

The risk assessment shows whether a failing electrical or mechanical system is at serious risk. For example, a failure within an office environment might be rated a low risk, while in an operating room, it could be a high risk. Likewise, an elevator failure in a dental office could be low risk, but high risk in an ICU or ED.

"NFPA 99 is laid out based on the level of risk, rather than based on the occupancy," Keyes says. "That's how you have to evaluate your systems."

• **Performing risk assessments.** Chapter four of the NFPA 99 explains how to perform risk assessments. Although anyone can conduct the risk assessment, it's ideal to employ someone who is knowledgeable and understands the systems. And it's best to put multiple people on the task, Keyes suggests.

Assessors can use any template, but the rule offers three recommendations of risk assessment templates to use.

"I advise clients to use risk assessments by the American Society for Healthcare Engineering [ASHE], which has done a much better job," Keyes says. "ASHE's template is simple and easy to use."

The risk assessments are performed once a year, or when the ASC adds a new level of service.

For example, if an ASC wants to provide a new service that requires heavy use of the medical gas system, then it might result in a facility change and a risk assessment should be performed, Keyes explains.

"Or if an addition is made and it affects the HVAC system, you need to evaluate that and see if there are any changes to patients' health and safety," Keyes says. "It sounds rather ambiguous, but you'd be surprised how many times something changes in the building, and people don't always think about how it affects the level of safety for patients and for the staff."

• **Comply with requirements precisely.** Unless an organization meets the specifics of an exception, it must comply with the requirements of the standards and life safety code, Keyes says.

"For example, the code does list five exceptions for locking doors, but if you don't qualify for any of the five exceptions, then it's a serious issue to not comply," he says. "You have to evaluate what your building is doing and whether it complies with the life safety code."

Also, the person who evaluates the building has to be knowledgeable enough to determine whether the building is in compliance.

"If a small ambulatory surgery center doesn't have a person on staff, then they have to provide that service somehow and go back to get someone to do it," Keyes says. "The challenge is finding a person who is knowledgeable and competent." It may help, for example, to consult with the architect or mechanical engineer who designed the ASC or its mechanical and electrical systems. Also, do not hire a contractor to make changes if this vendor has no real knowledge of Medicare and NFPA standards. ■

Here are Some Sample Items From New HFAP Requirements

New standards = new regulatory rules

The HFAP has released new environmental rules in its accreditation requirements for ASCs. The following are sample items from the new requirements:

• "ASCs must also ensure, however, that the OR humidity level is appropriate for all of their surgical and anesthesia equipment, and that supplies which require a different level of humidity than that in the OR are appropriately stored until used."

• "Each operating room should have separate temperature control. Acceptable standards for OR temperature, such as those recommended by the Association of periOperative Registered Nurses (AORN) or the FGI, should be incorporated into the ASC's policy."

• "Only the altered, renovated, or modernized portion of an existing system or individual component shall be required to meet the installation and equipment requirements stated in NFPA 99."

• "Each system must be evaluated for its potential impact on both the patients and the caregivers if the system should fail. Based on worst-outcome scenario of a failure's impact, the system is assigned a category."

• "Therefore, a Risk Assessment is required for certain building systems that the organization has, based on a documented defined procedure. HFAP does not prescribe what format the Risk Assessment must follow, but NFPA 99-2012 recommends the following documents:

- "ISO/IEC 31010 Risk Assessment – Risk Assessment Techniques;
- "NFPA 551 Guide for the Evaluation of Fire Risk Assessments;
- "SEMI S10-0307E Safety Guidelines for Risk Assessment and Risk Evaluation Process;
- "Other formal process."

• "All Risk Assessments must be available for review during a survey. Only the following building systems are required to be evaluated for categories in a Risk Assessment:

- "Gas & Vacuum Systems;
- "Electrical Systems;
- "HVAC Systems;
- "Electrical Equipment;
- "Gas Equipment."

• "The ASC's medical staff and governing body must adopt written policies and procedures that address the specific types of emergency equipment that must be available for use in the ASC's operating room."

• "The ASC must have qualified personnel capable of using all emergency equipment as necessary."

For more information about the new standards, please visit: http://bit.ly/2izgzjx. ■