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INSIDE

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Bundled Payment Models Growing Slowly in ASCs' World

Trend continues away from fee-for-service model

While bundled payment models are not yet a significant portion of most ambulatory surgery center (ASC) payment arrangements, they are gaining ground. Across the health care industry, 30% of Medicare payments are tied to alternative payment models, including bundling.[1]

In 2016 and 2017, a number of health care forecasters said bundled payments are the ASC trend to watch over the next year.

"From a nationwide perspective, bundled payments still are an extremely small component of anyone's business," says **Marian Lowe**, MBA, senior vice president of strategy for United Surgical Partners International (USPI) in Addison, TX. "I do think you'll see bundled payments be part of the future of surgery reimbursement strategies across hospital and ASC settings, but there is a limited universe of services where they will be extremely valuable because bundled payments work best for services where the beginning and end of an episode is easily defined."

> "FROM A NATIONWIDE PERSPECTIVE, BUNDLED PAYMENTS STILL ARE AN EXTREMELY SMALL COMPONENT OF ANYONE'S BUSINESS."

Bundled payments might not work with some chronic conditions, such as pain management or congestive heart failure, in which patients might not recover or suffer from multiple chronic conditions, and an episode's endpoint is nebulous. But these can

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AUTHOR: Melinda Young
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
AHC MEDIA EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

work in cases of surgical procedures.

"The patient has an acute condition that the surgeon repairs, and the individual can return to their daily activities. In these cases, it's easier to define what is done and who is accountable for the outcome," Lowe explains.

Bundled payment models could be a good fit for ASCs, but the industry's predominant payment model continues to be fee-for-service.

"The vast majority of people are not doing full-blown bundled payment arrangements, but we have seen some of it take off," Lowe adds. "People call what they're doing 'bundled' in the self-pay market to describe something that is more of a case rate for a day of surgery when someone is paying 100% out of pocket."

That's not the same bundle risk as the Medicare demonstrations, where providers are accountable for downstream costs after the person is discharged, Lowe explains.

"What you're not seeing yet is widespread penetration in the commercial payer market of bundles for services because they're running on legacy IT systems that are not set up to administer bundled payments," Lowe says. "Payers have not cracked the code on providing a bundled payment up front to a provider and having them administer the cost and payment of everyone providing service to the patient."

Industry movement toward shared savings, shared risk, and shared responsibility will help transform payment structures for ASCs and other healthcare entities, and bundled payments will be a model that grows with the transformation. *(See story on how to get ready for bundled payments, page 100.)*

"We're going to see more movement to providers being held accountable for cost and quality," Lowe predicts. "Whether or not that's with more bundles or more performance measures that increase or decrease contracted fee-for-service rates, the trend toward value-based payments will grow."

Bundled payments will be part of ASCs' future, says **Steven A. Gunderson**, DO, chief executive officer and medical director of

EXECUTIVE SUMMARY

Bundled payments are a small part of the business for most ambulatory surgery centers (ASCs), but the model is catching on and could be a major future trend in surgery reimbursement strategies.

- Bundled payments work best when there is a beginning and end to an episode, and these are defined easily.
- One bundled payment model involves The Zero Card, a company that connects providers with self-insured employers to offer covered workers their surgeries and other healthcare services with bundled payment options. ASCs can increase their business through accepting bundled payment patients.
- Retrospective bundled payment models direct insurers to pay all the claims to cover care provided for a plan's members, just as they do with fee-for-service payments. The amount paid to the bundled payment target price is compared with target price and then reconciled.

Rockford Ambulatory Surgery Center in Rockford, IL.

"I do think it will continue to grow," Gunderson adds. "But we're still in the infancy."

Rockford ASC has handled about 30 cases that use a bundled payment model in the past year. The ASC works with The Zero Card, a company that connects providers with self-insured employers to offer covered workers their surgeries and other healthcare services with bundled payment options. Employers save significant money on paying claims. ASCs can increase their business, and employees benefit because there are no out-of-pocket copays or costs, Gunderson explains. Employees could choose to pay for their surgery under the typical fee-for-service system, but it would cost them money out of pocket.

"This is something that probably will be great for the future," Gunderson says. "I would be surprised if insurance companies didn't latch on and say, 'If you can do bundled payments with The Zero Card, why can't we do a bundled payment with you, too?'"

ASCs are well-situated to handle alternative payment models, such as bundled payments, because they have better control over costs, and they know their costs well, Gunderson notes.

"Hospitals have to take all patients, those who pay and those who can't pay, so they have a much more difficult job keeping track on their costs than we do," he says.

In hospitals, most bundled payment structures are retrospective bundles, which is the model Medicare uses, Lowe says.

Retrospective bundled payment models direct insurers to pay all the claims to cover care provided for a plan's members, just as they do with fee-for-service payments. Then, they compare the amount paid to the bundled payment target price and reconcile the difference, paying anything additional to the provider or recouping anything paid in excess of the agreed target price, Lowe explains.

"We'll keep seeing value-based payments," she says. "Some will take the form of bundles; some will be adjustments to base rates to reflect performance on cost and quality metrics."

Medicare and other payers are focusing on high-cost, high-volume, and high-variation services in hospitals, which helps move some of these high-cost services, such as total joint replacement and complex spine procedures, to the ASC setting, Lowe says.

"The payment policies and bundles applied to those procedures on the inpatient setting will follow those procedures as they go into the outpatient setting," she adds.

For example, bundled payments can work well with total joint replacement and colonoscopies, Lowe says.

In these procedures, consumers and payers will value the bundled payment's predictability of pricing for the component costs, including facility, surgeon, anesthesiologist, and pathology services, Lowe says.

"If you look to Medicare's bundles as a guide, there is interest in spine and cardiology," She adds. "Surgery centers likely will have a growing interest in many of those same procedures."

Generally, bundled payment plans include case-rate, limited duration, and warranty plans. In a warranty-type model, if patients show up in the emergency room with post-op bleeding or another complication, the ASC would forgo its fee for the surgery because something went wrong, Lowe says.

Examples of bundled payment plans include case-rate, limited duration, and warranty plans. Under a warranty model, if patients arrive at the ED with post-op bleeding or another complication, the ASC would forgo its fee for the surgery because something went wrong, Lowe says.

"You are not at risk for the ER visit costs, but you're saying, 'I'm going to refund the payment if something happens to the patient afterward,'" she explains.

Another type is the all-inclusive, limited duration with warranty risk, bundled payment model. In this case, a surgical benefit management company might negotiate a price for certain surgeries and post-op physical therapy for a week, while assuming partial risk for any adverse events during that period.

"If you accepted that bundled payment, you take responsibility for the patient for that postoperative week," Lowe says. "But once the week is over, you're off the hook."

This model works well for travel surgeries in which people travel from another state or country to undergo surgery at an ASC and then arrange to leave after a week of recovery in a hotel.

A third option is an all-inclusive, episodic, full-risk bundled payment model under which the facility takes full responsibility for the patient for 30/60/90 days after the procedure. This is the model Medicare is experimenting with for joint replacements in hospitals.

"You're fully at risk for what happens to the patient," Lowe says.

The benefit of this model is that substantial savings can be generated by providing care more efficiently throughout the duration of the

episode, but the extra savings might not offset the cost of an occasional patient with a bad outcome, she notes.

"With ASCs, you're largely looking at the first two models: case rate and bundles with warranty-type guarantees," Lowe says. "It's hard to get to that full-risk piece without substantial volume of expensive procedures that have extensive post-discharge costs." ■

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Considering Adding Bundled Payments? Here's What You Need to Know

A win-win-win is possible

The key thing for ASC directors to know about bundled payments is that these are developed to reduce healthcare costs, improve outcome accountability, and create situations in which payers and providers share risk, savings, and costs.

Bundled payment models often include shared risk involving readmissions, ED visits, post-surgical care, and day-of-surgery care, including facility costs, surgeons, anesthesia, pathology, and lab work.

Commercial bundled payment plans seek to move patient volume to providers with favorable contract terms. They also compel doctors and ASCs to think about costs and motivate patients to use certain providers. It's often referred to as value-based care, says **Marian Lowe**, MBA, senior vice president of strategy for USPI in Addison, TX. Lowe speaks at national conferences about bundled payment models.

"You can see bundled payments going in two different directions: retrospective and prospective," she says. "Retrospective is paying fee-for-service claims, and someone is held accountable for the overall spend in a true-up on the back end of the time period. Prospective bundles are when the entity is given a fixed amount of dollars on the front end and is responsible for everything that happens to that patient."

ASCs considering bundled payment models might consider how many patients the contracting organization can offer and which providers will participate. They also should determine the physician's role in selecting and optimizing patients, managing care post-discharge, and collecting quality information. Transparency and accessible data, along with targets and benchmarks, also should be considered, Lowe says.

Surgeons and ASC directors might be skeptical about using a bundled payment model, but it is possible to find a bundled plan that will work for them and in their market, says **Steven A. Gunderson**, DO, chief executive officer and medical director of Rockford Ambulatory Surgery Center in Rockford, IL.

"At first, I felt bundled payments would never work in our community," he says.

But Gunderson kept an open mind, and soon he learned more about the model and was interested.

"I talked with some people who were putting together companies to sell plans to self-insured employers, and one of them contacted me," he says.

When The Zero Card contacted Gunderson, he agreed to put together a bundled payment price.

"I looked at our costs and put together a bundled payment plan that was very favorable to surgeons who participate in it. I pay them a higher percentage of the normal surgeon's Medicare rates," Gunderson explains. "I had no trouble getting multiple surgeons in our community to participate in this."

The ASC has handled about 30 cases since beginning to schedule bundled payment patients six months ago. "It took a little while to gear up," Gunderson adds.

Here's how it works: A patient agrees to use the bundled payment plan instead of their employer's regular insurance. The advantage to employers is that the bundled payment for ambulatory surgery is far less costly than the procedure typically would cost. Employees have an incentive to go with the bundled payment plan because they do not have to pay any deductibles or copays. The surgery is free to them, versus costing them hundreds of dollars out of pocket. From the ASC's point of view, surgeons are happy to receive additional business, and their bundled payment amount covers everything it needs to cover.

"We distribute the reimbursement directly to the surgeon and anesthesia provider, and we keep the difference," Gunderson says. ■

ASC's 'Pit Crew' Brings NASCAR Speed to Turnovers

The turnover rate decreased from 22.5 minutes to 15.8 minutes

When Surgery Center Fremont in Fremont, CA, opened a couple of years ago, the ASC faced multiple challenges, including building a team out of many people who didn't know each other.

The ASC's efficiency effort succeeded in reducing its average turnover time from 22.5 minutes to 17.6 minutes, a 22% reduction, within 30 days of implementing changes. It was reduced even more by June 2017 to 15.8 minutes. The program's creativity and success resulted in Surgery Center Fremont winning the 2016-17 Bernard A. Kershner Innovations in Quality Improvement Award from the Accreditation Association for Ambulatory Health Care (AAAHC).

"After we spent the first couple of months acclimating to the building, there was a whole trust piece of learning how to work together," says **Robin Menefee**, RN, BSN, MBA, nursing director at Surgery Center Fremont.

Employees had not yet learned to think like a team, and this deficit showed in the high turnover time, which was 22-25 minutes on basic cases, Menefee says.

"After our first huddle, we had to focus on that," she says. "We had to work on engagement and helping people get to know each other."

Menefee experienced a creative breakthrough one day while in her Mini Cooper waiting on a red light to change. A man in a racing BMW pulled up next to her, revving his engine and gesturing that he wanted to race. "I thought, 'Of course not!'" Menefee says. "It made me think of a NASCAR pit crew and how they can do whatever they need to do to get a racer back out there quickly, and that's what we're looking for in the OR — fast and efficient," she explains.

Menefee researched NASCAR pit crew work and turned that model into a model for her OR team. *(See story on how ASC cuts turnover time, page 102.)*

"We came up with titles for roles and talked about maintaining those same roles for people when they do a turnover," she says.

For example, the "kick starter" became a pre-op nurse, who starts the IVs for patients. The lack of an IV can delay a procedure. Another role is the "pit boss," which is the charge nurse. The pit boss/charge nurse manages the pit or core of the OR daily, directing staff and making sure cases are staged and prepared before the next case goes into the OR.

The "collector" is the surgical scrub tech, says **Nathalie Waite**, RN, MSN, CNL, registered nurse at Surgery Center Fremont.

"They collect all the dirty instruments and remove them from operating rooms to take to decontamination," Waite says. "Then, they come back into the OR and should be ready to start opening a new sterile table for the next case."

The "compressor" is the role fulfilled by the anesthesia technician, who handles turnover of anesthesia-related supplies and equipment. "They bring in any conditioning devices or airways needed for the next case," Waite says.

The last role is the "sweeper," which is a position assigned daily. The sweeper is the cleaner, the person who wipes down all surfaces, mops floors, takes out trash, and remakes the bed once everything has been cleaned, Waite says.

Each pit crew member had specific goals and tasks related to accelerating the turnover process.

Menefee presented the pit crew concept to the staff, and she hoped her enthusiasm for it would be contagious. But after she introduced the idea, she received pushback from employees.

"I gave them two months to say, 'I don't like this or that,'" she says,

EXECUTIVE SUMMARY

An ASC won a national award for its quality improvement and efficiency project to reduce average operating room turnover time, which was 22.8 minutes.

- One of the first challenges was building trust and a team mentality among the ASC's employees.
- The creative solution was to build team spirit through a NASCAR pit crew model. Then, the organization gave pit crew titles to operating room staff, including "kick starter" for the pre-op nurse, who starts the IVs for patients.
- Reinforce changes through feedback and praising staff for successes.

adding that she listened respectfully to complaints.

After a couple of months, Menefee told ASC staff that the new OR pit crew program would launch for a 30-day trial period. After trying the new process for a month, they could re-evaluate it and talk about improvements.

"After we started using that model, the comments were huge," Menefee recalls. "Doctors noticed the change immediately, and they would comment to staff, saying, 'Things are working so smooth — I love my turnover. What are you doing different?'"

Once the staff received the positive feedback from physicians, their perception of the change began to improve. Staff buy-in also improved when Waite began working at the ASC, soon after the beginning of the implementation, Menefee notes.

"Nathalie had a completely positive attitude and said, 'Sure, I'll do it,'" she says. "I'm not in the OR all the time, so when things are sliding back, I might not see it. But she was there, and she did daily huddles with the team to make sure they understood that this is what we were doing and will continue doing."

Waite embraced her role as pit crew cheerleader. "I have a very loud personality, at times, and I can get people excited about things if I'm excited about it," she says. "Quality improvement is very much about keeping people informed of their successes."

Each day, they'd see a report on turnover times, per room and case. Then, during the daily huddles, the team would discuss the times, what worked, and what could improve.

"People got competitive about it and wanted to do better," Menefee says.

"I have this deep-seated interest in quality improvement and efficiency, so I was excited about the idea," Waite says. "The bottom line is if you are more efficient, you can schedule more cases, and physicians are happy, patients are happy, and staff is satisfied." ■

ASC Initiates Several Changes; Cuts Turnover Time

As often happens with efficiency initiatives and quality improvement projects, the first big effort to make process changes — the low-hanging fruit — can result in swift and significant improvement. The second round of changes often are more challenging as an organization attempts additional improvements.

For the Surgery Center Fremont in Fremont, CA, the challenge was to accelerate and make more efficient the turnover process to use resources more effectively and increase staff, provider, and patient satisfaction.

The first step to reduce its lengthy OR turnover rate was to measure it and record delay reasons for each turnover. The ASC's patient traffic controller used a data collection tool that included a record of delays and the stated reasons for the delays for each turnover. OR members discussed ways to continuously improve the process during brainstorming sessions. Frontline staff, including employees from the OR, sterile processing, admissions, and leadership, identified causes and potential solutions to reduce lengthy turnover times.

The group also built itself into a team that the ASC called the NASCAR Pit Crew Model team. The NASCAR team-building approach improved communication and built trust. This went a long way toward improving turnover efficiency within the first 30 days after beginning the process improvement project. But it took additional data, brainstorming, and effort to further reduce turnover rates and improve efficiency. The following is how the ASC continued to improve its processes:

• **Reinforce "wins" — efficiency and improvements.** When people are engaged and having fun, it's much easier to sell any improvement ideas. One way to make the workplace and its faster pace fun was to recognize staff for their successes, says **Robin Menefee**, RN, BSN, MBA, nursing director at Surgery Center Fremont.

For instance, ASC leaders recognize individuals for their work and compliment the team on its wins. They also hold listening sessions to hear employees' complaints and frustration. Positive reinforcement helped mitigate staff frustration with the faster pace.

• **Boost morale.** Another change was the creation of a good humor committee, Menefee says.

"The short version is that good humor is all about employee engagement," she says. "It's a way for people to be acknowledged and staff-driven."

The committee acknowledges employees' birthdays with signs. There also is a wall of inspiration

that features a different message each quarter.

"This quarter, it's 'focus,' so we have signs and memos and everything that has to do with focusing," Menefee says.

Other inspirational words have included "humor," "strength," and "courage." Group team-building events have included barbecues and fundraising "cupcake war" challenges.

"The lab department challenged us in the cupcake war, and we thought we had the best idea, but the lab won," Menefee says. "We had blind judging, and after they voted, we sold the cupcakes and took the proceeds to donate to a family resource center in the area."

• Hold debriefing huddles each day. The ASC holds daily staff huddles, says **Nathalie Waite**, RN, MSN, CNL, registered nurse at Surgery Center Fremont.

"The huddles became a sort of debriefer at the end of every day," Waite says. "It was a chance for people to adjust to the change."

The end-of-day huddles were created to provide employees with the opportunity to discuss what worked well that day, what they learned, and where they saw opportunities to improve their turnovers, Menefee says.

"Recently, it has transformed into a venue to allow team members to voice frustrations within the group, which has increased the trust level within the team," she adds.

Waite suggested team members focus on the process and team, and not think about the time.

"In theory, if you follow the process, the time will follow," she says. "The most common frustration I heard was, 'You're pushing me, rushing me.' But it wasn't about the time; it was about the process we were trying to implement."

When an employee complained about feeling rushed, the underlying problem usually was that the worker had resorted to old habits and was repeating work that had already been done, or that the person had not followed the process, Menefee notes.

"That's where the pressure and stress were coming from, and some of it we're still working on," she says.

Also, the listening sessions were instructive. For instance, surgical scrub techs talked about feeling that a lot of the work fell on them as nurses pushed to bring in the next patient, Menefee says.

"They would say, respectfully, to that nurse, 'You really made me feel like all I do is turn over rooms,'" she recalls. "And the nurse would say, 'I didn't realize I did that. I'm sorry.'"

The main point was to get everyone to work as a team. Menefee wanted employees to trust that their concerns about feeling rushed, pressured, and pushed would be heard.

• Tackle each step that slows the turnover rate. One issue that affected turnover time was anesthesia regional blocks, Menefee says.

"The issue with regional blocks was related to our not knowing when blocks would happen," she explains. "Sometimes, anesthesia would do a regional block on a joint case, which works great for the patient."

But the problem, initially, was the regional blocks were not added to the schedule. The anesthesiologist would walk in, speak to the patient, and then go through the process of getting an ultrasound, which would delay turnovers, Menefee says.

"So, we spoke with anesthesiologists, asking them to let our in-house scheduler know of the regional block, so she could have it added to the schedule," Menefee says. "People then could prepare for the block, and we'd see it on the OR schedule."

Anesthesiologists made the change, and that helped improve turnover times.

Another problem that slowed the process involved instruments and trays. When there were back-to-back cases, someone had to prioritize the instrument tray for a turnover for the next case. But sometimes, when the tech or nurse in the room would go on a break, there would be no communication about using the tray again; the instrument tray would not be ready for the next case, Menefee explains.

"The tray would be sitting in decontamination," she says. "The sterile processing team came up with an idea to use a pink card system."

Laminated pink cards, which are placed on the OR's white board, indicate which instruments are required for the next patient. This ensures the instruments are ready faster.

"The pink card gives notice it needs to be prioritized," Waite says. "As a nurse, I was never involved in understanding which instruments I needed to have turned over. On a white board, the card is a big flag for me, and I can bring the tray to sterile processing way in advance so it's ready well ahead of time."

Prior to using the pink card system, OR staff relied on word-of-mouth communication, which fell through the cracks as people took their breaks, Waite adds. Plans are underway to purchase additional instruments.

• Keep quality improvements continuous. The program has succeeded in bringing turnover times to the goal range. The next step is to tweak it for further improvements, Waite says.

"There are some hiccups in the sense staff still feel rushed and pressured," she says. "I completed a staff survey several months ago, and

100% of staff felt rushed at turnover, and 58% felt unprepared for the start of the case."

When employees feel unprepared, that affects the efficiency process.

"This new project that I'm helping to start, along with the medical director, is where we expand on the staging process," Waite says. "Staging is part of the pit crew model; it's how we get prepared for an OR case."

The ASC's staging includes supplies and implementation. Eventually, staff members hope to expand it to include medication, positioning devices, equipment, and prep solutions, she adds.

"The goal is to take as much work out of the operating room as possible and get it done in advance," Waite says. "When the turnover occurs, what the nurse and tech need is all over the staging table."

There would be no last-minute search for a chest roll or hip wedge. Rather than pulling only medication vials, they'd pull everything they need to use that medication, including syringes, needles, and alcohol swabs. "Everything would be pulled and placed with meds, so the nurse doesn't have to walk to the cabinet and pull those items," she explains.

All items for all cards are pulled, and preference cards have an area for the hold items. Those items are pulled and placed in a separate basket so employees understand that they'll be held until requested for the case. Items that are unused are restocked at the end of the day. ■

ASC Successfully Improves Timeliness of Surgical Clearance Documentation

Before the ASC focused on the problem, there were too many incidences in which surgical clearance documentation arrived late — sometimes as late as an hour before the surgery.

"They should arrive at least three days out," says **Craig Rosfjord**, RN, BSN, PhN, quality improvement and safety RN at Mankato Surgery Center in Mankato, MN. Three days is the amount of time necessary for reviewing the documentation before patients arrive for their surgery day.

The late-arriving documentation could result in a patient cancellation. It also puts pressure on the anesthesiologist to quickly review the patient's information before clearing the patient for surgery, he says.

"Because of findings in the documentation, the anesthesiologist might say, 'You need another lab test, and that would cancel the patient,'" Rosfjord says.

Mankato Surgery Center tackled this problem, starting several years ago, says **Joleen Harrison**, RN, BSN, PhN, CASC, administrative director at Mankato Surgery Center.

"In the last year and a half, we've made really great strides," she says.

For example, the surgery center's baseline variance report rate was 10.35%, meaning slightly more than one in 10 surgical clearance documents arrived late. Now, the variance report rate is 2.17%. The quality improvement resulted in the ASC being named a finalist for the 2016-17 annual Bernard A. Kershner Innovations in Quality Improvement Award by the AAAHC.

The following is how the ASC addressed the problem:

1. Collect data. Rosfjord collected data on how frequently the surgical clearance documentation arrived late.

"I collected incidence reports that people were filling out and, then, from there I went in and verified the electronic medical records they received here," he says.

With a month's worth of inpatient data, Rosfjord collected metrics on total procedures, variance reports, and referring clinics and physicians.

EXECUTIVE SUMMARY

To prevent last-minute surgery schedule changes and cancellations, it's important for ASCs to receive surgical clearance documentation at least three days before the scheduled procedure. For one ASC, this was not happening often enough.

- The ASC found that last-minute surgical clearance documentation put pressure on anesthesiologists to review patient information quickly, which sometimes resulted in patient cancellations.
- After tackling the issue through a quality improvement project, the ASC reduced its variance report rate from 10.35% to 2.17%.
- After collecting and analyzing data, one of the first steps was to meet with referring providers to discuss the problem and seek solutions.

"It came down to the health history and physical form," he notes. "The HHPF was the documentation that was lacking the most, and it was always the latest."

He found late documentation resulted in a very small percentage of surgical delays, and had not yet caused a cancellation. But the late arriving paperwork resulted in preoperative intake nurses having to spend time making additional calls for the surgical documents to ensure they arrived in the morning of the patient's procedure.

2. Meet with referring providers. Rosfjord met with leadership at the multispecialty clinics that delivered surgical clearance documents latest.

"I explained what the issue was and our goals for when we wanted the documentation to arrive," he says. "We wanted the documentation equal to or greater than three days out."

In introducing the problem, Rosfjord made certain the clinic leaders knew his purpose wasn't to find fault or point fingers. "This is an issue that we can work together to resolve mutually," he says.

The clinics and ASC are part of the same large healthcare organization, Harrison notes.

"We're together in the organization to work collaboratively and help patients as best we can," she adds.

Multispecialty clinic directors took this information to their managers, staff, and physicians, and began to educate everyone about how to get the documentation in on time.

3. Learn reasons behind delays. For education to work, the ASC needed to figure out why the documentation was late.

"One thing we found in our discussions in multispecialty clinics is that schedulers, in their zest to provide excellent service, would schedule surgery within days of the consult, not realizing there wasn't enough time for the primary care physician to get the history and physical, labs, X-rays, and maybe a cardiology consult," Rosfjord says.

Also, some providers didn't know the documentation had to be returned to the ASC so quickly.

"It wasn't intentional that they were holding things back," he adds.

Another issue that slowed the documentation was that it took time for patients to get in to see some specialists, such as a cardiologist for a consult before surgery. When the ASC met with the multispecialty clinic, one cardiologist also attended the educational session and learned how important it was for the ASC to receive the cardiologist's consultation information quickly, Harrison notes.

"The cardiologist decided to see certain surgical patients at a quicker pace, moving them up to a high priority so the information could come back sooner," Harrison explains.

4. Assess improvements. The supervisor of scheduling services of the multispecialty clinic attended the educational session and then took the information to her schedulers to find a solution. They decided to check patients' electronic medical records to see when they were scheduled for a pre-op physical. They would schedule the surgery for a week after that date, giving providers enough time to collect lab and radiology results and submit paperwork to the ASC, Rosfjord notes.

"After the education, we waited a couple of months, and then I did a second study to see what kind of improvements were made," Rosfjord says.

It worked: The variance report rate dropped from more than 10% to about 2%. The 2% rate has held up since then.

"We are now concentrating on other items, such as patient surgical consents' accuracy, when they are filled out, incompletely, in the offices and sent to our facility," Harrison says. "This is making up about 1% of the 2% remaining variances we receive."

To compare its variance report rate with other ASCs, Rosfjord checked online and found a little information, suggesting that a good goal is to reduce variance report rates to less than 5%. Anecdotal evidence suggests there have been additional benefits to improving documentation timeliness. For example, ASC nurses have more time to review patient histories. They can focus on more important aspects rather than taking time to find the health and physical documentation, Harrison says.

"Nurses now can look for issues that need to be brought to the surgeon's attention," Harrison says.

Submitting documentation on time reduces stress on ASC staff, notes **Garret Hilgendorf**, MBA, department manager for nursing and quality at Mankato Surgery Center.

"[Eliminating] some of those panic moments before surgery has increased their engagement," Hilgendorf says. "They can go into surgery well prepared without having to scramble at the last moment to get some of that documentation."

The quality improvement project's success largely was because of team efforts by all stakeholders, Hilgendorf notes.

"Overall, we have a great team that really works well together to make sure every surgery goes off without a hitch, and this was a huge step in making that even better for patients," he says. "We've eliminated things we need on the day of surgery, so staff can focus on what they need to do with the patient in front of them." ■

SDS Manager

Reader Questions From the Summer

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

This summer has been busier than most, perhaps because of the new political climate and the buzz of anticipated changes in the nation's healthcare. Or, it could be just because it is so hot that many are staying in the cool of the surgery department longer than normal. Meanwhile, many readers have submitted questions. Here are some of the more interesting:

Reader Question: In August, you talked about setting up cardiac cath labs within a surgery center. That generated a lot of discussion at our facility. Our docs asked us to check into it, and we found out there is a lot of excitement from local cardiologists to do this. However, we want to do it in conjunction with our current surgery case load and not on separate days as you recommended. Why would we shut down the ASC just for those vascular cases?

Earnhart: As a Medicare Certified surgery center, one of the Conditions of Coverage for an ASC is that the surgery center cannot operate two businesses at the same time in the same space. Per CMS rules, a surgery center is only a surgery center, not a surgery center and a cardiac cath lab. I think you will find that most facilities can accommodate both by expanding hours, and even days, of operation.

Reader Question: We have been approached by a group of GI doctors to start using our surgery center for their cases. We are only performing surgery three days per week, and I am excited about it because it could take much of my staff from part time to full time. Before I approach my investor surgeons about it, I wanted to see if that made sense from a business standpoint.

Earnhart: The short answer is "yes." The longer answer? It depends on several factors, the greatest of which is: How many cases are they talking about? Your typical GI procedure is a relatively low-reimbursed case. Depending on your payor, it can only be between $350-$550. Out of that, you must figure in the cost of equipment and supplies. Although the supply cost per case is relatively low, the equipment cost is not. It can be as high as $300,000 just to outfit one procedure room. Normally, a busy GI doc wants to "fast-track" these procedures by flipping between two procedure rooms, potentially doubling your equipment cost. This is good news for your staff, but you must figure in that staffing expense, too.

Before you approach your business-minded surgeon investors, find out how many cases per month the GI doctors are talking about. Anything less than 200 cases per month might not be in your best interest after you factor in all the above. On another note, the GI doctors probably will want to "invest" in your facility before they bring over a significant volume. This means that some of your current investor physicians would have to dilute or sell some of their ownership for the GI doctors to buy. That may very well be your greatest obstacle, since many investor surgeons in an ASC do not like giving up equity or ownership.

Reader Question: We are building a new surgery center, but the surgeons do not want the expense of classifying it as a Medicare-approved facility. Can they do that?

Earnhart: Yes, they will need to be state licensed, but Medicare certification is not always a requirement. A downside is that they will not be able to provide services to Medicare or federal patients at the facility. Depending on their payor mix, that might not make a difference to them. There are many payors that require Medicare certification or the Medicare Provider Number before they will contract with you, so you would need to check with those providers to see if they have a problem with it.

Of note: The cost of going the extra mile for becoming a Medicare-certified facility is not all that expensive after you have obtained your state license.

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. ■

Study: Pediatric Patients Often Experience Pain, Exhibit Maladaptive Behavior Post-surgery

Young children undergoing ambulatory orthopedic, urology, general surgery, and otolaryngology surgical procedures frequently experience post-surgical pain and exhibit maladaptive behaviors, such as increased crying, difficulty with sleep, and acting out.[1]

Researchers wanted to know whether the maladaptive behavior accompanying post-op pain was a phenomenon in the pediatric population of children 1-6 years of age, says **Lena Sun**, MD, Emanuel M. Papper professor of pediatric anesthesiology at Columbia University Medical Center in New York.

Investigators found that 69% of 204 patients in the study had experienced pain after two to three days, and 17% still experienced pain after one or two weeks post-discharge. The maladaptive behaviors were reported in 55% of children after two or three days and 15% after one or two weeks post-surgery. Investigators used a questionnaire survey to determine the pediatric patients' pain levels and whether children exhibited maladaptive behaviors. They used the Parents' Postoperative Pain Measure (PPPM) and Post-Hospital Behavior Questionnaire (PHBQ).[1]

"We wanted to know in an ambulatory population whether or not this was a prevalent issue," Sun says. "We found it does occur for the first couple of days, but is relatively rare after a week."

Previous research literature reported that children experienced pain for longer periods. But ASCs today are better at taking care of pediatric patients and preventing longer-term discomfort, she notes.

"Our data suggest that the providers are giving children and parents directions to prescriptions to pain medications, and they're very compliant with taking those medications," Sun says. "With this group we've studied, this has contributed to the findings that we're doing a much better job than we used to do."

Communication is key. "Postoperative pain is something that always should be discussed with patients," Sun says.

"It's very challenging to take care of young children," Sun adds. "Especially with surgery and anesthesia, we don't want them to get upset about every potential issue that occurs, so we want to give them the resources they need."

Plus, physicians are better about identifying patients who need pain medication, and they're communicating the importance of treating the children's pain. The surgery team's experience helps identify patients who might experience more pain. They can judge how well pediatric patients might do based on what they observe about patients in the recovery room, she adds.

"Surgeons know which type of surgical procedures are most likely to be painful, and they need to make sure parents are instructed that this procedure will be painful and which medications, including Tylenol and ibuprofen, they might want to think about," Sun says.

If the procedure is not expected to be very painful, then that expectation can be conveyed, too. The point is that ASCs and physicians have gotten better at relaying these expectations along with post-surgery pain instructions.

"In the past, parents either didn't fill the prescription or didn't follow instructions well, so there was a barrier," Sun says. "In our study cohort, the compliance rate appears to be quite good."

The maladaptive behaviors identified in the children was associated with pain, but the other factors that affect such behavior are unknown, Sun says.

"It's not due entirely to pain," Sun says. "There are patients with zero pain who still have maladaptive behavior changes, so it's not 100% related to pain."

This is an area that should be studied further, she adds. It also helps families cope with their children's pain and maladaptive behaviors if they can call someone to whom they can express concerns or ask questions.

"It's important to make sure you have clear instructions and manage expectations and have communication open," Sun says. "Parents should be able to call us from time to time, and I think that needs to be emphasized." ■

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COMING IN FUTURE MONTHS

- QI focus on verifying cleaning processes
- Improve ASC medication management
- One-stop shopping trend drives consumer demand
- Prevent nurse burnout with this strategy

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. 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 an example of a bundled payment plan that ASCs might use?**

   a. Case rate
   b. Limited duration
   c. Warranty plans
   d. All of the above

2. **When Surgery Center Fremont in Fremont, CA, worked to improve its efficiency and reduce its average turnover time, what was the biggest initial challenge?**

   a. Operating room staff did not work well as a team.
   b. The sterilization process was too slow.
   c. Surgeons spent too much time between cases.
   d. None of the above

3. **Mankato Surgery Center tackled a quality improvement project to ensure surgical clearance documentation arrived three days before a scheduled procedure. The surgery center's baseline variance report changed because of the program. How did it improve?**

   a. It went from 20% surgical clearance documents arriving late to 14.3% arriving late.
   b. It went from 8% surgical clearance documents arriving late to 16% arriving late.
   c. It went from 10.35% surgical clearance documents arriving late to 2.17% arriving late.
   d. None of the above

4. **A recent study found that what percentage of young pediatric patients still experienced pain one or two weeks post-discharge from surgery?**

   a. 69%
   b. 43%
   c. 22%
   d. 17%

CME/CE 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 manage-ment practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

SDS ACCREDITATION UPDATE

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

AAAHC Develops Toolkit to Help ASCs, Others Prevent Opioid Abuse

Opioid prescriptions still too high

Opioid prescriptions have declined some in the past year, but remain triple the number prescribed two decades ago, according to a new report by CDC.[1]

At its peak in 2010, physicians prescribed 782 morphine milligram equivalents (MME) per person, up from 180 MME prescribed in 1999.[1]

In 2015, this amount had declined to 650 MME. The recent improvement was offset by a 33% increase in the average days' supply per prescription, from 13 days in 2006 to 18 days in 2015, according to the report.[1]

The opioid data show that physicians continue writing too many opioid prescriptions at too high a dose for too many days, according to **Anne Schuchat**, MD, principal deputy director of the CDC.

To help prescribers halt the opioid epidemic, the Accreditation Association for Ambulatory Health Care (AAAHC) has developed a "Patient Safety Toolkit: Opioid Stewardship."

The group is distributing the toolkit to more than 6,000 accredited organizations, and others can order it online for $10 a copy, says **Naomi Kuznets**, PhD, vice president and senior director at AAAHC.

The toolkit is an 11-by-17-inch poster with practical reminders and information about rating pain. On the flip side, it features information about why preventing opioid dependence is important, the clinical evidence, and references.

"It addresses the primary care chronic issues and procedural issues," Kuznets says. "The idea was to make it brief and to the point and include tools that you could put on the wall and refer to as necessary."

It's not all-inclusive, but contains useful, evidence-based information, checklists, and guidance.

> THE OPIOID DATA SHOW THAT PHYSICIANS CONTINUE WRITING TOO MANY OPIOID PRESCRIPTIONS AT TOO HIGH A DOSE FOR TOO MANY DAYS.

For example, the following is some of AAAHC's guidance on dealing with opioid dependence:

1. Prevent ASC patients from developing opioid problems.

Ambulatory surgery centers (ASCs) can conduct pre-op testing, such as a urine test, to check for opioid dependence and benzodiazepine use. They also can check a state databank to discover if a patient has an active prescription for opioids, Kuznets says.

If patients do have active prescriptions, they should take their opioid medication to avoid excruciating pain, Kuznets says.

"You need to make sure they take their opioids the day of the procedure so they're not in a withdrawal state," she says.

Surgeons also should be aware of the potential for opioid dependence post-surgery. The toolkit cites the statistic that 36.5% of surgical/procedural providers' prescriptions are for opioids. Also, 42% of orthopedists' prescriptions are for opioids.[2,3]

Surgery patients who were not taking opioids prior to their procedures were at greater risk of chronic

opioid use, including those who have undergone laparoscopic cholecystectomy, cataract surgery, transurethral prostate resection, and varicose vein stripping, the toolkit says.[4,5]

Only one in four ASC patients receive education on disposing of unused opioids.[6]

"People don't dispose of the medication," Kuznets notes. "They think, 'I'll keep this for when I have something that's really painful,' and you can't do that with people around in your household that might abuse them."

2. Calculate opioid safe dosages and prevent opioid dependence.

The first section of the toolkit notes how higher dosages of opioids are associated with higher risks of overdose and death, while demonstrating little benefit in reducing long-term pain. Then it provides guidance on calculating the total daily dose of opioids for safer dosage.

One strategy is to help set patients' expectations about post-surgery pain, Kuznets says.

"Talking to patients about this before the procedure is so critical," Kuznets says. "Have the patient consider other types of painkillers."

For instance, a patient undergoing an orthopedic procedure might benefit from a COX-2 inhibitor to reduce pain and provide an alternative to opioids.

Clinicians should discuss alternative pain therapies, such as local anesthetic techniques, acetaminophen, and nonsteroidal anti-inflammatory drugs, with patients and caregivers. Also, some patients might be better suited for inpatient admission so they can be closely monitored.

"It's really important for post-discharge prescribing to know how to calculate safe opioid dosages," Kuznets says. "There are a lot of studies that show people have a lot of opioids left over after procedures."

Until recently, physicians were unaware that patients would hoard leftover opioid pills or sell them, she adds.

"With surgery centers, it's the post-procedure prescribing that's important with regard to calculating," she explains. "Just don't do long doses of opioids, even for bone surgery, because within five days, most people are at the point where they should be weaning off the drug."

> "THERE'S A LACK OF UNDERSTANDING ABOUT LOW-LEVEL, ACHING PAIN VERSUS ACUTE, DISTRESSING, UP-FROM-THE-LEVEL-OF-PAIN-SCALE PAIN, AND WE REALLY NEED TO CONTROL THE EXPECTATION ABOUT ELIMINATING PAIN."

The days of writing high dosages for two-week prescriptions are ending, Kuznets says.

3. Assess patients' pain.

"Use an assessment tool for pain pre-op and post-op," Kuznets suggests. "It's a short tool that is fabulous for most clinicians."

The pain assessment tool, recommended by AAAHC's poster, offers clinicians three questions they can ask patients, including:

- What number best describes how, during the past month, pain has interfered with your enjoyment of life?

- What number best describes how, during the past week, pain has interfered with your general activity?

The answer choices are rated zero to 10.

Pain management goals for post-surgery patients should focus on helping them improve postoperative function and maintain their rehabilitation. It shouldn't be to achieve a specific pain score, Kuznets says.

"There's a trend of using non-opioid pain management — nonsteroidal anti-inflammatories — if you have a patient who can handle those," Kuznets says. "There are lots of options that people are considering more proactively, including TENS [transcutaneous electrical nerve stimulation] units, which are units that interfere with pain signals to the brain."

The whole idea is for surgeons to engage patients in discussions about non-opioid pain relief and to think about prescribing opioids in smaller dosages and for shorter periods, Kuznets says.

"Avoiding the discussion can lead you to some nasty issues and unrealistic expectations about pain control or prescriptions," she explains. "There's a lack of understanding about low-level, aching pain versus acute, distressing, up-from-the-level-of-pain-scale pain, and we really need to control the expectation about eliminating pain."

Editor's note: For more information about the AAAHC opioid toolkit, please visit: http://bit.ly/2w3R4y3. ■

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Create a Policy and Procedure Manual That Works and Is Survey-ready

Staff should find correct answers in P&P manual

The major problem ASCs encounter with creating policies and procedures (P&Ps) is making these applicable to their facilities.

"Policies and procedures are written for the safety of patients, employee validation, quality improvement, risk management, and to guide behaviors in the workplace," says **Jo Vinson**, RN, CASC, director of DeNovo Integration Management at Surgical Care Affiliates of Kernersville, NC. "That's why it's important to have your policies and procedures regularly reviewed and made applicable to your organization."

Facilities that fail to make their P&Ps relevant to their organizations end up with a P&P binder that no one uses. The goal, particularly from an accreditation organization surveyor's perspective, is for the P&Ps to be simple, direct, and thorough enough that employees could open them to the desired section and see exactly the policy they need to follow. Too often, a surveyor or someone questioning employees about specific policies will find that five different employees will give five different answers.

"No one knows the policy, or no one has changed the policy to reflect what they're doing these days," Vinson says. "I've walked in to do surveys and found maybe three different policies on the same procedure."

For example, Vinson found that one ASC's policies said the organization would save all records for seven years past the last date the patient was seen. Another P&P stated the records would be kept 10 years past the last date the patient was seen. A third P&P reflected that the records would be kept for seven years past the date the patient reached maturity.

"These were all in one policies and procedures book," she says. "If someone read the seven-year policy, then they'd purge at seven years. Someone else might say they shouldn't do that until 10 years. Policies should be current, thorough, consistent, and easy to follow."

This type of P&P confusion occurs when an ASC writes new policies but does not remove the old policies. If the two disparate policies are not dated, no one will know which is the most current and should be followed.

"It's recommended that prior policies and procedures should be pulled and retained in a way that you know which P&P was in place at a certain time," Vinson says. "Potential legal issues, including lawsuits, may result in requiring you to produce policies that were in place at the time of a surgery. It is suggested that copies of prior P&Ps are archived for the period of the statute of limitations in your state."

Any ASC that has not reviewed or updated its P&Ps within the past few years probably is overdue for an update. It can take six to 12 months to update them correctly, based on assembling a team and assigning one point person, who is working on the project about 10 hours per week, Vinson estimates.

Vinson suggests the following steps to revamping P&Ps:

• Step 1: Take small bites. Revising the policies and procedures can be overwhelming. Whether an organization is accredited by AAAHC or The Joint Commission, revise P&Ps by process, according to the accrediting body's chapters, Vinson suggests.

The accrediting organization's standards handbook is the best place to start. As the P&Ps are updated, the ASC also should keep state license requirements and Medicare Conditions for Coverage for reference, she says.

"You will want to make sure each policy is up to date, but this should be done by small bites and not with the whole pie at once," Vinson explains.

• Step 2: Put together a team. One person cannot revise P&Ps. It

requires a team effort, because some of the policies are based on the ASC's workflow practices.

"You have to bring in members of the patient care team to provide input, such as 'How are we transferring patients?'" Vinson says.

Start the team with the leader, the person who will be handling most of the work. Then, add team members as needed, depending on which policy is under revision, she suggests.

Team members can help answer questions about procedures and read over suggested policies to offer suggestions and clarity.

They also could help edit policies, keeping them as brief and to the point as possible.

"I've walked into facilities and have seen policies that were 24 pages long. I don't even want to read it as a surveyor, much less as a nurse," Vinson says. "I use the term 'activities of daily operations' — ADOs. It's something I use because we need to make everything as user-friendly for daily operations in our facility."

• **Step 3: Keep accreditation, other standards on desk.** There are many organizations that affect an ASC, and the P&P leader can check with those organizations' requirements and regulations while revising his or her organization's P&Ps.

"Always have those on your desk, so if there's a policy that has to do with the lab or X-ray, you can find those," Vinson says. "If it has to do with radiation safety, then find the state radiation safety rules."

People might want to have just one book for reference to all P&P questions, but it isn't that easy, Vinson says.

"It takes a little thought," she notes. "There are several national guidelines, so read them and see which applies to you."

For instance, ASCs in some states might have rules about disposing of medication. In another state, there are different requirements. Use a checklist to avoid confusion, especially at the beginning, Vinson says. The checklist could list each policy and all the standards that apply to each policy.

• **Step 4: Write a first draft**. Taking the revision one policy at a time and turning each into a chapter can help the P&P leader make progress in writing the first draft.

"I'VE WALKED INTO FACILITIES AND HAVE SEEN POLICIES THAT WERE 24 PAGES LONG. I DON'T EVEN WANT TO READ IT AS A SURVEYOR, MUCH LESS AS A NURSE. I USE THE TERM 'ACTIVITIES OF DAILY OPERATIONS.' IT'S SOMETHING I USE BECAUSE WE NEED TO MAKE EVERYTHING AS USER-FRIENDLY FOR DAILY OPERATIONS IN OUR FACILITY."

"When you finish it, it should be a pretty good draft of policies, and the administration can look at them and go through them," Vinson says. "The medical director and staff also can look at policies that affect them."

Once the draft is reviewed and revised, it's time to complete the final version and submit it to the ASC's governing board for final approval.

• **Step 5: Review P&Ps annually.** After the first major revision, the P&Ps can be reviewed once a year and updated as regulations, guidelines, and practices change. Vinson prefers conducting these reviews one chapter at a time throughout the year.

"A lot of people say they'll look at all of it every December," she notes. But finding time to review the entire book or books of P&Ps can be challenging, so a more pragmatic solution is to review one chapter each month. "Review chapter one in January, chapter two in February," Vinson says. "It doesn't have to be done all at once, and you can divide the chapters among three or four people."

• **Step 6: Archive old policies.** Archive old electronic copies of P&Ps and scan all hard copies of files and P&Ps to retain in an electronic file for as long as necessary or required, Vinson advises. Within the P&P binder, the newest version should be readily available to staff and anyone who needs to find something in it.

"Policies and procedures should be user friendly and accessible," Vinson says. "People will say they can't get to them because they're locked up in so and so's office, but they need to be accessible to [anyone] who [needs to] use them."

Vinson has divided P&Ps, placing pertinent information wherever they are needed. For instance, the P&P section on pathology would be kept in the lab; the old versions should be stored elsewhere.

"I used to keep the old binder with the new one, but it gets very bulky," Vinson notes. "You just need to be able to get to the old version if you need to show someone what the changes are."

Scanning by year that P&Ps were in place is great if you have hard copies. Or, instituting password access to archived electronic copies by year also allows you to maintain copies, she adds. ■