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INSIDE

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CMS Makes Regulatory Changes; ASCs Might Benefit From Trend

Agency wants to move away from mandatory models

The Centers for Medicare & Medicaid Services (CMS) proposed several surgery payment changes in recent months, suggesting that Department of Health and Human Services (HHS) Secretary Tom Price is following through on his stated goals of rolling back regulatory burdens for doctors.

The changes include a July 13, 2017, proposed rule pertaining to the Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgical Center Payment System. The change updates 2018 payment rates and quality provisions and also starts "a national conversation about improving the healthcare delivery system" to make Medicare less bureaucratic and complex.[1]

> THE CHANGE ... ALSO STARTS "A NATIONAL CONVERSATION ABOUT IMPROVING THE HEALTHCARE DELIVERY SYSTEM" TO MAKE MEDICARE LESS BUREAUCRATIC AND COMPLEX.

In August, CMS proposed cancelling episode payment models and the cardiac rehabilitation incentive payment model and to rescind regulations governing those models. In addition, CMS called for revisions to the Comprehensive Care for Joint Replacement Model.[2]

CMS also asked for comments on how to improve payment accuracy to ASCs, noting concerns about the difference between hospital outpatient payments relative to ASC payments. ASCs receive 56% of what their hospital-based outpatient counterparts receive

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in 2017. CMS proposed removing total knee arthroplasty, partial hip arthroplasty, and total hip arthroplasty from the inpatient-only list, making them eligible for coverage in a hospital outpatient department.[1]

Like some other ASCs, Mississippi Valley Surgery Center in Davenport, IA, has been performing joint replacement surgeries for commercial-covered lives for more than a decade. If CMS were to lift its rule requiring inpatient stays for Medicare patients needing total joint replacements, then ASCs could expand their services to more patients. This is a possibility, especially with CMS leaning toward removing inpatient-only status for total knee and hip surgeries, says **Michael Patterson**, FACHE, president and CEO of Mississippi Valley Health's Mississippi Valley Surgery Center.

"Not every patient would be clinically appropriate [for ambulatory surgery], but I predict somewhere around 30-40% of Medicare-age patients could safely have total joint replacement in an ASC," Patterson says. "That's the big news in all of these changes."

Secretary Price's focus on surgeries and reducing regulatory hurdles could lead to even more good news for ASCs.

"CMS proposed to put total joint replacements on a list of what outpatient hospital surgery centers could perform, and that's the first step for a procedure to be eligible for coverage in an ASC," says **Marian Lowe**, MBA, senior vice president of strategy at United Surgical Partners International in Addison, TX. "The agency asked for comments about whether total joint replacements were appropriate for ASCs. I suspect the comments will cut in both directions, given the various stakeholder perspectives on these procedures moving out of the hospital setting and the rates at which the agency has proposed to pay for these procedures. When you think of a Medicare population, there are a lot of people who have comorbidities and who would be inappropriate in an ASC setting, and, yet, there also are many individuals for whom the ASC would be appropriate."

CMS' changes to total joint replacement and incentive payment models appear to be philosophically aligned with Secretary Price's goals.

"To me, this change is a longstanding reflection of signals Secretary Price sent, dating back to his time in Congress, where he thought these demonstrations should primarily be on a voluntary vs. a mandatory basis," Lowe notes.

Still, it's unlikely the joint procedures will be put on Medicare's ASC list before 2019, she predicts.

"CMS will need to be cognizant of the cost of implants and the capital investments that go into a facility to make that procedure possible in an ASC, and they'll need

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) has proposed payment changes related to surgery, including joint replacement procedures.

- CMS proposes to update 2018 payment rates and quality provisions.
- CMS seeks to cancel episodic payment models and revise the Comprehensive Care for Joint Replacement Model.
- CMS sought comments on how to improve payment accuracy to ASCs.

to establish pricing to recognize the cost of the implants," Lowe adds.

Orthopedic surgeons are entrepreneurial, and they could find better patient care solutions, if given the opportunity, Patterson offers.

"They can find ways to care for patients in an optimal way, and a lot of them feel like that does not include care in a hospital," he says. "It could be care in an ASC."

Price and others want a market-based drive in innovation in care vs. CMS dictating policy for practice, which could be why CMS is rolling back aspects of the Comprehensive Care for Joint Replacement Model, he says.

"Surgeons are closest to the patient," Patterson explains.

Surgeons see patients prior to surgery, understand their disease progression, and know firsthand what the patient needs to recover mobility.

"If we put in strict guidelines, then that's all doctors will do, but it may not be what they think is best for their patient," Patterson says.

When it comes to total joint replacement surgeries, several healthcare advances have made this a more feasible option for ASCs. For example, studies have shown that early ambulation helps patients recover more quickly from surgery. Pain management practices have improved, giving patients enough early relief that they can get out of bed and move around post-surgery.[3,4]

"Clinical and technological advances in the [ASC] setting, in general, have made moving these types of complex procedures into that setting possible," Lowe says.

A chief impetus for moving more complex surgeries into the ambulatory surgery setting is efficiency — improvements in both cost and quality.

"We do one thing, and we do it really well, and that's surgery," Patterson says. "Hospitals are multimodal, large facilities that are there to care for a gamut of patient conditions, from oncology to obstetrics to trauma, neurology, pediatrics, internal medicine, and chronic diseases like diabetes, COPD, and CHF."

ASCs become experts on their sole focus of performing surgical procedures, he adds.

"The majority of surgeons want what's best for their patients," Patterson says. "Surgery centers were not about a financial gain; they're about control over how surgeons do their work, and that's the number one reason why [ASCs] came into being — surgeons wanted control over how they spend their days."

CMS' proposal to reduce the number of areas that have to participate in the CMS Innovation Center's Comprehensive Care for Joint Replacement Model and to make all mandatory participation voluntary might produce a negligible impact, Lowe and Patterson suggest.

It's doubtful CMS' move will dramatically shift the pace of change that is largely driven by what is happening with non-Medicare patients, Lowe says.

"It's always difficult for CMS to set up a new demonstration program and the infrastructure to evaluate the impact," she explains. "I think the primary trend you can read into what happened with the CJR demonstration is a trend toward models that are more likely voluntary in nature."

The CMS demonstration projects involving joint surgeries had invested considerable time, talent, and technology to develop what's needed to implement a comprehensive care model. But even if it showed a cost savings, it's questionable whether the savings offset the cost of implementation, Patterson says.

Secretary Price, who was an orthopedic surgeon before serving in Congress, understands what surgeons need. The CMS changes he's proposed, which would give surgeons more flexibility in how to innovate, reflect his belief that surgeons will know what works best. "I think this change will allow those surgeons that really want to innovate to have the flexibility to innovate in how they care for their total joint replacement patients," Patterson says.

"This is especially true if CMS approves to have total joints done on a Medicare patient in an [ASC]," he adds. ■

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Pharmacist Offers Tips on How ASCs Can Prevent Drug Diversion

With opioid epidemic, it's a big issue

Amid a nationwide opioid epidemic, ASCs are not immune to problems related to misuse of controlled substances. Drug diversion should be a chief concern.

"Drug diversion is a huge problem, and with the national opioid epidemic, it's gotten worse," says **Christopher M. Dembny**, RPh, president of Dembny Pharmacy Consultants in Richardson, TX. The company works with 85 surgery centers, overseeing their medication inventory and regulatory compliance.

Even if an ASC has instituted effective checks and balances against theft of opioids and other drugs, it still must complete documentation, such as regular listings of every controlled substance purchased and used, for the Drug Enforcement Agency (DEA).

"Surgery centers and any DEA registrant that has controlled substances is required by the DEA to do a biannual registry," Dembny says. "Every two years, you produce a document that shows how on this date you had each of these items, and there should be a set endpoint if they want to check your audit trail. That is required by law by the DEA, and a lot of people don't realize that it's a requirement."

To meet this requirement, ASCs must retain the blue copy of each DEA form 222 to keep in their records.

"You put that with your invoice to show what you ordered and what you received," Dembny says. "The overriding principle is to have a reproducible audit trail of everything that comes in and out of the facility. Keep all invoices. Keep blue copies of form 222, and keep records of where those drugs went."

Failure to maintain these records could land ASCs in trouble, he adds.

"The DEA won't haul you off to jail because you lost one bottle of morphine, but if someone is ordering morphine on the side and is taking it home, the DEA is going to have an issue with that," Dembny says.

With the right systems in place, diversion is less likely. The difficult part is implementing systems to prevent diversions that one could not imagine occurring.

Dembny offers a good example of a creative diversion: "It's the most embarrassing," he says.

"I had a nurse taking care of the pharmacy in my ASC. Each week, she would order a bottle of Ambien tablets. When the order came in, she'd take the invoice, cut it in half, and cover up the line of the invoice that listed Ambien on it," he explains.

"She sent it to accounts payable to be paid, and unless someone added up the totals, they'd never know there was a line missing," Dembny says. "She got away with that for several months — until we caught her. And it's one of those things where you say, 'How could you let that happen?'"

The nurse was extremely clever about covering her tracks, he says. In addition to doctoring the invoice, she stole the monthly drug vendor's summary of all the controlled substances that had been ordered. She was suspended prior to the discovery of her diversion due to other types of suspicious activity, according to Dembny. During her suspension, another nurse saw the Ambien order and asked someone why the ASC was ordering the drug when it was never used. That was how the ASC learned that the nurse had been diverting pills for several months.

"People will always steal drugs. It's just a question of how long, and in this case, the nurse was very clever and got away with it for a while," Dembny says.

Dembny learned from that experience that monthly summaries from wholesalers must be reconciled with the ASC's inventory. If pharmacists do not see the summary, they should call the wholesaler to ask for it.

Before the Ambien diversion, Dembny was not adamant about

EXECUTIVE SUMMARY

ASCs are at risk of drug diversion, but can reduce the risk by following best practices.

- If an ASC uses controlled substances, it must report all thefts and significant losses to the Drug Enforcement Agency.
- ASC leaders should be aware of staff acting out of the ordinary and possibly stealing drugs.
- Security cameras, monthly inventory-invoice reconciliation, and other strategies can help prevent diversions or catch them early on.

reconciling the monthly reports. "It was a learning experience," he says. "If you do [reconciliation], you don't have wholesale diversion because problems show up immediately. So, every time we get controlled substances, I validate they were added to our stock, and at the end of the month, I take a monthly summary and validate that every item is on that list."

Another good internal check on possible diversion is to direct one person to order the drugs and a different person to receive them, he says. ASC leaders should know that the drug diversion culprit often is the last person they might suspect. "They're the ones who will help you with anything. They might be young, friendly, happy, pretty, and everybody's friend," Dembny cautions.

There are several ways that drug diversions can occur. Some are difficult to detect, and can put patients at risk. For example, a nurse could take a patient's 10 mg of morphine and transfer half to another syringe, giving the patient only 5 mg of morphine.

"If a nurse pops off a top of morphine and puts saline back into it, she's exposing your patients to potential diseases," Dembny says.

This type of diversion is difficult to catch unless someone notices suspicious behavior, or sees that vial has been resealed, or if the ASC operates security cameras in all areas.

Another diversion could occur if an ASC employee opened a new account with an existing drug vendor, disposing of all documentation except for invoices sent to accounts payable. The only way this could be discovered or prevented is if accounts payable employees know how to question an unusual occurrence.

Small ASCs are most vulnerable to this type of diversion, and, occasionally, they are victims of embezzlement because of the same type of practice. Larger and chain ASCs typically put a series of loss prevention systems in place, Dembny notes. Although it's very important to prevent drug diversion from a patient safety standpoint, it's also important to maintain regulatory compliance, and ASCs must provide adequate resources to do so.

"You need to keep all Schedule II invoices together," Dembny says. "Document every location where drugs went after you received them."

"TRACK EVERY SINGLE DOSAGE UNIT THAT COMES INTO AND LEAVES A SURGERY CENTER, WHETHER IT'S THROUGH ADMINISTRATION TO PATIENTS, DESTRUCTION, OR THEFT AND LOSS."

For example, when drugs are administered to patients, documentation of this should be maintained separately from the patient chart, he advises.

"If you have expired medication, you send this to reverse management for destruction," Dembny says.

Reverse management companies are licensed by the DEA to destroy expired substances.

"Track every single dosage unit that comes into and leaves a surgery center, whether it's through administration to patients, destruction, or theft and loss," Dembny says. "If someone steals 10 fentanyls, I report this to the DEA and keep a record of it because I have to account for every dosage unit, including those that are lost."

Technically, organizations have to report all thefts and significant losses of controlled substances. A pill thrown out with the laundry might not be significant, but its loss could be documented. "I'm conservative on interpreting that," Dembny says. "If I lose more than three vials, I say that's significant. If it's one vial a week for three weeks, then that's a trend, and I'll say, 'What's going on here?'"

When losses seem random, but begin to escalate, that's a sign of diversion. As people steal drugs, they often become more careless, he notes. ASCs are required to institute adequate security on controlled substances, but this is not well defined.

"Some people say they have two locks, but the DEA doesn't say anything about two locks," Dembny says. "Adequate security, to me, is a substantial cabinet that is permanently affixed." Security cameras also are very helpful. "A lot of places have a security camera overlooking the drug cabinet," he adds. "And biometric IDs are very helpful."

Thanks to a newly installed security camera, one ASC solved a mystery of a narcotics loss. "After installing the camera, they saw the night maintenance guy was breaking into the supervisor's office, getting the key to the narcotic cabinet, helping himself to drugs, and then using alcohol wipes to wipe down the cabinet," Dembny recalls. "He didn't know the camera was installed on the ceiling."

The employee was fired, and there were no more medication losses. "People will find a way to steal drugs. It's our job to catch them," Dembny adds. ■

It Takes an ASC to Cultivate Moral Resilience in Staff

Error reports increase dramatically

The American Nurses Association (ANA) recently published a draft call to action on cultivating moral resilience as an antidote to nurses' and other clinicians' "moral suffering and distress."

The ANA paper further asks healthcare organizations to "create the conditions where moral and ethical practice can thrive." *(See table below for ANA's actions for nurse leaders.)*

ASCs can act to make ethical practice a priority, and a first step is to recognize what moral suffering and moral failing look like. An example of moral suffering or moral failing can be found when ASC nurses fail to report potentially dangerous practices, situations, or medical errors, says **Dana Bjarnason**, PhD, RN, NE-BC, vice president and chief nursing officer, Oregon Health & Science University (OHSU) in Portland.

"They don't report it for a variety of reasons," she says. "Maybe they didn't want to get somebody else in trouble."

The most overwhelming reason why people fail to report errors is because they fear punishment, according to safety surveys, Bjarnason says.

"At OHSU, I wanted to respond to this by taking a leadership stand and developing a culture of safety statements," she says. "We formed a culture of safety steering committee, and the first task was to develop a position statement for the organization."

They developed the position statement within six weeks, basing it on four principles. Then, the statement was circulated to various stakeholder groups for their endorsement.

"We took this around to professional boards, nursing leadership groups, and a hospital administration team, and we received a 100% endorsement for it," Bjarnason says. "Shortly after it was endorsed, it was entered into the OHSU code of conduct. Then, we developed a speakers bureau and went out to speak with large groups of people about the activities and how we were changing the culture at OHSU to be just a culture where we were encouraging reporting."

Because of these and additional

American Nurses Association's Ideas for Cultivating Moral Resilience

The American Nurses Association (ANA) recently published "A call to action: Cultivating moral resilience and a culture of ethical practice." The 27-page paper offers the following eight steps that nurse leaders can take to help improve moral resilience and ethical practice:

1. Ensure that every individual has access to resources to mitigate moral distress and cultivate moral resilience.
2. Participate in institutional mechanisms to form and support ethical issues such as ethics committees or consultation services to bring the nursing perspective into the dialogue and decision-making process.
3. Develop strategies to support nurses' moral resilience, based on evidence applied from other contexts of resilience.
4. Continue to systematically document and study the effect of individual interventions on nurses' and other clinicians' ability to address moral adversity, such as moral distress.
5. Support your team in ANA's "Healthy Nurse, Healthy Nation" strategies to foster clinician well-being as a foundation for cultivating moral resilience.
6. Become skilled at recognizing, analyzing, and taking ethically grounded action in response to ethical complexity, disagreement, or conflict.
7. Nurse leaders should adopt a standardized screening and intervention tool to recognize and address moral distress and build moral resilience.
8. Incorporate programs aimed at developing capacities and skills in moral resilience, including mindfulness and self-regulation, ethical competence, and self-care into pre-licensure, graduate, and doctoral programs, nursing residency programs, and continuing education. ■

changes and actions, there were positive outcomes: a 29% increase in patient safety incident reporting and a 13% increase in near-miss reporting, she says.

ASCs could employ similar strategies to improve safety and increase team and staff error reporting. Here's how OHSU made it work:

• **Put safety first.** The OHSU culture of safety position statement is one sentence: "OHSU's executive leadership team is committed to improving patient safety at OHSU by fully engaging OHSU leaders and employees in a culture of safety."

That simple directive is amplified in one page that provides context and the culture of safety's four principles. *(See table on the four principles at right.)*

In a preamble, the culture of safety paper refers to the Institute of Medicine and other regulatory agencies, noting they have urged healthcare organizations to create a culture of safety in which safety is a core value and high reliable systems of care are the core strategy.

To transform into a culture of safety, an organization must shift from the pattern of reacting to errors by blaming individuals or teams to an environment in which error reporting is valued as a performance improvement effort, the preamble notes.

"In 2014, an OHSU safety survey validated that many of our healthcare workers underreport errors due to concerns about being blamed, having a colleague blamed, or suffering punitive action from management," the culture of safety position statement preamble says. "We are committed to achieving a 'culture of safety' at OHSU by addressing all aspects of that culture, including creating an environment in which it is easy and desirable for anyone to report an error."

• **Create a "good catch" program.** The good catch program celebrates people who report errors, either after one occurs or "near misses," which are errors that were prevented from occurring.

"We have one of our executive team members go to the area where the person works," Bjarnason says.

The recognized employee receives a baseball hat and glove to wear. Then, the executive team member, supervisor, and a staff member pose for a photo that is turned into a poster. The poster, measuring 16 inches by 20 inches, is placed in the employee's unit and in a conference area. The image also is published on the facility's intranet.

"Some people do blush, but we explain the whole thing to them," Bjarnason says. "We tell them the reason we do it is because our staff said they weren't reporting errors because they would be punished, and so we wanted to make a big scene about thanking people who report errors in our organization."

The culture change and good catch program have become so integrated in the organization's culture that celebrants have come from unanticipated groups. For example, recognition recently went to a student nurse who saw that a nurse he was following had missed a count. He asked, "Are you supposed to do a count at this point? And the nurse said, 'Thank you for noticing. Yes, we should do a count,'" Bjarnason recalls.

"I said to the student nurse, 'Wow! That took courage to speak out,' and he said, 'Are you kidding?' That's the OHSU culture,'" she says.

The nurse who heard his question also has internalized the culture, carrying out her duties in this circumstance, saying "thank you," and then reporting the near miss

OHSU's Four Culture of Safety Principles

The Oregon Health & Science University (OHSU) has developed a culture of safety position statement that lists the following four principles:

• **Just Culture.** We recognize that most mistakes come from systems failures. We are committed to a nonpunitive and transparent response to error reporting. We maintain individual accountability for actions in a manner that reflects overall patterns of behavior and performance.

• **Reporting Culture**. We continuously dedicate ourselves to promoting open reporting of errors. We commit to a response that is objective, timely, reliable, and transparent.

• **Learning Culture.** We develop highly reliable systems and teams by engaging in process improvement efforts, using internal and external sources to guide our learning, and being transparent about lessons learned with patients, families, and all team members.

• **Engaged and Informed Culture.** We are mindful and respectful of the ideas and perspectives of all OHSU employees. We honor the courage of those who raise concerns and foster the development of trusting relationships that enhance our community. ■

to the charge nurse, faculty, and Bjarnason, who then could celebrate the student nurse with a good catch award.

• Adopt and disseminate the ARCC method. After launching the culture of safety program, they soon realized that some staff members do not engage in difficult safety conversations because they lacked the skills to make their voices heard.

They adopted the ARCC method:

- **A: Ask a question;**
- **R: make a Request;**
- **C: voice your Concern;**
- **C: engage in the Chain of resolution.**

The chain of resolution provides nurses and other staff with a fallback if they are unable to succeed using the first three steps of ARCC. If they are unable to speak with or get through to their immediate supervisor or the person who could address the error, then they can let someone else in the organization know what they saw, and that person can handle it.

"We recognize that not everybody will have the courage, authority, and scope to deal with every issue, so we only ask that you let someone know about the error," Bjarnason says. "Don't keep it a secret."

So far, issues have been resolved using ARCC, and the organization's staff recognize that the current culture is one of transparency and open communication, she notes.

"We've been really focused on how the key to being engaged in difficult conversations with others is through developing relationships and influence," she explains.

It also derives from both parties in a difficult conversation recognizing that it's not about either of them, but about the patient and patient safety. Keeping the focus on patients can lead to calm, collected conversations and solutions that move the issue forward and prevent problems from recurring, she adds.

"We developed a 15-minute, mandatory module for all nursing team members about ARCC, and we took it to the school of nursing to have students do the module, too," Bjarnason says.

"We rolled it out, hoping it would be another great tool for our team members as they enter into difficult conversations," she explains. "It should help them talk about problems in a way that prevents people from getting upset or lashing out. We realize it's all about patients and keeping employees engaged."

The module contains a video fireside chat between Bjarnason and the chief medical officer. It drives home the point that employees should always speak up, abiding by the motto of "if you see something, say something."

• Measure results. The culture shift has resulted in people expecting problems to be reported and followed up on. They no longer fear punishment when reporting an error. The organization will collect and analyze results, including following the percentages of incident reporting and near-miss reporting.

"We'll do a national validated survey about the safety environment next year," Bjarnason says.

The ARCC method and culture of safety have been popular with staff, she says.

"People were waiting with open arms for something to help them develop a system for addressing issues in a way that is accepted within the organization," Bjarnason explains. "People were hungry for a systematic way to know and do the right thing." ■

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Preventing Nurse Burnout Starts With Understanding Causes

Leaders can observe, identify signs

There are multiple factors that can contribute to nurse stress and burnout, including job frustration and overwork, poor work-life balance, substance use issues, emotional/family problems, and workplace bullying.

"What's burnout for one person is not the same for someone else," says **Jan Allison**, RN, CHSP, senior director of regulatory at AmSurg, based in Nashville, TN.

"Everyone's needs are different. Our lives are different," Allison says. "We have to do more with less. There are more new services coming into our facilities and greater financial restraints."

Everyone who works in a surgery center has to wear multiple hats, and finding time to spend on their

various responsibilities — outside of patient care — is challenging. For instance, nurses might have to complete audits and organize reports for the different roles, such as quality assurance/performance improvement, environmental safety, and infection control, she explains.

"That is a big struggle for those who wear those hats," Allison says. "Some people don't have the time they need to do the job well, and that's a lot of frustration for people."

For example, nurses with young families need time or help taking their children to various after-school activities. It can be difficult to schedule the day around these activities.

"You can't always get out of the surgery center when you need to," Allison notes. "It requires a balance to meet the needs of the personal life and work life, and that can lead to burnout."

Efforts to prevent nursing burnout can begin with the hiring process. For instance, if an ASC quickly jumps into hiring someone to fill a nursing vacancy, that hire might be the wrong fit for the center. A nurse could present with a great resume and skill set, but a disruptive and bullying attitude, Allison says.

"It's worth it to take more time to ensure that the person we're hiring has the right values," she notes. "You don't want to create an environment that people don't enjoy working in."

Allison has learned from 21 years of working in surgery centers that there will always be ups and downs in the job. But the best experiences occur when the staff gets along and supports each other in teamwork.

"There is nothing that beats that," she says.

Good leadership can provide the support that's needed in creating a good team. The key is for ASC leaders to keep an open-door policy, allowing people to check in when they have a problem. Leaders also need to recognize the signs of burnout and job stress. *(For more information, see story on preventing nurse/staff burnout below.)*

"Provide good recognition of jobs well done, and make sure everyone gets their breaks," Allison says. "I just talked with someone the other day who said, 'We don't ever get a break at work,' and I thought that was not good."

Leadership best practices are when the leader can step in and fill in when the ASC is shorthanded. This should be temporary, as leaders need enough time to monitor staff for compliance, she notes.

"I provide support for regulatory compliance," Allison explains. "People get rushed, lose focus, and skip steps. How will a leader know these things are happening if they're not out there monitoring for this?"

When leaders miss regulatory noncompliance, they miss opportunities to teach and train staff.

"I feel like leaders need to find a balance to lead," she says.

Identifying signs of staff stress and burnout and finding ways to prevent these events can affect an ASC's quality of care, as well as efficiency and bottom line. Organizations with fatigued staff run the risk of employees losing focus and making errors.

"When people are burned out, it reflects in the care you give and reflects in the attitude of your patients," Allison says. "If you're feeling burned out and angry, you're not focused in the same way or treating people in the same way."

After experiencing such fatigue and burnout, Allison understands it. When she was a hospital nurse years ago, she found that she was just working to get the job done and was losing compassion for her patients. "I think it makes a difference and impacts patient satisfaction and safety," she says.

One way to identify nursing and staff burnout is through a survey that asks questions about the employee's fatigue, negativity, and empathy. For example, MindTools.com offers a burnout self-test that contains 15 questions *(http://bit.ly/2w7RHry)*.

Leaders also can discern signs of burnout through observing staff behavior. One sign would be an employee who calls in sick more frequently than usual, or who constantly asks to leave work early. ■

Tips for Preventing Staff Stress, Burnout

It's the nature of ASCs to be fast-paced work environments that emphasize quality of care and safety. Nurses and others working in this setting run the risk of becoming stressed, overburdened, and burned out. However, ASC leaders can take various steps to prevent employees' healthy stress from turning into counterproductive, or even destructive, stress and burnout. The following are a few strategies for establishing burnout prevention practices:

1. Know staff, signs of burnout, and engage in open communication.

Knowing staff's needs helps,

and one way to do this is through an open communication policy. Employees with concerns or issues are more likely to share them with the boss if open communication is an established policy.

Also, everyone in an ASC should be educated on how to identify burnout. They should know why it's dangerous to let it proceed unchecked, says **Jan Allison**, RN, CHSP, senior director of regulatory at AmSurg, based in Nashville, TN.

"Keep communication open to prevent or overcome it," she adds.

2. Recognize, acknowledge, and celebrate staff.

"Give employees the recognition they need and celebrate them," Allison advises.

ASCs also could give staff necessary breaks during which employees could briefly recharge. Leaders could try new workflow strategies to improve efficiency and reduce individual workloads, Allison suggests.

"Provide an occasional lunch for employees," she says. "I remember how we would have so many cases in a day, and there was an automatic free lunch that day."

Small recognition and awards might include a $5 gift card to a coffee shop. Larger ASCs might provide bonuses when a fiscal year reaches its goals in volume. "This makes everyone excited to be busy," Allison says. "It's better to make it rewarding to be busy rather than just punitive if you don't reach your goal."

Another way to reward staff is to encourage creative solutions to any workflow or quality issues the ASC faces. For example, Allison has listened to employees complain about small problems, and she'd say, "Let's get information and make a quality improvement project."

Suddenly, the same disgruntled worker is happily working on a project.

"When people have ideas that they're contributing to make a difference in the workplace, and you are implementing their idea, they're happy," she says. "Our doctors have given staff $100 gift cards to spend at the mall if they suggested an idea that was approved, implemented, and that made a difference."

3. Set a zero-tolerance policy for workplace bullying.

"If you have someone who is negative and brings everyone down, it's better to get rid of that person, letting everyone else work a little harder until you replace the person," Allison says.

The best strategy here is prevention through wiser job interviewing.

"Hire the right person to start with, making sure you understand who the person is as a person and what the person's values are," Allison says. "Make sure they're a right fit for the team."

ASCs can improve their chances of weeding out the bad apples through team interviews. The ASC team can spend time with the new prospects and collectively decide whether that person would be a good fit. Employees would need to be coached on interviewing do's and don'ts, regarding rules and regulations, but it's worth the effort as another nurse's gut feeling might be a sign that a particular prospect would be a troublemaker in the workplace.

"A person might have a gut feeling and find something no one else did," Allison says. "I feel like different layers of interviewing is good."

If this strategy fails and an employee is bullying others, then the best course of action is to deal with the bullying worker immediately, through corrective action or letting the person go, she advises. "Once you let an employee's bullying go on for a long time, it becomes hard to deal with."

A less obvious form of negativity is when a supervisor plays favorites, treating certain employees with more respect and understanding than others are treated.

"Everyone needs to be treated with respect and fairness. You can't let it be obvious to everybody if you have a favorite," Allison says.

It's also possible that a physician is bullying nurses or staff, causing them to be too intimidated to speak up when they see a problem that could affect patient safety. When this occurs, managers must speak with staff and teach them skills on how to speak up for themselves and their patients.

"I've heard stories through the years of physicians who were so difficult they would have tantrums and even throw instruments in the operating room," Allison recalls. "If things didn't go their way, they would threaten to take their cases to the hospital, and those cases typically brought a lot of revenue. The loss of those cases would have a negative impact on the center, so no one wanted to speak up, thinking their job could be at stake if the physician left."

This is why it's important to teach nurses how to advocate for patients, even when it means dealing with a bullying authority, she says.

"Nurses need to be taught a skill set of what to do, and they should be backed by the governing body," Allison says. "If a physician says, 'I refuse to do a time out,' the staff can say, 'I refuse to proceed without a timeout,' and the governing body needs to support that."

4. Encourage healthy habits.

Some ASCs offer employees access to a fitness center and provide a wellness benefit that encourages healthy eating and exercise.

"Encourage people to work out," Allison says.

The wellness benefit can work by giving staff discounts on their insurance premiums, she adds. ■

SDS Manager
Outpatient Surgery on Steroids

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

Who would have thought it possible that we would be performing total hips, knees, multiple level spinal fusions, cardiac caths, stent placements, and send patients home the same day?

We treat a Chinese client who says China keeps patients hospitalized in a bed for 14 days following total joint replacement. Needless to say, they are shocked (and the local hospitals nervous) about the pace of outpatient surgery in the West.

Like many of you, I keep thinking, "No way that can be done on an outpatient basis." Yet, technology, pharmacological advances, and the need to reduce healthcare costs keep pushing it farther than any of us could imagine. We are constructing a freestanding ASC that will incorporate robotics. That was completely unheard of outside the walls of a hospital just a couple of years ago.

I have read and confirmed it with our spine docs that 98% of all spine surgery can be performed within a two-night stay in the hospital. Surgery centers can keep patients up to 23 hours and 59 minutes right now. How long do you think that wall will remain?

It is not just the freestanding for-profit surgery centers that are "amping up" and pushing the envelope. Many hospitals are expanding their offsite outpatient surgery facilities (hospital outpatient departments) to preserve as much of this business as possible and to keep it out of the hands and pocketbooks of the entrepreneurial surgeons. Hospitals also realize that they need a more cost-effective, efficient facility to compete with the for-profit bundling of these prized procedures. By developing what is essentially their own freestanding surgery centers (without physician investors), they can jump on the growing need for more outsourced surgical services and nonhospital rates.

Feeding on the chum-churned water, vendors are adding to the mix the availability of lower cost for the necessary equipment to perform this growing list of procedures outside the mothership. While the mainstream vendors are slow to lower costs, the secondary markets are jumping in with both feet to capture a piece of the expanding pie.

Although outpatient surgery normally was a place for only the healthiest and fittest, the ASA 1s and 2s, that's not true anymore. We are pushing into the 3s and even the 4s to be eligible for the esteemed outpatient qualified status. Helping us are the companies that take much of the burden of the preadmission process and evaluation outside the realm of the on-staff nurses and put it in the hands of the more efficient professionals who only deal with the patient assessment and can communicate better with patients via social media than we ever could with our typical staffing schedules.

The bottom line: The cost of healthcare will continue to rise in the United States and around the world. We are getting older, sicker, and more demanding. Ten thousand people turn 65 years old every day in the United States and will continue to do so for the next 20 years. That is a lot of knees, hips, spines, stents, shoulders, and transplants. The marketplace will find a way to provide surgery to all of them — and still be profitable. Will you? ■

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.

COMING IN FUTURE MONTHS

- Best practices in reporting and investigating infections
- Trends and strategies for ASC-health system joint ventures
- Strategies to cut costs while increasing cases
- Efficiency measures that could benefit all

SAME-DAY SURGERY

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **In 2017, ambulatory surgery centers (ASC) received which percentage of what their hospital-based outpatient counterparts received?**

   a. 46%
   b. 56%
   c. 71%
   d. 85%

2. **Which of the following is a good practice for preventing drug diversion in an ASC?**

   a. Install video cameras in areas where staff can access drugs.
   b. Reconcile wholesalers' monthly medication summaries with the ASC's inventory each month.
   c. Direct one person to order the drugs and a different person to receive them.
   d. All of the above

3. **Regarding an organization prioritizing its safety culture, what is a "good catch program?"**

   a. A good catch is an employee who is caught giving patients superb care.
   b. A good catch is when an organization's security crew catches someone in the act of stealing drugs.
   c. A good catch is when an employee reports a medical error or near miss.
   d. All of the above

4. **Which of the following is *not* one of the strategies ASCs can employ to prevent nursing and staff burnout and stress?**

   a. Recognize, acknowledge, and celebrate staff.
   b. Give staff three tries to improve their attitude and reduce their stress, then fire those who have made no improvement.
   c. Set a zero tolerance for workplace bullying.
   d. Encourage healthy habits.