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INSIDE

RELIAS
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ASCs Must Work Harder to Prevent Aerosol Infectants

Human version of mad cow disease is one risk

Prions and Creutzfeldt-Jakob disease are two issues surgery center administrators rarely consider when reviewing infection control and prevention policies and procedures. But these are part of a cautionary tale of why all surgery centers are better off spending extra time and money to develop the best filters and infection prevention equipment and processes.

"I was doing grand rounds for a university in the Southwest, talking about aerosols, when a CEO came over to me and said, 'Did I understand you that filters can stop prions?'" says **James M. Maguire**, PhD, who has served as a surveyor for The Joint Commission, provides health education, and is with Maguire Healthcare Consulting in Norwich, VT. Maguire also speaks at national surgery center conferences on operating room aerosols.

> THE CHIEF REASON TO FOCUS ON INFECTION PREVENTION AND CONTROL IS THAT INFECTIONS CAN BE DEVASTATING TO PATIENTS AND THEIR FAMILIES.

Prions cause Creutzfeldt-Jakob (CJ) disease, a condition that results in irreversible and serious brain tissue damage. CJ disease is similar to bovine spongiform encephalopathy, colloquially known as mad cow disease.

Maguire told the CEO that one company claims its filters can stop prions. Then, the CEO told him a story about a surgery patient who was discharged without incident — but two weeks later, the facility heard that the patient had contracted CJ disease. After meeting with risk planners and attorneys, facility

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administrators realized that they had to contact all patients who had used the same ventilator during the two-week period to notify them of possible exposure to prions.

"They'll have to follow them medically for the next 25 years because that's how long it takes," Maguire says. "And they'll have to throw away the anesthesia machine, and in the long run it will cost them hundreds of thousands of dollars."

If any patients develop CJ disease, it will cost them even more, Maguire adds. This could have been avoided if the surgery center had purchased the most effective filters. Better filters might increase supply costs, but the tradeoff is better infection prevention and control.

"The price of these filters is $3 or $3.50 for the best ones," Maguire says.

Risk of exposure to prions might be remote, but there are plenty of reasons why ambulatory surgery centers (ASCs) must pay greater attention to sterilization processes, infection control rules and regulations, and staff workflow habits.

The chief reason to focus on infection prevention and control is that infections can be devastating to patients and their families. Knowing that a patient became infected post-surgery also can affect staff morale, says **Tammeria Tyler**, RN, CIC, infection preventionist and quality, and chief post-acute care unit nurse at Southeastern Spine Institute Ambulatory Surgery Center in Mt. Pleasant, SC.

"We try so hard to do everything right," Tyler notes. "If there's a patient infection, we all get bummed."

To ensure best practice and maximize outcomes, it is important that optimal infection control practices are implemented in every ASC. While it is true that ASCs demonstrate very low infection rates, quality demands that all infections are investigated to identify and implement corrective actions to improve outcomes.

"For every action taken within the ASC, it is important that the staff knows why they do what they do and what is the regulation or rule that governs each action," says **Elethia Dean**, RN, BSN, MBA, PhD, chief executive officer of ASC Compliance in Columbus, OH.

Understanding the reasoning behind each action and effort in the ASC will assist in adjusting practices to become a best practice in the industry, Dean adds. A few of the most frequent infection control areas of concern are infection control training, instrument care and handling, and hand hygiene, she says.

EXECUTIVE SUMMARY

Infection control and prevention measures, along with using the most effective filters, can help prevent aerosol infectants, including prions.

- One surgery center encountered a major problem when a patient was diagnosed with Creutzfeldt-Jakob disease post-surgery.
- Minimize risks by instituting thorough infection control policies and procedures.
- Every ASC should obtain the manufacturer's instructions for each instrument used and document the time, temperature, and method for sterilization.

"Everyone in the ASC must have infection control training, including physicians," Dean says. "Where infection control can lapse is when everyone has had training, except the physicians. ASCs might feel physicians can have the requirement waived, but they cannot — everyone needs ongoing infection control training."

Maguire, Tyler, and Dean suggest ASCs improve infection control and prevention by following these steps:

• Use the Centers for Medicare & Medicaid Services (CMS) infection control guide. ASCs should approach infection control from the perspective of a CMS surveyor, Tyler suggests. The CMS ASC infection control surveyor worksheet is helpful. Administrators can use this worksheet annually to check off their own adherence to regulations and standards. *(See story on following the CMS infection control checklist, page 16.)*

"Use the checklist and go through it as if you were the surveyor, and you'd be surprised at how many things you overlook," Tyler says. "Everything you do should be policy-based."

• Follow regulations related to instrument cleaning and sterilization. Surgery centers run into potential infection control problems when instruments are not cleaned and sterilized according to the manufacturer's directions for use.

"It is imperative that every ASC get the manufacturer's instructions for each instrument used and document the time, temperature, and method for sterilization, as well as compliance with manufacturer's recommendations," Dean says.

Manufacturer requirements for sterilization containers are required, as are the instructions for each type of autoclave present in the ASC, Dean adds. It might be tempting, in an effort to save time, to clean only the instruments that were used during the case, but regulations and industry standards require that every instrument opened during a case must be cleaned and disinfected prior to sterilization, Dean explains. Also, there must be documentation of the time and temperature required for each instrument tray, and there should be evidence of compliance.

> "WHEN PEOPLE WASH THEIR HANDS, WATER CAN SPLASH UP AND HIT THE TAP. SO WHATEVER IS ON THEIR HAND WILL GET INTO THE TAP."

"Surveyors will ask for this information during both federal and accreditation surveys," Dean warns.

• Improve filtration and cleaning procedures. As a surveyor, Maguire would ask to see surgery centers' procedures for cleaning equipment. He quickly found that only machine exteriors were cleaned.

"When we looked at the machines, it became apparent that you can't clean the inside of the machines," he says. "I thought there was something wrong here, something we're not paying attention to."

Infectious agents could grow inside equipment, and filters were a main line of defense to keep them from becoming aerosol and infecting staff and patients.

"In these operating room theaters, there is significant airflow," Maguire says. "Even in rooms with high airflow, there are pockets where air is barely moving."

Stagnant air can hold aerosol agents. These bacteria and viruses can spread and colonize. Infectious organisms also can spread via air from humans to equipment, even during cleaning procedures. For instance, investigators have found that tap water faucets in healthcare facilities sometimes contain drug-resistant organisms, Maguire explains.

"It turned out the taps were getting contaminated, not from water coming in, but from aerosols coming in contact with the taps," he says. "When people wash their hands, water can splash up and hit the tap. So whatever is on their hand will get into the tap."

Also, when cleaning crews sanitize and clean patient rooms and the operating room, there's always the chance of lax procedures, like someone using the same cloth to clean the bottom of the sink and to wipe the tap, Maguire notes.

"A colony forming in tap water can be huge," he notes. "Anytime someone turns on that tap, the water, as it rushes past this colony of organisms, has some organisms that slough off and go downstream, and if you wash your hands you come into contact with these organisms."

Once a tap is infected with a colony of drug-resistant organisms, the only way to get rid of it is to turn up the hot water to a high temperature and hyper-chlorinate the building's water system over a weekend or in the evening, when fewer people are using the water, Maguire advises. After wiping out the colony, then a filter on the tap can prevent future colonization.

• Improve hand hygiene. "Hand hygiene is the single most important method of reducing infections in the healthcare setting," Dean says.

"So is the problem of wearing masks hanging around the neck."

ASCs can target hand hygiene with a quality assessment and performance improvement (QAPI) project, Dean suggests. *(See the brief on performing QAPIs, page 17.)*

The surgery center's governing body should set standards for its hand hygiene compliance, such as setting a rate of following all hand hygiene policies and procedures at 95% or whatever percentage is greater than what the ASC already achieves, she says.

Surgery centers can focus on staff education, monitoring hand hygiene procedures, and using peer pressure to encourage greater effort and compliance. For instance, an ASC can post a list of staff percentages on hand hygiene adherence in the break room. The list would not include staff members' names, but each employee would know his or her own adherence percentage. Seeing the high achievers' results would give staff an incentive to reach for that goal, Dean explains.

"I'd tell an employee, 'Your number is too low; you're not washing your hands enough,'" she says. "Then, I'd say that we're going to check hand hygiene monthly, and the governing board will have different people monitoring on different days."

Monitors can use their cellphones to record handwashing rates. This is less obvious to employees than if the monitor used a clipboard to record data, Dean adds. Once an audit is complete and data collected, the ASC can use the information to set a baseline for hand hygiene adherence and set improvement goals.

"Keep the information on the wall. Post actual results of where the staff stands with hand hygiene right now," Dean suggests. "When everyone shows improvement, you can give an incentive, which can be financial or even buying lunch on a surgery day."

The right incentive will lead to success in achieving compliance. Also, with peer pressure, if the incentive is tied to improvement by every staff member, if there is a member who is not participating, other staff can work with that member to achieve the goal set by the governing body, so that the incentive can be achieved, Dean says.

Providing quality care in the ASC is critical in obtaining optimal outcomes, as well as achieving financial success. Infection control practices implemented within the ASC can lead to positive outcomes and higher patient satisfaction levels, Dean adds. ■

ASCs Can Use the CMS Infection Control Checklist to Their Advantage

It's important to base policy on national guidelines

The ASC Infection Control Surveyor Worksheet could serve as a good tool for ASC administrators to use when assessing their own infection control and prevention policies and procedures. The survey is 17 pages of multiple questions with "yes" and "no" options, including the very basic question, number 15: "Does the ASC have an explicit infection control program?" *(The CMS checklist can be found at: http://go.cms.gov/2iYWS7o.)*

For every answer provided, CMS will want to see supporting documentation, according to **Tammeria Tyler**, RN, CIC.

"They like to see a policy based on national guidelines and documentation supporting what you're saying you're doing," she says. "In 2009, CMS said they'd start surveying us on infection control. Then they said you had to have a person in charge of this, a qualified person who is trained in infection control."

Certification wasn't required, but Tyler became certified because surveyors like to see the certification, she notes.

Question 17 on the CMS checklist asks, "Does the ASC have a licensed healthcare professional qualified through training in infection control and designated to direct the ASC's infection control program?" The question's highlighted note states that designating a professional is necessary to avoid a citation, but the person does not need certification, although CMS asks in question 17b: "Is this person certified in infection control (i.e., CIC)?"

"I'm a CIC, which is very hospital-driven, because that was the only thing out there when I became certified in 2013," Tyler explains. "Our patients, typically, are much different than hospital patients, who are ill with multiple comorbidities."

Another important question in the checklist relates to the IC guidelines. Question 16a on the checklist asks: "Is there documentation that the ASC

considered and selected nationally recognized infection control guidelines for its program?" The answer must be "yes," or CMS will consider it a deficiency, related to 42 CFR 416.51(b).

"We use the CDC as our chief guidelines, but we also pull from other sources," Tyler says.

For instance, both the Association of periOperative Registered Nurses (AORN) and the Society for Healthcare Epidemiology of America (SHEA) offer national infection control guidelines.

"A best practices policy is to document what you base your policy off of," Tyler adds.

In another example, question 19 asks: "Do staff members receive infection control training?" A CMS surveyor will want to see documentation of infection control training sessions, how often these have been held, and in what type of settings. There might be infection control training in staff meetings, during inservices, and/or on posters. All these types of education and training should be documented.

"We keep documentation of staff training in a separate binder," Tyler notes.

The CMS surveyor checklist also asks about hand hygiene, including whether patient care areas can readily access soap and water and alcohol-based hand rubs and whether staff perform hand hygiene after removing gloves, before direct patient contact, after direct patient contact, before performing invasive procedures, and after contact with blood, body fluids, or contaminated surfaces.

In addition to following the CMS checklist, Tyler recommends ASCs' designated infection control professionals attend national infectious disease conferences. These both can help them stay on top of the latest information, but also provide valuable networking resources. Once, an ASC patient presented with a strange infection. It made no sense in the context of the patient's procedure, so Tyler contacted an infectious disease expert she met at a conference and told him about the infection, describing the case in detail. The expert offered a plausible explanation: The patient's infectious agent had started in the patient's gut and migrated.

"He pulled two small studies for me," Tyler recalls. "We need to have the ability to pull on these resources when we run into something odd." ■

How Can an ASC Ensure Infection Control Compliance?

An infection control and prevention quality improvement project should be based on a set of standards. These standards start with federal, state, and local regulations, as well as industry standards, such as those from AORN, CDC, SHEA, and the Association for Professionals in Infection Control and Epidemiology.

Quality assessment and performance improvement (QAPI) is a process that should be a part of the policies of every ASC, according to **Elethia Dean**, RN, BSN, MBA, PhD. Regulatory agencies require that the policies are focused on high-risk, high-volume issues and problem-prone areas.

"Secondly, every QAPI program must consider incidences, prevalence, and severity of problems that may arise in the ASC," Dean says. "The ASC should also look at things that affect health outcomes, patient safety, and quality of care."

According to Dean, QAPI programs also should be data-driven and answer these and additional questions:

- What are the procedures the ASC performs most often?
- Looking at data from all recent surgeries, what are the problem areas?
- What is the rate of hospital admissions post-surgery?
- What is the rate of complications post-surgery?
- What procedures carry the highest risk?
- Which populations of patients pose the highest risk?
- What is the rate of post-op infections?
- Are there any patient attributes that could lead to problems, such as patients who are unsteady in their gait?

"Those things indicate the quality of care you give in the ASC," Dean says. "Do internal benchmarking and compare against past performance, as well as external benchmarking, and benchmark against all like entities."

Ensuring quality in an ASC is key to the success of the ASC. Facilities that provide high-quality care tend to treat a higher volume of patients, leading to better success financially, as well as with patient outcomes. Therefore, it is imperative that each ASC keep a finger on the pulse of what could affect quality of care and infection prevention. ■

Onboarding of Staff Should Not Be Haphazard, Rushed Event

During the onboarding process, identify good mentors who could help future new employees

Too often, surgery centers hire new staff hurriedly, trying to keep the fast-paced workflow moving without interruption. This is a mistake, according to **Ann Geier**, MS, RN, CNOR, CASC, chief nursing officer at Surgical Information Systems (SIS) of Alpharetta, GA.

"When they do hire people, they need them right away, so they cut corners," Geier says. "To me, that's a big issue because when people get hired, their orientation is very sketchy, and it doesn't meet the criteria for orientation. It's a mess."

Geier often speaks with ASC staff, asking, "How many of you received a thorough orientation?" Usually, no one answers affirmatively. "Nobody got a thorough orientation, and they find themselves in a job they can't handle, and they're scrounging for help," Geier says.

Couple this deficit with the fact that managers often do not hire "smart," and there can be major problems down the road.

"You have an opening and you're nervous about not having anyone to fill that role," she says. "Your staff is stressed out, and you feel like anybody can do this job, so you hire anybody."

A better solution is to buy some time by hiring a temporary worker from a staffing agency. Then, find the right person and take time to train the right person. This means ASCs should vet new prospective employees thoroughly, including making sure they'll fit in with the ASC's culture and conducting background checks, Geier recommends.

"One surgery center in California had been looking for a director for a year, and they finally found somebody with great references," Geier recalls. "I offered to help them out and found that the person had embezzled in a previous life, but the charges were dropped because she repaid the money."

This is an extreme example of how inadequate vetting could go awry. Here are Geier's suggestions for how ASCs can improve their new staff onboarding process:

• **Prioritize orientation.** The Accreditation Association for Ambulatory Health Care (AAAHC) has set a standard of providing staff orientation within 30 days for new employees. ASCs that are accredited by the AAAHC should include that written timeline into their policies, Geier says.

"Often, when I go into centers for an AAAHC survey, they have not even started their orientation checklist, or they haven't finished it within 30 days," Geier says.

Besides meeting accrediting rules, holding a timely orientation can positively affect teamwork, new employee buy-in, patient safety, and quality of care. Orientation is more than giving staff the policy and procedure manual to read, accompanied by a tour of the center and one day with a mentor, Geier notes. In fact, it should include several specific tasks and procedures, and ASCs could create an employee orientation checklist to ensure all are adequately met. *(See sample items from employee orientation checklist, page 19.)*

"Orientation needs to be done right for every employee," Geier adds.

• **Provide job-specific orientation and training.** Surgery centers that are owned by a health system might let the HR department handle the orientation. This might not be adequate, as it could be too general and not specific to particular roles.

"I suggest the HR department and ASC work together on training," Geier says.

HR departments can handle new staff records, but leave some specific training details to the surgery center. Here are some items that should be on every orientation/staff training list:

- *Infection control plan*: Cover infection control plans and policies, sharps injury prevention, medication administration, if applicable, and biohazardous waste management;

- *Fire safety*: Orientation would include identifying fire exits, extinguishers, pull boxes, medical gas shut-off valves, and the location of personal protective equipment;

EXECUTIVE SUMMARY

When surgery centers hire new staff, administrators should take time to provide a thorough orientation. Rushing through the onboarding process can lead to major headaches.

- Follow accreditation standards for orientation and training.
- Identify the best employees who could serve as mentors or preceptors for new staff.
- Make at least some of the training job-specific.

- *Evacuation and emergency management plans*: Orientation would include showing new staff the building's access and entry codes, when applicable, and review of the internal disaster plan, bomb threats, emergency preparedness plans, CPR protocols, and violence in the workplace plan.

Here are some job-specific items to include:

- take each job description and design competencies for each task outlined on it;

- review new hire's job description with new employee;

- provide a job-specific competency test or tests: If an employee will use a glucometer, then one competency would involve demonstrating use of a glucometer.

• **Select the best mentors to work with new staff.** Sometimes, the best worker can be the worst mentor. It takes knowledge of each employee's skill set and attitude to select people to mentor new employees.

"You will have some people who love to teach and others who are great at what they do, but don't give them a new employee, because they don't like teaching, and they won't help the newbie," Geier says.

For example, when Geier oversaw a hospital's surgical department, the best ortho nurse on staff, the one who was loved by doctors, appeared to be the ideal person to train new staff. "So when I got new employees, I put them with her to train, but she wouldn't talk to them or help them," she says. "I think she was threatened, afraid they'd take her job."

In another hospital, Geier worked with a nurse who talked nonstop and was thought of as a "goofy" employee. But every new employee paired with her would come back and say, "I learned so much from her, and she's fabulous," Geier recalls. "Now, she's an educator for a large health system."

ASC administrators might look for potential preceptors in employees who both like to teach and are effective in verbal communication. One way for a surgery center administrator to determine who would work best as a preceptor for new employees is to walk the floor, observe staff in action, and watch for these indicators of how they might perform in the role:

- Does the staff member have any bad habits or take shortcuts in work? If so, then the new employee likely would pick up those same bad habits, if that person was the preceptor.

- Who is the go-to person in the office or on the floor? Employees who are eager to help also might be willing to assist with new staff.

Preceptors also need some training, including instruction in how to conduct the following tasks:

- act as a liaison between physicians, staff, and the new employee;

- provide constructive criticism and fair evaluations to the new staff member;

- follow rules, policies, and standards precisely as expected;

- maintain an open-door policy for new employees to contact them with any concerns, ideas, and feedback.

• **Follow-up on the orientation.** Even after a thorough orientation, new staff training can continue with follow-up. For instance, managers should review the orientation checklist with employees regularly and complete any missing items. At 90 days, evaluate progress with the new employee's supervisor. ■

Here's a Sample Staff Orientation Checklist

The first step to improving new staff orientation and training is to make it more consistent using an employee orientation checklist. Reliable tools can make the difference between a poorly trained worker and one who has been thoroughly oriented to the new job, says **Ann Geier**, MS, RN, CNOR, CASC. Geier offers these sample checklist items from a three-page employee orientation checklist by the Ambulatory Surgical Centers of America:

- Tour of center and area of responsibility;
- Chemical hazard analysis form;
- Employee handbook review and acknowledgement form;
- Organizational chart;
- Mission, goals, objectives, principles, and signed acknowledgement;
- Exposure control plan;
- Infection control — policies and test;
- Risk management and adverse incident reporting policy;
- Advance directives/patient rights;
- Latex allergy;
- Fire/life safety;
- Utilities and equipment;
- Hazardous materials and waste;
- Security and safety;
- Sterilization/care and handling of instruments;
- Material data safety sheets. ■

Climate of High Deductibles Affects Billing Workflow

Surgery centers have seen an increase in high deductibles in recent years, which has created new billing workflow issues.

"In the past three years in the United States, patients' deductibles in healthcare have increased 50%, and a lot of it is attributed to the Affordable Care Act," says **Kevin McDonald**, senior vice president of sales and marketing at AdvantEdge Healthcare Solutions of Warren, NJ. "More and more, health plans are shifting responsibility from the insurance company to the patient. We're seeing plans become more like catastrophic plans. So, for more people, the majority of cost is coming out of their pockets."

For instance, the average deductible in 2017 was greater than $4,300, double what it was several years ago, McDonald notes. Thus, billing workflow has changed. Previously, the main task would be to verify the patient's insurance, occasionally check the deductible, and then collect the copay. Then, the ASC would file with the patient's insurance and bill the patient for the outstanding amount.

"We may have a $2,500 procedure done on a patient and five years ago, 80% would have been covered," McDonald says. "In today's environment, that $2,500 might be totally the responsibility of the patient. So, we're seeing the accounts receivables skyrocket because of the amount due [from] the patients themselves."

This means ASCs must change how they collect upfront and bill.

"Once the cost drops to the patient's responsibility, and you don't collect up front before the procedure is done, then the collection rate drops to 21%," McDonald says. "That's not ASC-specific, but in healthcare in general — the ASC rate could be higher. But once they leave that front window when they come in, your chance of recovery of that money drops significantly."

Increasing collections at the point of care carries numerous advantages, including:

- increasing overall collections;
- increasing patient satisfaction;
- reducing the overall cost to collect, cutting down the cost of sending statements to patients;
- reducing costs from collection calls;
- reducing bad debt.

Here are some tips on how to increase collection and reduce billing workflow problems:

• **Evaluate current workflow.** For many ASCs, the billing workflow will look the same now as it did 10 years ago. This would be a big mistake.

"I was in one surgery center recently, sitting at the front desk, and I watched patient after patient come in the door, and they collected zero dollars," McDonald says. "They didn't even have a credit card machine at the front door." That's the type of workflow that must change.

• **Provide upfront financial counseling.** ASCs can help patients understand what they will owe in copay and what their remaining deductible is. Providing this counseling will keep the costs transparent, so the patient is not suddenly hit with an unexpectedly big bill.

"This could change someone's role in the front office," McDonald says. "Figure out what the patient will owe and give this information to the front desk and the patient."

The information is based on the patient's current deductible, and the amount should be rechecked on the day before the procedure because it could change, McDonald adds.

"If you check the day before the procedure, you might have fewer refunds to process," he says.

Technology can make financial determinations and counseling easier. A software product could obtain information from insurance companies and compute the remaining deductible and out-of-pocket costs, based on the insurer's and ASC's arrangement, McDonald notes. It's a mistake financially and from a patient satisfaction standpoint to not provide this counseling, he warns.

"My son went in for knee surgery recently, and I knew I would have out-of-pocket expenses because I had not met my deductible," McDonald recalls. "I called the surgery center to say that my son was coming in and to ask for our cost."

The woman who answered the phone was dismissive. "She laughed at me, saying, 'Sir, why do you want to know ahead of time? Just come in, have the surgery, and we'll send you a statement for what's leftover,'" he recalls. "That's the way people have run their business. I pressed her, and she said it might take her 30 minutes, so I told her to put me on hold."

If ASCs want satisfied patients, then upfront cost disclosure is crucial.

"If patients don't know how much the procedure costs and then two months later they get a bill, you have a problem," McDonald explains. "The majority of facilities live in fear of alerting patients up front of what they owe. They think they won't have the surgery done if they know what it will cost them. Would you rather patients

not have the surgery done, or would you rather patients have it done and you don't get paid?"

• **Offer various ways to pay.** It is also important to provide payment options and plans. Credit card kiosks or down payments coupled with monthly plans are other options. Once patients know how much they still owe toward their deductible, they might change their surgery date to improve their financial advantage. So, if they've met the deductible or most of it near the end of a calendar year, patients might wish to schedule the procedure before the end of that year. If they have not yet satisfied the deductible, patients might wish to push surgery into the next year. Some patients maintain a health savings account, which they can use to pay out-of-pocket costs. These patients have saved money for anticipated healthcare expenses, and they can use health savings accounts cards like debit cards.

• **Obtain help from professionals.** "A lot of ASCs use billing companies," McDonald notes. "What I'd also encourage [ASCs] to do is renegotiate their contracts with billing companies."

Billing companies often charge 5% for handling the billing, and that's fine when these companies carry out most of the work, he notes.

"But in today's environment, there's a huge shift where there is a lot more onus on the ASC to collect upfront, and the ASC has not renegotiated those contracts to reflect the change," McDonald says. "The billing cost should be 3% or less because the ASC is taking on more of the upfront work effort." ■

Supreme Court Case, Joint Employer Issues Important in 2018

Several main employment issues, highlighted in recent legal actions, will affect ASCs and other employers in 2018. One of these hot topics is subject to a U.S. Supreme Court decision, which is expected to settle a major issue over arbitration agreements, says **Ed Boniske**, JD, attorney with Higgs, Fletcher & Mack in San Diego.

The Supreme Court has mandated that arbitration contracts are enforceable. Arbitration contracts are documents that outline when an employer and employees are required to settle disputes in arbitration, and they are prevented from inclusion in class action lawsuits. Even if there is an issue that involves exposure to all employees, they can't bring class action, Boniske says.

But in a decision by the United States Court of Appeals for the 9th Circuit (*Morris v. Ernst & Young*), justices vacated a district court's order compelling individual arbitration in an employees' class action, alleging that Ernst & Young misclassified employees to deny overtime wages. The court held that it was a violation of the National Labor Relations Act to require employees to sign an agreement that precludes them from bringing a concerted legal claim regarding wages, hours, and terms or conditions of employment. *(Read the court's opinion at: http://bit.ly/2o23J5u.)*

"The 5th Circuit has gone in the other direction," Boniske says. "This matters because there are 4 million Americans working under arbitration agreements. If the court decision is in favor of employees, it invalidates arbitration agreements."

If the Supreme Court decides in favor of arbitration agreements, then employers can continue to use these and be protected from class action suits. Even for smaller businesses, like independent ASCs, arbitration agreements could be useful.

Another hot topic involves joint employer issues. "We're seeing more and more of these on the litigation front," Boniske says. "More employers are dragged into lawsuits that involve someone who worked for the employer, even for a couple of days or weeks."

In joint employer issues, there is a staffing agency and the staffing agency's client. Employees of the staffing agency, who work for the client, might sue both the staffing agency and the client company. In the case of ASCs, it would be as if a staffing agency nurse sued both the ASC and the nurse's actual employer.

The lawsuits might deal with wage statements, overtime, work conditions, and other issues. The upshot is that ASC owners cannot assume they are safe from workplace lawsuits from contract workers.

"If you have control and direct their day-to-day workflow, you have potential liability as a joint employer," Boniske warns.

One strategy that might help prevent risk from a joint employer issue is for the ASC to make sure the staffing agency follows wage and labor laws. ASCs also can sign a contract that makes the staffing agency responsible for paying for the defense of any lawsuits brought about by a staffing agency's employees.

A third area of legal concern involves disability issues. "This is an area where you can get into trouble very quickly," Boniske says. "Under federal law, your obligation is to accommodate employees with disabilities."

Employers might forget that this law also pertains to people who must take time off of work because of an injury or illness. For smaller employers, this can create a significant burden as they are required to keep the employee's position open, but they also must find someone to perform the work while the employee is off work. Employers are expected to first engage with the employee to find out what kind of accommodation they will need, Boniske says.

"You should engage in a good faith process to determine the nature of their disability and what accommodations you might offer," he says. "This doesn't just mean accommodations to the workplace; it also might include an extended leave of absence or reduction in schedule."

There is an exception to the rules when there's undue hardship to the employer. "That's the one where I get a lot of calls," Boniske says. "People ask, 'What if my business can't afford to have an open seat?'"

Keeping a job open for a sick or disabled employee can be a big burden, but it might not qualify as an exception, depending on individual details of the case.

"The court will consider the length of disability and the nature of the restriction," Boniske says.

"If I have a client who gives me specific facts about the employee's issue, then I can guide them through the process," he explains. "Be very careful, work slowly, document every step, and make sure you're checking the boxes: documenting when you first had a conversation with the employee, how you offered an accommodation, and the employee's response."

Documentation is very important, particularly if the employee is fired later.

There is another issue employers should keep in mind about these cases involving disability: "Accept the medical notes you receive from healthcare providers," Boniske advises. "Often, employers will say, 'They got this doctor's note, but I don't buy it.' It's not up to you to make that decision." ■

Quick Steps to Increase Surgery Center Efficiency

Surgery centers seeking answers to improving efficiency could tackle staff cross-training and a communication improvement initiative. Any improvement in these areas can create a better team environment and improve productivity, says **Jeany Dunaway**, RN, CASC, administrator at Effingham Ambulatory Surgery Center in Effingham, IL.

Dunaway offers these suggestions for making these improvements work:

• **Cross-training.** "Cross-training allows staff to take accountability in several areas and improves morale, productivity, and job satisfaction," Dunaway says. "For example, if you are a scrub nurse in the OR, and you're also a circulating nurse, you understand better what that role is of that person on your team who is working with you. You take more accountability, and you work better with that person on your team because you know what that role requires."

Cross-training also is very helpful from a workflow standpoint, especially for smaller ASCs. For instance, when Effingham ASC places staff on maternity leave, there are cross-trained staff to fill in, Dunaway says.

An ASC could require staff to be cross-trained. Or, the surgery center could make opportunities for cross-training available to whoever is interested.

"If employees are interested in another role, they come to me and let me know that," she says. "I will have someone who has a lot of experience serve as a mentor and train the employee as time allows."

Sometimes, the staff member's cross-training desire does not fit the surgery center's current needs. When this happens, there can be a compromise. An example is when Effingham ASC scrub nurse in the operating room wanted to learn post-op work, Dunaway recalls.

"We couldn't do that for a few months because we were too busy," she says. "So I told her that I realized she hadn't gotten to train in the post-op area yet, and it was because of staff being out on maternity leave."

The key is to acknowledge the request and use a common-sense approach to explain why the request would need to be postponed. Cross-training mentors can be any employee who is skilled at the job and at teaching. For example, a scrub technician could teach the RN how to scrub. "Some people are good at their jobs, but they're not the best teachers, so it goes by experience and instincts," Dunaway explains.

• **Communication.** "If everyone feels they are being communicated to and are part of a team, then the team is more effective and more efficient," Dunaway says.

Dunaway maintains an open-door policy for people to speak with her about any issue, and the ASC holds a monthly staff meeting. She also places the meeting's agenda in a communication book so that people who are not there every day can look at the book to see what meetings were about. Daily huddles are important for maintaining communication among staff.

"The nurse that does pre-op calls, anesthesia, and someone from the pre-op OR and post-op all meet together daily to talk about the next couple days of patients," Dunaway says. "They discuss arrival times, patients with any potential problems, like someone who has a difficult airway, and they make sure we're bringing patients in within a reasonable time."

If someone sees a potential red flag, the person might say there isn't enough time for a case, and the team will have to adjust.

"It's a good overall look at our patients and procedures, every afternoon, and it's pretty much [about] 4:00 when we're done for the day," Dunaway says. "We find that's the best time because not everyone is here at 6:30 a.m. when the OR starts." ■

SDS Manager

Checklists and Decision Trees

By Stephen W. Earnhart, MS
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It's the planning time of year for your facility. At our facility, we're engaged in the following projects for 2018. These individual projects are diverse and they're across the country. Perhaps you're planning similar projects.

1. Restructure the governing body.
2. Modify the facility for the total joint program.
3. Recruit new surgeons.
4. Reduce operating expenses.
5. Re-syndicate the facility.
6. Develop new ASC.
7. Add "recovery suite" for 72-hour stays.
8. Add cardiac cath lab into the surgery center.
9. Add orthopedic urgent care center as feeder to ASC.
10. Audit expenses and adjust.

Although each project is different in scope and location, they all feature one common trait: A planning schedule. Someone said that every great idea needs a timeline to be effective. This is so true and relevant to all these endeavors.

At what point did everything seem to get more complicated in life? It seems like getting from point A to point B in any endeavor is almost overwhelming. It is not just the regulations, but the sequence of regulations that compound every task.

For example, over the years, we have developed a checklist for developing a new freestanding surgery center. This list grows each year as more regulations come into play for each state and for Medicare. Not only do we have to abide by a 523-item checklist, but we also have to execute certain tasks before each item on that list as well as what tasks have to follow the completion of the previous task. These procedures have saved us many hours and eliminated wasted efforts. This is one of our planning schedules that we just cannot function without.

In addition to a strong, well-crafted schedule and checklist (certainly a group effort), it's important to create a decision tree for when a once-viable path to completion becomes entangled in regulations, which requires a change in course (and checklist).

There are many templates for both the checklist and decision trees online that can accommodate just about anything in your facility or life that you are looking to accomplish. Check them out and get started.

When it comes to healthcare in the United States, goals seem to take longer to achieve than one would expect, cost more than they should, and will not please everyone, no matter what you do. That said, if you are not moving forward, you are going to get passed by everyone else that is planning new concepts and programs. We all play in a very competitive sandbox and the competition is getting fierce. You don't want to get caught off guard. Create a solid plan of action for your 2018 planning based on your individual marketplace.

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. ■

SAME-DAY SURGERY

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.

CE QUESTIONS

1. **Which of the following would be a good quality assessment and performance improvement question to ask as a surgery center looks at its own infection control and prevention policies and practices?**

   a. What are the procedures the ASC performs most?
   b. What is the rate of hospital admissions post-surgery?
   c. What procedures carry the highest risk?
   d. All of the above

2. **How many days do ambulatory healthcare facilities have to provide staff orientation to a new employee, according to a standard by the Accreditation Association for Ambulatory Health Care?**

   a. 21 days
   b. 30 days
   c. 45 days
   d. 90 days

3. **According to a three-page employee orientation checklist by the Ambulatory Surgical Centers of America, three of the following items should be included in an orientation program. Which one is not on the list of what should be included?**

   a. Employee handbook review and acknowledgement form
   b. Sexual harassment procedures
   c. Organizational chart
   d. Latex allergy

4. **What are arbitration contracts?**

   a. Documents that outline when an employer and employees are required to settle disputes in arbitration, and they are prevented from inclusion in class action lawsuits.
   b. Documents that are an option for employees who cannot afford to hire an attorney during a dispute with their employer.
   c. Documents that are enforced when a surgery center is in a dispute with a staffing agency.
   d. None of the above