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## INSIDE



# Human Traffickers Increasingly Take Victims to Outpatient Health Providers

*Even surgery centers might see victims*

Modern slavery, also called human trafficking, harms an estimated 21 million people around the globe. Victims include immigrants, young adults, and adolescents in the United States. They come from the suburbs, as well as the cities, and they work in brothels, farms, factories, beauty parlors, private homes, construction, and other places, according to Human Rights First *(Learn more at: http://bit.ly/2LgDJOa)*.

Sixty-eight percent of these victims might be hiding in plain sight. They visit EDs, urgent care clinics, and see nurses, primary care doctors, obstetricians/gynecologists, and other healthcare practitioners.[1]

Ambulatory surgery centers (ASCs) also see but rarely recognize these victims. "A number of studies show us that the majority of trafficking victims in the United States access healthcare at some point during their exploitation," says **Hanni Stoklosa**, MD, MPH, emergency physician, Brigham and Women's Hospital, director of the Global Women's Health Fellowship, Mary Horrigan Connors Center for Women's Health & Gender Biology, and executive director of HEAL Trafficking, all in Boston.

"They're accessing healthcare at every single point in the health system, and they all represent opportunities for healthcare professionals to interrupt that victim's cycle of violence and set them on a path toward safety and freedom," Stoklosa says.

Human trafficking is the subject of a new advisory by The Joint Commission, which calls human trafficking the fastest-growing criminal industry in the world. The advisory alerts healthcare professionals to recognize the signs of trafficking and to provide trafficking victims with information and options, while supporting victims as they connect with service providers *(Available online at: http://bit.ly/2O8KjF5)*.



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Traffickers are skilled at evading the law and will select healthcare settings where they are less likely to be caught, according to **Mellissa Withers**, PhD, MHS, associate professor of clinical preventive medicine, department of preventive medicine, at the Keck School of Medicine at the University of Southern California.

"[Traffickers] won't go to a place where people are well-trained in identifying trafficking victims, so they'll go to smaller places where they won't be questioned about it," Withers says. "And they won't use insurance. They will pay in cash."

Traffickers might even select a surgery center that is accustomed to treating out-of-state patients. For instance, when **Jasmine Marino** was a teenager, she was manipulated into a sex trafficking nightmare, sometimes beaten, always threatened, and for years unable to seek help. But she saw healthcare providers during this time, and mostly they didn't notice anything unusual about her.

At one point her trafficker, also a young man, flew her to Florida from Massachusetts for breast implant surgery. "My trafficker thought I would look better with the implants," Marino says. Marino's traffickers had been using the services of a surgeon whose cost was about half the price of local surgery centers, so the traffickers made Marino schedule an appointment by phone.

In a labor trafficking case, another young woman had worked for four years in domestic servitude. She was not paid for her work, and suffered from ingrown toenails that became so severe she could not wear shoes. When the traffickers allowed her to see a doctor, she had to have surgery to remove the toenails or she would have lost her toes, according to a report by the Human Trafficking Legal Center of Los Angeles *(Learn more at: http://bit.ly/2uSI1Bh)*.

Physicians and healthcare providers do not put trafficking victims on their radar unless they've been trained to look for signs. Even then, it can be difficult to spot because the traffickers are so skilled at manipulation and not getting caught, Withers says.

"They're good at not putting injuries on victims that are obvious that there's a problem," Withers says. "You don't actually see a lot of visible injuries in sex trafficking cases, while with labor, you'd probably see more of that because of the nature of the work."

Victims see healthcare providers under several different circumstances. For some victims, they see healthcare providers after they've been taken to the hospital by the trafficker or discarded by the trafficker because they're so sick. Other times, the trafficker might be trying to make the victim more profitable in sex trade by paying for plastic surgery. In labor trafficking cases, the victim might have sustained injuries that need treatment, Stoklosa says.

"We've seen horrible cases where the person was tortured by tooth extraction — the molars in the back, where they're not visible," she says. The extractions could lead to infection, which could lead to a doctor visit.

In another example, the victim might have been punched and kicked, leading to wounds or even orthopedic injuries.

"One pattern I've heard from providers is how when victims get to such a point of desperation that they will jump off the second floor of a building or jump from a moving car," Stoklosa says. "This clearly is a sign of desperation where they think, 'Maybe I can escape by dying.'"

## EXECUTIVE SUMMARY

Human trafficking is a worldwide problem. Often, victims are invisible to the public, including healthcare providers, who could help rescue victims if the public knew more about the issue.

- Most people who are trafficked in the United States for sexual or labor purposes are seen by healthcare providers, but are not identified as victims.
- Victims are seen in EDs, primary care offices, urgent care facilities, and surgery centers.
- Traffickers are skilled at hiding identities, and they select healthcare facilities where they're less likely to be caught.

At some healthcare facilities, staff members are trained to watch for fall injuries and screen these patients for trafficking. Premier Health in Dayton, OH, collaborates with other organizations to offer seminars for nurses about human trafficking, says **Patricia O'Malley**, PhD, APRN-CNS, nurse researcher for Premier Health.

"It was amazing to listen to the feedback from people speaking at the seminar," she says. "People involved in trafficking clinics and attorneys shared information about debt bondage, when people are terrified of the person holding them hostage."

The bondage situation usually begins when people from other countries are baited into traveling to the United States for friendship and financial reward via a work permit, O'Malley explains. "Once they're in that relationship, they can't get out because of the threats."

Healthcare workers should be aware that labor trafficking victims can come from several fields, including construction, farming, domestic service, restaurants, nail and hair salons, elder care, child care, forestry, and more.

"Healthcare has not figured out how to identify labor trafficking," Stoklosa says. "When you look at the studies, so many are focused on sex trafficking, which does disservice to labor trafficking cases because those numbers are so much higher."

When healthcare professionals see a patient whom they suspect might be a labor trafficking victim, there are some easy ways to question them to find out the truth. *(Editor's Note: See the story on p. 100 for more information.)*

"One of my strategies for labor trafficking is that if I suspect I'm seeing a victim, I ask the person if I can give them a work note to take time off and if they would be able to use it," Stoklosa says. "I've had patients who say, 'Of course, give me a work note,' and others say, 'No, I have to work.'"

When a patient declines the work note, this is an opportunity to follow-up, saying, "Tell me about your job," Stoklosa adds. "From there, explore whether there's any exploitation going on. Ask follow-up questions."

Some examples of questions to ask include:

- Why wouldn't you be able to use a work note?
- Do you get along with your boss?
- What is your job like day to day?

"Then, I say I care about the medical reasons they're there, but also about how they're doing in the rest of their life," Stoklosa says.

Unconscious bias can affect how the public, including healthcare providers, view sex trafficking victims. When sex workers are adults, providers often assume they chose this occupation and might not ask any questions to see if the person is a trafficking victim. For example, a patient who uses heroin might be a victim of exploitation. Some traffickers recruit people outside of methadone clinics, realizing that addiction is a vulnerability they can exploit, Stoklosa says. *(Editor's Note: See story on p. 101 for more information about trafficking myths.)*

"We need to address the myths and stereotypes about what a trafficking victim and trafficker look like," Withers says. "We have a Hollywood version of beaten and drugged and chained to a bed in a room and never having a day off or having a cellphone or being able to go to a grocery store or church."

This version of trafficking is not what healthcare providers will see. Instead, they might see a young person who has a cellphone and appears to have the freedom to escape. What the healthcare professional does not see is how this person has been psychologically manipulated, beaten down, and threatened until they live in terror. Traffickers do not need physical chains to hold them, Withers explains.

Marino believes it might have been obvious to her breast augmentation surgeon that she was in the sex trade because she was very thin, wore expensive jewelry, owned a designer pocketbook, and was with a young man. Her trafficker paid for the surgery in cash. No one at the surgery center asked her any questions or showed any suspicion about her circumstance. She saw other healthcare providers while she was a trafficking victim, and none of them

asked questions. "I saw my primary care physician the entire time I was in the trafficking situation, from age 19 to 25," Marino says. "My primary care doctor was just so interested in clicking his boxes on his check list and going through the motions of quick, rush, rush, appointment, and get me out."

Eventually, Marino rescued herself from trafficking with the assistance of a business owner who helped Marino demonstrate a work record, making it possible for Marino to secure her own apartment. Since then, Marino became the founder and director of Bags of Hope Ministries in Boston, an outreach organization that provides trafficking victims with socks and toiletries. ■

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# Signs a Patient Could Be a Trafficking Victim

The following signs of trafficking victimization are culled from several sources and encompass both labor trafficking victims as well as sexual and underage trafficking victims.

In the United States, sex trafficking often starts when the victim is between 12 and 14 years of age. Victims come from varied backgrounds and often have experienced some type of trauma or hardship. These include: homelessness or run away from home; history of neglect or sexual/physical abuse; family history of substance misuse, psychiatric problems, violence, and/or criminality; history of juvenile justice or child protective services involvement; lesbian, gay, bisexual, transgender, or other identity issues; and mental/behavioral problems.

Victims might have been involved with a gang or lived in areas with transient male populations such as military bases, truck stops, or convention centers.

Also, victims might be immigrants who lived in countries with political or social upheaval and police corruption.

While considering a patient's background, healthcare professionals also should be mindful of any physical injuries that could signal that the patient is a trafficking victim. These include: malnourishment and/or dehydration; bruises and other injuries consistent with physical and/or sexual abuse, restraint, confinement, or torture; bald spots on scalp or branding on skin; scars, burns, or bite marks; and trauma on torso, genitals, neck, or medial thighs in patterned appearance.

When giving a patient a physical exam, healthcare providers also might notice urinary tract infections or signs of sexually transmitted diseases, vaginal or rectal trauma, or a barcode tattoo below undergarments. Possible victims may demonstrate general signs of stress, anxiety, exhaustion, and depression, as well as aggression or oppositional behavior. These patients might avoid eye contact and show fear, shame, or paranoia.

Through verbal and nonverbal cues, healthcare professionals may notice symptoms of PTSD, suicidal ideation, or dental problems such as loose or missing teeth. Patients might report that they have had an abortion or experienced physical trauma during pregnancy or complain of stomach, jaw/neck, or chronic back pain.

There are other behaviors a patient could demonstrate during his or her visit that should raise red flags. These include an inability to produce identification documents, fearful reactions at the mention of law enforcement and general distrust of authority figures, inconsistencies in stories, and an inability to accurately describe their place of residence or other whereabouts.

A potential trafficking victim may appear isolated from everyone except for one person. There could be a "manager" or some other type of handler with the patient who seems to answer questions for the patient; carry the patient's ID, passport, money, or other possessions; or try to explain that the patient does not speak English.

During exam sessions, if patients offer clues about their background or identity, they might allude to a large debt that cannot be repaid. These patients might hint that they live or work in places with high security, opaque windows, barbed wire, or security cameras. This could signal that the patient is not free to leave or act as desired, which should be cause for concern. ■

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# Human Trafficking Myths Every Healthcare Worker Should Know

One reason why too few healthcare workers identify and help trafficking victims is because their mental picture of what a victim looks like does not always match the kinds of victims they'll see in their centers. There are several myths about trafficking. Experts dispel these myths and offer additional advice on how to identify and help victims.

• **Traffickers are men.** People don't think of female traffickers, yet an estimated half of all traffickers are women, says **Mellissa Withers**, PhD, MHS, at the Keck School of Medicine at the University of Southern California. "Often, when a healthcare professional sees another female, it doesn't raise a red flag with people," she says. "They assume that if the person's a female, she's not going to be a trafficker, and it's not true."

Women are more likely to accompany a female trafficking victim to the healthcare facility, particularly in cases of immigrant labor trafficking victims, Withers notes. "They send women to accompany the person who is being trafficked so no one will become suspicious."

• **Immigrant victims do not speak English.** "Traffickers will pretend the person being trafficked doesn't speak English, and they'll say, 'I need to be with her. She's my cousin from Thailand, and she doesn't speak English,'" Withers explains.

Traffickers might say they need to be with the patient at all times to translate. "There's never an opportunity for the victim to be alone with a provider because this person is watching over them," Withers says.

Healthcare providers should enforce a policy of separating patients from the person who accompanied them. If a translator is needed, the provider can use a telephonic interpretation service. Healthcare organizations that receive federal funding are required to offer professional healthcare interpretation services. It is a requirement in Section 1557 of the Affordable Care Act.

"This requires a policy shift on the part of the clinic, but it seems like it would be worth it in the end," Withers says. "In the clinics I work with, we say they need to institute a policy where at some point they can say, 'Due to confidentiality, you need to wait in the waiting room,' and they have interpreters available."

• **Underage prostitutes choose to be sex workers.** All sex workers under age 18 are trafficking victims. They are not legally capable of choosing to be sex workers. The mean age of U.S.-born trafficking victims is 16.5 years. More than half of the overall victims were under age 18 when they were first trafficked.[1] Healthcare providers are mandated by law to report cases of underage sex workers.

"Most health professionals would not know that someone under age 18 involved in commercial sex is being trafficked," says **Hanni Stoklosa**, MD, MPH, executive director of HEAL Trafficking in Boston. "But that's the federal definition of trafficking, and just by knowing that definition, it opens a health professional's eyes that the girl dressed weirdly in the middle of the night and who has a foreign body in her rectum or vagina is being trafficked. That's reframing what one may have judged or noticed, but didn't have a label for it."

## EXECUTIVE SUMMARY

Healthcare professionals and others often are mistaken about what human trafficking is and what its victims are like. Professionals could identify and help trafficking victims by learning the truth about the crime.

• Traffickers are women as often as they are men. Especially in healthcare settings, women are more likely to accompany female victims.

• If a healthcare worker suspects or knows an underage patient is a sex worker, then this must be reported. Sex workers under age 18 are trafficking victims and this situation is subject to mandatory reporting laws.

• Trafficking victims are not always poor. Some come from suburban middle class and affluent backgrounds.

Healthcare professionals know how to look for the signs of abuse, and now it's time to use the same skills to look for mismatches between the young patient's story and their physical and medical problems, Stoklosa adds.

"Look for why they broke an arm a week ago," she suggests. "Have the ability to ask questions, fill in gaps, and realize that some gaps might be caused by violence or abuse."

• **Trafficking victims come from poverty.** "Everyone thinks people who are trafficked come from poverty, and that's not true," says **Patricia O'Malley**, PhD, APRN-CNS, a nurse researcher with Premier Health. "Every economic stratum is subject to trafficking. Traffickers like to cruise malls in affluent communities, and they know how to identify children who are at risk."

Traffickers start relationships with young people, buying them extravagant presents, and eventually manipulating them into a relationship that becomes a bondage situation. "They like the suburbs," O'Malley adds.

One trafficking survivor's experience is an example of this phenomenon. "I was raised in an upper middle class neighborhood," says **Theresa Flores**, LLW, director and founder of the S.O.A.P. Project in Columbus, OH. Flores was 15 years old when a classmate drugged, raped, and photographed her. He blackmailed her with the pictures and threatened her life and her family's lives if she didn't do what he wanted. Flores was forced into prostitution, a stint that lasted two years.

Flores' rescue came when her father's work transferred him across the country. That was her escape, but she still never told her family what had happened to her until she was grown up and ready to share her story with the public to bring attention to trafficking.

"About five years after it, I told my family a little about it, but I didn't tell them more until I went on the 'Today' show," Flores says. "They thought that I was just going through teenage hormones or growing pains or being a rotten kid and having a hard time adjusting to where we were living. Who would have ever thought that was happening to your child when you live in a $200,000 home in a nice neighborhood?"

While Flores was a trafficking victim, she experienced migraines and gastrointestinal problems. Her parents took her to doctors for exams. "I believe those were directly related to the stress and trauma of being trafficked," she says. No physician or nurse asked Flores whether she was sexually active or whether anyone was doing something to her that made her uncomfortable. If they had asked, while her mother was in the room, she wouldn't have told the truth, Flores says.

"I know a lot of survivors that were trafficked by their fathers or a family member or a neighbor, and their mothers and the school had no idea," Flores says. "Traffickers brainwash people — like a cult, and they use anything they can to threaten you with, holding something over you so you're terrified to talk with anybody. You're just wishing and hoping somebody will say something to you to get you out of that situation."

• **If trafficking victims repeatedly visit doctors with obvious injuries of abuse, they'll be identified.** Unfortunately, this is not true.

"I've talked with some foreign-born victims, and one labor trafficking victim from Indonesia saw 17 healthcare providers, including in the ER, while she was being abused, and not one time did anyone ask her about the abuse," Withers says. "Another woman from Indonesia would go with [the victim] to these visits. Sometimes, [the victim] had an odd physical injury because of beatings, and still no one suspected she was a trafficking victim. The woman was enslaved for years before she was rescued when a neighbor called in a tip on the trafficking hotline."

• **Most trafficking victims will ask for help if they are alone with a healthcare professional.** This almost never happens. The victims are brainwashed, manipulated, terrified, ashamed, and distrustful of everyone in authority, including healthcare staff.

## More Educational Resources

• The American Medical Association adopted a policy that calls for physician education to identify and report suspected cases of human trafficking to authorities and to ensure victims have the necessary medical, legal, and social resources (http://bit.ly/2uPiXuH).

• The Institute of Medicine and National Research Council published a guide to confronting commercial sexual exploitation of minors for the healthcare sector (http://bit.ly/2Lsnqh8).

• Healthcare facilities could list ways for victims to reach help. These include the National Human Trafficking Hotline at (888) 373-7888 or the BeFree Textline (Text "HELP" to 233733). More information about trafficking signs and facts are available at: https://bit.ly/2z4P0vT.

"Do you believe you've never cared for a trafficked person? Think again. You have," O'Malley says. "[Victims are] very good at hiding. They're trafficked through fear and their relationship with the person trafficking them. It's modern slavery."

O'Malley explains that in addition to fear of personal harm or retaliation against loved ones, victims often feel shame for these relationships. Flores says healthcare providers should look these patients in the eyes and ask them whether someone is doing something to them that makes them uncomfortable or whether they're in an uncomfortable situation they'd like to get out of.

When trafficking survivors talk about their past trauma and experiences, many say that their healthcare providers knew they were prostituted, but never asked them about their lives, Flores says.

"Nobody wants to be in that life," she says. "No one chooses to have sex with 20 men every night. No one does it voluntarily. And there's no such thing as a 14-year-old or 15-year-old prostitute — that's trafficking."

**• Since victims often do not leave the trafficker, there's little point in healthcare providers trying to speak to them.** It can take many visits to healthcare providers who reach out and build trust with a victim before the person decides to escape trafficking. Each time a healthcare provider tries to help a victim, it can help lay groundwork for the time when victims feel strong enough to ask for help.

"Even if they get a woman alone in the room and ask her if she's being abused or trafficked, she may not want to say anything the first time around," Withers says. "But you still have the opportunity to say, 'If you are, this is a safe place where you could tell someone. I would be a good person to talk with, and I would keep everything confidential."

This creates space for trust. "Victims have been threatened, beaten, and have been told the police will arrest them ... but [victims] often will go back to that clinic and provider at a follow-up visit. Planting that seed is really important, whether or not they decide right then to reveal," Withers says.

O'Malley says healthcare providers can provide patients a trafficking hotline number to call for assistance after leaving the facility. Still, providers must report any time they suspect a person under age 18 is a trafficking victim.

"In clinics, provide information cards about trafficking," O'Malley suggests. "Put cards about the National Center for Human Trafficking and the trafficking hotline in your waiting room."

But providers should be cautious when they do identify a victim because the person lives under a constant threat. Providers should use discretion in assessment and referral, O'Malley counsels. Sometimes, providers use discretion for their own safety.

"I've gotten a call from a clinician in an outpatient clinic in a strip mall, and he says, 'I know this guy is a trafficker, and he comes in here with them, and I'm scared and don't know what to do,'" Stoklosa says. "I gave him a National Human Trafficking Hotline number so he could place it, stealthily, where the victim could find it."

Another reason a trafficking victim might be reluctant to speak, even when alone with a healthcare provider, is because traffickers use spyware on victims' cellphones to listen into their conversations, Stoklosa says.

"If they know spyware is on their phone, they might not be forthcoming," she says. "But you could write a message and give them a chance to say something that's not out loud."

One way to get trafficking victims alone is to walk with them to obtain a urine sample, and ask victims to leave their phone with the traffickers, she suggests.

**• If the victim lacks residency documents, helping them might also hurt them.** Foreign-born trafficking victims might have visas or passports that their perpetrators are guarding. Or, their legal status might be questionable. Either way, the government has the ability to process certain types of visas, specifically for

trafficking victims, Withers says. "It can be connected to services — housing, job services, and they're not forced to go home."

Healthcare providers should help identify trafficking victims and get them help whenever possible, Withers adds. "Imagine how sad it would be as a healthcare provider to think I had the opportunity, and I had this weird feeling in my gut, but I didn't say anything or pursue it. I didn't do anything, and the person spent another five years in slavery."

On the other hand, Withers asks healthcare providers to imagine helping someone get out of trafficking. "Think about how wonderful it would be to be the person who could save someone from that type of exploitation and abuse." ■

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# Shift of Surgical Care to ASCs Requires Some Cost Preparation

When the first ASCs opened decades ago, few might have predicted this would turn into a trend in orthopedic, neurological, and other high-acuity surgery cases.

"The shift of surgical care outside of an inpatient setting has been moving at varying rates since the first surgery centers were first opened," says **Jeff Dottl**, principal at Physician Surgery Centers in Tarzana, CA. "The first ASCs were a fissure in the dam, and now the dam is about to break with more codes shifting to outpatient between spine and other high-acuity orthopedic cases. Almost nobody does ophthalmology in a hospital anymore; pain management is entirely outpatient, and general surgery is more outpatient." With hernias, mastectomies, colonoscopies, and other gastrointestinal surgeries all shifting away from inpatient hospital settings to the more efficient and cost-effective ASC settings, the trend is exploding.

"We got news last year of Medicare moving total knee off the inpatient-only list," Dottl says. "That made the headlines, and it got a lot of hospitals to think about a trend that wasn't on the radar for them until now."

Challenges remain. For example, procedures involving devices are a struggle because of the low reimbursement surgery centers receive, Dottl notes. "We're at the bottom of the barrel when it comes to reimbursement. When there's a device-intensive case that the surgeon wants done in an outpatient setting, it can be challenging because reimbursement stinks," Dottl says.

Procedure codes feature three payment levels, depending on their setting. Hospital inpatient surgery receives the highest level of payment. Hospital outpatient surgery is second. ASCs receive the least amount of reimbursement.

"They are wildly different reimbursement rates, even with the same patient, same surgeon, same procedure," Dottl explains. "For procedures that involve neural stimulators or hardware implants and other devices, the device cost will be a driver on whether or not you can even do the case, financially, at the center."

This is a question ASC administrators, owners, and physicians must ask of each costly procedure: Can we perform this procedure safely and with high quality at the ASC reimbursement level? Dottl offers suggestions for how to assess whether new procedures will make financial sense for a surgery center:


## EXECUTIVE SUMMARY

Shift of surgical care to ASCs moved steadily over the decades and now encompasses orthopedic, neurological, and other high-acuity cases that once were unimaginable for this setting.

- ASCs still struggle with reimbursement of some devices.
- Overall reimbursement continues to be low, requiring ASCs to remain efficient.
- ASCs need to know what their costs are per case so they can better negotiate rates from payers.

**• How flexible are the ASC's surgeons in selecting devices?** Surgery centers might be able to afford some new surgeries, provided there is some flexibility in ordering devices. The issue is whether their surgeons will accept a change in device product or vendor.

"If there's a certain device manufacturer that doesn't want to play ball and sets their price too high so the surgery center can't make a reasonable profit on the case, you might want to seek an alternative," Dottl advises. "The biggest roadblock is the willingness of medical staff to find an alternative device."

From a surgery center administrator's perspective, the key is to not make changes that surprise physicians. "You don't like surprises, and neither do surgeons — so don't surprise them," Dottl offers.

Instead, review the economics of a potential change. Show physicians what the current cost is and how this makes the surgery economically unfeasible. Then, show how the surgery can work financially if the device cost were lower, such as using a competing device manufacturer's product, Dottl suggests.

"Put doctors in charge. Give them all the facts," he says. "I have yet to find a surgeon who is not appreciative of being told the costs, but you have to do it in a way that is not accusatory."

Dottl says one way to approach this conversation is to say: Dr. X, your cases cost this much with your preferred device. Here's what we would like to use, and here's the cost. "If information is relayed in this spirit, it's always taken well," Dottl adds.

**• What is the relationship like between an ASC and its contract managers and payers?** With fixed reimbursement, such as with Medicare, ASCs have to watch their costs closely because there is no possibility of changing the contract, Dottl says.

With commercial payers, there might be some flexibility. "They each have different ways of formulating their reimbursement model," he says. There might be an opportunity to negotiate a higher reimbursement rate for surgeries that involve high-cost devices.

**• Can the ASC obtain concessions from its vendors?** Vendor sales associates can help increase costs if ASCs are not collecting data and negotiating aggressively. For instance, if a vendor sales representative quotes an unreasonable price for a product, the ASC administrator can show data on how much of the reimbursement that product will absorb and how the ASC will lose money at that price, Dottl suggests.

"We might have a $2,500 reimbursement for a case, and the device the doctor wants is $2,700," he says. "At this rate, we'll lose money before the patient rolls back to the operating room."

This is why ASCs should know what their reimbursement looks like for each case. Armed with cost data, they can push back on vendor prices and improve their negotiating power, Dottl says. "Sometimes, the sales rep won't bend, and it won't work out."

In those cases, the ASC will have to turn down that procedure or switch to a much less expensive alternative.

"I've seen more than my share of these fly-by-night companies that pop up with some greatest thing for minimally invasive surgery," Dottl explains. "They're here today and gone tomorrow because they have a cost-prohibitive device. It sounds nice until you talk about outcomes, costs, and the science and evidence behind it." ■

# Reference Pricing Can Send More Surgical Cases to ASCs

A payment model gaining traction in California could drive more surgical cases to ASCs.

Called reference pricing, or reference payments, the strategy provides full coverage for a medical service or procedure up to a defined contribution limit. Patients have to pay the difference between the limit and the actual price charged.[1]

Research shows that reference payment for a surgery, such as colonoscopy, can result in a health plan's members using low-priced facilities, such as ASCs.[1]

For example, the California Public Employees' Retirement System (CalPERS) implemented reference payment in 2012. Investigators collected data on more than 21,000 enrollees that underwent colonoscopies in the three years before reference payment was implemented and more than 13,000 enrollees who underwent colonoscopies in the two years after implementation.

Investigators found that those subject to reference payment increased their use of low-priced facilities from 68.6% to 90.5% in 2013.[1]

CalPERS offers HMO and PPO options for its 1.5 million covered lives, says **James C. Robinson**, PhD, Leonard D. Schaeffer professor of health economics, director of Berkeley Center for Health Technology, and division head of health policy and management at the University of California, Berkeley. Robinson has conducted research on reference payments and also speaks at national conferences on how payment models affect ASCs.

Half a million CalPERS members are in the PPO product and implemented reference pricing for ambulatory surgical and diagnostic procedures, Robinson says. When employers are self-insured, they pay much higher prices for ambulatory procedures that are performed in hospital outpatient departments (HOPDs) rather than in ASCs or physician offices, he notes.

"Reference pricing is a benefit design with cost-sharing for patients," Robinson adds, describing the structure this way: "If it's managed by Anthem Blue Cross in California, Anthem is the contracted network of ASCs."

If a patient chooses to undergo surgery in an ASC instead of a HOPD, then the patient pays the usual copayment and deductible under the usual plan. But if the patient chooses to undergo a procedure in an outpatient hospital surgery facility, then the patient has to pay the cost share plus the difference between the charge at the facility and reference price. It's cheaper for them to undergo surgery at the ASC, Robinson says.

"When faced with this benefit design, there is a significant shift in market share from hospitals to free-standing centers," he adds.

Researchers studied complication rates before and after the shift to reference pricing. They found no differences between the hospital-based and freestanding procedures, Robinson says.

"Employers and insurers see very strong site-of-care price differences, depending on where procedures are performed," he notes. "If a doctor thinks a patient needs to go to another site, then they can file for an exception."

But the idea of reference pricing is to move as many people as possible to non-hospital settings because of the significantly lower prices, he adds.

"Another strategy is the payer could say they won't cover the procedure at all in a hospital-based center unless you have a clinical exception," Robinson says. "But reference pricing is a more lenient approach; you still can go to the hospital surgery center, but you have to pay more yourself." ■

## 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 management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

## REFERENCE

1. Robinson JC, Brown TT, Whaley C, Finlayson E. Association of reference payment for colonoscopy with consumer choices, insurer spending, and procedural complications. *JAMA Intern Med* 2015;175:1783-1789.

# Nurses Share Top Concerns

*By Stephen W. Earnhart, RN, CRNA, MA*
*CEO*
*Earnhart & Associates*
*Austin, TX*

I asked several nurses over the past few months about what their greatest concerns were related to their positions in ASCs and hospitals. I was surprised by what I heard. Since I have been away from the clinical side of nursing for many years, I could not relate to all comments.

Their number one fear is making a mistake that could cause harm to a patient. "First, Do No Harm" is something I remember from nursing school and, apparently, it has affected us all. Many worry about administering the wrong medication or dosage. These fears are justified.

Fortunately, manufacturers are making clearer labels to help prevent these errors. Regulators from the American Association for Accreditation of Ambulatory Surgery Facilities, the Accreditation Association for Ambulatory Health Care, The Joint Commission, and Medicare are strongly enforcing the proper labeling of syringes in the surgical environment. As a Medicare surveyor, I give more deficiencies for improper labeling than anything else. It is a concern to all of us and our patients.

Several commented on "minimally invasive management" vs. "in-your-face" management by some companies for your facilities. As the complexity and liability on oversight of surgical services intensifies, so do the risks. Many independent surgery centers shun corporate "meddling" in the day-to-day operations of their hard-earned pearl. Administrators are turned off by the high fees associated with such, but still want an outside "third party" to keep them compliant. This is a daunting task since rules and regulations change constantly. Those who cheered the loudest were the nurse managers and administrators who like to run their own shop but value outside advice on issues and comfort in complying with regulations.

**Celebrating people.** Many facilities are bringing back staff-related functions like "Wind Down Fridays," birthdays celebrations, and "Making Our Numbers" festivities. It is great to see medical professionals celebrating accomplishments and each other.

I received several questions about whether it is appropriate to serve alcohol at such events. Many of our new ASC board meetings with clients involve wine after the event, but these events take place offsite and involve small groups. Many staff parties furnish "near beer" or non-alcoholic drinks — same taste, but without the lawsuits.

**Site-neutral payment policy.** CMS plans to continue their site-neutral payment policy under Section 603 of the Bipartisan Budget Act of 2015. If this proposed rule takes effect, as it looks like it will, an off-campus hospital outpatient department for surgical services will only be paid 40% of the Outpatient Prospective Payment System amount for 2019. This means we may see many more surgery centers, as the payment differential between ASCs and hospitals continues to neutralize. Medicare is growing weary of paying more for the same procedure when it is performed in a hospital vs. an ASC.

**Freestanding emergency rooms.** Another trend to watch at your facility: If your freestanding ASC suddenly starts developing a freestanding emergency room in the same building, you might be in for a pleasant surprise soon. Several of our clients are doing just that as the climate for more physician-owned hospitals resurface. ■

*(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

- Avoid charting disasters by following these tips
- Vaccination time should be a top priority for ASCs
- Run tight ship, reduce case costing
- Expert outlines key areas of focus for a thriving ASC

SAME-DAY SURGERY



# CME/CE INSTRUCTIONS

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# CME/CE QUESTIONS

1. **Which of the following is a sign that a patient is a trafficking victim?**

   a. Bald spots on scalp, branding on skin
   b. Scars, burns, bite marks
   c. Depression, withdrawn, exhaustion
   d. All of the above

2. **Which of the following is *not* one of the common myths about human trafficking?**

   a. Traffickers are men.
   b. Trafficking victims are all genders.
   c. Underage prostitutes choose to be sex workers.
   d. Trafficking victims come from poverty.

3. **What is one of the biggest roadblocks to finding an alternative device for surgery when the proposed device is too costly?**

   a. Willingness of medical staff to seek an alternative device.
   b. All device costs are uniform and a rigidly set price.
   c. Surgical outcomes are worse with lower-cost devices.
   d. All of the above

4. **What is reference pricing?**

   a. When a medical device has one price reference that ASCs must pay.
   b. When a payer provides full coverage for a procedure up to a defined contribution limit, and patients have to pay the difference between the limit and the actual price charged.
   c. It is a term used to describe the agreed-upon price for surgery by a chain of surgery centers.
   d. None of the above

SDS ACCREDITATION UPDATE

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

# Joint Commission Infection Prevention Director Provides Tips to Meet Standards

Infection control in surgery centers over the past decade has focused on ensuring all medical devices and equipment are safe to use. When accreditation surveyors visit sites, they often identify issues related to basic infection prevention practices, dilution of disinfectants, sterilization, and following manufacturing instructions.

"Following manufacturing instructions for use is huge," says **Sylvia Garcia-Houchins**, RN, MBA, CIC, director of infection prevention and control, division of healthcare improvement, at The Joint Commission. "Equipment is incredibly complex these days, and there are a lot of integral parts that need to be monitored and maintained."

Ambulatory surgery centers (ASCs) can improve infection prevention practices and avoid deficiency findings by focusing on some of the most problematic areas, she says. There are several important practices:

• **Check equipment.** Surgery equipment and devices, as well as other equipment, need continual maintenance and assessment. For example, valves meant to protect patients can fail, if not maintained, and backflow contaminants to patients. Endoscopes can contain pinpoint holes that can miss detection and become contaminated with bacteria if staff fails to perform leak testing, Garcia-Houchins says.

"It is important to review all of the manufacturer instructions and designate someone who is detail-oriented to make sure that each step is being followed as specified by the manufacturer," she says.

This especially can be a problem for smaller ASCs, which might not employ designated staff to keep current on manufacturer's instructions and updates, Garcia-Houchins notes.

• **Carefully note which cleaning materials are appropriate.** Facilities might own more than 1,000 different instruments, and each comes with its own manufacturer's instructions. Even tools that look the same, but are produced by different manufacturers, can require different cleaning instructions.

"I performed a survey of 11 different manufacturer instructions for use and identified six different instructions for the same common instrument," Garcia-Houchins says. "Products used to clean the instrument might damage an instrument's finish and lead to corrosion, depending on the manufacturer."

Each manufacturer performs its own compatibility testing. While all manufacturers might say, "Don't let blood dry on the instrument," instructions can be divided on whether to use detergent A vs. detergent B.

"Keeping up with manufacturing instructions is an incredible challenge, but it is an essential step for patient safety, as well as the bottom line of an organization," Garcia-Houchins adds.

For instance, Garcia-Houchins has visited ASCs that purchased instruments of inferior quality to save money, or they reused instruments that were sold to them as single-use disposable items. Over time, certain instruments discolor or their surface becomes damaged because they weren't compatible with the detergent or cleaning process that the ASC used to clean other instruments. There's a huge level of detail to cover when reading manufacturer's instructions, she says.

• **Make priorities.** When revamping a reprocessing and instrumentation cleaning program, ASCs should start with the instrumentation and processes that carry the highest risk for infection, Garcia-Houchins suggests.

"Most organizations know their top scheduled procedures. For example, if your primary focus is orthopedics, identify the procedure your ASC performs most often or that has previously caused an infection problem," she says. "If a patient had a breast augmentation, and your ASC received a report that the patient developed a surgical site infection, staff should

review the manufacturer's instructions for reprocessing those instruments." Questions to ask include:

- Did staff follow all steps?
- Did staff use compatible products and equipment?
- Is all equipment used for the procedure maintained in accordance with manufacturer instructions?
- Is there anything from an instrument processing or equipment maintenance standpoint that could contribute to the risk of surgical site infection?

Answers to these questions can point the ASC in the best direction to focus on infection prevention resources. "Start somewhere that makes a difference, and, over time, go through the process with all of the instruments and equipment," Garcia-Houchins adds.

**• Learn to interpret manufacturer's instructions.** "The best time to read the manufacturer's instructions for use is before buying the equipment," Garcia-Houchins says. "Find out how long it will take to maintain and clean that piece of instrumentation or equipment. Staff may find that the facility cannot follow the cleaning process specified by the manufacturer or that it will take three times as long to clean; thus, any money savings is gone because the ASC cannot use the equipment without additional resources."

Sometimes, it seems easier to rely on the sales rep to explain and demonstrate the equipment's cleaning process. However, this person may not present or follow all the manufacturer's instructions, Garcia-Houchins notes.

"It might turn out he or she has not taught the facility every step of the manufacturer's instructions for use," she explains. "ASCs could have problems at a survey because surveyors are very good at reading manufacturer's instructions."

It's important to remember that routine maintenance of the equipment is a key element of the manufacturer's instructions, Garcia-Houchins adds.

**• Put someone knowledgeable in charge, and ensure staff are competent.** The person responsible for reprocessing must be qualified and experienced in instrument reprocessing and equipment maintenance. Instructions are complex, and, often, background knowledge is needed to ensure correct application. Just because a manufacturer says a product is compatible does not mean that it is the appropriate product to use for final disinfection.

Garcia-Houchins gave an example in which the manufacturer provided instructions for disinfection with two products that were appropriate for the intended use of the item. In addition, it provided compatibility information with products that would not be appropriate disinfectants based on the intended use of the item, but could be used for cleaning after use.

The correct product to use for disinfection wasn't clear, unless the person was an expert on instrument reprocessing. It was easier for the facility to use one of the products listed as compatible by the manufacturer, and facility staff didn't understand the difference between a cleaning product and a disinfecting product.

"These types of instructions add to confusion," Garcia-Houchins says. "But people reading those instructions need to understand the differences in terminology, cleaning vs. disinfection, and read the product labels to make sure they are appropriate for the items' intended use."

The person responsible for reading manufacturer's instructions and training staff on cleaning processes could improve their skills by obtaining training through professional organizations like the International Association of Healthcare Central Service Materiel Management. They also could take supply processing technician courses online or in person, attend seminars, or review online courses provided by manufacturers of products they use. Training isn't a one-and-done deal. Employees might require continual training and assessment for weeks to learn the proper cleaning, disinfection, and sterilization methods, Garcia-Houchins notes.

"Surgery centers need someone at the facility who is an expert on reprocessing equipment," she says. "People assume that because you are a nurse, you know how to reprocess instruments, but nurses do not learn instrument reprocessing in nursing school."

Do not assume that employees can correctly learn this on their own. Providing training opportunities and making certain employees are competent in cleaning and reprocessing is important. Ample staff should be trained to cover vacations and illnesses.

"Don't have just one person who is trained, because that one person will go on vacation or call in sick, and whoever is processing instruments has to be competent," Garcia-Houchins says.

The one time an ASC comes up shorthanded in reprocessing skills could be the time a surveyor visits and finds that the surgery center's staff is not competent to process instruments, she adds.

"Have a back-up employee rotate through the area and keep staff's skills current, so the ASC is not dependent on one person," she adds.

**• Assess compliance.** Some surgery centers use a detailed checklist to assess staff's competency. It might take a couple of hours to go through such a checklist, but it accurately identifies problem areas, Garcia-Houchins says.

"Some facilities might perform an audit and review once a month, but others check every day, for weeks, to make sure employees had the process down," she says. "They start with checking every day, move to once a week, then go to every week and, finally, once a month,

followed by a spot check." There is constant vigilance and constant striving for improvements in keeping patients safe, Garcia-Houchins adds. An essential element of an ASC's infection prevention program is staff that follow cleaning, disinfection, and sterilization protocols and processes. "There are many steps in reprocessing, and staff often do not realize how detailed you must be," Garcia-Houchins says. "They sometimes think reprocessing is simple, but it is actually very complex." ■

# Regulators Want ASCs to Build Infrastructure to Ensure Safety

ASCs need to build an infection prevention program that is managed by someone with knowledge and training in infection control.

Some states mandate that ASCs employ a certified infection preventionist or a nursing certified infection prevention consultant. The Centers for Medicare & Medicaid Services (CMS) requires surgery centers to develop a plan for preventing infections and to designate someone to be the quality and infection prevention officer, says **Donna Nucci**, RN, MS, CIC, infection preventionist at Yale New Haven Hospital and owner of Educated Nurses LLC.

"In ambulatory surgery, one of the challenges is that a lot of surgery centers have nurses taking care of the infection prevention portion and also working in the operating room or recovery room on a daily basis," Nucci says. "What Medicare is trying to say is that it's not enough to say that Mary who works in the OR is in charge of the infection prevention and quality program."

ASCs must be able to answer these questions:

- How are you preventing infections?
- How are you preventing skin abrasions?
- Who is going to be your quality and infection prevention officer?
- Who is taking charge of determining why there were three needlesticks in the past month?
- Who will conduct a root cause analysis and put a process in place to prevent it?
- Who investigates incidences of infection?
- Who has adequate experience and tools to complete an investigation?

"I think there's a push from Medicare to say that if you're a single ASC, then you have to think about what kind of infrastructure you're going to build to ensure the same kind of patient safety that a larger organization is doing," Nucci explains. "The pushback I hear from physicians is, 'They don't pay us the same as hospitals,' but Medicare does not take that into account."

A first step for ASCs is to decide on the duties for an infection preventionist. Many ASCs could combine the roles of infection prevention and quality improvement.

"They go hand in hand, and the type of training is similar," Nucci says. "Quality care is about preventing infections." Also, the role of a quality improvement director is not as complicated in an ASC as it would be at a hospital system, Nucci notes. "You don't have admissions to the emergency room, and you don't have exactly the same types of things for quality measures in an ambulatory setting, so it's easy to merge them together," she says. "In surgery centers with under five employees, their nursing director can do infection prevention and quality improvement as well."

For larger ASCs, one nurse could dedicate six to seven hours a week to quality improvement and infection prevention, Nucci adds. ASCs also could contract with an infection preventionist to conduct training, formulate a risk assessment plan, and monitor processes.

Accreditation organizations require ASCs to conduct quality projects annually, and some want the surgery center to show a quantifiable improvement in patient outcomes. Such projects could involve hand hygiene monitoring, surgical site infection prevention, and reducing occupational exposures.

Results of QI projects are reported to the surgery center's medical board in an annual report. Infection preventionists also must keep up on product and process updates from regulatory agencies, accreditation organizations, and device and equipment manufacturers.

For instance, Nucci, who follows changes for her ASC clients, recently sent an alert on reprocessing endoscopes. She also published a newsletter on her website about infection prevention tips, including:

- Evaluate exposure risks. Choose gloves, gowns, eye, face protection for durability, and appropriateness for the task;
- Droplets of blood or other potentially infectious material pose a hazard to the eyes, nose, or mouth. Wear masks in conjunction with eye protection, such as goggles or glasses with solid side shields or chin-length face shields to reduce risk of exposure.

Each surgery site's infection prevention liaison will need training and access to regulatory

and accreditation updates. "They should review it, and then provide information at staff meetings, making sure the information is well documented," Nucci suggests.

Nucci outlines other ways to ensure an ASC's infection prevention liaison can fulfill the job adequately:

• **Find the right person for the job.** The infection preventionist should be detail-oriented, well-organized, pragmatic, and a good communicator, Nucci says. "The person has to be a good educator and willing to educate staff," she says. "The person needs to be a quick learner or lifelong learner, someone who likes to learn new things and stay up to date on new guidelines."

Infection preventionists need to increase their knowledge base by attending conferences and other venues to learn more.

• **Dedicate hours for the role based on ASC's volume.** A surgery center's need for infection prevention work depends on its size and volume, which determine patient risk.

"Think about how many surgeries the center is doing in one year, and how many employees the infection preventionist will be in charge of training each year," Nucci says. "For smaller centers of under 100 cases a month, it might be OK for the nursing director to do that role because she has only one other nurse and a handful of physicians to train. Those with 40 to 60 procedures a day will need someone who can devote eight hours a week to the job."

• **Outline the preventionist's tasks.** Infection preventionists will train staff on infection prevention, conduct surveillance, and monitor staff for hand hygiene compliance.

They also will conduct prevention improvement projects, develop competencies, and keep up with the newest methods for preventing infection.

"The staff member needs to develop and maintain a program that actively prevents infection for each patient who walks through the door," Nucci says. "They do valuable risk assessment for the facility, including looking at the types of surgeries, volume of surgeries, and the post-op infections that might be involved in those types of surgeries." Then, this staff member formulates a plan to educate staff, physicians, and patients on what to do to prevent specific infection risks.

• **Work with ancillary staff.** "Infection preventionists work with ancillary, nonlicensed staff in the facility, providing education and, in the wording from Medicare, 'consistent and comprehensive education update for licensed staff, physicians, and nurses ... and persistent competency and audit for nonlicensed staff,'" Nucci says.

For instance, if a surgery center is reprocessing a few thousand instruments per week and turns over 20 to 40 cases a day, then two additional members of the staff will need competency training in infection prevention, she adds.

• **Formulate a plan.** The infection prevention liaison should be an LPN or RN, and the person should have some amount of designated time to formulate an infection prevention plan, come up with a consistent message, and conduct audits, Nucci says.

"Auditing is very important with The Joint Commission, AAASC, other accreditation organizations, and state surveyors," she says. "They want to see someone who is not working in the operating room or sterile processing area actually auditing what staff members are doing."

Liaisons might want to watch employees scrub their hands, ensuring everyone is scrubbing into surgery, according to national guidelines, and monitoring how surgeons prepare the surgical site with a single-use sterile prep, according to manufacturer instructions.

"Are they using DuraPrep appropriately or the waterless scrub appropriately? Audit, monitor, and document staff members to make sure they're competent on those high-risk prevention methods," Nucci says. "They should also do chart reviews for antibiotic prophylaxis and perioperative normothermia prophylaxis. Those are two other quality measures that you can't do while working in the OR, so schedule time off to do the chart reviews, and make sure those measures are meeting national standards." ■