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INSIDE

RELIAS MEDIA

Antimicrobial Drug-resistant Organisms Rising, Suggesting Risks for ASCs

New research highlights the growing problem of antimicrobial drug-resistant organisms worldwide, leading to some predictions that up to 10 million people could die from these infections by 2050.[1]

As antimicrobial resistance (AMR) increases, another disturbing trend involves outbreaks of measles, mumps, chicken pox, and other preventable infections. These resurgent viral infections can affect healthcare settings, including ambulatory surgery centers (ASCs). The CDC recently revealed that as of Sept. 8, there were 137 reported cases of measles in 24 states and the District of Columbia. *(Read much more about this deadly outbreak online at: http://bit.ly/2xqkRnz.)*

In Germany in 2015, a series of measles outbreaks was linked to unvaccinated healthcare workers. Researchers identified eight measles outbreaks involving healthcare workers in Europe between 2010 and 2014. Of 719 cases of measles, 205 were linked to healthcare workers infecting patients and contracting infections from patients.

"I recently heard about a surgery center that had an exposure because of a healthcare worker not being vaccinated," says **Jeffrey Silvers**, MD, medical director of quality, infection control, and pharmacy at Sutter Health in Sacramento, CA. "Measles is becoming much more common. There are a lot of people, unfortunately, who are not getting vaccinated. Our herd immunity of kids is lower than it used to be. It was 95%, and now it's below 92%."

Antimicrobial resistance can be found in all healthcare settings, including surgery centers. Studies highlight the problems of infections from methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant Enterococci (VRE), carbapenem-resistant Enterobacteriaceae (CRE), and others. CRE has been on the rise for

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nearly two decades. It is associated with a higher mortality rate than carbapenem-susceptible infections.[1-5] For example, Maryland health officials documented reports of a couple of residents with surgical sites infected with rapidly growing mycobacteria (RGM) after cosmetic procedures at a Dominican Republic clinic. In a study, investigators noted that RGMs are antimicrobial resistant and difficult to treat. Isolates from the RGM patients were resistant to multiple classes of antimicrobials.[5]

Emerging research suggests climate change has contributed to the rising rates of AMR. One new study says that both rising local temperatures and greater population density contributed to more antibiotic resistance. Investigators found that a temperature increase of 10° C was associated with a rise in antibiotic resistance of 2.2-4.2% for common pathogens, including antimicrobial-resistant *Escherichia coli*, *Klebsiella pneumoniae*, and MRSA.[1]

The CDC, World Health Organization (WHO), and the American College of Surgeons have published extensive guidelines for prevention of surgical site infections after operations. These include information about appropriate antibiotics and timing as well as proper skin preparation, says **Robert G. Sawyer**, MD, FACS, FIDSA, FCCM, chairman of the department of surgery at Western Michigan University Homer Stryker M.D. School of Medicine. Managing AMR is a huge concern for surgeons and other in healthcare, he notes.

"In this day and age, we're most concerned about MRSA, and there are some screening programs to use before operations," Sawyer says.

As surgery centers increasingly take on more complicated patients and procedures, the risk of AMR in patients rises, Silvers says.

"Make sure you have appropriate policies and procedures in place to ensure infections are not spread to patients," Silvers adds. "Be aware that if there is even one case that develops in the center, they need to do a root cause analysis."

The authors of a new study from Germany found that antimicrobial-resistant diseases were among the causes of periprosthetic joint infection among patients who had undergone total knee arthroplasty and total hip arthroplasty. Some of the AMR discovered included MRSA,

EXECUTIVE SUMMARY

The antimicrobial drug-resistance problem is getting worse, increasing risk for healthcare patients and workers in all settings. Another disturbing trend affecting the healthcare environment is the continuation of outbreaks of preventable infections, such as measles and mumps.

- A series of measles outbreaks in Germany was linked to unvaccinated healthcare workers. In the United States, measles cases climbed to more than 120 at the end of summer 2018.
- One new study found that antimicrobial-resistant diseases were among the causes of periprosthetic joint infection in patients who had undergone total knee arthroplasty and total hip arthroplasty.
- Patients need to be screened for antimicrobial resistance risk.

methicillin-resistant *Staphylococcus epidermidis*, ampicillin-resistant *Enterococcus*, and VRE.[6]

As ASCs see more patients for additional orthopedic and other procedures, they are at greater risk of encountering a patient with MRSA. Sawyer offers several suggestions for how to prevent exposing a surgery center to antimicrobial-resistant infection outbreaks:

• Evaluate patients for AMR risk.

This evaluation should occur at the initial physician-patient meeting. The literature supports preoperative screening for MRSA, as it is one of the leading causes of surgical site infection.[7]

Surgeons and staff can ask patients these questions:

- Have you been hospitalized recently?

- Have you received antibiotics recently?

- Has anyone ever told you that you have contracted MRSA or drug-resistant bacteria?

"If patients fall into one of those categories, or if they're just medically unwell ... then someone should check to see what's going on," Sawyer offers. "What resistant bacteria have they been diagnosed with in the past?"

If patients have been diagnosed with AMR, then the surgery center can make certain antibiotics used after surgery will work for that patient. Or, the ASC could decide to refer the patient to a hospital surgery setting that is better able to ensure the patient's safety.

"Some centers would not operate on those patients," Sawyer notes. "Or, if they do, they might want to isolate those patients from other patients so they don't spread the bacteria."

• Change antibiotic prophylaxis and improve infection control.

Adjust antimicrobial prophylaxis according to a patient's resistance pattern. Also, strictly enforce staff wearing gloves, masks, and avoiding contact with AMR patients.

A negative air flow room is not necessary for these cases, partly because transmission occurs most commonly because of patient-to-healthcare worker-to-patient transfer. "A negative air flow room wouldn't change that," Sawyer notes.

• Know the area's antibiotic-resistant bacteria.

"There are regional differences about which resistant bacteria happens to be out there," Sawyer says. "Some places know they have a lot of MRSA and others have resistant *Klebsiella*."

State and city health departments should offer some information about which AMR strains are common in an organization's area. Some states, like South Carolina, collect and analyze antibiogram data from all acute care institutions to create statewide antibiograms and to provide comparative looks at institution-specific susceptibility rates. *(Learn more about the South Carolina antibiogram program online at: http://bit.ly/2pryMpd.)*

• Follow up with patients after surgery for surgical site infections.

Some institutions provide post-surgery emails notifying surgery centers of patients who contracted infections. This reporting varies according to the organization, Sawyer notes. The goal is to know the types of organisms causing infection in the institution. If there are cases of AMR, the surgery center will learn of this quickly and respond appropriately.

"Somebody has to look at the data and say, 'We've had three MRSA infections last month, and three this month, so we need to look at whether there's something going on in our surgery center,'" Sawyer explains.

"ASCs have to do a good job of following up and documenting infections that occurred and gain an understanding of whether there is a common pathogen causing those infections." ■

REFERENCES

1. MacFadden DR, McGough SF, Fisman D, et al. Antibiotic resistance increases with local temperature. *Nat Clim Change* 2018;8:510-514.
2. Rump B, Timen A, Hulscher M, Verweij M. Ethics of infection control measures for carriers of antimicrobial drug-resistant organisms. *Emerg Infect Dis* 2018;24:1609-1616.
3. Pelrano G, Matsumura Y, Adams MD, et al. Genomic epidemiology of global carbapenemase-producing *Enterobacter* spp., 2008-2014. *Emerg Infect Dis* 2018;24:1010-1019.
4. Lutgring JD, Zhu W, de Man TJB, et al. Phenotypic and genotypic characterization of Enterobacteriaceae producing oxacillinase-48-like carbapenemases, United States. *Emerg Infect Dis* 2018;24:700-705.
5. Schnabel D, Esposito DH, Gaines J, et al. Multistate US outbreak of rapidly growing mycobacterial infections associated with medical tourism to the Dominican Republic, 2013-2014. *Emerg Infect Dis* 2016;22:1340-1347.
6. Rosteius T, Jansen O, Fehmer T, et al. Evaluating the microbial pattern of periprosthetic joint infections of the hip and knee. *J Med Microbiol* 2018; Sep 12. doi: 10.1099/jmm.0.000835. [Epub ahead of print].
7. Goyal N, Miller A, Tripathi M, Parvizi J. Methicillin-resistant *Staphylococcus aureus* (MRSA): Colonisation and pre-operative screening. *Bone Joint J* 2013;95-B: 4-9.

Mandate Staff Vaccinations to Prevent Infections

One way an ASC can reduce infection risk is by requiring staff to be up to date on vaccinations.

"This is about people raising their expectations of how infection control is performed at surgery centers," says **Jeffrey Silvers**, MD, noting ASCs should adhere to the same infection control practices as acute care hospitals. "There are a lot of activities and practices at surgery centers that would not be tolerated at acute care hospitals ... People need to make sure they follow all the infection prevention guidelines. One area I like to focus on is immunization of healthcare workers, which is a form of infection control in terms of keeping people from getting ill."

For example, from October through April, there is a serious risk of staff contracting influenza. "Influenza transmission from healthcare workers to patients or vice versa is a very significant risk in ASCs," Silvers says. "People do not necessarily take off work when they're ill."

The flu vaccine is not perfect, but it is helpful and should be encouraged. "In hospitals, we require a vaccinator mask," Silvers says. "Either you get vaccinated, or you wear a mask from Oct. 1 through the end of April every year to reduce the risk of transmission to other healthcare people or to patients."

Some local government ordinances require healthcare staff to take the annual flu vaccine or wear a mask during flu season. Even when the flu vaccine has lower immunity, it still covers 25-50% of strains circulating. Further, the flu vaccine could prevent healthy adults from infecting older or less healthy people, Silvers notes.

"Even if you never get sick, and you say you're healthy, you may have a mother, father, brother, and sister who can't afford to get sick, and they get sick because you don't take the vaccine," he says. "Getting the flu vaccine is really about everyone."

Shingles is another potential problem. "Recently, I was contacted by an ASC because of an issue they had with possible exposure by an employee with shingles," Silvers says. "We expect people to have immunity to chicken pox as part of the condition of their employment, and now we'll look at shingles. At Sutter Health, we consider immunization such an important component of our providing safe care that we mandate it. But not all hospitals and surgery centers will do that."

Sutter Health's vaccination rate rose dramatically after the policy change.

"It requires you to make vaccines available to staff," Silvers notes. "We offer them at no charge, making it easy for people to get vaccinated at work at scheduled times."

Sutter Health reports a high compliance rate. Physicians must show proof of vaccination before they get privileges. Healthcare workers need proof of immunization before they are hired.

ASCs could require physicians and staff to be up to date on vaccinations, too. Administrators also could place hand hygiene stations with masks, gloves, and gel at the entrance of the facility. Signs might read, "Cover your cough," or "If you have something contagious, please tell the facility," Silvers suggests.

"If these hygiene stations are easy and convenient, people will use them," he says. "We had a lot of success with them this past winter." ■

Complying With Immediate-use Sterilization Rules

The Andrews Institute Ambulatory Surgery Center of Gulf Breeze, FL, logged more than 2,400 immediate-use sterilizations (IUSS) per year in 2013 and earlier. After starting a program to reduce IUSS practices, the ASC cut that number to 131 in 2016, one in 2017, and zero in 2018 (so far).

"It's been a long process for us," says **Barbara J. Holder**, RN, BSN, LHRM, CAPA, quality improvement/infection control/safety/regulatory officer at Andrews. "First, there was the change in the regulations ... up until that time, people were abusing the intention of the regulations and doing a lot of [IUSS]. New regulations said [IUSS] had to be used solely for emergency purposes only, like a dropped instrument."

IUSS, which until 2014 was called flash sterilization, differs from short-cycle sterilization. Instruments undergoing IUSS are cleaned in a designated decontaminated area. These instruments cannot be stored for later use. Short-cycle sterilization follows device manufacturer's instructions for use. The process includes use of a dry time and is packaged in a wrap or rigid sterilization container, which can be stored for later use.

Prior to the federal regulatory change, the operating room culture never viewed IUSS from a risk standpoint, says **Danny Dillard**, CST, CASSPT, purchasing manager and sterile processing department manager at Andrews.

"People just assumed that this is what you did: If you drop something, you flashed it; if you forget to wrap a set, and you need tools for a case, then you flashed it," Dillard explains.

EXECUTIVE SUMMARY

Immediate-use sterilization episodes decreased from more than 2,400 per year five years ago to zero in 2018 at the Andrews Institute Ambulatory Surgery Center in Gulf Breeze, FL. The ASC implemented changes in 2013, resulted in the surgery center virtually eliminating its use of flash sterilization.

- Staff used daily huddles to plan according to future surgery caseload, which was central to the ASC's efficiency efforts.
- Another tactic was to adjust schedules in the sterile processing department.
- Talking to surgeons about reprocessing dropped instruments is an important part of the improvement process.

"There was no emphasis put on the risk portion of what the process has for patients."

Here's how the Andrews reduced their IUSS rate:

• **Streamline the process**. One way to reduce IUSS is to invest in more instruments. "When we started this process, we thought we'd have to invest hundreds of thousands of dollars into instrumentation," Holder says. "We did have to invest in some instruments, like retina trays. But when we looked at it, we actually [spent] less than $10,000 on new equipment."

The main way the ASC streamlined the process was to use physician preference cards.

"This was a major undertaking," Holder notes. "Danny and his team worked with surgeons ... to update, develop, and ensure accuracy of surgery preference cards for every type of surgery they do."

The preference cards provide data related to physician and surgery type. Physicians confirmed their preferences after reviewing the cards' instruments and equipment needs, Dillard explains. Review of preference cards takes place weekly or biweekly. When there are changes or requests for a change, these are listed and reviewed.

"We monitor our process to see if we're as current as possible," Dillard adds.

• **Form daily huddles.** "Our huddles in our sterile processing department occur the same time every day," Dillard says. "We found them so beneficial, we do two huddles a day, one at 8:15 a.m. and one at 3 p.m." The huddles also provide visual management, a reminder of the goal to eliminate IUSS, Holder says.

"The staff's biggest fear in accomplishing this goal was the huddles and open communication. They were against this, but now the huddles are essential to our daily infrastructure and what we do."

The huddles give staff time to assess each day's, the next day's, and even the next week's schedules to determine how many trays and other resources they'll need. Perhaps there are 20 cases scheduled one day, and the ASC only has 10 hand trays. Previously, Andrews staff would use the 10 trays and then perform IUSS on each hand tray as needed to complete the 20 cases, Dillard explains."What we changed with our huddles is we talked about the schedule the next day, how many cases of each specialty and how many trays and resources we'd need," he says. "Now, once that first set comes out of the OR, it's processed and decontaminated and available by the time the OR is doing case number 11, and so forth."

Daily huddles also can be used to educate sterile processing staff on new procedures, rules, and techniques.

"Every week, each department submits to me their huddle worksheet, and I put those together and post them on huddle boards in the doctor's lounge," Holder says. "I send these out by email and print colored copies that are posted." This was a culture change, forcing sterile processing staff to explore this from a different perspective. The change helped staff accomplish the goal of not using IUSS of any trays.

• **Adjust sterile processing staffing and schedules.** "I didn't have to hire new staff," Dillard reports. "I just restructured how our staff was allocated on assignments." Dillard says one sterile processing staff member's role is to prioritize the goal of avoiding [IUSS]. Sterile processing employees' shifts are staggered to provide full coverage throughout the day, Holder says.

Meanwhile, Dillard notes how many people are on staff on a particular day, and studies staffing over a six-week surgery schedule. Each employee is assigned to a certain task.

"All sterile processing department staff is 100% certified," Dillard says. "They have a good aptitude and knowledge base and are fully engaged in patient safety and care." Thus, staff know they are stakeholders in the surgery center's patient safety, and they take their duties seriously.

• **Work with physicians to better handle dropped instruments.** "Even if there is an instrument dropped, we can avoid [IUSS]," Dillard says. "It's just communicating with the surgeon." Before, there was a perception that surgeons would be angry if an instrument dropped and they had to wait for reprocessing. Dillard and Holder spoke with physicians about the goal to eliminate IUSS, explaining how reprocessing a dropped instrument might cause a 15-

to 17-minute maximum processing time. Once surgeons learned this information, they found the change more palatable. "Sometimes, there are other resources that can be used," Dillard says. "You can get the instrument turned over without immediate use. We did this the entire time last year." ■

Physician Stress, Frustrations Can Lead to Depression, Burnout

About half of general surgeons report experiencing burnout. Their levels of stress and frustration have reached the point where their mental health is at risk. *(Read more about the American Medical Association's research on burnout online at: http://bit.ly/2MIxNKs.)*

"All of us, whether or not we have underlying tendencies toward depression, could stand a little less frustration in our lives," says **Sharmila Dissanaike**, MD, FACS, FCCM, professor and Peter C. Canizaro chair, department of surgery, Texas Tech University Health Sciences Center in Lubbock, TX. "Learning to cope with daily frustrations is important ... one strategy is to learn to pick your battles; you need to know which areas to put your effort and energy and improve."

For example, if a surgeon is working in a surgery center that never opens the OR on time, the surgeon can choose to be frustrated each day when the 7:30 a.m. start time slides into 8 a.m. or 8:30 a.m. Or, the surgeon can push for a change to make OR staff more timely.

"But that takes a lot of effort and energy. You might decide that's not a battle worth fighting," Dissanaike says. "Anticipate that the OR won't start on time, and maybe you catch up on your paperwork, read your journals, or take a walk. Find something useful to do so you won't sit in the lounge, frustrated."

Dissanaike describes these additional ways stress can result in burnout and how to prevent them:

• Dealing with stress from the procedure. Experienced surgeons are less likely affected by stress from the procedures they perform. But this can be common when surgeons are in training, she says.

"As surgeons become more experienced, the stress level begins to drop," she says.

Surgeons learn how to cope with stress from their work through practice and finding that they can cope with different surgical scenarios, including patients who bleed or experience complications during surgery. Knowing the surgical team also helps reduce this type of stress.

"Make sure you have a team you are familiar with. Know who everyone is," Dissanaike suggests.

Surgeons can make surgical timeouts a standard practice. With these, they not only go over the patient and surgical site before beginning, but they also listen as team members introduce themselves, Dissanaike explains. "The surgeon knows the scrub tech by name." This sets the tone for a convivial team and reminds everyone that they work together. It creates a more positive environment and helps reduce individual stress.

"Before the operation, discuss the potential things that could go wrong and how they'll be handled," Dissanaike suggests. "Go over the contingency plan at the beginning of the case. It helps to make sure everyone is prepared and there's not poor communication in the room. It helps to ameliorate the stress of an adverse event in an OR."

For new surgeons, another stress-reduction strategy is to ask an experienced colleague or mentor to assist when there's a high-risk case. Or, ASC physicians might not take cases for which the risk is very high, Dissanaike says. "Know what types of cases are appropriate for that setting, and make sure you don't do anything beyond what can be handled in that setting."

• Coping with daily annoyances. "A lot of stress in a surgeon's life is accumulated slowly and is due to peripheral annoyances," Dissanaike says. "If you are never able to start the OR on time or you believe everyone is wasting your time, then that is a daily stress that can build up and lead to burnout."

Time-consuming note-taking or documentation also can be a stressor. The key is to not let time-wasting activities or long waits drain

COMING IN FUTURE MONTHS

- Surgeons needed to address systematic violence
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- Latest legal hurdles in healthcare
- Reduce complications with a standardized approach

a person's energy. "Daily stress can build up and lead to depression," Dissanaike says. "Either you try to fix the problem, or you find a different way to use your time. The worst strategy is sitting there and fuming each morning."

• **Handling difficult personalities.** It is stressful to argue with people or to deal with a conflict, Dissanaike laments. Surgeons might not be able to choose every person working with them in the OR, but there are ways to improve these relationships and reduce conflict.

"The fundamental understanding has to be that we cannot change other people's personalities," Dissanaike says. "We can barely change our own. You have to decide whether this person brings value in other ways." For example, the troubling co-worker might bring a varied skillset to the job and demonstrate a deep understanding of his or her job. If the person exhibits these positive attributes, then the conflict might be a personality conflict. The onus is on the surgeon to accommodate and accept that they will never be best friends with the person, but they can work together on a daily basis, Dissanaike explains. "You can learn to overlook the daily things that are irritating," she adds.

An exception might be if the other person's behavior is demeaning or disrespectful. For instance, perhaps one employee's habit is to call everyone "sweetie." The surgeon can wait for a calm moment to ask the person to stop this, saying, "I'd very much prefer you didn't call me that. You can use my first name, instead." Some things cannot change, such as a person who always speaks loudly. But if it is necessary to curb the irritating behavior, then it is important to focus on the behavior and not the person when speaking with the employee about correcting the problem, Dissanaike offers. Also, any attempt to change an employee's behavior should occur in person.

"It's very common now for people to send off angry emails when things don't go well," she says. "When you're angry, you overstate the case and exaggerate it. Other people reading the email think you are not reliable because you overstated the case."

Emails are an easy way to throw someone under the bus, and they cannot be taken back. Once an email is out there, it can be shared and live on forever. ■

Tactics to Increase Copay Collection

Copay collections at an ASC increased sixfold after the organization made some changes that included staff training and centralized registration.

More than 100 employees at Cooper University Health Care, including patient access employees and insurance verification specialists, attended a class teaching them how to improve the collection process.

"We really shadowed employees and stressed to supervisors on the front end the importance of the change," says **Pamela Konowall**, CHAM, assistant director of healthcare access at Cooper University Hospital in Camden, NJ. "We now have a manual for all healthcare access." Konowall shares what organization employees learned about increasing copay collections:

• **Patients pay copays up front.** Patients receive their first calls about copays two weeks before their scheduled surgery or service.

"If the copay is not collected over the phone, then we make another attempt in this office," Konowall explains. "The consultation copay is handled by the physician's office, but procedural copays are handled by our office."

• **Strategically word questions about copays.** The first call requesting a copayment is crucial. Employees were trained to handle patient responses in a way that will most likely result in a payment. For example, when the first call is made, the staff member tells the patient, *"Your copay is X amount of dollars. Will you be paying that by cash, credit, or check?"*

"If, instead, someone says, *'Do you want to pay your copay today,'* the person will say, *'No,'*" Konowall says. "If the patient says, *'I'm not prepared to pay now'* or *'I can't pay — I don't have that much money,'* then you say,

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.

'We can take half' or *'We can take $10.'"*

The goal is to collect something, even a small payment toward the copay.

The most common response to a patient saying he or she cannot pay now is to ask, *"How much can you pay?"* But that will not work, Konowall says. Success is contingent on how the questions are asked and answered.

Another option at the organization is to offer copay deduction to patients who also are employees, Konowall notes.

"That means any Cooper employee can choose to have that taken out of their paycheck. They could have it taken out over three paydays." Spouses of employees also could see their copay taken out of their spouses' paychecks. Traditionally, the copays for employees were less than $200, which made the payroll deduction feasible.

• **Make another attempt to collect three days out.** "Three days before the surgery, we make another attempt to collect the copayment," Konowall says. "We make every attempt to collect it before the patient comes in, but sometimes the patient will say, *'I won't pay over the phone. I'll pay on arrival.'*"

Each day that a patient has not paid the copay, a listing is distributed to staff in the centralized registration area. The listing tells how much the patient owes. "They're responsible to make the collection and get the payment before the person comes back to surgery," Konowall adds.

• **Keep communication consistent.** "We stress consistency in communication, and we try to improve patient understanding," Konowall says.

"It's not what you say, but how you say it," Konowall notes.

Employees are told to use common sense, smile, make eye contact, and use patient names. Employees also say, *"Good morning"* or *"Good afternoon,"* maintaining professionalism at all times.

Once employees learned these techniques and became more successful in collecting copays, they were amazed and pleased, Konowall reports.

"People came back to me and said, 'Now that we know how to do it, it is so much easier,'" Konowall says. "Before, people felt bad about asking people for money, and that has totally changed." ■

Consider Ethics of Financial Toxicity to Patients

A surgeon ethicist asks that physicians sometimes stop to consider how the cost of their services affect patients. There's a term for this: financial toxicity.

"Financial toxicity is the financial burden or stress patients endure in response to the cost of their treatment or care in the healthcare system," says **Catherine J. Hunter**, MD, FACS, associate professor of surgery at Northwestern University Feinberg School of Medicine. Hunter was enlisted to speak about financial toxicity for an ethics colloquium on money and modern surgical practice at October's American College of Surgeons' Clinical Congress 2018. "We need to be mindful that what we recommend for our patients has a financial impact on them and their families."

Included in financial toxicity are a patient's out-of-pocket expenses, deductibles, copays, and cost of health insurance.

"A person has objective and subjective financial concerns, and those lead to financial toxicity," Hunter says. "Stress can impair patient outcomes. Sometimes, [patients are] so stressed about the loss of finances and how they can't afford to live that it makes them ill. Other times, they cut corners or skip treatment or don't pick up pills."

Surgeons might consider whether it is the provider's responsibility to tailor or modify their patients' workup or care to consider what patients can actually afford, Hunter suggests.

"I don't routinely ask all my patients what their financial status is, but I also think we should come up with a plan of care that's not overly burdensome for a patient to complete," she says. "If you make a plan of care, even if it's a good plan of care, and it's not one a patient can successfully complete, then you're not doing the patient any favors."

Physicians also should be mindful of some of the tests they order for patients. "If a test has been done previously, then don't reorder it. If we can use simpler, less expensive tests to get similar diagnostic information, then we should do that," Hunter explains.

The key is to be mindful of what the patient can afford and really needs. "I sometimes see patients referred to me — a pediatric surgeon — for a workup of a hernia, and the provider did some imaging, an ultrasound or CT scan," Hunter says. "That's not necessary for my population. A physical exam is enough, rather than having people pay for additional imaging if they don't need it."

Healthcare providers also should reconsider prescribing expensive medication when existing options would work.

"From an ambulatory surgery care standpoint, physicians could try to provide some clarity for patients and transparency regarding costs," Hunter says. "Maybe patients could have some input. The physician could say, *'If we do this particular test, it would be potentially helpful, but this is the cost of this test versus that one.'*"

It is possible to measure financial toxicity as a patient-reported outcome. In 2017, researchers developed the COmprehensive Score for financial Toxicity (COST) to better understand cancer patients' characteristics, clinical trial participation, healthcare use, willingness to discuss costs, psychological distress, mood states, and quality of life.[1] COST questions ask patients about whether their out-of-pocket medical expenses were more than they expected. Also, COST queries patients to say whether they agree with a statement about how they have no choice in how much money they spend on care, Hunter explains.

While most of the research on financial toxicity has focused on cancer patients, medical ethicists and others are beginning to understand that financial toxicity is applicable to many other areas of medicine. "Healthcare costs are not always transparent," Hunter says. "If you go to a hair salon, you could look on their website and see what they charge for a particular style and treatment. Some centers offer that level of information, but it's not across the board."

Patients might never be told the total cost of their surgery, and they could be uncomfortable telling their doctors that they are scared from a financial standpoint. Physicians might be uncomfortable asking patients if they can afford a procedure.

"One of the main things that causes stress for people is when they can't anticipate what they're getting themselves into. It's that feeling of a lack of control over their financial situation when they find out their expenses are more than they anticipated," Hunter says.

It would be helpful for ASC staff to review a list of costs with the patient to fully show the extent of their financial burden, Hunter offers. "[Direct] a point-of-service individual [to] cover that information as part of the visit." ■

REFERENCE

1. de Souza JA, Yap BJ, Wroblewski K, et al. Measuring financial toxicity as a clinically relevant patient-reported outcome: The validation of the COmprehensive Score for financial Toxicity (COST). *Cancer* 2017;123:476-484.

Why ASC Leaders Should Embed a Credo in the Facility's Culture

One shortcut to ensuring staff share their surgery center's work ethic is a credo, or guiding principle. Building a credo into the organization's foundation is very important, says **Barbara J. Holder**, RN, BSN, LHRM, CAPA, quality officer at Andrews Institute Ambulatory Surgery Center in Gulf Breeze, FL.

Andrews Institute, named for James Andrews, an orthopedic surgeon who works with athletes, offers a credo for its employees. It is short enough to fit on a business card. "It's encouraged you have it on you and periodically take it out and read it so it becomes instilled in our culture," Holder says. The credo touches on the organization's mission to provide compassionate care, highest

quality care, and access to the latest technologies. These words also inform how employees handle informed consent. ASC employees know they must provide fully informed consent to attain their credo's ideals. Informed consent is another foundation because it is so important to the patient's experience, Holder says.

"If the patient has an understanding of the procedure, risks, benefits, [and] treatment ... it makes their experience so much better, and it makes our job easier, too," she explains. "Informed consent should not be initiated on the day of surgery." The surgery center follows regulations closely when providing informed consent. CMS requires informed consent before all treatment and procedures. 42 CFR 416.50(e), the standard for the exercise of rights and respect for property and person, says patients have the right to be "fully informed about a treatment or procedure and the expected outcome before it is performed."

Andrews Institute's informed consent rules go beyond the CMS regulations, outlining exactly what should be listed in the informed consent, including descriptions of the procedure, risks, benefits, treatment, and other items, Holder says. The informed consent process consists of questions and answers, giving patients time to absorb information and come up with questions.

"The physician or staff has to present it in a way that the patient understands," Holder says. "It can be written, verbal, a combination, a video. I've seen a lot of different ways doctors have done this."

Patients should learn what type of anesthesia is used and what types of alternative treatments are available. "When informed consent is done correctly, the patient will have all questions answered," Holder says.

An ASC can ensure informed consent is performed correctly though audits.

"We audit 100% of charts here for 6,000 surgeries a year," Holder says. "That's part of what I do."

Auditors look for completeness and follow these checklist questions regarding informed consent:

- Is the physician's office informed consent on the chart?
- Was the patient asked if the surgeon discussed the surgery to be performed?
- Was the patient asked if the surgeon explained the procedure to the patient's satisfaction and understanding?
- Was the patient asked if the surgeon answered all the patient's questions?
- Was the patient asked if there were any additional questions?

"When we audit charts, we audit for completeness and also gathering of charts for documents for peer review," Holder says.

In addition to thorough chart audits, the ASC spot checks verbal informed consent audits.

"We have a checklist and observation tool we use so that everyone who performs the spot check is on the same page," Holder notes. "It's not fair to judge one person one way and another a different way."

Auditors meet to agree on how the spot checks will be conducted. Spot checks are conducted for handwashing, informed consent, and safe injection practices. When an audit reveals a problem, Holder will meet with the employee and review policies and procedures. Often, staff will ask Holder for feedback. Checking for documentation of informed consent is the first priority in any audit or spot check. "We're not responsible for the informed consent, but we are responsible for ensuring it takes place," Holder says. ■

SDS Manager

Fall Makeover Time

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

Cooler temperatures, kids back in school, and renewed energy mean a change in season. As the seasons change, it is a good time get to the task of fixing a few issues at the office.

Here's one: surgeons taking out some equity in their investments in ASCs. It is a common practice that surgeons want to sell off some of their interest in their surgery center investment. Fall seems to be the high season for that. It is a good thing, as we need new blood in our facilities to bring improvement ideas, different procedures, and generally plot a new course for the facility. Not all like change. It can be intimidating and create a false sense of insecurity. It should be just the opposite in our line of work. CMS continues pushing more complex and higher-paying procedures into surgery centers, forcing many of us to respond with updated equipment, physical

renovations, new staff training, and higher revenue potential. Many facilities are incorporating complex spine procedures, total joint replacement, and cardiac cases into our rapidly expanding business model of freestanding facilities.

Conversely, many hospitals are tightening their belts and learning how to deal with the exodus of some of their prized money-making jewels. Is it any wonder that hospitals continue to develop their own ASCs, buy interest into existing centers, or buyout outpatient surgery centers? Is it any wonder that surgeons wanting to take some equity out of their investment are turning to these perceived deep-pocket hospitals as buyers?

Surgeon recruitment is becoming an industry of its own. I know of many facilities that are courting this new breed of surgeons who had no interest in partnering with a surgery center but now see others taking their formerly hospital-only procedures away and performing those procedures in an invested surgery center. If you are not actively hunting these new specialists and welcoming their procedures into your building, someone else will.

ASCs are paying handsomely to bring in these cases. Some, typically nurses or past employees of a surgery center or hospital, charge up to $10,000 for recruitment of a surgeon, plus a percentage of their contribution for up to a year after they bring their cases to the facility. You may say to yourself, *"I would never pay someone to bring surgeons to my facility."* It is happening all across the country, and it is time to discuss this trend internally.

Explore your facility and ask yourself if you can accommodate more cases. Are your older surgeons slowing down and taking longer and more frequent time off? Is staff getting a little bored with performing the same procedures all the time? Fall is a good time to refocus and re-energize yourself and your center.

The leaves will be changing soon and you should, too. ■

(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. Website: www.earnhart.com.)

CME/CE QUESTIONS

1. **According to the CDC, about how many cases of measles were reported in the United States through August 2018?**

   a. 22
   b. More than 120
   c. 667
   d. Just under 800

2. **Which of the following is a benefit of using daily huddles in a sterile processing department with a goal of eliminating flash sterilization?**

   a. The staff would love the huddles from the beginning.
   b. Huddles give physicians an opportunity to get to know sterile processing department staff.
   c. Huddles give staff time to assess each day's schedules to determine how much equipment they will need.
   d. None of the above

3. **What is financial toxicity in healthcare?**

   a. It is the cost of employing too many people during periods of fewer surgical cases.
   b. It is the financial burden or stress patients endure in response to the cost of their treatment or care in the healthcare system.
   c. It is the process of a buyout of a surgical practice that has a balance sheet in the red.
   d. All of the above

4. **Which of the following is a question surgeons might ask patients to screen for antimicrobial resistance?**

   a. Have you been hospitalized recently?
   b. Have you received antibiotics recently?
   c. Has anyone ever told you that you have MRSA or drug-resistant bacteria?
   d. All of the above

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