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INSIDE

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Strong for Surgery Program Could Help Centers Reduce Complications

Surgery safety measures have improved immensely over the past four decades. Physicians can use checklists, electronic data, and safety tools to ensure better outcomes. Now, there is a program that helps build on those safety successes.

Created at the University of Washington in 2012 and pilot-tested through 2013 at hospitals, Strong for Surgery can help surgeons improve care with evidence-based tools and a focus on preoperative visits, says **Thomas K. Varghese, Jr.**, MD, MS, FACS, one of the creators of the program.

"We look at what we can do from the day we first see a patient in the clinic," says Varghese, who today serves as the program director of the cardiothoracic surgery fellowship at the University of Utah and as an associate professor of surgery at the university's medical school. "We shift the spotlight from quality improvement [QI] efforts on the day of surgery to engaging in QI efforts the first time we see patients in the clinic."

> IT IS IMPORTANT FOR SURGERY CENTERS TO ENGAGE IN PREOPERATIVE EVALUATION AND FOCUS ON HELPING PEOPLE IMPROVE THEIR HEALTH BEFORE SURGERY.

With the United States' aging population, it is important for surgery centers to engage in preoperative evaluation and focus on helping people improve their health before surgery, Varghese and colleagues suggested in a recent study.[1]

The Strong for Surgery program, embraced by the American College of

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Surgeons (ACS), is widening the lens on where standardization should happen around surgical care, says **David R. Flum**, MD, MPH, FACS, professor of surgery at the University of Washington and director of the UW Medicine Surgical Outcomes Research Center in Seattle. ACS believes it is important for surgeons and institutions to improve the preoperation space and clinical outcomes, Flum notes.

"The Strong for Surgery program is perfect for ambulatory surgery centers [ASCs], especially as more and more procedures move from hospitals to ASCs and more patients with risk factors move to [ASCs]," Flum says.

These changes put greater pressure on surgeons and their practices to engage in QI and quality control. ASCs do not have the big budgets or the QI infrastructure of health systems, but they are well-suited for specific target programs like Strong for Surgery, Flum offers.

The program helps an administrator look "across the whole care continuum for the patient undergoing surgery," Flum says. "Strong for Surgery identifies areas for standardization to improve the care experience." By 2016, ACS had adopted Strong for Surgery, which was active in 50 clinical sites across disciplines, including general surgery, colorectal, vascular, and all surgical disciplines. By 2018, the program had spread to 230 active sites. Any surgery facility can use the program's tools for free at the ACS website.

"All we ask is that they register with us. It's a free process, but we want to learn how they did — good or bad," Varghese says. "By doing the registration process, it enables us to get them the implementation guide, training, conference calls, and make sure they've onboarded correctly."

To crowdsource the program's efforts and outcomes, surgery centers using Strong for Surgery will report what went well and what did not. "We want to know that story. The more sites we engage with, the more we learn," Varghese says. There are several components to the program:

• **It is designed to target health changes patients can make before surgery.** The classic example is smoking cessation. "We know that people who continue to smoke at the time of their surgical intervention have an increased infection rate and impaired wound healing rate," Varghese says.

"For a patient having spine surgery, one of the greatest risks of spine surgical complications and failure of

EXECUTIVE SUMMARY

Surgery safety measures are extending to the presurgery sphere. Hospitals, surgeons, and ambulatory surgery centers are working together under a Strong for Surgery program to teach facilities how to reduce post-surgical complications through engaging patients in activities that will improve their health before they undergo surgical procedures.

- Strong for Surgery tools and checklists are evidence-based.
- The shift is from only quality improvement in the surgical suite to quality improvement from the first moment a patient steps inside the door for a consultation.
- The American College of Surgeons offers program information and tools for free on its website. (*https://bit.ly/2TNBaEw*)

bone healing is whether they use cigarettes," Flum adds. "Many surgeons tell patients to stop smoking, but giving surgeons tools to help patients stop smoking is one of the opportunities of the program."

Varghese was involved in a study that revealed a financial benefit to directing patients into a preoperative smoking cessation program, which can help them reduce postoperative complications caused by smoking. The study authors found that such programs, on average, saved $304 in direct medical costs per patient.[2]

Strong for Surgery gives surgeons a checklist to assess patients' smoking habits. The program also provides resources, tools, and techniques to help patients get on a smoking cessation pathway before they begin the surgical pathway. These tools give physicians an example of how to ask patients to stop smoking, Varghese says. "Instead of saying, *'We won't offer surgery to you if you continue to smoke,'* the physician could say, *'If you need a successful outcome, you need to stop smoking, and here are the ways we can help you stop smoking,'"* Varghese offers.

When the smoking cessation tactics were used with spine surgery patients, physicians reduced the rate of cigarette use prior to surgery from 30% to 11%, Flum says. "We think this has a lot of possibilities for other types of surgery."

• **Tools assist with risk assessment and mitigation.** For example, in risk stratification for smoking, clinicians can ask patients if they have ever smoked. If so, the user records patients' smoking status (current or former smoker). Users also can ask about number of pack-years (packs per day multiplied by years smoking) and record the answer. If a patient says he or she smokes, program users advise the patient to quit and set a quit date within two weeks. Users also can refer these patients to one of several preferred cessation programs.

• **It is important to identify local resources.** Local resources references both institutional (the site where surgery is performed) and community and state resources, Varghese says.

"These are typically identified at the time of our initial conversations with the site. The key to this is to get all stakeholders to arrive at a consensus on which intervention tool to use," he says. "For example, there may be indeed several smoking cessation programs, sites, and interventions available."

Standardization is difficult unless the participating site agrees on a consensus on which resource to use each and every time, he adds.

"A lot of what we do when we recruit sites for the program is to identify local resources," Varghese says. "You may go into a site and say, *'Here's an incredible and robust smoking cessation program at your site. Have you thought about using that resource?'"*

In Utah, there is a state-sponsored phone line that people can call when

PREHABILITATION CHECKLIST

The Strong for Surgery program includes a screening checklist for prehabilitation, which ACS defines as "a process of improving the functional capability of a patient prior to a surgical procedure." Some of the items on the list include:

• **Does the patient report physical limitations or does he or she exhibit signs of frailty?** If yes: Use either grip strength or the Timed Up and Go test for baseline assessment, and consider referral to a geriatrician;

• **Does the patient present with unstable cardiac disease?** If yes: Consider referral for presurgery consultation with a cardiologist;

• **Does the patient report unstable pulmonary disease?** If yes: Consider referral for presurgery consultation with a pulmonologist;

• **Does the patient show poor mobility and/or diminished endurance?** If yes: Refer patient to physical therapy and start daily walking program.

(Learn more about this checklist at: http://bit.ly/2DmBSTz.) ■

they wish to stop smoking. Other locations might offer smoking cessation counseling, support groups, or other methods.

"Some people prefer online interactive programs," Varghese notes. "Figure out what helps with every patient or tell the patient that [a certain] program is the one we've found the most success with."

• ASCs using the Strong for Surgery program should engage surgeons and office staff. "This is especially important for the process of rethinking the preoperative process," Flum advises. "Right now, pre-op doctors' offices are a place where patients make a determination of whether you need surgery."

In addition to helping patients make that decision, surgeons and their staff could help patients learn how they might improve their health before surgery and prevent complications. ASC staff, surgeons, and administrators could think of that period before surgery as a way to help patients optimize their health and maintain control of chronic illness symptoms, he adds. ■

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Strong for Surgery Targets Specific Health Issues

The Strong for Surgery program includes checklists that target eight areas, including four lists that were released in November 2018. In addition to nutrition, glycemic control, and medication management, the new targets are safe and effective pain management after surgery, delirium, prehabilitation, and patient directives. *(Editor's Note: More details about each area are available at: https://bit.ly/2OSmX5S.)*

The program's goal is to help every patient in need of surgery and to ensure the patient is strong enough to experience the best possible surgical outcome, says **Thomas K. Varghese, Jr.**, MD, MS, FACS, a co-creator of the program. "If a patient is not strong for surgery, what can we do to help the patient prepare?"

Pain management is one of the new areas of focus because of the nation's opioid epidemic. Prehabilitation addresses patient frailty, says **David R. Flum**, MD, MPH, FACS, professor of surgery at the University of Washington.

"With patient directives, we're thinking about shared decision-making and making sure patients' preferences are being incorporated," Flum says.

Varghese and Flum offer further details about the new target areas and how ASCs can use the Strong for Surgery toolkit to address these issues:

• Blood sugar control.

"We know in the Medicare patient population that two out of four patients are diabetic," Varghese notes. "Another one out of four is prediabetic, which is when the patient has normal blood levels, but whenever faced with stress, such as surgery, the patient will respond with elevated blood sugar levels."

If surgeons wait until the prediabetic patient presents with high blood sugar levels, then the patient's risk of infection has already increased, he warns. "We say, *'Here are things for known diabetics to make sure their blood sugar is controlled, and we don't want to miss out on screening prediabetics,'"* Varghese says.

Patients' glycemic levels can be controlled in the ambulatory surgery setting, but physicians need to be aware of these potential problems. Strong for Surgery encourages physicians to make glycemic control part of the pre-op preparation, including directing patients to meet with a primary care provider or specialist.

• Prehabilitation.

Physical fitness and nutritional status are underaddressed and modifiable risk factors for surgery patients. According to a new study, surgical patients are at risk for frailty, sarcopenia, and reduced physical fitness. The authors concluded these patients could benefit from exercise-based prehabilitation activities designed to improve aerobic fitness.[1]

Prehabilitation programs help patients improve their health before surgery so their postoperative recovery will be optimal. The Strong for Surgery program explains in layman terms that prehabilitation is "to get you to a better place physically before an operation."

Program guidelines also advise patients that better fitness and a higher level of activity before surgery generally leads to better outcomes after an operation. *(Editor's Note: A detailed list of presurgery tips clinicians can share with patients is available at:*

https://bit.ly/2Tl8zWU.) The authors of a study about prehabilitation efforts (including muscle training, aerobic exercise, and/or resistance training) prior to intra-abdominal operations concluded that such efforts were beneficial in decreasing the incidence of postoperative complications.[2]

• Nutritional optimization.

"We're coming to realize surgery is a stressful period for people, and some people's bodies are depleted by surgery," Flum says.

For instance, patients might be low on amino acids that help the immune system fight infections. Flum worked on a study of elective colorectal surgery patients and use of arginine supplementation. Flum and colleagues found that an arginine-based immunonutrition approach resulted in significantly fewer readmissions and hospital days for the intervention group and lowered risk for infections and venous thromboembolism. Total costs also were lower.[3] Nutritional optimization also addresses undernourishment and obesity.

"Some people forget that some obese patients might be malnourished," Varghese notes. "They might not get the appropriate protein energy they need."

Other patients may only need to consider losing weight prior to a procedure.

• Medication reconciliation.

"If you ask patients what medications they are taking, most will say, *'Here are my prescription medications,'"* Varghese says, noting that patients sometimes forget about vitamins, over-the-counter drugs, and dietary supplements.

"There are 51,000 dietary supplements out on the market right now, and most are not FDA-regulated. We know of eight herbal medications that will increase bleeding after surgery."

Unless physicians specifically ask about vitamins and herbal supplements, most people will not say they are taking any of these. The Strong for Surgery program provides tools for checking patients' medications and supplements, ensuring patients stop taking the drugs and supplements that might increase their risk during and after surgery. ■

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Medicare's 2019 Final ASC Payment Rule Includes Several ASCA Suggestions

The final ASC payment rule for 2019 provides some long-awaited improvements regarding how ASC payment rates are determined, according to the details released Nov. 2 by CMS.

"We view this rule from 50,000 feet as an affirmation that CMS sees the ASC model as a valuable part of the Medicare program and believes that we can play a role going forward in reducing costs for the Medicare system," says **Bill Prentice**, chief executive officer of the Ambulatory Surgery Center Association (ASCA). CMS made several changes that have been on ASCA's wish list for years. "We look forward to seeing the impact of these changes in 2019, and we expect to see additional migration to the ASC setting," Prentice says. "One thing we know is when cases migrate to the surgery center setting, the healthcare system saves money."

The new rule has changed the way ASC payment rates are updated by tying their rate increases to the same inflation rate that has been used for hospital outpatient departments (HOPD). For instance, for both ASCs and HOPDs, the inflation update factor (before reductions) will be 2.9%. *(http://bit.ly/2RnVHhG)* Prior to this change, ASC payments were updated using an inflationary measure related more closely to the cost of consumer goods than to the costs involved in providing healthcare. This resulted in increasingly divergent Medicare reimbursement between ASCs and HOPDs. "We have been asking, probably for a decade or more, to be updated for inflation on the same terms as [HOPDs]," Prentice says. "In this rule, [CMS] did that, and it will help us."

ASCs still will not be paid the same as HOPDs, but at least the difference between the two reimbursements no longer will increase because of the inflationary

measure applied to the updates, Prentice notes.

"We see this as a positive element that will encourage more ASCs to see Medicare patients," he says. "Putting ASCs on the hospital market basket is a strong signal to ASC physicians that CMS values what they do."

More surgeons will bring Medicare cases to their surgery center, which could save money for the Medicare program as ASCs, Prentice predicts.

As the entire ASC model is based on providing efficient care, Prentice believes the new rule and its resulting better reimbursement will not cause ASCs to deviate from that model.

"ASCs still are reimbursed roughly half of what a [HOPD] receives for performing the same procedure on a Medicare beneficiary," he explains. "The Medicare payment change for ASCs does not make rates closer to each other, but it prevents [rates] from getting further apart from each other based on the inflation measure used to set the new rates." Another change in the 2019 Medicare payment rule for ASCs will make it more feasible for surgery centers to take on cases with expensive implants and other devices.

"The change is moving the device-intensive threshold from 40% to 30%, which makes it more likely a surgeon will bring a device-intensive procedure to the ASC," Prentice offers.

The device-intensive policy involves the cost of a device vs. the cost of the procedure. Previously, the rule dictated that if the device costs 40% or more of the total procedure's cost in the HOPD setting, then the ASC will be reimbursed for the cost of the device.

Now that this threshold has been lowered to 30%, there are more procedures with devices that will meet the threshold. This means it could be more likely ASCs will be reimbursed adequately for the procedure, Prentice believes.

"This reduces the financial barriers to bringing device-intensive procedures to the ASC," he says. "It was hard to actually come out even financially on them before." ASCs will submit the procedure codes for those procedures as before. Medicare has included reimbursement for the devices in its payments for those codes already, Prentice adds.

Another rule update concerns pain management. Previously, ASCs were not permitted to be paid separately for certain nonopioid pain modalities. With the Trump Administration focused on combatting the opioid epidemic, the goal is to find nonopioid alternatives for surgical and other pain.

Under the new rule, ASCs can be reimbursed separately for one specific alternative — Exparel, a long-acting local anesthetic.

Prentice notes that the updated rule applies only to Exparel. However, with other long-acting local anesthetics and other nonopioid alternatives heading to market soon, he hopes the rules will be amended further at a later date to expand choices available to ASCs. ■

ASCs Continue Struggling With False Claims Act and Anti-Kickback Statute

Some ASCs shell out millions of dollars to settle False Claims Act or federal Anti-Kickback Statute violations. These often are the result of whistleblower reports and could have been caused by ASCs not conducting proper research before selling shares in the business.

"A lot of times, the government piggybacks false claims into anti-kickback violations," says **Ashley Morgan**, JD, CMCO, CMRS, senior associate attorney at Liles Parker, a national healthcare law firm based in Washington, DC. "[The government] might get information from data-mining, which they can use for post-payment audits."

Other sources can be patient complaints and information from state licensing boards. One case in Florida involved the operator of an ASC who was accused of selling a minority ownership interest for less than fair market value to physicians — who were sending Medicare patients to that ASC, Morgan says.

ASCs are permitted to sell minority ownership interest to physicians under specific rules of a safe harbor in the Anti-Kickback Statute. This provision allows for the sale to occur if the price is fair market value. The sale price must be in writing and must not be based on the value of referrals, Morgan explains. In the Florida ASC case, the government determined the physicians did not pay fair market value, which resulted in a $5.1 million settlement. *(Editor's Note: One can read many more details about the Anti-Kickback Statute online at: https://bit.ly/2qVSKZK.)*

ASCs that end up in compliance trouble often land there because

leaders were not cautious when choosing tactics to improve their competitiveness in the healthcare marketplace.

There was a case in Tennessee that involved how an ASC compensated a referring physician for direct services to that ASC. This facility settled for $5.12 million with the federal government and had to enter into a corporate integrity agreement. ASC leaders were required to hire an independent review organization to ensure they met documentation requirements, Morgan says.

"You're allowed to have a medical director, as long as the person is under contract and the contract specifies what the person will do and how much the person will be paid," she explains. "The work has to correlate to the amounts they're going to be paid. You can't just say you'll pay [someone] $2,000 every week to do nothing more than looking over charts and signing orders."

The payment has to be fair market value, and the same salary would have to be paid to anyone who was hired for that job, she adds. "There is a lot of competition out there, and they have to get referrals from doctors for services," Morgan says. "Some organizations out there will just do the wrong thing."

An ASC administrator might argue that everyone else is doing this, and he or she has to do this to get referrals. "We tell providers, *'You have to get a good compliance plan in place and make sure referrals are up to date,'"* Morgan says. "If [providers] never have had a problem before, they typically do not want to hear this advice. [Providers] see everybody else doing it, and they worry that if they don't do it, they won't make any money."

Some physicians might even encourage incentives for referrals. "Sometimes, doctors pay a price for these relationships, but sometimes I see that the doctors will turn on the provider and say, *'I never signed any of those orders or referrals,'"* Morgan says. "They act like they don't know what is going on."

Under the Anti-Kickback Statute, it is illegal to offer, accept, or solicit for referrals. The rule concerns any instance of knowingly offering anything of value, both monetary and nonmonetary gifts. If physicians have an ownership stake in a healthcare entity, federal officials will target the doctors in their investigation.

"But more often, [federal investigators] go after the entities because the entity has more money and the entity is the one offering payment for physicians' services," Morgan says.

Financial penalties can be severe, but other sanctions physicians could face might be even worse. For instance, one case resulted in a physician's exclusion from the Medicare program, Morgan reports.

"In Florida, a managing surgeon at an ASC was alleged to have performed medically unnecessary procedures on Medicare patients. Two whistleblowers brought the [complaint] to the federal government, which filed a case against the ASC and managing physician," she recalls. Together, the ASC and physician settled for $4 million, which was on top of the physician's five-year Medicare banishment. During that time, the doctor will only be able to provide cash-and-carry medical services. After five years, the physician can reapply to be in the Medicare program.

If one is banned from Medicare, Morgan says that is "a death knell for providers." A banned physician cannot work at any organization that takes federal money. Further, Morgan says that a Medicare ban could damage relationships between the provider and hospitals or other private payers. "If Medicare doesn't want you providing services, they don't want *you*, either," Morgan adds.

ASCs and surgeons can steer clear of federal violations by documenting all relationships with referring physicians and following Safe Harbor guidelines. They also

should encourage employees to report problems. Management should follow up on these reports.

"If employees report something to you, and you don't do anything about it, then they might take their complaint to the federal government," Morgan warns.

Employees may be tempted to speak out because the federal government will pay whistleblowers up to one-quarter of a total settlement. From federal investigators' perspective, it saves time to pursue cases brought by whistleblowers because those whistleblowers have collected evidence already.

ASCs can avoid becoming ensnared in these investigations if leaders take steps to improve their regulatory compliance:

• **Evaluate relationships with referral sources.** Scrutinize contracts and lease agreements with physicians, Morgan suggests.

"Take a look at the ownership structure to make sure that investors are sources of referral, and get a compliance program in place," she says.

• **Train staff about compliance.** ASCs should make sure staff know and follow all policies and procedures. It is especially important to not put one person in charge of compliance.

"I always say it takes a team to run anything, including an ASC," Morgan says. "The team has to understand your responsibilities and what repercussions will be for noncompliance with the compliance plan."

• **Ensure employees are comfortable reporting problems.** "If you have employees comfortable with reporting things to you, you can stop the bleeding," Morgan says.

Organizations can discover problems early on by listening to their staff.

"I highly recommend that providers set up an anonymous reporting or compliance hotline or email where employees know they can use this to provide information," Morgan says. "A lot of times, employees don't want to come forward because even though there are anti-retaliation laws, they're worried they'll be retaliated against."

Morgan adds that ASCs can contract with outside companies to handle a compliance hotline and reporting.

• **Fix any problems discovered internally.** "Figure out the scope of the problem, and if there was an overpayment from Medicare, then make a repayment to the government," Morgan says. "The government doesn't expect you to be perfect. They expect you to try."

Once an organization admits to a problem and rectifies it, the government typically will not take the case any further, she notes.

All these steps can help prevent costly noncompliance investigations and settlements. It is not easy or cheap to take these steps, but it is worth the effort, Morgan says.

"It's like insurance," she adds. "No one wants to pay for it, but when you need it, you're glad you have it." ■

Collaboration to Standardize Care and Quality Improvement in Joint Replacement

The Joint Commission (TJC) and the American Academy of Orthopaedic Surgeons (AAOS) have created a new collaboration for Total Hip and Knee Replacement (THKR) certification.

AAOS brings clinical expertise to the collaboration while TJC contributes standards development and performance measurement requirements.

The two organizations will oversee scientific issues, performance measurement, quality improvement activities, data sharing, research, and education.

Effective Jan. 1, 2019, THKR-certified organizations must participate in a national registry that collects data for hip and knee replacement procedures, says **Mark Crafton**, executive director of TJC's state and external relations. One such repository is AAOS' American Joint Replacement Registry (AJRR), which contains data from more than 1.4 million procedures.

"They can use data from their participation in the registry for quality improvement purposes," Crafton says. "Generally speaking, organizations that enroll in and submit data to a national registry receive comparative/benchmarking data. Organizations that operate registries may also use de-identified, aggregate data for research, clinical guideline development, and publication purposes."

The THKR certification is site-specific, and a handful of ASCs had achieved the certification through the fall. The voluntary, advanced certification was established in 2016 for accredited hospitals, ASCs, and critical access hospitals.

ASCs, especially Medicare-deemed ASCs, should know that

only one site is included in the scope of the accreditation per CMS requirements, says **Pearl S. Darling**, MBA, executive director of TJC's ambulatory care services.

"Organizations eligible for certification can be granted THRK rather than the individual providers/practitioners that perform procedures at an organization," Crafton says.

Although there are organizations that already have obtained a two-year THKR certification under the old rules, they are expected to meet the new THKR requirements in 2019.

"While we understand it may not be fully implemented, there is an expectation that those who are already THKR-certified will be members of a registry and will have developed selection criteria," Darling says, adding that she believes ASCs should not experience problems joining a national registry.

The collaboration between AAOS and TJC has not changed the certification review process, Crafton notes. "The reviews will be performed by Joint Commission reviewers."

The onsite review evaluates compliance with advanced disease-specific care standards, requirements for total knee and hip replacements, preoperative, intraoperative, and postsurgical orthopedic surgical follow-up, and orthopedic consultation. "Organizations will be evaluated against the standards and review process in effect at the time of their onsite visit, regardless of whether it is an initial certification or recertification," Crafton explains. "[TJC] utilizes a two-year cycle for most disease-specific care certifications, such as THKR, to ensure that the most current scientific evidence is applied to the standards and performance measures evaluated during the review and in the clinical practice guidelines adopted by certified organizations."

The THKR certification places focus on clinical, evidence-based patient care related to pain management, quality of life issues, functional limitation in mobility, and return to normal daily activities. For ASCs and other certified organizations, this certification provides a pathway for improving patient outcomes through a focus on care consistency, reducing error risk, supporting collaboration and teams across the continuum of care, and committing to high standards for clinical service. ■

Finding Experienced OR Nurses Is a Challenge ASCs Should Tackle

Increasingly, hospital administrators and ASC leaders are finding it challenging to hire qualified operating room nurses.

"Whether there's a nursing shortage or not varies by region," says **Linda Plank**, PhD, RN, NEA-BC, associate dean for academic affairs at Baylor University's Louise Herrington School of Nursing. "Some places have a surplus of RNs, but more places have a shortage of RNs. It's not very consistent, and it only takes three people to retire or resign and you have a major staffing issue."

Plank says ASCs are at an advantage over hospital ORs when it comes to hiring nurses. For instance, the work hours in an ambulatory OR are more desirable. Still, both hospital and ASC OR settings will continue to see increasing shortages of nurses. ASCs will experience this problem because of their increasing case volume and rise in OR nursing demand.

"As more surgical cases go to the ASC or are affected by a surgical procedure, we need more good nurses in the operating room," Plank says.

Operating rooms function under conditions that can make the nursing shortage more severe than the general

nurse shortage because of the length of time it takes to orient someone in an OR, Plank says.

"You need six months to orient a nurse in an operating room, but only a few weeks or a few months in other settings."

Also, ORs traditionally drew most of their nursing staff from graduates with associate degrees in nursing (ADNs). Now, there are fewer schools training two-year ADN nurses as more students desire four-year degrees, Plank says.

"Two-year programs have closed or become four-year programs," Plank notes.

A third reason for the decline in available OR nurses is that the average age of an operating room nurse is four to five years older than nurses working in other areas. The Association of periOperative Registered Nurses (AORN) surveys OR nurses regularly, finding in every questionnaire that OR nurses are older and nearer to retirement.

"That's the main reason we see a bigger shortage in the operating room than in other parts of the hospital," Plank adds.

Colleges and universities are graduating increasing numbers of new nurses, but ORs are not benefiting from the new additions to the nursing workforce because the students lack exposure to OR nursing. Nursing schools give students exposure to med-surg units, obstetrics, pediatrics, and oncology, but not operating rooms. "The operating room stopped being a clinical site for nursing students decades ago," Plank laments. "If students are not exposed to the OR, they can't make a good decision of whether or not this is a good place for them to work."

The OR was taken out of the nursing student rotation schedule because of a lack of faculty comfortable in the OR and because the OR carries greater risk to students and patients, Plank says.

"A lot of hospitals felt it was too dangerous to have students in the OR; who would be watching them?" she explains. "[These students are] either unsupervised or they're a burden for the OR nurse. It's risky and burdensome."

In a recent study, Plank suggested a solution: Operating rooms, including those in ASCs, can collaborate with academic institutions to bring nursing students into the OR.[1]

"Since we started the perioperative elective [at Baylor's nursing school] in 2010, we've had nurses that chose to work in the OR and were offered jobs there after graduation," Plank says. "From the nursing school standpoint, we feel that's a win-win. The clinical time in the OR benefited the student, and the hospital ended up with [an] employee they wanted."

Although Plank has not tracked the long-term impact, she notes that some nurses who participated in the perioperative elective program are still working in operating rooms.

An academic practice partnership entails a commitment between a nursing school and a hospital or ASC to work together to give OR experience to nursing students.

Any ASC that experiences continual nursing staff shortages should contact the local nursing school and discuss forming a partnership, Plank suggests.

"It's better for everyone if nursing students are exposed to the OR long enough to make a decision and apply for a position, if it is a good fit."

Such a partnership could provide one day a week of experience in a med-surg rotation in an ASC or hospital OR. The student should have the opportunity to follow the patient from a first interview to meeting the anesthesiologist all the way through viewing the procedure in the OR and watching the patient start recovery, Plank suggests.

OR nursing salaries should be attractive to nursing students, too. According to AORN's 2017 data, staff perioperative nurses earn an average annual salary of $70,300, and perioperative nursing leaders earn an average salary of $117,000.[2] AORN

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.

COMING IN FUTURE MONTHS

- Bundled payment success tips
- Surgeons use social media to benefit their practices
- How independent ASCs can remain competitive
- Reduce appeals denials

notes that these salaries represent increases of $1,200 and $3,400, respectively, above what those jobs paid in 2016.

Asking ASC staffers to spend a little extra time with a nursing student is a better use of resources than paying for temporary nurses or overtime during a low staffing period, Plank argues. "If you don't want to have your staff work overtime or to hire contract nurses, there may be no other options," she says. "Contact your closest nursing school, and bring students into the OR." ■

REFERENCES

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2. Association of periOperative Registered Nurses. What Are You Worth? 2017 Salary Survey Top Takeaways. Published Dec. 13, 2017. Available at: https://bit.ly/2QWCseA. Accessed Nov. 19, 2018.

SDS Manager

New Year's Resolutions for 2019

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With a new year comes a time to set some goals to help your business succeed. Here are a few to get you started:

• **Start running your facility based on metrics.** Far too often, we keep doing the same thing, producing the same results. Yet, we often are surprised at this outcome. Almost all software packages hospitals and ASCs use contain metrics leaders can use to grade facility and staff performance.

• **Try something completely different.** For example, start serving lunch for staff one day a week. Offer free car wash services to top-performing surgeons.

• **Let anesthesia know the hoarding must stop.**

• **Pay more attention to your sterile processing department.** This is an area of operation in serious need of more attention. Listen to what staff has to say. You really will learn something new.

• **Start preparing for your next CMS or state survey.** There is a good chance you already are behind.

• **Make it a point to attend a national conference in 2019.** Try to take as many staffers with you as possible. Listening to the lectures at these conferences is educational, but do not forget the added fun of the giveaway toys and gadgets from vendors in the exhibitor areas of these shows.

• **Check out the new 2019 Medicare ASC and hospital facility fee reimbursement rates.** While usually a yawner, this year the rate change really is interesting stuff that will definitely affect your facility. *(Editor's Note: See story on page 5.)*

• **Also: Study the physician reimbursement changes for 2019.**

• **Step up your social media game.** Facebook is blasé. Instead, set up an Instagram account. It is fun and a great way to share your facility publicly.

• **Take an adult education course at a local community college.** These courses are cheap and can be a great diversion from the day-to-day routines of surgery. ■

(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.)

CME/CE INSTRUCTIONS

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SAME-DAY SURGERY

CME/CE QUESTIONS

1. **Which of the following is *not* a *new* health target that was added in November 2018 as part of the Strong for Surgery program?**

   a. Delirium
   b. Nutrition
   c. Prehabilitation
   d. Safe and effective pain management after surgery

2. **The ASC payment rule for 2019 provides some long-awaited improvements to how ASC payment rates are determined. Which of the following is one of those improvements?**

   a. The new payment rule will make it more feasible for surgery centers to take on cases with expensive implants and other devices.
   b. The new payment rule will reset Medicare payments for ASCs to the same level as hospital outpatient departments.
   c. The new payment rule will provide ASCs with separate funding to cover the cost of paying for an employee anesthesiologist.
   d. The new payment rule will allow ASCs to be reimbursed for a wide variety of nonopioid alternatives.

3. **Which of the following best characterizes the federal Anti-Kickback Statute?**

   a. The statute states that physicians cannot pay ASCs for the right to practice surgery in that space.
   b. The statute prohibits the knowing and willful solicitation, offer, payment, or acceptance of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind in return for referring patients to the facility.
   c. The statute prohibits employers from agreeing to send all their employees to a particular surgery center in exchange for the employer paying the ASC a set bundled payment fee.
   d. The statute says that quid pro quo is acceptable as long as no one ever finds out about it.

4. **The Joint Commission's certification review process for Total Hip and Knee Replacement certification includes all of the following *except*:**

   a. compliance with advanced disease-specific care standards.
   b. evaluation of total hip and total knee replacement requirements.
   c. following requirement to prescribe opioids for pain.
   d. evaluation of preoperative, intraoperative, and postsurgical orthopedic surgeon follow-up care.

5. **Which of the following is *not* a reason ASCs have struggled to maintain a proper number of operating room nurses?**

   a. Fewer schools are offering two-year associate degree in nursing programs.
   b. Case volumes in ASCs continue rising.
   c. Work hours in hospital operating rooms are much more flexible than ASC working hours.
   d. It takes longer to train and orient nurses to the operating room environment compared to other areas.