SAME-DAY SURGERY

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INSIDE

RELIAS MEDIA

Two Recent Infection Breaches Highlight Danger of Complacency

Infection breaches occur rarely in ambulatory surgery centers (ASCs). But when they do, the consequences can be daunting.

Two recent infection breaches have renewed focus on surgery centers. The most recent, which the FDA reported on in December *(http://bit.ly/2R4yr7o)*, involved two patients who developed the potentially fatal carbapenem-resistant Enterobacteriaceae (CRE) after undergoing colonovideoscope procedures on Oct. 12, 2018. As of this issue's reporting deadline, the FDA had not released information on where the procedures were performed, the medical status of the infected patients, or whether the patients were ill prior to their developing CRE. The cause of the event remains unknown.

"To my knowledge, this is the first time CRE is linked to a colonoscope," says **Susan Hutfless**, PhD, assistant professor and director of the Gastrointestinal Epidemiology Research Center at Johns Hopkins University. Hutfless conducts research on the rates of infection after colonoscopy and esophagogastroduodenoscopy in ASCs. *(Editor's Note: Read more about Hutfless' work in the sidebar on page 27.)*

In another potential infection exposure case, a New Jersey ASC sent letters to 3,778 patients asking them to be tested for hepatitis B, hepatitis C, and HIV because of a possible exposure at the surgery center between Jan. 1, 2018, and Sept. 7, 2018. The breach and patient letters were reported by dozens of local and national news outlets.

The New Jersey Department of Health shut down the center for several weeks starting on Sept. 7, 2018. The department's investigation uncovered deficiencies in infection control related to sterilization and cleaning of instruments and medication injections.

From an infection preventionist's perspective, the headlines suggest a potential breakdown in processes, according to **Phenelle Segal**, RN, CIC, FAPIC, president of Infection Control Consulting Services in Delray Beach, FL. "At times, I've seen these processes break down because of a lack of training and experience in reprocessing of

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medical devices and instruments," she says. "My next thought is: Are they following nationally recognized guidelines and standards? ... We have various standards available."

The New Jersey breach highlights potential equipment sterilization issues, but ASCs also must ensure other critical practices, such as safe injection practices and surgery site preparation, are adhering to infection prevention standards.

"It's disappointing when things like that do occur, but it's important to realize they're extreme outliers; it's very uncommon," says **Stanford R. Plavin**, MD, owner of Ambulatory Anesthesia Partners and principal of Technical Anesthesia Strategies and Solutions, both in Atlanta. "Patients can feel confident, especially nowadays with the sophistication of the processes we use and how we manage them reduces risk even more dramatically to every patient."

One way ASCs and anesthesiologists can reduce infection risk is by following the highest standards of infection prevention, including safety regulations, guidelines, and standards from the CDC. "We follow the one and only campaign — one patient, one needle, one syringe, one time for each injection," Plavin offers.

ASCs that need laryngoscopes infrequently can use disposable ones. This reduces risk and saves time and effort in reprocessing/sterilizing the equipment, he adds. "It's unfortunate if people are exposed to any pathogen because of improper sterilization technique or injection practices," Plavin says. "About the only positive is that it brings things to light so people can do a self-analysis and make sure they're maintaining quality and control and providing an utmost safe patient experience."

Surgical site infections are very rare in ASC patients, but they do occur, and several factors increase the risk, according to a new study.[1]

"Most of these surgeries are low rates of infection," says **Robert H. Brophy**, MD, study co-investigator, sports medicine specialist and professor of orthopaedic surgery at Washington University School of Medicine in St. Louis. Brophy says these New Jersey ASC outbreaks highlight why surgery centers should not let down their guard in maintaining infection prevention best practices, despite typically low rates of infection problems.

"It's not to belittle it or sweep it under the rug, but you want to put it in context," Brophy says. "It's a reminder to always be careful because most of the time we're doing things right. But anytime something comes up, look at it, and make sure you're being vigilant."

EXECUTIVE SUMMARY

Surgery centers should refocus on infection prevention efforts in light of recent reports of breaches involving HIV, hepatitis, and the potentially fatal carbapenem-resistant Enterobacteriaceae (CRE).

- Two cases of CRE were reported to the FDA late in 2018.
- A New Jersey ambulatory surgery center (ASC) notified thousands of patients of potential exposure to infectious diseases, a breach attributed to reprocessing failures.
- The problems point to the need for ASCs to follow the highest level of infection prevention standards and guidelines.

Brophy's study of surgical site infections among 22,267 orthopedic surgery patients revealed that older patients were at a higher risk for infection, which was not surprising. "Patients with diabetes had a higher risk of infection," Brophy adds. "Surgeries of the shoulder had the lowest rate of infection."

People who underwent hip surgery demonstrated the highest rate of infection (18.6 times higher than the infection rate of hand and elbow surgery). However, the higher risk for hip surgeries still is not high enough of a risk to set off alarms. "It was just a relatively elevated risk, adjusting for other factors," Brophy says. "We need a little more study, and it could be a variety of things." Other infection risk factors included receiving combined general and regional anesthesia and more tourniquet exposure.

When ASC directors and physicians hear about infection breaches, they should put the reports in context.

"This could be an isolated incident or global concern. Learn from it, and apply the lesson that everyone should stay vigilant," Brophy says. "What you see [with the infection breach at the ASC] in New Jersey is a reminder to be careful and do a better job, day in, day out. It's worth looking at, learning from it, and making sure it doesn't happen." Segal suggests paying attention to the details. For example, consider asking questions such as: Have you completed infection prevention training? Are you experienced in infection prevention? Do you follow nationally recognized guidelines and standards? Is there oversight? Is your facility conducting competency reviews? "Do facilities have established, written policies and procedures that are updated?" Segal asks. "I often come across outdated policies that can date back years prior to their original implementation date, and there's no record of their having been reviewed and revised."

Another problem concerns following manufacturer's instructions for

INFECTION RATES IN GI PROCEDURES

In a recent study comparing infections that resulted in a hospitalization within seven days of a procedure across types of procedures, the authors found that colonoscopies led to lower infection rate than esophagogastroduodenoscopies (EGDs).[1] Cases in which a patient's infection was documented on the day of procedure were not included.

"The concept was to look at infections that happened after endoscopic procedures," says **Susan Hutfless**, PhD. "Looking at the results, you'll see that infections were more common in EGD than endoscopy."

The study also revealed that patients undergoing a screening colonoscopy experienced lower rates of infection than those with a nonscreening colonoscopy. Hutfless says the findings were not surprising because screening colonoscopies generally are performed on healthy people, while EGDs and nonscreening colonoscopies might be performed on people with underlying health problems. "The EGD is surveillance for gastroesophageal reflux disease, Barrett's esophagus, and cancer," she explains.

The rates of infection were low in all procedures studied, with only 1.1 infections out of 1,000 procedures for screening colonoscopy, 1.6 infections out of 1,000 procedures for nonscreening colonoscopy, and 3.0 infections out of 1,000 procedures for EGD. ■

REFERENCE

1. Wang P, Xu T, Ngamruengphong S, et al. Rates of infection after colonoscopy and osophagogastroduodenoscopy in ambulatory surgery centres in the USA. *Gut* 2018;67:1626-1636.

cleaning, reprocessing, and sterilizing equipment and instruments. "That's where we usually find the biggest deficit in facilities," Segal notes. Today, manufacturers are better at specifying how to clean, disinfect, and sterilize their equipment and instruments. Still, there are occasions when manufacturers will not provide these detailed instructions, leaving it up to ASCs to create their own.

"I will insist they pull something together, or I would advise my clients to switch to different products," she says. "We absolutely have to follow manufacturer's instructions."

For instance, Segal found that one company provided no instructions on disinfecting its glucose meters. "I advised [the company] that unless they developed disinfection instructions, my clients would move to a different manufacturer," she recalls. The company had created *cleaning* instructions, which are not the same as *disinfection* instructions. After further discussion among all parties, the company went on to develop a proper disinfection process.

If it is not possible to obtain manufacturer's instructions for use, perhaps because the equipment is old and the instructions do not exist, then it is imperative for the ASC to follow nationally recognized guidelines and standards. The good news in the ASC industry is that optimal infection prevention practices are widespread, according to Brophy. "The vast majority of surgery centers are following best practices and trying to stay up with them," he says. "Just don't lull yourself into sleep. We're doing extremely well, but you need to stay vigilant and continue to pursue and maintain best practices." ■

REFERENCE

1. Brophy RH, Bansal A, Rogalski BL, et al. Risk factors for surgical site infections after orthopaedic surgery in the ambulatory surgical center setting. *J Am Acad Orthop Surg* 2018; Dec 31. doi: 10.5435/JAAOS-D-17-00861. [Epub ahead of print].

Document, Assess, Audit: Improving Infection Prevention Procedures

One way ASCs can improve their infection prevention processes is by keeping their policies and procedures (P&Ps) aligned with standards, regulations, and nationally recognized guidelines.

Phenelle Segal, RN, CIC, FAPIC, a Florida-based infection control consultant often sees outdated P&Ps. "Part of the annual plan should include a facility procedure for review and revision of the policies," she offers. "It's important to establish a process for handling outdated policies and procedures. Every facility should establish a process for reviewing and revising these on a routine basis."

Segal recommends that the schedule should be developed by the individual facility. The facility should review its infection control P&Ps at least every couple of years — if not more often. "They must keep a record of when the policy was approved by their governing body, and that's usually in the minutes," she notes. "Keep a record of when specific policies are approved."

These practices would be important to maintain in the event the ASC ever faces a lawsuit. There are several additional steps ASCs could take to improve their overall infection prevention program:

• **Create infection prevention cultures.** Atlanta-based consultant **Stanford R. Plavin**, MD, says surgery centers follow many different models for their operations. The vast majority are licensed, accredited, and provide the highest caliber patient care experiences. Some conduct quarterly evaluations and audit their infection prevention activities regularly. How surgery centers conduct hand hygiene, how they ensure staff wear protective equipment properly, and how they clean and process equipment are scrutinized and evaluated with these ongoing infection prevention processes.

But Plavin says there is a less visible aspect to infection prevention compliance: "For me, it's important to make sure staff is aligned," he explains.

A positive change is that recently trained physicians are more familiar with appropriate infection prevention practices. While older physicians tend to have to adapt and change habits according to more regimented guidelines, hand hygiene and other practices are habits new doctors have developed since they began their training. Thus, newer doctors could serve as natural role models for all ASC staff, Plavin notes.

"It all comes down to the leadership," he adds. "Leaders set the tone and hold staff accountable."

• **Focus on staff education.** "Communication is absolutely key," Segal says. "When issues come about in the surgery center, whether they're identified from an outside source or within, communicate this information to all

staff members." Everyone in the ASC needs to hear the message and feedback.

"While doing an onsite consult, I recently heard a complaint from a surgery center employee who said, *'Why don't we ever see your report?'"* Segal recalls. "Whenever outside personnel come in and either do a survey or consult or any discussion, it needs to be communicated to staff and used to educate staff as well."

Staff education about reprocessing and disinfecting equipment might come from product sales reps, particularly when an ASC purchases new equipment and products. "Get in touch with the sales reps and have them come in and do an inservice," Segal advises. "That's a good way to educate staff."

Infection prevention education also should include periodic updates, often based on the infection preventionist's observations of staff's compliance with infection prevention P&Ps. For example, Segal often sees inconsistencies in how surgery center staff handle skin preparation. Whenever the ASC introduces a new product or piece of equipment, there should be an educational session.

"Make sure employees fully understand how to use it, clean, disinfect, and sterilize the equipment," Segal says. "This also is where the company selling the product can do an inservice."

Online training also is useful. Sometimes, this is the best option because employees can complete this training when it is most convenient for them.

"They can sign off on the educational sessions electronically," Segal adds.

ASCs can find great examples of online infection prevention education through the Association of periOperative Registered Nurses (AORN) and the Association for Professionals in Infection Control and Epidemiology (APIC). AORN offers several webinars and publications related to infection prevention, including information about hand hygiene. *(Available at: http://bit.ly/2DouVkn.)* APIC offers information on the developmental path of the infection preventionist. *(Available at: http://bit.ly/2FFZZhR.)*

Since education really should be ongoing, another easy way to ensure staff maintain cleaning, disinfection, and sterilization compliance is to place instructional posters in key areas, such as the decontamination room and the sterilization room, Segal suggests.

"Keep a binder with all of the manufacturers' instructions for use [IFU] in a central location that is accessible to every employee," she adds. "Surveyors will come in and ask where this information is kept." Another option is to keep manufacturers' instructions for use available online through a subscription with a company that maintains current and past IFUs.

• **Document diligently and thoroughly.** The reprocessing department should document their process, including details about monitoring, sterilization, and the physical, chemical, and biological properties that have to be monitored and documented as per guidelines, standards, and manufacturer's instructions.

• **Document all staff education.** "Use sign-in sheets for inservices," Segal says. "Always document who was there, the date, the speaker, the topic, and have everyone sign it."

• **Monitor and audit in house.** In-house auditing could be designated to a consultant. This work usually includes assessment of the reprocessing room and central processing department along with monitoring of sterilization processes, Segal explains.

"When I go in as a consultant, the first thing I want to see is their logs," she says. "Their monitoring of the sterilization processes has to be placed in logs and available for review."

• **Provide annual competencies.** When a surgery center's processes are audited, reviewers typically look at the annual competencies, Segal says. "These include the central processing techs," she adds. "Infection prevention designees should have annual competencies." APIC offers a sterilization competency that includes a step-by-step process on central sterilization. Safe injection practices should be monitored by way of a competency.

• **Handle breaches.** It is important to maintain documentation that can be reviewed in the event of a breach. The infection preventionist can conduct a root cause analysis and also determine if there has been a more far-reaching breach that may require notifying the health department and (possibly) patients.

"If they identify a breach, it's up to the surgery center to figure it out and take a systematic approach to figure out what went wrong," Segal says. ■

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.

Thanks to High-Deductible Plans, ASCs Must View Patient as Payer

An insider breaks down potential reimbursement issues facing surgery centers

To find out what the rise in patient deductibles means for surgery centers' bottom line, *Same-Day Surgery* turned to **Kylie Kaczor**, MSN-RN, CASC, CPCO, CMPE, vice president of clinical and regulatory affairs at National Medical Billing Services. Kaczor speaks nationally about surgery centers and reimbursement issues.

SDS: *How are high-deductible health plans changing the way ASCs handle patient payments and collection practices?*

Kaczor: As a result of the growth in high-deductible health plans, we now have to view the patient as a payer. The average deductible for single coverage among all workers increased 53% since 2013, in part due to the rapid increase in high-deductible health plans.[1] Patient responsibility now makes up 25% of total revenue, with experts anticipating this to reach 50% over the next decade.[2] Just last year, the out-of-pocket expense rose on average by 11%. Patient responsibility made up nearly 30% of income for medical practices and roughly 10-15% in the ASC arena specifically, only further supporting the patient's role as payer in our marketplace today.[3]

Not only is it important for providers to pay close attention to the trends in patient responsibility, but it is equally important for them to understand that collecting patient responsibility at time of service may be the best approach to maximizing revenue and improving the overall patient experience.

This process will increase your cash flow while decreasing the administrative burden associated to back-end collection costs. In 2017, TransUnion reported that 68% of consumers were unable to pay their financial responsibility after services were provided and additionally expects the percentage of patients not paying their medical bills in full to rise to 95% by the year 2020.[4] From just 2015 to 2016, alone, the number of consumers failing to pay full patient responsibility increased by 15%, a trend that is expected to continue.[4]

As a result, we're seeing a growing focus on collecting patient responsibility and appropriately estimating time-of-service costs to patients. Facilities and practices are also exploring where their inefficiencies and wastes lie and are aggressively working to cut costs while maintaining quality in care.

SDS: *What are time-of-service collections?*

Kaczor: Time-of-service collection is the patient financial responsibility due to the provider including copayments, deductibles, and co-insurance on the day a service is provided. For self-pay patients, this is the total self-pay rate due from the patient for the procedure or service that will be performed on the day of service.

SDS: *Could you please provide some best practice examples of how a surgery center can improve its collections process?*

Kaczor: Does the ASC have a sound financial policy relative to collections and patient responsibility? If so, has it been provided to the patient? Or, is it publicly available?

It is recommended to provide this policy to the patient as early as possible, preferably before they arrive at your center. You can also post this policy publicly on your websites if you have them or in your waiting areas and office spaces. The earlier you set clear expectations relative to payment with patients, the better. You want to avoid surprises wherever possible.

Already this year, we've watched the almost continuous barrage of headlines regarding healthcare technology, the expansion of telehealth, wearable health tracking devices, and cloud-based services, among others. Technology is incorporated in all areas of healthcare, and revenue cycle is no exception. Consumers want convenient access to healthcare and a streamlined process. As a result, providers are looking for ways to implement new technologies that promise to promote accuracy and efficiency while positively impacting the patient experience.

While we know that there will always be a human component to the revenue cycle, there are areas where automation makes a big difference. To help providers collect these higher patient responsibilities, many practices are implementing automated tools that can evaluate patient benefits and eligibility and produce accurate time of service quotes. Having this information available will better prepare front office staff and set proper expectations for the consumer. This type of technology implementation helps to streamline the time-of-service collections process while ensuring that patients arrive prepared and in understanding their responsibilities.

These estimates also offer the providers and office staff the supportive and accurate information they need to discuss personal and customized

financial responsibility with their patients, fostering a positive relationship between the provider and the consumer. Automation of this type can also help to reduce patient phone calls and decrease administrative burden associated to collections.

SDS: *What are the top steps a surgery center can take to navigate the appeals process successfully?*

Kaczor: Understand who your payers are. Is the plan self-funded or fully insured? Self-funded plans or plans where the employer is the one responsible for payment on a claim, *not* the insurance carrier? These plans are governed by the Employee Retirement Income Security Act.

With self-funded plans, employers are required to provide their plan participants with a summary plan description. This document will tell you exactly how claims should be paid and how you can appeal your denials. With fully insured plans, you want to be sure to review the plan documents to understand what should be covered and what benefits exist for the patient. Your appeals can include language from contracts, fee schedules, and state laws.

We've found that having significant supportive language to defend your stance — state laws, federal law, even reference to court rulings and judgments — helps to strengthen your appeal. If you are able to obtain a certificate of coverage or an estimation of benefits from the plan without exhausting an appeal effort, you can also use the language in that document to support your appeal.

SDS: *Are there any outcomes you could note about what happens when surgery centers implement these kinds of collections process changes?*

Kaczor: With any standardized process, you can expect to see improvements in collections. This standardization also helps to protect providers from unintentional discriminatory practices relative to patient collections. When business office staff is well-trained and efficient with processes, facility financial policies are applied consistently, and the number of demographic errors and others will decrease.

This supports improved time-of-service collections and efficiency in claims submission and subsequent claims adjudication. ■

REFERENCES

1. The Kaiser Family Foundation. Employer Health Benefits 2018 Annual Survey. Available to view online at: https://bit.ly/2T4qwbQ. Accessed Jan. 23, 2019.
2. Tanner S, Ceruti A. Patient financial responsibility: How to protect your margins. Advisory Board, March 27, 2015. Available to view online at: https://bit.ly/2DvzaLn. Accessed Jan. 23, 2019.
3. Cavanaugh M. Improve Patient Collections and Stay Compliant with Payor Requirements. *Billing*, May 10, 2017. Available to view online at: https://bit.ly/2DtKkzU. Accessed Jan. 23, 2019.
4. TransUnion. Patients May be the New Payers, But Two in Three Do Not Pay Their Hospital Bills in Full, June 26, 2017. Available to view online at: https://bit.ly/2MgSKxv. Accessed Jan. 23, 2019.

ASCs Can Improve Reporting Culture

Healthcare entities can prevent staff errors and improve response to problems if they focus on developing an effective reporting culture.

One place to start is the new *Sentinel Event Alert* from The Joint Commission about improving a healthcare organization's reporting culture. The initiative includes a one-page flier, titled, "The 4 E's of a Reporting Culture." It provides four basic steps that healthcare organizations can take, starting with establishing trust.

"Ambulatory surgery centers, being generally smaller than inpatient acute care settings, have an advantage," says **Coleen Smith**, MBA, MSN, RN, director of High Reliability Initiatives at The Joint Commission Center for Transforming Healthcare. "One of the best ways to understand barriers is to talk with small groups of staff. This can be done more effectively in smaller organizations because more viewpoints can be accessed."

The *Sentinel Event Alert* asks leaders to establish clear performance expectations among employees within a safe environment, meaning people do not need to fear negative consequences when they report mistakes. The goal is to eliminate the "no harm, no foul" mentality, which leaves near-miss incidents unreported.

Technology makes it easier to report problems and errors, The Joint Commission notes. Organizations can build these features into their incident reporting system: wide accessibility, ease of use, timely data analysis, and a feedback loop to let employees know someone is acting. ASC directors should remember that staff might be more forthcoming about issues with people who are not in their reporting structure, Smith offers.

"For instance, the manager of sterile processing could meet with the OR nurses, and the business manager might meet with support staff," she says. "Appreciative inquiry, which is a model that involves stakeholders in

positive change, can guide such focus group discussions."

ASCs could learn more about barriers and solutions through these discussions. "Having a formal performance improvement project to address the barriers and take these suggested solutions forward is equally important," Smith says. "This is the starting point as the 4 E's are a journey, not a spring."

Once trust is formed, ASCs could encourage reporting with a feedback loop that lets staff know that action is taken to address safety problems, and they could eliminate fear of punishment. Fear is one of the primary reasons why it is difficult to build a robust reporting culture, Smith notes.

"The aviation industry eliminated this issue by having their reports go to NASA, not the FAA," she says. "Healthcare, unlike the high reliability industries such as nuclear power or commercial aviation, is not in the habit of being preoccupied with failure."

One way to eliminate fear as a barrier to a reporting culture is to develop a "good catch" program in which employees are rewarded for reporting errors. Some organizations might give employees a safety star for reporting a near miss, according to The Joint Commission. Organizations with exceedingly safe operations, despite operating in hazardous conditions, never rest and are always looking for the next bad thing to happen and trying to prevent it.

"In healthcare, we generally expect bad things to happen because that is the norm," Smith says. "For instance, medications arrive late, equipment is missing or hard to locate, and disruptions are common. All of these are unsafe conditions, though not reported as such because they are accepted."

A final step toward improving an organization's reporting culture is to examine errors, close calls, and hazardous conditions. Healthcare has not created the robust process improvement capacity that exists in other industries, Smith says. "This impacts the ability of healthcare organizations to improve on the issues that are reported," she explains. "If follow-up is not occurring, reporting dries up." ■

REPORTING CULTURE BUILDING BLOCKS

The Joint Commission has created "The Four E's of a Reporting Culture" to help employees learn from mistakes and to maintain an overall safer working environment. The key ideas are:

- Leaders build a sense of trust;
- The organization encourages reporting;
- Policies eliminate fear of punishment for those reporting;
- Examine error-prone situations and hazardous conditions.

Learn more about the four E's at: https://bit.ly/2RLcsqY. Further information from The Joint Commission about creating a better reporting culture is available at: https://bit.ly/2SWSnL9. ■

Prescribers Have Contributed to Opioid Epidemic but Can Help Stop It

Ohio is home to Dayton's Montgomery County, a place that has reported the highest rate of overdose deaths in the United States. Ohio was second only to West Virginia in its overall rate of deaths from overdoses in 2017, according to the CDC.[1] Much of Ohio's overdose deaths involve fentanyl, and most of those are for prescription drugs.[2]

Also, according to the 2017 Ohio Automated Rx Reporting System, 80% of Ohioans who died of a drug overdose in 2016 had a history of receiving prescriptions for controlled substances.[3] The Ohio Hospital Association, with a new $530,000 grant from the Cardinal Health Foundation, has begun to tackle the opioid epidemic with an initiative to collect benchmark data on opioid prescribing habits in pain management.

"We're looking at what's occurring from overdoses and mortality types of situations because it's having a huge toll on Ohio communities and families," says **John Palmer**, director of media and public relations for the Ohio Hospital Association (OHA). "In 2016, hospitals were managing 27,377 total overdose encounters, a 52% increase over 2015, and it was a 52% jump from just a year before. When you go [back] to 2008, it [has increased] 500%." More than 70,000 people died from drug overdoses (47,600 from opioids) in the United States in 2017, a rate of death that was more than double the rate in

2016. The authors of a new study[4] using county-by-county data from the CDC and other sources found that pharmaceutical company marketing of opioid products to physicians resulted in increased opioid prescribing and higher overdose mortality. In all, nonresearch-based opioid marketing totaled nearly $40 million, targeting 67,507 physicians in 2,208 U.S. counties.

Investigators found that there was a greater proportion of opioid-related deaths in counties in which opioid pharmaceutical representatives more frequently contacted physicians. One in 12 U.S. doctors received opioid-related marketing between 2013 and 2015, and one in five family physicians received the same marketing. Among Medicare patients, this marketing is associated with increased opioid prescriptions.

Efforts like the OHA's opioid prescribing initiative will give doctors information about the dangers of opioid addiction, overdoses, and overprescribing. OHA launched its opioid initiative after reviewing 2017 data on opioid overdoses and deaths.

"We went to work creating this opioid initiative, working with hospital members, some on the clinical side and some on the community/administrative side of the hospital," Palmer says. "We listened to what they were seeing and encountering and what they perceived as prevention."

The group has collected prescribing data and examines what hospital EDs are encountering regionally and statewide. "We look at trends and patterns and will do data collection and analysis, and then we'll report back to the hospitals to address this," Palmer explains. So far, about 70 hospitals have committed to participate out of the state's 270 hospitals.

NONRESEARCH-BASED OPIOID MARKETING TOTALED NEARLY $40 MILLION, TARGETING 67,507 PHYSICIANS IN 2,208 U.S. COUNTIES.

"We're continuing to get interest to participate in that effort," Palmer reports. "Cooperation will be critical. We'll collect data to build effective solutions to change practices, as appropriate."

The partnership with Cardinal Health Foundation will build on Cardinal Health's opioid action program and Generation Rx. Opioid-sparing efforts and national attention on the opioid epidemic's death toll already have affected prescribing habits in Ohio. For instance, the 2017 Ohio Automated Rx Reporting System's annual report shows that the total doses of opioids dispensed to Ohio patients decreased by 28.4% (225 million doses) from 2012 to 2017. The report's authors also found that doctor-shopping behavior plummeted by 88% from 2011 to 2017, a decrease from 2,205 individuals in 2011 to 273 individuals in 2017.[3]

Once developed, Palmer says Ohio's opioid-sparing initiative's best practices will be shared nationally with any states and providers interested in the information. ■

REFERENCES

1. Centers for Disease Control and Prevention. Drug Overdose Deaths. Available at: https://bit.ly/2aowy2C. Accessed Jan. 23, 2019.
2. Daniulaityte R, Juhascik MP, Strayer KE, et al. Overdose deaths related to fentanyl and its analogs - Ohio, January-February 2017. *MMWR Morb Mortal Wkly Rep* 2017;66: 904-908.
3. Ohio Automated Rx Reporting System. *2017 Annual Report*. Available at: https://bit.ly/2HsH1xc. Accessed Jan. 23, 2019.
4. Hadland SE, Rivera-Aguirre A, Marshall BDL, Cerdá M. Association of pharmaceutical industry marketing of opioid products with mortality from opioid-related overdoses. *JAMA Netw Open* 2019; Jan 4;2:e186007. doi: 10.1001/jamanetworkopen.2018.6007.

SDS Manager

It Is the Little Things That Go a Long Way

By Stephen W. Earnhart, RN, CRNA, MA
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So much of what we do at our hospital or surgery center can seem overwhelming, making it difficult to keep track of all the details. However, it is important to remember that we are in a service industry that thrives on relationships. Our primary target relationship is our surgeons. Next, our patients, followed equally by patients' friends and family and our own staff.

It is easy to forget who we serve, but it is always important to be reminded. While we often (perhaps subconsciously, anyway) think of ourselves as a higher service provider, we really share the same retail markets as a Walmart or McDonald's. Consider that retail business is defined as the activity of selling goods or services directly to consumers or end users. This might be a rude awakening, but it is shockingly true.

What do other service industries provide to their consumers? Probably more than what most of us provide. The greatest benefits might be job security, full-time employment, retirement plans, and full benefits that make it tough for many facilities to compete. Typically, our education and training requirements are higher; ergo, higher pay. But our hours are not all that attractive for most. We might get an employee discount, but it involves surgery. Like most things in life, it is the little things that make a difference to all of us in healthcare and retail.

Over the years, I have made a list of things I have done, heard of, seen others do, thought of, or dreamed of. I am sure you could add other items to the list below. The following are gestures that really can enhance and promote great customer service and will set you apart from others. These suggestions are of a personal and not business nature; however, you are a part of the business with which you work and it will, at the same time, promote a better image of your facility.

For me, this is the oldest I have ever been; yet, it is the youngest I will ever be. I am going to try to make every day count and try to follow as many of these "little things" as I can:

- Smile to everyone you make eye contact with;
- Remember birthdays and special events for those close to you;
- Acknowledge feedback from others, good or bad;
- Hold eye contact for an extra second or two — you will feel the bond;
- Say "thank you," followed by the person's first name when possible;
- If you shake hands with someone, place your other hand on top of theirs for just a second;
- "Please" remains the best way to start or end a request;
- Only offer constructive criticism and only if really necessary;
- Show respect to everyone;
- Be extra helpful to older patients. Many are hard of hearing, will hide it, and be overwhelmed because they did not understand what you said;
- Remember that our facilities are scary to patients — most patients think they are going to die. A simple touch of your hand and telling them it will be fine is human compassion;
- Listen when someone is speaking to you — do not rush them unless it is absolutely necessary;
- Ask someone something — nothing makes us feel special when someone asks our opinion;
- Find something to compliment — a jacket, or watch, or anything;
- Train your staff properly so they understand everything about your center and can respond to any question;
- Never say "no" to a staff member, surgeon, patient, or anyone — there are many other ways to respond;
- As always, follow the Golden Rule — do unto others, as you would have others do unto you. ■

(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates can be reached at 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. Email: searnhart@earnhart.com. Web: www.earnhart.com.)

COMING IN FUTURE MONTHS

- Update on CRE colonoscopy cases
- Pharmacy tips for surgery centers
- Medicare reimbursement updates
- Tips for dealing with business associates

Medicare's Online Procedure Price Lookup Tool Could Be Useful for Patients

ASC patients with Medicare coverage now can use a simple tool to compare total costs and what they will pay for procedures and surgeries in ASCs and hospital outpatient departments.

CMS launched the online procedure price lookup tool on Nov. 27, 2018. The tool was a requirement of the comprehensive 21st Century Cures Act that President Obama signed into law in December 2016.

CMS Administrator Seema Verma noted in a blog post that healthcare spending accounts for one out of every five dollars spent in the United States. Further, she pointed out that patients are shouldering the costs through deductibles and copays. Verma wrote that the procedure price lookup tool provides national averages for the amount Medicare pays a hospital or ASC and the national average copayment of Medicare beneficiaries with no Medicare supplemental insurance. *(Editor's Note: Read much more from Administrator Verma on this issue at: https://go.cms.gov/2FQoOY3.)*

The Ambulatory Surgery Center Association (ASCA) supported the 21st Century Cures Act and the price comparison tool. "ASCA commends the growing recognition in the U.S. Congress of the value that ASCs provide," says ASCA Director of Government Affairs **Heather Falen Ashby**. "We commend the passage of the legislation that created the procedure price lookup tool."

The lookup tool's main page asks consumers to enter the name or procedure number of their anticipated surgery. It provides a dropdown list of options if they put in a single word, such as colonoscopy. After selecting an option, the tool displays costs in two columns, one for ASCs and one for hospital outpatient departments (HOPDs).

> "PATIENTS BENEFIT WHEN THEY KNOW THEIR OUT-OF-POCKET COSTS UP FRONT."

For example, if a patient selected the procedure titled, "Cancer screening of the colon (large bowel) using an endoscope (colonoscopy) for individuals who are not high risk," the tool displays:

- For ASCs: Average Medicare pays — $370;
- For HOPDs: Average Medicare pays — $710;
- Patient pays (average): $0.

In another example, for the procedure titled, "Removal or shaving of hip joint socket cartilage using an endoscope," the tool displays:

- For ASCs: Average Medicare pays — $2,177 and average total cost — $2,721;
- For HOPDs: Average Medicare pays — $4,485 and average total cost — $5,606;
- Patient pays (average) for ASCs: $544;
- Patient pays (average) for HOPDs: $1,121.

"Although it is still a very new resource, ASCA is pleased that the procedure lookup tool is easy to use and intuitive for patients," Ashby says. "This is a significant step toward transparency, but is limited in providing only national average amounts. Actual copays will vary based on a patient's geographic location." *(Editor's Note: Readers can interact with the new tool by visiting: https://bit.ly/2Q68QiK.)*

ASCs might refer Medicare patients to the tool for an idea of the cost difference between the two surgical settings. "Patients benefit when they know their out-of-pocket costs up front," Ashby says. ■

SAME-DAY SURGERY

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Log on to ReliasMedia.com then select My Account to take a post-test. *First-time users must register on the site.*

3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CME/CE QUESTIONS

1. **How can surgery centers improve infection prevention efforts?**

   a. Employ an infection preventionist and provide infection prevention training.
   b. Follow nationally recognized infection prevention guidelines and standards.
   c. Provide infection prevention oversight and conduct competencies.
   d. All of the above

2. **According to the American Medical Association, patient responsibility now makes up what percentage of total revenue for healthcare organizations?**

   a. 12%
   b. 17%
   c. 25%
   d. 31%

3. **Which of the following is not a feature that should be built into an incident reporting system in a surgery center?**

   a. Disclaimer to ensure management actions are confidential
   b. Wide accessibility
   c. Ease of use
   d. Timely data analysis

4. **According to the 2017 Ohio Automated Rx Reporting System, what percentage of Ohioans who died of a drug overdose in 2016 had a history of receiving prescriptions for controlled substances?**

   a. 50%
   b. 80%
   c. 63%
   d. 74%

SDS ACCREDITATION UPDATE

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

The Joint Commission Focuses on Preventing Workplace Violence

Healthcare workers, especially nurses, are at a high risk of violence, largely at the hands of patients. Research shows that healthcare workers are at greater risk from violence than almost every other worker, and the problem is on the rise.[1,2]

"Over the last decade, healthcare workers have accounted for approximately two-thirds of the nonfatal workplace violence injuries involving days away from work," according to **John Howard**, MD, director of the National Institute for Occupational Safety and Health, writing for the CDC *(http://bit.ly/2FQpOLr)*.

Recognizing the risk, healthcare organizations are developing and sharing resources to help mitigate workplace violence. This is why The Joint Commission decided in 2018 to release *Sentinel Event Alert* #59, which was about physical and verbal violence against healthcare workers *(http://bit.ly/2RAB6KW)*.

> RESEARCH SHOWS THAT HEALTHCARE WORKERS ARE AT A GREATER RISK FROM VIOLENCE THAN ALMOST EVERY OTHER WORKER.

Government statistics show that healthcare workers are much more likely to be victims of violent acts than workers in most other occupations, says **Coleen Smith**, MBA, MSN, RN, director of High Reliability Initiatives at The Joint Commission Center for Transforming Healthcare. From 2002 to 2013, there were four times as many incidents of serious workplace violence among healthcare workers than there were among workers in private industry, according to the Occupational Safety and Health Administration *(Read more at: http://bit.ly/2RCQE0F)*. The Joint Commission's *Sentinel Event Alert* advises hospitals to monitor, report internally, and investigate these acts of workplace violence:

- Injuries to patients or others;
- Occupational injuries and illnesses;
- Property damage;
- Security incidents;
- Hazardous material spills and exposures;
- Fire safety management problems and failures;
- Medical or laboratory equipment problems and failures;
- Utility systems management problems and failures.

Ambulatory surgery centers (ASCs) and other healthcare sites also could follow these guidelines. The Joint Commission offers a public workplace violence prevention portal that provides specific examples of how healthcare organizations have addressed workplace violence *(http://bit.ly/2T6TrfA)*.

It is important for healthcare organizations to create policies and procedures about workplace violence because of the way the subject often is misunderstood or unacknowledged.

"For many healthcare providers, being hit or assaulted by a patient they're trying to help causes a kind of disconnect," says **Judy Arnetz**, PhD, MPH, PT, professor and associate chair for research in the department of family medicine at Michigan State University.

Healthcare employees often feel guilty when a patient assaults them, and this is why they often do not want to report the incident, Arnetz explains. Healthcare organizations should make it clear that every incident should be reported. Staff might suffer from short- and long-term repercussions after an act of violence. In some cases, workers might leave their jobs or even their professions after experiencing violence in the workplace.

"We definitely have seen in our research that it leads to burnout, feelings of not enjoying your work any longer,

and some studies saw that victims of violence physically distanced themselves from patients out of fear," Arnetz says. "Even if it's a patient with a psychiatric disorder or an older person with dementia, it can leave its mark psychologically."

These all are reasons why healthcare organizations need to pay close attention to the potential for workplace violence and address these occurrences directly.

ASCs and other healthcare organizations should create an effective reporting culture to show staff that workplace violence is not tolerated, no matter who is the perpetrator. The Joint Commission's focus on this issue is intended to address barriers to effective reporting of incidents of violence.

"The biggest barriers that healthcare organizations experience, inclusive of ambulatory surgery centers, are fear of punishment and the failure of leadership to let 'reporters' know what was done with their reports," Smith says. "In the case of fear of punishment, this relates to the days when mistakes were cause for an entry in someone's personnel record or even disciplinary action up to and including firing. As healthcare has moved toward safer practices, including establishing a strong patient safety culture, leaders have realized that errors and mistakes are the cost of being human, and most often these are the results of faulty systems and processes."

Despite this, healthcare employees remain hesitant about reporting acts of violence. A prevention strategy could focus on education, communication, and creating a culture in which employees feel safe to report incidents. ■

REFERENCES

1. Havaei F, Macphee M, Lee SE. The effect of violence prevention strategies on perceptions of workplace safety: A study of medical-surgical and mental health nurses. *J Adv Nurs* 2019; Jan 15. doi: 10.1111/jan.13950. [Epub ahead of print].
2. Larson LA, Finley JL, Gross TL, et al. Using a potentially aggressive/violent patient huddle to improve health care safety. *Jt Comm J Qual Patient Saf* 2019; Jan 9. pii: S1553-7250(18)30103-X. doi: 10.1016/j.jcjq.2018.08.011. [Epub ahead of print].

Management, Workplace Culture Key Elements of Violence Prevention

Surgery centers can work to prevent workplace violence by following a strategy that includes culture changes, data collection, and conducting analyses.

There are no federal standards or regulations for workplace violence prevention; everything is advisory, but there are some key elements to prevention and actions healthcare organizations can take, according to **Judy Arnetz**, PhD, MPH, PT, with Michigan State University. She offers the following tips for ASCs:

• Obtain management commitment and employee participation.

"Management has to be committed to creating a culture in which efforts are made to mitigate or reduce and prevent violence as far as possible," Arnetz says. "Management has to recognize that idea and recognize violence as an occupational hazard."

Employees must shoulder responsibility, too. "They have to abide by policies, report incidents when they occur," she says.

Guidelines from the Occupational Safety and Health Administration (OSHA) specifically address healthcare workers. ASC staff should be aware of fully aware of these guidelines.

• Collect data about an organization's incidents of violence. Each surgery center needs to know whether and how employees experience

RISK FACTORS CHECKLIST

OSHA has developed a checklist for healthcare sites that includes these potential risk factors:

- Working with people who have a history of violence;
- Transporting patients and clients;
- Working alone in a facility or in patients' homes;
- Poor environmental design of the workplace that blocks workers' vision or interferes with their escape from a violent incident;
- Poorly lit corridors, rooms, and parking lots;
- Absence of emergency communication;
- Lack of staff training for de-escalating hostile behavior;
- Understaffing;
- High worker turnover;
- Inadequate security and mental health personnel;
- Long waits for patients and overcrowded waiting rooms;
- Unrestricted movement of the public;
- Perception that violence is tolerated and victims cannot report the incident to police;
- Patients with firearms, knives, and other weapons;
- Location in areas with high crime rates.

workplace violence. Incidents might involve violence from patients and their visitors, bullying from supervisors or managers, or worker-to-worker violence.

"There are many terms included in describing workplace violence," Arnetz explains. "We talk about disruptive behavior, incivility, bullying, lateral violence, or horizontal violence."

Horizontal violence is expressed in overt and covert hostility, and it can devastate healthcare staff, resulting in high turnover rates, decreased productivity, and more illnesses.[1] A lot of what is considered a form of violence might include behavior that is not physical, which needs to be studied differently, according to Arnetz.

"There are different risk factors and interventions that are part of the worker violence spectrum," Arnetz says. "The Joint Commission sees violence as a huge risk, not just for worker well-being and safety but also for overall health of the hospital or organization."

As an accrediting body, The Joint Commission wants to see that healthcare organizations are taking proper steps to reduce and prevent violence. Collecting data is an important first step.

• Conduct a worksite analysis.

First: Know the site's risks. "We usually talk about doing a worksite walkthrough," Arnetz says. "Go through the unit to see if there are any physical things that could be done or things that pose risk." For example, a room might lack a fire alarm or lack barriers between reception desk staff. The analysis should be based on data, too, Arnetz explains.

"Unless you know the types of incidents that occur and where they occurred, it's difficult to do a workplace analysis," she says. "Always begin with data."

THE JOINT COMMISSION WANTS TO SEE THAT HEALTHCARE ORGANIZATIONS ARE TAKING PROPER STEPS TO REDUCE AND PREVENT VIOLENCE.

• Enforce hazard prevention and control processes.

"What we have looked at in our studies and what OSHA suggests is you look at environmental things, engineering controls," Arnetz says. "Can you improve lighting in a certain area? Can you make more space? Can you make sure you have two exits instead of just one in the treatment room?" Healthcare organizations can create a way of flagging charts of patients known to be violent. They also can develop de-escalation training for every employee who interacts with patients and the public, Arnetz says.

• Provide safety and health training.

Among other regular training sessions, an ASC could include training to raise awareness about workplace violence prevention policies and de-escalation training.

The National Institute for Occupational Safety and Health offers a training module for nurses on workplace violence. The course teaches how to identify factors contributing to workplace violence, behavioral warning signs, communication and teamwork skills to prevent violence, and how to find resources for injured workers, as well as the steps to take to implement a comprehensive workplace violence prevention program *(http://bit.ly/2WbnioP)*.

Other training might involve active shooter skills. Many hospitals are implementing this type of training, Arnetz notes.

"Regular training is the way to stay safe and healthy," she adds. ■

REFERENCE

1. Bloom EM. Horizontal violence among nurses: Experiences, responses, and job performance. *Nurs Forum* 2018; Oct 17. doi: 10.1111/nuf.12300. [Epub ahead of print].

Every Violence Prevention Program Starts With Reporting and Data Collection

One barrier to preventing workplace violence is an organization's failure to close the loop with healthcare workers (HCWs) by giving those employees information about what happened once they reported an incident, according to **Coleen Smith**, MBA, MSN, RN, with The Joint Commission Center for Transforming Healthcare. This is surprisingly difficult to address.

"Most reporting systems, whether electronic or paper, do not make it easy to close the loop by informing both the person who reported the issue and other staff affected by any improvement actions," Smith explains. "It's not so much a matter of mechanics, but rather one of process. Some issues take longer to address, while others might involve staff behaviors. The outcomes cannot be shared specifically."

In cases that involve a broken piece of equipment, it might be easier to let staff know the issue has been addressed. However, this assumes the organization offers a venue for communication to occur, Smith notes. "It is usually most effective for organizations to have multiple methods by which to share this information: in person, in writing, and electronically," she says. "In healthcare, it is pretty hard to overcommunicate given the issues related to 12-hour shifts and rotating shifts."

Collecting data on workplace violence should be a policy and expectation. "Sites should be collecting data continuously, starting with developing a reporting system," says **Judy Arnetz**, PhD, MPH, PT, with Michigan State University.

Incident reports might include questions such as: What occurred? Who was involved? Where did it occur? Was there a resulting injury? What happened afterward?

"There is a basic problem of healthcare staff underreporting," Arnetz laments. "One of the big reasons for not reporting is they say, *'I didn't get hurt. There was no injury, so I didn't bother to report it.'"*

A workplace violence prevention program includes an understanding of what workplace employees experience. Without records, there is no way to understand the magnitude of the organization's problems. To keep records of workplace violence incidents, an ASC would need management commitment and employee participation.

"Management has to encourage employees to report immediately what occurs so they can develop interventions," Arnetz offers. "Employees need to understand what to report, and this all is part of building a prevention culture."

Managers and staff need to know what types of events occur, regardless of whether such episodes result in injury, because this information is crucial to developing prevention programs, Arnetz explains.

"Even if an employee didn't get hurt one time, the next time something happens, an employee could be hurt," she says. "We need to keep employees, patients, and innocent bystanders safe."

Threats, bullying, and assaults should be reported. "If someone raises his voice, causes a disruption, but no one gets hurt, then it should not be reported," Arnetz says. "It could be noted in the patient's chart, and it should not go unnoticed."

If a patient or former patient says to a healthcare provider, *"I know where you live. I know where your children go to school,"* then that is a threat that must be reported, Arnetz says. Likewise, bullying (defined as negative or deliberately harmful behavior) often that continued over a long period should be reported.

"If someone comes to work and has a bad day and snubs you, that's a one-time incident and not bullying," Arnetz explains. "They usually apologize the next day. But what we're talking about with bullying is repeated negative behavior in which a person is singled out and is the object of negative behavior from one other person or a group."

In operating rooms, there are reported incidents of surgeons throwing instruments or head butting someone to get the person out of the way, Arnetz notes. "Surgery is a high-stress environment," Arnetz notes. "Emotions can flow in these high-stress environments, but that doesn't give you the right to throw a scalpel." ■