SAME-DAY SURGERY

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SEPTEMBER 2020 Vol. 44, No. 9; p. 97-108

INSIDE

RELIAS MEDIA

Preoperative Screening Can Save a Life — If Staff Ask the Right Questions

Preoperative screening is routine. Occasionally, a physician or nurse might save a life by asking the right questions in ways that cause patients to go deeper in their answers.

Take the case of an ear-nose-throat (ENT) nurse, whose years of experience gave her the confidence to follow her instincts during a preoperative screening visit with a patient.

"She walked in and said, 'We are going to cancel this next case,'" recalls **Catherine Ruppe**, RN, CASC, associate principal at ECG Management Consultants in Seattle.

The nurse had asked the patient questions about allergies, and the woman said something about an allergy to lidocaine. This triggered the nurse's suspicion. She asked if the patient was related to anyone who reacted negatively to anesthesia. The patient first said, 'No,' but she changed her mind as the nurse continued to ask questions.

"She asked the same question 10 different ways, kept going, and ferreted out the answer that the patient had an aunt or uncle who died during surgery," Ruppe says.

The nurse suspected malignant hyperthermia, even though that is rare, and she told the patient she would need to be tested for the condition before undergoing surgery. Later, the patient called the surgery center to report she did test positive for the condition.

"The patient said, 'I was pretty mad that you canceled that surgery that day, but you may have saved my life,'" Ruppe says. "Probably 80% or 90% of people would have missed this. Whatever it was that the patient said, it made the nurse's antenna go up."

The better a surgery center's preoperative assessment of patients, the better their chances of experiencing positive outcomes and avoiding risks. "Nobody likes surprises," Ruppe says. "It's better to be very thorough on the front end."

There are several ways surgery centers can improve the preoperative assessment process and reduce post-surgery risk. For example, centers could collect data that

Financial Disclosure: Nurse Planner **Kay Ball**, PhD, RN, CNOR, CMLSO, FAAN (Nurse Planner), reports she is on the speakers bureau for AORN and Ethicon USA and is a consultant for Mobile Instrument Service and Repair. Editor **Jonathan Springston**, Editor **Jill Drachenberg**, Author **Melinda Young**, Author **Stephen W. Earnhart**, RN, CRNA, MA, Physician Editor **Steven A. Gunderson**, DO, FACA, DABA, CASC, RN, CRNA, MA, Consulting Editor **Mark Mayo**, CASC, Editorial Group Manager **Leslie Coplin**, and Accreditations Director **Amy M. Johnson**, MSN, RN, CPN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

SAME-DAY SURGERY

Same-Day Surgery (ISSN 0190-5066) is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Same-Day Surgery*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.

GST Registration Number: R128870672.

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This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 36 months after the date of publication.

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is surgeon-specific. "Surgeons have the training and background to know the relative risk of procedures. What would be more valuable to them is to know their own statistics," says **Charles Dinerstein**, MD, MBA, FACS, director of medicine for the American Council on Science and Health in New York City.

Data on morbidity in terms of infections and post-op problems is a worthwhile track, Dinerstein offers. For instance, organizations could track physician-level data about the number of infections that occur within 30 days after surgery. Surgery centers that are part of healthcare systems might have access to that level of data through their health system's registries.

Another tactic is to ask questions while keeping the overall picture in mind.

"If you ask a simple question, you will get a simple answer," Ruppe says. "You have to look at the overall picture and use all the information you receive, including a review of body systems from the surgeon's office."

Nurses are good at conducting a thorough review of systems and eliciting better answers, according to Ruppe. "Nurses usually develop a routine and go over everything." If a patient responds to a question about blood pressure problems by saying that is no longer is a problem, then the nurse might point out the patient is on several blood pressure medications. Nurses also might ask patients about prior surgeries and family history to learn more about potential problems with anesthesia.

"Ask whether the patient or any blood relatives ever had a problem with anesthesia," Ruppe suggests. "If the patient says their cousin had a big problem, and the doctors said he shouldn't have surgery anymore, then that answer should lead to more questions."

Sometimes, nurses might examine anesthesia records from the hospital, even with same-day surgery candidates. The risk is small for malignant hyperthermia, but the consequences are huge.

One of the best methods for improving the preoperative screening process is to direct physicians, nurses, and anesthesiologists to develop guidelines for optimal screening, Dinerstein suggests.

"Spend a few hours to figure out what people need," he says. "Give everyone dinner, moderate a discussion, and walk them through the guidelines that will give them an opportunity to talk with one another without the stress of 'I have a case to do.' It pays dividends that way."

EXECUTIVE SUMMARY

Surgery centers can improve their preoperative screening process, which can lead to safer and more efficient outcomes.

- A nurse discovered a patient had presented with undiagnosed malignant hyperthermia by digging into the details of the patient's allergies and family history.
- Surgeons, nurses, and anesthesiologists should work together to develop screening guidelines.
- One technique is to ask questions that keep the big picture in mind.

Then, they can put these suggestions into guidelines with which everyone agrees, thereby improving the surgery center's flow. The guidelines should include an assessment of patients' medical issues, as well as the American Society of Anesthesiologists (ASA) physical status classification system priorities.

Anesthesiologists study patients' diseases and, using the ASA classification system, they categorize patients according to level one (a normal, non-smoking, healthy patient) to level five (a patient who might not survive without surgery) and level six (a brain-dead patient). *(Learn more about this system at: https://bit.ly/30wSJ01.)*

The ASA classification can help predict perioperative risks. If the anesthesiologist, in conjunction with the surgeon, classifies the patient an ASA 1, then the patient may not need any extra presurgery interventions. If the patient is an ASA 2, then the surgeon might ask the patient to quit smoking for a couple of weeks before surgery and for several weeks after. Perhaps the surgeon would ask the patient to take other actions to reduce his or her risk of postoperative complications. This collaborative approach to developing preoperative screening guidelines is much more efficient and helpful than the surgeon making the decision to go ahead with a patient's procedure, only for the anesthesiologist to intervene, Dinerstein observes.

"There's nothing worse than scheduling a patient, going in for preoperative testing three days before, and, in the end, the anesthesiologist says the diabetes is not under control. The case comes off the schedule with nothing in its place," Dinerstein explains. "The surgeon who is booking the case should have a clear set of ideas of what is going to be required." ■

Tactics for Improving Preoperative Screening Questions

Preoperative screening is more than a form with a checklist of questions to be answered. Surgery center staff may be walking a well-worn path, but the key is asking a familiar question in a way that could elicit a different, better response.

"The physician [conducts] the pre-op. Then. nurses do it on the phone, and then anesthesia also reviews what the doctor and nurse sent over," says **Catherine Ruppe**, RN, CASC, associate principal at ECG Management Consultants in Seattle.

The important thing is to ask the same question, but in a different way. For example, a nurse could call a patient for screening and say, "OK, Mrs. Smith, I received your health history, and I'd like to review that with you," Ruppe says. "The nurse could ask this question this way and get a better answer."

Sometimes, patients are under less stress when answering questions by phone rather than at an in-person visit, and so they might elaborate on a particular answer. These are some tips for improving the preoperative screening process:

• **Cover the most common health issues.** Physicians can screen patients weeks before surgery and have them make changes that could improve their health before their procedures.

Two of the most common risks that can be mitigated when patients make lifestyle changes presurgery are smoking and diabetes.

"With smoking, it's not uncommon for doctors to ask that the patient not smoke for at least two weeks," says **Charles Dinerstein**, MD, MBA, FACS, director of medicine for the American Council on Science and Health in New York City. "There is good evidence to show that current smoking inhibits wound healing. [Patients] can get a nicotine patch."

For total joint surgery, surgeons often recommend patients abstain from smoking for a month prior to the procedure, Ruppe notes.

Diabetes needs to be well-controlled in the perioperative period — before, during, and after surgery, Dinerstein says.

Anesthesiologists might be the gatekeeper, setting a cutoff for a patient's blood glucose level.

"If the patient's lab results come back wonky, then the physician will contact the primary care provider and see if there's an issue we need to be aware of and get pre-op clearance," Ruppe says.

Preoperative screening is a way for physicians and surgery centers to identify underlying risks that might not have been noticed, Dinerstein says. "We make sure diabetes, cardiovascular condition, and hypertension are all addressed preoperatively," he explains. "You can say, 'You have a small degree of hypertension, and I want you to see your internal medicine doctor and get that addressed.'"

• **Look closely at the risk obesity poses.** When the first screening

indicates a patient is obese, the surgeon will decide whether it is better to proceed with the procedure or ask the patient to lose weight first, Ruppe says.

"If it's a procedure they can wait on, they will suggest some exercises and say, 'Go back and see your primary care provider, and when you've lost 25 to 50 pounds, I'll be happy to help you,'" she adds.

There is a well-established preoperative management approach by orthopedic surgeons, who want the weight to come down before knee surgery, Dinerstein says.

Bariatric surgeons also might make this request as an insurance hurdle to show how much patients really want this procedure. Established bariatric programs have a long preoperative evaluation, he adds.

Some surgery centers have an upper limit for patients' weight, Ruppe says.

"They might stop at 35 or 40 or 45 body mass index," she adds. "Once a patient is larger than that, the equipment might not handle them, and it's hard on the staff."

• Go over pre-op instructions clearly and repeatedly. "The doctor goes over things in the office about what patients should expect and gives general instructions that nurses can reiterate to patients," Ruppe says.

The pre-op assessment emphasizes the instructions of patients not bringing in valuables, not wearing jewelry, and not eating or drinking since the evening before, she adds.

"Nurses tell patients what medications they can and cannot take before surgery," Ruppe says.

It is a good idea to let them know why these instructions are important, such as explaining that if they have a full stomach, they might feel nauseous and vomit.

• Address sleep apnea risk. Physicians should screen for sleep apnea, both diagnosed and undiagnosed.

For instance, patients need to be asked about their sleep patterns, snoring, and drifting to sleep while driving. If they are overweight and have any sleep issues, sleep apnea could be a problem, Dinerstein says.

"It's easy to screen them and refer them to someone who can address it," he adds. "There are three or four questions you can put into the patient care flow to pick up those patients."

• Screen for COVID-19. Most surgery centers have instituted strict screening protocols for COVID-19. Staff take patients' temperatures before even entering a facility.

Additionally, staff could ask patients about recent travel, symptoms, and fever in a preoperative phone call. Screening for COVID-19 can occur close to surgery time because handling the process two weeks early may not be as helpful.

For instance, a patient may test negative at one visit, then test positive one week later. Similarly, but much worse, a patient could undergo a COVID-19 test, the results return negative three days later, and the patient starts exhibiting symptoms the day after that. ■

As Uninsured Rates Skyrocket, ASCs Need Flexibility in Collections

The COVID-19 pandemic led to job losses, which in turn caused 5.4 million laid-off Americans to lose their health insurance between February and May.[1]

From a surgery center's perspective, this means some patients on payment plans fell behind in their payments. Other patients who wanted to schedule surgery may have to pay more out of pocket and need flexible repayment terms.

"We need to loosen some of our tight restraints to allow a little more flexibility," says **Jessica Weathers**, CPC, revenue cycle manager at Proliance Surgeons, Inc. in Seattle. "It's all new for all of us, and we're trying to manage it. Our philosophy now is we're trying to adapt to this and make surgery feasible for a patient."

Proliance Surgeons owns 20 surgery centers, which were closed to elective cases from March to May. Since then, the centers have reopened, and employees are working through backlogs, Weathers reports.

The organizations work with a decentralized structure — separate leadership, boards, policies, and procedures. But the offices also collaborate on what is working from the revenue side of the business. "We ask each other, 'What is working for your office? How are you approaching these scenarios?'" Weathers says.

The surgery centers accept bank checks, debit cards, and credit cards for payment of patients' out-of-pocket expenses. Staff typically ask patients pay half their estimated out-of-pocket costs, including copays and deductibles, up front. Then, the centers place the remainder on a repayment plan that usually lasts 12 months or less, depending on the amount, Weathers explains.

EXECUTIVE SUMMARY

With a record number of Americans newly without health insurance, surgery centers face additional financial challenges as they cope with the COVID-19 pandemic. To survive, surgery centers will have to stay flexible and work closely with patients on payment plans.

- Surgery centers may need to adjust existing policies regarding preservice payments. For example, instead of asking for 50% payment, a center could ask for 25%.
- Some patients who are making payments for surgeries that were performed already might need a little more time to retire their debt.
- Educating patients on various payment options, including applying for Medicaid and signing up for insurance through Affordable Care Act exchanges, is crucial to improving collections.

For instance, if a patient owed $500 after the procedure, they would be put on a plan to repay within four or five months. However, the pandemic has changed practices.

"It's a different time than it was [in February] when the unemployment rates were very low and the uninsured rates were low," Weathers says. "Everyone has to change their tone and mindset in how they approach this situation. It will keep evolving, probably get worse before it gets better."

Weathers offers these techniques for improving collections from patients during the pandemic:

• Work with post-surgery patients on their repayments. Revenue cycle staff talk with patients who are behind in their payments to see whether they need some flexibility in their repayment schedule, Weathers says.

"Before COVID, we'd recommend that anyone who owed $500 or less repay it within five months," she says. "Now, we are extending it to eight months."

It is important to be creative and allow patients more time to pay off their surgery debt. Centers can extend their monthly payments to make them more affordable, Weathers offers. "We have a lot of folks who don't work and are trying to juggle what they can pay right now," she observes. "We find that a lot of us are making concessions, trying to make a more affordable payment plan, where we had an account under 12 months, and now are pushing these out longer, allowing a little leeway."

Sometimes, centers will allow patients to skip a month. Patients appreciate these efforts and flexibility. "They're in a bad situation. As long as we're willing to work with them, they're willing to pay us," Weathers says. "If we said, 'Sorry you're in a tough spot, but I'm not going to change our ways,' then they might say, 'You're the last bill I'll pay, then.'"

• Give new patients thorough and clear information about costs. Even before the COVID-19 pandemic, the Proliance surgery centers were successful with benefit and financial counseling before each procedure, Weathers notes.

Not every ambulatory surgery center offers preservice financial counseling, which can be a vital service in good times and bad. "Our more successful centers had a robust process in place and followed that," Weathers says. "COVID put a wrench in that. But, ultimately, as long as they hold fast and are communicating with patients, then that lets patients drive their care and understand what is going to happen with payment for the procedure, rather than getting a surprise on the back end."

Patients would rather go into a procedure knowing what is expected of them instead of receiving an unexpected $3,000 bill after surgery. "We verify their benefits and try to come very close to whatever their out-of-pocket is," Weathers says. "It's up to each financial representative to educate them and have a thoughtful conversation."

With thorough information about costs, patients can make a better-informed decision about the procedure and how they might pay for it. For some patients, this might mean they will choose to delay an elective procedure until they are re-employed or can afford the out-of-pocket costs.

"I've seen [patients] choose to push their procedure out, hope to be back at work, get medical benefits, and be in a better situation before they have that procedure," Weathers adds.

• Guide patients to alternative insurance. Surgery center staff might need to guide some prospective patients to apply for Medicaid or sign up for coverage through Affordable Care Act exchanges.

"We educate and provide information for patients to get their own insurance through the exchange program," Weathers says. "Or, if their household is completely out of work, they can apply for Washington state's Medicaid program."

Patients often do not know what their options are or how to apply for another type of insurance. "There are resources out there to provide that information so they can feel more empowered to do research and see

what the best plan is," Weathers says. "We can educate and provide them with those resources so they know there are options out there for them."

The trickiest cases are those in which the patient does not qualify for Medicaid, but earns an income that would make out-of-pocket surgery expenses too costly. "In those cases, we have some charity programs that will allow for extended payment plans," Weathers adds.

The surgery center's office staff can provide patients with information, but it is up to patients to complete their applications and take the next step. Unlike hospitals, there are no financial counselors at Proliance surgery centers to review the application process, Weathers notes.

• Adjust upfront costs and payment plans for new patients. Surgery centers must use more patience and flexibility as the pandemic continues to disrupt business.

For example, when Proliance patients say they would struggle to come up with a $3,000 upfront payment, a surgery center's revenue cycle employee might suggest they pay 25% up front, and then pay installments over a longer period. "We've seen a fair amount of folks try to negotiate a different out-of-pocket cost and an extended payment plan," Weathers says.

If a patient selects self-pay because of a lost job and has some savings to pay up front, then the center could offer a discount to make it more affordable. "We were doing that before COVID, and are still doing it after COVID," Weathers notes.

• Encourage staff to show compassion. The pandemic led to a near-halt to all elective surgeries, which in turn led to plenty of surgery center employee furloughs. Those who have returned to work can empathize with patients about what it is like when to lose a job and worry about income.

It is important for revenue cycle staff to keep an open dialogue while trying to work with patients to make payment plans work. "We let our staff know that we don't know the situation the person who is on the other end of the phone is facing," Weathers explains. "Fear of surgery is scary enough, and now they have a financial situation where they may not have insurance or have a job. You have to be mindful of that in every call you take."

The biggest problems are when patients cannot make even a partial payment. Each situation is unique. There can be no cookie-cutter approach to handling these cases. "Every family situation dynamic is different," Weathers says. "Each individual case has to be reviewed and have someone understand the circumstances behind it."

A patient might have experienced a worst-case scenario, so it is important for employees to approach each call in the softest manner. "Put yourself in their shoes," Weathers offers. "When our staff is working with patients, I see a lot more people being compassionate because they've been there, they've been in the same shoes for the last three months." ■

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Moving into Flu Season, Align Plans with COVID-19 Contingencies

One of the important lessons learned so far during the COVID-19 pandemic is that surgery centers need to stay fluid to survive and thrive.

On top of managing COVID-19 spikes, surgery centers are making preparations for flu season. Since the last flu season, all healthcare facilities have had to take sick leave policies much more seriously, says **Lee Anne Blackwell**, BSN, CNOR, CAIP, vice president of clinical services for Practice Partners in Healthcare, Inc., in Birmingham, AL.

"Guess what our policies have always been? Don't come into work sick," Blackwell says. "People have gone to work sick in the past, but that is going to change."

The COVID-19 crisis has made everyone gun-shy about being around anyone with flu-like symptoms. But plenty of surgery centers and many other public places now require everyone to wear masks, which could result in an unusually subdued flu season. "We might not have as high of a flu situation because people are going to wear masks and do social distancing," Blackwell offers. "We may not see flu spikes because people are working from home."

In July, the World Health Organization's influenza surveillance update suggested influenza activity was reported at lower levels than expected. In fact, Southern Asia and Southeast Asia reported no influenza

detections. Still, surgery centers should prepare for the worst.

In Southern states, the pandemic reached a crisis level in some places over the summer because in May, beaches, restaurants, and bars reopened too soon. This created problems for school districts trying to decide between holding in-person learning or virtual classes this fall.

Surgery center leaders faced similar quandaries. For facilities that cut off elective surgeries in March and later resumed such procedures, administrators may have to press pause again, depending on local circumstances, if they have not already.

Further complicating the issue is the lack of uniform guidance from elected officials. When it comes to allowing elective procedures, orders vary widely. Some hospitals cannot perform these procedures, but perhaps same-day surgery centers can — it all depends on the state, city, and/or county.

Clearly, long-term planning is trickier than ever. Here is how surgery centers can continue to stay safe and open moving into the fall:

• Make COVID-19 policies clear. Practice Partners' facility welcome signs direct patients to follow strict instructions: wear a mask during the entire visit, wash hands or use a hand hygiene product before entering the facility and throughout the visit, and limit contact with others by remaining six feet apart.

• Keep staff safe and well. Healthcare workers have been hit hard by the pandemic. That is something surgery centers also manage, Blackwell says.

"Society, in some parts of the country, has gotten lax. It's been a risk that still hasn't changed," she says. "We still have risk for the elderly and others who are immunocompromised, and surgical patients are at risk."

Requiring universal masking helps improve safety. Also, many surgery centers are asking patients' guests to stay in their cars until it is time to pick up patients. Surgery centers may be taking even more infection prevention precautions in common areas.

Even with all these additional efforts, employees are at risk of acquiring COVID-19 via community spread. Staff must report all possible exposures to the surgery center director.

"I just had a nurse contact me to say her husband works at the hospital in the same city where she's a surgery center nurse. He came down with COVID-19 symptoms," Blackwell says. "I said, 'You need to stay home for 14 days and monitor for symptoms, taking your temperature, documenting it, and take care of your husband from a distance.'" The nurse did stay in a separate room from her husband and disinfected common area surfaces. While she did not experience any symptoms, the situation meant she was out of work for an unplanned two-week period. Administrators must plan for unforeseen, sudden staff shortages.

In another case, an employee, who often experienced sinus infections, developed a particularly bad case. When she visited her primary care provider, the employee was prescribed a steroid dose pack. However, the employee did not get better.

"She had just been to work the day before," Blackwell recalls. "She called the nurse manager when she had the COVID test, and was told she needed to stay home until she got a negative test."

Even undergoing the test was a challenge. "She called her doctor and asked for a COVID test, but he said 'No,'" Blackwell says. "Then, [the doctor] finally tested her for COVID, and she was positive. She had been carrying COVID and transmitting it."

• Explain policies in pre-op phone calls. "We do a pre-op screening patient phone call, following guidelines from the Centers for Disease Control and Prevention [CDC]," Blackwell says.

These phone call screening questions may include: Have you returned from travel outside this state within the last 14 days? Have you or

another person been in close contact with or been near a person known or suspected to have COVID-19? Do you or another person you have been in close contact with currently have a fever of 100.0° F or higher? Are you experiencing cough or shortness of breath?

"We dropped the cruise question because that fell off," Blackwell notes. "We keep it to 14 days if they've been out of state, and we're monitoring between state travel because there are hot spots, including Florida, parts of Georgia."

Staff calling patients for pre-op screening give them information about COVID-19 protocols. "We let them know we are wearing masks throughout the day, and they will wear masks while they're in the center," Blackwell says. "We will take off the mask when we intubate them, but when we extubate them, we put the mask back on."

• Take pandemic precautions. During the procedural visit's first phase, nurses wear face shields and N95 masks. "We take temperatures every day, using a distance thermometer with a gun trigger," Blackwell explains.

It is becoming more apparent the virus can float in the air, making it especially important to properly train staff to use personal protective equipment (PPE). Even if the virus is airborne, wearing PPE, using hand hygiene, wearing masks, and maintaining social distancing can be effective. "The reason the N95 mask is so effective is because it blocks moisture particles that are a size it is designed to block," Blackwell notes.

Practice Partners has instituted protocols for PPE reuse and has increased its use of N95 masks. Every staff member wears some kind of mask, according to their organization's policy and protocol.

"We have general supply chain procedures and contingency plans for seeking alternatives, and now a crisis management plan for reusing PPE," Blackwell says. "We even have one company that is authorized to disinfect masks for organizations."

• Follow infection prevention protocols. Practice Partners centers clean with a disinfectant that is approved by the Food and Drug Administration for its efficacy in killing the virus. Ambulatory surgery centers are directed to the Environmental Protection Agency's website, specifically to List N, which includes updated products effective against coronaviruses. *(See the list at: https://bit.ly/2WM0jmc.)*

"This is what has had a big, impactful change," Blackwell says. "We are cleaning better, more thoroughly, more often now, too."

• Give patients information about staying free of COVID-19. Surgery center staff tell patients how to monitor for signs and symptoms specific to COVID-19. They also ask them to continue to follow CDC guidelines on maintaining social distancing, wearing masks, and following hand hygiene procedures. Also, staff ask patients to avoid going out in public as much as possible during recovery days, Blackwell says.

"We call them about four to seven days later to screen for COVID symptoms," she adds. "If they have them, they need to contact their physician." ■

Screen Patients for Frailty, a Major Risk Factor for Death and Complications

When patients are frail, they are more likely to experience postoperative complications or die after surgery.[1]

"There is no such thing as a minor operation for frail patients," says **Myrick Shinall, Jr.**, MD, PhD, assistant professor and general surgeon at Vanderbilt University Medical Center. "Even for procedures that we as surgeons think of as minor surgery, we need to think about and evaluate whether or not our patients are frail. If they are frail, we should include that piece of information in our shared decision-making with them."

Shinall and colleagues measured frailty and surgery outcomes using the Risk Analysis Index and an operative stress score.[1] "My colleagues have developed a tool to measure frailty that can be administered in person to folks as they are preparing for surgery," Shinall explains.

For research purposes, frailty also can be determined using quality improvement records, such as data from the Veterans Affairs Surgical Quality Improvement Program, which is what Shinall and colleagues used for their study. "We were able to see the level of frailty of patients undergoing all sorts of noncardiac operations, including what we consider minor procedures on an outpatient basis," Shinall says.

The study included 432,828 unique patients (92.8% were men; mean age = 61 years). Investigators identified 36,579 patients who were frail.

The 30-day mortality rate among the frail patients, undergoing the lowest-stress surgical procedures (e.g., cystoscopy), was 1.55%.

For frail patients who underwent a moderate-stress surgical procedure, (e.g., laparoscopic cholecystectomy), the 30-day mortality rate was 5.13%. In both cases, the mortality rate exceeded the 1% mortality rate used to describe high-risk surgery. Operations were ranked from one (low risk) to five (major procedure).

"We looked at mortality of patients based on their frailty and level of operation they had," Shinall says. "What we found is that even frail patients undergoing the lowest-stress operations ... had significant mortality within one month and six months after that operation."

Shinall says surgeons may be seeing patients who are frail, but those patients may not be recognized as such.

"We're not factoring that into the decisions about whether they can withstand the stress of an operation or whether they have enough life expectancy to justify the expense and discomfort that comes with doing an operation," he offers.

The study's findings suggest surgeons should engage in nuanced discussions and shared decision-making with patients. Surgeons can talk to patients about how even a small operation could lead to death, Shinall suggests.

"They can say, 'We need to consider whether this operation is the right thing for you at this point,'" he adds.

The first step is to use a screening tool for frailty. Shinall refers again to the Risk Analysis Index.[2]

"Although we used the tool in a retrospective way, my co-authors have shown it's easy to administer prospectively when making decisions about whether to operate on them or not," he says. "We need to think about screening people, and not just for big operations but for minor outpatient procedures as well. With screening for frailty, we can make better decisions with our patients."

The screening can be handled over the phone.

"The tool's calibration for predicting mortality is very good," Shinall adds. "The other nice thing about it is that in addition to quantifying risk, it gives you an idea of where the risk is coming from, whether it's the patient's nutrition, comorbidity, or whatever."

If a patient scores high on frailty screening, then clinicians can act accordingly. "As a clinician, the screening tool can give you a feeling that if the patient would benefit from this operation, there are things you can do to lower their risk," Shinall says. For example, if the screening tool suggests the patient is malnourished, then the surgeon could suggest the patient meet with a nutritionist or take supplements before the procedure. If mobility is a problem, the patient could see a physical therapist and perform exercises to become stronger.

"A lot of it comes down to good, old-fashioned, patient-doctor communication," Shinall says. "I think the big thing is being open and honest with the patient about what you know about their risks. I would frame it this way: 'As a surgeon, this is something I am very worried about for you. Because of these issues, you are at higher risk for this surgery.'"

If there is no way to lower the patient's risk, then the clinician can say, "If you want to go through with this operation, we want you to go through it knowing this is a risk and to make sure it's an operation that fits with your goals." ■

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Antibiotic Treatment Before Abdominal Aortic Aneurysm Surgery Does Not Help

A new study reveals there is no benefit to asking abdominal aortic aneurysm patients to delay surgery while they attempt to reduce inflammation through antibiotic use.[1]

If a patient's aneurysm could grow too large, surgery is the chief option. "Doxycycline, an old antibiotic, has the ability to block enzymes that break down tissue," says **Tim Baxter**, MD, a vascular surgeon and professor of surgery at the University of Nebraska Medical Center. "There has been a lot of interest in the possibility that doxycycline would keep aneurysms from growing ... animal studies showed good results. One small clinical trial had good results, too, suggesting this treatment could keep people from having surgery."

To see if these results would hold up in a randomized, clinical trial, Baxter and colleagues enrolled patients, age 50 years and older, from 22 U.S. clinical centers between May 2013 and January 2017.

All patients had small infrarenal aneurysms. A total of 133 patients were assigned doxycycline and 128 were assigned to placebo.

"We thought this drug could work. It doesn't have a huge number of side effects, and it's not expensive — or at least it wasn't when we started the trial," Baxter explains. Researchers collected blood work and performed a CT scan every six months for a two-year period. The aneurysms were small enough that physicians would observe them to see if they would grow.

If the antibiotic worked, then researchers would expect to see slower growth among patients who received doxycycline than among the placebo cohort.

The results were surprising: Baxter and colleagues observed no significant difference in the change in aortic diameter between the doxycycline group and the placebo group. Deaths were similar in the two groups.

"In a primary analysis of how much change occurred between the size of the aneurysm at enrollment and the size at two months, we found that the placebo group and doxycycline group grew at exactly the same rate," Baxter says. "It didn't do anything." Researchers also were surprised to see that doxycycline alleviated inflammation, even if the drug did not affect the aneurysm, he adds.

After two years, 13 doxycycline patients and nine placebo patients underwent an aneurysm repair procedure. Three people in the doxycycline group and four in the placebo group died.

Patients with an abdominal aortic aneurysm that might require surgery should be told there is no treatment to slow the growth of their aneurysm, Baxter says.

"If they continue to smoke, the aneurysm will grow a little bit faster, so we encourage them to stop smoking," he says. "Then, we tell them that we'll watch it, and at the [small] size it is, the risk of a rupture is very small." Aneurysm repair surgery can occur in a 23-hour stay, Baxter notes.

From a patient perspective, the good news is the aneurysms were growing slower than expected, based on historical data, Baxter notes.

"It's possible the measurements in the past were inaccurate, or something else we're doing is making them grow slower," he offers. "That's good news for patients because it means it's more likely that they won't have to have their aneurysm fixed." ■

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Take to Heart the Best Opportunities for ASCs

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

We all know and love total joint procedures in ambulatory surgery centers (ASCs). The Centers for Medicare & Medicaid Services (CMS) continues to expand procedures that make the Medicare approval list that most payers honor (i.e., if the procedure is not on that list, the procedure cannot be performed in an ASC). Many may not understand that, but that is for another column.

If you are not at least talking to your local cardiologist about a cardiac lab in your ASC, you are missing a golden opportunity. Two of the most desirable procedures for ASCs in 2020 and beyond are cardiology and vascular procedures, which CMS has just blessed for ASC reimbursement. This includes most catheterizations, angioplasties, and stenting procedures. Setting up a cardiac lab in an ASC requires some homework. They are not necessarily difficult or terribly expensive, but there are fine details worth understanding well. Rewards include the following current procedural terminology (CPT) codes and reimbursement, although this may vary by ZIP code:

- 37227: Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed = $10,940.75;
- 37226: Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed = $6,444.32;
- 37238: Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein = $6,193.74;
- 36906: Transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit = $10,181.47;
- 33207: Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular = $7,633.32;
- 33249: Insertion or replacement of permanent pacing cardioverter-defibrillator system = $26,699.15;
- 92928: Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty, when performed; single major coronary artery or branch = $6,057.39.

Be careful, as the devices can be outrageously expensive. Conduct thorough research to find the most sensible deals. While some procedures have been on the CMS-approved list for a while, most people do not know about them. This reinforces the need to always stay on top of what CMS is up to. Over the coming years, CMS could push more cases and procedures to ASCs. Thus, many hospital outpatient departments may convert to ASCs. Keep following those developments closely. ■

(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Address: 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. Instagram: Earnhart.Associates.)

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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.

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CME/CE QUESTIONS

1. **Which question is important to ask to identify a patient who might have malignant hyperthermia?**

   a. Do you have any siblings who have struggled to sleep while on anesthesia?
   b. Have any relatives died of congestive heart failure?
   c. Have you or any blood relative ever struggled with anesthesia?
   d. Have you run marathons within the past four weeks?

2. **With millions of Americans out of work and without insurance because of the COVID-19 pandemic, what is one example of a good policy when dealing with patient collections?**

   a. Be flexible and offer longer payment terms or lower upfront payments.
   b. Ask patients to put the surgery cost on their credit cards.
   c. Send lapsed payments to a credit collection company faster than usual.
   d. Negotiate with insurers to reduce patients' out-of-pocket costs.

3. **As surgery centers prepare for a combined influenza/ COVID-19 season, which is an important question to ask patients before their procedure?**

   a. Have you been on a cruise lately?
   b. Have you traveled in Europe within the past two weeks?
   c. Have you traveled outside the state within the past two weeks?
   d. Have you visited an indoor sporting arena within the past two weeks?

4. **Research reveals frail patients are at a significant risk of death within one month after:**

   a. high-risk surgery.
   b. low-stress operations.
   c. medium-risk procedures.
   d. emergency surgery.

SDS ACCREDITATION UPDATE

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

Need a Quality Improvement Project for the Fall? Examine Center's COVID-19 Response

The COVID-19 pandemic gives accredited surgery centers both a challenge and an opportunity.

Plenty of administrators continue to cope with the fallout of no elective surgeries for two or more months. But there is a ready-made quality improvement (QI) project waiting for attention: Ensuring all policies and procedures are in line with state, federal, and other infection prevention requirements concerning COVID-19.

After collecting data on the center's performance, managers can write the QI report during any future times when elective surgeries are postponed because of COVID-19 surges, says **Crissy Benze**, RN, BSN, MSN, senior consultant at Progressive Surgical Solutions in Denver.

"Throughout the quarter, you are gathering all the data on different things occurring in your center, including operational data such as hand hygiene, medication management errors, [and] incident reports," Benze says. "Then, the thing that can be done when you have down time — like [during] the pandemic — is to take credit for the work you're doing and write up the study."

The QI project's goals will coincide with any new federal and state regulations. For example, some states require all patients to undergo a test for COVID-19 infection before surgery. These requirements, and any policies the surgery center has written, should be part of the policies and procedures customized to the facility.

Benze suggests surgery centers take several steps when performing a COVID-19 QI study:

• **Designate a coordinator.** Typically, surgery centers work with a quality assessment performance improvement (QAPI) committee. For the COVID-19 QI project, managers should designate a coordinator and select employees who will be involved in collecting and analyzing data.

• **Align practices with regulations.** "Make sure all policies and procedures are based on state requirements for universal masking, screening employees and medical staff, screening patients, and doing intubation and extubation," Benze says.

If a surgery center uses general anesthesia, then there should be a respiratory protection program. Some centers may consider purchasing N95 respirators.

• **Conduct inservice education.** Inservice education about COVID-19 practices and requirements should be given to all employees, regardless of time served.

"Go over all policies and procedures to ensure understanding of what is being implemented and monitored for compliance," Benze suggests. "It's easy to say, 'Yes, we're universally masking,' but we know in some facilities the business office staff sits at their desk and they're not putting on their mask. It's easy to become complacent on some of these things."

Education should include practice donning and doffing personal protective equipment (PPE) to ensure staff follow the steps correctly.

"Go over screening policies and all new and revised policies," Benze adds. "Make sure policies are based on nationally recognized guidance and state requirements for conducting elective surgery."

Surgery centers can refer to videos about how to wear PPE or show staff information provided by the Centers for Disease Control and Prevention (CDC). *(See more at: https://bit.ly/2OIpUbs.)*

"There are great videos by the CDC," Benze says. "Or, you could have signage up at your facility to show the order of donning and doffing."

• **Monitor compliance.** The QAPI committee should monitor compliance over time, typically in three-month

intervals. After collecting data, QAPI leaders should analyze their findings. For example, if there is excellent compliance among facility staff, but not among medical staff, then the solution would be to offer more education for the medical staff, Benze says.

The QAPI committee should select target goals. With COVID-19, these usually will be 100% compliance. "This is not like hand hygiene [in pre-pandemic times] where you knew you would not get 100% compliance," Benze notes.

• **Observe behavior.** Monitors will collect information about staff's compliance with wearing masks, washing hands, wearing PPE correctly, disinfecting areas, screening patients, and enforcing social distancing.

If the goal is for all staff to wear masks at all times, then that behavior should be observed. The surgery center might specify when and who needs to wear N95s and PPE. All this must be observed and documented.

"Depending on the surgery center and how easy it is to get PPE, your business staff might wear masks from home," Benze suggests. "If they are wearing masks from home, then you should go over cleaning protocols and expectations so they are not wearing a cloth mask day after day without washing them."

Whatever the monitor observes, write it down. "Documentation is the only way you can demonstrate what was done," Benze adds.

• **Analyze data, and re-educate.** If observation data suggest staff complied only 85% of the time with some requirements, then the surgery center needs to re-educate staff on appropriate areas.

"Maybe everyone is doing a great job with screening for patients and staff, but it's really around proper PPE that is a problem," Benze explains. "Conduct more education for staff on how to wear PPE, and you spend the next quarter doing a remeasurement."

For example, anyone wearing the N95 respirator has to go through an Occupational Safety and Health Administration (OSHA) fit test to ensure it is placed on the face properly. OSHA offers respiratory protection training videos online at: https://bit.ly/39qISNr.

With other PPE, there is a certain order to which the items are put on and taken off. "It's like with hand hygiene. Make sure they're using alcohol hand rub or soap and water correctly," Benze says.

• **Update policies, as needed.** Every surgery center has instituted a new visitor policy. Such policies usually call for visitors to stay in their vehicles until the patient is ready to return home. But these might need to be updated as the pandemic evolves in certain areas or as regulatory requirements change. For example, cleaning nonpatient care areas. This procedure now includes the nursing care station, where staff should be disinfecting phones after each use. Staff also should maintain a cup for disinfected pens, wipe down the reception desk, and monitor bathrooms for frequent cleaning.

• **Write QI report.** "You write it up, and report it to the QAPI committee at quarterly meetings," Benze says. "The QAPI committee reports it to the governing body. If there is any corrective action needed, it's discussed at the governing body level." ■

AAAHC's Refreshed Standards Focus on Medications, Site Marking

The Accreditation Association for Ambulatory Health Care (AAAHC) is focusing on site marking and high alert/confused drug name medications as part of new standards released in July and that are set to take effect on Nov. 1.

"We encourage organizations to conduct a thorough review of the changes to the standards and a gap analysis to ensure they are in full compliance by that effective date," says **Hallie Brewer**, CA-AM, senior vice president of learning and development for AAAHC. Brewer lists several noteworthy changes to the accreditation standards in version 41 (v41) of the *AAAHC Accreditation Handbook for Ambulatory Health Care* and the *Accreditation Handbook for Medicare Deemed Status*:

• **Site marking (10.1N and 10.I.O).** Requirements for procedure verification and site marking have been divided into separate standards. Now, it is possible for someone other than the person performing the procedure to mark the site. This is a revision.

• **High alert/confused drug name medications (11.F).** This requires monitoring the presence or absence of high alert medications and medications with confused drug names, such as lookalike and sound-alike names. This is a new standard.

• **Vaccine management (11.N).** This standard requires organizations to handle and store vaccines in

accordance with nationally recognized guidelines. This is a new standard.

• **Pathology and medical laboratory services.** These changes include a new standard for proficiency testing if required by Clinical Laboratory Improvement Amendments (CLIA), a CLIA Accrediting Organization, the state, and/or the organization's own policies. This is a revision. AAAHC's release of new and revised standards is part of the organization's tradition of ensuring ambulatory health sites can access relevant standards and education for improvement of their patient care environment, Brewer says.

"We update our standards regularly to reflect proven developments in medicine, technology, and specialty practice," she says. "The v41 provides a seamless transition for quality improvement efforts."

More information about the new standards is detailed in the AAAHC webinar "Moving Forward with Enhanced v41 Standards," which is available to view online at this link: https://bit.ly/32JFL1G.

AAAHC will host a virtual conference, with an in-depth review of standards and tips for how to prepare for accreditation, in September 2020 (formal date to be announced). ■

Joint Commission's Patient Safety Goals Emphasize Surgical Site Infections

The Joint Commission's latest National Patient Safety Goals for the Ambulatory Health Care Program, effective as of July, includes a few minor changes, but also emphasizes the importance of preventing mistakes in surgery and surgical site infections (SSIs).

The COVID-19 pandemic is not mentioned, but the guide provides fresh context to the accreditation organization's emphasis on handwashing and infection prevention. *(Learn more at: https://bit.ly/2WnDOE5.)*

"The Joint Commission continues to require organizations to comply with the following requirements related to hand hygiene to provide protection at all times, including during the current pandemic," says **Maureen Vance**, MSN, RN, clinical project director in the department of standards and survey methods for The Joint Commission.

In the first goal (NPSG.01.01.01), The Joint Commission's refreshed recommendations focus on how to identify patients correctly. The guideline authors say surgery staff should "use at least two ways to identify patients." One way could be the patient's name and date of birth. Other identifiers could be the patient's assigned identification number, phone number, or another person-specific identifier.

The guideline authors also recommend using hand-cleaning guidance from the World Health Organization. Other notable updates:

• Provide equipment and supplies, such as soap and water and hand sanitizer gel, to support infection prevention and control activities, including hand hygiene (IC.01.01.01 EP 3).

• Develop and implement written infection prevention and control goals that address prioritized risks; limit unprotected exposure to pathogens; limit the transmission of infections associated with procedures; limit the transmission of infections associated with the use of medical equipment, devices, and supplies; and improve compliance with hand hygiene guidelines (IC.01.04.01. EP 1).

• Use standard precautions, including personal protective equipment, to reduce infection risk. These precautions are general and applicable to all patients. For further information regarding standard precautions, refer to the Centers for Disease

Control and Prevention (IC.02.01.01 EP 2).

• Implement methods to communicate responsibilities for preventing and controlling infection to licensed independent practitioners, staff, visitors, patients, and families. Provide information for visitors, patients, and families that includes hand and respiratory hygiene practices. Information can be communicated through different forms of media, such as posters or pamphlets (IC.02.01.01 EP 7).

The latest revision contains no new National Patient Safety goals (NPSGs), Vance says, but they do include revisions in these areas:

• NPSG.01.03.01: Transfusion errors, which is moved to PC.02.01.01;

• NPSG.03.06.01: Accurate medication information, which contains editorial changes to EPs 2 and 4;

• NPSG.07.05.01: SSIs, which was moved to IC.02.05.01 and PI.02.01.01. "The changes made to NPSG.03.06.01, accurate medication information, were limited only to editorial revision, including the removal of notes in both EP 2 and 4," Vance says. "The intent of the requirements in NPSG.03.06.01 has not changed."

Also, the revised version has removed the notes in EPs 2 and 4.

"The notes in EPs 2 and 4 were removed to eliminate confusion and to provide clarity and consistency, based upon feedback we have received from the field," Vance explains. ■

Update and Quick Tips on Improving Medication Reconciliation

The COVID-19 pandemic is increasing drug shortages, particularly for generic drugs, as people are stockpiling medication.

Stockpiling can make medication reconciliation more challenging for surgery centers as they work to meet related accreditation requirements.

"As part of ensuring that high-quality healthcare is provided to patients, AAAHC standards require organizations to conduct medication reconciliation," says **Hallie Brewer**, CA-AM, senior vice president of learning and development for the Accreditation Association for Ambulatory Health Care (AAAHC). "Best practices in surgery include providing patients with written instructions for discontinuation and resumption of medications prior to and after a procedure, as well as explicit instructions regarding any new medications post-discharge."

For example, many organizations do not document medication contraindication or whether patients are taking medications as prescribed, according to a 2019 AAAHC benchmarking study. *(Read more at: https://bit.ly/2BkraOL.)*

This study showed only 65% of providers documented whether a patient was taking medication as prescribed. In 16% of charts, providers failed to document that a new medication was started and when. Sixteen percent of organizations did not report documenting whether there was a medication contraindication with the use of any medications listed.

The repercussions can be life-threatening when a patient does not resume a critical medication, such as an antiplatelet or anticoagulant, or when they resume the medication too early. Among the biggest problems in medication reconciliation are age, language barriers, hearing/visual/cognitive impairment, cultural issues, polypharmacy, and health literacy.

When it comes to providers and organizations, providers may not be updating medications at each encounter routinely. They may not engage in detailed discussions about medications with patients and caregivers. Further, providers may not provide enough explicit instructions regarding stopping medications before the procedure and resumption of medications after the procedure. This could include instructions on new medications to be taken after discharge.

Brewer suggests five steps as general best practices in medication reconciliation:

• Commit to medication reconciliation as part of the organization's safety culture.

• Implement a single source document policy for tracking patients' current and past medications.

• Verify and document medications before and after each patient exam and procedure.

• Resolve any discrepancies by communicating with the patient, provider, and pharmacy.

• Communicate with patients and ask them to verify they agree with the current medication list.

"By vigilance and fostering communication among providers themselves and with patients/caregivers, the process of medication reconciliation may result in improved coordination of care, increased patient engagement and satisfaction, and increased overall quality of care," Brewer says. ■