



# SDS ACCREDITATION UPDATE

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## AAAHC Takes Pragmatic Approach in Latest Edition of Handbook

**A**mbulatory surgery centers (ASCs) will find some important updates in the latest version of the Accreditation Association for Ambulatory Health Care (AAAHC) handbook.

In September, AAAHC published the *Accreditation Handbook for Medicare Deemed Status*, version 41, the first time the handbook is marked by a version number and not by the year of release. Perhaps most notably is the inclusion of a standard on vaccine management.

The importance of this standard has been amplified during the COVID-19 pandemic, as the world waits for a safe and effective vaccine that could be distributed to 7.8 billion people.

“A lot of surgery centers, in the past, have had vaccines only for staff,” says **Meg Kerr**, MPA, vice president of standards development for AAAHC. “But now we live in a new world, with new vaccines for new uses. Although we were not aware of that when the standard was created, it has taken on new significance.”

Issuing revised standards during a pandemic was challenging, but AAAHC decided the changes could benefit accredited organizations.

“The changes being made, we believe, will help clients [develop] more clear and consistent programs,” says **Hallie Brewer**, CA-AM, senior vice president of learning and development for AAAHC. “It helps [clients] have a way better picture of how we are evaluating them with standards. We believe the changes we’ve made will make things more understandable and make things more clear.”

Version 41 of the accreditation handbook will be used by all sites with an accreditation anniversary date on or after Nov. 1, 2020. Ahead of the handbook’s September release, AAAHC published a primer to help clients understand the coming changes.<sup>1</sup>

“In the back section of each book, there is a crosswalk to the previous version,” Kerr says. “If they want to see what’s changed the most in the book, then that’s their snapshot of what’s changed and what is deleted.”

Brewer and Kerr outline several other notable updates:

- **Surgical site marking.** Version 41 includes standard 10.I.O, which is 10.I.S in the Medicare deemed status program, for marking a site prior to surgery. The standard states: “Prior to a surgery or procedure involving level or laterality, the site is marked.”

It also requires five elements of compliance, including “a written site-marking policy is present” and “clinical records contain documentation of site-marking.”

“We clarified that the standard only applies if the organizations conduct certain surgeries and procedures,” Kerr says.

For example, the standard applies to procedures involving level or laterality. “Our last version of the handbook noted that the standard did not apply to endoscopic procedures,” Kerr explains. “This time, we changed it to clarify level and laterality.”

The revised standard also removed the statement indicating the site can be marked only by the person

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providing the procedure, aligning this standard closer to CMS regulations regarding site-marking. Now, another member of the surgical team can mark the surgical site, so long as that member is going to be in the OR during the time out. Surgery centers will need to define what they mean by “surgical team” and who is included on it. However, centers that work under a policy that only allows the person performing the procedure to mark the site can keep that policy.

AAAHC does not always align its standards to CMS rules. “We always assess what we believe is the best thing for the patient,” Brewer explains. “There are some other changes where CMS may have lightened the requirements, but we believe it should still remain as it is now because it’s better for patient safety. But, in this case, we believe the change is appropriate and common practice.”

#### • High-alert medications.

Version 41 includes standard 11.G and 11.H, which are standards 11.I and 11.J in the Medicare deemed status program, for procedures to prevent high-alert medication errors.

Surgery centers must keep a list of high-alert medications, put processes in place to prevent errors from administration of these medications, and maintain a system for keeping the drugs with sound-alike/look-alike names separate so staff know which is which. The handbook includes a link to the Institute for Safe Medication Practices evidence-based list of high-alert medications.<sup>2</sup>

High-alert medications are not necessarily more dangerous. However, administering the wrong dose can lead to major trouble.

“People thought they could download a list from a website and meet standards,” Kerr observes. “Now, we say that sites have to be

aware and monitor their medication on a regular basis for the presence of those types of drugs.”

If a surgery center does not stockpile any of these problematic drugs, then they do not have to do anything more than monitor and document that those drugs are not at the center. “If you do find some of those drugs, then the standard has additional requirements to make sure you’re taking steps to prevent potential errors from the use of those medications,” Kerr adds.

• **Quality improvement (QI) process.** Version 41 includes standard 5.I.D, which is standard 5.I.G in the Medicare deemed status program: “The organization demonstrates that continuous improvement is occurring by conducting quality improvement studies when the data collection processes, described in Standard 5.I.C, indicate that improvement is or may be warranted.”

The standard’s elements of compliance include this example: “At least one current quality improvement study demonstrates that improvement occurred and has been sustained.”

“Quality improvement is something we care a great deal about,” Brewer says. “But we also find it’s an area that organizations struggle with because it’s not always easy to come up with a great QI study.”

“For a long time, we had 10 elements of the quality improvement process,” says Kerr, noting that now, the 10 elements are no longer included; in version 41, they are detailed in the back of the handbook. “There has to be at least one completed QI study in order to be in compliance with that standard, while previously they were expected to have at least two QI studies when they applied for a survey,” she says.

“But there was no time frame given on that.”

Version 41 includes a specific time frame: At least one QI study must be performed within the current accreditation term of three years, or within the last 12 months of the initial survey, Kerr explains.

Smaller sites might be expected to conduct fewer QI studies, while larger sites might be expected to perform one each year. “The number of QI studies they conduct has to reflect the nature and complexity of the facility,” Kerr says.

When leaders observe a decline in any process quality, that is the time for an improvement project. “Monitor performance indicators on an ongoing basis and take steps, as needed, to show improvement occurs,” Kerr offers. “Find an issue with the current process, find ways to improve it, implement those steps, remeasure to see if steps improve it, and, if so, you’re good to go. If not, then take further steps.”

AAAHC says it will no longer tie an edition of its handbook to a calendar year. The group has pledged to issue changes whenever it makes sense, using version numbers from now on. “We often find that an annual change is the right call,” Brewer says. “The change could be for clarity and evolved medical practice, or because of a shifting landscape and living in a post-COVID world.” ■

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# Analysis: ASCs Saved Nearly \$29 Billion in Medicare Costs 2011-2018

A recent analysis of Medicare ambulatory surgery centers (ASCs) reduced Medicare costs by \$28.7 billion from 2011 to 2018.<sup>1</sup>

The estimated savings occurred because ASCs performed procedures that otherwise would have been handled in hospital outpatient departments (HOPDs) — and at a higher cost. KNG Health Consulting, which conducted the analysis in conjunction with the Ambulatory Surgery Center Association (ASCA), estimates ASCs could reduce program costs by another \$73.4 billion from 2019 to 2028.

ASCA CEO **William Prentice**, JD, spoke with *Same-Day Surgery* (SDS) in greater detail about the report. The transcript has been lightly edited for length and clarity:

**SDS:** How did KNG arrive at the \$28.7 billion figure?

**Prentice:** The analysts looked at real claims paid by Medicare to ASCs and HOPDs from 2011 to 2018. From these claims, they were able to determine an average payment amount for every procedure code for each year.

They considered the difference between the HOPD average payment and the ASC average

payment to be a procedure-specific amount that the program saved whenever that procedure was performed in an ASC rather than an HOPD during the year.

They then multiplied the ASC volume for each procedure in a given year by its savings amount to get total savings for each procedure for the year. For example, if a cataract removal was, on average, paid \$100 in a hospital and \$50 in an ASC, then each time a cataract removal was performed in an ASC, Medicare would save \$50. If ASCs performed 100 cataract removals in a year, the program savings would be \$5,000 that year. (*Editor's Note: These numbers are just examples, and do not reflect actual costs.*)

After doing that calculation for every procedure paid by Medicare and adding all the savings in each year, the analysts reported total savings for years 2011 through 2018 of \$28.7 billion.

**SDS:** How is the projection of another \$73.8 billion in savings, between 2019 and 2028, determined?

**Prentice:** Since that number is a future projection, the analysts could not rely on real claims or volume data. Instead, they looked at each procedure, how much the procedure

volume grew or decreased from 2011 to 2018, and applied that trend forward for the next 10 years.

They used 2018 payment amounts as a baseline, and updated payments for each year using amounts CMS is expected to use. Then, the savings were calculated in essentially the same way as [the 2011 to 2018 figure]: The difference in HOPD payments and ASC payments was multiplied by the projected ASC volume for every procedure in every year. All those savings were combined to determine total savings.

Notably, the analysts also accounted for changes in the Medicare population based on census data and the Medicare Trustees report.

**SDS:** What kind of shift in total knee arthroplasties (TKA) from the HOPD to the ASC setting is expected between now and 2028?

**Prentice:** Since 2020 is the first year ASCs could perform TKAs for Medicare beneficiaries, we have no data yet on ASC volume and likely won't for a couple years. Therefore, this shift was somewhat difficult to project.

For guidance, the analysts consulted subject matter experts that included orthopedic surgeons,

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payment specialists, and third-party administrators. Ultimately, they decided to model the shift in TKA on the shift that occurred in partial knee arthroplasty (PKA), and make conservative assumptions to protect against overestimating savings.

TKA has been payable in HOPDs since 2018, so there are baseline data for that year. PKA saw 30% annual growth rate in the outpatient setting overall. The analysts considered a scenario that depicts that continued growth rate, but also considered scenarios with much lower growth rates.

Using PKA as a guide, the analysts projected ASCs would do roughly 13% of outpatient TKAs in 2020, growing to roughly 18% in 2028. That means that even in the most ambitious projections of TKA migration to the outpatient setting in the next 10 years, we don't expect ASCs to perform even one in five of those outpatient cases by 2028.

**SDS:** The report indicates cataract surgeries and colonoscopies contributed to most of the savings between 2011 and 2018. How much are each of those procedures' share of the savings?

**Prentice:** A cataract code (66984) accounted for 27.1% of savings between 2011 and 2018. The colonoscopy code (45380) accounted for 5.2% of the total savings. Total savings across all procedures from 2011

to 2018 were \$28,684,154,658. Total 66984 savings from 2011 to 2018 were \$7,783,966,656. Total 43580 savings from 2011 to 2018 were \$1,486,231,872.

**SDS:** Why do you predict that five specialty areas (eye, cardiovascular, nervous system, digestive system, and musculoskeletal surgery) will save more Medicare money by 2028?

**Prentice:** The savings numbers predicted in this analysis are based solely on growth rates seen in volume from 2011 to 2018. Other than the standalone TKA analysis, the total savings numbers don't take any new policies that could be adopted into account and even ignore recent policy changes that allow cardiac catheterization procedures to be performed in ASCs.

CMS has shown a willingness in recent years to expand the types of procedures that ASCs can perform, as increasingly complex procedures are shown to be clinically safe with the right patient selection protocols. Medicare's proposed payment rule released in August this year contains a proposal that would change the ASC exclusionary criteria ... ASCA supported this proposal, but we do not know yet if it will be finalized.<sup>2</sup>

To be clear, the numbers in this analysis do not incorporate these policy considerations. Therefore, if anything, specialties like nervous system, cardiovascular, and

musculoskeletal surgery are likely to deliver even more savings than we project.

**SDS:** Based on this analysis, how should ASCs and HOPDs prepare for the future?

**Prentice:** ASCs are so widely varied in size and specialty that it's impossible to make universal recommendations. Having clinically sound patient selection protocols that help appropriate patients have the procedures they need in ASCs is the best path forward for every center.

For those centers interested in performing some of the more complex surgical procedures that have and will become payable in the ASC setting for Medicare beneficiaries, putting together facility-specific policies and procedures will take dedicated time and effort. ASCs remain a small component of Medicare's outpatient spend, and HOPDs are still expected to see increases in patient volume. ■

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## Racial Disparities Persist in Surgery

**A**frican Americans continue experiencing worse surgical outcomes than white patients. Hispanic Americans also do worse. Why do these disparities persist despite technological advances and insurance expansion?

“We don’t know what’s really going on,” says **Olubukola O. Nafu**, MD, FRCA, MS, vice chair for academic affairs in the department of anesthesiology and pain medicine at Nationwide Children’s Hospital in Columbus, OH. “Some of the reasons put forward include hospital factors, systemic factors, societal factors, and ... patient factors.”

Patient factors include preoperative morbidity burden. “African American patients tend to have higher disease burdens at the time of surgery and at the time of presenting in the hospital,” Nafu explains. “That is one explanation for why there are differences in outcomes.”

Nafu is lead author of a recent study that showed that even among apparently healthy children, African American patients were at a higher risk of postoperative complications and mortality.<sup>1</sup> The

authors found African American children were more than three times more likely to die within 30 days after surgery.

Another study revealed pain scores after knee arthroplasty were higher for African American patients than for white patients.<sup>2</sup>

“We knew, going into this study, that African Americans underutilize knee replacement for many good reasons, including a lack of trust in the health-care system,” says **Daniel L. Riddle**, PT, PhD, FAPTA, professor in the departments of physical therapy, orthopedic surgery, and rheumatology at Virginia Commonwealth University in Richmond. “Patients who are African American tend to rely on social networks to inform them about what kinds of effects these treatments have. The literature has suggested that patients who are African Americans don’t do as well, but all of these factors combine to lead to substantial underutilization of knee replacement surgery.”

Knee replacement surgery is an effective procedure for patients with severe knee osteoarthritis and knee pain.

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Any lack of access to the procedure can negatively affect a person's quality of life.

For two decades, research has documented racial or ethnic differences in knee and hip joint replacement. A report from 2010 indicated African American and Hispanic individuals reported receiving joint replacement two-thirds less often than white individuals.<sup>3</sup>

The authors of a more recent study found racial and ethnic disparities continue to be a public health challenge for patients undergoing total knee arthroplasty, based on a review of data gathered from 2011 to 2017.<sup>4</sup> "Although health disparities are well-established, limited recent data exist in orthopedic surgery, and most reports we limited by focusing on select demographic groups," says **Mohamad J. Halawi**, MD, associate professor and chief quality officer for musculoskeletal services at Baylor College of Medicine.

In recent years, there have been tremendous improvements in the perioperative care of patients undergoing orthopedic surgery. Halawi decided to present an updated analysis of the state of health disparities, especially as they related to hip and knee replacement, which are among the most commonly performed orthopedic procedures. "We used a

large patient sample from very recent years, and analyzed and looked at all major racial and ethnic groups in this country as defined by the National Institutes of Health," Halawi says.

Halawi and colleagues reaffirmed what other had before them: Disparities still exist, with Black and Hispanic patients affected most. "The study also showed that the Asian group outperformed any other group as far as better outcomes," Halawi adds.

Racial and ethnic disparities also exist in terms of access to life-enhancing surgeries. "There are a couple of surgical procedures that are life changers," says **Stephen B. Thomas**, PhD, director of the Maryland Center for Health Equity at the University of Maryland. "One is cataracts, a procedure so straightforward now [that] you get a new lease on life. The second ones are knee replacement and hip replacement — they change your life by keeping you independent."

Thomas notes another disparity exists in amputation rates. "Why are Black people with type 2 diabetes more likely to have their toes, legs, fingers amputated?" he asks.

Earlier studies show that Black patients with peripheral arterial disease undergo amputation at two to four times the rate of white patients. Black

## EXECUTIVE SUMMARY

Healthcare disparities, primarily affecting African American and Hispanic patients, persist despite years of research.

- One study revealed African American children are three times more likely to die within 30 days after surgery.
- Other research indicates pain scores after knee arthroplasty were higher for African American patients than for white patients.
- Black patients are much less likely than white patients to undergo attempts at limb salvage before an amputation.

patients also are much less likely than white patients to undergo attempts at limb salvage before amputation.<sup>5</sup>

“These disparities would be easy to ignore if they were not so well documented,” Thomas says. “There are a lot of judgment calls made when you’re deciding whether or not to do a surgical procedure that amputates a leg vs. trying to save it.”

Although surgeons could argue they do not see these patients until their infections are severe enough that amputation is the only life-saving alternative, Thomas suggests surgeons can and should do more to stop the disparity. For instance, they could become advocates for governmental and payer policy changes that would help reduce disparities and improve everyone’s health.

“They have to use their voice, privilege, and rank ... to move the needle and look at how it’s not just what happened to the person in the surgical suite, but what happened before the surgical suite,” Thomas says. “Do I expect surgeons to end poverty or racial discrimination? No, but there’s a lot more they can do to use their voices of power.”

One important way surgery leaders can contribute to changes that improve health equity is by hiring surgeons and other staff from underrepresented minorities. The OR suite in America is relatively homogenous, says **Lesly Dossett**, MD, MPH,

assistant professor of surgery at the University of Michigan. “We instituted a new recruitment practice, and incorporate best practices from industry to make sure to build diversity,” she reports.

Diversity includes cognitive diversity, bringing new ideas to the OR, as well as demographic diversity, Dossett adds. “A few principles we have instituted, which seem really straightforward, include open-posting every position,” she explains. “We advertise all physician positions in national organizations.”

Employing more minority surgeons and other staff could help build trust with Black and Hispanic patients. Trust is a major impediment to some minority groups accessing surgery like joint replacement. “There is a distrust that the surgery will be helpful for the patient,” Riddle says.

Surgery leaders can address this distrust through data, too. For instance, they could use data to create a decision aid that informs patients where they are in the disease spectrum, how severe their pain is when compared with other people’s pain, and how their pain would change after surgery.

“Patients who are African American should be more confident than they are that they will benefit substantially from the surgery,” Riddle says. “Showing different outcomes and showing improvement in what

they could experience, compared with other people who get knee replacements, would be informative for patients who are considering knee replacement.” ■

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# Social Determinants of Health Affect Surgical Care Disparities

One important contributing factor to ongoing racial disparities in surgical care appears to be social determinants of health, although data are limited.

The World Health Organization defines social determinants of health this way: “The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.”<sup>1</sup>

“Our national surgical databases do not commonly collect information on social determinants of health,” says **Mohamad J. Halawi**, MD, associate professor and chief quality officer for musculoskeletal services at Baylor College of Medicine. “If we are to have a truly significant or meaningful root cause analysis, we need much more comprehensive data. We currently live in a system that looks primarily at organic causes of disparities, and that is a shortcoming based on our research.”

In a recent study on racial differences in pain and function

after knee arthroplasty, investigators’ analysis accounted for social determinants of health, using more of these data than had been used in prior analyses.<sup>2</sup>

“We found that if you account for these different social determinants of health, these are factors that feed into having more severe pain or functional loss prior to surgery,” says **Daniel L. Riddle**, PT, PhD, FAPTA, professor in the departments of physical therapy, orthopedic surgery, and rheumatology at Virginia Commonwealth University in Richmond. “For example, patients who are African American tend to have higher levels of pain catastrophizing, higher levels of depressive symptoms, lower income, and lower education.”

Riddle and colleagues also found African American patients tend to underuse knee arthroplasty, waiting until the condition was more severe before they sought treatment.

“When we accounted for all these factors in our comparisons, the difference became very small and, clinically, probably not relevant,” Riddle says. “When social determinants of health are

accounted for, the differences in not only baseline preoperative pain and function, but also improvements in pain and function over time, are substantially reduced.”

Disparities in surgical and health outcomes go beyond the color of a patient’s skin. Psychological distress can be a social determinant of health, too.

“One of the psychological health constructs is pain catastrophizing. It’s related to having a difficult time coping with pain,” Riddle explains. “Because of social inequities that have been in our society for decades and centuries, psychological distress levels tend to be higher for African Americans.”

When people engage in pain catastrophizing, they tend to ruminate about their pain, thinking about it often. Those who do this tend to experience persistent pain.

“In our study, pain catastrophizing varies, depending on how much pain a person has,” Riddle says. “If you can reduce pain, catastrophizing also will [disappear].”

African American surgery patients tend to experience more pain and for longer periods because they often delay treatment. They also tend to deal with more life stressors.

“If you are under constant stress, live in a stressful neighborhood, have challenges to putting food on the table, and the stress of racism, then it all adds up,” Riddle says.

In addition to measuring and assessing social determinants of health, surgeons can help reduce disparities by adopting a philosophy of patient-centered surgery, Halawi suggests. “You learn about the whole patient and treat them as a whole,”

## EXECUTIVE SUMMARY

Social determinants of health are the conditions in which people are born, grow, work, and age.

- Psychological distress can be a social determinant of health that is not as well understood or easy to measure.
- Before learning more about surgical disparities and their effects on various racial and ethnic groups, researchers will need more data on patients’ social determinants of health.
- Patient-centered surgery that addresses social determinants of health can be used to optimize surgical outcomes.

he says. This includes looking at the patient's individual needs, support system, expectations, and overall health.

"Surgeons need to understand where patients are coming from and what their needs and limitations are," Halawi says. "Do whatever you can to tailor the surgery to the patient and to make sure they're well-informed."

Patient-centered surgery includes patient preparation to optimize outcomes. Take into account these actions:

- Modulate modifiable risk factors (e.g., smoking cessation);

- Optimize any of the patient's medical issues;
- Team with patients and their caregivers so everyone is on the same page;

- Bridge any language or cultural barriers;

- Ensure the patient understands what to expect from the surgery, but also respect the patient's cultural beliefs.

"Many factors, including social, cultural, and economic, likely play a big role in why we have health disparities," Halawi says. "It's only when we have more robust and comprehensive data that we can have

more effective discussion toward the resolution of this problem." ■

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## Healthy Black Children More Likely to Die After Surgery

The authors of a recent study found African American children who are otherwise apparently healthy are 3.43 times more likely to die within 30 days after surgery when compared with white patients.<sup>1</sup>

In a retrospective study, investigators analyzed the National Surgical Quality Improvement Program Pediatric database, identifying children who underwent inpatient operations from 2012 through 2017. They included children who were assigned an American Society of Anesthesiologists (ASA) physical status classification of 1 or 2.

An ASA classification of 1 means the patient does not have any disease. A classification of 2 means the patient has mild, systemic disease that does not interfere with activities of daily living, says **Olubukola O. Nafiu**, MD, FRCA, MS, vice chair for academic affairs in the department of anesthesiology and pain medicine at Nationwide Children's Hospital

in Columbus, OH. Of 172,549 apparently healthy children, the 30-day mortality rate was 0.02%, postoperative complications were 13.9%, and serious adverse events were 5.7%. There were significant differences between African American children's outcomes and those of white children. Among African American children, researchers observed a 18% relative greater odds of developing postoperative complications and a 7% relative greater odds of developing serious adverse events.

"The two key areas of questions we set up in the database provided one answer we were expecting and one answer we didn't expect," Nafiu says. "We expected complications and mortality rates would be low in this relatively healthy group of children, and the overall mortality was low."

But what investigators did not expect was that African American children, who represented about 12%

of the study sample, would be much more likely to die within 30 days of surgery.

"We did not expect that magnitude of difference in outcomes," Nafiu shares. "These were relatively healthy children, and we thought we wouldn't find any difference by race, if the argument was that health drove postoperative mortality."

Even after controlling for as many variables as possible, including surgical severity, investigators still observed a more than three times difference in death after surgery.

But there were limitations. For instance, the data do not indicate where surgery took place. "It's possible that just a few hospitals are contributing to the majority of the numbers, but [the name and location] of hospitals is not included in the database," Nafiu explains.

"We cannot say that mortality rates are coming from this hospital and are drivers of complications.

That's important because previous investigators have shown that hospital volume and quality affect patient outcomes, and African American patients tend to receive care from low-quality-type hospitals."

Nafiu and colleagues also could not access information about patients' socioeconomic status. They did not know ZIP codes or other information that might help them assess patients' access to care and timeliness of care, which are important predictors of surgical outcome.

"There can be two patients present with the same lump in a leg or belly. On one hand, it might take one patient a week or two to

see a primary care provider and get to a surgeon. On the other hand, it might take months to get to a doctor and surgeon," Nafiu explains. "All of those things can affect outcomes, and we don't have access to those data."

Other factors that affect surgical outcomes include a surgeon's volume of patients and how comfortable the surgeon is in caring for children of any particular group. Also, some surgeons have more experience and skill in recognizing complications and dealing with them.

"I would argue that data like these have shown that it's important to consider a patient's race when it comes time to care for them," Nafiu says. "When you are risk-stratifying

patients before any procedure, keep in mind that patients of a specific ethnicity have a higher risk of complications and mortality."

The goal is to be alert to this as a factor so that it might help surgeons improve patient care and raise awareness about possible complications. "We need to continue to search for answers and find underlying causes for these disparities in outcomes," Nafiu adds. ■

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# Organizations Say It Is Time for Clinicians to Speak Out for Change

**A**fter George Floyd died with a police officer's knee on his neck, protests broke out across the world. Most were peaceful demonstrations against racism and for changes to U.S. policing policies.

Many healthcare organizations, including the American Medical Association, the Association of periOperative Registered Nurses (AORN), and others, joined hundreds of businesses in condemning racism and the brutality that led to Floyd's tragic death.

The American College of Surgeons (ACS) issued a call to action on racism as a public health crisis, calling it an ethical imperative, particularly as the COVID-19 pandemic takes a disproportionate toll on the African American community.<sup>1</sup>

"These unprecedented crises call for enlightened and innovative leadership, inspired intervention, and compassionate service from all

members of the ACS," the group wrote on June 9.

The ACS said the organization is committed to creating a more just and inclusive environment for everyone and to ensure the development of a culturally competent and inclusive environment.

AORN's statement calls for everyone to stand together against hatred and discrimination.<sup>2</sup> "It is our belief that those who bear witness, but remain silent, are collaborators. Silence is consent and, in their silence and inaction, collaborators are as guilty as the perpetrators who commit the crime," AORN President **David A. Wyatt**, PhD, RN, NEA-BC, CNOR, said.

The emphasis on addressing racism and health disparities is welcome, but should not be the only action physicians and nurses take, says **Stephen B. Thomas**, PhD, director of the Maryland Center for

Health Equity at the University of Maryland.

"Where were they before that?" Thomas asks. "How do we hold them accountable for what they said? Is it just a statement? Is it window-dressing or accountable? Let's give them credit for stepping up, but it's late in the game. We've been dealing with health disparities and access to surgical care for a long time, not just in this time of COVID-19 and racial reckoning in America."

Clinicians can advocate for and share evidence-based information. One traditional format for speaking publicly is through opinion pieces in medical journals. In July, *The New England Journal of Medicine* published a perspective piece, titled, "Stolen Breaths." The authors, including two physicians, used George Floyd's dying words, "Please, I can't breathe," to highlight the health effects of racism in America, including on Black men

and boys killed by police, the legacies of segregation and environmental racism, and the higher rates of asthma and cancer among black communities.<sup>3</sup>

Physicians also are speaking out on newer platforms, including social media, about the pandemic, racism, gun violence, and other issues. For example, one physician posted on Twitter in July: “Hi, ER Doc here. If you think wearing a piece of cloth makes it ‘hard to breathe,’ then trust me, you do NOT want COVID-19.”<sup>4</sup>

Rob Davidson, MD, who uses the hashtag #WearAMask, frequently tweets about misinformation about COVID-19 and what he personally sees in the hospital emergency room.<sup>5</sup>

Another physician, Leana Wen, MD, tweeted in: “All 62 residents in a single nursing home in Kansas have tested positive for #covid19. 10 have died. This is so tragic & yet another reminder that ‘herd immunity’ does not work. You can’t wall off the vulnerable from an extremely contagious disease.”<sup>6</sup>

Before the pandemic, medical professionals used Twitter, Facebook, Instagram, and other social media platforms to advocate for solutions to gun violence. They formed @ThisIsOurLane on Twitter.<sup>7</sup> Healthcare workers also have joined protests in support of Black Lives Matter and to demonstrate against police violence.<sup>8</sup>

Disparities go beyond racist policing and gun violence tragedies. Poverty and limited access are huge contributors to inequities. Surgeons are witnesses to this, although they might not recognize how inequities and access issues have contributed to disparate outcomes.

For instance, Thomas worked with surgeons and cardiologists who showed him a list of patients

diagnosed with a heart problem who needed valves replaced. Before that procedure, patients needed to receive clearance from a dentist to confirm there are no active cavities or gum infections. Such confirmation reduces the chances of postoperative infections.

Patients on the list had not secured dental clearance, which led to delays for some as long as one year. In the interim, certain patients would present to the emergency room for heart-related conditions. The problem was they did not have the money to pay for dental work that was necessary before they could receive the clearance.

“Many people are not able to have surgical procedures because they don’t have dental insurance,” Thomas notes. “Surgeons can speak up about that, about how it’s important for patients to access dental care, and how it’s necessary for their surgical procedure.”

This is a problem that disproportionately affects low-income people and Blacks, Hispanics, Native Americans, and Alaska natives.<sup>9</sup>

One solution to the dental access problem is the Mission of Mercy emergency dental clinics that provide weekend-long free dental care on a first-come, first-served basis. A study of one Mission of Mercy clinic in Maryland showed how 66% of those who received free dental services lived with one or more chronic conditions or risk factors. The clinic provided dental services to more than 1,000 people, of whom 49% were Black and 23% were Hispanic.<sup>10</sup>

“Physicians know that you cannot do some surgeries without dental clearance, but they say that’s somebody else’s job. I have a problem with that,” Thomas says. “They have to speak up. If COVID-19 does anything, it’s exposed the broken

parts of our infrastructure.”<sup>11</sup> Thomas calls on white surgeons “to use their privilege and rank” to help advance fairness. “That’s what health equity is all about. We’re not asking them to end poverty in America, but to do what they can where they are,” he adds. ■

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# Decision Aids Can Help with Surgery Utilization

Surgeons can use educationally based decision aids to improve rates of knee arthroplasty utilization among African Americans, according to the authors of a recent study.<sup>1</sup>

The decision aids should include information about pre- and postoperative pain and performance outcomes, showing that these outcomes are not likely to be different for African Americans vs. non-African Americans.

“It would be an algorithm, a flow chart, where the patient provides various types of information about what their problems are, how much pain they have, and other aspects of life

affected by knee issues,” says **Daniel L. Riddle**, PT, PhD, FAPTA, professor in the departments of physical therapy, orthopedic surgery, and rheumatology, Virginia Commonwealth University in Richmond.

The decision aid could include social determinants of health, as well as the typical questions about the usual conditions, such as:

- comorbidities;
- psychological distress;
- joints affected by arthritis;
- patient’s activities of daily living affected by pain;
- patient’s independence level;
- patient’s functional deficits.

“It’s still in the formative stages of development for researchers, who are chasing the best ways of getting these decision aids,” Riddle says. “This is something we’ll see in the next few years.” ■

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# Operating Room Noise May Be Louder Than It Seems

Surgeons, nurses, and other OR staff work in one of the noisiest clinical areas, and the volume could affect patient safety and employees’ health, according to recent research.<sup>1</sup>

“The research started with a clinical concern I had experienced in the OR about noise because of patient safety,” says **Glendyle Levinskis**, BSN, RN, CNOR, staff nurse in the OR at Vanderbilt University Medical Center. “The

literature showed that noise impacts patients and staff performance. I had a concern about noise impacting the performance of providers, and thought this was a clinical concern that needed to be addressed.”

Levinskis worked on a study protocol, received approval from an institutional review board (IRB), and then conducted a noise assessment in an OR to obtain baseline levels. The assessment revealed many

sources of noise production: ventilation-producing noise, music, conversations among OR staff, and sounds from procedures.

ORs feature louder air exchange than any other room in a hospital. That, on top of sounds from instruments, suction, and people moving around, opening and closing doors. “It’s a symphony of noise, and it impacts us as we care for our patients,” Levinskis observes.

Nurses, surgeons, anesthesia providers, and others in the OR have to talk with each other to complete the work, and there are a lot of people in the OR, says **Elizabeth Card**, MSN, APRN, FNP, nursing research consultant at Vanderbilt University Medical Center.

Researchers consulted with a research engineer about how to cut the sound. She used an iPhone with a sound measurement app and meter to measure the noise. “It was a pretty

## EXECUTIVE SUMMARY

Surgical noise can affect OR staff’s performance and patient safety.

- The authors of a research project found the average noise level in one OR was 68 decibels, with a maximum average noise level of 87 decibels, which is about as loud as a hairdryer.
- The peak noise level was comparable to the sound of a bulldozer.
- Programs to reduce OR noise would focus on reducing decibel levels during the critical times of intubation, extubation, surgical count, and whenever there is an emergency event.

scientific measuring device that measures only decibels,” Card shares.

“There was an external microphone on the iPhone, and we brought it into the OR, with the speech and hearing department, and compared the sound level app with other sound meters. It was comparable in results,” Levinskas adds.

They measured the noise level at some critical times in surgery, including when there is an instrument count and when there is anesthesia extubation. They measured the levels during multiple surgical specialties.

The average noise level of the OR was 68 decibels, and the average maximum noise level was 87 decibels, which is close to the sound of a hairdryer. The peak noise level, which is a spike of noise, was 106 decibels, comparable to the sound of a bulldozer.

“We tested noise levels at different times and on different days, and we did measurements for almost a month [March to April 2018],” Levinskas says. “After the results and assessment, we organized a noise reduction task force. We had discussions and did a review of the literature to see what are the ways to decrease operating room noise.”

They reviewed information from the Association of periOperative Registered Nurses (AORN), the American College of Surgeons,

and other organizations. “Then, we did another surveillance of multidisciplinary members of what is the expected way to decrease noise, and we had input from staff on focusing on strategies,” Levinskas says. “We synthesized the results and discussed the things we wanted to include in noise reduction in the OR.”

The focus became reducing noise during the critical times of intubation, extubation, surgical count, and whenever there is an emergency event.

Addressing OR noise can be controversial when the subject is raised, especially when it comes to music. “People would ask if we were going to take out the music in the OR,” Levinskas says.

Sensitive to the controversy, investigators met with surgeons and the multidisciplinary task force to brainstorm ways to reduce noise during critical times in the OR. A popular idea was quiet time at critical moments during a procedure, including cutting off all music. The surgeons talked about their music, acknowledging these sounds can positively affect their performance. But they also agreed to turn off the music at critical times.

Other noises that can be reduced include the sounds from people entering and exiting the OR. For example, people who enter the OR

to bring in supplies often carry walkie-talkies. When these are left on full volume, there might be a call for them while they are in the OR. This can disrupt communication and raise the noise level during critical junctures. The task force suggested people turn down their walkie talkie volume control when they enter the OR.

Another noise-producer is the handling of metal instruments. “Part of the [solution] is to educate staff to handle those instruments quietly,” Levinskas offers.

The goal is for staff to handle certain noisy activities quietly without allowing these volume changes to interrupt their workflow. “Also, we can have conversations in the operating room, but in critical times, there should be no conversations that are not related to patient care,” Levinskas says.

For surgery centers that are renovating their ORs or are building a new facility, they should consider purchasing equipment that produces less noise. Levinskas talked with engineers about ventilation changes that could reduce the sound volume. Another potential change involves finding vent covers that are less noisy, Card notes. Still another solution is finding computers and other electronic devices that produce less noise. Administrators could install a visual meter that lets staff

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know how high the sound decibel level is in the OR. This innovation could be placed somewhere on the wall, using color-coded cues to show when noise levels are too high during critical times.

The OR team could use select code words when a critical point in the procedure is beginning, indicating to everyone that they need to lower the volume. When they hear the code words or phrase, staff can turn off the music and stop casual conversations. “We came up with the phrase, ‘sound check,’” Levinskas

says. Her group voted on the phrase “sound check,” in reference to Vanderbilt’s home of Nashville, TN — “Music City USA.”

“That’s why that particular phrase was so well received,” Card says. “It’s a fun thing, rather than a command.”

Empowering staff to help make these choices is important. “The heart of our noise reduction program is for everyone to be quiet, engaged, and focused,” Levinskas says. “I like to empower nurses. We might feel like we’re ordinary nurses, but we

can make a big difference and change for patients’ safety.” ■

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# HHS Releases Latest Iteration of Antibiotic Resistance Action Plan

The U.S. Department of Health and Human Services (HHS), in conjunction with several other federal agencies, has published the *National Action Plan for Combating Antibiotic-Resistant Bacteria 2020-2025*,<sup>1</sup> which builds on the first national plan from 2015.

The five-point strategy remains the same, but the tactics have improved to help execute the goals. For example, the new plan includes details about stronger and more evidence-based activities that have reduced antibiotic resistance, such as optimizing the use of antibiotics in human and animal health settings, that public health officials can lean on to drive progress.

“This plan continues to prioritize infection prevention and control to slow the spread of resistant infections and reduce the need for antibiotic use. To ensure that patients receive the right antibiotic care, the plan supports innovative approaches to developing and deploying diagnostic tests and treatment strategies,” the plan authors wrote. “A One Health approach, which recognizes the

relationships between the health of humans, animals, plants, and the environment, is integrated throughout the plan, with an expanded effort to understand antibiotic resistance in the environment. The plan also focuses on collecting and using data to better understand where resistance is occurring, support the development of new diagnostics and treatment options, and advance international coordination.”

This is a plan to guide U.S. government activity on the subject, but public health officials and healthcare providers can use the guidance to steer their own initiatives. That notion is reflected in a progress report from the United States Task Force for Combating Antibiotic-Resistant Bacteria, published in October 2017, about steps forward since the 2015 plan was published.

For instance, the progress report indicated the percentage of all U.S. hospitals administering antibiotic stewardship programs that meet all of CDC’s Core Elements rose

to 46% in 2015 and to 64% in 2016. The Infectious Diseases Society of America (IDSA) issued a statement of general praise for the next-generation action plan, calling it “an important, sustained federal commitment to addressing the crisis of antibiotic resistance, which threatens modern medical advances and complicates our responses to public health emergencies, including the COVID-19 pandemic.”<sup>2</sup>

IDSA underlined the new plan’s support for additional investigators to bolster research capacity. “[This] reflects a crucial understanding that a highly skilled workforce is necessary to effectively combat antibiotic resistance,” the group wrote.

The plan’s authoring committee admitted there are ongoing challenges, including proper resource allocation, obstacles to gathering and sharing data, and uncertainty about industry and research partner participation. The IDSA concurred, arguing failure or success will boil down to funding.

“While the objectives and activities described in the plan all represent

important steps, they are unlikely on their own to meet current and future patient needs for new antibiotic development,” the IDSA wrote. “A new financing mechanism that provides a meaningful, predictable return on investment for the most critically needed antibiotics and that

is delinked from the sales and use of those antibiotics is essential.” ■

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# SDS Manager

## Hospitals Without Walls

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

In April, CMS unveiled “Hospitals Without Walls,” a COVID-19 pandemic-specific policy likely to affect both hospitals and surgery centers. It provides a path for a Medicare-approved ASC to change its status to a hospital, thus allowing just about any Medicare-approved procedure permitted in a hospital to be performed in a surgery center — and at hospital reimbursement rates.

So far, it appears this program will be available only for the duration of the COVID-19 pandemic. However, there is talk of extending the initiative. Additional CMS background is available at this link: <https://go.cms.gov/3kgRGtF>. Also, National Medical Billing Services produced a webinar about the program, which is available here: <https://bit.ly/34dRZja>.

We are in the process of converting several ASCs under the tenets of Hospitals Without Walls. In August, CMS released an exhaustive update regarding regulatory flexibilities, including about the Hospitals Without Walls program. That update is available here: <https://go.cms.gov/3jldiPL>.

Speaking of regulations, I often receive questions about unique and tricky legal subjects, including:

- out-of-network reimbursement;
- “under arrangement” deals with hospital outpatient surgery departments and physician ownership;
- paid medical directorships in an ASC for each specialty;
- profits to an ASC or the physicians for pathology and anesthesia arrangements;
- selling shares to new surgeons in an ASC at lower amounts;
- not following medical staff bylaws or the Health Care Quality Improvement Act.

These are difficult-to-understand subjects, but they are valid. It is important to understand the implications for facilities and staff. Work with governing boards and attorneys to conduct a legal review of all your practices.

It is not a coincidence the federal government has dramatically increased funds allocated to

healthcare fraud enforcement. On a related note, as a Medicare surveyor myself, I have noticed a huge increase in Life Safety Code violations when selling or buying a surgery center.

It used to be that if an ASC was currently licensed and accredited at the time of sale, the center usually did not have to be up to date on new ASC codes. This appears to be changing. If buying or selling, clarify the policy with governmental bodies and accreditation agencies. ■

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# SAME-DAY SURGERY

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## CME/CE QUESTIONS

- 1. Surgical disparities continue to be a public health challenge for patients undergoing total knee arthroplasty, especially for:**
  - a. Asians and Pacific Islanders.
  - b. LGBTQ patients.
  - c. African Americans and Hispanics.
  - d. Native Americans and the disabled.
- 2. When researchers analyzed a large database of children undergoing surgery and their 30-day post-surgery outcomes, they were surprised that mortality and morbidity rates were much higher for African American children because the children studied:**
  - a. all were from a middle-class or upper middle-class background.
  - b. all were apparently healthy.
  - c. all were from the Northeastern United States.
  - d. all were on Medicaid.
- 3. For physicians to learn more about the causes of healthcare and surgical disparities, they need to look at organic causes, including:**
  - a. patient demographics.
  - b. hospital sizes and locations.
  - c. social determinants of health.
  - d. surgeon's years of practice and number of patients.
- 4. Which is a good technique to reduce the noise level in an OR to improve patient safety?**
  - a. Stop music and casual conversations during critical times of surgery.
  - b. Eliminate smartphones in the OR.
  - c. Keep non-OR staff out of the OR during a procedure.
  - d. Put carpeting in the OR.

## 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.