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Proposed APC regulation 'final nail in coffin' for hospital outpatient surgery

Proposed hospital/ASC reimbursement changes delayed until mid-2000

The proposed prospective payment system (PPS) for hospital outpatient services, published in the Sept. 8 *Federal Register*, spells death for hospital-based outpatient surgery services, some industry experts say. Hospital outpatient surgery managers already must contend with insurance companies, physician practice management companies, and corporate surgery center chains that are driving their business into surgery centers. And now, the proposed reimbursement system for hospital outpatient services, called ambulatory payment classifications (APCs), will lower their payments even further, experts predict.

For hospitals, the issue is margin, says **Stephen W. Earnhart**, MS, president and CEO of Earnhart and Associates in Dallas. "You may get more money than surgery centers, but your reimbursement will come way down," he warns.

Managers of hospital outpatient surgery departments have difficulty identifying, controlling, and decreasing costs, he maintains. "You have high labor costs, poor supply cost management, and fixed overhead too

EXECUTIVE SUMMARY

On Sept. 8, the Health Care Financing Administration (HCFA) in Baltimore published its proposed reimbursement system for hospital outpatient services, based on ambulatory payment classifications (APCs). Experts predict the system will devastate the hospital industry, including surgery.

- Hospital outpatient surgery managers face decreased margins under the proposed system, according to same-day surgery experts.
- In other news, HCFA announced it will delay implementation of the proposed ambulatory surgery center (ASC) reimbursement changes until at least mid-2000. The ASC and hospital APC changes will be implemented concurrently.
- HCFA has extended the deadline for comments on the ASC proposal until Nov. 9, which also is the deadline for comments on the hospital proposal.

high for reimbursement on these procedures. APCs are the final nail in the coffin for outpatient surgery being performed in hospitals today."

Surgery center experts are analyzing the hospital regulation, but, ironically, some express preliminary concerns that the differences in payment between hospitals and surgery centers may be too great.

"I think there are instances in which the higher payment to the hospital would not appear to reflect the actual differential in costs associated with performing the procedure in a hospital vs. the ASC," says **Michael Romansky**, JD, partner in the health law practice at McDermott, Will, and Emery in Washington, DC.

ASC changes officially delayed

In other news, the Health Care Financing Administration (HCFA) announced Oct. 1 that it will suspend publication of the final ASC reimbursement rule until after year 2000 computer problems are resolved. Previously, HCFA had announced a delay of the hospital outpatient reimbursement changes until those problems are resolved.

This announcement means the proposed rule for ASCs will be adopted concurrent with the publication of the new prospective payment system for hospital outpatient services, Romansky says. "As such, current facility rates based on the eight procedure groupings will remain in effect until mid-2000 at earliest," he explains.

He hails the delay of the ASC reimbursement changes as a "phenomenal victory for the ASC community."

"HCFA had developed a proposed rule which had many methodological flaws, resulting in very significant and unwarranted cutbacks in virtually all high-volume procedures performed in ASCs," he says. **(For more on reaction to the proposed ASC reimbursement system, see *Same-Day Surgery*, August 1998, p. 101.)**

The comment period for the proposed ASC reimbursement system has been extended again

To Mail Comments

The Health Care Financing Administration will consider comments received at the appropriate address provided here, no later than 5 p.m. on Nov. 9, 1998. In commenting, please refer to file code HCFA-1005-P. Mail written comments (one original and three copies) to this address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-1005-P, P.O. Box 26688, Baltimore, MD 21207-0488.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses: Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave. SW, Washington, DC 20201; Room C5-09-26, 7500 Security Blvd., Baltimore, MD 21244-1850.

To Order Copies

For copies of the Sept. 8 *Federal Register* containing the proposed hospital outpatient prospective payment system, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date of the issue requested and enclose a check or money order payable to the superintendent of documents, or enclose your Visa or Mastercard number and expiration date. Credit card orders also may be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is $8.

As an alternative, you can view and photocopy the *Federal Register* document at most libraries designated as federal depository libraries and at many other public and academic libraries across the country that receive the *Federal Register*. This document also is available from the Federal Register on-line database through GPO Access, a service of the U.S. Government Printing Office. The superintendent of documents home page address is http://www.access.gpo.gov/nara/index.html. ■

COMING IN FUTURE MONTHS

- Determining costs of your outpatient surgery procedures
- How to avoid patients waking up during surgery
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- 10 easy ideas guaranteed to boost patient satisfaction
- Benchmarking with other same-day surgery programs

to Nov. 9 so it is concurrent with the deadline for submission of comments on hospital outpatient rule. **(For information on how to access the *Federal Register* notice and how submit comments, see box, p. 138.)**

Concerns about the proposed hospital notice extend beyond specific reimbursements for surgical procedures. In fact, the notice is predicted to have a significant harmful effect on the hospital industry as a whole.

The proposed regulation provides for a new method of calculating beneficiary copayments so beneficiaries eventually pay 20% of total payments rather than 20% of charges. HCFA representatives have stated they believe behavior will change and volume will increase under the new payment system to offset losses in revenue, says **Linda Magno**, interim vice president for policy at the American Hospital Association in Washington, DC. "But hospitals don't generate volume," she says. "It's the division that orders services."

HCFA revealed it will lose $570 million in reduced beneficiary coinsurance, and it's passing on that loss to hospitals. The system was supposed to be budget neutral, Magno stresses. "As a result, the system, rather than being budget neutral, which we believe Congress intended it to be, takes 3.8% of outpatient revenue out of the system. It essentially takes it out of our pockets, because it reduces the total payments to hospitals."

HCFA caps volume expenditures

The negative impact doesn't end there: HCFA also is placing a cap on volume expenditure. HCFA is required to develop a method for controlling unnecessary increases in the volume of covered outpatient services and can adjust the conversion factor to do so. HCFA's proposed regulation states, "The volume of services is a significant concern, particularly during the first few years of the outpatient PPS, because of the possible incentives under PPS to increase utilization."

"Our concern is that the business of projecting future volume in the outpatient business is messy, not precise," Magno says. "We're not sure HCFA can accurately distinguish appropriate increases in volume from inappropriate increases in volume and [distinguish] generating additional services from providing unnecessary services."

The outpatient area, in particular, is unpredictable in terms of what future levels of outpatient services should be, she says. "On any given day, a new therapy or new drug allows patients currently treated in inpatient settings to be treated in outpatient settings. You may create tremendous growth in outpatient areas. It's appropriate and desirable. You shouldn't penalize hospitals for changing delivery to respond to those new therapies and new drugs, because you can't predict them."

Projections are projections, she emphasizes. "They're only as good as what you know at any given time. If we do the right thing by our patients, we get penalized in future because the outpatient volume is higher than HCFA predicted it would be."

And now, the good news

Is there any good news? At this point, Magno isn't sure. Others see a couple of silver linings to the cloud:

- HCFA withdrew its proposal requiring hospitals to bill for all diagnostic tests ordered for outpatients, including those furnished outside the hospital.
- HCFA revised its proposal requiring hospitals to bundle diagnostic tests with surgery or medical visits. The rule only requires hospitals to bundle related costs, such as those that result from the use of an operating room, recovery room, drugs, and blood.

"MedPAC has stated that, at least at the outset, the unit of payment should be narrowly defined," explains **James Mathews**, PhD, policy analyst at the Medicare Payment Advisory Commission (MedPAC) in Washington, DC, which advises Congress on Medicare payment issues. "If there are any add-ons, any diagnostic services provided in connection with the surgical procedure or medical visit, we'd like to have those paid separately under PPS but with a distinct line-item payment. HCFA seems to have concurred."

Keep in mind that services such as EKGs, which will be paid separately from surgical APCs, still must meet medical necessity criteria, warns **Lois Yoder**, ART, CCS, president of The enVision Group, a resource management and consulting firm for hospital-based services in Naples, FL. Yoder has worked with APGs since states began implementing them for Medicaid.

"And that means if there isn't a clinically relevant diagnosis to justify the EKG, it still may not get paid," she warns. **(For more information on documentation issues and other areas that need preparation, see story, p. 140.)** ■

SOURCES

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Health Care Financing Administration. Contact: **Janet Wellham** for general information, (410) 786-4510; **Kitty Ahern** for details on the classification of services into ambulatory payment classification (APC) groups, (410) 786-4515; **Suzanne Letsch** for information on volume control measures and updates, (410) 786-4558; **George Morey** for details on the determination of provider-based status, (410) 786-4653; or **Janet Samen** for details on the application of APCs to community mental health centers, (410) 786-9161.

APC Codes Include These Items

- ❑ Operating room
- ❑ Recovery room
- ❑ Anesthesia
- ❑ Medical and surgical supplies
- ❑ Pharmaceuticals
- ❑ Observation services
- ❑ Blood
- ❑ Intraocular lenses
- ❑ Casts and splints
- ❑ Donor tissue
- ❑ Incidental services such as venipuncture

Source: Health Care Financing Administration, Baltimore.

HCFA lists proposal for surgical APCs

By **Rita A. Scichilone**, MHSA, RRA, CCS, CCS-P
Professional Management Midwest
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According to the proposed hospital outpatient prospective payment system published in the Sept. 8 *Federal Register*, it is Medicare's intent to use the same surgical groups in the payment systems for hospitals performing outpatient surgery and freestanding ambulatory surgical centers (ASCs). It does not intend to reclassify procedures from one group to another routinely but will restrict changes to additions, deletions, and revisions in the coding systems.

Any changes to ambulatory patient classifications (APCs) will maintain budget neutrality. Under the proposed rules for ASC prospective payment, published in the June 12, 1998, *Federal Register*, cataract surgery code 66984 is grouped to APC 668 with a proposed rate of $863 (down from the current rate of $928). For the hospital, code 66984 is grouped to APC 668 also, with a projected payment rate of $976.91. In both settings, intraocular lens reimbursement is included in the payment for the surgery.

A cystoscopy with biopsy code 52007 groups to APC 522 in both settings. Performed in an ASC, the allowance is $393 (down from $422), while the hospital performing this procedure would receive $530. Payment amounts are based on proposed rates only.

Multiple surgery reduction

When more than one procedure is performed during a single session, Medicare would pay the full amount for the first procedure, then reduce the second and subsequent procedures by 50%.

As expected, the hospital modifiers are used to communicate discontinued or terminated procedures that are not carried out as planned. Modifier -53, which is assigned when the patient has undergone anesthesia and the procedure is under way when it is terminated, allows 100% of the payment for the APC. Modifier -52 is used for those patients who are prepared for surgery and have been sedated, but not to the point of anesthesia induction. For these patients, 50% of the APC payment will be made. ■

What it takes to succeed in the new millennium

Conference targets disposables, redesign

The two pairs of laparoscopic scissors have the same steel blades, but the "disposable" one has plastic handles, and the "reusable" one has steel handles. If you could sterilize the disposable scissors for half the price of buying a new pair, would you do it? Is it safe and ethical?

Those questions lie at the heart of the controversy over reprocessing disposable items. To ensure their programs' survival well into the next century, same-day surgery managers want to save money while maintaining the safety and quality of patient care. Some vendors, meanwhile, cry foul over the practice. That issue will be among those debated at an upcoming conference, *Balancing Cost and Quality: The Secrets of Successful Ambulatory Surgery Programs.* Sponsored by *Same-Day Surgery* newsletter, the conference will be held March 14-16 in Atlanta. **(For more on the conference, see source box, p. 142.)**

"Out of reimbursement and cost issues, a new industry has been formed that is possibly cutting into the profits of some of the bigger [medical supply] companies," says **Vern Feltner**, president of Alliance Medical Corp., a reprocessing firm with offices in Asheville, NC.

In this cost-conscious era, bucking the status quo can be the key to survival. The *SDS* conference will prepare you for the next millennium as managers share their paths to greater efficiency.

You may think there's no way to squeeze more money out of your costs. But conference speakers such as Feltner may make you think again. Reprocessing a single-use item costs about half as much as purchasing a new replacement, he says. For example, a surgical saw blade may cost $40 new; a reprocessor would charge $20 to sterilize, sharpen, refurbish, and inspect a used one.

"Every device is 100% inspected for cleaning, functionality, and sterility," he says. "It's guaranteed, and the facilities are indemnified against liability," Feltner says. "Each facility gets its own instruments back."

The reprocessing industry is regulated by the U.S. Food and Drug Administration. "There has never been a patient injury. There has never been a lawsuit [related to reprocessing disposables]," he says. "It's not surprising that's true, because we're not talking about reprocessing pacemakers. We're talking about reprocessing very simple instruments that have been reprocessed for years."

In fact, Feltner asserts that disposables were created by the generous cost-plus reimbursement of the '50s and '60s, in which hospitals fared better with new supplies than by attempting to recoup reprocessing costs. "Many of these products they were buying that were labeled single-use were the very same products that they were buying as reusable," he says.

EXECUTIVE SUMMARY

Finding new ways to improve efficiency and patient care will ensure your survival in the next century, according to same-day surgery experts who are scheduled to speak at the March 1999 *Same-Day Surgery* conference in Atlanta.

- Some disposable devices are essentially the same as the reusable version and can be safely reprocessed, says **Vern Feltner**, president of Alliance Medical Corp. in Asheville, NC.
- New anesthetic agents enable some patients to move through recovery more quickly, which can add time to your OR schedule, says **Jan Odom**, MS, RN, CPAN, FAAN, clinical nurse specialist at Forrest General Hospital in Hattiesburg, MS.
- Same-day surgery managers need to identify equipment and software that may be affected by year 2000 problems and contact vendors to ensure they will continue to function properly, says **Jim Keller**, MS, director of the health devices group at ECRI, a technology assessment firm in Plymouth Meeting, PA.

Getting a handle on Y2K concerns

Jim Keller, MS, director of the health devices group at ECRI technology assessment firm in Plymouth Meeting, PA, will demystify the year 2000 (Y2K) bug. SDS managers can avoid unnecessary costs as they review equipment for Y2K problems, Keller says. "A lot of hospitals will use the Y2K problem as an excuse to buy a new piece of equipment when it's not really that much of a problem. There are going to be some legitimate times when a device needs to be replaced or upgraded. But there will be other times when there's an easy work-around."

You may think the Y2K bug won't bite you. But anything that has a computer chip and a date could be affected when the millennium arrives. That means everything from scheduling and

SOURCE

For more on *Balancing Cost and Quality: The Secrets of Successful Ambulatory Surgery Programs*, to be held March 14-16 in Atlanta, contact:

American Health Consultants, Customer Service, P.O. Box 740056, Atlanta, GA 30374. Phone: (800) 688-2421. Fax: (800) 284-3291. E-mail: custserv@ahcpub.com.

billing software to devices such as pulse oximeters, infusion pumps, and imaging equipment. Same-day surgery managers need to identify equipment that uses a date and verify, through vendors, that the product is not susceptible to the Y2K problem, he says.

In some cases, a monitoring device such as an ECG recorder may print the wrong date, recognizing "00" as 1900. A nurse could scratch out the incorrect date and initial the change. In other cases, equipment may use the incorrect date to calculate a patient's age and come up with a negative number; that could cause the program to lock up.

"You can't ignore it," Keller says of the Y2K problem. He acknowledges that the biggest barrier for same-day surgery managers may be finding time to contact vendors for each of their items. But if you ignore this veritable time bomb, your other efforts to create efficiencies will be for naught.

'Fast-track' patients move past phase 1

Other cost-saving ideas may not be as dramatic as the reuse issue. But by examining your processes, you may improve patient care, satisfaction, and efficiency. At Forrest General Hospital in Hattiesburg, MS, clinical nurse specialist **Jan Odom**, MS, RN, CPAN, FAAN, has "fast-tracked" some patients through recovery, allowing them to bypass phase one. The use of shorter-acting anesthetic agents, conscious sedation with local anesthesia, and less-invasive surgical techniques enables patients to spend less time in recovery.

But simple changes also can have an impact, Odom says. For example, making sure prescriptions and physician orders are available at the time of discharge enables patients to leave when ready. Pre-op education can prepare patients for the recovery room. "You're trying to make your processes more cost-efficient," she says.

By moving patients more efficiently through your center, you may free time in your OR schedule and increase your caseload, she says. ■

Guidelines address staffing in phase III

Justify your post-op numbers

Same-day surgery managers now have guidelines available to establish nurse/patient ratios in the phase III setting. **(See copy of the guidelines, enclosed in this issue of *Same-Day Surgery*.)**

The guidelines, which were developed by the American Society of PeriAnesthesia Nurses (ASPAN) in Thorofare, NJ, have been added to guidelines for the phase I and II areas and can be used to justify the presence of staffing in postoperative areas. **(For more on staffing in phases I and II, see *SDS*, November 1997, p. 146. For AORN staffing formula for the OR, see *SDS*, October 1997, p. 129.)**

Phase III is for extended observation

The phase III standards were written for patients who have completed phase I and phase II recovery but might need extended observation, says **Ellen Sullivan**, BSN, RN, CPAN, director of clinical practice for ASPAN and nurse in charge of the postanesthesia care unit at Brigham and Women's Hospital in Boston.

"Or it's for persons who develop entrepreneurial ideas and open a bed and breakfast or a freestanding [postsurgical recovery care] unit that might keep patients until the next day who really have recovered but need observation or pain management before they go home," says Sullivan.

EXECUTIVE SUMMARY

The American Society of PeriAnesthesia Nurses in Thorofare, NJ, has developed staffing guidelines for phase III recovery settings. These guidelines, along with the guidelines for phases I and II, can be used to justify staffing in postoperative areas.

- Phase III is for patients who might need extended observation, might be waiting for transportation home, or have no caregiver.
- Consider patient acuity and nursing intensity when staffing for phase III.
- There should be one competent RN for at least every five patients in phase III, the guidelines say.

The guidelines also say phase III staffing guidelines apply to patients waiting for transportation home and those who have no caregiver.

According to ASPAN, staffing in phase III is dictated by patient acuity. This advice is echoed by **Dorothy Fogg**, RN, BSN, MA, perioperative nursing specialist at the Center for Nursing Practice, Health Policy, and Research at the Denver-based Association of Operating Room Nurses.

"If I have some patients with comorbidities, such as a diabetic coming in for cataract, I'd consider that," Fogg explains. "I'd make sure I have a nurse to devote extra time to that patient."

As a guideline, ASPAN says there should be one competent RN for at least every five patients. These guidelines, along with the guidelines for phases I and II, can be used to justify staffing in postoperative areas. ■

SOURCES

For more on nurse/patient ratios in post-op areas, contact:

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A copy of *Standards of PeriAnesthesia Nursing Practice 1998* is available from:

American Society of PeriAnesthesia Nurses, 6900 Grove Road, Thorofare, NJ 08086. Phone: (609) 845-5557. Fax: (609) 848-1881. E-mail: aspan@slackinc.com. The cost is $30 for members and $50 for non-members; add $5 for shipping and handling.

Same-Day Surgery Manager

The bottom line: Problems with surgeons

By **Stephen W. Earnhart**, MS
President and CEO
Earnhart and Associates, Dallas

One beauty of penning this column every month is the great e-mail, phone calls, and faxes I receive. I am averaging about 75 per month. Most are supportive. I get a lot of comments like this from readers: "You validated to my bosses what I have been telling them for years."

I get great jokes! I appreciate them all — please keep them coming. But even better than the jokes and thanks are the questions and the give-and-take discussions on the issues. I thought I'd share some of the more recent ones with you. The questions and responses have been altered slightly to protect the writers' identities.

Question: "We suspect one of our ophthalmologists is involved with an IOL [intraocular lens] rep. I don't know if there is any connection between their relationship and the price of the lens the surgery center is paying. We are up to almost $200 for this lens! He does just enough cases at the center for us to want to keep his business.

"We have tried repeatedly to get a better price on the lens from the rep. She keeps saying that this is what the doctor wants, and this is the price. We have met with the surgeon and explained that we just cannot afford this lens price — especially when the lens the other ophthalmologists use is less than half the price of this "special lens" he uses. We have asked him to let us negotiate a better price with the rep and to support us. Nothing works. Any ideas?"

Response: It sounds as if you have done everything possible. I suggest the following, if you can get support from your ASC board: Explain to the physician that he can use any lens he wishes; however, the ASC will only pay up to $75 per IOL. Any additional price must be paid by the surgeon.

Bottom line: I had to follow up on this issue with the administrator. It seems the board did support the decision and granted her the authority. She told the surgeon, and apparently there was a big stink for a couple of days. The surgeon switched to a less-expensive lens (the same one the other physicians in the center were using) and, after several weeks, he stopped complaining.

Question: "Our facility is owned by several surgeons. They are constantly complaining that our costs are too high, that we pay too much for

supplies, and that the nurses are way overpaid. We don't think that is the case, but we have no way of comparing our prices to others. What can we do to shut these guys up?"

Response: Not much, unless you can prove your indicators are appropriate and in line with the rest of your peers. Benchmarking your top 10 procedures will go a long way to show where you are.

Bottom line: The center did gather cost information about its procedures, and we compared them to a database of like cases at other physician-owned, for-profit centers. The result was that the center was well below the average supply cost per case and right in line with personnel costs. They shared this information with their surgeons, who stopped complaining about the costs.

(Editor's note: Earnhart can be reached at Earnhart and Associates, 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: surgery@onramp.net. World Wide Web: http://www.earnhart.com.) ■

Fake surgeon caught — others let him slip by

Primary verification was the key

"Doctor" Dennis Edward Roark practiced medicine for more than a decade, never running afoul of the credentialing process at the many institutions where he worked — despite the fact that he was not a doctor. But then he applied for privileges at Ingham Regional Medical Center in Lansing, MI. That's where he found out that a good credentialing program can be quite a hurdle for a fake doctor.

Roark, 39, a resident of Sterling Heights, MI, pleaded guilty July 15 in Ingham County Circuit Court to a felony charge of using false documents to obtain a medical license. He faces up to 14 years in prison. He also faces possible federal charges for Medicare and Medicaid fraud, related to claims he filed while pretending to be a doctor, plus state charges of insurance fraud.

Roark claimed on state licensing applications and his curriculum vitae that he was a 1986 graduate of Rush University Medical School in Chicago, but the school says he never attended. Prosecutors also say Roark used forged documents, including medical board test scores, to gain admission to four residency programs in Michigan, Ohio, and a Canadian province. Hospitals where he worked report that Roark participated in more than 300 operations, including heart transplants and amputations, though his exact involvement in those procedures remains unclear, prosecutors say.

In addition to the criminal penalties he faces, a disciplinary subcommittee of the Michigan Board of Medicine has fined Roark $100,000 for using phony documents to obtain a medical license. Roark has told the court he has no funds to pay the fine, but failing to pay within 30 days could mean additional prison time. The *Detroit Free Press* reports that at least two lawsuits have been filed against Roark by former patients, and state officials are investigating cases in which Roark's care may have led to injuries or the death of patients.

Roark was just another doctor applying for privileges. Then a few phone calls started setting off alarm bells that ultimately would send him to prison.

His medical license was suspended April 2, when the apparent deception was discovered, but by then, Roark had posed as a heart and lung surgeon for four years and held other physician positions for another 16 years. He had worked in the urgent care center at Madison Heights Community Hospital from 1994 until early 1998. He also participated in a one-year training program at St. Joseph Mercy-Oakland Hospital in Pontiac, MI.

At Madison Heights Community Hospital, chief operating officer **Tim Dengel** says the facility acted appropriately in credentialing Roark. The state verified that Roark had a valid medical license, he says, and there was no reason to suspect that any of Roark's credentials were invalid.

It is difficult to determine exactly what Roark's experience was, even though it is now known that he posed as a physician for many years and undoubtedly performed many medical procedures and prescribed drugs. While Roark claimed in a summary of cases to the American Board of Thoracic Surgery that he had participated in more than 500 procedures, including eight heart transplants and four lung transplants, prosecutors now say that may have been another lie told to bolster his credentials.

It appears that Roark never encountered any serious threats to his charade until he applied for

SOURCE

For more on primary verification, contact:
Michelle Hoppes or **Linda Nash,** Ingham Regional Medical Center, 401 W. Greenlawn, Lansing, MI 48910. Phone: (517) 334-2918.

privileges at Ingham Regional Medical Center. He never got as far as practicing there, and risk manager **Michelle Hoppes**, RN, AHRMQR, says no one at the facility had even heard of him when he submitted his application. There was no immediate cause for concern, she says. Roark was just one more doctor applying for privileges, so they put his application through the same verification process that all others go through.

Then a few phone calls started setting off the alarm bells and set into motion the process that ultimately would send Roark to prison.

"From a risk management standpoint, this was a very proud day," Hoppes says. "It really shows that risk management is not just the risk manager's job. I'm so proud of our staff and that we were able to stop an individual who could have posed a significant liability risk for our organization and threatened our patients."

Linda Nash, MD, medical director at the hospital, was in charge of overseeing the credentialing of physicians, and it was her investigation that blew Roark's cover. How did she do it? "I can tell you in two words: Primary verification," she says. "You can't take anyone else's word that the credentials are valid. You have to go right to the source and verify it yourself."

The hospital has a strict policy of requiring primary verification for physician credentialing, Hoppes says. Obviously, not all facilities have the same requirement, relying instead on simply seeing that the applicant has an apparently valid state license and possibly checking his most recent employment. Hoppes and Nash say that's not enough because you're relying on others to verify that the applicant's string of credentials is valid. As Roark demonstrated, even having a "valid" license to practice medicine from the state is not sufficient proof the applicant has all the training and experience he or she claimed to get the license.

Even if the application is valid with regard to the most important and basic items, such as graduation from a medical school, there may be outright lies or excessive exaggeration about other points that are crucial for whatever type of care the physician intends to provide at your facility.

Hoppes points out that many regulatory bodies require health care providers to verify the credentials of applying physicians, but they usually do not specify exactly what "verification" must entail. Many facilities take a somewhat lax approach, she says, but her hospital always has believed that "verification" means "primary verification" of all significant training and credentials. The risk management department conducts annual audits of the credentialing process, reviewing the files to ensure primary verification.

"We work closely with the credentialing process to make sure that any time there is a red flag, we hold up the whole process and put the burden on the physician to give us what we need," Hoppes says. "Sometimes there is pressure to move things along, but we will not rush the process. A lot of organizations depend on other facilities and the state to have done all the proper credentialing, but it's quite clear to us that we have to depend on ourselves." ■

Barred physician operated on wrong patient

Same physician once amputated wrong foot

The same physician who received national notoriety in 1995 for amputating the wrong foot from a patient has now been barred from practicing medicine because he performed surgery on the wrong patient.

Rolando Sanchez, MD, had his state medical license revoked because he implanted a catheter into the shoulder of an 89-year-old woman with a brain disorder; her roommate was supposed to have the procedure instead. The woman who received the catheter could not speak. She was not significantly harmed by the minor surgery, according to a report from the Florida Department of Health.

Sanchez amputated the wrong foot of a patient at University Community Hospital in Tampa in 1995, an incident that resulted in national publicity for the doctor and the facility. The patient settled the lawsuit with the hospital for $900,000 and received $250,000 from the doctor's insurance.

He was accused of amputating a woman's toe without her consent six months later at Tampa's Town & Country Hospital, causing state officials to suspend his license for six months. ■

Redesign challenge lies in making it stick

Clarify expectations, measure improvements

It's fine, even fun, to redesign your operations, says **Donna Reck**, MSN, RN, CNA, of PennState Geisinger Health System in Hershey, PA, but the important question is, "How do you sustain change?"

As a key player in designing a new preadmission center, she found that physical and system changes can happen quickly. Attitude and cultural changes, however, take more time, adds Reck, who serves as director of the surgical division for the health system.

The goal was to address — with a one-stop shopping approach — delays in OR scheduling, long preadmission visits, and the resulting patient dissatisfaction, she says. "The preadmission arena was fragmented, there were lots of pieces of paper, and patients had to give the same information to five or six people just to get into the hospital."

Taking the initiative, she says, "We redesigned to streamline. We located all the services to one area to allow one-stop shopping except for the visit to the surgeon. We built in time to align information with business needs and discuss any concerns with the patients, and we considered coordination of their needs, such as travel arrangements."

Here are some essential elements Reck says weren't in the initial process:

1. Communication and clarification are essential.

"It's very helpful to clarify expectations upfront," she explains. "What happened with us is that we redesigned this [preadmission process] from a physician focus to a patient focus, and focused everything on the patient. We looked at all the possibilities of what we should achieve from the patient's point of view but did not clarify the expectations of the staff, the physicians, and the different managers involved." For example, one of the proposed outcomes of the redesign was that patients would complete a preadmission center (PAC) visit in two hours or less. However, it wasn't clarified with physicians that this would be a separate visit from when the patient came to see them or whose responsibility it would be to inform the patient of the new procedure.

As a result of this miscommunication, the hospital was sending out letters letting patients know what to expect, but the physician was telling them something different, she explains. Told by the physician their preadmission testing would take only 15 minutes or so and could be done any time before surgery, patients would show up without an appointment and/or have unrealistic expectations of how long their visit would be, she adds. Despite the letter they'd received, "patients tend to remember only what the physician says."

2. Everyone should participate.

"We learned to include everyone, including physicians," she says. "We did have physician representatives on the committee for the design process who brought back information [to their colleagues], but there was a missing link on how many people they were actually able to get to."

Physicians who didn't understand the whole picture were filling in the gaps for themselves with how they thought it should go, she adds.

There is now a core group, involved in the redesign since its inception, that goes out to the staff meetings of each medical service and explains the reasons behind the redesign changes, she says. "This is very time-intensive, but we feel it will add value." That group includes the PAC's medical director, assistant manager, and Reck.

The hospital also has initiated a monthly schedulers' breakfast for all the employees who schedule for the physicians, she adds. "The [assistant manager of utilization review and the supervisor of preadmissions] answer questions and go over pieces of the process and help educate them about insurance issues. It helps [the physicians' staff] to see why certain pieces of information are so important. It also helps by putting a face to a name."

3. Improvement measures need to be identified and monitored.

"It's critical to identify upfront items you can measure to see if you've been effective and to continue to monitor them throughout the process," Reck points out. Although the hospital appointed a quality committee and identified the items to measure, it didn't actually measure them, she adds. "One of the key [participants] was promoted to another position, so the committee never got together. We had hearsay — but no data — and couldn't show where we were improving or not improving."

In November 1997, six months after PAC implementation, the committee redefined the measures, and data collection began, Reck says. "It's not anecdotal now. We can go to people and say, 'I know you feel you're doing a good job, but the numbers show you have a 15% error rate, and we really want to keep it below 3%.'"

4. One-step rather than staggered implementation would be easier on the staff.

"We phased in the [medical] implementation service by service, and it took about three months," she says. "It was very difficult and frustrating for staff in admission and preadmission because they were working with patients processed in the old way and the new way, with different [kinds of] paperwork." In retrospect, she would have delayed implementation, conducted intensive training, and made the change all at once.

5. Set more more reasonable expectations for employees.

The primary reasons given for the staff resistance and high turnover were schedule changes and the demand for cross-training, she says. Staff were expected to rotate through five different sections, learn all the aspects of those jobs, and become more autonomous in their dealings with patients, she says. In addition, they were asked to work extra hours until new people could be hired.

"We realized that was too much," she adds. "We decided we could break that down and let people choose two or three areas [to become proficient in] rather than five."

Also, Reck says, she learned that training employees for a redesign must be continuous, with refresher sessions as the process continues to be refined.

As a result of the changes, she adds, employee turnover has decreased, and there is relative stability in the PAC operation.

"We're able to show staff where they've gotten better, and we're breaking down and identifying areas that need improvement and working on them one at a time." ■

SOURCE

For more on the redesign, contact:
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ACCREDITATION TIP

Assess patient readiness to learn before discharge

When patients leave your same-day surgery program, are they able to understand what you're saying to them? Are they ready to learn?

"They may not be," says **Ann Kobs**, sentinel event specialist for the Department of Standards at the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL. "You may have to talk to a spouse or a significant other. Or, in the case of an elderly person, a son or daughter."

Between January and July 1997, 6.5% of facilities undergoing JCAHO accreditation received a score of 3, 4, or 5 for education standard PF.1:

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learning needs, abilities, and readiness assessed.

Patients who have undergone general or monitored anesthesia care often don't remember the instructions, warns **Ray Grundman**, general manager of Surgicenter of Greater Milwaukee and surveyor for the Accreditation Association of Ambulatory Health Care in Skokie, IL. Because such patients are discharged with a responsible party, ask that party to sign the written instructions, he suggests. "When we do a chart audit, we can see that the care partner received the instructions. That's ideal."

Patients should be educated about the medications they will take after they leave, not the ones they're receiving at the facility, Kobs says. Patients need to be educated about food and drug interactions if there's a potential problem with the drugs they'll take at home, she says.

Grundman likes to see a two-ply patient teaching form used so one copy can remain in the chart and one can be send home with the patient. It's also important that patients have written instructions on how to get in touch with someone if they have a problem, Kobs points out. ■

• **Preparing for the CNOR Examination** — Nov. 13-14, Bakersfield, CA; March 5-6, Houston; June 11-12, Naperville, IL; Sept. 10-11, Fort Lee, NJ. Sponsored by Association of Operating Room Nurses. Contact: AORN Customer Service / Registration, 2170 S. Parker Road, Suite 300, Denver, CO 80231-5711. Phone: (800) 755-2676.

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CE objectives

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After reading this issue, CE participants will be able to identify:

1. The result of a facility using shorter-acting anesthetic agents, conscious sedation with local anesthesia, and less invasive surgical techniques.
2. The guidelines for nursing staffing ratios from the American Society of PeriAnesthesia Nurses.
3. A strategy for addressing a surgeon who refuses to standardize a device.
4. The requirement from the Joint Commission on Accreditation of Healthcare Organizations for educating patients about medications. ■