Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 30 Years

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IN THIS ISSUE

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Health reform raises more questions than answers — what should you do?

While the details of health care reform were uncertain at press time, one point is clear: Change will be coming to outpatient surgery regardless, and providers need to be prepared.

One red flag raised by sources interviewed by *Same-Day Surgery* is that a health care system might emerge that is more focused on cost savings than patient safety.

"If you want to provide safe care and you're hoping to reduce costs, that's one thing; but if you want to reduce costs to provide safe care, that's another," says **F. Dean Griffen**, MD, FACS, attending surgeon at Louisiana State University Health Sciences Center (LSUHSC) in Shreveport, and CHRISTUS Schumpert Highland, and director of surgical stimulation, director of undergraduate surgical education, and professor of clinical surgery at LSUHSC. Griffen serves in leadership positions for the American College of Surgeons and is a former member of that organization's Health Policy Steering Committee. **(For story on the American College of Surgeons' response to some comments by President Obama, see story, p. 99.)**

Payers often don't consider the upfront costs, Griffen says. For example, an antibiotic impregnated venous catheter costs more than one that is nonimpregnated; however, administrators might not see the value of buying a more expensive item, he says.

"The savings is after the fact, because you have fewer infections, fewer

EXECUTIVE SUMMARY

Regardless of the status of the health care reform legislation, change is coming to outpatient surgery.

- Changes are likely to occur in technology development and investment, the amount of paperwork, and scrutiny of physician ownership.
- To make your voice heard, promote yourself in the community and meet your Congressional representatives and their aides.

prolonged hospitalizations, and better outcomes because you spent more up front," Griffen says. "If the new health care system designs itself around cost instead of safe care, they might miss a chance to spend money up front to save money later."

Also consider the example of surgeons who have experience with a particular type of device and who have better outcomes because of their experience with that device, even if it is more expensive, Griffen says. "If, on the other hand, some bean counter says only use this particular device because they have special deal contracted with a particular company that makes it cheaper, the persons with less experience with that device are compelled to use it and may have worse outcomes until they get used to it," he says.

Consider these other potential impacts:

• The financial hit could be significant.

Ambulatory surgery centers already are taking a tremendous financial hit in the Medicare arena, says **Bobby Hillert**, executive director of the Texas Ambulatory Surgery Center Society in Austin. "So, any bill that uses the Medicare reimbursement model as a vision for health delivery would certainly have a negative impact on ASCs," he says. "If a health care overhaul law includes a public health insurance option with rates similar to Medicare that will put a very tight squeeze on the industry's finances."

On the positive side, millions more potential patients could gain health coverage under proposals to expand Medicaid and provide subsidies to purchase health coverage, according to a study by the Robert Wood Johnson Foundation and Kaiser Commission on Medicaid and the Uninsured.[1] The groups also released studies estimating how many uninsured parents, childless adults, and children would be covered under these and other scenarios being considered as part of health care reform. *(Editor's note: To access these studies, go to www.rwjf.org. Select "Health Reform." Under "latest reports from RWJF, select "How will the Uninsured Be Affected by Health Reform?")*

• Providers might be less likely to invest in technology.

Providers will be paid a flat rate for a procedure regardless of the cost of the equipment, sources point out.

"If there is advanced technology that would do same thing as something else in less time, albeit not better, they would stick with the old equipment," Griffen says. And that's not all, he says. There will be less of a stimulus for manufacturers to develop new technology, he says.

• Managers' paperwork burden might increase.

The government's "Cash for Clunkers" program was an indication of a backlog in terms of the government's ability to complete deals, Griffen says. "Consider all the time it takes to fill out forms, and even then, the government can't act on it as rapidly as they send it in," he says.

Health care providers already carry a significant cost for paperwork, Griffen says. "It's largely designed for safer care; but on the other hand, when it becomes burdensome, and reimbursement

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doesn't allow one to show overhead cost, and it gets higher than your income, you're in trouble," he says.

• ASCs could get lumped in with attack on physician ownership.

At press time, a health care reform bill included language that would ban physician self-referral to hospitals in which they have an ownership interest, with limited exceptions for existing facilities that meet strict investment and disclosure rules. Could this focus on physician ownership affect physician-owned surgery centers? Absolutely, say sources interviewed by *SDS,* including **Craig Jeffries**, Esq., public policy consultant for the Association of periOperative Registered Nurses (AORN).

"I will tell you: Absolutely whatever is happening with physician ownership applies to surgery centers," Jeffries says. From "a political perspective, as long as Pete Stark [D-CA] is in Congress, sure, they're going to be lumped together."

The attack on physician-owned facilities is interesting, particularly in light of a recent report from *Consumer Reports* that show physician-owned hospitals ranking as the No. 1 hospital in 19 states, he says. Such reports seem to have little impact, sources say. "It's a continuing threat for physicians who have ownership in an ASC," Jeffries says. All physicians, regardless of what segment of the industry they might own, should be concerned by any attack on physician ownership, Hillert says. "Attacks on one segment of the health care industry can lead to attacks on other physician-owned segments of health care," he adds.

What you should do now

Regardless of the status of health care reform bills, there are steps that outpatient surgery managers can take to guide future policy, sources say.

One is to promote your program in the community through health fairs, speakers, and open houses, sources say. Another step is to build relationships with policy-makers. Work through your associations and your local representatives, Griffen says. "Those types of interventions are deemed to be your access to the system," he says.

If you've never been to a town hall meeting or visited the office of your representative or senator, start there, Jeffries advises. Introduce yourself to the staff, and invite the Congressional representative to your facility and/or to a meeting of the local chapter of your industry association, he says.

Build a personal relationship with your member of Congress and his or her health aides, Hillert says. "A lot of people are intimidated by the idea of building that relationship, but it's often as easy as picking up the phone," he says.

When Congressional representatives were on a recent break, Hillert and members of his association took advantage of that time to speak with their Congressional representatives and their aides. They told them how many surgery centers are in the state, how many people they employ, how much those centers pay in taxes, and what the projected economic impact is for 2009.

Their big message? "Despite the variety, these ASCs all have one thing in common: an intense emphasis on safety and quality," Hillert says. **(For information about a reform bill that addresses reporting of health care-associated infections, see story, p. 100.)**

Reference

1. Dubay L, Cook A. *How Will the Uninsured Be Affected by Health Reform?* Princeton, NJ: Robert Wood Johnson Foundation; August 2009. ■

College of Surgeons takes issue with Obama

Some "uninformed" statements from President Obama "deeply disturbed" the American College of Surgeons, which responded with an Aug. 12 press release defending the high-quality care provided by surgeons.

"We want to set the record straight," the college said. Here is an excerpt of its response:[1]

Three weeks ago, the President suggested that a surgeon's decision to remove a child's tonsils is based on the desire to make a lot of money. That remark was ill-informed and dangerous, and we were dismayed by this characterization of the work surgeons do. Surgeons make decisions about recommending operations based on what's right for the patient.

We assume that the President made these mistakes unintentionally, but we would urge him to have his facts correct before making another inflammatory and incorrect statement about surgeons and surgical care.

Reference

1. American College of Surgeons. Statement from The American College of Surgeons Regarding Recent Comments from President Obama. Aug. 12, 2009. ■

Infectious disease groups back HAI reporting bill

Staffing requirement viewed favorably

Five organizations representing the nation's experts in infectious diseases medicine, infection prevention in health care settings, and public health and disease prevention announced their support for a provision requiring national reporting of health care-acquired infection (HAI) rates, which, at press time, was contained within the health care reform bill introduced by leaders of the U.S. House of Representatives.

The Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), the Council of State and Territorial Epidemiologists (CSTE) and the Trust for America's Health (TFAH) sent a joint letter to members of Congress regarding HR 3200, the America's Affordable Health Choices Act. The bill would require hospitals and ambulatory surgical centers to report HAI data through an existing national reporting network managed by the Centers for Disease Control and Prevention as a condition of participation in Medicare and Medicaid.

"Overall, this is a win for patients," says APIC 2009 president **Christine J. Nutty**, RN, MSN, CIC. "Public reporting of HAIs may drive further improvement in health care processes which will reduce infections, save lives, and preserve health care dollars. We are pleased that the House bill would also address the need for highly trained staff to effectively implement the system."

HAIs claim 99,000 lives annually and incur more than $20 billion in excess health care costs. The groups agreed that the public reporting provision found in HR 3200 is superior to approaches that have been put forth in other legislation. HR 3200 would establish a single national standard for HAI reporting, and it would ensure that public health scientists at CDC determine which infections are reported and how. By mandating reporting via CDC's National Healthcare Safety Network, the bill will build on existing mechanisms and create a robust system to monitor, study, and ultimately prevent HAIs. ■

Same-Day Surgery Manager

What can you reform in your program?

By **Stephen W. Earnhart**, MS
CEO
Earnhart & Associates
Austin, TX

Interesting things going on out there, aren't they? Town meeting riots, "death panels," trillion-dollar budgets, "evil businesses." As a clinician, a business owner, and a health care consumer (I broke my foot skydiving a few weeks ago), I've got to tell you: I am OK with the system as it is . . . almost.

I do think we need to change it around a bit. Tort reform is necessary to eliminate much of the unnecessary testing. It would be a start to make catastrophic coverage more affordable, to price coverage per pound and by cigarettes consumed per day, and to not mandate that businesses foot the bill. I think Americans simply are tired of paying for others' indulgences. The system is not broken as some believe, but it could stand some scrutiny. Consider these suggestions:

- **Revenue enhancement.**

I speak a lot about revenue in my column because it is revenue, not expenses, that drive a successful business. I rely greatly upon growing a business by bringing in new surgeons and procedures. I rely upon others to deal with the appropriateness of the expenses of the venture.

Toward that end, there is a company named MediGain USA in Dallas (www.medigain.com) that I consider to be one of the top full-service accounts receivable management companies with a unique service model. It has increased revenues an average of 24% and increased payment time by 30% for their clients. It runs its operations using metrics and analytics, as Fortune 500 companies do in other industries, that provide more visibility into your operations to manage it better. I like MediGain because it offers you a free analysis of where you are and where you could be. You can contact MediGain for more information at (877) 237-9539 or info@medigain.com.

You already have hustled to bring in the business to your department or surgery center. You now need to maximize those efforts.

• **Online patient registration.**

Are you allowing your patients to preregister online? If no, why not? It is fast, simple, and a growing extension of your operation. It is also a great way to obtain patient satisfaction input. Make your web site as interactive as possible not only for your patients but for your staff. I promise you that members of your staff (or their kids) can do it for you.

• **Pictures in the waiting room.**

Do something inexpensive to set yourself apart: Put a picture of your staff members in your waiting room. The cost is less than $3 per picture, and that includes the frame! We receive such positive feedback from patients at our centers about this simple consumer service feature. Pay the kid who is doing your web site to post them there as well.

• **If you have the money . . .**

If you can afford it — and most of you can — put a flat screen in your waiting room that gives the progress of the patient's movement through the facility. It makes it easy for family members to track their loved ones. Each patient has an identifier that shows if he or she is in pre-op, the operating room, recovery, or step-down unit.

This saves your receptionist from calling back all the time asking if the patients still are in surgery and how they are doing. It also makes your facility look high-tech and gives the waiting room visitors something to do.

• **Validate parking.**

Come on! Making surgical patients pay to park is like putting in a toll booth at the drive-thru window at McDonald's. And your patients aren't "lovin' it." Keep in mind that the Office of Inspector General says that freebies for Medicare beneficiaries should be limited to a $10 value, and no more than $50 annually. *(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78750-2254. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.)* ■

Did facilities do enough to protect staff from H1N1?

Provide training, communication about plan

The outbreak of a novel H1N1 virus in the spring was a colossal pandemic preparedness drill for a future virus or for a stronger resurgence of the strain this fall. This "drill" takes on a greater meaning in light of a recent report from the President's Council of Advisors on Science and Technology which estimates that swine flu could infect half the U.S population and cause as many as 90,000 deaths this fall and winter.

So in the spring, how did health care facilities do in their mission to protect staff, including providing appropriate protective equipment (PPE), training, and communication?

The results varied. Some facilities moved swiftly to ensure that their employees were properly fit-tested for respirators and beefed up their stockpiles of protective equipment. Others declined to provide N95 respirators even when it wasn't clear how virulent this strain would be.

Just as the first cases were emerging in Mexico, the Service Employees International Union (SEIU) released the startling results of a survey on pandemic preparedness: About one-third of union leaders at 104 facilities in 14 states said their facilities did not have a written pandemic plan. Less than half (43%) reported that their facilities had provided training to employees on pandemic influenza or communicated to employees about pandemic plans (48%).

In an SEIU "snapshot" survey of nurses who were union leaders at 16 facilities in California, only one said the facility was adequately protecting its staff during the H1N1 outbreak. Some 44% said their facility had not provided worker health and safety training to staff related to H1N1. The surveys were conducted in May.

Scripps Memorial Hospital in La Jolla, CA, had previously fit-tested about half the hospital's employees, including outpatient surgery staff. In an emergency, even nonclinical staff in outpatient surgery might have to help with duties that would increase their risk of exposure, notes **Linda Good**, PhD, RN, COHN-S, manager of employee occupational health services. "We don't want to ask someone to do something they weren't protected to do," she says.

Members of the outpatient surgery staff are given the same level of protection as inpatient surgery staff in terms of immunizations, PPE, and training, because in a pandemic, "they may be called upon to pitch in," she says.

To avoid the spread of H1N1, it's critically important to screen outpatient surgery patients ahead of

E-cards available to encourage vaccination

The Centers for Disease Control and Prevention (CDC) has launched a social media campaign to encourage information sharing about H1N1 flu. The campaign includes social networks such as Facebook and Twitter, mobile information, online videos, and e-cards.

For more information on the e-cards, go to www2a.cdc.gov/ecards. Click on "all cards," and then select "flu" in the "select category" box. One card, titled "Don't Get the Flu," shows a woman saying, "I can't cover my shift," and is targeted for health care professionals. ■

time for illness, says **Meaghan Reshoft**, RN, BSN, MBA, CASC, executive director of surgical services at Northwest Community Hospital & Northwest Community Day Surgery Center in Arlington Heights, IL.

"Make sure you provide instructions that say, if they become ill before the surgery appointment, they should contact their physicians and the ASC for the next step," Reshoft says. "You certainly don't want to perform surgery on someone coming down with the flu."

Also address potentially sick employees, Reshoft advises. Northwest employees can obtain free influenza testing through the hospital employee health department. The hospital and surgery center also have a policy for employees who potentially are acquiring the flu that addresses when they should come back to work. This policy is based on guidance from the CDC, which at press time was expected to be updated in mid-September.

The web sites www.cdc.gov/H1N1 and www.flu.gov have a "wealth of information, including how to prepare your facility and home for a flu pandemic," Reshoft says. "In addition, state and local government web sites may contain information on local area outbreaks and other information specific to the state and community level," she adds. Northwest's web site has links to several sites where staff and patients can obtain more information about H1N1, Reshoft says. **(For information on how to send an e-card to your staff about flu vaccination, see box, left.)** ■

NY mandates: HCWs get shots for the seasonal flu

In a likely prelude to a battle over mandating a swine flu vaccine, the New York State Health Department overrode nursing union protests recently in enacting an emergency regulation requiring seasonal flu shots for health care workers (HCWs).

Other states will no doubt scrutinize the New York regulation, and even in the absence of state laws, individual facilities may take up the mandate banner in a pandemic flu season when health care providers may need both seasonal and swine flu vaccinations. The Association for Professionals in Infection Control and Epidemiology (APIC) urges health care facilities to require annual flu vaccines for all employees with direct patient contact.

In New York, the State Hospital Review and Planning Council approved the regulation Aug. 6, 2009, with the mandate applying to all personnel working in hospitals, ambulatory surgery centers, diagnostic and treatment centers, certified home health agencies, long-term home health care programs, AIDS home care agencies, and hospices licensed under Article 28 of the New York State Public Health Law.

Facilities have been gearing up for the mandate as discussions surfaced, with health officials saying poor compliance with seasonal flu shots can

no longer be ignored. "Many hospitals have been actively promoting influenza vaccine every year for their staff, but those who work in the field know that the uptake of the flu vaccine has been low," says **Jane Zucker**, MD, assistant health commissioner for immunization in New York City (NYC). "This mandate will help to dramatically increase the vaccination rate, and I think [health care facilities] view that as very positive."

Regardless, don't expect employee health and union groups that have long resisted a mandate to go gently into that good night. The New York State Nurses Association (NYSNA) fought the regulation, calling it a "scorched earth" approach that ignores risk assessment and alternative intervention measures. The NYSNA challenged the state's authority to enact such a regulation in hearings.

At a recent hearing on the regulation, **Eileen Avery**, MS, RN, associate director of NYSNA, said, "The nurses association questions the authority of this body to impose such a sweeping mandate as an emergency rule, without the declaration of a public health emergency."

One could argue that seasonal influenza actually fits those criteria with 36,000 deaths annually, though that would essentially mean reclassifying every flu season as a public health emergency. The prevailing opinion has been that of groups such as the American College of Occupational and Environmental Medicine, which argues in its position statement that patient safety data are not sufficient to justify a mandate that overrides the worker's autonomy to refuse vaccination. That argument is clearly under siege.

As New York State moves to mandate the seasonal flu vaccine for health care workers, the elephant in the room is this question: Will immunization against the H1N1 influenza A pandemic strain be required as well? The vaccine is expected to be available this month. A projected vaccine shortage means that only the highest-priority groups, including health care workers, are likely to be initially offered the shot. Two doses will be required per vaccinee. **(For more information, see supplement on H1N1 enclosed in this issue.)**

Mandating immunization for the H1N1 influenza A pandemic strain when the vaccine becomes available is "something that is being discussed" by public health officials, Zucker confirmed.

While some doubt that a vaccine that has been fast-tracked would be mandated, a pandemic vaccine researcher emphasizes that the benefit to workers and patients will almost certainly outweigh the risk.

There was a time when people could only wish they had a SARS vaccine, recalls **Donald Kennedy**, MD, a professor of infectious diseases at Saint Louis University. "In Canada, health care workers were taking care of people, getting the disease, and dying from it," he says.

Kennedy is one of the researchers conducting H1N1 vaccine trials in humans at the Center for Vaccine Development at the university. "If we have a safe and effective vaccine, health care workers —- particularly those who provide care to patients who would do poorly should they get H1N1 — should be vaccinated," he says.

Vaccinating high-risk patients does not provide complete immunity, Kennedy adds.

While conceding that risks are a legitimate issue for discussion, Kennedy reminds that the H1N1 vaccine was made with the same techniques used for seasonal virus. "We have been doing this for years without testing each seasonal flu vaccine every year," he notes. "This is not something we can sit around and debate for six months. Doing it two years from now probably won't help much. If we had a 1918 flu vaccine but gave it to everyone in 1920, it wouldn't have done much good." ■

CNE/CME instructions

Physicians and nurses participate in this CNE/ CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- Payers and out-of-network payments
- Propofol fallout from Michael Jackson death
- Writing a strategic plan for your program
- Should you join the social media revolution?

CNE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

13. To avoid the spread of H1N1, it's critically important to do what, according to Meaghan Reshoft, RN, BSN, MBA, CASC?
A. Offer free vaccinations to your staff.
B. Fit-test all employees for N95 masks.
C. Screen outpatient surgery patients ahead of time for illness.
D. All of the above

14. What facilities are required to vaccinate staff for influenza, based on recently passed regulation in New York?
A. All personnel who work in facilities that treat young children.
B. All personnel who work in facilities licensed under Article 28 of the New York State Public Health Law.
C. All personnel working in hospitals, ambulatory surgery centers, diagnostic and treatment centers, certified home health agencies, long-term home health care programs, AIDS home care agencies, and hospices licensed under Article 28 of the NY State Public Health Law.

15. To meet the National Patient Safety Goal on reducing the risk of health care-associated infections, does the person who performs the staff education need to be certified, according to The Joint Commission and the Centers for Medicare & Medicaid Services?
A. No
B. Yes
C. It depends on the setting.

16. According to Kelly Fugate, ND, RN, leaders who are accountable for infection control include:
A. CEO or the senior managers.
B. Staff in areas such as housekeeping and equipment processing.
C. Staff and family educators.
D. Staff that support infection prevention and control programs, the laboratory, and the IT department.
E. All of the above

Answers: 13.C; 14. C; 15. A; 16. E.

SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission and AAAHC Standards

With Jan. 1 deadline bearing down, are you ready to comply with NPSG on infections?

Outpatient surgery managers in hospitals, surgery centers, and offices still have a lot of questions about The Joint Commission's (TJC's) National Patient Safety Goal (NPSG) on reducing the risk of health care-acquired infections, despite the fact that this goal must be fully implemented in a few short months.

By Jan. 1, 2010, hospitals, ambulatory surgery centers, and offices are expected to be in full compliance with these goals:

- **NPSG.07.04.01**, central line-associated bloodstream infections;
- **NPSG.07.05.01**, surgical-site infections.

Also, hospital-based programs are expected to be incompliance with NPSG.07.03.01, which focuses on multidrug-resistant organisms (MDROs).

"By Jan. 1, it's not a phase-in anymore," says **Kathleen A. Catalano**, RN, JD, FHIMSS, director of health care consulting for Perot Systems Corp., a Plano, TX-based provider of information technology services and business solutions.

Michael Kulczycki, executive director for ambulatory programs at TJC, says, "It's important to focus on, that by Jan. 1, they need to have entire program in place."

Meeting the deadline isn't the only reason to get your infection control program in order, Catalano says. There is an epidemic of *Clostridium difficile (C. diff)*, according to the Centers for Disease Control and Prevention (CDC). The CDC estimates there are 500,000 cases of *C. diff* infection annually in the United States, up from 150,000 cases in 2001, and they contribute to 15,000-30,000 deaths. Methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci (VRE) are seeing the same types of growth, Catalano says.

To get your program in compliance, consider these common questions, with answers from TJC staff:

• How do I meet the requirements for best practices?

The Joint Commission goal says providers need to implement best practices for preventing surgical-site infections, but some providers aren't certain what constitutes a "best practice," says **Virginia McCollum**, MS, RN, associate director of standards interpretation.

The definition is a practice that probably has found an effective way to implement an evidence-based guideline, McCollum says. For example, strategies that have been developed to meet CDC

EXECUTIVE SUMMARY

Hospitals, ambulatory surgery centers, and offices must be compliant with the National Patient Safety Goal on reducing the risk of health care associated infections by Jan. 1.

- Educate staff about prevention of surgical-site infections upon hire, annually, and when new surgical procedures are added. Educators do ***not*** have to be certified.
- You must track surgical infection rates for one year for implantable devices, 30 days for all other procedures.

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guidelines and that have been successful would be considered best practices, she says.

• What is an evidence-based guideline?

The best example of an evidence-based guideline is from a group such as the CDC that has published guidelines that, based on research and evidence, are considered to be effective, "rather than perhaps someone's opinion on what might work," McCollum says.

Groups considered to be good sources for evidence-based guidelines include Healthcare Infection Control Practices Advisory Committee (HICPAC, www.cdc.gov/ncidod/dhqp/hicpac_pubs.html), the Centers for Medicare and Medicaid Services (CMS, www.qualitynet.org), and the Institute for Healthcare Improvement (www.ihi.org/IHI/Topics/HealthcareAssociatedInfections). The Association of periOperative Registered Nurses (AORN), another good source, has tools including *Recommended practices for prevention of transmissible infections in the perioperative practice setting*. *(For more information or to order, go to www.aorn.org. Under "Practice Resources," select "AORN Standards And Recommended Practices.")*

Secondly, managers must provide the resources needed, Fugate says. Infrastructure requirements are personnel, education, and decision support and reminders.

• What are the education requirements?

To comply with the NPSG, patients who are undergoing a surgical procedure and their families must be educated about surgical-site infection prevention before the procedure.

Educating staff about prevention of surgical-site infection should be given upon hire, annually, and when new surgical procedures are added, McCollum says.

Some freestanding surgery centers have assumed that the education must be conducted by someone who is certified by an infection prevention society, Kulczycki says. "Certification is not a requirement," he says. The Centers for Medicare & Medicaid Services also has clarified that certification is not required as part of their Conditions for Coverage. "They just need to demonstrate in some way that they have education or additional training that demonstrates their expertise," Kulczycki says.

• How do we meet the challenge to measure and report the infection rates for 30 days following a procedure?

The goal requires providers to report and measure infection rates for the first 30 days following procedures. Implantable devices are to be followed for one year.

"Gathering that data for ambulatory and outpatient departments can be a challenge, depending on your relationship with the surgeon and providers," McCollum says.

The issue is that technically, the surgery center doesn't "own" the patient, Kulczycki says. "It's the physician's patient," he says. Thus, is takes a combination of effort by the outpatient surgery program and the physician to determine if there's been a post-surgical infection, Kulczycki says. For example, the center can ask the physician's office if it has had any communication with the patient about post-surgical infections.

McCollum says as you collect that data, "you can do a root-cause analysis, a performance improvement activity, to see if you're having an infection rate trend upward." ■

Step-by-step guide for stopping SSIs

Meeting the National Patient Safety Goal (NPSG) on surgical-site infections (SSIs) is important, and not just from an accreditation standpoint, said **Kelly Fugate**, ND, RN, associate project director-specialist in the Division of Standards and Survey Methods at The Joint Commission.

SSIs are a concern because they add postoperative hospital days, increase risk of death, require lifestyle interruptions, cause suffering, and cost money, says Fugate, who spoke on "Strategies to Prevent Surgical-Site Infections" at the Perioperative Care Symposium sponsored by Joint Commission Resources earlier this year.

To address SSIs, use the "Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals" (www.shea-online.org/about/compendium.cfm) from The Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA). The compendium addresses SSIs, central line-associated bloodstream infections (CLABSIs), catheter-associated urinary tract infections, ventilator-associated pneumonia (VAP), *Clostridium difficile,* and methicillin-resistant *Staphylococcus aureus* (MRSA).

To use the compendium, follow these steps, Fugate suggests:

- Start with a risk assessment.
- Determine your focus/goals based on

identified risks.

• Compare organizational practices with NPSG requirements (see NPSG.07.03.01, NPSG.07.04.01, and NPSG07.05.01).

• Refer to the compendium for further clinical detail on strategies to prevent health care-acquired infections (HAIs).

• Identify gaps.

• Plan and implement actions to align organizational practices with the compendium strategies.

• Evaluate effectiveness.

This approach is not required and will not be used during accreditation surveys by The Joint Commission, Fugate emphasizes.

The basic practices for SSI prevention and monitoring, according to Fugate, are:

• **Surveillance.**

Provide feedback on SSI surveillance and process measures to leaders, licensed independent practitioners, nursing staff, and other clinicians, she says.

• **Clinical practice.**

Clinical practices to follow include antimicrobial prophylaxis, hair removal if necessary, blood glucose level control. Managers should provide feedback on compliance with process measures. Also, programs should implement policies and practices aimed at reducing SSI risk that meet regulatory and accreditation requirements and are aligned with evidence-based standards.

• **Education.**

Educate surgeons, perioperative staff, patients, and families about preventing SSIs, Fugate says.

There are patient guides on HAI available at www.preventinghais.com/files/1074/SSI.pdf. Under "download the patient guides," you can click on "surgical-site infections," then select "Central Line-Associated Bloodstream Infection," "Catheter-Associated Urinary Tract Infection," "Methicillin-Resistant *Staphylococcus aureus"* (MRSA), "Vancomycin-Resistant *Enterococcus"* (VRE), or other topics. Large print/English and large print/Spanish are available.

• **Accountability.**

Leaders must establish priorities for performance improvement (PI). They must identify the individual(s) responsible for the infection prevention and control program, and they must evaluate the effectiveness of the infection prevention and control plan. Also, leaders allocate needed resources for the infection prevention and control program.

Accountability doesn't stop with the CEO or the senior managers, Fugate emphasizes. It includes staff in areas such as housekeeping and equipment processing, staff and family educators, and staff that support infection prevention and control programs, the laboratory, and the IT department. ■

19 practices ID'd that reduce cataract times

A new report has identified 19 practices that reduce facility times for ambulatory centers performing cataract extraction with lens insertion. The *Cataract Extraction with Lens Insertion 2008 Report: Performance Measurement and Benchmarking in Ambulatory Organizations*, is the ninth in a series of reports on cataract surgery conducted by the AAAHC Institute for Quality Improvement, a not-for-profit subsidiary of the Accreditation Association for Ambulatory Health Care.

"In the study, only procedure times are used for benchmarking because the processes involved are not dictated by clinical guidelines and are, for the most part, within the control of the organization," said **Naomi Kuznets**, PhD, managing director of the AAAHC institute. "They also are indicators of safety and patient satisfaction."

For example, pre-procedure or operating room "wait" times can be associated with patient satisfaction. Lengthy discharge times might indicate an overuse of medication during the procedure.

Organizations with the shortest times attributed their success to a variety of factors, including:

• As much paperwork as possible is completed when scheduling the patient.

• Patients are sent home from scheduling with a packet, including informed consent, anesthesia consent; visual function questionnaire, pre-surgery instructions, eyedrop prescription, and scheduler's business card.

• Patients are called prior to the day of surgery to remind them of pre-surgical eyedrop regimen, arrival time, and NPO status, and to answer their questions.

• At one organization, a special compound dilating solution is used. If the patient isn't completely dilated he/she is brought into the OR where the physician uses a numbing solution of 1% lidocaine and epinephrine, which completes dilation in a few seconds. At another, eyedrops are administered on patient arrival, and the physician uses Shugarcaine if the patient isn't dilated in 30 minutes.

• A pre-op nursing/anesthesia form is used so that the nurse's documentation of patient

Average Times

- Facility time, defined as the time the patient checks into the facility to the time he/she meets criteria for discharge, ranged from 52 to 183 minutes, with an average of 117 minutes.
- Pre-procedure time — from the time the patient checks into the surgery center until the beginning of the procedure (incision) — ranged from 37 to 138 minutes, with an average of 81 minutes.
- Procedure time — the time the procedure starts (incision) to the time the procedure ends (dressing on) — ranged from six to 32 minutes, with an average of 14 minutes.
- The average procedure time with IV and topical anesthetic was 12 minutes; IV and peribulbar block, 21 minutes; and IV and retrobulbar block, 20 minutes.
- Discharge (recovery) time — from dressing on to the time patient meets discharge criteria — ranged from four to 45 minutes, with an average of 22 minutes.

Source: Cataract Extraction with Lens Insertion 2008 Report, AAAHC Institute for Quality Improvement.

medications and history can be used by anesthesia staff.

• Patients are instructed to arrive in short-sleeve, button-down shirts, and not required to change into gowns.

• Patients are provided with postoperative instructions before surgery.

• Pre-op assessment forms, discharge forms, and routine orders are standardized.

• Local anesthesia and mild IV sedation are used.

• High-volume surgeons are given two operating rooms.

• Laser surgeries are done when all other surgeries are completed.

• Cases using a phacoemulsifier are scheduled first, and longer cases are scheduled at the end of the day.

• Staff members are cross-trained.

• A stretcher that converts to a chair is used for quick transfers.

• CRNAs keep patients stabilized in the OR and accompany them to recovery, and they stay with the patients until the physician clears them for discharge.

• A family member is with the patient at pre- or post-procedure to hear discharge instructions, confirm follow-up appointments, and address questions.

• Patients whose post-procedural vital signs are not stable or who have postoperative nausea are moved to another area for monitoring and care.

• Patients are offered water and juice (no snacks) before discharge.

• Patients are transported to their rides via wheelchair or by a dedicated post-op staff escort.

The 77 ambulatory organizations that participated perform from 64 to 12,000 cataract procedures each year. Study participants included 55 freestanding single specialty ambulatory surgery centers (ASCs), 17 multispecialty ASCs, and five office-based surgery practices. Eighty-three cases were listed as complicated or nonroutine and excluded from the analyses. The most frequent reasons for listing a case as complicated or nonroutine were associated with intraoperative floppy iris syndrome (IFIS).

To order copies of the report or for more information, visit www.aaahciqi.org and click on "Order Products." The *Cataract Extraction with Lens Insertion 2008 Report CD-ROM* is $110. The *Cataract Extraction with Lens Insertion 2008 Report PDF* is $85. **(For average times, see box, at left. For information on outcomes, see article, below.)** ■

Patients report on their outcomes

As part of the *Cataract Extraction with Lens Insertion 2008 Report* from the AAAHC Institute for Quality Improvement, about 82% of patients (1,418) were contacted within 14 days of their cataract procedures to obtain information about outcomes. While not every patient answered every question, here are their responses:

• 98% said they were comfortable during their procedures;

• 97% reported they were comfortable post-discharge;

• 94% said their vision was better, 4% said it was the same as it was pre-surgery, and 2% said it was worse;

• more than 99% said they would recommend the procedure to a friend or relative;

• 66% were able to return to daily activities within two days, 14% within three to four days, 12% within five to seven days, 3% within eight to 10 days, and 3% within 11-14 days. Two percent reported they had not yet returned to activities of daily living. ■

With HIN1 vaccine shortage expected, highest-risk groups go to front of line

Who is at risk for serious infections and why?

By **Gary Evans**
Senior Managing Editor
Hospital Infection Control & Prevention

With a vaccine shortage projected for novel H1N1 influenza A, only the highest priority groups are likely to be offered the shot when initial lots are cleared for distribution this fall. These groups include critical support personnel such as health care workers, as well as people at risk of severe complications if infected: pregnant women, young children, and those ages 5 to 18 with chronic medical conditions.

Time is of the essence. The estimated mid-October initial vaccine release date is expected to coincide with a resurging wave of the first pandemic flu virus in 41 years. "There is a lot of circulating H1N1 virus in the Southern Hemisphere right now causing a lot of trouble," says **Donald Kennedy**, MD, a professor of infectious diseases who is running clinical trials on the H1N1 vaccine at St. Louis University. "The anticipation is that this is coming back."

Donald Kennedy

A wider risk pool of H1N1 vaccinees was initially identified, but public health officials are now expected to target the highest-risk groups because there will be considerably fewer doses than the 120 million originally projected.

"It appears we are going to have about half [of what was estimated]," Kennedy says. "The second half is going to take longer to manufacture. It may not be until December or later and that's a problem."

Public health officials estimate that up to 195 million doses may be distributed incrementally by the end of 2009. However, with two doses required per vaccinee, many people will remain at risk if H1N1 spreads as widely as anticipated. In particular, the immunocompromised still could be in jeopardy even if vaccinated. No vaccine is 100% effective in any case, but they may also struggle to mount an immune response. That essentially means that the people at risk for H1N1 complications also warrant immediate consideration for antiviral treatment if symptomatic. Though it was unclear which group would be at the absolute front of the line, the people cited by the Centers for Disease Control and Prevention to receive H1N1 vaccine during a shortage are detailed as follows:

• Health care and emergency services personnel with direct patient contact

Frontline health care workers are a high priority because immunization will protect both them and patients, particularly those with underlying conditions. In a case that set an ominous tone for the resurging pandemic, a healthy 51-year-old oncology nurse who worked in Carmichael, CA, died in July of a coinfection with H1N1 influenza A and methicillin-resistant *Staphylococcus aureus* (MRSA). With MRSA endemic in many hospitals, this deadly bacterial-viral coinfection may hit other health care workers as the pandemic unfolds. In general, older people seem to have some residual immunity to H1N1, so younger health care workers may be at more risk of infection. There are concerns about maintaining adequate staffing to deal with a pandemic if health care workers are infected, or for that matter, not offered the vaccine. "I don't want to come to work and take care of an H1N1 patient if I am not vaccinated against H1N1," Kennedy says.

• Pregnant women

Historically at risk of flu infection, pregnant women appear to be highly vulnerable to H1N1 infection. "The highest-priority message is to treat pregnant women with influenza-like illness as soon as possible; treatment should not be withheld pending results of testing for influenza,

Supplement to *AIDS Alert, Alternative Medicine Alert, Critical Care Alert, Clinical Trials Administrator, Contraceptive Technology Update, Case Management Advisor, Drug Formulary Review, ED Nursing, ED Management, ED Legal Letter, Emergency Medicine Reports, Hospital Employee Health, Hospital Infection Control & Prevention, Hospital Case Management, Hospital Peer Review, Hospital Medicine Alert, Hospital Home Health, Healthcare Risk Management, Internal Medicine Alert, Infectious Disease Alert, IRB Advisor, Medical Ethics Advisor, OB-GYN Clinical Alert, Occupational Health Management, Patient Education Management, Primary Care Reports, Pediatric Medicine Reports, Practical Summaries in Acute Care, Same-Day Surgery, State Health Watch,* and *Travel Medicine Advisor.*

if testing is done," the CDC reports on its H1N1 web site. An excess of influenza-associated deaths among pregnant women was reported during the pandemics of 1918-1919 and 1957-1958. Adverse pregnancy outcomes have likewise been reported following previous influenza pandemics, with increased rates of spontaneous abortion and preterm birth, especially among women with pneumonia, according to the CDC.

The reasons pregnant women are so vulnerable are not completely understood, but prevailing theories include some compromise of the immune system, Kennedy says. "This is an observed phenomenon — when pregnant women get the flu, they get it bad," he says. "They can have a lot more morbidity and mortality compared to age-matched controls that were not pregnant."

• People who live with or care for children younger than 6 months of age

"When a child is born the only immunity he has is what is passed from the mother at the time of birth," Kennedy notes. Of course, if the mother has been immunized during pregnancy, some residual protection against H1N1 may occur in the infant. In general, however, unless their caregivers are immunized, infants with fledgling immune systems could be infected with H1N1. Safety concerns trump risk in terms of actually vaccinating babies, who may not have an immune response to the shot anyway, he adds.

• Children 6 months through 4 years of age

This group is expected to be able to achieve immunity, though the six-month cut point is somewhat arbitrary. "The older they get, the better they respond to protective immunity," Kennedy says. Some think this group and possibly older children may be particularly prioritized because children do not generally practice hygiene etiquette and are robust viral shedders when infected. Thus, immunizing children could have the secondary effect of protecting their adult contacts.

• Children 5 through 18 years of age who have chronic medical conditions

"People with underlying medical conditions — diabetes and renal failure, etc. — their immune systems are not normal," Kennedy says. "When they get flu infections they tend to be more severe. If you're going to target a protective strategy with limited resources you are going to be looking at who is likely to get [HIN1], but also who is going to do poorly if and when they get it."

According to the CDC, underlying conditions that could complicate H1N1 infection in all age groups include cancer, blood disorders (including sickle cell disease), chronic lung disease [including asthma or chronic obstructive pulmonary disease (COPD)], heart disease, kidney disorders, liver disorders, neurological disorders (including nervous system, brain, or spinal cord), neuromuscular disorders (including muscular dystrophy and multiple sclerosis), and people with weakened immune systems (including people with AIDS or those who are receiving chemotherapy).[1]

CDC recommendations for people with chronic conditions during the pandemic include:

— Seek medical attention if you have a fever and symptoms of the flu.

— Limit contact with crowds and avoid crowded places. If you can't avoid crowded settings, consider wearing a facemask or respirator to decrease your chances of getting infected.

— Be careful not to touch your face, and wash your hands often.

— It is estimated that staying at least 6 feet away from a person who sneezes or coughs may be a safe distance.

— Talk with your doctor about having a two-week supply of medication.

— Keep the name, phone number, and office address of your doctor or health care provider with you at all times. Find out the best way to communicate with your doctor.

— Get a written record of the kind of chronic disease(s) you have and the treatment you are receiving. Keep this information with you at all times.

— Prepare a typed or printed list of all medications usually taken and the times of day they are taken. Also include necessary medical supplies or equipment such as syringes, strips, lancets (if you have diabetes), or oxygen (if you have COPD).

— Determine how you will access ongoing medical care such as chemotherapy or radiation therapy. Ask your health care provider if they have a plan to deal with a severe flu outbreak.

— If you use medications for your condition, continue taking them even if you become sick with the flu, unless your doctor or health care provider says otherwise.

— Be alert to changes in your breathing, especially if you have heart failure, congestive heart disease, or COPD. Promptly report changes to your doctor or health care provider.

Reference

1. CDC. Information about the Flu — including the new H1N1 Flu — for People with Certain Medical Conditions. Available at: http://www.cdc.gov/flu/professionals/flugallery/2009-10/pdf/certain_medical.pdf. ■