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Are staff stealing your supplies and selling them on the Internet?

Warning: Nurse nabbed $300,000 worth of surgical goods

Surgical blades, a surgical camera, and laparoscopes disappear over two years from a hospital. The culprit? A nurse who admitted to stealing more than $300,000 worth of medical equipment and supplies from the hospital and reselling them over the Internet.[1]

Angela DeVarso, 33, stole the equipment and supplies by using her access to operating room areas to take the items, place them in a large bag, and take them home, according to the United States attorney for the District of New Jersey.[2] DeVarso admitted that she did so on several occasions and that the stolen equipment included large quantities of sterile sutures, staples, and vials. She faces a maximum penalty of 10 years in prison and a fine of $250,000 or twice the gross loss to the hospital.

"In this era, in these economic times, there are questionable motives on the part of people, and greater vigilance is essential," says **Larry Trenk**, president of the New Jersey Association of Ambulatory Surgery Centers in Oradell, NJ. However, "there are ways you can prevent this," says Trenk, who is the chief operating officer at Oradell-based Surgem, which develops, finances, and operates 10 multi-specialty surgery centers in New Jersey and Florida.

Outpatient surgery programs are "extremely vulnerable," he says. Not all such programs can afford security guards, expensive video systems, and other protective safeguards, he points out. "So as an organization, you have

EXECUTIVE SUMMARY

In these economic times, employees are finding ways to remove equipment and supplies from medical facilities.
- Segregate responsibilities of staff for a system of checks and balances.
- Monitor monthly supply costs and supply item usage.
- Keep an eye on your employees through video cameras or more informally by noting extravagant purchases that seem out of line with the employee's income.

AHC Media LLC

to have strict, concrete, internal controls: financial-, or procedural-, or documentation-wise," Trenk says. Consider these suggestions:

• Segregate responsibilities among your staff and also with your vendors.

Smaller outpatient surgery providers might lack a system of checks and balances, says **Mark Mayo**, an ASC consultant and executive director of the Ambulatory Surgery Center Association of Illinois. For example, Mayo says, problems arise when the "same person who opens the mail can post -- or not post -- payments to accounts." Or, that person might post the amount as a credit instead of a payment and keep the cash, he warns. "This looks like it's all OK and in balance as the patient has zero balance, so no more bills, and the credit adjustment stops the need to look for payment or for a deposit," he says. "This same person may be the office manager, who also prepares the deposit and takes it to the bank, minus some for themselves."

In other cases, items are charged to the facility but diverted for personal use, he says. This "can happen more in a larger practice where an item is coded as an approved expense for one of the doc partners, so others do not question," Mayo says.

You must have internal controls within your organization, Trenk agrees. There must be segregation of responsibilities among your staff, he says. For example, "the person who orders an item isn't the person who receives it," Trenk says.

In other cases, when the facility managers get "too cozy" with supply representatives, they have allowed reps to count the inventory for the facility, or they haven't checked the consignment bill against the actual use records, Mayo says. "There have been cases where supply reps have charged for consignment items not actually used," he says.

You don't want a rep counting your inventory, Trenk agrees. "That is a matter of restricting access," he says. "It's a no-no. You're asking for trouble if you let sales reps do the inventory for you." They will disregard par levels and inventory controls, and they propose that you purchase items, he says. "I've heard horror stories," he says. "They say, `You need one more. There's nothing on the shelf.'"

Another system of checks and balances is needed for medications, Trenk advises. There should be multiple sign-offs before medication can be dispensed, even through an automated dispensing process, he says. *(For stories on massive medication thefts, see p. 87 and p. 88.)*

• Monitor your data.

From a financial standpoint, monitor your costs for any blips or exaggerations in your supply cost expense on monthly basis, Trenk advises.

"One of the failsafes or internal controls you have: Ensure there aren't major discrepancies over a period of time," he advises. "Especially if you have the ability to identify and isolate your costs per case, you should be able to put up some kind of microscope as to what your costs are," Trenk says.

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Identify and understand your inventory levels and any inequities in cost over time, he says. "Understand your cost structure," Trenk adds.

• **Monitor for missing equipment.**

To avoid theft, look for sudden changes in your supply item usage, Mayo advises.

"If your supply usage is going up while your case volume is staying the same or is going down due to fewer cases, then you may want to watch out for unauthorized use or theft," he says. "You may also notice a change in use pattern for certain specialty areas like ortho supplies going up or other supply orders going up if your materials manager is in on the deal. They may order more, but the item not showing up in case use and still missing from inventory may equal theft."

Limit access to certain areas of inventory and equipment, Trenk advises.

• **Monitor your employees.**

Consider installing security cameras, Trenk advises. "That's a strong deterrence for employees dealing with equipment and services," he says.

Watch these employees

Be alert for those employees who work odd hours on weekends or are consistently the last persons to leave at the end of the day, Trenk says.

Additionally, be alert to any major changes in employee's lifestyle, in terms of purchases, he says. While acknowledging that you don't know the income of an employee's spouse, be alert to situations such as someone who makes $50,000 a year driving a Hummer, Trenk says. "Those are things that don't agree with one another," he says. "Be mindful."

An internal controls program, with periodic audits, is essential, Trenk says. "Most likely, the audits should be done by independent, objective third party," he says.

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2. United States Attorney, District of New Jersey. Nurse Pleads Guilty to Stealing Medical Equipment from Passaic County Hospital and Selling It on the Internet. April 27, 2010. Accessed at www.justice.gov/usao/nj/press/press/files/pdffiles/DeVarso,%20Angela%20Plea%20PR.pdf. ■

Large pill theft shows challenge of securing drugs

Drug theft is a vexing problem for any health care provider, but a health system in Texas is finding that the thefts can be on such a scale that federal investigators become interested and the community starts asking how the provider could have let the thefts continue for so long.

The Texas State Board of Pharmacy reacted forcefully to the theft of 370,000 pills from The Parkland Health and Hospital System of Texas, in Dallas, by what hospital officials and police say was a coordinated team of health system employees and criminals who sold the tranquilizers and painkillers on the street. In May, it levied $20,000 in penalties against Parkland for failing to prevent the massive narcotics theft, among the largest fine ever imposed for pharmacy wrongdoing in Texas, according to a statement released by the board of pharmacy.

The hospital system's troubles may not be over, however. **Ron Anderson**, MD, Parkland's president and chief executive, issued a statement saying the hospital system is cooperating with the federal Drug Enforcement Agency (DEA) and Justice Department prosecutors as they investigate the narcotics loss. Parkland discovered the problem in 2007 and it alerted regulators and fired some employees, including a supervising pharmacist who the health system says alerted subordinates to the Parkland investigation, the DEA reports.

The dismissed head pharmacist was identified by the health system and police records as Ronald Woody. A police affidavit indicates he told investigators "he had warned the pharmacy technicians of the ongoing theft investigation and that they needed to watch their backs, because they were all suspects," according to *The Dallas Morning News*.

Parkland self-reported the incident and asked

EXECUTIVE SUMMARY

A Texas hospital system is under investigation for a series of drug thefts within the hospital. Employees and outsiders worked together to steal drugs and sell them on the street.

- The health system has been fined and might face other sanctions.
- Safeguards were in place to discourage theft.
- The provider revamped its drug security program and hired a drug diversion officer.

the appropriate agencies to investigate, says Candace White, spokeswoman for the hospital. The hospital also sent a detailed letter to the State Board of Pharmacy explaining what hospital officials knew of the thefts and what actions had been taken in response. In the letter, the hospital says that "despite its commitment to improving the health and wellness of a culturally diverse community with a growing indigent population, Parkland was the victim of five employees, some of whom operated as a coordinated criminal ring, who abused their positions of trust within Parkland."

The hospital confirms that during 2007, five Parkland employees and two outsiders stole 500-count bottles of hydrocodone 10/650 mg, hydrocodone 5/500 mg, diazepam, alprazolam, and lorazepam. The drugs cost the hospital $13,247.59. Their street value was about $1 million, according to federal estimates.

Most troubling are reports that the drug thefts went on for nine months to a year before being discovered, says **Julie Malida**, SSA, MAAA, principal for health care fraud at The SAS Institute, a software company with a consulting group that addresses fraud and financial crimes, based in Cary, NC. "With the appropriate inventory tracking and the appropriate data analytics applied against that inventory management, there should never be a nine-month or 12-month period of loss before missing prescriptions are noticed," Malida says. "Inventory management should require multiple sign-offs before scripts can be dispensed, even if it is an automated dispensing process. Data analytics can examine prior patterns of dispensing and apply sophisticated modeling, rules, and linkages, to determine what spikes may constitute an outlier. This would enable the hospital and/or pharmacy to stop the bleeding before nine to 12 months of losses occur."

Such an extensive theft ring should not go unnoticed for months if the provider uses a tracking system that records drug inventory and all drug transactions, scanning on a regular basis for variances, Malida says. The data must be reconciled at the end of the day or the end of the week, and then analytics utilized to look for patterns of commonalities among any variances, she says.

"The advanced analytics will look for patterns and outliers that will reveal your problem much sooner than letting a year go by and realizing that 60% of your Valium and 10% of your hydrocodone is missing," she says. "You would never have to wait an entire year to discover those aberrations."

SOURCES

For more information on preventing drug theft in health care facilities, contact:

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Data analytics also would help you spot collusion among employees, such as was reported at Parkland. Malida points out that data analytics software will flag details that might be overlooked by investigators, such as the same people being involved in some or all of the thefts, or a pattern such as every 10th pill being stolen, or the same person signing for all the missing prescriptions.

"The first line of defense is having appropriate tracking and reporting processes in place," she says. "The second step is that, whether you use advanced analytics or not, someone has to be looking at the data on a regular basis. You can have a great inventory control system and security measures in place, but if you don't look at the data regularly and often, and deeply enough, you won't know if those measures are working." ■

Hospital details drug thefts

The theft ring at Parkland Hospital in Dallas was discovered and self-reported to all appropriate agencies by Parkland's director of pharmacy services, **Vivian Johnson**, according to a letter the hospital sent to the State Board of Pharmacy.

In that letter obtained by AHC Media, publisher of *Same-Day Surgery*, the hospital explains that once Johnson discovered the thefts, Parkland conducted its own investigation and spent about $1.3 million in system upgrades, additional security measures, and an independent review by Ernst & Young.

The Parkland Police Department's investigation at the Parkland Prescription Center led to the arrest and indictment of Sharron Benson, a pharmacy technician, who confessed to the diversions at the prescription center, according to the hospital's letter. Benson has been indicted and is awaiting trial. The police investigation at the Parkland

Community Oriented Primary Care Southeast Pharmacy led to the arrest and indictment of several Parkland pharmacy technicians, a drug dealer, and the husband of one of the technicians, according to the letter. "These individuals were involved in a conspiracy to steal controlled substances from Southeast [Pharmacy] and sell them on the street," the hospital's letter says.

The pharmacist in charge of the prescription centers was fired for alerting the pharmacy technicians that they were being investigated, the hospital reports. That pharmacist was one of the people arrested.

Parkland tells the State Board of Pharmacy that the losses were not the result of a failure to properly oversee the pharmacies. At the time of the loss, the sites of the theft had cameras, locked controlled substance cabinets, card access for cabinets and entrances, and comprehensive policies and procedures that conformed with federal and state law, the letter says. "Some criminally intentioned individuals simply decided to steal," the letter explains.

Parkland emphasizes in the letter that it had discovered the drug theft on its own, conducted an investigation, and terminated five employees. The hospital already has spent more than $1 million to prevent a recurrence of the drug theft, and it has implemented a significant loss prevention program that included the hiring of a drug diversion officer. ■

Ranking 95th percentile in patient satisfaction

Hamilton Ambulatory Surgery Center in Dalton, GA, has received the Summit Award from Press Ganey Associates for the fourth year in a row. The award recognizes health care facilities that rank in the 95th percentile or higher in patient satisfaction for three or more consecutive years, which means that Hamilton has achieved those scores for seven straight years.

The center's patient satisfaction scores range from the 95.6 percentile to the 98.1 percentile, says **Kristi House**, RN, BSN, the director of the center.

Achieving such consistent scores starts with the design of the center, House says. From its beginning, the center was created to present a warm, comfortable setting, she says. "We're trying to help with anxiety and stress," House says.

The design includes comfortable furniture, "warm" colors such as olive green, and a large family waiting area, she says. "We let the family get involved in the process as much as possible, up to the point of going to the OR, basically," House says.

Additionally, when patients are discharged and receive their instructions, they also receive a letter asking them to complete a survey, she says. "It has my number on it, and if they have any problem, they can call," House says. Including a self-addressed stamped envelope has helped boost the response rate to 42%, she says.

In addition to the questions compiled by Press Ganey, the center's administrators have added a couple, House says. One area added was waiting time and delays, because patients can become dissatisfied easily in those areas, she says. Patients are asked, "Were you given information about why delays are occurring?" and "Were you updated throughout the process?" Also, the center asks about IV sticks, which are a source of patient anxiety, House says. Patients are asked, "Do you think your nurse was skilled?"

By addressing these areas, "I think we've added some comfort through [addressing responses to] the questions about the process," House says.

Members of the surgery center staff also make follow-up calls the day after surgery to assess how patients are doing and to see if they were satisfied with their experience at the center.

Every member of the staff is committed to the patient care experience from registration to physicians to administration, House says. "We listen, respond, and respect the patient's needs," she says.

EXECUTIVE SUMMARY

Hamilton Ambulatory Surgery Center in Dalton, GA, has received the Summit Award from Press Ganey Associates for the fourth years in a row. The award recognized facilities that have scored in the 95th percentile or higher for three or more consecutive years.

- Survey questions were added in two areas of potentially great dissatisfaction: waiting delays and IV sticks.
- Staff members receive a small reward when a patient makes a positive comment or they are nominated by a fellow staff member or manager for doing "whatever it takes."
- Patients are called before their accounts are turned over to collection agencies.
- A quiz game with prizes encourages interdepartmental relationships.

Some of the strongest positive patient reactions are to the billing department, with the center sometimes receiving cards and letters mentioning the positive experience with that area, House says. "It's weird when someone mentions a billing person by name," she says. "You don't get that often" in medical care, House says.

The reason for the positive feedback? When a patient hasn't made a payment in 45 days, staff members make an attempt to contact them before taking any action to turn over the account to collections, House says. The result is that the center receives more payment, she says. Also, depending on the type of payment, some patients are offered discounts for timely payments, House says.

It all starts with a happy staff

Another sure way to keep patients happy: Keep your staff happy, House says.

"Of course if they're happy, they do a better job of caring for patients," she says.

At Hamilton ASC, the lounge/break area is not separated for physicians, she says. "We all congregate in the same area," House says. "They listen to opinions from staff about things that will work better. It's very open." Managers also solicit opinions from staff on improving patient care and staff morale, she says.

Staff members who go beyond their normal job duties are recognized with a "whatever it takes" card. Recipients of the card can be nominated by other staff members, physicians, or managers, House says. Also, staff members who are mentioned by name in positive comments from patients are recognized with the cards, she says. "It encourages them to go out of their way to be kind to all our patients," House says.

The cards offer a reward of a meal from the hospital cafeteria, a movie ticket, or a gift certificate to the gift shop, she says. It's important that "they have some value to them," House says.

Also, interdepartmental relationships are fostered through an ongoing game at the center, she says. A box in the lounge posts questions, and staff must find answers by talking to people in other departments, House says. For example, the question "What do the colored letters on the patient file stand for?" might send staff to the business office to get an answer. "It helps them understand what others' jobs are," she says. Staff members who compile all of the correct answers receive a reward comparable to the "whatever it takes" cards, House says.

The center's administrators also plan a group outing once or twice a year, she says. Recently, staff attended a minor league ball game on a weekend, and family members were invited, House says. "I think that helps with morale here," she says.

Despite their success with patient and staff satisfaction, the center isn't stopping its efforts to improve. Press Ganey provided an analysis of the areas of greatest increases and decreases. "We look at areas we need to maybe improve on," House says.

The administrators take the patient satisfaction scores and discuss them at staff meetings, along with patient comments. "We say, `This is the way we're being viewed,'" House says.

The administrators and staff are always looking to improve, she says. "Even though we won [Press Ganey recognition] four times, we want to meet and exceed that level if we can," House says. "We don't want to get complacent with it." ■

SOURCE

For more information on improving patient satisfaction, contact:

• **Kristi House**, RN, BSN, Director, Hamilton Ambulatory Surgery Center, Dalton, GA. Phone: (706) 876-5002. E-mail: khouse@hhcs.org.

Same-Day Surgery Manager

Managing patients' time — Fair to make them wait?

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

I go through 400-500 patient satisfaction surveys per month. Like you, I am relatively busy just getting through life, but these are 400 to 500 patients and their family taking time out of their lives to tell me how we are doing as a business. Regardless of what you might think, health care in 2010 is a business!

Included each month in these missives are the usual, but the ones thing that continuously stands out are:

"I waited for almost two hours before I was taken back to the changing area."

"My time is important, and why did I have to show up 90 minutes before surgery when you did nothing to me in that time?"

"If I knew I was going to have to hang around doing nothing for two hours, I would have brought my laundry with me!"

"You are getting paid for this, I am paying you. Why did you make me wait so long!?"

Come on, people! We can do better than this!

"I sat in your waiting room for an hour before anyone called my name ... I counted eight different staff people in your waiting area. Not one of them came over and told me when I would be taken care of. It was that way with all of us in the waiting room. I will never be back!" (Author note: I called her personally and apologized. She told me to go to hell -- seriously!)

"This is no way to run a business. No matter how well everything else was, the time I said around doing nothing ruined the experience for me!"

I promise you that most of your patient complaints are time-related. If you are not reading these surveys every month or distributing their contents in staff meetings, you are missing a great chance to make a difference at your facility.

When should you have the patients show up to your facility? Thirty minutes before surgery? Two hours? What is the right amount of time?

Most of us know that the surgeon puts pressure on us to have the patients arrive very early in case someone cancels or he/she is ahead of schedule. There is some merit to that, but at the inconvenience of the patient. So, question: Who should be inconvenienced, the surgeon or the patient? You can argue both very rationally, but someone is going to be put out either way. What usually happens is the surgeon wins 95% of the time. Again, you can rationalize it back and forth and make it seem right, but still -- what about the patient's time?! You've got to figure that there are many other places they would rather be than sitting in the waiting room. I mean, after all, they are the one paying for this. After they have figured out what everyone else in the room is having done, it gets pretty boring pretty quick!

If you delay a person's flight on an airline, the airline gets fined in an effort to force the airlines to be more cognitive of their travelers' time. Is that what it is going to take? Are we going to be government-regulated? (Well, we probably will be anyway.)

I estimate that I will receive a large number of e-mails after this is published defending the facility for having the patients show up earlier than they need to, just so they know the patient will be there! Or I'll receive e-mails saying that anesthesia needs to see the patient, and they need that much time. Or they'll say that their lab work cannot be ready in time. Or they'll say those cases will be canceled if they are not there two hours before surgery. Or they'll say they cannot be trusted to find the center. Or, or, or! I have heard them all before, and none of these excuses are valid.

Many centers still have the patients come in several days before surgery to have their lab work performed and to be seen by anesthesia. If you are one of those centers, then you are about 10 years behind the times and should be ashamed of the way you disrespect your patients. What you are doing is making the patients work around your schedule. It should be the other way around.

If I receive enough responses to this column, I will devote a future column to explaining, in detail, how you can have your outpatient surgery patients show up 45 minutes before surgery and not require a pre-op visit earlier in the week. If that is interesting to you, let me know. *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management.]* ■

Steps to determine validity of vendor

[Editor's note: This is the second part of a two-part series in avoiding liability in contracting. In last month's issue we told you about how you can end up contracting with the wrong company and what your liability can be. In this issue, we give you specific steps to take to investigate vendors, and we offer a list of items to watch for in the contract. We also discuss accreditation requirements.]

When looking at contracting with an outside vendor, follow the paper trail, say experts interviewed by *Same-Day Surgery*.

Look up the company's articles of incorporation, suggests **Richard Bays**, RN, MBA, CPHQ, CLNC, health care consultant with R Bays Consulting, Houston, TX. This information

should be available on the secretary of state's web site in the state in which they organized. Public records often list the officers, Bays points out. "That's a big deal, if someone is holding themselves out as the CEO or COO or authorized agent to make decisions at a certain level," he says. The date that the articles of incorporation were filed indicate when the corporate structure was initiated, Bays says.

When Bays was looking at contracting with one company, he cross referenced to another company they were supposedly affiliated with, but the second company had different officers, he says.

"They said it was a different entity formed prior, and since modified, but they didn't modify with the state," Bays said. Tax statements indicated different tax ID numbers, he says. "What we found out was that they were operating independently and paying taxes as two entities," he says.

When Bays asked for clarification, he found out that one operated out of another state, and there were two sets of investors. Because the representatives of the business had not been upfront about their organizational structure, Bays decided not to do business with them. "The word 'fraud' comes to mind," he says.

Ensure the company has named all of its locations and entities, Bays suggests. You can ask for a copy of their insurance contract and look under "locations and entities," he says. You also can cross reference what you find with the articles of incorporation, he says.

Consider these other suggestions:

• **Follow the money trail.**

Look at the vendor's tax status, Bays advises. Your state might have a comptroller of public accounts that can be accessed online, he says. You can determine the vendor's tax status and use the company's taxpayer ID number to cross reference, Bays says.

Vendors who are licensed by the state department of pharmacy also might have tax records, he says.

Bays points out that the Office of Inspector General has a web site with a list of individuals and entities excluded from federal contracts (oig.hhs.gov/fraud/exclusions/exclusions_list.asp). The General Services Administration also has an excluded parties list (www.epls.gov), he says.

• **Consider a request for proposals (RFPs).**

RFPs can be useful when a contract is complex and spans more than one year, or touches several facets of your organization, says **John Schario,** MBA, CEO of Nueterra Healthcare in Leawood, KS.

"RFPs allow you to clearly articulate the parameters of your service needs," Schario says. "It is the who, what, when, and where along with service expectations and response times."

However, determine how much you want to disclosure, Bays advises. "If it's a construction bid, it's fine to get more competition in," he says. However, if it's a more sensitive area such as a line of business you're considering developing, you'll want to be more discreet, Bays advises.

Representatives of group purchasing organizations (GPOs) often are willing to confirm whether a vendor is a member of the GPO, even if the facility requesting the information is not a member of the organization.

• **Credential.**

Anesthesiology services are being contracted more often to outside groups, Schario says.

"In those cases it is even more important to understand who you are dealing with and who will be delivering the actual service," he says. "I would encourage interviewing the actual service providers to make sure that their credentials meet your standards and that their attitudes regarding customer service and interpersonal interaction match your surgery center's culture."

Ask if the anesthesiologists have worked with CRNAs, says **Stephen Trosty,** JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI. Ask how many OR suites were assigned to each anesthesiologist, he says. Also ask how they hire CRNAs and ask about their qualifications,Trosty says.

Find out how long the vendor has been providing the service and what organizations they provided their services for, he says. Obtain references for the individual physicians, Trosty advises. Ask if those physicians are affiliated with the organizations and whether the organization did independent credentialing, he says.

In the case of anesthesiologists, surgeons should talk to surgeons in their specialties at the facility where the anesthesiologists currently are working, advises **Mark Mayo,** an ASC consultant and executive director of the Ambulatory Surgery Center Association of Illinois. Another option is for the manager to contact the surgeons, Mayo says. Ask if they are pleased with the professionalism of the anesthesiology team, he advises.

Know your vendor and know who they are using to provide the service, Schario advises.

"I would mandate the right to interview and approve all staff coming into my facility and working on my patients," he says. "Credentialing is an important part, but I would not sacrifice a face-to-face interaction." ■

Contract pitfalls you should avoid

Finding a vendor you want to do business with is only the first step, says **Richard Bays**, RN, MBA, CPHQ, CLNC, health care consultant with R Bays Consulting, Houston, TX.

"Most contracts you have to look at closely," Bays says. Examine these areas:

• **Payment terms.**

Payment terms and fees associated with late payments can be a surprise, says **John Schario**, MBA, CEO of Nueterra Healthcare in Leawood, KS.

Ask how soon their accounts payable (A/P) department can process a monthly service bill, Schario suggests. He says to ask, "if the invoice is due within five business days after the close of a month, can you make that?" Also determine whether if you miss that deadline, you are assessed interest or late fees. Also, make sure you give your A/P department adequate time (15-30 days) to process payment, Schario says.

• **Extra fees**.

Service repair contracts, especially, can hide extra fees for items you consider standard, Schario warns.

"Watch for when overtime rates are charged and how much after-hours call will cost you," he advises. Some contracts begin overtime rates at 3 p.m., Schario warns. "If your service repair contract covers parts, does it cover new or only refurbished parts, or is that the choice of the vendor?" he says to ask.

Also, be aware of large fees for routine or "special delivery" shipping and handling fees for "rush" orders. Sometimes the processing and shipping bill can exceed the cost of the item, sources warn.

• **Notification of concerns**.

Know how to properly notify your vendor of concerns, Schario says. For example, "I may be expressing concerns to my sales rep, but by the terms of the agreement, I have to express those concerns in writing and send them to a specific address to be compliant with the contract," he warns.

• **Assignment.**

Often contracts are assignable to affiliated companies, Schario says. "And when that language exists, ask about those affiliated companies and the likelihood of a transfer," he says. "In the end, if the vendor is misrepresenting itself, that can usually be uncovered through references, banking relationships, or a simple credit check."

If the services can be assigned to another group at the discretion of person singing contract, look at that clause and mutually agree upon it, Bays says. "If you agree to unilateral ability to assign a contract, you may have someone sent to you [that] you never saw before," he warns. "You may be unhappy with them, unhappy with the quality of service. This happens a lot."

• **Indemnification.**

When a vendor asks for indemnification or a hold harmless agreement, look at what you're actually doing for that vendor, Bays advises. "Don't sign something that gives them all the favor, he says. "Make sure it's a level playing field."

Ask, "Are you going to indemnify me, and at what level?" Bays suggests. You don't want global indemnification for your vendor, he says. Be specific, Bays says.

• **Term and termination.**

Termination clauses are important, Schario says. "How you get out of a contract can often be expensive or not available," he says.

Determine how you renew a contract and under what timeframe, Schario advises. "Many people get caught in evergreen contracts with automatic increases simply because they did not realize they had to give 90 days notice and are now looking at a three-year extension," he says.

Termination, breaches and cure periods should be specified to protect yourself, Bays advises. You might have a clause addressing material breach of contract, with a mandatory cure period, he says. "It's an opportunity for the person in breach to rectify, within the confines of the agreement," Bays says.

"Examine these areas closely with any contracts: medical supplies, linens, services for physicians, anything," Bays says. "See where you stand if you want to terminate or modify services."

Also, don't forget standard questions such as whether the vendor is licensed if needed, whether

they carry a minimum amount of general liability insurance, sources say. You need a copy of the insurance certificate and if you are a named-insured, ensure you are notified if the vendor drops the insurance, they say. ■

Build a process to manage contracts

Managing contracted services is required by The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), and the Centers for Medicare & Medicaid Services (CMS), and if not managed well, can be a huge risk to your organization. As **Frank Ruelas**, MBA, principal of www.hipaabootcamp.com and director of compliance and risk management at Maryvale Hospital in Phoenix, says, "if it happens under your roof, you better know what's going on."

The Joint Commission requires an annual evaluation of whether to continue or terminate a contract. AAAHC requires a continuous and ongoing evaluation off all issues within an ambulatory facility, including contracts, by the governing body; however, responsibility for contracted services can be delegated, says **Marsha Wallander**, assistant director of accreditation services at AAAHC. CMS requires that a senior staff person be responsible for contracts, which led to a new element of performance this year for The Joint Commission, says **Michael Troncone**, FACHE, principal of Michael T. Troncone and Associates and administrator for patient intake services at Calvary Hospital in the Bronx.

Because it's a high-risk area, accreditation groups might be looking closely at this, Troncone says. Can you imagine, he asks, going in front of a judge and saying "No your honor, I didn't know the person installing the new televisions was a sexual predator. No your honor, I didn't know what cleaners the window washer was using, and I didn't know he was going to use bleach and ammonia to wash our windows." He evens recounts a story of a surgeon bringing in his unemployed brother-in-law to assist in surgery.

Troncone says that, when thinking about contracted services, a manager should ask: "Who is representing the facility? Do those contracts you have in place meet all the appropriate regulatory and legal requirements? Are we getting our money's worth? Are we getting what we paid for?"

Getting started

Troncone suggests these steps to effectively manage all contracted services:

- Perform an inventory of all the contracts in your organization.
- Establish a centralized process for managing them.
- Ensure that there's a formal approval process for all of the different kinds of contracts.
- Have criteria for managing each type of contract.
- Create performance measures for each type of contract.
- Have a review and renewal process for each type of contract.

The Joint Commission requires a process for corrective action, should a contract fail to meet required specifications, and a contingency plan for contract termination.

Who should be at the table? Troncone suggests:

- an expert panel to review the contracts;
- a legal expert to review the contract language;
- a privacy officer to approve business associate and confidentiality clauses;
- subject matter experts, "people who are familiar with the performance of that particular clinical or nonclinical service so they can approve the services and methodology of the delivery of services and establish performance indicators";
- an administrative authority who approves the contracts.

He also promotes using templates for your contracts and assigning responsibility for each contract to a senior lead, with the department head most closely associated with the particular service monitoring the contract day to day to ensure quality and delivery of services. That department head reports on the contract to the contract management group.

"By having that department head involved on a daily basis, problems are identified early," Troncone says. Each department head might have up to seven contracts, but it's within his or her span of control, he says. They should have a checklist with the appropriate indicators, which could be supplied by the contract management company or by data already collected on that service line.

The contract management group should meet

at least once a year to determine if a contract should be renewed or terminated, and if terminated, where you are going to go to get the service. Troncone says you should be able to review 25% of your contracts at the meeting. The department head should make a recommendation for renewal or termination. The second item on the agenda should be any worrisome contracts and what you're going to do about them, he says. Look at whether you have identified a need for a new contracted service.

Consider a one-year term agreement, sources suggests. A one- year term forces an annual review, so vendors are less likely to ignore you for years, they say.

You also need to ensure your contracted services are oriented to your policies. For example, gardening services are spraying pesticides and fertilizers and using power equipment. Troncone says you should ask yourself: "Do they know where the oxygen lines are? Do they know where your air intakes are so they're not spraying pesticides in the air intake for the operating room? Are they following the appropriate infection control procedures?"

If you take anesthesiologists, he says, "What standards are they following? What are their outcomes? If an anesthesiologist call in sick, who do they provide as back up? Is it someone who's already been oriented and privileged by the hospital?"

With accredited services, you should be aware of their accreditation status. With those not accredited, you should do your own "tracer" of sorts, Troncone says. You should make sure they're fulfilling standards. "So you need to do an onsite review," Troncone says. "You need to review and approve their policies and procedures. You need to ensure that they're doing all the appropriate life safety things, and that means you need to get your infection control person, your safety officer, your privacy officer, and your clinical people to do an in-depth review."

Medical staff should have the opportunity to review and comment on clinical services and performance data. Troncone says the corporate compliance officer should ensure that contract terms and bidding and awarding of contracts meet the organization's corporate compliance requirements.

Offsite services should meet credentialing and privileging standards. "Clinical services require the most intensive orientation, and the organization has to ensure current competency, licensure, education, and continuous improvement of competency for contracted clinical staff," Troncone says. Maintain a personnel file for each clinical staff person.

Surveyors with an accreditation agency are "not going to sit down and review individual contracts and [try] to identify a problem," Troncone says. "If they identify a pattern or trend with contracted services, they will certainly start reviewing contracts."

They might ask to see a contracted person's competency and credentialing and privileging files. They might ask people on the floor if contracts are being monitored or if services are being delivered appropriately, Troncone says.

They might ask senior leadership if there is a process for managing contracted services, he says; or if someone is installing television, they might ask if he or she got an infection control and patient privacy inservice.

The most work-intensive part of the process is getting all the contracts together and creating your process for managing them. "Once the process is set up, ongoing compliance becomes easy," Troncone says. ■

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

- Should your CRNAs be supervised? What is required
- Are you ready for a life-threatening emergency?
- What facilities are doing to avoid surgical errors
- Helping patients prepare for the day of surgery

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.

5. How was the theft of 370,000 pills from The Parkland Health and Hospital System of Texas discovered?
   A. The State Board of Pharmacy reported irregularities to the hospital system.
   B. Local police traced illegal narcotics back to the hospital pharmacies.
   C. The Drug Enforcement Administration detected a high rate of narcotic prescriptions.
   D. The Parkland Health and Hospital System discovered the thefts on its own.

6. Why does the billing department receive such positive feedback at Hamilton Ambulatory Surgery Center, according to Kristi House, RN, BSN, director?
   A. When a patient hasn't made a payment in 45 days, staff members make an attempt to contact them before turning over the account to collections
   B. The preoperative call from the billing department
   C. The patient education literature includes billing information
   D. Patients are given generous time periods to pay their bills.

7. Where can you find a list of individuals and entities excluded from federal contracts?
   A. Office of Inspector General (OIG) web site
   B. General Services Administration (GSA) web site
   C. Both the OIG and the GSA web site
   D. Neither the OIG nor the GSA web site

8. Some service repair contracts begin overtime rates at what time, according to John Schario, MBA, CEO of Nueterra Healthcare in Leawood, KS?
   A. 2 p.m.
   B. 3 p.m.
   C. 4 p.m.
   D. 5 p.m.

Answers: 5. D 6. A 7. C 8. B