Same-Day Surgery®

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Court case, study raise question: Should your CRNAs be supervised?

A patient goes in for a colonoscopy in which a certified registered nurse anesthetist (CRNA) provides anesthesia care. According to the subsequent lawsuit filed by the family, the patient told the CRNA that he had sleep apnea and used a continuous positive airway pressure machine (CPAP) when sleeping.[1] The CRNA looked at the patient's neck, said it looked normal, and administered a reduced dose of propofol, the lawsuit says.

The patient deteriorated, and the CRNA tried to intubate but couldn't, according to the lawsuit. The CRNA performed a cricothyroidotomy to open the airway and administered CPR for 45 minutes, it says. The patient died. The family maintains that because the patient had a history of sleep apnea and difficult intubations in prior surgeries, the CRNA should have been supervised by an anesthesiologist and should not have used propofol. The CRNA and the hospital have maintained that they were not negligent.

"I think this case is an excellent example of why an anesthesiologist

EXECUTIVE SUMMARY

In a recently filed lawsuit, a patient reported to have sleep apnea died after deteriorating during a case in which anesthesia services were provided by a certified registered nurse anesthetist (CRNA) who was not supervised by an anesthesiologist. Also, a study has been released that shows no differences in outcomes when anesthesia was provided by CRNAs, anesthesiologists, or CRNAs supervised by physicians.

- State laws control the scope of practice for CRNAs. Clinical privileges should be based on their education, training, experience, and expertise.
- In the case of high-risk patients, an anesthesiologist should have input on the anesthetic, one source says.
- If an anesthesiologist is supervising a set number of CRNAs, the number should be manageable.

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should be involved in difficult or potentially difficult cases and/or why an anesthesiologist should be available to immediately to respond to a problem," says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI.

A CRNA must understand when to call an anesthesiologist and should be required to do so when merited, Trosty maintains. "The fact that there had been previous problems with intubation, coupled with the sleep apnea, are indications that this should have been done by an anesthesiologist and not a CRNA," he comments.

The history of prior problems with intubation, combined with the sleep apnea, make this a more difficult case than usual, Trosty says. "To say that 'the neck looked normal' is not adequate in a case such as this," he says.

The Centers for Medicare & Medicaid Services (CMS) prohibits Medicare payments to hospitals and ambulatory surgery centers (ASCs) when CRNAs provide anesthesia care in the absence of physician supervision, although the requirement does not specify that the physician must be an anesthesiologist, according to the American Association of Nurse Anesthetists (AANA). However, starting in 2001, CMS began allowing states to "opt out" of this requirement for CRNAs, the AANA says. Since that time, 15 states have opted out. *(See list of states, p. 111.)*

Even if a governor elects to opt out of the requirement, hospitals and ASCs still can require physician supervision of CRNAs through their own bylaws, the American Society of Anesthesiologists (ASA) points out. In addition to bylaws, your policies can designate when and where CRNAs can provide anesthesia, says **Patricia S. Calhoun**, JD, associate at Buchanan Ingersoll & Rooney, Tampa, FL. "For example, some bylaws require the anesthesiologist to be present during intubation, and some require anesthesiologist to administer spinal anesthesia," Calhoun says. *(For more on anesthesiologist supervision, see story, p. 111.)* Also, many states have their own statutory physician supervision requirements, according to the ASA. There are no accreditation requirements regarding anesthesiologists' supervision from The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), or American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF).

Although the colonoscopy patient's death occurred in a state (Kentucky) that hasn't opted out of the federal supervision requirement, there was a supervising physician: the gastroenterologist performing the colonoscopy, Calhoun says. "The bigger question might end up being should that facility permit CRNAs to administer anesthesia to patients with known sleep apnea and a history of difficult intubations," Calhoun says.

The controversy over physician supervision

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recently gained strength after a published study found no differences in outcomes when anesthesia was provided by CRNAs, anesthesiologists, or CRNAs supervised by physicians.[2] *(For more on that study, see story, p. 112.)*

Tips for avoiding liability with CRNAs

State laws control the scope of practice for CRNAs, so managers should "review that state's nurse practice act to determine the scope of practice for CRNAs in their state," Calhoun says.

Additionally, outpatient surgery managers should determine clinical privileges for CRNA based on their qualifications: "education, training, experience, and expertise," Calhoun says.

In the case of an actual or potential high risk patients, an anesthesiologist should have input regarding the type and amount of anesthetic to be used, says Trosty, who adds that "the CRNA has to recognize his/her more limited education and more limited skills."

Trosty says to consider the example of a patient with sleep apnea, which "presents a potentially more hazardous patient when it comes to anesthesia." Patients with sleep apnea can have somewhat obstructed airways, he says, "which makes it even more imperative that there be the involvement of an anesthesiologist, at least in the selection and amount of the anesthetic, and that there be an anesthesiologist available to step in immediately if there should be a problem, as was true in this case" above.

However, in the recently published study on CRNA supervision, the authors controlled for all manner of comorbidities, says AANA President Paul Santoro, CRNA, MS, chief executive officer of Anesthesia Staffing Consultants in Bingham Farms, MI. The AANA's position is that decisions regarding physician supervision "need to be made at the local level, where patient acuity and provider competencies are all taken into account. Those decisions are best made at local level, and not at Washington, DC."

With the implementation of health care reform coming by 2014, there will be 30 million new insured Americans, Santoro says. "Medicare and our entire health care system need to look at ways of improving efficiency in delivery of high quality care," he says. "We should start with elimination of unnecessary federal regulations which drive up costs and decrease access to care." *(For more on the issue of supervision of CRNAs, see "Study: CRNA-Only Anesthesia Delivery Is Most Cost Effective,"* Same-Day Surgery Weekly Alert, *July 9, 2010.)*

List of "Opt-out" States

- Alaska (October 2003)
- California (July 2009)
- Kansas (March 2003)
- Idaho (March 2002)
- Iowa (December 2001)
- Nebraska (February 2002)
- Minnesota (April 2002)
- Montana (January 2004)
- New Hampshire (June 2002)
- New Mexico (November 2002)
- North Dakota (October 2003)
- Oregon (December 2003)
- South Dakota (March 2005)
- Washington (October 2003)
- Wisconsin (June 2005)

RESOURCES

For more information on physician supervision of certified registered nurse anesthetists, see the following:

- Scope of Practice of Nurse Anesthetists, American Society of Anesthesiologists. Web: www.asahq.org/Washington/nurseanesscope.pdf.
- The American Association of Nurse Anesthetists. Web: www.aana.com. Select "Advocacy," and then "State Issues." Under "Resources," Select "Information on Opt-Outs and Federal Supervision Requirements."

REFERENCES

1. Curtis v. Hohlbein. No. 1 (US District Court, Western District of KY) April 27, 2010.
2. Dulisse B, Cromwell J. No harm found when nurse anesthetists work without supervision by physicians. *Health Affairs* 2010;29:1469-1475. Doi: 10.1377/hlthaff.2008.0966. ■

Source: Limit number of CRNAs being supervised

Role of anesthesiologist debated

If an anesthesiologist is supervising a set number of certified registered nurse anesthetists (CRNAs) during procedures, the number being supervised should be kept to a manageable level,

says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI.

Trosty's previous employer, a medical liability insurer, would not insure an anesthesiologist who supervised more then four CRNAs at one time, he says. Additionally, "there had to be a backup anesthesiologist available at all times if the supervising anesthesiologist is required to go and help a CRNA, and another anesthesiologist should be available to take over the supervision of the other CRNAs," he says. "Ideally, we there should be only three CRNAs being supervised while doing procedures, but four was acceptable."

The president of the American Association of Nurse Anesthetists, however, takes a different stance. Paul Santoro, CRNA, MS, chief executive officer of Anesthesia Staffing Consultants in Bingham Farms, MI, points out that Medicare requirements are for physician — but not specifically anesthesiologist — supervision, and that supervision is required only for facility reimbursement, not physician reimbursement. "I think it's important to note that in all 50 states, CRNAs can practice safely without anesthesiologist supervision," Santoro says. ■

Associations debate meaning of research

Study finds no harm with no supervision

There are no differences in patient outcomes when anesthesia services are provided by certified registered nurse anesthetists (CRNAs), physician anesthesiologists, or CRNAs supervised by physicians, according to the results of a new national study conducted by RTI International.[1]

"The RTI findings demonstrate that the Medicare physician supervision rule for CRNAs is obsolete and unnecessary," the American Association of Nurse Anesthetists (AANA) said in a statement.

The study, titled "No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians," was sponsored by the AANA and appears in the August issue of *Health Affairs*. The study examined nearly 500,000 cases.

The authors compared patient outcomes in states where the Medicare requirement for physician supervision of CRNAs is in place with outcomes in 14 states that had opted out of the requirement between 2001 and 2005. It found that the opt-out requirement did not result in increased deaths or complications. The study also compared outcomes by provider type and found no differences in patient outcomes of anesthesia services delivered by solo CRNAs, by solo anesthesiologists, or by CRNAs being supervised by anesthesiologists.

The authors recommend that the Centers for Medicare and Medicaid Services (CMS) allow CRNAs to work without physician supervision. The authors say that repealing supervision "would free surgeons from the legal responsibility for anesthesia services provided by other professionals [and] would also lead to more-cost effective care as the solo practice of CRNAs increases."

James Walker, CRNA, DNP, former president of the AANA, said, "The results validate what we have known all along: that the quality of care and safety record of nurse anesthetists is of the highest caliber, regardless of physician supervision."

The research shows no disparity in care in states that have opted out of the supervision requirement, Walker says. "In fact, the opt-out states have given nurse anesthetists the opportunity to prove, beyond a shadow of a doubt, what patients are most interested in knowing, and that is whether anesthesia is equally safe when provided by CRNAs or their physician counterparts," he says. "I'm happy to emphatically report that yes, it is."

AANA President **Paul Santoro**, CRNA, MS, chief executive officer of Anesthesia Staffing Consultants in Bingham Farms, MI, said, "This study should encourage other states to think critically about their health care needs and how nurse anesthetists can expand access to anesthesia services."

The American Society of Anesthesiologists (ASA) retorted with a strong response calling the study "an advocacy manifesto masquerading as science."

"It makes dangerous public policy recommendations on the basis of inadequate data, flawed analysis and distorted facts," according to the ASA statement. It is impossible to perform meaningful analysis of anesthesia outcomes solely from billing codes, the association said. "The paper acknowledges that anesthesiologists care for patients undergoing the most complex procedures, but does not recognize that this is also true for the sicker patients undergoing even routine surgery," the ASA said.

The authors claim that the training of nurse anesthetists and anesthesiologists is basically equivalent, the ASA said. "Since nurse anesthetists receive approximately two and a half years of training following the bachelor's degree and anesthesiologists spend eight years preparing for practice after the pre-medical undergraduate education (four in medical school and four in residency), this claim defies arithmetic," the association said.

The authors also claim that unsupervised nurse anesthesia is more "cost effective," the ASA said. "Considering that the payment for anesthesia services under Medicare's system (adopted by most private insurers, too) is identical whether provided by an unsupervised nurse, solo physician or the physician/CRNA team, the fallacy of the 'cost effective' claim is evident," it said. *(For more information on the study, go to www.aana.com/optoutstudy).*

REFERENCE

1. Dulisse B, Cromwell J. No harm found when nurse anesthetists work without supervision by physicians. *Health Affairs* 2010;29:1469-1475. Doi: 10.1377/hlthaff.2008.0966. ■

Anxiety about anesthesia may up postponements

Lack of understanding and apprehension about anesthesia might lead as many as one in four patients to postpone surgery, according to the Vital Health Report, a quarterly health survey of Americans by the American Society of Anesthesiologists (ASA).

The survey was administered online June 7-9, 2010, to 1,019 Americans split evenly between men and women age 18 plus. The survey consisted of 44 questions.

More than 75% of Vital Health Report respondents expressed concern about the use of anesthesia during surgery. However, anesthesia-related mortality rates have decreased dramatically over the past 25 years, from two deaths per 10,000 anesthetics administered to one death per 200,000 to 300,000 anesthetics administered. To put this into perspective, a person is about 40 times more likely to be struck by lightning than they are to die from anesthesia-related complications, according to the ASA.

The Vital Health Report also found that there is a lack of knowledge about anesthesia. Nearly 40% of Vital Health Report respondents incorrectly believe that being under general anesthesia is the same as being asleep, while 17% of those surveyed mistakenly think that general anesthesia numbs a small area of the body without altering a patient's awareness.

The ASA urges Americans to educate themselves about anesthesia and to maintain their health. It suggests patients not only live a healthy lifestyle, but also make sure they know the status of the underlying vital measures that ultimately define their health and impact wellness and positive medical outcomes.

Outpatient surgery staff can encourage patients to go to www.knowyourvitalhealth.com to learn more about anesthesia and to use the Know Your Vital Health Tool. The tool offers a series of health-related questions from which patients receive a customized, anonymous report of health and wellness information that can help them better understand their health status and anesthesia risks. The tool also offers health management and modification suggestions.

The ASA suggests these tips to patients who will be undergoing a procedure that requires anesthesia:

- Discuss your medical history and inform your anesthesia provider about the medications you are taking or have recently taken, including herbal remedies.
- Ask your anesthesiology provider about the anesthesia that will be administered, the duration of the anesthesia, and the associated risks for a person with your medical profile.
- Check the credentials of the staff performing your procedure, including the anesthesia provider.
- Work to be in the best possible health prior to your procedure. ■

Class on financial end of surgery defuses confusion

Hospital administrators understand that the complexity of health care insurance and billing these days requires continuous education of staff.

However, financial leaders at the Cleveland Clinic in Independence, OH, have realized that if patients aren't educated about all these issues as well, they are understandably confused and even

angry when they are presented with out-of-pocket charges that they did not anticipate.

"Patients come to us because we provide outstanding quality of care, and they expect and deserve the same level [of quality] from a billing perspective, and the more complicated we make it, the more we are immune to their needs and the less likely the patient is to return," explains **Susan Milheim**, MA, senior director of patient financial services at the Cleveland Clinic.

To mitigate some of this confusion and arm patients with the information they need to understand their benefits and obligations, the health care system has developed free courses that patients can take to help them better navigate the financial aspects of their care. "The idea came out of focus groups we held when we were revamping our patient statement," explains Milheim.

Input that the health system received made it clear that patients would be receptive to this type of education. The classes were rolled out in mid-2008, "The classes have been very well received by our patients," Milheim says.

Given that the classes are open to anyone in the community, part of the strategy is to attract new customers to the Cleveland Clinic, she says. Milheim says the classes are well-attended.

"We get between 30 and 50 people per session, depending on what it is," she says.

One quarterly class, Preparing for your Surgery, is designed for patients who are scheduled in advance for surgical procedures. *(See box, right, for learning objectives.)*

Patients are sent a postcard in an envelope that tells them about the class and invites them to bring their insurance information when they attend. The trainers walk them through the referral process and precertification. They tell them what out-of-pocket expenses to expect and how to read their benefit package, says Milheim.

"We try to have those conversations and educate them as much as we can," she says.

The class is offered at the family health centers, regional hospitals, and the Cleveland Clinic main

EXECUTIVE SUMMARY

Financial leaders at the Cleveland Clinic in Independence, OH, have found that it isn't enough to train their front-line staff about the complexities of insurance and billing. They think that providing classes to patients on high-interest areas of financial concern can mitigate confusion and dissatisfaction while also strengthening the partnership the health system has with its customers.

- The health system has developed courses that deal with such topics as the financial aspects of preparing for surgery.
- Satisfaction surveys indicate that patients appreciate the classes and think they should be more visible.
- Administrators observe that patients who have attended the classes have a better working relationship with financial coordinators.

Preparing for Your Surgery from a Financial Perspective Learning Objectives

After completing this program, patients will be able to:

- Define key insurance and billing terms
- Identify steps taken prior to surgery to ensure smooth billing process
- Insurance Verification (verify if coverage is active, identify co-pays, deductible, co-insurance, and determine if pre-certification is required)
- Pre-Certification /Authorization (if required)
- Co-Pay/Co-Insurance/Deductible
- Differentiate multiple separate bills
- Physician Bill
- Anesthesiologist Bill
- Radiologist Bill
- Hospital Bill
- Recognize key elements on the Explanation of Benefits (EOB) from their insurance company
- Recognize key elements on statement(s). Billing statement from hospital? Yes.
- Recognize when final payment is due
- Identify payment options: cash, check, or credit card.
- Locate online payment options via MyAccount. Set up online on your web site? Yes. Free service. Allows patients to see their statements online. Make quick payments by providing checking account info or credit card info. Can look at previous statement, can store credit card and checking account info. Secured and follows encryption guidelines. Makes it easy to monitor your billing.
- Identify lines of ongoing support for questions regarding medical finances. We give them our info: who they can contact. Information on their statement, point to that, also back of handout we give them. We give them information: contact customer service, financial coordinators.

Source: Cleveland Clinic in Independence, OH.

SOURCE

• **Jovanka Djukic,** MEd, Director, Revenue Cycle Training, Cleveland Clinic, Independence. E-mail: djukicj@ccf.org.

campus, says **Jovanka Djukic,** MEd, director of revenue cycle training, Patient Financial Services. It lasts about two hours. *[The computerized graphic presentation from the class is posted with the online issue of* Same-Day Surgery. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

The presentation is interactive and presented with adult learning in mind. "It's never just a straight presentation," Djukic says. For example, in the surgery class, patients are given a guided note-taking sheet. Patients fill in key educational points presented, which helps them process and retain information. Patients also are asked circle specific information on the explanation of benefits (EOBs). "It triggers additional questions, which is what we want," Djukic says.

Patients are asked to respond to questions, and sometimes the presenters offer small prizes such as lotions or items with the Cleveland Clinic logo.

For patients who cannot attend the classes, the health system has started videotaping some of the sessions so that patients can view the classes online thorough the health system's web site. The surgery class is scheduled to be videotaped this fall and posted by December. *(The videotape will be offered at www.clevelandclinic.org. Under Patients & Visitors, select "Billing." Then select "Educational Forums." At the bottom right corner of the screen, a list of educational programs displays. Also, a handout is offered to surgery patients who cannot attend the class. See the online issue of* Same-Day Surgery. *For information regarding the impact of the class, see next story.)* ■

Financial classes impact patients

While the health system has not yet assessed what impact these classes have had on front-end confusion, patients who have filled out satisfaction surveys following the classes have provided overwhelmingly positive input, according to **Jovanka Djukic,** MEd, the director of revenue cycle training at the Cleveland Clinic.

"They are also suggesting that we need to promote the programs more so that they are more visible" to the community, Djukic says.

Class attendees have established more of a partnership with the health system's financial coordinators, she says. Administrators facilitate this connection by asking patients who register for the classes where they go for care, she says.

"We try to have the financial coordinator who works at that facility attend the session, and then the patient has an opportunity to visit with the financial coordinator at that time," she says. "They know they have someone they can turn to, and they know they can work with someone face-to-face. It is one of the greatest benefits we see on the front end." ■

Same-Day Surgery Manager

13 steps to convert to 45-minute arrivals

Patients show up day of surgery for first time

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

In my recent column, I lashed out at facilities that require patients to arrive an hour or two or more before their surgery time. I thought then and still think this is unnecessary and a waste of the patients' valuable time. I also said that making patients take a day off from work to come to the center for their anesthesia interview and pre-op testing a few days before surgery is further wasted time and an inconvenience.

I received quite a response from you. The majority of the feedback was positive, and the others were asking "how?"

Let me explain my premise for having the patient arrive at your facility — for the first time — the day of surgery, 45 minutes before. Right now most facilities, to minimize delayed or canceled cases, penalize all patients by making them arrive hours before their surgery and days before their surgery for testing. Reverse that! It

is an overwhelming inconvenience and one of the greatest complaints on patient satisfaction surveys.

An excuse that facilities often use for having patients arrive hours before their posted surgical time is the surgeons want the patients there so they can move up patients if some patients are "no-shows" or if a second room opens up. This is a frequent issue with pain management, GI, cataract, and other high-volume, quick-turnaround cases. This issue needs to be addressed in a conversation between you and the surgeon! You can pretend the issue isn't there, or let the surgeon know that your staff will make every effort to minimize no-shows so you do not need to "cattle call" patients.

Let me first state some facts on pre-admission testing. For the average outpatient surgery patient (ASA 1 and 2) having elective surgery, most preop testing is a waste of time and money. Remember that the facility does not require any preop testing! You are bricks and sticks! The testing required is determined by anesthesia personnel or the surgeon, with anesthesia taking the lead. The reason some anesthesia personnel or surgeons order such extensive and expense testing is mostly defensive and, again, unnecessary. Sit down with your medical director and discuss what tests are being routinely ordered. Find out what you can eliminate or modify. If everyone is comfortable with it, change them. Remember that if anesthesia or the surgeon orders the tests, they also have the ability to waive them if they think it is indicated. If the facility orders the tests, you cannot waive them! Let those tests be between anesthesia and the surgeon. Stay out of it.

So, how can you have patients arrive 45 minutes before their surgical slot and not mess up your schedule? First, address the above issues. Meet with your staff, and listen to their suggestions. They will be skeptical. I can assure you this will not work without everyone's support.

Here is how it will work for most of you. (Not all!)

1. Receive internal approval to move forward from medical director, department head, administrator, etc.
2. Address the issues above.
3. Have anesthesia personnel call the patient two or three days before their surgical date and perform their assessment.
4. A couple of days before, have the nurse call patient and perform the nursing assessment.
5. Make sure patients know they need history & physicals (H&Ps).
6. Make sure patients know they (might) need pre-admission testing and to have it completed at _____ (fill in the blank).
7. Make sure patient knows what time to be there and where you are at that address!
8. Make sure they stay NPO, etc.
9. Make sure any issues that arise from number 3 and 4 above are addressed, and make appropriate responses. Some of these responses could be to order more pre-op tests, have a one-on-one visit, obtain clearance from the local medical doctor over and above the H&P, etc.
10. When patients arrive at the facility — assume they will and be on time; affirm it — follow your normal pre-admission routine.
11. If patient needs lab work or it is not available, perform appropriate testing on-site (H&P, pregnancy, blood sugar, etc). All can be done in under 30 minutes! Yes they can!
12. Move them into pre-op.
13. Perform surgery as usual.

I can assure you it works, but only if you want it and allow it. You can come up with many reasons why it will fail at your center, but the reality is that it can and is being done.

Will there be late patients? Of course! Will there be missing lab work or H&Ps? Definitely! But it will be for less and less each week while you perfect the process. After a while, it will become second nature. You can make a difference. *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 13492 Research Blvd., Suite 120-258, Austin, TX 78750-2254. E-mail: searnhart@earnhart.com. Web: www.earnhart.com. Tweet address: Earnhart_EAI.]* ■

Infection control is focus for 2011

AAAHC announced changes

Accreditation organizations are making an "all-out effort" to focus on safe needle use in 2011, according to **Marsha Wallander**, RN, assistant director of accreditation services at the Accreditation Association for Ambulatory Health Care (AAAHC).

AAAHC and The Joint Commission are participating in the Safe Injection Practices Coalition and its One and Only Campaign (www.oneandonlycampaign.org) to promote one needle, one syringe, only one time. "We're all jumping on the same thing," Wallander says. *(For more on The Joint Commission's focus, see "On-site Survey: Focus on Safe Injection Practices,"* Same-Day Surgery Weekly Alert*, July 23, 2010. To subscribe to this free weekly ezine, contact customer service at customerservice@ahcmedia.com or (800) 688-2421. Also, see The Joint Commission's action on National Patient Safety Goals, right.)*

The emphasis on needles is part of a broader focus on infection control and prevention, Wallander says. That focus includes cleaning and high level disinfection of surgical instruments including endoscopy scopes. Use practices that ensure those instruments are sterile, she emphasizes. "That's our thrust for 2011," she says.

Another addition for next year is that a facility must be able to show documented evidence of period testing and preventive maintenance, according to manufacturers recommended guidelines for critical pieces of equipment, Wallander says. "There's been some lapses in the health care environment," she says. *(For more information, see "Hepatitis outbreaks underscore ongoing transmission risk,"* **Same-Day Surgery,** *August 2009, p. 80.)*

One of the most frequently asked questions

Another changes for 2011 is acknowledgement that electronic records are becoming prominent in ambulatory settings, Wallander says. Facilities frequently ask about what to do if they are in transition to electronic records, she says.

"It's perfectly fine for an organization to be in a transitory state when we come in to survey," Wallander says. "We understand that — it's part of doing business — and we expect that the organization has done an implementation plan that keeps its records organized and available for providers who need access."

Another issue that has popped up for accredited organizations is that sometimes the patients are not clear about which specific parts of an organization have been accredited, she says. Consider the example of a large multi-specialty clinic that also has an ambulatory surgery center attached to it. The ASC might be accredited, but the primary care clinical side might not be.

"Organizations will need to be clear about how they represent accreditation," Wallander says. "They need to make sure the patient population is advised what is and what is not accredited."

Another area that AAAHC has clarified is that managers performing quality improvement (QI) studies seemed to think those studied needed to be limited to a problem, issue, or adverse event, she says. "We clarified that QI can look not just at problems, but processes that organization may feel need to be looked at," Wallander says. "They are given credit for those QI programs that aren't simply problem-related, but a process improvement related."

The new standards will be available at the beginning of January, and compliance is expected by July, Wallander says. ■

The Joint Commission revises NPSGs

While The Joint Commission will have no new National Patient Safety Goals (NPSGs) for 2011, it has revised elements of performance (EPs) within those goals to remove specific requirements related to clinical practice.[1] The changes to the EPs are effective immediately.

Those changes include the EPs for NPSG 07.05.01, implement evidence-based practice for preventing surgical site infection. The EP is applicable to ambulatory care, hospitals, critical access hospitals, and office-based surgery practices.

The NPSG requires accredited organizations to administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations (no longer "evidence-based best practices").

The Joint Commission will not accept practices that are not supported by evidence or widespread consensus. "During the on-site survey, surveyors will explore the source of the practices the organization follows," it says.

The following EPs have been removed:

- Facilities should administer intravenous antimicrobial prophylaxis one hour before incision. (Two hours are allowed for the administration of vancomycin and fluorquinolones).
- They should discontinue the prophylactic antimicrobial agent within 24 hours after surgery. (Within 48 hours is allowable for cardiothoracic procedures).

The NPSG also says that when hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations ("Clippers or depilatories" has been removed).

The Joint Commission says that a limited number of NPSGs contain requirements for practices that reflect current science and medical knowledge. "In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations," it says. "This means that the practice used by the organization must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies)." *[For information on changes to the medication reconciliation NPSG, see "Joint Commission to Revise NPSG on Medication Reconciliation Again,"* Same-Day Surgery Weekly Alert, *Aug. 13, 2010.]*

REFERENCE

1. The Joint Commission. *Joint Commission Perspectives* 2010; 30(8). ■

Surgery center offers student internships

Most young people who are interested in becoming surgeons have only TV to give them a glimpse of a world that is normally off limits to all but clinical staff and patients. Earlier this year, however, two Westlake High School students with a keen interest in becoming surgeons saw life in the OR up close as student interns in the Aspen Surgery Center in Simi Valley, CA, in affiliation with Simi Valley Hospital.

Brett Kaplan and Ashley Chang were selected for the program after a rigorous screening process that included meeting a grade point average requirement and submitting an essay about their interest in the program. Each student worked individually at the center from 6:30 a.m. to 3:30 p.m. two or three days a week — a total of 80 hours — between June 14 and July 12.

"This is a branch off the job shadow day we had earlier this year," said **Jeanine Maurer**, director of the Aspen Surgery Center. "The students we hosted said they wished they could spend more time here."

Maurer said that the idea of a high school internship program at the surgery center had come up in the past, and the job shadow students' interest in a deeper experience renewed her desire to formalize an internship program. She connected with Laurie Looker, school-to-career coordinator at Westlake High School, and the two began working on the details of the internship. Maurer put together a curriculum for the program, which later received approval from the Conejo Unified School District.

During each of the four weeks of their internship, Kaplan and Chang had specific educational objectives. They learned how a surgery program works, from pre-admission through discharge and follow-up. They also received an in-depth look at a variety of surgical specialties and procedures, such as knee arthroscopy, colonoscopy, hernia repair, cataract removal, and tonsillectomy.

In addition, they memorized a list of medical terms each week, completed two case study reports, and spent time with Maurer, a former nursing instructor, learning about the Physicians' Desk Reference, cardiac rhythms, staffing ratios, infection control, and disaster protocol and planning. Each week, they were given a test Maurer developed on the material they had studied.

For their work, the students will receive five general elective credits — equivalent to a semester of a high school class.

In addition to their academic studies and the opportunity to interact with surgeons from a variety of specialties, Kaplan and Chang participated with staff on many tasks related to running a surgery center.

"This was a working internship, and they became part of the team in that respect," Maurer said. "They helped turn over rooms, make beds,

EXECUTIVE SUMMARY

Aspen Surgery Center in Simi Valley, CA, in affiliation with Simi Valley Hospital, offered two student internships during the summer.

- The internship was developed by the director of the surgery center and the school-to-career coordinator at the local high school. The director put together a curriculum.
- Students worked from 6:30 a.m. to 3:30 p.m. two or three days a week for four weeks. They received five general elective credits.
- The internship was designed to "help grow good doctors" by showing students what happens behind the scenes from preop to recovery.

take out the trash, clean gurneys, and so forth. As they move forward in their careers, they won't forget those experiences. Those basic things you learn make you a better leader." And that point, Maurer said, was the main reason for the internship.

"With this program, we're trying to help grow good doctors," she said. "One area in which physician training usually falls down in is that the doctors don't know what's going on behind the scenes, in places like preop and recovery. These kids are going through the entire process and are getting the true experience of what it's like to work in a surgery center."

Days before the end of his internship, Kaplan called the experience "an amazing chance for a high school student to see a surgery setting."

Kaplan, who has now started his junior year at Westlake High School, said he is interested in becoming a surgeon but is not yet sure about what specialty. In the meantime, his high school courses will include biology and physiology to help him prepare for college and medical school.

The opportunity to help people has drawn Kaplan toward his interest in becoming a surgeon, he said. Among his many experiences at the Aspen Surgery Center, he said he discovered a particular quality that surgeons must possess.

"I didn't realize how much patience is required to be a physician," he said. "If something goes wrong, it takes a lot of patience to work through it." Kaplan said that nothing could replace his experience at the surgery center. "You can study all you want and see surgeries on TV," he said, "but watching in person is really cool." ■

Usability testing ensures clear info

Make sure instructions can be understood

Consider evaluating educational materials, such as an educational sheet, self-care instructions, or an informational web site, with a usability test instead of a focus group, says **Dana Botka,** manager of customer communications with the Washington Department of Labor and Industries in Olympia.

According to Botka, usability testing is a tool for determining if an instructional piece follows the rules of clear communication. The communication problems Botka helps solve are similar to those that occur within the health care industry. These problems might include a form on which customers tend to make repeated mistakes that have to be corrected, or a letter providing instructions that people find confusing and thus inundate staff with phone calls.

When designing a piece, make sure the process is centered on the people who will use it, says Botka. To correct a document that is not working, gather subject-matter experts. As a group, gather around a projected laptop screen and develop a clearer, more usable document, she adds.

"The second step is to test the product, which may be a form or letter, with a representative sample of the real people who would use the document in real life," says Botka.

Taking a medical example, Botka explains that by creating user-centered design, postoperative instructions would begin by considering the demographics of the patients who undergo the surgery. It is important to have the typical users clearly in mind when creating the document, says Botka. To make sure the piece is on target, it then would be tested with a representative sample of the typical audience. ■

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

- Free software cuts cost, time to compile quality data
- Latest news on preventing surgical site infection
- Tips for avoiding liability with medication safety
- Should you have a full-time quality director?

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. What is the position of the American Association of Nurse Anesthetists (AANA) regarding physician supervision of certified registered nurse anesthetists (CRNAs), according to AANA President Paul Santoro, CRNA, MS.
A. Physician supervision is never needed.
B. Physician supervision is virtually always needed.
C. Decisions regarding physician supervision need to be made at the local level, where patient acuity and provider competencies are taken into account.

14. What was the finding of a recent study by RTI International examining patient outcomes when anesthesia services are provided by CRNAs, physician anesthesiologists, or CRNAs supervised by physicians?
A. There were no differences in outcomes.
B. There were better outcomes when care was provided by an anesthesiologist.
C. There were better outcomes when care was provided by a CRNA supervised by a physician.
D. There were better outcomes when care was provided by a CRNA supervised by a anesthesiologist and when care was provided by a CRNA supervised by a physician.

15. According to a quarterly survey by the American Society of Anesthesiologists, what might lead one in four patients to postpone surgery?
A. Lack of a ride
B. Lack of a home care provider.
C. Lack of funds for copay.
D. Lack of understanding and apprehension about anesthesia.

16. An internship at Aspen Surgery Center is addressing one area where physician training usually falls down, according to Jeanine Maurer, director. What is that area, according to Maurer?
A. Doctors don't know what's going on behind the scenes, in places such as preop and recovery.
B. Doctors usually don't know the length of the patient's visit.
C. Doctors usually don't understand the financial end of a patient's visit.

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

Summary

Scheduled for Surgery

Once you are scheduled for surgery, we will contact you to register you for surgery. Registration is handled one of three ways:

- We call you.
- Via MyChart on the Internet; if you are a MyChart user, when you are scheduled for surgery, you will see a notice from us that we need to register you.
- At your Pre-Admission Testing Appointment

The registration process is critical because it lays the foundation for a smooth billing process.

If we do not have accuracy in your details, then we are unable to verify your insurance information.

Registration/Insurance Verification Process

Once your surgery is scheduled and your registration is verified, we have a team that contacts your insurance company to verify that your insurance coverage is active and to verify your benefits.

During the insurance verification process, the Cleveland Clinic determines

- Co-Payment
- Co-Insurance
- Referral
- Pre-Certification
- Lifetime Maximum Benefit
- Pre-Existing Conditions
- Medicare Days

It is recommended that you contact your insurance company to confirm your benefits prior to your surgery.

Notification of Estimated Out-of-Pocket Expenses

Once we have verified your insurance and identified any out-of-pocket expense such as: co-payment, co-insurance, or deductible, we will contact you to notify you of your co-payment expense.

Surgery: Co-Pay/Estimated Co-Insurance/Deductible Due

As a third party to your insurance benefits, we are responsible for collecting your co-pay before or on the day of your surgery.

We can take your payment over the telephone or at the time of service, when you arrive for your surgery. Payment methods include: cash, check, or money order and all major credit cards.

Claim Sent to Your Insurance Company

After your surgery, we will send a claim to your primary insurance company. The claim lists what was done and it serves as a bill for the services that were performed.

Your insurance company will review the claim and will respond to us with an approval or a denial.

An approval means that your insurance will pay the claim according to the benefits of your policy but not including any amounts that they consider to be your responsibility, such as: co-pays, co-insurance, or deductibles.

A denial means that your insurance will not pay the claim or part of it and it could be for a number of different reasons.

Having all of your current registration and insurance information and verifying this with the insurance company prior to your surgery is how we minimize denial.

Explanation of Benefits (EOB)

The insurance company reviews the claim we send to them to determine your benefits.

If another insurance company is involved, the insurance companies coordinate benefits to determine which plan is responsible for charges.

You may receive a printed EOB or you can view it online. Most insurance companies provide EOBs online for your viewing.

An EOB lists:

- The patient and the services provided.
- The amount we charged (the provider).
- The amount of the charges that are covered and not covered under your plan.
- The amount paid to us.
- The amount you are responsible for.

Keep in mind that an EOB is not a bill. An EOB explains what was covered by your insurance. We will bill you separately for any charges that you might be responsible for.

Itemized Statement

If you are having your surgery done at one of our hospitals in the West or East, you will receive multiple separate bills and an itemized statement from us, detailing for you what was sent to your insurance company.

Western Region Hospitals

- Fairview
- Lakewood
- Lutheran
- Marymount

Eastern Region Hospitals

- Euclid
- Hillcrest
- Huron
- South Pointe

If you are having your surgery done at the Main Campus, the first monthly statement that you receive after your surgery will include the itemized, detailed description of charges. Statements that follow that will not be itemized but will be totaled.

Payment Due

If the Explanation of Benefits from your insurance company identifies a patient responsibility, we will indicate this amount due on your statement if it was not collected prior to the service being rendered.

There are a number of different payment options available to you.

- Online Bill Pay-MyAccount
- Submit Check with Payment Stub.
- Submit Credit Card information with Payment Stub.
- Call in your payment information.

Support

If you have any questions about your statement, please contact us. We always include a contact number on your statement.

Source: Cleveland Clinic, Independence, OH