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Alleged patient assaults by docs raise question: What would you do?

Here's expert advice on how to handle cases

Many outpatient surgery managers might think that the situation of a clinician sexually assaulting an incapacitated patient is so unlikely that they don't need to prepare for such an event. However, those managers would be mistaken, according to sources interviewed by *Same-Day Surgery*.

"I have been retained as an expert witness in a number of such cases involving anesthesiologists and other physicians, as well as employees in hospitals, surgery centers, and skilled nursing facilities," says **Paul B. Hofmann**, DrPH, FACHE, president of the Hofmann Healthcare Group in Moraga, CA, which consults on ethical issues in health care and specializes in performance improvement efforts.

Some of those cases have been publicized by the media recently:

• A former plastic surgeon in Tracy, CA, admitted to sexually assaulting 36 female patients, including some who were anesthetized and one who was age 15.[1] Peter Chi, 48, surrendered his medical license and will be sentenced to six years in prison.

• In Chicago, the medical director of Grand Avenue Surgical Center in Chicago, Nercy Jafari, MD, was convicted of sexually abusing a patient

EXECUTIVE SUMMARY

Recent allegations of sexual assault by clinicians against incapacitated patients has made outpatient surgery managers realize that they need to put the spotlight on this area.

• Perform credentialing, check references with specific questions about disciplinary actions, check with state medical licensing boards and the National Practitioner Data Bank, and perform criminal background checks.

• Have a policy on how you will handle strongly negative events, and notify new employees and contractors at the time of hiring.

• When an incident is reported, a legal consultant can help you ensure the rights of the patient and the clinician. Investigate the alleged incident discreetly.

and sentenced to 24 months of sex offender probation.[2] When Jafari continued to practice, the state Department of Public Health moved to shut down the center, although the alleged incident took place at another location. According to information obtained by Same-Day Surgery, the center has appealed this ruling to the Cook County Circuit Court. Until the case is heard, the judge granted a temporary stay that allows the facility to remain open, but with the condition that Jafari has a female chaperone during examination and treatment of female patients. Jafari denied that he sexually abused a patient and said routine, normal, and medical necessary procedures can be perceived as sexual misconduct by a nonmedical person.[2]

When a clinician is accused of abusing a patient, the outpatient surgery manager needs to act quickly, sources advise. "It is not only possible, but it's absolutely imperative to stop any individual who is or may be sexually abusing others, particularly patients," Hofmann says. "Any excuse or rationalization for not doing so because of the person's professional position or organizational status is simply unacceptable." *(See accreditation and Medicare requirements, p. 47. For more on this topic, see "Center given moratorium after abuse allegations — State: Some complaints weren't investigated,* Same-Day Surgery, *August 2006, p. 92.)*

Managers should put the clinician on administrative leave, advises **Elizabeth G. Russell**, JD, partner at Kreig DeVault in Indianapolis, IN. "Until they figure out what's going on, they need to relieve that person from continuing to practice at the surgery center," Russell says. If the person is on leave for longer than 90 days, then you have to report the incident to the National Practitioner Data Bank. "You want to do the investigating as quickly as you can, but obviously, the surgery center wants to protect itself," Russell says. "I wouldn't let a physician practice while the investigation is ongoing."

The alleged abuser should not be able to treat patients until the results of the investigation are evaluated, Hofmann says.

What's the next step?

When a clinical has been accused of sexually abusing a patient, inform the individual's chief of service, and obtain legal consultation "to ensure the rights of both the victim and the alleged abuser are recognized," Hofmann says.

Review the bylaws to identify the physician's right to due process, Russell says.

Talk to any witnesses as well as the patients, sources say. If a patient is upset, you might want to encourage them to undergo counseling, suggests **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI. Be straightforward and honest with patients, Trosty says. "My personal belief is that

Same-Day Surgery® (ISSN 0190-5066) is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, NE, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Same-Day Surgery®, P.O. Box 105109, Atlanta, GA 30348.

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Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $83 each. (GST registration number R128870672.)

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Regulatory Requirements: Sexual Assaults by Clinicians

• The Joint Commission's Sentinel Event Policy addresses sexual assaults by clinicians by treating them as sentinel events. Sentinel events are events that require substantive analysis along with implementation of corrective actions to mitigate the risk of recurrence. This requirement also is referred to in the Leadership chapter for the ambulatory, office based surgery, and hospital programs in standard LD.04.04.05 which addresses an organization's approach to patient safety and how they are to respond to serious safety incidents.

• A standard (RI.01.06.03) in the Joint Commission's Rights and Responsibilities of the Individual chapter of the ambulatory and hospital manuals states that the patient has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

• Standard EC.04.01.01 from the Joint Commission's Environment of Care chapter for all three accreditation programs requires the organization to have a process for monitoring, reporting, and investigating staff injuries and security incidents involving patients or staff, as well as others within the facilities. Standard EC.02.01.01 requires organizations to manage safety and security risks.

• The Accreditation Association for Ambulatory Health Care (AAAHC) has a standard (7.II.A-6) that says elements of the safety program include physical injuries involving patients, staff, and all others.

• Medicare §416.50(a)(3) standard states that for submission and investigation of grievances: The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC. The grievance process must specify timeframes for review of the grievance and the provisions of a response. The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished. The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.

• Medicare §416.50(a)(3) standard states that for submission and investigation of grievances: All alleged violations/grievances relating, but not limited to, mistreatment; neglect; or verbal, mental, sexual, or physical abuse must be fully documented. All allegations must be immediately reported to a person in authority in the ASC. Only substantiated allegations must be reported to the state authority or the local authority, or both.

• Medicare §416.50(c) standard for privacy and safety states that the patient has the right to receive care in a safe setting, and be free from all forms of abuse or harassment. ■

honesty and openness go further than if you think someone is trying to hide something," he says. If a patient demands that the clinician be suspended immediately, you can explain your processes, Trosty says. If that individual says he or she is going to the policy, try not to be obstructive, he advises. *(See information on developing a policy and procedure, p. 48.)*

The investigation should be handled discreetly and privately, Trosty says. However, if the patient has reported the incident and given you permission to share his or her name, there shouldn't be any patient privacy issues. The HIPAA privacy rules says that "if it's part of the normal business of the healthcare operation, then you can discuss it with others who are appropriately involved," Trosty says.

If the clinician is under contract with the facility, examine the contract to see what it allows. If the clinician continues practicing during the investigation, considering having a staff member of the opposite sex in the room while the patient is incapacitated, sources advise. *(For steps to take with applicants, see story, below. For more on this topic, see these stories in the January 2006 issue of* Same-Day Surgery*: "In light of 2 criminal cases, how do you ensure employees don't abuse patients?" p. 1, and "Take these steps to cut liability risk," p. 4. You can search for these stories at www.same-daysurgery.com.)*

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Where to investigate a job applicant's history

Outpatient surgery patients are vulnerable, and it is up to the organization to allow

only fully qualified clinicians who meet high professional standards and codes of conduct to practice there, says **Paul B. Hofmann**, DrPH, FACHE, president of the Hofmann Healthcare Group in Moraga, CA.

"Therefore, it is incumbent upon these organizations to exercise due diligence and be extremely thorough in the appointment and privileging process," Hofmann says.

If not, you might end up being accused of inadequate due diligence and/or negligent credentialing, he says. "Inadequate reference checks, insufficient investigation of previous claims, and incomplete peer review activities are representative examples of how the process can be flawed," Hofmann says. Consider these steps:

• Credentialing.

Appropriate verification of credentials is critical, says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI. You can use an outside verification service to conduct this task, Trosty points out. "If there's no credentialing and no verification and no contract, you're really in a tough spot," he says.

• Check references.

Have clinicians sign a form that frees you from liability for performing reference checks, Russell says. Follow up with facilities where they say privileges have been issued, she says.

Trosty says that when checking references, don't ask general questions such as "What do you think of this person?" Instead, he says, ask "Has there ever been a problem? Has there been any disciplinary action taken that you're aware of? Was this person ever referred to a disciplinary committee?"

You might not receive a direct response, "but if you read between the lines, you get an answer," Trosty says.

• Check with state and national boards, databanks, and registries.

Check with the medical licensing board in the states where a person practiced previously to determine if any action was taken against them, such as having their license revoked or suspended, Trosty advises. Further investigation might be indicated, he says.

States are beginning to look at increased disclosure for clinicians and others. The Ambulatory Surgery Association of Illinois has proposed to the Illinois Department of Public Health that there be revisions to the application process and form for ASCs to require greater and more complete disclosure for owners, administrators, and physicians. The change would require greater and more complete disclosure of convictions, arrests, charges, denials or restrictions on past licenses, and any fines or actions by Medicare or Medicaid including those for sexual misconduct, child abuse, elder abuse, domestic violence, and substance abuse. It would affect initial and renewal licensing of ASCs.

Managers and administrators also should check with the National Practitioner Data Bank (NPDB) to determine if any action has been taken against a physician's privileges, says **Elizabeth G. Russell**, JD, partner at Kreig DeVault in Indianapolis, IN. "That's a huge red flag," Russell says.

Also, some states allow criminal background checks, Trosty says.

Additionally, check pedophile registries to ensure your applicant hasn't abused children, he says. "Unfortunately, there have been instances where this has happened," Trosty says. ■

Develop a policy on crisis management

Address staff and strongly negative events

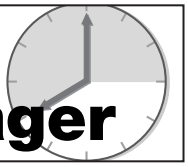
Have a policy and procedure that addresses investigations of employees and contracted staff for incidents of strongly negative events, says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI.

The policy should address who will respond and what action will be taken, Trosty says.

Write your policy ahead of time, not after the fact, he says. "Let it be made known to all clinicians at the time they're hired or become part of the group so they're not taken by surprise," Trosty says.

Consider addressing inappropriate actions in your contracts with clinicians, Trosty says. For example, you might want to have language that says if a complaint is found to be legitimate, it could result in temporary suspension or a requirement that another professional of the opposite sex be in attendance, he says. ■

Same-Day Surgery Manager



Block booking — Is it antiquated?

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

If your block booking of procedures is working for you — great! You are one of the few. Pat yourself on the back, and go have lunch. If, however, you are among the majority of us, read on.

It makes no difference if you are hospital-based or freestanding; an effective block schedule is difficult to manage — really difficult. Since I get paid to deal with issues like this all the time, I am going to take some editorial license here and speak from a position of authority.

First, block scheduling is an active, dynamic process. Unlike what many might believe, you do not set it up and forget it. It is a fluid process that demands attention and massaging — always massaging. By the end of this column, most of you will change the way you block schedule your cases.

Let's start with the basics. Block scheduling is nothing more than a management tool to accommodate as many surgeons as possible. It is nothing more (or less). A poorly designed block schedule (which accounts for 90% of the problems we see) causes far more problems than it solves, so pay attention to details. A well-designed block should look something like the one below.

		Monday		Tuesday		Wednesday		Thursday	Friday		
		EAI ASC		EAI ASC		EAI ASC		EAI ASC	EAI ASC		
	OR	7:30	11:30	7:30	11:30	7:30	11:30	7:30	11:30	7:30	11:30
Week 1	1	Chris	Chris	Steff	Steff	Chris	Chris	Hart		Earn RIM	RIM
04-01-11	2	Austin		Spice	Spice	RV	RV	Howse	Howse	RIM	RIM
	3	S & S	S & S	Sugar		S & S	S & S			Park	RV
	4	Hart		Dentler	Dentler	Kim	Jeremy		RIM/1:30	Bucko	Bucko
	5									Waitansee	Toner
Week 2	1	Chris	Chris	Howse	Howse	Chris	Chris	Steff		RIM	RIM
04-09-11	2	Chris				RV	RV	Spice		 RV	Heil
	3	S & S	S & S	Sugar		S & S	S & S	Howse	Howse	Bucko	Bucko
	4	Austin		Austin		Kim	Jeremy		RIM/1:30	Brat Chen	Brat/Chen
	5									EARN	Plasticguy
Week 3	1	Chris	Chris	Steff	Sugar	Chris	Chris	HART		EARN RIM	Redde RIM
04-16-11	2	Austin		Spice		RV	RV			RIM	RIM
	3	S & S	S & S	Howse	Howse	S & S	S & S			Park	RV
	4	WWF		Dentler	Dentler	Kim	Jeremy			Bucko	Bucko
	5									EARN	Brown
Week 4	1	Chris	Chris	Howse	Howse	Chris	Chris	Steff		RIM	RIM
4-23-11	2	Chris		Dentler	Dentler	RV	RV	Spice		RV	RV
	3	S & S	S & S	Sugar		S & S	S & S	Howse	Howse	Bucko	Bucko
	4	Austin		Austin		Kim	Jeremy		RIM/1:30	Brats Chen	BratsChen
	5			Brown	Brown					EARN	Stoner

It is not complicated, but it needs to be comprehensive. Below is a bulleted list of the common mistakes we find. I know that they don't always apply, and there always are exceptions. However, most of the time they do apply to you.

• Avoid full block days. They are rarely fully utilized, and you are better served breaking them up.

• Allow your surgeons office to post into your system directly from their office and bypass calling you. What?! Of course you can! Call your IT/IS people and tell them to do it. Don't give them an option. What? Then get rid of them, and get someone who can! Good heavens. This is not rocket science.

• Do not be the heavy and establish the priority of who can pick their block first. This is especially an issue if you are new or just setting up a block schedule.

If the surgeons don't play well together, then have the medical executive board, the physician advisory board, or the executive committee establish the pecking order. Do not get caught in that crossfire. If all else fails, go by seniority, age, or rock /paper /scissor. Bribes apparently work well too.

• Unutilized block times should be released 24 hours (or 36, 48, or 72 hours) beforehand so others can capture those slots.

• If an underutilized block occurs greater than three times in a time period, then the block needs to be reduced in size. I suggest a one-month time period. Others use a quarter, but I think that is too long.

• If the number of operating rooms allow, always try to have a "free, unblocked room" for first-come, first-served cases.

• Allow for trading of block time among the surgeons, if you have the equipment available.

• You might want to have the same grid as on p. 49 for your treatment rooms as well. Some surgeons like to block their local cases separate.

You need to add your own rules and expand the above. Just remember that this is also a management tool that you should use for staffing, equipment, and budget. Use it wisely. Happiness is a full block!

[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. Twitter: SurgeryInc.] ■

Consider your options for recovery care

Services range from hotels to home health

With Medicare's 2009 change in the definition of an ambulatory surgery center (ASC), the door opened for keeping patients up to 23 hours and 59 minutes. Some ASCs now start cases later in the day, but need post-surgical recovery care of patients in the ASC or elsewhere.

If the patient stays in the ASC, you have to pay overtime or extra shift staff, plus offers meals and emergency coverage. For this reason, many managers are considering options for recovery care outside their doors. Those options include rehabilitation hospitals, home health nurses, and hotels.

When patients are having surgery at the University of Wisconsin Hospitals and Clinics in Madison, they have access to a concierge that can help them locate a hotel room for the night before and after surgery, if needed.

Members of the guest services staff know what hotel rooms are available, and they have negotiated special rates for patients, families, and visitors. "Madison hotels can be very busy because of University of Wisconsin athletic events or because of the many conventions that we host in Madison," says **Shawn Arneson**, concierge and supervisor of guest services. "Members of the Guest Services staff take this worry and frustration away from the patient, as we do not want them to be calling every hotel in Madison only to find out that they are full." The hospital also has three free spots for recreational vehicles that need electrical hookups.

To access these services, patients or their family members simply call a phone number or stop by the hospital's main information desk. "We are

EXECUTIVE SUMMARY

As ambulatory surgery centers have adapted to a new Medicare definition that allows them to keep patients up to 23 hours and 59 minutes, more are considering new recovery care options outside of their facilities.

• Some providers find hotel rooms for patients and their families, and some send a staff nurse to provide care for 12-24 hours.

• Some work with acute rehabilitation hospitals, which allows more intense procedures.

• Home health nurses can visit patients at hotels or residences every 2-3 days to check wounds and help patients meet their goals.

actually like a personal travel agent for the patient and their visitors," Arneson says. "We explain the options, take their information, reserve the room and give the patient the confirmation number, directions, explain amenities, travel, and shuttle options, etc."

Using a rehab hospital

Advanced Ambulatory Surgery Center in Redlands, CA, which offers orthopedic procedures, makes arrangement on a per-patient basis for post-recovery care at Robert H. Ballard Rehabilitation in San Bernardino, CA, which is a licensed, acute rehab care hospital.

"Most of our patients will utilize physical therapy in their recovery process, so the patients that we have referred/transferred to Ballard for immediate post-op care also have access to therapy," says **Kathryn R. Di Stefano**, MSN, RN, CNOR, administrator at Advanced ASC.

Patients or their insurance companies pay for the care, Di Stefano says. Offering this service allows the center to accept more acute cases, she says. Bilateral lower extremity fractures are one example.

"If you have two broken legs, you're not exactly 'ambulatory,' and you wouldn't usually be considered a candidate for an ambulatory surgery center," Di Stefano says. "Depending on the patient's home support system, they may require 24-hour care and cannot be discharged directly home from this facility. But they also don't require an inpatient hospital admission, just supportive care."

Sending staff nurses home with patients

Diagnostic and Interventional Sports and Spine, and Diagnostic and Interventional Surgical Center (DISC), both in Marina del Rey, CA, hire nurses to accompany patients to their homes or to hotels for what is typically 12-24 hours of post-recovery care. This service is offered for procedures such as anterior lumbar interbody fusions and also for frail elderly patients.

The nurse helps the patient and family to the car and follows them to their home or hotel. The center uses its own nurses and pays the nurse's travel time to the center and an additional $9-$14 an hour above the base rate. The center absorbs the cost of the post-recovery care staffing to provide better patient outcomes and improved patient satisfaction, says **Karen Reiter**, RN, CNOR, RNFA, chief operating officer of DISC.

The nurse doesn't provide intravenous or intramuscular pain medication, Reiter says. "She's there solely for education and helping the family with mobilization," she says.

One critical piece of the process is having the nurse meet with the patients and caregivers preoperatively to discuss expectations for mobilization, patient management, and restrictions, as well as the role of the nurse, Reiter says. The nurse also talks about wounds, showering, bowel care, and laxatives, she says. Reiter tries to schedule the same nurse to offer preoperative education and postoperative care. "With spine patients, if one person says one thing, and another person says another, they're not as confident with their recovery," she says. Patients also are more comfortable having a nurse caring for them after surgery that they've met previously, Reiter says. Surgeons are quick to respond to any questions from the nurses, she says.

The centers have negotiated significantly reduced rates at five nearby hotels that range from simple structures to The Ritz-Carlton. The center also has access to a condominium for patients who are staying in the area for an extended time.

The recovery care has worked out well for international or bicoastal patients who fly in for the surgery, as well as for area patients who live a long drive away, Reiter says. The centers work with a private concierge service that brings in patients from Indonesia. That service picks up patients at the airport, takes them to their preoperative visit, takes them to the surgery, and picks up their medication. The patients pay one flat rate to the concierge, and the concierge service pays the surgery facilities.

Offering recovery care gives patients "safety and piece of mind," Reiter says. Patients are more comfortable committing to the surgery, she says. "I think it opens up a bigger audience," Reiter says. (Home health nurses also are an option for recovery care. See story, below.) ■

Agency nurses follow patients to their homes

As outpatient surgery patients increasingly are older and have more acute procedures, some programs are finding that the best option for post-surgical care is a home health nurse.

Increasingly, outpatient surgery managers are turning to agencies such as Visiting Nurse/Hospice Atlanta, which is a home healthcare agency certified by Medicare and licensed by the state.

"Depending on the type of surgery, the nurse can do medication teaching, evaluate patient incisions -- wherever they may be -- for healing, see if there are dressings that need to be changed, and educate the patient and family on how to manage the dressing, if it's long term," says **Andrea Stevenson**, BSN, MPH, director of clinical development for Visiting Nurse/Hospice Atlanta. "Also, depending on the surgery, we can provide physical, speech, and occupational therapists to provide rehab to regain the functional independence they had prior to surgery."

The agency typically sees outpatient surgery patients if the patients are elderly, have elderly caregivers, or they have complex treatment or therapy. They also see patients who have had post-surgical complications and need infusion therapy to treat infections and other problems after surgery.

Nurses typically visit 2-3 times a week, depending on the physician orders. The nurse develops a plan of care with a physician and visits the patient until the goals of the plan are met. Visits typically last 30 minutes to one hour. Nurses can visit patients at hotels as well as their homes, Stevenson says.

Patients who meet Medicare eligibility criteria are not charged. Most insurance plans cover a limited amount of home health services, but prior authorization often is required and often is approved on a visit-by-visit basis.

When looking for a home health agency, keep in mind that not all of them have contracts with insurance companies, Stevenson points out.

If the post-surgical patients have a medical problem that isn't urgent, they can call the agency. "It gives us the opportunity to assess the problem, talk to a physician, and prevent hospitalization," Stevenson says. However, patients who are experiencing a medical emergency such as chest pain or uncontrolled bleeding are instructed to call 911.

What should you look for?

If you're looking for a home health provider, consider one who has expertise in the requirements your patients will have, such as infusions or wound.

"Also you want to look for a provider who has a good history of preventing admissions to the hospital," Stevenson says. Simply ask the agency for its hospital readmission rate, she suggests. Also, go to medicare.gov. Under "Resource Locator," select "Home Health Agencies" to see the Home Health Compare service. This service provides scores for key clinical outcomes and processes.

Also look for an agency that can start care in a timely manner. You also want the agency to provide a coordinator to work with your staff to transitions patients to their home in a safe manner, Stevenson says.

Communication between the two entities is key, she says. "Home health and the referring provider need to be very willing to communicate about patient status, what's going on, what issues they're having, so things can be resolved quickly to prevent rehospitalization," Stevenson says. "If a physician doesn't call us back, we're between a rock and a hard place." ■

OSHA cracks down, cuts OR injuries

TN OSHA expects safer practices

It is notoriously difficult to convince surgeons to change their methods and tools in the operating room to improve sharps safety. But in Tennessee, stubbornness is apt to lead to a citation from the Tennessee Occupational Safety and Health Administration (TOSHA).

A "special emphasis program" honed in on the bloodborne pathogen hazards in the operating room, and TOSHA has made it clear that they expect to see safe work practices (such as double-gloving and hands-free passing of instruments) and safer devices (such as blunt suture needles and safety engineered scalpels).

From October 2006 to October 2010, TOSHA conducted 175 inspections and issued 1,280 citations for serious hazards, 10 for repeat hazards, and 57 for other than serious hazards. The total fines: $587,000. Needless to say, those citations have received some attention, and they have made a difference. TOSHA's modest goal was to reduce sharps injuries in the state's hospitals and ambulatory surgery centers by 10% over five years. In four years, the sharps injuries dropped by 14.5% in hospitals and by 17.1% in surgery centers. The reductions came despite an emphasis on better recordkeeping.

"There's an increased awareness. Most everybody's on board," says **Jan Cothron**, manager of health compliance at TOSHA in Nashville.

Cothron and her colleagues knew it would be a challenge to address sharps safety in the OR. For example, an analysis of sharps injury data showed that injuries rose by 6.7% in the OR from 1993 to 2006 while they declined by 31.6% elsewhere in the hospital. Cothron knows the burden of needlesticks, both in actual costs and in repercussions for the health care worker. She was stuck 34 years ago when she managed a blood-testing lab for a doctor's office. She was pregnant at the time but never reported the injury. She worried, over the years, that the source patient had hepatitis, but she was never tested.

As she travels the state, Cothron also hears from healthcare workers who have had needlesticks and have contracted hepatitis B or C. "We're trying to stop these [events] however we can," she says.

ORs must comply with law

Since the federal Needlestick Safety and Prevention Act was passed in 2000 and the U.S. Occupational Safety and Health Administration beefed up its Bloodborne Pathogen Standard, safety needles have become commonplace. Everywhere, that is, except the OR.

Tennessee has its own law, passed in 1999, which requires the use of safety devices and the reporting of sharps injuries within six days of an incident. "People are not complying with this law," Cothron says bluntly. TOSHA's job was to make sure they complied, through awareness, compliance assistance, and enforcement, she says.

Cothron began by obtaining baseline data. TOSHA requested submission of sharps injury logs from the state's 161 hospitals and 158 ambulatory surgery centers. The logs and previous inspections revealed common problems, including removing scalpel blades with forceps or hands, hand-washing contaminated surgical instruments without cut-resistant gloves, failure to use safer devices, hands-free passing or double-gloving, and lack of compliance by anesthesiologists and surgeons.

TOSHA offered free seminars across the state and compliance assistance. The agency also created randomized inspection lists of hospitals and surgery centers. "We developed a checklist and provided it to participants" to indicate what TOSHA would look for in inspections, says Cothron. "Are people double gloving where they can? Are they using blunt tip suture needles where appropriate? "We're interviewing employees to find out if these [measures] that are in written programs are being implemented."

If surgical kits came with non-safety devices, TOSHA informed hospitals and surgery centers that they must replace those items with a safety-engineered device. Exceptions to using safety-engineered devices needed to be explained in writing, and they needed to be specific to a procedure. After all, the American College of Surgeons has endorsed the use of blunt suture needles and safety scalpels.

"We've had hospitals tell surgeons, 'It's a condition of employment at our hospital,'" says Cothron.

This tough stance has paid off. From 2009 to 2010, TOSHA found that sharps injuries stayed steady or declined at 106 out of 161 (65%) hospitals and 125 out of 158 (80%) ambulatory surgery centers. Some individual facilities had dramatic results. One hospital system experienced a 58% decrease in suturing injuries from 2001 to 2010, Cothron says.

"Overall, it's made work safer for the employees," she says. ■

Will OSHA build on 10-year BBP success?

Rule review may result in changes

Ten years ago, the U.S. Occupational Safety and Health Administration issued its revised Bloodborne Pathogens (BBP) Standard. As the agency now considers making changes to that rule, it has amassed largely favorable reviews from healthcare providers, professional organizations, and safety experts alike.

Unquestionably, the Bloodborne Pathogens Standard has led to fewer injuries and reduced risk of transmitting HIV and hepatitis B and C. It is the only standard directed specifically at the health care industry, and it is the most frequently cited standard in inspections of hospitals.

About 95% of core hypodermic needles and blood collection needles purchased by acute care hospitals are safety-engineered, according to manufacturer data. And sharps injuries dropped by about one-third (31.6%) from 1993 to 2006, according to surveillance data collected by the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville.

Since 2001, OSHA has conducted almost 20,000 inspections in health care facilities. The largest number of inspections occurred in nurs-

ing homes, which have been included in targeted inspection programs as a high-hazard workplace. The most cited section of the standard: Employers must update their exposure control plan annually and consider new technology. Failure to use safety devices is the second most-frequent cause of citations.

"We are more frequently citing that section of the standard that deals with use of engineering devices because there are more devices available, and it's easier for us to say...employers should be using those," says **Dionne Williams,** MPH, an OSHA senior industrial hygienist who presented the enforcement data at the conference of the International Healthcare Worker Safety Center marking the 10th anniversary of the Needlestick Safety and Prevention Act.

The center plans to release a white paper outlining areas for improvement in sharps safety. The comments received in OSHA's review of the Bloodborne Pathogens Standard also reveal what might be the new direction for needle safety.

More emphasis on the OR?

In 2007, suture needles were responsible for about one-quarter (23.9%) of all sharps injuries, and OR was the site of 35.9% of sharps injuries, according to EPINet surveillance data from the International Healthcare Worker Safety Center. Sharps injuries rose by 6.7% in the operating room while they declined by almost 32% elsewhere in hospitals.[1]

Jane Perry, MA, associate director of the International Healthcare Worker Safety Center, says, "We think more focused attention by OSHA on enforcement and compliance in this clinical setting is warranted and needed."

The American College of Surgeons has endorsed the use of blunt suture needles, double-gloving, a neutral zone for passing instruments, and other safety devices in the OR. The Association of periOperative Registered Nurses (AORN) also is pressing for safer practices in the OR.

Weaker rules in non-hospital settings?

The National Federation of Independent Business (NFIB) asked OSHA to scale back its enforcement of the sharps safety rules, particularly in dentists' offices.

Susan Eckerly, NFIB senior vice president for public policy, says, "OSHA should limit the scope of this standard to only the most at-risk workplace settings. By doing so, OSHA could substantially limit the number of small businesses affected by this clearly burdensome standard, without sacrificing the safety of the workers employed by those businesses."

However, others argued for continued protections for healthcare workers outside acute care. "For outpatient settings, particularly long-term care and home health, the need is for more basic epidemiological research. We need a better grasp on how the sharps injury risk picture differs in the various healthcare settings that are grouped in the category 'alternate sites,' " says Perry. "These vary from a single healthcare worker providing in-home care to large staffs working in long-term care facilities or nursing homes. While data for outpatient and alternate care settings are limited, it would be unwise to weaken any part of the standard or grant exemptions to specific non-hospital settings, given that non-acute care settings are currently the most rapidly expanding segment of the health care market."

More pressure on manufacturers?

Healthcare employers are required to provide safety devices, when possible, but manufacturers are not required to produce the devices. While manufacturers have responded to the demand for safety products, there are still gaps remaining, as noted in comments to OSHA.

For example, surveillance data from Massachusetts hospitals found that in 2008, 20% of sharps injuries involved devices contained in pre-packaged kits. Some 58% of those injuries involved devices that had no safety feature. **Angela Laramie**, MPH, epidemiologist with the Sharps Injury Surveillance Project in the Massachusetts Department of Public Health in Boston, wrote, "Many hospitals are working to comply with the letter and spirit of the regulations but find that much energy is put into negotiating with product suppliers and manufacturers to obtain [devices with safety-engineered sharps injury prevention]. Hospitals have also questioned how it is possible that manufacturers and suppliers can continue to provide devices lacking sharps injury prevention features."

REFERENCE

1. Jagger J, Berguer R, Phillips EK, et al. Increase in sharps injuries in surgical settings versus nonsurgical settings after passage of national needlestick legislation. *J Am Coll Surg* 2010;210:496–502. ■

GUEST COLUMN

Consultant addresses trends among ASCs

By **Richard Bays**, RN, MBA, CPHQ, CLNC
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Question: As a consultant, you specialize in helping ambulatory surgery centers (ASCs) get in compliance with accreditation and licensing. Are there any parts of the almost two-year-old 2009 Medicare Conditions for Coverage that ASCs are having a difficult time handling?

Answer: Some of the areas I've seen difficulties are in the four outlined below:

— § 416.42 Condition for coverage — Surgical services.

Physicians must have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC. In reviewing physician files, the problems are one, have they been granted privileges prior to performing surgery and two, was their license verified as current prior to performing cases at the ASC.

— § 416.44 Condition for coverage — Environment.

Life Safety Code violations are becoming more frequent as inspectors are focusing more on this area. Physical fire wall penetrations, lack of documentation for fire drills, and fire safety training are the most common items being cited.

— § 416.47 Condition for coverage — Medical records.

One of the issues I see during closed record reviews is improperly executed consents. Consents should specify the procedure to be performed, site (right/left), the time and date of execution, the patient's name and name of the witness.

— § 416.48 Condition for coverage — Pharmaceutical services.

Medication administration continues to be an ongoing compliance issue, with anesthesia tending to be the weakest area. Medications should be labeled when they are on the sterile field, multi-dose vials should be labeled when opened, and controlled substances should be accounted for and secured. Expired medications are the no. 1 problem area.

Question: What are some of the most significant trends that you have seen in the ASC industry over the past few years?

Answer: Some of the ASCs are choosing to not accept Medicare patients and relying solely on private insurance and cash pay patients. This model can work, depending on your overall case mix and long-term strategic planning. It also eliminates the accreditation process that most facilities participate in to gain access to CMS/Medicare. Another sometimes painful reality is the need for diversification at some facilities. Many single-specialty ASCs have expanded their services to offer new procedures. Physical expansion or additional equipment costs are weighed into a "repackaging" of the ASC. Some ASCs have explored selling partial interest in the facility or joint ventures with others. The trend recently has been examining a longer-range plan to remain profitable and diligent preparation for possible scenarios revolving around the new healthcare reform that is brewing. Every facility has its own personality; there's no magic bullet. *[Editor's note: This article is reprinted with the permission of the Texas Ambulatory Surgery Center Society.]* ■

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 activity with the June issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a letter of credit. When your evaluation is received, a letter will be mailed to you.

COMING IN FUTURE MONTHS

- New strategies to avoid identity theft
- 30 days to prepare for accreditation survey
- What to do when your facility floods
- How to prepare for a brutal Medicare survey

CNE/CME OBJECTIVES

- **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.

CNE/CME QUESTIONS

17. What should managers do if a clinician has been accused of sexually assaulting a patient, according to Elizabeth G. Russell, JD, partner at Kreig DeVault in Indianapolis, IN.
A. Hold a staff meeting to discuss the alleged incident.
B. Put the clinician on administrative leave.
C. Obtain a signed statement from everyone involved in the alleged incident.

18. Which of the following does Stephen W. Earnhart, MS, CEO of Earnhart & Associates, recommend regarding block booking?
A. Avoid full block days.
B. Allow your surgeons office to post into your system directly from their office and bypass calling you.
C. Unutilized block times should be released 24 hours (or 36, 48, or 72 hours) beforehand.
D. All of the above.

19. At Diagnostic and Interventional Sports and Spine, and Diagnostic and Interventional Surgical Center (DISC), what is the role of the nurse who accompanies the patients to their home or hotel?
A. provide intravenous or intramuscular pain medication
B. education
C. helping the family with mobilization
D. B and C

20. From 2006 to 2010, the Tennessee OSHA focused on sharps safety in the OR. How much did OR sharps injuries decline in hospitals?
A. 5.5%
B. 10%
C. 14.5%
D. 23%

Answers: 17. B; 18. D; 19. D; 20. C