Same-Day Surgery®

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

August 2011: Vol. 35, No. 8
Pages 77-88

IN THIS ISSUE

Financial Disclosure:
Executive Editor **Joy Dickinson**, Board Member and Nurse Planner **Kay Ball**, and Board Member and Columnist **Stephen W. Earnhart** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor **Mark Mayo** reports that he is an Administrative Consultant to USPI Chicago Market. **Steven Schwaitzberg**, MD, Physician Reviewer, discloses that he is on the speakers bureau for Stryker Corp. and Merck & Co., he is a medical advisor to Surgiquest, and he is a stockholder in Starion Instruments.

AHC Media

Recent verdict raises issue: When do you refer to a high-volume provider?

A major vein was torn during a Whipple procedure at a hospital that performs the procedure a few times a year, according to a case reported on *The Law Med Blog*.[1] The patient experienced complications, went in for a second surgery, and subsequently died. The patient's husband filed a lawsuit and claimed the patient should have been referred to a major facility and that the surgeon didn't correctly voice concerns during the procedure. Specifically, the patient had no information that she might be safer in the hands of a more experienced surgeon, according to the husband's attorney.

According to the husband's attorney, a facility that performs the Whipple procedure less than seven times a year is considered a low-volume facility. The surgeon had performed the surgery three times before the fatal outcome.

The defense's position was that the physician was a board-certified general surgeon who had successfully performed the surgery previously, and 42% of Whipple surgeries are done in community hospital settings. If the patient had been referred to a facility that performed a high volume of these procedures, the risk of a recognized complication would not have been reduced, the defense said.

The patient was found to be cancer-free. Members of the jury were unani-

EXECUTIVE SUMMARY

A jury recently awarded a $4.4 million judgment after a patient died from complications experienced during a Whipple procedure. The number of times the surgeon and facility had performed the procedure became an issue during the trial.

- Before granting privileges, ensure the surgeon has undergone a certified course and determine how many similar procedures he/she has performed.
- Determine if your staff members have the skills and abilities to address complications.
- If there is a nearby center of excellence for a procedure, the surgeon should disclose that information, suggests one source.
- All procedures as well as outcomes should be on a periodic review.

mous in their decision to award $4.4 million to the husband. Perhaps they were considering the wording on the web site of the American Cancer Society, which describes the Whipple procedure as a "very complex operation" that is "best done by a surgeon who has done it many times in a hospital that does at least 20 Whipple procedures per year."

This verdict raises questions for outpatient surgery managers: How can you be sure your surgeon is experienced enough to perform an outpatient surgery procedure, and when should you refer patients elsewhere? Consider these suggestions:

• First, determine if the surgeon is qualified to perform a procedure.

MemorialCare Health System in Fountain Valley, CA, is similar to many providers in that granting of privileges is dependent on the surgeon's training and experience.

Generally, each MemorialCare facility has a surgical committee that reviews and approves new procedures based on the procedure itself; the surgeons' training, competency, and privileges to perform the procedure; proctoring; and the ability to provide consistent support staff and equipment to consistently support the procedure, says **John C. Metcalfe**, JD, FASHRM, vice president of risk and insurance management services.

Richard Satava, MD, FACS, professor of surgery at the University of Washington Medical School and surgeon at the University of Washington Medical Center, both in Seattle, says it's important that the surgeon is well trained to quantifiable and verified outcome measures, "not something on a weekend" or solely from the industry. Satava also serves as a consultant to the American College of Surgeons Committee on Emerging Surgical Technologies.

The chairman of a department of surgeon must consider multiple measures, including how many similar procedures a surgeon has performed in preceding years when granting privileges, Satava says. The chairman also should look beyond the surgeon's technical abilities, he says. Technique is part of it, but the fundamental principles in preop and perioperative care should be looked at as a global measure of competency, Satava says.

• Examine how often a complex procedure is performed within the facility and whether staff can respond to complications.

According to **Jane J. McCaffrey**, DFASHRM, MHSA, director of compliance, clinical operations at St. Joseph Medical Center in Towson, MD, "The most important consideration should start with how often a particular complex procedure is being performed within the facility." While physician skill is critical, "equally critical are the skills and resources of all the others caring for the patient," McCaffrey says.

Staff must have the skill and ability to address any complications, because "even in the most experienced hands complications can and do occur," she says. McCaffrey points to the Whipple procedure discussed above and asks three questions: Was the surgical team skilled and prepared

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.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

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.)

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 16.5 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 16.5 Contact Hours.

AHC Media is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media designates this enduring material for a maximum of 20 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 24 months after the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey**.

AHC Media

Editorial Questions
Questions or comments? Call Joy Daughtery Dickinson at (229) 551-9195.

to deal with the complication? Was the complication more appropriate for a vascular surgeon than a general surgeon? Did the facility have the diagnostic equipment and other support services?

"The 'driver' for whether a procedure is to be done at a facility is not just the credentials/training and skill of the physician; it is also the capabilities and resources of the facility," she says. Particularly in rural areas, resources include referral agreements with regional facilities, McCaffrey advises

• The surgeon should disclose if there is a nearby center of excellence performing the same procedure.

Some surgeons might be performing procedures for which there is a center of excellence in the same city. In that case, after discussing the procedure, risks, and complications, Satava suggests they acknowledge the following: "If you want to have this procedure, knowing the risks and complications, I'm happy to perform the surgery. There is a specialty center available whose outcomes are as good or perhaps a little better. If you decide to do your procedure there, I understand."

However, 60-75% of procedures are relatively simple and straightforward, and for those procedures, there is no reason to refer patients to a major tertiary center, he says. For example, with a laparoscopic procedure, there is an initial learning curve, but once surgeons reach a certain level of cases, there are no differences in the outcomes between local community hospitals and tertiary teaching facilities.

Another factor to consider is the added cost to the patient and his or her family to travel to a tertiary facility, Satava says. "Those are hidden costs, when patients have to go somewhere else: the hotels and transportation," he says. "Those are a huge economic burden not accounted for in the cost of medical care."

• All procedures and outcomes should be on periodic review.

Physicians have ongoing periodical performance evaluation (OPPE), McCaffrey points out. "Facilities need to evaluate the information so they can determine if they are able to perform the procedure as expected," she says.

Administrators can use resources for determining expectations such as specialty societies, measure reports from the Centers for Medicare and Medicaid Services (CMS), and registries, McCaffrey says.

There is a trend toward regionalization in surgery, McCaffrey says. "There are many locales throughout the country that are creating regional centers where lower volume/higher technical procedures are consolidated," she says. This trend allows facilities to have all the appropriate resources on a continuing basis, McCaffrey maintains.

"Smaller facilities are beginning to limit the scope and services to more basic aspects that they can better control," she says.

REFERENCE

1. *The Law Med Blog*. Lack of Surgeon's Experience Cited in $4.4M Verdict. May 26, 2011. Web: lawmedconsultant.com/2060/lack-of-surgeons-experience-cited-in-4.4m-verdict.■

Response to infections: Hire an overseer

Source: Give them time to learn job and do it

Several incidents of infection control breaches have been reported in recent months among ambulatory surgery providers:

• In New Jersey, more than half of the ambulatory surgery centers (ASCs) inspected in the past two years failed to meet federal safety standards, according to a media report.[1] One state quality official described the results as "alarming." One surgery center didn't properly clean scopes between colonoscopies, according to the media report. Another didn't fully sterilize equipment, it said. Inspectors found staff walking through sterile operating rooms in street clothes, improperly sanitized patient beds, single-use items being used for more than one patient, and expired medications. At one center, staff failed to change the water and refill the sink with fresh cleaning solution between scope procedures. Now lawmakers are looking at passing bills that would require one-room centers to be inspected, as well as certified or accredited. The state health department is proposing the same. *(See response from New Jersey ambulatory surgery association, box, p. 80.)*

• A review of two Veterans Administration (VA) hospitals found staff needed more training to protect themselves and patients from infectious diseases, according to a news report.[2] Of 37 staff training records that were inspected, only five had received annual education on fighting multidrug-resistant organisms and on safety practices related

EXECUTIVE SUMMARY

Infection control issues have been reported recently at ambulatory surgery centers and hospitals. To avoid these highly publicized problems in your facility:

- Designate an infection preventionist.
- Rather than piling infection control duties on top of patient care responsibilities, give your preventionist time to learn the job and perform it, our source says.

to bloodborne pathogens, the report said. The company that runs the hospitals responded that employees had received the training, but it was not the computer-based program required by the VA. The company has made that training part of annual performance reviews. This report follows earlier reports of improper hygiene practices at VA hospitals that resulted in testing that found eight HIV-positive patients and 61 confirmed cases of hepatitis B or C.[3] Those cases have not been confirmed to have resulted from treatment at VA hospitals.

How do such problems happen? Often at surgery centers, there is person whose sole responsibility is to handle infection control, says **Marcia Patrick**, RN, MSN, CIC, director, of infection prevention and control at MultiCare Health System in Tacoma, WA, and board member of the Association for Professionals in Infection Control and Epidemiology (APIC).

"What we're seeing is the result of years of neglect," Patrick says. Even where there is oversight, surveyors don't always know what details to look for, such as making sure the autoclave is maintained and works, she says. "It really goes back to having someone responsible for this," she says. "That's what CMS [Centers for Medicare and Medicaid Services] guidelines call for, and that is what APIC has always promulgated." According to CMS, the person should be a licensed MD, RN, or LPN, Patrick says. This infection preventionist needs to perform risk assessments, as well as ensuring staff are "simply cleaning their hands between patients," Patrick maintains.

Blaming infection control problems on a staff member who has had no training, who doesn't understand nuances of infection control and the needs of the facility, and not giving them time to learn the job and do it, will help the facility, she says. You can't simply tell a nurse, "This is your job in addition to your patient care job, and we're not giving you time to do it," and expect to pass inspections, Patrick says. *(See Resources, p. 81, for training opportunities.)*

"If you don't have trained people who know infection control, who know about processing instruments properly, cleaning hands, and cleaning the environment properly, it puts patients at risk," Patrick says. "I think we're hitting the tip of the

New Jersey group responds to ASC critics

In response to reports that more than half of the ambulatory surgery centers (ASCs) in New Jersey inspected in the past two years failed to meet federal safety standards, the New Jersey Association of Ambulatory Surgery Centers (NJAASC) responded that all surgery centers and other healthcare providers in that state "operate within a rigid regulatory environment."[1]

"While any violation is important and must be immediately addressed, most of those cited in the Health Care Quality Institute's report were incidental infractions and, in any case, the vast majority of all violations were corrected promptly," the association said. Additionally, in almost all cases, there were no adverse outcome, it said.

In response to legislative reforms being discussed, the association pointed out that one-room surgery centers cannot be licensed under current state law. "It's a legislative matter the NJAASC is working to address, and the association would certainly welcome more frequent inspections," it said.

In a letter to the editor of a newspaper, **Larry Trenk**, the president of NJAASC said, "As the association that represents ASCs across the state, we are treating these allegations very seriously because even one incident that jeopardizes patient safety is one incident too many. However, we want to reassure both state regulators and patients that proper safety protocols are in place and that our centers adhere to current state laws."[2]

REFERENCES

1. Success Communications Group. Ambulatory Surgery Group Cites Misinformation as Serious Risk to Patients. May 25, 2011. Accessed via personal e-mail.
2. Trenk L. Tight oversights on surgical centers. June 5, 2011. The Record. Accessed at http://www.northjersey.com/news/opinions/123177878_Tight_oversights_on_surgical_centers.html. ■

iceberg in ambulatory care."

REFERENCES

1. Layton MJ. NJ clinic errors 'alarming.' The Record. May 19, 2011. Accessed at http://www.northjersey.com/news/health/other_health/122222593_Clinic_errors__alarming_.html
2. Wilemon T. Report critical of VA centers in Murfreesboro, Nashville. The Tennessean May 24, 2011. Accessed at http://www.tennessean.com/article/20110524/NEWS07/305240039/Report-critical-of-VA-centers-in-Murfreesboro-Nashville.
3. Associated Press. VA infection risk leads to 12,000 tests. May 30, 2011. Accessed at http://articles.boston.com/2011-05-30/news/29600379_1_va-hospitals-report-infections-antibiotic-resistant-staph-infections.

RESOURCES

• Healthmark's Crazy4Clean.com has launched **"TOSIman's Delivery Service,"** a free online flash-based game that takes you on an adventure to the sterile processing department, earning a free CEU. Web: http://crazy4clean.com/games.php.

• **Partnering to Heal: Teaming Up Against Healthcare-Associated Infections.** This free computer-based, interactive game from the Department of Health and Human Services allows participants to assume the identity of a character in a video simulation that calls for decisions to ensure infection prevention. The characters include a physician, nurse, infection preventionist, patient family member, and medical student. The game can be used by groups or individuals. Web: www.hhs.gov/ash/initiatives/hai/training.

• The Association for Professionals in Infection Control and Epidemiology is offering **"Infection Prevention for Ambulatory Surgery Centers: Meeting CMS Conditions for Coverage."** This course is Aug. 5-6, 2011, in San Francisco and Oct. 21-22 in Miami. The cost is $495 for members or $680 for non-members. To register, go to http://www.apic.org. ■

After Joplin tornado, center gives quick aid

EXECUTIVE SUMMARY

Stateline Surgery Center in Galena, KS, responded quickly when a tornado destroyed St. John's Regional Medical Center in Joplin, MO, just 10 minutes away.
• The Weather Channel had more accurate information about the hospital's damage than the local TV station.
• Once full power was restored, the administrator texted staff and surgeons to notify them they would be open. Once sufficient staff members were on site, word was spread through notifying police and EMTs, as well as texting surgeons in the area.
• Future disaster drills will incorporate overcoming communication difficulties and treating patients from the community, instead of an internal disaster.

You can't believe everything you hear on TV. After tornados were reported in the area of Joplin, MO, in May, **Jenny Morris**, administrator of Stateline Surgery Center in Galena, KS, turned to the local television station. The station reported that there was merely debris damage at St. John's Regional Medical Center in Joplin, which is about 10 minutes from the center.

Morris sent a text to a member of her board, who was out of town, to let him know what was going on. He informed her that the Weather Channel already was showing that the hospital had been seriously damaged by the tornado. In fact, the hospital was closing and evacuating patients.

Morris immediately called her maintenance staff person to find out if the generator at her center was working. It was, and by the time she arrived at the center, the power was back on. "Once I knew we were on full power and we were not damaged, I called the president and said, 'I think we need to open up.'" He agreed.

Morris sent a text to all of the center's staff and physicians to inform them that they were opening. Two nurses had to crawl out of stores that were extensively damaged, and one of those nurses was limping when she arrived. Even the PRN staff showed up. Some of the staff from the hospital came, as well as some others from a surgery center in Joplin where Morris worked previously. In about 45 minutes, the center had enough staff on site to open. "We had more surgeons than we needed," she says.

Cell towers were not working, so Morris used texts to get out the word that the center was accepting patients. She texted surgeons at the hospital. One staff member's spouse went to the police department and asked them to notify emergency responders that they could bring injured persons to the center. "Once we did start receiving patients through ambulances, I told the EMTs, 'get on the radio and tell them, you can bring patients here.'"

St. John's brought two busloads of patients to the surgery center. "We worked to get patients to another hospital," Morris says. "They were here for several hours, with nowhere to go."

Staff worked continuously from Sunday after-

noon until 5 p.m. Monday. The center treated 68 patients for mostly abrasions and fractures. One storm victim had a board through her shoulder, so the staff performed a shoulder reconstruction. Supplies, including oxygen tanks, were contributed by other facilities including St. John's. Additionally, members of the community contributed a large amount of food for members of the staff and the patients.

On Tuesday, members of the staff saw a few patients for follow up, and then they started distributing supplies to other facilities that needed them. They distributed the leftover food to shelters.

Now the center is trying to assist a large number of surgeons who want to join the facility. Because the facility is in Kansas, the Missouri physicians must obtain a Kansas license. The governor's office is assisting by having their county included in the Missouri disaster area.

Members of the staff were prepared for the disaster: They perform tornado drills every spring. Still, they learned a lesson. Most of the drills had focused on the center being hit by a tornado and how they would take care of the patients already there. Now, drills will incorporate communication difficulties and the handling of an external disaster.

"If the community is struck, we're treating them, more than we're hit," Morris says. ■

Don't wait too long — Verify patient's coverage

Outpatient surgery POS collections jump 47%

Patients gradually are becoming accustomed to being asked for payment upfront, according to **Marcy Quattrochi**, manager of financial counseling at NorthShore University HealthSystem in Evanston, IL.

"If you go into a doctor's office nowadays, you are expected to pay your copay," Quattrochi says. "Patients are pleased to know what they're going to owe. They may need to budget or make payment arrangements for a procedure. I think it is very, very positive."

At the same time financial counselors inform surgical patients about their estimated out-of-pocket expense, they ask for a deposit or payment upfront. "Right now, we are doing this for select services only, but patients seem to be very pleased with it," Quattrochi says. "Our point-of-service collection has definitely increased."

EXECUTIVE SUMMARY

Patients are increasingly concerned about their out-of-pocket responsibility due to higher coinsurance and deductibles and are asking patient access staff for detailed information. When giving estimates:

- Determine whether patients are eligible for charity care.
- Verify benefits well before a patient comes in for surgery.

Obtain insurance information before the patient comes to the hospital.

Point-of-service (POS) collections for fiscal year 2011 increased by 46.9% for outpatient surgery compared with the previous year, she reports.

"The major change we made is that we are verifying benefits further out, instead of a day or two *before*," Quattrochi says. "We prefer not to call a patient right before he or she is coming in for surgery." If the insurance is verified a week out, says Quattrochi, it gives staff enough time to have a conversation with the patient before their scheduled services.

Patients might be registered as self-pay because registrars don't have the insurance information before they come into the hospital, says Quattrochi. "The registration areas work with the doctor's offices to obtain that information before they come in, if they do have insurance," she says.

In some cases, says Quattrochi, patients are genuinely surprised to find that they qualify for financial assistance. "Our charity program is very generous," she says. "Many people have the misunderstanding that only those unemployed or with little income can qualify. You can have a substantial income and still qualify for a discount."

Well-informed patients

For elective cases, registrars at St. Joseph's Healthcare System in Paterson, NJ, verify benefits, verify that an authorization has been obtained, and determine the patient's out-of-pocket responsibility, says **Sandra N. Rivera**, RN, BSN, CHAM, director of patient access.

In the past, registrars only collected copays because calculating the co-insurance and deductible was so complex, says Rivera. "We are now working on being able to calculate the co-insurance and deductible as an estimate prior to elective services," she says. "This is a new process for us.

It is being rolled out in stages."

Registrars use price estimation software that takes into account payer contracts, the patient's benefits, and 18 months of billing history, says Rivera." To be able to provide an accurate estimate, you need all this information," she says.

Registrars contact the payer to learn how much the patient has paid toward the deductible and what the balance is, says Rivera. "The more information you can share, and the more transparent the process, the better informed the patient is," she says. *(For information on estimating out-of-pocket expenses, see story, below.)*

SOURCES

For more information on estimating patient out-of-pocket responsibility, contact:

• **Marcy Quattrochi**, Manager, Financial Counseling, NorthShore University HealthSystem, Evanston, IL. Phone: (847) 570-2078. Fax: (847) 733-5223. E-mail: mquattrochi@NorthShore.org.
• **Sandra N. Rivera**, RN, BSN, CHAM, Director, Patient Access, St. Joseph's Healthcare System, Paterson, NJ. Phone: (973) 754-2206. E-mail: riveras@sjhmc.org.
• **Cindy Thomas**, AS, CHAM, Outpatient Access Manager, Danbury (CT) Hospital. Phone: (203) 739-8204. Fax: (203) 739-1905. E-mail: cindy.thomas@danhosp.org. ■

Give straight answer on out-of-pocket expenses

Patients might need to plan ahead

"How much will I owe for this procedure?" Your response to this seemingly simple question from a patient could be the deciding factor as to whether he or she chooses your facility, says Marcy Quattrochi, manager of financial counseling at NorthShore University HealthSystem in Evanston, IL.

"Often times, they are shopping for the best price and may seek services elsewhere," Quattrochi says.

A patient's out-of-pocket responsibility isn't always easy to determine, but more patients are demanding this information upfront, according to **Sandra N. Rivera**, RN, BSN, CHAM, director of patient access at St. Joseph's Healthcare System in Paterson, NJ. "This allows for the patient to properly financially plan ahead, instead of receiving a bill later for an unknown amount," she says.

The price you quote can be the difference between a patient having a procedure at your hospital or somewhere else, says Rivera. "Some patients are starting to price shop," she adds. "They will even tell you the price they received from another facility."

Many patients are not aware of their deductible or out-of-pocket expenses, says Quattrochi, and they find it difficult to calculate what they will owe for any given service.

Patients with scheduled services often call to find out how much they're going to owe, Quattrochi adds. "There are a lot of people who are very concerned because of higher deductibles," she says. "If they're unable to pay the portion not covered by insurance, we do have a very generous charity care policy."

Patient access staff and financial counselors use newly implemented price estimation software to estimate what patients will owe for scheduled services, she says. "It gives us their copay, their deductible, and their estimated amount owed," Quattrochi says. "We are able to access this in many areas of the hospital, so we can have a conversation with the patient regarding their benefits."

The system gives an estimate based on previous patients who have had the procedure with a specific doctor, explains Quattrochi, but cost still varies from patient to patient, depending on time in the OR and recovery room, and necessary supplies.

Medicare coverage is particularly difficult to explain to patients, notes Quattrochi. "It is based on how many days you are inpatient within a specific timeframe, and it gets very confusing to try to explain," she says. "If the patient is in-house and a family member wants to talk to somebody, we can go over it very specifically with them."

It's just an estimate

At Danbury (CT) Hospital, registrars are careful to give patients as close an estimate as possible, says **Cindy Thomas**, AS, CHAM, outpatient access manager. "But unless it is a clear co-pay, it would be just an estimate. You need to be extremely careful," she says.

It is difficult for staff to accurately estimate what portion of a deductible already is met and what to request as a deposit, Thomas explains. "It is safer to stay away from requesting co-insurance or even giving an estimate of what would be owed," she says. "There are too many variables."

For deductibles and co-insurance, says Thomas,

a patient's balance will depend on how many physician visits, testing, or inpatient stays a patient has. "The balances are based on what bills hit first," she says. For this reason, staff members collect only copays. "This is a clear-cut expense," she says. "We can ask for this without the possibility of having to do a refund for overpayment."

Good estimates depend for a large part on information from clinical areas, such as an accurate estimate of OR time, adds Thomas. Patient access staff can't quote an exact price for an ED visit because this price is dependent on all of the testing that is done at the time of service, professional fees, and level of care, she notes.

Staff can give endoscopy patients a close estimate, says Thomas, but if they find polyps during the test, there will be additional biopsies and pathology fees. For surgical patients, OR time can change during the procedure, she notes.

"Everything has variables. We tell the patient we can tell them only what we know for sure. The rest we will not know until after treatment and discharge," says Thomas. "Usually, this is accepted by the patient." *(See related story on providing explanations when collecting, in box below.)* ■

Strong red rules and safety cells cut errors

(Editor's note: This issue includes the second part of a two-part series on how a hospital addressed a wrong-site surgery. Last month, we looked at the details of the event and how the facility responded. This month, we look at what specific changes were made and how the top leader started networking with other CEOs on safety issue.)

In response to a task force's recommendations following a wrong-site surgical error, Cayuga Medical Center in Ithaca, NY, implemented several changes, including safety cells.

The safety cells are made of groups of caregivers who are responsible for certain patients, such as everyone who works on a particular unit. This safety cell meets regularly, often at the beginning

Asking for payment? First, give explanation

When a patient asks what he or she will owe for a procedure, registrars at St. Joseph's Healthcare System in Paterson, NJ, consider the payer contract, procedure code, procedure amount, and patient benefits, says **Sandra N. Rivera**, RN, BSN, CHAM, director of patient access.

"Registrars must be able to properly explain the health insurance benefits to the patient, including covered benefits, authorization requirements, and in- and out-of-network coverage," she says.

Most payers have a web site and customer service phone number for patients to call with any questions, notes Rivera, but patients prefer receiving a written estimate. Previously, registrars collected only on the day of service, says Rivera, but collections have moved to the pre-registration process. "This allows patients to go directly to point of service when they arrive," she explains.

Staff use scripting to practice asking for payment, and they often use the words, "Would you like to pay by cash, check, or credit card?"

"They also need to understand how we come up with the estimates," she says. "They need to answer any questions the patient may have."

Registrars soon will be able to hand patients a brochure with information on the payment process, financial assistance programs, and where to go for assistance, says Rivera. Physicians, patient financial services, planning and development, the hospital's chief financial officer, patient access, and the marketing department are working together to create the brochure, says Rivera. "The brochure can be given to patients at any time in the process," she says. "We also created a patient access video that is played in our lobby. It explains the registration process to patients as they wait."

At times, staff members connect the patient directly to the insurance company via telephone to discuss their coverage, says Rivera. "This allows for the patient to speak directly to the payer and have the information explained first-hand," she says.

If the patient still is confused about their benefits, says Rivera, the case is referred to a manager. "This allows management to review any issues with the staff that may need clarification," she says. "It also helps to identify any payer trends or process changes that may need to be addressed." ■

of each day or the change of every shift. Members make sure each person knows about possible safety problems, such as a high-risk medicine being used in the ward or two patients with the same last name. They also discuss any safety breaches that occurred earlier.

"They will go over any issues such as falls that occurred recently, the cause of the fall, and what can be done immediately to prevent any other falls," says **David Evelyn**, MD, vice president for medical affairs at Cayuga. "The safety cells also go over any issues discovered by other cells, so it becomes a way to quickly communicate any issues and solutions."

Each safety cell sends a representative to serve on the hospital's Safety Council, which meets regularly and includes the risk manager, Evelyn, the infection control manager, the patient safety officer, and other key individuals.

The hospital also implemented these changes:

• Stronger red rules.

Cayuga already used red rules, which are rules that clinicians are expected to follow in all the time, no matter the circumstances. One example is using two forms of identification with each patient for every interaction, such as administering medications or performing procedures. Another is labeling any samples taken from patients at the bedside, before there is a chance to lose or confuse them with another patient's samples. Staff underwent additional training.

"We emphasized the inviolate nature of our red rules," Evelyn says. "Every hospital has lots of policies and procedures, and sometimes you can't follow them because of the situation or it just seems unnecessary in those particular circumstances. We made it clear that these are rules you absolutely cannot violate. There can be no situation, no excuse that will make it OK to violate a red rule at Cayuga Medical Center."

• Tighter enforcement for the Universal Protocol.

Similar to its renewed dedication to red rules, Cayuga emphasizes to clinicians that the Universal Protocol must be followed without exception. The surgical team confirms the patient's name, date of birth, procedure, side the procedure should be on, equipment and supplies needed, position the patient should be in, and any extra safety precautions or allergies. Each team member must affirm each item, with full attention on the time out, before the operation can proceed, Evelyn says.

"If they don't do the Universal Protocol, the procedure is not going to happen," he says. "And we expect every person in that room to object if the protocol is not followed."

CEO 'safety huddles' yield ideas for better care

CEO **Rob Mackenzie**, MD, used his leadership position to help drive the culture change at Cayuga Medical Center in Ithaca, NY.

"I said I wanted to get more education on patient safety and be the flag bearer on this one," Mackenzie says. "I've shared our experience with other hospitals and sought information about their patient safety problems and improvements, and that turned into a CEO patient safety networking group that meets every other month to see what we can do as CEOs to raise this issue to a higher level in our organizations."

One idea that came out of that networking was for Cayuga to have a "safety huddle" for the top directors in the organization at the end of each week that acts in effect as an organizationwide safety cell.

"Just like the cells on the patient care units, we cover any issues we know of throughout the organization and use that meeting as a communication tool," Mackenzie says. ■

• A new patient safety director.

Cayuga leaders determined that the hospital needed a full-time patient safety director and hired Karen Ames, MA, director of performance improvement, to take on the role. Mackenzie says they chose to hire from within because they wanted someone who knew the hospital and its culture.

• A new executive level committee.

Cayuga developed an administrative committee made up of board members, executive level leaders, and administrators, named the Quality and Patient Safety Committee. This committee is charged with overseeing the hospital's patient safety efforts and encouraging a culture of safety. The involvement of the board of directors not only provides the in-house clout to make things happen, but it also signals to the entire organization that the hospital is taking patient safety seriously, Evelyn says.

SOURCES

• **David Evelyn**, MD, Vice President for Medical Affairs, Cayuga Medical Center, Ithica, NY. Telephone: (607) 274-4011. E-mail: develyn@cayugamed.org.
• **Rob Mackenzie**, MD, CEO, Cayuga Medical Center, Ithaca, NY. Telephone: (607) 274-4011. E-mail: rmackenzie@cayugamed.org. ■

Same-Day Surgery Manager

Trends I learned about at association meetings

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

This has been a grand month so far. I had the pleasure of speaking at the Ambulatory Surgery Center Association (ASCA) meeting in Orlando in May and The Gulf States ASC Conference in Biloxi in June. I reacquainted with old friends and made new ones, and I gathered many months of ideas for my column.

The one thing that impressed me more than anything at these meetings was that as an industry, we are marching forward and are not daunted by the economic woes around us. Of course, being in healthcare and not real estate helps, but still, I gathered an upbeat mood from surgery center owners, companies, hospital department heads, surgeons, techs, and vendors. It was refreshing to witness. We should all feel good about our career choice! Here is my take on what I observed:

1. Surgeons are investing in their future. Granted, some physicians are becoming employees of large healthcare systems, but I see that as positive as not everyone is an entrepreneur and there is comfort in the pack for those individuals. But this trend helps to clear the vision for others and does carve out a larger niche for surgeons who wish to pursue a business venture (i.e. their own surgery center) combined with professional satisfaction and growth.

2. More and more hospitals are partnering with surgeons. Again, some are hiring them as employees, but mostly they are partnering in surgery center projects. This is heartening as it not only brings more business to the industry, but it also validates it. Not that we need it, of course.

3. A lot of people and companies are looking to buy surgery centers. According to Healthcare Appraisers, 52% of the health care companies plan to buy surgery centers this year. Could you be one of them? Better smile at strangers walking through your center. You never know!

4. The "giveaways" (the little trinkets on their tables) at the vendor's booths are cheap and paltry. COME ON! We are professionals spending real money here. Cough up the good stuff if you want us to stop at your table!

5. Seemingly, as a group, we are getting older. Are there going to be enough new nurses to replace us in the next 10 years? I don't think so.

6. There were many private meetings going on all around me involving business-type people (they wore suits) with surgeons (they wore scrubs, so they would be easy to spot in their casual indifference) discussing all manner of things that could only be good for all of us.

7. It appears, according to all the vendors present, that many of us are outsourcing services from our facilities. And, based upon all the equipment vendors, we are breaking a lot of our stuff!

All in all, it was great. I know that many of you that read this don't always have the opportunity to go to these meetings. It's such a shame and a missed opportunity for you. You need to let your department head or supervisor know your desire to attend. You will come away like I did: rejuvenated, inspired, and networked!

You also need to get involved in your organization, whatever it might be, because it does make a difference. For example, almost every state has a hospital and surgery center association. Google yours to find the contact info. Surgery centers also can go to http://ascassociation.org/about/state to find their state associations.

I received my first real break in this industry by attending a conference years ago. I was so inspired by the speakers that I signed up to speak at the following year's conference (completely forgetting about my fear of public speaking at the time), and that was the start of what I do now. Whether you work in a surgery center, a hospital outpatient department, or a surgeon's office, the networking and experience is well worth your time! *[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.]* ■

Want staff to speak up? Use step-by-step process

(Editor's note: This is the second part of a series on staff keeping silent when danger looms.)

To improve patient safety by encouraging providers to speak up about their concerns, managers should focus on the influences that have the strongest effect on behavior, suggest the authors of *The Silent Treatment*, a report released by the Association of periOperative Registered Nurses, the American Association of Critical-Care Nurses, and VitalSmarts, a training company in Provo, UT.

The authors suggest focusing on these six sources of behavioral influence:

• **Personal motivation.** If it were up to them, would they want to speak up? Does it feel like a moral obligation or an unpleasant annoyance?

• **Personal ability.** Do they have the knowledge and skills they need to handle the toughest challenges of speaking up?

• **Social motivation.** Are the people around them (physicians, managers, and co-workers) encouraging them to speak up when they have concerns? Are the people they respect modeling speaking up?

• **Social ability**. Do others step in to help them when they try to speak up? Do others support them afterward so the risk doesn't turn against them? Do those around them offer coaching and advice for handling the conversation?

• **Structural motivation.** Does the organization reward people who speak up or punish them? Is speaking up included in performance reviews? Are managers held accountable for influencing these behaviors?

• **Structural ability.** Does the organization establish times, places, and tools that make it easy to speak up, such as surgical pauses and handoff procedures? Are there times and places when caregivers are encouraged to speak up? Does the organization measure the frequency with which people are holding these conversations and use these measures to keep management focused on this issue?

The Silent Treatment also recommends how organizations can use this approach to create a culture where people speak up effectively:

1. Establish a design team. Enlist a small team that includes senior leaders; managers in targeted areas; and opinion leaders among caregivers. This team works with all caregivers to identify crucial moments, vital behaviors, and strategies within each of the six sources of influence. The team provides a few initial strategies within each source and helps teams in patient care areas select, modify, and create additional strategies.

2. Identify crucial moments. There are a handful of perfect-storm moments when circumstances, people, and activities put safety protocols at risk. The team needs to spotlight these moments so that people will recognize them. An example of one is when the surgery schedule is pushed later and people are in a rush.

3. Define vital behaviors. People need to know what to say and do when they find themselves in these crucial moments. These are the vital behaviors that keep patients safe. Examples of vital behaviors include "200% accountability." Each staff member is 100% accountable for following safe practices and 100% accountable for making sure others follow safe practices.

4. Develop a playbook. Safety requires that the vital behaviors be acted on in a highly reliable way. Create a multifaceted influence plan that uses all six sources of influence. ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

- Four apprehended for identify theft — Here's how
- Visitor charged with stealing surgery schedules
- How to ensure required authorizations are obtained
- How to boost morale among members of your staff

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

5. When considering whether to offer a procedure at your facility, what is equally important to physician skill, according to Jane J. McCaffrey, DFASHRM, MHSA, director of compliance, clinical operations at St. Joseph Medical Center?
   A. The location of the nearest facility offering the procedure.
   B. The skills and resources of all the others caring for the patients.
   C. The expense of the equipment.
   D. None of thee above.

6. When determining what is necessary for infection control, what do Centers for Medicare and Medicaid Services guidelines call for, according to Marcia Patrick, RN, MSN, CIC, director, of infection prevention and control at MultiCare Health System?
   A. A designated infection preventionist who is a licensed MD, RN, or LPN
   B. A designated infection preventionist who is a staff member, but may be unlicensed
   C. Infection prevention duties spread among no more than three staff members.

7. After responding to the tornado in Joplin, MO, what changes is State Line Surgery Center going to make to future disaster drills?
   A. They will incorporate working without power.
   B. They will incorporate alternate transportation methods for staff to arrive at work.
   C. They will incorporate overcoming communication difficulties and treating patients from the community, instead of an internal disaster.
   D. They will incorporate having police for security backup.

8. What is the major change made at NorthShore University HealthSystem that allowed it to increase point-of-service (POS) collections for fiscal year 2011 in outpatient surgery by 46.9%?
   A. Verifying benefits further out, instead of a day or two before surgery.
   B. Telling patients that unpaid balances would be turned over to a collection agency at 30 days.
   C. Adding alternative methods of payment.