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Theft of thousands of schedules raises alarm for surgery managers

Tips offered for avoiding HIPAA case at your facility

A woman stole paper surgery schedules for about 4,500 patients at an Alabama hospital and used the names, dates of birth, and Social Security numbers to commit identity fraud, according to a media report.[1] She has been charged with violations of the Health Insurance Portability and Accountability Act (HIPAA) and faces up 10 years in prison and a fine of up to $250,000 if convicted.

The woman took the schedules for previous years from a patient registration area while she was visiting a hospital patient several times between March 22, 2011, and April 8, 2011. "From the story…it appears that the hospital was keeping books of past surgical schedules," says **Jonathan Beal**, JD, health policy consultant for the Ambulatory Surgery Center Association. "She stole the books that had many records in them."

The police found the surgery schedules at a search of her house while conducting a fraud investigation, according to a newspaper report.

The hospital notified the patients whose records were stolen and offered a year of free credit monitoring. "As a result of the theft, the hospital is increasing security by changing access to the registration area of the involved department," the hospital said on its web site.[2]

Surgery providers should take note: They potentially could be liable for medical record theft, even if criminal activity is involved. "It would likely depend

"Same-Day Surgery Salary Survey" available in print, electronically

This year you have multiple options for filling out the annual "Same-Day Surgery Salary Survey." You may go online to http://www.surveymonkey.com/s/samedaysurgery, or if you have a smartphone, you may scan the QR code and complete the survey on your phone. A print version of the salary also is enclosed in this issue that may be mailed in.
Look for salary survey coverage in an upcoming issue of "Same-Day Surgery."

upon the foreseeability and whether the provider's security efforts were reasonable," says **Robert Markette**, of counsel at Benesch, Friedlander, Coplan & Aronoff, Indianapolis, IN. "If this was a preventable crime, the government might determine to assess a penalty."

While the Centers for Medicare and Medicaid Services (CMS) and accreditation groups have requirements about what identifying information must be included in the medical record, "none of this, however, means that this information has to be on the schedule," Beal says.

The Alabama theft appears to be caused due to problems with controlling access, Markette says. "If she was able to get back into the registration area on multiple occasions, she was probably also able to then grab a pile or pile of patient records. Laying stacks of old surgery schedules around seems like a risky way to do business," says Markette, who acknowledges that the records might simply have been in an unlocked file cabinet. If a staff member responsible for controlling access to an area has to leave, he or she should put protected health information (PHI) away and lock cabinets, he says.

"If an individual gains unauthorized access to an area, but is unable to obtain PHI, because the information is secured in cabinets or otherwise, this type of `crime of opportunity' might be prevented," Markette says.

Understand that medical record theft can happen anytime, Markette advises. "Thefts can occur while the hospital is open and staff are present," he says. "Some criminals are bold enough to simply try to walk into an area to see what they can get."

Don't allow visitors to be unaccompanied, Beal suggests. Staff members must be aware and must keep an eye on what individuals are coming and going, Markette says. "A staff person cannot leave the door unattended and just assume that because it is normal business hours, everything is OK," he says. "Hospital privacy officers need to train the personnel that facility access must be monitored at all times."

When your facility experiences theft of patient data, first determine the scope of the theft, Markette advises. Report the crime, and notify patients, he says. "Often, contemporaneously with this effort, policies and procedures should be reviewed to see if changing the policies and procedures would prevent a similar theft in the future," Markette says.

Include your HIPAA policies and procedures, he says. "Generally, they should be reviewed annually,

EXECUTIVE SUMMARY

Paper surgery schedules for about 4,500 patients, including their names, dates of birth, and Social Security numbers, were stolen at an Alabama hospital when a woman was visiting a patient.

- Providers could be liable, even when criminal activity is involved, if the theft was foreseeable and the provider's security efforts were not reasonable.
- Thefts can occur when the facility is open. Monitor access, keep past records locked away, and don't allow unescorted visitors.

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but incidents like this can lead to the decision to review more frequently," Markette says.

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EXECUTIVE SUMMARY:

A surgeon who complained that patient safety was threatened by inadequate administration support of his department alleges that his privileges were restricted by the hospital in retaliation. He subsequently won a $4.7 million settlement in arbitration.
Cedars-Sinai Medical Center in Los Angeles denies the claim and says the surgeon was restricted for other reasons.
An appeals court recently upheld the arbitration award.
The plaintiff's attorney estimates that the hospital has spent as much as $1 million on appealing the case.

Surgeon whistleblower awarded $4.7 million

Cedars-Sinai Medical Center in Los Angeles will have to pay almost $4.7 million to a surgeon who claims the hospital retaliated against him for blowing the whistle on unsafe practices in his department, unless the hospital manages to have the award overturned.

The hospital already has spent as much as $1 million to appeal the arbitration decision, according to the informed estimate of the plaintiff's attorney.

In a 2009 arbitration, the hospital agreed to pay Hrayr K. Shahinian, MD, $4.7 million for economic, emotional, and punitive damages, but then it asked a California appeals court to reverse that decision. The court recently denied Cedars-Sinai's request to strike down the arbitrated award.

Cedars-Sinai provided a statement to the publisher of *Same-Day Surgery* that says the hospital is considering a further appeal of the decision and claims that the surgeon's competence was an issue that was not adequately considered in the arbitration. "As a general rule, Cedars-Sinai does not believe it is appropriate to comment on matters pending in the judicial process. We are doing so now only to set the record straight in light of Dr. Shahinian's incomplete and inaccurate statements in his recent news release," the statement says. "Although this matter remains pending in the appellate system, Dr. Shahinian has made certain claims about the outcome of the process so far that are incorrect as to what both the arbitrator and Court of Appeal actually decided. He has also presented an incomplete and inaccurate picture, ignoring that the arbitrator *rejected* some of the very claims for which he says he was vindicated." *(See the story on p. 92 for more of the response from Cedars-Sinai.)*

The crux of the case was that the hospital did not follow its own bylaws when restricting the surgeon's privileges, says the plaintiff's attorney, **Robert C. Baker**, JD, a partner with the law firm of Baker, Keener & Nahra in Los Angeles. That action ultimately led the arbitrator to side with Shahinian, he says. *(For details on the dispute, see the story on p. 92.)*

Shahinian contends that the hospital punished him for complaining about patient safety and other concerns in the department. "Two witnesses testified that they targeted him because he complained," Baker says. Baker says he expects the hospital to appeal once more, this time to the California Supreme Court. The hospital's continued fighting almost defies logic, he says. Testimony from the Cedars-Sinai chief financial officer revealed that the hospital has $800 million in cash or cash equivalents, Baker says, an astounding sum which he says might explain why it is willing to continue fighting even after the arbitration.

"My educated guess is that since November 2009 they've spent probably at least a half million and maybe a million dollars on their appellate lawyers, and they've run up interest in the neighborhood of $600,000. That's on top of the $4.7 million the arbitrator told them to pay," Baker says. "They've got enough of a bankroll to continue pursuing this beyond anything that is remotely close to what everyone else would consider reasonable. They don't like this guy, and they're willing to spend a huge sum of money to get him."

SOURCE

Robert C. Baker, JD, Partner, Baker, Keener & Nahra, Los Angeles. Telephone: (213) 241-0900. ■

Hospital dispute led to restriction of duties

Court records indicate that Cedars-Sinai recruited **Hrayr K. Shahinian**, MD, to establish and direct its skull-base surgery program in 1996. The doctor's experience at the hospital was rocky from the start, says his attorney **Robert C. Baker**, JD, a partner with the law firm of Baker, Keener & Nahra in Los Angeles.

The hospital's neurosurgeons doubted his qualifications for the task, and even the chairman who had recruited him said that he had alienated hospital management, Baker says. Shahinian stated in August 2002 that the hospital's lack of support for the program compromised patient care, and a month later he was notified that his position as a faculty physician and the program's director would end in one year.

Before that year was up, Shahinian registered complaints over the unavailability, malfunctioning, and inadequate reprocessing of surgical instruments, Baker says. Court records report that a hospital investigation bore out Shahinian's protests and revealed that certain instruments, which had been routinely flash sterilized, were contaminated with bioburden.

After his termination, Shahinian sued Cedars-Sinai for tortious discharge in violation of public policy, a suit that was settled in June 2005, Baker says. Under the settlement, the hospital agreed to extend Shahinian operating privileges in a non-retaliatory manner and to properly maintain its supply of surgical instruments, Baker says. The disputes continued, however. There was disagreement over who was responsible for maintaining the surgeon's custom instruments, and the hospital issued a 90-day moratorium on Shahinian performing any surgeries at the center while it investigated the surgeon's safety concerns. The parties then argued about the conditions Shahinian would have to meet to perform surgeries there. These conditions included providing his own sets of instruments, having his own employee clean them prior to sterilization, and personally inspecting the instruments before use or agreeing that the hospital's instrument handling process was satisfactory.

Shahinian sued the hospital again in December 2006 and argued that the hospital had restricted his privileges and damaged his career without a fair hearing process. The surgeon and the hospital agreed to arbitrate the matter. In November 2009, the arbitrator concluded that the hospital's moratorium on Shahinian's surgeries was unlawfully retaliatory, Baker says.

The arbitrator pointed to the fact that no other surgeon was barred from operating or burdened with conditions because of concerns over the safety of the hospital's practices, and the arbitrator noted that the moratorium was enacted without a peer review or hearing process. Shahinian was awarded $508,124 in economic damages for breach of contract and interference with his practice, $1.6 million in emotional distress damages, and $2.6 million in punitive damages, Baker says. Shahinian agreed to give up his staff privileges at Cedars-Sinai.

After agreeing to the arbitrated award, the hospital took it to court and argued that it exceeded the arbitrator's powers and violated public policy. The trial court rejected this claim, and the appeals court recently upheld that ruling.

"Defendant may be unhappy with the result, but defendant agreed to 'final and binding' arbitration, and that is what it got," the court wrote in its decision. "None of these rules of law or public policies is implicated when a hospital becomes embroiled in a dispute with a doctor that has nothing to do with the doctor's competence or the doctor's professional conduct that puts patient care and safety at risk." ■

Hospital: Competence of surgeon was issue

In challenging the arbitration award of $4.7 million to a surgeon whose privileges were restricted, Cedars-Sinai Medical Center in Los Angeles alleges that the doctor's competence was in doubt.

"The arbitrator found that Dr. Shahinian's competence was at issue," says a statement the hospital provided to the publisher of *Same-Day Surgery* after a court of appeals found in favor of the surgeon. "However, she refused to decide one way or the other whether the concerns that Cedars-Sinai harbored about Dr. Shahinian's competence were justified. Thus, she did not vindicate Dr. Shahinian on the question of competence — she did not decide the issue. But she did bar Dr. Shahinian from reapplying to Cedars-Sinai's medical staff until 2016."

The arbitrator found that parts of Shahinian's testimony lacked credibility, the hospital notes. "Her finding of lack of credibility is consistent with another recent judicial finding. Last year, in a case

having nothing whatever to do with Cedars-Sinai (Dr. Shahinian had already left the Center and was practicing elsewhere), a Los Angeles Superior Court judge found against Dr. Shahinian for both professional negligence and fraud," the statement says. "It awarded over $950,000 against him, including $300,000 in punitive damages. Among other things, the judge found that Dr. Shahinian was negligent in performing a surgery; that he had falsely represented to his patient that the surgery had a 98% rate of success; that, in a 'failed attempt at subterfuge' Dr. Shahinian caused an altered pathology report to be sent to the plaintiffs in willful and conscious disregard for plaintiff's health and safety; and that he engaged in 'trickery' and 'was more interested in marketing than medicine as it relates to these plaintiffs.'"

The hospital also notes that "The arbitrator rejected Dr. Shahinian's allegations that Cedars-Sinai 'failed to adequately clean or sterilize instruments' and that Cedars-Sinai failed to supply non-custom instruments. The arbitrator found that Dr. Shahinian failed to live up to his obligation to provide sufficient custom instruments." ■

Want zero surgeries on the wrong site?

Follow solutions from pioneers

Despite *Sentinel Event Alerts* and partnerships between The Joint Commission and professional organizations, wrong-site surgeries continue at a national rate as high as 40 times per week, according to **Mark Chassin**, MD, MPP, MPH, president of The Joint Commission and the Center for Transforming Healthcare.

"Awareness about the problem has increased, but we clearly have to do more to get a lot closer to zero," Chassin said.

All surgical providers are at risk, he said. "Unless an organization has taken a systematic approach to studying its own processes and determining its risk of wrong site surgery, it is literally flying blind," Chassin said. *(See procedures at highest risk for wrong-site surgery, p. 94.)*

The Joint Commission worked with five hospitals and three ambulatory surgery centers to focus on solutions. The project found that addressing documentation and verification in the preop holding areas decreased the percentage of risks from a baseline of 52% to 19%. The incidence of cases containing more than one risk decreased by 72%. The Joint Commission Center for Transforming Healthcare held a conference June 29 to share some solutions from the project:

EXECUTIVE SUMMARY

Five hospitals and three ambulatory surgery centers worked with The Joint Commission recently to focus on solutions for wrong-site surgery. The incidence of cases containing more than one risk decreased by 72%.

- Standardize scheduling information.
- Mark the surgical site close to where incision will be made. Standardize how the mark will be made. Use approved indelible pens.
- Turn off the music, and have every member of the OR team participate in the time out.

• In scheduling, address lack of standardization for identifying the patient and procedure.

Office schedulers often work with multiple facilities that might have various ways of collecting information, Chassin points out. The solution "is a carefully standardized way of collecting information that has several ways to identify the patient, not just by name, with spelling errors and little typos that can be a problem, and a way to specify exactly what the procedure is, what side of the body it will be performed on, exactly how it will be, so that the information can be conveyed down the line," Chassin said.

• Audit yourself.

Lifespan Corp., a four-hospital system based in Providence, RI, had several public wrong-site surgeries about three years ago. The hospitals now audit themselves every day for every procedure. The leaders determine whether there is a deviation from the script or from the marking, said **Mary Cooper**, MD, JD, senior vice president and chief quality officer. They have achieved zero deviations from the script and the marking policy, and the facility has not experienced any wrong-site surgeries since these changes, Cooper said.

• Educate physicians.

Leaders at Seven Hills Surgery Center in Henderson, NV, found that if you educate physicians by explaining the significance of the problem and the impact on patient outcomes, they will embrace changes. The education should be done one-to-one, said **Rudy Manthei**, CEO of Seven Hills Surgery Center and a practicing ophthalmologist.

If you don't challenge physicians' authority, they respond openly, Manthei said. "Once we find the physician that is buying into the system in the process, because it does tend to slow them down intensively,

Procedures at Risk for Wrong-Site Surgery

- Orthopedic procedures, which almost always have a laterality to choose from.
- Spinal surgery, which requires designating the level in the spine that the operation will occur.
- Ophthalmological surgeries, in which there is a laterality issue in the anesthesia and the operation.
- More than one surgical procedure scheduled at the same time.

Source: Mark Chassin, MD, MPP, MPH, Joint Commission Center for Transforming Healthcare's Wrong Site Surgery Project News Conference. June 29, 2011. ■

but it does create the leadership necessary for the staff, because staff wants to do the right thing," he said.

At press time, Chassin said the solutions from the wrong-site surgery project will be added to The Joint Commission's Targeted Solutions Tool (http://www.centerfortransforminghealthcare.org/tst.aspx) later this summer. They will be pilot tested later this year, he said.

However, Chassin emphasized, "I don't think anybody needs to wait." If you don't know your risks and haven't measure them, start there, he advised. Standardize the way you collect information, Chassin emphasized. Look at the specific problems on the center's web site and identify the specific kinds of risks, including those that are introduced in scheduling and the risks that are introduced by the failure to have the surgeon mark the site. Also, pay attention to the critical details of how the mark is done, what kind of pen is used, and how close it is to the incision, he says. Look at the time out to determine if it's being done "without full participation, without full attention and without all of the documentation that's necessary to verify the patient's identity, etc.," Chassin said. *(See details of these and other solutions, at right and p. 95.)*

When the Targeted Solutions Tool is available, there will be specific instructions for organizations to use to measure their risks and identify where they are, he says. "And that's what we certainly would encourage every hospital, surgery center and office that does surgical procedures to do in order to measure its risk and find out where it is so that they can get rid of it," he said. ■

Surgical site marks need monitoring

In The Joint Commission's recent project focusing on wrong site surgery, the percentage of cases that had risks introduced in the OR from all of issues around time out and marking were at 59% before the interventions and 29% after.

"So, that was a drastic reduction in the risks, and we expect that that will get even better as interventions mature over time," said **Mark Chassin**, MD, MPP, MPH, president of The Joint Commission (TJC) and the Center for Transforming Healthcare.

At Lifespan Corp.'s four-hospital system based in Providence, RI, the Center for Transforming Healthcare introduced "robust process improvement" to the OR staff over 18 months after a strong of write-site surgeries. The state health department fined the hospital $150,000 and ordered it to hire a consultant to observe surgery for three years, shut down surgery for one day, conduct mandatory training on surgical procedures, and install audio- and video-monitoring equipment in the operating rooms for periodic observation. *(For more information, see "RI fines hospital for surgical errors,"* Same-Day Surgery*, February 2011, p. 20.)* "At the end of that 18 months, we shut down our operating rooms for a day in order to teach everyone our new protocol for arriving at safe surgery, and I'm pleased to say that it has been approximately 20 months since that occurred without — and I knock on wood every day — any wrong site surgeries in our ORs, says **Mary Cooper**, MD, JD, senior vice president and chief quality officer for Lifespan Corp., which participated in the TJC project.

At Lifespan, sometimes there were discrepancies between what was seen in the holding area, where the surgeon was not participating, and what the surgeon thought was being done in the OR. "So, we transformed our process with the help of the Center for Transforming Healthcare, by having the surgeons all go out to the holding area to make the initial mark with the patient and the staff in the holding area, and then subsequently affirm that mark by placing their finger on the mark that they had made out in the holding area and asking if everyone could see the mark," Cooper said.

Lifespan shut down the ORs for one day to communicate this system to surgeons, nurses, techs, anesthesiologists, and other staff. The managers took them through didactic and experiential train-

ing, and all new staff are required to go through the same training, Cooper said.

Site marking outside the OR

Seven Hills Surgery Center in Henderson, NV, which also participated in TJC Project, identified a most common defect was the site was not marked properly or consistently. The leaders identified that 88% of the site-marking defects were in the pain management room. The leaders changed the policy so that the site marking requirement for pain management was moved to a holding area, which essentially eliminated that problem, Manthei said.

"So, we were able to identify a significant risk factor and created a solution for that," he says.

Mark the surgical site close to where incision will be made, or the mark might be covered by drapes, Chassin said. "So, the specific procedure for how the surgical site is marked, to make sure that it's close enough where the incision will actually be made so that it's visible at the time of the last time out, is a critical intervention," he said.

The Center for Health Ambulatory Surgery Center in Peoria, IL, which participated in TJC project, found variation in the marks, said **Tom Feldman,** CEO for the center, which participated in TJC project**.** For example, some physicians would use a dot, while others would write "OK," use their initials, or write the word "yes." "So, there seemed to be some variation there," Feldman said.

Some facilities have found that unapproved pens were used to mark the surgical site, and the mark was washed away during the surgical site prep, Chassin said. Ensuring that approved indelible pens were used was "a simple, but nevertheless, important intervention, to get rid of that part of the problem," he said. ■

The time out: How to do it right

At the four hospitals that are part of Providence, RI-based Lifespan Corp., every person in the OR stops what they're doing for the time out, according to **Mary Cooper**, MD, JD, senior vice president and chief quality officer for Lifespan, which participated in a recent project by The Joint Commission focusing on wrong-site surgery.

"We stopped all other activities so that everyone could focus on that last opportunity to correct a mistake, to make sure that we didn't end up making an incision in the wrong place," Cooper said.

The staff point and ask, "Can everyone see the mark?" Everyone has to respond, Cooper said. This step "helped us tremendously," she said.

Turn off the music during the time out, said **Mark Chassin**, MD, MPP, MPH, president of The Joint Commission and the Center for Transforming Healthcare. Every staff person has a role, and those roles should be specified, Chassin said.

There might be variation in the timing and the initiation of the time out, Chassin said. For example, does the time out occur before the prep and drape, or after? Another area of variation is the initiation and leading of the time out. Did the circulating nurse call for it, or the attending surgeon?

Tom Feldman, CEO for The Center for Health Ambulatory Surgery Center in Peoria, IL, which participated in TJC project, said, that "trying to close some of those gaps and decrease the type of variation, I think, helped everyone in terms of awareness in the OR room." ■

Payer auth requirements shouldn't blindside you

Prevent needless claims denials

Payers are asking for more preauthorizations, even for services that previously didn't require them, reports **Connie Campbell**, director of patient access of Mercy Medical Center in Oshkosh, WI.

"We need authorization for select outpatient procedures, which I am sure will also turn to all outpatient procedures," Campbell says. "Even some of the Medicaid products are starting to require authorizations, where before they did not."

Magnetic resonance imaging (MRI), ultrasound, nuclear medicine, and CT scans require authorization, she says. Authorizations also are needed for durable medical equipment (DME), medications, hospital stays, physical therapy, radiology, behavioral health, the pain clinic, and all inpatient surgeries, she adds.

Registrars find it increasingly difficult to keep up with all of the different insurance company requirements, says Campbell. "We have no software to easily pop up with what specifically is needed for what is ordered," she says. "There is no way to easily translate the CPT and ICD-9 codes for physicians so they can see what is needed."

Needless denials occur as a result of getting the

wrong authorization or failing to obtain one that is required, says Campbell. "We considered forming a large authorization department to deal with the new requirements," she says. "But since that project was turning to be out too immense, we decided to focus on obtaining authorizations for the high-dollar radiology procedures."

Otherwise, says Campbell, each office or specialty is responsible for staying current and obtaining the necessary authorizations. "We did start putting the requirements on spreadsheets," she says. "We also try to build in as many cues as we can into our computer systems."

Identify mismatches

At Valley Health System in Ridgewood, NJ, the information services (IS) department built a tracking system so staff can see what pieces of the pre-registration function are outstanding at any point in time, says **Maura Corvino**, MSOL, RN, CEN, assistant vice president for emergency services and patient access.

The missing pieces might be data from the physician necessary for case day or pre-authorization because the case was scheduled too far in advance to obtain it from the payer, she says.

"Another customization our IS department built allows us to compare the planned disposition for the patient with the requirements by the insurance company," says Corvino. "If there is a mismatch, we can rectify it *before* the patient arrives." *(See more on Valley Health's system, p. 97. Also, see related stories on obtaining more authorizations, p. 97, and timeframe for obtaining authorizations, at right.)*

SOURCES

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EXECUTIVE SUMMARY

Payers are asking for preauthorizations even for services that previously didn't require them. To ensure required authorizations are obtained:
Put requirements on spreadsheets.
Obtain authorizations before a procedure or inpatient stay.
Allow enough time to get additional clinical information.

Last-minute auths die: Most are 20 days out

At Valley Health System in Ridgewood, NJ, patient access staff perform pre-registration up to 20 business days before most scheduled procedures, reports **Maura Corvino**, MSOL, RN, CEN, assistant vice president for emergency services and patient access.

"We make sure that the physician's intention matches what the validation is," says Corvino. "Four days before case day, we are really working closely on that group of people."

Certain procedures are mandated by insurers as "inpatient only," explains Corvino, but the physicians might not think the admission is necessary. When this situation happens, the physician is notified so he or she can write the appropriate orders well before case day, she explains.

The new process means that more OR procedures are starting on time, says Corvino. "More on-time starts for the physicians will probably open up ORs for a few more cases," she adds. "That has the potential to bring us some more revenue as well."

Many claims denials were occurring because authorizations weren't obtained upfront and were obtained only after the patient was in the hospital, explains **Susan Sigler**, supervisor of Valley Health System's patient access center. "That was a big driver of this change," Sigler says. "We had to go back and make the corrections and get the denials overturned."

This system meant a lot of manual work for the case management department that is no longer necessary, says Sigler. "In moving that work up to the front end, we expect to see a really significant drop in denials," she says. "By ensuring the right disposition for a given procedure, whether admit, observation, or discharge, everybody is on the same page with the insurance company."

More data needed

If the procedure code doesn't match the diagnosis code, registrars have to get more information from the physician, says Sigler.

"The physician is very knowledgeable about the plan of care and the patient's condition, but sometimes not so detailed when they give the diagnosis

code," she says. "Sometimes it takes a little bit more data than what we have initially to get the authorization."

Previously, there wasn't time for this back-and-forth dialog, which meant that the case was delayed or the patients were left with a bill that they didn't anticipate, says Sigler. Corvino says, "Because this is medicine, a diagnosis code may change. If that's the case, we can go back and change it while the patient is still here, rather than getting that denial and going back for the rebill."

Sigler expects patients will be more satisfied with the new process. "If we are able to do all of this in a manner that streamlines things for the patient, hopefully that will be reflected in our hospital patient satisfaction scores," she says. "With new emphasis on the HCAHPS [Hospital Consumer Assessment of Healthcare Providers and Systems], that could impact how we are reimbursed going forward." ■

Revamped role to mean fewer denials

At Valley Health System in Ridgewood, NJ, a major goals are to obtain more authorizations, says **Maura Corvino**, MSOL, RN, CEN, assistant vice president for emergency services and patient access.

A new Patient Access Center will help with this goal by centralizing Valley Health's registration, Corvino reports. "We have initiated some new software and reallocated resources," she says. "We expect to get a very low error rate and a very good return on investment."

While registration was decentralized almost two decades ago to make registration more convenient for patients, this decentralization no longer made sense as the patient access role expanded says **Susan Sigler**, supervisor of Valley Health System's patient access center. "The kind of work that was being added to the job of the business associates was quite varied and very unfocused," Sigler says. The business associates perform a wide variety of tasks, only one of which is registration, she explains.

"The business associates wear many hats," says Sigler. "Whenever there was a new responsibility that did not fit cleanly into another role, it was absorbed by the business associates on the individual units."

While that served all the individual units very well, says Sigler, it made it challenging for the individual business associates to maintain the quality of their registrations. Errors occurred that resulted in inaccurate billing, she explains. "This led to more back office work to correct and edit, and the need for re-billing," Sigler says. "It ultimately decreased patient satisfaction, as they dealt with both the insurance company and the hospital billing office to rectify the inaccurate bill."

Designated role

While endoscopy, the emergency department, and diagnostic imaging were high in registrations per business associate, the volume of registrations per business associate was low in some units, says Sigler. Because those employees did registrations only rarely, they had trouble keeping up with all of the different payer requirements, she explains.

"It became a real challenge to provide that education in a manner that didn't disrupt the rest of their duties," she says.

Corvino says that by having patient access staff pre-register patients with scheduled procedures and obtain authorizations, "everybody there is an expert in these work activities. They are marching through a systematic process of validating and checking."

Now, members of the patient access staff "huddle" each day to talk about the next day's cases with staff from the patient care areas. "We make sure that we are crystal clear that everybody's covered," says Corvino. "If we do all this work upfront, we won't be talking over the patient on the stretcher about the authorization that we didn't get. We'll be focused on their care." ■

Registrars, departments partner on denials

Avoid costly mismatches

Claims denials often occurred at Valley Health System in Ridgewood, NJ, because the patient's disposition didn't match up with what the Centers for Medicare & Medicaid Services (CMS) required to authorize a procedure, reports **Maura Corvino**, MSOL, RN, CEN, assistant vice president for emergency services and patient access.

"The physician knew what he wanted to do, but he wasn't writing it in the language that was

required for the correct type of admission," she says. These changes were made:

• Patient access staff gave community physician offices a list of the information needed for scheduled patients.

"The office manager provides us with what we need to schedule and speak to the patient, and move forward with the process," says **Susan Sigler,** supervisor of Valley Health System's patient access center. "We set it up in a way that we think flows nicely for the patient."

• A physician champion visited provider offices to go through an online learning module with physicians.

"This made the communication easier, and the buy-in by the physicians a bit better and faster," says Corvino.

Physicians were instructed to use the CMS inpatient list to validate their intent, says Corvino. "We then verify that what they want equals what CMS allows for that procedure," she says.

The physicians were asked to provide certain data points when requesting a procedures or an admission, explains Corvino. "This facilitates patient access staff in obtaining the necessary certifications and authorizations prior to case day or admission," she says.

• When patients undergo surgery, every step in the process is now time-stamped on an electronic dashboard.

This change means that office staff can keep track of where the physician is at all times, says Sigler. "Previously they were always trying to track their physician down. Were they in the OR, the PACU, or in a patient room? So this turned out to be an unexpected benefit for them," she says. "It is a nice perk that has helped engage them in using the system."

This change also means that all of the areas involved in the patient's care can see what is happening, says Sigler. Transport can see when they need to move patients, PACU can see the planned departure time from the OR, and the inpatient units can see when the patient is scheduled to leave the PACU, she explains. "Everybody has that transparency to know what is coming, without needing to scratch their head and wonder when the patients are coming to them," says Sigler. "It allows for the pre-planning of staff and work activities."

SOURCES

For more information on working with other departments on claims denials, contact:

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Same-Day Surgery Manager

Get yourself up to date on fun facts and figures

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

The kids are back in school (Thank GOD!), the heat is starting to break, the floods are receding, and the fires are burning out.

It was an interesting summer. I spoke at several conferences, and I have to say that the Gulf States ASC Conference & Tradeshow in Biloxi, MS, was one of the best conferences I have had the pleasure of speaking at. The Ambulatory Surgery Center Association conference in Orlando was great too.

These conferences left me with a question: How many of your centers and hospitals are paying someone or some company a management fee? How much? Are you getting ripped off? Well, according to the results of a survey by HealthCare Appraisers in Delray Beach, FL, 56% of centers are paying between 3% and 6% of the net revenue of the center for the pleasure of telling you what to do. For hospitals, the average is about $25,000 per month, not including personnel. Are you in that range? Are you angry? *(For information on how to access that report, see note at end of the column.)*

A. Here are some questions for you from that survey. See how many you get right.

1. What, referring to the same survey, is the least desirable specialty in surgery centers (and I am adding hospital outpatient departments as well)?
2. What is the most desirable specialty?

3. What percent of surgery center companies were looking to purchase surgery centers last year?

B. Here are some of my questions based upon responses from the conferences I spoke at over the summer (not quite as sophisticated):

1. What I hate most about working in surgery is _____?
2. What I like most is _____?
3. If I could change one thing it would be _____?
4. The most exciting people in healthcare are _____?
5. The most entertaining surgeons are _____?

OK, that was fun. However, on a serious note, most of us are concerned about the future of our industry. But the reality is that we need to focus on what we can do at our own workplace and not worry about the global issues. I will recommend that all of you Google the following words and understand their meaning. These words are going to impact your lives over the next 10 years to a much greater degree than ever. You need to understand them.

* cash flow;
* Return on Investment (ROI);
* Stark law;
* Earnings Before Interest, Taxes, Depreciation, and Amortization (EBITDA);
* breakeven;
* distributions;
* economic credentialing;
* passive investor;
* one-third one-third regulation;
* under arrangement.

Most of you know this stuff, but it still is a good exercise.

C. Last question for the ambulatory surgery center group: "Who is the most important person in your facility?"

1. Surgeon?
2. Investor surgeon?
3. Anesthesia (Sorry. Even I had to laugh at that!)
4. Vendor
5. Staff

D. Last question for hospital staff: "How many meetings do you attend per week?"

1. 1-3
2. 4-7
3. 8-11
4. 12-18
5. More than 20

Answers for questions from group A:

1. Plastic surgery
2. Orthopedics
3. 82%

Answers for questions from group B:

1. The early start time
2. The job security
3. A better retirement plan
4. Nurses
5. Orthopedic surgeons

Answer for questions from group C:

2. The investor surgeon because they bring the patients to the center while being concerned about the running of the center.

Answers for questions from group D:

4. 12-18 per week. (Oh, come on people!) *[To access a copy of the HealthCare Appraisers report, go to http://www.healthcareappraisers.com/ASC_Survey_2010.pdf. 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.* ■

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

■ Disaster drill: Computer systems go down

■ How to reprocess and do it right

■ New strategies to address drug shortages

■ New tool to audit hand washing

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

9. What were the circumstances in which a woman stole paper surgery schedules for about 4,500 patients from previous years at an Alabama hospital and committed identity fraud?
   A. She hacked into the hospital's computer system.
   B. She broke into the hospital's patient registration area at night.
   C. She took the schedules from a patient registration area while she was visiting a patient several times.

10. According to Robert C. Baker, JD, a partner with the law firm of Baker, Keener & Nahra, representing the surgeon who sued Cedars-Sinai Medical Center, how did the hospital err in restricting his privileges?
    A. The crux of the case was that the hospital did not follow its own bylaws when restricting the surgeon's privileges.
    B. The hospital took too long to notify the surgeon of concerns about his performance.
    C. A court had ordered the hospital not to restrict the surgeon's privileges, but it did so anyway.
    D. An administrator failed to sign the documents restricting the surgeon's privileges.

11. In educating physicians about wrong site surgery, which of the following steps are necessary, according to Rudy Manthei, CEO of Seven Hills Surgery Center and a practicing ophthalmologist?
    A. Explain the significance of the problem and impact on patient outcomes.
    B. Educate them one-to-one.
    C. Don't challenge their authority.
    D. All of the above.

12. How did Lifespan Corp. do after 18 months of "robust process improvement" handle staff education in the new protocol for safe surgery?
    A. Went to an off-site retreat.
    B. Brought in a staff education consultant.
    C. Shut down the ORs for a day.

SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission and AAAHC Standards

Specimen labeling still a major risk for ID errors, can lead to huge liability

Technology, focus on human factors can help

Patient identification errors continue to plague the healthcare industry despite years of efforts to eradicate this potentially disastrous problem. Understanding why patients and specimens are misidentified is key to reducing or eliminating errors, and managers can make progress by focusing on the human behavioral components.

Specimen labeling is one of the biggest risks for misidentification, with errors leading to delayed or wrong diagnoses, missed or incorrect treatments, blood transfusion errors, and additional laboratory testing. Literature reviews have identified specimen labeling error rates of 0.1% to 6.5%.

Recognizing this risk, The Joint Commission has implemented two National Patient Safety Goals (NPSGs) for 2011 related to patient identification for hospital and ambulatory organizations, as well as office-based surgeons:

- NPSG.01.01.01 is "Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment."
- NPSG.01.03.01 is "Make sure that the correct patient gets the correct blood when they get a blood transfusion."

The College of American Pathologists also includes patient and sample identification as one of its five top patient safety goals. *(For information on efforts by the Accreditation Association for Ambulatory Health Care, see story, p. 2.)*

Phlebotomy is one of the fields most focused on labeling errors, and many healthcare providers take a punitive approach to errors, says **Fran Charney**, RN, MSHA, CPHRM, CPHQ, CPSO, FASHRM, director of educational programs with the Pennsylvania Patient Safety Authority (PPSA) in Harrisburg, PA. Before joining the PPSA, Charney was a healthcare risk manager and patient safety officer.

"Many organizations talk about taking a systems approach, but when it comes to phlebotomy, they have a 'three strikes and you're out' approach," Charney says. "Then we ask if the problem went away when they fired that phlebotomist, and of course they say it didn't." *(The PPSA recently sponsored a multi-hospital blood specimen labeling collaborative that resulted in a 37% decrease in labeling errors. For more on that effort, see the story on p. 3.)*

Charney encourages managers to look at specimen labeling errors as a system problem, treating them much like any adverse event and asking not just who made the error, but why that error was possible and how it could be prevented. "A

Special Report: Patient ID errors

This month's *SDS Accreditation Update* includes a focus on the perennial and potentially disastrous problem of patient identification errors.

Despite an intense focus on proper specimen labeling and other strategies for reducing identification errors, these problems still occur. Our special report provides tips and the latest advice for how to reduce identification errors in your own healthcare organization.

Financial Disclosure:
Senior Managing Editor Joy Dickinson and Board Member and Nurse Planner Kay Ball 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.

EXECUTIVE SUMMARY:

Almost one in 1,000 specimen labels are identified incorrectly.

- The Joint Commission has implemented two National Patient Safety Goals (NPSGs) for 2011 related to patient identification for hospital and ambulatory organizations, as well as office-based surgeons.
- The Accreditation Association for Ambulatory Health Care (AAAHC) requires accredited organizations to avoid patient identification errors by having unique patient identifiers.

lot of times we don't dig deep enough to see why the error occurred," she says. "We just say Sally the phlebotomist made a mistake and put that in her record. If she forgot to double check the ID because the phone was ringing off the hook, why was that? Because you were short staffed?"

Understanding human factors is a big part of reducing identification errors, says **Megan Shetterly**, RN, MS, patient safety liaison for the Northeast Region of the PPSA. When investigating an error, ask not only what happened and how, but why, she says. "We need to ask them why several times, to drill down and find out what led to this error, not the simple mechanics of how it happened," Shetterly says. "The nurse or phlebotomist might say she grabbed the wrong label, but you can't leave it at that. Why did she take the wrong label? What was going on, and what about your procedures made it possible for her to do that?"

Common causes are disruptions, interruptions, and increased work load, Shetterly says. The most often cited explanation is that the employee was not following procedures, but the next question must be why, she says. The answer also involves the workload. "They often say that to get the workload done, they don't have time to do the A, B, C, and D that are spelled out in the policies and procedures," Charney says. "So they decide C isn't really necessary, and they do a workaround. That sounds like an individual decision, but we put them in an unsafe place where that looks like the only way out."

Patients should be involved with confirming their identification as much as possible, Charney says. Too often, she says, the caregiver enters the room and asks "Are you Mr. John Smith?" or says "You're Mr. Smith, right?" and the patient nods or mumbles a response. That interaction is not acceptable, Charney says. "A much better way is to say, 'Can you state your name for me?'" she says. "That is a very different question, and you get a much better response. Sometimes you can go on and ask the patient to spell the last name. That kind of active participation by the patient is crucial."

Bar coding technology can significantly reduce patient identification errors, but it is not a panacea, Shetterly says. She notes that the Centers for Disease Control and Prevention has recognized bar coding as a best practice for specimen collection. *(See the story on p. 4 for more on bar coding.)*

"The technology is very good, but it's only as good as the person using it," Shetterly says. "You still have the human element, so errors can occur. *(See story on liability, p. 3. See the story on p. 4 for more solutions for reducing errors.)* ■

AAAHC lists patient ID standards

The Accreditation Association for Ambulatory Health Care (AAAHC) requires accredited organizations to avoid patient identification errors by having unique patient identifiers, according to **Michon Villanueva**, assistant director of accreditation services.

These standards include:

- Chapter 6, Clinical records and health information, standard B-1: An individual clinical record is established for each person receiving care. Each record includes, but is not limited to: an identification number (if appropriate).
- Chapter 6, Clinical records and health information, standard F-3: A designated person is in charge of clinical records. This person's responsibilities include, but are not limited to: the unique identification of each patient's record.
- Chapter 7, Infection Prevention and Control and Safety, Subchapter II, Safety, standard: Unique patient identifiers are consistently used throughout care.

In addition, an organization that provides surgical and related services is required to have a process to verify a patient's identification prior to performing the procedure:

- Chapter 10, Surgical and Related Services, Subchapter I, General requirements, standard V: Immediately prior to beginning a procedure, the operating team verifies the patient's identification, intended procedure, and correct surgical site, and that all equipment routinely necessary for performing the scheduled procedure, along with any implantable devices to be used, are immediately

available in the operating/procedure room. The provider performing the procedure is personally responsible for ensuring that all aspects of this verification have been satisfactorily completed immediately prior to beginning the procedure. ■

Are you at risk for being sued?

Mislabeled specimens are liability

The malpractice implications of a mislabeled specimen are significant, says **Laura A. Dixon**, JD, RN, CPHRM, director of the Department of Patient Safety for the Western Region of The Doctors Co., a malpractice insurer in Napa, CA.

A patient might receive care indicated for someone else, while the other patient does not receive needed treatment. "Some of these errors can have long-term lasting physical effects on the patient," Dixon says. "But in addition to the physical problems, the individual also may the emotional trauma. Of the claims we have from identification errors, the majority are about emotional trauma rather than physical injury."

The typical lawsuit involves a relatively young and healthy individual who underwent an unnecessary procedure and believed for some period that he had cancer or another serious illness, Dixon says. The potential liability will depend on how state law addresses claims of emotional distress, but the payout tends not to be in the millions of dollars, she says.

Delayed diagnosis is a bigger liability risk, Dixon says. A delayed diagnosis of cancer because of a specimen mixup, for instance, could result in a costly malpractice lawsuit, she says. "Those cases tend to involve real injury and perhaps an impact on long term survivability, so they can be quite costly, both in terms of the payout and the cost to defend them," Dixon says. ■

PA hospitals cut label errors by 37%

A project designed to analyze labeling errors and devise solutions resulted in a 37% decrease in errors across nine hospitals in Pennsylvania.

From August 2009 through October 2010, the Pennsylvania Patient Safety Authority (PPSA) sponsored a multi-hospital blood specimen labeling collaborative. The PPSA worked with the hospitals to measure blood specimen labeling error rates, document hospital-specific interventions to reduce the labeling error rate, and measure the outcome of the interventions.

Eight acute care hospitals and one rehabilitation hospital participated in the collaborative, says **Megan Shetterly**, RN, MS, patient safety liaison for the Northeast Region of the PPSA. Some of the hospitals used bar coding technology in some areas but not throughout the hospital. Each hospital assembled a team to participate in the collaborative, and team members included laboratory directors, phlebotomy supervisors, patient safety officers, and risk management, quality and performance improvement, and regulatory compliance personnel.

PPSA provided educational sessions about reliable design, just culture, and human factors engineering. Subsequently, each hospital team mapped its blood specimen labeling process, assessed the process for compliance through direct observation, and presented an overview of the processes to the rest of the collaborative participants. This project was an opportunity for the collaborative participants to identify barriers to labeling compliance that transcended specific care areas and organizations, Shetterly says. Common barriers were those related to technology, communication, education, staffing, workflow, and leadership.

PPSA also trained participants in root cause investigations, and by October 2010 it had collected and analyzed 485 investigations. Facilities reported 520 contributing factors associated with the mislabeling errors. The top three contributing factors were procedures not followed, distractions and interruptions, and unplanned workload increase.

The collaborative participants implemented more than 20 interventions between April and July 2010. There were six major categories of barriers to blood specimen labeling accuracy: technology, communication, education, staffing, workflow, and leadership. The collaborative participants implemented several interventions within these domains to improve specimen labeling accuracy. Overall, there was a 37% statistically significant decrease in blood specimen labeling errors in the collaborative over the 18 months, Shetterly says.

The PPSA project also involved patients by

encouraging them to question caregivers about following proper identification procedures. Patients were given pens as a small gift that might be used and seen often, and signs were posted in rooms with the slogan "Did you ID me?" The program is similar to the national campaign from The Joint Commission, with the Centers for Medicare and Medicaid Services, to urge patients to take a role in preventing errors by becoming active, involved, and informed participants on the healthcare team.

Shetterly also encourages healthcare facilities to shadow staff doing blood draws and other specimen collection. "We followed around some of these nurses who were doing the blood collection, and we saw things that the project managers in the hospital didn't see," Shetterly says. "Sometimes it takes a fresh set of eyes. If you're around the same place long enough, you don't notice that cobweb up in the corner anymore." *(The full PPSA article, "Reducing Errors in Blood Specimen Labeling," is available online at http://www.patientsafetyauthority.org.)* ■

Bedside barcodes reduce pharm errors

Barcoded wristbands can greatly reduce the opportunity for patient identification errors, says **David Grant**, RPh, MBA, vice president of pharmacy and clinical process improvement at Summit Health in Chambersburg, PA.

The barcoded wrist band is placed on the patient at admission and then is used for all specimen collection and medication administration, Grant says. Summit Health first began using the barcode technology about six years ago, when about 15% of U.S. hospitals were using it, he says. Now that figure is closer to 35%, he says.

Summit's barcode system is used in the pharmacy when the medication is dispensed and also at the bedside before it is administered. "The nurse uses a handheld scanner to read the barcode, and if they have the right patient, they are allowed to proceed with administering the medication," he says. "If they don't have the correct patient, it closes the medication administration record and notifies them that they don't have the right patient."

As a result of the barcode technology, "wrong patient administration errors have all but disappeared," Grant says. That success eliminates about 30% of all medication errors, because administration errors make up about 15%, dispensing errors account for another 15%, and transcription errors result in about half of all medication errors, he says.

Staff members have responded well to the new system, with more experienced nurses saying they would never want to go back to paper medication orders, Grant says. Summit spent about $1 million on the hardware and other infrastructure necessary for the barcode system. Planning took about two years, and the new system was rolled out over eight months.

"It's been a resounding success for us, and we wouldn't go back," he says. ■

Performance measures on blood management

Preop screenings released

The final "Patient Blood Management Performance Measures," formerly named the "Blood Management (BM) Measure Set," have been placed in The Joint Commission Library of Other Measures and are available for all healthcare organizations to use in internal quality improvement initiatives. The "Implementation Guide" for The Joint Commission Patient Blood Management Performance Measures 2011 is also available.

The guide provides detailed specifications for the seven measures related to select elective surgery patients and transfusions. The Joint Commission encourages providers to begin reviewing their processes related to transfusion. The measures are:

- transfusion consent;
- red blood cell (RBC) transfusion indication;
- plasma transfusion indication;
- platelet transfusion indication;
- blood administration documentation;
- preoperative anemia screening;
- preoperative blood type testing and antibody screening.

The "Patient Blood Management Performance Measures" are available at http://www.jointcommission.org/patient_blood_management_performance_measures_project. The "Implementation Guide" is available at http://www.jointcommission.org/assets/1/6/PBM_Implementation_Guide_20110624.pdf. For more information, contact Harriet Gammon at hgammon@jointcommission.org. ■