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Whistleblowers and privacy rights: How to manage the overlap

Avoid revelation of patient data, but prepare for conflicts

A physician complained to the chief of staff and hospital management that surgical equipment was not being sterilized properly and a patient died as a result. The hospital responded by firing the physician, says **Dave Scher**, JD, a principal with The Employment Law Group in Washington, DC, who handled this case and specializes in representing whistleblowers.

And whistleblowing situations aren't limited to physicians. A New Hampshire hospital recently agreed to settle a lawsuit filed after a former OR/endoscopy nurse said she was fired after she complained about medical procedures in the endoscopy unit.[1] *(For more on whistleblowers, see package of stories that ran in* Same-Day Surgery, *September 2011, p. 91.)*

Retaliation against whistleblowers in healthcare is risky, probably illegal, and simply not good strategy, say legal experts. Managers should work to formulate internal structures that minimize the chances of an employee going outside the organization to report problems, they say, and managers should be prepared with a more effective response in the event that someone does blow the whistle.

Even if so inclined, the ability to constrain a whistleblower is limited, says Scher. Firing the whistleblower rarely goes uncontested and can lead to other penalties. In the case of the physician who was fired for complaining about poor sterilization, the complaint led to a federal investigation that shut down the surgical suite for four days. Subsequently, the hospital had to settle with the physician for firing him, which is a common outcome, Scher says.

In healthcare, managers often wonder how confidentiality requirements might restrict a whistleblower's ability to reveal potentially damaging information. The overlap can be tricky, Scher says, but in most cases patient privacy concerns do not prevent the disclosure. Confidentiality agreements, often used in settlements in an attempt to keep damaging information under wraps, can provide a false sense of security, Scher says.

"Claiming that you had a confidentiality agreement and you disclosed a private agreement, therefore you can't be trusted, is almost always just a smokescreen," Scher says. "It's a weak argument, and the organization does not tend to be looked on favorably when they try to use that defense."

Whistleblowers in healthcare are protected by multiple laws, more than

employees in most industries, says **Kevin Troutman**, JD, an attorney with the law firm of Fisher and Phillips in Houston, TX. Healthcare providers must take into account these many protections when considering how they will respond to whistleblowers, particularly the whistleblower exceptions for the Health Insurance Portability and Accountability Act (HIPAA), he says. "I've found that this really surprises managers sometimes. They are shocked that they can't discipline an employee for violating confidentiality or revealing patient information," Troutman says. "Sometimes you can inadvertently set up a whistleblower claim if you take action without really analyzing the circumstances and the protections that might apply."

Healthcare providers often use HIPAA as an excuse when trying to dissuade an employee from revealing damaging information, Scher says. HIPAA privacy concerns have been drilled into employees so effectively that many people can be convinced that it is impossible to report fraud without violating the law themselves, he says. "We see it all the time. It's very, very common," Scher says. "It's an easy hook to say, 'Sure you can expose the fraud, but you violated HIPAA so you're out.' That is completely the wrong strategy for the employer and usually will just make matters worse for you."

That advice does not mean, however, that healthcare employees can recklessly reveal protected health information (PHI) as part of their effort to report problems, Scher says. To encourage responsible reporting and avoid potential post-reporting conflicts, managers should establish internal procedures that allow employees to voice concerns while still maintaining patient confidentiality, he says. "We have them disclose information by case number, rather than by naming the individual," he says. "If you don't provide a mechanism for reporting concerns, and then you jump on the employee for violating confidentiality, you are going to be seen as trying to avoid the real issue."

It is possible to fire a whistleblowing employee and cite a reason other than reporting fraud or other misdeeds, such as blaming it on improper disclosure of patient information, but Scher says that move is a desperate one that often backfires in the form of litigation and a costly payout. A better plan, he says, is to foster a culture that results in people wanting to discuss their concerns internally and to have a procedure for responding to those concerns. *(See the story on p. 16 for steps to take in responding to concerned staff, and below for the dangers of staff investigating on their own. See the story on p. 15 for federal and state protections for whistleblowers.)*

Troutman advises managers to work closely with human resources to determine when whistleblower protections might apply. If you wait until human resources already has disciplined or fired the employee for a confidentiality breach, it might be too late to avoid the damage, he says.

Aside from retaliation being a bad strategy, there is another reason for healthcare providers to provide an appropriate mechanism for reporting concerns. Without guidance and a safe way for employees to speak up, the employer can be held responsible for

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the whistleblower's privacy breach, explains **Tammy Marzigliano**, JD, partner with the law firm of Outten & Golden in New York City. Marzigliano represents employees in litigation regarding employment law. "That's one reason it makes sense to give employees a constructive way to bring these concerns to you without violating HIPAA," she says. "If you don't, their next step may be to go public and blurt out a lot of information or hand over documents to the media that they shouldn't, and you as the employer are going to be held at least partly accountable for that."

REFERENCE

1. Haberman S. Exeter Hospital settles suit with 'whistleblower.' *Exeter News-Letter*. June 20, 2011. Accessed at http://www.seacoastonline.com/articles/20110620-NEWS-110629978 ■

SOURCES/RESOURCE

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The Ambulatory Surgery Center Association has an ASC Compliance Hotline, operated by National Hotline Services, that allows workers to anonymously report concerns. The employer is notified in a manner that does not disclose identity of caller. Web: http://ascassociation.org/publications/hotline. ■

Beware of staff probing on their own

Violations of the Health Insurance Portability and Accountability Act (HIPAA) are a growing focus for whistleblowers, says **Tammy Marzigliano**, JD, partner with the law firm of Outten & Golden in New York City.

Marzigliano recently spoke with a potential client who was concerned that her healthcare employer was not adequately protecting a database with PHI. The employee reported her concerns internally, but the healthcare provider did nothing, Marzigliano says.

"So she started working with IT, gathering documents and investigating herself, which is the wrong way to go about it," the attorney says. "HIPAA does provide protection for those trying to report problems, but it requires that you include the minimum amount of patient information possible. She was going way beyond that leeway."

In a situation such as that one, the employer might have a legitimate reason to terminate the employee, Marzigliano says. The employee overstepped her bounds and violated HIPAA in a way that is not protected, no matter how good her intentions, so dismissal could be justified, she says. "But the employee is going to argue that you dismissed her because she complained and you retaliated," she says. "In this case, you might be able to prove otherwise. But you still have a messy situation, some expensive litigation, and you still haven't addressed the root problem. You would have been better off listening when she first came to you with her concerns."

HIPAA does allow individual healthcare employees to copy records and provide them to their attorneys if they think some violation has occurred, says **Kevin Troutman**, JD, partner with Fisher & Phillips, Houston, TX. "It's not entirely clear how far that they can go with that, but there is an exception," Troutman says.

Education is key in this area, Marzigliano says. Having an employee hotline is not enough, she says. In addition to encouraging people to come forward, managers also must educate employees about where their obligations stop. Many employees will be under the impression that they cannot report potential fraud, for instance, without having the evidence to back up their claims. In trying to gather and provide that evidence, they might violate HIPAA and other regulations, which creates additional trouble for the employer and could rob the whistleblower of protections that otherwise might be available.

"They need to know that it's their job to speak up but not their job to investigate," she says. "It can be really unfortunate when you have someone who has the best intentions, and whistleblowers tend to be really righteous people, but they go overboard because they thought it was necessary. I'm horrified when they come to me with these documents." ■

Federal, state laws protect whistleblowers

Many states offer protection to whistleblowers, and a federal statute protect whistleblowers reporting false claims, explains **Amy S. Leopard**, JD, partner with the law firm of Walter & Haverfield in Cleveland, OH. If the court

finds that the employer terminated the employee because of the whistleblowing, the employer will be required to reinstate the employee and provide double back pay for the period in question.

Gag orders written into settlement agreements also will be difficult or impossible to enforce when the employee is trying to report wrongdoing to the government, she says.

"All the government has to do is get wind of the false claim, and they will subpoena the person who knows about it," Leopard says. "You can't enforce any type of confidentiality agreement if the employee or former employee is subpoenaed for a government interview."

Employees' concerns about impropriety are not always well founded, of course. The employee might be mistaken about the facts or the law, Leopard says, but the provider still should take the employee seriously. It can be a costly mistake to casually dismiss the employee's concerns or even indicate annoyance that the employee is trying to stir up trouble over nothing, she cautions. That response can prompt the employee to feel righteous indignation and investigate the matter independently, then take the concerns to outside regulators.

"You always are best advised to listen to any complaint seriously and express that this is exactly what you want people to do if they are concerned something might be wrong," she says. "If you determine that, in fact, there is no problem, then you can explain that to the person without making them feel like you're blowing them off."

SOURCE

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Be quick, proactive to avoid whistleblowing

When an employee has concerns about fraud or other wrongdoing within your organization, that person can take two paths: either report it internally, or report it to regulators and become a whistleblower.

You always will fare better by having the person report internally, says **Dave Scher**, JD, a principal with The Employment Law Group in Washington, DC, who specializes in representing whistleblowers. However, if you don't respond properly, the person still might turn into a whistleblower. Here is Scher's advice:

1. As soon as an employee voices a concern about possible fraud or other improper activities, sit down with him or her to discuss the situation. Do not delay. Listen carefully to the employee's concerns, and indicate that you are glad he or she reported them. Tell the employee that you will research the matter further and report back with more information.

2. Have the compliance staff conduct a thorough investigation. Do not minimize the employee's concerns or dismiss them as unfounded. Every allegation should receive a thorough investigation. Even if the conclusion is that the concerns are unfounded, the healthcare provider has performed due diligence and created a paper trail showing that it responded in a responsible way. When a legitimate problem is uncovered, the provider's actions will show regulators that it responded in a proactive way as soon as it was notified of potential trouble.

3. If the concerns are well founded, the organization should consider publicly disclosing the problem through the media and explaining what steps are being taken to fix it.

4. Thank the employee for bringing the issue to your attention. Most importantly, protect the employee from retaliation. Remember that the retaliation might not originate with your office or the executive suite. The employee's line level supervisor and coworkers might retaliate if they see the whistleblower as a troublemaker, so go directly to the supervisor and emphasize that any sort of retaliation is inappropriate and will not be tolerated. Consider reassigning the whistleblower, supervisor, or coworkers if necessary. ■

Does staff understand how to use interpreters?

Correct access is critical

Providing interpreter services is not enough to ensure good communication between patients, family members, and clinicians. It is important to make sure staff understands when to access interpreters, what services are available, and how to use the resources.

Staff education at The Ohio State University Medical Center in Columbus begins at orientation for all newly hired employees. Interpreter Services provides information on the resources available during a half hour class

EXECUTIVE SUMMARY

Communicating effectively with patients and family members who do not speak adequate English requires an interpreter.

- To make sure staff members understand what resources are available and how to use them, provide education.
- Good staff education should include a demonstration of how to access resources, and provide information on communicating with the aid of an interpreter.

that is part of the orientation and takes place every two weeks.

Education on interpretive services is important because there are laws, regulations, mandates, and accreditation standards that require the use of these services for clear communication, says **Milly Valverde**, MA, manager of Interpreter Services at The Ohio State University Medical Center in Columbus. "It is good to push that empathy piece also, telling employees to put themselves in that person's situation," says Valverde.

Policy at the medical center requires staff to request an interpreter any time they are interacting with a patient who does not speak English. They are also encouraged to use an interpreter with patients who are semi-fluent because medical vocabulary and technical terms are more difficult to understand.

In addition to orientation, Valverde has set in place opportunities for staff education. Once a year, a workshop is offered that focuses on working with refugees. Sometimes workshops are offered that cover communicating with Asian American patients or Hispanic patients. However, these are general to avoid stereotyping, says Valverde. *(For information on key elements included in all classes see article at right.)*

A computer-based learning module covers cultural competency as well as the use of interpreters. This module is offered through the healthcare system's intranet. To broaden awareness, interpreters write articles about specific ethnic holidays such as Ramadan. Also posted on the intranet is information on resources offered by Interpretive Services and video clips on how to use the resources.

A two-hour class on communicating with deaf patients is offered quarterly. Staff members may obtain continuing education credits for enrolling, and it also counts toward customer service training. Every year each employee is required to take a two-hour class that is part of the customer service curriculum, and there are about 10 selections. For three years, Interpreter Services offered a class specific to its services, which was a broad spectrum of everything the department offers.

Interpreter Services has 12 onsite interpreters that cover the top seven languages spoken by patients who access the medical center. These include Spanish, Somali, American Sign Language, Arabic, Russian, Mandarin Chinese, and French. Agencies that provide onsite interpreters in other languages also provide services, and three telephone interpreter agencies can be accessed. In addition, there is video interpretation from units throughout the healthcare system.

The use of an onsite interpreter is encouraged for more complicated encounters. For example, when a patient might have cognitive issues, a large family support system in which many people may participate in the discussion, or during emotional conversations, also when a patient is deaf.

Another resource empowers patients by providing a toll-free number by which they may access an interpreter directly to ask questions of clinic or hospital staff or make an appointment.

"We encourage all our staff at all levels to take to take our classes because it is important to create a hospital culture that really embraces the inclusiveness and respect for other cultures," says Valverde. *(For more on this topic, see package of stories on language and cultural diversity in November 2010 issue of* Same-Day Surgery.*)*

SOURCE

For more information about providing staff education on interpretive services, contact:

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Several elements necessary for training

Teach how to work with interpreter

While there are different class formats for staff education offered by Interpreter Services at The Ohio State University Medical Center in Columbus, certain information is included in all the classes.

About 15 to 20 minutes focuses on how to work effectively with an interpreter. For example, there is discussion about looking at the encounter from a patient's perspective and considering how one would feel if two people in a room were discussing your health but never looked at you, says **Milly Valverde**, MA, manager Interpreter Services at the medical center.

In addition, the amount of information that should be shared before pausing to allow the interpreter to speak is covered. Some clinicians will speak for five

minutes before pausing for the interpreter to repeat the information, and then he or she is only able to give key points not repeat word for word, says Valverde.

A few cases that have been won in court due to miscommunication are also discussed during the classes. Valverde picks a couple to read during the class, and one usually highlights a situation in which a family member or friend was allowed to interpret for the patient. These cases reinforce the need for clinicians to access Interpreter Services.

Health systems in other parts of the world are covered because in many, the patient is the last to know about his or her condition, says Valverde. Healthcare decisions are made by certain family members or the head of the household on behalf of the patient. This situation reinforces the need for the use of an interpreter rather than using family members during medical discussions.

Trends are another aspect of the education. The medical center tracks the requests for interpreters and the language requested. By sharing this information, staff can see the changes from year to year and the breadth of languages covered. "Last year, we offered interpreters in 96 different languages," says Valverde.

A demonstration on how to use the resources including video and telephone services is given. While there are instructions on the web, some think it is too complicated, Valverde says. By demonstrating access, staff sees how easy it is to use an interpreter.

Just to make sure staff members do not forget how to access an interpreter, each one receives a badge card with all the resources listed and how to access an interpreter 24 hours a day, seven days a week. ■

Multilingual materials improve communication

Web sites put info at your fingertips

Communication with non-English speaking patients is an important factor in good health outcomes. Language barriers can impact quality education that results in an understanding of how to correctly take a medication or effectively handle postoperative care.

Yet healthcare institutions have limited budgets to spend on resources for non-English speaking patients. To prevent duplication of efforts, we have assembled agencies and organizations that produce health resources for people who do not communicate well in English.

• **Echo Minnesota.** Web: www.echominnesota.org.

This organization has health and safety handouts available in a variety of languages on their web site including Spanish, Somali, Hmong, Lao, Vietnamese, and Khmer. Click the 'topics' tab, then 'health and safety' for health topic categories and languages. Topics include "Medications."

• **EthnoMed.** Web: ethnomed.org.

EthnoMed contains medical and cultural information about immigrant and refugee groups in the Seattle area but it is applicable to many geographic areas. It is produced by Harborview Medical Center. Click on "Patient Education" for resources on various topics, including "Test/Procedures/Radiology," and in a variety of languages.

• **Health Information Translations.** Web: www.healthinfotranslations.com.

Translations of health information created through a partnership of The Ohio State University Medical Center, Mount Carmel Health System, and Nationwide Children's Hospital. Select health information by topic, including "Surgeries or Treatments," or language.

• **Healthy Roads Media.** Web: www.healthyroadsmedia.org.

Free health education materials in various languages and formats is offered on this web site. There are written handouts, audio, multimedia, web video, and iPod video. Select "All Topics" to access topics such as "Medical Tests and Treatments."

• **MedlinePlus.** Web: www.nlm.nih.gov/medlineplus/languages/languages.html.

The National Library of Medicine and National Institutes of Health has posted materials in 44 languages on MedlinePlus. This section offers handouts in a variety of languages. The English equivalent of the text is included on the handout. Select "Health Topics" to access "Diagnosis and Therapy," which includes the topic "Surgery and Rehabilitation."

• **National Library of Medicine.** Web: www.nlm.nih.gov.

The web site for this organization provides resources in multiple languages. At the left of the screen, under "Databases," select "MedlinePlus." Scroll to bottom of the page and in the right corner, select "Multiple Languages." You will be able to browse information in multiple languages by health topic or by language.

• **Refugee Health Information Network (RHIN).** Web: www.rhin.org.

Information in various languages is available. At the bottom of the page, select "Health Topics in Multiple Languages," then select "A to Z Listing of Resources: An index of all RHIN documents." Topics include "Surgery" and "Surgical Procedures."

• **Utah Department of Health Multilingual Library.** Web: http://health.utah.gov/disparities/multilinguallibrary. The Center for Multicultural Health provides

health education materials in many languages to assist healthcare professionals in communicating with people who don't speak English or have a low English proficiency. The homepage has lists of languages and topics. ■

Proactive approach predicts patient status

Surgical case manager does reviews

Sherman Hospital in Elgin, IL, takes a proactive approach to ensuring that surgical patients are placed in the proper inpatient or observation status by asking physicians to fill out a surgical reservation form before the surgery is scheduled.

The form includes space for the name of the surgical procedure, the CPT code, and the ICD-9 code.

It has space for insurance and pre-authorization information and boxes where physicians can check to indicate if they predict that the patient will be an outpatient, be admitted as an inpatient, or require an extended recovery.

In addition, the hospital has dedicated a case manager to the surgical unit to review all scheduled surgeries and ensure that they are in compliance with Medicare and other payer guidelines.

"There's too much money at stake not to do this. We want to get the patient status correctly established up front to avoid having the Recovery Audit Contractors (RACs) take back the whole payment for surgeries done in the wrong setting," says **Ronald Hirsch**, MD, FACP, medical director of care management for the 255-bed hospital, and physician advisor in case management for B.E. Smith healthcare consulting firm with headquarters in Lenexa, KS.

The surgical reservation form, which is available on the Sherman Health Documents web site, reminds physicians that observation services must be ordered after surgery and only if there is a medical reason to monitor the patient. It instructs them that Extended Recovery should be chosen for non-medical patient stays that are for the convenience of the physician or patient.

The Sherman Health document library also has a copy of the Medicare Inpatient-Only List and instructs surgeons that if a procedure is on the list, they should order an inpatient admission and that if procedures are not on the list and surgeons want to admit the patient, they must document the reasons on the medical record. The web site also includes a page describing outpatient, inpatient, and extended recovery and when each is appropriate. *(See resource at end of story.)*

Once the physician fills out the form, he or she faxes it into the scheduling department. The scheduling nurse reviews it to determine if the procedure is on the Medicare inpatient-only list and, if so, to make sure the doctor has ordered an inpatient admission. If not, the nurse contacts the physician and asks for new orders. When the patient gets to the surgical unit, **Heather LaCoco**, RN, BSN, surgical care case manager, reviews the record to make sure the orders are appropriate and the documentation is complete.

"A big part of my job is educating the surgeons and their office staffs about the difference between observation services, inpatient admissions, and extended recovery to help them understand the appropriate admission status for their patients. Surgeons just want to be doctors and surgically fix their patients and safely send them home. Case managers are the glue that puts it all together to make sure patients receive the care they deserve, that insurance and Medicare regulations are followed, and the hospital is capturing the information it needs to be appropriately paid for the care we deliver," LaCoco says.

The post-operative order sheet gives surgeons three choices: they can leave the status they designated preoperatively, change it to an inpatient admission, or order observation services for the patient. "We've worked hard to educate the physician that observation is indicated only when patients need monitoring beyond the usual recovery," Hirsch adds.

The hospital created the information sheets and forms for physicians after reviewing the RAC rules and records, and determining that in many cases, observation was not appropriate. "We also realized that some surgeries that were on the Medicare inpatient-only list were being performed as outpatient procedures and that there were instances where older patients with comorbidities needed inpatient care after routine procedures that were not on the list. The orders were not appropriate, and we were being poorly compensated for the services we provided," Hirsch says.

The hospital has created an extended recovery status for patients who need to stay overnight but their conditions don't warrant observation services or an inpatient stay. An example is a patient who has a procedure that Medicare has deemed to be outpatient surgery but the physician isn't comfortable sending the patient home after a four-hour recovery. "The hospital gets no additional payment for patients in extended recovery, but it keeps the surgeons happy, and the patients appreciate it," Hirsch says.

LaCoco reports spending a lot of time educating physicians and office staff about the need for accurate documentation and making it simple for them to get the right patient type, so the hospital can capture the services it is providing for patients and get paid appro-

priately. For example, a laparoscopic colectomy might be a simple outpatient for some patients, but not for an 82-year-old patient with heart failure, chronic obstructive pulmonary disorder, and diabetes.

"In this case, we need to educate the surgeon and the office staff to document that due to his comorbidities and risk factors, the patient needs to be admitted after surgery for close monitoring and medical management," she says. "This way we are capturing patient needs and are able to bill accurately for the care we provided." *(For more on surgical admissions, see story below.)*

SOURCES/RESOURCE

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• **Sherman Health Document Library**. Web: www.ShermanDocs.com. ■

Dedicated case managers review surgery schedule

Inpatient vs. outpatient is focus

At Port Huron (MI) Hospital, a full-time case manager is dedicated to the surgery department and reviews the cases of all patients scheduled for surgery to make sure they are in the proper status of being an inpatient or observation patient.

Hospitals must walk a fine line when it comes to determining if surgical patients who need more than normal recovery times should be admitted or remain as outpatients with observation services, says **Rochelle Schiller**, RN, MBA, director of care management at the 186-bed community hospital. Hospitals lose money if they provide observation services for patients who meet admission criteria. On the other hand, if they have a large number of one-day inpatient stays, it attracts the attention of the Medicare Recovery Audit Contractors (RACs), Schiller adds.

"We determined that we needed someone on site to prospectively conduct a clinical review of surgical cases. We knew we needed an RN case manager with expertise in admission criteria to make sure the patients are in the proper status. A case manager dedicated to the surgery department was the solution," she says.

Working with the hospital administration and the business office, Schiller conducted an analysis of surgical cases over 12 months. The analysis showed that in some cases, procedures were ordered as outpatient procedures, but the patients were being transferred from recovery to the inpatient unit for a variety of reasons. "Some had clinical issues. Others were social admissions, and some simply didn't belong there," Schiller says. In all cases, the hospital was getting paid only for the outpatient services and not for the inpatient stay, she says

"We were losing revenue on some patients who met medical necessity criteria but were kept overnight as outpatients. We also determined that there were a lot of outpatients in beds when their care was not reimbursable," she says

The case management department worked with the business office to track all of the write-offs because the patients were treated as outpatients but the procedure was on the Medicare inpatient-only list. "We were missing the boat on some inpatient procedures. The procedures were being booked as outpatient procedures, and the patients were being kept in observation, so we weren't getting paid," she says.

The case management team looked for trends and picked the 15 most common procedures where there were problems, then educated the surgeons about the inpatient-only list, starting with those who performed the most common procedures. In addition, the surgical case manager compares the procedures scheduled for Medicare recipients to the inpatient-only list and makes sure that an inpatient stay is ordered. "We want to admit patients if they are having procedures on the inpatient-only list so we can get paid correctly," Schiller says.

As part of their initiative to place patients in the correct status, Port Huron Hospital created an outpatient extended stay level for patients who need to stay overnight for non-clinical reasons, such as they don't have a ride home or the doctor doesn't discharge them until the next day.

The extended stay level enables the hospital to put patients in a bed overnight without billing Medicare. "It doesn't generate a room charge, so it doesn't count as a one-day stay, and there's no red flag for the RACs. We have compassion for patients who can't get home late in the day, but it's not appropriate for us to bill for those services," she says.

SOURCE

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Same-Day Surgery Manager

Get your house in order for 2012

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

The holidays finally are over, and most of us have nothing really important to do this month. OK, maybe four of you have something really important to do at work this month, but for the rest of us…

I've written and spoken for years about the need for hospitals and surgery centers to get together and find a common goal to work toward. Hospitals know that they are losing money on many of their outpatient cases. If they think they aren't losing money, it is just because their antiquated accounting software doesn't capture all their expenses, which deceives them into thinking they are doing well.

Conversely, most surgery center out there are over-built and have capacity ('cept ours of course…) to do more cases. Furthermore, many surgery centers are doing procedures that should go back to the hospital since our backward-thinking method of reimbursement is driving them back into that model. Come on!

Chances are, if you are a GI-only surgery center, you probably are better off financing and doing these cases in your office, not in any facility-fee environment, and taking the high professional fee reimbursement rather than the minuscule facility reimbursement. Either do that, or push them back to the hospital and start recruiting new specialties and surgeons into your surgery center. Of course hospitals, even with their higher reimbursement, cannot make money on them either. So … what to do? What to do? With the exception of the above, you are sort of running out of options, huh? Don't get so smug eye centers; you have a bull's-eye on your back too!

So, this month each entity needs to establish dialog with each other. It is completely legal and aboveboard to do so. Many great minds in the insurance industry already are finding ways to ratchet down reimbursement further, so we (you!) need to start doing some planning as well.

Every single person reading this is experiencing accounting errors in their facility. This month, you need to reach out and grab an invoice and check the amount you are being charged by the vendors versus what you contracted. I have eased up on the vendor reps over the years because I am now convinced that overcharging or incorrect charging is not really their fault. They have to face us too often to pull that kind of stuff. I think it is just poor communications or keystroke errors on those at their home office doing the invoicing. Regardless, you still are overpaying! Do yourself, your facility, and your investors a favor and just audit 10 — no, 20 — invoices this month while you're just hanging around. (Oh, hate mail is on the way!)

Another reaching out effort this month is to check your reimbursement per your agreed-upon contracts. We are all in that same sinking boat. Again, audit! Just check 20 claims from your top payers, and see where you are. Again, those facilities that are "right on" are in the minority!

Reach out for your employee files. It is guaranteed that many competencies and licenses are in need of updating.

Even if you sub out your credentialing, you are going to find some expired insurance coverage. It's not all that big a deal now, but when someone else discovers them, or there is a problem and someone looks at them and finds out there is no coverage, it is going to be at the worst possible time. Again, do it now, and get it over with.

Just when you want to really fire someone, up jumps the regulations demanding more employee protections. That is all well and good, but you never signed on to be a babysitter or an employment agency. Put those issues behind you this month.

Lastly, book that trip to the islands! The weather is miserable, and the world probably will blow up this year anyway, so get your vacation in early. If you do believe the world is ending this year, put your vacation on your credit card! *[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.]* ■

Average salary for nurses jumps

AORN releases salary survey results

The Association of periOperative Registered Nurses (AORN) has announced the results for its annual salary survey of perioperative nurses. Survey participants

included staff nurses, managers, (i.e., nurse managers/supervisors/coordinators/team leaders/business managers) high-level managers (vice presidents, directors, assistant directors, and hospital/facility administrators), educators, RN first assistants (RNFAs), and clinical nurse specialists.

Highlights of the results include:

• The pay in university/academic ASCs was more than in any other facility type, though the author noted there was a small sample size for this group.

• Nurses generally receive more compensation in larger facilities.

• The average staff nurse earns $67,800 ($1,400 more than in 2010).

• The average VP/director/assistant director of nursing earns $107,600 ($4,700 more than in 2010).

The survey results were reported by **Donald Bacon**, PhD, a professor of marketing at the University of Denver and a research associate at Rocky Mountain Research, Denver. According to Bacon, part of the difference in salary across titles is explained by the difference in the percentage of time spent on direct patient care versus the percentage of time spent on other tasks such as management or administration.

For the eighth consecutive year, AORN conducted its survey online. In July, 5,053 unique responses from 46,113 potential respondents, including 31,622 AORN members, were reduced to a usable sample of 2,670. All respondents were employed full-time in the United States.

Bacon used a multiple regression model to examine how a number of variables, including job title, education level, certification, experience, and geographic region, affect nurse compensation. The survey also addresses the perioperative nursing shortage and focuses on perceived changes in staffing-related aspects of the perioperative nursing workplace during the last three years.

The perioperative nurse salary survey results are published in the December issue of AORN Journal. It is free to members and $12 for non-members. To order, go to http://bit.ly/uCm3EP. *(For information on salaries of outpatient surgery managers, see results of the annual S*ame-Day Surgery *Salary Survey in supplement to January 2012 issue of* Same-Day Surgery.*)* ■

Action urged to fight healthcare worker fatigue

The link between healthcare worker fatigue and adverse events is well documented, prompting The Joint Commission to issue a new Sentinel Event Alert: Health care worker fatigue and patient safety. The alert urges greater attention to preventing fatigue among healthcare workers and suggests specific actions for organizations to mitigate the risks.

An article in The Joint Commission Journal on Quality and Patient Safety reported that nurses who work more than 12-hour shifts and residents working recurrent 24-hour shifts were involved in three times more fatigue-related preventable adverse events.[1] In addition, healthcare professionals who work long hours are at greater risk of injuring themselves on the job. Some agency and part-time employees might come to your facility immediately after finishing a full shift at another facility.

"Healthcare is a round-the-clock job, and safety has to be the priority," says **Mark R. Chassin**, MD, FACP, MPP, MPH, president of The Joint Commission. "The recommendations in this alert give healthcare organizations the strategies to help mitigate the risks of fatigue that result from extended work hours, and, thereby, reduce the likelihood that fatigue will contribute to preventable patient harm."

The alert addresses the effects and risks of an extended work day and of cumulative days of extended work hours. The Joint Commission alert recommends that healthcare organizations:

• Assess fatigue-related risks such as off-shift hours, consecutive shift work, and staffing levels.

• Examine processes when patients are handed off or transitioned from one caregiver to another, a time of risk that is compounded by fatigue.

• Seek staff input on how to design work schedules that minimize the potential for fatigue and provide opportunities for staff to express concerns about fatigue.

• Create and implement a fatigue management plan that includes scientific strategies for fighting fatigue such as engaging in conversation, physical activity, strategic caffeine consumption, and short naps.

• Educate staff about good sleep habits and the effects of fatigue on patient safety.

The Joint Commission also suggests that healthcare organizations encourage teamwork as a strategy to support staff who work extended work shifts or hours. For example, use a system of independent second checks for critical tasks or complex patients. Also, organizations should consider fatigue as a potentially contributing factor when reviewing all adverse events, They should educate employees on the importance of good sleep habits, including ensuring their rest environment is conducive to sleeping.

The warning about healthcare worker fatigue is available at http://www.jointcommission.org/sea_issue_48. It is one of a series of alerts issued by the Joint Commission. Previous alerts have addressed

healthcare technology, wrong-site surgery, and others. Past issues of Sentinel Event Alert can be found on the Joint Commission web site at http://www.jointcommission.org/sentinel_event.aspx. *(For more on this topic, see package of stories on surgeon fatigue and liability in the March 2011 issue of* Same-Day Surgery, *beginning on p. 25.)*

REFERENCE

1. Lockley SW, Barger LK, Ayan NT, et al: Effects of health care provider work hours and sleep deprivation on safety and performance. *Joint Comm J Qual Pat Safety* 2007; 33:7-18. ■

Joint Commission guide focuses on LGBT patients

Goal is to provide equitable care

The Joint Commission provides instruction for hospital staff on how to create a more welcoming, safe, and inclusive environment for lesbian, gay, bisexual, and transgender patients and their families in a new field guide.

"Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community: A Field Guide" features a compilation of strategies, practice examples, resources, and testimonials designed to help facilities in their efforts to improve communication and provide more patient-centered care to their LGBT patients. *(For detailed instructions on how to obtain the guide, see resource information at the end of this article.)*

The Joint Commission urges facilities to adopt a combination of the strategies and practices found in the guide as a foundation for creating processes, policies, and programs that are sensitive and inclusive of LGBT patients and families. The Joint Commission stated research demonstrated LGBT patients often do not receive the same level of care as other patients because of social stigma, lack of awareness, and insensitivity to their unique needs.

What health disparities exist? Often the LGBT community has less access to insurance and healthcare services. Also it experiences higher rates of smoking, alcohol and substance abuse, a higher risk for mental health issues such as anxiety and depression, a higher risk of sexually transmitted infections, and increased incidence of some cancers.

In a checklist at the end of the guide, healthcare staff members are encouraged to "provide information and guidance for the specific health concerns facing lesbian and bisexual women, gay and bisexual men, and transgender people." Suggestions include the following: "Become familiar with online and local resources available for LGBT people. Seek information and stay up to date on LGBT health topics. Be prepared with appropriate information and referrals."

According to The Joint Commission, the field guide can serve as an educational resource for facilities to use in the development of staff training as well as in their efforts to comply with laws, regulations, and standards pertaining to the treatment of LGBT patients.

EXECUTIVE SUMMARY

A new field guide issued by The Joint Commission addresses disparities in the care of lesbian, gay, bisexual, and transgender (LGBT) patients.
- The field guide supports the patient-centered communication standards issued for hospitals in 2011.
- It helps facilities identify areas needing improvement and offers ways to strengthen outreach efforts.

RESOURCE

To download a copy of "Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community: A Field Guide," go to: http://www.jointcommission.org/lgbt. ■

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

- Gold stars among outpatient surgery providers
- How to score a 97-plus in patient satisfaction
- Will drug shortage put your accreditation in jeopardy?

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

1. What does Tammy Marzigliano, JD, partner with the law firm of Outten & Golden, advise regarding how to educate employees about reporting their concerns regarding fraud or other wrongdoing?
   A. Stress that they should fully investigate the matter and bring evidence when reporting their concerns.
   B. Remind them that it is their obligation to report their concerns but not to investigate the problem.
   C. State that they are subject to disciplinary action if they report mere suspicions without providing proof.
   D. Indicate that employees should report their concerns directly to outside regulators rather than trusting anyone within the organization.

2. What should be a top priority when an employee internally reports concerns about possible fraud or other wrongdoing?
   A. Warn the employee that disciplinary action may follow if the concerns are unfounded.
   B. Insist that the employee provide documentation to back up the claims.
   C. Thank the person for coming forward with the concern and reporting it through your organization's proper channels.
   D. Indicate to the person's supervisor that the employee should be watched carefully to ensure there is no prying into the area of concern.

3. At The Ohio State University Medical Center in Columbus, how are staff reminded
   how to access an interpreter?
   A. Each staff member receives a badge card with resources and information.
   B. The information covered at least once a quarter in staff meetings.
   C. The information is posted on flyers on the bulletin boards.

4. When patients at Port Huron Hospital don't meet criteria for an inpatient admission or observation services but need to stay overnight, their doctor can issue order for extended recovery, but the hospital does not bill Medicare for those services.
   A. True
   B. False