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Healthcare reform moves forward, but where do you stand?

By **Joy Daughtery Dickinson**, Executive Editor

Brace for millions of more patients. With the recent Supreme Court ruling that cleared a path for most provisions of the Patient Protection and Affordable Care Act (PPACA) to proceed, you might see a measurable increase in surgery patients as early as next year and continuing through the end of the decade, predicts the Association of periOperative Registered Nurses (AORN).[1]

However, as one news report from Associated Press explained, "it's not a slam dunk."[2]

Rich Umbdenstock, president and CEO of the American Hospital Association, said in a released statement "… [T]ransforming the delivery of health care will take much more than the strike of a gavel or stroke of a pen. It calls for the entire healthcare community to continue to work together, along with patients and purchasers, to implement better coordinated, high-quality care."

The ruling is expected to transform the healthcare insurance market, which will affect outpatient surgery for years to come, the Ambulatory Surgery Center Association (ASCA) predicts.[3] **Linda Groah**, MSN, RN, CNOR, NEA-BC, FAAN, executive director/CEO of AORN, says that with 27 million newly insured people predicted by 2016, "that means they'll have access to primary care, which then has a potential impact on ORs and number of people having elective surgery that put it off because they didn't have health coverage."

Bill Prentice, CEO of the ASCA, agrees. "If more people have health insur-

EXECUTIVE SUMMARY

With the Supreme Court's recent ruling on healthcare reform, outpatient surgery providers are bracing for 27 million more patients, with the influx predicted to start as early as next year.
- Hospitals are predicted to have more interest in providing outpatient care, but more volume might be shifted to freestanding centers.
- Ambulatory surgery centers (ASCs) are concerned about being excluded from accountable care organizations (ACOs).
- The Independent Payment Advisory Board (IPAB) is predicted to target ASCs, physicians, and others for payment reductions.

ance and use it, I think clearly that would bring more patients to the front doors of physicians, ASCs, and hospitals, rather than people putting off care they should be getting taken care of, but can't afford to," Prentice says. "I hope if they have coverage, they can get the care they need."

Because hospital ORs can handle only a set amount of surgery, more surgery will be driven to freestanding centers, Groah predicts.

One bonus for outpatient surgery providers: The Supreme Court upheld the waiving of deductibles and copays for colorectal cancer screenings. "This provision may incentivize more patients to have a colorectal cancer screening…," according to the ASCA.[3] An oversight in the current law requires Medicare beneficiaries to cover the cost of their co-payment for a "free" screening colonoscopy if a polyp is discovered during the procedure. The "Removing Barriers to Colorectal Cancer Screening Act of 2012," currently before Congress, would waive coinsurance for colorectal cancer screening tests, thus covering 100% of their cost under Medicare part B.

With the changes coming, hospitals are likely to have added interest in outpatient care, Groah says. However, that interest might not necessarily translate to building additional facilities, she says. "But they may take some existing facilities, for example, they may remodel or look at whether they can incorporate a portion of the inpatient surgeries' space and use as ambulatory surgery centers," Groah says. "For example, if they have 10 ORs, they might take two or three and make them into a small section for ambulatory surgery."

With the increase in patients, it will be important for perioperative nurses to continue their educations so that they are well-trained, AORN has said. The Supreme Court decision sustained funds for nurse education, quality, and retention, the association said.

Increased consolidation in the marketplace

The Supreme Court decision allows the Medicare Accountable Care Organization (ACO) program to continue.

"ACOs are in the process of forming, and their impact on ASCs remains to be determined," the ASCA said.[3]

Prentice says, "The potential for increased consolidation in the healthcare marketplace concerns us. It should concern everyone."

The accountable care organizations, which are being established to try to create networks to coordinate care of Medicare patients, "sounds like a good thing" he says, "but there are serious concerns about healthcare consolidation in certain markets. You've got one health system controlling the patient base in that marketplace and choosing who can participate in that system. If they wanted to freeze out certain physicians or delivery models, like ASCs, there's that potential."

In some marketplace, hospitals and health systems are buying up primary physician practices, Prentice says. "That should be a concern to those who view free market positively and the innovation that come with competition in marketplace," he says.

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Editorial Questions

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Coordinated care arrangement should include surgery centers, due to their cost savings and patient convenience, he maintains. *(For more information on the impact of the Supreme Court ruling, see stories, below and p. 96.)*

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2. Johnson A. High court ruling benefits most health care firms. June 28, 2012. Accessed at http://apne.ws/NDxD2D.
3. Ambulatory Surgery Center Association. How the Supreme Court's ruling on health care affects ASCs. Government Affairs Update. June 28, 2012.

RESOuRCE

The entire Supreme Court opinion is available at http://bit.ly/M8yRq6. ■

Brace for less money, more emphasis on quality

With the Supreme Court clearing the way for about 27 million new covered patients under the Patient Protection and Affordable Care Act (PPACA), about half of the patient newly covered by a payer will be Medicaid patients, according to a report from the Associated Press (AP).[1]

Medicaid patients equal less reimbursement than cost, the AP story points out. In addition, Medicare payment increases will be less under the law, AP says. The reason is the Independent Payment Advisory Board (IPAB), which will reduce Medicare's costs beginning in 2014 by recommending specific Medicare reductions, the ASCA says.[2]

"Because certain providers such as hospitals are exempt from the cuts until 2018, and because benefits cannot be targeted for cuts, the IPAB would, by necessity, have to target ASCs, physicians, drug manufacturers and nursing homes for reductions in order to meet their targets," according to the Ambulatory Surgery Center Association (ASCA).

That's a worry, says **Bill Prentice**, CEO of the ASCA. "We have real concerns, as do many physician groups, with the independent payment advisory board," he says. "We're concerned about that being a 'black box,' leading to cuts that don't make sense."

Brace yourselves, say outpatient surgery leaders, including **Bobby Hillert**, executive director of the Texas Ambulatory Surgery Center Society. "The IPAB and state-based health insurance exchanges that could result in narrow provider networks to keep costs low are among the issues that could have a dramatic impact on both the Medicare and commercial insurance markets," Hillert says. *[Editor's note: On June 9, we sent an email bulletin about new Medicare proposed payment rates for ASCs and hospital outpatient departments. If you didn't receive the bulletin, we don't have your email address. Contact customer service at customerservice@ahcmedia.com or (800) 688-2421. Also, receive breaking news by following us on Twitter @SameDaySurgery.]*

The Centers for Medicare and Medicaid Innovation (CMMI) created by the ACA will continue to look for innovative payment and delivery system models to cut Medicare and Medicaid costs, the ASCA says. "ASCA has been working with CMMI and evaluating the possibility of establishing a pilot to pay ASCs for performing total joint procedures on Medicare beneficiaries," the ASCA says.[2]

Prentice says, "We're interested in using the program to show ASCs can save money if we could do more complicated procedure than Medicare currently allows us to provide to beneficiaries."

Although the impact of the health insurance exchanges to be set up in each state is unknown, reimbursement rates should be better than the bad debt that is generated now by the uninsured, says **David A. DeSimone**, Esquire, vice president and general counsel at AtlantiCare Health System, Egg Harbor Township, NJ, and co-chair of the ACO Task Force of the American Health Lawyers Association.

Consider these other impacts:

• Requirements to offer health benefits to your workforce.

With all the good news, there is an area of the ACA that provides pause, DeSimone says.

"One caveat for small businesses like surgery centers and surgery practices is the requirement to offer health benefits to their own workforce for the first time with the individual mandate in 2014," DeSimone says. "There is hope that the insurance exchanges will provide market forces to keep health benefit costs competitive and preventive care will help make workers healthier and thus more productive, but it also could fuel further healthcare integration as providers, including surgery centers and surgeons, seek to share overheads costs such as benefits in large groups or networks."

• Increased emphasis on quality.

Government and private insurers are predicted to demand improved outcomes, the AP said.1 Healthcare providers will be forced to make improvements such

as electronic health records, which are expensive, it points out.

Linda Groah, MSN, RN, CNOR, NEA-BC, FAAN, executive director/CEO of AORN, says, "Quality is always important. With the ACA, there is even more emphasis on it."

Value-based purchasing includes not just quality and performance improvement, but also patient satisfaction, she says, "and that's a part of what the DRG payment and outcomes measures will be all about."

Perioperative nurses and others are working toward zero adverse events, such as surgical site infection and retained foreign objects "that don't represent the best quality we can provide to our patients," Groah says.

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2. Ambulatory Surgery Center Association. How the Supreme Court's ruling on health care affects ASCs. Government Affairs Update. June 28, 2012. ■

Physician-owned hospitals still under restrictions

The recent Supreme Court ruling to uphold most of the Patient Protection and Affordable Care Act (PPACA) left physician-owned hospitals still under what has been described by their association as "onerous restrictions."

"Despite the fact that these are some of the very best hospitals in the country, PPACA unilaterally banned any new hospitals owned by or in partnership with physicians from seeing Medicare and Medicaid patients.," said **John Richardson**, executive director of Physician Hospitals of America.

While there was a grandfathering exemption for existing physician-owned hospitals, even those hospitals can't add new beds or operating rooms, Richardson points out.

"The law also prevented a limited number of hospitals with physician ownership, which were still under construction, from receiving their license to treat Medicare and Medicaid patients," he says.

The Physician Hospitals of America is strongly encouraging repeal of the act "so that Congress can consider the types of reforms that the American people are longing for — reforms that ensure patients have access to high quality care when they need it," Richardson says.

Support has come from what some might see as an unexpected ally: a state ambulatory surgery center association. **Bobby Hillert**, executive director of the Texas Ambulatory Surgery Center Society, says, "As a state society, we support physician ownership in not only ASCs but other facilities, such as hospitals, and ancillary services, such as imaging. Federal laws have allowed physician in a number of areas over the years because it results in better quality and convenience for patients." ■

CMS issues pay proposal, but rates could be less

Debt ceiling deal in Congress could cut 2%

[Editor's note: Same-Day Surgery *tweeted about the 2013 Medicare proposed rates on July 9 @ SameDaySurgery and sent an ebulletin on the same date. If you didn't receive our ebulletin, we don't have your email address. Contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]*

The Centers for Medicare & Medicaid Services' (CMS') proposed fee schedule for Medicare outpatient services for calendar year 2013 would boost hospital outpatient payment rates by a net of 2.1%, while ambulatory surgical centers would see a 1.3% net increase. However, according to **Bobby Hillert**, executive director of the Texas Ambulatory Surgery Center Society, as a result of last year's debt ceiling deal in Congress, all Medicare providers will witness a 2% cut if the sequestration happens.[1]

"Congress will have to decide soon," Hillert said.

Medicare providers will continue to bill for normal Medicare rates, he said. Providers will be reimbursed at 98 cents on the dollar, "so this could result in a 0.1% increase for HOPDs [hospital outpatient departments]," Hillert said.

As a result of sequestration due to last year's debt ceiling deal in Congress, Medicare will see a 2% cut if Congress does not act, Hillert said. "This would result in a .7% cut for ASCs in 2013," he said.

The Ambulatory Surgery Center Association (ASCA) blasted CMS for its use of an urban consumers variation of the Consumer Price Index. According to ASCA, this index results in a payment calculation of roughly $43 for ASCs compared to nearly $72 for hospitals for some undefined aggregate set of services.

The ASC community potentially will see the

gap in reimbursement between hospital outpatient departments (HOPDs) and ASCs widen, according to the ASCA. Although CMS did explicitly recognize that "the CPI-U [Consumer Price Index for All Urban Consumers] … may not best reflect inflation in the cost of providing ASC services," it declined to adopt the hospital market basket as the basis for updating ASC payments, the ASCA says. "This disparity in updates could mean that the gap between ASC payments and HOPD payments would increase from 56% to 58%," the ASCA says. To correct this problem, ASCA is supporting federal legislation: the "ASC Quality & Access Act of 2011."

CMS states in the proposal that it would like to change the payment methodology for ambulatory classification services "from median costs to geometric mean costs" to determine the relative payment weights of services, a switch from the median cost measure the agency has used since the inception of the Outpatient Prospective Payment System

Proposed New ASC Covered Surgical Procedures for CY 2013

• 37205 (2012 HCPCS) — Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel. G2 (2013 Payment Indicator).

• 37206 (2012 HCPCS) — Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (list separately in addition to code for primary procedure). G2 (2013 Payment Indicator).

• 37224 — Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty. G2 (2013 Payment Indicator).

• 37225 — Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed. G2 (2013 Payment Indicator).

• 37226 — Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed. G2 (2013 Payment Indicator).

• 37227 — Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed. G2 (2013 Payment Indicator).

• 37228 — Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty. G2 (2013 Payment Indicator).

• 37229 — Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed. G2 (2013 Payment Indicator).

• 37230 — Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed. G2 (2013 Payment Indicator).

• 37231 — Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed. G2 (2013 Payment Indicator).

• 37232 — Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (list separately in addition to code for primary procedure). G2 (2013 Payment Indicator).

• 37233 — Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure). G2 (2013 Payment Indicator).

• 37234 — Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure). G2 (2013 Payment Indicator).

• 37235 — Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure). G2 (2013 Payment Indicator).

• 0299T — Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound. R2 (2013 temporary office-based payment indicator)

• 0300T — Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care. R2 (2013 temporary office-based payment indicator). ■

(OPPS). The agency claims that geometric mean costs "better reflect average costs of services than the median," but adds that the geometric mean already has been used in the inpatient prospective payment system (IPPS) for more than a decade. CMS states that such a move with the outpatient system "would have a limited payment impact on most providers, with a small number experiencing payment gains or losses based on their service-mix."

In its proposal, CMS indicates that payment for medical device-intensive procedures will be the same for ASCs as for hospitals. The statement explains that the phrase "device-intensive procedure" is defined as one in which the device "accounts for more than 50% of the cost.

Sixteen new procedures were added to the ASC list of payable procedures beginning Jan. 1, 2013. *(See list, p. 97.)* Six procedures were on a list of ASC covered procedures proposed for permanent office-based designation for 2013. *(See list, below. For physician fee schedule highlights, see below.)*

The agency is accepting comments until Sept. 4. To access the proposal, go to http://bit.ly/NcUSSZ.

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1. Hillert B. "CMS Releases ASC & Physician Payment 2013 Proposed Rules." Texas ASC Society Newsletter. July 13, 2012. ■

ASC Covered Surgical Procedures Proposed for Permanent Office-based Designation for 2013

The Centers for Medicare and Medicaid Services proposed to permanently designate the following codes as office-based because they were performed more than 50% of the time in physicians' offices.

- 31295 (2012 CPT code) — Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g., balloon dilation), transnasal or via canine fossa. G2 2012 ambulatory surgery center (ASC) payment; P2 2013 ASC payment.
- 31296 — Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g., balloon dilation. G2 2012 ASC payment; P2 2013 ASC payment.
- 31297 — Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g., balloon dilation. G2 2012 ASC payment; P2 2013 ASC payment.
- 53860 — Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence. G2 2012 ASC payment; P2 2013 ASC payment.
- 64566 — Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming. G2 2012 ASC payment; P2 2013 ASC payment.
- G0365 — Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow. G2 2012 ASC payment; P2 2013 ASC payment. ■

Physician Fee Schedule Highlights

- The physician fee schedule included a provision that would send Medicare reimbursement payments for pain management services directly to certified registered nurse anesthetists (CRNAs) in states where CRNAs are allowed to furnish them. While several industry publications indicated that this move was a significant story, it was expected. The Centers for Medicare and Medicaid Services (CMS) indicated that they would like to leave scope of practice issues up to states.
- Physicians, like all Medicare providers, will face a 2% cut for all services if the sequestration events occur.
- Congress will be required to act at the end of this year to prevent massive Medicare physician payment cuts (approximately 24%). CMS proposed 7% payment increases for family physicians. Cuts to certain specialists would offset this family physician increase.
- "A proposal to revise a regulation that only allows Medicare to pay for portable X-rays ordered by an MD or DO. The revised regulations would allow Medicare to pay for portable X-ray services ordered by physicians and non-physician practitioners acting within the scope of their Medicare benefit and state law."
- "A proposal to include additional Medicare-covered preventive services on the list of services that can be provided via an interactive telecommunications system."

Source: Hillert B. "CMS Releases ASC & Physician Payment 2013 Proposed Rules." Texas ASC Society Newsletter. July 13, 2012. ■

Facility cuts falls 88% and med errors 30%

Butler County Health Care Center (BCHCC) in David City, NE, is small — it has 25 beds serving a rural community of 2,500 — but the administrators think big. Using a program that enhances teamwork, the hospital has reduced patient falls by 88% and medication errors that reach the patient by 30%.

The improvements came as a result of the free Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) program offered by the Agency for Healthcare Research and Quality (AHRQ), which improves communication teamwork.

The effort began as BCHCC was working on a project to reduce medication errors, explains CEO **Don Naiberk**. "We had had a couple of medication errors that, although they didn't result in harm to the patient, were significant and could have caused harm," Naiberk says. "We really felt like we needed to do something different."

By studying error reports and the results of root cause analyses, the organization learned that poor communication was the most frequent cause of mistakes. The organization's staff needed to find a way to work as a team, not as independent healthcare providers. TeamSTEPPS training was identified as a way to help BCHCC staff overcome communication barriers and improve workplace culture. With that goal in mind, Naiberk and two other hospital leaders — a registered nurse from the outpatient department and the new director of patient safety -— took the master training course offered by AHRQ in 2008.

BCHCC began implementing TeamSTEPPS incrementally. The Surgery Department was among the first, and two TeamSTEPPS tools were introduced there: CUS ("I'm **C**oncerned, **U**ncomfortable, this is a **S**afety issue") and the two-challenge rule, which requires assertively voicing a concern at least twice to make sure it is heard. The Magic Wand exercise — in which participants are asked what they would improve in their department if they had a magic wand — was used in the first meeting to help identify safety problems that were rooted in exchanges with other departments and staff members.

After a few sessions, it was evident that a global approach was needed to improve patient safety, Naiberk says.

Training began with supervisors and managers. During a supervisor retreat, TeamSTEPPS fundamentals were taught in a four-hour session. After evaluating this phase of the training, the TeamSTEPPS team realized that more support for TeamSTEPPS was required, so five more master trainers were added, including a member of the medical staff. To increase its effectiveness, training became more interactive, and class size was limited to 14 participants.

A series of two training sessions, each lasting one-half day, for all employees was scheduled during a four-week period to intensify the training and results. Training was held off site to minimize distractions and lend a sense of priority to the sessions. Finally, training groups were implemented across departmental lines. *(See the story on p. 100 for details on how TeamSTEPPS was implemented at the hospital.)*

All 117 employees at BCHCC have received TeamSTEPPS Fundamentals training, and the hospital regularly offers refresher courses and training for new employees, Naiberk says. There have been numerous improvements as a result, he says. The most prominent improvements were reducing medication errors that reach the patient by 30% and patient falls by 88%, both the result of using TeamSTEPPS tools to identify problems and improve communication, he says.

"The program leads you to identify the underlying issues in any target problem. TeamSTEPPS doesn't by itself solve your patient safety problem, but it gives you the tools to work together and identify those root causes better," Naiberk says. "Staff communicate better, and there don't seem to be the conflicts that we used to have. They're given tools to deal with conflict and avoid having things escalate to the point that administration has to intervene." *(For the schedule and other information on TeamSTEPPS, go to http://teamstepps.ahrq.gov.)* ■

EXECUTIVE SUMMARY

A small rural hospital in Nebraska has reduced falls by 88% and medication errors by 30%. The improvements were achieved with the Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) program offered by the Agency for Healthcare Research and Quality.

- The program encourages teamwork and open communication.
- Facilities can send employees to free master training sessions.
- TeamSTEPPS provides specific tools and techniques for improving communication and reducing errors.

Creative ideas keep staff on TeamSTEPPS

Butler County Health Care Center (BCHCC) in David City, NE, has an enthusiastic team of master trainers who provide training and coaching in the Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) program offered by the Agency for Healthcare Research and Quality, which improves communication teamwork.

Without constant reinforcement and the instilling of the TeamSTEPPS tools as new habits, the old, less desirable habits will return, says CEO Don Naiberk. The master trainers brainstorm to come up with ideas to keep TeamSTEPPS in front of the staff. These were some of their ideas:

• **BCHCC has a stuffed penguin mascot named YaYa that travels around the hospital, building situational awareness.** He moves to a different location each week and carries a sign that holds the name of a TeamSTEPPS tool or strategy. There is a weekly prize drawing for employees who complete a form listing where they found YaYa, what his message is, and what the message means (how or where can it be used).

There's a bit of excitement and mystery associated with YaYa and a bit of healthy competition in finding him, Naiberk says. The explanation of YaYa's tools have been complete and detailed, showing the staff learned well or are diligently looking in their pocket guides to refresh their memories, he says.

Knowing that poor communication was a major cause of error and confusion in the hospital, another cartoon penguin character, Didga U. Know, was created. His purpose is to alert staff about new policies or other important information. When Didga is posted at building entrances to give staff a heads-up, it is their responsibility to seek out the new information through their supervisors, posted notices, and the hospital's online resources.

Because of remodeling, there is a temporary, unfinished wall in the hospital dining room that was made into a TeamSTEPPS graffiti wall. Its artwork and text reinforce TeamSTEPPS tools and strategies. Staff members are invited to share their team success stories by posting them on the wall.

• **A "Play and Learn" TeamSTEPPS session is held the first Friday of every month.** Sessions feature a tool or strategy and an opportunity to practice using it. Along with the featured tool, simple team-building exercises are conducted. The Play and Learn is set up in the staff cafeteria during break times, and treats are used to encourage participation.

• **BCHCC developed a DVD to introduce TeamSTEPPS to new hires as part of their orientation.** It explains the concept of teamwork and the tools and vocabulary of TeamSTEPPS so individuals will understand the team tools when they are used. As new hires are added, they are trained in TeamSTEPPS Fundamentals in group settings. A quarterly Fundamentals training in two four-hour sessions is held to ensure all employees have the same training and understanding of the TeamSTEPPS concepts. ■

Same-Day Surgery Manager

The big question: To bill, or not to bill?

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

If you are the director or employee of a hospital-based surgery facility, don't think this topic doesn't apply to you. Read on.

A big debate in the freestanding ambulatory surgery center (ASC) business has always been, "Is it better to outsource our surgical services billing to a company that only does that service, or save a few bucks and do it ourselves?" (Yes, hospital staff, this does apply to you. You just don't hear about it as much. Read on.)

In the old days (pre-Obama), it probably was a tossup. I don't do my own dentistry. I could save some money drilling my own teeth, but would I enjoy it? Just as painful is billing. It requires staff (yes, they can be cross-trained to do other stuff), a good coder (getting harder and harder to find), and lots of liability to the facility. For the centers that did our own billing, it seems as if that correspondence file got bigger every day from claims that were denied simply to preserve cash for the payers that had to be worked daily by our staff so we would get paid. The strain on management resources to oversee the "days-in-accounts/receivable" questions seems to overtake patient satisfaction issues. Something is wrong with that process.

With the upcoming (like a speeding bullet!) changes in our healthcare system, many physicians that refer patients to our surgeons are going to be paid more to do less, meaning that surgical referrals are going to slow down and less surgery will be done. Anyone remember capitation? Doctors are going to be cutting back on referrals to specialist (surgeons) and consequently -- right or wrong, good or bad -- surgery is going to go down. Period. Until things resolve, we are going back to the dark ages in our healthcare delivery system.

So, what does all this information have to do with billing? It means that we need to focus on two areas: expenses and revenue. Revenue enhancement and revenue cycle management are going to become greater issues for all of us. If you suddenly had a pay cut from your job, what would you do at your home? Well, the same thing is going to have to happen at the workplace.

Our experience has been that we find many centers that do their own billing leave far too much money on the table. More facilities are good at collecting the bills, but many quarters, dimes, and nickels are left. You need that change now. An improperly filed claim for payment automatically adds another 30 days before you receive payment. In our past 20 audits, we found that 35% of all claims filed by facilities were improperly filed or had some minor errors that denied payment, hence the growing correspondence file on claims that need to be re-filed. Of those claims that needed to be re-filed, more than 45% were not even re-filed within 30 days. Add another 60 days before you get the check. Scary, but of the claims that were re-filed, there were errors on 25% of those!

Sometimes it is best to leave it to the professionals.

Of my visits to centers where they are doing their own billing, 75% of my time with the management team is spend on dealing with some issues related to accounts receivable. Of the centers where it is outsourced, less than 10% of my time is related to those issues.

Hospitals, you are no exception to this; you probably just don't have to deal with it on a day-to-day basis. Make no mistake, it does affect you. Any facility that is only collecting 60% of the money they have earned, and even then it takes over 90 days to receive it, is going to be affected!

Be aware of it and start asking questions. Questions that all should ask are:

1. What is our collection rate?
2. How much is written off as uncollectable?
3. How much is lost due to incorrect underbilling or other billing errors?
4. What are our days in accounts/receivable?

As we do less and less surgery, collecting what we have earned is going to become a real issue. Only you can decide for yourselves the best course of action for your facility. *[Editor's note: Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates new address is 238 S. Egret Bay Blvd., Suite 285, Houston, TX 77573-2682. Phone: (512) 297.7575. Fax: (512) 233.2979. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.]* ■

Invasive MRSA infections 'completely preventable'

In what is getting to be a familiar, tragic refrain, the improper use of single-dose vials (SDVs) has resulted in pain clinic patients in Arizona and Delaware acquiring serious bacterial infections that were "completely preventable," the Centers for Disease Control and Prevention (CDC) reports.

"Ultimately, 10 patients in the two clinics were hospitalized for treatment of mediastinitis, bacterial meningitis, epidural abscess, septic arthritis, bursitis, and sepsis — all severe infections caused by either Staphylococcus aureus or its drug-resistant form MRSA," **Michael Bell**, MD, an epidemiologist in the CDC's Division of Healthcare Quality Promotion, reported in a blog post . *(To access that blog post, go to http://bit.ly/OGwGoE.)*

The CDC details on the Arizona outbreak included the following key points:

• On April 8, 2012, the Arizona Department of Health Services was notified of a patient with acute mediastinitis with blood and pleural fluid cultures positive for MRSA. The report indicated this patient and two other patients with culture-confirmed invasive MRSA infections had undergone procedures recently at an outpatient pain management clinic.

• Investigations by the county and state health departments confirmed that the three MRSA-infected patients received pain injections on the same day, along with 25 other patients. Two MRSA-infected patients received epidural steroid injections, and one received a stellate ganglion block. Ten persons, including the MRSA-infected patients, received contrast injections for radiologic imaging to guide medication needle placement.

• Each morning, clinic staff members typically prepared contrast medium in the patient procedure room, before the arrival of patients; two new syringes were used to withdraw 5 mL each from a 10 mL SDV of contrast medium (300 mgI/mL) and a 10 mL SDV of saline solution. The contents from each syringe then were transferred to the alternate vial, resulting in two 10 mL vials of diluted contrast solution, one for use in the morning and one reserved for the afternoon. Among patients receiving contrast on the day of the outbreak, six received injections from the morning vial, and four received injections from the afternoon vial. All of the patients with MRSA infections received diluted contrast from the afternoon vial.

• **The three patients with MRSA infections went to a local hospital 4-8 days after their outpatient pain remediation procedures.** They required inpatient care for severe infections, including acute mediastinitis, bacterial meningitis, epidural abscess, and sepsis. Hospitalization ranged from 9 to 41 days, with additional long-term acute care required for one patient. The fourth recipient of diluted contrast from the afternoon vial was found deceased at home, six days after treatment at the clinic. The cause of death was reported as multiple-drug overdose; however, invasive MRSA infection could not be ruled out,

"These breaches resulted in life-threatening — yet completely preventable — infections in a number of patients receiving injections for pain relief," Bell noted. "In both outbreaks, healthcare providers were splitting single-dose/single-use medication vials meant for one patient into new doses for multiple patients. There was a lack of awareness that this practice puts patients at risk of infection. Because injections were prepared with new needles and syringes and, in one of the clinics, in a separate "clean" medication preparation room, providers thought they were being safe. However, these preservative-free medications are not safe for multipatient use."

In both outbreaks, providers reported having difficulty obtaining smaller vial sizes that better matched patient treatment needs because of a shortage or because the smaller vial size isn't manufactured.

"These scenarios do not excuse unsafe practices," Bell says. "However, providers do have options. High-quality pharmacies that adhere to standards in United States Pharmacopeia General Chapter 797 can be used to more safely split doses from SDVs to increase availability, prevent waste, and minimize risk to patients. In addition, some providers are using appropriate alternate medications in times of shortage."

In response to the Arizona outbreak, the state Department of Health Services provided recommendations to the facility regarding standard precautions, including safe injection practices, and CDC's *Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care*. In response to the Delaware outbreak, providers and ancillary staff received extensive education regarding standard precautions. *(For a copy of the CDC report, go to http://1.usa.gov/OA1AQF.)* ■

Tablet computers help distract during cases

Whether it's the smartphones, tablet computers, or e-readers, new technology is all the rage these days. At the Shriners Hospitals for Children in Erie, PA, this mobile technology is being used to help patients.

The child life department at Shriners Erie recently received a donation of three tablet computers to be used with patients facing challenging procedures in the facility's Ambulatory Surgery Center and Outpatient Specialty Care Center. As nurses and physicians administer treatments and perform procedures, children can become anxious. With the tablet computers, the child life staff can download applications providing interactive games, puzzles, and cause/effect type programs. Working alongside the nurses and medical staff, child life specialists are present during procedures to help decrease patient anxiety, promote positive coping skills, and support the use of the tablet computer.

Programs are available for all developmental levels from toddlers to teens. These activities provide cognitive distraction from the stress of medical procedures. The tablet itself can be used as a barrier to block the line of sight for procedures and can be placed in a variety of positions depending on the procedure.

"Using the iPad gives patients a specific role during the procedure and helps them focus while distracting them from stress," said **Kristin Maguire**, child life specialist. "The nurses and physicians can complete procedures efficiently and effectively when patients are calm and relaxed."

Maguire noted that the child life staff also uses the tablets to teach patients about various procedures they might experience. "Providing information in developmentally appropriate language helps the child

understand what will take place; what they will see, feel, hear, and smell," she said. ■

NQF board endorses patient safety measures

The National Quality Forum (NQF) board of directors has endorsed 14 patient safety measures with a focus on complications. The measures address a range of quality concerns, including surgical safety, medication safety, venous thromboembolism, and care coordination.

"Preventable errors in healthcare are costing Americans in a number of ways, whether in premiums, lost work time and wages, or undue stress and anxiety for patients and families," said **William A. Conway**, MD, senior vice president and chief quality officer at Henry Ford Health System in Detroit and co-chair of the Patient Safety — Complications Steering Committee. "This measure set will ensure the healthcare community has the right measurement tools to help alleviate these burdens and provide patients with high-quality care."

Endorsed measures are:

• 0267: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (Ambulatory Surgical Center Quality Collaboration);

• 0344: Accidental Puncture or Laceration Rate (PDI 1) (Agency for Healthcare Research and Quality, AHRQ)

• 0345: Accidental Puncture or Laceration Rate (PSI 15) (AHRQ);

• 0362: Foreign Body left after procedure (PDI 3) (AHRQ);

• 0363: Foreign Body Left During Procedure (PSI 5) (AHRQ) ;

• 0263: Patient Burn (Ambulatory Surgical Center Quality Collaboration) ;

• 0022: Use of High Risk Medications in the Elderly (National Committee for Quality Assurance);

• 0372: Intensive Care Unit Venous Thromboembolism Prophylaxis (The Joint Commission);

• 0373: Venous Thromboembolism Patients with Anticoagulant Overlap Therapy (The Joint Commission);

• 0450: Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12) (AHRQ);

• 0346: Iatrogenic Pneumothorax Rate (PSI 6) (AHRQ);

• 0348: Iatrogenic Pneumothorax Rate (PDI 5) (AHRQ);

• 0349: Transfusion Reaction (PSI 16) (AHRQ) (reserve status);

• 0350: Transfusion Reaction (PDI 13) (AHRQ) (reserve status).

The measures include only those that have been endorsed for at least three years and are now undergoing NQF endorsement maintenance. The ongoing evaluation and updating of endorsed measures ensures they are current and relevant to NQF's patient safety portfolio. In all, 27 measures were evaluated against NQF's endorsement criteria, with 14 receiving endorsement status. Three measures still are under consideration.

Pamela Cipriano, PhD, RN, senior director at Galloway Consulting and co-chair of the Patient Safety Measures steering committee, said, "These measures are an important part of the NQF measure portfolio. They help providers examine adverse events and increase accountability to implement improvements that will protect patients and enable the safe, high-quality, and compassionate care they deserve."

NQF is a voluntary consensus standards-setting organization. ■

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

■ Can you stop testimony from a lying "expert"?

■ Latest quality data for ambulatory surgery

■ Successful strategies for your next survey

■ Unexpected source for benchmarking data

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 are providers' concerns about the Independent Payment Advisory Board (IPAB), according to Bill Prentice, CEO of the Ambulatory Surgery Center Association?
   A. That hospital payments will be cut, which will impact hospital-affiliated surgery centers.
   B. That benefits will be targeted for cuts.
   C. That it will be a "black box" and lead to cuts that don't make sense.

2. Butler County Health Care Center (BCHCC) reduced patient falls by 88% by using the free Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) program offered by the Agency for Healthcare Research and Quality to do what?
   A. A. Identify problems and improve communications.
   B. Pinpoint providers who had safety issues.
   C. Pinpoint departments that had safety issues.

3. Which of the following were used by BCHCC as part of TeamSTEPPS?
   A. A stuffed penguin mascot holds the name of a TeamSTEPPS tool or strategy. A weekly prize is drawn for employees who list where they found the penguin, his message, and how/where can it be used.
   B. A cartoon penguin character alerts staff about new policies or other important information.
   C. A temporary, unfinished wall in the dining room was made into a TeamSTEPPS graffiti wall.
   D. All of the above

4. According to Stephen W. Earnhart, MS, CEO, Earnhart & Associates, what question(s) should all outpatient surgery managers ask?
   A. What is our collection rate?
   B. How much is written off as uncollectable?
   C. What are our days in accounts/receivable?
   D. All of the above.

SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission and AAAHC Standards

Want to ace infection control part of your survey? Perform an audit of your hand hygiene program

Outpatient surgery programs around the country are reporting that accreditation survey teams are sending an additional surveyor who targets infection control during the survey process.

"It's a big deal for certification and surveyors," says **Richard Bays**, RN, MBA, CPHQ, CLNC, of R Bays Consulting in Houston, TX.

Before you undergo a survey, set an initial baseline of compliance by gathering data from direct observation audits of staff, advises **Kathleen Richmond**, RN, MS, CIC, associate director of the Standards Interpretation Group, Division of Healthcare Improvement at The Joint Commission. [*Two handwashing audit tools are included with the online edition of this month's* Same-Day Surgery. *The Hand Hygiene Monitoring Tool was adapted for larger facilities. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

There is no requirement for that compliance rate, Richmond says. Subsequently, set a realistic compliance goal that is higher than the initial baseline. "For example, an organization may have an initial baseline compliance of 64%, and its first quarterly goal might then be set at 75% followed by 80% for the next quarter," Richmond says.

EXECUTIVE SUMMARY

A hand hygiene audit tool can prepare your program for the infection control piece of accreditation and licensing surveys.

- Determine your baseline level of compliance and measure your progress with an audit tool. *(Two are enclosed with the online copy of this issue of* Same-Day Surgery.*)*
- Identify the source of problems, in terms of departments and staff level.
- Ensure employees wash their hands, even after removing gloves.

Have the safety officer or infection control nurse monitor the rate weekly or monthly unless you have a problem that needs to be addressed immediately, Bays suggests. Such problems might include a report of a case infection from improper hand hygiene or not changing gloves between patients, which potentially could lead to an infected surgical wound when a dressing is changed, for example.

At the infection control meetings, discuss the results of your audit and any improvement or problems since your baseline recording, Bays advises. "If there is any deviation toward goals, take appropriate action and record that," he says.

Advertise the results of the audit to members of your staff, he advises. If the results are of your audit are less than 100%, talk about the results, and post updates in lounges or employee newsletters, Bays advises. If it's 100% compliance, tell them to keep up the good work, Bays says. At Spring Surgical Center in The Woodlands, TX, "we reward our staff and celebrate with cake, ice cream, and lunches. It varies," says **Elda Navarro**, business office manager.

Bays urges you to aim for full compliance. "I think, given a moderate amount of effort, you can reach 100%," he says.

The most important step? Share compliance data, Richmond says. "Staff should then be enlisted to get involved in improving the organization's hand hygiene compliance and take ownership of the results," Richmond says.

All levels of staff should participate with hand hygiene compliance, Bays advises. "It shows some cohe-

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siveness with meeting infection control practices," he says.

What do surveyors expect?

What is one of the most important preventative measures in decreasing healthcare-associated infections (HAIs)? According to Richmond, it is "improving the hand hygiene of healthcare workers."

The Joint Commission's National Patient Safety Goal (NPSG) 07.01.01 requires facilities to comply with hand hygiene guidelines from the Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the World Health Organization (WHO).

"It is essential to the accreditation survey process that an organization fosters a culture of hand hygiene and that appropriate hand hygiene is evident to the surveyors," Richmond says. "An organization with a comprehensive hand hygiene program will have compliance monitoring through direct observation and feedback to the staff in order to promote continual improvement."

Accreditation surveyors will expect that the level of complexity of your hand hygiene program matches the complexity of your program, Bays says. "If it's extremely complex, it's going to take a more complex [hand hygiene] program," he says.

The Accreditation Association for Ambulatory Health Care (AAAHC) requires that organizations adopt nationally recognized guidelines for handwashing, such as one from WHO, the CDC, the Association for Professionals in Infection Control and Epidemiology (APIC), or the Association of perioperative Registered Nurses (AORN).

"We don't care which one or which combination," says **Jack Egnatinsky**, MD, the immediate past chair of the AAAHC Board of Directors and one of two medical directors for AAAHC. Egnantinsky also performs surveys.

Once a program's leaders have adopted one set of guidelines, they must provide education and active surveillance, including in the area of hand hygiene, he says. Also, Medicare surveys have an infection control questionnaire, Egnatinsky points out. "They have a whole section that deals with hand hygiene," which supplements and complements the AAAHC standards, he says.

Also the AAAHC surgical services chapter requires organizations to have a written policy on appropriate and timely surgical hand antisepsis. Additionally, AAAHC surveyors follow patients from admission to the postoperative care unit (PACU). "Some of the observations we are looking for is to see if they are compliance with their organization's policy on hand disinfection," Egnatinsky says.

The growing interest of accreditation surveyors in infection control means a renewed focus by healthcare facilities, Bays says. Ten years ago, infection control used to be the job of one or two people, he says. "We've tried to expand it to everyone who comes in touch with patient care areas or patients themselves," Bays says.

Still, you need a leader, Bays says. "I see problems when there's not a champion or someone overlooking program," he says. "Otherwise, you may have audit, but it falls off and doesn't get reported to the committee." *(See tips for improving compliance, below.)* ■

Steps to help you improve compliance

If you find that your staff's hand hygiene compliance is less than stellar, drill down to try to identify where the problem is, suggests **Richard Bays**, RN, MBA, CPHQ, CLNC, of R Bays Consulting in Houston, TX.

"For example, are you lacking compliance in preop, postop, or the OR?" Bays says. "Or is the compliance problem with a level of employee, such as nursing"

The problem might be mechanical in nature, Bays says. "For example, if you have a wall-mounted antisepsis, it's sometimes not in a place convenient for actual practice," he says. "Instead, it is in a place where it was convenient to mount."

Talk to staff to determine the problem, he advises. You might find that a sink is broken, and members of the staff have to go to a different department to perform hand hygiene. An antisepsis dispenser might always be empty, or a sink might frequently be out of paper towels. "Those are things that can sink your program," Bays says.

If you want to improve hand hygiene performance and compliance, staff education is a key factor, says **Kathleen Richmond**, RN, MS, CIC, associate director of the Standards Interpretation Group, Division of Healthcare Improvement at The Joint Commission. *(The Joint Commission offers a Targeted Solutions Tool [TST] for hand hygiene that can be found on The Joint Commission Center for Transforming Healthcare's website at http://bit.ly/NrD0pZ.)*

Consider these additional tips:

• Focus on hand sanitizers.

Provide antiseptic hand sanitizers on a wall and also distribute individual sanitizers to staff members to keep in their pockets, Bays suggests.

"When surveyors come out, you may be doing great job, but they have to see it to 'give you points,'" he says.

• Disinfect the hands after removing gloves.

Medicare standards says that even if staff members

are performing hand hygiene and wearing gloves, they are expected to disinfect their hands after contact with blood and body fluids, says **Jack Egnatinsky**, MD, the immediate past chair of the Accreditation Association for Ambulatory Health Care (AAAHC) Board of Directors and one of two medical directors for AAAHC.

"People think when they're wearing gloves, that's all they have to do," Egnatinsky says. "But they can create environment for bacteria to grow rapidly with higher body temperature and higher humidity that comes with sweating in gloves. "

As a surveyor, this is the area where he has seen the greatest failure to comply with policies. "Physicians are usually the people who don't follow that," Egnatinsky says.

• Don't forget the physicians.

Physician compliance is a sticking point for many programs, Bays admits.

"Spend time with the doctors," he advises. "They tend to be forgetful, but once they get into the habit, it tends to stick."

Egnatinsky says to educate everyone, from aides and nurse assistants to nurses and physicians, "anybody at all that has any direct contact with patients or equipment used by patients. It's a simple thing to do, and it has such as positive impact on outcomes." ■

Posters let patients access safety info on smartphones

Program offers education at bedside, during care

The SAFE CARE Patient Safety Education program uses free posters that healthcare facilities can hang in patient rooms or patient care areas that allow patients and families to instantly access and watch safety videos by topic.

Patients and family members can watch the videos on their own smartphones by simply pointing a smartphone at a QR code on the poster or texting the word "SAFE" to 411247 to receive a link to Safe Care's safety video library. The nine short videos address the most common patient safety issues in healthcare facilities including hand hygiene, preventing infections, avoiding medication errors, and patient falls. Organizations are also able to customize the videos for a fee. For the free version, you must be able to print on 11 x 17 paper. *(For more information, go to http://safecarecampaign.org/poster/welcome.html.)*

The SAFE CARE program was developed to assist healthcare organizations in educating patients to help prevent medical errors. The campaign features videos from The Joint Commission's Speak Up campaign, the Centers for Disease Control and Prevention (CDC), Kimberly-Clark, the Patient Channel from The Wellness Network, and Safe Care Campaign. ■

AAAHC tailors program for office-based centers

Hospital survey program also pilot tested

The Accreditation Association for Ambulatory Health Care (AAAHC) has announced an accreditation program that is tailored to the specific needs of practices that offer office-based surgery (OBS), and it is priced to be cost-effective for smaller practices. AAAHC defines an OBS center as an organization that has no more than four physicians/dentists and no more than two operating/procedure rooms.

"All organizations, including OBS centers, must meet nationally recognized standards to be accredited by AAAHC, but as healthcare evolves, new types of organizations with different needs and perspectives have sought accreditation," said **John Burke**, PhD, AAAHC president and CEO. "In response, AAAHC has developed innovative programs to meet the unique needs of these organizations, including those that perform office-based surgery."

Features of the OBS Accreditation program include:

• The AAAHC OBS Standards are written as statements describing the characteristics required of an accreditable organization. The Accreditation Handbook for Office-Based Surgery with Review Guidelines is a tool that gives OBS organizations a clearer understanding of how compliance with each of the standards will be assessed.

• A reduction in accreditation fees has been made to reflect the smaller size of OBS organizations compared to ambulatory surgery centers (ASCs). The total cost of $3,500 includes a $775 application fee and a $2,725 fee for the onsite survey and related activities. All subsequent surveys also cost $3,500.

AAAHC also recently announced the launch of a new accreditation program for hospitals. The accreditation, which will focus on small hospitals located in rural, urban, and suburban regions in the United States, will be offered through the Accreditation Association for Hospital/Health Systems (AAHHS). AAHHS and AAAHC will have separate governing boards and function independently as operating entities of an umbrella organization, The Accreditation Association. The hospital accreditation will be launched as a pilot program in 2012. ■

Joint Commission updates FAQ

The Joint Commission has updated its frequently asked question about non-licensed, non-employee individuals for the ambulatory, hospital, critical access hospital, and office-based programs, as well as home care, laboratory, and long-term care programs.

In the "Human Resources" section, The Joint Commission has the following question listed: "What are The Joint Commission's expectations regarding non-licensed, non-employee individuals in health care organizations, including health care industry representatives (HCIRs)?"

The Joint Commission's updated response includes the following (with new information in boldface): **"For non-employees brought into the organization by licensed independent practitioners,** there are two additional requirements regarding qualifications and competence of these individuals (HR.01.02.05, EP 7 and HR.01.07.01, EP 5). **Note: This requirement does not apply to health care industry representatives as they are not under the direction of a licensed independent practitioners.**" *(Editor's note: HR.01.02.05 EP 7 addresses review of the qualifications of a nonemployee who enters the facility through a licensed independent practitioner to provide care, and HR.01.07.01 EP 5 addresses review of the performance of a nonemployee who enters the facility through a licensed independent practitioner to provide care.)* ■

Joint Commission's video highlights patient rights

The Joint Commission has released its seventh episode in the animated Speak Up video series, "Speak Up: Know Your Rights." The new video features characters as they depict the rights every patient should expect from their caregivers.

"Speak Up: Know Your Rights" emphasizes that everyone has the right to:

- be informed about the care they will receive;
- make decisions about their care, including refusing care;
- have their pain treated;
- receive information about their care in their own language;
- be provided with an up-to-date list of their current medications; and
- be listened to and treated with courtesy and respect.

Produced by The Joint Commission, Speak Up's 60-second videos are intended as public service announcements. The series airs on The Joint Commission's YouTube Channel, (http://www.youtube.com/TheJointCommission) and other venues. This latest Speak Up video provides viewers with tips to help them better understand their rights as a patient.

Previous videos in the series emphasize the importance of being comfortable speaking up and asking questions about healthcare; preventing infection; managing and taking medication safely; preparing for, and what to ask during, doctor's office appointments; encouraging children to feel confident asking questions about their health; and reducing the risk of falling.

The Joint Commission's award-winning Speak Up program also features brochures and posters on patient safety topics. The national program urges patients to take a role in preventing healthcare errors by becoming active, involved, and informed participants of the healthcare team. The basic framework of the Speak Up campaign encourages patients to:

Speak up if you have questions or concerns. If you still don't understand, ask again. It's your body, and you have a right to know.

Pay attention to the care you get. Always make sure you're getting the right treatments and medicines by the right healthcare professionals. Don't assume anything.

Educate yourself about your illness. Learn about the medical tests you get and your treatment plan.

Ask a trusted family member or friend to be your advocate (advisor or supporter).

Know what medicines you take and why you take them. Medicine errors are the most common healthcare mistakes.

Use a hospital, clinic, surgery center, or other type of healthcare organization that has been carefully checked out. For example, The Joint Commission visits hospitals to see if they are meeting The Joint Commission's quality standards.

Participate in all decisions about your treatment. You are the center of the healthcare team.

Since its launch in 2002, the Speak Up program has grown to include 19 campaign brochures and five posters, as well as Spanish language versions of all brochures. Free downloadable files of all Speak Up videos, brochures and posters (including Spanish language versions of the brochures) are available on The Joint Commission website at: http://www.jointcommission.org/speakup.aspx. Speak Up brochures and posters also are available for purchase through Joint Commission Resources at (877) 223-6866 or online at www.jcrinc.com. ■

Hand Hygiene Monitoring Tool

Month/Year _____

Initials of Monitor:_____

Healthcare Worker (HCW) Type:

1 = Physician
2 = Anethesia
3 = Medical Student
4 = Physician Assistant
5 = CRNA
6 = Nurs Asst
7 = Registered Nurse
8 = Licensed Practical Nurse
9 = Technician
10 = Radiology Tech
11 = Environmental Services Worker
12 = Other

HW = Hand Wash
HR = Alcohol Hand Rub
Y = Yes
N= No

# Obs	Date	Dept	HCW Type	Hand Hygiene BEFORE Touching Patient				Hand Hygiene AFTER Touching Patient, Environment, or Objects				Patient Contact Precautions Required		Gloves Worn			Gown Worn		
		(Pre,Post,OR)	(See Key)	Yes HR	Yes HW	No	N/A	Yes HR	Yes HW	No	N/A	Y	N	Y	N	N/A	Y	N	N/A
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
	Totals																		

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INFECTION CONTROL – HAND WASHING AUDIT

Instructions:
• Circle the applicable response, as well as information on the manner in which information was obtained
• If N/A is circled, please explain why there is no associated observation, or why the question is not applicable

I. Hand Hygiene - Additional Instructions:
• **Observations are to focus on staff directly involved in patient care (e.g., physicians, nurses, CRNAs, etc.).** Hand hygiene should be observed not only during the case being followed, but also while making other observations in the ASC throughout the survey. Interviews are used primarily to provide additional evidence for what the surveyor has observed, but may in some cases substitute for direct observation to support a citation of deficient practice.

Practices to be Assessed	Was practice performed?	Manner of confirmation
A. All patient care areas have:		
a. Soap and water available	1 Yes 2 No 3 N/A	4Observation 5Interview 6Both
b. Alcohol-based hand rubs available	1 Yes 2 No 3 N/A	4Observation 5Interview 6Both
B. Staff perform hand hygiene:		
a. After removing gloves	1 Yes 2 No 3 N/A	4Observation 5Interview 6Both
b. After direct patient contact	1 Yes 2 No 3 N/A	4Observation 5Interview 6Both
c. Before performing invasive procedures (e.g., placing an IV)	1 Yes 2 No 3 N/A	4Observation 5Interview 6Both
d. After contact with blood, body fluids, or contaminated surfaces (even if gloves are worn)	1 Yes 2 No 3 N/A	4Observation 5Interview 6Both
C. Regarding gloves, staff:		
a. Wear gloves for procedures that might involve contact with blood or body fluids	1 Yes 2 No 3 N/A	4Observation 5Interview 6Both
b. Wear gloves when handling potentially contaminated patient equipment	1 Yes 2 No 3 N/A	4Observation 5Interview 6Both
c. Remove gloves before moving to the next task and/or patient	1 Yes 2 No 3 N/A	4Observation 5Interview 6Both
D. Additional breaches in hand hygiene, not captured by the questions above were identified (If YES, specify further in comments)	1 Yes 2 No 3 N/A	4Observation 5Interview 6Both
Comments:		