Same-Day Surgery®

35th Anniversary

Covering Hospitals, Surgery Centers, and Offices for More than 35 Years

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AHC Media

Avoid stolen and counterfeit devices, or risk liability for poor patient outcomes

Harmonic scalpels and staples were missing at a hospital in Florida. A review of videotapes showed what appeared to be a surgical resident leaving the equipment storage room with items he was not authorized to take. After a picture of the resident was circulated, a security officer noticed a man in scrubs resembling the photo going into the storage room. The resident eventually confessed to the theft and was arrested.

Subsequent investigation revealed he was selling the devices to a Florida medical supply company that advertised itself as being a distributor of recycled and used medical equipment. The resident was convicted of grand theft.

Sometimes there are red flags for such incidents, such as employees who appear to be living beyond their means. One hospital scrub tech reportedly was living in a $600,000 house, driving two new BMWs, and building some condominiums. The employee subsequently was found to be stealing medical devices from his hospital.

In the current economy, outpatient surgery providers are reporting increases in stolen and counterfeit items.

"If they are being sold out your back door by your own staff so they can make a few extra bucks, this is costly theft — not only the cost of replacing missing instrumentation, but the risks when a backup piece is not available

Upcoming issues: Salary survey results, plus special issue with cost-cutting success stories

Next month's issue of *Same-Day Surgery* will include the results of our annual salary survey. Find out how your salary compares with your peers. Also see what other outpatient surgery programs are doing to recruit and retain staff.

The February issue is one of our most anticipated issues of the year: an entire issue full of cost-cutting and revenue generating ideas. If you have some cost-cutting or revenue ideas that you would like to share with your peers, please contact Joy Daughtery Dickinson, editor, at (229) 551-9195 or joy.dickinson@ahcmedia.com.

Don't miss these special issues of *Same-Day Surgery*!

should a needed instrument break during a case," says **Mark Mayo**, executive director of the ASC Association of Illinois and principal at Mark Mayo Health Care Consultants, Round Lake, IL.

Hospitals and surgery centers might find themselves out more than a few dollars, however, says **Dan Kelley**, director of global brand protection, Ethicon Endo, Cincinnati. "If a facility elects to purchase from an unauthorized source, then it is buying products that have left the normal supply chain, which raises the potential for poor patient outcomes and subsequent liability," says Kelley. "The product may not have been stored or handled properly, which may create patient risk." Some counterfeit items have been found stored in residential garages in south Florida or other environments lacking cleanliness and temperature control, he says. "And if the general public knew those devices were going to be used on them, they would be shocked," Kelley says. "In addition the product may have been recalled or might be recalled in the future, and manufacturers would have no way of contacting you about those recalls," he says. For its part, Ethicon Endo-Surgery doesn't warrant or assume liability for products purchased from unauthorized sources.

Another concern is counterfeit devices that are deceptively passed off as an original product by copying the look of a genuine device. Some counterfeit devices are poor quality, manufactured from the wrong material, and/or may have questionable effectiveness, Kelley adds.

Could you identify a counterfeit item?

Based on the growing number of counterfeits items detected each year, counterfeit items aren't always easy to spot, Kelley says.

"Counterfeit packaging is deceptive and difficult to distinguish," he says. "Doctors, nurses, and patients think it's our product."

Consider the class I recall of counterfeit polypropylene surgical mesh in 2010. Various sizes of counterfeit flat sheets of polypropylene surgical mesh were marketed in the United States labeled with the C. R. Bard/Davol brand name. They were distributed for more than a year. RAM Medical admitted purchasing misbranded surgical hernia mesh from a company in the United Arab Emirates and in India. The company also acknowledged selling boxes of mesh containing numerous micro-

EXECUTIVE SUMMARY

The number of surgical devices and equipment that are counterfeit or stolen appears to be growing, and outpatient surgery providers could be held liable for poor patient outcomes.

- Only purchase items from manufacturers or authorized dealers.
- Track your equipment and device purchases, and ensure they line up with actual usage.
- Make sure missing items are reported, even if they are thought to be misplaced.
- For storage rooms, consider using card access, video cameras inside the room, and staff supervision.

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organisms to several distributors and individuals. *(For more information, go to http://1.usa.gov/clhXJD.)*

Another potential liability exists with products stolen out of hospitals. More than 60 people have been charged with theft since 2004, Kelley says. At ebay.com, there are hundreds of listings for any piece of surgical equipment, he points out. These are products that are not available in general merchandise stores, Kelley says. "The question everyone should be asking is, 'What's the source of that product?'" It might be safe to assume that the product is "walking out of hospitals," he says. *For more information on theft, see "Are staff stealing your supplies and selling them on the Internet?" August 2010, p. 85.)*

The counterfeit samples were not sterile although they were labeled as sterile. They had a weave pattern and structure that was different from the authentic mesh. The counterfeit mesh did not have properly finished selvage edges, and that factor might have allowed the counterfeit mesh to unravel. Also, the expiration dates on the labels of some of the counterfeit product samples did not match. RAM Medical was sentenced to three years of probation and ordered to pay a $100,000 fine and about $73,000 in restitution. Several lawsuits have been filed.

To avoid problems at your facility, consider these suggestions:

• Buy direct from a manufacturer or through authorized distributors.

Mayo says "I think you are going to find the bottom line here to be caveat emptor and make purchases from reputable vendors. People should not be out there on the internet or social media trying to save a few bucks buying instruments."

He admits that there is appeal to getting a deal on backup instrument tray sets when hospitals close or consolidate, but Mayo asks, "Is it worth the risk?"

Be wary of Internet promotions, e-mails, and flyer promotions, Kelley warns. Several sources are sending hospitals faxes and emails, and they say they can sell devices cheaper than hospitals can get from authorized sources. Managers are under pressure to cut costs, so they might be tempted to purchase from these sources, Kelley says.

Possible sources of diverted products include online auction sites; products stolen from hospitals; sales samples; damaged products, such as ones that are water damaged; obsolete hospital inventory; product that has been fraudulently rebated; product intended for training labs; and product imported from out of the United States, Kelley says.

• Track actual product usage versus purchases.

Look for shrinkage, Kelley advises "Figure out if you're losing product," he says. "You know what you used on patients. Make sure what you used on patients equals what you purchased."

Another tip is to look for appropriate product utilization. For example, look at number of reloads used per stapler. Facilities that use a particular Ethicon stapler should be buying about 5.5 reloads per stapler. "If they are buying too many reloads versus the number of their guns, they may have a theft problem," Kelley says. Ethicon runs quarterly reports and contacts facilities at which the number of reloads doesn't seem to match the number of stapler guns. If you use another manufacturer, ask what controls are being put in place to measure items such as this one, Kelley advises. Products that come in small packages like stapler reloads, and expensive capital equipment like flexible GI scopes are examples of common theft items.

At the Florida hospital where the resident thefts occurred, a large number of stents were replaced over several months. "I was called and asked what was my opinion of what was going on," says the director of security, who requested anonymity for this interview. "I said, 'They're being stolen.'"

• Ensure missing items are reported.

Employees often are reluctant to report missing items because they think the items simply are misplaced, says the security director at the Florida hospital.

Missing items probably are stolen, the security manager says. "Some equipment may be misplaced, but reporting lets security department know if there is a problem," he says. If the missing items are found later, the theft report can be amended, he says.

• Increase security.

At the hospital in Florida where the resident thefts occurred, the storage room had a combination lock. "Everyone had the combination," says the security manager. "The doctor told us if he forgot it, he asked, and someone would give it to him." The security staff had recommended changes before the thefts, but the recommendations were ignored, the security manager said.

Now the storage room has card access and a video camera inside the storage room. Additionally, one staff person is assigned to work in the room.

Ensure that your facility has small, high-value products in a secure location, and place cameras in high-dollar supply areas, Kelley advises. *(For more information, see "Video cameras shine as your best*

detective," April 2011 SDS*, p. 39.)*

Audit product-handling processes and identify areas of risk, such as your receiving dock and trash cans, Kelley says. Be on the lookout for employees exiting with boxes or bags, Kelley says. Also, conduct background checks on all employees, he suggests. *(For more information on background checks, see package of stories in July 2012* Same-Day Surgery*, beginning on p. 76.)*

"Make sure you've got proper processes in place to prevent people from stealing from you," Kelley says. ■

Preop guidelines published for geriatric surgery patients

Guidelines from ACS and American Geriatrics Society

New comprehensive guidelines for the preoperative care of elderly patients have been issued by the American College of Surgeons (ACS) and the American Geriatrics Society (AGS).

The joint guidelines, published in the October issue of the Journal of the American College of Surgeons, apply to every patient who is 65 years and older.

"The major objective of these guidelines is to help surgeons and the entire perioperative care team improve the quality of surgical care for elderly patients," said **Clifford Y. Ko**, MD, FACS, director of the ACS National Surgical Quality Improvement Program (ACS NSQIP) and the ACS Division of Research and Optimal Patient Care in Chicago, professor of surgery at University of California, Los Angeles (UCLA) and director of UCLA's Center for Surgical Outcomes and Quality.

The U.S. Census Bureau projects the percentage of men and women 65 years and older will more than double between 2010 and 2050 and will increase by 20% of the total population by 2030. In 2006, elderly patients underwent 32% of outpatient procedures and 35% of inpatient surgical procedures, according to the study authors.

Gisele Wolf-Klein, MD, FACP, FAGS, director of geriatric education at North Shore-LIJ Health System in Great Neck, NY, and professor of clinical medicine, Hofftra North Shore-LIJ School of Medicine in Hempstead, NY, is "delighted" at the recent release of the geriatric guidelines. "I believe more and more elderly are going to have to face surgery," Wolf-Klein says. "It is imperative that we develop higher quality care criteria for ambulatory surgery patients."

13 key areas to address

The guidelines recommend and specify 13 key issues of preoperative care for the elderly: cognitive impairment and dementia; decision-making capacity; postoperative delirium; alcohol and substance abuse; cardiac evaluation; pulmonary evaluation; functional status, mobility, and fall risk; frailty; nutritional status; medication management; patient counseling; preoperative testing; and patient-family and social support system.

Assessing patient cognitive ability and capacity to understand the anticipated surgery "is particularly important since we have data indicating that between one-third and one-half of patients over the age of 85 have a degree of cognitive impairment, which is often not appreciated and recognized by healthcare practitioners," Wolf-Klein says.

First, you need to make sure the patient understands the procedure and the informed consent process. "You need to make sure the patient has the cognitive ability to undertake the procedure, and to accept and fulfill the postop recommendations," she says. "In other words, if the surgeon recommends drops, ointment, dressing — whatever it is — a person with cognitive impairment might not be able to follow up."

She shares that one of her patients had inguinal hernia repair surgery while he was in Florida. Apparently the patient was told to return to have the sutures removed, but he didn't obtain follow-up care until he returned to New York and saw Wolf-Klein for a routine visit. The sutures had not been removed, and infection had developed.

To evaluate cognitive impairment, the guidelines suggests a "mini-COG" test based on a clock draw test that Wolf-Klein published about in the mid-1970s. The mini-COG suggests having a patient remember three words, then draw a clock, then repeat the three words. This test is essential but often overlooked, Wolf-Klein says.

A depression screen also is important, she says. Depression is frequently seen in older patients, and those patients typically do worse after surgery because they don't have the will to carry on and they don't comply with their surgeon's recommendations, Wolf-Klein says.

Equally important is the suggestion to identify patients at risk for developing postop delirium, which is often under-recognized and under-treated, she says. While most staff can recognize the signs of hyperac-

tive delirium, they don't always recognize the signs of hypoactive delirum, when the patient is staring and vague. Patients in that condition often don't have the capacity to carry out the surgeon's recommendations, Wolf-Klein says.

The expert panel recognized there are complex problems specific to the elderly, including use of multiple medications, functional status, frailty, risk of malnutrition, cognitive impairment, and comorbidities. "When surgeons evaluate elderly patients before they undergo operations, they want to know how many and what specific medications their patients are taking. This step will enable them to identify potential medication issues before operations and before the surgeons start adding pain medication to the patient's medication list," Ko explained.

The guidelines state that you should "consider minimizing the patient's risk for adverse drug reactions by identifying what should be discontinued before surgery or should be avoided and dose reducing or substituting potentially inappropriate medications."

Check for underlying medical problems

The number and severity of underlying medical problems call for special strategies by the entire surgical team, according to Ko.

"Patients who are 90 years old tend to have more comorbidities than those who are 65 years," he said. "There may be something wrong with the heart, the lungs, the kidneys, the liver. Surgeons have to plan and deal with these comorbidities simultaneously while the patient is undergoing a surgical procedure."

The guidelines state that evaluating patients for developing heart disease and heart attack is critical to identify patients at higher risk. All patients should be evaluated for perioperative cardiac risk.

"Caring for the elderly generally requires a team approach," said Ko. "The surgeon knows how to perform surgery, and the cardiologist knows how to take care of the heart. It's best for everyone to work together to take care of the patient. We want everyone on the same page of providing good quality care."

ACS NSQIP has worked with the Centers for Medicare and Medicaid Services (CMS) to develop "The Elderly Surgery Measure." This hospital-based measure assesses the outcome of elderly patients undergoing surgery. At press time, the ACS and CMS were scheduled to launch a pilot program in October that would give hospitals the opportunity to publicly and voluntarily report the outcome results. *(For more information on caring for geriatric patients, see "Ways you can tackle concerns with geriatrics,"* Same-Day Surgery, *September 2010, p. 101.)* ■

ASC foundation awards $58,000 in scholarships

3-year-old program has surpassed fundraising goals

When you hear about foundations giving scholarships in the healthcare field, you normally think of hospitals. But leaders at one large multi-specialty surgery center haven't let the fact that they run a freestanding surgery center stop them from making a difference in their community. The Bend (OR) Surgery Center Foundation has awarded $58,000 in scholarships over the past three years to approximately 64 area high school seniors interested in entering the medical profession.

Here is how they did it:

• Establish a board, and apply for non-profit status.

"We essentially put a board together from community partners that we have as a surgery center," says **Neal Maerki**, RN, CASC, president of the foundation. That board included an attorney, accountant, a vice president of banking, a surgery center physician, the center's human resources/accounting director, a nursing professor from the local community college, and Maerki.

The board went through the application process to be designated as a 501(c)3 not-for-profit organization.

EXECUTIVE SUMMARY

The Bend (OR) Surgery Center Foundation has awarded $58,000 over the past three years to area high school seniors interested in entering the medical profession.

- A board was established, and not-for-profit status was obtained. Many of the board members belonged to organizations that became partners for the foundation.
- An annual music event is the fundraiser for the foundation. It includes a silent auction, live auction, and "Paddle Up."
- Student applicants must have participated in a medical career class at their schools or volunteered in the medical profession. They must have a 3.0 grade point average.

• Find partners for the foundation.

One of the lessons the foundation leaders have learned is that when putting together a foundation, don't sell yourself short.

"Initially we thought, we will raise no more than $7,500," Maerki says. However, the foundation has partners committed to paying from $500 to $5,000 and up for each year they elect to be partners.

The first year, partners included the center's anesthesia group, a large clinic that used the surgery center, the law firm and bank represented on the foundation board, and the surgery center itself. "We [the surgery center] have not thrown a ton of money at the foundation," Maerki says. "We don't want it to be relying solely on the ASC. We rely on partnerships."

At the lowest level, a $500 partner is listed on the back of the program at the annual fundraiser, plus it is listed on a computer presentation at the beginning and intermission of the event. At the highest level, $5,000 partners are mentioned as sponsors in advertisements on television, radio, and in print media. They also are given tickets to the event.

• Plan a fundraiser.

The annual fundraiser is a music event held at a local theater that the surgery center helps to support. "In return, we get one night's use of the theater, which we gift to the foundation," Maerki says.

Two of the three previous fundraisers have included music from groups made up of physicians and some nurses. For the upcoming year, the foundation is exploring the hiring of a well-known act.

In addition to the sponsorships, funds are raised through a silent auction, a live auction, and a "Paddle Up." Each attendee is given a program and a paddle with a number for bidding. Students who have received previous scholarships provide a testimony about how the scholarships have helped them. The testimony is followed by the auctioneer or member of the foundation ask if anyone will provide a $10,000 or $5,000 scholarship. After those gifts are recorded, the announcer continues to ask for scholarships in decreasing amounts down to $50. "When we get to the $1,000 range, we have multiple responses," Maerki says. "Last year, we raised $7,000 in the Paddle Up."

This year the foundation added a pre-event dinner and cash bar at a local Japanese restaurant with a sushi bar. Title sponsors were given 10-12 tickets each. "It was a huge success," Maerki says. "We thought we'd have about 50 people, but 80% of the people who could come, did."

Each year the fundraiser has raised between $45,000 and $53,000 for scholarships. About eighty cents of every dollar is used for the scholarships themselves. Approximately $48,000 has been put into a reserve fund that will be available for students who complete undergraduate degrees in the future to receive as graduate scholarships of $5,000 to $10,000.

• Award scholarships.

The foundation's scholarships are given to 11 area high schools. The student must have participated in a "Careers to Healthcare Pathways" class at their school, which exposes them to the medical field, or volunteered in the medical field in some capacity. Also, the student must have a 3.0 grade point average. The students must submit transcripts with their application, which includes three essay questions. The students respond to those questions with 100-word answers.

Each year, the foundation has received 39-47 applicants. The applications are de-identified. A committee of three persons reviews the applications, with at least two members reviewing each application. Each student is given a combined score of 1-10. The highest scoring students receive the largest scholarships. The highest scholarship amount, which goes to one person, is $5,000.

"I think there's some good community benefit and potential positive down the road in terms of having some scholarship recipients come back and practice medicine," Maerki says.

RESOURCE/SOURCE

• **Bend (OR) Surgery Center Foundation.** Web: http://www.bendsurgerycenterfoundation.org.

• **Neal Maerki**, RN, CASC, President, Bend (OR) Surgery Center Foundation. Email: NMaerki@bendsurgery.com. ■

Same-Day Surgery Manager

Year-end cleanup: 10 lessons we learned

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

It has been a wonderful year, right? Some will nod; others will not. It has been a mixed year for me. Relocating to Houston was good. We said goodbye

to some clients and hello to others. Ebb and flow. We learned a lot, though. Take a look:

• **Employee theft.**

We discovered a new way to steal, sadly. While preparing for some clients' employee reviews, we found some staff members at several locations were in cahoots with the business office staff. The scam was that some employees' PTO (paid time off) had been tampered with and up to several weeks of PTO had been secretly added to their account. It is apparently pretty widespread. You might want to audit your PTO accounts.

• **Unit pricing.**

While many facilities are showing the unit price of each item in their supply rooms, they are not keeping up with price changes.

• **Reimbursement mismatch.**

More than you would think, facilities are not being reimbursed their contracted rates. You need to dig into the computer and check. Sadly, we are finding too many office managers are just not doing their job. Some facilities are underpaid, while other are overpaid. The bad news is that you need to discover on your own the underpaid. The overpaid eventually are discovered by the payer, who will come back at you for a refund. That's not cool if it already has been spent.

• **Unrealistic budgets.**

Since when did you decide not to do a budget? We review so many unrealistic budgets that we are amazed at how blind the financial community has become. It is so much easier in the long run to prepare a budget that is at least in the ballpark rather than constantly trying to justify one that is not.

• **Anesthesia — 2013.**

This year just might be the year you hire your own anesthesia staff and get away from the burdensome chains around your ankles. Surgery is usually uncomfortable without anesthesia, but some anesthesia groups have become so large and inflexible that you might be tempted to try. The stipends and restrictions that many hospitals and surgery centers pay or tolerate for coverage is becoming ridiculous. It might be time to consider alternatives.

• **Regulatory compliance.**

Do you know what Medicare changes have taken place for 2013? Do you know the new accreditation standards? Tick-tock-tick-tock…

• **Accountable care.**

You think you hate the paperwork now? Just wait. Much like an undertaker secretly enjoys a good plague, the insurance companies are gleefully rubbing their hands at the prospect of reducing payments to you because of poor outcomes. You better get caught up on this change!

• **Surgeon retention.**

While there are some you hope will leave, most of them you need to hang on to. While many surgery center managers are tracking surgeon's utilization, most of our hospital clients are not! Well, they are, but no one reads the printouts. We can't blame them too much as there is so much other paper that is screaming for attention. But still.

• **Nasty staff.**

Back stabbing, passive-aggressive, lazy, incompetent, moronic, and just plain rude employees seem to be gaining a foothold in many facilities. Why? I know it is a legal minefield getting rid of these individuals, but they seem to be growing at an alarming rate, and they are being tolerated. Do what you want, but wow!

• **Parties.**

December is a good time for staff parties, but you need to incorporate more during the year. Have as many get-togethers as you can afford in 2013. My experience is that a cohesive staff is a happier staff, and a happy staff typically has better outcomes. Enjoying your job more in 2013 would be a cool thing. Party on! Thank you, and HAPPY HOLIDAYS! *[Editor's note: Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates' 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.]* ■

AAAHC institute releases new benchmarking data

New reports issued in 2012 by the AAAHC Institute for Quality Improvement offer performance measurement and benchmarking data for four of the most common outpatient procedures: cataract surgery, colonoscopy, low back injection, and knee arthroscopy.

The reports include data such as preoperative techniques, complications, non-routine procedures, anesthesia, wrong-site surgery prevention and patient outcomes. They also include information about factors such as staff and supply costs. The studies were performed between January and June 2012. The procedures are:

• **Colonoscopy.** Data were submitted on 2,086 cases by 61 organizations. Combined, the organizations perform more than 241,220 colonoscopies annually.

— Pre-procedure times ranged from 12 to 97

minutes (median 62). Organizations with the shortest procedure times used processes that included preparing the patients and paperwork prior to arrival and having patients arrive only 15 to 30 minutes prior to the time the procedure is scheduled.

— Procedure times ranged from 9 to 27 minutes (median 18).

— Discharge time ranged from 13 to 62 minutes (median 36). Organizations with the shortest discharge times attributed their results to use of short-acting anesthesia.

— Total facility time ranged from 57 to 166 minutes (median 121).

— Patient outcomes. Follow-up surveys with patients found that:

- 97% indicated that they were able to schedule their procedures as soon as they wanted;
- 100% said they had an adequate understanding of the procedure;
- 76% said they experienced little or no discomfort during their bowel preparation;
- 99% said they experienced little or no discomfort during their procedure;
- 99% said they were comfortable post-discharge;
- 100% said they received written discharge instructions;
- 98% said they would recommend the procedure to a friend;

• **Knee arthroscopy.** Information on 796 cases was submitted by 33 organizations. The organizations perform a total of more than 18,706 procedures annually. The five most frequent indications for the procedure were joint line tenderness, painful catching/popping/locking, effusion, positive McMurray's test, and arthritis.

— Pre-procedure times ranged from 24 to 115 minutes (median 90). Organizations with the shortest pre-procedure times attributed their results to practices such as calling their patients the day before the procedure to remind them of their appointment time and making sure patients understand the pre-procedure requirements.

— Procedure times ranged from 17 to 42 minutes (median 27).

— Discharge time ranged from 48 to 113 minutes (median 71). Organizations with the shortest discharge times attributed their results to factors such as having patients leave the OR as they are waking up so their comfort level can be assessed as soon after the procedure as possible.

— Total facility time ranged from 119 to 246 minutes (median 192).

— Patient outcomes. Follow-up surveys with patients found that:

- 88% were able to schedule their procedures as soon as they wanted;
- 99% had an adequate understanding of the procedure;
- 99% experienced little or no discomfort during the procedure;
- 99% were comfortable post-discharge;
- 100% received written discharge instructions;
- 96% had begun walking (with or without crutches);
- 98% would recommend the procedure to a friend or relative.

• **Pain management — low back injection.** Information was submitted on 488 cases by 25 organizations that perform nearly 52,491 procedures annually.

Pre-procedure times ranged from 16 to 102 minutes (median 53). Organizations with the shortest pre-procedure times attributed their results to processes that included sufficient staffing and preparation prior to the procedure day.

Discharge time ranged from 9 to 48 minutes (median 25). Organizations with the shortest discharge times attributed their results to sufficient staffing.

Total facility time ranged from 49 to 166 minutes (median 92).

— Patient outcomes. Follow-up surveys with patients found that:

- 93% indicated they were able to schedule their procedures within a reasonable time;
- 99% said they had an adequate understanding of the procedure;
- 82% reported that they were performing their usual daily activities;
- 77% indicated that their pain had improved;
- 6% had reduced their pain medications;

• **Cataract extraction with lens insertion.** Sixty organizations submitted information on 1,884 cases. These organizations account for more than 120,734 cataract surgeries performed annually.

— Pre-procedure times. The pre-procedure time (defined as patient check-in to start of the procedure) ranged from 26 to 143 minutes (median 83). Organizations with the best pre-procedure times attributed it to policies such as optimal staffing, chart audits prior to admission, procedure room supply and use efficiencies, and standardization of forms.

— Procedure times. Average procedure times (defined as the time the procedure starts; i.e., incision, to the time the procedure has ended; i.e., dressing on) ranged from 6 to 34 minutes (median 14). Average procedure times were lowest for those that used IV plus topical or peribulbar (15 minutes) and greatest for IV plus retrobulbar block (25 minutes).

— Discharge times. The median discharge time (defined as end of the procedure until patient meets

discharge criteria) was 21 minutes (range 9 to 57). Organizations with the shortest discharge times attributed their results to practices such as appropriate patient education and preparation, minimizing sedation for most patients, streamlining paperwork, and adequate staffing.

— Facility time. Facility time is the time the patient checks into the facility to the time the patient meets criteria for discharge. Overall, facility times ranged from 62 to 216 minutes, with a median of 118 minutes and an average of 122 minutes.

— Patient outcomes. Follow-up surveys with patients found that:

- 97% were able to schedule their procedures as soon as they wanted;
- 99% had an adequate understanding of the procedure;
- 99% were comfortable during the procedure, and 98% were comfortable post-discharge;
- 94% reported that their vision was better post-surgery, and 4% said it was the same;
- 94% returned to normal activities of daily living (ADLs) within one week of the procedure.

In the results given, not every organization/patient answered every question. In most cases, patient outcomes are based on patient questionnaires administered in the days/week immediately following the procedures.

Organizations that participated in the AAAHC Institute studies all were volunteers, and most were accredited by AAAHC. ■

Q&A with author of provocative new book

Major causes of death: medical mistakes, infections

Martin A. Makary, MD, MPH, an associate professor of surgery and health policy at the Johns Hopkins Medicine in Baltimore, MD, is the author of the recently published book "Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care." AHC Media, publisher of *Same-Day Surgery*, talked to him recently about healthcare associated infections (HAIs) and other patient safety issues raised in his provocative book.

"I talk about infections a fair bit and about the progress that has been made in measuring infections, and how increased measurement results in improvement in infection rates," Makary says. "When infection rates are available to the public, hospitals place more resources into the effort to prevent them."

AHC Media: The old recommendation to calculate and feedback surgeon-specific surgical site infection (SSI) rates seems to have fallen out of favor. Why isn't that being done more?

Makary: "The problem with surgeon specific infection rates is that they are often not statistically valid because if you look at the case mix of an individual surgeon, many times they have a broad range of operations that they do with high and low risk of infections. I believe that the best level to evaluate infection rates is at the hospital level. When the hospital infection rate is public, the administration will scramble to tap their local wisdom, to talk to their infection control personnel and their doctors to find out how to fix the problem. The public disclosure of infection rates is what creates accountability at the hospital level, and accountability is what drives resources to be dedicated to fix the problem on a local level."

AHC Media: Regarding SSIs, are many post-discharge infections still going undocumented for lack of follow-up? Historically, that has been a problem.

Makary: "It's still an issue; we still lack standardized measures nationwide. For example, the American College of Surgeons (ACS) has a program called NSQIP — the National Surgical Quality Improvement Program — that has highly standardized independent definitions of what constitutes an infection. Yet only 500 hospitals in the United States participate in their measurement program. Historically, we have a problem with hospitals that do a poor job of measuring infections coming out looking good, but those that do a very good job of tracking down their infections come out looking bad. Without standardized definitions, we end up punishing people that are doing a good job."

AHC Media: What about the Centers for Disease Control and Prevention's (CDC's) rapidly expanding surveillance system – the National Healthcare Safety Network (NHSN)?

Makary: "It definitely moves to more standardized definitions for infections. The best way to measure surgical infections is actually the one authored by the surgeons: the standardized definitions by the American College of Surgeons. There are so many types of surgical infections, there are deep infections within the abdomen, or you could have a superficial infection of the skin. There are so many different types, and of course, certain types of operations are more likely to have higher rates versus the others. But I applaud the CDC's NHSN as a force to try standardize the definitions."

AHC Media: Such systems are still only as good as the data they receive, of course, and we hear anecdotal stories of pressure to narrowly define infections in an age of "zero tolerance" for HAIs.

Makary: "There are flaws to self-reported data that is not independently collected. The American College of

Surgeons tries to use independent clinical reviewers. In business we have the Sarbanes-Oxley Act, which means if a CEO misreports their earnings they can go to jail. In healthcare, a hospital can misreport their performance on infections, and there is really no accountability for it. That is a problem, and unfortunately with self-reported data that means again we reward those who do a sloppy poor job of closely following their patients while penalizing those that do a very aggressive job tracking their patients."

AHC Media: We are certainly hearing calls for increased transparency regarding HAIs and other patient outcomes, but how does that really translate to improved quality?

Makary: "We have seen this before in states that reported mortality rates for heart bypass surgery. When the hospital average is a bad outlier – I don't want to say 'high' or 'low' because that can confuse people – with respect to the national average, [administrators] put more resources into fixing the problem. Many times the local doctors and nurses on the front lines say that they know how to improve quality of care and reduce infections, but they often describe feeling disempowered. They describe feeling like their management isn't interested in their input. So you have the sense of frontline workers feeling like tenants and the hospitals are their landlords. When frontline providers don't own the entire delivery of care, their performance [suffers]."

AHC Media: Are you hopeful that ongoing efforts to improve transparency will improve outcomes?

Makary: "Well, anytime there is a valid measurement of healthcare outcomes, outcomes globally seem to improve. Transparency is a great way to empower the public, because right now we have a free market that is dysfunctional. Patients choose hospitals based on the ease of parking and other factors which essentially leave them walking in blind when it comes to quality. Measurement is a dangerous business when the measures are not scientifically valid. We have suffered with invalid or inaccurate measures for a long time, which is why now there is an exciting revolution in healthcare where doctors have endorsed valid ways to measure complications like infections fairly. The question we have to ask as a society now is, do we believe the public has a right to know about the quality of their hospitals? The information is now collected, for example by the ACS program. It is being housed in a database where you have valid ways to measure infection rates in hospitals in a way that is endorsed by surgeons. But the information is not available to the public — yet. It is becoming available, and that is the revolution I talk about in the book."

AHC Media: Did you write the book as a sort of call to action?

Makary: "Exactly. There are massive disparities in the quality of healthcare in the United States. And in observing disparities and participating in the revolution in these quality improvement efforts, it became clear to me that there is a dilemma in society right now. We have good valid information about hospital outcomes that the public have a right to know about. Medical mistakes and preventable infections constitute the number three cause of death in the U.S. One of the reasons why that statistic is a shock to people — even doctors — is that we have not been a culture that openly talked about this problem in the past. It is only now that doctors' groups are talking about trying to improve this problem. [We are talking about] transparency with valid and fair ways to measure outcomes, with physician endorsed measures — the right measures.

AHC Media: There will be the inevitable questions and comments about the additional cost of adopting these better metrics and other improvements.

Makary: "Absolutely, hospitals have to pay for this. But I think increasingly Medicare is realizing that hospitals shouldn't be losing money by trying to improve quality. We saw that with the readmission reimbursement provision that went into effect [recently]. Hospitals are going to be docked 1% based on whether or not they are outlier in readmissions. Right now it is just [readmissions] for heart disease, heart attacks, and pneumonias, but that will likely expand. Even though it's the 1% this year, it is going to be 2% next year and 2% the following year. It is all part of the Affordable Care Act. I think it is already making a difference with readmissions. In the past, hospitals that reduced readmissions would earn less money because they wouldn't be able to profit from the readmission. Now it is a more even playing field." ■

GOLD STAR *Award*

Kirchner awarded *SDS* Gold Star

Beverly A. Kirchner, RN, BSN, CNOR, CASC, owner and president/CEO of Genesee Associates, in Dallas, has been name a winner of *Same-Day Surgery*'s Gold Star award as part of our 35th anniversary celebration. *SDS* is awarding

Gold Stars to outstanding leaders and innovators in the outpatient surgery field. Genesee Associates is a national ambulatory surgery center development, consulting, and management company.

Kirchner is a healthcare professional whose career includes 33 years as an operating room nurse with 28 years in ambulatory management. Her career positions range from staff nurse and director of nursing to administrator, executive vice president of operations, president, and CEO of an Ambulatory Surgery Center (ASC) company.

Kirchner enjoys working side by side with leaders at ASCs and hospital outpatient departments (HOPDs) to train staff and leaders on how to provide cost-effective, quality, safe care to patients while protecting themselves. She has demonstrated her knowledge of accreditation and certification preparation and needs by never failing a survey. She created a policy and procedure manuals for ASCs. She has consistently exceeded expectations in financial performance of the centers she has assisted in developing.

Kirchner is a lifelong learner. She has obtained and maintained the CNOR certification since 1982 and CASC certification since 2002. She has served in various roles with the Association of periOperative Registered Nurses (AORN) since 1981. She developed the ASC Administrator Course for AORN and regularly teaches the course. She has served on the Ambulatory Surgery Center Association (ASCA) Education Committee since 2010.

SDS salutes our Gold Star winner! ■

OIG to evaluate ASCs compared to HOPDs

The Department of Health & Human Services (HHS) wants to determine the extent to which hospitals acquire ambulatory surgery centers (ASCs) and converts them to hospital outpatient departments (HOPDs), according to the ASC Association. The project is included in the Fiscal Year 2013 Work Plan for the HHS Office of Inspector General (OIG).

The OIG will examine the effects of such acquisitions on Medicare payments and beneficiary cost sharing. Also, the OIG plans to review the appropriateness of Medicare's methodology for setting ASC payment rates under the revised payment system. The OIG also will determine whether a payment disparity exists between the ASC and HOPD payment rates for similar surgery procedures provided in both settings.

According to the OIG, the Centers for Medicare & Medicaid Services (CMS) and stakeholders also are interested in comparative data regarding the safety and quality of care provided by ASCs and HOPDs. Thus, the OIG plans to assess preoperative care, as well as care provided during surgeries and procedures, in both settings.

To access the OIG 2013 work plan, go to http://1.usa.gov/RyosV6. ■

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. ■

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.

COMING IN FUTURE MONTHS

- How should you handle a disease outbreak?
- Ethics of paying surgeons to perform more cases
- A better survey for measuring patient satisfaction
- Tips for improving OR productivity

CNE/CME QUESTIONS

1. After a resident was discovered stealing harmonic scalpels and staples at a Florida hospital, what changes were made?
   A. The storage room has card access
   B. A video camera was added inside the storage room
   C. One staff person is assigned to work in the room.
   D. All of the above

2. According to Gisele Wolf-Klein, MD, FACP, FAGS, director of geriatric education at North Shore-LIJ Health System and professor of clinical medicine, Hofftra North Shore-LIJ School of Medicine, what number of patients over the age of 85 have a degree of cognitive impairment?
   A. About 15%
   B. About one-fourth
   C. Between one-third and one-half
   D. More than one-half

3. What is a new type of employee theft identified by Stephen W. Earnhart, MS, CEO of Earnhart & Associates?
   A. The business office staff added to some employees' paid time off
   B. Employees are stealing supplies and equipment earmarked for charities.
   C. Employees are stealing business office supplies.

4. In a report issued in 2012 by the AAAHC Institute for Quality Improvement for colonoscopy, to what did organizations with the shortest discharge times attribute their results?
   A. Preoperative testing done two days in advance
   B. Use of short-acting anesthesia.
   C. Experienced staff.

SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission, AAAHC, and Medicare Standards

Cutting through the confusion: Clarifying history & physical and update notes

One of the most confusing areas for outpatient surgery providers undergoing Medicare surveys is the history and physical (H&P), including update notes.

While the rules from the Centers for Medicare and Medicaid Services (CMS) don't specify what constitutes a "comprehensive" history & physical (H&P) or which elements of the pre-surgical assessments may be incorporated into the H&P, the regulations provide that an update note does not act as an H&P and doesn't make an H&P older than 30 days current.

"The update examination for any changes in the patient's condition since the H&P was performed is more abbreviated than that of a comprehensive H&P," says **W. Jan Allison**, RN, CHSP, director of accreditation and survey readiness, Clinical Services Department, , Birmingham, AL. "In other words, when an H&P is older than 30 days, the H&P must be redone and is not eligible to be updated since the update assessment is not comprehensive enough to make the H&P current."

Allison cites the CMS regulations as her source. "In addition, it is the expectation during survey from the surveyors," she says. "It has been cited as a deficiency during surveys when the H&P has been older than 30 days, in spite of the H&P containing an update note indicating assessment of the patient on the day of service."

Regardless of the type of surgical procedure, a "comprehensive" medical H&P assessment must be completed by the physician not more than 30 days before the date of surgery, according to 416.52(a)(1), Allison says. "The standard set forth in 416.52(a)(2) additionally requires that upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner and that, at a minimum, there must be an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented history and physical assessment," she says.

A memo issued by CMS in December 2010 (S&C-11-06-ASC) clarifies that a comprehensive H&P may be performed on the same day as the surgery, Allison says, "and in the event it is, some elements of the required pre-surgical assessments may be incorporated into the H&P." *(That memo can be accessed at http://go.cms.gov/PGo60B.)*

The Joint Commission also requires accredited facilities to have an H&P in the record before the procedure (RC.02.01.03 EP 3 for hospitals; PC.03.01.03 EP5 and PC.03.01.03 EP6 for ambulatory and office-based organizations). The Accreditation Association for Ambulatory Health Care (AAAHC) requires organizations to have it completed within 30 days prior to scheduled surgery, or according to local and state requirements (whichever is stricter). The exact language can be found in Standard 10.I.D. (*For guidance on what items constitute a comprehensive H&P, look to the CMS "Evaluation and Management Services Guide" at http://go.cms.gov/KrBG4l. Also see story, p. 2.)*

Medicare also requires a pre-procedure anes-

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

EXECUTIVE SUMMARY

While the rules from the Centers for Medicare and Medicaid Services (CMS) don't specify what constitutes a "comprehensive" history & physical (H&P) or which elements of the pre-surgical assessments may be incorporated into the H&P, the regulations say that an update note does not act as an H&P and doesn't make an H&P older than 30 days current.

• A CMS memo clarifies that a comprehensive H&P may be performed on the same day as the surgery, and some elements of the required pre-surgical assessments may be incorporated into the H&P.

• Your facility's forms may require your physicians to check a box to note that the H&P update has been completed, but physicians receive no credit for doing the update if the box is not checked. Consider using a form that offers easier compliance.

thesia assessment.

Your independent practitioners might be completing the H&P update but not getting credit for it, warns **Jennifer Cowel**, RN, MHSA, vice president of Glendale, AZ-based Patton Healthcare Consulting, which offers regulatory compliance and accreditation readiness consulting. Cowel is a former surveyor for The Joint Commission and former director of service operations in accreditation in the central office. Cowel spoke earlier this year at a webinar sponsored by AHC Media, publisher of Same-Day Surgery, about "The Surveyors are Here, Now What? Successful Strategies for Your Next TJC Survey." (For ordering information, see Resource at end of this article.)

"The H&P update is something you expect your licensed independent practitioners to do, you expect them to document it, but a lot of organizations are still expecting the physician to check a little box," Cowel says. "[W]hat we see on-site is that the physician will sign it, date it, time it, do it, and get no credit because a box is not checked."

Use forms with easier comliance

Look over your forms to see which ones still mandate checkboxes, and consider implementing a form that offers easier compliance, she says. "You have canned language that says, 'I have examined the patient. I have reviewed the findings, the history & physical, and there are no changes other than noted below,' … or 'there are no changes,'" Cowel says.

Have the practitioner sign, date, and time it, she says. "By virtue of their signature, they are attesting to the fact that this sentence up here has occurred," Cowel says. "No checkbox is necessary."

ReSo URCe

The webinar "The Surveyors are Here, Now What? Successful Strategies for Your Next TJC Survey," offers an up-to-date view of what to expect when surveyors come to your facility and learn how to be prepared when they do. If offers success strategies for a smooth and successful survey. The price for the webinar is $350. To order, go to http://bit.ly/RNe7Ga. ■

What is included in the history & physical

A comprehensive history & physical (H&P) includes the following items: a chief complaint; an extended history of present illness; a review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; and complete past, family and/or social history, according to **Jan Allison**, RN, CHSP, director of accreditation and survey readiness, Clinical Services Department, Surgical Care Affiliates, Birmingham, AL.

Include these details, as pulled by Allison from the Medicare "Evaluation and Management Services Guide" at http://go.cms.gov/KrBG4l:

• **Chief complaint:** a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter.

• **History of present illness (HPI):** a chronological description of the development of the patient's present illness from the first sign and/or symptom (onset) or from the previous encounter to the present. HPI elements are:

– location;
– quality;
– severity;
– duration;
– timing;
– context;
– modifying factors;
– associated signs and symptoms.

• **Complete review of systems (ROS):** an inventory of body systems obtained by asking questions to identify signs and/or symptoms that the patient might be experiencing or has experienced. It include a complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (mini-

mum of 10) organ systems.

"Those systems with positive or pertinent negative responses must be individually documented, Allison says." "For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least 10 systems must be individually documented."

• **Complete past, family, and/or social history (PFSH):** PFSH consists of a review of three areas:

– Past history including experiences with illnesses, operations, injuries, and treatments.

"Here you list patient's useful, ongoing medical problems and a list of surgeries," Allison says.

If something is recent or pertinent to the current (present) illness, more detail should be added, she says. "Include dates and time of pertinent items, if they are pertinent to the current complaint," Allison says. "Also, chronic problems should be addressed as to whether or not they are well-controlled, uncontrolled, etc., especially, if they pertain to the current illness."

– Family history, including a review of medical events, diseases, and hereditary conditions that might place the patient at risk.

– Social history including an age-appropriate review of past and current activities.

A complete PFSH is a review of two or all three of the areas, depending on the category of the evaluation and management (E/M) service. ■

Survey over? Time to start preparing again

Non-survey years are more important

Aaaahhhh. The survey is over. "I don't have to worry about this for another two and one-half years," you might think.

But you'd be wrong, says **Jennifer Cowel**, RN, MHSA, vice president at Glendale, AZ-based Patton Healthcare Consulting, which offers regulatory compliance and accreditation readiness consulting, and a former hospital surveyor and director of service operations in accreditation in the central office for The Joint Commission. Cowel gave a presentation earlier this year for AHC Media, publisher of *Same-Day Surgery*, on "The Surveyors are Here, Now What? Successful Strategies for Your Next TJC Survey." *(For ordering information, see Resource, p. 2.)* .

Your survey success depends on several items, Cowel says. "One is what happens when they show up at the door, but more importantly is managing the non-survey years," she says. If you start preparing far ahead of time, "you're going to be able to present your best face, and your best quality to that survey team," Cowel says.

After the survey, keep the momentum going. Realize you might not have your next survey in the year it's due. The Joint Commission reserve the right to conduct random validation surveys, and they do those surveys in about 5% of hospitals and surgery centers in any given survey year, Cowel says. "So you want to have your ducks in a row even if you don't think The Joint Commission is going to be there for another year or two," she says.

Facing the challenges

Several areas present challenges in the non-survey years, Cowel says. One is your plan for improvement (PFI).

On your Joint Commission Extranet site, see the section titled PFA Part 4, Cowel says. "It is a list of things that you have self-disclosed to The Joint Commission that are in your environment, that are not working, that need to be fixed, that impact Life Safety," she says.

That section includes a timeframe for addressing compliance problems, Cowel says. If you have leadership changes, this timeframe can fall off the radar, "and you will have had a Life Safety violation that you said you were going to fix six months ago," she warns.

Consider these other suggestions:

• **Keep your policies simple.**

One facility Cowel visited had a policy for verbal order authentication that was so detailed that it dictated what color ink a nurse had to use

EXECUTIVE SUMMARY

What you do during your non-survey years has a heavy impact on your success during the survey. Keep your eyes on plan on The Joint Commission's (PFA) Part 4, which includes a timeframe for addressing compliance problems.

• Keep your policies simple, because non-compliance with your own policies will mean non-compliance with the accreditation agency.

• Implement new standards and National Patient Safety Goals (NPSGs) as soon as they are implemented.

• Focus on the standards and NPSGs with the highest level of non-compliance.

• Perform mock surveys.

(green) and what acronym had to be used (VORB).

"The Joint Commission will look at your policies, and you can be scored out either at the standards or your own policies," she says.

Keep you policies simple so they are flexible enough to adapt to different areas, such as outpatient and inpatient, Cowel says. "And don't get yourself in a situation where your good intention on a very detailed policy trips you up during your survey because it's just not implementable at the level of detail that someone envisioned it," she says.

• Implement standards and National Patient Safety Goals (NPSGs) as soon as they are published.

The Joint Commission, for example, implements new standards and updated elements of performance (EPs) twice a year: Jan. 1 and July 1, Cowel says. The Accreditation Association for Ambulatory Health Care (AAAHC) updates their standards around March 1 annually.

"This is the time that you want to send them out in your department meeting minutes," she says. "Send them out as assignments. Follow up to make sure that they are implemented in your organization."

Joint Commission surveyors go through training on new standards and EPs every year in January, just after the holidays, Cowel says. "And oftentimes what we see in the January and February surveys: Everything that's new is now a focus area," she says.

• Focus on the top 10 scored standards and NPSGs.

The top 25 or 30 standards with the highest noncompliance rates are scored in about 90% or more of the findings that are scored throughout the country, throughout the year, Cowel says.

While you do have to be compliance with all of the standards, your risk are in the top scored 25 standards or NPSGs, she says, "so keep your eyes on those."

If you focus your limited resources and funds on those standards, "that will get you very far in getting yourself a very smooth survey processes and a good survey outcome," Cowel says. *(To access the most recent list of highest non-compliance among standards and NPSGs for hospitals, ambulatory organizations, and office-based organizations, go to http://bit.ly/Tbo68i.)*

• Use your staff to perform mock surveys.

Use unit managers and infection control staff to perform mock surveys, Cowel advises.

"You are going to get incredible valuable information about your own internal compliance, and you'll also be able to do mid-term corrections along the way in those areas that you are struggling with," she says.

For example, you might find during mock surveys that anesthesia staff aren't complying with checking the box that says "I did an immediate pre-induction assessment prior to anesthesia." Look at your flow to see if that checkbox is out of order, Cowel suggests. If needed, change the flow or change the forms, she says. Change something "so that your staff can do good work but the forms, the flow, the policies are not an impediment to taking credit for the good work you do," Cowel says. ■

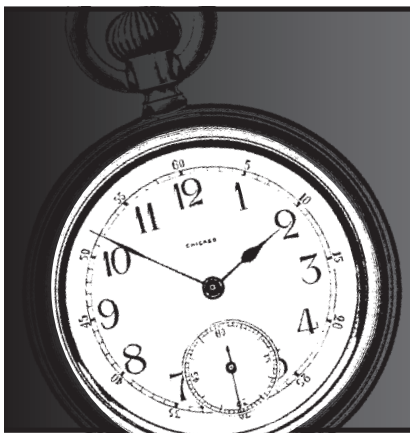
Free tool improves patient handoffs

Ambulatory surgery providers looking for ways to prevent miscommunication and improve their internal and external patient handoffs now have a free, proven tool to make their job easier. The Joint Commission Center for Transforming Healthcare recently released a new Hand-off Communications Targeted Solutions Tool (TST) to assist organizations with passing necessary and critical information about a patient from one caregiver to the next, or from one team of caregivers to another.

Using the tool and the solutions from the center's Hand-off Communications Project, healthcare organizations reported an increase in patient and family satisfaction, staff satisfaction, and successful transfers of patients. One healthcare organization reduced readmissions by 50%.

Jacksonville (FL) Center for Endoscopy is one of the organizations that piloted the TST. "The scope of our project was from the preop nurse report to the anesthesia provider," says **Cynthia Hall**, RN, administrator. "Our biggest lessons learned were that nurses and anesthesia providers were faced with the same challenges during patient handoffs, and that interruption was the major cause of delay during handoffs."

The TST was created to measure the effectiveness of handoffs within an organization or to another facility, and provide proven solutions to improve performance. Healthcare organizations were able to complete their Hand-off Communications Project in about four months, using minimal resources. In fact, no staff was added, and only minor changes were made to the roles and responsibilities of existing staff. To access the tool, go to http://bit.ly/OZOG3s. ■



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