

Same-Day Surgery®

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

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IN THIS ISSUE

- Preventing postsurgical infections starts in the patient's home cover
- ASCs awarded for reducing SSIs, improving patient survey. 28
- Is physician texting putting you at risk for HITECH violation? 29
- Changes to HIPAA Privacy and Security Rules finalized 32
- 39 times a week, a foreign object gets left inside a patient 32
- 6 ways a vendor or consultant could get you sued 33
- **Same-Day Surgery Manager:** What technology could make your job easier? 34
- Pre-service collections for scheduled surgeries jump \$1.5 million 35

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Want to get a jump start on preventing infections? Have patients do the prep work

By Joy Daughtery Dickinson, Executive Editor

The times, they are a changin'. Surgical patients used to arrive at hospitals the day before surgery, where staff did all the prep work to ensure patients were as clean as possible to avoid post-surgical infections.

"Now you stay home and take several showers with special soap so you are squeaky clean when you go in," says **Barb Ludlow**, a patient who blogged about her experience having outpatient surgery at <http://www.greenbaypressgazette.com>. Additionally, some providers are telling their patients, including Ludlow, to wash their hair twice, wear freshly laundered clothes or pajamas, plus sleep in freshly laundered sheets before surgery.

You might learn something from some of these practices. Surgical teams at Cedars-Sinai in Los Angeles reduced surgical site infections by more than 60% for patients who undergo colorectal procedures by introducing evidence-based protocols that included patients using chlorhexidine antiseptic solution to shower the evening and morning before surgery. (*For more information on this project, see story, p. 27.*)

Outpatient surgery programs are joining the trend toward at-home prep for surgery. Sometimes these changes are in response to infection monitoring. This past year, DISC Surgery Center in Marina del Rey, CA, had its first infection in six years, says **Karen Reiter**, RN, CNOR, RNFA, chief operating officer. "It made us look at what we were doing," Reiter says. "We brought the [patient skin preps

This month's special focus: Infection control

Increasingly, federal regulators and accreditation groups are taking a close eye at infection control. This month's issue will help you stay on top of trends and developments in the field. First, we tell you about how some preoperative practices handled by patients can reduce your infection control rate. Next we provide a case study of a facility that reduced surgical site infections (SSIs) with colorectal procedures by 60% by introducing some of these steps. We tell you about another facility that received national recognition for its program to decrease surgical infections in knee, hip, and back cases. We complete our package with a heads up about an upcoming national effort to reduce SSIs.

We hope you enjoy this special issue of *Same-Day Surgery!*

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with chlorhexidine gluconate] back in, inserviced all staff, and started education for the patients.”

In terms of staff, “everyone thinks they’re doing it the right away,” she says. Much of the center’s educational efforts focused on the surgeons, with the help of a lead surgeon, Reiter says.

Here are some practices that outpatient surgery providers are taking to reduce the opportunity for infection:

- Screen for methicillin-resistant *Staphylococcus aureus* (MRSA) and any infection that didn’t heal.

At Reiter facilities, patients are asked if they have

a history of MRSA or any infection that didn’t heal when they are being screened for surgery at the doctor’s office and during the preop nurse call. If patient has had a positive history of MRSA, staff members try to obtain a preoperative screen and have the patient treated prior to surgery. If the patients haven’t had the swab conducted before they arrive for surgery, the swab is conducted when they arrive at the center, and they are isolated. The center is considering switching to a new nasal treatment with povidone-iodine topical antiseptics.

- Preoperative showering.

Gina Parsons, senior product manager for surgical products at StartClean Procedural Solutions, part of Leawood, KS-based CareFusion, says, “The literature is growing in regard to including preoperative bathing regimens as part of the pre-surgical bundle.” StartClean combines a chlorhexidine gluconate (CHG) cleansing kit with an individualized service that reminds patients to cleanse before they come in for surgery. (For more on the StartClean product, see resource at end of this article.)

Guidelines from the Centers for Disease Control and Prevention (CDC) include one for patients to shower or bathe with an antiseptic agent on at least the night before the operative day. That guideline was ranked as Category IB, which means strongly recommended for implementation and supported by some experimental, clinical, or epidemiological studies and strong theoretical rationale. (For information on how to access the guidelines, see resource at end of this story.)

The Association of perioperative Registered Nurses (AORN) recommends preoperative showers. “We generally say two showers before surgery” usually using CHG, says Sharon A. Van Wicklin, MSN, RN, CNOR/CRNFA, CPSN, PLNC, perioperative nursing specialist at AORN. The information is included in the recommended practice “Preoperative Patient Skin Antisepsis.”

Reiter’s facility follows the two-shower guidance

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Editorial Questions

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EXECUTIVE SUMMARY

Surgery providers are changing their infection control practices, including the addition of some initiated by patients, to reduce the opportunity for postsurgical infections.

- Some patients are being asked to shower with chlorhexidine gluconate (CHG) the night before and the morning of surgery.
- Providers are prepping the incision sites with solutions that contain isopropyl alcohol, and allowing appropriate drying time.
- Surgical teams at Cedars-Sinai reduced surgical site infections by more than 60% for colorectal surgery patients by using protocols such as asking patients to shower preoperatively with chlorhexidine antiseptic solution and preparing operative sites with a sterile chlorhexidine and alcohol antiseptic solution.

by asking patients to buy a bottle of antiseptic antimicrobial skin cleanser. They are told to shower with it the night before and the morning of surgery. “We don’t let them shave the morning of, and no ‘lotions or potions,” Reiter says.

- **Preop skin preparation.**

The CDC recommends thorough washing and cleaning at and around the incision site before performing antiseptic skin preparation, as well as using an appropriate antiseptic agent for skin preparation (both Category IB). AORN specifies that the agent should be approved by the Food and Drug Administration, such as CHG or povidone-iodine.

Van Wicklin says, “You don’t want to use Dial soap. It’s not approved for that.”

The CDC also recommends applying preoperative antiseptic skin preparation in concentric circles moving toward the periphery. This is a Category II recommendation, which means it is suggested for implementation and supported by suggestive clinical or epidemiological studies or theoretical rationale.

The National Quality Forum (NQF) board of directors has maintained endorsement of Safe Practice 22, which addresses appropriate skin preparation to prevent surgical site infection. The final safe practice directs providers to preoperatively use solutions that contain isopropyl alcohol as skin antiseptic preparation until other alternatives have been proven as safe and effective, and allow appropriate drying time.

Reiter says, “We hit the code clock when you finish the prep, and wait three minutes before draping.” This clock helps staff at some facilities address concerns about surgeons who are in a hurry, she says. “You may as well not prep if you don’t follow manufacturer specifications,” says Reiter.

Providers, as well as patients, are buying in to these practices, says **Marcia Patrick**, RN, MSN, CIC, consultant in infection prevention and former member of the board for the Association for Professionals in Infection Control and Epidemiology. “I can tell you on personal note, if I was going to have a hip or knee replaced, any kind of significant surgery, I would do exactly that: shower the night before with a CHG-containing product, then again the morning of,” she says. “I would put on clean pajamas. I would sleep in clean sheets. And I would put on freshly laundered clothes to go to hospital or wherever [I’m] having outpatient surgery.” (For more on this topic, see “Surgical site infection rate drops to zero in months,” *Same-Day Surgery*, June 2006, p. 65.)

RESOURCES

- The “1999 CDC Guideline for Prevention of Surgical Site Infection” from the Centers for Disease Control and

Prevention. Web: http://www.cdc.gov/hicpac/pdf/guidelines/SSI_1999.pdf.

- The StartClean program encourages compliance for preoperative bathing. The surgeon or staff enters the patient’s contact information into the reminder program and provides him or her with the kit and a patient education template. This program combines a 4% CHG cleanser and sponges with an individualized service that reminds patients (text, email, or voice message) to cleanse before surgery. For more information, call (800) 523-0502 or visit www.carefusion.com/startclean. ■

SSIs reduced 60% for colorectal patients

Surgical teams at Cedars-Sinai in Los Angeles have reduced surgical site infections by more than 60% for patients who undergo colorectal procedures by introducing evidence-based protocols that are easy to follow and relatively low in cost.

Surgeons, nurses, operating room staff, and patients collaborated in a quality improvement project that measured surgical site infection rates for one year.

“This work marks a significant step toward achieving Cedars-Sinai’s goal of zero hospital-acquired infections,” said **Rekha Murthy**, MD, director of hospital epidemiology. “It represents the first of several projects to eliminate postop infections.” The new approach modified or optimized past practices:

- Patients used chlorhexidine antiseptic solution to shower the evening and morning before surgery.

- Surgical teams prepared operative sites with a sterile chlorhexidine and alcohol antiseptic solution. After surgery, patients were bathed with chlorhexidine wipes daily.

- Antibiotics used immediately prior to surgery were standardized, which allowed only those from a short list of appropriate alternatives. For operations lasting more than four hours, a second dose of antibiotics was administered to reduce infection risk.

- Use of wound protectors was encouraged to reduce contamination of the skin while handling the intestines.

- After completing the contaminated portion of colorectal procedures, members of surgical teams changed to new gowns and gloves, used new instruments, and re-draped operative sites with sterile covers. This reduced contamination of the abdomen and skin during surgical closing procedures.

- The technique of daily wound probing was broadly applied in some cases of wounds considered to be at high risk for infection. This involved a simple and inexpensive daily process using cotton-tipped applicators to release contaminated fluid trapped in wounds.

As a result of these steps and others, the rate of post-operative surgical site infections (SSIs) after colorectal surgeries dropped from a baseline of 15% to less than 5% within six months.

Cedars-Sinai conducted its test as part of a larger national research project on surgical site infections piloted at seven large hospitals across the country. Under the collaboration coordinated by The Joint Commission's Center for Transforming Healthcare, the hospitals each worked to develop a protocol to dramatically reduce surgical site infections among patients who underwent colorectal procedures. *(For more information, go to <http://bit.ly/V1uspJ>.)*

Shirin Towfigh, MD, a faculty member in the Cedars-Sinai Division of General Surgery and the Center for Minimally Invasive Surgery, said, "Our work illustrates that with institutional collaboration and low-cost changes in practice, surgeons can dramatically reduce their patients' surgical site infections." *(For information on another facility's success in reducing SSIs, see story, below.)* ■

Program to decrease SSIs wins quality award

Also awarded: revamped patient survey

A program to decrease surgical infections in knee, hip, and back procedures is a winner of the 2012 Bernard A. Kershner Innovations in Quality Improvement Awards. The award for surgical/procedural care is given annually by the AAAHC Institute for Quality Improvement (AAAHC Institute). An initiative to increase patient satisfaction garnered honorable mention.

The staff at the Siouxland Surgery Center (SSC), Dakota Dunes, SD, noticed an increase in surgical site infections (SSIs) in knee and hip arthroplasty and lumbar spinal fusion patients. The philosophy at SSC is that one surgical site infection is one too many. They immediately created an improvement plan. The plan identified areas for improvement, such as surgical instrument cleaning and decontamination processes, as well as some of their infection prevention processes. The improvement plan included a new workflow pattern in the decontamination room to minimize cross-contamination.

"Everyone on the leadership team and staff collaborated on the redesign and implementation of new processes and received detailed training on the new processes," said **Jennifer Hadley**, RN, BSN, CIC, the director of quality and infection prevention at SSC. "It worked. Everyone took ownership, and infections have

been reduced to zero in the last quarter. It feels good knowing every employee, every day is doing their best for every patient."

After the program, hip arthroplasty and knee arthroplasty infection rates have decreased to zero in last quarter. Lumbar spinal fusion infection rates have decreased by 61.5%.

Patient satisfaction survey improved

A study to improve patient satisfaction questionnaires received an honorable mention in surgical/procedural care for the Madison Surgery Center (MSC), Madison, WI.

The questionnaire they were using allowed patients to check-box one of three options: "Yes, exceeded my expectations," "Yes, met my expectations," or "No, did not meet my expectations." It didn't weigh positive and negative perceptions, and it didn't offer a "neutral" or "not applicable" response.

The former questionnaire assessed patient perception by admission, prior to your procedure, during the procedure, and recovery and discharge. These categories fostered finger-pointing and an attitude of "it's not my problem," according to the center. Eliminating these categories encouraged a team-based improvement attitude where patient satisfaction became everyone's responsibility.

"Instead of looking at a few separate areas, we went to a questionnaire that encompassed the patient's entire experience as a whole," said **Pam Smestad**, RN, quality and risk manager at MSC. "This will allow us to improve our quality of care for every patient."

To better understand patient needs, the center updated the questionnaire process to include:

- updates to the range of information collected from patients; a more detailed rating scale to better measure patient satisfaction; additional questions to score the center as a whole; improved communication of results to staff members.

The updates to the questionnaire were completed recently, and data will continue to be analyzed and compared quarterly. *[A copy of the questionnaire is included with the online issue of Same-Day Surgery. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

Once completed, tabulated and interpreted, survey results historically have been presented and discussed at management meetings and a couple of committee meetings. Now outcomes are communicated to staff and performing physicians through a daily report, a patient satisfaction bulletin board in the staff lounge, various committee meetings, in-services, and monthly staff meetings.

“By revising our patient questionnaire and our processes — questions asked, use of an equally weighted scale, engaging staff, communicating data, and influencing change — MSC hopes to bring to life our philosophy of ‘Every patient, every time,’” the center said in its application. ■

Effort will target outpatient complications

The Health Research & Educational Trust (HRET) of the American Hospital Association (AHA) has been awarded a contract by the Agency for Healthcare Research and Quality (AHRQ) to reduce surgical site infections (SSIs) and other surgical complications in ambulatory surgery. A second contract will improve patient care in the primary care setting by strengthening teamwork among primary care teams.

Maulik Joshi, president of HRET and senior vice president of AHA, said, “We are eager to begin these projects since they validate and build upon existing work that has dramatically improved care to all.”

To improve care around the surgical suite, the objective will be to carry out an effective national implementation of a proven surgical safety checklist and development and implementation of a program to improve ambulatory surgery safety. The AHRQ ambulatory surgery safety project will adapt the Comprehensive Unit-based Safety Program (CUSP), which has been used to reduce other healthcare-associated infections, and apply it to reduce SSIs and other surgical complications. ■

Physician texting poses HITECH security challenges

Vague messages, secure network add protection

With almost 80% of cell phone owners reporting they use text messaging,¹ it is no surprise that physicians are doing the same. A survey of pediatric hospitalists found that 57% of clinicians send work-related messages, and 12% of the physicians reported texting 10 or more times per shift. Messages were received on personal phones by 41% of respondents and on healthcare facility-owned phones by 18% of respondents.²

“The world is text messaging for all types of communications, so it is not surprising to find physicians taking advantage of a tool that is faster, more convenient, and

more direct than other forms of communications,” says **Jeffrey Evans**, co-founder of Santa Monica, CA-based TigerText. “Email is cluttered and not fast enough for an immediate, open conversation, even when email can be accessed by a smartphone.”

Texting makes sense for physicians because a doctor’s job is inherently mobile, Evans points out. “A physician is rarely sitting in front of a computer,” Evans says. Performing surgery, making rounds, and seeing patients in the office means being away from a computer, he explains. “A doctor can be more efficient if he or she can check for lab results, confirm the time of surgery, or ask for a consultation while moving from place to place,” Evans says.

Although texting might be more efficient for physicians and healthcare employees, there are security issues a facility must address, says **Steve Hunt**, CPP, CISSP, director of Neohapsis Labs, the research division of Chicago-based Neohapsis, a security risk consulting service. Although there are a several risks posed by texting protected health information (PHI), one of the more challenging risks is authentication of the sender or receiver’s identity. “Unlike a telephone conversation during which you hear a voice and can exchange information to verify identity, you don’t know who is holding the phone and responding to your text.” A misdialled phone number or a misplaced cell phone might result in information being sent to the wrong person.

For this reason, Hunt suggests that physicians who text follow these suggestions to maintain compliance with Health Information Technology for Economic and Clinical Health Act (HITECH) privacy and security rules:

- When texting a patient with health information, keep it vague. Don’t say: “Your test is positive, give me a call.” Instead text: “Your test results are ready. Please call.”

EXECUTIVE SUMMARY

The convenience and speed of text message communications has created challenges for healthcare IT security officers as they attempt to catch up to technological advances that move from personal settings to the workplace. Challenges related to authentication of sender and receiver, and protection of health information on the phone can be addressed in several ways:

- Keep messages vague with no reference to specific health information when communicating electronically with patients.
- Separate text messages into multiple messages so health information and patient identification are not included in one message.
- Require installation of encryption, password protection, and device management software that enables a remote “wipe” of data.
- Educate physicians and employees about the higher risks associated with text messaging.

- When texting physician to physician, separate data into several messages so a patient's identification information is not in the same message as health information. For example, send one message with: "I'd like to inquire about Mrs. Smith." Follow this message immediately with: "Was her test positive or negative?"

Both of these steps minimize risk but will not completely eliminate it, points out Hunt. "If a phone is lost, an unauthorized person can put together multiple messages to see PHI."

Encryption is another way to minimize risk, but it is not foolproof. "Text message data is not encrypted when at rest or in transit," explains Evans. Even if a phone is password-protected, the data is available to anyone who has the password, he points out.

Providers can improve security by sending messages on a secure network that receives messages, notifies the recipient that a message is waiting, and provides a link to the message, says Evans. Whatever system a provider implements must be able to authenticate senders and receivers as well as ensure information can't be accessed by unauthorized persons, he suggests.

Personal phones used by physicians also can pose problems, points out Evans. A facility-provided phone can be encrypted and contain protection such as passwords, but it is more difficult to get someone to allow a hospital to install software on a personal phone. "It is difficult to enforce encryption or other security measures when physicians or staff members are using personal phones," he admits. A facility "needs to develop good policies about the use of mobile devices and enforce them.," Evans says. (*See story on personal devices, below.*)

The most important step to take is education, says Hunt. "Physicians and employees are so comfortable with text messaging, they don't think about security risks," he says. Explaining the risks of text messaging and encouraging vagueness in messaging are important now as communicating with text messages becomes more commonplace in the workplace.

"This is a good time to establish secure communication practices," he adds.

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SOURCES

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BYOD policies address personal issues

Enforcement needs upfront collaboration

Smartphones, laptops, and tablets are everywhere. The convenience of mobile devices has made health-care documentation, follow up, and communication simpler and faster. Limiting access to electronic protected health information (EPHI) to healthcare facility-owned devices that are encrypted and contain security tools such as "remote wipe" is one way to enhance EPHI security, but the reality is that physicians and employees are using personal devices as well.

"It's not a surprise that people want to use the phones with which they are most comfortable," says **Steve Wu**, attorney and partner at Cooke, Kobrick and Wu in Silicon Valley, CA. In most cases, personal devices such as tablets or smartphones offer more functionality than facility-provided devices. "People also don't want to carry two different devices," he says.

The increasing use of personal devices for work-related communications makes it critical for healthcare organizations to develop Bring Your Own Device (BYOD) policies, says Wu. These policies differ from typical security policies related to the use of mobile devices. "A BYOD policy can be incorporated into other policies or developed as a separate policy, but it needs to address issues related to the device being owned by someone else," not the healthcare facility, Wu says.

The first step is to include all areas of the hospital in the policy development, especially the information technology (IT) department, he says. "Too many times, the IT department is handed a policy developed by others and told to find a way to implement it," he says. In the case of mobile devices, the challenge is that people already are using their devices, so policies need to reflect the reality of use and apply security measures that make sense, he says.

"Once representatives from legal, risk management,

IT, and the privacy and security officers for the organization have developed a policy together, it is easier to implement,” Wu says. Some facilities require employees who have the need to access EPHI to use only facility-issued devices, he says. Employees who are not accessing EPHI are allowed to use their own devices for general communication that does not involve sharing patient information.”

Organizations that do allow employees to use personal devices to access patient information should require healthcare facility-provided encryption as well as mobile device management software on each device to mitigate EPHI loss, says Wu. Requiring the programs provided by the facility raises some issues when the device is owned by the employee, he points out. “One of the key security measures is software that will wipe all data off the device if it is lost or stolen,” he says. “When someone is using their device for personal as well as work-related activities, this means all family photos or personal communication is also wiped clean.” Making sure physicians and employees understand the ramifications of using their own phones, tablets, or laptops, may make some decide not to use their own device.

If you do allow employees to use their own devices, be clear about whether using a personal device is an expectation. “Employees may ask the [facility] to pay for the cost of, or a portion of the cost of the device if they believe they are expected to use the device for work,” says Wu.

The other issue that must be addressed by members of the IT staff is the type of mobile device platforms they want to support in the security program, says Wu. “Because different types of operating systems may require different security solutions, some IT departments may find it more effective to specify which platforms are supported,” he says.

In addition to addressing the issues related to employees’ access with their personal device, be aware that in addition to protecting EPHI, the facility must protect its own network, says Wu. “When people use their own devices, the network is exposed to ‘shadow IT’ or programs that are downloaded to the mobile device to enhance functionality,” he says. These programs include Dropbox, iCloud, personal email programs, social media sites, and text messaging. “These programs increase the opportunity for malware to compromise the [facility] network when connected,” Wu says. Limiting the types of mobile applications that can be downloaded to the device is one way to address the problem, he suggests. (*For other mobile device management tips, see article on HHS guidance, below.*)

Address employee termination in your BYOD policy as well, recommends Wu. “It’s a simple process to

discontinue access for an employee’s password, but a [facility] must also be able to delete work-related EPHI information on the personal device as well,” he says. This means having a process in place to delete information before the employee leaves.

Education is an important step to take when implementing a BYOD policy. “Although employees will view the ability to use their own smartphone, laptop, or tablet as convenient, it’s important they understand that the presence of EPHI or [facility]-related information on their device lessens their privacy,” he says. “In the case of a breach or a lawsuit, the employee’s device becomes evidence.”

A BYOD policy is important for all healthcare organizations because people are using their personal devices, but physicians and employees need to understand all of the issues, says Wu. “The best security is separate mobile devices: one for personal use and one for work.”

SOURCE

For more information about Bring Your Own Device policies, contact:

• **Steve Wu**, Partner, Cooke, Kobrick and Wu, 166 Main St., Silicon Valley, CA 94022. Telephone: (650) 917-8045. Email: swu@ckwlaw.com. ■

Security tips offered for mobile devices

Healthcare providers can find free tips and information about the secure use of mobile devices at a new website launched by the Department of Health and Human Services. The site describes risk assessments, offers guidance on development of policies and procedures, and offers educational materials for staff training.

Eleven tips for mobile device security identified and explained on the site are:

- Use a password or other user authentication.
- Install and enable encryption.
- Install and activate remote wiping and/or remote disabling.
- Disable and do not install or use file sharing applications.
- Install and enable a firewall.
- Install and enable security software.
- Keep your security software up to date.
- Research mobile applications (apps) before downloading.
- Maintain physical control.

- Use adequate security to send or receive health information over public Wi-Fi networks.
 - Delete all stored health information before discarding or reusing the mobile device.
- Go to www.HealthIT.gov/mobiledevices to access the information. ■

HHS finalizes changes to HIPAA Requirements

The Department of Health & Human Services (HHS) has finalized changes to the HIPAA Privacy and Security Rules.

According to the Ambulatory Surgery Center Association, modifications to the HIPAA requirements allow patients to:

- request a copy of their electronic medical record in electronic form;
- instruct their provider not to share information about their treatment with their health insurance company if they paid for their treatment on their own;
- authorize the use of their health information for research and other purposes in a more streamlined manner.

The changes also set new limits on how health information can be used in marketing and fundraising and prohibit the sale of health information without a patient's permission.

The rulemaking may be viewed in the Federal Register at <http://1.usa.gov/XnApg0>. Visit ASCA's HIPAA webpage at <http://bit.ly/V5hMx0> for a complete list of resources. ■

Surgical 'never events' occur 79 times per week

After a cautious and rigorous analysis of national malpractice claims, Johns Hopkins patient safety researchers estimate that a surgeon in the United States leaves a foreign object such as a sponge or a towel inside a patient's body after an operation 39 times a week, performs the wrong procedure on a patient 20 times a week, and operates on the wrong body site 20 times a week.

The researchers, reporting online in the journal *Surgery*,¹ say they estimate that 80,000 of these so-called "never events" occurred in American hospitals between 1990 and 2010, and they believe their estimates are

likely on the low side.

The findings — the first of their kind, it is believed — quantify the national rate of "never events." Documenting the magnitude of the problem is an important step in developing better systems to ensure never events live up to their name, the researchers say.

"There are mistakes in healthcare that are not preventable. Infection rates will likely never get down to zero even if everyone does everything right, for example," says study leader Marty Makary, MD, MPH, an associate professor of surgery at the Johns Hopkins University School of Medicine. "But the events we've estimated are totally preventable. This study highlights that we are nowhere near where we should be and there's a lot of work to be done."

For the study, Makary and his colleagues used the National Practitioner Data Bank (NPDB), a federal repository of medical malpractice claims, to identify malpractice judgments and out-of-court settlements related to retained-foreign-body and wrong-site, wrong-procedure and wrong-patient surgeries. They identified 9,744 paid malpractice judgments and claims over those 20 years, with payments totaling \$1.3 billion. Death occurred in 6.6% of patients, permanent injury in 32.9% of patients, and temporary injury in 59.2% of patients.

Using published rates of surgical adverse events resulting in a malpractice claim, the researchers estimate that 4,044 surgical never events occur in the United States each year. The more serious the outcome, the more the patient (or his family) was paid.

Makary says the NPDB is the best source of information about malpractice claims for never events because these are not the sort of claims for which frivolous lawsuits are filed or settlements made to avoid jury trials. "There's good reason to believe these were all legitimate claims," he says. "A claim of a sponge left behind, for example, can be proven by taking an X-ray."

By law, hospitals are required to report never events that result in a settlement or judgment to the NPDB. If anything, he says, his team's estimates of never events are low because not all items left behind after surgery are discovered.

In their study, never events occurred most often

EXECUTIVE SUMMARY

Johns Hopkins patient safety researchers performed an analysis of national malpractice claims.

- They estimate that a surgeon in the United States leaves a foreign object such as a sponge or a towel inside a patient's body after an operation 39 times a week.
- They estimate that a surgeon performs the wrong procedure on a patient 20 times a week and operates on the wrong body site 20 times a week.

among patients between the ages of 40 and 49, and surgeons in this same age group were responsible for more than one-third of the events, compared to 14.4% for surgeons over the age of 60. Sixty-two percent of the surgeons were cited in more than one malpractice report, and 12.4% were named in separate surgical never events.

Makary notes that at many medical centers, patient safety procedures have long been in place to prevent never events, including mandatory “timeouts” in the operating room before operations begin to make sure medical records and surgical plans match the patient on the table. Other steps include using indelible ink to mark the site of the surgery before the patient goes under anesthesia. Procedures have long been in place to count sponges, towels and other surgical items before and after surgery, but these efforts are not foolproof, Makary notes. Many hospitals are moving toward electronic bar codes on instruments and materials to enable precise counts and prevent human error. Surgical checklists, pioneered at The Johns Hopkins Hospital, are also often in place.

Along with better procedures to prevent never events, better reporting systems are needed to speed up safety efforts, says Makary. He advocates public reporting of never events, an action that would give consumers the information to make more informed choices about where to undergo surgery, as well as “put hospitals under the gun to make things safer.”

Currently, he notes, hospitals are supposed to voluntarily share never event information with The Joint Commission that assesses hospital safety and practice standards, but that doesn’t always happen.

REFERENCE

1. Mehtsun WT, Ibrahim AM, Diener-West M, et al. Surgical never events in the United States. *Surgery*. Published online Dec. 18, 2012. Web: <http://dx.doi.org/10.1016/j.surg.2012.10.005>. ■

Advice from consultant or vendor can result in suit

There are several disparate areas in which following a vendor or consultant’s recommendations could lead to liability for a provider or facility, warns Henry C. Fader, JD, an attorney at Pepper Hamilton in Philadelphia. Here are some scenarios that carry risks:

- **A consultant hired to assist your surgical practice in becoming more efficient might recommend a new approach for obtaining consent.**

For example, the consultant might suggest asking

patients to indicate “I Agree” on a tablet computer as they are wheeled into surgery. “This device saves much time and effort in obtaining informed consent, but one of your patients sues for medical malpractice, and you have to testify that you provided the patient with informed consent,” says Fader.

In this situation, he says, the plaintiff is likely to move for a directed verdict in favor of the patient since the physician is unable to testify that adequate informed consent was obtained. (*For more information, see “Is informed consent better on a computer?” Same-Day Surgery, July 2011.*)

- **You might fail to meet criteria for the Centers for Medicare & Medicaid Services’ (CMS’) “meaningful use” payments.**

One of the Obama administration’s initiatives is to expand the number of providers who use electronic medical records (EMRs) with incentive payments, but several criteria must be satisfied, notes Fader.

If you hire an information technology vendor to put the EMR into service, and the EMR does not meet the appropriate certification criteria or doesn’t perform particular functions in accordance with the required criteria, you might inadvertently make a false claim to the Medicare or Medicaid program when requesting “meaningful use” payments, warns Fader.

- **A consultant might arrange for your facility to share de-identified patient information with a pharmaceutical company to examine prescribing practices with respect to a particular diagnosis.**

When you provide access to your EMR records to the consultant, all of the patient-identifying data is loaded on the consultant’s laptop. “The laptop is stolen from the consultant’s vehicle. Your practice has now suffered a breach under Health Insurance Portability and Accountability Act [HIPAA] and the HITECH [Health Information Technology for Economic and Clinical Health] laws,” says Fader.

While the consultant has joint responsibility under HITECH for the breach as a “business associate,” your practice has to explain to patients how the breach

EXECUTIVE SUMMARY

Physicians and facilities face some significant liability risks stemming from recommendations from a vendor or consultant. Some areas of risk:

- A consultant hired to assist your practice/facility in becoming more efficient might recommend a new approach for obtaining consent.
- Electronic medical records might not meet appropriate criteria to qualify for incentive payments.
- Data provided to consultants could result in violations of patient privacy regulations.
- Outsourced human resources functions might result in inadequate checks on employees.

occurred, says Fader. This situation results in loss of reputation as well as potential fines from the Office of Civil Rights, he says.

- **If you are part of an accountable care organization (ACO) which requires you to follow clinical guidelines and report patient satisfaction, you might hire a consultant to assist in the provision of appropriate clinical guidelines for your patients.**

“But the consultant is providing advice and recording results that unfortunately enhance the practice’s statistics. These are then used to qualify your patient population for gain-sharing payments,” says Fader.

As a result of using these enhanced statistics due to the consultant’s advice, you might have filed a false claim and would need to return the savings to the ACO and the Medicare program, he explains.

- **You decide to outsource your human resources (HR) function to a consultant, who handles interviews and completion of employment and benefits paperwork. The consultant is supposed to verify credentials, verify references, and perform a criminal background check.**

Fader gives the following scenario: An employee embezzles funds from the practice’s bank account, and when you notify the police of the loss, they advise you that the employee had been convicted of theft previously.

“When you confirm the situation with the HR consultant, you get the bad news that they never performed the required criminal background check on the employee, costing the practice thousands of dollars in losses,” says Fader. (*For more information, see “Background checks useful, but limited,” SDS, July 2012.*) ■

Same-Day Surgery Manager



Technology to make your work life easier

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

Part of my job is to review technology: hardware, software, web applications, cell phone apps, and the like. What a sweet job, right?

Much of my research is with entrepreneurs, CEOs, and geeks. (Oh, my!) I don’t know which of this group I enjoy more. I do admit that I bluff my way through many of the geek conversations, and I suspect they know that I know nothing, but it still is fascinating to hear what technology already is here for all of us.

Regardless of where you work, hospital or surgery center, both are embracing the technology. Essentially, as I see it, much of what is here and ahead of us is cloud-based, from patient medical passports, to billing, to patient registration, to electronic medical records, to pre-op and post-op interaction with our patients.

Imagine an interactive web based program that does the nursing assessment (with real time RNs) and anesthesia consults, orders preop tests based upon a menu-driven decision tree, and prints detailed instructions and even directions to your facility from the patient’s home. Imagine the patient registration process, including the signing of all necessary paperwork from the patient’s home with document-signing software embedded into your forms. The registration processing time has just been reduced by 80% and with a much higher patient understanding because they can actually take the time to read what they are signing. In comparison, they often feel pressured to sign documents by the front desk staff just trying to push the patient through the system.

In addition, your entire medical history, lab tests, consultations, operations, complications, meds, reactions to meds, X-rays, and MRI/CT scans and interpretations are readily available to your surgical provider, while still conforming to and protecting your privacy. How cool.

Furthermore, all your postoperative phone calls are made to your patients, which frees up valuable staffing time. Slick, isn’t it? Don’t give me that “we are losing contact with our patients” argument. You are not. You are enhancing the patients experience by eliminating duplication, late patients, lost patients, and canceled cases, and you are freeing up staff to focus on the patient’s surgery.

What about controlling your cost? You will be updating your inventory at the end of each day. You will be making sure you are being charged exactly what you negotiated with your vendors. What if your vendors had access to your inventory online and automatically replenished your PAR stock? What if you never had to see a vendor again? Well, probably not a good idea. Who would buy lunch and bring doughnuts? (No hate mail from vendors please! We know we cannot survive without your input and advice.)

Let’s not forget the surgeon’s staff. We want the surgeons to like us, but we really want to remove bar-

riers for the surgeon's staff when they are booking cases. Again, imagine the surgeon's block schedule available to his/her staff so that they can post the case without a single phone call. At the same time, they can integrate the patient's demographic information into your facility software, which reduces duplication of efforts and errors. Imagine if there is an error in the posting, and it is the surgeon's office fault and not ours. How satisfying is that?

Now let's look at what I look at: cash flow!

What if everything you need to know about your department or facility billing, return of investment, billed patients, rejected claims, days in receivable, insurance reimbursement tied to your contracts, patient deductible information, outstanding invoices, late payments, and dozens of other financial information was on a single page of your computer. Now imagine that being cloud-based. It could be accessible by as many people as you grant access to, and they could watch the indicators change in real time. Sweet!

Guess what? All of it and more is here right now and surprisingly inexpensive. We have some sharp people in this great country. I have had the great privilege to meet all these innovative companies and developers, and I am still in awe of what is here and cannot wait to see what is ahead! *[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.]* ■

Hospital achieves \$1.5 million increase

Pre-service collections for surgeries jump

During the first year of a three-year project to increase point-of-service (POS) collections at Oregon Health & Science University in Portland, leaders set and reached a goal of increasing pre-service collections for scheduled outpatient and inpatient surgeries to \$2 million, starting from a baseline of \$500,000 a year.

Staff members increased the amount of deductible and coinsurance they asked for prior to service delivery, reports Mela Gant, director of patient access services.

"We used to ask for the deductible, plus \$100," she says. "However, we did not tell the patient before-

hand that we would be asking for any money at all. So they were unprepared to pay at the point of admission for surgery or an inpatient stay."

Admissions staff typically asked patients, "Would you like to pay that now, or would you prefer to be billed?"

"Most of the time, patients preferred to be billed," says Gant. "We are now asking for varying amounts, depending on the patient's insurance and the service being delivered, ranging from \$300 to \$600."

If the patient is not able to pay the full amount, staff members ask for half the amount, and if they are not able to pay that, staff members ask what they are able to pay today.

If patients state they are unable to pay, this statement opens up the conversation to the hospital's financial assistance program or the option to make payment arrangements after they receive their bill.

"We take a very soft approach if patients are uncomfortable or unable to pay," says Gant. "We start by asking for a lesser amount." Then, staff members give the patient options to contact the billing office after receiving the bill to discuss a payment plan or to inquire about the hospital's financial assistance program. ■

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

- Major verdict for improperly sanitized equipment
- Preventing hepatitis B virus transmission from staff
- Dangers with electronic medical records
- Should your program allow off-label use?

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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. How do staff members at the DISC Surgery Center confirm that the preop skin antiseptic preparation is dry?
A. They make a visual confirmation.
B. They use a code clock and wait three minutes before draping.
C. Draping normally takes a few minutes and allows the preparation to dry.
D. None of the above.
2. Which of the following practices did surgical teams at Cedars-Sinai in Los Angeles use to reduce surgical site infections by more than 60% for colorectal surgery patients?
A. Patients used chlorhexidine antiseptic solution to shower the evening and morning before surgery. Operative sites were prepped with a sterile chlorhexidine and alcohol antiseptic solution.
B. Use of wound protectors was encouraged to reduce contamination of the skin while handling the intestines.
C. After completing the contaminated portion of colorectal procedures, members of surgical teams changed to new gowns and gloves, used new instruments, and re-draped operative sites with sterile covers.
D. All of the above.
3. What are some of the potential security challenges with texting, according to Steve Hunt, CPP, CISSP, director of Neohapsis Labs?
A. Authentication of the sender or receiver's identity.
B. A misdialled phone number.
C. A misplaced cell phone.
D. All of the above.
4. Organizations that allow employees to use personal devices to access patient information should require what, according to Steve Wu, attorney and partner at Cooke, Kobrick and Wu?
A. Healthcare facility-provided encryption
B. Mobile device management software on each device
C. A and B
D. Neither A nor B

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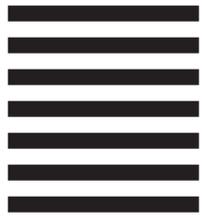


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MADISON SURGERY CENTER QUESTIONNAIRE

You recently received care at the Madison Surgery Center. Your health care team would like to hear your thoughts about your experience at the surgery center. Your feedback on the enclosed survey will help us improve the care and service we provide to all our patients. You can respond by completing the printed survey provided here.

Please mark the response that most closely reflects your experience.	Strongly Disagree	Slightly Disagree	Neutral	Slightly Agree	Strongly Agree	Does Not Apply
1. I was informed about what to expect on the day of my procedure.	<input type="checkbox"/>					
2. I was kept informed of any/all delays.	<input type="checkbox"/>					
3. My needs were handled promptly and efficiently by the admission staff.	<input type="checkbox"/>					
4. On the day of my procedure, the sequence of events was explained to me.	<input type="checkbox"/>					
5. The clinical staff was responsive to my needs and concerns.	<input type="checkbox"/>					
6. My surgeon showed concern and sensitivity to my needs.	<input type="checkbox"/>					
7. My anesthesiologist showed concern and sensitivity to my needs.	<input type="checkbox"/>					
8. The needs of my family/support person were met during my stay at Madison Surgery Center.	<input type="checkbox"/>					
9. The clinical team kept me informed about what was taking place during my stay at Madison Surgery Center.	<input type="checkbox"/>					
10. I was satisfied with the way my pain was addressed.	<input type="checkbox"/>					
11. Medication and care at home were explained to me in a way I could understand.	<input type="checkbox"/>					
12. My privacy was respected during my entire stay at Madison Surgery Center.	<input type="checkbox"/>					
13. I knew who to call if I had questions or concerns after my stay at Madison Surgery Center.	<input type="checkbox"/>					
14. I consistently received respect and compassion while at Madison Surgery Center.	<input type="checkbox"/>					
15. I would recommend Madison Surgery Center without hesitation to others.	<input type="checkbox"/>					

If you have any suggestions or comments, please print them in the box below.

Please indicate the area of service for which you received care:

Colonoscopy Cataract Pain Surgical/Procedure

Date of Visit: MONTH DATE YEAR

Name(optional) _____

		/			/				
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Thank you for your comments. Please fold, tape shut, and return.