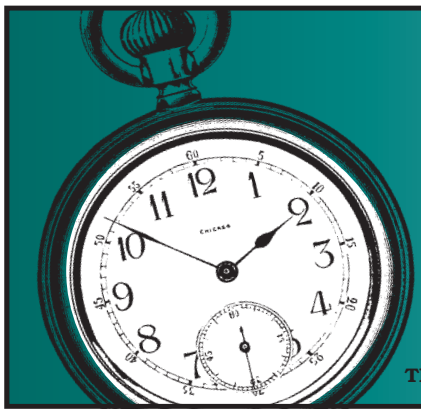

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2 incidents raise concerns: How do you protect staff and patients from violence?

By **Joy Daughtery Dickinson**, Executive Editor

In November, a patient's son ran through Good Shepherd Ambulatory Surgical Center in Longview, TX, with a hunting knife and screamed, "You're not going to kill my mother." He stabbed and killed a nurse and a patient's father and injured three others. The 22-year-old attacker ran from the scene but soon was caught and arrested.

In December, a former patient who claimed to have had a botched vasectomy three years ago opened fire at Urology Nevada in Reno. He fatally shot the urologist and injured two others before fatally shooting himself. He had posted Yahoo messages for years saying his doctors were responsible for his declining health. In his postings, he said he had learned that immune reactions, nerve damage, and back pressure issues could result from vasectomy, but he claimed not to have been informed of these potential side effects. *(See more on this story, p. 41.)*

Incidents of violence are not uncommon, particularly in healthcare. Since 2000, an average of 552 work-related homicides occurred annually in the United States.[1] A 2012 report said 27% of businesses had experienced an incident of workplace violence within the last five years.[2] Sixty-one percent of workplace assaults are by healthcare patients or residents of a healthcare facility.[3]

Employers are obligated, under the Occupational Safety and Health Administration (OSHA) General Duty Clause, to provide a workplace "free from recognized hazards that are causing or likely to cause death or serious physical harm." In some cases, workplace violence prevention has been accepted as falling under the General Duty Clause, according to the National Institute for Prevention of Workplace Violence in Lake Forest, CA. "Additionally, any incident will likely trigger an OSHA investigation, which could result in a fine," the institute says.[1]

If you don't have security, what do you do?

The recent incidents of violence raise concerns among outpatient surgery managers, particularly those who work in offices or facilities where there is no security staff.

"While it is certainly not possible to prevent all incidents of workplace violence

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because they depend on the quirks and variability of human behavior, the vast majority of incidents are preventable if organizations take the potential threat of workplace violence as a serious one and invest in the necessary level of pre-planning and preparation," says **Barry Nixon**, SPHR, executive director of the National Institute for Prevention of Workplace Violence and publisher of The Workplace Violence Prevention eReport. "High levels of planning, preparing, and focus on prevention will reduce the need for reaction and response," Nixon says. Workplace violence experts suggest these steps:

• Establish policies and procedures.

"Policies and procedures can be put in place so that employees know what is expected of them to identify and address potentially violent situations," says **Corinne Peek-Asa,** PhD, director of the Injury Prevention Research Center at the University of Iowa in Iowa City.

Establish a multidisciplinary team to develop and implement procedures for reporting and communicating about events, she says. "This can be in the form of a safety committee or a threat management team," Peek-Asa says.

• Educate your staff.

Train all employees on policies and procedures, as well as offering general training on patterns of, signs of, and response to potentially violent situations, Peek-Asa says. *(See "The Unlucky 13: Early Warning Signs of Potential Violence at Work," p. 39.)*

"While the tendency of healthcare is to focus on patient violence, it is also important to include worker-on-worker violence, intimate partner violence, and the potential for robbery," she says.

Don't stop with staff, Nixon says. "Supervisors should be educated about the firm's workplace violence prevention policy and program which defines their responsibilities including legal requirements, how to handle information reported to them or that they observe, identification of early warning signs, and how to intervene and what to do if an incident occurs," he says.

James Bray, police area representative of the Longview Police Department, teaches a two-hour class on how to respond to violence, but for those with time limitations, Bray and others point to a 6-minute YouTube video titled "Run! Hide! Fight!" developed by the City of Houston. Access it at http://binged.it/1e1nsQV.

Bray was told that employees responded well to the stabbing at the Longview center. Visitors who couldn't get out of the building were locked in exam rooms and offices. Ensure that your patient rooms can be locked from the inside, Bray says. Another option is to put fur-

EXECUTIVE SUMMARY

Two recent incidents of fatal violence at outpatient surgery programs are putting new focus on how to prevent such incidents, particularly because many surgery centers and surgeon's offices lack security staff.

- Have a multidisciplinary team develop and implement procedures for reporting and communicating about potential violence.
- Educate and train staff and supervisors at least annually. Hold drills.
- Have local law enforcement conduct a security survey.

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niture in front of a door. If it's necessary to fight, "have the mindset that I'm going to fight with everything I have, and I'm going to be the one who walks away from the incident," Bray says.

If you use packaged educational programs, augment them with information specific to your worksite, Peek-Asa advises.

• Train employees and hold drills.

In terms of violence prevention, "everyone has hurricane drills, tornado drills, but no one ever has that type of drill," Bray says.

He suggests that you ask employees to sit or stand at their normal workstations and answer these questions: Where is the closest exit? Where will I hide if I need to

The Unlucky 13: Early Warning Signs of Potential Violence at Work

1. Threats: Person makes direct, veiled, or conditional threats of harm.

2. Unreasonable: Person constantly makes slighting references to others. He is never happy with what is going on. He is consistently unreasonable and over reacts to feedback or criticism. He blows everything out of proportion. He is unable to accept criticism of job performance; he has a tendency to take comments personally and turns it into a grudge.

3. Intimidation and control-oriented: Person feels a need to constantly force their opinion on others. He has a compulsive need to control others. He uses intimidation of others to get his way (can be physical or verbal intimidation).e.g., fear tactics, threats, harassing behaviors including phone calls, stalking, etc.

4. Paranoid: Person thinks other employees are out to get them. She thinks there is a conspiracy to all functions of society. She feels persecuted or a victim of injustice.

5. Irresponsible: Person doesn't take responsibility for any of their behaviors or faults or mistakes; it's always someone else's fault. Employee does not accept responsibility for own actions; makes excuses; blames others, the company, the system for problems, errors, and disruptive behaviors, etc.

6. Angry, argumentative, and lacks impulse control: Person has many hate and anger issues on and off the job with co-workers, family, friends, or the government. He is frequently involved in confrontations, is belligerent, and argues with others including supervisors, co-workers, neighbors, etc. He has low impulse control; is frequently involved in arguments and altercations; physically slams things, doors, etc.; pounds fist or is verbally demonstrative; and uses inappropriate language.

7. Antisocial behaviors: Has fascination with violence and acceptance of violence as a way to handle situations; Person applauds violent acts portrayed in the media such as racial incidents, domestic violence, shooting sprees, executions etc. He might have had trouble with the law, even just a minor incident. He is fascinated with the killing power of weapons and their destructive effect on people coupled with extreme interest in guns, particularly semi-automatic or automatic weapons. Has a pattern of behavior that demonstrates a disregard for the rights of others.

8. Vindictive: Person makes statements like "he will get his" or "what comes around goes around" or "one of these days I'll have my say." She often verbalizes hope for something to happen to the person against whom the employee has a grudge.

9. Bizarre and weird behavior: Person is quirky, strange, considered weird, and behaves in unusual manner. Their presence makes others feel uneasy and uncomfortable.

10. Desperation: Person is experiencing extreme desperation with recent family, financial, or personal problems.

11. Obsessive compulsive behavior: Person has obsessive involvement with the job, particularly when no apparent outside interests exists; has a romantic obsession with co-worker who has no interest in him/her; suffers from other forms of obsessions. May have a zealous interest on a specific topic; may have perfectionist tendencies.

12. Substance abuse: Person has signs of alcohol and/or drug abuse.

13. Chronic depression: Person displays chronic signs of depression, loss of interest and confidence in life or work, is lethargic, lacks energy, particularly when this is a significant change in behavior.

Source: Reprint permission granted only to "Same-Day Surgery." National Institute for Prevention of Workplace Violence, Lake Forest, CA. For more information on the "Early Warning Signs of Potential Violence at Work" and appropriate intervention techniques, visit www.Workplaceviolence911.com, the leading site on the Internet for comprehensive information on workplace violence, or contact Barry Nixon at Barry@wvp911.com or (949) 770-5264. ■

hide? What do I have available to use as a weapon if I need it? Also consider how you can help protect patients during the threat.

Conduct scenario exercises as a tabletop exercise or a simulated scenario, Peek-Asa suggests. "Scenarios focused on upstream identification [of potentially violent situations] and response are most helpful," she says.

Drills are valuable, agrees Deputy Chief **Mac Venzon** of the Reno Police Department — Support Services Division. " By having a plan in place, employees are not left to determine what they should do; rather they have rehearsed a response that they will then act in accordance with more quickly."

The end result will be better outcomes, Nixon says. "When a crisis occurs, logic and rational thinking will not be sufficient," he says. "People will inevitably rely on what they have been trained to do."

Conduct violence prevention training at least annually, and behavior de-escalation should be "first and foremost," says **Lisa Pryse Terry**, CHPA, CPP, president of healthcare services and chief of company police at ODS Security Solutions, Richmond, VA, and Raleigh, NC. ODS Security Solutions delivers security services for healthcare, commercial, and government clients.

"Recognition and de-escalation of violent behavior is an essential tool for healthcare providers," Terry says.

• Work with your local law enforcement.

Most law enforcement agencies are willing to come to your facility and perform a "security survey," Bray says. "We can't guarantee you'll be 100% crime-free, but we can offer suggestions about how to make it less inviting for a criminal," he says.

Police can offer suggestions on how to control access to facility, Venzon says." By controlling access to back offices, should an assailant present himself, there is a better chance at minimizing the damage if movements are controlled," he says.

An added advantage of a security survey is that managers meet police and might be more inclined to call, Venzon says. "All too often we find that citizens feel like they would be bothering the police if they report something that does not reach the level of criminal activity, but just doesn't seem right," he says.

In Reno, the shooter pulled a shotgun from his vehicle and walked from the parking lot to the third floor, passing several patients and visitors, but nothing was reported until he started shooting, Venzon says." As police, we need the public as our eyes and ears so that we can react as quickly as possible to try and minimize the damage and tragedy caused by an active assailant," he says.

• Be vigilant.

"When you notice someone that is not acting right, or makes statements that might seem out of place and dangerous in nature, let someone know," Venzon says. "It is my experience that many active assailants have let on that they are planning something terrible."

You can notify local law enforcement or mental health professionals, if a person seems to be making statements that are concerning, he says. "Further, being keenly aware of people that may pose a threat, and notifying someone — law enforcement, mental health professionals, or even family members — that something is not right with the individual will go a long way in attempting to prevent such tragedies," Venzon says.

Preparation is vital, Peek-Asa emphasizes. "The most effective approach is to focus on prevention: identifying any potentially violent situations early and having a structure in place about how to handle them," she says.

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RESOURCES

• The **Center for Personal Protection and Safety** has developed training modules, videos, and evaluation tools on workplace violence prevention ("Flashpoint – Healthcare") and Active Shooter Response ("Shots Fired – Healthcare"). Web: www.cppssite.com.

• **The National Institute for Occupational Safety and Health** (NIOSH) has launched an online training program, complete with free continuing education. The course describes risk factors for patient assaults as well as co-worker aggression. The course offers intervention strategies to help staff prevent a situation from escalating. Case studies illustrate appropriate ways to respond. NIOSH also provides checklists and sample incident reports. Web: www.cdc.gov/niosh/topics/violence/training_nurses.html.

• The **National Institute for Prevention of Workplace Violence** has specific methods, tools, and processes on workplace violence. Web: www.WorkplaceViolence911.com. Sign up for a complimentary subscription to "The Workplace Violence Prevention eReport," which is published online every other month, at http://www.workplaceviolence911.com/preventionreport#formhere.

• Occupational Safety and Health Administration's ***Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers.*** Web: http://1.usa.gov/1hsgTin. ■

Informed consent can play part in violence

Informed consent has been raised as a potential factor in patient violence after a former patient who claimed to have had a botched vasectomy three years ago opened fire in December at Urology Nevada in Reno. Two persons — the urologist and the shooter — died, and two others were injured.

The shooter had posted Yahoo messages claiming his doctors were responsible for his health problems. He said that he was not informed that vasectomy could cause immune reactions, nerve damage, and back pressure issues.

Although no research has made a connection between informed consent and potential violence, it is always best to ensure patients are well-educated about potential negative side effects, violence experts say.

"When a 'reward' is allocated or a decision is made, people often make a judgment about whether or not the outcome was fair," says **Barry Nixon**, SPHR, executive director of the National Institute for Prevention of Workplace Violence in Lake Forest, CA, and publisher of The Workplace Violence Prevention eReport. "Add to this the human tendency to imagine 'worst-case scenario' in the absence of other information being provided, and lack of high quality patient education/information becomes a formula for a problem to occur."

When patients are well-informed about possible downsides, they are better prepared for any negative consequences, Nixon says. Thus, they are less likely to allege negative intent on the part of providers or facilities, he says.

"We need to give them sufficient information to make informed decisions," Nixon says. "Doing so will pay tremendous dividends in reducing the likelihood of the person subsequently blaming someone else for negative consequences that may occur, which is the beginning stage of a flame that can rage into violence."

Also, monitoring what patients are writing online about your program can help you address negative posts early, sources say. *(For more information on monitoring online comments, see stories in the April and May 2012 issues of* Same-Day Surgery.*)* ■

Med/mal claims show consistent factors

Researchers look at routine procedures

(Editor's note: This is the first part of a two-part series on claims involving routine procedures. This month, we tell you the contributing factors. Next month, we tell you ways to reduce the risk of malpractice claims.)

The fact that routine medical procedures — scopes, injections, punctures, biopsies, insertion of tubes, or imaging — were involved in a large percentage of malpractice claims didn't come as a surprise to researchers at CRICO Strategies.

"We are all aware of punctures or perforations from misdirected NG [nasogastric] tubes, nerve injuries from blood draws, and tissue damage from IV [intravenous] infiltrates. These events are typically related to technical skill," explains **Gretchen Ruoff**, MPH, CPHRM, program director of patient safety services for CRICO Strategies, a Cambridge, MA-based patient safety and medical professional liability company. One claim involved a splenic laceration during a screening colonoscopy, which resulted in an extended hospital course and admission to an intensive care unit.

The researchers were surprised, however, by these factors that were consistently correlated with the technical errors across multiple procedure types:

- working without adequate training or supervision;
- working with unfamiliar equipment;
- performing a procedure on an inappropriate candidate or in an unsuitable setting due to the patient's health status or comorbidities.

Researchers analyzed 1,497 malpractice cases filed from 2007 to 2011 that alleged malpractice involving a non-surgical procedure. More than two-thirds of the injuries were relatively minor or temporary, but 14% involved patients who died. The cases represent $215 million in incurred losses, and most involved skill-based

EXECUTIVE SUMMARY

Claims involving routine medical procedures — scopes, injections, punctures, biopsies, insertion of tubes, or imaging — resulted in $215 million in incurred losses, according to an analysis of 1,497 cases. In this study, legal outcomes often hinged on these factors:

- failure to obtain or document a thorough, voluntary informed consent;
- lack of appropriate credentials or experience with the procedure;
- failure to follow published safety policies.

errors.

Whether the injury was a known possible complication of the procedure or resulted from a judgment failure, the legal outcomes of these cases often hinged on these factors:

- failure to obtain or document a thorough, voluntary, informed consent;
- a provider's lack of appropriate credentials or experience with the procedure;
- failure to follow published safety policies.

"While these factors do not indicate negligence per se, cases with these factors are harder to defend in a court of law and in the court of public opinion," says Ruoff. She recommends that physicians take these actions to reduce liability risks:

- Diligently and thoroughly explain the risks, benefits, and alternatives of a procedure to the patient prior to a procedure. Accurately document these conversations in the medical record.
- Adhere closely to procedural protocols.
- Recognize that the end of a procedure does not mark the end of the provider's responsibility for monitoring, communication, and follow-up with the patient and the rest of the care team.

"Close monitoring and swift responses to signs of a complication are critical to patient, and provider, safety," says Ruoff.

- In the event of an untoward outcome, offer patients compassionate and informative communication and, when appropriate, disclosure and apology.

"This not only serves to minimize patients' worries, but also begins to rebuild the trust necessary for thorough recovery and healing," says Ruoff.

Unmet expectations are red flag

Missed diagnosis following routine medical procedures can cause the relationship between the healthcare provider and the patient to deteriorate and cause the patient or a family member to seek representation for their harm.

Carmen Lester, RN, JD, CPHRM, co-owner of Yin Yang Medical Services, an Omaha, NE-based provider of risk management services, says, "Red flags should be raised when the patient's outcome differs from the patient's expectations."

Examples of malpractice involving routine medical procedures include:

- a failure to communicate pathology reports to appropriate physicians, often seen in cases involving biopsies;
- delayed diagnosis, when the diagnostic workup does not include all of the testing components needed to arrive at the definitive diagnosis;
- complications or infections following routine procedures, such as insertion of a Foley catheter.

"It is important to point out that there are surgical procedures that are considered 'routine,' such as appendectomies and cholecystectomies, that can have adverse outcomes," adds Lester. Lester points to the recent national news story concerning a 13-year-old girl who was declared brain dead following a tonsillectomy.

When adverse events occur, physicians should notify their malpractice insurer of the potential compensatory event. "The family is most likely seeking counsel for representation," says **Jan Kleinhesselink**, RN, CPHQ, co-owner of Yin Yang Medical Services.

Physicians can take steps to prevent the same incidents from happening again by completing a root cause analysis. "Don't sweep adverse events under the rug," says Kleinhesselink. "Rather, focus on prevention of future occurrences."

Focus on underlying condition

Cases involving routine medical procedures are more defensible if the defense can convincingly argue that the patient's underlying condition ultimately caused the patient's bad outcome, says **Phillip B. Toutant**, Esq., an attorney in the Southfield, MI, office of The Health Law Partners.

Toutant recalls a wrongful death case in which a middle-aged woman with a history of alcoholic liver cirrhosis had a routine colonoscopy at an ambulatory surgery center. During the procedure, she suddenly became hypotensive, and it soon became evident that she was bleeding internally. "The ambulatory surgery center did not have packed red blood cells available, let alone platelets or even whole blood, which would have been far preferred for a patient with severe liver disease," says Toutant.

It was discovered that the patient had a varix between her ovary and her large bowel, which ruptured during the procedure. The defense argued that the abnormality was significant and highly unexpected. The defense said that it was caused by portal hypertension, which was caused by her cirrhosis, which ultimately was caused by the patient's alcoholism. This alcoholism, they argued, resulted in the patient bleeding to death in what otherwise would have been a routine procedure.

Because the case involved a woman who was a co-owner of a sizeable business with significant income, there was potential for substantial wage loss damages in this wrongful death case. The case was settled for a dramatically lower amount than the plaintiff's lawyer's wage loss projections. The disparagement in the settlement amount was largely due to challenges in terms of proving violations of the standard of care.

"In cases where routine procedures result in significant morbidity or mortality, oftentimes the bad outcome is the

result of latent, unpredictable, pre-existing pathology," says Toutant. "Needless to say, this aids in defending the providers."

RESOURCE

• CRICO Strategies' 2013 report, ***Malpractice Risks in Routine Medical Procedures,*** is available free of charge. Go to http://bit.ly/1eIGvl7 and next to the report title, select "PDF" or "Paper." ■

Guidelines address safety in GI endoscopy unit

The American Society for Gastrointestinal Endoscopy (ASGE) has issued "Guidelines for safety in the gastrointestinal endoscopy unit." The purpose of this guideline is to present recommendations for endoscopy units in implementing and prioritizing safety efforts and to provide an endoscopy-specific guideline by which to evaluate endoscopy units.

Although ASGE has previously published guidelines on staffing, sedation, infection control, and endoscope reprocessing for endoscopic procedures, rare reports of outbreaks in which the transmission of infectious agents were related to GI endoscopy have highlighted the need to address potential areas in the endoscopy care continuum that could impact patient safety.

Changes to the Centers for Medicare and Medicaid Services (CMS) Ambulatory Surgical Center Conditions for Coverage that went into effect in 2009 eliminated the distinction between a sterile surgical room and a non-sterile procedure room, which provided further impetus for this guideline. As a result of these conditions, non-sterile procedure environments, including endoscopy units, are now held to the same standards as sterile operating rooms even though requirements for facilities, infection control, staffing, and sedation applicable to the sterile operating room might not be relevant or necessary for endoscopy units.

"Over the past two years, surveyors have called into question accepted practices at many accredited endoscopy units seeking reaccreditation," said **Audrey H. Calderwood**, MD, co-chair of the ASGE Ensuring Safety in the Gastrointestinal Endoscopy Unit Task Force. "Many of these issues relate to the Ambulatory Surgical Center Conditions for Coverage set forth by CMS and the lack of distinction between the sterile operating room and the endoscopy setting. ASGE recognized a need to develop nationally recognized guidelines for endoscopy units that provide recommendations for the implementation and prioritization of safety efforts within GI endoscopy. These endoscopy-specific guidelines will also serve as an important resource for surveyors tasked with evaluating endoscopy units."

The guidelines contain a summary of issues that have been faced by endoscopy units along with the ASGE position and accompanying rationale.

Key safety strategies

To summarize, key strategies to maintain safety in the GI endoscopy unit are:

- Each unit should have a designated flow for the safe physical movement of dirty endoscopes and other equipment.
- Procedure rooms vary in size, with more complex procedures requiring greater space for more specialized equipment and, in some cases, additional staff.
- Before starting an endoscopic procedure, the patient, staff, and performing physician should verify the correct patient and procedure to be performed.
- A specific infection prevention plan must be implemented and directed by a qualified person.
- Gloves and an impervious gown should be worn by staff engaged in direct patient care during the procedure.
- The unit should have a terminal cleansing plan that includes methods and chemical agents for cleansing and disinfecting the procedural space at the end of the day.
- For patients undergoing routine endoscopy under moderate sedation, a single nurse is required in the room in addition to the performing physician. Complex procedures might require additional staff for efficiency, but not necessarily for safety.
- At a minimum, patient monitoring should be performed before the procedure, after administration of sedatives, at regular intervals during the procedure, during initial recovery, and before discharge.
- For cases in which moderate sedation is the target, the individual responsible for patient monitoring may perform brief interruptible tasks.
- For cases in which moderate sedation is the target, there are inadequate data to support the routine use of capnography.

The guidelines were published in "GIE: Gastrointestinal Endoscopy" online. To read the guidelines, go to http://bit.ly/1lqFpyu.

The guidelines were developed by the ASGE Ensuring Safety in the Gastrointestinal Endoscopy Unit Task Force, co-chaired by Calderwood and Frank J. Chapman, MBA, and it was reviewed and approved by the ASGE Governing Board. The guideline was reviewed and endorsed by the American Association for the Study of Liver Diseases, American College of Gastroenterology, American Gastroenterological Association Institute,

Ambulatory Surgery Center Association, American Society of Colon and Rectal Surgeons, and Society of American Gastrointestinal and Endoscopic Surgeons. ■

Hospital finds it pays to fight fraud charges

Case dragged on for 16 years

With healthcare facilities defending themselves from all manner of civil cases and federal prosecution, a big win for a provider is reason to celebrate. The recent victory for George Washington University (GWU) Hospital in Washington, DC, is welcome news, even if it took 16 years.

In 1998, four certified registered nurse anesthetists (CRNAs) formerly employed by GWU filed a lawsuit claiming that the hospital submitted false claims to Medicare for reimbursement of anesthesia procedures. The claims were fraudulent, they alleged, because GWU regularly said the anesthesia procedures had been performed entirely by a licensed anesthesiologist when parts of the anesthesia process had been performed by residents or CRNAs.

The allegations led to a *qui tam* case in which the federal government joined to claim that the hospital had defrauded the government of Medicare funds because of improper coding for the anesthesia services.

GWU was represented by William D. Nussbaum, JD, and Jonathan L. Diesenhaus, JD, of the law firm Hogan Lovells in Washington, DC. They declined to comment on the victory and GWU also refused, except to say they were pleased with the outcome.

The judge's ruling in the case suggests that the years of haggling eliminated so much evidence that the case just fell apart, says **Nicholas D. Jurkowitz**, JD, a healthcare attorney with the law firm of Fenton Nelson in Los Angeles who represents healthcare facilities. Whatever evidence was left after both parties argued over admissibility was insufficient to sustain the case, he says.

EXECUTIVE SUMMARY

George Washington University (GWU) Hospital in Washington, DC, prevailed in an 16-year-old lawsuit accusing the hospital of False Claims Act violations. Legal analysts say the outcome should be encouraging to healthcare managers.

- The case involved allegations of anesthesia billing fraud.
- Plaintiffs might have been hampered by the extensive nature of the allegations.
- Managers should assess the reporting mechanisms available to staff members who suspect fraud.

The outcome suggests that, despite the False Claims Act and *qui tam*, individuals face significant obstacles when suing such a large institution, Jurkowitz says. "The institution is a much bigger entity and has far more resources for fighting, but in addition, all of the information is within the institution," he says. "The hospital has all the information. For the individuals, even if they have seen something and have some knowledge, it is harder for them to access this information and move forward."

The outcome of the case should be heartening to managers who fear that individuals can make claims against a hospital and then have the federal government jump on board with a bias toward finding fraud, says **Mark Kadzielski**, JD, an attorney with the law firm of Pepper Hamilton in Los Angeles. "This is a decision that we have seen in other cases where allegations have been made but were not proven under the False Claims Act, and plaintiffs were procedurally given the chance to put up or shut up," he says. "If they can't, then the case is thrown out. This is reassuring in a sense that you can't take a large institution to court with allegations like this and expect there to be some assumption of fraud or some largesse in terms of a settlement."

Plaintiffs in the GWU case were hampered in part by their own expansive allegations of fraud, which required gathering records from numerous physicians and patients that went back to 1989, before the current GWU management and before current methods of document storage, Kadzielski notes.

Sixteen years is an extremely long time for such a case to drag out, and Jurkowitz points out that even the victory must have cost GWU a fortune in legal expenses. Even with in-house counsel, such litigation usually is handled by outside attorneys, he notes.

Managers should take the GWU case as a reminder to assess their own compliance programs, Jurkowitz says. In particular, he suggests assessing whether there is a mechanism in place, a person who can be contacted easily and without fear of repercussion, when a low-level employee suspects fraud. "Sometimes people at the bottom of the totem pole are reluctant to speak up, especially if there is no easy way for them to report it without putting themselves in jeopardy," he says. "Their fears might be overcome if they realize they can file suit and potentially reap a big reward."

Fighting early might be best chance

The case is a reminder that the hospital must take an aggressive stance with fraud charges from the beginning, says **Mark H.M. Sosnowsky**, JD, an attorney with the law firm of Drinker Biddle & Reath in Washington, DC. Don't focus so much on the poten-

tial liability that you are moved to settle or admit wrongdoing before making the plaintiffs prove their claims, he says.

Case law has given the government some advantages when litigating false claims, but hospitals still can demand that the plaintiff prove individual allegations, Sosnowsky notes. Often the hospital's best opportunity comes in the motion-to-dismiss stage, when it can aggressively demand proof and have some allegations thrown out. After that stage, the fight gets more difficult and more expensive.

"You have to make the relator demonstrate their case early on, and in this case the hospital did file motions for dismissal and whittled down the allegations to the point that it won on summary judgment," he says. "These cases are imminently winnable, but you do have to have the stomach for this kind of fight and the potential for significant damages. That is what makes litigating a case like this extremely risky." ■

Same-Day Surgery Manager

Reimbursement update on spine and pain cases

Also: How to address 5 difficult situations

By **Stephen W. Earnhart**, MS
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For those of you who have not followed what is going on in the battles over spine and pain cases reimbursement, there is much to learn that could benefit all.

Pain case professional fee reimbursement is taking it right on the chin in 2014 — so much so that most pain practitioners are being forced to rely upon facility fee reimbursement to keep the lights on. The bottom line is that pain physicians who traditionally have performed procedures in their offices probably will be forced to start performing them, and having an ownership position, in freestanding surgery centers. The debate is raging, but based upon the number of calls we are receiving, it seems like many of these physicians are ready to build their own surgery centers or become a partner in an existing facility.

I know that many facilities are vexed at providing this service as they tend to "bottleneck" the recovery area of many facilities not designed to cope with 20 or 30 new cases coming into their center. Depending upon the sedation used for the pain patients, they can jam the recovery room with prolonged recovery time, especially for those patients who receive conscious sedation for their procedure. A further complication for these procedures is the relatively low reimbursement for many of these cases.

On the opposite side of the ledger is the "two-midnight" rule being hotly watched by many. Essentially payers are pushing that spine surgery procedures performed in a hospital must stay overnight for at least two nights (hence, Medicare's "two-midnight" rule) or they are not going to reimburse the surgeon or the hospital.

The effect is that many spine specialists are looking to doing these procedures in a surgery center, but most need to keep their patients at least one night. The equipment is expensive, and staff training is very detailed. Again, most freestanding facilities do not have the space nor the inclination to spend the money on the equipment and training.

How to address 5 difficult situations

Last month we were looking at making decisions, and I gave some suggestions on several actual scenarios. In that same vein, here are some additional questions and answers.

• It looks like a staff member slipped a vial from the anesthesia cart into his pocket. What do you do?

Answer: Because the person who saw this was not his supervisor, the best option is for that person not to confront the individual but to report what she saw to his supervisor.

• Cases are running very late, and a very busy and irate surgeon demands that you call your supervisor and let her know that he is just starting his elective case at 9:30 pm, five hours late. He is demanding to speak with her and "give her hell." What do you do?

Answer: Since this situation happened to the circulator on the "call team," the best approach is to call her and let her deal with the situation since she has more experience in dealing with situations like this one.

• You have a mandatory staff meeting scheduled for 8 a.m. At 8:15, only a few of the staff are there. What do you do?

Answer: No question here. Start the meeting without them and let them know they can find out what they missed from the ones who arrived on time. I don't know how many staff meetings I have started over the years with no one there. After a while, people learn how to use a watch.

• Your instrument rep's new boss is visiting your facility and wants to know how his rep is treating you. The

rep is terrible, but he has saved you before in getting an instrument to you when you needed it. What do you do?

Answer: Part of the rep's job is to save you when you need it. Be up front with the new boss. Chance are she already has heard the truth from other facilities.

• Only one staff member can attend the upcoming surgical conference. The person most qualified to attend has only been on the job for a year. The person that assumes she will go has been there 15 years. What do you do?

Answer: I think we are all getting a little tired of staff members resting on their laurels from days past and not focusing on what is happening today. It is not fair to the qualified individual who has worked hard to qualify to go; nor is it fair to the 15-year staff member to be rewarded for something they didn't earn. Send the most qualified! *[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.]* ■

Patient participation in checklist is win-win

Patients feel safer — and likely are safer — when they receive a surgical safety checklist and request that their healthcare providers use it, suggests a pilot study being presented at the American Society of Anesthesiologists' Practice Management 2014 meeting.

Use of the World Health Organization (WHO) Surgical Safety Checklist (SSC) has been reported to reduce complication rates. Seeking ways to boost compliance of the SSC, researchers at Tulane University Hospital and Clinic decided to involve patients. Patients were informed of the list and asked their providers to be sure to follow it.

"The checklist is only beneficial when it is used, and we found that involving patients helps ensure that surgical teams complied with it," said **Seth Christian**, MD, MBA, director of quality for the Department of Anesthesiology at the Tulane University Hospital and Clinic, New Orleans. "Empowering patients to participate in their own care creates a culture of safety and makes them feel safer — and rightly so."

The study compared compliance of the SSC in 61 patients who were not informed about the list and 43 patients who were told about the list and given a copy. The copy included a place for providers to sign agreeing they would follow it. When patients were informed, compliance was higher for all 26 checklist items. The difference was statistically significant for 19 of the 26 items. For example, allergies were confirmed in 95% of the informed patient group vs. 69% of the uninformed group. The surgical site was confirmed in 74% of informed patients vs. 54% of uninformed patients. Sponge and instrument counts were formally reviewed in 87% of informed patients vs. 19% of uninformed patients. Actual performance of each task on the list was confirmed by students who secretly were auditing its use while observing the surgeries.

While only 35% of informed patients had heard of surgical safety checklists, all said the SSC made them feel more comfortable going into their surgeries.

Although Tulane uses a slightly modified version of the WHO SSC to include the addition of a section on preprocedure check-in, researchers focused the study on compliance of the items on the WHO's version of the list. ■

Publicly reporting data from surgery is targeted

Guidance document focuses on quality measures

The Surgical Quality Alliance (SQA), with the American College of Surgeons (ACS), has released "Surgery & Public Reporting: Recommendations for Issuing Public Reports on Surgical Care." This resource document provides organizations that publicly report on surgical quality measures with a better understanding of the considerations when reporting on aspects of surgical care. The document will assist organizations reporting on surgical quality from the patient, provider, payer, and purchaser perspective

This document is the first report of its kind to be issued by surgical associations with a focus on public reporting of surgical care. It addresses issues that surgical teams should take into account when defining specialty — specific reporting metrics and highlights the tenet that surgical specialists, in consultation with their patients, are uniquely qualified to provide input on quality measurement and defining clinical excellence in surgery.

"A key component of improving the quality of care provided in our nation's healthcare system hinges on transparency and accountability," said ACS Executive Director **David B. Hoyt,** MD, FACS. "This document is an important step in ensuring that reports, which are made available for public use, incorporate the nuances of surgical care and, more importantly, promote the concept that the information in the reports is important

and understandable to our patients."

SQA chair **Frank Opelka**, MD, FACS, said, "A guidance document of this magnitude can carry significant weight with healthcare organizations. We're issuing this report in an era when federal legislation now mandates that components of care be measured and publicly reported. Many organizations are just beginning to explore how to specifically report on surgical care. This document is designed to directly provide guidance on those organizational efforts, not just so that they comply with federal requirements, but so we can collectively ensure the information that patients want and need about their surgeons is available to them."

This report also addresses the importance of coordinated teamwork in clinical care. This effort involves team-based surgical care that is safe, effective, and efficient. The document emphasizes that public reports about the quality of care should follow not only individual surgeons, but should be based on the reality of how care is delivered and follow the teams of providers that deliver care.

The SQA is a collaborative effort of more than 20 surgical and anesthesia specialty societies. The document is available online at: http://www.facs.org/ahp/sqa/index.html. ■

Study finds evidence lacking on value of preop testing

Cataract surgery was the exception

A new research review from the Agency for Healthcare Research and Quality (AHRQ) found that, with the exception of cataract surgery, there is a lack of reliable evidence about benefits, harms, and resource utilization with routine or "per protocol" preoperative testing.[1]

According to the review, there is a high strength of evidence that preoperative tests do not affect outcomes in patients scheduled for cataract surgery. "There is high strength of evidence that, for patients scheduled for cataract surgery, routine preoperative testing has no effect on total perioperative complications or procedure cancellation," the study said.

However, no conclusions could be drawn about the value of routine preoperative testing for other procedures. Given the large number of patients undergoing elective surgery, better evidence is needed to indicate when routine testing improves patient outcomes and reduces potential harms, according to the review.

REFERENCE

1. Balk EM, Earley A, Hadar N, et al. Benefits and harms of routine preoperative testing: Comparative effectiveness. comparative effectiveness review no. 130. AHRQ Publication No. 14-EHC009-EF. Rockville, MD: Agency for Healthcare Research and Quality; January 2014. Web: www.effectivehealthcare.ahrq.gov/reports/final.cfm. ■

CNE/CME OBJECTIVES & INSTRUCTIONS

After reading *Same-Day Surgery*, the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- how current issues in ambulatory surgery affect clinical and management practices.
- Incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.
2. Scan the QR code below or 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 emailed to you instantly. ■

COMING IN FUTURE MONTHS

■ Patients get their prescriptions before they go home

■ Lessons for caring for geriatric patients

■ Address generational differences in the OR

■ Should you expand into retail and other areas?

CNE/CME QUESTIONS

1. What should be "first and foremost" in violence prevention training, according to Lisa Pryse Terry, CHPA, CPP, president of healthcare services and chief of company police at ODS Security Solutions?
   A. Evacuation procedures
   B. Behavior de-escalation
   C. Physical defense

2. Claims involving routine medical procedures — scopes, injections, punctures, biopsies, insertion of tubes, or imaging — resulted in $215 million in incurred losses, according to an analysis of 1,497 cases. In this study, legal outcomes often hinged on what factor(s)?
   A. Failure to obtain or document a thorough, voluntary informed consent.
   B. Lack of appropriate credentials or experience with the procedure.
   C. Failure to follow published safety policies.
   D. All of the above.

3. How did George Washington University (GWU) Hospital prevail in its 16-year case in which former employees alleged false claims?
   A. A federal judge recently determined that there is no admissible evidence left to accuse GWU of overbilling the government for anesthesia services.
   B. A federal judge recently weighed the evidence and issued a ruling in favor of GWU.
   C. A federal judge recently accepted GWU's argument that the plaintiffs did not have standing to bring the case.
   D. A federal judge recently agreed with GWU that the scope of the document requests by the plaintiffs exceeded what could be reasonable and prudent.

4. What was the basis for the lawsuit alleging false claims involving GWU?
   A. Employees of the hospital alleged that it billed for surgery that was not performed and also for surgery that was not necessary.
   B. Employees of the hospital alleged that it billed for services of anesthesiologists when the doctors did not actually perform all aspects of the anesthesia.
   C. A group of physicians claimed that GWU excluded it from participation in services by billing for services at a rate below market value.
   D. A group of physicians claimed that GWU improperly attributed therapy services to them while actually retaining the reimbursement for the hospital.