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June 2014: Vol. 38, No. 6
Pages 61-68

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AHC Media

Can't afford a new surgery center? Maybe your competitors can help you

3 healthcare organizations create joint facility and report efficiencies

Faced with significant changes in insurance plans, reduced reimbursements for services, the desire to achieve economies of scale, and a growing patient population, three Nashua, NH, hospitals teamed up to build an ambulatory surgery center (ASC).

St. Joseph Healthcare, Southern New Hampshire Health System, and Dartmouth-Hitchcock Nashua, a physician group practice employed by Dartmouth-Hitchcock health system, chipped in a total of $1.6 million to create a non-profit three-OR outpatient surgery center on the first floor of an existing medical building. The center is applying to be a Medicare-deemed ASC, according to **Craig Beck**, Dartmouth-Hitchcock Nashua administrative director. The results from the center have been positive, Beck says.

"Certainly, with the case volume we have been able to shift to the ASC, we are getting the typical efficiencies you see in an ASC setting: faster turnover of similar cases, staff geared toward these cases, focused workflows, etc.," Beck says.

The organization has even higher expectations for the future as it obtains more payer contracts and Medicare deemed status, he says. "The organizations are in it for the long haul and feel comfortable in having a collaborative plan on a cost-effective space for the community as focus continues to move toward outpatient settings," Beck says.

Each of the three healthcare organizations has an equal ownership in Surgery Center of Greater Nashua. Each organization appoints two people to the six-person board. And this isn't the first joint venture of the group. Twenty years ago, the three organizations joined to create the Radiation Center of Greater Nashua.

Sanders Burstein, MD, Dartmouth-Hitchcock Nashua medical director, says, "The collaboration between our three organizations is an important step toward creating a sustainable health system in the greater Nashua community. We are able to offer a surgical service of great value to the community by providing high quality surgical care, as efficiently as possible in the outpatient setting. We can only do that if we work together."

Such joint ventures should fit well in the new healthcare environment of account-

able care organizations (ACOs) and the growing emphasis on cost containment.

Beck says, "At the end of the day, an outpatient setting is a better value for the patient than being in the hospital. When you're looking at utilization or expenses or equality, it matches what we're trying to do for an ACO or site-of-service plan and changes in reimbursement." Consider these advantages they say they've found:

• Cheaper to establish.

Same-Day Surgery® (ISSN 0190-5066) is published monthly by AHC Media, LLC, One Atlanta Plaza, 950 East Paces Ferry Road, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Same-Day Surgery®, P.O. Box 550669, Atlanta, GA 30355.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: U.S.A., **Print:** 1 year (12 issues) with free *AMA Category 1 Credits*™ or Nursing Contact Hours, $519. Add $19.99 for shipping & handling. **Online only, single user:** 1 year with free *AMA Category 1 Credits*™ or Nursing Contact Hours, $469. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Back issues, when available, are $83 each.(GST registration number R128870672.)

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The healthcare organizations spent roughly $1.6 million to convert space into an outpatient surgery center. "We utilized existing space that was going unutilized," Beck says. The cost was evenly split to create a three-way joint venture.

"The cost might have been slightly less with one or two rooms, but you lose economies of scale," Beck says.

• Cost-saving opportunities.

The surgery center uses the health systems' resources for services such as credentialing, central sterile supply, and administration, Burstein says. Also, the center uses the systems' financial reporting resources, Beck adds, "so we're not replicating services where we can avoid it."

For employee benefits, the center used the same structure as the jointly owned radiology center. "In terms of collaboration, we use it where we can to minimize the expense exposure rather than doing everything from scratch on our own."

Consider these lessons learned

The project wasn't without challenges, Beck says.

"We had to work through the CON [certificate of need] process, apply for Medicare deemed status, work through The Joint Commission, and work through operational needs," he says.

For example, the Medicare deemed status application and contracting with insurance plans was time-consuming, Beck says. "You want to assume they know you — they've worked with all three hospitals — but the nuts and bolts of getting up and running a joint venture was a little more cumbersome than I would have expected," he says.

Because physician groups of all three health systems will use the surgery center, the center developed a clinical committee that had representatives from each organization. Each group can have different opinions on topics such as credentialing, equipment, and clinical guidelines, Beck says. "You have to set up processes so they're coming to the same page," he says.

EXECUTIVE SUMMARY

Rather than having the expense of each opening an outpatient surgery center, three healthcare organization in Nashua, NH, created a joint-venture center.

- Leaders reduced expenses by creating one facility and sharing ongoing services. The center uses the healthcare systems for credentialing, financial reporting, and administrative services.
- The project was more time-consuming than originally thought, as policies and procedures and payer/accreditation applications had to be handled from scratch.

Another challenge was that one of the health systems is Catholic, which meant it had different policies on sexual health and reproductive concerns than the other two. Anything that would violate the religious or ethical direction of that institution will not be done at the surgery center, Beck says.

A nurse director was hired to come up with policies and procedures. She had to identify the staff members that were needed, time the hiring, develop criteria for an anesthesia group and determine which group to use, and work on approval from Medicare and insurance companies. Burstein said, "Despite working her tail off, and she worked hard, it takes longer than she anticipated."

In areas such as Medicare approval, hospitals are accustomed to already having those arrangements. "With a brand-new entity, we had to start from scratch," Burstein says. "You couldn't begin until you had the entity created, with policies and procedures." Even with The Joint Commission, every rule had to be satisfied. "The application takes months." ■

Technology helps cut readmission rates

Patients access info by phone or computer

With the help of personalized recorded discharge information and educational videos available to patients by telephone or computer, Cullman (AL) Regional Hospital has reduced 30-day readmissions by 15% and increased scores on the discharge section of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) by 63%.

"Our hospital has been hotwired for a couple of years. If there is a piece of technology we can use to help the staff be more efficient, we are willing to be a beta site for it," says **Cheryl Bailey**, RN, BSN, MBA, chief nursing officer and vice president of patient care services for the 145-bed hospital located between Birmingham and Huntsville, two of Alabama's largest cities.

When the hospital was approached by a vendor to test a new solution for technology to reduce 30-day readmissions, the leaders jumped at the chance. Using MP3 players, the nurses record the discharge instructions as they give them to patients. After they get home, patients or their family members may use a PIN to access the instructions by telephone or via computer for 30 days. The nurses still give patients a hard copy of their medication and discharge plan.

"Nursing told us that many times patients are focused on the door because they are ready to go home and they don't really listen to the discharge teaching. Another problem is that many times when the nurses go over the discharge instructions, the primary caregiver is not in the room, and when they get home and have questions about the care, the patient doesn't remember. These are real issues that happen in every hospital every day. We thought using technology would help alleviate both problems," she says.

The hospital started the initiative it calls Good-to-Go in a 31-bed step-down unit where the congestive heart failure, acute myocardial infarction, and pneumonia patients were placed and has expanded to other parts of the hospital. "We knew that if we could make a difference in readmissions on this unit, we could roll it out throughout the hospital," she says.

Other units that use the technology for patient education include same-day surgery, surgical, medical, preadmission testing, and pediatrics. Ancillary services, such as respiratory therapy, also have created educational videos for their patients.

"Not all of the videos are aimed at reducing readmissions. We also use them to help with education and improve the patient's experience after discharge," she says.

When Bailey explained the project to the nursing staff, they balked at first, saying they hate to hear themselves on a recording. She pointed out that the nurses wouldn't have to listen to themselves, and the nurses agreed to try it.

To increase efficiency and not add time to the discharge process, the hospital created templates that the nurses can use to make the recordings. "It's easy and simple. The nurse just adds two to three minutes of information specific to that patient," she says.

The nurses use a script that starts with them introducing themselves. They go over the medications and ask the patient to repeat the instructions. They go over the discharge plan and remind patients to take their eye glasses, dentures, or other devices with them when they leave the hospital. They end by saying, "Thank you for choosing Cullman Regional Medical Center."

"If a family member calls in, we want them to hear everything that they would have heard if they had been in the room," Bailey says.

When the initiative began, the only option was for patients to call in on a landline and listen to the instructions. Now the second version of the technology allows the hospital to include videos and written materials.

If patients or families call in on the Good-to-Go landline, they hear the live recording made by the nurse in the room and other prerecorded information. If they log into the hospital's secure access system via computer, they can access the recording, videos, and see a hard copy of the information.

The process has a lot of flexibility for customizing the information for the needs of each individual patient, Bailey says. For example, the nurse can take a picture of the patient's swollen leg as a baseline and instruct the family to call the doctor if the leg looks more swollen the next day. The nurses can take a video on how to change the dressing on a wound. Other options the nurse can choose from include a video demonstrating how to care for a skin graft that was approved by a plastic surgeon and a video of a physician providing pacemaker education.

"We are constantly adding to our templates and videos and creating new ones," Bailey says.

The hospital rolled out the system in October 2011 and has modified it constantly. Bailey, the case managers, and nurses can check the system to see how many times patients are accessing videos. If the instructions have been accessed multiple times, the nurses can call the patients to see if they have questions or concerns. If high-risk patients or those who have been readmitted are not accessing videos, the nurses call to make sure they understand their treatment plan. Staff tell patients they can come to the emergency department if they have any issues. They also outline when to call the physician.

The case management team met with area skilled nursing facilities, described the Good-to-Go project, and created a template for each one that includes directions, what information patients or family members need to bring, what personal items to bring, what not to bring, a phone number to call if there is an issue, and other information patients need for a skilled nursing stay. When a patient and family choose a nursing home, the case manager records that conversation and the web address for the nursing home so the patient and family can log on and see everything they need to know. The case managers give their counterparts at the nursing home the PIN so they can log in and hear what patients heard.

"This helps us in our efforts to improve relations with post-acute providers. The next step will be to meet with all the home health agencies and develop a template for them," Bailey says. ■

Patients create their own estimates

Self-serve portal provides out-of-pocket costs

Patients at Danville, PA-based Geisinger Health System can create their own estimates online via a self-serve portal, MyEstimate.

"This provides patients with out-of-pocket estimates on nearly 300 services," says **Barbara Tapscott,** vice president of revenue management.

After patients enter their insurance information, estimates are tailored to the verified benefit coverage and the location of the service requested. Patients can select an ambulatory surgery center, a hospital, a physician's office, or a hospital-based clinic for their estimate.

"The Geisinger product provides a combined estimate, in that it includes hospital and physician expenses," says Tapscott. Because the patient's insurance is verified, the estimate takes into consideration negotiated insurance rates rather than gross charges. If the patient is uninsured, or if a service is unlisted, MyEstimate directs the patient to a financial counselor. The counselor can be accessed by a toll-free number, by creating an online request, or by visiting a Geisinger location.

"Financial counselors can assist uninsured patients with alternative funding options, such as state program enrollment," adds Tapscott. ■

Implementation delayed of 1 quality measure

[Editor's note: We tweeted about this news on April 2, 2014. To catch breaking news as it happens, follow us on Twitter @SameDaySurgery.]

The Centers for Medicare & Medicaid Services (CMS) has announced that it will delay implementation of the new quality reporting measure ASC-11, Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, until Jan. 1, 2015, according to the Ambulatory Surgery Center Association (ASCA).

CMS intends to issue proposals regarding data collection for this measure in the upcoming 2015 proposed outpatient prospective payment system/ASC payment rule with comment period, the ASCA said. ASCA staff members have been in ongoing communication with CMS quality reporting staff to voice concerns about the new measures since the rule was proposed. ASCA has also worked closely with a coalition of representatives from the American Academy of Ophthalmology, the American Society of Cataract and Refractive Surgery and the Outpatient Ophthalmic Surgery Society to influence CMS and raise awareness in Congress. This coalition, along with the American Hospital Association (AHA) and other organizations, sent a letter to CMS Administrator Marilyn Tavenner explaining that ASC-11 is inappropriate as a facility

measure, the ASCA said. The organizations urged the agency to withdraw or suspend the measure, which was adopted without being specified for or tested in the hospital outpatient and ASC settings, the AHA said. CMS acknowledged "operational difficulties" with the measure, according to AHA.

This delay does not affect the data collection period for ASC-9, Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients, and ASC-10, Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps — Avoidance of Inappropriate Use. Data collection for those measures began April 1. They are being collected by hospital outpatient departments, as well as ASCs.

For more information, contact the support contractor for the programs at (866) 800-8756 or https://cms-ocsq.custhelp.com. ■

Patch for SGR, delay of ICD-10 signed

President Obama has signed a one-year patch for the Medicare Sustainable Growth Rate (SGR) formula to postpone a 24% cut in Medicare payments to physicians that had been scheduled to take effect April 1, 2014, according to the Ambulatory Surgery Center Association (ASCA). Contained within the patch is a provision delaying the implementation of ICD-10 for one year, until Oct. 1, 2015, the ASCA said.

Most concerning for specialty physicians and surgeons is a provision used to pay for the $20 billion patch that implements severe payment cuts for services that are deemed to be "misvalued"' within the Medicare physician payment system, the ASCA said. To read more, go to http://bit.ly/1flLjjl.

Sen. Ron Wyden (D-OR), chairman of the Senate Finance Committee, still believes repeal can be achieved before the end of this Congress, although this short-term patch is a set-back to full repeal. "I believe that we are going to get permanent repeal and replace before the end of this Congress," said Wyden. He cited Rep. Dave Camp's (R-MI) interest in the issue as well. Camp is outgoing chairman of the House Ways and Means Committee.

Without pressure from the individuals impacted by this "flawed" formula, Congress might continue to pass short-term reprieves that don't address the larger problems of the system, the ASCA said. ■

CDC: Test your staff for Hep B immunity on hire

Those immunized as children may be vulnerable

By **Michelle Cohen Marill**, Executive Editor, *Hospital Employee Health,* published by AHC Media. Web: http://www.ahcmedia.com/public/products/Hospital-Employee-Health.html.

A growing number of healthcare workers are coming into their professions with childhood vaccination against the hepatitis B virus (HBV). Yet 5% to 10% of them might unknowingly be non-responders, according to the Centers for Disease Control and Prevention (CDC).[1]

The most protective strategy would involve serologic testing of these previously vaccinated employees at hire, the CDC says in recently released guidance. If they do not have antibody levels of at least 10 mIU/ml, they should receive a booster dose of the vaccine and retesting, the CDC says. They may receive up to three new doses of HBV vaccine, the agency says.

Yet the CDC also says employers may adopt a post-exposure approach, based on risk and cost factors. "The risk in certain occupations is an important consideration, as well as whether the person is a trainee or a non-trainee," says **Trudy Murphy**, MD, a medical epidemiologist and unit leader for the CDC's vaccine unit and a co-author of the guidance.

For example, some communities or hospital units might have a low prevalence of HBV, and employees who are not involved in direct patient care would have a lower risk, Murphy notes. Conversely, trainees have a higher rate of bloodborne pathogen exposures and therefore would be at higher risk, she says.

In a post-exposure program, healthcare workers would receive HBV serologic testing at the time of an exposure and would be revaccinated if they have antibody levels below 10 mIU/ml. If the source patient is positive for Hepatitis B surface antigen (HBsAg) or the HBsAg status is unknown, those exposed healthcare workers also would receive one dose of Hepatitis B immune globulin.

A post-exposure approach hinges on prompt reporting and follow-up. Yet only about half (54%) of percutaneous and 17% of mucocutaneous exposures are reported, CDC notes.

REFERENCE

1. Schillie S, Murphy TV, Sawyer M, et al. CDC guidance for

evaluating health-care personnel for Hepatitis B. Virus protection and for administering postexposure management. *MMWR* 2013; 62(rr10); 1-19. ■

Same-Day Surgery Manager

Where is the compassion for our patients?

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

Most facilities now have online registration. Great! I want to see that expanded. Some facilities outsource the patient assessment also. Even better! It allows the patient to respond to medical questions in the comfort of their homes where they do not feel rushed. That gives us more accurate information.

By the time the patients arrive at the surgical department or ambulatory surgery center (ASC), they can be taken right into "processing for surgery." Love it! Get them in, and get them out, right? We have what we want with complete paperwork and no missing data. All the T's are crossed and all the I's are dotted. EHR supreme!

I receive many comments on my columns from readers. Your questions for the most part are supportive (thank you) or will take the broad topic of the column deeper than space allows in this newsletter. I want to share one of these, slightly paraphrased, comments with you.

Comment: "I picked up an older 'Same-Day Surgery' newsletter in the lounge the other day, and I liked what you said about being more receptive to our patient's emotional needs the day of surgery. Could you expand what you mean?'

My response: It is important to remember how scared practically everyone that comes to our facilities are. Not just the patients themselves, but family members, friends, or whoever comes with them. In our continuing efforts to be effective and efficient in our day-to-day activities, I fear we are sacrificing some good old human compassion for those who entrust themselves or family members to our care. I am just as guilty as the next person in making sure we "process" the patients through the system in the proper fashion and in a high quality, safe method. I think most of us have that process down now.

Almost.

After I received the above comment from a reader a few months ago, I had the opportunity to do some observations at a couple of hospitals and ASCs that I want to share with you. I watched patients go through the process at several facilities, and I was proud and impressed and at how well we have gotten down the processing of patients. However, because of the comment from one of you, I actually visually followed the patients at each of the facilities from the reception desk back to the waiting room chair and saw, sadly, where it all fell apart.

I could see the confusion on the patient's face, the gesturing with their family members, the shrugging shoulders, and knew that we have made serious sacrifices and had done a disservice to those who pay our salaries and wages.

I went up to several patients at each location and asked if they had any questions. Here they are: "I'm scared that I will have a panic attack in there [pointing to the door into our chambers]. Has that ever happened before? Who can I talk to about my friend who had this operation some years ago and didn't make it? There was no place [on the registration form] for me to ask that. Can you help me?"

Another patient's comment. "Do I have to take off my underwear?" "Sometimes I have accidents, and I'm embarrassed about who will see that."

Here are more comments from patients:

"You are the first person who has asked me how I feel. Not one person asked me that. I feel like I have lost control over my body and my dignity and my modesty. It is horrible!"

"Does anyone here smile?" I could use a smile and a hug right now." (I gave him both.)

"When I brushed my teeth this morning I accidently swallowed some of the water. I was afraid they would get mad at me over there [pointed to the desk], so I didn't say anything. Can that hurt me?"

"This place is really great. Everyone is so good at what they do, but I feel like I am being 'pushed' through here, and it makes me a little nervous."

"I am so scared of what is going to happen when I get behind that door."

"My son usually has a bowel movement in the morning, but he will be in surgery when he normally goes. Will that mess up the surgery?"

"Has this place done this kind of surgery before?"

"I went online and tried to find out reviews from other patients who were here before but couldn't find any. How long has this place been open?"

"Don't a lot of patients die during surgery?"

"I feel helpless."

Let's work on this, OK? [*Earnhart & Associates is a Houston, TX-based consulting firm specializing in all aspects of outpatient surgery development and management.]* ■

HHS confirms billions of cost savings tied to ASCs

ASCA: Data also reveals reimbursement issues

In a just-released report, the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) found that outpatient surgical procedures that do not pose significant risk to patients performed in ambulatory surgery centers (ASCs) have saved Medicare more than $1 billion in each of the last several years. The report also said that they have the potential for even greater savings.

As a result of the cost-savings that ASCs offer, the report concludes, "… Medicare saved almost $7 billion and beneficiaries saved an additional $2 billion during CYs 2007 through 2011. Also, Medicare and beneficiaries could save an additional $12 billion and $3 billion, respectively, during CYs 2012 through 2017."

William Prentice, CEO of the Ambulatory Surgery Center Association (ASCA), said, "Ambulatory surgery centers can save Medicare and its beneficiaries billions more than we currently do, but policymakers need to be mindful of how we maintain our high quality. ASC reimbursement under Medicare needs improvement, and any plan to adjust reimbursements to providers or shift volume to take advantage of the high quality and efficient care in ASCs must take that into consideration."

Medicare could generate savings of as much as $15 billion for CYs 2012 through 2017 if the Centers for Medicare and Medicaid Services (CMS) reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs, the OIG said.

OIG recommended that CMS:

• seek legislation that would exempt the reduced expenditures as a result of lower outpatient prospective payment system (OPPS) payment rates from budget neutrality adjustments for ASC-approved procedures

• reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments;

• develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

CMS did not concur with the recommendations, OIG says.

Officials identified patients as high risk, low risk, or no risk on the basis of risk factor conditions such as age 80 and older, cancer, diabetes, heart disease, asthma/chronic obstructive pulmonary disease, renal failure, obesity, etc. A high-risk patient was defined as having two or more of these conditions. A low-risk patient was defined as having one of these risk factor conditions. Officials defined these risk factors by grouping chronic diagnosis codes and then identifying records of patients with discharges including these diagnosis codes.

The full OIG report is available at http://1.usa.gov/1k06h8x. ■

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.
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COMING IN FUTURE MONTHS

■ New ambulatory surgery benchmarking results

■ Do you have a well-reasoned list of high-alert meds?

■ How to manage multiple dose vials

■ Is one "look alike/sound alike" list sufficient?

CNE/CME QUESTIONS

1. When three healthcare organizations in Nashua, NH, created a joint-venture surgery center, what services did the center have handled by the health systems?
   A. Credentialing
   B. Financial reporting
   C. Administrative services
   D. All of the above

2. When Cullman (AL) Regional Hospital added personalized recorded discharge information and educational videos available to patients by telephone or computer, what success(es) did it realize?
   A. Reduced 30-day readmissions by 15%
   B. Increased scores on the discharge section of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) by 63%.
   C. Neither A nor B.
   D. A and B.

3. Patients at Geisinger Health System can create their own estimates online via a self-serve portal, MyEstimate. What happens when a patient is uninsured or a service is unlisted?
   A. Patients cannot use the system in that situation.
   B. MyEstimate directs the patient to a financial counselor.
   C. MyEstimate directs the patient to a web site.
   D. None of the above.

4. Which quality reporting measure has been delayed by the Centers for Medicare & Medicaid Services (CMS) until Jan. 1, 2015?
   A. ASC-9, Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients.
   B. ASC-10, Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use.
   C. ASC-11, Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

SDS ACCREDITATION UPDATE

Covering Compliance with TJC, AAAHC, AAAASF, and Medicare Standards

Should you change accreditation groups? Some take that leap and find advantages

You've gone through your survey process and received full accreditation. Six months later, Medicare surveyors come along and say your facility is close to failing. The disconnect between Medicare accreditation and some survey processes has providers considering accreditation from other groups.

Some providers are turning to the Healthcare Facilities Accreditation Program (HFAP), at least partially because it has Medicare deemed status and its surveys are based on Medicare's conditions for coverage (CfC) for surgery centers and Medicare's Conditions of Participation (CoPs) for hospitals. HFAP performs acute care accreditation, including specialty hospitals; ambulatory care accreditation, including office-based surgery centers and ambulatory surgical centers; and rural hospital accreditation and critical access hospital accreditation, including day procedure units. It also performs behavioral health accreditation, laboratory accreditation, and stroke certification.

About 80% of HFAP standards are cross-walked to the Medicare CoPs and associated requirements, according to HFAP. At least 85% of standards are cross-walked to the Conditions for Coverage (CfC), HFAP says.

"They're written in a little bit different language, but it is following them exactly," says **Beverly Kirchner**, BSN, RN, CNOR, CASC, president of Genesee Associates, a Dallas-based national ambulatory surgery center development, consulting, and management company. Kirchner has gone through one accreditation with HFAP.

"We decided we would rather follow one set of standards, rather than Medicare CfCs and have to go back and fill in nuances for this AAAHC [Accreditation Association for Ambulatory Health Care] or JC [The Joint Commission]," Kirchner says. "They felt it was less work and less stress, and they weren't trying to meet dozens of standards that Medicare did not require but other accrediting agencies did."

Some administrators and clinicians have felt frustrated with The Joint Commission standards that they have seen as "too prescriptive" and not flexible enough to meet basic Medicare requirements, according to **Rebecca Lewis**, MSN, RN, CNOR, vice president of patient care at Grandview Medical Center in Dayton, OH. Lewis spoke about accreditation options at last year's meeting of the Association of periOperative Registered Nurses (AORN).

Another area of dissatisfaction is cost, Lewis said. According to Lewis, the average cost of TJC survey is $33,000 for three years, while the average cost for HFAP services average $25,000 for three years. *(See responses from TJC and AAAAHC, p. 2.)*

Advantages of another group

One of the advantages of being surveyed with HFAP is that your facility can use notebooks, compiled by providers, for the accreditation process, Kirchner says.

"You take their standards for each department, go down line by line, and put together a notebook," she says. "Each department puts together their notebook based on what they fall under in their survey." The notebooks includes policies and proce-

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Executive Editor **Joy Dickinson** and Board Member and Nurse Planner **Kay Ball** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.Consulting Editor **Mark Mayo**, Consulting Editor, reports that he is principle in MMC Health Care Consultants, Round Lake, IL. **Stephen Punzak**, MD, physician reviewer, discloses that he is CEO, founder, and a stockholder with Medical Web Technologies, LLC.

dures, as well as examples of how those policies and procedures are met, she says.

When the HFAP surveyors arrived for the survey at Kirchner's facility, they had notebooks in hand that they used to see if the policies were being followed. "You knew exactly what they were going to survey and what they were looking for," Kirchner said. "They told you how to meet that standard."

TJC also has crosswalks to the Medicare standards, but Kirchner says that she considered HFAP's process to be more detailed. "It was almost like a process book," she says. "When you write a processor instructions on how to do something, it's very concise. From my perspective, the HFAP guideline was very concise in what they expected and what they were looking for, a little more than TJC and AAAHC."

Another advantage of HFAP is that accreditation is based on the facility's ability to correct deficiencies, so if any "opportunities" are uncovered during the survey, there is no "punishment," Lewis said. "If a deficiency is identified, surveyors are experienced healthcare professionals who can draw from professional experience to offer on-the-spot practical solutions," she said.

In comparison to the surveys performed every three years by TJC and HFAP, surveys from Milford, OH-based DNV GL Healthcare surveys also have deemed status, but they are performed annually, said **Janet C. Gilmore**, RN, MSN, CMSRN, director of perioperative services at Houston Methodist, Texas Medical Center. Gilmore also spoke on accreditation at last year's AORN meeting. DNV performs annual surveys for hospitals and some ancillary organizations. The surveys range from about $12,000 to $51,000. Its accredited hospitals are listed online at http://dnvglhealthcare.com/hospitals. DNV has an application pending with Medicare for deemed status ty for ambulatory surgery centers and anticipates approval this year

With DNV, you have the same survey team every year, Gilmore says. "Same survey team every review allows for a more thorough survey with surveyors that already know the physical plant and processes," she says. "Each survey starts with the issues discovered the previous year to assess conformity. This drives quality." Gilmore touts the DNV's approach to accreditation. "It's all about process, not the people," she says. *(For more on what is involved in changing accreditors, see story, p. 3.)*

SOURCES

DNV GL Healthcare, 400 Techne Center Drive, Suite 100, Milford, OH 45150. Web: http://dnvglhealthcare.com. Phone: (866) 523-6842

Healthcare Facilities Accreditation Program, 142 E. Ontario St., Chicago, IL 60611. Phone: (800) 621-1773. Web: www.hfap.org. Twitter: @hfapquality. HFAP offers free continuing education webinars for clinicians and engineers. ■

EXECUTIVE SUMMARY

Some healthcare providers are turning to other accreditation groups after frustration that their survey standards don't match Medicare's conditions for coverage (CfC) or Conditions of Participation (CoP).

- About 80% of Healthcare Facilities Accreditation Program (HFAP) standards are cross-walked to the Medicare CoPs and associated requirements. For surgery centers, at least 85% of standards are cross-walked to the CfCs.
- According to one source who has undergone accreditation through The Joint Commission (TJC) and HFAP, the cost of HFAP accreditation was $25,000, compared to $33,000 for TJC.

Joint Commission, AAAHC tout benefits

Why go through accreditation with The Joint Commission? The agency says that it's the only accreditor that accredits across the continuum of care, including long-term care and home health care.

"That's an advantage, because healthcare reform has moved toward looking at managing populations of patients across the continuum," says **Ann Scott Blouin**, RN, PhD, FACHE, executive vice president of customer relations at TJC.

In response to complaints that TJC standards don't line up concisely with Medicare standards, Blouin says "We have worked hard to make sure survey, our standards, included CoP [Conditions of Participation] or CfC [Conditions for Coverage] as a foundation for quality and safety. However, TJC goes beyond that foundation to areas that its leaders believe are important to safety, such as nursing care, process improvement, and the medical staff, she says. National Patient Safety Goals (NPSGs), including the need for two patient identifiers, are one example of ongoing challenges, she says.

Blouin says TJC is putting a significant emphasis on looking at Medicare survey results to decrease the disparity rate. She also says TJC had added more life safety code surveyors, because that was at

area of discrepancy.

In defending the cost of TJC surveys, Blouin says the price range is based on the size and complexity of the organization. She points out that in the last five years, there has been a 1% increase in 2012 and a 1% decrease in 2014. "We're conscious of fiscal constraints of hospitals and ASCs [ambulatory surgery centers] these days, and we make sure we don't contribute to increased costs when possible," Blouin says.

She also points out that TJC customers have access to tools and resources in important safety areas such as prevention of infections, suicides, and falls.

AAAHC benefits

The Skokie, IL-based Accreditation Association for Ambulatory Health Care (AAAHC), offers accreditation surveys every three years for $4,600 and up and is a deemed status organization.

A strength of AAAHC is that it has accredited about 6,000 ambulatory organizations, says **Geoffrey Charlton-Perrin**, marketing and communications director. AAAHC surveys are conducted by clinicians and administrators who work in the field, Charlton-Perrin says.

"We have strong consultative and educational component to accreditation process," he says ■

What's involved in changing accreditors?

The timeframe for switching from The Joint Commission to Healthcare Facilities Accreditation Program (HFAP) is about three to six months, according to **Rebecca Lewis**, MSN, RN, CNOR, vice president of patient care at Grandview Medical Center in Dayton, OH. Lewis spokes on accreditation choices at last year's meeting of the Association of perioperative Registered Nurses.

Grandview is a member of the Kettering Health Network, which previously had six hospitals being accredited by The Joint Commission and two hospitals being accredited by HFAP. System leaders decided to have one accreditation agency for all of the hospitals in the network. It chose HFAP because its requirements most closely lined up with Medicare's Conditions of Participation (CoPs), Lewis said.

The system went to a single steering committee and had two accreditation managers for the network instead of one at each hospital. Lewis said the first step was to study the accreditation manual. Groups worked with chapter leaders across the network. For example, all OR leaders worked on the same chapter. The next step was to conduct self-assessment compliance, share and address deficiencies, and share knowledge, she said. The last step was to educate and communicate with the staff, she said.

Before changing accreditors, check with your payers, advises **Beverly Kirchner**, BSN, RN, CNOR, CASC, president of Genesee Associates, a Dallas-based national ambulatory surgery center development, consulting, and management company. "You need to look at all your managed care contracts and understand their requirements," Kirchner said. For example, the language might say you need to be accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) and The Joint Commission (TJC). If your new accreditation agency isn't listed, ask your payers to add that agency as an accrediting body.

Also, if you accept Medicare patients, you'll need to notify the Centers for Medicare and Medicaid Services (CMS) about your deemed status survey, Kirchner says.

Be cognizant of your scheduling, Lewis advises. "The timing just needs to be arranged so the facility has accreditation from the new provider before the old one expires," she says. ■

Eligibility criteria revised for ambulatory

Effective July 1 if seeking TJC reaccreditation

The Joint Commission (TJC) has revised eligibility criteria for its ambulatory care program, including criteria for organizations seeking reaccreditation and organizations seeking accreditation for the first time.

These revisions take effect July 1, 2014, for ambulatory customers seeking reaccreditation and are effective immediately for organizations seeking ambulatory care accreditation for the first time.

According to The Joint Commission, the major revisions are:

• The minimum number of patients or volume of services required for organizations to be eligible for survey now applies to organizations seeking accreditation for the first time and to organizations

seeking reaccreditation.

• The minimum number of patients/volume of services has increased to 10 patients served with two active at the time of survey, from three patients served with one active at the time of survey.

• Instead of only "when appropriate," those who review the quality of an organization's care, treatment, or services now must include clinicians who have knowledge of the type of care, treatment, or services provided.

• Tests, treatments, and interventions must now be authorized by a licensed independent practitioner in accordance with state and federal requirements.

• The organization has a facility license or registration to conduct its scope of services, if required by law.

For more details, see the April 2014 issue of *The Joint Commission Perspectives*. Web: http://bit.ly/1lzRSTB. The revised eligibility criteria also will be published in the spring 2014 E-dition update and the "2014 Update 1" to The Joint Commission's *Comprehensive Accreditation Manual for Ambulatory Care*.

If you have questions, contact your ambulatory account executive or Gail Weinberger, director of accreditation and certification policy and administration, at gweinberger@jointcommission.org, or (630) 792-5766. ■

Report shows where facilities struggle

The Accreditation Association for Ambulatory Health Care (AAAHC) released a proprietary research report from its Institute for Quality Improvement that shows the need for continued focus on proper documentation of patient allergies and practice privileges for healthcare professionals, as well as suitable internal emergency and disaster preparedness planning.

The AENEID (Accreditation Association Electronic National Evaluation and Information Dataset) report highlights ambulatory organizations' high marks for respecting and involving patients in the healthcare decisions, as well as for cost-controlling measures such as concern for relevance for treatments and administrative efficiencies.

"For 35 years, AAAHC has collected performance data on ambulatory healthcare organizations, and the AENEID initiative represents the first time we're transforming our warehouse of information into a useable educational tool, both for our accredited organizations and for the industry as a whole," said John Burke, PhD, president and CEO at AAAHC. "The AENEID identifies overall trends in ambulatory healthcare and allows us to see patterns of compliance with AAAHC standards and to sort and analyze the results in multiple ways."

3 areas where compliance was lacking

AAAHC-accredited organizations were highly successful: (99.9% or greater scored as substantially compliant in meeting standards. AAAHC-accredited organizations were commonly cited as deficient (10-25% scored as partially compliant or noncompliant) in meeting standards in these areas:

• **Standard 2.II.D:** Privileges to carry out specified procedures are granted by the organization to the healthcare professional to practice for a specified period of time. The healthcare professional must be legally and professionally qualified for the privileges granted. These privileges are granted based on an applicant's qualifications within the services provided by the organization and recommendations from qualified medical personnel.

• **Standard 6.K:** The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistent location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified.

• **Standard 8.E:** 2012 wording: The organization requires at least one drill each calendar quarter of the internal emergency and disaster preparedness plan. One of the annual drills must be a documented cardiopulmonary resuscitation (CPR) technique drill, as appropriate to the organization. The organization must complete a written evaluation of each drill and promptly implement any needed corrections or modifications to the plan. "Appropriate to the organization" means appropriate to the facility's activities and environment. Examples include medical emergencies; building fires; surgical fires; tornados; hurricanes; earthquakes; bomb threat; violence; and chemical, biological, or nuclear threats.

Top challenges are broken down by ambulatory surgery center, office-based surgery practices, and primary care organizations in the report. To access the report, go to http://bit.ly/QXT9HB. ■