SAME-DAY SURGERY

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INSIDE

AHC Media

Keep vendors and their surprises out of your ORs and your contracts

You're doing all you can to reduce your expenses, but then a vendor shows up in the operating room with a "surprise" implant. Or an expensive piece of technology breaks down, and you have to call in the vendor to repair it. Ambulatory surgery programs are getting creative in how to address these problems, which can blow up your budget before your year has barely begun.

At Belmont/Harlem Surgery Center in Chicago, staff members lay out scrubs for staff and physicians the night before. Each set of scrubs has the name of the staff member or physician on it. No other scrubs are available in the locker room, but extra scrubs are at a control station and must be signed out. This system prevents a sales representative from going into the operating room without first signing in and obtaining advance approval from the administrator or the surgical director/nurse.

"Since implementation we have cut down on the number of reps, we have a controlled process for the implants, and I definitely do not have to hear the surgeons complaining about 'always being out of scrubs,'" says **Faith**

This month: Best cost-saving ideas

This month's issue is one of the most anticipated by our readers because it's full of cost-saving ideas. We tell you how to keep vendors and their "surprise" devices out of the ORs. We share how to control your equipment expenses. We tell you how one facility cut about $10,000 worth of inventory at its bedsides. Columnist Steve Earnhart has 10 money-related ideas. We tell you how to save money by reprocessing single-use devices. We also share how to improve collections by moving financial counseling to the front end. Also, our publisher offers several discounts. Enjoy this special issue of *Same-Day Surgery*! ■

Financial Disclosure: Executive Editor Joy Dickinson and Columnist Stephen W. Earnhart report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Nurse Planner Kay Ball reports that she is a stockholder with Steris Corp., she is on the speakers bureau for Ethicon Endosurgery, and she is a retained consultant with Mobile Instrument & Service, IC Medical, and Megadyne. Mark Mayo, Consulting Editor, reports that he is executive director of Golf Surgical Center in Des Plaines, IL. Robert S. Bray Jr., MD, physician reviewer, discloses that he is a stockholder with RSB Spine and with DISC Integrated Medical Group.

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McHale, administrator. While the center can't afford to have a vending machine with scrubs, "with this process we can keep tabs on scrubs being taken out of the facility, and we can ensure the scrubs are being laundered with a list we receive back from our laundry vendor." The laundry vendor is ImageFIRST Healthcare Laundry Specialists in King of Prussia, PA.

The center keeps only par levels, per size, "not per reps' preferences," McHale says. The facility has saved about $6,000 to $10,000 per year.

At Day Surgery Center (DSC) at Northwest Community Healthcare in Arlington Heights, IL, the surgical hallways are locked with identification access. The physicians and staff members obtain their scrubs from a machine. The center had a rent-to-own contract with the vendor, so now it owns the dispensing and return machines, says **Roxanne Matias**, director of the center. The machine is stocked by the hospital linen staff, but it easily could be stocked by anyone in charge of receiving the linen, Matias says.

"The MDs and staff are given a max of three credits," she says. "If they don't return their scrubs, they have to justify why they do not have any credits. This, for the most part, solved the lost scrub issue."

Vendor representatives who visit the center are required to check in via a kiosk from Flower Mound, TX-based Reptrax, which is in the lobby. *(For more information on vendor credentialing, see the two-part series in December 2013 and January 2014 issues of* Same-Day Surgery*.)* The kiosk has a generic code for reps. Reptrax generates a name tag sticker. "The sticker must be presented to the DSC staff before anyone will retrieve scrubs from the Scrub Avail dispensing machine," Matias says. "The scrub dispensing machine is outside the locked areas, so once the rep receives their scrubs, the DSC staff member swipes them into the locker room."

The reps also are required to sign in at the reception desk so that the staff easily can determine who is in the unit in the event of an evacuation, she says. "We identified the need for a sign-in board during one of our fire/evacuation drills," Matias says. "In an emergency, no one has time to print a report from Reptrax."

When the reps gain access to the OR, they might bring similar devices to those already in stock but at a far higher price because the facility has not had the opportunity to "trial" the device or negotiate a fair pricing structure, says **Mark**

EXECUTIVE SUMMARY

Ambulatory surgery programs often find they have various unexpected expenses due to vendor activities. Vendor reps might enter your ORs with "surprise" devices, and they might saddle you with high charges to maintain and repair equipment.

- You can control dispensing of scrubs to vendors by keeping vendor scrubs at a control station where they must be signed out.
- You can make a rent-to-own arrangement for a scrub dispensing machine.
- A biomed technician can be trained to maintain and repair equipment, as well as handle duties not related to technology.

Mayo, CASC, executive director of Golf Surgical Center, Des Plaines, IL. "Sometimes the rep has seen the surgeon at another facility or in the surgeon's office and suggests trialing a new device, and the surgery center has been left out of the conversation and has not been provided with an opportunity to negotiate pricing or to show the surgeon that a similar item is already in stock and is covered under a discounted group purchasing program that saves the surgery center and the patient money," Mayo says.

Some ambulatory surgery programs reduce surprise devices by setting up committees that meet monthly to approve new devices, he says. At those centers, "there is a policy that no implant can be used unless it is already on the list of approved items," Mayo says. "They look at costs, alternatives, and benefits."

Save with a biomed tech

Saving money with staff and vendors doesn't have to be limited to scrubs. OA — Centers for Orthopaedics in Portland, ME, has placed a biomedical technician on the staff, which has freed the centers from expensive preventive maintenance contracts on their "big-ticket" items.

The biomed technician does service work on items ranging from mini C-arms to, beginning this year, autoclaves. The tech was trained by the vendors. Such training can be paid for by the facility, or it can be part of the contract when new technology is purchased, says **Linda Ruterbories**, adult nurse practitioner and director at OA.

The tech handles preventive maintenance, Ruterbories says. "You don't have to call in the rep, pay travel expenses and hourly rates," Ruterbories says. Preventive maintenance contracts can run as high as $20,000 on a mini-C arm after the first year, she points out. As soon as you send the tech to training, "then you don't have to pay any of that," she says. The tech also can handle repairs. Otherwise, the center would have to call the vendors, wait for the reps to get there, and pay them $150 an hour plus travel expenses, Ruterbories says. "Then they may get there, and it might be easy to fix, if it's not critical, or if it is critical, they have to order parts. They have to spend the night," which adds even more expense, she says.

Also, the tech is available to handle other duties in the current "technology-crazy" environment, Ruterbories says. He can maintain arthroscopic equipment, high def cameras, and LED light sources. "They're very costly if they go down, and it may cost you an OR if you don't have backup," Ruterbories says.

Their "multi-faceted" employee handles other tasks that aren't related to equipment, she says. "He can do any 'construction' we need done, such as putting in a desk," Ruterbories says. If the tech is qualified to perform all high-level mantienanace and repairs, the position pays $60,000.

She describes hiring the tech as being a "phenomenal" experience. "You get an immediate fix and immediate cost savings," Ruterbories says. *(For more ideas on saving money with equipment, plus another cost-saving idea, see story below.)* ■

Tips for cutting inventory and cancelled cases

Do you have thousands of dollars tied up in supplies sitting at each bedside? There is a better way, says **Linda Ruterbories**, adult nurse practitioner and director at OA — Centers for Orthopaedics in Portland, ME.

The leaders at OA determined that they had about $10,000 worth of inventory at bedsides in all of the bays. However, it didn't make sense to have that amount of money tied up, Ruterbories says. "We know exactly 99% of the time what 'picks' we will need," she says.

Now staff members pick the supplies the day before, which means they're not running around at the last minute looking for something that's missing. "It's all ready for the patient," Ruterbories says. "We're not going to storerooms."

Other than narcotics, all other needed supplies are put into containers that travel with the patients throughout their stays. "We know how many patients we're going to have, and we know what we're going to use for supplies, so you don't have to overstock," Ruterbories says.

The supplies are waiting for the patient in the induction room. When the patient goes to the OR, the bag with the remaining supplies goes immediately to the recovery room. "It's awaiting their arrival when they get there," Ruterbories says. This system avoids overstocking a large variety of supplies at each area where patients will be, such as pre-op and recovery, and substitutes with just the supplies that a particular patient with a particular type of surgery will need.

OA — Centers for Orthopaedics also has reduced its expenses with online preoperative screening. They use a program from Simple Admit in

Baldwinsville, NY.

"When a patient makes an appointment with a practice, they are instructed to go online and fill out medical history," Ruterbories says. There are "trigger questions" that alert staff to clinical issues such as diabetes or malignant hyperthermia.

"But we get that information even before the patient walks in the door," Ruterbories says. If patients answer "yes" to certain trigger questions, the staff immediately know that patient will need to be booked at the hospital, she says. At the same time, the staff can work with those patients and their primary care physicians on issues such as hypertension to have the conditions controlled before surgery. "It prevents us from booking cases that we would inevitably cancel," Ruterbories says. "It makes us cost-effective, and it's safer for our program."

The preop screening program they use costs several hundred dollars a month. "A surgical case alone, if you have to cancel the day before or day of, you've lost $1,200 worth of profit" or more, depending on the case, Ruterbories says.

In 2012, the center had 80 cancellations on the day before or day of surgery. In 2013, as the staff improved its screening process, the cancellations were reduced to 60. In 2014, that number was down to 30 at press time. "Out of those 30, they are not necessarily ones we could have prevented," says Ruterbories, who points to problems such as patients ignoring preop instructions and drinking or eating after midnight. "You can't do anything about those cases," she says.

RESOURCE

Simple Admit, Baldwinsville, NY. Telephone: (877) 848-4726 (4SAM). Web: https://www.simpleadmit.com. ■

SDS Manager

Make money by reducing expenses and increasing your facility's efficiency

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

Like you, I have bills to pay and expenses to cover in my business and personal life. It is not something I particularly enjoy, but by meeting my obligations, I can keep a roof over my head.

Much of my business involves generating income for clients. As I essentially am an employee of my own company, that function, in turn, generates income for myself. My goal, for clients and myself, is to bring in more revenue than I pay out. I am always looking to find ways we both can benefit. Here are some ideas that might work for you in 2015.

Income generation:

1. Income goal. Most of us have a personal financial goal but not necessarily one for our place of employment. An annual budget for that business is fine, but someone other than you often determines that budget. Set your own goal for your surgery center or department in cooperation with your peers. Make it realistic, achievable, and fun. The saying that "a person's reach should exceed their grasp" sounds good, but it's not always realistic. A good goal might be to have your surgeon bring in six more cases per year. Constantly pushing them to do so often can make it happen.

2. Payer contracts. If you have one person in charge of the process, shake it up a bit by putting together a panel of staff members to examine your reimbursement and outliers. I always am amazed at what a second set of eyes and a fresh look can pick up that others might have missed.

3. New procedures. Pain management physicians have taken a nasty reduction in their professional fees in the last couple of years to the point that many will have to move procedures out of their offices and into surgery centers if they want to stay in business. Reach out to them, and be receptive to inquiries. The facility reimbursement for some of these procedures has increased significantly.

Cost saving:

1. Supply costs. Many fail to understand that if you save $20 in supplies per case, you have generated $20 in income. Money saved is new revenue. Multiply that by the number of cases you do per year. I can assure you that I could find a way to cut $20, and if I can do it, you can.

2. Incentives. Offer an incentive to staff members, or recommend an incentive for staff members be offered. Go back to income goal number one (at left). Let your staff know you have a goal to find "x" amount of money to save this month, quarter, or year. Give awards to those who find them. While cash prizes are sweet, I have found that

peer recognition is just as effective in incentives to staff members.

3. Unknown cost. Anesthesia supplies almost always are overlooked when looking at cost per case. Because many leaders in hospitals or surgery centers are somewhat reluctant to examine these costs, audit those expenses and work with the anesthesia staff to find out how you can reduce cost. There often is expensive waste.

Increase efficiency:

1. Cross training. Cross training staff not only makes life interesting, but it is a more efficient way to utilize personnel. As a former OR nurse, I enjoyed mixing it up once in a while.

2. Turnover. Sending full-time staff home when their cases are complete, with no reduction in their pay, incentivizes them to become more productive without penalizing them. Nothing encourages surgeons to do more procedures than to have a fast turnover time and happy staff.

3. Part-time staff. If the above tip doesn't work for you, consider more use of part-time staff who don't mind leaving when their cases are complete.

4. Agency staff. Avoid "agency" personnel as they rarely consider an occasional shift at your facility to be fulfilling, and they often are not as motivated to be efficient.

In short, while we all work in an exciting, often enriching service industry, we can make it more rewarding by keeping it finely tuned. The one thing I enjoy about working with professionals is the way they can rally around a worthwhile cause. *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates' address is 5114 Balcones Woods Drive, Suite 307-203, Austin, TX. 78759. Phone: (512) 297-7575. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.]* ■

How your facility can save with reprocessing of devices labeled for single use

Have you wanted to start a reprocessing program for devices labeled for single use but faced a barrage of concerns from your physicians and clinical staff? Many of these objections are based on fiction, according to **Amy J. Gagliardi**, vice president of the supply chain at Westchester, IL-based Regent Surgical Health, which develops and manages surgery center partnerships. Gagliardi spoke on reprocessing at the most recent Ambulatory Surgery Center Association annual meeting.

The usual cost of a reprocessed device is one-half the cost of a new device, she says. You can save between $15,000 and $25,000 per OR, Gagliardi said. In 2013, Regent Surgical Health had $197,000 in device savings and $3,582 in waste savings, she said.

Gagliardi expects Regent to save half a million in 2014. "It's a no-brainer," she said. "You'll save 50% off what you're currently paying. That's negotiable; always ask for more." Regent reuses devices two to three times, with stringent testing.

Three thousand hospitals and 1,500 ambulatory surgery centers are reprocessing, donating, or recycling, Gagliardi said.

"Opened but not used pulse oximeters are a great place to start," Gagliardi said. When Regent reuses a device, it is documented on the operative records. There is a sticker on the patient chart and preference card.

In its *Guideline for Sterilization*, the Association of periOperative Registered Nurses (AORN) recommends that devices labeled for single use shouldn't be reprocessed unless the FDA guidelines for reprocessing them can be met. Most healthcare facilities don't have the capabilities to meet these requirements, AORN says.

The Food and Drug Administration (FDA) has passed regulations for reprocessing and stated that reprocessed medical devices are to be viewed no differently from those of the original equipment manufacturer (OEM), Gagliardi said.

Gagliardi offered these "fact-or-fiction" statements to help sort out the misinformation about reprocessed devices:

• Manufacturers label some medical devices "single use" because these devices are unsafe for more than one use.

Answer: Fiction. The FDA has no labeling requirements regarding the number of times a device can be used, Gagliardi said. The term "single use only" was developed by OEMs for products they determined to be disposable, she said.

• Remanufactured medical devices fail more often than original devices, which leads to more patient harm.

Answer: Fiction. Gagliardi says the FDA's analysis of adverse events related to single-use devices (SUDs) shows that there is no "causative link between a reprocessed SUD and reported patient injury or death."[1]

In addition, the Government Accountability Office (GAO), formerly the General Accounting Office, reviewed available information and said there was no indication that SUDs present a greater risk to patients than new devices do, she said. One GAO report said, "The hospital infection control practitioners, risk management executives, and patient safety experts we interviewed told us that careful reprocessing of the types of SUDs that can be properly cleaned and sterilized does not pose an additional risk to patient health."[2] However, the same report said, "It is also clear that some SUDs cannot be safely reprocessed, procedures for safe reprocessing are not always followed, and the limitations of the information available about SUD reprocessing argue for monitoring the practice."

• Only the OEM can safely reprocess a device.

Answer: Fiction. Whoever is reprocessing the device must ensure that the device will be the substantive equivalent of a new device, Gagliardi said. The device re-processors must show documentation to the FDA that their reprocessing processes will provide a safe and effective product. OEMs don't have to do this, Gagliardi said.

• The physician is liable if a reused product fails.

Answer: Fiction. The OEM or re-processor that becomes the OEM bears full responsibility and liability for the safety and efficacy of the device, Gagliardi said. There is no distinction because the devices are equivalent, she said.

Here are some reprocessing tips from Gagliardi:

• Investigate medical device reprocessing (MDR) companies. Not all are alike, she said, so visit their facilities and include your surgical techs, Gagliardi said. If you have staff members who are resistant to reprocessing, have them visit the MDR facility early in the process, she said. Determine if the MDR reprocesses all devices or is selective.

"We had blinders on," she said. "One company could reprocess half of the products another company could."

Also find out if the employees are certified. Ask for a copy of their most recent Good Manufacturing Practices (GMP) inspection by the FDA.

• Establish a reprocessing committee named a "re-manufacturing committee." Include representatives from the OR, materials management, infection control, sterile processing, risk management, and quality improvement. Have your committee in place before any decisions are made, Gagliardi suggested. "Word will get out quickly, so you need to work fast," she said. Establish monthly meeting to discuss objectives, savings, and issues, and keep minutes, she advised.

• Develop an intensive educational program for surgeons and staff. Take advantage of the MDR's resources to go into the OR and work with the surgeons and staff.

On the physician preference cards at Regent Surgical Health, the device is listed and the reprocessed device, with an "R" in front, is listed at the reduced cost, sometimes 50%. Physicians circle which one they want to use.

Emphasize safety, Gagliardi said. Require the MDR to provide continual education, she advised. The most important person to educate is the surgical tech, Gagliardi said.

Education, early and often, is a critical step, Gagliardi said. "We thought we educated enough, then found the OEMs undermined the entire process," she said. The result was that the potential savings for the nine hospitals in the system was reduced from $3.5 million to $500,000 in one year.

• Don't take an approach of "try it." It might give a signal that the process is not safe, Gagliardi said.

• Have numerous locations for device pick-ups.

• Make sure shipped containers meet Department of Transportation regulations.

• Notify the MDR if you receive a recall notice from the OEM. If the MDR has a recall, have a system in place for immediate notification, such as an email blast.

• Document quality issues. Save product and packaging if possible. Save the MDR quality assurance report. Keep all reports in a central storage area.

• Keep an updated record of all devices your MDR has reported to the FDA as being re-processed.

• Ensure any new contracts you sign don't have exclusions for reprocessing.

Regent has been reprocessing since 2008 and still meets resistance. "It's difficult to undo the damage from sales reps who are unhappy that they will lose business," Gagliardi said.

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2. General Accounting Office. Medical Devices. *Reprocessing and Reuse of Devices Labeled Single-Use*. June 27, 2000. Accessed at http://www.gao.gov/assets/110/108509.pdf. ■

Patient has high out-of-pocket costs? Find out earlier! Move financial talk to front end

More patients have access to insurance coverage today, but they also have higher out-of-pocket responsibility.

"Our greatest challenge is getting the information we need to verify healthcare benefits and coverage for their stay," says **Susan Kole**, director of patient access at Saint Francis Hospital and Medical Center in Hartford, CT.

The sooner employees have this information, the sooner they can reach out to patients and make them aware of their out-of-pocket expenses, which impacts collections. "We are working with our schedulers to identify self-pay patients and those with high deductibles," reports Kole.

If staff members know this information at the time of booking, it gives them more time to identify all options for financial assistance and to offer payment plans. "Ideally, this discussion should take place in the physician's office," says Kole. "The more information the patient has, the easier it is for them to make the right decision for their care."

Registration leaders are working with OR schedulers to add questions to the scheduling questionnaire. At the time of booking, schedulers will do the following:

- ask whether the patient is insured, and if so, whether the plan was purchased on the Health Insurance Marketplace;
- identify if there are special rates for specific procedures that should be collected at the time of, or prior to, admission.

Previously, scheduling and registration systems were not integrated. "Now that we are on an integrated system, our registrars and [authorization] specialists will be able to start the process as soon as the case is booked," says Kole.

In moving financial counseling to the front end, says **David Kelly,** director of revenue cycle at Mary Rutan Hospital in Bellefontaine, OH, "you need to determine what 'teeth,' if any, your institution wants to have when a patient falls through the cracks."

> "WE BELIEVE THERE ARE SIGNIFICANT GAINS FOR PATIENTS, PHYSICIANS AND REFERRAL SOURCES, AND THE HOSPITAL."

Managers also need to decide whether to combine scheduling, pre-registration, and financial clearance process into a single call — what Kelly calls "schegistration" — or call the patient back later. "The former might make the patient happier, but yield less reliable information," says Kelly. "The latter is a dissatisfier because of the two calls but allows for very accurate capture of patient information."

Some healthcare providers route calls to financial counseling if the patient is calling to schedule a service, but they use the two-call method if the physician's office is calling to schedule for the patient. "This seems to work well. But smaller institutions such as ours may have trouble with the systems and personnel to support such a plan," says Kelly. "We're currently investigating how to design this project best for an institution our size."

In preparation for moving things to a "pre-service" model at Mary Rutan, leaders are scrutinizing the entire process. "We believe there are significant gains for patients, physicians and referral sources, and the hospital," says Kelly. *(For information on how facilities can use a patient payment estimator to tell patients what they'll owe before they schedule an elective surgery, see story, p. 20.)* ■

EXECUTIVE SUMMARY

To inform patients of their out-of-pocket responsibility earlier and improve collections, healthcare providers are moving financial counseling to the front end. Some successful approaches include the following:

- Have financial discussions at the point of scheduling.
- Integrate scheduling and registration systems.
- Combine scheduling, pre-registration, and financial clearance in a single call.

Tools allow for accurate estimates: Patients get the 'whole story'

Staff at NorthBay Healthcare in Fairfield, CA, use a newly implemented patient payment estimator to tell patients what they'll owe before they schedule an elective surgery.

"The patient feels like they have the whole story from the very beginning, and we avoid the expense of carrying a balance on accounts receivable, making phone calls, and sending statements," says **Lori Eichenberger**, interim senior director of revenue cycle management at NorthBay.

About 40% of the hospital's revenue comes from Medicare patients. "We find that our Medicare patients are less willing to give us credit card payments over the phone," she says. "After the phone conversation, patients come in prepared to pay."

At Children's Healthcare of Atlanta, patient access leaders created a centralized process to provide estimates in a consistent and seamless manner. "Because it's embedded in our financial counseling department, it's enabled us to provide financial assistance as needed for uninsured and underinsured customers," says **Lori A. Schwieg**, CHAM, CPAR, manager of quality assurance, training, and projects for patient access.

The overall goal is to provide price transparency by providing estimates before services are rendered.

"We expect to see an increase in collections for planned elective services and overall customer satisfaction with the use of payment arrangements and prompt-pay discounts," says Schwieg. ■

Sponges retained in patients during surgery are reduced by 93% in study

The results of a new study published in the *Journal of the American College of Surgery (JACS)* show an adjunct technology for the detection and prevention of retained surgical sponges (RSS) reduced the incidence of RSS by 93%. RSS are expensive in terms of X-rays, OR time, reduced reimbursement for hospitals, and potential liability.

It takes, on average, 20 minutes to resolve a miscount, which potentially requires the patient to spend more time under anesthesia while waiting for X-rays and/or a thorough search. Every minute of OR time is estimated to cost $62, according to RF Surgical Systems in Carlsbad, CA, which manufactures the RF Surgical Systems that was studied. RF Surgical System quotes an unnamed 2010 study in the *Journal of Clinical Anesthesiology.* X-rays used in the sponge count protocol impart a cost of about $285 per miscount, according to RF Surgical Systems, which quotes an unnamed 2014 study in the *JACS*.

Hospitals are required to submit data on retained surgical items and other "never" events to the Centers for Medicare and Medicaid Services (CMS). The information is available to the public on the Hospital Compare web site. Also, retained items are one of eight events that impact hospitals' CMS reimbursement levels. At least one insurer (Wellpoint) also requires patient quality measure before it offers payment increases.

Medical malpractice claims and legal fees related to retained surgical items can range from $150,000 to $5 million or more per incident, says RF Surgical Systems. The findings from the study detail OR efficiencies:

- clinically proven to provide cost savings (OR time, X-rays) and cost avoidance (legal and reimbursement expenses) at a rate of 3.13 times implementation costs;
- clinical evidence of reduction of OR time by 16 minutes per procedure, which resulted in a cost savings averaging $1,000 per procedure.

An estimated 39 U.S. cases of retained surgical objects occur weekly, says the National Center for Health Statistics. Surgical sponges account for nearly 70% of all retained surgical objects. Nearly 88% of RSS incidences occur when the counts are thought to be correct. The study can be accessed at http://bit.ly/1oHx0cu.

RESOURCE

RF Surgical Systems, Carlsbad, CA. Phone: (855) 522-7027. Web: http://www.rfsurg.com/products-and-technology/products/rf-assure-detection-system. ■

Savings on infection control and Medicare resources

As part of this issue's special focus on cost savings, AHC Media, publisher of *Same-Day Surgery* and dozens of other educational products, is offering the following discounts to *SDS* readers:

• **Publication:** *Hospital Infection Control.* Get a one-year subscription for $349, which is $150 off the regular price.

• **Webinar:** *Ensuring Compliance with CMS Anesthesia Standards*. Purchase for $199, which is $150 off the regular price.

• **Webinar:** *Maneuvering the Maze of CMS and TJC Informed Consent: Standards Every Hospital Should Know.* Purchase for $199, which is $150 off the regular price.

For more information about these products and to subscribe, please visit http://goo.gl/uDlP6U or call (800) 688-2421 and mention the code SDS15 to obtain these discounts. ■

Malpractice caused Joan Rivers' death, critics say

What at first seemed the tragic but otherwise unremarkable death of an elderly woman, comedian Joan Rivers, has turned out to be preventable and the result of malpractice, according to a federal report and malpractice attorneys.

The Manhattan clinic that treated the 81-year-old celebrity made several errors, including failing to identify deteriorating vital signs and providing timely intervention, according to a report by the Centers for Medicare & Medicaid Services (CMS). *(To access the report, go to http://bit.ly/1ys2U3S.)* Rivers died Sept. 4, 2014, a week after an appointment at Manhattan's Yorkville Endoscopy clinic. *(For more on her death, see "Joan Rivers' death puts spotlight on safety of freestanding centers,"* Same-Day Surgery*, November 2014, p. 113.)*

CMS noted these errors could have contributed to Rivers' death:

• failing to identify deteriorating vital signs and provide timely intervention;

• failing to record Rivers' weight prior to the administration of medication for sedation;

• failing to consistently document the dose of propofol, a sedative, administered;

• failing to obtain Rivers' informed consent for each procedure performed;

• failing to ensure that she was cared for only by physicians granted privilege in accordance with the clinic's bylaws;

• failing to abide by its own policy by allowing a photograph to be taken of a surgeon and Rivers while she was under sedation.

The string of deficiencies does not surprise **Jamie Koufman**, MD, an acid reflux specialist and director of the Voice Institute of New York in New York City. She is an expert in the type of surgery that Rivers was undergoing, and she says standards of care are insufficient. The standard of care clearly was not met in the Rivers case, Koufman says, but she says patients are at risk even when the standard is met. Koufman says too many physicians offer complex surgery in an outpatient setting without the proper training, equipment, or precautions.

The Rivers case shows the longstanding problem of inadequate preop examinations, says **Harry Nelson**, JD, partner at Nelson Hardiman in Los Angeles. Some surgeons aren't making sure "all of the 'i's' are dotted and 't's' are crossed," Nelson says. Obtaining vitals for all patients and screening them thoroughly for risk issues is time-consuming and not well-reimbursed, he says.

Nelson's firm has represented plaintiffs in several cases of patient deaths and injuries that probably were preventable with better compliance on pre-surgical review. There have been proposals for legislative solutions to the issue, Nelson notes.

Many doctors are concerned only with ensuring the patient is hemodynamically stable, Nelson says. "Also, surgery center owners must insist on more compliance policies and procedures to cover the need for better pre-ops," he says.

EXECUTIVE SUMMARY

The clinic and surgeons caring for comedian Joan Rivers at the time of her death made several errors that could have contributed to her death, according to a federal report.

- A report by the Centers for Medicare & Medicaid Services (CMS) found multiple deficiencies at the clinic.
- The clinic has issued a plan of correction.

However, the insufficient pre-op review was not the only problem, notes **Kenneth D. Powell Jr.**, JD, a partner in the Medical Malpractice Group at the law firm of Weber Gallagher in Philadelphia. It appears that one or more of the physicians were not properly credentialed, and the institution is always responsible for proper credentialing, he says.

"There are inconsistencies in the documentation concerning the use of propofol, and the importance of accurate documentation can never be emphasized enough," Powell says. "Failing to accurately record a patient's weight exposes all healthcare providers involved, particularly when the weight is needed to calculate an appropriate dose of medication."

Citing reports that the physician performed a procedure other than what the patient consented to, Powell points out that in most jurisdictions this is a technical battery and the physician is liable even if the patient is not harmed. In Pennsylvania, the institution is not responsible for the battery, but that law might not be the same in other jurisdictions, he says.

"Based on reports in the media, it appears that the clinic had ongoing and systemic problems that were not corrected. Because they were not corrected, this adds to the exposure in the Rivers case," Powell says. "The publicity tends to bring other potential claimants to the forefront who will be able to use these system failures to their advantage."

Yorkville Endoscopy issued a statement in response to the CMS report and noted that it already has "submitted and implemented a plan of correction that addressed all issues raised. The regulatory agencies are currently reviewing the corrective plan of action and have been in regular contact with Yorkville. In addition, the physicians involved in the direct care and treatment referenced in the report no longer practice or provide services at Yorkville." ■

Guideline developed for prevention and treatment of postoperative delirium in older patients

A new guideline is available to help healthcare providers prevent and treat one of the most common postop complications in older patients: delirium. The *Clinical Practice Guideline for Postoperative Delirium in Older Adults* was developed by the American College of Surgeons (ACS) and other participants in the Geriatrics-for-Specialists Initiative.

A companion best practice statement to use with the guideline appears online as an "article in press" on the *Journal of the American College of Surgeons* website, in advance of its publication in the *Journal* early this year.[1]

Studies show that when a patient's age is over 65 years, it greatly raises his or her risk of delirium after an operation.[2] Delirium can prolong the patient's stay and lead to other postoperative complications, including reduced physical or cognitive function. Furthermore, patients age 70 and older commonly have the hypoactive subtype of delirium,[3] which is characterized by symptoms such as lethargy, confusion, and inattentiveness and often goes undiagnosed.

"Postoperative delirium is the most common neurologic surgical complication for older adults, occurring in 15-50% of older adults after a major operation,"[4,5] said **Thomas Robinson**, MD, MS, FACS, co-chair of the panel that wrote the practice guideline and a professor of surgery at the University of Colorado School of Medicine, Aurora. "Yet it is preventable in up to 40% of cases."[6-7]

Potentially preventable risk factors for postoperative delirium include immobilization, lack of orientation to surroundings, disrupted sleep, dehydration, inadequately controlled pain, and infection.[2] Other contributors to delirium are chronic cognitive decline or dementia, vision or hearing impairments, severe illness, poor physical function, and presence of a urinary catheter.[2]

Recommendations to prevent postoperative delirium in older adults include:

- All surgical patients aged 65 and older should receive a preoperative assessment of their risk factors for delirium.
- For surgical patients at risk of postoperative delirium, healthcare

COMING IN FUTURE MONTHS

- Better ways to contact your patient's family and friends
- Advice on how to easily monitor hand hygiene compliance
- Simple tool to improve patient safety
- A free tool that translates for your patients

professionals should implement multiple nondrug interventions, for example:

√ Orient the patient to the time and their surroundings several times.

√ Have the patient walk as soon as safely possible after the operation and at least twice a day.

√ Allow the patient to wear his or her eyeglasses and hearing aids if applicable.

√ Ensure that the patient gets adequate fluids and nutrition.

√ Promote good sleep hygiene.

• The patient should receive adequate control of pain, preferably with nonopioid medications, such as acetaminophen.

• Patients should not receive medications known to increase the chance of postoperative delirium (unless the benefits outweigh the risks). *(These medications are specified in Table 7 of the published guideline.)*

Recommendations regarding treatment of postoperative delirium in older adults include:

• Avoid prescribing cholinesterase inhibitors (used to treat dementia) in patients who have not previously taken these medications.

• Do not use benzodiazepines as first-line treatment of agitation resulting from delirium.

• Avoid prescribing antipsychotics or benzodiazepines for treatment of postop delirium in patients who are not agitated and not threatening harm to themselves or others.

> "... IT IS PREVENTABLE IN UP TO 40% OF CASES."

The comprehensive guideline and evidence tables are available from the American Geriatrics Society via GeriatricsCareOnline.org. (*See "AGS Clinical Practice Guideline for Postoperative Delirium in Older Adults – just released."*)

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Joint Commission revises pain management standard

Revisions to The Joint Commission's *Provision of Care, Treatment, and Services* standard PC.01.02.07, which addresses pain management, were effective Jan. 1.

Following an extensive literature review, The Joint Commission revised the rationale and added a note to element of performance (EP) 4. Clinical experts in pain management provided feedback on these revisions and guidance on the future direction of pain management. The experts affirmed that treatment strategies might consider "pharmacologic and nonpharmacologic approaches." In addition, when considering the use of medications to treat pain, organizations should consider the benefits to the patient as well as the "risk of dependency, addiction, and abuse" of opioids.

Revisions will be included in the 2014 Update 2 for accreditation manuals. ■

CNE OBJECTIVES

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

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

SAME-DAY SURGERY

CNE INSTRUCTIONS

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 to the right or log on to the new AHCMedia.com site to take a post-test. Go to "MyAHC" and then "My Courses" to view your available CE activities. Tests are taken after each issue. First-time users will register on the site using the 8-digit subscriber number 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 test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. A credit letter will be e-mailed to you instantly.

CNE QUESTIONS

1. **How does Belmont/Harlem Surgery Center in Chicago handle scrubs?**

   A. Staff members lay out scrubs for staff and physicians the night before.
   B. Each set of scrubs has the name of the staff member or physician on it.
   C. No other scrubs are available in the locker room, but they are at a control station and must be signed out.
   D. All of the above

2. **How did OA – Centers for Orthopaedics in Portland, ME, reduce the $10,000 worth of inventory at bedsides in all of the bays?**

   A. Staff members pull the supplies the day before.
   B. Supplies are put into containers that travel with the patients throughout their stays.
   C. Both A and B
   D. Neither A nor B

3. **According to Stephen W. Earnhart, MS, CEO of Earnhart & Associates in Austin, TX, what might be a good goal for income generations?**

   A. Increase income by 1% per month
   B. Increase income by 5-10% annually
   C. Have your surgeon bring in six more cases per year.
   D. Don't focus on income. Focus on cost-cutting.

4. **According to Amy J. Gagliardi, vice president of the supply chain at Regent Surgical Health, based in Westchester, IL, how does the usual cost of a reprocessed device compare to the cost of a new device?**

   A. The usual cost of a reprocessed device is one-half.
   B. The usual cost of a reprocessed device is two-thirds.
   C. The usual cost of a reprocessed device is three-fourths.
   D. The usual cost of a reprocessed device is four-fifths.