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INSIDE

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Examine your practices after large outpatient hepatitis C outbreak

Be on the alert: 1 in 100 providers are reusing needles and syringes

Outpatient managers typically assume that their anesthetists adhere to basic infection control practices, such as using needles and syringes only once. Three hepatitis C outbreaks and a survey in the last two years make the point perfectly clear: Some providers — probably one in 100 — are not following the basics.

The results can be devastating. Dozens of patients can be infected with an infectious disease before the problem is uncovered. Such an outbreak leads to loss of staff privileges, the unwanted attention of accreditation organizations, a public relations nightmare, and financially devastating lawsuits.

"All health care providers must understand that it is entirely unacceptable and extremely dangerous to reuse needles and syringes on multiple patients," says **Elliott Greene**, MD, associate professor of anesthesiology at the department of anesthesiology at Albany (NY) Medical College.

Cross contaminating between patients indicates "incredible poor judgment and technique," says **Larry Hornsby**, CRNA, president of Anesthesia Solutions, a physician group practice in Mobile, AL, and vice president of Anesthesia Resources Management, a physician group

EXECUTIVE SUMMARY

Three hepatitis C outbreaks in the last couple of years and a follow-up survey by the American Association of Nurse Anesthetists indicate that some providers — one in 100, according to the survey — are not following basic infection control practices, such as using needles and syringes only once.

- Reuse of syringes isn't considered acceptable, even with a needleless system.
- Educate and update your staff, and monitor their practices, particularly concerning multidose vials.
- Use information from national organizations to update your infection control policies and procedures.
- Thoroughly investigate any reports of lapses in infection control.

practice in Birmingham, AL.

"It costs pocket change for a needle or syringe," says Hornsby, who is the former president of the American Association of Nurse Anesthetists (AANA) of Park Ridge, IL.

The three most recent outbreaks have been reported in outpatient settings, where staff may feel pressured due to caseloads and cost-saving measures, says **Arnold J. Berry**, MD, MPH, professor of anesthesiology at Emory University in Atlanta. "But neither of these concerns should prohibit use of appropriate infection control techniques in patient care," Berry emphasizes.

Consider these examples of outbreaks in the outpatient setting:

• An Oklahoma City nurse anesthetist admitted he caused a hepatitis C outbreak after reusing needles and syringes to inject pain medication, according to media reports.

The practice, which involved injecting medication through intravenous tubes, infected 80 patients at a hospital pain management clinic.

"By my understanding, this is the biggest outbreak of hepatitis C that has taken place as a result of transmission within a health care facility," said **Michael Crutcher**, state epidemiologist at the Oklahoma Department of Health.

It is unknown how many patients have been exposed to the virus at two surgical facilities where the nurse anesthetist practiced.

Such an outbreak can be caused when a provider uses a syringe to administer medicine to a patient who has hepatitis C, then draws more medicine from the same vial, health officials say.

There can be a backflow of blood into the intravenous tube, experts say. Of the 80 patients who tested positive for hepatitis C, the Oklahoma State Health Department has determined there is "strong evidence" that 38 cases are associated with the injections. The nurse anesthetist and the physician who supervised him have lost their hospital privileges. More than 20 of the infected patients have filed lawsuits against those two providers and the hospital.

• At least 81 people treated at a Fremont, NE, cancer clinic have tested positive for hepatitis C in an outbreak discovered in October 2002 that may have been caused by a physician's reuse of syringes, according to reports.

• In 2001, 19 patients of a Brooklyn, NY, clinic contracted hepatitis C when an anesthesiologist reused needles and a vial of medication.

However, at that clinic, inadequate cleaning and disinfection or sterilization of endoscopic equipment also was identified as a possible source of the infection.[1]

Infectious disease outbreaks are not considered sentinel events by the Joint Commission on Accreditation of Healthcare Organizations. However, the agency typically requests a response from an accredited facility, reviews the response, and, if it's accepted, refers the incident to the surveyor handling the facility's next survey.

The practice of reusing needles and syringes apparently isn't isolated. A recent survey of providers who give medications through injections reveals that one in 100 reuse the same needle and/or syringe on multiple patients, according to the AANA. **(For more information, see resource box, p. 27.)** The AANA points out that if even a

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small percentage of providers reuse needles and/or syringes, it potentially exposes millions of patients each year to needles or syringes contaminated with hepatitis, HIV, or other life-threatening infectious diseases.

The telephone survey, which was prompted by the outbreaks, included a random selection of anesthesiologists, other physicians, certified registered nurse anesthetists (CRNAs), other nurses, and oral surgeons. In addition to educating its members, the association is developing a public education campaign to make patients and their families aware of standards for needle and syringe reuse. This campaign could lead to questions from patients and their families regarding your policies and procedures.

Reuse of the same needle and/or syringe on multiple patients is considered unacceptable in the guidelines and practice standards of the AANA, the American Society of Anesthesiologists in Park Ridge, and the Association for Professionals in Infection Control and Epidemiology in Washington, DC. Using the same needle and syringe on multiple patients is considered unacceptable regardless of whether the provider uses needles or a needleless system to administer medications.

"The recent outbreaks of hepatitis C have demonstrated that not all providers are complying," says **Arnold J. Berry**, MD, MPH, professor of anesthesiology at Emory University in Atlanta. "The cause for any lapses in the recommended infection control practices is not known, but the reuse of needles and syringes in any practice setting could demonstrate a lack of appropriate education on the risks of not following proper infection control protocols."

Consider these suggestions to avoid an infectious disease outbreak at your facility:

- **Educate and monitor your staff.**

Go over the basic principles, such as a single needle and a single syringe for a single patient, and the potential for contamination with multidose vials, suggests **Beth P. Bell**, MD, MPH, chief of the epidemiology branch in the Division of Oral Hepatitis at the National Center for Infectious Diseases of the Centers for Disease Control and Prevention.

On an annual basis, provide updated information on bloodborne infectious diseases including hepatitis B and C and HIV, Greene advises.

Many outpatient anesthesia medications are provided in multidose vials, but the doses for individual patients may vary, Bell says. "Any areas within health care that involve multidose vials are places where managers need to pay close attention to infection control practices," she says.

These fundamental principles are not high tech, but they are particularly important in the outpatient setting, Bell adds. "As more and more health care is done in the outpatient setting, [managers] need to make sure the same emphasis on infection control is translated to those settings," she says.

- **Update your policies.**

Department policy and facility policy manuals need to incorporate pertinent aspects of infection control guidelines and indicate resources where additional information can be obtained, Green says. Look at current recommendations and

SOURCES AND RESOURCES

For more information on hepatitis C outbreaks, contact:

- **Arnold J. Berry**, MD, MPH, Professor of Anesthesiology, Emory University, 1364 Clifton Road, Atlanta, GA 30322. Telephone: (404) 778-3937. Fax: (404) 778-5194. E-mail: arnold_berry@emoryhealthcare.org.
- **Centers for Disease Control and Prevention**. General questions: (404) 371-5900. Web: www.cdc.gov/ncidod/diseases/hepatitis/index.htm.
- **Elliott Greene**, MD, Associate Professor of Anesthesiology, Department of Anesthesiology, Albany Medical College, 43 New Scotland Ave., Albany, NY 12208. E-mail: greenee@mail.amc.edu.

- The *Recommendations for Infection Control for the Practice of Anesthesiology*, prepared by the American Society of Anesthesiologist's Task Force on Infection Control can be reviewed online at www.asahq.org. Click on "Publications and Services" and then "Physician Booklets."
- For more information on the American Association of Nurse Anesthetists' study, go to www.aana.com. Under Quick Links, click on "press releases," then "press release archives." Click on the release for Nov. 13, 2002: "Reuse of Needles and Syringes by Healthcare Providers Puts Patients at Risk."
- The Federated Ambulatory Surgery Association (FASA) offers access to an ASC Compliance Hotline. Staff members can report confidentially on sensitive compliance issues, potential legal violations, or general standards of conduct. Within one day of the call, managers receive a written report and can handle the situation internally. For more information, contact FASA at (703) 836-8808. E-mail: fasa@fasa.org.

updates from the national organizations, sources suggest. **(See resource box, p. 27.)**

- **Encourage employees to report lapses.**

In many outbreaks of infectious diseases, poor infection control practices have been noticed by others, and in some cases, they have been reported to supervisors, Bell says.

"It's extremely important for administrators to take reports seriously, investigate, and make sure good infection control practices are being adhered to all the time in these settings," she says. **(See information on confidential hotline in resource box, p. 27.)**

These outbreaks are a wake-up call, Hornsby says. "They are an opportunity for every health care professional that comes in contact with contaminates, even beyond needles and syringes, to look at what you're doing, your practice, and eliminate any possibility that you could cross-contaminate from one patient to another," he says.

Reference

1. Muscarella L. Recommendations for preventing hepatitis C virus infection: Analysis of a Brooklyn endoscopy clinic's outbreak. *Infect Control Hosp Epidemiol* 2001; 22:669. ■

Malpractice crisis: Some surgeons walk off the job

Reform sought at state, national levels

As the liability insurance crisis comes to a head in many states and some surgeons are organizing walkouts, facilities are facing dire financial impact from those walkouts.

For example, when surgeons in the northern panhandle of West Virginia walked off the job due to rising liability insurance rates, Wheeling Hospital lost $210,000 a day in revenues, and about two-thirds of the amount was attributable to cancelled ambulatory surgery procedures. Eighteen surgeons walked off the job at the hospital. In terms of the ambulatory surgery department, "for all intents and purposes, it was shut down," says **Donald H. Hofreuter**, MD, president and chief executive officer at Wheeling Hospital.

There was a spillover effect to other departments of the hospital, he says. Fewer colonoscopies were performed, and certain gynecological procedures were not scheduled because some specialists feared that patients might encounter difficulties and require immediate surgery by a general surgeon. Also, the cancellations of orthopedic surgeries affected rehabilitation and other areas.

EXECUTIVE SUMMARY

Surgeons in West Virginia walked off the job for 15 days in protest of rising liability insurance rates. Similar frustrations, and action, are being reported in other states.

- In West Virginia, one hospital paid the same-day surgery staff and used the time for education, filing, documentation, and other administrative tasks.
- West Virginia and other states are looking at set litigation award caps.
- President Bush has asked Congress for national liability insurance reform that would cap noneconomic damages, such as pain and suffering, at $250,000 and limit punitive damages.

The hospital continued to pay all full-time and part-time employees. The nurses were provided with their annual mandatory education, Hofreuter adds. "Those not involved in direct patient care were assigned other duties: catching up on filing, doing certain medical records, other administrative tasks, so we might have had a $20-a-hour nurse doing filing," he explains.

The physician's leave of absences were not the responsibility of other staff, Hofreuter says. "We felt we had a responsibility to them to maintain their livelihood the best way we could," he says.

Most surgeons returned after 15 days when the governor presented his plans for a medical liability reform bill and area legislators reassured the surgeons that they were in support of the legislation. The bill, as written at press time, would set litigation award caps, explain how appeals will be conducted, and require that patients reimburse their insurance providers after they receive their settlements.

Many other same-day surgery providers around the country face rising liability insurance rates. Many surgeons are retiring early or moving their practices. One such surgeon is **Joseph E. Gutierrez**, MD, FACS, former president of the Medical Society of the District of Columbia.

"The high liability insurance premiums in [Washington] DC, led to my closing my DC office and relocating to Virginia, where liability insurance premiums are lower," Gutierrez says. Virginia has a cap on noneconomic losses, but DC does not, he adds.

Consider these other recent developments:

- At press time, surgeons and obstetricians were

leading hundreds of doctors in New Jersey on a work action against elective surgery.

Physicians were asking for a reduced statute of limitations for filing suits and a $250,000 dollar cap on pain-and-suffering damages.

"This is the line in the sand," says **Michael A. Goldfarb**, MD, FACS, chairman and program director of the department of surgery at Monmouth Medical Center in Long Branch, NJ. "The patient has to decide that good health care is more important than a chance to win the lottery [with exorbitant liability awards]," he says.

Surgeons have seen their malpractice insurance policies increase severalfold, and some cannot afford it, according to Goldfarb.

The situation is critical: Rising rates are preventing people from entering the surgical field and causing early retirements, he says. "We have only one pediatric surgeon for Monmouth and Ocean counties," which includes a population of 1 million, he says.

The latest twist is that surgeons are being required to pay a "monster" amount of money for tail coverage, he says. For example, surgeons can be required to pay for twice their last year's insurance rate for that coverage. "Who will go for that?" Goldfarb asks. "That's like making a deal with the devil."

The New Jersey Department of Banking and Insurance is trying to establish a state subsidy fund to help lower the cost of physicians' liability premiums.

• In Pennsylvania, a mass walkout by physicians protesting high insurance costs was canceled in January when the governor vowed to fight for $200 million in aid for physicians.

Before the governor intervened, some hospitals had cut back on scheduled operations and reportedly cut back on some staff members' hours to prepare for the walkout.

Insurance costs for Pennsylvania doctors more than doubled in 2002 for thousands of physicians. About 900 physicians have left the state since 2001 to avoid paying malpractice premiums as high as $200,000 annually, according to the Pennsylvania Medical Society.

• In January, a dozen surgeons at four hospitals in southern Mississippi left work to protest that insurance companies dropped their malpractice coverage or severely raised premiums.

The surgeons refused to perform emergency surgery as well. Many elective procedures were cancelled, due to concerns over patients who might develop complications and need a general surgeon.

• Also in January, more than 800 Florida doctors stayed away from work in protest of liability insurance rates.

A task force appointed by Florida Gov. Jeb Bush recently recommended that jury awards for punitive damages and pain-and-suffering awards in medical liability cases be capped at $250,000.

• On the national level, President Bush has asked Congress again to pass medical liability reform legislation that would cap noneconomic damages, such as pain and suffering, at $250,000 and limit punitive damages.

President Bush also called for joint and several liability reform that would assign blame fairly and protect doctors who share information with patients or other providers.

The president said that "frivolous and junk lawsuits" are the primary cause of the rise in health care costs and doctor shortages. "The problem of those unnecessary costs don't start in the waiting room or the operating room. They're in the courtroom," he said. "Everybody's suing, it seems like. There are too many lawsuits in America, and there are too many lawsuits filed against doctors and hospitals without merit."

According to the president, the answer is capping jury awards in medical malpractice suits.

"We need reform all across America, and we need a law coming out of the United States Congress," he said. **(For more information on how this crisis is affecting outpatient surgery programs, see "Malpractice premiums rise, and some can't obtain insurance: How to survive," *Same-Day Surgery,* June 2002, p. 73; and "Med/mal contracts offered to ASCs, surgical hospitals," December 2002, p. 153.)** ■

SOURCES

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Same-Day Surgery Manager

Don't blow productivity with too many meetings

By **Stephen W. Earnhart**, MS
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(Editor's note: This is the second of a two-part series on productivity. Last month, we told you what productivity really *means and discussed why 100% productivity may not be a good idea. This month, we offer you realistic ideas for improving productivity.)*

In our informal and highly unsophisticated pool, we have surveyed same-day surgery managers about one of the biggest productivity busters and one of my great pet peeves: meetings!

The freestanding management staff reported that the formal meeting schedule was a total of seven for the month. My definition of a "formal meeting" is any meeting that is called more than three days in advance. You could call them "scheduled meetings" vs. "impromptu meetings."

The actual time spent in those seven meetings was 9½ hours or 240 minutes for the month. The meetings averaged about 45 minutes per meeting. The breakdown was as follows: one investor meeting, four staff meetings, one vendor meeting, and one meeting with a consultant. Not bad.

The hospital sector was 60 meetings per month! Time spent in meetings for the month was 3,300 minutes or 55 hours — more than one whole week. The breakdown was as follows: staff meetings, two; management meetings (mostly with areas outside of the surgical department) 40; off-site meetings with various groups, five; consultants, eight. (All of the consultant meetings were OK.) Every single hospital professional expressed anger at being called away for "silly unproductive hospital meetings."

I asked them if they were not in all these meetings, what would they be doing? They said that they would be in the operating environment being productive. They cited the following as what they considered productive: observing, seeking out the surgeons for feedback, staff training, and assessing patient satisfaction.

Of the 40 meetings that our peers have to attend that are "areas outside of the surgical department," many were dealing with Health Insurance Portability and Accountability Act (HIPAA) issues, overall hospital strategy in reducing cost, budget management, compliance regulations, patient satisfaction, expansion plans for the system, senior level "pep talks," and capital equipment request from other departments. When asked, "How important would you rate these meetings to the goals of your surgical department," 90% of the individuals said, "Little, if any."

The vast majority of these types of meetings are not interactive. They serve only to "inform and make aware of" issues that affect the hospital and the various departments. In other words, very few of the meeting attendants actually contribute; they sit and take notes. I know. I have been there. A far better way to handle this is via a hospital management-level newsletter. Put all the facts in a two- or three-page newsletter and e-mail it to the department heads. Ask for a "read receipt" of the e-mail so you know they got it. No one has to waste valuable time going or taking notes — you have all the info in front of you — and you can get on with the important issues of running a productive surgical environment.

One area where the freestanding industry lags behind the hospital market is being aware of what is happening in the global industry. The hospital sector is much better at understanding the bigger picture. Granted, they spend too much time in meetings to achieve it, but they still have it.

Many freestanding managers were not aware of the change in reimbursement in the 2003 Medicare rates and did not know of changes in regulatory issues within their own states.

I suggest that one staff member who has access to the Internet be assigned to be the "information officer" of the center. Spending a few hours a month at the *Federal Register* (www.access.gpo.gov), the local department of health web sites (www.apha.org/public_health/state. htm), and talking with peers in other surgery centers **(refer to source boxes throughout this issue)** can be of enormous benefits. That person can pass on the information he or she receives in a short newsletter to the employees and investors each month. Also, participation in state associations can help keep your staff informed about proposed regulatory changes, and you can submit comments

when the regulations are poorly designed.

And one more note on efficiency: Get rid of television sets in the postoperative care unit. They probably are responsible for more logjams than any other factor in the hospital and free-standing markets. Just pull the plug. No need to meet about it.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

MedPAC urges payment cuts for surgery centers

Impact could be devastating for some, FASA says

In a report to be submitted this month to Congress, the Medicare Payment Advisory Commission (MedPAC) will recommend that ambulatory surgery centers (ASCs) receive no inflation update for 2004 Medicare payments and that no surgical procedures be paid more in an ASC than a hospital outpatient department.

If the ASC reimbursement cuts are approved by Congress, the change would reduce payments for a few hundred of the 2,300 procedures that Medicare reimburses in ASCs.

Many of these procedures are high-volume procedures and are most likely to be performed in single-specialty ASCs, which could result in a devastating impact for those centers, according to **Kathy Bryant**, executive director of the Federated Ambulatory Surgery Association (FASA) in Alexandria, VA.

In making the recommendation, MedPAC staff said that because Wall Street is investing in the industry and contributing to its growth, Medicare payments must be more than adequate and can be cut. "This is ludicrous logic and certainly not based upon a considered judgment about Medicare reimbursement in ASCs," she says. "This appears to say if an industry can be successful, Medicare must be paying too much."

Bryant says FASA plans to fight the recommendations, and she says their chances of winning are excellent. However, other sources point out that Congress frequently approves MedPAC's recommendations.

Bryant says the recommendations should not be approved for the following additional reasons:

• Congress established a system for reimbursing ASCs, and the Centers for Medicare & Medicaid Services (CMS) is "woefully behind" in implementing it, she says.

For example, at press time, updates to the procedure list were years behind. "Rather than cutting a few procedures, the entire system should be looked at," she says.

Time taken to implement this proposal will put CMS even further behind in implementing other priorities, including a new cost survey, Bryant says.

• The payments under the hospital outpatient system are fluctuating widely and should not be the standard for reimbursing other providers, Bryant maintains.

How many and which procedures are affected would vary every year, she says.

"Adding to the complications is that the two systems do not have rates go into affect at the same time, so ASC payment rates might have to be adjusted twice per year," Bryant says. "Given the problems that already occur with carriers, this seems impossible."

• If approved, the recommendations would make reimbursing ASCs "incredibly complicated" because in addition to the nine groups, there may be several additional rates due to a cap at the hospital level, she says.

• Medicare clearly pays below appropriate reimbursement, she maintains.

In addition, "discouraging ASCs from treating Medicare patients is bad policy and, in the long run, will cost Medicare far more than the few dollars we are talking about here," Bryant maintains.

EXECUTIVE SUMMARY

The Medicare Payment Advisory Commission agreed to recommend this month that ambulatory surgery centers (ASCs) receive no inflation update for 2004 and that surgical procedures be paid the same in hospitals and ASCs.

- The result would be a decrease in payment for a few hundred procedures on the ASC list.
- The Federated Ambulatory Surgery Association executive director will fight the recommendation, which she says is based on "ludicrous logic."
- MedPAC recommended that hospital outpatient departments receive Medicare payment updates in 2004 equal to the market-basket rate -0.9 percentage point.

Medicare adopts 2000 Life Safety Code

The Centers for Medicare & Medicaid Services (CMS) has adopted the fire safety regulations of the 2000 Life Safety Code, updated and published by the Quincy, MA-based National Fire Protection Association.

The 2000 code could impose "significant new burdens" on new or renovated ambulatory surgery centers (ASCs), according to the Federated Ambulatory Surgery Association (FASA) in Alexandria, VA.

However, the 2000 code is considered less onerous that those changes originally proposed by CMS, according to the San Diego-based American Association of Ambulatory Surgery Centers (AAASC). Existing ASCs already in compliance with earlier versions of the code will not have to comply with the 2000 version unless they undergo substantial renovation and/or reconstruction, according to FASA. Case-by-case waivers also will be considered, the association says.

Most hospital outpatient departments already are in compliance with the 2000 code due to fire marshal requirements, according to the AHA.

Among other things, the final rule provides that an existing ASC will not be required to have a Type I Essential Electrical System (EES) or upgrade its medical gas capabilities, according to AAASC.

ASCs in compliance with earlier editions of the life safety code EES, and medical gas standards will not be required to upgrade to the 2000 edition, provided the ASC continues to meet the life safety code requirements applicable when it was constructed, the association says.

However, an ASC will be required to meet the 2000 edition of the code if its EES or medical gas system is renovated, altered, or modernized, AAASC points out.

Additionally, the final rule does not change the requirements for vertical openings and fire-rated wall standards applicable to ASCs, the association says. ASCs will be required to upgrade emergency lighting consistent with requirements specified in Chapter 21.2.9.1 of the 2000 edition of the code, but they will have three years to make such changes, it says.

The regulations take effect March 11, and health care facilities must comply with most changes by Sept. 11. The rule appears in the Jan. 10 *Federal Register*. (Web: www.access.gpo.gov.) A program on the implications of the life safety code is included in the March 12-15 annual AAASC meeting. (Web: www.aaasc.org). ■

While hospitals are paid more than ASCs for many procedures, American Hospital Association (AHA) officials claim there is disparity in payment rates for certain procedures from ASCs to hospital outpatient, says **Ashley Thompson**, MHA, senior associate director of policy development at the AHA.

"We want to make sure they aren't incentives built in the system for patients to be seen in one setting over another," Thompson says. "We prefer that it be based on clinical considerations rather than financial considerations."

Hospitals typically incur greater costs in treating outpatients, maintains Thompson, who points to requirements such as Emergency Medical Treatment and Labor Act regulations and the large percentage of Medicare and Medicaid patients.

However, AHA officials aren't certain that lowering the ASC payments to match hospital outpatient rates is the right answer. "Overall, hospitals are only getting 83 cents on the dollar for the care they provide to seniors," she says. "That system is really underfunded."

In its March report, MedPAC will recommend that hospital outpatient departments receive Medicare payment updates in 2004 equal to the market-basket rate -0.9 percentage point. ■

Staffing standards require look at multiple indicators

(Editor's note: This is the second of a two-part series on effective staffing for same-day surgery programs. Last month, we looked at how to determine how many people and what skills are needed for a successful program. This month, we look at accreditation standards on staffing effectiveness and how the standards will affect same-day surgery managers.)

You expect your overtime pay to increase if you have an unusual increase in volume during a month, but have you ever looked at employee sick leave in relation to an increase in volume?

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, is putting staffing effectiveness standards for ambulatory organizations through a pilot test. One of the organizations involved in the pilot test looked at the comparison of sick leave to volume increase. The data showed that during times of

JCAHO indicators address clinical and HR issues

In the pilot study of the ambulatory care staffing effectiveness standards for the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, some indicators have been identified as appropriate for ambulatory care programs. They are as follows:

- **Clinical/Service Indicators**
  - — patient complaints
  - — turnaround time from order to time of completion for diagnostics or lab work
  - — pathology turnaround time
  - — medication errors
  - — rescheduled/delayed/postponed procedures
  - — transfer to hospital
  - — patient injuries
  - — surgical site infection
  - — cycle time (time patient enters facility to time patient leaves)
- **Human Resource (HR) Indicators**
  - — staff vacancy rate
  - — overtime
  - — staff turnover rate
  - — outside agency/contract use
  - — staff injuries on the job
  - — staff satisfaction
  - — number of education hours per staff
  - — understaffing compared to organization's staffing plan
  - — sick time ■

increased volume, sick leave taken by employees also increased.

The next step for this organization is to investigate further and find out if employees were ill or were just trying to take time off when vacation leave would not be approved, says **Wilma Delaney**, staffing effectiveness team leader for the Joint Commission. An issue such as this one might result in a change of policy, she says. For example, the facility might allow some scheduled vacation time during busy months in an effort to better plan staffing levels without having to incur overtime or additional expense for per-diem help, Delaney adds.

This type of study is a part of the staffing effectiveness standards that the Joint Commission implemented for facilities accredited under the hospital standards in July 2002. Results of the pilot program for the staffing effectiveness standards for ambulatory facilities will be evaluated in 2003, with implementation probably occurring in 2004, she says.

The purpose of these standards is to have same-day surgery programs look at how staffing issues affect clinical outcomes, explains Delaney. "We don't intend to create more work for the organizations; in fact, many of the indicators used to meet the staffing effectiveness standards already are reviewed by organizations as part of ongoing quality assurance," she points out. **(See list of indicators, at left.)**

The standards require an organization to select two human resource indicators and two clinical indicators and track the data to see if trends in the human resource indicator have affected results measured by the clinical indicator, says Delaney. For example, a same-day surgery program might evaluate the effect that an increase in volume has on post-op infection or how an increase in overtime affects medication errors, she says.

Because an organization may choose indicators that don't produce significant results, a same-day surgery program probably should measure multiple indicators, suggests Delaney. "If after six months of data, it is clear that the indicators chosen are not producing any valuable information, the organization can stop collecting the data and switch to another indicator," she explains.

While the standards call for one year of data for the studies, Delaney points out that the some organizations surveyed soon after implementation of the standards may not have a full year's worth of data. "We'll implement the standards gradually," she says. ■

[Editor's note: This is the second in a series of periodic columns that will address specific questions related to Health Insurance Portability and Accountability Act (HIPAA) implementation. If you have questions, please send them to Sheryl Jackson, Same-Day Surgery, *American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com.]*

Question: How do I assess my readiness for the privacy requirements?

Answer: Start by looking at all of your policies and procedures to see which already comply with

HIPAA, says **Michael R. Callahan**, partner and head of the HIPAA section for Katten, Muchin, Zavis and Rosenman, a Chicago-based law firm. Depending on your organization's resources, this step can be accomplished externally with a consultant or internally, he says.

"Many state associations and trade associations have posted information on the Internet to help same-day surgery programs and other providers review their HIPAA readiness," Callahan says.

Compare your state regulations to the HIPAA requirements, he suggests. Many state trade associations have undertaken this task to help their members, he says. "In Illinois, we had to go line by line through 324 state statutes and regulations and compare them to HIPAA," he points out.

The good news is that most state regulations are more stringent than HIPAA requirements. "If the state requires more than HIPAA, you follow the state requirements," says Callahan.

As you go through your assessment, be sure to look not only at your policies, but at your actual practice as well, suggests Callahan. "We're finding that most problems are related to sloppiness," he says. The most typical problems in outpatient surgery are:

- Medical records sitting on a desk or countertop in an area that is open to public traffic.

Records can be left in a designated place for physicians to sign or to enable easy access for nurses, but they must not be left in an area in which nonhealth care providers travel.

- Computer monitors that display patient information are positioned so that people in the reception area can see them.

Turn your monitors or rearrange desk areas so that only the employee can see the information.

- A scheduling white board that includes patient names, procedures, or surgeons, on which nonhealth care providers can see names.

Make sure this information is placed in a location that is seen only by appropriate health care personnel.

- A sign-in sheet contains not only the patient's name but also some other identifier such as procedure or reason for coming into the facility.

Sign-in sheets are fine, as long as they don't contain other information that is related to the patient's medical history, Callahan points out.

As you review your HIPAA readiness, remember that patients may come to you and ask for an accounting of how their protected health care information was used and to whom it was given, says Callahan.

SOURCE

For more about Health Insurance Portability and Accountability Act (HIPAA) compliance, contact:

- **Michael R. Callahan**, Partner, Head of HIPAA Section, Katten, Muchin, Zavis and Rosenman, 525 W. Monroe St., Suite 1600, Chicago, IL 60661-3693. Telephone: (312) 902-5634. Fax: (312) 902-1061. E-mail: Michael.Callahan@kmzr.com.

"Be sure your records are linked in such a way that you can find any and all information related to billing, medical treatment, and claims filings," he says. "You must be able to pull together all of the information, along with the log sheet showing how the information was shared, within 30 days."

This requirement means that you may have to find parts of records in radiology, laboratory, pharmacy, quality assurance, accounting, and any number of other areas, he says.

You also want to work with your information technology department or consultant to make sure additions can be made easily to the record, because Callahan points out, "In addition to giving the patient the right to inspect records, the patient also may amend the record, so make sure you have that capability in place." ■

Antimicrobial suture cuts surgical site infections

A new product, approved by the Food and Drug Administration in December, can help address more than 675,000 surgical site infections that occur each year.[1]

Vicryl* Plus, manufactured by Ethicon in Somerville, NJ, is the first antimicrobial suture to be marketed in the United States.

The suture is coated with triclosan, an antibacterial agent that is proven effective in in vitro studies against *staphylococcus aureus*, *staphylococcus epidermidis*, and methicillin-resistant strains of *staphylococcus* such as methicillin-resistant *staphylococcus aureus* and methicillin-resistant *staphylococcus epidermidis*, the leading surgical site bacteria.

Because more than 60% of surgical site infections are confined to the incision, the use of a suture coated with an antibacterial agent will reduce infection.[1]

The triclosan coating will provide protection for a minimum of 48 hours. Triclosan is then absorbed into the bloodstream, metabolized by the liver, and eliminated via the kidneys through the liver. There is no evidence of accumulation over time.[2]

The suture will be available this year, but at press time, an exact date had not been set, according to an Ethicon spokesperson. The cost of the suture should add less than $10, probably as little as a few dollars, to each surgical procedure.

(Editor's note: For more information about the Vicryl Plus Antimicrobial Suture, go to www.ethicon.com and click on Vicryl*Plus.)*

References

1. Mangram AJ, Horan TC, Pearson ML, et al. Guideline for prevention of surgical site infection, 1999. *Infect Control Hosp Epidemiol* 1999; 20:247-248.
2. Barbolt TA. Chemistry and safety of triclosan, and its use as an antibacterial coating on coated VICRYL* Plus Antibacterial Suture (coated polyglactin 910 with triclosan). *Surg Site Infect J* December 2002 (suppl). ■

Survey targets open but unused devices

Read alerts: Send supplies to third-world countries

The American Hospital Association (AHA) has conducted a survey of open but unused single-use devices (SUDs) and has concluded that there's no need for the Food and Drug Administration (FDA) to regulate the handling of such devices.

The AHA survey of 675 hospitals found that three-quarter of hospitals discard open but unused single-use devices (SUDs). Most of the hospitals that resterilize the devices use third-party reprocessors.

None of the hospitals in the survey that resterilized the items themselves had any adverse patient outcomes associated with later use of the goods, according to the AHA. The letter sent to the FDA also was signed by the Association of Professionals in Infection Control and Epidemiology and the Federation of American Hospitals. **(For more information, see "Comment on open, unused single-use devices," *Same-Day Surgery*, November 2002, p. 143.)**

Where to send open but unused supplies

Recovered Medical Equipment for the Developing World (REMEDY), a New Haven, CT-based nonprofit organization that distributes open and unused medical supplies and equipment to third-world countries, now has a web site that includes e-mail alerts about urgent needs.

AIRE-mail links donors and recipients by posting notices of urgent needs and available donations. Supplies and equipment offered through AIRE-mail have ranged from disposable, non-durable materials, such as unused disposable latex gloves, to larger durable equipment and machines, such as autoclaves and anesthesia machines. Donations also have included full diagnostic units, such as an ultrasound machine and a full mammography unit.

(Editor's note: To receive the notices, go to www.remedyinc.org. Under "Quick Links," click on "AIRE-mail.") ■

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the **answer key on p. 36** to test their knowledge. To clarify confusion concerning any questions answered incorrectly, consult the source material. After completing this semester's activity with the June 2003 issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- New procedure moves to outpatient setting
- What you can learn from magnet facilities
- Tips from recently surveyed facilities
- How to avoid medical mistakes during procedures
- Latest anesthesia news — get patients out quicker

CE/CME objectives

If you have any questions about the new CE/CME testing method, please contact customer service at (800) 688-2421.

- Identify whether using the same needle and syringe on multiple patients is considered acceptable under any circumstances (*See "Examine your practices after large outpatient hepatitis C outbreak,"* in this issue.)
- List the accurate recommendations in the March 2003 report from the Medicare Payment Advisory Commission (MedPAC) to Congress. (See *"MedPAC urges payment cuts for surgery centers."*)
- Explain the purpose of the staffing effectiveness standards of the Joint Commission on the Accreditation of Healthcare Organizations. (See *"Staffing standards require look at multiple indicators."*)
- Identify the length of time that the coating of an antimicrobial suture will provide protection. (See *"Antimicrobial suture cuts surgical site infections."*)

Answer Key: 9. C; 10. A; 11. B; 12. D

CE/CME *questions*

Effective with this semester, *Same-Day Surgery* is changing its testing procedure. You will no longer need to return a Scantron answer sheet to earn credit for the activity. **For more information, refer to the "CE/CME Instructions," p. 35.** This testing procedure has proven to be an effective tool for adults learners.

9. Which of the following statements is true?
   A. Using the same needle and syringe on multiple patients is considered acceptable.
   B. Using the same needle and syringe on multiple patients is considered unacceptable unless a needleless system is used.
   C. Using the same needle and syringe on multiple patients is considered unacceptable regardless of whether the provider uses needles or a needleless system to administer medications.

10. Which of the following statements is true of the March 2003 report from MedPAC to Congress?
   A. The recommendations are that ambulatory surgery centers (ASCs) receive no inflation update for 2004 Medicare payments and that no surgical procedures be paid more in an ASC than a hospital outpatient department (HOPD).
   B. The recommendations are that ASCs receive a small inflation update for 2004 Medicare payments and that no surgical procedures be paid more in an ASC than a HOPD.
   C. The recommendations are that ASCs receive a small inflation update for 2004 Medicare payments and that some surgical procedures be paid more in an ASC than an HOPD.
   D. The recommendations are that ASCs receive a large inflation update for 2004 Medicare payments and that some surgical procedures be pain more in an ASC than an HOPD.

11. What is the purpose of the JCAHO's staffing effectiveness standards, according to Wilma Delaney, staffing effectiveness team leader?
   A. Make sure that same-day surgery programs are collecting a wide range of quality assurance data.
   B. Enable same-day surgery programs to evaluate the effect of human resource indicators on clinical and service outcomes.
   C. Ensure that same-day surgery programs hire the right number of people.
   D. Reduce sick leave and overtime pay.

12. The triclosan coating of a newly approve antimicrobial suture will provide protection for a minimum of how long?
   A. 12 hours
   B. 24 hours
   C. 36 hours
   D. 48 hours