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IN THIS ISSUE

APRIL 2003
VOL. 27, NO. 4 • (pages 37-48)

Surgery centers, hospitals could lose millions under OIG recommendations

Report suggests uniform payment rates, deletions from ASC list

If implemented, recent recommendations from the Department of Health and Human Services' Office of Inspector General (OIG) would result in millions of dollars in payment reductions for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs). OIG's report recommends that the Centers for Medicare & Medicaid Services (CMS) set uniform rates for outpatient services provided in ASCs and HOPDs.

The OIG report claims that reimbursement disparities between hospitals and surgery centers has resulted in $1.1 billion in additional hospital payments. The failure of CMS to remove procedures from the ASC list of covered procedures, when the procedures didn't meet the agency's criteria, has resulted in overpayments of $8 million to $14 million, the report says. **(For information on accessing the report, see resource box, p. 41.)**

Some sources express concern that these changes could cause procedures to shift settings.

"Payment amounts definitely influence the willingness of any provider — hospital, ASC, or physician — to provide services, and thus any

SDS addresses nurse recruitment and retention in the outpatient surgery setting

In this month's issue, beginning on p. 42, we include a special report on how to recruit and retain nurses in the outpatient surgery setting. On p. 42, we tell you how one hospital has had success with a code of conduct. On p. 43, we discuss magnet hospitals and what you can learn from them. On p. 44, we profile a hospital that has a 93% retention rate two years after hiring nursing graduates, as well as a turnover rate of less than 2%. We hope you enjoy this special report!

changes to lower current amounts would certainly influence their decision," says **Craig Jeffries**, executive director of the American Association of Ambulatory Surgery Centers in Johnson City, TN.

Safety is an issue being raised by some surgery providers, Jeffries says. The recommendations, if implemented, could push surgeries into physician offices in states that don't require such settings to meet ASC or hospital standards, he says.

Here are OIG's recommendations for CMS:

- **CMS should seek authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services.**
- **CMS should conduct and use timely ASC survey data to re-evaluate ASC payment rates.**
- **CMS should remove the procedure codes that meet its criteria for removal from the ASC list of covered procedures.**

CMS has failed to remove 72 procedure codes from the list that don't meet the agency's established criteria, the OIG says. Cutting these codes would have reduced ASC payments by $8 million to $14 million, the report says.

At press time, the draft final regulation for adding and removing procedures from the ASC list was being circulated among agencies.

According to the OIG, only six of the 72 procedure codes are scheduled for deletion. However, there may be hundreds of procedures proposed for addition. Sources estimate that final rule will be published and implemented before summer.

If the recommendation for uniform payments were implemented, it would lower HOPD payments rates for 66% of the 453 procedure codes examined by OIG. The median reduction would be $282.33. Four codes are paid 200% or greater more than ASCs, 69 codes are paid 100% to 199% more than ASCs, 88 are paid 50% to 99% more than ASCs, and 118 are paid 1% to 49% more than ASCs.

If these hospital payments were lowered to the surgery center amount, and hospitals decided to quit performing certain procedures because the payment was too low, then ASCs might benefit from increased business, acknowledges **Kathy Bryant**, JD, executive director of the Federated Ambulatory Surgery Association in Alexandria, VA. "However, this is too speculative to estimate at this time," she adds. "Reducing the payment

EXECUTIVE SUMMARY

The Department of Health and Human Services' Office of Inspector General (OIG) has recommended that hospitals and ambulatory surgery centers (ASCs) be paid the same rate for the same procedures and that 72 codes be removed from the ASC list of approved procedures.

- The disparity in payments has cost Medicare $1.1 billion, the OIG says. Failure to remove the 72 codes has cost Medicare $8 million to $14 million.
- The Centers for Medicare & Medicaid Services or Congress would have to adopt the OIG's recommendations.
- At press time, the final list of ASC-approved procedures was expected to be published and implemented by summer. Only six of the 72 procedures in the OIG report are recommended for deletion in the draft being circulated.

Same-Day Surgery® (ISSN 0190-5066) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Same-Day Surgery**®, P.O. Box 740059, Atlanta, GA 30374.

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Subscription rates: U.S.A., one year (12 issues), $499. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $399 per year; 10 to 20 additional copies, $299 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

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Procedure Code Rates (Excerpt)

HCPCS	OPD Rate	ASC Rate	Differences
56405	$119.57	$433.00	($313.43)
62367	$22.61	$433.00	($410.39)
62368	$22.61	$433.00	($410.39)
68810	$132.64	$323.00	($190.36)
67005	$1,706.18	$612.00	$1,094.18
67010	$1,706.18	$612.00	$1,094.18
67015	$1,706.18	$323.00	$1,383.18
67031	$245.67	$433.00	($187.33)
67036	$1,706.18	$612.00	$1,094.18
67038	$1,706.18	$696.00	$1,010.18
67107	$1,706.18	$696.00	$1,010.18
67141	$147.71	$433.00	($285.29)
67255	$1,706.18	$495.00	$1,211.18
67880	$303.45	$495.00	($191.55)

Source: Department of Health and Human Services Office of Inspector General. *Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers.* Washington, DC; 2003.

for procedures in hospitals would have no immediate effect on ASCs."

In 145 procedure codes examined by the OIG, Medicare reimbursed ASCs more. For those procedures, 12 codes are paid 200% or up more than the hospital rate, 41 codes are paid 100% to 199% more than the HOPD rate, 26 codes are paid 50% to 99% more than the HOPD rate, and 66 are paid 1% to 49% more than the HOPD rate. However, sources point out that CMS has no current data on the cost of these procedures because the ASC cost survey hasn't been conducted for several years.

If the HOPD and ASC rates were equalized, some procedures, such as cataract removal, might have mixed results, says **Eric Zimmerman**, JD, partner with McDermott, Will, and Emery in Washington, DC. The payment rate for cataracts is higher in hospitals, but when it's performed with a YAG laser, the payment in higher in the ASC, Zimmerman says. If the OIG's recommendation was implemented, more cataract procedures might move to ASCs, but more YAG procedures might move to hospitals, he speculates.

The bottom line would be whether providers could continue to provide the service at the new reimbursement rate, Zimmerman says. "If not, they may stop," he says. "More realistically, a lot of settings will stop providing services to Medicare beneficiaries."

One example is gastrointestinal (GI) procedures, Zimmerman says. The OIG says that there are 13 endoscopy/upper GI that are paid higher in ASCs, and 13 that are paid higher in hospitals. If the recommendation for equal payments is implemented, the OIG estimates the potential savings at $28,370,205. "If reimbursement for GI ASCs comes down as much as OIG says, it will not be cost-effective for ASCs to furnish," he says.

What's wrong with the recommendations?

It is a logical question to ask why a different rate should be paid to ASCs and HOPDs, Bryant acknowledges. "Right now, the answer is that different statutes provide different ways of calculating rates and are going to result in different payments," she says.

Correction

In the March 2003 issue of *Same-Day Surgery*, an executive summary of the story on recommendations from the Medicare Payment Advisory Commission (MedPAC) misrepresented the recommendation for hospital and surgery center payments. The recommendation is that surgery centers would not be paid more than hospitals for the same procedures. ■

However, sources express these specific concerns about the recommendations:

- **Hospitals have different requirements.**

Leveling the playing field to some extent makes sense, acknowledges **Ashley Thompson**, senior associate director of policy development at the American Hospital Association in Washington, DC. "But the problem is that hospital care is much more expensive in the outpatient setting, due to different requirements that hospitals must meet, such as EMTALA [Emergency Medical Treatment and Labor Act] provisions, life safety code, being open 24 hours a day/seven days a week, and having to treat everyone who walks in the door," Thompson says. "These create a different set of requirements for hospitals."

- **Hospitals already are losing money on Medicare outpatients.**

Already, 57% of hospitals lose money overall caring for Medicare patients, says Thompson, citing the AHA annual survey. "We think that further reducing payments would have tremendous impact on patients and facilities," she says. "It's not the right move to make."

- **The analysis is flawed, sources say.**

The OIG used a simplistic approach, explains Zimmerman. "For example, they didn't recognize fully that the payment systems are developed in different ways and intended to reimburse for different bundles of costs, and also, in fact, there may be cost differences between the settings that may result in different payment levels," he says. It's as if the OIG was exaggerating to make a point, he says. "I think it's almost absurd that they were saying that the payment rate should be paid at the lowest level," he says.

Their report presumes that payment rates for ASC and HOPD services are accurate at the lower of two levels. "Actually, ASC rates aren't actual reflections of anything because the data are so old," he says. Also, the ASC reimbursement mechanism of nine payment groups is crude, he says.

The HOPD payment data are more current, but the payment rates don't reflect the cost of providing a service, Zimmerman says.

Also, the OIG report used 1999 volume and 2001 rates, Bryant says. Using 2001 volume and 2003 rates indicates that cutting all ASC payments rates that currently exceed HOPD rates would result in $115 million in payment reductions, she says.

Also, some HOPD rates have changed significantly from the data used to compile the report, Bryant says, For example, HCPCS 52000, which had a significant payment difference in ASCs and HOPDs, is now less than $4 different, she says. FASA offers software that allows individual ASCs to assess the proposed reduction of payment to the HOPE level. **(See ordering information in resources box, p. 41.)**

Also, FASA recalculated the overpayments f or the 72 procedures that the OIG recommends deleting from the ASC list of approved procedures. FASA's recalculations used 2003 data and 2001 volume. "In fact, Medicare would save only $80,000 if the procedures that the OIG recommended were deleted from the ASC list and moved to HOPD," Bryant says. " Of course how much more it might cost beneficiaries is not calculated."

Also, the OIG makes clear in the report that its analysis is simply a financial one, Bryant says. "They note that they did not consider access or quality, but only considered cost," she says.

A better analysis could results in fairer payments and benefit to Medicare patients, says Jeffries.

HCPCS Codes Recommended for Removal from ASC List by OIG

23620	23600	42104	41112	67141	13101	14061
24670	56405	30801	68810	51725	51772	14041
27786	31235	65805	13100	11424	13131	13132
28400	12021	51710	64420	20670	13121	51726
62367	46050	56605	31525	11604	13151	52281
22305	45305	31238	11446	11444	14000	55700
27780	31233	40814	13120	67031	11644	14040
27760	21920	19100	13150	62368	14021	14060
27520	31570	69145	11624	15740	13152	52000
27808	38505	30802	31237	11404	67921	26605
					14020	52285

Source: Department of Health and Human Services' Office of Inspector General. *Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers.* Washington, DC; 2003.

SOURCES AND RESOURCES

For more information on the payment rate proposals, contact:

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- **Craig Jeffries**, Executive Director, American Association of Ambulatory Surgery Centers, P.O. Box 5271, Johnson City, TN 37602-5271. Telephone: (423) 915-1001. Fax: (423) 282-9712. E-mail: CraigJeffries@AAASC.org. Web: www.AAASC.org.

- A copy of the new Office of Inspector General report, *Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers*, is available on the Internet at oig.hhs.gov/oei/reports/oei-05-00-00340.pdf.
- The Federated Ambulatory Surgery Association (FASA) is offering a computer disc with an Excel program to assess the proposed reduction of surgery center payments to the hospital payment level. To use, you simply insert your center's volume for each procedure, and the total reduction is provided. The cost is $15 for FASA members and $30 for nonmembers. To order, contact FASA. Telephone: (703) 836-8808.

"CMS certainly can provide a more methodical analysis of the current site of service differential to help achieve a more reasonable payment rate for ASC procedures that are currently underpaid, compared to the HOPD payment, and thus expand beneficiary choice," he says.

FASA has reminded its members through the web site that the OIG report includes recommendations only, and CMS has no immediate plans to implement the recommendations. CMS's official response to the report says that further compatibility is desirable between ASC and HOPD payments; however, the solution is not obvious.

"One approach would be to use the lower payment rate in all settings," according to the response. "A second approach would be to attempt to pay an amount in each setting that would reflect in a comparable way the relative costs of using each site."

For the recommendations to take effect, CMS or Congress would have to act, Zimmerman points out. While those groups will be looking at payment disparity, they are unlikely to implement the OIG recommendations, he contends.

Instead, he expects the groups to give more weight to recommendations that were expected from the Medicare Payment Advisory Commission (MedPAC) at press time. MedPAC will recommend that no surgical procedures be paid more in an ASC than a hospital outpatient department. **(See "MedPAC urges payment cuts for surgery centers," *Same-Day Surgery*, March 2003, p. 31. Also, see correction in this issue, p. 39.)** ■

Same-Day Surgery Manager

Ensure your program succeeds in tough times

By **Stephen W. Earnhart**, MS
President and CEO
Earnhart & Associates
Dallas

There was a kinder time in the world. Nations were relatively at peace, and the future held nothing but blue skies and harmony. While our own industry is as stable as any, changes in reimbursement, shifting of physician loyalties, and profit compression have changed the way we operate our facilities. Or they should.

The fact is that most managers are not responding to these changes. Back when we were flush with profits and increasing growth of cases, it was easy for managers to let little things slide, such as increased tardiness by staff, cases starting later than normal, margins slipping but still very good, and the overall discipline of sound business models deteriorating.

Well, it is time to wake up and realize that times are tougher indeed than they were in the past. We are losing market share as corporate chains struggle to increase their earnings and develop new facilities. More than ever, our surgeons are faced with more options of where to perform their cases. Loyalties are become blurred as new deals are presented to them.

There is confusion in the reimbursement area as well, with news of equalizing payments between hospitals and ambulatory surgery centers (ASCs). Is this good for ASCs, or is it good for hospitals? Conversely, it is bad for hospitals, or bad for ASCs.

It is all getting a little out of control.

So how do we respond? I certainly did not coin the phase, but it makes more sense now than ever: "When the going gets tough, the tough get going." This is a time for leadership. It's a time when our staff and physicians are going to be looking for stability in an unstable time.

We need to increase the frequency of staff meetings and tighten up the discipline of the facility. This is not the time to be lax or turn away from issues that need to be handled. Let your department and staff know that it is business as usual and that while we cannot do much about external forces, we can make sure that our house is in order. Most staff members need clear direction and boundaries defined if you want to achieve optimal productivity. Now is the time to redefine those lines. Focus on the basics: marketing to the physicians, maximizing time efficiencies, and decreasing costs.

When was the last time you invited one or two surgeons to your staff meetings and asked for their input? As a firm, we interview thousands of surgeons, and overwhelmingly, they respond negatively when we ask them, "When was the last time the surgical staff asked you to assist them in reducing costs?" They are typically quite upset that no one has asked.

I have said it too many times, but you have to post your expectations of efficiencies. Staff need to know what your goals are. You cannot just talk about it. You must prove that you are serious and that there are repercussions if goals are not met.

Those departments and centers that are not profitable today will be less profitable in the months and years to come without a dramatic change in direction. Reduction in personnel must accompany reduction in procedures. Even with the difficulty of finding good staff today, you should not hoard staff who are unproductive or unnecessary.

On the brighter side, those centers that are doing well should expect to do better. Surgery is up all over the country. Baby boomers are having more surgery, and it is time to reach out and get some of it.

While it may be tough to be a manager these days, it is not difficult to attract new patients. The best way is to attract new surgeons! It is so rare that you will be approached by them; you need to seek them out. Ask your current users to identify those whom you should approach.

Redo your block schedule if necessary to make more time available. Expand your block to those who need it. A huge complaint we get from surgeons is that they could do more surgery if they could expand their block. Get your OR committee behind you to revamp your block requirements.

We will all weather this storm, but the strong will get stronger indeed, and the weak eventually will fall away unless they take action.

(Editor's note: Earnhart and 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.) ■

Code of conduct attracts and keeps nurses

Respect, courtesy result in less tension at work

As same-day surgery managers struggle to recruit top quality nurses, retention of current staff is more important than ever. One way to keep nurses in your same-day surgery program is to make sure the work environment is one in which they feel appreciated, respected, and valued.

At Strong Memorial Hospital in Rochester, NY, the same-day surgery staff members not only believe that they work in such an environment, but they have it in writing. "Our code of conduct is a multiparagraph statement of the program's expectation of how staff members will interact with each other,"

SPECIAL REPORT

EXECUTIVE SUMMARY

Nurses usually don't leave same-day surgery programs with pleasant working environments. The surgery staff at Strong Memorial Hospital in Rochester, NY, promotes this type of environment with a code of conduct that applies to all employees and physicians.

- Code of conduct emphasizes professional respect, courteous communications, and honesty.
- The workplace is less stressful as staff members work together to solve problems.
- Improved communication enables staff members to focus on solutions rather than point fingers at others' bad behavior.

SOURCE

For more on a written code of conduct, contact:
- **Deborah G. Spratt**, RN, MPA, CNOR, CNAA, Nurse Manager, Strong Memorial Hospital, 601 Elmwood Ave., Rochester, NY 14618. Telephone: (585) 275-9618. E-mail: Deborah_Spratt@urmc.rochester.edu.

says **Linda R. Knox**, RN, MS, CNOR, operating room nurse educator for the surgery program.

"The statement not only reiterates the program's commitment to the hospital's core values of respecting patients and providing excellent care, but it also says that we expect all patients, employees, and medical staff members to show each other respect and courtesy by being open, fair, and honest in all interactions," she explains.

The code was developed a couple of years ago when the surgical nursing staff began addressing several issues that affected operations, says Knox. "We had complaints about equipment, supplies, lab results, and all of the typical issues that affect a surgical department, but we realized that many of the issues could be traced back to communications between departments and people," she says.

"We set up an interdisciplinary committee of employees and physicians who were respected by their colleagues to develop a mechanism that promoted good communication between different groups to enable all of us to accomplish our goals," Knox explains. The committee members came up with the code of conduct that mandated teamwork, courteous communication, respect, and appropriate methods of conflict resolution, she says.

The code was distributed to all surgery departments as well as departments with which surgery regularly works, such as housekeeping, anesthesia, sterile supply, says **Deborah G. Spratt,** RN, MPA, CNOR, CNAA, nurse manager of the surgery department. "In addition to discussing the code in orientation, nursing does address it in all personnel evaluations," she says. "We also include the code in all physicians' credentialing packets."

Continuing education programs on interpersonal behavior, modification of behavior, and conflict resolution are presented three to four times each year to reinforce the importance of the code, says Spratt.

The code has affected behavior and interaction between people, says Knox. "In an interdisciplinary survey taken before implementation of the code, all of the departments pointed to each other as causing problems and behaving inappropriately," she says. "After implementation, we still found frustration about equipment and supply problems, but the complaints focused on the issue, not the personalities or behaviors involved."

Exit interviews with nurses who have left since the code of conduct was put into place have shown that the nurses did not leave because of dissatisfaction with the work environment, says Spratt. Even with continued growth of the surgery program, expansion of the department, and a busier schedule, there is less tension among staff members than there was before the code, she says.

While the code of conduct was initiated by the surgery program, it has since spread throughout the hospital and is now a hospitalwide policy, says Spratt. Having the code of conduct in writing is a great tool for managers, she adds.

"Previously, if you had a 'bad boy' or 'bad girl,' you just said 'stop acting that way,'" Spratt says. "Now, we have a written policy to back us up when we tell the employee to behave a certain way." ■

Magnet status aids recruitment, retention

While most same-day surgery programs are struggling to recruit and retain nurses, managers at some facilities are watching nurses jump at positions, even when the specific positions weren't their first choice.

What's their secret? Magnet status.

The Magnet Recognition Program administered by the American Nurses Credentialing Center (ANCC) in Washington, DC, is designed to publicly recognize nursing systems within health care organizations that involve nurses in patient care decisions and promote a professional environment for nurses. The rigorous certification criteria has been met by the 65 hospitals throughout the country that have achieved magnet status.

SPECIAL REPORT

With the ongoing paperwork required by other accreditation and regulatory bodies, why would a hospital's nursing staff take the time and spend the money to achieve certification in another program?

Being able to include the magnet certification logo on brochures, in advertisements, and on the web site has had a positive effect on recruitment

EXECUTIVE SUMMARY

As same-day surgery managers look for ways to attract and keep the best nurses in the midst of a nursing shortage, designation as a "magnet facility" by the American Nurses Credentialing Center is one tool that many managers have used to their advantage.

- Magnet certification attracts nurses because it is national recognition that the facility offers a professional nursing environment that promotes excellence in patient care.
- The application document requires attention to detail and specific examples of how nurses make an impact on patient care.
- Site surveyors focus on the overall involvement of nurses in patient care decisions rather than technical aspects such as specific skills of nurses.

and retention of nurses, says **Miriam Jolly,** RN, BSN, CPAN, post-anesthesia care unit (PACU) and day surgery coordinator at Catawba Valley Medical Center in Hickory, NC. Not only does her hospital enjoy a low turnover rate of less than 2% when the national average is more than 20%, but managers also have found that even when nurses do leave, more than half of them return within a year, she says. **(See how magnet status can help with retention and recruitment, below.)**

The magnet logo alone doesn't create staffing success, and what makes those facilities successful can be adapted by other facilities, points out Jolly. "Even before you apply for certification, you have to have policies, standards, and practices in place that are conducive to excellent nursing," she says.

Nurses want to work in a program that emphasizes respect, professionalism, and communication between co-workers within the same and between different departments, she explains.

The process of preparing the application for magnet certification differs from program to program. While Jolly's facility used a team approach, the staff at Capital Health System in Trenton, NJ, appointed one person at the "magnet guru" to oversee the whole process, explains **Doreen A. Donohue**, RN, MSN, director of perioperative services.

One thing to remember as you prepare the application is that the ANCC wants to see specific examples of how your organization encourages a professional environment for nursing, Donohue says. "Anything you do to encourage your staff, promote nursing excellence, or create a positive nursing environment should be added to a file so that you can easily pull out examples when needed," she says.

For example, her organization offers reimbursement for tuition, conferences, classes, or

Magnet facility enjoys low turnover, few open positions

In this age of a nursing shortage, the same-day surgery program and other departments at Catawba Valley Medical Center in Hickory, NC, enjoy the enviable reputation as a place that nurses want to work.

After achieving certification in the Magnet Recognition Program administered by the American Nurses Credentialing Center in Washington, DC, the facility looked for ways to use the recognition to enhance their nurse recruitment efforts.

"Whenever we get an application for employment, a representative from our organizational learning department calls the applicant and explains what magnet status means to nurses," says **Miriam Jolly,** RN, BSN, CPAN, PACU and day surgery coordinator at Catawba Valley Medical Center in Hickory, NC. "Even if we don't have the exact position for which the nurse was applying, we can explain what other positions are available."

The explanation of magnet status and the positive nursing environment that must exist to achieve magnet status often make nurses willing to accept another positions because they know they'll get a chance to work for a facility that values its nurses, she explains.

In addition to attracting good nurses, magnet status has affected the same-day surgery program's and the overall hospital's retention rate, says Jolly. The facility had always enjoyed a low turnover rate, but now the rate has dropped even lower: less than 2%, she says.

The best news is that 93% of the new graduate nurses that the same-day surgery program hires are still employed by Catawba two years after their hire date, she says. "This is important because new nurses typically jump to other jobs if there is a signing bonus or any type of increase in pay," she says. "We don't want to lose them after we've spent time and money training them, so keeping 93% of them is an important success," she adds.

Another statistic that demonstrates the importance of the "magnet approach" to nursing is the fact that 53% of nurses who do leave Catawba for other employers return within one year, says Jolly. "We don't offer signing bonuses but we are essentially fully staffed, with waiting lists for some departments," she says. ■

seminars that improve nursing or nurse management skills, she says. Because reimbursement programs often are among the first items cut in budget crunches, Donohue is proud that it has not been affected at her facility. By keeping track of nurses who take advantage of the program and the amounts of money the organization has committed to the nurses, she can demonstrate a commitment to nursing excellence, she explains.

It is important to review the *Scope and Standards for Nurse Administrators* (Washington, DC: American Nurses Association; 1996) to assess whether your program is at a point at which you can apply, says Jolly.

"You can't just decide that you are going to become a magnet program overnight by completing the application," she says. "You have to already have everything in place when you apply."

At first, the thought of applying for magnet status was overwhelming because the only other hospital in the area with magnet status is a large teaching hospital, she explains. "But once we started going through the list of standards, we realized that we already did everything that was required," Jolly says. It took 18 months to gather all the documentation and complete the application, she adds.

In addition to providing policies and descriptions of committees that involve nurses in key decisions, the facility has to provide examples of the opportunities nurses have to affect patient care, points out Jolly. "One example from the same-day surgery program was the development of a single, interdisciplinary patient education form so that nurses, therapists, surgeons, and any other staff member responsible for teaching the patient can see what information has been given by someone else," she says.

Another example of a nurse-initiated change in practice is the provision of chlorhexidine to physicians' offices for patients undergoing back or abdominal surgery, says Jolly. "In an effort to further reduce postoperative infections, we've always given chlorhexidine to patients to use when they shower at home prior to surgery," she says.

Patients whose preadmission visit occurred over the telephone rather than in the preadmission area did not receive the chlorhexidine, so nurses suggested providing the anti-infective agent at no cost to the physicians' offices, she adds. Now, there are few patients who do not use the chlorhexidine as instructed, she adds.

Once ANCC determines that the facility appears to meet the criteria, based upon the application, a site visit is scheduled, says Donohue. "The surveyors want to confirm that your nursing environment is as you described in the application," she says. "The focus is on patient care, but it's not the same as survey by an accrediting body such as the Joint Commission [on Accreditation of Healthcare Organizations]," she adds.

The surveyors want to see that nurses have an impact on patient care, so they ask questions of staff members such as, "Do you have a voice in the care of your patients? How do you collaborate with physicians? Why is this a good place for nurses to work?"

"The honesty of your staff is important," says Donohue. For this reason, there is no way to prompt answers, but you do need to make sure all nurses are aware of the surveyors visit and the possibility that any one of them will be asked about nursing practices, interdepartmental communications, and involvement in patient care, she adds.

Although the process involves staff time as well as application and survey fees, it is worth the effort and expense, says Donohue. **(See resource box, above.)**

"The process of looking at how we, as nurses, affect patient care is important to morale," she says. "It gave us a chance to be proud of what we do." ■

SOURCES AND RESOURCE

For more information on magnet hospitals, contact:

- **Miriam Jolly,** RN, BSN, CPAN, PACU and Day Surgery Coordinator, Catawba Valley Medical Center, 810 Fairgrove Church, Road S.E., Hickory, NC 28602. Telephone: (828) 326-3290. E-mail: mjolly@catawbavalleymc.org.
- **Doreen A. Donohue**, RN, MSN, Director of Perioperative Services, Capital Health System, 750 Brunswick Ave., Trenton, NJ 08638. Telephone: (609) 394-4520. E-mail: ddonohue@chsnj.org.

The Magnet Certification Program is open to any nursing service system within a health care organization. The application fee is $1,000. Survey fees for hospitals and long-term care inpatient facilities are based upon number of beds and begin at $3,700. For information about fees for nonhospital settings, contact the staff. For more information, contact:

- **American Nurses Credentialing Center**, 600 Maryland Ave. S.W., Suite 100 West, Washington, DC 20024-2571. Telephone: (800) 284-2378 or (202) 651-7000. Fax: (202) 651-7001. E-mail ANCC@ana.org. Web: www.nursecredentialing.org.

HIPAA Q & A

[Editor's note: This column addresses 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: What is an organized health care arrangement [OHCA], and why should I join one?

Answer: With some limited exceptions, the privacy standards require every provider to present their patients with their own notice of privacy practices (NPP), says **Joshua M. Kaye**, Esq., an attorney with McDermott, Will & Emery in Miami.

"This could result an administrative and logistical nightmare as the ASC [ambulatory surgery center] staff overwhelms the patients with the NPPs of the ASC as well as of the patients' treating providers," he explains.

To ease such burdens and help avoid patient confusion, the privacy standards allow for same-day surgery programs and other similar entities to be treated as an organized health care arrangement, says Kaye.

"As an OHCA, the same-day surgery program and medical staff may utilize a single joint NPP and more freely share protected health information among each other," he explains.

"Assuming your center is deemed an OHCA under the privacy standards, it is advisable to formalize this arrangement by amending your center's medical staff bylaws to incorporate necessary provisions regarding the use and sharing of patients' protected health information."

Question: Have the final security standards been announced?

Answer: On Feb. 13, 2003, the Department of Health and Human Services adopted final security standards that protect patient information that is maintained or transmitted electronically.

The rule requires covered entities to implement administrative, physical, and technical safeguards to protect electronic protected health information in their care. The security standards were published as a final rule in the Feb. 20 *Federal Register* with an effective date of April 21, 2003.

The rules require organizations to provide security awareness training to all employees, to conduct risk analyses to identify security vulnerabilities, to establish policies that allow access to protected health information on a need-to-know basis, to limit physical access to information, to establish audit controls, and to enforce sanctions. The regulations will become enforceable for most covered entities April 21, 2005. ■

SOURCE

For more information, contact:

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Bronchoscopes suspected after infection outbreak

In California, nonsterile endoscopes found

Allegheny General Hospital in Pittsburgh has determined that the cause of an outbreak of pulmonary infections in 12 patients may be contaminated bronchoscopes that weren't properly sanitized. Of the 12 patients, one patient died.

Based on its assessment, hospital officials contend the source of the increase in *pseudomonas* transmission discovered in 2002 is connected to the bronchoscopes and the possibility of defective equipment or failure of the bronchoscope sterilization technique.

The equipment used was a Steris System 1 Sterile Processing System, manufactured by Mentor, OH-based Steris. One accessory, a Steris Quick Connect Kit, was voluntarily recalled by the company in 2002 when it was determined that an incorrect adapter component might affect the sterilization process of scopes, according to the Food and Drug Administration (FDA). However, Allegheny General had not purchased the accessory and thus was not notified of the recall, according to a Steris spokesperson.

The recall had no impact on any other accessories, the company emphasized.

In response to the Allegheny General outbreak, Steris told its customers in a letter that it conducted an investigation in October 2002 and determined that proper cleaning and disinfection procedures may not have been followed within

the hospital. The FDA investigation is ongoing, according to an agency spokesperson.

In response to the outbreaks, the hospital took the following steps:

- All bronchoscopes were taken out of services, and new ones were purchased.
- An alternative sterilization process was implemented.
- The hospital contacted all former patients, or families of such patients, who underwent a bronchoscopy at the hospital between June 1, 2002, and Oct. 1, 2002.
- A hotline, (877) 226-6439, was established to help educate such patients about their risk of exposure to the bacteria and provide them with appointments for free diagnostic follow-up care at the hospital, if necessary.
- A question-and-answer sheet for patients and families was posted on the web site. **(See sheet enclosed in this issue. For more information on sterilization issues, see, "Are you using sterile equipment on your patients? How can you be sure?"** ***Same-Day Surgery*****, May 2002, p. 61.)**

In other news, nonsterile endoscopes were found at two California hospitals and prompted national warnings from the manufacturer, Olympus America, to ensure proper sterilization is being conducted. No patient harm resulted at either hospital, according to the Sacramento-based California Healthcare Association.

Olympus America posted a safety notice on its web site (www.olympusamerica.com), which says that some customers inadvertently may be neglecting to reprocess the auxiliary water channels on certain 160 series Olympus endoscopes. An auxiliary water channel, also known as a water-jet, is found on the following Exera models: CF-Q160L, CF-Q160I, CF-Q160S, CF-Q160AL, CF-Q160AI, and GIF-2T160.

"This notice is to remind you that the auxiliary water channel must be reprocessed each time the endoscope is used," the company says. This step is necessary, even if the auxiliary water feature is not used during the procedure, Olympus America emphasizes.

Certain older model Olympus endoscopes also contain auxiliary water connections and must be regularly reprocessed, the company says. The auxiliary water inlet on these endoscopes is found on the control section of the endoscope, either immediately above the suction valve or just below the grip. *(To see diagrams, go to www.olympusamerica.com/msg_section/msg_home.asp. Click on "Important Safety Notice.")*

To obtain additional copies of reprocessing manuals for Olympus endoscopic equipment, call (800) 848-9024. For information on endoscopy educational programs sponsored by Olympus, go to www.olympusuniversity.com or call (800) 645-8100, ext. 6200. ■

CE/CME objectives

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. (See *"Nurse loses license, must pay $99,000 fine,"* in this issue.)
- Describe how those issues affect clinical service delivery or management of a facility. (See *"Bronchoscopes suspected after infection outbreak."*)
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *"Code of conduct attracts and keeps nurses" and "Magnet status aids recruitment, retention."*)

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 to test their knowledge. To clarify confusion on 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

- Liposuction benchmarking study: How do you compare?
- 'Internal marketing' improves staff morale
- Patient satisfaction: Freestanding vs. hospital-based program
- HIPAA requirements for business associate agreements
- Expect the unexpected in your disaster plans

Nurse loses license, must pay $99,000 fine

Reuse of needles, syringes preceded outbreak

The nurse in Oklahoma City who admitted to reusing syringes and needles, which may have infected dozens of patients with hepatitis C, has had his nursing license revoked for five years and was given a $99,000 fine. The decision was the harshest allowable under Oklahoma state law.

According to the Centers for Disease Control and Prevention (CDC), the nurse's needle reuse led to the infection of 38 patients with hepatitis C, and 10 contracted hepatitis B.

In 42 other cases, patients at the clinic tested positive for hepatitis C; however, the CDC could not determine whether they contracted it in connection with the nurse's reuse of needles and syringes. **(For more information, see *Same-Day Surgery,* March 2003, p. 25.)** ■

CE/CME *questions*

If you have any questions about this testing method, please contact customer service at (800) 688-2421.

13. One of the benefits of a code of conduct, according to Linda R. Knox, RN, MS, CNOR, operating room nurse educator, is:
    A. Staff no longer complain about equipment problems.
    B. Staff keep their problems within their own departments.
    C. Staff focus on issues instead of behaviors and personalities.
    D. Paperwork is completed in a timely manner.

14. Which is an example of a nurse initiative that has a positive impact on patient care submitted by Catawba Valley Medical Center in the application for magnet certification offered by the American Nurses Credentialing Center?
    A. Nurses helped complete the application for certification.
    B. Nurses practiced for the site visit.
    C. Nurses read the *Scope and Standards for Nurse Administrators*.
    D. Nurses developed an interdisciplinary form for patient education.

15. Which is true of reprocessing the auxiliary water channel of an endoscope, according to Olympus America?
    A. The auxiliary water channel should be reprocessed each time the endoscope is used, even if the auxiliary water feature is not used during the procedure.
    B. The auxiliary water channel does not need to be reprocessed unless it is used.
    C. The auxiliary water channel should be reprocessed once every 10 cases, regardless of whether it is used.
    D. The auxiliary water channel should be reprocessed once a day, regardless of whether it is used.

16. The nurse in Oklahoma City who admitted to reusing syringes and needles, which may have infected dozens of patients with hepatitis C, faced what consequences?
    A. His nursing license was revoked for one year, and he was given a $10,000 fine.
    B. His nursing license was revoked for two years, and he was given a $25,000 fine.
    C. His nursing license was revoked for three years, and he was given a $50,000 fine.
    D. His nursing license was revoked for five years, and he was given a $99,000 fine.

Answer Key: 13. C; 14. D; 15. A; 16. D

Q&A for Patients and Families

How will I know if I am, or have been, infected with *pseudomonas?*
The most common symptoms of infection include fever, cough, increased shortness of breath, and increased phlegm (sputum) following your bronchoscopy. However, an accurate diagnosis cannot be made without consulting a doctor.

I feel fine now, but is it possible I could become sick with this infection later?
For most patients, this is highly unlikely. However, we are urging patients to call our hotline at (877) 226-6439 and schedule an appointment to be tested.

Can I see a doctor right away about this?
We consider this a priority. If you are having symptoms (fever, cough, increased shortness of breath) or wish to be tested or make an appointment, you will be seen right away. Please call our hotline at (877) 226-6439 to speak with our staff, and they will assist you.

Will I be charged for this?
You will not be charged for this visit or for tests to determine if you are infected, and results will be sent to your doctor or doctors.

What is a bronchoscopy?
A bronchoscopy is a common procedure that allows direct visual examination of the upper airway and lungs. During bronchoscopy, a physician inserts a bronchoscope, which is a small flexible tube about the width of a pencil, through the patient's nose or mouth and into the windpipe (trachea).

Could I have had the infection before I had the bronchoscopy?
Yes. That may have been a reason that your doctor asked you to have the procedure.

If I had an infection before I had the procedure, would the procedure make it worse?
It can be very hard to tell if an infection would be made worse under these circumstances. That is why it's important for us to check with you and follow your health status carefully. Please call the hotline at (877) 226-6439 to speak with our staff.

Was the bronchoscope used on me contaminated?
It is not possible to know the answer to this with absolute certainty. That is why it is important to be alert to symptoms and to call the hotline at (877) 226-6439. Our staff will help you to obtain testing and to see a physician.

Why can't you tell me if the bronchoscope used during my procedure was contaminated?
We did not track the bronchoscope used in each procedure with the patient, nor is it common to do so. However, we have put that process in place going forward.

Should I take antibiotics anyway to prevent infection?
Generally, it is not a good idea to take antibiotics without some clear evidence of risk or infection. Your doctor will advise you whether antibiotics are needed in your case. Our infectious disease and lung doctors are available to help your doctor and you in this decision.

Is *pseudomonas* infection contagious?
Person to person or other means of transmission is rare.

What about other procedures such as arthroscopy and endoscopes?
We have not found any contamination related to these other instruments.

How can I be sure this contamination won't happen in the future?
All hospitals that treat very sick patients see a higher rate of certain infections than hospitals that do not. Allegheny General Hospital has in place a number of processes and cleaning procedures to keep our infection rates as low as possible. We now use different scopes and a different sterilization process.

Source: Allegheny General Hospital, Pittsburgh. Web: www.wpahs.org.

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

On-line tool makes self-assessment easy to access

Penalty-free time to fix problems is a welcome benefit

Continual survey readiness, no last-minute crush of work to prepare for a site survey, and a penalty-free period to correct deficiencies that you identify are a few of the benefits cited by participants who underwent a self-assessment during the pilot project of the Joint Commission on Accreditation of Healthcare Organizations' new approach to accreditation.

A self-assessment is one part of the Joint Commission's Shared Vision-New Pathways initiative that introduces a new approach to accreditation. **(For more information, see *Same-Day Surgery*, December 2002, p. 145.)**

Self-assessment tools are a part of the process for most accreditation organizations, so the Joint Commission move to include self-assessment is not a new idea, says **Carol Gilhooley**, director of process improvement for the Joint Commission. The Accreditation Association for Ambulatory Health Care in Wilmette, IL, offers a self-assessment tool for its accredited members to use internally to prepare for a survey, but AAAHC does not collect results of the self-assessment.

The Joint Commission's self-assessment tool must be submitted 18 months prior to the scheduled survey visit so it will be mailed to organizations three months prior to the 18 month-mark, says Gilhooley. For example, organizations that are scheduled for a survey in July 2005, the first time self-assessment will be incorporated, will receive access to their self-assessment tool in October 2003 and have a deadline of January 2004, she explains.

To use the tool, an organization accesses a secure web site that is password-protected, explains Gilhooley. "Basically, the organization is using the same tool used by our surveyors. It lists the standards, rationale for the standards, and elements of performance," she says. "If the organization is not in compliance, the person submitting the information can click on a button to submit a brief plan of action to correct the deficiency."

Because the tool contains the same information used by the surveyor, it is a little like getting the answers to a test, says **Thomas P. Moerschel**, BSN, MBA, director of performance improvement for Shriners Hospital for Children in Spokane, WA, one of the pilot project participants.

The opportunity to assess the organization in a penalty-free environment is very appealing, says **Angie King**, RN, CPHQ, quality management director for Tift Regional Medical Center in Tifton, GA, and one of the participants in the first pilot test for the new accreditation process.

"You either meet the standards or you don't, and the self-assessment gives you an opportunity to develop the policies or implement a program that will bring you into compliance with the standards," she says. The best news is that you are not penalized for any deficiencies you identify

EXECUTIVE SUMMARY

The self-assessment portion of the Joint Commission's new accreditation survey process receives positive endorsements from participants in the initial pilot project.

- Programs scheduled for site surveys beginning in July 2005 will receive their self-assessment tool 21 months prior to the survey and will have three months to complete it.
- The self-assessment process promotes continual survey readiness, according to pilot project participants.
- Communication between departments is essential to successful completion of the tool.

during the self-assessment phase, King points out. "Once you've identified your own deficiencies, you submit a plan to correct them," she adds. Then, you have 18 months to implement those corrections, she says.

You also obtain the support and advice of Joint Commission staff after submitting a plan of correction, points out Gilhooley. "Within one month of submission of the self-assessment and plans of action, a conference call between organization representatives and Joint Commission subject matter staff is scheduled," she says.

The group discusses the results of the self-assessment and the corrective action plans, she explains. During the conversation, the group members discuss additions or changes to plans and agree upon final corrective action plans that are to be implemented in the 18 months before the accreditation survey, she adds.

While the Joint Commission staff members do clarify information and offer some suggestions, they did not find unidentified deficiencies during the pilot test, says Gilhooley. "We found that organizations are usually harder on themselves than any of our surveyors or staff members would be," she adds.

Although only one person in the organization is given the ability to submit the self-assessment, it is set up so that multiple people can access the tool, says Gilhooley. This system makes it easier for the person coordinating the assessment to gather information from different departments.

There were some initial software setup problems, but they were fixed, and the self-assessment tool worked well, says Moerschel.

Because the initial pilot test did not address all standards, King did not need all departments to provide information, but that will not be the case when the organization undergoes its actual self-assessment. "I will coordinate the process, but I will have the same-day surgery staff provide information on issues such as infection control and surgical-site verification," says King.

The same-day surgery staff will be able to use the web site to see what policies or measurement and monitoring information they must provide, she adds. Then they can enter it directly on the tool for the coordinator to review and prepare for submission, she explains.

"We've always had an ongoing self-assessment process in place, but the Joint Commission tool will help many organizations foster a mindset of continual survey readiness, says Moerschel. "It also increases communications between departments on an ongoing basis, because we need everyone's input to complete the tool."

The greatest benefit will be seen during the site survey, King adds. "Because the self-assessment enables us and the Joint Commission to review policies and paperwork prior to the site survey, the surveyors and organization staff members are free to look at real issues of patient care, patient safety, and quality during the survey," she says. ■

SOURCES

For more information on self-assessment, contact:

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Anesthesia monitoring requirements clarified

'Immediately available' differs between programs

Requirements for credentialing and privileging, responsibility for patient care, anesthesia monitoring, and availability to resuscitate have undergone major changes in the Wilmette, IL-based Accreditation Association for Ambulatory Health Care's standards for 2003.

The committee members charged with reviewing and revising these standards spent considerable discussion on anesthesia-related issues, says **Francis P. DiPlacido**, DMD, a Fort Myers, FL, oral and maxillofacial surgeon and chairman of the AAAHC's Standards and Survey Procedures Committee.

"We decided that it was impossible to come up with a one-size-fits-all standard that defined the term 'immediately available' when talking about a person being available to provide resuscitative

EXECUTIVE SUMMARY

The 2003 standards for the Accreditation Association for Ambulatory Health Care more clearly define a same-day surgery program's responsibility in several areas.

- Standards require physicians to be "immediately available" to monitor or resuscitate a patient under anesthesia, but surveyors are given leeway to judge the program's ability to meet this standard.
- Credentialing and privileging are emphasized as separate activities, and programs are warned not to automatically grant blanket privileges simply because physicians have met credentialing requirements.
- A program is responsible for the patient's safety and care as long as the patient is in the facility, including the waiting area.

measures," says DiPlacido.

The standards define immediately available as being ready to apply resuscitative measures in a timely manner, he says. "We decided not to apply a specific timeframe as the definition of immediately available because that would place unrealistic and unnecessary limitations on some organizations," he adds.

Because the ability to meet this standard will differ from facility to facility, surveyors will have to use their own judgment, DiPlacido points out.

"Not only will surveyors evaluate the physical facility, but they also will evaluate the level of skill and training of personnel other than the anesthesiologist or surgeon," he says.

For example, immediately available in a same-day surgery program that is part of, or attached to, a hospital might mean the physician or dentist is somewhere within the hospital, he says. For freestanding facilities, the surveyor will have to evaluate the training of the staff, level of anesthesia typically used, and equipment available in the recovery area to determine if the dentist, surgeon, or anesthesiologist can leave the facility and still be immediately available, he adds.

"The bottom line is patient safety," DiPlacido says. "The best way to evaluate your policy is to ask yourself if you would want one of your own family members in your facility with its current definition of immediately available."

Another addition to the standards clarifies that the organization is responsible for the patient as long as the patient is in the facility, DiPlacido says. This responsibility includes even the waiting room if the patient has been discharged from recovery and is waiting for a ride home, he adds.

RESOURCE

For information, contact: AAAHC, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091-2992. Telephone: (847) 853-6060. Fax: (847) 853-9028. Web: www.aaahc.org/accreditation/standards.shtml.

Although AAAHC standards have always addressed privileging and credentialing, the new standards have been amplified and enhanced, says DiPlacido. "We want to make sure that organizations understand that credentialing and privileging are two separate processes that require ongoing evaluation and review. Just because a physician or dentist's credentials have been verified, a same-day surgery program should not grant blanket privileges," he states.

"Each physician should be granted privileges for specific procedures based upon the procedures for which he or she is trained and qualified," he explains. The practice of allowing a physician to perform all procedures without verifying the training or skill for each is unacceptable, he adds. When verifying a physician or dentist's educational and training, the organization must rely upon primary sources for verification, DiPlacido says. Primary sources include the schools, training programs, or colleges at which the applicant was trained, he says. The new standards manual includes a list of primary sources acceptable for verification of training, education, board certification, and licensure, he adds.

The new standards are well defined without placing an unreasonable burden on the accredited organization, DiPlacido points out.

"We recognize that each organization is different, and we developed standards that allow for those differences without jeopardizing patient safety, which is our main concern," he says. ■

Focus on underreported infection-related events

Panel to revamp standards for sentinel events

The Joint Commission on the Accreditation of Healthcare Organizations is targeting infection control as a key focus for revision of standards and enhancement of sentinel event reporting efforts.

The Joint Commission is addressing infection control in several ways, says **Nancy Kupka**, RN, MS, MPH, associate project director of the division of research and evaluation for the Joint Commission. The agency convened an expert advisory panel that met for the first time in February 2003 to begin evaluation of the infection control standards, she says.

All Joint Commission standards have been reformatted and reworded to include easier-to-understand language and examples as part of the new accreditation initiative. However, Kupka points out that comments from organizations in the field that reviewed the revisions demonstrated a need to include more information and expand the standards' requirements for infection control.

Although the panel primary task will be to evaluate and revise the standards, panel members also will be instrumental in defining and clarifying the requirements for reporting sentinel events related to infections, says Kupka.

Because the panel has just begun meeting, it is too early to determine when revised standards, or definitions for sentinel event reports, will be complete, she says. "We will keep our accredited organizations updated on our progress through direct communications as well as information on the Joint Commission web site [www.jcaho.org]," she adds.

Another way Joint Commission is addressing the importance of infection control is the inclusion of the issue in the fixed performance areas for random unannounced surveys for hospitals in 2003. **(For other topics for unannounced surveys, see box, at right.)**

The Centers for Disease Control and Prevention (CDC) in Atlanta estimates that nearly 2 million patients in the United States acquire an infection as a result of care in a hospital, surgery center, long-term care facility, clinic, or dialysis center, and that almost 90,000 of those patients die as a result of the infection. Despite these numbers, only 10 infection-related reports have been reviewed as a sentinel event reported to the Joint Commission on the Accreditation of Health Care since the sentinel event policy was implemented in 1996. *(Editor's note: A series of articles on unhealthy hospitals that appeared in the* Chicago Tribune *in fall 2002 raised questions about the effectiveness of Joint Commission efforts to track and monitor infections in health care organizations that are accredited by the agency.[1])*

In December 2002, the Joint Commission sent a letter to all accredited organizations to draw attention to reportable sentinel events for which there appear to be lower frequency of reports than expected. The letter referenced unanticipated deaths or permanent loss of function that appear to be related to nosocomial infections.

"We do believe that infection-related sentinel events are underreported to us, but we don't believe the underreporting is due to malice or an attempt to cover up a situation," says Kupka.

"Infections are underreported as sentinel events because it is hard to determine if a very ill person succumbed to the infection or the illness," she says. "Patient safety is a priority for our accredited organizations, and infection control is an important element in patient safety," Kupka points out.

Reference

1. Berens MJ, Japsen B. Patients suffer as agency shields troubled hospitals: Clean bills of health are awarded despite deaths, infection outbreaks. Series: Tribune Investigation, Unhealthy hospitals: The inspectors. *Chicago Tribune*; Nov. 10, 2002. ■

Random unannounced survey topics identified

In a random unannounced survey (RUS) by the Joint Commission on the Accreditation of Healthcare Organizations, surveyors review fixed and variable performance areas, along with the variable topics based upon the organization's last survey report. The fixed performance areas that will be reviewed during RUSs in 2003 by the Joint Commission are as follows:

- **Ambulatory care:**
  - — credentialing and privileging of licensed independent practitioners;
  - — competence assessment;
  - — implementation within environment of care standards;
  - — improving performance;
  - — medication use.
- **Hospitals:**
  - — surveillance, prevention, and control of infection;
  - — initial assessment;
  - — role in improving performance;
  - — medication use;
  - — human resources planning.

Approximately 5% of organizations accredited by the Joint Commission undergo a RUS each year. Organizations surveyed by the Wilmette, IL-based Accreditation Association of Ambulatory Health Care do not undergo random surveys. ■

PATIENT SAFETY ALERT™
A quarterly supplement on best practices in safe patient care

Retained instruments: Rare error or safety concern?

Establish a strategy to make such errors less likely

A paper in the Jan. 16, 2003, *New England Journal of Medicine* has the safety community abuzz; are too many instruments and sponges being left inside patients after surgery?

The paper, widely regarded as the largest and most reliable to date on the subject, reported that such errors occur in approximately 1,500 out of 28 million patients each year. The research was conducted by staff at the Brigham and Women's Hospital in Boston.

The figure of 1,500 was projected from data in insurance records from about 800,000 operations in Massachusetts for 16 years ending in 2001. The researchers counted 61 forgotten pieces of surgical equipment in 54 patients, and calculated that this would translate into a national estimate of 1,500 cases yearly.

"First of all, I think the study was very well done," says **F. Dean Griffin,** MD, FACS, a practicing physician in Shreveport, LA, and chair of the patient safety / professional liability committee of the Chicago-based American College of Surgeons.

"The shortcoming is that all of the patients came from insurance company records, and only dealt with cases that became litigated. You and I know there are more patients [with similar experiences] that didn't sue."

Other observers also have suggested the real number may be higher because hospitals are not required to report such errors to public agencies.

This one shortcoming does not decrease the significance of the study, Griffin says. "It is one of many that come voluntarily from people in medicine that point out problems in quality, to educate our peers so we can do a better job."

Besides, he says, the exact number is not nearly as important as the fact that such errors are being made. "The thing is, one such error is one too many; having an exact number is not that important. We have to do a better job of controlling these errors."

Emergency department key

Perhaps one of the least surprising findings in the study was the fact that emergency department operations were nine times as likely to lead to such errors, given the press of time and the stressful nature of such procedures.

"Your goals may actually be in conflict with safety," notes **James A. Espinosa,** MD, FACEP, FAAFP, chairman of the emergency department at Overlook Hospital in Summit, NJ. "For example, you want to finish on time, so you might do a little less thorough exploration of the abdomen. At the same time, the nurse responsible for checking and counting instruments might be distracted."

Espinosa notes that a number of principles of human performance come into play with such errors. In addition to the aforementioned goal conflict with safety pressures, they include, among others, deviation from nominal work flow and poor coordination across silos. "The more complex the action, the more likely you are to have human performance problems," he notes. "The solution is to build in simplicity."

Complexity clearly is a key problem, adds **Tina Maund**, MS, RN, director of performance improvement at Overlook. "You have multiple technologies at work, very advanced kinds of physical technical procedures being applied, high levels of knowledge, and often high levels of experience being brought to the table," she notes.

"Carrying out a technical procedure at hand using instruments and applying learning and critical thinking [at the same time] is tough."

Griffin agrees. "Technology is growing so rapidly that what we're doing in medicine is increasingly dangerous," he says.

It's important when seeking to understand the causes of these errors that you look beyond the provider, asserts **Marilyn Sue Bogner**, PhD, head of the Institute for the Study of Human Error, LLC, in Bethesda, MD. "The paper examined what other factors there were [in addition to the providers]. That made me feel good," she says.

"We must take a systems approach to error," she continues. "In the context of care, a number of characteristics of defined systems provoke error on behalf of the care provider."

For example, the Boston researchers noted a higher degree of errors for patients with a higher body mass index (BMI). "People never consider the characteristics of the patient — we're always so busy looking at the provider," notes Bogner. "But with obese patients, you have to peel back several vertical inches of fat to get to the area you need to work on, and maybe your vision is obscured."

Even political, regulatory, and legal factors can work their effects down to the provider level, she adds.

Searching for solutions

Given these diverse pressures, how should one approach a strategy to reduce these errors? "First, you have to figure out why the errors happen," Bogner says. "Examine the characteristics of the situation, the patient, and other conditions. Then, what is it about the emergency department that contributes to these errors — time constraints or workloads?" Of course, you also need to talk to the care providers and ask them what the problems are. "Since people understandably don't want to admit to error, ask them about accidents that *almost* happened," she suggests.

"What was the circumstance: the type of surgery, time constraints, and so on? Had the surgeon had any rest, or were there back-to-back surgeries? What time of day was it performed?" Bogner asks.

From there, you can move to potential solutions, such as adjusting staffing or scheduling. Solutions become a bit more problematic if the error stems from the nature of the patient, but even there possible solutions exist. "The researchers talked about using X-rays," she notes. "Maybe that's not necessary for every patient, but you can target obese patients or make an extra special count on people who are larger than the run-of-the-mill patient."

This makes sense conceptually, Griffin says. "Consider the universal precautions we take, for example, in terms of AIDS or hepatitis. Originally, we thought we should treat those patients differently, but the facts are we treat everyone the same; we take the same maximal precaution with every case so as to not have to rely on patient confidentiality issues, and so on; we can just assume everyone has AIDS or hepatitis. In many ways, the universal precaution should apply to this issue; treat everybody maximally, even if the risk is lower. However, that may not be practical."

Since it may be impractical to X-ray the abdomen of every single emergency case after surgery, "you could maybe take a subset," Griffin suggests. However, he recalls a strategy employed by the Mayo Clinic that might be practical.

"In the operating room they built many years ago, there was an X-ray unit incorporated in the doorway, so as the patients were rolled out of the room, it automatically took a picture of them," he notes. "But it's not the standard of care [today]."

Despite the admitted challenges of technology, "this may be an event where technology is an utterly necessary adjunct," Espinosa suggests. "The fact that in the paper the counts were right indicates we may be exploring the limits of human performance." He notes human reliability research that shows people can have difficulty even with a series of simple math questions. "Your mind 'sees' the right answer," he explains. "You can be asked to subtract six from eight, you write down three but you see two."

In some situations, he continues, there is just no substitute for technology. "It would be helpful if there were some way to have a detection system, where all the instruments were tagged in such a way that you could have one sweep of that patient," he suggests. "That would not be the end of the problem, but another way of measuring."

Griffin agrees. "I would hope there would be technology that would provide some type of implantable device in these instruments that would be detected with a probe, but nothing is being done to my knowledge," he says.

Without such a development, Espinosa suggests, the progress that can be made in reducing these errors will be limited.

"Human performance without computer or machine guidance tends to be in errors of parts per hundreds of thousands," he notes. "It's hard

to get past that unless you use very strong technology. So, 50 errors per million is five per 100,000 — it's actually astonishing they can get that low with human performance. To get to parts of tens of millions, you would need much more robust technology."

"Nonetheless," concludes Griffin. "You have to remember to always work toward perfection."

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Pfizer to bar code drugs to reduce dispensing errors

Codes can be read by bar code readers

New York City-based Pharma company Pfizer, Inc. will use a new bar code technology on its hospital unit-dose products in an effort to help reduce dispensing errors at hospitals and pharmacies nationwide. The bar code system — developed in accordance with the new Reduced Space Symbology standards established by the Uniform Code Council (UCC) in Lawrenceville, NJ — allows for each unit of product to be identified by its national drug code, its expiration date, and its lot number in machine and human readable format.

"It is going to improve patient safety, especially dispensing errors, and if we can do it, we should be doing it," says **Rich Hollander,** Pfizer's senior director of packaging services. While the UCC only recently introduced its standards, Pfizer has been working on the problem for two years. "The initial push came through our CEO's office," he recalls. "He asked, 'Why are we not doing something about bar coding — especially on unit doses?' We thought that was a pretty good question, so we began to research what hospitals were looking for, whether there were industry standards, and what we could do about it."

For years, some companies, Merck among them, had been using scanning technology for a single element — the national drug code. So Pfizer began investigating that area, but in talking to hospitals, they found "they couldn't tell us what they wanted," Hollander reports. "The fact was, with very few exceptions, most people were not scanning, but said it would help, and they would love to do it."

Pfizer's due diligence revealed there were no standards governing bar coding. "At the same time, looking at standard linear bar code symbologies, we realized they required a lot of 'real estate,'" he notes. "We would have had to retool our products, which would in turn have decreased production rates. We were willing to do this, but it would have taken a long time."

A couple of key events helped speed the process along. Organizations such as the Food and Drug Administration (FDA) and the National Coordinating Council for Medication Error Reporting and Prevention (NCC-MERP) joined forces to look at preventing dispensing errors, and in August 2002, came out with a white paper calling for bar codes, not only for the drug code, but for the expiration date and lot number (the latter would help with traceability and, if needed, recalls).

"Both [of the new elements] were highly controversial," Hollander says. "After all, opponents asked, how often would you need them?"

However, the paper received a lot of attention. Then, Tommy Thompson, secretary of the Department of Health and Human Services, made a trip to a Veterans Affairs (VA) hospital and saw how they were using bar codes to prevent dispensing errors.

Although that was being done through repackaging rather than on the original product containers, Thompson said it should be considered a benchmark. At his urging, the FDA published a requirement in the Dec. 12, 2002, *Federal Register*.

"Most of the industry was pushing back against this, and saying you did not need the other two elements," Hollander notes. "You didn't have the technologies available to do it, and the size of the packages was also an issue."

At about the same time, the UCC developed its new Reduced Space Symbology standards, calling for the NDC (National Drug Code) to be put on very small packages. "However, you still could not go small enough for 3 cc or 5 cc vaccine vials, or ampules," he says. "With packages that small, nobody knew of a linear symbology that worked."

Pfizer challenged itself to develop one package

configuration that would work without the need to retool product lines, and without compromising the already crowded real estate on the package. "We realized it may be some years before hospital systems can adapt to read them, but we developed a standard we feel will work in any hospital," says Hollander. "We also wanted make sure the human readable quality was just as good." Pfizer introduced its first lot just before the end of 2002. The codes can be read by conventionally available bar code readers. "We've had a lot of favorable comments from hospitals, congratulating us for leading in this effort," he says. "There have been no complaints to date about the human readable aspect."

No data are in yet on error reduction, but Hollander says the NCC-MERP web site (www.ncc-merp.org) contains studies on the VA experience. Pfizer plans to be imprinting on all its hospital unit dose packages by the end of 2003, and on other types of packaging as technology permits. "Ultimately, this system will help reduce dispensing errors, and make sure you are using the right product, at the right strength, for the right patient," he predicts.

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AHRQ unveils web-based medical journal

Focus on medical errors in blame-free environment

The Agency for Healthcare Research and Quality (AHRQ) has launched a monthly peer-reviewed, web-based medical journal that showcases patient safety lessons drawn from actual cases of medical errors. Called *AHRQ WebM&M* (Morbidity and Mortality Rounds on the web), the web-based journal (webmm.ahrq.gov) was developed to educate health care providers about medical errors in a blame-free environment.

In hospitals across the country, clinicians routinely hold morbidity and mortality (M&M) conferences to discuss specific cases that raise issues regarding medical errors and quality improvement. Until now, there has been no comparable national or international forum to discuss and learn from medical errors. AHRQ saw the opportunity to use the web to host an ongoing national M&M conference aimed at improving patient safety by sharing information from anonymous cases.

"The AHRQ WebM&M web site offers the medical community a unique opportunity to learn about patient safety from the experiences of their colleagues across the country and around the world," says AHRQ director **Carolyn M. Clancy**, MD. "The anonymity safeguards will enable physicians to share their experiences without fear of reprisal. Their involvement will contribute to the education of other providers about how to prevent medical errors and improve patient safety."

Every month, five selected cases of medical errors and patient safety problems — one each in medicine, surgery / anesthesiology, obstetrics-gynecology, pediatrics, and other fields, including psychiatry, emergency medicine, and radiology — will be posted along with commentaries from distinguished experts and a forum for readers' comments. Each month, one case will be expanded into an interactive learning module ("Spotlight Case") featuring readers' polls, quizzes, and other multimedia elements and offering continuing medical education credits. Cases are limited to near misses or those that involve no permanent harm.

The web site was developed for AHRQ under a contract to an editorial team at the University of California, San Francisco. The editorial team is led by Robert M. Wachter, MD, associate chairman of UCSF's Department of Medicine and chief of the medical service at UCSF Medical Center. The editorial board and advisory panels include many of the nation's experts in patient safety.

Lucian Leape, MD, a leading patient safety researcher and a member of the AHRQ WebM&M advisory panel, praises the new journal. "To make real progress in patient safety, we have to engage physicians and break down the shame and silence surrounding errors. By presenting real-life cases of medical errors along with dynamic, systems-oriented expert commentaries, AHRQ WebM&M is an ideal way for physicians to learn more about and ultimately improve patient safety."

In its inaugural issue, the web-based journal features cases on a mix-up involving two patients with the same last name in the same hospital room; a mistaken drug administration causing a patient to stop breathing unexpectedly; a procedural mishap requiring emergency vascular surgery; an infusion pump flying into a magnetic resonance imaging machine, narrowly missing a child; and a misdiagnosis of delusions in a man later found to have metastatic brain and spine cancer. ■

Same-Day Surgery Reader Survey

In an effort to learn more about the professionals who read *Same-Day Surgery*, we are conducting this reader survey. The results will be used to enhance the content and format of *SDS*.

Instructions: Mark the appropriate answers by circling your response. Please write in your answers to the open-ended questions in the space provided. Return the questionnaire in the enclosed postage-paid envelope by May 15.

1. What are you most dissatisfied with in your job?
   A. staffing
   B. heavy workload
   C. low morale in your department or facility
   D. impact of cost-cutting on quality of care
   E. problems with administrators or physicians
   F. other (please specify) _____

SATISFACTION

2. Are the articles in *Same-Day Surgery* newsletter written about issues of importance and concern to you?
   A. always
   B. most of the time
   C. some of the time
   D. rarely
   E. never

Please rate your level of satisfaction with the following. Please mark your answers in the following manner.

A. excellent **B. good** **C. fair** **D. poor**

3.	quality of newsletter	A	B	C	D
4.	article selections	A	B	C	D
5.	timeliness	A	B	C	D
6.	quality of supplements	A	B	C	D
7.	length of newsletter	A	B	C	D
8.	overall value	A	B	C	D
9.	customer service	A	B	C	D

10. Do you plan to renew your subscription to *SDS*?
    A. yes
    B. no. If no, why not?_____

_____

11. Including *SDS*, which publication do you find most useful, and why?

_____

_____

ABOUT YOU

12. What is your title? (please choose the title that most closely reflects your position and responsibilities):
    A. Director/CEO
    B. Administrator
    C. Ambulatory Surgery Manager
    D. Nurse Manager
    E. other (please specify) _____

13. What is the highest degree that you hold?
    A. high school
    B. associate's or two-year
    C. bachelor's degree
    D. master's degree
    E. other (please specify)_____

14. How long have you been employed in outpatient surgery?
    A 0-2 years
    B. 3-5 years
    C. 6-9 years
    D. 10-15 years
    E. 16 or more years

15. From where do you most frequently get your continuing education contact hours?
    A. facility-provided
    B. travel off-site to live conferences
    C. subscription-based newsletters/journals
    D. outside-sponsored audio conferences
    E. other (please specify)_____

16. How much time do you spend accessing job-related information via on-line services (e-mail listservs, web sites, etc.)?
    A. 0 hours per week
    B. 1-5 hours per week
    C. 6-10 hours per week
    D. more than 11 hours per week

17. Please describe your facility
    A. hospital-based
    B. hospital, freestanding-affiliated
    C. freestanding, independent
    D. freestanding, part of chain
    E. office-based

COVERAGE

Questions 18-34 ask about coverage of various topics in *SDS* newsletter. Please mark your answers in the following manner: **A. very useful** **B. fairly useful** **C. not very useful** **D. not at all useful**

18.	managed care	A	B	C	D
19.	legislation	A	B	C	D
20.	risk management	A	B	C	D
21.	23-hour care	A	B	C	D
22.	new surgical procedures	A	B	C	D
23.	anesthesia	A	B	C	D
24.	quality improvement/benchmarking	A	B	C	D
25.	cost containment	A	B	C	D
26.	reimbursement/finance	A	B	C	D
27.	documentation	A	B	C	D
28.	accreditation	A	B	C	D
29.	infection control	A	B	C	D
30.	management	A	B	C	D
31.	federal regulations	A	B	C	D
32.	technology	A	B	C	D
33.	lasers	A	B	C	D
34.	alternative medicine	A	B	C	D

35. What is the top challenge you face in your job?
    A. costs/reimbursement
    B. staffing
    C. staff morale
    D. workload
    E. caseload
    F. difficult physicians
    G. federal regulations
    H. documentation/paperwork
    I. other (please specify) _____

_____

36. What do you like most about *SDS* newsletter? _____

_____

_____

37. What do you like least about *SDS* newsletter?_____

_____

_____

38. What new surgical procedures would you like to see written about in *SDS* newsletter?_____

_____

_____

39. What new medications or anesthetics would you like information on?_____

_____

_____

40. What are the most effective teaching methods used to train staff at your facility?_____

_____

_____

41. What, if any, outside vendors do you use for your training programs?_____

_____

_____

42. Has reading *Same-Day Surgery* changed your clinical practice? If so, how?_____

_____

_____

OPTIONAL CONTACT INFORMATION

Name _____ Facility _____

City _____ State _____

Telephone _____ E-mail _____

NOTE: Please remember to return your survey in the enclosed envelope.