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ASCs must brace for possible 1% reduction and no increase until 2010

The news is mostly good for hospital outpatient surgery departments

Beginning April 1, 2004, ambulatory surgery center (ASC) payment rates will be frozen until 2010. And the news may be worse: The payments may be frozen at a rate that is 1% below current rates.

The exact amount at which the rates will be frozen hasn't been determined. The reason is that there may be some discrepancy on what consumer price index (CPI) numbers the Centers for Medicare & Medicaid Services (CMS) used to calculate the update. It's possible that ASCs will not receive a reduction on April 1, but will stay at the current rate with a freeze until 2010. The Health and Human Services (HHS) general counsel is reviewing this discrepancy to tell CMS how to interpret it, according to the Alexandria, VA-based Federated Ambulatory Surgery Association (FASA).

Technically, ASCs may receive a CPI adjustment, minus 1%, but the net effect may be a 1% decrease in payments, with no increase until the

EXECUTIVE SUMMARY

The new Medicare bill passed by Congress is favorable mostly for hospital-based outpatient services, but it has drawn concern from ambulatory surgery centers (ASCs) and surgical hospitals.

- ASCs may receive a cost-of-living adjustment, minus 1%, so the effect could be a 1% decrease in their payments beginning April 1, 2004, under the new Medicare bill recently signed by President Bush. Also, the rates will be frozen at the April 1 level until 2010.
- Rural outpatient hospital departments received some relief. The bill provides payment for outpatient drugs at 95% average wholesale price or a transition percentage for two years.
- The bill would impose an 18-month moratorium on development of new specialty hospitals, including surgical hospitals, and limit expansion of existing ones.

end of the decade, under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

"The very negative impact on CPI updates over the next six years has a painful impact on the ability to keep pace with rising costs," says **Craig Jeffries**, executive director of the American Association of Ambulatory Surgery Centers (AAASC) in Johnson City, TN.

The Washington, DC-based Congressional Budget Office estimates it will cut ASC reimbursement by $3.1 billion over 10 years. "With regard to the cut and freeze, it would appear that some ASCs are going to decide that they can't provide services at less than today's rate until the end of the decade," says **Kathy Bryant**, executive director of FASA.

The system of ASC reimbursement also is likely to be changed, with no more cost surveys. The bill requires the Washington, DC-based General Accounting Office (GAO) to conduct a study that compares the costs of procedures in ASCs to the cost of procedures performed in hospital outpatient departments (HOPDs). The study findings will include a recommendation on whether the HOPD system is appropriate as a basis for the ASC payment rates. The study is to be submitted to CMS by Jan. 1, 2005.

CMS has discretion to design the payment system, although the agency must take into account the GAO's recommendations, Jeffries says. CMS is to develop an ASC payment system based upon the HOPD system that will be effective between Jan. 1, 2006, and Jan. 1, 2008.

Jerry W. Henderson, RN, CNOR, CASC, executive director of the SurgiCenter of Baltimore in Owings Mills, MD, says that while "it could have been worse," the recent congressional action still is a blow to the industry. "As our expenses continue to go up every year, we can't afford to have any cuts or freezes in our reimbursements," he says. "When expenses exceed reimbursement at some point in the future, it may come down to a business decision to not do Medicare patients."

Despite his concerns about the rate freeze, Jeffries says his organization's initial assessment is that overall the changes will be a net positive for ASCs. The move away from cost surveys and toward a new system for re-basing ASC payments is a "clear victory," he points out.

"Importantly, the legislation requires CMS to implement the new rates in a budget-neutral manner, which effectively prohibits CMS from lowering overall ASC spending when implementing the new payment rates," Jeffries wrote in comments e-mailed to AAASC members.[1]

In his e-mail, Jeffries offered several important advantages to ASCs, including the following:

• ASC rates usually are lower than hospital rates. "As such, while a hospital-ASC rate linkage might mean rate reductions for some ASC procedures where ASC rates are presently higher, it likely would mean important increases for the majority of ASC procedures," Jeffries said.

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• CMS has access to more and better data from hospitals than from ASCs, and it recollects that data each year.

• CMS is required to update hospital outpatient service rates annually. "While CMS is required to revise ASC rates every five years, it has ignored this obligation, because the ASC program is a low priority compared to the demands of developing and annually updating hospital outpatient service rates," Jeffries wrote. If ASC and hospital outpatient rates were linked, CMS likely would update ASC rates annually, he explained.

• The hospital community is a stronger lobbying force and more effectively can persuade Congress and CMS to address reimbursement problems, Jeffries said. "If ASC and hospital outpatient rates were linked, ASCs could, to some extent, ride the coattails of hospital industry efforts to improve payments," he said.

• Hospitals are entitled to payment add-ons and adjustments that are not available to ASCs. "If ASC and hospital outpatient rates were linked, ASCs might likewise benefit from some of these beneficial payment rules, including medical device pass-through and outlier payment opportunities," said Jeffries.

Bryant is more conservative in her outlook. "With regard to the tie to HOPD, whether this is a good thing or not depends on how it is implemented," she says. "By Congress simply directing CMS to do so with little guidance, it is impossible to determine even the major outlines of such a proposal."

In the meantime, surgery centers and surgeons who work in them should write their congressional representatives explaining the impact of freezing the ASC rates, Bryant recommends.

"It was made clear to us that we were absorbing a larger than our fair share of cuts because ASCs were not politically active," she says. "The only way to stop such draconian cuts is to have members of Congress understand the consequences."

Secondly, look at your costs for performing Medicare procedures and determine if you can cover your costs if you are providing them at 3% less than today's rates, Bryant says. "Prior to this bill passing, at least small annual increases were promised," she says. "Now we've been told no increases."

Focus on restraining the growth in costs with emphasis on more efficient purchasing and materials management, Jeffries suggests**. (The AAASC annual meeting pre-conference will include this topic. See resource box, at right.)**

The freeze is especially upsetting considering that ASCs are paying increased salaries for some employees, Bryant says. In the 2003 *Same-Day Surgery* Salary Survey, almost 67% of respondents experienced an increase that ranged between 1% and 6%. **(For more information, see *SDS*, November 2003, supplement.)**

"With FASA's salary survey showing increases of 20% for salaries for some employees, I think many ASCs will have difficulty providing services to Medicare beneficiaries under this scenario," Bryant says.

For hospital outpatient surgery departments, the news was good overall. The "hold-harmless" provision of the outpatient prospective payment system (OPPS) was extended for two years (calendar year 2004 and 2005) for rural hospitals of less than 100 beds and sole community hospitals (SCHs) in rural areas. The bill asks HHS to determine if rural hospitals experience higher costs than urban providers under OPPS.

The bill also provides payment for outpatient drugs at 95% average wholesale price (AWP) or a transition percentage for two years from 2004-2005. The transition period payments follow.

• **Sole source:** 88% AWP for 2004, 83% AWP for 2005.

• **Multisource:** 68% AWP for 2004, 68% AWP for 2005.

• **Generic:** 46% AWP for 2004, 46% AWP for 2005.

The 2006 rates will be based on a GAO survey on hospital costs. For 2007 and beyond, rates will

SOURCES AND RESOURCE

For more information on the Medicare prescription bill, contact:

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The American Association of Ambulatory Surgery Centers will hold its annual meeting March 3-6 in Orlando, FL. The pre-conference on March 3 will cover "Business Planning for Development of a New Ambulatory Surgery Center" and "Improving Performance: Materials Management Purchasing."

be drafted by the HHS secretary, as needed.

The bill limits the "functional equivalence standard" used to determine whether facilities are eligible for pass-through payments. Also, the bill requires the GAO to study hospital costs for drugs greater than $50 by 2006. **(For more on how the bill affects surgical hospitals, see story, below.)**

For fiscal year 2005, the Medicare Payment Advisory Commission (MedPAC) has recommended an update of market basket minus 0.9% for hospital outpatient services. The recommendation came at the group's Jan. 14-15 meeting.

Reference

1. Jeffries C. *Medicare Legislation Update.* E-mail: Dec. 4, 2003. ■

Moratorium imposed on surgical hospitals

The recently passed Medicare bill would impose an 18-month moratorium on development of new specialty hospitals, including surgical hospitals, and limit expansion of existing ones retroactively beginning Nov. 18, 2003.

Current facilities are limited to either expansion of 50% of their current licensed beds, or five beds, whichever is greater.

"The effect of the moratorium is that it will slow the growth of the industry because there will be relatively few developments during this period of time due to uncertainty," says **Michael Lipomi**, MSHA, president of the San Diego-based American Surgical Hospital Association and CEO of Stanislaus Surgical Hospital in Modesto, CA. "However, we're very optimistic that industry will continue to grow in the long term."

There is a grandfather clause in the Medicare bill, but whether that clause is good news is debatable, he says. "The grandfathering language is of concern to us because there is a possibility that facilities that are at some stage of development and have expended large amounts of money may not qualify due to local or state regulations," says Lipomi.

The wording of the bill calls for certain tasks to have taken place in order to be "under development. Some municipalities are backlogged for months on those issues," he notes. "One facility may be just as far along as in another area, but because the zoning council or city council haven't acted, they may not be grandfathered, but they have spent as much money as another facility that has qualified." The bill calls for two studies on surgical hospitals to be conducted in the next 15 months:

- The Washington, DC-based Medicare Payment Advisory Commission (MedPAC) will study any differences in costs of services furnished to patients in specialty hospitals and general hospitals. Also, MedPAC will study the extent to which specialty hospitals treat patients within certain DRGs, in areas such as cardiology, as compared to specialty and general hospitals. MedPAC also will determine the financial impact of physician-owned specialty hospitals on local full-service community hospitals. The agency also will determine how the current DRG system should be updated to better reflect the cost of providing care in a hospital setting.

"This is in response to the concern that they are underpaying some procedures, overpaying others, and there is cost-shifting going on," Lipomi says. Finally, MedPAC will compare the proportion of patients received, by type of payer, of specialty and full-service hospitals.

- The Department of Health and Human Services will determine the percentage of patients admitted to physician-owned hospitals who are referred by physicians with an ownership interest, as compared to patients referred to full-service community hospitals. ■

SOURCE

For more information on surgical hospitals, contact:
- **Michael Lipomi**, MSHA, CEO, Stanislaus Surgical Hospital, 1421 Oakdale Road, Modesto, CA 95355.

MASH unit learns you can perform surgery anywhere

Battling sand and dirt, staff focused on saving lives

Could you perform surgery if patients had their hands tied together and were being watched by armed soldiers? Can you imagine treating patients in rooms that are coated regularly with dirt and sand?

These were the experiences faced by members of a mobile army surgical hospital (MASH) unit in Iraq. The staff thought they would be performing surgery only on American soldiers, but they also performed procedures on Iraqi soldiers and

Iraqi civilians: men, women, and children.

"Sometimes, the soldier was in one bed, and next to him was a POW Iraqi soldier — who knows, maybe the one who tried to kill him earlier," says Maj. **Lillian Cardona**, RN, head nurse of central material services (CMS) for the operating room in the Army's 212th MASH from Miesau, Germany.

Maj. **George P. Lawrence**, BSN, head nurse of the operating room/CMS, says, "We treated them all, but it was difficult performing surgery on the Iraqis because they had to have an armed guard on them at all times and [the soldiers'] hands were tied together with zip ties."

Lawrence says he and his staff learned several lessons that can be benefit his civilian peers. For example, if you have to make do with what you have, you can perform surgery just about anywhere while attempting to maintain sterility as best you can, he says. His staff learned to conserve supplies. In fact, they wouldn't use any supplies that weren't absolutely necessary, Lawrence says.

"We never received any resupply, and we sometimes had to substitute similar items," he says. "For example, we ran out of bulb syringes and had to use catheter tip syringes. We ran out of disposable universal packs and started sterilizing linen drapes that we brought along."

Also, expect the unexpected, because you never know what can happen with even the smallest procedure, Lawrence says. "It may appear to be a simple procedure and turn into a nightmare because in Iraq, we were lucky to get any kind of history and no physical," he explains.

Also, there were no latex allergy precautions, because there wasn't adequate time or supplies to address that concern, he says.

"Anything can go wrong, and you have to stay on your toes and be prepared and anticipate the possibilities," Lawrence stresses.

Capt. **Gregory Hubbs**, RN, BSN, CCRN, head nurse of intensive care unit (ICU) No. 2, agrees that flexibility is key, regardless of whether you're performing surgery in the Iraqi desert or in a snug suburban surgery center.

"Always have contingency plans," he advises.

The unit crossed into Iraq on March 22 and stayed two months. "Because the main supply roads and towns were not secure, it took us about 78 hours to convoy the hospital 260 miles to outside of Baghdad," Lawrence says.

For the convoy, nurses and doctors were driving 5-ton trucks while maintaining a perimeter of security, because there was no support, Cardona explains. The MASH staff watched the sky become illuminated with rocket missiles and heard nearby bombs detonate, she says.

Cardona describes the experience as "nerve-wracking and exciting at the same time."

The 36-bed hospital was set up. Three expandable boxes created the OR with two tables, lab, and CMS with four sterilizers. The rest of the hospital was made of tents. There were 18 OR staff members, including technicians and anesthesia staff. The MASH also included X-ray, lab, emergency medical treatment (EMT) area, three ICUs, pharmacy, dining facility, shower and bath, power team (personnel who handled power cables, generator power, and air exchanges), medical maintenance, and a motor pool.

Once the hospital was set up, patients started coming. "Communication wasn't the best in the world, and we received anywhere between four and 14 patients at a time," Lawrence adds.

Almost all of the patients required surgery, and the physicians had to triage them to see who went first, he says. "As they came into the EMT area, if they needed surgery immediately, they would go directly to surgery as soon as their airway was stabilized and they had an IV in place," he explains.

Patients who were stable but needed surgery were taken to the ICU until hose in critical condition were treated. The injuries and procedures included amputations; debridement of open wounds; high velocity wounds from gunshots; blast injuries from artillery, rockets, mortars, and mines; injuries from vehicle accidents; spine and crush injuries on downed helicopter crews; head wounds; torso wounds from shrapnel; feet that were partially dismembered; and burns. "You never what was coming in your door, and you had to pull the instruments and supplies when you found out what the injuries were," Lawrence adds.

The two operating tables were side by side with no divider. They often had patients on them at the same time. "The surgeries are different in the field

SOURCES

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because, although we do maintain a sterile environment, we are operating under harsh conditions in the mist of sand, dirt, and who knows what else," Cardona says. The space was tight, and sometimes sterility might "go out the window, but we are treating very dirty cases, so cleanliness is not what we concentrated on," she notes. "Our job was to save lives." The environment was fast-paced, but care and vigilance always were shown to the patients, Cardona says. The team members came together as one, she adds.

Hubbs also witnessed great unity. When a large number of patients arrived, "everyone stepped up and helped each other out," he says.

One cardiothoracic surgeon even mopped the OR floor between cases, Cardona says. The physicians acted differently in Iraq, she says. "All of the sudden, they really see what's important. They don't worry about the little things and learn that supplies are precious items and things are not opened, 'just because/maybe [we] will need it,'" Cardona adds.

Fatigue was an issue, Hubbs says. "We went seven days a week working 14- to 16-hour days, sometimes longer," he says. "We tried to take advantage of every opportunity we had to rest and relax." The staff also experienced some emotional exhaustion, Hubbs continues. "It was difficult at times seeing so many wounded soldiers," he says. "We cared for everything from minor lacerations to traumatic amputations. It was a very challenging experience."

In one three-week period, in addition to surgeries, the unit treated 700 minor injuries. If the patients could be cleaned and bandaged without going to the OR, they were treated in the EMT area and sent to the ICU to wait for evacuation. The MASH unit is not designed to hold any patient for more than 72 hours. After being treated, patients were evacuated to a combat-support hospital.

"Our job is to stabilize and evacuate out as soon as possible to make room for more incoming casualties," Lawrence says.

While several staff members previously had performed outpatient surgery in the United States as civilians, they faced many differences in how care was provided in Iraq. However, some areas, such as time between cases, were similar. "We had a very fast turnover evacuating patients to hospitals in Kuwait," Hubbs says.

And even near the battlefield in Iraq, you can't escape paperwork, Cardona says. "We performed 101 [surgical] cases and kept accurate documentation on them," she says. ■

Wounds heal faster with autologous platelet gel

New procedure generates patients, revenue

Looking for a program that attracts new patients, requires a minimum of staff education, and nets an average profit of between $1,200 and $1,300 per procedure?

By utilizing the autologous platelet grafting gel, developed by SafeBlood Technologies in Little Rock, AR, the staff at Northwest Texas Surgery Center in Amarillo have performed 350 grafts on 275 patients in the past two years, with a net average profit of $1,300.

"The effectiveness of this graft has blown us away," says **Dave Clark**, executive director of the surgery center. The center began using the product two years ago as a site for the pilot test of the product. "After the testing period, we found that the costs of treating wounds decreased by almost 90% for patients and insurers because the wounds were healing faster, and we were eliminating some of the traditional treatments such as repeated surgical debridements, hyperbaric chamber, and ultimately, amputations," he says.

The procedure requires only one hour to draw about 60 cc blood from the patient, separate the blood into different components by spinning it in a centrifuge, and adding the agents that create the gel, says **Kevin Russell**, EMT, coordinator of special services, including the wound graft program, for Northwest Texas Surgery Center.

"Once the gel is sized and shaped to fit the wound, it is put into place and covered with a

EXECUTIVE SUMMARY

Use of autologous platelet gels to graft hard-to-heal wounds can create new patients and generate revenue. By offering an alternative to amputation, continuous surgical debridements, and use of hyperbaric treatments, same-day surgery programs can lower costs for wound care and help patients avoid the psychological trauma of amputation.

- Autologous platelet gels can be used to treat wounds resulting from surgical dehiscence, trauma, spider bites, venous stasis ulcers, and burns.
- Staff and patient education is simple and requires little extra time.
- Average profit of one same-day surgery program is $1,300 per procedure.

SOURCES AND RESOURCES

For more information, contact:

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- **Calvin P. Britton**, DPM, 10018 W. Markham Road, Little Rock, AR 72205. Phone: (501) 534-8888. E-mail: drfootsie@yahoo.com.

Companies offering equipment and supplies to produce autologous platelet gel grafts include:

- **SafeBlood Technologies**, 1100 N. University Ave., Suite 109, Little Rock, AR 72207. Phone: (800) 854-4855 or (501) 614-8550. Fax: (501) 666-4504. Web: www.safebloodtech.com.
- **Harvest Technologies**, 40 Grissom Road, Suite 100, Plymouth, MA 02360. Phone: (508) 732-7500. Fax: (508) 732-0400. Web: www.harvesttech.com.
- **PPAI Medical**, P.O. Box 62078, Fort Myers, FL 33906-2078. Phone: (888) 801-8814 or (941) 481-7725. Fax: (941) 481-7724. Web: www.ppaimedical.com.

clear dressing and a bandage," he says. After three to seven days, the physician removes the initial dressing and applies a wet dressing.

A wet dressing that is changed regularly by the patient stays on for up to two weeks, Russell says. "At this point, we usually see 50% to 70% closure of the wound. The wound continues to heal after this point, with only a small percentage of patients requiring an additional graft," he adds.

Teaching staff members to use the equipment and chemicals that create the grafting gel is not a complicated process, Russell explains. Consent forms, protocols, and patient education handouts related to the procedure were developed using the manufacturer's templates and modifying them for his center, he adds. **[To see a copy of the platelet gel grafting documents, go to *www.same-day surgery.com* and click on the "toolbox." Your subscriber number on your mailing label is your user name. Your password is sds (lowercase) plus your subscriber number (no spaces.)]**

While grafting materials have been available for many years, the availability of a turnkey system that utilizes a tabletop centrifuge and easy-to-handle materials is a real step forward, says **Calvin P. Britton**, DPM, a podiatrist in Little Rock, AR. **(For information on companies offering graft systems, see resource box, above.)** The initial investment for the SafeBlood system is between $7,500 and $8,000, but there are disposable supplies for each procedure, he says. The costs of these disposables vary according to the volume ordered, he adds.

While most of his wound care patients are diabetic patients with foot ulcers that won't heal, Britton points out that the grafting gel can be used effectively to treat wounds resulting from surgical dehiscence, trauma, spider bites, venous stasis ulcers, and burns. "You can draw up to 400 cc blood to create large grafts for larger wounds," he says. The graft must be used on noninfected wounds, Britton says. Also, patients with poor circulation, anemia, debilitated condition, or poor venous access, may not be appropriate for the procedure because good circulation and a proper amount of blood for creation of the gel is necessary for a good outcome, he adds.

While patients, physicians, and same-day surgery center staff members are excited about the outcomes of wound care with autologous platelet gels, Britton stresses this procedure is not a replacement for other types of wound care.

"This is a significant new development in wound care, but it doesn't replace good, standard wound care techniques," he says. "It should be evaluated as one more tool to use for hard-to-heal wounds that don't respond to other treatments." ■

Same-Day Surgery Manager

Here's a peek into the surgeon mentality

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

Who do we love? Our surgeons, of course! Who do we hate? Our surgeons, of course. What is it about this group of practitioners that can drive us all to extremes, often within one day?

At Earnhart & Associates, we have almost 4,500 one-on-one, hard-core, direct interviews with surgeons. I took that database and then asked a group of surgeons I know well and

respect to give me some insight into areas related to the OR. I want to share with you how the surgeons view themselves:

• **How do most surgeons perceive themselves?** We have this "captain of the ship" mentality. We are trained from day one to be in charge of, responsible for, and liable for everything that happens to our patients. We have been selected and conditioned to be aggressive, ruggedly independent, always in control, and intolerant of anything contrary to our patients' best interests.

• **What are your negative biases?** Silly, stupid rules designed to generally make people angry by people who do not know the operating room. HMOs in general. Hospitals as majority business partners. Autocratic, top-down management policies in the operating room.

• **Be honest. What do you really want in the operating room?** EVERYTHING! Total control, maximum efficiency, top quality, LOTS of extra income . . . but no investment, no risk, and no effort.

• **You are doing your own surgery center with the hospital. What do you want that facility to give you?**

— Control. A medical advisory board, controlled by surgeons, that determines clinical management of the program: policies and procedures, rules and regulations, credentialing, facility certification, personnel training, and performance evaluation.

— Accountability to fellow surgeons.

— Efficiency. Short turnover times: a 10-minute target vs. 45+ minutes in the hospital. That alone can save me up to a half-day per week.

— Efficient posting: Block scheduling. No bumping. Flexible hours.

• **What about quality? You know surgeons are sometimes criticized on quality when they have control. What do you expect your staff to provide?** Fair question but not true. We want higher patient satisfaction, superb nursing skills and training, best equipment and instruments, low complication rate, accreditation, and strict quality assurance and utilization review monitoring.

• **What, above all else, do you hate the most in the surgical environment?** Loss of control! HMOs, arbitrary hospital or surgery center operating room policies, and the sense that our control over the OR environment has been and continues to be slipping away. That is enough for this issue. Next month, I will answer these and other questions:

• What do you love in the operating room?

• Do you guys *really* want to be in control?

• How hard do you think it is to run a surgery center or hospital operating room environment — honestly?

• How can hospitals head off surgeon relation problems?

(Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 8303 MoPac, Suite C-146. Austin, TX 78759. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

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*, Thomson American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com.]*

Question: Does the security rule specify how a risk analysis must be conducted?

Answer: The security rule requires all covered entities to perform an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information in its possession, says **Robert W. Markette Jr.**, an Indianapolis attorney. "The rule does not specify how a covered entity should perform this assessment," he says. "Frankly, even computer security experts don't all use the same methods."

The goal of a risk analysis is to identify potential risks and their likelihood of occurring, he explains. A risk assessment can be performed by hiring outside consultants or can be performed by the same-day surgery staff, Markette says. "Same-day surgery programs will need to use their own judgment when deciding whether to handle the risk assessment on their own or to hire outside consultants," he says. The decision may depend on the program's individual staff resources and expertise, he adds.

Question: How should passwords be chosen to ensure security?

Answer: There are rules of thumb for choosing passwords, Markette says.

"First, do not use words from the dictionary or obvious words such as relatives' names or pets'

SOURCE

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names," he emphasizes. "Do not use your birth date or a relative's birth date," he says.

Birth dates and names are learned easily and often are the first things a hacker will choose when guessing a password, he explains.

"Generally, a password should be a combination of letters, numbers, and, perhaps, even other ASCII characters," Markette suggests. "Of course, this is a two-edged sword." The more complicated the password, the more difficult it is for a hacker to guess, but it also is more difficult for an employee to remember, he adds. Complicated passwords are of absolutely no value for security purposes if the employee writes it on a note that is stuck to the computer screen, he says.

There are a couple of ways you can come up with difficult-to-guess but easy-to-remember passwords, Markette adds. "You can combine somebody's initials with the last four digits of another person's phone number, or take the first letter from each word in an easily remembered phrase and combine it in some way with a birth date or phone number," he suggests. For example: The phrase "Asta la vista baby" combined with the last four digits of a phone number could become any of the following: alvb5543, a5l5v4b3, 5543alvb, 5a5l4v3b.

"None of these passwords are easily guessed, but for the employee, they should be simpler to remember than trgh678# or some other randomly generated password," he explains. ■

Nurses play strong role in patient satisfaction

In outpatient surgery, a patient's pain is treated immediately after surgery, and patients are sent home. However, the pain control after discharge may be more important than the initial treatment at the bedside, says **Elaine A. Yellen**, RN, PhD, assistant professor at Texas A&M — Corpus Christi (TX) University. "We need to do a lot of discharge education for them about how to control pain at home," she says. "They may have a lot more trouble once they are at home by themselves."

Yellen recently published research from an ambulatory surgical unit that indicated communication is one of several nurse-sensitive variables that influence pain satisfaction.[1]

"We often get in such a rush to go out the door, but they have to be encouraged to ask questions," she says. "We need to be making sure they don't have any more concerns or questions. Try to ask if there is anything else we can get for them."

Waiting time also is an issue for outpatient surgery patients, Yellen says. "Sometimes it's difficult to decrease the waiting time, but at least tell them why they're waiting and how long they might expect to wait," she advises.

Yellen's study was conducted at a 300-bed urban hospital in south Texas. A sample of 132 participants was drawn during a six-week period. After surgery, one group completed a patient satisfaction instrument,[2] while others completed an ambulatory surgery survey from Press Ganey Associates in South Bend, IN.

Yellen's research indicated that pain control is a key nurse-sensitive variable affecting patient satisfaction. She also determined these variables apply:

- **Age.** Nurses need to have a heightened sensitivity to pain, Yellen suggests. Older people may not complain as much about pain as younger persons, she explains. "Sometimes, we have to make suggestions for them, to assist them in how they should be treating their pain," Yellen says. "They might not know."

Additionally, clinicians don't know how pain medications will affect older patients, she says.

"Sometimes, they are more sensitive; and sometimes, they are less sensitive," Yellen says.

Most drug research has been performed on

EXECUTIVE SUMMARY

Discharge education and explanation of waiting times are key areas of communication in which nurses can affect patient satisfaction, according to research. Pain control is another key area.

- You may have to suggest to older people how they should treat their pain. Also, some older patients are more sensitive to pain meds, while others are less sensitive.
- Accept men's expressions of pain, and be aware of any biases you might have about how they should act.
- Language barriers can be addressed with interpreters or family members who speak English, but be aware that some cultures may express pain differently, for example, by being stoic.

SOURCE

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young or middle-age people, she points out.

• **Gender.** Yellen's research indicates that men weren't as satisfied with their pain control as women. "I don't want to generalize, but often nurses are women, and we're asking men about pain," Yellen says. "We have to be sensitive that there's a gender issue."

For example, accept men's expressions of pain, and be aware of any biases you might have, she says. "We have to make sure we're not stereotyping and possibly projecting our own impressions of how they should act," Yellen says.

• **Culture.** The Corpus Christi area has a 50% Hispanic population, Yellen says. Her research indicated that the Hispanic patients were not as satisfied with their care as Caucasian patients, she says. "Even our hospitals systems are not culturally sensitive," Yellen maintains. The language barrier may be one factor, she says. "We need to invite them to express their pain to us, whether we need an interpreter or sometimes a family member to help us," Yellen says.

Even with an interpreter, however, it can be difficult for that person to interpret pain as well as the language, she points out. "We need to remain open to expressions of pain, and try to be sensitive to how other cultures express themselves, too," Yellen adds.

For example, some members of the Hispanic culture are deeply religious and, as part of their belief system, may think they should be stoic about suffering, she says.

"While suffering might be part of their religious thinking, I think they should also be relieved of their pain," Yellen says. **(For more suggestions on treating the Hispanic population, see *Same-Day Surgery*, January 2002, p. 5; and February 2002, p. 25.)**

References

1. Yellen E. The influence of nurse-sensitive variables. *AORN J* 2003; 78:783-793.
2. Risser NL. Development of an instrument to measure patient satisfaction with nurses and nursing care in primary care settings. *Nurs Res* 1975; 24:45-52. ■

Board certification urged for office-based surgeons

Guidelines target moderate, deep, general sedation

Physicians who offer moderate, deep, or general sedation in their offices should be board-certified in the type of surgery they perform in the office setting, under new guidelines for office-based surgery approved by the American College of Surgeons (ACS) and the American Medical Association (AMA), both in Chicago.

"That was controversial because the AMA has a policy of not invoking board certification or terminology," such as board qualified or board eligible, explains **Richard B. Reiling**, MD, FACS, Medical Director of Presbyterian Cancer Center in Charlotte, NC. Reiling served on the ACS Board of Governors Committee on Ambulatory Surgery, which developed the guidelines.

With the increasing regulation of office-based surgery at the state level, ACS and AMA members grew concerned that states were developing guidelines that were prescriptive but weren't scientifically based and didn't really make sense, he adds. "There would be figures that were drawn out of the air, such as physicians need 12 hours of CME [continuing medical education] every year on delivery anesthesia," Reiling says.

"We thought the experts, surgeons and anesthesiologists, needed to develop guidelines that make sense and can be used in other states," he says.

The 10 core principles of the guidelines are:

1. Guidelines or regulations should be developed by states for office-based surgery according to levels of anesthesia defined by the American Society of Anesthesiologists' (ASA's) "Continuum of Depth of Sedation"

EXECUTIVE SUMMARY

Physicians should be board-certified in the types of surgery they perform in the office setting if they offer moderate, deep, or general sedation, according to new guidelines from the American College of Surgeons and the American Medical Association.

- States developing their own guidelines can use these newly approved ones.
- The guidelines address proper patient selection and informed consent criteria, facility accreditation, emergency transfer protocols, physician training and competency, and emergency resuscitative techniques.

statement dated Oct. 13, 1999, excluding local anesthesia or minimal sedation. The statement is available at www.asahq.org/publications andservices/standards/20.htm.

2. Physicians should select patients by criteria, including the ASA Patient Selection Physical Status Classification System, and document accordingly. The ASA physical status classification system is available at www.asahq.org/clinical/physical status.htm.
3. Physicians who perform office-based surgery should have their facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), the American Osteopathic Association (AOA), or by a state-recognized entity such as the Institute for Medical Quality, or be state licensed and/or Medicare-certified.
4. Physicians performing office-based surgery must have admitting privileges at a nearby hospital, have a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.
5. States should follow the guidelines outlined by the Dallas-based Federation of State Medical Boards (FSMB) regarding informed consent. (Source: *Report of the FSMB Special Committee on Outpatient [Office-Based] Surgery.)*
6. States should consider legally privileged adverse incident reporting requirements as recommended by the FSMB (Source: *Report of the FSMB Special Committee on Outpatient [Office-Based] Surgery)* and accompanied by periodic peer review and a program of continuous quality improvement.
7. Physicians performing office-based surgery must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, AOA, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that generally is recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.
8. Physicians performing office-based surgery may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.
9. At least one physician, who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (advanced trauma life support, advanced cardiac life support, or pediatric advanced life support), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. **(For more information, see "Revised standards clarify medical and physical discharge," in *SDS Accreditation Update*, p. 1, inserted in this issue.)** In addition, other medical personnel with direct patient contact should at a minimum be trained in basic life support.
10. Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.

The guidelines were based on a document that was approved by the following groups and others during a March 17, 2003, ACS/AMA coordinated consensus meeting:

- AAAHC;
- AAAASF;
- ASA;
- American Society of Cataract and Refractive Surgery;
- FSMB;
- Joint Commission on Accreditation of Healthcare Organizations. ■

COMING IN FUTURE MONTHS

■ What if a surgeon is infected with a blood-borne pathogen?

■ Safety and efficacy of new minimally invasive procedure

■ Help ensure patient-controlled analgesia is safe

■ Avoiding adverse outcomes with surgical supplies

■ How to reduce injuries from sharps

CE/CME objectives

After reading this issue you will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. (See *"AAAHC standards clarify medical and physical discharge"* in this issue.)
- Describe how those issues affect clinical service delivery or management of a facility. (See *"PPR options developed by Joint Commission."*)
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *"Wounds heal faster with autologous platelet gel,"* and *"HIPAA Q&A."*)

CE/CME *questions*

1. According to Kevin Russell, EMT, coordinator of special services for Northwest Surgery Center, what is the typical outcome two to three weeks after an autologous platelet gel graft procedure has been performed on a patient's hard-to-heal wound?
   A. 30% to 40% wound closure
   B. 40% to 70% wound closure
   C. 70% to 90% wound closure
   D. 100% wound closure
2. Why are complicated passwords a problem for same-day surgery staff, according to Robert W. Markette Jr.?
   A. It makes it difficult to share passwords.
   B. They require too many characters.
   C. Staff members can't remember them.
   D. They require too much time to input.
3. According to the *2004 Accreditation Standards* of the Accreditation Association for Ambulatory Health Care, who must be present or immediately available until the patient is physically discharged?
   A. the physician
   B. any same-day surgery staff member
   C. an employee who is trained in advanced resuscitative techniques
   D. a family member
4. Why did the Joint Commission develop options to the periodic performance review, according to Harold Bressler, general counsel?
   A. Organizations that scored well in last survey don't need to conduct self-assessment.
   B. Some organizations don't have resources necessary for the process.
   C. Other types of benchmark studies effectively can replace periodic performance review.
   D. Some organizations were concerned that sensitive information could become discoverable in a legal action.

Answer Key: 1. B; 2. C; 3. C; 4. D

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 2004 issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. ■

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

AAAHC standards clarify medical and physical discharge

Medical discharge requires physicians' presence, then they can leave

Physicians must be present or immediately available until patients are medically discharged, but they don't need to be present until the patient leaves the same-day surgery program area, according to revised standards approved by the Wilmette, IL-based Accreditation Association for Ambulatory Health Care (AAAHC) for 2004. The standards become effective upon publication late this month.

While the 2003 standards made it clear same-day surgery programs are responsible for patients until they physically have left the facility, the 2004 revisions further clarify the responsibility, says **Beverly K. Philip**, MD, director of the Day Surgery Unit for Brigham and Women's Hospital in Boston and chair of AAAHC Standards and Survey Procedures Committee. "The difference between the 2003 and the 2004 standards is that the physician does not have to be present or immediately available once the patient is medically discharged," she explains.

To address the same-day surgery program's responsibility after medical discharge, Standard T-I states that personnel who are qualified in advanced resuscitative techniques such as advanced cardiac life support, or pediatric advanced life support, must be present or immediately available until the patient has physically left the facility, Philip states.

Another revision passed by the AAAHC board is a requirement that same-day surgery programs that serve pediatric patients develop and maintain a policy defining the care of pediatric patients with reference to specific components of perioperative care, Philip says. "This revision emphasizes our recognition that pediatric patients do require specialized care," she explains.

While AAAHC always has required accredited organizations to use the National Practitioner Data Bank for original credentialing, organizations now must use the service for reappointments in addition to verification of current licensure, Philip adds. "This step ensures that the organization has the most current, up-to-date information because things in the physician's profile may have changed since the original credentialing," she says. (For information about the National Practitioner Data Bank, go to www.npdb-hipdb.com/.)

Another important enhancement to the standards is the inclusion of related services in standards that typically have applied only to surgical facilities, Philip explains. "These standards now apply to any organization that performs invasive procedures such as pain management, endoscopy, cardiac catheterization, lithotripsy, and in vitro fertilization in addition to surgery." The reason for the change is patient safety, she says. "Although these are not necessarily surgical procedures, they are procedures that are done inside the body and carry some of the same risks that surgical procedures carry. For that reason, we want to ensure all AAAHC-accredited organizations meet the highest patient safety standards," Phillips says. ■

EXECUTIVE SUMMARY

The 2004 standards for the Accreditation Association for Ambulatory Health Care clarify a same-day surgery program's responsibility in a variety of ways.

- Physicians must be present or immediately available until patients are medically discharged.
- Staff members with advanced resuscitative techniques must be present or immediately available until the patient physically has left the facility.
- Policies must describe pediatric-specific care when the program serves pediatric patients.
- Reappointments for medical staff privileges must include verification through the National Practitioner Data Bank as well as licensure verification.

RESOURCES

The 2004 edition of the *AAAHC Accreditation Handbook for Ambulatory Care* will be available soon. The cost is $120 and includes shipping costs. To order, contact:

- **Accreditation Association for Ambulatory Health Care**, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091-2992. Phone: (847) 853-6060. Fax: (847) 853-9028. Web: www.aaahc.org.

The *2004 Comprehensive Accreditation Manual for Ambulatory Care* provides a detailed description of all standards and requirements for accreditation in a three-ring binder and costs $240. The softcover *2004 Standards for Ambulatory Care* is a reference guide and costs $95. Other manuals include the *Accreditation Manual for Office-Based Surgery Practices* ($95) and *The 2004 Comprehensive Accreditation Manual for Hospitals* ($350). A separate standards manual for hospitals is available for $110. Costs include shipping. Any organization that submits an application for survey receives a complimentary copy of the accreditation manual, and currently accreditation organizations receive complimentary updates of the manuals. Contact:

- **Joint Commission on the Accreditation of Healthcare Organizations**, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (877) 223-6866 or (630) 792-5800. To order on-line, go to www.jcrinc.com, choose "publications" at top of home page, then choose "manuals" on left navigation bar.

Here are revised AAAHC standards

Patient safety, clarification of credentialing and reappointment requirements, and requirements for laser privileges are a few of the major categories addressed in the revised 2004 accreditation standards from the Accreditation Association for Ambulatory Health Care. Among the standard revisions are:

- Develop and maintain a policy defining the care of pediatric patients, with reference to specific components of perioperative care as listed in standard 10-U.
- The organization must show it has established procedures to obtain information necessary for primary or secondary source verification of the application and is responsible for obtaining this information.
- Under Standard 2-II-B-5, on an application for reappointment, in addition to verifying current licensure, the organization also must obtain information from the National Practitioner Data Bank (www.npdb-hipdb.com/).
- In reference to medical discharge procedures under Standard 9-K-1, a physician or dentist is present or immediately available until medical discharge of the patient.
- Chapter 10's provisions have been expanded to include surgical and related services, and the provisions now also apply to organizations that provide any invasive procedures, such as pain management, endoscopy procedures, cardiac catheterization, lithotripsy, and in vitro fertilization, as well as surgery.
- Under Standard 10-I, staff qualified in advanced resuscitative techniques such as advanced cardiac life support or pediatric advanced life support when pediatric patients are served, are present or immediately available until all patients operated on that day have been physically discharged. A physician or dentist is no longer required to be present or immediately available until physical discharge, but he/she must be present or available by telephone any time that patients are present.
- Under Standard 10-L, only authorized people are allowed into the surgical or treatment area, including laser rooms. **(For more information on nonsurgical staff in the operating room, see S*ame-Day Surgery*, July 2000, p. 88; and December 2001, p. 144. These stories are available on the *SDS* web site, www.same-day surgery.com, in the archives. Your user name is your subscriber number from your mailing label. Your password is sds [lowercase] plus your subscriber number, with no spaces.)**
- As part of an organization's responsibility to ensure that its facility provides a safe environment for using laser technology, the organization will grant privileges for each specific laser. In addition, to ensure appropriate laser fire protection, the organization must have the immediate availability of electrical-rated fire extinguishers for equipment fires, maintain a wet environment around the operative field, and ensure the immediate availability of an open container of saline or water where ignition of flammable materials is possible. Also, the organization must ensure that drape material is not positioned in front of the laser beam. Drapes should be checked prior to use of laser to ensure that material has not shifted during the procedure. Also, organizations must ensure that procedures are done in accordance with

laser manufacturers' guidelines and are consistent with the current version of the American National Standards Institute's *Standards for Safe Use of Lasers in Health Care Facilities*.
- Additions were made to pharmaceutical procedures under 15-B-6, that prescribed that all injectable medications drawn into syringes or oral medication removed from the packing identified by the original manufacturer must be appropriately labeled if not administered immediately. ■

PPR options developed by Joint Commission

Options available when legal issues arise

Even before the new accreditation survey process goes into effect, the Joint Commission on the Accreditation of Health Organizations has created options to the self-assessment component of the survey. The periodic performance review (PPR) is an integral part of the Joint Commission's new accreditation process that debuts in 2004, but health care attorneys and risk managers have been afraid that information uncovered in this proprietary self-assessment may be discoverable information in some cases in which the organization is facing a lawsuit.

The concern does not apply to all states equally, says **Harold Bressler,** general counsel for the Joint Commission. In fact, the law is not clear in any state, which means that different attorneys in each state might interpret their risk differently, but there was enough concern that the Joint Commission put together a task force to develop options to the PPR, he adds. The Legal Issue Task Force comprised representatives from the Joint Commission, the Chicago-based American Hospital Association (AHA), and state hospital associations from Alabama, Connecticut, New Jersey, and South Carolina, he says.

"The greatest concern came from hospitals, but the options we developed are applicable to all organizations, including freestanding same-day surgery centers," says **Michael Kulczycki**, ambulatory accreditation program executive director for the Joint Commission. Although the PPR is not a public document, and, in fact, surveyors don't have access to the PPR, some organizations were concerned that an opposing attorney in a legal action might be able to obtain the information, he says.

The PPR is designed as a "no-harm" method for same-day surgery programs to conduct a self-assessment as to compliance with accreditation standards and correct any deficiencies prior to their standard survey, Kulczycki notes. "We created these options for the times that an organization may be vulnerable to a legal action," he adds. "We don't have any sense of how many organizations will choose the options to the PPR, but we anticipate that there will not be many."

The options are:

• **Option 1.** The first option is designed to address the "waiver of confidentiality" that could be implied if the same-day surgery program or other health care organization shares self-assessment information with the Joint Commission, says **Maureen Mudron**, Washington counsel for the AHA. Option 1 enables the organization to:

— perform the midcycle self-assessment and develop a plan of action and measure of success for areas in which accreditation standards were not met;

— attest that the foregoing activities have been completed but, for substantive reasons, advice has been given to the organization not to submit its self-assessment or plan of action to the Joint Commission;

— discuss standards-related issues with Joint Commission staff without identifying specific levels of standards compliance;

— provide measures of success to the Joint Commission for assessment at the time of the complete on-site survey.

• **Option 2.** This option addresses concerns that different states describe protected information specifically enough to make the information included in a self-assessment fall outside the protected classification, Mudron says. Under Option 2, the same-day surgery program can:

— decline to conduct midcycle self-assessment;

— undergo an on-site survey that is about one-third the length of a full survey at the midpoint of the organization's accreditation cycle;

— develop and submit a plan of action for deficiencies found in the midcycle survey;

— provide measures of success at the time of the complete on-site survey.

"Organizations choosing the second option will have to pay a fee to cover the costs of the survey, but we have not yet decided what those fees will be," Kulczycki says.

If a same-day surgery program chooses one of the two options to the PPR, it is not necessary to give reasons, he says. The choice is made on the

SOURCES

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self-assessment form that is accessed through the Joint Commission's secure web site using the organization's password.

"The chief executive officer of the organization must also attest to the choice of the option rather than the PPR," Kulczycki adds.

These options were developed to address a worst-case scenario for a Joint Commission-accredited organization, he says. "We don't expect a large number of organizations to choose them, but we want them to be in place so that we don't jeopardize the PPR process for everyone," Kulczycki explains. "PPR is a convenient and important tool for health care managers to audit their continual compliance with standards." ■

Infection control, safety key issues for endoscopy

Surveyors look at safety goal compliance

Low-stress, thorough, and focused on patient safety are a few of the adjectives same-day surgery managers use to describe their recent experience with the Joint Commission on the Accreditation of Healthcare Organization surveyors looking at their endoscopy labs.

"Not only did our surveyor look for policies and practices for our lab that met the requirements of the national patient safety goals, but the surveyor also wanted to see how we made sure our contracted services were meeting the goals as well," says **Nichole Breeden**, RN, BSN, safety and infection control coordinator for Tallahassee (FL) Endoscopy Center. **(For more information about the patient safety goals, see *Same-Day Surgery*, September 2003, p. 104.)**

The surveyor looked at the center's contracts for physical plant concerns such as elevator, sprinkler system, and emergency generator contractors, as well as clinical areas such as pathology and pharmacy for which the center uses outside contractors, Breeden says. "The surveyor wanted to see specific wording in the contract that described the need to meet the requirements of the patient safety goals," she explains.

Patient safety also was at the top of the list for the surveyor visiting the endoscopy lab at Kalispell (MT) Regional Medical Center. The surveyor especially was interested in the process for patients undergoing any type of sedation or analgesia, says **Karen Lee**, RN, director of surgical services. "Our process clearly defines a need for a history and physical by the physician, a patient evaluation by the anesthesiologist, a re-assessment immediately prior to administration of anesthetic, and vital sign monitoring every 10 to 15 minutes," she adds. "Although the Joint Commission does not set a specific time frame for monitoring, our surveyor was pleased to see that we were specific."

Rather than just read the procedure, the surveyor asked different staff members, including physicians, to articulate the process, she says.

Infection control also was an important item for the surveyor at Tallahassee's Endoscopy Center, Breeden explains. The center's zero infection rate impressed the surveyor, who spent time with the medical assistant who is responsible for cleaning scopes, she says.

One of the keys to Breeden's excellent control of infection is consistency, she explains. "We have the same staff members cleaning the scopes all of the time, instead of rotating the responsibility," she says. This not only gives the staff members an opportunity to perfect their jobs, but also gives them a real sense of responsibility, Breeden adds. "The staff members who clean the scopes are especially proud of the zero infection rate."

While Kalispell's surveyor talked with employees one-on-one, even asking nurses about their credentials that were specific to endoscopy, the Tallahassee surveyor spent more time looking at the process from a patient's perspective. "The surveyor started at our front reception desk, then walked through the process, asking employees to explain what is done at each step and why," adds Breeden.

Overall, she says she is pleased with the different approach the surveyor took during this survey. "The surveyor's demeanor was very open, and we definitely felt that this survey was a beneficial process with everyone learning from it." ■