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## IN THIS ISSUE




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# Ensure your uninsured patients aren't being hounded for payment

*Nearly 300 facilities sued over billing and collection practices*

Outpatient surgery managers are taking notice of 31 lawsuits that have been filed against nearly 300 nonprofit hospitals and the Chicago-based American Hospital Association (AHA) in federal court since June.[1] The lawsuits claim some tax-exempt hospitals charged uninsured patients more than insured ones or that they use aggressive collection practices against low-income patients. In light of these suits, outpatient surgery managers are re-examining their own practices.

Some of the lawsuits claim the AHA and the hospitals have collaborated to force uninsured patients to pay "full excessive health care costs."[2]

The first provider to settle, North Mississippi Health Services in Tupelo, agreed to provide an estimated $150 million in refunds, debt forgiveness, free care, and discounts to about 48,000 eligible uninsured patients.[3] The settlement includes six hospitals and two surgery centers.

This litigation, along with increased congressional scrutiny, has

## Hospital outpatient services get 6.6% increase

Hospitals would receive a 6.6% total increase in payments for outpatient services under a proposed outpatient prospective payment system (OPPS) rule issued for calendar year 2005. The Center for Medicare & Medicaid Services (CMS) includes a 3.3% payment rate increase for OPPS services. This rate increase, along with other policy changes, will increase Medicare OPPS payments from $22.7 billion in 2004 to $24.2 billion, a 6.6% increase in total payments. CMS has suggested these changes:

- The proposed rule increases payment rates to hospitals for some screening examinations. Flexible sigmoidoscopy increases 7.42%, and screening colonoscopy 9.9%.
- The rule continues the provision that sets rates for brachytherapy sources on charges adjusted to cost and creates new definitions for new codes for high activity brachytherapy sources.

*(Continued on page 107)*

caused outpatient surgery managers to reevaluate their own practices. And nonprofits aren't the only ones who should be concerned, say sources interviewed by *Same-Day Surgery.*

According to one report, aggressive collection practices by some hospitals have included placing liens on homes, attaching wages, and arresting some patients.[1] **(For tips on how to handle collections, see story, p. 99.)** The suits also claim some facilities have large cash reserves that they should be using to provide charity care.

The lawsuits are led by attorney Richard Scruggs, who led multibillion dollar lawsuits against the tobacco industry that netted him $1 billion in fees.[1]

On the government front, CEOs of nonprofit hospitals have been challenged in congressional hearings that examined their hospitals' not-for-profit status. Also, there have been numerous state and federal reports focusing on billing practices for uninsured patients, says **Michael J. Taubin**, partner in Nixon Peabody, a Garden City, NY-based law firm.

*Nightline* devoted an entire episode of its television show to the issue. And don't expect the heat to let up anytime soon. Michael Moore, whose documentary *Fahrenheit 9/11* continues to receive widespread attention, has indicated that his next movie will target health care.

In the meantime, many same-day surgery providers are re-examining their billing and collection practices to determine whether they are legal and ethical. "I think that [providers] can't be looking the other way on this issue," says **Lisa W. Clark**, partner with the law firm of Duane Morris in Philadelphia. "Not only could they be a party to the litigation, but they could be investigated by their local tax authority" concerning their tax-exempt status, she says.

In August, nearly half of Chicago's City Council asked the county tax assessor to revoke the tax-exempt status of not-for-profit Resurrection Health Care, which operates eight hospitals. Twenty-four of 50 alderman said in a letter to the county assessor, "There's been a steep decline in charity care,

## EXECUTIVE SUMMARY

Lawsuits regarding hospitals' charity care, as well as their billing and collection practices, have caused all outpatient surgery providers, including for-profit ones, to re-examine their policies and procedures. The American Hospital Association has developed new free guidelines.

- Look at your demographics to determine what level of charity care should be offered.
- Determine upfront if an individual patient should receive financial assistance or charity care. Instead of negotiating with patients on a case-by-case basis, ask the same questions of and apply the same standards to each patient.
- Examine your collection agency's practices and perform an audit to ensure the agency's practices don't reflect poorly on your facility.

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### Editorial Questions

Questions or comments? Call **Joy Daughtery Dickinson** at (229) 551-9195.

implementation of restrictive charity care policies and aggressive collection procedures, including lawsuits against poor patients."[4] The hospital responded that in 2003, it provided more than $124.5 million dollars of care that was never compensated or reimbursed.

The AHA has offered a hand to providers who feel under fire by developing "Hospital Billing and Collection Practices." **(For information on how to access the guidelines, see resource box, p. 101.)**

The guidelines address how facilities can communicate more clearly and concisely with patients, provide information upfront to make billing and collection more transparent to outpatients, and follow concrete steps to make care more affordable for patients, notes **Carmela Coyle**, senior vice president for policy at the AHA.

"One of things [the AHA] said was to re-examine your policies to make sure they're in line with your mission," Clark says. "Don't go against any state law and Medicare, and generally, determine whether they do what your hospital wants to do legally and from a mission standpoint."

Hospitals are following through, Coyle adds. "We've now gone back and asked every hospital CEO to sign on the dotted line and let us know that either they already have changed their policies and practices to meet their guidelines or they are in the process of doing that," she says. More than 3,000 hospital CEOs have signed that "Confirmation of Commitment," Coyle notes.

"I think it's an area that needed to be addressed by the hospital community," Taubin adds, "because of the inconsistencies in the way billing was done, in terms of these patients."

Some of that inconsistency was addressed earlier this year when the U.S. Department of Health and Human Services clarified that hospitals *can* discount charges for uninsured patients of limited means, Coyle says.[5] "We're seeing a number of hospitals adopt and implement discounting policies for the uninsured," she says.

So how do you manage to provide charity care and also ensure your program isn't overwhelmed with bad debt? Consider these suggestions:

- **Look at your demographics.**

Consider your geographical area when examining your payment and collection policies and procedures, Clark advises. However, even in suburban areas where patients have higher incomes and higher property values, they may find it difficult to pay bills on time, she says.

## Is your collections agency reflecting poorly on you?

Keep in mind that for public relations (PR) purposes, and in some cases for legal purposes, a collections firm is an extension of your program, says **Scott Becker**, CPA, JD, co-chair of the Health Care Department at the Chicago-based law firm McGuireWoods. "Thus, if the collections firm acts in an overly aggressive manner, the provider can be liable or at least the recipient of bad PR," he warns.

To ensure your collections agency doesn't create a poor image of your facility, take the following steps:

- **Review the billing rates.**

Becker suggests you ask these questions: What are the rates charged to those without coverage? Would they be embarrassing if they show up on the front page of the local newspaper?

- **Determine if you are being aggressive enough in offering relief or lower rates when a patient is poor or has financial challenges.**
- **Review reports concerning complaints from patients.**

Collection practices should not create fear and anxiety for patients, says **Carmela Coyle**, senior vice president for policy at the Chicago-based American Hospital Association. "When patients incur medical debt, it's not the same as credit card debt or car debt," she says. "These are unexpected expenses."

Because outpatient surgery is often elective, it shouldn't be necessary to place liens on homes because bills go uncollected, says **Ann S. Deters**, MBA, CPA, CEO and founder of SevenD & Associates, an Effingham, IL-based consulting and management company affiliated with 17 surgery centers.

"If you take care of these things upfront, if you understand where the patient is, and you communicate upfront, you shouldn't have to revert to those things if the patient is honest and truly trying to pay for the procedure," Deters says.

- **Ensure collection practices comply with state and federal law.**
- **Consider a sample audit of your collections firm.**

Examine 10 to 20 claims that have gone through your collections agency, Becker suggests. Determine the exact process that occurred from the time the bill was delivered to the collection agency, including how the agency tried to collect from the patient, he says.

"Understand how the process will work and whether at the end of the day, you'd be comfortable with the process, if exposed to plaintiff's lawyers or newspapers," Becker adds.

*[For more information, contact Scott Becker at McGuireWoods, 77 W. Wacker Drive, Suite 4100, Chicago, IL 60601. Phone: (312) 750-6016. Fax: (312) 920-6135. E-mail: sbecker@mcguirewoods.com.]* ■

The key element is to develop polices that are fair, says **Ann S. Deters**, MBA, CPA, CEO and founder of SevenD & Associates, an Effingham, IL-based consulting and management company affiliated with 17 surgery centers. "Every provider has to evaluate its own circumstances, demographics, and decide accordingly," she says.

**• Determine patient's need for charity care or financial assistance.**

Look at your registration and admission procedures to decide if patient eligibility for charity care and financial assistance is being determined, Taubin suggests. "Hospitals need to be making sure these people don't slip through the cracks and eventually get billed for complete charges for services rendered by the hospital," he explains.

At R. Hewlett Lee Surgecenter of Palo Alto (CA), physicians sometimes request that the center reduce fees for uninsured poor patients, and the center reduces the fee to equal the facility's most common insurance carrier, says **Margo Mynderse-Isola**, RN, chief executive officer. "We ask that [patients] pay at least 50% of it and sign a credit agreement to make monthly payments, depending on how much is left," she says. The center strives to make the monthly payments affordable (some are $25), and no interest is added, Mynderse-Isola says. Also, the center and surgeons occasionally provide charity work, particularly on plastic surgery performed on children from other countries.

At Valley Health System in Winchester, VA, designated eligibility staff help qualified outpatient surgery patients apply for state assistance, says **Ann R. Ryder**, CPAM, corporate director of patient accounts. "If they do not qualify for these programs, we offer total write-off up to 200% of the poverty guidelines," which is determined by proof of income and size of family, Ryder explains. If they exceed the income level, the hospital sets up an interest-free payment plan, she says.

For this process to work, patients must provide the necessary information to determine their eligibility, Ryder adds. "If patients will not provide us information to work with and simply ignore our bills, then it is possible, based on all information that we can obtain, that we will obtain judgment and place liens or garnishments as necessary," she says. "Every effort is made to avoid this by evaluating their individual situations."

In terms of charity care, typically your community will have an expectation that you provide some, Clark advises. "There could be state or federal laws that could apply, even if for profit, that you're providing some charity care," she says. And even for-profit organizations can be sued, Clark warns. "By far, it's a not-for-profit problem, but take a second look at the situation, based on applicable law, if you're for profit," she adds. **(For information on a group that offers free outpatient surgery procedures, see box, below.)**

## This group helps uninsured with free outpatient surgery

In the San Francisco Bay area, providers are addressing the needs of uninsured patients by offering free outpatient surgery procedures.

Operation Access, a nonprofit organization, brings together 110 physicians, 155 nurses and techs, and 16 hospitals that volunteer their OR time, fees, pharmaceuticals, and other supplies. In 2003, the organization performed 260 cases.

Surgical teams add uninsured patients to regular surgical schedules and limit the numbers receiving services each month, or they volunteer their services on Saturdays on a quarterly basis. One advantage of adding patients to the regular schedule is the financial status of patients is disclosed only on a need-to-know basis.

The criteria for the patients, who must live in six specific counties in the area, are the procedures must be elective, income must not exceed 250% of the federal poverty level, and patients must be ineligible for government insurance programs.

"The target clients are those who do not quality for publicly funded insurance programs, but they are not offered benefits through employment and can't afford to purchase health insurance on their own," says **Mary Gregory**, program director. "They are people who get stuck in the middle."

The most common procedure is hernia repair, which accounts for about 40% of the surgeries performed. Other cases include minor anorectal procedures, orthopedic cases, and head and neck surgeries, among others.

The program started in 1993 when surgeons grew concerned about patients being dropped from a hospital's elective surgery schedule when they weren't able to pay their required cost of the procedures. A grant was received from the Robert Wood Johnson Foundation in Princeton, NJ, which is now one of 20 foundations that support the group's work, in addition to individual contributors.

*[For more information, contact Operation Access, 115 Sansome St., Suite 1205, San Francisco, CA 94104. Phone: (415) 733-0052. Fax: (415) 733-0019. E-mail: info@operationaccess.org. Web: www.operationaccess.org.]* ■

## SOURCES AND RESOURCE

For information on treating the uninsured, contact:
- **Lisa W. Clark**, Partner, Duane Morris, One Liberty Place, Philadelphia, PA 19103-7396. Phone: (215) 979-1833. Fax: (215) 979-1020. E-mail: lwclark@duanemorris.com.
- **Margo Mynderse-Isola**, RN, CEO, R. Hewlett Lee Surgecenter of Palo Alto, 795 El Camino Real, Palo Alto, CA 94301.

To access the free guidelines from the American Hospital Association, go to:
- www.aha.org/aha/key_issues/bcp/content/guidelinesfinalweb.pdf.

**• Apply policies consistently.**

Look at your policies to determine how the uninsured are handled in terms of discounts and sliding scales, Taubin says. "See if the policies have been applied consistently and whether or not they have adequate marketing of the policies to the geographic service area," he says.

Patients who fail to pay on time also should be handled consistently. When patients of Surgecenter of Palo Alto fall behind, they are sent three statements in increasing intensity, Mynderse-Isola says. **[To access the letters, go to www.same-day surgery.com and click on the "toolbox." Your user name is the subscriber number on your mailing label. Your password is sds (lowercase) plus your subscriber number (no spaces). The letters are listed under "Collections."]**

The third and final notice is sent via certified mail with a return receipt requested. If patients contact the center, staff attempt to work out a payment arrangement, she says. If the patient doesn't respond, a letter from a collection agency gives the patient 30 days to make payment. "If they make it, then there's nothing against their credit, and we get the whole amount," she adds. After 30 days, the amount is written off as bad debt and turned over to a collection agency. If money is collected then, the total is split evenly with the agency, Mynderse-Isola explains.

Keep in mind the Centers for Medicare & Medicaid Services can investigate if you're claiming Medicare bad debt, Clark warns. "They'll look to see if your indigent policies and collection policies are uniform for Medicare and non-Medicare patients alike," she says.

Over the years, many providers with good intentions have negotiated with patients on a case-by-case basis, Clark says. Instead, have standards in place, she advises. For example, should patients receiving assistance have an income that is a set amount over poverty level? Also, examine what other financial pressures, such as other sick family members, patients may have, Clark says. "Make sure the questions you ask and the standards you apply to each person's case is consistent."

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**Same-Day Surgery Manager**

# How to replace a medical director, other quandaries


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


I often receive multiple questions from *Same-Day Surgery* readers, but they're on the same topic. I've addressed several below. I always welcome your e-mails. All are confidential and deleted from our server when read, so you can speak honestly!

**Question:** The medical director in our surgical department refuses to come to meetings, stating they are a waste of his time. The hospital administrator doesn't want to get in the middle of it, and as a result, many of the tasks that we need him to perform do not get done. How can we replace

him in a manner that is politically correct?

**Answer:** In all honesty, many of the surgical department meetings really are a waste of time. This is especially true when you are meeting on a monthly basis just for the sake of meeting. Your bylaws (upon review) require meeting on a quarterly basis or "whenever an event or series of events" require a special meeting. I would consider approaching the individual and work out a schedule that meets all of your needs.

If that does not work, ask your medical director to use his authority to have another individual speak on his behalf at the meetings. Make sure your medical staff bylaws grant him this authority. It also could help the medical director if you prepare in advance a list of items that you need his input on or that you need him to approve.

**Question:** Many of our patients come to the operating room without the required H&P (history and physical) examination. Our anesthesia staff used to do them before administering anesthesia. However, one of the patients ran into trouble during a case, and the surgeon blamed the anesthesia department for not doing an adequate H&P. Now the anesthesia staff are refusing to do any of them. Can we replace the anesthesia department for refusing to do them?

**Answer:** Actually, you should buy them lunch everyday in gratitude that they formerly did them for you! They did you a great favor by doing them before this incident because they don't have to do that. Plus, if they do the H&P as you describe on the day of surgery, they don't even get paid to do it! I don't blame them for not doing them. I wouldn't either. It sounds as if you have a great anesthesia department that got tired of being taken advantage of by the surgical staff.

**Question:** I have heard you speak at conferences where you say that same-day surgery programs do not have the time to deal with "difficult employees." You said that same-day surgery margins do not allow the ability to deal with this issue. We recently hired a new business office manager who listened to your tape on the subject. She said, "Our employees are a huge asset to us, and we need to do everything in our power to maintain their confidence in us to stand by them." She said the cost of dealing with problem employees is cheaper than replacing them as you suggest. Any thoughts?

**Answer:** Of course. Fire the new business office manager, and hire one who understands you are not an employment agency or rehab facility.

**Question:** How much money should the hospital budget for new equipment in the coming fiscal year for the operating department?

**Answer:** Find out what you spent last year, and use that as the baseline. Get with the chief of each department, and write down their upcoming equipment needs for the coming year. That will give you some idea of what you will need. Submit that amount, but expect that you will probably only get half of it. When you ask the department heads to list their needs, make sure you get their priority on each piece as well. That information will make it easier to decide who gets what in the budget.

**Question:** How many cases can we do in our hospital per year per operating room?

**Answer:** On average, plan on about 800 per year per OR. It varies greatly, but you were not specific on the types of cases.

*(Editor's note: Do you have more questions? Contact Earnhart at 8303 MoPac, Suite C–146. Austin, TX 78759. E-mail: searnhart@earnhart.com. Web: www.earnhart.com. Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management.]* ■

# New patient safety goals set outpatient priorities

*JCAHO adds avoiding falls, surgical fires as goals*

Medications, surgical fires, timeliness of reports, and falls are new additions to the 2005 National Patient Safety Goals and Requirements published by the Joint Commission on the Accreditation of Healthcare Organizations.

Most of the new goals or requirements are similar for same-day surgery programs surveyed under

**EXECUTIVE SUMMARY**

The Joint Commission 2005 National Patient Safety Goals contain a few additional requirements for existing goals and three new goals. Changes include:

- Hospital-based organizations must address the risk of patient falls.
- Ambulatory and office-based same-day surgery programs must educate staff and independent contractors as to the causes of surgical fires.
- All organizations must collect a complete list of prescription, over-the-counter, and herbal medications used by patients.
- A list of look-alike/sound-alike drugs must be developed by all organizations.

hospital or ambulatory and office-based accreditation manuals, but there is one difference, says **Michael Kulczycki**, executive director of the ambulatory accreditation program for the Joint Commission. **(See patient safety goals, at right.)**

Programs that are surveyed under hospital standards have a goal to reduce the risk of patient harm resulting from falls, and programs that are surveyed under ambulatory standards have a goal to reduce the risk of surgical fires, Kulczycki points out. There are many more areas within a hospital that a patient is at risk for falls than in the surgery area, so reducing the risk of falls becomes a priority for hospital organizations, he explains. Organizations that are exclusively same-day surgery do not have patient falls as a priority because patients are in the facility for such a short time, and they are monitored closely by staff throughout their brief stay, he explains.

Surgical fires were identified as a priority for ambulatory organizations, Kulczycki says. "I don't know that we had information that surgical fires were more prevalent in an ambulatory setting than in a hospital setting, but the sentinel event and ambulatory advisory groups that contributed to these goals believed that they were more of priority than other goals that might have been considered," he says.

Because there are different advisory groups for hospital and ambulatory settings, the different perspectives do result in some differing priorities, Kulczycki explains. While falls and surgical fires were considered by both groups, the ambulatory advisory group contended that patients in the ambulatory setting were at more risk for a surgical fire than a fall, he says. The fact that surgical fires and patient falls were not included in hospital and ambulatory goals does not mean that same-day surgery programs in either setting can ignore the risk of surgical fires or falls, he points out.

Surgical fire education is an essential part of staff education for the hospital-based and surgery center-based staff at St. Joseph Regional Medical Center — Covenant in Milwaukee. Surgical fire prevention is a regularly discussed topic in staff meetings and education classes, says **Connie Geigle-Mietla**, RN, nurse manager of surgery and peri-anesthesia at the hospital.

Staff discuss the risk of oxygen collecting under drapes, and supervisors and managers conduct OR rounds to make sure all other electrosurgical equipment are holstered properly, she says.

Proper use of preparation solutions before electrosurgical procedures also is covered in a staff

## Joint Commission 2005 National Patient Safety Goals

The following new goals and/or requirements apply to hospital-based, freestanding, and office-based same-day surgery programs. The new goals or requirements are indicated in bold.

- Goal: Improve the accuracy of patient identification.
  - **— Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.**
- Goal: Improve safety of using medications.
  - **— Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.**
- **Goal: Accurately and completely reconcile medications across the continuum of care.**
  - **— During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient's current medications upon the patient's entry to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.**
  - **— A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner, or level of care within or outside the organization.**

This goal applies only to ambulatory or office-based same-day surgery programs:

- **Goal: Reduce the risk of surgical fires.**
  - **— Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels, and establish guidelines to minimize oxygen concentration under drapes.**

This goal applies only to same-day surgery programs surveyed under the hospital accreditation standards manual:

- **Goal: Reduce the risk of patient harm resulting from falls.**
  - **— Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks.**

*Source:* Joint Commission on the Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

education session at least once each year, Geigle-Mietla adds. "We emphasize the need to make sure the area on which the solution is placed is completely dry before the patient is draped," she says.

Meeting the surgical fire safety goal, as well as other patient safety goals, is especially important in Wisconsin because patient safety data are collected by the state hospital association and published on a patient safety web site that members of the public can access, she points out. **(See story on state efforts to emphasize safety, below.)**

A more challenging new goal will be to "accurately and completely reconcile medication across the continuum of care," Kulczycki notes.

"This general requirement to collect a complete list of medications is not new, but inclusion in the patient safety goals formalizes the requirement and emphasizes the need to communicate this information when transferring the patient to another caregiver," he says.

The requirements for this goal do not mean that a same-day surgery staff member must call all of the patient's physicians to obtain the list, but instead can obtain this list from the patient, he adds. "The key is to ask for over-the-counter medications as well as herbal medications, in addition to prescription medications," he adds.

The goals have emphasized the need to reduce

## State programs emphasize the need for patient safety

*Web sites and shared protocols improve efforts*

Although the Joint Commission on the Accreditation of Healthcare Organizations has provided a standardized, national road map to improvement of patient safety with its national patient safety goals, two states have approached patient safety as a statewide initiative that requires collaboration and communication.

In Ohio, 12 health care-related organizations worked together to develop a protocol for surgical and procedure verification. "We believed that standardization of a protocol that could be used in different hospitals would improve patient safety because many of our surgeons have privileges at more than one hospital, and it was difficult to comply with protocols that differed in each place," says **Deborah Percha**, RN, MSN, director of surgery at Alliance Community hospital and a member of the Ohio Patient Safety Institute task force that developed the protocol. **[See Ohio surgical and procedural protocol at www.same-day surgery.com. Click on "toolbox." Your user name is your subscriber number from your mailing label. Your password is sds (lowercase) plus your subscriber number (no spaces). The protocol is list under "policies and procedures."]**

"Even though all of the organizations agreed to the importance of a standard protocol, there were some issues that were challenges," Percha admits. These differences included who was the appropriate person to mark the site, with some organizations requiring physicians to mark the site and other organizations allowing nurses to mark the site. The actual protocol uses the wording physician/designee to allow each organization to follow the protocol in a manner that fits their normal practice, she adds.

In Wisconsin, patients can check out performances of hospitals in several safety categories, including surgical site identification and procedural verification at www.wicheckpoint.org. An independent, multidisciplinary body composed of insurers, employers, and health care providers guided the development of CheckPoint, which provides data submitted by hospitals on a voluntary basis and is coordinated by the Madison-based Wisconsin Hospital Association.

It's important to provide patient safety information to give patients information about their health care choices, says **Connie Geigle-Mietla**, RN, nurse manager of surgery and peri-anesthesia at St. Joseph Regional Medical Center-Covenant in Milwaukee. She says she is proud of her hospital's 95% compliance rate for site marking and 97% compliance for procedural verification. "The key to our success is the physician buy-in that we obtained prior to implementing our policy," Geigle-Mietla explains.

The proposed policy included several points at which site and procedure are verified and a time-out in the operating room. By taking the proposed policy to section and department meetings, the surgery staff were able to educate physicians as to the importance of the policy and assure them these extra steps would not delay procedures.

Acceptance of the policy is evident in the time-out process, Geigle-Mietla notes. "Although we have designated the circulating nurse as the staff member who will call a time-out prior to the incision, any person in the OR can call for a time-out," she says. She laughs and adds that it's not unheard of for a physician to call for and time-out and say, "Let's get it right."

*[For more about surgical site verification, contact:*

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*• **Deborah Percha**, RN, MBA, Director of Surgery, Alliance Community Hospital, 1310 Desert St. N.E., Uniontown, OH 44685. Phone: (330) 829-4000. E-mail: dpercha@achosp.org.]* ■

## SOURCES AND RESOURCE

For more information, contact:

- **Michael Kulczycki**, Executive Director, Ambulatory Accreditation Program, Joint Commission on the Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: 630) 792-5290. E-mail: kulczycki @jcaho.org.

To find frequently asked questions and answers, as well as updates to the goals and requirements, go to www.jcaho.org, and under the "Top Spots" section, choose "National Safety Patient Goals & FAQs."

medication errors in previous years with requirements for approved or unapproved abbreviations that might lead to dosing errors and for standardizing the number of drug concentrations available in one organization. The 2005 goals point out another area of concern, Kulczycki says.

"Organizations are required to identify and review a list of look-alike/sound-alike drugs and take actions to prevent the interchange of these drugs," he explains. The creation of a list will increase staff awareness and, along with other safeguards such as read-back of verbal orders, these drugs should not get mixed up, Kulczycki notes.

Another requirement has been added to the goal of improving effectiveness of communication. The new requirement is to measure and assess the timeliness of reporting and receipt by the caregiver of critical tests and values, he points out. If the organization finds that critical information is not handled in a timely manner, actions must be taken to improve reporting and receipt of information, Kulczycki adds.

At the time of publication, the Joint Commission had not defined "critical tests and values." He suggests same-day surgery managers check the Joint Commission web site for clarification of national patient safety goal specifics during the next few months. **(For information on how to access the web site, see resource box, above.)**

The new goals and requirements will be effective January 2005. "Our intent is to give organizations several months to review and understand the requirements and enhance any safety programs they may already have," Kulczycki says.

"Our accredited organizations are already addressing these issues, but the new goals focus our efforts on areas considered the most critical for each type of organization," he adds. ■

# Freezing a tumor improves accuracy of the procedure

*Cryo-assisted lumpectomy reduces recurrence*

Lumpectomy has long been recognized as an effective alternative to mastectomy for many types of malignant tumors, but the use of a cryoprobe to locate and isolate small tumors promises even more benefits to surgeons and patients.

In a peer-reviewed prospective study of 24 patients to test the technology, cryo-assisted lumpectomy was shown to be more effective at removing the entire breast tumor than the current use of needle wire localization.[1] A follow-up clinical study of 250 patients is under way, says **Lorraine Tafra**, MD, medical director of the Breast Center at Anne Arundel Medical Center in Annapolis, MD, and lead investigator in the study.

"Breast surgeons have faced a dilemma now that women are aware of early breast cancer detection efforts, and tumors are found when they are very small," she says. "When a tumor is very small, surgeons can't feel it in the breast tissue the way we can when the tumor is larger."

When the tumor is too small to feel, a radiologist uses ultrasound to locate the tumor, then marks it with a wire inserted into the center of the tumor, Tafra says. "This process leaves a lot to be desired," she admits. In addition to the discomfort to the patient who has to undergo two procedures back to back, there is the scheduling challenge presented with the necessity for the wire placement to immediately precede the lumpectomy, she notes.

As more surgeons become accustomed to using ultrasound in the OR, some are placing the wires

## EXECUTIVE SUMMARY

As women discover smaller breast tumors through self-breast exams and mammography, surgeons are faced with the challenge of operating on lesions that they cannot feel.

- Cryoprobe-assisted lumpectomy gives the surgeon a chance to locate and define the tumor to enable complete removal.
- Because the ultrasound-assisted placement of the cryoprobe is performed in the OR, there is no need to coordinate scheduling with other departments.
- Data from the clinical study and reimbursement information should be available in early 2005.

## SOURCES AND RESOURCE

For more about cryo-assisted lumpectomy, contact:
- **Richard Fine**, MD, 702 Canton Road N.E., Marietta, GA 30060. Phone: (770) 428-4486.
- **Lorraine Tafra**, MD, Medical Director, The Breast Center, Anne Arundel Medical Center, 2002 Medical Parkway, Annapolis, MD 21401. Phone: (443) 481-5300. E-mail: ltafra@aahs.org.

For information on cryoprobe technology, contact:
- **Sanarus Medical**, 5880 W. Las Positas Blvd., Suite 52, Pleasanton, CA 94588. Phone: (925) 460-6080 or (800) 909-3060. Fax: (925) 460-6084. E-mail: info@sanarus.com. Web: www.sanarus.com.

themselves, Tafra says. "This eliminates some of the scheduling problems, but it still leaves the surgeon guessing as to how much tissue surrounding the tumor to remove," she adds.

Cryo-assisted lumpectomy allows the surgeon to use ultrasound to insert a cryoprobe into the center of the tumor, then activate it until the tumor and a set amount of surrounding tissue is enclosed in the ice ball, says **Richard Fine**, MD, a breast surgeon in Marietta, GA. "The ice ball makes a nonpalpable tumor palpable and easier to remove with accuracy," he explains. Results of the pilot study showed that if more than a 6 mm ice margin is created around the tumor, then the entire tumor is removed with clean margins 94.4% of the time. This compares to a rate of clean margins of 40% to 60% when the standard wire localization is used.[1]

"There are different studies that say that women undergoing lumpectomy need to return to surgery anywhere from 15% to 40% of the time because not enough tissue was removed to produce a clean margin," Fine says. No matter what the actual percentage for return to surgery is, it's clear some women have to return to the OR, he adds.

"With the cryoprobe, I can determine how much tissue surrounding the tumor I will freeze and I can easily feel the symmetrical area I am going to remove," Fine explains. That improves the chance of getting clean margins and eliminates the need for repeat surgeries, he says.

There is only one risk to the patient with the use of the cryoprobe, Fine says. "If the surgeon is freezing a tumor that is close to the skin and does not pay close attention to the growth of the ice ball, it can create frostbite on the skin," he adds.

Techniques such as injecting saline between the skin and the top of the ice ball can prevent this problem, as will diligent monitoring of the ice ball growth, he adds. Because the use of a cryoprobe is not dangerous and is used in other applications such as treatment for fibroadenomas, it can be used by surgeons now, Fine points out.

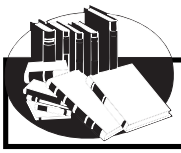
It is true that the equipment is available to surgeons now, but "there is no reimbursement currently available, so it makes it uneconomical for a physician or facility outside the clinical trials," says **Scott Tremberth**, director of marketing for Sanarus Medical, the Pleasanton, CA-based manufacturer of the cryoprobe for breast surgery. "We hope to have reimbursement in place in the next six months," he says.

Costs of the disposable probes, gas tanks, and other supplies will add about $1,485 to the cost of the procedure per patient, but the overall costs to the surgeon and the same-day surgery program will be reduced because of the decrease in repeat surgeries, Tremberth notes.

Tafra say she sees this technology as one more step to enhance breast cancer treatments. "Lumpectomies make it possible for women to conserve their breasts; early detection makes it possible for smaller tumors to be found in time to remove the cancer before it spreads; and cryo-assisted lumpectomy reduces the need for repeat surgeries and improves the precision of our surgery," she says.

### Reference

1. Tafra L, Smith SJ, Woodward JE, et al. Pilot trial of cryoprobe-assisted breast-conserving surgery for small ultrasound-visible cancers. *Annals of Surgical Oncology* 2004; 10:1,018-1,024. ■



## JOURNAL REVIEW

Dexter F, Macario A. **When to release allocated operating room time to increase operating room efficiency.** *Anesth Analg* 2004; 98:758-762.

While same-day surgery managers debate the best way to allocate and release OR time to surgeons who need extra time, a recent study in *Anesthesia & Analgesia* shows it doesn't matter when you release one surgeon's time to another surgeon. It is the fact that you allocate OR time correctly and then make adjustments based on scheduled workload that make a difference.

Researchers used real surgery schedules into which they inserted hypothetical cases that

exceeded one service's or one surgeon's allocated OR time. The effects of the insertions, three to five days before the surgery date and the day preceding the surgery date, on OR efficiency were evaluated.

The study used data from two surgical suites. There were 754 regularly scheduled OR days during the three-year period studied. The schedules included 16,114 elective cases at the ambulatory surgery center participating in the study and 30,775 elective cases at the hospital surgical suite.

The authors took the real surgical schedules from the two surgery programs and evaluated the results when hypothetical cases that ranged in duration from one to three hours in length were added to the schedule at different times. They repeated this process with the hypothetical case scheduled on Thursday prior to the Friday on which surgery would occur.

The authors found that postponing the decision of which service has its OR released for the new case until early the day before the surgery reduces overutilized OR time by less than 15 minutes per OR per day unless the surgical suite typically handles cases of three hours in length.

They noted postponing the decision to release time until the day before the surgeon wants to schedule a case most likely will reduce the satisfaction of the surgeon asking for the time. The delay, however, will increase the satisfaction of the surgeons whose time is being released, they added. ■

*(Continued from cover)*

- The rule continues the two-year extension of hold harmless payments for small rural hospitals having fewer than 100 beds and for sole community hospitals in rural areas.
- The rule includes a way for hospitals to receive payment for new drugs and biologicals as soon as they are approved by the Food and Drug Administration.
- CMS proposes a new fixed dollar threshold, in addition to the current outlier threshold, for outlier payments.

At press time, the proposed rule was scheduled to be published in the Aug. 16 *Federal Register.* Go to: www.cms.hhs.gov/providers/hopps/. Under "highlights," click on "CMS-1427-P." Comments will be accepted until Oct. 8, and the final rule is scheduled to be published by Nov. 1. ■

# Protect your hospital's tax-exempt status

Class action lawsuits on behalf of the uninsured have been filed against a number of nonprofit hospitals in multiple states. More suits are expected to follow as this issue draws increasing media and political attention. If your nonprofit hospital is typical, it's likely hanging by a financial thread. Do you know what actions you can take to protect its tax-exempt status? And do your staff know about the many services available to help the needy?

Thomson American Health Consultants is offering an audio conference to help you learn where your hospital may be exposed, what policies and procedures you need to reform to preserve your tax-exempt status, and how to continue to provide necessary care for the uninsured.

**Billing and Collections Practices Regarding the Uninsured: What You Need to Know to Preserve Your Hospital's Tax-Exempt Status**, which will be held Thursday, Sept. 6, 2004, from 2:30 to 3:30 p.m., EST, will be presented by **Jay Wolfson**, DrPH, JD. Wolfson is a professor of public health and medicine at the University of South Florida Health Sciences Center in Tampa and is an expert in the field of health care law. He has done extensive research, written numerous books and articles, and given many talks on the subject.

Your facility fee of just $249 entitles you to invite as many participants to listen as you wish. You will receive presentation materials, additional reading, a 48-hour replay of the live conference, and a CD recording of the program upon request at no additional charge. And if you register by Aug. 26, you will qualify for the discounted facility fee of just $199 (a $50 discount off the regular price of $249).

To register or to get more information, visit us at www.ahcpub.com, or contact customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com. When registering, please reference code **T04120-61822.** ■

## COMING IN FUTURE MONTHS

- Top 10 denied procedures and how to address them
- How to handle anxious parents
- Quality improvement doesn't require high-tech solutions
- Latest comment from the feds on ASCs and surgical hospitals
- Update on certificate of need laws

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

## 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 "*New patient safety goals set outpatient priorities"* and "*State programs emphasize the need for patient safety,"* in this issue.)
- Describe how those issues affect clinical service delivery or management of a facility. (See "*Freezing a tumor improves accuracy of the procedure.")*
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See "*Journal Review: When to release allocated operating room time to increase operating room efficiency*.")

## CE/CME *questions*

9. What is one way to reduce the risk of surgical fires in a same-day surgery program, according to Connie Geigle-Mietla, RN, nurse manager of surgery and peri-anesthesia at St. Joseph Regional Medical Center — Covenant?
   A. Minimize the number of electrosurgical procedures.
   B. Document steps you take to prevent fires.
   C. Practice evacuation plans.
   D. Provide ongoing training that identifies the causes of surgical fires.

10. Why did the members of the Ohio Patient Safety Institute believe a standard, statewide protocol for surgical site identification and procedure verification was important, according to Deborah Percha, RN, MSN, director of surgery at Alliance Community hospital and a member of the task force that developed the protocol?
    A. None of the organizations had a well-developed protocol.
    B. Many surgeons practice at different hospitals, and differing protocols were confusing.
    C. Insurance reimbursements will increase with standard protocols.
    D. Standard protocols don't allow for any variations.

11. How does the ice ball created by the cryoprobe in cryo-assisted lumpectomy improve outcomes for patients, according to Richard Fine, MD, a breast surgeon?
    A. It anesthetizes the area to reduce pain.
    B. Insurance covers a greater portion of the surgery costs.
    C. Repeat surgeries to obtain clean margins are needed less often.
    D. The surgery costs less.

12. What is the effect on OR overutilization when the decision to release allocated OR time from one service to another is made the day before surgery, according to a study in *Anesthesia & Analgesia*?
    A. Overutilization increases by less than 15 minutes.
    B. Overutilization increases by 25 minutes.
    C. Overutilization increases by more than 30 minutes.
    D. Overutilization decreases by 14 minutes.

## CE/CME answers

**9. D** **10. B** **11. C** **12. A**