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IN THIS ISSUE

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Some surgeons can open centers or work at the local hospital, but not both

Economic credentialing comes to forefront at state, national level

A surgery center opens in a community, and rumors are spread about the quality of care provided by the physicians there.

• Leaders of a state hospital association testify before a state group that hospitals have the right to offer credentials based on economic criteria or any other criteria.

• A hospital CEO tells employees that they will lose their part-time jobs there if they work at a competing surgery center, and he tells them he intends to bankrupt the center.

• A physician is denied re-credentialing privileges because he's told that he didn't fill out his forms correctly and that the hospital staff didn't think he would ever be able to fill out his forms correctly.

• A hospital refuses to sign a transfer agreement with a competing surgery center, forcing the center to establish these agreements with hospitals more than 30 miles away.

Welcome to your worst nightmares, courtesy of the growing trend

EXECUTIVE SUMMARY

The issue of economic credentialing has become a bigger issue as hospitals and surgery centers battle over hospital use of economic criteria for credentialing or re-credentialing physicians who open competitive facilities.

- The American Medical Association warns against economic credentialing and has established model bylaws.
- States are battling the issue in the legislative, judicial, and executive branches.
- In a related issue, the U.S. Supreme Court let stand a lower court ruling that said efforts by a hospital to limit the dissemination of truthful, nondeceptive comparative information by a physician who was opening his own surgery center had no meaningful effect on competition.

toward hospitals and surgery centers battling over outpatient surgery patients.

Recent national and state action

Part of the trend toward economic credentialing can be attributed to a shift in hospital ownership, says **Jeff Turk**, MD, president of Surgery Center of North Central Missouri in Moberly, which recently faced opposition from its local hospital, which refused to sign a transfer agreement with the new center.

"We're seeing more and more hospitals that are not particularly community-based and community Samaritans," Turk says. "If you have a publicly traded, for-profit corporation owning and operating local and rural hospitals, they want to make as much money as possible, pass it on to shareholders and corporate entities, and not have the one-on-one relationships with those individual in those communities that typically local ownership would provide."

For its part, Moberly Regional Medical Center released a statement saying, in part, "Moberly Regional Medical Center (MRMC) is not opposed to fair competition, but physician-owned surgery centers do not represent fair competition. Because physician owners of surgery centers pick and choose the services they provide as well as the patients they target for their facility — often referring only healthier, well-insured patients and providing only highly compensated services — they have an unfair advantage." [1]

In another sign of the times, The U.S. Supreme Court let stand a lower court ruling that surgery centers are not entitled to protection under the antitrust laws until they open.[2] Also, the upheld ruling said that efforts by a hospital to limit the dissemination of truthful, nondeceptive comparative information by a physician who was opening his own surgery center to compete with the hospital had no meaningful effect on competition. The ruling came out of the Third Circuit, which includes Delaware, New Jersey, Pennsylvania, and the Virgin Islands.

Craig Jeffries, Esq., executive director of the American Association of Ambulatory Surgery Centers, says, "It was unfortunate that the U.S. Supreme Court did not take the case because it emboldens other hospitals in that region to take a similar tact. We strongly oppose this restraint on competition and will look for other opportunities to defeat the precedent."

In other action, the latest edition of the American Medical Association's (AMA's) *AMA's Physician Guide to Medical Staff Bylaws* state that economic credentialing is a "dangerous practice" for medical staffs and hospitals.[3] Medical staff bylaws should bar credentialing based upon any criteria other than education, experience, and clinical competence, the guide says. "Utilization requirements imposed for the purpose of generating hospital revenue could also be seen as violating the Medicare fraud and abuse laws," according to the guide. **(See sample bylaw that addresses the AMA's concerns, p. 76.)**

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Editorial Questions

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There has been dramatic action regarding competition between hospitals and surgery centers in several states. Here is a synopsis:

• At press time, **Massachusetts** senators were debating their state budget bill. An amendment originally proposed would have placed a three-year moratorium on physician ownership of ASCs unless the surgery center was opened with an acute care hospital, a hospital affiliate, or the member of a hospital system. Also, no existing surgery center would have been allowed to expand or add services unless it was owned in part by a hospital, hospital affiliate, or part of a hospital system. The amendment was changed to require the inspector general to conduct a study, including a cost-benefit analysis, regarding the impact of services in physician-owned, multispecialty ambulatory surgical centers and the impact of new technology claims. At press time, the amendment was before a state legislative committee.

• In **New York**, a surgery center and hospital settled a case in mid-2005 that involved several issues, including a bylaw provision that was enacted the month the surgery center went into business. The provision said that having an economic interest in a competitor was the basis for removal from the staff. The center went out of business 18 months after it started, about two months after the largest payer signed an exclusive contract with the hospital, according to **William G. Kopit**, JD, an attorney with Washington, DC-based Epstein Becker, who represented the center.

• In an **Arkansas** court decision earlier this year, the court held that a hospital that refused to allow a qualified physician to renew with the hospital on economic grounds committed a "tortuous interference" with the doctor/patient relationship,[4] says **Tim Markham**, JD, director of government relations at the Colorado Ambulatory Surgery Center Association in Denver. "We're hopeful that there will now be more widespread recognition that economic credentialing is a heavy-handed and misguided retaliatory tactic that interferes with the patient/doctor relationship and the development of innovative surgical techniques," Markham says.

• In **Colorado**, a committee defeated legislation that would have prevented hospitals from refusing to award, retain, or renew medical staff membership, clinical privileges, or other credentialing to health care practitioners because of his or her financial interest in another health care facility, according to Markham.

• In **Missouri**, the governor intervened and assisted a surgery center that initially was denied full licensure because the administrators at the town's only hospital refused to sign a transfer agreement. The center responded by obtaining transfer agreements with other hospitals in the region.

Also in Missouri, the state hospital association has posted three publications on its web site: "Limited Service Providers: An Overview," "The Public's Concerns About Limited Service Providers," and "Physician's Concerns about Limited Service Providers." In those publications, the association says it contracted with two national polling firms to survey likely Missouri voters about limited service providers, including ambulatory surgery centers, outpatient medical imaging facilities, and radiation therapy facilities. The papers present the results those surveys, which the association says indicate voters and physicians are concerned about providers such as surgery centers. **(To view the publications, go to web.mhanet.com/asp/Governmental_Relations/state_advocacy/limited_service_providers.asp, and click on the report names.)**

As the issue grows, surgery centers are examining how best to respond.

Outpatient surgery managers should join their

SOURCES/RESOURCES

For more information on economic credentialing, contact:

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- **Tim Markham**, JD, Director of Government Relations, Colorado Ambulatory Surgery Center Association, 6825 E. Tennessee Ave., Suite 510, Denver, CO. Phone: (303) 761-3596. E-mail: tim.markham@cascacolorado.com.
- **Jeff Turk**, MD, President, Surgery Center of North Central Missouri, 1509 Silva Lane, Moberly, MO 65270. Phone: (660) 263-8986 or -1266.

For information sheets on ambulatory surgery centers, go to the web sites for the following organizations:

- **American Association of Ambulatory Surgery Centers.** Web: www.aaasc.org. Under "Advocacy," click on "About Advocacy" and "ASC Fact Sheets."
- **Federated Ambulatory Surgery Association.** Web: www.fasa.org. Click on "FAQs about ASCs."

Sample Bylaw: Economic Credentialing

Medical staff membership and privileges may be granted, continued, modified, or terminated by the Board only upon recommendation of the medical executive committee for reasons directly related to quality of patient care and other provisions of the medical staff bylaws, according to the procedures set forth in these bylaws. Under no circumstances shall economic criteria unrelated to quality of care be used to determine qualification for initial or continuing medical staff membership or privileges.

Source: Office of General Counsel, Organized Medical Staff Services, American Medical Association. *Physician's Guide to Medical Staff Organization Bylaws, Third Edition.* Chicago; 2005.

state associations and become leaders in those groups, says Jeffries. Keep your state and national associations apprised of battles you are facing, he says. Additionally, managers should participate in the Ambulatory Surgery Center Political Action Committee, he says. (Web: www.aaasc.org/advocacy/documents/ASCPACInvoice.doc).

Make sure the general population understands that it is to their benefit to have access to ambulatory surgery centers, Turk advises. "Make sure legislators understand it is good thing, and ask them to protect further access to health care and be actively involved in health care cost containment," he says. "Surgery centers are effective in providing efficient access and cost-effective access to health care." **(To learn how to access information sheets about surgery centers, see resource box, p. 75.)**

Send out press releases and hold press conferences detailing the issue, Markham suggests. "Health care is complicated, and many members of the public and even many legislators don't have any idea that this is happening," he says.

Bring legislators into your surgery center for a tour, and have your doctors brief them on the issue, Markham advises. Also, consider introducing legislation to end the practice of economic credentialing, he says. "If you can educate the public, the political fights become easier," Markham says. **(Editor's note: The American Hospital Association did not respond by deadline to requests for interviews for this story. For more resources on economic credentialing, go to aaasc.org/state/StateResourceLibrary.html. In the "State Resource Library" chart, see column on "physician ownership." For more on hospital/surgery center issues, see "Hospitals and surgery centers throw punches at national, state, local level," *Same-Day Surgery,* May 2004, p. 49.)**

References

1. Moberly Regional Medical Center. *Statement issued by MRMC on Surgical Center facility in Moberly.* Moberly, MO; 2006. Accessed at www.moberlyregionalmedicalcenter.com/body.cfm?xyzpdqabc=0&id=17&action=detail&ref=21&dataFrom=Facility.
2. *Alan D. Gordon, MD, Alan D. Gordon, MD, PC, Mifflin County Community Surgical Center, Inc. v. Lewistown Hospital,* No. 05-1000, U.S. Supreme Court (March 13, 2006).
3. Office of General Counsel, Organized Medical Staff Services, American Medical Association. *Physician's Guide to Medical Staff Organization Bylaws, Third Edition.* Chicago; 2005.
4. *Baptist Health v. Bruce E. Murphy, MD, Scott L. Beau, MD, David C. Bauman, MD, D. Andrew Henry, MD, David M. Mego, MD, and William A. Rollefson, MD, Baptist Health v. Murphy,* No. 04-430, Supreme Court of Arkansas (Feb. 2, 2006). ■

Environmental control, education cut infections

(Editor's note: This is the second part of a two-part series that looks at effective strategies to reduce surgical site infection rates. This month, experts talk about glucose management, environmental control, and new products. Last month, we looked at the importance of reducing the use of razors, using prophylactic antibiotics, and keeping the patient warm.)

While a key component of preventing surgical site infections is to educate staff members and physicians, don't forget that your patients and their family members need to understand the basics of infection control and infection identification.

Education about surgical site infection is critical, says **Cynthia Spry**, RN, MA, MSN, CNOR, clinical consultant with Advance Sterilization Products in Irvine, CA. Make sure family members know how critical hand washing is to the prevention of infection, she recommends. "Also, let them know what to look for as they change bandages or check the wound," she says. "Explain what a normal, healing wound looks like and talk about what potential signs of infection are, and when to call the physician's office."

Although outpatient surgery staff members want to prevent infections, it is just as important that an infection be treated early to prevent more

EXECUTIVE SUMMARY

Some strategies for reducing your surgical site infections are overlooked because they may not be directly related to the procedure or the patient.

- Educate family members about the importance of hand washing and the need to report signs of infection as soon as possible.
- Include all staff regarding communications about techniques to reduce infection to make sure their actions do not contradict your strategies.
- Evaluate new products that reduce infection, but make sure your procedures are designed to reduce infection before new products are introduced.
- Avoid flash sterilization of instruments as much as possible.

problems, Spry adds.

Remember that monitoring staff actions is also important to ensure that staff members practice what they learn, she suggests. "It's one thing to know the basics of infection control and quite another thing to practice it all of the time," she points out. "Staff members in the operating room areas know to wear gloves, but then they pick up the telephone, or open doors and cabinets with the gloves on their hands, then go back to patient care." It's necessary to offer continuous education to ensure staff stay aware of actions they take might put a patient at risk, Spry says.

You can also make surgical site infection reduction a standing agenda item to keep the topic at the top of the mind for everyone, suggests **Ann Beauregard**, RN, RN, performance improvement manager at Porter Hospital in Middlebury, VT. "We talked about the changes we were implementing at all staff meetings and physician meetings," she says. "We took small steps, changing one thing at a time."

For example, one of the first changes was a change of clippers to a product that seemed to be easier to use and less likely to cause abrasions that might become infected, she says. "We explained how we tested different clippers and why we made the choice we did," Beauregard says. Throughout all of the changes, all staff members and physicians had a chance to offer input, she adds.

Beauregard says when reviewing research that supported the changes proposed, members of the performance improvement committee noticed that a number of studies discussed the importance of glucose management for improved wound healing for cardiac patients. "While we don't handle cardiac procedures in our outpatient program, we did see a relationship between glucose management and improved wound healing," she says.

Beauregard's staff members always have known to monitor patients who were identified as diabetic, but they are starting to screen for abnormal glucose levels in all patients, she says. "We are purchasing glucose screening monitors for our post anesthesia care unit so that we are able to monitor all patients," Beauregard adds. "A policy that calls for glucose monitoring of all patients won't work if you don't get the enough equipment for staff members to perform the monitoring."

Evaluate surroundings and supplies

Don't forget to review the entire environment of the surgery area when you are looking for potential causes of infections, says **Melinda Rogers**, RN, CNOR, clinical development specialist for the surgical services department at Northside Hospital in Atlanta.

"We control traffic in the operating room areas carefully," she points out. "We restrict who comes into the area and if people not directly involved in patient care must come into the area, we keep them away from patient care areas." For example, when a maintenance engineer had to come into the operating room to fix a leaky pipe behind one of the operating room walls, the first step was to have an infection control nurse survey the area and decide how to keep the people and equipment needed during the repair isolated from other areas in the surgery department, Rogers says.

Don't forget that there are employees from departments other than surgery that can affect your patients' environment, says Beauregard. Even if your operating room staff knows to keep patients warm, let other employees know as well, she suggests. "We monitor the temperature in our operating rooms and we noticed that the rooms were always cold for the first procedures."

After checking with operating room staff to see why thermostats were turned down, Beauregard discovered that the housekeeping staff would turn the thermostats down after they finished cleaning the area at night. "While their intentions to save on energy costs were good and were appropriate for other areas of the hospital in which no one works at night, we had to ask them to change their procedure in the OR," she says. This was a good example of why all different areas should be included in

any performance improvement project, she adds.

There are also new products that are designed to reduce infection and outpatient surgery managers should take a look at them, suggests Spry. "Antimicrobial sutures are relatively new products that surgery managers are evaluating," she points out. "There are so many different ways that we can reduce infections that it is hard to point to one product or one technique that will have the best effect."

Rogers agrees that changing supplies is not the first step in an infection control program. "We are in the process of evaluating the antimicrobial sutures, but first we want to evaluate our procedures to make sure the way we care for our patients doesn't increase their risk of infection," she says.

Spry's last tip is to avoid flash sterilization whenever possible. "I believe this practice may be more prevalent than anyone realizes," she says. Staff members in a surgery area who are responsible for sterilization must be thoroughly educated in the instrument sterilization process and must take no shortcuts, or a patient's risk of infection rises, Spry explains. "Flash sterilization should not be used for convenience to the surgery program but should only be used in the case of a critical instrument for which there is no replacement," she says. ■

Upfront efforts result in better collections

Verify detailed patient benefits, not just coverage

[Editor's note: This is the second part of a two-part series that looks at results of a nonclinical benchmarking study conducted by the Institute for Quality Improvement (IQI). Last month, we looked at patient scheduling practices, staff costs, use of electronic medical records, and patient satisfaction results. This month, we look at effective billing and collections practices.]

You won't get paid for a procedure until you bill for it. That's why participants in the Ambulatory Surgery Non-Clinical Study for Colonoscopy focus on getting payments upfront and to getting bills out to insurance companies and Medicare quickly. The study was conducted by the Association for Ambulatory Health Care's Institute for Quality Improvement.

Permian Endoscopy Center in Odessa, TX, is a small center that only does about 150 colonoscopies each month, says **Alice Jolley**, assistant administrator and clinical director. "Our colonoscopies are usually completed in the morning, and we have one person who prepares and sends those bills that same afternoon," she says.

Because she has only five staff members, Jolley relies on cross-training to improve her efficiency in activities including billing. "My recovery room RN had previously worked in a physician's office and has the knowledge and experience to handle billing, so she is also our billing department as well as our recovery room RN," she explains.

Jolley's center did report the quickest turnaround on sending bills out of all 40 organizations participating in the study. The range of days required to send bills was same day to 11, with a median of two days.

Cindy Nichols, patient accounts manager for Lakeland Surgical & Diagnostic Center in Lakeland, FL, knew they would be over the median in this category because they handle all of the billing for two centers in a central office. A separate claims and billing staff is necessary for the center because in addition to a variety of other procedures, Lakeland handles 3,000 colonoscopies annually. "We bill within three to four days of the procedure because we have to get the information following the procedure from the center, and we also double check insurance information and coding before we send the claim," she explains.

The median percentage of bills that were outstanding for more than 90 days for all study participants was 5%. Nichols' center averages 8% for bills that are outstanding more than 60 days and much lower for 90 days, she says. "We handle all of our own billing and collections up to the 90-day point, then we turn the account over to a collections agency," she explains. "We rarely have to turn accounts over."

Tell patients what they will owe

Upfront efforts to collect money are the key to her center's high collection rate, says Nichols. "We collect the patient's copay, coinsurance, and deductible that are owed the day that they come into the center for the procedure," she explains.

This collection can be done by verifying not only insurance coverage prior to the procedure, but also by verifying benefits, Nichols says. They contact the patient's insurance company with information provided by the physician at the

SOURCES

For more tips from participants in the Ambulatory Surgery Non-Clinical Study for Colonoscopy, contact:

- **Alice Jolley**, Assistant Administrator and Clinical Director, Permian Endoscopy Center, 315 E. Fifth St., Odessa, TX 79761. Telephone: (432) 335-8300. Fax: (432) 335-8330. E-mail: ajol@cableone.net.
- **Cindy Nichols**, Patient Accounts Manager, Lakeland Surgical & Diagnostic Center, 115 S. Missouri Ave., Lakeland, FL 33815. Telephone: (863) 683-2428. Fax: (863) 683-3717. E-mail: cnichols@lsdc.net.

time the procedure is scheduled. "We find out what percentage of the procedure the patient's plan will pay, what copay is due, and how much of the patient's deductible has already been met," she says. "Then we calculate the patient's portion of the bill based upon the CPT code for the procedure, and we arrive at a very close estimate of the patient's responsibility for the procedure."

Collect on a case-by-case basis

When collecting deductibles, be sure to review your contract with the insurance company, suggests Nichols. "Some insurance companies do not permit you to collect based on the deductible," she says. None of the insurance companies with whom she has contracts prevents her from collecting deductibles, but Nichols does decide how much to collect on a case-by-case basis. "If the patient has a very small deductible or the patient tells me that he or she has been to the doctor three times in the past month, I usually don't collect it because it is likely that the deductible will be met when I bill the insurance company," she explains.

A letter than explains the costs, expected insurance benefits, and patient's responsibility is sent to the patient at least three days prior to the procedure. "Because patients know what to expect, we almost always collect 100% of the amount due from the patient on the day of the procedure," says Nichols. If there is a true financial need for the patient to pay in installments, Nichols staff will work out a 90-day payment plan, but they do not extend payments beyond that point, she says. **(For more information about financial obligation letters and samples of letters, see "Improve collections with info and communication," *Same-Day Surgery,* April 2005, p. 43.)**

In addition to the upfront preparation, Nichols' staff also gets a copy of the patient's insurance card at the time of the procedure and checks the information on the card against the information used to prepare the financial obligation letter and initial bill. "We occasionally find that physicians' offices have sent outdated information that we didn't discover in our initial contact with the insurance company or that patients have billing addresses or insurance plan changes between the time the procedure is scheduled and the time it occurs," she explains.

By double-checking the card itself, her staff is able to correct errors. "We have very few denials because we double-check everything before we send the claim," Nichols adds. A low claim denial rate is true for most study participants, who reported a denial rate range of 0 to 17%, with a median of 1.5%.

Supply costs per procedure for participants in the colonoscopy study ranged from $5 to $77, with a median of $37. Permian Endoscopy was well below the median at $10 per case because there is only one doctor at the center and he is very cost-conscious, says Jolley. "We don't use intravenous medications for the patients so we don't need IV supplies, and we also don't use sterile gloves," she says. "It is not necessary to spend the money on sterile gloves because our procedure is nonsterile."

The center is a member of a purchasing group because they are small and need the group to obtain discounts on supplies, Jolley says. "We do purchase supplies in volume to take advantage of the best prices," she adds.

Conduct informal comparisons

The best way to improve cost effectiveness and efficiency is to constantly check with peers about how they handle things in their organizations, suggests Nichols. "We were not surprised by any of the results of this study, because we are constantly comparing ourselves informally through conversations with peers at meetings or through a variety of benchmark studies," she says. It is difficult for a large organization to stay efficient because the tendency is to hire more people when you get busier, Nicholas admits. "Benchmark studies let us know where we have room for improvement and help us constantly look for better ways to handle our jobs," she says. ■

Same-Day Surgery Manager

Staff and physician woes, plus question on OR size

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

Question: Many of our surgeons pledged a certain number of cases they would do when we built our ambulatory surgery center last year. Wisely, I saved that list. I have been comparing it to what they are actually doing, and most of them are not even close! I don't want to rock the boat, but I think they should live up to what they said they were going to do. Our numbers are not even close to what they should be by now, and I am getting heat about it. Suggestions?

Answer: You need to individually approach each of the 11 surgeons. Review the numbers with them, and see what the problem is. Further, at your upcoming board meeting, demonstrate on a computer graphic the number of cases per month by investor, and compare that number to the number of cases they pledged. Speaking with them before that meeting will give you an opportunity to give the board the surgeons' feedback on why they are missing the numbers.

Question: As the head of human resources at our hospital, I am awash in our operating room staff resignations as a result of two new large surgery centers opening up within a mile of our campus. As a not-for-profit hospital, there is no way we can compete with what these centers are offering our staff. Any suggestions?

Answer: This is a very common complaint from our hospital clients. There is much you can do. I suggest that you have a more detailed exit interview with your departing staff and find out what the surgery center is offering that is so attractive to them. I can assure you that it is not salary. What you probably will find out is that your departing staff will not have "call" or weekends, no holidays, and they probably will have an opportunity for profit-sharing. Your institution can offer the same to your staff. You just need to be creative in how you structure it.

Question: We are building a new hospital and have the opportunity to look at the new size of our operating rooms. Currently they are 320 square feet. We know that they need to be closer to 400 or even 500 square feet. What are you finding in the industry?

Answer: So much of our operating room floor space is taken up with anesthesia machines, wires, poles, and other specialty equipment that walking around can become hazardous to our health. I would not consider anything fewer than 500 square feet and would recommend that you shoot for 700 to 800 square feet. We actually have surgery centers out there that have 800 square feet operating rooms that feel there is a need for that size.

Question: Members of our anesthesia department keep complaining that they need to start our surgical cases on time in the morning or they are not going to be able to provide us service. I admit that often our 7 a.m. cases do not get started until 7:45 or later on a routine basis. The reasons are varied, I am sure, but we have never had a chance to actually document where the problems lie. Any experience with this and how can we solve it?

Answer: First, join the club. Almost 100% of our hospital clients have cases that start on time less than 50% of the time. You can improve it by finding out where the problems lie. I can tell you right now — without even meeting you — that the bulk of your delays are paperwork. The staff needs to have a completed chart, but the history and physical or lab work is usually late or missing. The solution is as simple as requesting that the info needs to be at the operating room *two days* before surgery instead of the *day of* surgery. It's sort of like telling a chronically late friend to meet you at 6:30 instead of the real time of 7. Then they show up on time. You also will find that about 30% of your late starts are because anesthesia is late. But you need to have this info for your own institution. Have someone audit your late cases for two weeks and get the bigger picture. You will find that you usually can get back on track.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 3112 Windsor Road, Suite A-242, Austin, TX 78703. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

CMS clarifies payment for implants, prosthetics

The Centers for Medicare & Medicaid Services has clarified Medicare policy for payment and billing of services such as implants and prosthetics that are not covered by the ambulatory surgery center (ASC) facility fee. The notice informs providers about which additional services are to be paid and to whom they are to be billed.

According to the Federated Ambulatory Surgery Association, the advice includes:

• **Durable medical equipment (DME).** If the ASC furnishes DME to patients, it is treated as a DME supplier, and all the rules and conditions that are ordinarily applicable to DME are applicable to the ASC, including obtaining a supplier number and billing the DME regional carrier (DMERC) where applicable.

If the ASC furnishes items of implantable DME to patients, the ASC bills the local carrier for the surgical procedure and the implantable device and receives payment from the local carrier for those items.

• **Prosthetic devices.** An ASC may bill and receive separate payment for prosthetic devices, other than the intraocular lenses (IOLs) that are implanted, inserted, or otherwise applied by surgical procedures on the ASC list of approved procedures. The ASC bills the local carrier and receives payment according to the DME equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule. **(For additional examples of services that can be provided in ASCs, see list, below. To view the transmittal, go to fasa.org/CMSImplants 506.pdf.)** ■

Payment and Billing for Items/Services That Are Not ASC Facility Services

Items Not Included in the ASC Facility Rate	*Who May Receive Payment*	*Submit Bills To:*
Physicians' services	**Physician**	***Carrier***
The purchase or rental of *non-implantable* **durable medical equipment** *(DME)* **to ASC patients for use in their homes**	*Supplier — An ASC can be a supplier of DME if it has a supplier number from the National Supplier Clearinghouse*	*DMERC*
Implantable DME and accessories	*ASC*	*Carrier*
Non-implantable prosthetic devices	*Supplier. An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the National Supplier Clearinghouse*	*DMERC*
Implantable prosthetic devices **except intraocular lenses (IOLs and NTIOLs) and accessories**	*ASC*	*Carrier*
Leg, arm, back, and neck braces	**Supplier**	***DMERC***
Artificial legs, arms, and eyes	**Supplier**	***DMERC***
Services furnished by an independent laboratory	**Certified lab. ASCs can receive lab certification and a CLIA number**	***Carrier***
Procedures NOT on the ASC list	*Physician*	*Physician bills carrier for procedure and any implantable prosthetics/DME using the ASC as the place of service. See Pub. 100-4, chapter 12, section 22.4.*
Items not included in the ASC facility rate	*Who may receive payment*	*Submit bills to:*

Source: Centers for Medicare & Medicaid Services (CMS). Pub 100-04 Medicare Claims Processing, Transmittal 942. Baltimore; 2006.

Surgical hospitals finally have good news

CMS doesn't plan to extend moratorium

In some long-awaited good news for surgical hospitals, the Centers for Medicare & Medicaid Services (CMS) has publicly announced that it doesn't plan to extend the moratorium. However, specialty hospitals that open in the future will face tighter scrutiny, according to testimony by CMS administrator Mark McClellan before a Senate Finance Committee.

That news leaves the American Surgical Hospital Association "cautiously optimistic," says **Molly Gutierrez**, executive director. "We are excited that we're turning a bit of a corner, hopefully."

That news also is reflected in a CMS' interim report on specialty hospitals. CMS is required to develop a strategic and implementation plan regarding whether physician investments in specialty hospitals are proportional to investment returns, whether the investment is a bona-fide investment, and whether CMS should require annual disclosure of investment information. The interim report found general hospitals made an average of 22 operational changes, such as quality evaluations, and eight clinical service changes, such as adding or expanding cardiology services, they would have made regardless of whether or not they competed with a specialty hospital.[1]

". . . There was little evidence to suggest that general hospitals made substantially more or fewer changes or different types of changes if some of their competitions came from a specialty hospital," according to the interim report.[1]

In its interim report, CMS reports on several actions undertaken during the past year, intended to diminish the incentives for the development of specialty hospitals, according to a release posted by the American Association of Ambulatory Surgery Centers.[2] These actions include reform payment rates for surgery centers, reform payment rates for hospital inpatient services, and the disclosure that CMS will define a hospital on a case-by-case basis.

CMS is surveying specialty hospitals and general acute care hospitals seeking information about physician investment interests and provision of care to low-income patients. CMS is scheduled to submit a final report to Congress by Aug. 8.

References

1. U.S. Government Accountability Office. *General Hospitals: Operational and Clinical Changes Largely Unaffected by Presence of Competing Specialty Hospitals.* GAO-06-520. Washington, DC; 2006. Accessed at www.gao.gov/htext/d06520.html.
2. American Association of Ambulatory Surgery Centers. CMS Report Views ASCs and Payment Reform as a Solution to the Proliferation of Specialty Hospitals. Accessed at www.aaasc.org/advocacy/documents/CMSReport51206.doc. ■

Volunteers add extra touch in outpatient surgery

Select them carefully, stress patient confidentiality

Candy stripers and pink ladies have been delivering flowers and mail to hospital patients for as long as anyone can remember, but today's volunteers are moving into other areas of the hospital where they can help outpatient surgery staff with many tasks.

DeKalb Medical Center in Decatur, GA, has five volunteers who work in the outpatient surgery admissions department and the post anesthesia care unit, says **Linda Dacey-Caban**, volunteer coordinator. "They do not provide one-on-one patient care, but they help check in patients, transport patients, file, and run errands throughout the hospital for the staff," she says. "Volunteers in the area find it to be an exciting place to work because it is so busy and they are really needed."

Outpatient surgery managers who do use or who want to use volunteers in their program should think carefully about their screening, selection, and training process, points out **Margaret Spear**, MD, a

EXECUTIVE SUMMARY

Volunteers can help outpatient surgery staff members by handling tasks that take nurses and other staff members away from patient care. Be careful how you set up your program to ensure you get the most from your volunteers and still meet accreditation requirements.

- Develop a process to screen and interview applicants.
- Offer thorough training and orientation, with a focus on the importance of patient confidentiality.
- Use job descriptions and evaluations to define expectations.

SOURCES

For more information about volunteers in an outpatient surgery program, contact:

- **Linda Dacey-Caban**, Volunteer Coordinator, DeKalb Medical Center, 2701 N. Decatur Road, Decatur, GA 30033. Telephone: (404) 501-5079. E-mail: dacey-caban_linda@dkmc.org.
- **Marie Shattuck**, RN, Manager, Pre-Op and Recovery, Northwoods Surgery Center, 1230 Bald Ridge Marina Road, Cumming, GA 30041. Telephone: (770) 888-7105.

surveyor for the Accreditation Association for Ambulatory Health Care (AAAHC). While accreditation standards don't specifically address volunteers, it is important to note that surveyors will expect volunteers to receive the same training on issues such as patient confidentiality as employees receive, she says. "In fact, teaching volunteers about the importance of patient confidentiality is probably more critical because they are volunteering in a facility in which their neighbors or friends might be visiting for care that they want kept private."

"Our volunteers receive the same information on patient confidentiality that our employees receive but we spend more time on it than we do with employees," says Dacey-Caban. Although volunteers, even those who help with filing, don't have the same access to patient information that employees will have, just knowing that a church member or neighbor is at the hospital for surgery is information that they should not share with others, she explains.

"We also teach them how to act when the patient is someone they know," says Dacey-Caban. Being greeted by a neighbor who is volunteering can be disconcerting to the patient, and sometimes, to the volunteer as well, she says. "We teach them to be congenial but not to ask questions about the patient's reason for being at the hospital for surgery and not to repeat that they've even seen the patient."

No surgery program would hire an employee without a criminal background check, references, and interview process, and you should include all of these activities when selecting volunteers, says Spear. While a volunteer may not need as extensive a file as an employee, every surgery program manager should have some form of documentation that shows that the volunteer did go through a selection process and did receive the training and orientation needed to perform their responsibilities.

"It is also important that your volunteers be clearly identified with a name badge that describes them by name and volunteer," Spear points out. "This will be something that an accreditation surveyor will expect to see," she adds.

At DeKalb Medical Center, "We do follow the same process to select people who apply for volunteer positions as we follow for employees," says Dacey-Caban. "One difference is that we require the potential volunteer's doctor to sign a form that states the person is capable both physically and mentally to perform volunteer duties within the hospital." This is necessary because, unlike employees, volunteers do not undergo employment health screenings or physicals, she points out. This physician approval is required for all volunteers regardless of age or area in which they want to work, she adds.

Once the interview process is complete, Dacey-Caban assigns the volunteer to an area based on requests from different departments, her assessment of the volunteer's ability to work in different

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 **December** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- ■ New treatments for lower back pain
- ■ Profiles of best performers in cost per case
- ■ Treatment moves outpatients and has fewer complications
- ■ New National Patient Safety Goals

areas, and the volunteer's requests. Volunteers are given job descriptions that clearly describe their duties and how they will be evaluated, she explains. Even with the job descriptions, some volunteers find that they are not comfortable working in the surgery area, Dacey-Caban adds. The most successful outpatient surgery volunteers are very outgoing, energetic, and comfortable with a fast-paced business day, she says.

While Dacey-Caban doesn't have trouble attracting volunteers at a hospital-based program, some freestanding surgery programs do have more challenges. One man did volunteer for a brief time, says **Marie Shattuck**, RN, manager of pre-op and recovery at Northwoods Surgery Center in Cumming, GA. "He was an older man, and he wanted to volunteer to socialize with other people his age as well as stay busy," she says. "We don't have other volunteers, and we don't have a cafeteria where a variety of people gather, so we could not offer him what he wanted." While she sees the value of volunteers as an adjunct to her staff, Shattuck admits that it will be hard for her freestanding center to find them.

In addition to providing extra help for your staff, remember that volunteers often are the face and voice of your surgery program, Spears says. "Don't recruit a volunteer as an extra pair of hands unless they project the image and attitude that you want all of your employees to project," she says. "Patients and visitors don't know the difference between employees and volunteers, they look upon everyone they meet as a representative of the outpatient surgery program." ■

CE/CME *questions*

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

1. What is the first step in addressing the reduction of surgical site infection rates, according to Melinda Rogers, RN, CNOR?

A. Switch to antimicrobial sutures.
B. Evaluate all of your processes that can increase risk of infection.
C. Monitor glucose levels.
D. Be flexible about traffic in the operating room.

2. Why do you need to verify more than coverage with a patient's insurance carrier prior to a patient's procedure, according to Cindy Nichols?

A. To verify CPT codes.
B. To make sure no schedule changes occur at the last minute.
C. To make sure enough staff is scheduled for that patient's surgery.
D. To make sure you collect all monies due, including copayment, coinsurance, and deductible payments.

3. In addition to undergoing an interview process what does Linda Dacey-Caban require her volunteer applicants to submit with their application?

A. Proof of insurance
B. A description of their transportation to and from the hospital
C. Their own picture identification for use in the facility
D. A letter from their physician stating their physical and mental competence to perform volunteer duties

4. According to Stephen W. Earnhart, MS, what's one way to address late start times?

A. Take away block time from physicians who are chronically late.
B. Track your late starts and compare them with other similar facilities in your region.
C. Ask paperwork to be at the facility two days before surgery instead of the day of surgery.
D. Bring in patients earlier.

Answers: 1. B; 2. D; 3. D; 4. C.

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Three National Patient Safety Goals present compliance challenge in outpatient surgery

Abbreviation standards not met in more than 17% of surveys

Ambulatory programs' compliance rate for 13 of the 16 applicable National Safety Patient Goals exceeded 93% in 2005. However, the remaining three goals met compliance requirements less than 89% of the time. Timeout before the start of a procedure, read-back of verbal orders, and standardization of abbreviations are all challenges for organizations accredited by the Joint Commission on Accreditation of Healthcare Organizations, according to 2005 compliance data.

Hospital compliance rates for the three categories were 82.7% with timeout requirement, 87.7% with read-back of verbal orders, and 61.4% for standardization of abbreviations.

Compliance for the goal that requires a timeout in the operating or procedure room immediately before the procedure to verify the patient's identity, the surgical site, and the procedure was only 86.1% at ambulatory facilities. "We tend to see higher compliance in settings that involve more major procedures, so ambulatory surgery is vulnerable to a breakdown in this process," says **Richard Croteau,** MD, executive director for patient safety initiatives for the Joint Commission.

While the organization may have a written policy and may have educated staff members on the process, because the procedures are minor, staff members don't always conduct timeouts consistently, he explains. "Orthopedics is probably the specialty area that most consistently verifies site and procedure, but no specialty is exempt from performing a timeout," he points out.

EXECUTIVE SUMMARY

Although most outpatient surgery programs are complying with the National Patient Safety Goals from the Joint Commission on Accreditation of Healthcare Organizations, three goals have presented major challenges.

- Standardization and incorporation of a "do-not-use" list of abbreviations requirements were only present in 82.1% of all ambulatory organizations surveyed and 61.4% of hospitals surveyed in 2005.
- Only 86.1% of ambulatory organizations and 82.7% of hospitals routinely performed timeouts before the procedure to verify patient name, procedure, and site.
- Slightly more than 89% of ambulatory programs and 87.7% of hospitals had staff members writing verbal orders and then reading back what was written to verify the information.

Using visual reminders

At SurgiCenter Services of Pitt in Greenville, NC, staff members always remember to perform timeouts, says **Ann Purvis**, RN, BSN, CNOR, surgical services clinical director and director of nursing. "In our educational sessions, we stress the fact that every staff member must stop what they are doing for the timeout, and we not only perform a verbal verification of patient name, procedure, and site, but we also have a visual reminder for staff members," she explains.

A staff member writes the patient and procedure information on a whiteboard in the operating room as the information is verified, Purvis adds.

Timing of this process is important, she points out. "You can mark the site at any time, but the timeout to verify the site must be done after the

patient is prepped and draped and immediately before the procedure," she says. Waiting until the patient is draped is critical because you want to make sure that staff can see the marked site after the drapes are on the patient, Purvis adds.

Only 89.3% of ambulatory programs complied with the patient safety goal that requires the read-back of verbal or telephone orders to ensure accuracy, Croteau says. While outpatient surgery managers may have the policies in place, the actual read-back is not happening, he explains.

It is important that staff members understand that repeat-back and read-back are different things, Croteau points out. "When receiving a telephone or verbal order, the staff member should write the order, then read what is written back to the physician to make sure the order was heard correctly," he says. Too many times, a staff member will just repeat what was said, then invert numbers when he or she writes the order, Croteau says. "A true read back will prevent this error from occurring."

At SurgiCenter Services of Pitt, staff write and read back all verbal orders, even those given to the nurse during surgery, Purvis reports. While some staff members initially may believe that writing and reading back standard orders is not necessary, she emphasizes that it must take place for every order.

The manager of an outpatient surgery program in the Southeast, who asked not to be identified, admits, "We got gigged on this part of the patient safety goals."

During one of the procedures that the surveyor observed, the surgeon asked the nurse to administer an antibiotic, she says. Because the nurse worked with the surgeon every day on the same type of procedure, she administered the medication without reading back the order. "The nurse told me that because the surgeon asked for the same medication for every patient undergoing this procedure, she just thought of it as a standing order," the source says. "We now know that even routine, recurring instructions must be read back."

Abbreviations pose problems

The goal that posted the lowest compliance rate for both ambulatory and hospital organizations is the requirement to standardize abbreviations. Only 82.1% of ambulatory organizations and 61.4% of hospitals complied with this goal.

"I'm not surprised that all organizations are having trouble with this safety goal," admits Croteau. "You are asking people to change behavior that they learned many years ago in medical or nursing school."

In addition to continuous education and monitoring, programs might consider automated order systems that will not accept improper abbreviations, suggests Croteau. "Other surgery programs have had success with pre-printed order sheets on which none of the prohibited terms are included," he adds.

The do-not-use abbreviations that most frequently appear in the charts reviewed by surveyors are "QD" and "U," says Croteau. "We are seeing more people accepting the fact that they need to write 'units,' but many practitioners don't want to give up 'QD,'" he admits.

In addition to these three problem areas identified in 2005, Croteau points out a few 2006 National Patient Safety Goals that are presenting challenges to organizations surveyed this year. "Hand-off communications, medication reconciliation, and labeling medications in the sterile field are all tough goals for outpatient surgery programs," he says.

SOURCES/RESOURCE

For more information about meeting patient safety goal requirements, contact:

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- **Ann Purvis**, RN, BSN, CNOR, Surgical Services Clinical Director and Director of Nursing, SurgiCenter Services of Pitt, 102 Bethesda Drive, Greenville, NC 27834. Telephone: (252) 847-7700. E-mail: apurvis@pcmh.com.

A list of abbreviations, symbols, and dose designations most often associated with medication errors is available at the Institute for Safe Medication Practices (ISMP) web site: www.ismp.org/PDF/ErrorProne.pdf. Some of those notations are included in the current National Patient Safety Goal 2B, a do-not-use list of error-pone abbreviations and dose designations; however, ISMP's listing includes additional abbreviations that have been associated with medication errors reported to the USP-ISMP Medication Errors Reporting Program. For more information, contact:

- **ISMP**, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Phone: (215) 947-7797. Fax: (215) 914-1492. E-mail: rbrehio@ismp.org.

(For tips on medication reconciliation and labeling, see article, this page.) "We don't have a full year of data yet on these goals, but they appear to be presenting the most problems for our surveyed organizations," Croteau adds. ■

Surveyors want up-to-date info, detail in documents

Obtain patients' medication lists, and label all meds

(Editor's note: This month, we look at tips and suggestions from outpatient surgery programs that have undergone surveys in recent months from the Joint Commission on Accreditation of Healthcare Organizations. In a future issue, we will present tips and suggestions from organizations surveyed by the Accreditation Association for Ambulatory Healthcare.)

Medication reconciliation, labeling medications, staff competency, and Life Safety Code requirements were all topics upon which surveyors focused for organizations surveyed by the Joint Commission on Accreditation of Healthcare Organizations in the past six months.

Managers at Manatee Surgical Center in Bradenton, FL, knew that National Patient Safety Goals would be a focus of the survey. "But even when you know about it and when you prepare for questions about your processes to meet these goals, you will have outliers, or staff members, that don't follow procedure," warns **Linda M. Nash**, MBA, CASC, LHRM, administrator and risk manager for the center and partner in Global Surgical Partners, a surgery center development and management firm in Bradenton, FL. "Our policy is to label all medications used in the operating room, but one of the certified nurse anesthetists [CRNAs] in our center who was the last staff person interviewed by the surveyor made an exception to our policy," she says.

The surveyor had observed a number of procedures with no deficiencies noted, but as he was preparing to leave the facility, he saw the CRNA and asked her one final question, she explains. When asked about labeling medications in the operating room, the CRNA stated, "I label all medications except Diprivan [AstraZeneca, Wilmington, DE] because it is the only white medication in the room."

"We were cited on this item because you can label 99 out of 100 medications, but that one that you don't label results in a deficiency," Nash says.

Reconciling medications is also a challenge for outpatient surgery programs, admits Nash. "When patients go into the hospital, they are more careful about making a list of all of their medications because it seems more serious," she says. "With outpatient surgery, patients don't see it as a serious issue so they are less likely to remember to tell you about everything."

Nash's staff starts building the list of medications for each patient with the physician's history and physical. When they noticed that the physician often stated "see list" to refer to a crumpled piece of paper on which the patient had scribbled the names of some items, they developed a more comprehensive list that is now given to the patients by the physician for completion before the day of surgery. **[Editor's note: A copy of this form is available with the on-line version of *Same-Day Surgery*. If you're accessing your on-line account for the first time, go to www.ahcpub.com. Click on the "Activate Your Subscription" tab in the left-hand column. Then follow the easy steps under "Account Activation." If you already have an on-line subscription, to go www.ahcpub.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose "*Same-Day Surgery,*" and then click "Sign on" from the left-hand column to log in. Once you're signed in, select "2006" and then select the July 2006 issue. For assistance, call Customer**

EXECUTIVE SUMMARY

While National Patient Safety Goal issues such as medication reconciliation and labeling of all medications in the surgical area top the list of issues surveyors evaluate, outpatient surgery managers report that surveyors also are checking for thorough documentation in many areas.

- Make sure hazard vulnerability analysis is up-to-date and reflects changes in your building or your location.
- Perform different forms for staff competency testing of employees who perform Clinical Laboratory Improvement Amendment (CLIA)-waived testing.
- Documentation related to human tissue should include all information about storage and handling of the tissue from procurement by the tissue bank to delivery to the operating room for the procedure.

Service at (800) 688-2421.]

"When our nurses make their pre-op calls, they remind the patient to complete the form and bring it with them on the day of surgery," she says. "If they lost the form, or if they seem confused by it, we ask them to bring in all of their pill bottles, for prescription and over-the-counter medications, and we fill in the form for them."

Compliance with Life Safety Code

In addition to looking at clinical issues and patient safety goals, the surveyor who visited the HealthSouth Surgical Center of Elizabethtown (KY) looked carefully at the outpatient surgery program's compliance with the Life Safety Code. **Robin Boles**, administrator of the center, says, "We were very surprised at how much time the surveyor evaluated our hazard vulnerability analysis and items such as firewall penetration. They had moved into a new building 12 months before the survey, so they believed that because they had recently undergone building inspections from the state, not as much time would be spent on this are.

"We did notice that the surveyor was especially interested in making sure that our hazard vulnerability analysis had been updated and changed to reflect our new building," she adds.

Staff competencies important

Not only did her surveyor want to see the organization's policy on Clinical Laboratory Improvement Amendment (CLIA)-waived testing, but Nash learned that simply observing employees perform the tests was not enough to prove competence.

"Our team leaders have always observed and documented their observations of employees who perform our hemoglobin, hematocrit, blood glucose, or pregnancy tests, but the surveyor wanted to see two forms of competency assessment," she says. Now, in addition to supervisor observations, all employees who perform these tests must take a written test, developed in-house to reflect their policies, as part of the competency assessment, Nash says.

Thorough documentation also is required to address standards related to the handling of human tissue, Nash says. "While we have standardized forms, we were told to add more detail to include where the tissue came from, all of the information related to the tissue bank, how the tissue has been stored and transported along the way, and who is responsible for the tissue once it is in our facility," she says. "We have enhanced all of those forms."

While Boles was not unhappy with the results of her survey, she does admit that she made a mistake when she invited all staff members to the exit interview with the surveyor. "Throughout the survey, I heard the surveyor praising us and using words such as 'stellar' and 'excellent,' so I did not expect to hear about any deficiencies," she explains.

The surveyor did point out some deficiencies and some processes that should be improved during the exit interview. Even though they were not major and were easily corrected, Boles' staff members took the report as criticism of them, she says. "Next time, I will meet with the surveyor and a few key supervisors, then report back to the staff," she says. "This will enable me to put the comments in perspective and make it less threatening to staff members." ■

SOURCES

For more information about survey experiences, contact:

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JCAHO to publish separate ASC standards

The Joint Commission on Accreditation of Healthcare Organizations will publish a separate standards manual for ambulatory surgery centers that will become effective in January 2007.

The standards, which are expected to be available in the third quarter of 2006, will be similar to the standards that the Joint Commission publishes for office-based surgery providers, according to the Federated Ambulatory Surgery Association. ■

PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Massachusetts considering patients-per-nurse limits

Nurses claim staffing levels can affect patient safety

Depending on who you ask, the state of Massachusetts is either: a) on the verge of; or b) seriously considering following California's lead and limiting the number of patients who can be assigned to nurses. Potential legislation has been working its way, in a series of fits and starts, through the state legislature.

The sooner, the better, says **Julie Pinkham**, RN, MS, executive director of the Massachusetts Nurses Association (MNA), a strong proponent of such limits, who says it has been clearly demonstrated that assigning too many patients to nurses can have a direct impact on patient safety.

"Every piece of research we have seen says that the number of patients a nurse has is directly related to morbidity and mortality," she says. "Linda Aiken was the first one to quantify that." (Aiken's article in the October 2002 *Journal of the American Medical Association* found that "in hospitals with high patient-to-nurse ratios, surgical patients experience higher risk-adjusted 30-day mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction."[1]) "This research validated what nurses have been saying to us."

Pinkham adds that "another paper by Jack Needleman found a direct correlation between patient outcomes and the number of patients per nurse."[2]

Because of these findings, says Pinkham, nurse-patient ratios must be looked at in terms of delivery of care. "Registered nurse assignment of patients is not unlike any other type of care we do — like cancer screenings, for example," she asserts. "Look at it this way: Insurance companies, after doing their research, decide whether or not the money they are investing in a treatment is worthwhile — if it is efficacious. If it is, we expect it to be covered. But in nursing care, even though we have a direct correlation between a nurse having more than four patients and increased risk, one hospital will give you 8-to-1 and another 4-to-1."

She notes that research also shows that improving nurse-to-patient ratios can be cost-effective, as well as safer.[3] "This last one finally puts it in perspective," she says. "Imagine going to a hospital, having a stroke, but the hospital is saying that even though research shows you should be treated with a certain protocol, they are not going to do it?" she poses. "That's why we're saying we need to have a limit in place — and that it needs to be directly linked to patient outcomes. Patients also need to understand what the limit is, and that, for example, their nurse should only have three additional patients."

Easier said than done

While the issues are clear to Pinkham's organization, and the Massachusetts Hospital Association (MHA) is certainly supportive of improving patient safety, incorporating those goals into legislation that both groups can support is not that easy.

"Essentially, everyone agreed there should be a limit on the number of patients assigned to an RN," says Pinkham. "We have been negotiating a waiver for financially strapped hospitals [who say they cannot afford additional staff], and what the 'ideal' number should be."

But, counters **Daniel P. Moen**, president and CEO at Heywood Hospital in Gardner, MA, and board chairman-elect of the MHA, "There has not really been any in-depth discussion on waivers [for financial concerns]. Before we get to that point, we

have major concerns as to whether these guidelines are based on research and evidence."

Pinkham says the state Department of Public Health will have public hearings and set standards and limits, and that there would be an acuity system to adjust those limits up and down. "The final regulations will be developed over a period of 12 months, once the legislation passes," she reports.

"Our biggest concern right now is that this is still a piece of legislation that addresses RNs only," says Moen. "Our board feels strongly that any type of legislative guidelines on staffing need to include the whole direct care team — LPNs, CNAs, and perhaps other types of providers like mental health and rehab units that need to be counted in the staffing pattern."

> "Everybody wants to see mandatory overtime go away, but only if it's done in some way that gives hospitals the flexibility they need to protect patients."

The target issue of the MNA, says Pinkham, is retention, while supply was the key concern of hospitalists. This latter concern is natural in light of the current nursing shortage, but it may not be as big a challenge in Massachusetts, she notes.

"We have the highest ratio of nurses per capita in the nation, and every single [nursing] school is full," Pinkham concedes. "But after three years, these nurses tend to leave the bedside; if we do not set a limit on working conditions, we will continue to lose these people."

She goes on to report that a number of nurses who have left the bedside "have told us they would return if the situation changed."

The numbers game

What exactly are the appropriate standards that should be established? "The limits in our bill for the ICU were no more than two patients per RN, which is also the recommendation of the Institute of Medicine and hard to negotiate around — and that's almost 50% of all beds," says Pinkham. "In med/surg, we say it should be 4-to-1." The bottom line, Pinkham says, is that "we have to have some leap of faith that the Department of Public Health will not abandon all scientific recommendations out of hand."

But Moen is not comfortable with hard-and-fast numbers. "We are very strong on the point that if there are going to be guidelines there needs to be flexibility around them," he shares. "What we're saying is, certainly hospitals and patients differ, and a one-size-fits-all approach ties management's hands as far as using the resources of the organization."

For example, Moen notes, when there is a huge influx of patients and conditions change rapidly, a hospital needs to maintain flexibility. "Or, for example, if you have a patient who is just about to be discharged, they may require only minimal staffing.

"We are not agreeing to something that's a hard-and-fast ratio by another name," he continues. "In reality, you will probably find that most ICUs are staffed that way [with two patients per nurse], but you can have an ICU where there are four patients but two are boarders — they are there for other reasons. In that case, should you have to adhere to that same level?"

Other states following suit?

The legislative moves in Massachusetts may only be the beginning of a developing national trend, says Pinkham. "I believe there are 14 states working on similar legislation," she reports. "And New York's may be even more aggressive than ours."

The states that pushed this type of legislation, she explains, were those that saw the highest penetration of managed care. "They saw big pressure to reduce LOS [length of stay], there were a lot of hospital closures and they really consolidated patients into a small number of beds," Pinkham says. "Since then, we've seen an increase in acuity. Now, we have the sickest of patients and an exodus of nurses from the bedside; it's a perfect storm."

As for whether the legislation becomes reality in Massachusetts, the jury is still out. "Everybody wants to see mandatory overtime go away, but only if it's done in some way that gives hospitals the flexibility they need to protect patients," insists Moen. "We've made a commitment to stay at the table, but we have certain lines we just won't cross; short of that, we are open for discussion."

References

1. Aiken LH, Clarke SP, Sloane DM, et al. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA* 2002; 288(16):1,987-1,993.

2. Needleman J, Buerhaus P, Mattke S, et al. Nurse staffing levels and the quality of care in hospitals. *N Eng J Med* 2002; 346:1,715-1.722.

3. Rothberg M. Improving nurse-to-patient staffing ratios as a cost-effective safety intervention. *Med Care* 2005; 543:785-791. ■