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IN THIS ISSUE

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GAO report is out — but with ASC system proposed, does it matter?

Agency: ASC cost is 84% of HOPD, when weighted by Medicare claims

It was mostly good news in a long-awaited report from the General Accounting Office (GAO) analyzing costs at ambulatory surgery centers (ASCs).[1]

In the report, GAO looked at the difference in costs between the hospital outpatient departments (HOPDs) and the ASC settings. The median cost ratio among all ASC procedures was 0.39, but it rose to 0.84 when weighted by Medicare claims volumes.

"Unfortunately, GAO provides a distorted picture of the cost of performing procedures in the ASC and HOPD," says **Marian Lowe**, vice president of federal health policy for Strategic Health Care, a firm that provides marketing, communications, and business development consulting in Washington, DC.

The 0.39 estimation leads to GAO's "unreasonable assertion" that ASCs can perform a procedure for less than 40% of what it costs a hospital to do the identical service, she says. "In their analysis that accounted for the procedures actually performed in an ASC — the weighted cost — GAO found that ASCs were performing procedures at 84% of a hospital's

EXECUTIVE SUMMARY

The General Accounting Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) have weighed in on costs at ambulatory surgery centers (ASC) compared to hospital outpatient departments (HOPDs).

- The GAO report says ASCs were performing procedures at 84% of a hospital's cost for the same service.
- GAO affirms that the upcoming ASC payment system should be based on the HOPD rate.
- The MedPAC report looked at three procedures and found no patient characteristics that should result in higher costs in either setting. The report also found reports of adverse events were low in both settings.

cost for the same service," Lowe says. "Eighty-four percent is in line with what we expected to see."

Craig Jeffries, Esq., executive director of the American Association of Ambulatory Surgery Centers, reports being pleased with the weighted average in the 84 range. That number is significant because it presents a "public policy target" that is higher than the 75% of the HOPD payment rate that ASC associations have been seeking through legislation and the 73% figure that the associations suggested in comments to the Centers for Medicare & Medicaid Services (CMS), based on the agency's budget neutrality formula, he says. The 84% is considerably higher than the 62% figure that CMS included in its proposed ASC payment system, he points out. "Clearly this will be utilized by Congress in their oversight function of CMS' implementation of the final rule on ASC payment," Jeffries says. The final rule is expected to be published in spring 2007.

Anything that addresses the 62% figure is beneficial; however, the 62% figure already has been proposed by CMS, which in many ways makes the GAO findings "insignificant," says **Kathy Bryant**, president of FASA. CMS is required to implement a budget-neutral system, so agency officials didn't examine costs, she points out.

The final conclusion of the GAO report is that the ASC payment system should be based on the outpatient prospective payment system (OPPS), and it should take into account the lower relative costs of procedures performed in ASCs. "Overall, we were pleased that GAO agrees that system of payment should be based on HOPD system that CMS proposed and that we've advocated for four years," Jeffries says.

The report also compared additional services billed with procedures performed in ASCs with those billed with procedures performed in HOPD and examined whether there were any Medicare payments associated with those services. These additional services include additional procedures, laboratory services, radiology, and anesthesia services.

The agency found that few of these services result in an additional payment in one setting but not the other. "This suggests that hospital patients are not significantly sicker than ASCs, or at least it didn't cost more to treat them," Bryant says. "It's an interesting conclusion that may be broader than just Medicare."

The GAO findings seem to be supported by a recent report from the Medicare Payment Advisory Commission (MedPAC), which looked at three services — cataract surgery, colonoscopy, and MRI of the head, neck, and brain — and determined "no single setting had consistently higher rates of [patient] characteristics that might increase the cost of the procedure."[2]

Bryant finds some vindication in that report. "Hospitals' strategy has been to argue that direct competition wasn't relevant, that we're really providing different care," she says. "All of these reports are saying, we're really providing similar care."

The report will be useful to MedPAC, Jeffries

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predicts. "Specifically, it will inform MedPAC staff on an earlier conclusion that they had drawn that there was a higher acuity level for patients in a hospital outpatient department than in an ASC, at least for ophthalmic and [gastrointestinal] procedures, which are highest volume for Medicare patients."

The MedPAC report also said rates of adverse outcomes were very low in all settings. There's never been any reports to suggest ASCs were doing procedures that weren't safe, Bryant says. Still, "any time a government body is providing information that shows, in fact, the complication rate is very low, I think it helps us," she says.

Lowe says the MedPAC report is further testament that ASCs are a safe and appropriate alternative to the hospital for outpatient surgical services. "Coupled with the GAO report and the new Medicare payment system, we can assure patients that the care they receive in an ASC is of equal quality, but less cost, than in a hospital outpatient department," she says. *(Editor's note: The American Hospital Association did not respond to requests to provide sources for an interview.)*

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2. Medicare Payment Advisory Commission. *Further Analyses of Medicare Procedures Provided in Multiple Ambulatory Settings.* Washington, DC; 2006. Web: www.medpac.gov/ publications/contractor_reports/OCT06_Multiple_Ambulatory_CONTRACTOR_INTRO.pdf. ■

ASC officials praise quality reporting initiative

Those who fail will face 2% penalty

Leaders of the ambulatory surgery community are praising Congress for passing a provision that requires the Centers for Medicare & Medicaid Services (CMS) to develop quality reporting requirements for ambulatory surgery centers and hospital outpatient services.

The provision requires a full inflation update to hospital outpatient and ambulatory surgical facilities that provide designated quality data starting no sooner than 2009. It also requires CMS to develop quality measures for hospital outpatient and ambulatory surgery services using national consensus organizations. Failure to report will result in a 2% payment penalty of the inflation update, according to the American Association of American Surgery Centers (AAASC).

CMS will post reported information on its web site for public viewing.

As the collection of quality data is integrated into the Medicare program in 2009, physicians and patients will have more data with which to make informed choices about their surgical care, reports **Marian Lowe**, vice president of federal health policy, Strategic Health Care, a consulting firm in Washington, DC. "I believe that a body of evidence will emerge to document the high-quality care physicians and the ASCs they practice in provide every day," she says.

Craig Jeffries, executive director of AAASC, says, "Congress has made an important step to help inform the public about their choices and the safety of ASCs and to utilize the work of national consensus organizations like the [National Quality Forum] in developing consensus standards." The National Quality Forum is a not-for-profit membership organization focused upon the development of quality measurement and reporting systems for health care. ■

CMS posts 2007 list of ASC procedures

The Centers for Medicare & Medicaid Services (CMS) has posted the 2007 list of Medicare-approved procedures for ambulatory surgery centers (ASCs). The list of HCFA Common Procedure Coding System (HCPCS) codes, including deletions/additions, and payment rates is effective for services performed on or after Jan. 1, 2007. The list is available at www.cms.hhs.gov/ASCPayment/01_Overview.asp. ■

Updated guidelines focus on monitoring pediatrics

Recommendations address before, after sedation

Updated guidelines for all medical and dental practitioners regarding the monitoring and management of pediatric patients during and after sedation have been developed jointly by the American Academy of Pediatrics and the American

EXECUTIVE SUMMARY

Updated guidelines address the management of pediatric patients during and after sedation.

- The staff must have a comfort level appropriate to the level of sedation. When more than mild sedation is used, a second professional trained in pediatric life support should be in the room.
- Providers should know pharmacokinetic and pharmacodynamic effects of the medications, should be educated on drug interactions, and have training and skills in airway management.
- Providers should have age-appropriate crash carts; up-to-date monitoring devices; child-sized face masks, intravenous lines, and breathing tubes; and protocols for contacting backup emergency services.
- Discharge instructions should include an emergency contact and information about side effects and how long the child should be monitored.

Academy of Pediatric Dentistry.

"This document goes into greater detail about the responsibilities of the person administering the sedatives and monitoring the patient as well as the responsibilities of the physician/dentist overseeing that person," says **Randall M. Clark**, MD, chair of the American Society of Anesthesiologists' (ASA) Committee on Pediatric Anesthesia.

The significance of the document is that it specifically recognizes that pediatric patients frequently need a deeper level of sedation to accomplish a procedure than an adult would need for a similar procedure, he says. "The practitioner must recognize that this puts the pediatric patient at greater risk than an adult in a comparable situation," he says. This document also discusses the concept that a greater depth of sedation than intended can frequently occur "and therefore the practitioner must be prepared and qualified to 'rescue' the patient from that deeper level."

Speaking from his personal viewpoint, Clark sees a troubling trend developing in pediatric outpatient surgery. Traditionally, pediatric anesthesiologists were asked, "Do you think we can take care of this child at the outpatient surgery center [OSC]?" "That, I think, is the proper question," he says. "It puts the onus on the caregivers to say, 'Have we met all of the tests necessary to take this child out of a care setting with significant backup — like a hospital — and put them in a setting with fewer safeguards?'"

Clark says the question now seems to be, "Why can't we do this child in an OSC?" "While the change is subtle, in this second scenario some children that are not appropriate for care in an OSC will slip through because no one spoke up ahead of time," he says. "This puts some of these pediatric patients at greater risk, in my personal opinion."

Take these steps to avoid trouble

To avoid treating a patient beyond the capabilities of your program, the guidelines recommend the following[1]:

• Appropriate fasting for elective procedures and a balance between depth of sedation and risk for those who are unable to fast because of the urgent nature of the procedure.

Health care providers should find out what a child has eaten or drank in the past 24 hours and identify any medical conditions or treatments that could complicate sedation, the guidelines say.[2] For instance, many children take herbal treatments such as St. John's wort or kava that can prolong the effects of anesthesia or deepen the level of sedation, according to anesthesia experts.[2]

• Age- and size-appropriate equipment for airway management and venous access, plus appropriate medications and reversal agents.

All programs administering pediatric sedation should have crash carts that are appropriate for the age of the patient, monitoring devices that are updated, and other equipment such as face masks that are sized for children, intravenous lines, and breathing tubes, according to the guidelines.[2] Also, programs need policies that are well established for contacting backup emergency services, the guidelines say.[2]

Zeev Kain, MD, chair of the ASA's Subcommittee on Pediatric Anesthesia and professor of anesthesiology, pediatrics, and child psychiatry at Yale University School of Medicine in New Haven, CT, says, "What I advocate is always predict the most extreme situation and make sure you can handle that situation. It will happen."

• Appropriate physiologic monitoring during and after the procedure. A properly equipped and staffed recovery area, recovery to pre-sedation level of consciousness before discharge from medical supervision, and appropriate discharge instructions.

When the pediatric patient has recovered from anesthesia, parents should receive an emergency contact number, information about potential side effects, and information about how long they

should carefully monitor their children, the guidelines say.[2] Parents also should be told that young children traveling home in car seats could stop breathing if they slump over while they are taking naps, the guidelines say.[2]

This danger is of special concern because car seats often lay infants somewhat on their backs and typically seat them backward, says **Melissa Ehlers**, MD, director of pediatric anesthesia at Albany (NY) Medical Center. "If you're alone in the car, you can't see what's happening," she says. Ehlers recommends that the parent has a second adult in the car to ride beside the infant.

Obviously, the issue of monitoring pediatric patients before and after sedation is a significant one for outpatient surgery providers, Kain says. "It is the biggest issue," he says. Always be prepared by considering the pharmacodynamics of medications such as chlorohydrate which can be long-lasting, and by ensuring that your discharge criteria are met. "If you've finished the procedure, that's nice, but you can't send them home until pharmacodynamically, this patient is ready to go," Kain says. **(See more recommendations, this page.)**

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2. American Academy of Pedatrics. New Guidelines for Sedation of Pediatric Patients Reinforce Safe and Proven Standards for All Medical Care Providers. Chicago; 2006. Web: www.aap.org/advocacy/releases/dec06sedation.htm. ■

SOURCE/RESOURCE

For more information on the guidelines for monitoring pediatric anesthesia patients, contact:

- **Randall M. Clark**, MD, 1601 E. 19th Ave., Suite 5300, Denver, CO 80218. Phone: (303) 278-4350. Chair of ASA's Committee on Pediatric Anesthesia.

The guidelines were published in the December 2006 issue of *Pediatrics.* They are available at pediatrics.aappublications.org. Click on "Past Issues" to access that issue, then click on "Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update."

Is your staff prepared to monitor a sedated child?

The biggest challenge for outpatient centers is having the anesthesiologists, anesthetists, sedation nurses, circulating nurses, and post-anesthesia care nurses who have the knowledge and experience to care for sedated pediatric patients, says **Randall M. Clark**, MD, chair of the American Society of Anesthesiologists' (ASA's) Committee on Pediatric Anesthesia.

"Beyond just the knowledge base, there is also an art to caring for pediatric patients that only comes from frequent and regular exposure to this population," he says. "These staff must have a comfort level that is appropriate to the level of sedation that is needed to accomplish the procedure."

Concerns from Randall and other pediatric anesthesia experts have led to the development of updated guidelines for all medical and dental practitioners regarding the monitoring and management of pediatric patients during and after sedation from the American Academy of Pediatrics and the American Academy of Pediatric Dentistry. The guidelines advise careful pre-sedation evaluation for underlying medical or surgical conditions that would place the child at increased risk from sedating medications. Also, no sedating medications should be administered without the safety net of medical supervision, they say.

Providers should have a sufficient number of staff to carry out the procedure and monitor the patient during and after the procedure, the guidelines say. In many procedures, the same health care provider is doing the procedure and providing the sedation, says **Zeev Kain**, MD, chair of the ASA's Subcommittee on Pediatric Anesthesia and professor of anesthesiology, pediatrics, and child psychiatry at Yale University School of Medicine in New Haven, CT. "That should not be the same person, and you should make sure they're not the same person," he says. "If you're doing a colonoscopy, you can't be focused on managing the airway."

If anything more than mild sedation is used, the new guidelines advise that a second professional trained in pediatric life support be in the room to monitor the patient's vital signs and assist in "any supportive or resuscitation measures if required."

Also, providers must have a clear understanding of the pharmacokinetic and pharmacodynamic effects of the medications used for sedation as well as an appreciation for drug interactions, the

guidelines say. They must have appropriate training and skills in airway management to allow rescue of the patient should there be an adverse response, they say.

The guidelines say that "sedation and anesthesia in a nonhospital environment (private physician or dental office or freestanding imaging facility) may be associated with an increased incidence of 'failure to rescue' the patient. . . . Rescue therapies require specific training and skills."

When a medication such as propofol is used on a child who continues to scream and move around, a provider may push the medication to a level of moderate sedation, Kain says. If the child still is agitated to the point that the procedure can't be conducted, a provider may push the sedation even more to the point of general anesthesia, he says. "The drug is capable of providing all these various aspects of the sedation, so you really have to appreciate that when you use a drug such as propofol." .

With medications such as phenobarbital, you have to be sure you can resuscitate the patients, intubate them, perform mask ventilation, and provide general anesthesia, Kain says. "You don't know when the patient is going to convert from talking to you to going apnea," he says. "That's the message that needs to be sent out there." ■

Gastroenterologists brace for potential 20% rate cut

Report offers ideas for surviving changes

According to a newly released report, reimbursement for gastroenterology procedures provided in surgery centers will decrease by as much as 20% in coming years, which will require a significant restructuring of many practices.[1]

In the proposed 2008 Medicare reimbursement system for ambulatory surgery centers, gastroenterology has been "singled out" for substantial deductions, says **Robert S. Sandler**, MD, MPH, vice president of the American Gastroenterological Association (AGA) Institute and chief of the Division of Gastroenterology and Hepatology, University of North Carolina, Chapel Hill.

Lobbyists are working to achieve a more generous final payment plan. However, many gastroenterologists have taken on significant debt to build their own centers, according to the report from the AGA Institute. The final result for them may be financial hardship, he says. "People need to be alert to that possibility," he says.

There may be options that can lessen the potential financial losses, according to the AGA report, which says that recertifying an ASC as an independent diagnostic testing facility (IDTF) may allow physicians heavily invested in ASCs to purse other developing diagnostic technologies and to buffer themselves from changes in reimbursement. The IDTF certification allows providers to perform radiological procedures, Sandler says. Providers need to perform six CT scans daily to make such an investment feasible, the report says. Additionally, some large gastroenterologists may find that an IDTF designation allows them to perform their own pathology work and capture those fees, Sandler says.

Gastroenterologists have been concerned that CT colonoscopy might become popular and replace screening colonoscopies. "If we were doing a lot of CT colonographies for screening, it could be done in an IDTF and kept within the GI [gastrointestinal] practice." Sandler says.

The report recommended that the AGA Institute provide detailed information and workshops that teach computed tomographic colonography (CTC) and how it may be incorporated into GI practice, including the potential transition from a designated ASC to IDTF. However, keep the "ifs" in mind when considering designation as an IDTF, Sandler advises. For example, a big "if" is whether CTC actually becomes popular and widely embraced, he says. "Now, it's thought to be experimental by some people," he says.

In fact, the report points to a "range of issues" with CTC, including its relative sensitivity, technological challenges, costs, and reimbursement issues. Currently CTC is not covered by Medicare. "However, local coverage decisions by specific third-party payers in 46 states allow for CTC for patients in specific clinical situations, such as incomplete colonoscopy for any reason," the report says.[1]

Another "if" is whether gastroenterologists are able and willing to read those examinations, Sandler says. "Most of people I talk to say gastroenterologists would be better to read the colon than the radiologists, so we're fully capable or reading the colon part of those examinations," he says.

Reference

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Same-Day Surgery Manager

My top suggestions to avoid fraud, theft in your program

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

Eventually, we will all be the victim of unscrupulous individuals that wish to plunder our coffers of supplies, cash, or other value at our facilities. The issue is not how to deal with it after it occurs (a nightmare), but rather how to prevent it in the first place.

All the holiday bills start rolling in, and people often get strapped for money. This is the time of the year that people get desperate. So this also is the time of the year for you to review some basic theft prevention procedures. Let me share some tips:

• **The business office.**

Some of the most significant issues here deal with the theft of cash, forgery, and bank fraud. The key to prevention is diligence. It's sad to say, but you really need to assume that each of your staff members is capable of thievery.

How to spot trouble: Whoever does your books — that is, who writes checks for you and enters them into a computerized general ledger system — needs to know that someone is looking over their shoulder. You need "checks and balances" to avoid problems. Using three individuals in the process effectively reduces your chances of theft.

One person should order supplies, another person should check the shipping statement to make sure they are all there, and the third should write and sign checks for payment. My strongest recommendation is that you have another person review the bank statements and canceled checks each month as well. Most banks do not submit the actual check to anyone. They give you the option to view it online, which most of us are too busy to do. You want the actual physical check to look at each month.

Why? Here is a common way crooks steal your money from your account. They go into your general ledger and make out a check to themselves or a fictitious individual. They print the checks to be paid, including the one made out to them. Once that check is printed, they stamp it with your name or simply forge the check and cash it. After the check is printed, they go back into the system and edit the check entry and change the payee to a real account. Unless you have the physical check to look at each month, you would never know what happened, and your account would balance each month.

Another method they use is to take a blank check and put a piece of tape over the Payee line. They print the check made out to a current, legitimate vendor, then remove the tape and put their own name on the check. Very effective.

So, diligence is needed in the business office.

• **Supplies.**

Don't for a moment think that your supplies are safe from plunder. There are countless situations in which staff members are selling supplies right out the back door of your facility. Do an audit of your supplies on a regular basis and randomly. Install a security camera on your loading dock — even if it is a nonworking model they sell at your local Radio Shack for about $20.

Also be alert for vendor counts on consignment supplies. For example, a vendor may say that you used 20 of an item, when your surgical case information shows you actually used 16. The vendor would be charging you for four that you do not use and getting credit for the sales.

• **Reputation.**

Your reputation can be stolen as well. You need to safeguard it like you do your other assets. So often I heard from surgeons working in a hospital or surgery center about poor turnaround times and start time inefficiency. In most cases, it is not true. However, the damage has been done when they tell other surgeons that you are not efficient.

Prevent that theft by posting your actual turnaround time on your web site and in the locker rooms. If they are bad, post the corrective action. If they are good, make sure everyone knows it! Don't hide your light under the basket, as they say.

Nasty stuff can happen out there. Prepare yourself.

(Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

Music soothes the soul, reduces anxiety in surgery

Tailor choice of music to patient and to setting

EXECUTIVE SUMMARY

Surgeons and nurses in the perioperative area have found that music can reduce anxiety, distract patients from pain, and give them a familiar sound upon which to focus during surgery.

- Avoid loud music that might offend patients, especially if they are awake for their procedures.
- If you provide music players to patients, keep infection control issues in mind as you choose headphones or speakers.
- Offer a wide variety of music to appeal to all patients, especially if the music will be played on a personal music player.

He receives requests for certain songs. People bring their own CDs for him to play. And there are days that everyone in the room is tapping their toes.

No, he's not a local disc jockey entertaining a group at a special event. He's a ophthalmologic surgeon.

"I started playing music 17 years ago during my residency, and I haven't stopped," says **Jamie Zucker**, MD, an ophthalmologic surgeon in Canton, OH. "My patients are awake during surgery, so music gives them something to focus upon, other than the surgery, and it relaxes them," he says.

The music fits in with his casual style in which he talks with the patient during surgery and tries to create an atmosphere of relaxation and calm, Zucker adds. "I don't play hard rock, and I don't play any music that is loud," he emphasizes. "Most of my music includes Frank Sinatra and big band music." While he's never had a patient complain about his music, he has some patients who bring their own CDs in for him to play during their surgery. "Whatever reduces their anxiety is fine with me," Zucker adds.

The hospital surgery department and the outpatient centers at which he performs surgery all have a sound system to enable surgeons to play music, says Zucker. While the technology exists for personal music players to plug into some systems, it always is a good idea to keep a stock of CDs with you, he suggests. "I do keep my iPod with me as well because it does contain so many more songs," he adds.

The legal department at Children's Hospital in Columbus, OH, wasn't sure about copyright laws related to iPods and other personal music players, so the perioperative staff stuck with CDs for its music program for surgery patients. Known as CALM, an acronym for Calming Anxieties through Listening to Music, the program has been in place for almost two years. "We know that research has shown that music reduces anxiety and distracts patients from pain," says **Andy Zarrelli**, RN, RN care manager at the hospital. "We started with an eight-week evaluation of the program to see if our plans would work and if the reaction of patients and parents was positive," she explains.

Not only was the reaction to the pilot program positive, but also the hospital is looking at expanding the program to its family waiting room, and the hospital marketing department is planning to include the program in marketing efforts, says Zarrelli.

"We started by purchasing 30 CD players and 30 pillow speakers [manufactured by C. Crane, Fortuna, CA]," she reports. Small pillow speakers that hang in a pouch on the bed were chosen when the infection control department expressed concern about using headphones that could not be cleaned adequately, she says. "If a patient brings in his or her own CD player and headphones, that is OK," Zarrelli adds.

A combination of different types of music CDs purchased with a donation of a few hundred dollars from a local community group and CDs donated by families formed the beginning of the CD library. "We listened to all of the CDs, paying close attention to lyrics, then we classified each one," she says. **(See resource box for web sites that provide lyrics, p. 25.)** A simple color code system is used to designate type of music such as country or gospel, as well as the range of ages most likely to enjoy the music, she says. A supply of rechargeable batteries was purchased, and volunteers in the surgery department as well as staff members make sure that there are always fresh batteries in the players and other batteries are being charged, says Zarrelli.

'Works best with less paperwork'

Checkout of the players or the CDs is simple, says Zarrelli. "We considered a checkout log and someone assigned to oversee the inventory, but

SOURCES/RESOURCE

For more information on music in the perioperative setting, contact:

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Several web sites provide lyrics to most popular or current music to make review of the age-appropriateness easier for staff members. A few of the web sites are www.azlyrics.com, www.lyricsplanet.com, and www.smartlyrics.com.

we decided the program works best with less paperwork," she says. Because the speakers hang in a special pouch made by a child life specialist on staff, it is pretty obvious that the CD player and speaker belong to the surgery department, not the patient, she adds. "Although we set the original guideline that the CD player and speaker don't leave the perioperative department, if we have a child that needs to be admitted or moved to another area, we have let it go with the patient if it is calming him or her," she says. The numbers of CD players that have disappeared is minimal, she adds.

Although she has not done a formal study on the program's effects, Zarrelli says a simple questionnaire that asks patients or their parents if they felt as if the music helped them stay calmer resulted in overwhelmingly positive responses. "Nurses also noted positive changes in their vital signs and that patients rested more easily with music," she says. ■

Tie competency process to performance appraisals

Start with regulatory, accreditation requirements

(Editor's note: This is the first of a two-part series that examines the components for a successful competency assessment program in outpatient surgery. This month, we look at the essential components of a program, and next month we'll look at some of the components that outpatient surgery programs routinely neglect to put in their competency assessments.)

A good competency assessment program for an outpatient surgery program should encompass skills that relate to each employee's job and specific patient populations served and should apply to all employees, according to experts interviewed by *Same-Day Surgery*.

The most effective competency programs are actively linked to job descriptions, orientation checklists, and performance appraisals, **Dawn Q. McLane**, RN, MSA, CASC, CNOR, chief development officer of the Nikitis Resource Group, a consulting firm based in Broomfield, CO. The documentation of the competency assessment should be incorporated into the performance appraisal process so that the competency assessment documents are submitted along with the employees' own self-appraisal, McLane recommends. "This is a successful motivator when each employee knows that they cannot complete the appraisal process and get their maximum pay increase without also completing the competency process," she explains.

There are different challenges for hospital-based programs and freestanding or office-based programs when developing competency assessment programs, admits McLane. "All of the employees within the hospital-based outpatient surgery program have similar jobs, mostly clinical," she says. "The difficulty for the freestanding center is that there are so many different types of jobs such as business office, admissions, and nursing." The challenge of creating appropriate competencies for a wide range of jobs is magnified by the limited

EXECUTIVE SUMMARY

Many outpatient surgery managers are looking for ways to improve the effectiveness of their competency assessment programs.

- Link the competency assessment process to the performance appraisal process to emphasize the importance.
- Address requirements of accreditation and regulatory organizations.
- Evaluate specific needs of your facility.
- Re-evaluate competency program on an annual basis to make sure that competencies are still current with accreditation, training, and regulatory requirements.

resources, McLane adds. "A hospital-based program has access to the education, risk management, and infection control departments for help," she points out.

Another challenge for freestanding centers is the fact that accreditation organizations have not always required the same level of competency assessments from freestanding centers as in hospitals, says **Marcy Grow-Dorman**, RN, BSN, ambulatory surgery center director at Orthopedic Sports Medicine Center in Elkhart, IN. "Years ago, surveyors did not understand ambulatory surgery centers well and didn't require as much competency assessment," she says. Newer surgery centers are doing well meeting competency assessment requirements because surveyors have been requiring stricter adherence to standards recently, Grow-Dorman says. "Those centers that have been open for a while have had to change the way competency assessments were handled to meet the more rigorous requirements," she says. For example, making sure that a competency assessment addresses core competencies as well as competencies specific to the employee's job is important, Grow-Dorman adds.

The basic requirements for any competency program should include the following areas, according to McLane:

- Any area required for annual review by accrediting organizations or regulatory bodies such as federal requirements for bloodborne pathogens or exposure control plans.
- Organizationwide requirements that are specific to your institution such as policies, staffing, scheduling, and human resources.
- Role- or job description-specific competencies for each employee to include core competencies for all people in a certain category, such as nursing, and role-specific competencies that focus on the individual's job, such as equipment competencies for the surgical nurse.

Once you've developed your competencies, don't assume that they won't change, Grow-Dorman says. "You must re-evaluate the competencies on an annual basis," she advises. Biohazard handling requirements, basic and advanced cardiac life support certification, and other issues are constantly changed and updated by regulatory or research organizations, she points out.

"I find that the Association of periOperative Registered Nursing competencies are a good starting point," says Grow-Dorman. **(See resource box, left.)** "Then you must look at your facility and your patient population to identify additional competencies for your staff." ■

SOURCES/RESOURCE

For more information on developing competency programs, contact:

- **Marcy Grow-Dorman**, RN, BSN, Ambulatory Surgery Center Director, Orthopedic Sports Medicine Center, 2310 California Road, Suite B, Elkhart, IN 46514. Phone: (574) 970-4454. E-mail: mgrow-dorman@osmc-online.com.
- **Dawn Q. McLane**, RN, MSA, CASC, CNOR, Chief Development Officer, Nikitis Resource Group, 4962 Democrat Drive, Broomfield, CO 80020. Phone: (303) 828-4996. E-mail: DAQuay@aol.com.

To order a copy of the Association of periOperative Registered Nursing (AORN) competency assessments, go to www.aorn.org. Under "Products," choose "bookstore." Type "PNDS" in the keyword search box, then scroll down to "Kleinbeck: PNDS@Work: Clinical Competencies and Job Descriptions." The cost is $20 for non-AORN members and $15 for AORN members. The book can be ordered online or by calling customer service at (800) 755-2676.

Task force releases report on TASS outbreak

No single factor identified as cause

A total of 113 cases of toxic anterior segment syndrome (TASS) were evaluated by the TASS task force set up by the Fairfax, VA-based American Society of Cataract and Refractive Surgery (ASCRS) since the increased incidence of TASS that began in early 2006.

TASS is a postoperative, acute inflammation in the anterior segment of the eye as a result of the introduction of a noninfectious, toxic substance during ophthalmic surgery. The toxic substance causes serious and potentially irreversible damage to intraocular tissue. **(See "Surgery providers warned of TASS outbreak," *Same-Day Surgery*, June 2006, p. 72.)** The task force's final report concludes that there is no single factor responsible for the outbreak, but it identifies a number of potential factors that might contribute to TASS:

- Short amount of time between cases to

reprocess and clean instruments.

• Use of reusable cannulated instruments that are not properly cleaned. Ultrasound hand pieces or other hand pieces used for irrigation and aspiration should be flushed thoroughly and immediately at the end of the case. The task force recommends the use of sterile, deionized/distilled water for flushing.

• Improper rinsing of instruments cleaned between cases with water baths, enzymes, or detergents. Enzyme or detergent residue on the instruments may cause TASS.

• Improperly cleaned ultrasound baths used to clean ophthalmic instruments. They should be emptied and cleaned after each use or at least at the end of the day to prevent the contamination of the water with gram-negative bacteria.

• Endotoxin contamination with the sterilizer. Steam sterilizer filters, water chambers, and inside of autoclave units should be cleaned thoroughly according to manufacturers' recommendation on a regular basis to prevent contamination by an endotoxin within the sterilizer.

• Additives that are not preservative-free. Medications placed into the eye must be preservative-free. The task force identified the addition of epinephrine to the balanced salt solution to maintain pupilary dilation as a potential problem. Epinephrine containing preservatives or stabilizing agents such as bisulphites or metabisulphites can be toxic to the corneal endothelium and other cells within the anterior segment.

• The use of intracameral anesthetics. Not only should the anesthetic be preservative-free, but the dose of the anesthetic should not be highly concentrated when injected into the anterior chamber of the eye. It should also be thoroughly diluted and flushed from the eye at the conclusion of the case.

Not mentioned in report

While he praises the task force's recommendations, **Lawrence F. Muscarella**, PhD, director of research and development for Custom Ultrasonics in Ivyland, PA, and editor of *The Q-Net Monthly*, points out that the report does not mention the use of low-temperature sterilizing agents as a potential source of TASS. Sterilizers that use peracetic acid, hydrogen peroxide, or plasma gas to sterilize ophthalmic instruments can oxidize nickel or chrome-plated brass hubs to create copper and zinc compounds, which can be toxic to the cornea, he says. It is important that surgery managers be aware of the issues that led to the removal of the ABTOX Plazlyte system in the 1990s, he adds. **(For more information, see www.fda.gov/cdrh/abtox.html.)**

To see a full copy of the Task Force's final report, go to www.ascrs.org. Choose "press releases" on the navigation bar at the bottom of the home page, then select "Final TASS Report." ■

Silicone implants approved for U.S.

The Food and Drug Administration (FDA) has approved the use of silicone breast implants. This decision comes 14 years after the FDA restricted access to the silicone implants because of safety concerns.

The FDA decision followed a lengthy process

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the **June** 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

- Colonoscopy best practices revealed
- Study shows risks of herbal medicines prior to surgery
- 2 surgical approaches to common medical problem: Which is best?
- Cost-saving tips from your peers

in which the agency sent "approvable with conditions" letters to the two silicone breast implant manufacturers in the second half of 2005. The approvable letter stipulated conditions that the manufacturers needed to satisfy to receive FDA final approval to market and sell silicone breast implants. These letters came after an FDA advisory panel hearing in April 2005 in which the panel heard more than 20 hours of data presentations from the manufacturers and public comment.

Approximately 300,000 women chose breast augmentation in 2005, according to statistics from the American Society of Plastic Surgeons (ASPS) and from the American Society of Aesthetic Plastic Surgeons. Nearly 58,000 women had breast reconstruction in 2005, according to ASPS. ■

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.

5. According to updated guidelines for managing and monitoring sedated pediatric patients, when should a second professional trained in pediatric life support be in the room?
A. In all cases.
B. When more than mild sedation is used.
C. Only when the heaviest sedation is used.
D. Never

6. What is one option for gastroenterologists who are concerned that CT colonoscopy might become popular and replace screening colonoscopies, according to a report from the American Gastroenterological Association (AGA) Institute?
A. Hire radiologists.
B. Outsource the CT colonoscopies.
C. Convert to an independent diagnostic testing facility (IDTF).
D. None of the above

7. Why did the staff at Columbus Children's Hospital choose pillow speakers for the perioperative music program rather than headphones, according to Andy Zarrelli, RN?
A. Cost was less.
B. Speakers were donated.
C. Patients don't like headphones.
D. Headphones cannot be cleaned adequately.

8. In addition to providing additional training on patient transfers, what else did the staff at San Leandro Surgery Center receive to help prevent patient falls, according to Jeanne Linda, RHIT, CPMSM, CPHQ?
A. Additional staff
B. Fewer patients
C. Transfer belts and boards
D. A new paging system

Answers: 5. B; 6. C; 7. D; 8. C.

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Don't wait for a patient fall in your facility: Evaluate your program now to address issues

NPSGs, standards require risk assessment, prevention

San Leandro (CA) Surgery Center typically experienced one or two patient falls a year, so managers were shocked when three falls occurred in a three-month period in early 2006. Those falls led to development of a prevention program that has been honored with an Innovations in Quality Award from the Accreditation Association for Ambulatory Health Care.

The center has tracked patient falls in its quality improvement data since 2001, but with so few falls, there was no indication that there was an increasing risk, says **Jeanne Linda**, RHIT, CPMSM, CPHQ, director of medical staff services and quality review for the center. Following the series of three falls, the staff performed a root-cause analysis of each incident, she says. One of the causes identified was a number of new staff members who had less experience with patient transfers, Linda says. "We identified the need for more education for all staff members related to patient transfers, more patient education, and more active communication between staff members."

It was important that active communication be emphasized because nurses are accustomed to handling things by themselves, and they often are reluctant to call out for help, says **Sheila L. Cook**, executive director of the center. Although everyone is busy, every staff member should be comfortable calling out, "I'm having trouble here," she says. "In our follow-up educational programs, we gave everyone permission to ask for help because it not only protects the patients if the nurse is having trouble with the transfer, but it also protects the nurse from injury as he or she tries to catch a falling patient."

In addition to encouraging staff members to ask for help, an ergonomics expert was brought to the center to conduct an inservice on the proper techniques for transferring patients, says Linda. **(For information on the ergonomics company, see resource box, p. 2.)** "It was a 2½-hour educational and hands-on workshop in which we practiced transferring patients in different situations," she says. Staff members learned how to transfer patients between chairs and gurneys as well as from wheelchairs to cars, she says.

Staff members also learned how to use tools such as transfer boards and transfer belts, says

EXECUTIVE SUMMARY

Patient falls in an outpatient surgery program are not common but are increasing as sicker patients, patients undergoing lengthier procedures, and patients on more medications are seen.

- Make sure nurses know to ask for help if they have difficulty transferring a patient.
- Teach staff members the proper way to transfer patients to ensure the safety of patients and staff members.
- Include falls risk assessment in all preoperative assessments.

Financial Disclosure:
Author Sheryl Jackson, Senior Managing Editor Joy Dickinson, Associate Publisher Coles McKagen, and Board Member and Nurse Planner Kay Ball report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Mark Mayo reports that he is an employee of Symbion Healthcare.

Linda. "We weren't using any tools to help with patient transfers before we evaluated the program," she says. "Now, the staff is confident that transfers are safer for themselves and for patients because there is more support for the patient."

Assess patient risk for falls early

There are several reasons to focus on patient falls as both a quality improvement program and a patient safety issue, says Linda.

"Not only do accreditation standards require that we ensure patient safety, but it is important to involve the staff in identifying and solving problems," she says. **(For accreditation-related issues, see p. 3.)**

The experience at the San Leandro center is not isolated, says **Susan R. Chmieleski**, APRN, FASHRM, JD, vice president of risk management and client services for Farmington, CT-based Darwin Professional Underwriters. "Our company has only been writing malpractice insurance for ambulatory surgery centers for three years, but during that time we have seen claims related to patient falls increase," she says.

An increase in falls in an outpatient surgery setting is not surprising when you consider that as more procedures and as older patients are moved into outpatient surgery, the staff are seeing patients with more medical problems and at higher risk for falling, Chmieleski says. "Some procedures that are now only performed as outpatient procedures, such as cataract surgery and colonoscopy, are routinely performed on elderly patients who have balance problems or a history of falls," she says. "Add anesthesia and a lack of food for a period of time before surgery, and you increase the chance for dizziness and falls." For these reasons, every outpatient surgery program should have a risk assessment for falls built into their pre-surgical assessment form, she recommends. Patients who are at higher risk for falls can be identified by age, medications, visual impairment, or medical conditions such as diabetes or obesity, says Chmieleski. While you should ask all patients about their history of falls or problems with balance and you should be aware of all medications that might affect balance, be especially alert to patients who are in the higher risk category, she suggests.

Don't forget to look at the type of surgery and anesthesia that the patient will undergo, says Cook. "Age is not as much of a factor in assessing falls risk as the type of anesthesia," she explains. "We've seen an increase in the use of blocks, and a 28-year-old undergoing an orthopedic procedure who doesn't have full control of his legs will fall just as easily as a 70-year-old."

Once the risk for falling is determined, be sure that the patient is not left alone, Chmieleski says. "Most falls occur when a staff person is not immediately present and the patient attempts to go to the toilet or move off the bed," she says. Although many outpatient surgery programs allow family members to be with the patient during the final stage of recovery, be sure that the family members understand the risk of falls, Chmieleski says. "Everyone forgets that outpatient surgery is serious, and family members see the patient talking and feeling fine. They forget that anesthesia can affect balance," she says.

Staff members not only should educate the patient and instruct them not to move around without a staff person present, but they also should inform family members of the risk of falls, says Chmieleski.

Another key part of education for orthopedic patients is instruction on how to use crutches, points out Chmieleski. "This is probably the first time the patient has used crutches, so teach the patient before surgery and before any medication is administered," she suggests. Let them walk with crutches on carpet as well as a smooth surface such as a linoleum floor, she says.

A surgery program's responsibility doesn't end at the front door of the center, so make sure that the sidewalk is in good repair and that it is easy to get from a wheelchair to the car, says Chmieleski. "Be sure, too, that family members are prepared to help the patient from the car into the house and that they understand how long the effects of anesthesia might affect the patient," she says. "Just because you are not legally responsible for a fall that occurs in the home, ethically, you should make sure the patient and family understand the risks." ■

RESOURCE

For information about ergonomics training, contact:

- **Onsite Ergonomics** Inc., P.O. Box 3938, Walnut Creek, CA 94598. Telephone: (925) 673-3009. Fax: (925) 476-1566. The company provides worksite ergonomics training to a variety of industries, including health care. Price is determined by needs, number of employees, and number and type of educational sessions.

Standards focus on risk assessment

Falls NPSG applies only to hospital-based programs

One way to make sure your outpatient surgery program is covering all of its bases to prevent patient falls is to carefully review accreditation standards and National Safety Patient Goals, says **Jeanne Linda**, RHIT, CPMSM, CPHQ, director of medical staff services and quality review at San Leandro (CA) Surgery Center.

Although her center is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), Linda also reviews the Joint Commission on the Accreditation of Healthcare Organizations' National Patient Safety Goals, especially the goal related to prevention of patient falls (Goal 9).

Although Goal 9 of the NPSGs applies only to outpatient surgery programs surveyed under hospital standards, there are standards that require ambulatory and office-based surgery centers to look carefully at assessing patients' risk for falls, says **Virginia McCollum**, RN, MSN, associate director of the standards and interpretation group at Joint Commission. "Standard EC.1.10 requires managers to assess the safety risks to patients. An organization should assess a patient's risk for falling during the initial assessment," she says. Evaluate the patient's age, medications, and the patient or family member's reports of previous falls, she suggests.

Look carefully at the physical environment of your facility as well, suggests McCollum. "Hallways should be at least 44 inches wide, and floors should not be slippery," she points out. Bathrooms should be designed to follow the guidelines set by the American for Disabilities Act, McCollum adds. "Hand bars, emergency call lights, and railings on the beds are all important," she says.

Surgery programs are responsible for the safety of patients outside their doors even if they do not own the building, McCollum says. Because surveyors trace a patient's entire trip through the visit to the surgery program, the condition and location of the parking lot, the patient drop-off area, sidewalks, hallways, stairs, and elevators will be evaluated, she adds. "Work with the owner of the building to make sure that all safety requirements are met," McCollum suggests. Make sure that the building owner knows to check for cracks in the sidewalk, uneven pavement in the parking lot, and icy patches during the winter, she adds.

Monitor incidents and evaluate reasons for falls on an ongoing basis, suggests McCollum. "Once you've evaluated the reasons for falls, be sure to develop and implement plans to reduce the risk of future falls," she adds.

It is best to be proactive, says Linda. "Even one fall can be devastating to the patient, the staff, and the facility," she says. ■

RESOURCES

- **Joint Commission on Accreditation of Healthcare Organizations'** web site has a frequently asked question section related to the patient falls' National Safety Patient Goal. While this goal applies only to hospital-based programs, it offers guidance on development of a falls prevention program and suggests resources. Web: www.jointcommission.org. Under "Patient Safety" on top navigational bar, click on "National Patient Safety Goals." Under "2006 Resources," look for "Frequently Asked Questions." Choose "Goal 9."
- **The National Guideline Clearinghouse** offers research and clinical practice guidelines on a range of health care issues. Go to www.guideline.gov and type "falls prevention program" in the search box. More than 60 guidelines appear, including: *Guideline for the Prevention of Falls in Older Persons.* American Academy of Orthopaedic Surgeons — Medical Specialty Society, American Geriatrics Society — Medical Specialty Society, British Geriatrics Society — Medical Specialty Society. 2001 May. Nine pages. NGC:002199.

Surveyor in the ceiling, and one patient scheduled

Be ready every day for your survey

When she read the news stories and alerts from Joint Commission on Accreditation of Healthcare Organizations about fake surveyors, **Suzanne L. Broome**, RN, center director of Blue Ridge Surgery Center in Seneca, SC, instructed her staff to be sure to check the identification of anyone who claimed to be a surveyor. A few days later, when only one case was scheduled and all

SOURCES

For more information about survey experiences, contact:

- **Suzanne L. Broome**, RN, Director, Blue Ridge Surgery Center, 10630 Clemson Blvd., Suite 200, Seneca, SC 29678. Telephone: (864) 482-5100. E-mail: sbroome@broa.com.

staff members except Broome and one other nurse were off for the day, the receptionist called her to say that the Joint Commission surveyor was in the lobby.

"I play practical jokes on my staff, so I thought this was a joke on me," says Broome. The timing of her instructions to the staff about identification checks and the lack of staff at the center made her respond to the call with, "Don't pull my leg," she says.

It was a Joint Commission surveyor, and he spent the first of his two days at the center looking at policies and examining the physical facility because of the lack of patients to trace or staff members to interview, she says. There were no surprises with the questions the surveyor asked, but Broome was surprised by his detailed examination of the building. "He asked for a ladder, then climbed up to look into the ceiling and check the firewalls," she recalls. "He made sure that the firewall did go all the way up to the ceiling and that there were no unsealed holes in the wall."

The surveyor also looked carefully at a performance improvement project conducted by Broome's staff. "We studied antibiotic reactions that occurred in two patients to determine the cause of the reaction and prevent future reactions," she says. "We discovered that we infused the antibiotic too quickly, and we retrained our staff to make sure we prevented future reactions." While Broome thought the performance improvement study fulfilled requirements, the surveyor indicated that he would prefer to see a proactive as opposed to a reactive study.

"This year, we are surveying our physicians to determine satisfaction levels," says Broome. "We have undergone staffing changes and added new equipment, so we believe this will be a good proactive study to identify any potential dissatisfaction before we hear complaints."

The performance improvement study that resulted in standardized forms to collect patient and procedure information received high marks from the surveyor who visited Rogers Park One Day Surgery Center in Shelby, NC.

"Standardized forms eliminate the opportunity to miss information or signatures that are needed for consent forms and other surgery forms," says **Evan Giline**, RN, director of nursing for the center.

While the surveyor did trace a patient's progress through the center, there were no surprises related to clinical care, says Giline. However, they do need to redo their handwashing policy, she says. "Some of our staff members were not washing their hands between patients because they were changing gloves between patients," Giline says. The surveyor pointed out the need to wash hands between patients, even if new gloves are used for each patient, she adds. "We are re-educating staff members about all aspects of hand washing, including how to wash, when to wash, and how to scrub nails," she says. ■

AAAHC announces new standards

The board of directors of the Accreditation Association for Ambulatory Health Care (AAAHC) recently adopted revisions to its standards. Changes include:

- Significant revisions to Chapter 17, now titled "Diagnostic and Other Imaging Services,"to ensure standards apply to the wider range of imaging services performed in ambulatory health care settings. Revised areas include the definition of imaging services; standards for health care professionals who provide or interpret services or results; patient and personnel safety; and standards affecting orders for services, reports, quality assurance, and records' storage.
- Revisions to Chapter 9, "Anesthesia Services," to clarify the standards' recommended monitoring of exhaled CO_2 during the administration of deep sedation, as well as the monitoring of end-tidal CO_2 and the measuring of body temperature during the administration of general anesthesia.
- An addition to Chapter 8, "Facilities and Environment," to underscore safety and security precautions.

Standards revisions will be incorporated into the 2007 version of the AAAHC *Accreditation Handbook for Ambulatory Health Care* and will take effect in March 2007. ■