30th Anniversary

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IN THIS ISSUE

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When you have a serious adverse event should you apologize, waive charges?

University of Michigan system cuts number of pending cases by 80%

How would you like to drop the number of cases pending against your program by more than 60%? A full disclosure policy that includes apologizing to patients and waiving charges on a case-by-case basis has had a dramatic impact on the outpatient surgery program and other departments at University of Michigan Health System in Ann Arbor. As part of the policy change, system administrators determined that there would be no settling when lawsuits were without merit. The number of cases dropped from 262 in August 2001 to fewer than 100 in January 2007. While hospital administrators won't go as far as saying that the entire decrease is due to the change in policy, the new policy was implemented in 2002.

Often administrators fear they will face financial catastrophe with a transparency approach to unanticipated outcomes, says **Richard C. Boothman**, chief risk officer at the University of Michigan Health System. "What we can say is that we have not seen financial disaster by being open and honest with disgruntled patients and families," he says.

Most of the time, when people bring a lawsuit, it's not for revenge or attribution, says **Charles Boyd**, MD, MBA, FACS, associate chief of staff

EXECUTIVE SUMMARY

Apologizing for serious adverse events to patients and their families can help decrease your liability.

- Two national groups of employers have called on hospitals to apologize and waive charges for 28 "never" events, including several surgical mistakes.
- The University of Michigan Health System saw its cases drop from 262 to fewer than 100 after it took a full disclosure approach that included apologizing and not settling cases that were without merit.
- Look at waiving charges on a case-by-case basis, experts advise.

at the health system and system professor in facial plastic surgery at the University of Michigan. "It's really to get answers, Boyd says. "That was the impetus for our policy."

Because the hospital is self-insured, fewer claims helped lead to a lowering of physicians' malpractice rates and eventual paybacks to the hospital of about $20 million, Boyd reports. However, the health system did pay increased attorneys' fees in the early years of the policy as they tried more cases to a verdict, Boothman says. Additionally, the health system is spending more on risk management and pro-activity, he says.

Apologizing for adverse events recently has come into the spotlight with a call from two national groups for hospitals to apologize and waive charges when certain "never" events occur. The Leapfrog Group, which is a Washington, DC-based national coalition of large businesses such as General Motors, and the Midwest Business Group on Health, a Chicago-based business coalition that represents dozens of employers, say hospitals should take these actions when one of 28 adverse events occurred. That list of events includes:

- unintended retention of a foreign object in a patient after surgery or other procedure;
- surgery performed on the wrong body part;
- surgery performed on the wrong patient;
- wrong surgical procedure performed on a patient;
- intraoperative or immediately postoperative death in an ASA Class I patient. **(For information on how to access the most recent list of never events, see resource box, p. 31.)**

In some states, words of sympathy are legally protected. **(See list, p. 31.)**

The action from The Leapfrog Group and the Midwest Business Group on Health follows a policy a couple of years ago by HealthPartners, Minnesota's third-largest insurer, to not pay hospitals and surgery centers for cases involving serious adverse events. **(See "Insurer says facilities won't get paid when serious adverse events occur," *Same-Day Surgery*, January 2005, p. 1.)**

Lawyer: Apologizing generally is a good idea

Apologizing can reduce the likelihood of a lawsuit, says **Ken Braxton**, partner with Stewart & Stimmel in Dallas and a medical malpractice litigator.

"I think what it does is that it gets over the hump of the patient thinking, 'You might be hiding something from me,'" he says. "It gets rid of the feelings of anger that may come up."

At Indiana Methodist Hospital in Indianapolis, a transparency approach to adverse events means a patient advocate joins the surgery staff in notifying patients and/or family members about any adverse events. "We want to make sure that when an incident occurs, we are the first to advise and notify the family and tell them what we are doing to correct situations." Indiana Methodist made national headlines in 2006 when staff publicly

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apologized to the families of three premature infants killed by a drug overdose.

Indiana's transparency policy regarding adverse events includes an online incident reporting system for staff and the public. One advantage of this policy is that it lets patients know the doctors and nurses are human and capable of error, says **Lee Williams**, MSN, RN, director of clinical operations for the perianesthesia nursing division. "By operating in an honest forum, it gives people the best opportunity to know what to expect, to know we're diligent about correcting any negative connotations toward our surgery."

3 tips regarding adverse events

Consider these suggestions when addressing your policy on adverse events:

• Follow your state law, and be straightforward with patients.

Be very candid with your patients when apologizing, Braxton suggests. "They're part of the team," he says. The message you should convey to the patients is, "We want to get through this together," he says.

Speak at a level that patients and family can understand, Williams advises. "You don't want to confuse them at all," he says.

Also ensure you are complying with your state regulations with the apology, Braxton advises.

• Approach area plaintiff's lawyers to notify them of policy changes.

When the University of Michigan went to a full disclosure policy in 2002, they went to area lawyers to let them know "business as usual" was not going to occur, Boyd says.

"If we felt we were in error, we would admit it to the family and patient, then we would try to settle the case," he says. "If we felt we were not, we would fight them aggressively."

RESOURCES

- **For more on the University of Michigan Health System approach**, go to www.med.umich.edu/news/umhsm.htm/
- **To see The Leapfrog Group's sample policy**, go to www.leapfroggroup.org/for_hospitals/never_events. Click on the hyperlink where it says "Sample hospital policy, as it will appear on Leapfrog's 2007 Hospital Quality and Safety Survey." To see the list of 28 reportable events, click on the policy and follow the hyperlink, or go to www.qualityforum.org/pdf/news/prSerious Reportable Events10-15-06.pdf.
- ***The Sorry Works! Coalition* is a national group** advocating a formal apology program for medical errors. For information, go to www.sorryworks.net.
- **To see an article titled "**Disclosure of medical errors — Is honesty the best policy legally?" go to www.abanet.org/health/esource/vol2no5/braxton.html.

State Laws that Protect Words of Sympathy

- **Arizona**: A.R.S. § 12-2605 (2005)
- **California**: Evidence Code §1160 (2000)
- **Colorado**: Revised Statute §13-25-135 (2003)
- **Connecticut**: Public Act No. 05-275 Sec. 9 (2005)
- **Delaware**: HB 412 (2006)
- **Florida**: Stat § 90.4026 (2001)
- **Georgia**: Title 24 Code GA Annotated 24-3-37.1 (2005)
- **Hawaii**: HRS Statute § Sec. 626-1 (2006)
- **Illinois**: Public Act 094-0677 Sec. 8-1901 (2005)
- **Louisiana**: R.S. Statute § 3715.5 (2005)
- **Maine**: MRSA Statute § 2908 (2005)
- **Maryland**: MD Court & Judicial Proceedings Code Ann. § 10-920 (2004)
- **Massachusetts**: *ALM GL* ch. 233, § 23D (1986)
- **Missouri**: HB 393 (2005)
- **Montana**: H.R. 24 59th, Leg. (2005)
- **New Hampshire**: RSA § 507-E:4 (2005)
- **North Carolina**: General Stat §8C-1, Rule 413
- **Ohio**: ORC Ann §2317.43 (2004)
- **Oklahoma**: 63 OKL. St. § 1-1708.1H (2004)
- **Oregon**: Rev. Stat. Statute § 677.082 (2003)
- **South Carolina**: Ch. 1, Title 19 Code of Laws 1976, 19-1-190 (2006)
- **South Dakota**: H.R. 1148 Eighth Leg. (2005)
- **Tennessee**: Evid Rule § 409.1 (2003)
- **Texas**: Civil Prac and Rem Code Statute §18.061 (1999)
- **Vermont**: S 198 Sec. 1. 12 V.S.A.§ 1912 (2006)
- **Virginia**: Code of Virginia § 8.01-52.1 (2005)
- **Washington**: Rev Code Wash §5.66.010 (2002)
- **West Virginia**: HB 3174 (2005)
- **Wyoming**: Wyo. Stat. Statute §1-1-130

Source: Aon Corp., Chicago.

• Establish a medical liability and review committee.

The University of Michigan established a Medical Liability and Review Committee, which Boyd co-chairs. The committee, which is multidisciplinary and multispecialty, includes lawyers and administrators. The group meets monthly. When the health system receives a notice of intent to sue, representatives of the risk management and quality departments interview the staff to determine the facts of the case. Members of the committee review each case to determine if there was a violation of the standard of care. The committee also examines whether the care adversely impacted the patient's outcome. A second committee, the Claims Management Committee, includes three physicians including the chief of staff, two financial officers, an insurance specialist, the chief risk officer, and the risk management director. This group makes decisions on settlement authority and whether to take a case to trial.

The committees are shielded from disclosure under state laws that protect quality improvement for the Medical Liability and Review Committee and protect both committees under "work product" privileges and attorney-client privileges.

The University of Michigan surgeons are happier with the new system, Boyd says. "They've recognized that we as health system are going to back them up and support them," he says. "If we feel they're not in error, we support them to the best of our ability." ■

Weigh waiving charges after an adverse event

Should your program waive charges after a serious adverse event occurs? The Washington, DC-based Leapfrog Group and the Chicago-based Midwest Business Group on Health, both of which represent employers, have called on hospitals to take this stand.

The University of Michigan Health System at Ann Arbor allows patient relations representatives to review and waive charges on a case-by-case basis, says **Charles Boyd**, MD, MBA, FACS, associate chief of staff at the health system and system professor in facial plastic surgery at the University of Michigan. "One thing we certainly try to prevent is the never outcomes from occurring, but when they do occur, we try to do the right thing and make it better for the patient and family," Boyd says.

For its part, the American Hospital Association supports the waving of charges. In a prepared statement, **Rich Umbdenstock**, president-elect, said, ". . . the Leapfrog Group articulates what many hospitals are already doing — apologizing to patients and working to do the right thing for them and their families. We agree: Patients should not have to pay the costs directly related to the event, and hospitals should recognize patients' unique circumstances and work with them."[1]

The Leapfrog Group, in response to questions from *Same-Day Surgery*, has clarified that their request wouldn't necessarily apply in situations where the hospital has done nothing wrong, but an adverse event occurs anyway. An example might be a case in which a patient withholds information that would have resulted in a cancellation of the surgery. While there may be an adverse event, it technically wouldn't qualify as a "never" event, says **Rachel Weissburg**, program associate for Leapfrog Group. "As far as waiving charges, we would ask hospital to use its very best judgment and do what they think is the best thing," Weissburg says. "If they think a patient knowingly withheld information, we would leave that up to hospital's discretion."

Reference

1. American Hospital Association. AHA Statement on Leapfrog's Policy on Health Care "Never Events." Washington, DC; 2006. ■

Connect to physician offices through Internet

Quick, effective communications boost scheduling

(Editor's note: This is the first of a two-part series that examines the use of computers and networks to communicate with employees and physician offices. This month, we look at how an outpatient surgery program can use the Internet to tie physician offices into the scheduling system. Next month, we evaluate the use of an intranet to communicate with employees.)

Coordinating operating rooms, surgical equipment, and staff to come up with a surgery schedule that has no cancellations, few delays,

EXECUTIVE SUMMARY

Some outpatient surgery programs are using a web-based system that ties into the surgery scheduling system they already use to enable physician office schedulers to see the schedules, request specific days and times for procedures, and enter the patient's demographic and financial information.

- Surgeons and anesthesiologists can access schedules from any location to check for additions and changes.
- Physician office schedulers can post their requests or holds times at any time of the day or week.
- Surgery program schedulers maintain final control of schedule by evaluating holds and ensuring that there are no conflicts.

and happy surgeons is a challenge. While most outpatient surgery programs still rely upon faxes, e-mails, or phone calls from surgeons' office staffs to schedule OR time, some programs are using the Internet to provide interactive, real-time communication with surgeons' schedulers to improve the process.

"We schedule almost 8,000 cases each year, and we have always relied upon faxed forms from the surgeons' offices to develop the schedule," says **Laurie Eberly**, chief operating officer of Newark Surgery Center in Newark, OH. Some faxes contained illegible or incomplete information, which meant extra telephone calls to the surgeons' office to gather information and more calls to confirm the schedule, she points out.

"We were looking at using our web site as a way for office schedulers to send in information, and then we discovered another web-based product that would do what we wanted without the need to create our own system," she says. The product is Surgery Center Online Resource (SCOR) from SurgeryCenter.com in Columbus, OH. "Now, physician office schedulers can access their surgeons' schedule as well as the block times assigned to them to see what is open," Eberly says.

The initial implementation fee for the product starts at $1,000, and monthly fees are determined by volume of surgery program. The company offers a 30-day free trial to enable the surgery program to identify customized needs.

The office scheduler uses the web-based system to submit a request for a day and time for a surgery. "The request includes the patient's name, address, phone numbers, insurance information, diagnosis and CPT codes," she says. "All of this information helps us get started on the registration process as soon as the procedure is scheduled.

Even though the physician office scheduler can view the schedule and place a hold on spots in the schedule, the final decision is made by the surgery program scheduler, says **David Moody**, RN, administrator of Knightsbridge Surgery Center in Columbus, OH. Approval of the "hold" or "request" is based upon staffing and equipment, he says. "At one point, we only had one C-arm, so if a physician's office scheduled a procedure that required the C-arm at the same time another surgeon was using it, we could not schedule both," he explains.

Once the schedulers have reviewed the request to make sure that there are no conflicts, the procedure is scheduled. It appears on the surgery schedule that can be seen by the physician's office scheduler. If there is a need to adjust the requested time or day, an e-mail message is sent to the physician's scheduler, Moody says.

The nice thing about the e-mail communications is the instant documentation of all communications with the physician's office, says Eberly. "It was hard to keep track of phone notifications or communications when multiple calls were made to set a schedule, and sometimes the scheduler was not able to document everything," she says. There is a record with the automatic messaging, which results in less miscommunication and documentation that the notifications of changes were made, Eberly adds.

Because physicians can access their schedule using their password on any computer that is connected to the Internet, there is less confusion about schedules, says Eberly. "We used to have one surgeon who was a challenge because he could not keep his schedule straight," she says. With the ability to check his schedule from home, he doesn't arrive late anymore, Eberly adds. "We even have some surgeons show up for their first procedure carrying the schedule their office scheduler printed off our system," she says with a laugh. Anesthesiologists also find it helpful to be able to check the center's schedule from their homes so that they can adjust their hours to fit the caseload, Eberly says.

The concept of using the Internet to give access to real-time communications with your surgery program is a natural evolution of case scheduling, says **Scott Riemenschneider**, president of ScheduleSurgery.com in Columbus, OH. Although different facilities use intranet for

interdepartmental communications, there is less communication between surgery programs and physician offices outside the hospital or surgery center because these offices are not part of the surgery program's network, he points out. "We began development of SCOR after one of our information technology consultation clients asked if there was something available that would give all of their physician offices access to the schedule so they could improve the efficiency of scheduling," Riemenschneider explains.

Key requirements for the initial surgery center, as well as subsequent clients, were meeting Health Insurance Portability and Accountability (HIPAA) regulations as well as maintaining control of the schedule, he says.

Logins and passwords protect privacy

Surgeons and their office staff are given access only to schedules or block time on the schedule that belongs to that specific surgeon or practice, Riemenschneider says. This practice prevents a surgeon's scheduler from affecting anyone else's schedule, and it protects the privacy of patient information, he explains.

The office scheduler only can place a hold on the surgery schedule, Riemenschneider adds. "The procedure is not actually on the schedule until the surgery program schedule reviews the request, confirms that there are no conflicts, and approves the request," he says.

Because the web-based system acts as an interface between the physician office and the surgery program's scheduling software, there is little training required because schedulers don't need to learn how to use a completely new system, Riemenschneider says. "It is important that the system is compatible with a variety of scheduling software systems so that it is easy to implement," he adds.

Training required for surgery schedulers was minimal, says Eberly. "Because the information entered into the SCOR system automatically transfers to our Advantix system, our schedulers don't have to spend time re-entering information," she says. Educating the physician office schedulers took about five minutes. After an initial period during which schedulers were tentative about trusting the system, use of the web-based system to set schedules grew quickly, she says. "About 95% of all of our physician office schedulers use the web-based system exclusively," she says. The others use a combination of web-based and phone calls to set the schedules or make adjustments, she adds.

They are seeing about 50% of cases scheduled through the web-based system, Moody says. "But we do have some physician schedulers who are in offices without computers or Internet connections, or have urgent requests for today or tomorrow and prefer to talk to a person," he says. Because so many of the routine scheduling issues are handled more efficiently, the surgery program schedulers now have time to handle urgent requests, Moody points out.

One concern expressed by Eberly's schedulers when the software was introduced was that they would lose their jobs. "It's important to reassure your schedulers that they are still critical to the surgery program and that this is not a tool to replace them, but it is a tool that will help them better do their job and will improve customer service to our physician offices," she says.

An efficient scheduling process also is a good marketing tool, Eberly says. Because a person doesn't have to be on the other end of the phone to discuss scheduling options or to respond to a fax after hours, physician schedulers who are in offices with extended hours, or schedulers who choose to stay after normal work hours to send in requests because it is quiet, can do so anytime, she says. "It is not necessary to wait until Monday to talk with someone; nor is it necessary to wait for confirmation that a fax is received," she says. "Although some adjustments may be necessary

SOURCES/RESOURCE

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- **For more information about the Surgery Center Online Resource (SCOR)**, go to www.schedulesurgery.com.

once the surgery scheduler reviews the request, the physician's scheduler can be sure that there won't be big changes. This flexibility has increased the likelihood that the scheduler uses our center rather than one without this type of system." ■

Sutures used to treat acid reflux disease

There are plenty of medications from which to choose for patients with acid reflux disease, but the medications don't work for all patients, while other patients want to eliminate the need to take daily medication.

The gold standard of treatment for gastroesophageal reflux disease is laparoscopic fundoplication, explains **Michael S. Nussbaum**, MD, interim chairman of the Department of Surgery at the University of Cincinnati. "Laparoscopic fundoplication has a 90% success rate, but not all patients want to undergo surgery if there is another option," he says.

An endoscopic procedure that can be performed on an outpatient basis using minimal sedation is available as a step between treatment with medication and surgery, says Nussbaum. The Plicator procedure (NDO Surgical; Mansfield, MA) offers patients an option to fundoplication, he says.

The Plicator procedure uses small sutures to tighten the opening between the stomach and the esophagus. "The Plicator has proven to be successful in 70% of patients undergoing the procedure," says **Gregory Haber**, MD, a gastroenterologist at Lenox Hill Hospital in New York City. "This is a simple procedure that can be repeated if necessary and does not prevent fundoplication in the future if needed." Even patients for whom the procedure does not completely eliminate acid reflux do say it improves their day-to-day life, Haber adds.

The typical patient is one whose acid reflux is controllable by medication but who wants to eliminate the cost and need to take medication on a daily basis, says Nussbaum. Contraindications include hiatal hernia that is 2 cm or larger or an upper gastric tract revised by a previous surgery, he says.

Reimbursement often is determined on a case-by-case basis, but more payers are seeing the benefit of eliminating the cost of medication and avoiding the more invasive surgery, says Haber. Nussbaum says that the Plicator procedure also is a useful adjunct to fundoplication for patients who still have some reflux following the surgery. "There is a small subset of patients for whom everything related to surgery is fine, but they still experience some reflux," he explains. The Plicator can be used to tighten up the valve to eliminate the reflux, says Nussbaum.

Although this procedure might not have the same high success rate as fundoplication, Nussbaum points out that many patients appreciate a chance to try the outpatient approach. "Patients are concerned about the long-term effects of taking medication, as well as the risk of infection that accompanies acid suppression," he says. "This is a relatively simple, safe way to eliminate the medication without undergoing major surgery." ■

EXECUTIVE SUMMARY

Gastroesophageal reflux disease traditionally has been treated with medication or with a surgical procedure that requires an overnight stay and general anesthesia. Now, a minimally invasive procedures offers a middle step for patients who want to eliminate the medication without undergoing major surgery.

- The Plicator procedure (NDO Surgical; Mansfield, MA) utilizes a suturing device to tighten the esophageal sphincter.
- The procedure is performed endoscopically and requires minimal sedation.

SOURCES/RESOURCE

For more information about outpatient treatment for gastroesophageal reflux, contact:

- **Michael S. Nussbaum**, MD, Interim Chairman, Department of Surgery, University of Cincinnati, 231 Albert Sabin Way, Cincinnati, OH 45267. Telephone: (513) 558-4014. E-mail: michael.nussbaum@uc.edu.
- **Gregory Haber**, MD, Gastroenterologist, Lenox Hill Hospital, 100 E. 77th St., New York, NY 10021. Telephone: (212) 434-6279. E-mail: ghaber@lenoxhill.net.

For more information about the Plicator procedure, contact:

- **NDO Surgical**, 125 High St., Suite 7, Mansfield, MA 02048. Telephone: (508) 337-8881. Fax: (508) 337-8882. Web: www.ndosurgical.com.

Age, gender, culture are key competencies

Assess management skills as well

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

Does your competency assessment program address age-, cultural-, and gender-specific competencies? Does your program address management and administrative issues? A good competency assessment program goes beyond regulatory and accreditation requirements, but these additional areas pose challenges for outpatient surgery programs, say competency experts interviewed by *Same-Day Surgery*.

A cultural or diversity competency assessment must apply to all employees and managers within the program, says **Dawn Q. McLane**, RN, MSA, CASC, CNOR, chief development officer of the Nikitis Resource Group, a consulting firm based in Broomfield, CO. Not only do individual employees need to be aware of the different values, beliefs, or practices of the different cultures the program serves as they provide one-on-one care, but also managers or administrators need to be aware of the effect their actions may have on the community.

"I was a consultant to a new surgery center that developed a problem with woodpeckers that kept pecking holes in the building," McLane says. "The cost to spray the building to keep the birds away was high, so the administrative team opted to put statues of owls on top of the building to scare the birds away."

What managers did not take into account was the fact that the large American Indian population in the area viewed owls as a sign of death, which is not the best advertising for a surgery center, she admits. "We had to remove the owls and arrange for a medicine man to bless the building to rid it of evil spirits to reassure community members that it was safe to come to the facility," McLane adds.

While a manager needs to ensure that staff members are able to respect cultural and diversity differences in the patient population, showing respectful behavior toward co-workers also is important. Assess your staff's ability to avoid sexual harassment in the workplace, suggests **Marcy Grow-Dorman**, RN, BSN, ambulatory surgery center director at Orthopedic Sports Medicine Center in Elkhart, IN. One way to approach this issue is to talk about communication between co-workers and how the intent of different messages can be perceived, she says. Observing staff members interacting with each other and asking staff members about the appropriateness of certain jokes or comments can be used to evaluate the staff member's comprehension, she says.

Gender differences in your patient population also must be addressed in your competency assessment, says Grow-Dorman. "Women are physically more sensitive to pain, so we cannot expect reported pain levels to be the same in men and women,"[1] she says. Nursing assessments that recognize the physical differences enable the staff to help women better control pain after surgery, she adds.

Age-specific competencies also must be included in your program, says McLane. If your program treats all ages of patients you should develop competencies for pediatric, adult, and geriatric patients, she says. For example, nurses should be able to start an intravenous line in pediatric patients using appropriate pediatric supplies as well as geriatric patients with fragile skin, she says.

Be sure to check your pharmacy and nursing staff's knowledge of medication differences for different ages within your competencies, says Grow-Dorman. "We don't treat a lot of children, but we do see some during the year, so it is important that we know how to determine a

EXECUTIVE SUMMARY

The most successful competency assessment programs are developed with input from staff members who support assessing and documenting competencies on an annual basis. Even successful programs typically omit areas that are essential.

- Address cultural or diversity issues in your community.
- Identify differences in reaction to pain, medication, and surgery for different genders and ages represented in your patient population.
- Assess management competencies such as cost analysis, personnel evaluation, and leadership.

SOURCE

For more information on developing competency programs, contact:

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pediatric dose," she says.

Another area of competency assessment that is frequently overlooked is management, says McLane.

"This is one area that is important to freestanding centers because they do have limited resources for management to call upon for help, so we have to make sure that managers do know how to lead a team, perform a cost analysis, and evaluate personnel," she explains.

Hospital-based program managers do have other departments for assistance, but freestanding centers are on their own, McLane says. "Typically, a good staff nurse is promoted into a management position for which he or she is totally unprepared," she says. A thorough competency assessment will help identify areas of knowledge needed for the job so that the new manager can get the education or training needed, McLane adds.

Ask staff to identify competencies

Although oversight of a competency assessment program ultimately must be the responsibility of the manager, it is important to involve staff members, says McLane. "I think it is critical to involve the staff in developing the program from the ground up and helping maintain the program," she says. "In all roles, they should actively participate in identifying what department- and role-specific competencies they believe need to be practiced and documented regularly in order to demonstrate competency."

Competencies that are included in an assessment program may be:

- high-volume procedures such as performance of an accurate glucometer test;
- low-volume but high-risk procedures such as response to a code blue, malignant hyperthermia, or scope to open procedure for scrub techs;
- items identified in the quality or risk management program of the organization that require extra education and training for the staff.

If you do identify items related to your quality or risk management program, you may want to include them only for one to two years or until you are satisfied that you've addressed the issue, says McLane.

Because every successful competency assessment program is designed to meet the specific and unique needs of your outpatient surgery program, there is no "one-size-fits-all" program, McLane says. "I believe that the most effective program is one where the employees are charged with the responsibility of participating in the creation and maintenance of the program so that they buy into it and understand their individual responsibilities to document their professional competencies on an annual basis," she says.

Reference

1. Mowlavi A, Cooney D, Febus L, et al. Increased cutaneous nerve fibers in female specimens. *Plast Reconstr Surg* 2005; 116:1,407-1,410. ■

Same-Day Surgery Manager

Comments on anesthesia and finding good staff

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

Statement: I heard you speak in Dallas a couple of months ago, and you said that anesthesia can help to make or break a surgical environment. I still am offended by that remark. My staff and I work hard to make our department the best that it can be and with no help whatsoever from our anesthesia department. They just come in, do their cases, and leave. They do not interact with the staff, clean up after themselves, or do anything to help make this a better department.

Response: Unless you hear screaming up and

down your sterile corridor, I would say that anesthesia is doing their job.

Statement: With reimbursement changing for much of our GI procedures, we have had to make difficult financial decisions in our center that have affected much of the staff personally. We have reduced our staffing by three nurses and one receptionist, eliminated free Friday lunches for the staff, and gave up our Christmas party this year. It seems unfair that we have been singled out for these reductions.

Response: Health care still is a sector in the U.S. job market that enjoys remarkable job security. Look at other companies in the news that have cut back on staff and expenses to stay competitive in the marketplace. While we all hate to see these reductions, it does help keep the overall industry "healthier."

Statement: I have always enjoyed your commentary on dealing with difficult employees by simply terminating them and hiring someone else. Lately, I don't know. It just seems like it is getting more difficult to find good staff. Maybe I should invest in trying to "fix" the ones I have.

Response: Staff, good staff, is more difficult to find — I agree. Some staff members just need a little bit of time to adjust to the work environment and meeting the expectations we put upon them. How much time does that take? How much time do you spend waiting for them to "get it?" I am not a patient person, and I think in terms of weeks, not months. Others are willing to give staff members more time to adjust. Obviously, that is a judgment call on your part. What offends me is when time is taken away from a productive individual who has a great work ethic and positive influence on the rest of the staff who is neglected for a disruptive staff member. Personnel that need a little bit more time than average to adjust to your center are in a different situation; and you are right, they deserve the chance to have time to adjust. But, disruptive, manipulative staff members are unprofessional and have no place in a good surgical environment. The sooner you remove them, the better.

Statement: I work at this hospital as an instrument tech and never planned for it to be more that just a job. I read *Same-Day Surgery* newsletter all the time and like it. Even though I have only been here for a few months, the more I see, the more I am impressed by the job the nurses and the rest of the staff do here. Sometimes we (in the instrument room) hear the nurses talking about their patients, and you can tell they are genuinely interested in them. Some of the staff are sort of rude to us or don't notice us. They don't seem to be very happy in their jobs. But for the most part, the rest are dedicated to what they do and seem to really enjoy it. I am thinking of making a career in this field based upon what I see.

Response: We never know who is watching and listening . . .

(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.) ■

COMING IN FUTURE MONTHS

- Should your staff chat in the OR?
- Challenging pediatric populations in outpatient surgery
- Learning from others' mistakes — Lessons from your peers
- Preparing for changes in Medicare payments

Physicians own all or part of 95% of ASCs

A survey of freestanding ambulatory surgery centers by the American Association of Ambulatory Surgery Centers (AAASC) examined ASC ownership trends between 2004 and 2006. The survey asked for ownership information for the responding ASC facility and then asked the same respondents to answer similar questions about ownership for up to four other ASCs in their geographic markets.

The results of the survey demonstrate that of the almost 5,000 ASCs nationwide, 32% of ASCs have some element of hospital ownership today, a 3% increase from 2004. Hospitals now account for approximately 1,500 ASCs nationwide, according to the AAASC study.

Physician ownership of ASCs has not changed dramatically from 2004 to 2006. ASCs that are owned only by physicians represent 47% of all ASCs. If ASCs with some physician ownership, along with corporate or hospital ownership, are added to the number of ASCs owned exclusively by physicians, a total of 95% of all ASCs have some physician ownership. ***(Editor's note: Another publication that highlights physician ownership of ASCs, Physician-led ambulatory surgical centers vital to meeting surgical needs of tomorrow, is available through the Foundation for Ambulatory Surgery in America at www.fasa.org. Select "Publications and Services" on left navigational bar, then choose "Other Publication" in the pull-down menu. Scroll down to white paper. Cost is $25 for members and $40 for non-members.)*** ■

Plan to attend medical error audio conference

Examining issues, questions and pitfalls that arise

Intense feelings of anxiety and humiliation, not to mention fears of being sued or professionally censured, are extremely common. Not surprisingly, the appearances of defensive and self-protective strategies that urge concealment are common as well. Nevertheless, ethics, as well as recent reports showing declines in malpractice claims and costs when disclosure and apology are implemented, are changing the ways health care organizations manage the aftermath of medical errors.

These issues will be addressed in our upcoming live audio conference: **When the Worst Happens: Techniques to Manage Medical Error Disclosures,** on March 13, 2007, from 2:30 pm to 3:45 pm EDT.

This presentation will examine a number of considerations bearing on error disclosure. Participants will gain an appreciation of the psychological factors that affect error disclosure conversations so that they might better manage their and their listeners' feelings and reactions. The latter half of the presentation will explore numerous communication strategies to employ at particularly significant moments in the disclosure conversation. Ultimately, this presentation will provide a glimpse into the overall 'architecture' of error disclosure conversations as well as discuss "what words to use," such that error disclosure occurs ethically, professionally, and empathically.

On-line bonus book for *SDS* subscribers

Readers of *Same-Day Surgery* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2007 Healthcare Salary Survey & Career Guide*.

The report examines salary trends and other compensation in the hospital, outpatient, and home health industries.

For access to your free 2007 on-line bonus report, visit **www.ahcmedia.com**. ■

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. ■

Our presenter, **John Banja**, PhD, is a medical ethicist at Atlanta's Emory University who is nationally regarded in the area of medical errors and their disclosure. His book, *Medical Errors and Medical Narcissism,* was published by Jones and Bartlett in 2005.

The fee of just $299 ($349 for the live conference and CD combo) allows you to invite as many listeners from your facility as you can accommodate around your conference telephone. Plus, you and your staff will benefit from the interactive question-and-answer segment immediately following the presenters' prepared remarks.

Call (800) 688-2421 or go to **www.ahcmediainteractive.com** to register today or order the CD (MP3 format) for this audio conference to educate your entire staff. ■

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.

9. The Leapfrog Group and the Midwest Business Group on Health has called on hospitals to:
A. apologize for serious adverse ("never") events.
B. waive charges when certain never events occur.
C. apologize for never events and waive charges when certain events occur.
D. None of the above

10. What is the position of the American Hospital Association regarding waiving of charges after never events?
A. Disagrees with waiving charges in all circumstances.
B. Supports the waiving of charges, but only when a death occurs.
C. Supports the waiving of charges.

11. What is one issue that makes it important to include gender differences in your competency assessment program, according to Marcy Grow-Dorman, RN, BSN, ambulatory surgery center director at Orthopedic Sports Medicine Center?
A. More women than men seek health care and surgery.
B. Women respond to pain differently than men.
C. Insurance companies require it.
D. Women don't ask as many questions as men.

12. What is an important feature of a web-based physician-to-surgery-program scheduling system, according to Scott Riemenschneider?
A. Meeting privacy requirements.
B. Allowing surgery program schedulers to maintain control of schedule.
C. Easy interface with existing surgery scheduling system.
D. All of the above

Answers: 9. C; 10. B; 11. B; 12. D.