Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 30 Years

AHC Media LLC

IN THIS ISSUE

Financial Disclosure:
Author Sheryl Jackson, Senior Managing Editor Joy Dickinson, Associate Publisher Coles McKagen, Board Member and Nurse Planner Kay Ball, and Board Member and Columnist Stephen W. Earnhart 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 Magna Health Systems and a consultant for DayOne Health.

FEBRUARY 2008
VOL. 32, NO. 2 • (pages 13-24)

Could your surgery program be accused of fraud? Recent cases raise question

Recent federal and state cases involving accusations of fraud against outpatient surgery providers have gotten the attention of managers who wonder, could my program fall under similar scrutiny?

These cases have raised questions about waiving out-of-pocket expenses, among other issues. "Providers think that by doing certain things, they think it is helpful to the patient," says **Jan Crocker**, MSA, RHIA, CCS, CHP, senior manager of the performance group of Crowe, Chizek, and Co., a South Bend, IN-based CPA and consulting firm.

Four surgery centers in New York are being accused of submitting an insurance claim with false information, which might be considered insurance fraud there and has implications for providers nationwide.[1] "If you 'willfully and knowingly' do that, or if you are actually making up information — which is an intentional and willful event also — in most states, that is considered fraud," she says.

The four providers in New York were targeted by the insurance plan for the state's employees. Such audits are routine, Crocker warns. The New York civil service commissioner, **Nancy G. Groenwegen**, labeled the surgery centers as "sophisticated providers" who were willing to break the rules.

Auditors examined medical claims for four of the state's largest ambulatory surgery centers for January 2001 through December 2006. They

EXECUTIVE SUMMARY

Accusations of outpatient surgery programs committing insurance fraud by the New York State Comptroller's office and a legal decision against self-referral to surgery centers in New Jersey have raised concerns among providers.

- Know what your state requires, have everything in writing, and use a lawyer with health care experience.
- Have a policy for waiving out-of-pocket expenses.
- To ensure claims are coded correctly, provide training and monitoring.

found that these providers routinely waived out-of-pocket costs for state employees who used the Empire Plan and inappropriately billed United HealthCare, the state's insurance administrator, for these costs, which totaled $8 million. The claims did not reflect the fact that the providers had waived out-of-pocket costs, according to the state comptroller.

"The abuse identified in these audits is particularly insidious and difficult to detect because each instance appears on the surface to show a physician merely agreeing to accept what the insurance company pays," Groenwegen said in a released statement. She referred to "systemic abuse" and said such activity necessitates "increased audit activity to ensure that taxpayer dollars are not wasted." The auditors recommended that United HealthCare recover the $8 million from these providers and work with the Department of Civil Service to develop action to prevent providers from inappropriately waving patients' out-of-pocket costs.

NJ: Owners can't refer to their surgery centers

In New Jersey, a court recently ruled that referral of a patient to a surgery center in which the referring physician owns an interest violates the New Jersey anti-self-referral law (the Codey Act), according to *The Philadelphia Inquirer*.[2]

"We're looking at appealing that decision," says **John D. Fanburg**, JD, chairman of the health law practice group at WolfBlock Brach law firm in Roseland, NJ, which represents the New Jersey Association of Ambulatory Surgery Centers, Orthopedic Surgeons of New Jersey, Orthopedic Surgery Center of Northwest Jersey, and other groups in the case.

Could New Jersey become the only state to bar physician ownership of and referrals to surgery centers? Yes, according to Fanburg.

Health Net of New Jersey, the insurance company, said the surgery center had committed insurance fraud and should not be paid, the newspaper reports. The Codey law specifically exempts centers that treat patients who need certain kidney stone, dialysis, or radiation oncology treatments, but not centers performing surgery. The legal defense for the surgery center maintains that federal law allows physicians ownership of and self-referral to surgery centers, the newspaper says. The state Board of Medical Examiners proposed rules in 2007 to allow surgeons to refer patients to centers they own, with restrictions; for example, surgeons must tell patients about the ownership interest.

Association supports NJ ASCs

In the meantime, New Jersey has the support of the Ambulatory Surgery Center (ASC) Association, says **Kathy Bryant**, president. The ASC Association was encouraged by the language in the judge's opinion that indicated he found no evidence of insurance fraud or unnecessary care,

Same-Day Surgery® (ISSN 0190-5066) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Same-Day Surgery**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $495. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 16.5 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 16.5 Contact Hours.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 20 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 24 months after the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Senior Vice President/Group Publisher: **Brenda Mooney** (404) 262-5403 (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen** (404) 262-5420 (coles.mckagen@ahcmedia.com).
Senior Managing Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Senior Production Editor: **Nancy McCreary**.

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

Bryant says. "The New Jersey law is unique, when compared to the laws in other states," she says. "Nonetheless, it's important to not just defend physician ownership, but to extol the benefits of physician ownership."

The association is having ongoing talks with legislators and the state board of medicine, she says. "The case hasn't finally been resolved, but we don't think it's wise to wait to fix the problem," Bryant says.

In a December meeting, the New Jersey Board of Medical Examiners reviewed the recent decision and received an application from the Medical Society of New Jersey and other physician organizations seeking a special advisory opinion. **Thomas J. Pliura**, MD, JD, physician and attorney at law in LeRoy, IL, says, "The medical board in NJ is quickly moving to specifically write a law that will protect these surgery centers and physicians in this particular type of arena." **(See future issues of *Same-Day Surgery* and *Same-Day Surgery Weekly Alert* for updates. For another case involving a fraud settlement with HealthSouth, see story, p. 16.)**

5 tips to help avoid liability

To avoid winding up as the target of an investigation of fraud, consider these suggestions:

• Be familiar with your state laws.

While federal laws affect certain situations, you also must follow specific state laws, Crocker warns. This information is particularly important for ambulatory surgery providers that have locations in more than one state, she says. "Because of state laws, they could be treated differently."

• Have a well-defined policy on how you will qualify patients to waive out-of-pocket expenses.

You can't routinely waive deductibles and copayments under federal Medicare law and many state laws, Pliura says. If you do, the insurance company will maintain that the bill to them was too high, he warns.

"Insurance companies encourage providers to always make a good-faith effort to collect copays and deductibles," Pliura says. Otherwise, "it's the same thing as me running an ad in the paper and saying, 'I'll pay you $20 to come to me.'" The federal government will maintain that you're bribing the patient, he says. Providers, on the other hand, complain that it cost more to pursue collections of smaller bills than the copay or deductible is worth, Pliura says.

There may be some legitimate, legal reasons for waiving out-of-pocket expenses, Crocker says. "Most generally, those good reasons may be that the patient is indigent, or the patient falls below a certain [line] of the federal poverty level," she says. Their income may not be low enough to qualify for Medicaid, yet they may not be able to pay out-of-pocket expenses, Crocker says. "Indigent care is a true exception," she says. Your policy should spell out such exceptions, she says.

• Take steps to ensure claims are correct.

False claims can result from a variety of causes, Crocker says. "Surgeons and their billing and coding staff must be knowledgeable of Medicare and Medicaid billing requirements and know how to stay up to date with new requirements as they are developed," she says. Providers can stay updated through provider manuals on their web sites, Medicare and Medicaid listservs, and provider representatives, Crocker says. Diagnoses and procedure codes are updated at least annually, she points out.

Ensure that your staff are coding diagnoses and services correctly, complying with medical necessity guidelines, and following correct coding initiatives at all times, Crockett suggests. "When billing questions regarding these payers arise, Medicare and Medicaid provider representatives should be contacted for guidance," she says. "Any interactions with the provider representatives should be thoroughly documented for future reference."

Ensure that your training is ongoing, and monitor the coding and billing, Crocker advises.

• Have a strong compliance program in place.

Document your compliance program in a written plan, Crocker advises. "One of the steps is to identify high-risk areas that can affect the appropriate functioning of billing or any aspect of their business," she says. Once you've identified the risk areas, including insurance fraud, take steps to determine how to provide "ongoing, continuous monitoring," Crocker says.

For example, when a surgeon starts performing a new procedure, you may be at a high-risk area for coding and billing appropriately, she says. "Therefore, claims generated for the surgeries performed by that surgeon should be monitored regularly for correct coding and billing," Crocker says. "In addition, remittances for those services should be monitored to watch for appropriate reimbursement or for claim denials that could indicate issues with the accuracy of the claims."

Regularly track and monitor any claim denials that you receive, she advises. Ensure physicians are listing the correct place of service code, Crocker suggests.

• **Use your legal counsel.**

Always involve your legal counsel when you are developing policies and procedures that have legal questions, Crocker says. "I can't stress enough the importance of not just doing these things because they've read this might work, or they know of another organization doing this, and we don't know of the arrangements made through attorneys," she says. And don't hire just any attorney, Crocker warns. "You can have attorneys that deal with tax issues, manufacturing, and overseas interactions," she says. "You would want attorneys that do have health care expertise involved in this."

References

1. Office of the New York State Comptroller. DiNapoli: Audits Find More Abusive Practices in New York State Health Insurance Program — Medical Facilities Inflated Bills, Costing Taxpayers $8 Million. Dec. 3, 2007. Accessed at www.osc.state.ny.us/press/releases/dec07/120307.htm.

2. Burling S. N.J. ruling threatens surgery centers. *The Philadelphia Inquirer*. Dec. 13, 2007. Accessed at www.philly.com/inquirer/business/20071213_N_J__ruling_threatens_surgery_centers.html. ■

HealthSouth case offers lessons

HealthSouth Corp. and two physicians will pay $14.9 million to settle allegations that the company gave the government false claims and paid illegal kickbacks to physicians who referred patients to its ambulatory surgery centers and hospitals, as well as its outpatient rehabilitation clinics, according to the Department of Justice (DOJ). HealthSouth was one of the nation's largest providers of ambulatory surgery services until it sold that line of business in 2007.

The HealthSouth settlement also resolves allegations that the company paid kickbacks to, and entered into improper financial relationships with, other physicians, in what the government said was an attempt to induce the referral of patients. The DOJ is continuing to investigate other physicians.

"Just from the fact that the company agrees to pay $14.2 million suggests that HealthSouth may have believed that they had some potential liability," says **Thomas J. Pliura**, MD, JD, physician and attorney at law in LeRoy, IL.

To avoid liability in your program, consider these suggestions:

• **Document business arrangements and have them reviewed.**

Surgeons can take steps to protect themselves from illegal kickback situations by carefully considering their business arrangements, says **Jan Crocker**, MSA, RHIA, CCS, CHP, senior manager of the performance group of Crowe, Chizek, and Co., a South Bend, IN-based CPA and consulting firm. Any arrangements should be documented in a contract or agreement that is signed by both parties, she says. It should specify the time frame, the services, and the compensation.

"The compensation must be set in advance, be consistent with fair market value, and not determined based on the referral volume, value of referrals from the physician, or other business generated by the referring physician," she says. "Agreements or contracts should be reviewed by health care attorneys who can advise surgeons on avoiding arrangements that may result in noncompliance with the anti-kickback statutes." Be sure to use attorneys' experience in health care law, particularly in billing and insurance claim issues, experts advise.

Surgery programs should follow similar steps, she says. "If a surgery center is reimbursing a surgeon for services or items, a written contract is essential, as is review by a health care attorney," Crocker says. The surgery center must be able to demonstrate that the terms of the contract, such as the services agreed to, are being fulfilled, she says. "Therefore, using time sheets, work schedules, or some way to document physician time spent completing services is important," she says.

• **Avoid providing anything that resembles a kickback.**

Pliura emphasizes that you should avoid offering anything that could be construed as a kickback. "Time and time again, the state and federal governments say you cannot give tickets to a football game, no below-market rent, and you can't pay extra money for a medical director's fee when the work isn't in any way commensurate to what they're doing," Pliura says. "It's a bribe to induce them to bring cases."

• **Make full disclosure to patients.**

Physician owners should make patients aware of the fact that they can choose to have the procedure done anywhere the physicians have privileges, Pliura says.

"Making full disclosure to your patients is protection, meaning disclosing the fact that you may be a physician doing surgery there as owner or

investor, and the patient has no obligation to have surgery there," he says. ■

Outsiders may know of phone use in OR

(Editor's note: This is the second part of a two-part series on surgeons using cell phones during surgery. In last month's issue, we offered viewpoints on what is acceptable. In this month's issue, we give you examples of phone use during surgery and tell you about cases from other countries.)

In many cases, inappropriate phone calls are more obvious to people other than the patient or the manager. For instance, **Bonnie Russell**, owner of 1st-Pick.com, a public relations agency in Del Mar, CA, says she has had several conversations with surgeon clients while they were operating on patients.

"I originally decided to work with one cosmetic surgeon because he regularly made trips to Mexico to help poor kids with cleft palates and things like that, all on his own dime. This impressed me," she says. "However, Dr. Do-Good's darker side very quickly emerged. He repeatedly called me from the operating room to talk about the need for more media exposure. It really kind of freaked me out to think that he was talking to me while operating on a patient. I mean, sure I wanted to talk to him, but not that much."

Russell says she has talked with several surgeons who seemed to think it was fine to take nonmedical calls in the middle of an operation. "I also had this one neurologist who bragged to me that he could be reached by phone anytime, and he really meant *any* time," she says. "I told him that just wasn't necessary, and I didn't want to talk to him in surgery." **(See the story, below, for more on the cases from other countries.)** ■

Foreign cases show phone use cited

Two international cases show how phone use during surgery can be cited as a contributing cause to alleged malpractice. In a case from Israel, a woman underwent hand surgery in Tel Aviv's Sheba Medical Center and then filed a lawsuit claiming malpractice by her surgeon.[1]

The woman remained awake during the procedure and, according to the lawsuit, the surgeon's cell phone rang. He instructed a nurse to answer but eventually took the phone and spoke. According to the complaint, immediately after ending the conversation, the surgeon stated that he had mistakenly cut a nerve. The patient claimed that the doctor then told a nurse, "You see, one shouldn't speak on a phone during surgery." The disposition of the malpractice claim is unknown.

In 2000, the Hong Kong Medical Council banned surgeons from using cell phones while operating.[2] The move followed a week of controversy after the council ruled that Tung Hiu-ming, MD, who answered his mobile phone during surgery, had not acted unprofessionally. The council ruled in favor of Tung despite records showing that he was on the phone for 14 minutes. He claimed he was only on the phone long enough to speak one sentence and that the other party, by accident, had not hung up.

The patient, however, said he had heard his doctor discussing the purchase of a new car while he was under a local anesthetic to have a polyp removed from his intestines. The patient required a second surgery within hours to repair a punctured colon wall.

References

1. Cell phone leads to malpractice suit. *Israel Faxx.* Accessed at www.allbusiness.com/middle-east/israel/207129-1.html.
2. Docs banned from using phones surgery. Reuters. Accessed at www.totalobscurity.com/mind/news/2001/cellphone-surgery.html. ■

Community-acquired MRSA boosts need for awareness

Hand hygiene, knowledge block cross-contamination

Antibiotic-resistant infections are not new to the health care setting, but headlines throughout the country have increased public awareness of the potential risk of infection to a wider range of people in the community.

According to a study by the Association for Professionals in Infection Control and

EXECUTIVE SUMMARY

The increase in community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) presents a new challenge to outpatient surgery programs. Healthy patients with no known risk factors for health care-acquired MRSA may be colonized with community-acquired MRSA but show no symptoms.

- Ask patients about their medical history to identify risk factors for MRSA. If a patient indicates a past history of MRSA or a family member with MRSA, treat the patient as an MRSA patient.
- Have isolation carts with gowns and gloves readily available for use.
- Schedule patients with known or suspected MRSA at the end of the day.

Epidemiology, methicillin-resistant *Staphylococcus aureus* (MRSA) accounted for only 2% of all *S. aureus* health care-associated infections reported to the Centers for Disease Control and Prevention (CDC) in 1972. Today, MRSA accounts for more than 60% of *S. aureus* infections. **(For information on the study, see resource box, p. 19.)**

Outpatient surgery programs are seeing an increase in the number of cases of community-acquired MRSA, says **Robert G. Sawyer**, MD, professor of surgery and public health sciences at the University of Virginia Medical School in Charlottesville.

"Ten years ago, it was easy to identify patients who were at high risk of having MRSA," Sawyer says. Patients who had spent time in the hospital, especially the intensive care unit, and patients who had taken certain antibiotics were easy to identify as potential MRSA patients, he says. "Now, with community-acquired MRSA, healthy people coming into an outpatient surgery program can carry the bacteria and not be symptomatic," Sawyer says.

There is a significant amount of debate about the need to test all patients coming to the hospital or surgery center for MRSA, admits Sawyer. "A more practical approach might be to test patients who do have risk factors such as previous illness that required hospitalization or use of antibiotics," he suggests.

Some surgery programs also are choosing to test patients who are undergoing procedures in which an MRSA infection would produce a more serious complication, Sawyer says. "An example would be orthopedic procedures that require implants," he says. An infection could result in the need for removal of the implant and further surgery, Sawyer explains.

Ruby Day Surgery Center in Morgantown, WV, screens for potential MRSA at the pre-admission visit, but not by culturing patients, says **Mary Wilson**, RN, BSN, CNOR, clinical preceptor for the operating room and endoscopy. "We ask the patient if they or a family member has been diagnosed with MRSA," Wilson says. Although there has been some discussion about the need to culture patients before admission, there are concerns about the rate of false negatives in the screening, she says. "We don't want to give staff members a false sense of security with screening tests that produce false negatives," Wilson says.

There is an in-house study under way at West Virginia University Hospitals, of which her surgery center is a part, to determine the rate of false negatives, she says.

Start with good hand hygiene

Overall, the best protection for patients, physicians, and staff members is the standard infection control procedures that are commonly used in surgery, says Sawyer. Sterilization of equipment, proper hand hygiene, and thorough cleaning of the operating rooms are the best protection against the spread of MRSA, other antibiotic-resistant organisms, and all other infectious organisms, he says.

At Naugatuck Valley Surgical Center in Waterbury, CT, universal procedures and thorough cleaning of the operating rooms and recovery areas are taken seriously, says **Betty Bozutto**, RN, MB, CASC, executive director. "We treat every patient as if he or she is at risk for contracting or spreading an infection, and we make sure that everything in the room is clean before and after the patient is in the room," she says. Operating rooms and recovery areas are cleaned by the staff between patients, and a terminal cleaning of the operating rooms is performed at the end of the day, she says. "If we do have a patient that may have MRSA, we try to schedule him or her at the end of the day," Bozutto says. **(For other isolation techniques in outpatient surgery, see article, p. 19.)**

Although her staff have not changed protocols for cleaning the operating rooms, Wilson says that a checklist completed by the cleaning staff at night is posted on the door to the operating room so that the nurses can double-check everything in the morning. "The list includes everything that is cleaned during a terminal cleaning including floors, counters, beds, sharps containers, telephones, cords on equipment, doorknobs, and

RESOURCE

For information about the methicillin-resistant S*taphylococcus aureus* (MRSA) study conducted by the Association of Professionals in Infection Control and Epidemiology, go to www.apic.org. Highlight "Research Foundation" on the left navigational bar, and then select "National MRSA Prevalence Study."

cabinet handles," she says.

At Baltimore Washington Medical Center in Glen Burnie, MD, "everything in our pre-op, operating room, and recovery area is cleaned, even hard-to-clean surfaces such as computer keyboards," says **Toni B. Hughes**, RN, BSN, MA, CNOR, perioperative education specialist. "We have dispensers in every area that contain cloths with cleaning solutions designed to clean hard surfaces such as counters and keyboards so staff members can quickly grab a cloth to clean an area," she says.

Because hand hygiene also is a key to preventing spread of MRSA as well as other infections, Wilson's facility keeps waterless alcohol handwash dispensers at bedsides in the pre-op and recovery areas as well as every operating room. "Installation of the dispensers was part of a hospitalwide campaign to remind staff members to wash their hands," she explains. The campaign includes screensaver reminders as well as signs posted in all patient areas and next to all sinks, reminding people to wash hands to prevent the spread of infection, Wilson adds. Other facilities post signs in waiting rooms and public bathrooms next to waterless alcohol hand cleanser dispensers to remind visitors how to avoid spreading germs.

The development of antibacterial sutures, dressings, and catheters has created some discussion within surgery programs, but none of the experts interviewed by *Same-Day Surgery* are at facilities where the products are used. "We've had a few questions from surgeons about the products, but we're not using them," says Hughes. "These are products that we'll evaluate when there is enough surgeon interest."

Sawyer says, "There is not much clinical data available about the effectiveness of antibacterial products to prevent infection in surgery, and there is no product specific to prevention of MRSA." If a facility chooses to use these products, they should be viewed as an adjunct to other infection control procedures and protocols that are designed to keep the surgery department clean and sterile, he suggests. ■

Patient isolation tips for outpatient surgery

Gowns, gloves, and staff awareness are key

Hospital inpatients with methicillin-resistant *Staphylococcus aureus* (MRSA) are isolated from other patients to reduce the risk of colonizing other patients or visitors, but how does an outpatient surgery program isolate a patient when there often is a shortage of space and a need to move many patients through a single area in a short time?

The first step is to ensure that staff members in all areas of the surgery program know the patient is positive for MRSA or has a high likelihood of having MRSA, says **Toni B. Hughes**, RN, BSN, MA, CNOR, perioperative education specialist at Baltimore Washington Medical Center in Glen Burnie, MD. Because her facility doesn't culture all patients, if a patient indicates that he or she has had MRSA in the past or if a family member has it, the patient is considered positive, she says. "MRSA appears in the face sheet of the chart to alert all staff members to take precautions against the spread of MRSA."

They're fortunate that their outpatient surgery center has all private rooms in pre-op and recovery, so there is little risk of cross-contamination while the patient is in those rooms, says Hughes. "We do clean the rooms, including bedrails and all hard surfaces, before the next patient is moved into the room," she says.

The staff at Ruby Day Surgery Center in Morgantown, WV, follow isolation guidelines set for the entire hospital for MRSA patients within the context of surgery, says **Mary Wilson**, RN, BSN, CNOR, clinical preceptor for the operating room and endoscopy at the center. **[A copy of the isolation guidelines are available with the online edition of the February 2008 issue of *Same-Day Surgery*. Go to www.ahcmedia.com. For assistance, contact customer service at customer service@ahcmedia.com or (800) 699-2421.]**

"We wear gowns and gloves at all times and we make sure the wound is covered during transport," Wilson says. Staff members also seem to wash their hands more frequently when the patient is known to have MRSA, she adds. "We also have isolation

carts that contain supplies and equipment necessary for isolation so that nurses can easily access gowns and gloves as they approach the patient's bedside," says Wilson. The isolation carts used in Wilson's facility include the following items:

- oral and rectal thermometers;
- one box of alcohol wipes;
- a package of about 25 plastic bags with zipper-type closures;
- five small plastic garbage bags that can be attached to bedrail with tape for patient's personal trash;
- boxes of three types of masks: masks with splash guards, regular masks, and N95 respirator masks;
- one box each of different sizes of exam gloves;
- a bag for dirty linen;
- two to three disposable goggles;
- two disposable stethoscopes;
- 10 yellow isolation gowns.

Also, if a patient is known to have MRSA, you can decrease the risk of transmission to another patient by scheduling the procedure at the end of the day, says **Robert G. Sawyer**, MD, professor of surgery and public health sciences at the University of Virginia Medical School in Charlottesville. An end-of-the-day procedure means that the operating room will be terminally cleaned following the procedure, and patient care areas occupied by the patient can be thoroughly cleaned before the next morning, Sawyer says. ■

Protect your patients and their environment

Going 'green' can save money, involves staff

Although patient care is the No. 1 priority for outpatient surgery managers and staff members, a growing number of health care employees are recognizing that their workday activities can affect more than a patient's health. They also can affect the environment.

"Many of us recycle and conserve resources in our homes because it is easy to see how to do these things in our personal life, and it is harder to see how to carry this philosophy into our professional lives," says **Gary Laustsen**, PhD, APRN, assistant professor of nursing at the Oregon Health and Science University in La Grande. Surgery programs provide a wide range of opportunities to decrease waste, conserve resources, and recycle, he says. "We can't solve all of the environmental problems of the world, but we can start with small things, and the effects add up to a bigger impact."

EXECUTIVE SUMMARY

As more health care organizations and staff members focus on the ethics of protecting the environment, surgery managers are finding simple, effective ways to be good stewards of the environment.

- Reduce waste by decreasing amount of packaging for supplies.
- Make sure that all employees appropriately use red bags and regular trash bags.
- Recycle materials and supplies by donating to other organizations and/or allowing employees to use items that are not needed.
- Consider emptying unused narcotics into bags of trash rather than the sink.

In Boulder, CO, the effort to reduce the amount of blue wrap used in the sterile processing area resulted in a 50% decrease in the amount of waste material, or approximately 11 tons annually, which translated to a yearly financial savings of $111,000, says **Julie Moyle**, RN, MSN, surgery manager at Boulder Community Foothills Hospital. Such efforts prove that environmentally friendly efforts can be presented to administrators as potential cost savings, Moyle says. "Reducing waste is the right thing to do for the environment, but sometimes you need to prove that a change in protocol or materials used will also be a sound business decision."

Her hospital system has an environmentally conscious, or "green," culture, which reflects the philosophy and beliefs of the surrounding community, Moyle says. Thus, it makes sense that all employees look for ways to recycle and conserve resources, she says. Her facility opened in 2003 and was constructed as a "green" facility with features that enabled her staff to easily conserve resources from the beginning, but her surgery staff are always coming up with new ways to reduce waste and recycle, she reports.

"One of my nurses set up a recycling cart at the employee entrance near the time clock," says Moyle. Surgery employees, as well as other hospital employees, are encouraged to place packaging or other items on the cart for everyone to sort through in case they need boxes, bags, or even irrigation bottles for projects at home, she explains. "One of our pharmacists is using irrigation bottles from the cart as mini-greenhouses for seedlings that will be

transplanted to a garden in the spring," she says. "The key to finding environmentally friendly projects that work is to be creative." **(For a list of other ways that Boulder Community Foothills Surgery Department conserves and recycles, see article, right.)**

Finding ways to recycle materials is one way to reduce the amount of waste that must be disposed of by incineration or by burial in a landfill, says Laustsen. "Saline bottles that have expired dates or 4-by-4 bandages that have been opened but unused and are clean but not sterile, can be used by local veterinarians," he suggests. Other supplies such as unopened packs, blue sheets, or gowns can be donated to international medical relief organizations, he adds. **(See resource box for names of organizations.)**

You also can reduce waste by controlling what comes into your surgery program, says Laustsen.

"Work with vendors to minimize packaging and to customize packs to include only the most commonly used items," he says. If you notice that an item is routinely not used by most surgeons, leave it out of the procedure pack and have it available as a separate item for use by the few surgeons who may use it, Laustsen suggests.

The biggest culprit of inappropriate disposal of waste is red bag waste vs. regular trash, says Laustsen. In a study he performed at one hospital, a red bag was removed from an operating room following a procedure, and each item in the bag was removed and inventoried as legitimate red bag trash or regular trash, according to state guidelines for regulated medical waste. "I found that 97% of the trash should have been placed in the regular trash bag," Laustsen says.

Not only can red bag trash be up to 10 times more expensive to dispose of, but the incineration of items such as intravenous bags and tubing can release dioxin into the atmosphere if the incinerator's temperature is not high enough, Laustsen points out. "The less inappropriate trash that we put into the red bags, the less chance that dangerous chemicals will be released into the atmosphere," he adds.

In addition to routinely reminding staff members what items are red bag trash and what items are regular trash, Moyle suggests that trash bins for regular trash be easily accessible to staff members. "In our operating rooms, the red bag container is actually difficult to reach for most staff members, and the regular trash container is more convenient," she says. This placement reminds staff members that the majority of trash does not have to go into the red bag, Moyle adds.

While the idea of reducing waste throughout the surgery program may seem overwhelming, the first step to take is to conduct a waste assessment, suggests Laustsen. **(For waste assessment tool, see resource box, p. 22)** The assessment will give you a good idea of how your program is handling waste, what waste you generate, and how the waste disposal affects your program financially, he says. After the assessment, you can identify which areas you want to address first, Laustsen adds.

Don't try to make all of the changes at one time or address every area at once, warns Moyle. "Start small and choose a project that will produce results that everyone will notice," she recommends. "Report those results in clear, easy-to-understand language that lets employees know how their efforts positively affected the environment." For example, if you reduced water consumption over a period of time, don't just report the number of gallons saved; instead, tell employees how many five-minute showers that represents, she suggests.

When evaluating your waste disposal procedures, don't forget medications, says Laustsen. "If you have to waste a narcotic, don't pour it down the sink," he says. "That just puts the drug into our water system," he points out. Pour the medication into a trash bag, he suggests. "There's no danger of anyone getting that narcotic as it soaks into other trash."

Overall, health care employees are very receptive to opportunities to have a positive effect on the environment, says Laustsen. "People are usually not resistant, just ignorant of the opportunities that exist in a surgery program," he says. "The key is to explore alternative ways to approach conservation and waste reduction, and to take baby steps as people get accustomed to the new approach." ■

Small steps add up to major waste reductions

No conservation project too insignificant

Environmental consciousness is such a big part of the corporate culture at Boulder (CO) Community Foothills Hospital that the surgery program staff constantly comes up with new ideas to help the department reduce waste, recycle, and conserve resources.

The surgery department's following "Green

RESOURCES

- **Hospitals for a Healthy Environment (H2E), www.h2e-online.org.** This web site contains tools, resources, and information about waste reduction in health care. Information includes definitions of regulated medical waste and hazardous waste, and links to state regulations. A waste assessment tool can be found by going to the main page, selecting "waste reduction" from the top navigational bar, and scrolling down to "getting started." A link to the assessment tool is imbedded in the introductory paragraph.
- **Healthcare without Harm, www.noharm.org.** Web site contains information on waste reduction, environmentally preferable purchasing, and design of a healthy building.
- **CleanMed, www.cleanmed.org.** This web site lists conferences that focus upon waste reduction, environmentally preferable purchasing, and recycling. Free downloads of presentations and information from previous conferences are available on the web site.

List" demonstrates how each area of a surgery program can promote environmentally friendly practices in the workplace:

• **Operating Rooms:**

— Place paper and recycle bins in OR (for packaging such as plastic irrigation bottles, hard-shell containers from sponges, bovie, etc.) and work areas. Place commingled containers (glass, aluminum, paperboard, and tin) and newspaper recycle bins in lounge areas.

— Reuse hard plastics (tray liners, medicine cups, sponge containers, and bowls) in local school arts program.

— Resterilize (via third party) opened, unused, expired disposables, and compression sleeves.

— Donate unused soft goods (gowns, gloves, drapes, ambu-bags, facemasks, etc.) and supplies (catheters, bovies, etc.) to support international health care missions.

— Use reusable pulse oximeters, blood pressure cuffs, trochar sleeves, and light handles.

— Reduce use of sterilant and indicators by running quality improvement indicators with actual loads of instruments.

— Install motion sensors on scrub sinks.

— Reduce number of towels used during surgical procedures by not lining back table with sterile towels.

— Use full-spectrum (Reveal, General Electric) light bulbs. They use less energy and have longer life and less eye stress.

— Use unused paper towels as armboard covers.

• **PACU:**

— Reuse disposable flex tape pulse oximeters.

— Conserve linen by transferring with patient from pre-op to OR, from OR to PACU, and from PACU to recliner.

— Cut down obsolete orders and charge sheets into note pads.

— Return styrofoam coolers to medication vendors for reuse.

• **Sterile Processing:**

— Run power washers on "power-saving" cycles, which reduce by one-third the electricity and water used.

— Install automatic detergent delivery devices in decontamination rooms, ensuring accurate delivery of detergent and water.

— In building the instrument inventory, place instrument inventory in Sterrad-compatible hard-shell containers, which eliminates to the fullest extent possible the utilization of blue wrap.

— Run autoclave and washer-decontaminator only with a full load.

— Use bio-steam pack cards and gown turn tabs for scratch paper/notes.

— Reduce number of towels from eight to six in towel packs.

— Sterilize light handles, towels in basin sets.

• **Materials:**

— Participate in housewide battery recycling program.

— Implement rechargeable battery system for pagers and label makers.

— Products committee considers packaging and post-consumer recycled material when evaluating new products (paper, drinking cups, and toner cartridges).

• **General.**

— Reuse backside of printed paper in SPD, scheduling, and OR control desk before placing into recycle bin.

— Participate in housewide cardboard recycling program. Cardboard recycle bin is located in area of trash/linen chutes.

— Use dishwasher in OR lounge for reusable dishware and silverware in lieu of disposable plates, cups, and utensils.

— Staff members self-launder scrubs.

— Reusable sharps containers placed by vendor in patient care areas.

— Motion sensors put at all sinks to conserve water.

— Motion-activated towel dispensers reduce

paper towel use and waste.

— Motion-activated lighting installed in bathrooms.

— Alternative transportation used by staff (bus and bicycle). ■

Same-Day Surgery Manager

Things I'm gonna change in 2008

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

Now that we've started a new year, let's have no more resolutions. We're going to do something different this year. We are going to change our behavior (oh, yes, completely different from resolutions!) in areas that scream for attention. Let me make some suggestions:

• **Surgeons:**

If I have an investment in a surgery center, then I will do my cases there (as I said I would in the beginning).

I will not sneak in the operating room, late for my case, and then complain that everyone else is late.

I will not lie about the length of the case when I post it.

I will not book a case at 8 p.m. and pretend it is an emergency. (We all know that it isn't by now.)

I will fork out some money at least once a quarter for donuts to replace the ones I eat when I think no one notices.

I will not say the "F-Word" in mixed company.

I will not play opera music in the operating room so everyone will think I am cultured.

I will walk up to one member of the staff and thank them for something, anything!

• **Anesthesia:**

I will clean up my own area between cases.

I will pay attention when wheeling the stretcher to PACU.

I will not complain about anything for one hour in 2008.

I will help the staff turn over the room at least once in 2008.

I will not drag out the case so the next case goes into another room.

I will thank the staff for cleaning up my area between cases.

I will not take the last cookie or the last cup of coffee in the lounge.

I will walk up to one member of the staff and thank them for something, anything!

• **OR Nurses:**

I will not roll my eyes at the surgeon during the case.

I will not clean up after anesthesia.

I will not drag out the case so the next case goes to the other OR.

I will be nice to the new nurse.

I will not spread rumors that I know don't have a merit of truth to them.

I will not eat someone else's food from the fridge.

I will complete the chart before I get to PACU.

I will walk up to one member of the staff and thank them for something, anything!

• **PACU staff:**

I will not laugh openly at the new surgeon.

I will not call members of the anesthesia staff names.

I will smile when I take report from the OR nurse.

I will rise to a higher level when I accept a patient with an incomplete chart.

I will not retch with my patients.

I will not question the surgeon's orders while laughing.

I will be courteous to the patient's family even though . . .

I will walk up to one member of the staff and thank them for something, anything!

• **Reception desk:**

No matter how provoked I am, I will not tell someone to learn how to spell.

I will smile though my heart is breaking.

COMING IN FUTURE MONTHS

■ New ideas for reducing nausea and vomiting

■ Could your program be targeted for violence/arson?

■ What to do when insurance won't cover your anesthetic

■ New outpatient surgery procedure — It is right for your program?

I will not blog during business hours.

I will always be kind to children and their parents.

I will learn the names of the surgeons.

I will interact with the staff more.

I will not chew gum when patients are at the desk.

I will walk up to one member of the staff and thank them for something, anything!

It is going to be a fantastic year! Enjoy it.

(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.) ■

CNE/CME *questions*

Physicians and nurses participate in this CNE/ 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.

- **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. What is the law concerning waiving copayments and deductibles, according to Thomas J. Pliura, MD, JD?

A. You can't routinely waive deductibles and copays under federal Medicare law and many state laws.
B. You can routinely waive deductibles and copays under federal Medicare law and many state laws.
C. You can waive deductibles and copays for any patient if the cost of recovering the deductible and copay exceeds the amount owed.
D. None of the above

6. If a surgery program is reimbursing a surgeon for services or items, what is required, according to Jan Crocker, MSA, RHIA, CCS, CHP?

A. Documentation in a contract or agreement.
B. Review by a health care attorney.
C. Neither A nor B.
D. Both A and B.

7. What has changed in the past 10 years to increase the challenge of identifying MRSA patients in the outpatient setting, according to Robert G. Sawyer, MD?

A. Severity of illness in hospital patients.
B. Inaccurate screening tests.
C. Increase in community-acquired MRSA.
D. Speed at which patients move through the outpatient surgery area.

8. What is the first step to take when developing a waste reduction program at your outpatient surgery program, according to Gary Laustsen, PhD, APRN?

A. Educate employees.
B. Conduct a waste assessment.
C. Ask for money to purchase recycling bins.
D. Implement several initiatives at one time to see which works best.

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

Emergency Department Adult Sepsis Orders
Loma Linda Umiversity Medical Center

✓	**Attending Physician:**
	Diagnosis: ☐ **Severe Sepsis** ☐ Septic Shock
	Condition: Critical
	Allergies:

	Routine Emergency Department Orders
	Cardiac Monitoring & Continuous Pulse Oximetry
	Vitals q 1 hr with Progress Note Documentation by Nurse or MD
	Activity: Bed Rest
	Diet: NPO
	IV Saline lock with flush of Normal Saline 3 mL q 12 hours
	Calibrate & Initiate Central Venous Pressure and $Scv0_2$ Monitoring after line placement verified by MD
	Alert MD if Central Venous Pressure is < 8 mmHg or > 15 mmHg
	Alert MD if Systolic Blood Pressure is < 90 mmHg or > 160 mmHg
	Alert MD if $Scv0_2$ < 70%
	Alert MD if Hemoglobin (or Hemacue) is ≤ 9 g/dL
	Alert MD if Lactate > 2 mmol/L

	Diagnostics			
	Blood culture & sensitivity, urine culture & sensitivity, sputum culture sensitivty, urinalysis, CBC with differential,			
	Comprehensive metabolic panel, Troponin I, D-Dimer, PT/PTT/INR	reason:		
	Lactate level (drawn in grey tube on ice) now and repeat in 6 hours	reason:		
	Venous blood gas from central line & arterial blood gas	reason:		
	Chest X-ray	reason:		
	Physician Signature:		Date:	Time:

Medications (Check or circle one or more as needed. Date and time must be entered for each order)		
Physician Signature	Date and Time	
		Allergies:
		Intravenous fluids - NS 500 mL IV bolus until Central Venous Pressure 8 to 12
		mmHg, then continue NS to run at 150 mL/Hour
		Antibiotics - See Parenteral Antibiotic Order Form
		Vasopressors - (SBP = Systolic Blood Pressure)
		Norepinephrine 8 mg/D_5W 250 mL at at 2-20 mcg/min., titrate to SBP > 90 mmHg
		Dopamine 800 mg/D_5W 250 mL at 5-20 mcg/kg/min., titrate to SBP > 90 mmHg
		Phenylephrine 10 mg/NS 250 mL at 40-200 mcg/min., titrate to SBP > 90 mmHg
		Vesopressin 20 mg/NS 100 mL at 0.01-0.04 units/min., titrate to SBP > 90 mmHg
		Epinephrine 1 mg/NS 250 mL at 2-10 mcg/min., titrate to SBP > 90 mmHg
		Dobutamine 500 mg/NS 250 mL at 2.5-20 mcg/kg/min., titrate to $Scv0_2$ > 70%
		maintaining SBP > 90 mmHg and Heart Rate < 140 per min
		Nitroglycerin 100 mg/D_5W 250 mL at 10-60 mcg/min., titrate to SBP < 140 mmHg
		Type & Cross 2 units
		Tranfuse ____ unit PRBC - See Blood Transfusion Order Form
		Dexamethasone 2 mg IV q 6 hr
		Xigris (Drotrecogin alfa activated) - See Separate Medication Order Form

TRANSMISSION-BASED ISOLATION CATEGORIES AND BARRIERS

CATEGORY	ROOM		MASK	GOWN	GLOVES	DISEASE EXAMPLES
	PRIVATE	NEG PRES				
AIRBORNE	YES	YES	ALWAYS (See disease examples for specific type)	CLOSE CONTACT	SECRETION	TUBERCULOSIS *a* MEASLES *c* VARICELLA ZOSTER *b,c* (disseminated or in immuncompromised host)
CONTACT	YES	NO	SOMETIMES *c* (dressing changes, suctioning, secretion handling)	ALWAYS	ALWAYS	MRSA, SERRATIA, VRE ENTERIC INFECTIONS e.g., CLOSTRIDUM DIFFICILE RSV, ENTEROVIRUS IN CHILDREN LARGE DRAINING WOUNDS PEDICULOSIS, SCABIES ZOSTER, LOCALIZED (in immume competent host)
DROPLET	YES YES		YES *c*	CLOSE CONTACT	SECRETION HANDLING	PERTUSSIS HAEMORPHILUS INFLUENZAE Type b (invasive) INFLUENZA, VIRAL MENINGOCOCCAL MENINGITIS, NEUMONIA, SEPIS (disseminated) DIPHTHERIA (pharyngeal)

a. Special N95 (or equivalent) mask required. *b.* Use both airborne and contact signs
c. Regular surgical mask NEG PRES = Negative Pressure Room

Source: West Virginia University Hospitals, Morgantown.

Glutaraldehyde Use Survey

This survey, developed by Jamie Tessler for the Sustainable Hospitals Program at the University of Massachusetts–Lowell, can be used to identify where glutaraldehyde is being used in the facility, improve work practices or protection, and monitor possible health effects. It can be adapted to incorporate glutaraldehyde substitutes.

Date: _____

Facility: _____

*Interviewer:*_____

General Information

1. Clinical Area where disinfection is performed: _____
2. Room Number where glutaraldehyde is used: _____
3. Are patients examined (or undergo procedures) in this room?_____
4. Name of employee(s) who performs disinfection activities (Optional) _____

_____

5. Commercial product name (and % glutaraldehyde, if known):_____

Health Effects

6. Noticeable odor when using this product?: Yes ____ No _____
7. If you answered "Yes" to #4, is the Odor Strong ____ or Weak ____ ?

Any symptoms or health complaints associated with working with this product?

Yes____ No ____ If Yes, please describe: _____

_____

Please describe the following procedures:

8. Name of device(s) disinfected in this area: _____
9. What type of container is used for the glutaraldehyde solution? (Check box that applies to your situation.)

☐ Open Bin (describe Bin type or brand if available) _____

☐ Open Bin with Lid (describe Bin type or brand if available) _____

Are Lids kept on ☐ most of the time? ☐ some of the time?

☐ Enclosed System (list name brand and model if available)_____

10. Is this device routinely pre-cleaned before it enters the glutaraldehyde solution? (If yes, please list the name of the pre-cleaning solution utilized). _____
11. Length of time device is soaked in glutaraldehyde solution: _____
12. Method of retrieving device from glutaraldehyde solution (e.g. remove with gloved hand , tongs, etc):

_____

13. Type of gloves worn, if any (brand and material): _____
14. Type of protective gear worn, if any (e.g., goggles, face shield, apron): _____
15. How often this procedure is performed (specify daily, weekly, or other): _____
16. Where do you dispose of the spent glutaraldehyde solution? _____
17. How do you dispose of the glutaraldehyde? _____
18. How much glutaraldehyde is disposed of per week? _____ Per month? _____
19. How do you refill the soaking bin or system with glutaraldehyde? (check box)

☐ pour from bottle
☐ pour from bottle with funnel
☐ pour with special glutaraldehyde spout
☐ other (please describe): _____

Source: Sustainable Hospitals Program, www.sustainablehospitals.org.