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Welcome to the first issue of *OR Manager's* monthly Ambulatory Surgery Center (ASC)-focused supplement: *ASC Manager.* This supplement will be inserted quarterly and is a new benefit for subscribers.

The ASC market is projected to increase from $36 billion in 2018 to $40 billion by 2020 according to a recent market watch report. Every month, we publish content for ASCs in *OR Manager* that keeps you on top of trends, regulatory updates, and case studies to increase efficiencies. Your first quarterly supplement expands on this coverage by honing in on facility safety, patient safety, and practical business advice.

We know that your role is constantly changing, and we created this supplement to continue to deliver valuable articles to positively impact your organizations and your professional development. We hope you enjoy this first issue of *ASC Manager*, and please don't hesitate to reach out if you have any feedback.



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Cybersecurity should be high on healthcare priority lists

No homeowners willingly allow a burglar to enter their home and steal their most valuable possessions. Instead, people put locks on doors, install alarm systems, build fences, or keep big dogs. The thieves may still get in, but deterrents like these will reduce the risk of a successful burglary.



Nelson Gomes

Ambulatory surgery centers (ASCs) should likewise think about security measures to protect their digital information. There may be no foolproof way to stop determined hackers. But why make it easy for them?

"You can and should decrease your cybersecurity risks," says Nelson Gomes, president and CEO of Priority-One Group, which provides information technology (IT) services and solutions to healthcare organizations and other businesses.

Conducting a risk assessment, implementing protective devices and practices, and educating employees about the prevalence of hacking are essential action items for avoiding potential security breaches.

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A clear and present danger

Statistics and news reports make clear that healthcare data is a priority target for cybercriminals. Although statistics may vary, the 2017 Annual Data Breach Year-End Review found that the business sector topped the list with 870 reported incidents, followed by the medical/healthcare sector with 374 breaches (23.7% of total breaches). The report was released by the Identity Theft Resource Center® , a nonprofit organization established to support victims of identity theft, and CyberScout® , a company that provides data and identity defense services.

"There is money to be made in hacking health information," says Federal Bureau of Investigation Supervisory Special Agent Timothy Russell, head of the criminal cyber squad in Boston. "If you are involved in healthcare, you are being researched, reconnoitered, and targeted."

Despite the facts, many healthcare systems are nowhere near ready for the remarkably sophisticated, well-structured, and highly successful organizations of criminal hackers. And it may be some time before they are adequately prepared, experts say.

Patient safety threat

Healthcare leaders must change their world view to see the relationship between cybersecurity and patient safety, says Gerard M. Nussbaum, Esq, a principal with Zarach Associates.

In June 2017, the Health Care Industry Cybersecurity Task Force reported to Congress that it believes preventing the theft of healthcare information is just as serious as preventing medical errors. "The healthcare system cannot deliver effective and safe care without deeper digital connectivity. If the healthcare system is connected but insecure, this connectivity could betray patient safety," its report states.

The biggest danger is not identity theft, supply chain disruption, or fraud, but the disruption to patient care and hospital systems from breaches of electronic health records, medical devices, tablets, and computer systems, says Theresa Meadows, senior vice president and chief information officer for Cook Children's Health Care System in Fort Worth, Texas. Meadows was co-chair of the cybersecurity task force.

It may be only a matter of time before a cybercriminal works out how to shut down IV pumps or change medication dosages on the pumps if more is not done to protect healthcare system data.

"If we don't get in front of the problem, I think it could happen," Meadows says.

The 1999 Institute of Medicine (IOM) report, "To Err is Human: Building a Safer Health System," was a call to arms for patient safety. In the same vein, the cybersecurity task force hoped its report would galvanize both the public and private sectors to comprehensively address cybersecurity challenges to protect patients, Meadows says.

Although the response was not as immediate as that seen after the IOM

What would the FBI do?

The most frequent attacks on healthcare networks are for personally identifiable information, or PII, and personal healthcare information, or PHI, says Timothy Russell, supervisory special agent with the Federal Bureau of Investigation (FBI).

The hacking tools used to steal PII and PHI are readily available on the Darkweb. "I could launch an attack in 30 minutes," says Russell, supervisor of the Boston Criminal Cyber Squad, which covers Massachusetts, Maine, New Hampshire, and Rhode Island. His squad's responsibility includes responding to cyber incidents to the healthcare industry.

Ransomware attacks are one of the most frequent types of attacks investigated by the FBI, according to Russell. Ransomware attacks occur when malicious actors successfully introduce malware into a computer system.

This usually happens when someone inadvertently clicks on a link or attachment that looks legitimate. The malware then encrypts the critical files on that system and makes the decryption inaccessible to system users unless a specified ransom is paid to get the key to decrypt the files.

Here are the FBI's tips to protect computers from ransomware.

- Make sure you have updated antivirus software on your computer.
- Enable automated patches for your operating system and web browser.
- Have strong passwords, and don't use the same passwords for everything.
- Use a pop-up blocker.
- Only download software—especially free software—from sites you know and trust (malware can also come in downloadable games, file-sharing programs, and customized toolbars).
- Don't open attachments in unsolicited e-mails, even if they come from people in your contact list, and never click on a URL contained in an unsolicited e-mail, even if you think it looks safe. Instead, close the e-mail and go to the organization's website directly.
- Use the same precautions on your mobile phone as you would on your computer when using the Internet.
- To prevent the loss of essential files caused by a ransomware infection, it's recommended that individuals and businesses always conduct regular system backups and store the backed-up data offline.

The FBI does not recommend paying hackers for the decryption key if an organization's computer system is successfully breached by ransomware. There is no guarantee the key will be provided or that it will work, Russell says.

The FBI is aware of over 67 different variants of ransomware and is investigating a number of them.

report, a quiet momentum has been building during the last year, particularly in the Food and Drug Administration and the Department of Health and Human Services (HHS), Meadows says.

These agencies are looking at some of the cybersecurity report's recommendations, such as how new medical devices can be built so they can be patched and updated once in use. Private individuals have also formed committees to look for practical ways to implement the report's recommendations.

"I think the action is picking up, and we will be seeing more reports," Meadows says.

Building a secure system

Although even the most highly secured computer systems are still vulnerable to attacks, that does not mean healthcare administrators should just throw up their hands and ignore the problem, Nussbaum says.

Cybersecurity is often considered to be less important in small healthcare organizations than in large ones. However, smaller organizations, such as ASCs, may face even greater challenges and can be more vulnerable to attack because they typically have:

- an inability to devote time to monitoring security and patching systems
- budget limitations
- an overall less secure environment
- less technical security expertise.

Budget restrictions can hold healthcare administrators back from spending more on something intangible but necessary, like cybersecurity, than on staff providing direct patient care. The challenge is convincing them of the need.

The cybersecurity task force report found that healthcare leaders who have not experienced a serious breach or loss of data often do not see the value of cybersecurity expenditures. Many security professionals say it is difficult to convince leaders about the importance of cybersecurity and being proactive, which can in the long run limit possible patient harm, according to the 2017 report.

"It's really difficult to find a balance," Meadows says. "But there are many steps that can be done for little or no money to increase a system's cybersecurity defenses."

Indeed, the two most important steps ASC leaders can take are educating all employees about cybersecurity and conducting a cybersecurity risk assessment. At least then they will recognize risks, prioritize them, and hopefully start taking additional security measures, Meadows says.

The challenge in educating ASC staff is making cybersecurity relevant to their work. This can be done by using interactive campaigns that show how cyber breaches can potentially harm patient care.

For example, both Gomes and Meadows recommend conducting false "phishing campaigns." These are done by sending employees false emails to see if they respond. Meadows says her facility sends false emails saying that a package has arrived for an employee and instructing the person to confirm by clicking on a specified link.

If a staff member takes the bait, up pops educational material about how phishing works, what it does, and how to recognize it, Meadows says.

Cook Children's Healthcare System has used "lunch and learn" sessions during which staff go into an ICU room and are asked to point out potential cybersecurity breaches in all the equipment they see.

Don't forget HIPAA

Education on the HIPAA Privacy Rule also needs to be continuously administered and reinforced. This information should include:

- proper handling of suspicious emails
- proper use of passwords
- inappropriate texts and social media posts sharing personal health information.

Other security steps include the following.

Choose a security leader.

Small organizations like ASCs may not have the money to hire a full-time IT specialist. Most contract with IT security companies to keep their computer systems safe.

But experts agree that someone within the organization must be designated to oversee other security initiatives, such as employee training and education. This should be someone within the ASC who is willing to take on the additional role of leading cybersecurity planning and providing oversight.

Conduct a cybersecurity risk assessment.

An assessment will reveal where systems are most vulnerable to attack. A security plan can then be built based on the assessment's findings. The plan should be tested at least annu-

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ally, if not more frequently.

Also plan for how your ASC would respond to a successful cyberattack. "Do you have a plan so that you can do your core business function if your system goes down?" Russell asks.

Encrypt all your data and patch networks.
There is no excuse not to encrypt data and keep patches current, Nussbaum says. Encryption is a method of scrambling data with an algorithm so that it is unreadable to anyone who does not have the encryption key. Patching is updating the computer software with a new version that enhances functionality or closes security vulnerabilities.

Oversee your IT vendor.
The contracted vendor that provides IT and security services for your ASC should be held accountable. Do not assume this vendor is doing everything possible to secure and protect your ASC's data.

Purchase cybersecurity insurance.
ASCs should purchase cybersecurity insurance. But before purchasing a plan, Gomes suggests asking if it covers ransom payment if a ransomware attack occurs.

Think ahead.
Prepare for a possible security breach by anticipating what you will need to mitigate the loss of data. But remember the tried and proven military adage: "The best defense is a good offense"—even when the enemy is not visible. ✣

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References

2017 Annual Data Breach Year-End Review. https://www.idtheftcenter.org/images/breach/2017Breaches/2017AnnualDataBreachYearEndReview.pdf.

Curren S. Better Protecting the Healthcare System—and, Ultimately, Patient Care—Against Cyberattacks. June 2, 2017. https://www.hhs.gov/blog/2017/06/02/better-protecting-healthcare-system-against-cyberattacks.html.

Gomes N, Russell T. ASC Cyber Security Guidance from the Front Lines. Presented at 2018 ASCA Conference.

Health Care Industry Cybersecurity Task Force. Report on Protecting Cybersecurity in the Healthcare Industry. June 2017. https://www.phe.gov/Preparedness/planning/CyberTF/Documents/report2017.pdf.

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Early action advised to achieve better OAS CAHPS responses

Mandatory implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) originally scheduled for 2018 has been delayed, but that does not mean it should be ignored, say ambulatory surgery center (ASC) leaders.

The earliest projected date when the survey could become mandatory is fall 2020, after the Centers for Medicare & Medicaid Services' (CMS) annual rulemaking cycle in 2019. But many details are involved in implementing OAS CAHPS. It requires planning and practice before lessons can be learned from patients' responses regarding their surgical experiences.



Michelle George, MSN, RN, CASC

"Implementation is not like flipping a switch; it is not a simple system," says Michelle George, MSN, RN, CASC, vice president of professional development, Surgical Care Affiliates, Deerfield, Illinois, which manages approximately 220 ASCs. ASC leaders should start getting up to speed now (https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/OAS-CAHPS.html).

Voluntary participation in OAS CAHPS began in January 2016. Early adopters are not required to publicly report their results, but implementing the survey early allows ASCs to improve areas of weakness before public reporting of results is mandated through OAS CAHPS. Indeed, OAS CAHPS scores prompted one facility to revamp its discharge instructions and, in the process, increase patient satisfaction (sidebar, p 6).

A work in progress

OAS CAHPS is designed to measure patients' experiences in Medicare-certified hospital outpatient departments (HOPDs) and ASCs, notably:

- communication and care provided by healthcare providers and staff
- preparation for the surgery or procedure
- preparations for discharge and recovery.

Patients also provide an overall rating of the facility and their willingness to recommend it to family or friends.

Although OAS CAHPS has 37 required questions, individual ASCs may add up to 15 additional questions. However, too many questions will deter people from answering, according to George.

"Around 60% of our centers implemented the survey during the early adoption period, and we have seen a few drop out since OAS CAHPS mandatory reporting has been delayed," she notes.

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Why isn't OAS CAHPS ready for mandatory implementation?

The survey is too long.

The survey should be distributed online as well as by phone or mail.

The cost to implement the survey is too high.

These are the concerns voiced by ambulatory surgery center (ASC) leaders that prompted the delay in mandatory implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) by the Centers for Medicare & Medicaid Services (CMS).

Mandatory implementation was expected this fall in CMS-certified ASCs. But CMS chose to resolve the above issues first, according to CMS. Sources would not say if they anticipated OAS CAHPS would be mandatory after the next round of annual rulemaking in 2019, the only way in which the rule can be changed.

For now, the implementation of OAS CAHPS remains voluntary.

Currently only about one-fifth of more than 6,000 ASCs voluntarily participate in OAS CAHPS, CMS sources say.

Length. The survey now consists of 37 required questions. ASCs are free to add up to 15 additional questions. CMS is examining whether some of the questions can be eliminated and still enable the survey to elicit the sought-after information about the quality of the ASC experience.

Mode of distribution. CMS is currently working on a web mode to see if it is a feasible means of distribution, in light of the concern that some older people may not have Internet access. Once that work is completed, a decision can be made about web distribution, CMS sources tell OR Manager. The ASC industry also wants the option of distributing the surveys onsite.

Cost. Shortening the survey and allowing a web version of OAS CAHPS should make it less expensive to implement, CMS says.

Survey data. Survey results from the first year of full OAS CAHPS implementation for 2017 are available on the CMS website. But ASCs are not required to make survey results public while OAS CAHPS remains voluntary.

The survey results are currently not in a format that consumers can use. Once the survey and public reporting become mandatory, a more consumer-friendly version of the results will be on the CMS website.

Once OAS CAHPS is mandatory, it will be the first standardized survey instrument to assess patient experience at ASCs and hospital outpatient surgery departments.

Source: Centers for Medicare & Medicaid Services.

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Patients tend to stop answering questions after about the fifteenth question, says Ann Shimek, MSN, BSN, RN, CASC, senior vice president of clinical operations for United Surgical Partners International, Addison, Texas.

United Surgical Partners owns and manages 250 freestanding ASCs. Of those, she says, 85% have been early adopters of OAS CAHPS.

Shimek thinks expecting patients to answer 37 questions or more may be unrealistic. Indeed, concern about the survey being too long is one of the reasons mandatory implementation was delayed (sidebar, p 5).

Some ASCs already conduct their own surveys and may continue to do so. But the questions in those surveys are probably different from those in OAS CAHPS. For example, George says: "Our old survey asked how well we did something. OAS CAHPS asks patients how frequently you did something, which is a little bit different."

Perhaps the most important step in implementing OAS CAHPS is finding the right vendor. Only CMS-certified vendors

Simple changes net higher numbers on recovery questions

Voluntary implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) at the Northwell Health Center for Advanced Medicine (CFAM) Ambulatory Surgery Center, part of the Long Island Jewish Medical Center in New Hyde Park, New York, began in 2017. Leadership wanted the early adoption so as to be fully prepared before OAS CAHPS becomes mandatory for all ambulatory surgery centers (ASCs), says Ellen Carpenter, BSN, RN, nurse manager.

Early action has already paid off through the development of better discharge instructions, leading to higher patient satisfaction scores.

Recovery is one of five categories represented in OAS CAHPS. Nine of the 37 questions on OAS CAHPS focus on recovery. The first is: "Did your doctor or anyone in the facility prepare you for what to expect during your recovery?" Subsequent questions ask about nausea, vomiting, pain, infection, and bleeding.

Practical and pretty

Recovery-related scores among Northwell Health's patients were not as high as anticipated—only 80%. Recognizing that perhaps patients needed better discharge instructions, staff formed a task force to work on a solution. Within 3 months of replacing old discharge instructions with a new and improved format, leaders saw an increase in scores for recovery-related questions from 80.5% to 95%.

The improvement came not from large, costly changes, but rather from common sense, patient-centered modifications to information that was already being provided to patients after surgery.

The idea for the changes came from staff nurse Susan Miller, BSN, RN, a member of the patient experience committee. Her suggestions were embraced by Maureen Early-Donohue, MSN, RN, senior administrative director, patient and customer experience, Long Island Jewish Medical Center, and a task force was formed.

The task force created a discharge folder with handouts outlining detailed information about the possibilities of pain, nausea, bleeding, and infection following surgery and what to do if those things happened. On the second side of the folder, a handout was created for surgeons' direct discharge instructions for the patients' particular type of surgery and related side effects.

The handouts were designed using the latest information on health literacy in a colorful, easy-to-navigate format that patients were less likely to toss in the trash when they went home.

The previous discharge instructions were provided on a one-page, uninspired handout with small type and did not mention bleeding or infection. The low OAS CAHSP scores revealed the original handouts were not as helpful to patients as they were meant to be.

The new folders were distributed to patients beginning in October 2017. But to reinforce the instructions, they are discussed during presurgery calls to patients. Some patients cannot fully absorb information at the time of discharge because their memories may be impaired by anesthesia. Family or friends who are with them at the time may not accurately remember the details, either.

Sustaining the gains

Despite the jump in patient satisfaction scores to 95%, team members did not rest on their laurels. To sustain the high score, surgical team members track an OAS CAHPS scorecard to monitor any significant changes, and they check in weekly with frontline staff and monthly with ASC leadership.

Gloria M. Collura, MSN, RNC, senior administrative director II, patient care services, perioperative services, at Northwell CFAM ASC, offers this advice for anyone wishing to make similar improvements in OAS CAHPS scores:

- ➤ know your data from your ASC's OAS CAHPS scores
- ➤ start with a simple goal
- ➤ use teamwork.

Because of the success regarding recovery and discharge, team members involved with anesthesia are examining ways to improve their OAS CAHPS scores as well.

can be used to administer the survey. To date, only 22 survey vendors are certified for more than 6,000 ASCs in the country (https://oascahps.org/General-Information/Approved-Survey-Vendors).

Choosing a vendor

The dearth of certified vendors is one reason to consider implementing the survey before it becomes mandatory. ASC leaders and CMS sources say it is important to talk to at least three vendors before signing any contracts. The prices for vendors and their services are not equivalent.

CMS does not approve what vendors charge or any additional services they may include beyond what is required, CMS sources say.

"Cost varies by vendor and the scope of work, as well as the number of surveys distributed," George says. "We are having our vendor develop additional reports for our company, so that will increase the overall cost of survey implementation." Costs are also likely to change once CMS revamps its requirements for the survey.

Shimek adds that implementation time varies, but in general takes 3 to 4 months.

Here are some recommended steps for choosing a vendor:

- Get cost estimates from three vendors.
- Ensure vendors have experience with ASCs.
- Inquire about vendor's return rates and monthly sample size, which affects cost.
- Ascertain if the vendor has experience with the ASC's patient-accounting system.
- Request a free quarter to see how the survey implementation works.
- Select a designated employee to work with the vendor.
- Ask the vendor to do a demonstration of the survey.
- Ask how many reports the vendor will issue to the ASC and when.

Nine out of the 37 required OAS CAHPS questions are based on what happens before the patient even arrives at the ASC. Many of these experiences occur in the surgeon's office, which is why it's important to get physicians engaged, says Shimek.

Physicians tend to be driven by data, so once survey results are received, they can be shown to surgeons to help them understand the importance of OAS CAHPS.

The preadmission phone call is an invaluable step ASCs can take between the surgeon's office and the day of the procedure. This helps set patients' expectations of the upcoming experience and notification of the survey. However, although patients can and should be informed about the survey, there are do's and don'ts of how they should be informed, Shimek says. For example, coaching on how to answer questions is not allowed (sidebar above).

Educating ASC staff, physicians, and board members about the survey is important for achieving good scores. Shimek recommends reviewing the survey questions with staff and discussing responses indicating high satisfaction as well as areas where improvements are needed.

"Traditional ASC survey results have been reported using a Net Promoter Score based on percentage of responses. The OAS CAHPS calculation process uses the percentile methodology, which is typically a lower number," George explains.

"It is important for leaders to understand this because it can be confusing at first. It is equally important for them to evaluate their performance in the various composite categories and focus on strategies to improve the patient's experience in those key areas," she adds.

Early adopters have more time to improve performance, overcome staff doubts about the survey, convince physicians of its importance, and refine messaging to patients about the survey, say Shimek and George.

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What to tell patients about OAS CAHPS

It is important to avoid influencing patient responses to the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) survey. Any information or communication about the survey from hospital outpatient departments (HOPDs) and ambulatory surgery centers (ASCs) may introduce bias to the survey.

It is acceptable for HOPDs and ASCs to inform patients that they may be asked to respond to a patient experience survey. This information can be provided in writing or verbally with discharge instructions or with paperwork provided to the patient in advance of the surgery or procedure. Information to patients about the survey can include the following messaging:

- The HOPD/ASC is participating in the survey to learn more about the quality of healthcare that patients receive.
- Patients may be selected to participate in a survey about their experience at the HOPD/ASC.
- Indicate the mode of the survey that the patient should anticipate receiving (telephone or mail).

It is not acceptable for HOPDs or ASCs to do any of the following:

- Provide a copy of the OAS CAHPS questionnaire or cover letters to the patients.
- Ask any OAS CAHPS or similar questions of patients prior to administration of the survey or after discharge.
- Include words or phrases verbatim from OAS CAHPS in marketing or promotional materials.

Source: Outpatient and Ambulatory Surgery CAHPS® Survey, Protocols and Guidelines Manual.

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Two of the lowest rated areas in surveys from UPSI's facilities were the receptionists and the lobby, Shimek says. The lobby was criticized for being messy, and the receptionists for being rude. Those problems were easy to fix. "We started having someone from the business department go through the waiting room," she says. "Little things make a big difference."

Other areas frequently cited for improvement in OAS CASHPS are wait times, delays, and pain control. "If a surgeon is late, we apologize but tell patients that the good news is the excellent care they will receive once the surgeon arrives," Shimek says.

Studies show that 12 minutes is about as long as a patient wants to wait before some type of staff interaction. "We do a lot of patient rounding and make sure there is a staff interaction with a patient every 10 minutes," George says. "We also frequently update families about what is happening."

Once OAS CAHPS is mandatory, ASCs will be able to do an apples-to-apples comparison of performance within their own ranks, rather than HOPDs, says Shimek. ✣

Janet M. Boivin, BSN, BSJ, RN, is a freelance health writer/editor in the Boston area.

References

https://oascahps.org/General-Information/About-OAS-CAHPS-Survey.

Shimek A, George M. What You Need to Know Now About the OAS CAHPS Survey. ASCA 2018.

How many different procedures are right for your ASC?

When launching a new ambulatory surgery center (ASC), owners must consider a myriad of issues—financing, design, building construction or purchase, regulatory compliance, certification, staffing, and marketing. Underlying all of these considerations are which procedures the center will provide and whether the ASC will be single specialty, like gastrointestinal (GI) or ophthalmology centers, or multispecialty, offering numerous service lines.

"From the very beginning, ASC owners need to ask themselves what they want to be when they grow up," says Sandra Jones, MBA, MSM, CPHRM, LHRM, CHCQM, CASC, FHFMA, founder of Ambulatory Strategies Inc in Dade City, Florida, a certified risk manager, and a surveyor for the Accreditation Association for Ambulatory Health Care. "Do they want to start out offering multiple specialties or begin as a single specialty with room to expand later?" Jones asks.

She has seen many ASCs design their facilities as single specialty, which leaves them no room to expand later. "Some ASCs are overbuilt, so their overhead is really high. Others are underbuilt, and within a couple of years they're bursting at the seams," Jones says. "The first ASC I ever opened designed the facility so a third OR could be added if it had a need based on volume. They never needed it, but it was there if they wanted to."

She points to orthopedics and pain management to illustrate this balance. "If I'm in an orthopedic surgery center, I will need fewer pre- and postop bays than if I also have pain management. But if I add pain management, those procedures turn over more quickly, and I will need those postop bays to get patients in and out. It's certainly more cost-effective to think about this up front and plan not just for the short term but also for what the future might hold," Jones says.

Like orthopedics and pain management specialists, physicians within the same or complementary specialties often join to form single- or multispecialty ASCs. Other complementary specialties are GI and urology or ENT combined with ophthalmology and plastic surgery. "GI and endoscopy more often operate as single-specialty ASCs because they do not require sterile corridors and historically have generated enough volume to justify running independently," Jones says.

Pros and cons

There are both advantages and disadvantages to operating single- or multispecialty ASCs.

"A multispecialty center offers a broad, diversified procedure base, maximizes payer relationships, and enhances recruitment of staff who find working with a mix of specialties more appealing," says Beth Derby, MBA, BS, RN, senior vice president for clinical and facility development at Compass Surgical Partners, a surgery center management, acquisition, and development firm in Raleigh, North Carolina. "Because of its diverse service lines, a multispecialty center is not dependent on the swings of either technology or reimbursement."



Beth Derby, MBA, BS, RN

Multispecialty ASCs may have lower cost per case, depending on the case mix, because the costs are spread across multiple specialties. They are also in a better negotiating position with contract payers, Derby says.

"Multispecialty ASCs have more negotiating power," Derby adds. "They can say to payers, 'I'm not just asking you to execute a contract for a single specialty. I can offer you five different specialties at a lower cost than the hospital HOPD [hospital outpatient department].' The more procedures you can offer them, the more appealing you are as a facility."

"The mix of surgical specialties provides a challenge to staff," says Marsha Rowe, MBA, BSN, RN, administrator and clinical director of Southeastern Ambulatory Surgery Center, a majority hospital-owned ASC in Lumberton, North Carolina. "Today was an eye day, tomorrow is pain management, and the next day is orthopedics and podiatry. It really keeps us on our game. The variety is very good for our professional development."

Rowe says the ASC has had almost no turnover of the clinical staff, most of whom came from the hospital and were familiar with a range of cases. "They really like the variety," she says.

Southeastern Ambulatory Surgery Center performs about 3,200 procedures a year, including ENT, ophthalmology, gastroenterology, gynecology, orthopedics, and pain management. The 4-year-old center's annual goal is 4,000. With four operating rooms, two gastroenterology suites, and a procedure room, the center's utilization is at 50%. "We'll get there," Rowe says. "We're ramping up. We just added a gastroenterologist and an ophthalmologist, and we're recruiting more ob-gyns."

When Southeastern was getting off the ground, the hospital signed loans for the building, instruments, equipment, and supplies. "As a multispecialty center, it's always a fine dance of coming up with capital," Rowe says. "We have to purchase a lot of different kinds of equipment and supplies.

"If we were just an eye center, we would know what we need every week, but our materials vary based on the procedure and physician preference. And we want each of our specialties to have what they feel they need."



Marsha Rowe, MBA, BSN, RN

Southeastern works to standardize equipment preferences and purchases among surgeons. "When orthopedics need implantables, we need to make sure they don't cost an arm and a leg, no pun intended."

Streamlined, bulk purchasing is an advantage single-specialty ASCs have over multispecialty ASCs.

"When you buy six of one item instead of three, you're going to get a better price," says Michele Bossi, MSN, RN, director of clinical operations and administrator of OSS Health Ambulatory Surgery Center, an orthopedics-only center in York, Pennsylvania. "Because we only do orthopedics, we can negotiate with our vendors and standardize as much as possible.

"We have very thorough historical data on our physicians and their procedures, so we can accurately assign them block times. And because we have the same staff assigned to a physician each time, they have much faster case times and turnover," Bossi says.

Single-specialty exposure

Single-specialty ASCs are not without their disadvantages, including dependence on fewer physicians and higher exposure to changes in reimbursement.

"You are at much higher risk if one of the three partners, who is the heaviest practitioner, is no longer able to work," Derby says. "Your center can take a big hit. When you are dependent on fewer people, each active provider becomes much more critical."

Also, changes in Medicare reimbursement for that one specialty can greatly compromise a center's revenue stream and its ability to cover costs. For example, some pain management codes took an increased hit in 2017. Medicare reduced payment for some high-volume epidural injection codes by 16% to 25%, depending on the code. Nipple/areola reconstruction was reduced 18%, and repair of anorectral fistula with plug was reduced 17%.

Determine market share

Any ASC, whether single- or multispecialty, must determine its market share before investing resources into its center.

"Perform an analysis of current and future volume by CPT code, and ensure there is enough volume in your community to justify each specialty," Jones advises. "Your analysis needs to factor in what percentage of your cases are appropriate for the ASC setting and what percentage will always be done in the hospital, such as patients with higher comorbidities.

In the end, physician interest in performing surgeries at an ASC will determine the caseload.

"Make sure your physicians are happy and want to come to your center," Bossi says. "While we specialize in orthopedics, we wouldn't turn away anyone who wants to come in and do their procedures at our center. But the surgeon needs to bring enough cases to support new equipment purchases and training staff in a different procedure." ✣

Leslie Flowers is president of Flowers Communications in Indianapolis.

References

Flowers L. Do Medicare's latest code changes help or hurt ASCs? OR Manager. 2017;33(8),28.

2017 Surgery Medicare Updates. Cook Medical. https://www.cookmedical.com/wp-content/uploads/2017/02/SUR-BEI-SURMUEN-RE_201701.pdf.

Track ASC metrics to produce a healthy bottom line

Each day seems to bring new tasks for leaders of ambulatory surgery centers (ASCs), adding to their already overflowing plate. One task that can easily fall off that plate is collecting and analyzing metrics, yet failing to do so can have serious financial consequences. OR Manager recently asked ASC leaders to share strategies for managing financial and clinical metrics.

Tracking financial metrics

"ASC administrators need to know they are maximizing their profitability because that's what the board is expecting," says Ann Geier, MS, RN, CNOR, CASC, chief nursing officer for Surgical Information Systems in Alpharetta, Georgia. Profit margin goals for most ASCs are in the 30% range or less, according to Geier.

Although ASC leaders are on firm ground when it comes to clinical metrics, Geier says they may struggle with financial ones. She recommends tracking a core group of high-impact financial metrics (sidebar, p 11).

"The most expensive items in an ASC are supplies and payroll," says Deborah Comerford, BSN, RN, CNOR, CASC, LHRM, senior vice president of operations for Ambulatory Surgical Centers of America, based in Hanover, Massachusetts.

"You want to make sure those costs don't creep up, which can easily happen," she cautions.

Supplies

"Too many administrators haven't entered their inventory into the computer," Geier says. "That leads to bad contract negotiations because you don't know how much supplies cost."

A good benchmark is that about 21% of the collections coming into the facility covers supplies. "Knowing that number will let you know if you aren't paying the best price," Geier says.



Ann Geier, MS, RN, CNOR, CASC

ASC leaders might want to trim their item master because centers tend to use only 12% of what's on the list. Managing supplies can also improve the operating cash flow of the ASC.

A group purchasing organization (GPO) can help control costs, Comerford notes, but ASC leaders should still check frequently to ensure that the center is getting the best price.

"The GPO should be able to tell you what you should be paying, so you can compare against what you are paying," she says. Leaders responsible for multiple ASCs should compare costs among centers.

Comerford recommends using case costing to compare surgeons doing the same procedure. If one surgeon's supply costs are unusually high, drill down to find out why, and bring it to the surgeon's attention.

"[The surgeon] may have not thought about the cost for that particular item, and might be willing to evaluate a similar, lower-cost item," she says, adding that even surgeons who aren't ASC owners understand the need to control costs. "We don't dictate that they have to change, but they might consider it if there is a comparable product at a lower price," Comerford notes.

Case costing also helps assess overall financial health. "You want to know total costs for each case and what you will be reimbursed," says Ann Shimek, MSN, RN, CASC, senior vice president of clinical operations for United Surgical Partners International in Addison, Texas. "If a self-pay case takes up to 6 hours, but you could have done five knee arthroscopies during that time, it would be better to do the knee cases."

Payroll

Geier recommends tracking staff hours as percent of collections and staff hours per case. "If you are a fast throughput center [eg, GI, ophthalmology, pain management], your total staff hours per case should not be higher than 7 or 8, and that includes everybody [such as business office staff]," she says.

For longer cases, such as spine and orthopedics, the target number should be about 10 to 12 hours. Of course, case mix factors into hours per case.

Staff hours should be tracked on a daily basis. "It's easy for nurses to head into overtime, and that can hit your finances," Shimek says.

The type of employee also plays a role. "Don't use a lot of full-time employees," Geier says. "Part time gives you more flexibility."

Other financial metrics to track include those related to payment, volume, and patient satisfaction.

Payment best practices



Deborah Comerford, BSN, RN, CNOR, CASC, LHRM

"Send billing paperwork out the same day or the day after the procedure," Comerford recommends. Ideally, it should take fewer than 30 days to receive payment, although many factors affect that figure, including case mix, number of patients out of network, and number of specialties.

For instance, ophthalmology ASCs may receive payment quickly because most patients are on Medicare, but cases with multiple billing codes may take longer.

If accounts receivable (AR) days are high, Geier suggests hiring another collector. "The cleanup can pay for itself 10 times over," she says.

Geier says ASC leaders should also track AR percentage current, which re-

fers to what has just been billed; best practice is that 72% of the amount billed should be less than 30 days.

"If you don't get paid quickly, it's very difficult to collect, particularly after 90 days," she says. "You should be aggressively working on anything over 60 days because if you don't get [payment] then, you probably aren't going to get it."

To avoid payment delays, ensure that patients are precertified by their insurance provider, and collect any costs not covered by insurance before the procedure. Recovering costs becomes more difficult as time passes, Geier says.

She recommends tracking how each patient plans to pay uncovered costs. If it's by credit card, business staff should obtain payment information during the preoperative call with the patient. At the other end of the spectrum, refunds owed patients should be processed promptly to avoid dissatisfaction.

ASC leaders can use a simple Excel spreadsheet to track denials and help them identify trends, such as whether an insurer is denying a particular CPT code.

The denial rate should be not more than 1% to 2%. Geier recommends appealing denials immediately and tracking the results.

She also advises watching for trends in payment such as unexpected drop in collections, increase in denials, and not obtaining patient payments at the time of service.

Volume

"The more cases you do, the more you can spread out overhead costs," Geier says. If the ASC isn't meeting the industry standard of 19.4 cases per day (which will vary somewhat by case mix), explore how ORs are being utilized.

If there are only enough cases for two ORs and the ASC has four open, for example, it may be necessary to

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Financial metrics to track

Ann Geier, MS, RN, CNOR, CASC, chief nursing officer for Surgical Information Systems in Alpharetta, Georgia, says the following financial metrics have the most impact.

Metric	Benchmark	Comments
EBITDA (earnings before interest, taxes, depreciation, and amortization) margin	12.8% (< $3 million net revenue) 37.3% (> $9 million net revenue) - > 40% = good - 30% to 39% = typical - < 40% = poor	Calculation: Subtract operating expenses (eg, labor costs, supplies, utilities) from revenue Also called operating cash flow or operating earnings
Case volume	19.4 cases per day = industry average Average of 4.4 surgical cases per OR per day (number of cases will vary based on case mix)	ASC procedure rooms perform about 5.5 nonsurgical procedures per day
Efficiency/throughput	Turnover time: < 7 minutes for short routine cases (eg, cataracts, GI, pain management) < 10 minutes for equipment-intensive cases and those with complicated setups (eg, spine, shoulder arthroscopies)	Good turnover time is important for physician satisfaction.
Collections	Denial rates should be less than 5%, ideally, only 1% to 2%	Depends on case and payer mix Monitor every day; need to know how much is owed and when it's expected
Accounts receivable days (how long it takes to get paid)	Less than 30 days	Calculation: (total outstanding charges)/ total monthly charges) x 30 days
Accounts receivable current (how much money has just been billed)	72% should be current	Higher is better
Supplies	$456 for drugs and medical supplies 21.6% for supplies as percent of collections	A typical ASC only uses only 12% of items in the item master
Payroll	$426.02 for staffing cost per case 23.5% for staffing as percent of collections Mean of 14.4 hours per case, which includes nurse, tech, and administrative staff.	Monitor staff hours per case daily, weekly, and monthly
Patient satisfaction surveys	34% for rate of return High 90s for scores	Watch for trends and check comments The Centers for Medicare & Medicaid Services had planned to make the Outpatient and Ambulatory Surgery Survey Consumer Assessment of Healthcare Providers and Systems mandatory starting in January 2018, but the implementation date has been delayed. Watch for future developments.

Benchmark sources: Multi-Specialty ASC Study Intellimarker, Becker's ASC Review, Ambulatory Surgery Center Association benchmarking survey, Accreditation Association for Ambulatory Health Care Institute for Quality Improvement, ASC Quality Collaboration.

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consolidate cases into a smaller number of rooms.

Leaders should also track volume by surgeon. According to VMG Health's Multi-Specialty ASC Intellimarker 2017, the top two physicians in the ASC perform nearly one-third (31%) of cases, the top five account for 54% of volume, and the top 10 account for 73%.

Turnover time can affect volume and physician satisfaction. Geier notes that tracking turnover time when "flipping" rooms is difficult, and adds that flipping typically isn't helpful financially because the practice doesn't allow the ASC to generate additional revenue.

Another volume-related metric to measure is on-time starts for the first case of the day.

Unhappy patients lead to lower reimbursements. Unfortunately, return rates for patient satisfaction surveys are typically only 15% to 20% for ASCs. To improve return rates, Shimek asks staff to tell patients on the preoperative call to expect a survey after the procedure and explain why it's important for surveys to be returned.

Tracking clinical metrics

Many clinical metrics are required by state and national regulatory agencies. For example, each year the Centers for Medicare & Medicaid Services (CMS) lists measures that will factor into payments. The measures, which are updated each year, can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting/.

Many have been consistent for several years, including patient burn; patient fall; wrong site, wrong side, wrong patient, wrong procedure, wrong implant; hospital transfer/admission; prophylactic intravenous antibiotic timing; and safe surgery checklist use.

The number of measures has risen from five in 2014 to 12 for 2018, but some relief may be in sight. "CMS is considering taking away measures such as the timing of antibiotic administration because everyone got the message, and now it's not a problem," Comerford says, cautioning that metrics will likely continue to be added.

Other clinical metrics include those based on standards from the *AAMI ST 79 Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities*. For example, the guide states immediate use steam sterilization should only be used in "urgent clinical situations," so this should be monitored.

ASC leaders should also track metrics related to clinical standards from organizations such as AORN and the American Society of PeriAnesthesia Nurses.

Shimek recommends administrators have a binder or folder for unexpected events and track them on a spreadsheet. "You want to identify people involved, not from a finger-pointing perspective, but from the perspective of what actions might be needed to improve practice," she says. For instance, a nurse involved in multiple medication errors might need education on prevention.

Shimek also suggests tracking good catches—problems that were caught before patients or staff were injured. "If you don't address these problems, harm will ultimately occur," she says.

Collecting and analyzing data

An electronic health record helps with collecting data. "We log 'wheels in' and 'wheels out' in our computer system," says Mary Jo Turner, MSN, RN, CEN, an OR charge nurse at Lowry Surgery Center in Denver.

Of course, no system, electronic or manual, is infallible. That's where double-checking can help. Staff at Lowry, for instance, enter billing numbers from a reference sheet. Sometimes the numbers are transposed, so at the end of the day, the billing office staff verify the entries. Turner also reviews billing records daily for accuracy.

In search of benchmarks

ASC leaders can use the following resources to benchmark results.

➤ Accreditation Association for Ambulatory Health Care Institute for Quality Improvement (http://www.aaahc.org/institute).

Established in 1999, the institute provides clinical benchmarking reports, the opportunity to participate in benchmarking studies of interest to the ASC, and patient safety tool kits.

➤ Ambulatory Surgery Center Association Benchmarking (http://www.ascassociation.org/asca/resourcecenter/benchmarking/ascabenchmarking).

A subscription service that ASC leaders can use for analyzing their own clinical and financial data and comparing it against national results.

➤ ASC Quality Collaboration (http://www.ascquality.org).

Formed in 2006, the collaboration provides a free quarterly report of clinical quality measures collected by participating facilities.

➤ Becker's ASC Review (http://www.beckersasc.com).

Frequently publishes financial and clinical benchmarks.

➤ VMG Health's Multi-Specialty ASC Intellimarker (http://vmghealth.com/publications/intellimarker).

A free download of financial benchmarking data from 2015 and 2016 for 278 ASCs around the country, representing an aggregate surgical case volume of more than 1.3 million. Includes benchmarks for income statement, balance sheet, liquidity, case mix, case volume, payer mix, net revenue per case by specialty, EBITDA (earnings before interest, taxes, depreciation, and amortization) margin, staffing, operating expenses, and facility information. Also has regional analysis.

"It's not enough to collect the data; you have to do something with it," Shimek says. Analyze results against internal, regional (if possible), and national benchmarks, checking closely for trends (sidebar, p 12).

"If you find a deficiency as a result of a quality improvement project, that's another way to set a benchmark," Comerford says.

Survey results can be a source of internal benchmarks. For instance, if a state survey found that 45% of history and physicals weren't complete, the ASC could work on improving the percentage and collect data to track results.

"You should also look at medical records to see if regulatory requirements are being met," Comerford says. She recommends using a checklist to review a sample of charts every month to verify practices such as obtaining a complete history and physical before surgery.

Financial metric results should be compared with the business plan for the center. "Administrators may not have seen the business plan, but they need to see it," Geier says.

The plan can help the leader identify problem areas. For instance, orthopedic centers are highly profitable, so if a center is losing money or earning only a small profit compared to what was anticipated in the plan, the leader should compare the number of cases per day to what was forecasted.

Geier doesn't routinely recommend an annual budget for the ASC because the most important measure is whether the center is completing the number of cases planned for in the business plan. Once a center reaches the final year projected in the plan, the leader should continue to grow the case volume.

Shimek says that multiple people should be involved in the analysis, depending on the metric. For instance, the safety officer would want to examine data related to equipment failures.

"You have to stay on top of the data," Turner says. She and her colleagues check many metrics daily, using some of the data to manage staffing. Staff hours are categorized by department: preoperative, postanesthesia care unit (PACU), administration, OR, overnight PACU, pain management, and the business office. Hours for the sterile processing department are listed with the OR's hours, and hours for materials management are included in administration.

Aim for 7 to 8 total staff hours for short cases and 10 to 12 total hours for longer cases, and try to avoid overtime.

If you have short cases, [the system] works great, but if you have long cases or a surgeon who tends to run over, it works to your disadvantage," Turner says. "It's best to have a mix of short and long cases for this method to work." Hours not used can be carried over and applied to low census days within a pay period.

Communicating results

"Communication is vitally important," Shimek says. "We post results in the physician and staff lounges and share them at meetings."

During monthly staff in-services, she talks about what the ASC is doing well and opportunities for improvement. "You also want to get from the front-line staff where the pain or pressure points are," she says. "The whole team has to be engaged."

Reporting is typically done monthly or quarterly, depending on the metric. "Turnover times and late starts are reported monthly to the ASC committee and the staff," Turner says.

Shimek adds that it's important to foster the right culture when sharing information. "You want to make sure it's not a blame game, but instead it's about the process of what we are doing and how we can improve."

Turner says it helps to explain the meaning behind the statistics. For instance, preoperative staff need to understand that if patients are delayed because of an incomplete history and physical, the entire schedule will be affected.

When it comes to improvement initiatives to correct deficits identified by metrics, Turner says, "you have to clean up your own house before you venture into others'."

Problems are first addressed in the OR and preoperative care unit before Turner approaches physicians. "You need to pick champions," she says, adding that it's important to give feedback about what is and is not working when improvements are made.

A good resource for improving patient safety metrics is the Toolkit to Improve Safety in Ambulatory Surgery Centers, from the Agency for Healthcare Research and Quality. A free download is available at https://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/ambulatory-surgery/index.html.

To encourage forward progress on quality goals, ASC leaders should acknowledge staff when goals are met. "We reward the entire team for starting on time because it takes a team effort," Turner says. That includes those in the OR, the preoperative staff, and those who accurately filled the case cart so nothing was missing.

Improving efficiency and effectiveness

How can ASC leaders be more efficient and effective in managing metrics? Comerford suggests scheduling report reminders in electronic calendars and using software such as QuickBooks or AdvantX to analyze data.

Data from many software programs can be exported into Excel for additional

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analysis. "Excel is great for analyzing information, and it's on your computer already," Comerford says.

Shimek says to delegate to others when possible. For example, staff in materials management could analyze costs per case, and the business office manager can have a white board that shows collection status and how it relates to goal.

Delegating to those who do the work can pay off financially. "A scheduler who tracks block time and who sees an open block can call surgeons to notify them of the available time," Shimek says.

"Be organized, delegate what you can, and have good communication across the organization," she adds. ✣

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References

Dryda L. 110 ASC benchmarks & statistics to know—2016. Becker's ASC Review. Oct. 5, 2016. http://www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/110-asc-benchmarks-statistics-to-know-2016.html.

VMG Health. Multi-specialty ASC study intellimarker 2017. http://vmghealth.com/publications/intellimarker/.

Walk the talk: Words matter when it comes to patient safety

Every week Ann Shimek, MSN, BSN, RN, CASC, hits the road to communicate about communicating. Shimek is senior vice president of clinical operations at United Surgical Partners International (USPI) in Addison, Texas. She and her team of six clinical nurses travel among USPI's 21 hospitals and 260 ambulatory surgery centers (ASCs) to reinforce one message: We can avoid medical mistakes and increase patient satisfaction by communicating effectively.

"Breakdowns in communication are the number one cause of medical errors, and there are 440,000 preventable medical errors annually in the United States," Shimek says. "So we are continuously focused on improving our communications with our patients and with all ASC team members."

The work she pushes out to USPI facilities focuses on three avenues of communication: Communicating to the patient, about the patient, and for the patient.

Communication tools

Shimek and her team are big users of the AIDET® patient communication tool developed by the Studer Group, a healthcare consulting group. AIDET® stands for five positive communication behaviors:

AIDET® Communications Behaviors

	Acknowledge	Introduce	Duration	Explanation	Thank you
Key message	You are important to me.	You can trust me and you can trust our care.	You are important to me. You can trust me and you can trust our care.	Explain the care plan and listen to the patient's story. Make the experience about the patient.	Thank you for entrusting us to care for you.
Behavior	▪ Greet by name ▪ Make eye contact ▪ Smile ▪ Give full attention ▪ Sit or kneel at patient's level	▪ Introduce yourself by name and department ▪ Describe how you are going to help ▪ Escort people where they need to go	▪ How long will the procedure take ▪ How long will the family need to wait to see the patient or speak with the doctor ▪ How long until the results are available ▪ How long until the patient can be discharged ▪ How long will the patient have to wait before you come and check them again	▪ Explain what you are going to do ▪ Ask if there are any questions or concerns ▪ Integrate key words at key times into the discussion ▪ Communicate further steps the other person may need to take ▪ Ask if the other person understands (if not, clarify)	Thank the patient for: ▪ Cooperation ▪ Communication ▪ Letting you be their caregiver today Thank the family for: ▪ Assistance ▪ Being there to support the patient

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Acknowledge, Introduce, Duration, Explanation, and Thank you (sidebar, p 14). They are designed to decrease patient anxiety, increase patient compliance, and improve clinical outcomes.



Ann Shimek, MSN, BSN, RN, CASC

"AIDET takes service to the next level," Shimek says. "It's treating your patients how you'd want your family member or yourself to be treated at a healthcare facility."

To raise patients' perceptions of competency of the ASC team to the next level, Shimek recommends another Studer Group communications tool called "managing up," which is a method of introducing yourself, colleagues, and physicians to magnify the team's qualifications.

For example, when introducing yourself, you could say, "Good morning, Mr Baker. My name is Kimberly, and I'm going to start your IV this morning. I've received special training to start IVs and start hundreds of them a month."

When managing up a colleague, say, "Hello, Mr Baker. In a few minutes you are going to meet your OR circulator, Randi. She will be your voice while you are asleep. Randi has been a nurse for 15 years, and her patients love her because she does everything she can to prioritize their safety. If I were having surgery today, I would want Randi to be my nurse."

And when managing up a physician, say, "Mr Baker, Dr Byrne will be in to speak with you in a few minutes. You are in good hands with Dr Byrne. She does everything to ensure her patients experience an excellent outcome. She will be able to answer any questions you have about your procedure."

The right vocabulary

Shimek and her team equip frontline staff with another Studer Group communications tool: key words at key times (KWKT). KWKT are words and actions that help patients understand their care, particularly at moments when they feel the most vulnerable, such as when entering the facility, changing into gowns, at

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Using key words at key times

Key words	Key time	Examples
For your safety	Correct patient, site, side Cold facility temperature	"For your safety, each member of the team caring for you is going to verify your identity, procedure, and surgical site." "For your safety, we keep our facility cold because germs don't thrive in a cold, dry environment."
For your privacy	When patient is changing; nurse is pulling a curtain or giving personal medical education	"Here is an extra gown for your privacy to assure you stay covered while you are walking." "For your privacy, I will pull the curtain. If you need me, please use your nurse call button.' "For your privacy, I am going to write this down instead of saying it out loud."
For your comfort	When patient is in pain or discomfort	"Mr Baker, my goal is to make you more comfortable, so can you tell me on a scale of 1-10…" "Mr Baker, we are going to work together to get your pain to a more comfortable level, OK?" ▪ "I am administering this medication to you, Mr Baker, so you will be in less pain." ▪ "Let's see if a warm blanket (or a pillow behind your back, or massaging the area, etc) can make you more comfortable. OK, Mr Baker?"
To provide you with excellent care	During introductions	"Mr Baker, is there one thing I can do to assure I provide you with excellent care today?" "Mr Baker, my goal is to provide you with excellent care today. If at any time during your stay you feel you are not receiving excellent care, will you please let someone know?"
Is there one thing I can do for you?	At the close of each conversation	"Mr Baker, is there one thing I can do for you before the doctor comes in?" "Mr Baker, is there one thing I can do for you before we go back to the OR?"

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handoffs, and at departure. "KWKT are a must-have behavior," Shimek says. "They decrease patient anxiety, improve care coordination, and align staff behaviors to meet the needs of the patient, which then improves our patients' perceptions of their care" (sidebar, p 15).

The Joint Commission reports an estimated 80% of serious medical errors involve miscommunication between caregivers during patient transfer. To ensure patient safety and continuity of care when communicating about a patient during a handoff from one caregiver to the next, USPI has implemented the I-SBAR communications technique. I-SBAR stands for Introduction/Identity, Situation, Background, Assessment, and Recommendation It is a real-time process of passing patient-specific information from one caregiver (the sender) to another (the receiver).

"We have found that I-SBAR facilitates a culture of safety and ensures clarity of information to reduce medical errors and also improve the patient's perception of care," Shimek says.

Last in Shimek's communications toolbox are actions taken to communicate for patients, especially when they cannot communicate for themselves. "Patients surrender everything when they go into an OR—their clothes, their bodies, and their consciousness. Nurses are really the eyes and ears for their patients," Shimek says.

In fact, to ensure patient safety, Shimek teaches nurses to "CUS." This acronym stands for Concerned, Uncomfortable, and Stop. To CUS, nurses speak the escalating phrases of "I am concerned that…"; "I am really uncomfortable with…"; and "This is a safety issue. I need to stop the line."

Shimek stresses that, for the CUS process to succeed, ASCs must establish a culture of support for nurses speaking up. "We coach nurses to speak out about their patient safety concerns. When someone says stop the line, everybody stops. The ASC manager drops everything and resolves the situation," she says.

"Even if a nurse is wrong, we thank them and support them for stopping the line," she adds. "We're all human, and we're all on the same team."

USPI tracks both adverse events and good catches, whether it's water on the floor or preventing a wrong site surgery. "Tracking these events allows us to call out and recognize our staff for good catches and benchmark against national safety data," Shimek says. "It also reveals where we have potential breakdowns in processes so we can correct them before they ever reach the patient."

Shimek and her team continuously reiterate and retrain USPI staff and physicians around the country on these communication practices.

"This training is not something you can do once and not talk about anymore," she says. "You do it constantly."

Her team has developed numerous presentations, regional trainings, and in-services on communications topics. She pushes out weekly and quarterly updates about communications across USPI.

"When your frontline employees know why they're there and what they're supposed to be communicating to make the patient feel safe and comfortable, it makes it a whole lot easier to implement healthy communication across the organization," Shimek says. ✣

Leslie Flowers is president of Flowers Communications in Indianapolis, Indiana.

References

Joint Commission Perspectives® . 2012;32:8.

Shimek A. Why communication is important in the ASC. Presented at ASCA 2017.

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