

SEPTEMBER 2019

Issue 2

ASC Manager

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Healthcare providers have seen a steady stream of inpatient-only procedures migrate to ambulatory surgery centers (ASCs) over the past few years. Medicare is reimbursing an increasing number of procedures performed in the outpatient setting, many of them cardiovascular in nature. This issue of ASC Manager explores the development of a hybrid office-based lab/ASC model for managing many of these cases. We also provide a roadmap for how to add total joints to an ASC's repertoire.

Other articles in this issue discuss managing workplace violence and complying with Medicare's emergency preparedness requirements. They offer resources and expert advice on how to prepare for these situations.

ASC Manager, a new quarterly supplement for OR Manager subscribers, delves into the latest industry trends affecting outpatient care and the evolving roles of ASC leaders. If you missed the first issue, published in June, please let us know. Every issue offers news you can use to lead your staff and protect your patients in a rapidly changing surgical services environment.



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Cardiology services: The next wave in ASCs?

Many experts see cardiovascular (CV) care as the next wave in ambulatory surgery centers (ASCs), and a hybrid office-based lab (OBL)/ASC model is gaining momentum across the country.

Robert J. Zasa, MSHHA, FACMPE, president and CEO of Ambulatory Systems Development, LLC, in Incline Village, Nevada, sees the hybrid arrangement as a prime growth area for ASCs. The company has established hybrid facilities in five locations, with a goal to establish five more in other areas. As Medicare continues to look at the types of cardiac procedures that could be performed in ASCs, it's likely that private payers will follow, thus expanding this offering to more patients.

"It's a lot less expensive to have a physician perform a proper cardiology surgery case in an outpatient setting than in a hospital, which is under more regulatory controls than an office," Zasa says. And an outpatient facility offers greater comfort and convenience for patients.

But setting up these facilities is no easy task. Hybrid OBL/ASCs must comply with Medicare's specific requirements, get proper certification, and gird themselves for any hospital competitors posing a challenge to their business under state Certificate of Need (CON) laws. "It's a sophisti-

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cated shop to run," says Marc Toth, chief executive officer of ACA Cardiovascular, Incline Village, Nevada, which has set up several hybrid OBL/ASC facilities throughout the United States and plans to add more.

Birth of the hybrid CV model



Dustin Douglas, RCIS, BSB

In 2008, the Centers for Medicare & Medicaid Services (CMS) significantly increased Medicare coverage for peripheral artery disease (PAD) treated in physicians' offices, and almost overnight, the market shifted from the hospital to the office, with more than 500 OBLs doing these procedures. As a result, CMS added other codes for office-based CV work. In 2015, CMS approved electrophysiology pacemaker and implantable cardiac defibrillator implants for surgery centers.

Medicare now has anywhere from 70 to 100 approved CPT codes for ASC cardiology procedures. About 20 fall into the most "frequently used" category, which includes PAD and pacemaker codes. In 2019, Medicare added coronary diagnostic cases, "a huge step forward in coronary stenting," says Toth. He anticipates Medicare will approve additional procedures for ASCs in 2020.

In 2010, a hybrid OBL/ASC model started to gain traction, as Medicare expanded its approvals of certain CV procedures in the outpatient setting. The next wave of ASC growth with these hybrids "is definitely taking off right now. We have about a dozen in various stages of development: 16 total projects, with 12 functioning as hybrid ASCs," Toth says.

Hybrid OBL/ASC model

The hybrid model has attracted interventional cardiologists and interventional radiologists eager for lucrative Medicare reimbursement rates.

Many of these cardiologists had OBLs or were doing this type of work in catheterization (cath) labs. To get reimbursed by Medicare under the hybrid model, cardiologists must convert their OBL into a Medicare-accredited and certified surgery center that alternates as an OBL or a surgery center for different purposes on different days, with the OBL and the ASC maintaining separate tax ID and National Provider Identification (NPI) numbers.

"They are separate legal entities," explains Zasa. The ASC gets facility

Hospitals eyeing ASCs to expand CV care opportunities



Joe Sasson, PhD

Hospitals have reacted in a number of different ways to the outpatient cardiovascular (CV) services boom, says Joe Sasson, PhD, executive vice president of MedAxiom, Neptune Beach, Florida, a membership organization and consultancy focused on accelerating the transformation of CV care. "While some hospitals feel that ASCs [ambulatory surgery centers] may not pose a threat in their market, others are concerned enough that they're planning to open their own ASCs to do CV procedures that we expect Medicare to approve in the near future," Sasson says.

MedAxiom sees CV services as a growth area. In addition, there's a continual push to lower costs by transitioning more work to the ambulatory setting as safely and effectively as possible when it's appropriate to do so. "That includes ASCs," Sasson says. Although some hospitals are waiting on safety data to reach a more confident positioning, "all are certain that the ASC is a lower-cost setting." In a world of bundled payments and accountable care organizations, it's an important view to take, he adds.

In 2018, MedAxiom announced a corporate partnership with National Cardiovascular Partners (NCP) in Houston and ACA Cardiovascular in Incline Village, Nevada, to provide its members with options surrounding a CV ASC strategy. Both organizations aim to help provide more accessible, lower-cost care in facilities focused on safety and an improved patient experience.

"Cardiovascular care is very market dependent, and there is little competition in some areas and a great amount of competition in others. Combined with the varying legislation that states have around ASCs, market-specific factors play an increasingly important role in determining a path forward for an ASC strategy," Sasson says.

Because each situation is unique, healthcare systems should conduct a comprehensive market analysis before committing to any ASC strategy. Such an analysis should include:

- patient population characteristics
- disease prevalence
- state laws (including any Certificate of Need concerns)
- access and wait time concerns in the community
- the landscape of provider organizations (including ASCs already in existence or proposed to be built)
- other factors that shape an organization's ASC strategy.

"This is certainly an area in which expert guidance is crucial," Sasson says. "We believe that MedAxiom's two partners in the ASC space do a phenomenal job of helping our members navigate these concerns."

Reference

National Cardiovascular Partners Joins MedAxiom. September 25, 2018. fmcna.com/national-cardiovascular-partners/about/newsroom/.

fees only and does procedures from a Medicare-approved list. The OBL fee is an enhanced professional fee that combines a fee for the physician and some money for covering the expense of doing the procedure in the OBL.

When the ASC is open, patients who undergo procedures in the OR are billed by the ASC for a facility fee. The physician charges a separate professional fee for doing the procedure. When the OBL is open and a physician performs a procedure there, he or she bills the patient for an enhanced professional fee, using a professional NPI and tax ID number.

The Heart & Vascular Center in Bryan, Texas, one of the first CV hybrid models in the state, operates as an OBL on Monday, Tuesday, and Wednesday, and as an ASC on Thursday and Friday. The facility offers services including implantable cardioverter defibrillators, pacemakers, coronary angiograms and interventions, and peripheral angiograms and interventions.

Two local private practice cardiology groups partnered with National Cardiovascular Partners (NCP) in Houston, a pioneer of the hybrid model, to form the ASC/OBL. "NCP has an excellent process in place when opening new centers or converting an existing facility," says Dustin Douglas, RCIS, BSB, the facility administrator.

"Our physician partners have complete control over how the center operates, the staffing at the center, and the equipment they use. NCP takes care of the rest. It's a perfect partnership," Douglas says. NCP partners with hybrid OBL/ASCs in Texas, California, Arizona, Kansas, Louisiana, and Florida.

Advantages to providers, patients

The hybrid structure offers certain financial advantages, Toth says.

Medicare provides different reimbursements for the same procedure based on site of service. The hybrid model "allows those providers to enjoy the best reimbursement based on site of service," Toth says. Alternating between an OBL and ASC on different days offers a risk mitigation formula of sorts because "sometimes Medicare pays better in an ASC, sometimes in an OBL," he explains.

A good example of this is Medicare's decision in 2017 to reduce reimbursement for fistula repair in diabetic patients, angioplasty, and stenting by 40% in OBLs, a measure that forced 20% of these businesses to close their doors. "When this happened, many of these businesses came to us, asking them to help them convert to an ASC [to avoid the cuts]," Toth says.

At least 120 OBLs in the United States converted to ASCs. Many of these facilities received assistance from ACA Cardiovascular on building requirements and certifications.

The OBL/ASC model also benefits patients and the government, advocates say. ASC care often means same-day discharge for a CV procedure. The setting is also more private, serving just 10 to 15 patients at a time.

"At a hospital, a patient may get bounced from one department to the next with different nurses or staff. At a hybrid ASC, one nurse takes care of you when you come in the door from start to finish for quality continuity of care," Douglas says. For this reason, Douglas says his facility enjoys a 99% patient satisfaction survey rate.

The hybrid model reduces costs for CMS because cases performed in this setting are 40% cheaper than in a hospital. "Our 10,000 square foot buildings are more efficient than a multimillion-dollar hospital campus," says Toth.

That said, any ASC hybrid has to meet the same standards as a hospital in addition to meeting Medicare's requirements. This means getting accredited by either the Joint Commission or the Accreditation Association for Ambulatory Health Care (AAAHC). Facilities should prepare for Medicare surveys in which the agency sends in a third party like AAAHC to assess the air conditioning, the width of hallways, and other minute details. "Everything has to be up to standards," Toth emphasizes. Both the cath lab and ASC at the Heart & Vascular Center have Joint Commission accreditation.

CON challenges

Providers looking to set up a hybrid OBL/ASC should be aware of state laws affecting these businesses, says Jason S. Greis, JD, a partner with McGuireWoods LLP, Chicago, which represents a variety of healthcare providers. About one-third of all US states won't allow ASCs to simultaneously operate as an OBL or ASC on alternating days. Most states also require that physicians go through an application process to add a new service line, or spend a certain dollar amount to build out an ASC to add a service line. It's a process that doesn't take place overnight, cautions Greis.

"What people don't understand is, it can take 6 months to a year in non-Cer-

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tificate of Need states, and even longer in CON states." This is because an applicant has to go through an additional step of obtaining approval from a state's CON board or department of planning to build a new facility. That can take 6 to 12 months, on average, Greis says.

Meetings to approve these types of facilities take place only at certain times of the year, and delays are often inevitable, Greis adds. "Even if your meeting is on the calendar, there's no guarantee that you're going to get a favorable decision. Or, your project may get pushed back to the next meeting." A state agency health facility planning board in states with CON has the authority to determine whether there's a need to develop a service line in a particular geographic area.

Competitors also present roadblocks if they object to a proposed service line that duplicates their own services. "Hospitals are notorious for doing this," Greis says. In some states, competitors have an opportunity to object to new applications and attempt to "kill" a project. The Trump administration, which sees CON laws as a restriction to access to care, has supported their removal. "I don't know if CON laws will be rolled back, but that would improve access to ASCs," Toth says.

Not all states allow certain types of CV procedures in settings outside of a hospital. "While most will allow physicians to do peripheral vascular and cardiac rhythm management procedures, some states have regulatory barriers on performing cardiac cath and interventional procedures," says Trey Domann, senior director of cardiovascular development at Surgical Care Affiliates (SCA) in Houston, which represents both ASCs and surgical hospital providers across the United States.

"CV care is complex, and each opportunity will have its own unique conditions that impact the business case," Domann says. Physicians have to look at state regulations on procedure types, payer relationships, cost of build-out, and capital equipment, as well as CON statutes, to decide whether or not this is worth the risk. Health system leaders are also aware of how profitable the CV service line is, and they'd rather not lose these procedures to an ASC. "This is part of the reason so many CV physicians are either employed or closely affiliated in multiyear agreements with hospitals," Domann says.

But not all hospitals are pushing back. Some, in fact, are thinking of establishing their own ASCs to do these types of procedures (sidebar, p 2).

Federal officials have their own concerns related to financial motivations for setting up a hybrid. For example, exploring a hybrid to take advantage of differentials in reimbursement is a risk, Greis says. The government might respond with an investigation of any documents, emails, and text messages that might indicate improper intent or a violation of the federal Anti-Kickback Statute.

Hybrid developers should analyze the arrangement to ensure that it meets an exception under the federal Physician Self-Referral Law (Stark law),

The three buckets of cardiac care

"Cardiovascular care is complex, and barriers to entry vary dramatically from market to market, which is why so many ASCs [ambulatory surgery centers] have not capitalized on what's considered one of the last major service lines to enter into the ASC space," says Trey Domann, senior director of cardiovascular development at Surgical Care Affiliates (SCA), in Houston, which represents both ASCs and surgical hospital providers across the United States.

Developing an office-based lab (OBL) for peripheral artery disease procedures has gotten easier over the past 10 years, with favorable reimbursement, minor construction, lower capital expenditures, and assistance from device and equipment vendors. The process gets more complicated once that OBL decides to transition to an ASC, Domann says. "Among other challenges, there's an accreditation process to go through, state laws to comply with, and possible costly upgrades to the facility." Any provider who wants to do this has to weigh the risks with the overall return on investment, Domann notes.

When adding cardiovascular (CV) procedures to a multispecialty center or developing an OBL/ASC hybrid model, SCA usually looks at the opportunity within three buckets of nationally targeted outpatient CV procedures. Cardiac rhythm management procedures are often the easiest to establish because little additional equipment or construction upgrades are needed.

"From a staff training perspective, it's a relatively seamless integration," says Domann. Procedures may include loop recorder, automatic implantable cardioverter defibrillator and pacemaker implants, and battery changeouts.

Adding peripheral vascular procedures to an existing ASC requires additional due diligence on the front end. "You have to make sure that your physicians are comfortable with the existing imaging equipment," Domann says. It may be necessary to add a float table and an injector, and upgrade to a vascular package on the C-arm.

State regulatory barriers, cost of equipment, and space needs make cardiac catheterizations and interventions the most challenging bucket of procedures to add to an existing ASC. Compared to most multispecialty ORs and procedure rooms with mobile C-arms, catheterization (cath) labs with fixed unit C-arms need additional space for the equipment. Most cath labs have an additional control room for monitoring and recording the cases. "There is also more radiation involved with cath procedures, so you'll need to look at adding lead shielding to the walls," says Domann.

advises Greis. There are also state fraud and abuse laws to comply with, "and it is critical to review those statutes as well," he adds.

Separation of church and state

"You can't be an OBL on the same days as an ASC," Toth says. There needs to be a separation of church and state, so to speak. Some states require a separate entrance and exit, separate scheduling, and separate contracts for the ASC and OBL with private payers. "You might even have to answer the phones differently on different days," adds Toth. Surgery centers in the meantime have stricter building and certification requirements than OBLs.

Toth advises ASC leaders to hire a professional management company to run the hybrid operation rather than rely on the office manager because it is a big job. Having unrealistic expectations for volume is another pitfall. Many physicians will open a center expecting that their respective partners will bring in a certain number of cases per week, and that may not happen, Toth notes. And some physicians might be keeping one foot in the hospital setting and may not be fully committed to the ASC, he adds.

Facilities that don't have enough volume or procedures don't go forward, Zasa says. Physicians need to assess their volume or caseloads, and know what types of procedures they're going to offer. What procedures under which CPT codes will their physicians be comfortable with?

Then there's the question of the facility itself. Cardiologists typically have an OBL procedure room in their office, or they might work in a medical office building with a cath lab. Zasa has seen some physicians look for a new location, which might mean moving and building a new office with a surgery center attached to it. The important thing is to have a firewall between the office and the surgery center, per Medicare's rules for the hybrid facility, he says.

Constructing a new facility is very expensive, and existing buildings or office spaces may need renovations. "Before ASC leaders do this, they need to look at the costs involved to fix the facility to meet regulations," Zasa says.

ASCs aren't for everyone

Whether a patient has a CV procedure in an ASC or a hospital is ultimately up to the referring physician, Zasa notes.

Not all CV cases are appropriate outside of the hospital, Domann says (sidebar, p 4). "States that have restrictions on cardiac cath and percutaneous coronary intervention outside of the hospital usually lump the procedures in with cardiac surgery, and you see language around prolonged entry into major blood vessels," which means that only a select group of patients will be eligible for the outpatient setting.

Still, Domann anticipates that the outpatient boom will continue in the CV space. "With CMS adding 12 cardiac cath codes to the approved procedure list for ASCs for 2019, we have already engaged in conversations with states with existing cardiac restrictions around efforts to loosen up restrictions on performing these procedures outside of the hospital." ✣

Jennifer Lubell is a healthcare writer based in Rockville, Maryland.

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Vigilance best protects ASCs from workplace violence

Violence is a fact of life in healthcare settings. The Occupational Safety and Health Administration estimates that, on average, healthcare workers are four times as likely to be victimized as those in private industry. Most types of violent incidents involve patients or visitors acting out against staff, accounting for 93% of all assaults and 75% of all aggravated assaults in hospitals, according to a 2014 study in the New England Journal of Medicine on hospital crime.

Ambulatory surgery centers (ASCs) are no strangers to workplace violence, and because they often have more limited resources than hospitals, it can be challenging to ensure the safety of patients and staff alike. OR Manager recently spoke with several individuals who advise raising awareness of potential conflicts in the ASC setting, putting safety measures in place, and taking action to protect people from harm.

When familiarity breeds contempt



Jennifer Dickman, DNP, RN, CPN

Jennifer Dickman, DNP, RN, CPN, recalls the time a domestic situation at her surgery center nearly reached a boiling point.

Incidents commonly arise between a patient's parents at North Surgery Center, a pediatric ASC that is part of the University of Pittsburgh Medical Center (UPMC). Things escalated when a mother estranged from the family decided to visit the day of her child's surgery. "The father was upset, and one of my nurses was concerned about how heightened he was onsite," says Dickman, the center's director. Staff called the local police, alerting them to a potential domestic situation and possible interaction. "It turned out to be a non-issue—the mother didn't even show up—but it's a good thing police were there" to speak with the father and ensure that things didn't escalate further, she says.

Most of North Surgery Center's security concerns have involved potential domestic disputes that resolve with minimal police or security staff intervention. "However, we cannot get away from the realities in the world. This is at the forefront in the minds of staff," says Dickman. She has sent leaders to classes in crisis management, and has scheduled sessions and drills with local police on workplace violence response strategies.

The microcultures of smaller facilities like ASCs make them particularly vulnerable to domestic violence, says Ronell Myburgh, MBA, MHA, RN, manager, orthopedic certifications and specialty programs at DNV GL Healthcare, an accreditation and certification company in Milford, Ohio. In 2017, the Bureau of Labor Statistics reported that seven intentional shootings resulted in fatal injuries, and there were more than 1,300 intentional injuries by "other persons" in these facilities.

ASCs usually involve a small group of people working together in a family-type atmosphere. Such environments pose a threat to a partner of a staff member who seeks control. This individual will act on the threat with violence, notes Myburgh, who once lost a coworker to domestic violence. "These partners recognize that it's easy to access the organization," she says.

Incidents may also involve someone the patient knows. In 2013, the family member of an admitted patient at Good Shepherd ASC in Longview, Texas, launched an attack on staff, visitors, and patients with a knife, killing two people. Quick actions by staff and police likely prevented further casualties.

In many instances, ASCs have found it necessary to partner with local police to de-escalate situations. Others have been fortunate to employ former law enforcement officers to guide and train staff.

Security staffing challenges

Large health systems usually have the capital to increase police presence, offer response training and security drills for staff, install 360-degree digital cameras, and place metal detectors at emergency department entrances. Some hospital groups have fought against violence through unique communication strategies (sidebar, p 7).

Since the 2013 attack, Good Shepherd ASC has instituted more frequent security rounds and installed keypad access on stairwells and radiofrequency identification badge access to clinical areas.

But not all ASCs have the adequate funds or staff to invest in security equipment or hire armed guards. Most ASCs are for profit, which means that they don't qualify for grants to support additional resources. Environmental controls such as security at all entrance points aren't always an option for these types of smaller organizations. "Transparency and awareness are the only mitigation strategy to keep personnel safe," Myburgh says.

Cost, and the fact that the facility is located in the suburbs and not in a higher-incident city environment, are reasons why North Surgery Center doesn't have onsite security. Fortunately, "the local police department knows us and is very responsive," Dickman says. Staff try to be judicious in its 911 calls. "We don't call the police on every case, but we do if something doesn't sit right with us."



Jim Donlon

Even some of the bigger ASCs face security issues. At the Center for Advanced Medicine, an ASC that's part of New York-based Northwell Health, staffing enough security is a challenge

because of the facility's large size. "We're so big that we have 18 entrances," says Jim Donlon, manager of corporate security operations. Donlon and his assistant manager, both retired law enforcement officers, are in the process of hiring more staff, and they are continually updating their security measures and plans.

As is the case at North Surgery Center, police are located near the Center for Advanced Medicine. "We have a great relationship with the men and women of the Lake Success Police Department, and we have access to three other police agencies just a couple of blocks away: Nassau County, New York State, and New York City police departments. If something happened, police would be everywhere," says Donlon.

Options to run or hide



Jason Venturella

The Department of Homeland Security instructs people to "run, hide, or fight" in active shooter situations. But for healthcare workers whose primary responsibility is to take care of patients, this is a difficult formula to comply with.

"Most of these workers don't have the comfort of running away or hiding because of their obligation to protect patients," says Jason Venturella, president of Stealth Security Consulting in Economy Borough, Pennsylvania, which specializes in helping community businesses prepare for emergency situations. "As opposed to a corporate setting where you're only responsible for yourself, healthcare workers have to find secure areas while looking out for other people." This is why so many hospitals have armed guards, he adds.

If patients are ambulatory, Donlon says his staff are trained to help patients, visitors, and employees evacu-

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Addressing violent patient risk through communication

Patients at risk for violence often feel the most agitated in the beginning stages of their hospital stay. After experiencing several incidents, an academic hospital decided to tackle this issue head-on. An article in the Joint Commission's Journal on Quality and Patient Safety describes a communication tool the facility used to better manage patients and ease staff concerns.

In the study, a multidisciplinary quality improvement team used two iterative Plan-Do-Study-Act (PDSA) cycles to develop and test a "huddle handoff tool." Under this method, an emergency department (ED) nurse would inform the admitting unit about an at-risk patient presenting to the ED. Both the admitting care team and ED team would participate in a huddle to discuss a plan for managing this patient during handoff to the inpatient unit. The communication tool was used in 21 and 18 transfers in the first and second PDSA cycles, respectively.

Before the intervention took place, ED nurses and nurses from other medical units said they felt safe just 55% of the time during the transfer process. That figure rose to 100% once the huddle handoff process went into effect. Satisfaction with transfers among ED workers also increased from 53% to 75% between the first and second cycles.

"These evidence-based quality improvement strategies have traditionally been used to address patient safety issues, but the innovation here lies in the authors' application of these strategies to workplace safety. This agitation handoff tool provides the receiving inpatient unit a comprehensive plan for managing potential violent episodes and anticipating additional behavioral needs to safely deliver care," say Ambrose H. Wong, MD, MSEd, and co-authors in a related editorial.

Other models from the Joint Commission offer guidance on de-escalating potentially violent situations in ED and inpatient settings. Quick Safety 47: De-escalation in Health Care lists a series of interventions to defuse potentially aggressive behavior in patients, such as using nonthreatening body language and verbiage to approach the patient, showing support and respect for the patient's concerns, responding to those concerns, and setting specific limits for the patient to follow.

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ate the building during an active shooting or other catastrophic event.

In his view, if an active shooter enters the building and starts firing a gun, staff should follow the "run, hide, or fight" protocol. If shots are fired while a patient is still in recovery after surgery, a staff person should lock the door to that room. The choice to run or secure themselves in the room with the patient is up to the clinicians. They won't be abandoning their patient if they leave—they will be conserving their resources, ie, they will be able to return and continue patient care or help treat any wounded people, Donlon adds. "Just remember: You're no good to the patient if you become a patient yourself and are bleeding on the floor from a gunshot wound," he says.

Venturella says he talks to facility administration to see which areas of the building need to be secured. The ability to lock down is much like the procedure in a school classroom. "It's important to ensure that you have doors capable of keeping people from coming in. Facilities do have that ability, but you have to set that in place."

There also has to be a communication process whereby everyone understands their roles immediately in the event of an attack. A comprehensive plan that is not understood by all employees or practiced could lead to tragedy. "All the pieces of a plan have to flow together," he says.

Local incident spurs additional training

Northwell Health, including its Center for Advanced Medicine, decided to up its game on emergency response training following a shooting that took place at nearby Bronx-Lebanon Hospital Center (now BronxCare Health System) in 2017. A disgruntled former employee, who happened to be a physician and hadn't yet turned in his ID, entered the hospital dressed as a physician and

Violence prevention: One ASC's protocol



Beverly A. Kirchner, BSN, RN, CNOR, CASC

SurgeryDirect, LLC, an ambulatory surgery center (ASC) in Highland Village, Texas, holds two different active shooter drills each year at its centers. "We have the police come in and work with us to ensure we have enough safety options like a locked-down clinical area that has badge access only," says Beverly A. Kirchner, BSN, RN, CNOR, CASC, SurgeryDirect's chief compliance officer.

During the first drill, police help staff identify the best exit strategies from the center. Within the facility, staff can lock doors within enclosed rooms. If a door is on a badge-activated lock, the room has a device that can wedge under the door to keep it from opening from the outside.

A second drill may involve one of two scenarios: Staff either react to a mock code for an active shooter, or a table top drill takes place in which all interested parties sit around a table, reenact an active shooter event, and discuss possible responses. The assigned observer for the drill reports what was seen during the drill, with staff making a commitment to work on gaps identified in the drill during staff or education meetings.

"If there is a threat over the phone, the team members have been instructed on how to keep the person on the phone and get help," Kirchner says. Staff are trained to lock down and send people home if police determine that a threat is real.

If a violence threat comes from an employee or an employee's spouse, significant other, or visitor, the center's leader is tasked with de-escalating the situation and alerting police via phone or a panic button. The hope is that police will arrive in time before harm occurs. "If the threatened violence is an out-of-control physician, the medical director is notified if the center's leader is not able to defuse the issue," Kirchner says.

The medical executive committee will review the incident and make a recommendation to the center's board per medical staff bylaws, if this involves a physician or allied health credentialed member, she says.

SurgeryDirect reviews its violence training process annually and also during staff orientation.

Additional security features will always come at a cost, but the investment is worthwhile for peace of mind and the safety of employees, visitors, and patients, Kirchner says. She advises ASC leaders to:

- Buy a security system that locks down the center, and only allows employees or physicians with badges to access the clinical area. Systems will run approximately $1,500 per door.
- Keep all outside doors locked, except the lobby entrance.
- Provide staff with panic buttons. These are available as wireless devices that staff can carry like keys or can be installed in areas that can't be locked down, such as the receptionist desk and in the preoperative area and the postoperative anesthesia care unit.
- Ensure each staff member is competent and can react in a violent situation.
- Find someone to train the team—and especially the leaders—on how to de-escalate a potentially dangerous situation.
- Work with the local police department.

shot and killed a half-dozen people with an automatic weapon.

"Northwell has been conducting active shooter training since 2016, but this incident—as well as others around the country—helped us rethink some of our security measures," says Donlon. The health system continues to conduct active shooter trainings at its 23 hospitals and hundreds of nonhospital locations.

Donlon has yet to witness any active shooter or other violent incidents at his facility. "Thankfully, nothing violent has ever happened where we had to call police." Still, the Center for Advanced Medicine provides active shooter training to all new employees, going into great depth on "run, hide, fight" scenarios. They get a tutorial on the building, including the location of items such as the fire extinguisher and panic buttons, and how to use these devices.

Donlon also makes himself available to meet with employees in smaller groups, offering refresher training and providing advice on handling emotionally distressed people. In all training, "we go over the whole culture of care system, and how to deal with and respond to patients," he says.

North Surgery Center has also begun organizing active shooter drills with local police. So far, local police have done two in-service programs about active shooter situations, sharing information about identifying suspicious vehicles and items, calling 911, and building a response plan.

"The next step is doing an actual drill" at the facility, says Dickman.

Some ASCs schedule multiple drills throughout the year (sidebar, p 8).

Education is everything

Venturella conducts his active shooter mass casualty incident training in three parts. His team does an initial evaluation at the facility to determine any vulnerabilities and assess where the most common threats may arise in order to recommend a plan.

The next step is education. Most facilities have some kind of plan, but education is critical and must be followed by training that covers everything from prevention to response.

If people aren't properly trained, the response plan is not going to have an impact on their ability to survive an attack, Venturella says. "Even in some of the bigger hospitals, not everyone quite understands their role in the event of an emergency."

There are many inconsistencies. Some staff members are unsure of what actions should be taken, whereas others have a basic understanding but fill in the holes with whatever plan they've created in their minds.

The last piece is to carry out the training, where people gain an understanding of what this looks like in their environment and what they need to do.

Prevention—identifying behavior before it happens—is what Venturella strives for in his training of facility staff. This involves educating people to be aware of their surroundings and to look for suspicious people, vehicles, and items. "If someone is approaching the facility with a gun, sounding an alarm can save lives."

Surgical facilities that want to ramp up on security and violence prevention should be proactive about it, says Venturella. "Any ASC worker who thinks there's value in having this type of training should express that to facility managers and/or leadership to get the proper security they need."

Retraining through redirection

At UPMC, hospital and system leadership have been very responsive to North Surgery Center's concerns about active shooters and what they see on the news. All of its departments have been asked to do crisis management training, which teaches de-escalation and interaction techniques. Training has been open to leadership as well as primary care practitioners and nursing.

The ASC has also gained some knowledge through its hospital emergency preparedness group. It's not always apparent where to look for resources on workplace violence prevention, says Dickman. Sometimes people don't know where to start. "We recently had two staff members at the surgery center join that group to give us better ties to resources [in the community]", she says.

Very often, staff feel out of their depth with assessing these types of situations, Dickman says. "Nurses are good at physical assessments and talking with patients, but they're not always sure if they should escalate something they hear on a phone call." They don't want to be alarmists, but they also don't want to miss something.

One strategy is to redirect the conversation and remind a parent that his or her child is having surgery. It's important to ask: Is there anything that will interfere with our ability to provide a safe outcome and experience for your child the day of surgery? With children, the stakes and emotions are high, and the stress response takes over sometimes, Dickman notes.

The power in a cup of coffee

There's a delicacy in handling a patient who is growing agitated because of a long wait time to see a physician. In these scenarios, it's important to exercise common sense and remain calm—no matter what the person is saying, Donlon advises.

"You tell them, 'I'm terribly sorry, I can find out how much longer you have to wait. Can I get you a cup of coffee or water?' A cup of coffee goes a long way, especially if you ask them what they want in their coffee. You offer that hand of assistance," Donlon says.

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Employees at the Center for Advanced Medicine are trained to inform a supervisor if a situation appears to be escalating. Donlon says there are times when he steps in. "I tell the staff, 'let me give it a try.' When I show up, things always seem to calm down," he says.

Leadership should also remain cognizant of the emotional pulse within their facilities. It's not enough to check a box and say "we did workplace violence training," Myburgh says. If an incident occurred, everyone should get together, talk about it, and discuss ways to prevent such incidents in the future.

Staff may be facing their own potential domestic violence situations at home. "People don't want to bring that shame to the workplace. But they need to overcome that. Leadership needs to establish venues where people feel comfortable talking about these situations," Myburgh says. Staff in need of help should receive counseling about safe spaces and a possible exit plan.

"Look out for each other," she advises. No one should have to sort this out for themselves. ✣

Jennifer Lubell is a healthcare writer based in Rockville, Maryland.

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Total joints present increasingly attractive option for ASCs

The migration of total joint replacements for knees and hips from inpatient hospital ORs to hospital outpatient departments and ambulatory surgery centers (ASCs) is spreading.

On November 1, 2017, the Centers for Medicare & Medicaid Services (CMS) bolstered the trend when it approved the removal of total knee arthroplasty (TKA) from the inpatient-only list for 2018. Total hip arthroplasty (THA) and partial hip arthroplasty are still on the inpatient-only list, but outpatient surgery advocates are pushing for CMS approval of these procedures as outpatient.



Troy Sparks, BSN, RN, CNOR

The Ambulatory Surgery Center Association (ASCA) reported an eightfold increase in the number of US ASCs performing outpatient joint replacements in the past 3 years, from approximately 25 to 200. "As more physicians and ASC teams get the training and experience they need to safely and comfortably move these procedures into the outpatient setting, we can expect the volume performed in hospital outpatient departments and ASCs to increase," says Steven Miller, ASCA chief operating officer.

"Total joints in the ASC is the hottest topic in orthopedics right now," says Michael Kimball, MD, an orthopedic surgeon who performs both THA and TKA at the Outpatient Surgery Center of La Jolla in La Jolla, California. "There were a large number of sessions about outpatient total joints at the American Academy of Orthopaedic Surgeons' annual meeting, and a growing number at every meeting we attend."

Dr Kimball began doing total joint replacements at the Outpatient Surgery Center of La Jolla 7 years ago. He says he prefers the ASC setting because of greater efficiencies, higher patient satisfaction, and lower infection rates. "I couldn't get enough OR time at the hospital to do my cases," he notes.

Look for low risk, high volume

Research has shown that low-risk patients are successful candidates for outpatient hip and knee replacement. They can leave the ASC within 24 hours with low risk of complication, infection, or readmission to the hospital within 5 days of the procedure, and patient satisfaction rates are high.

"ASCs operate in a way to get the patient in and out with a more pleasant experience. A 7 am case starts at 7 am, and I can be in my office seeing patients by 8:30," Dr Kimball says. "If I do the surgery at the hospital, I will not get to my office until 9:30.

"Patients with commercial insurance who choose to have surgery at a surgery center pay approximately 30% to 50% less than a patient having the same procedure in a hospital," he adds. "These are some of the highest-paying cases that we do."

Sg2, a healthcare analytics and consulting company, projects that 52% of all primary knee replacements caused by osteoarthritis will be performed in an outpatient setting by 2026.

"Unless hospitals come up with effective strategies to retain these volumes, factors such as independent surgeon ownership of ASCs, rising consumer demand for affordable pricing,

and pending site-neutral legislation will lead to much of these volumes moving to ASCs," Kristi Crowe, Sg2 vice president, comments in a blog.

In order to be successful, ASCs must have physician champions who are comfortable doing total joints in the outpatient setting and can teach and collaborate with the ASC staff to fold these procedures into the ASC, according to Troy Sparks, BSN, RN, CNOR, regional vice president and total joint program coordinator for AMSURG, which partners with 263 ASCs.



LaVerne Haller, RN

"Not every surgeon is interested in or comfortable taking care of patients outside the hospital," Sparks says.

At the Surgery Center of Long Beach (California), an AMSURG partner, a committee consisting of everyone who interacts with the total joint patient developed its program around the surgeons' preferences, says LaVerne Haller, RN, the center's administrator. "We copied the surgeons' preference cards from the hospital OR and met with them weekly to learn their preop and postop preferences until we developed a program they would like to have implemented here," Haller explains.

The Surgery Center of Long Beach has been doing both total knee and total hip replacements for 4 years. In December 2017, the center received the first-ever Center of Excellence Award in Orthopaedic Certification by the Accreditation Association for Ambulatory Health Care (AAAHC) (sidebar above).

Assess volume and value

To determine if a total joint program is financially feasible, ASC leaders must project volume and payer reimbursement. "Do you have just one surgeon who might bring one or two cases every 6 months, or several surgeons bringing multiple cases each month?" Sparks asks. "I would say centers should do at least a couple of cases per month at a minimum so that staff stay competent with the routine and the preferences of the surgeon."

This is especially important when starting out because of the initial costs to modify a surgery center for total joints. "For some centers, these may be minor because they are already doing uni-compartmental knees or other large orthopedic cases, and they already have things like power equipment, instruments, positioning devices, and other equipment necessary for these procedures," Sparks says.



Scott Leggett

Other centers may be starting from scratch and will need adequate power equipment, augmented sterile processing, a specific OR table, and modification of a private room or an area in recovery designated for 23-hour stays, according to Scott Leggett, co-managing director of Convergent Same Day Orthopedic Strategies, a consulting firm. Leggett developed the consulting company with his business partner Tom Wilson to advise other ASCs on building total joint programs based on the lessons they learned at the ASCs they manage in San Diego and Monterey, California. Dr Kimball sits on the advisory board of Convergent, whose mission is to get surgery centers "joint ready," according to Leggett.

"There are so many aspects of total joints that need to be addressed," says Leggett, who with Wilson also co-owns Global One, a third-party administrator for bundled payments in the ASC. "We found that when we met with ASCs about negotiating bundled payments, very few had intentionally thought through all the pieces, including negotiating reimbursement."

Return on investment is a factor of facility need, size, number of total joint surgeons, and capital investment,

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AAAHC creates new orthopedic certification for ASCs

The Accreditation Association for Ambulatory Health Care (AAAHC) is rolling out a new orthopedic certification program for ASCs seeking to demonstrate high quality of care and compliance with rigorous industry requirements.

After an ASC has achieved overall accreditation, it can acquire the certification to demonstrate excellence in orthopedics by meeting specific industry standards. The requirements touch on several aspects of the ASC orthopedic specialty, including credentialing and privileging of providers, rigorous prescreening criteria to ensure optimal patient outcomes, and clinical care based on current evidence-based guidelines.

"AAAHC-accredited ASCs requested an orthopedic certification to create an organized structure that ensures high-quality delivery of care and strong patient outcomes in orthopedic procedures," says Tess Poland, MSN, BSN, RN, senior vice president of accreditation services for AAAHC.

The orthopedic certification program standards and the *2018 Accreditation Handbook for Ambulatory Health Care*, which includes updated standards for 2018 and the Centers for Medicare & Medicaid Services' emergency preparedness requirements, are available at aaahc.org/publications. More information is at aaahc.org/en/Certification/Program-Levels.

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Leggett says. Data collected at the facilities Leggett and Wilson operate indicate that with appropriate payer contracting to ensure appropriate payment and implant pricing, an ASC can annually add as much as six figures to its bottom line with as few as three to five total joint arthroplasties per month.

While awaiting future Medicare rulings on coverage, surgery centers and device manufacturers will continue to negotiate reimbursement with commercial payers. However, the cost savings at surgery centers works both ways: Although costs can be lower, so can reimbursement, especially if commercial payers reimburse at Medicare rates that may not include carve-outs for medical devices.

"Data collection will be extremely important as we negotiate with payers," Leggett says.

The American Joint Replacement Registry, the official registry of the American Association of Hip and Knee Surgeons, requests that ASCs performing total joints submit their data to its national registry at ajrr.net.

Establish protocols and procedures

"The most successful ASCs doing total joints are the ones that have evidence-based programs and protocols in place that everybody follows," Leggett says. "Unlike a hospital, at an ASC there's no discharge planner or a department that coordinates everything around the surgery. You have to build your own program using the staff you have, from preoperative evaluation to managing postoperative home health. These are the issues that somebody else takes care of for surgeons at the hospital. But at an ASC, you either need to come up with the protocols on your own or hire a consultant to do it for you."

At AMSURG, Sparks—along with the company's physician advisory board and selected physician champions—developed a total joint implementation guide that follows evidence-based best practices and industry standards established by AAAHC.

The Joint Commission has an orthopedic certification as well.

"One of our first hurdles was developing protocols to care for patients staying overnight at our center," Haller says. "That's new for most ASCs."

Establish patient selection criteria

"You need to develop your patient selection criteria and stick to it," Sparks says. Standards for total joint patient selection are more narrow than for other surgeries performed in an ASC because of the size, complexity, and recovery time required for these cases.

For example, an ASC may have a body mass index threshold of 45 for patients undergoing general surgery, but that may be 35 to 40 for total joint procedures. There are other factors to consider as well, such as diabetic status and cardiac history, Sparks says.

The Surgery Center of Long Beach worked with Convergent to develop its patient selection criteria. Convergent has studied patient selection criteria extensively and created a preoperative assessment tool the company says accurately predicts patient success for outpatient THA or TKA.

Convergent physician advisors presented the tool methodology at the 2017 annual meeting of the American Academy of Orthopaedic Surgeons. It is available online by contacting info@convergent.com.

"You're picking winners," says Dr Kimball. "Patients are in better shape, have lower ASA [American Society of Anesthesiologists] scores, are motivated to recover quickly, and have support at home to help them."

The screening data also are important when educating regulators and insurance companies about the safety and quality of outpatient total joints, Dr Kimball says.

"Patients still need to be qualified outpatient candidates. We're not doing anything different in prescreening than we would do for an ACL [anterior cruciate ligament] or hernia repair. And if someone wakes up with chest pain after a total joint procedure, it's the same protocol that it would be for a bunionectomy. Everybody is screened, and everybody has preoperative clearance for outpatient surgery," he explains.

Deliver preoperative education

Managing expectations through preoperative patient education is imperative, Sparks says. The Surgery Center of Long Beach gives a VIP tour of the facility prior to surgery.

"It helps ease some of the anxiety because patients have already been here and seen some of the faces of the people who will be caring for them," Haller says.

AMSURG is testing a virtual patient education pathway that rolls out patient education materials online in digestible chunks, "rather than sitting through an extensive class where patients and their home caregiver may not retain all of the information," Sparks says.

The online tool educates patients about the procedure as well as pre- and postoperative care, and it also provides automated phone calls, text messages, emails, and phone app notifications throughout the perioperative process. After surgery, an online tool collects patient satisfaction data. Convergent has developed its own educational series as well.

"What we found when we started to take a deep dive is that the easiest part of doing total joints in the ASC is the surgery itself," Sparks says. "The surgeons and staff are skilled, and the joint looks the same to them wherever they do the surgery. The puzzle that we had to solve is getting the right patients to the surgery center and giving them the proper education beforehand and the proper follow-up afterward."

There has been a dramatic shift from

overnight stays to patients going home within 4 to 6 hours postoperatively. With appropriate selection, education, planning, and postoperative support, this model is attractive to patients, payers, and providers, says Dr Kimball, who still prefers that his patients stay overnight.

"For your peace of mind and for patients' peace of mind, keep them there 23 hours if you have that capability," he advises. "Until an ASC has all of its protocols in place and the postoperative home care—especially pain management—is running smoothly, centers will have a better understanding of and more control over how patients are feeling if they stay the first 23 hours."

Although some ASCs have dedicated private overnight rooms for 23-hour stays, others devote a section of the postanesthesia care unit to recovery. At the Surgery Center of Long Beach, total joint patients recover in a corner bay with a privacy curtain. The center added a TV, dimmable lights, and comfortable chairs for visitors.

Post-discharge care

After patients leave the ASC, some centers have physical therapists waiting to meet them at home; others begin physical therapy after the first postoperative appointment with the surgeon.

"The key is continuity and consistency in postoperative home care," Dr Kimball says. "This is critical to making outpatient total joints work, particularly if you are sending people home the same day. You must have a standardized perioperative plan, with physical therapy and home health caregivers in place who are following the protocols you've established for pain management, anticoagulants, and physical therapy."

Leggett says it can be challenging to find home care companies that work with PPO (preferred provider organization) patients and not just Medicare.

Dr Kimball also notes that newer telemedicine apps can monitor patients' wound temperatures and mobility, and report the data back to the surgery center.

When there is inadequate support at home, Dr Kimball's surgery center works with a nearby skilled nursing facility. For continuity of care, he hires the same hospitalists who round on his orthopedic patients at the hospital to round at the skilled nursing facility.

Future outlook

The cohort of appropriate patients for outpatient total joint replacement will increase, with volume expected to reach 3.5 million procedures by 2030, according to Leggett.

"Total joints are the next ACLs," he says. "Just a little over 10 years ago, ACLs were done primarily in hospitals, and now almost 100% are done in surgery centers." He urges ASCs to consider adding total joints, especially if they already do orthopedics: "If you're a joint-ready surgery center and prepared to take on these volumes, it's going to mean a lot of business for your surgery center. The volume potential is tremendous." ✣

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

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Planning eases compliance with CMS emergency preparedness rules

As of November of 2017, healthcare providers—including ambulatory surgery centers (ASCs)—receiving reimbursement from the Centers for Medicare & Medicaid Services (CMS) were expected to comply with the 2016 Emergency Preparedness Requirements. And as with most government regulations, there are multiple pages of instructions to dissect and understand to satisfy the requirements.

"Has anyone read the new CMS regulations for emergency preparedness?" Pat Ewald, RN, asked attendees at the 2018 Ambulatory Surgery Center Association (ASCA) conference. "It is like reading War and Peace, but upside down and backward." Ewald is one of the clinical liaisons to United Surgical Partners, International, for ASCs and surgical hospitals in the Dallas/Fort Worth, Texas, region.

Resiliency through regulation

Congress passed the first Pandemic and All Hazards Preparedness Reauthorization Act in 2006, in the wake of Hurricane Katrina, to enable the federal government to support communities in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters. Since that time, the programs and partnerships under the act have made significant progress in fostering a more resilient nation.

Hurricane Katrina was the landmark moment for healthcare systems across the country as they watched facilities struggle to provide care for their own patients as well as those injured from the hurricane-force winds and ensuing floods. Administrators and clinicians realized they had better be prepared if a disaster on the scale of Katrina should someday come their way too, Ewald says.

The intent of the CMS requirements is for healthcare systems to work together with community, state, and federal organizations should a disaster occur, says Andrea Bishop, RN, project manager for emergency preparedness for northeast Ohio, Center for Health Affairs, told OR Manager. This article contains a list of key requirements, all of which should be reviewed and updated at least annually.

Learn from others



Pat Ewald, RN

Fortunately, ASC administrators and managers do not need to start from scratch to comply with the new CMS requirements. Ewald and Bishop suggest reaching out to other healthcare systems and organizations that most likely already have well-established emergency plans in place.

Many states are developing healthcare coalitions that ASCs can join or that can provide other states with emergency preparedness information, Bishop says.

Wisconsin, for example, has a wealth of ASC-specific information thanks to its seven healthcare emergency readiness coalition regions. According to its website, the coalitions have coordinated how public health, healthcare institutions, and first responder agencies, such as police, fire, and emergency medical services, will manage their efforts to enact a uniform and unified response to an emergency, including a mass casualty or other catastrophic event. (For a list of resources, see sidebar, p 16.)

The ASCA conference was held in Boston just days before the fifth anniversary of the Boston Marathon terrorist bombing, which tested the readiness of most of the city's hospitals. CMS wants ASCs to be prepared should an overwhelming man-made or natural disaster occur in their community, too.

CMS requirements consist of the following key elements:

Risk assessment and emergency planning (including but not limited to)

- hazards likely in geographic area
- care-related emergencies
- equipment and power failures
- interruption in communications, including cyberattacks
- loss of all/portion of facility
- loss of all/portion of supplies

Communication plan

- plan complies with federal and state laws
- system contacts staff, including patients, physicians, other necessary persons
- plan is well coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies
- ASCs do not need to provide occupancy information
- ASCs are not required to develop arrangements with other ASCs and other providers to receive patients in the event of limitations or cessation of operations
- ASCs are not required to include the names and contact information for other ASCs in their communication plan.

Policies and procedures

Policies and procedures must address a range of issues, including subsistence needs, evacuation plans, procedures for sheltering in place, and tracking patients and staff during an emergency.

- Develop and implement policies and procedures based on the emergency plan, risk assessment, and communication plan.
- System tracks on-duty staff and sheltered patients during the emergency—if an ASC is able to cancel surgeries and close, this requirement is not applicable.

Training and testing

- Plan complies with federal and state laws.
- Risk assessment and emergency planning (include but not limited to):
  - develop and maintain training and testing programs, including initial training in policies and procedures, and demonstrate knowledge of emergency procedures and provide training at least annually or initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role
  - provide emergency preparedness training at least annually
  - maintain documentation of all emergency preparedness training and testing
  - demonstrate staff knowledge of emergency procedures
  - annually participate in a full-scale facility-based exercise and additional exercise of facility choice (community-based drill not required).

Risk assessment and planning

The CMS-required all-hazards approach for assessment and planning means predicting anything that can happen outside of the facility over which there is no control, as well as for the events that can happen inside, such as a loss of power or fire, over which there is more control, Ewald says.

The planning for natural or man-made disasters is done by performing a hazard vulnerability analysis (HVA) of the possible natural and man-made disasters that could possibly occur to an ASC based on a variety of factors, such as geography, physical location, and past history of disasters.

A plan of mitigation then needs to be tailored for each disaster identified by the HVA. Possible disasters include:

- pandemic flu (eg, H1N1 influenza virus)
- hurricanes
- tornadoes
- fires
- earthquakes
- power outages
- chemical spills
- nuclear or biological terrorist attack.

Planning for the worst

"Ask yourself, what is pertinent to my location? What disasters have occurred in previous years and decades? What is the probability of something happening again? And if it happens again, how bad could it be?" Ewald says.

The possible events must then be ranked according to the potential threat to life or health, disruption of services, financial impact, failure possibilities, and legal issues. The emergency preparedness plan should focus on those disasters most likely to occur in and around your ASC.

For example, tidal waves could not occur in the Midwest, so such events do not need to be in the disaster plans for Illinois, Indiana, and other Midwest states. On the Pacific Coast, tsunamis are a rare but distinct possibility and, in the West, wildfires are a common phenomenon.

The goal of a response plan is to reduce the loss of life and property by lessening the impact of future disasters. If your ASC already has an emergency plan, assess whether you need a new one or if it needs to be revised. Planning should include how your ASC will continue to operate during an emergency or if it even should.

Ewald says points to consider include:

- what business functions are necessary during an emergency
- a staffing strategy accounting for whether the ASC needs more staff or less, depending on the situation
- a plan to contact staff when needed
- any services your ASC would be able to provide for the local community
- how you will continue documentation if computers are not working.

ASCs must determine what would happen if the center's key people are not available during an emergency, Ewald says. Alternates must be selected and designated through written authorization and be made part of the plan.

Communication is crucial

Communication is the foundation upon which every type of emergency response is built, Ewald says. During the Boston Marathon bombing, for example, staff at the city's hospitals learned the value of texting to communicate quickly with key members of their disaster response teams, along with the use of social media, to find out what was happening at the terrorist site and other areas even before the media.

Communication includes coordinating patient care within the facility, across healthcare providers, and with state and local public health departments and emergency management systems.

Two reliable forms of communication must be available so that you can communicate internally and outside the facility if you need support. This type of planning requires old-school thinking, Ewald says, such as using walkie talkies or finding any ham radio enthusiasts in your area. Don't rely solely on the most advanced technology available to record this vital information. Have paper lists of staff contacts available and other pertinent information in your plan.

Consider how you will share medical records and patient information if patients are discharged or remain at the ASC, Ewald says. HIPAA Privacy Rule considerations are still required. The HIPAA-At-A Glance Disclosure Decision Flowchart is available on the CMS website.

Policies and procedures for each ASC must be based on the risk assessment

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and align with identified hazards, Ewald says. They can be incorporated into the plan or compiled in a separate document.

Train, then test

Training should be done for each new hire and continue through the year, Bishop says. ASC employees must be able to demonstrate knowledge of emergency procedures.

Both Ewald and Bishop say training and testing need to be cyclical, and CMS requires two testing exercises each year:

- a full-scale, facility-based exercise that simulates an emergency or disaster
- a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

Full compliance with emergency requirements may seem daunting, but CMS offers one reprieve: An ASC that responds to a significant disaster need not conduct training for 1 full year following the event, Ewald says.

"If you think about the regulations with a collective groan, then you will never do it well," Ewald says. "Think about your neighbors instead. It's about doing the right thing at the right time." ✣

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

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