



Outpatient • Office Based • Non-Operating Room

SAMBA 2021 ASC MEDICAL DIRECTORS & LEADERS VIRTUAL SUMMIT

SATURDAY, JANUARY 23, 2021

SYLLABUS

Jointly Provided by the American Society of Anesthesiologists
(ASA) and the Society for Ambulatory Anesthesia (SAMBA).



PROGRAM INFORMATION

Target Audience

This meeting is intended for Ambulatory Surgery Center Medical Directors & Leaders.

About This Meeting

The purpose of this meeting is to educate and share information that is tailored to physicians, AHPs, Medical Directors, and Administrative staff who practice in Ambulatory Surgery Centers. Opportunities for questions and answers will be provided at the conclusion of each panel.

Registration

Registration for the 2021 ASC Medical Directors & Leaders Virtual Summit includes access to all sessions and the program syllabus. Note that all fees are quoted in U.S. currency. Registration for the meeting is available to members and non-members via SAMBA's website at www.sambahq.org.

Disclaimer

The information provided at this accredited activity is for continuing

education purposes only and is not meant to substitute for the independent medical judgment of a healthcare provider relative to diagnostic and treatment options of a specific patient's medical condition.

Accreditation Statement

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Society of Anesthesiologists. The American Society of Anesthesiologists is accredited by the ACCME to provide continuing medical education for physicians.

The American Society of Anesthesiologists designates this live activity for a maximum of 5 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Commercial Support

Acknowledgement

The CME activity is supported by an education grant from Medtronic.

Special Needs

The Society for Ambulatory Anesthesia (SAMBA) fully complies with the legal requirements of the Americans with Disabilities Act and the rules and regulations thereof. If any attendee in this educational activity is in need of accommodations, please contact the SAMBA Executive Office at 414-488-3915.

Cancellation Policy

Cancellations received through January 15, 2021, will receive a full refund. Cancellation of a meeting registration must be submitted in writing. Refunds will be determined by date written cancellation is received at the SAMBA office in Milwaukee, WI.

OVERALL LEARNING OBJECTIVES

At the conclusion of this activity, participants should be able to:

- Describe the function of a medical director and the skills needed.
- Assess their environment for practicality of adding new services and how to plan for it.
- Assess their practice for compliance in legal and accreditation matters.
- Evaluate their culture in regard to patient safety and risk reduction.

PROGRAM SCHEDULE *(All Times Listed are in Eastern Time)*

Saturday, January 23, 2021

10:00am – 11:15am

Panel: Leadership in Today's ASC

Moderator *Arnaldo Valedon, MD, SAMBA-F*

Industry Trends – William Prentice, JD

Strategic Planning – Matt Pate

11:15am – 12:30pm

Panel: Your Responsibilities as the Medical Director of an ASC

Moderator: *Leopoldo V. Rodriguez, MD, MBA, FAAP, FASA, SAMBA-F*

CMS Legal Requirements – Judith Jurin Semo, J.D.

Pharmacy Regulations – Lea Schilit, PharmD, CPh, MS, RD

12:30pm-1:00pm

Break

1:00pm – 2:15pm

Panel: Creating and Maintaining a Patient-Centered Culture of Quality and Safety

Moderator: *Arnaldo Valedon, MD, SAMBA-F*

Patients Satisfaction – Jane Hyde, PhD

Safe and Just Culture – David Shapiro, MD

2:15pm – 3:30pm

Panel: Managing Your ASC

Moderator: *Leopoldo V. Rodriguez, MD, MBA, FAAP, FASA, SAMBA-F*

Adding Service Lines – Robert Eisenberg, RN, MBA, CASC

Staffing and Conflict Resolution – Rena Courtay, MBA, BSN, RN, CASC

PROGRAM PLANNING COMMITTEE

Leopoldo V. Rodriguez, MD, MBA, FAAP, FASA, SAMBA-F

2021 ASC Medical Directors & Leaders Virtual Summit Co-Chair

President, SAMBA

Assistant National Medical Director, Ambulatory Anesthesiology, AmSurg & Envision Physician Services

Assistant Professor of Anesthesiology, Nova Southeastern Allopathic School of Medicine

Medical Director, Surgery Center of Aventura

Boca Raton, FL

Arnaldo Valedon, MD, SAMBA-F

2021 ASC Medical Directors & Leaders Virtual Summit Co-Chair

Medical Director, Outpatient

Perioperative Services; Medical Director and Directors Anesthesia Services WellSpan Health and Surgery Center

WellSpan Health Hanover, PA

Steven Butz, MD

SAMBA Meetings Committee Co-Chair

Professor of Anesthesiology, Medical College of Wisconsin

Associate Chief Medical Officer, Children's Wisconsin Surgicenter Milwaukee, WI

STAFF

Andrew Bronson, CAE

Executive Director
Society for Ambulatory Anesthesia
(SAMBA)
Milwaukee, WI

Julianna Cibula

Account Coordinator
Society for Ambulatory Anesthesia
(SAMBA)
Milwaukee, WI

Claire Murray

Account Coordinator
Society for Ambulatory Anesthesia
(SAMBA)
Milwaukee, WI

FACULTY

Rena Courta y, MBA, BSN, RN, CASC

President
Solutions for Outpatient Surgery
Fort Lauderdale, FL

Robert Eisenberg, RN, MBA, CASC

Administrative Director of Ambulatory
Surgery Planning and Integration
WellSpan Health
Reisterstown, MD

Jane Hyde, PhD

SVP/Chief Experience Officer
WellSpan Health
Mount Gretna, PA

Matt Pate

Chief Operating Officer
National Partners in Healthcare
Dallas, TX

William Prentice, JD

Chief Executive Officer
Ambulatory Surgery Center Association
New Alexandria, VA

**Leopoldo V. Rodriguez, MD, MBA,
FAAP, FASA, SAMBA-F**

President, SAMBA
Assistant National Medical Director,
Ambulatory Anesthesiology, AmSurg
& Envision Physician Services
Assistant Professor of Anesthesiology,
Nova Southeastern Allopathic School
of Medicine
Medical Director, Surgery Center of
Aventura
Boca Raton, FL

Lea Schilit, PharmD, CPh, MS, RD

Assistant Vice President
Clinical Pharmacy Services-Eastern
Region HCA Healthcare Ambulatory
Surgery Division
Miramar, FL

Judith Jurin Semo, J.D.

Principal
Judith Jurin Semo, PLLC
Bethesda, MD

David Shapiro, MD

Tallahassee, FL

Arnaldo Valedon, MD, SAMBA-F

Medical Director, Outpatient
Perioperative Services; Medical
Director and Directors Anesthesia
Services WellSpan Health and
Surgery Center
WellSpan Health
Hanover, PA

DISCLOSURE STATEMENT

The American Society of Anesthesiologists remains strongly committed to providing the best available evidence-based clinical information to participants of this educational activity and requires an open disclosure of any potential conflict of interest identified by our faculty members. It is not the intent of the American Society of Anesthesiologists to eliminate all situations of potential conflict of interest, but rather to enable those who are working with the American Society of Anesthesiologists to recognize situations that may be subject to question by others. All disclosed conflicts of interest are reviewed by the educational activity course director/chair to ensure that such situations are properly evaluated and, if necessary, resolved. The American Society of Anesthesiologists educational standards pertaining to conflict of interest are intended to maintain the professional autonomy of the clinical experts inherent in promoting a balanced presentation of science. Through our review process, all American Society of Anesthesiologists accredited activities are ensured of independent, objective, scientifically balanced presentations of information. Disclosure of any or no relationships will be made available for all educational activities.

The following faculty, staff, and/or planning committee members have indicated that they have relevant financial relationships with commercial interests to disclose:

Name	Type of Relationship	Company
Leopoldo V. Rodriguez, MD, MBA, FAAP, FASA, SAMBA-F	Consulting Fees	AcelRx Pharmaceutical

All other planners, faculty, and staff have reported no relevant financial relationships with commercial interests to disclose.

MARK YOUR CALENDAR AND BE SURE TO JOIN US AT FUTURE SAMBA MEETINGS!

Office-Based Anesthesia (OBA) Virtual Symposium
Saturday, March 20, 2021

SAMBA 2021 - A Virtual Experience
May 13-16, 2021 · #SAMBA2021

HANDOUTS

Leadership in Today's ASC - Industry Trends

William Prentice, JD

Panelist

01/23/2021

10:00-10:30am Eastern (Q&A From 11:00-11:15am Eastern)

HANDOUTS

Leadership in Today's ASC - Strategic Planning

Matt Pate
Panelist

01/23/2021

10:30-11:00am Eastern (Q&A From 11:00-11:15am Eastern)

SAMPLE

Sample Strategic Plan – Sunshine Surgery Center

Date: _____

Mission – (This is why the ASC exists. Try to use 15 words or less – the elevator speech)

We will take care of all patients in a safe and comfortable environment.

Values – (4-6 words/statements that reflect your culture and drive your priorities)

Respect, Compassion, Integrity, Respect, Teamwork, Excellence

S.W.O.T. – (an assessment of your ASC’s environment)

<p>Strengths (internal)</p> <ul style="list-style-type: none"> • location • reputation • size of facility • quality of nursing staff 	<p>Weaknesses (internal)</p> <ul style="list-style-type: none"> • business office off-site • managed care contractual rates • old building • parking
<p>Opportunities (external)</p> <ul style="list-style-type: none"> • buy a second c-arm • Saturday procedures • improve look of waiting room 	<p>Threats (external)</p> <ul style="list-style-type: none"> • new ASC opening 5 miles away next month • hospital employing our general surgeons • High patient deductibles • Dr. Davis retiring

Goals – (aspirational statement identifying a future desired outcome)

Service – Have patients and surgeons that recommend our ASC to their friends and colleagues

People – Have qualified and satisfied employees

Quality – Improve patient outcomes

Finance – Have a financially viable surgery center

Growth – Always be adding new physicians

Objectives – (4-6, specific measurable statements implementing your goals)

Defined using the S.M.A.R.T. framework; **S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime-Bound

Under the typical pillars; Service, People, Quality, Finance/Profitability, Growth

Pillar	Objective	Measure	Time Frame
Service			
	Improve patient satisfaction scores	Be at or above 4.5	Before end of the year
	Schedule our physician’s first request	Schedule physician’s first request > 95% of the time	Each month this year
People			
	Have satisfied employees	Employee satisfaction scores > 90%	Survey completed by Sept 30 th
	Don’t lose good employees	Turnover rate < 10%	Dec 31 this year vs. last
Quality			
	Eliminate hospital transfers	0 occurrences	Entire year
	Eliminate wrong sites	0 occurrences	Entire year
Finance /			

SAMPLE

Profitability			
	Exceed our budgeted bottom line (EBTIDA)		
Growth			
	Add two new surgeons to our partnership		

Strategies: (2-3 actions designed to achieve each objective, describing what the strategy will be)

Objective	Strategies	Owner	Cost
Improve patient satisfaction scores	Negotiate an agreement with Press Ganey. Start sending PG surveys to all patients. Share feedback with entire staff each month. Convert all PACU bays to semi-private. Solicit and implement ideas to improve from the staff.	Dianne – PACU manager	\$10,000
Schedule our physician’s first request	Have board review our current block schedule policy. Shift all pain management volume to Thursday and Friday. Call each physician scheduler one week before block day.	Denise – scheduler	\$0
Have satisfied employees	Hire happy people. Conduct staff meetings once per month. Plan three social events outside of the ASC.	Ann – Administrator	\$0
Don’t lose good employees	Develop succession plans for each key position. Allow and promote continuing education.	Ann – Administrator	\$10,000 in raises
Eliminate hospital transfers	Review protocols on fusion cases. Require anesthesia to stay past 5:00pm.	Lisa – OR Manager	\$0
Eliminate wrong sites	Conduct a time out on all cases.	Lisa – OR Manager	\$0
Exceed our budgeted bottom line (EBTIDA)	Renegotiate agreement with vendor. Solicit cost savings ideas from the staff. Have consultant renegotiate Blue Cross and UHC agreements.	Dr. Dave – Medical Director	\$10,000
Add two new surgeons to our partnership	Target ENT. Identify all ENT’s that have an office within 10 miles of the ASC. Meet with each of the target physicians. Give each a tour of our ASC.	Karen – BOM/Physician Liaison	\$5,000

Strategic Plan – _____

Date: _____

Mission – (This is why the ASC exists. Try to use 15 words or less – the elevator speech)

Values – (4-6 words/statements that reflect your culture and drives your priorities)

S.W.O.T. – (an assessment of your ASC’s environment)

Strengths (internal) _____ _____ _____	Weaknesses (internal) _____ _____ _____
Opportunities (external) _____ _____ _____	Threats (external) _____ _____ _____

Goals – (aspirational statement identifying a future desired outcome)

- Service - _____
- People - _____
- Quality - _____
- Finance - _____
- Growth - _____

Objectives – (4-6, specific measurable items that will implement your goals)

Defined using the S.M.A.R.T. framework; **S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime-Bound
 Under the typical pillars; Service, People, Quality, Finance, Growth

Pillar	Objective	Measure	Time Frame
Service			
People			

Quality			
Finance / Profitability			
Growth			

Strategies: (2-3 actions designed to achieve each objective, describing what the strategy will be)

Objective	Strategies	Owner	Cost

SAMBA - ASC Medical Directors
 & Leaders Virtual Summit

Leadership in Today's ASC –
 Strategic Planning

January 23, 2021

1

Learning Objectives

- Discuss the purpose of an ASC strategic plan
- Review the key elements of a strategic plan
- Learn how to start creating a strategic plan

2

Purpose of an ASC Strategic Plan

- Sets the future direction for your organization
- Focuses efforts and everyone working towards common goals
- Setting a path motivates everyone to succeed
- Prioritize financial needs and connects to your annual budget
- Aligns resources for optimal results

"Failing to plan is planning to fail" - Benjamin Franklin

3

Key Elements of a Strategic Plan

- Mission: The fundamental purpose of your ASC, why it exists. "the elevator speech"
- Values: Beliefs that are shared among the stakeholders of your ASC, they drive your ASCs culture and priorities
- S.W.O.T.: Strengths, Weaknesses, Opportunities, and Threats

4

Key Elements of a Strategic Plan

- Goals: Aspirational statement identifying a future desired outcome, in five areas; Service, People, Quality, Finance and Growth
- Objectives: These are what your ASC is specifically trying to achieve with your goals
 - In 5 pillars: Service, People, Quality, Finance/Profitability, Growth
 - Follow the S.M.A.R.T. format (Specific, measurable, achievable, relevant, time-bound)
- Strategies: The actions you will be taking to achieve your objectives that support your mission

5

Start Creating a Strategic Plan

- Mission
- Values
- S.W.O.T.
- Goals
- Objectives
- Strategies

- Sample Plan
- Blank Plan

6

Matt Pate, COO

National Partners in Healthcare

mpate@nphllc.com

7

7

HANDOUTS

Your Responsibilities as the Medical Director of an ASC - CMS Legal Requirements

Judith Jurin Semo, J.D.
Panelist

01/23/2021

11:15-11:45am Eastern (Q&A from 12:15-12:30pm Eastern)

Your Responsibilities as the Medical
 Director of an ASC – CMS Legal
 Requirements

SAMBA 2021 ASC Medical Directors & Leaders Virtual
 Summit

January 23, 2021

Judith Jurin Semo, J.D.
 (202) 331-7366 | jsemo@jsemo.com

© 2021 Judith Jurin Semo



1

Disclosures

- Am an attorney in private practice,
- I have no other financial interests to disclose

2

Objectives

- Review multiple sources of a Medical Director's obligations
- Review areas of Medical Director responsibility
- Review areas of exposure for a Medical Director
- Suggest strategies to enhance a Medical Director's ability to be successful in carrying out his/her obligations

3

Conclusion Preview

- The Medical Director is the point person in the ASC
 - An administrative position that is inextricably tied to clinical decision-making
 - High stakes/high-risk position
 - Similar to anesthesia – may be straightforward much of the time, but when a problem arises, the Medical Director must make a quick & informed decision
 - Understanding the scope of the obligations & the potential risks – along with strategies to minimize exposure – can help a Medical Director navigate the position

4

ASC Medical Director
 Sources for Areas of Responsibility

5

Sources of Obligations

- ASC governing documents
- Services agreement – either
 - Part of anesthesiology services agreement or
 - Separate medical director agreement
- External legal requirements, including:
 - State licensing requirements
 - CMS Conditions for Coverage (regs & guidelines)
- Accreditation requirements

6

Sources of Obligations

- Because obligations may derive from contracts, they may differ from one ASC to another
 - There may be a Medical Director of the ASC *and* a Medical Director of Anesthesia
- Important to understand the duties of multiple Medical Directors (if there are multiple ones)

7

CMS Requirements

- Medical Director obligations stem from CMS requirements
- Source documents:
 - CMS Regulations: 42 C.F.R. (Code of Federal Regulations) Part 416: Ambulatory Surgical Services
 - Available at <https://www.ecfr.gov/cgi-bin/text-idx?SID=1032e2866e2c1e88b6804e2c36667b428&mc=true&nnode=pt42.3.416&rgn=div5>
 - CMS Policy: *State Operations Manual*, Pub. No. 100-07, Appendix I: Guidance for Surveyors: Ambulatory Surgical Centers
 - Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_1_ambulatory.pdf

8

Your Responsibilities as an ASC Medical Director

9

Areas of Responsibility

- Importantly: CMS lays obligations for ASCs at the hand of the ASC
 - Not any Medical Director
- The duties we will review are those of the ASC – but typically are delegated to the Medical Director

10

Areas of Responsibility

- To participate as an ASC:
 - Must meet the definition of ASC (in 42 CFR § 416.2)
 - Have agreement with CMS
 - To qualify for an agreement: Must either
 - Have “deemed compliance” – accreditation by national accrediting body or licensed by State agency, or
 - Be surveyed by State survey agency

11

ASC Definition

- Definition of ASC (42 CFR § 416.2):

Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of this part.

12

ASC Conditions for Coverage



- The 14 specific conditions for coverage all relate to the role of the Medical Director
- #1: Compliance w/State licensure req'ts (42 CFR § 416.40)
- #2: Governing body and management (42 CFR § 416.41)
 - Hospitalization: Effective procedure for immediate transfer to a hospital
 - ASC must periodically provide local hospital w/written notice of its operations and patient population served

13

ASC Conditions for Coverage



- #3: Surgical services (42 CFR § 416.42): Likely direct area of Medical Director responsibility
 - This section contains detailed requirements relating to anesthesia, including:
 - Anesthetic risk & evaluation
 - Immediately before surgery
 - Before discharge from ASC
 - Who may administer anesthesia
 - Including supervision of nonphysician anesthetists – unless exemption for CRNAs under state law

14

ASC Conditions for Coverage



- #4: Quality assessment & performance improvement (42 CFR § 416.43): Likely direct area of Medical Director responsibility
 - ASC must develop/maintain data-driven quality assessment & performance improvement program (“QAPI”)
 - Monitor effectiveness & safety of services
 - Monitor quality of care
 - Identify ways to improve care
 - Typically falls to Medical Director to oversee

15

ASC Conditions for Coverage



- #5: Environment (42 CFR § 416.44): Likely shared responsibility between Medical Director & ASC
 - Physical environment – functional & sanitary environment for surgical services
 - Fire safety: Medical Director often must implement
 - Building safety: More for ASC to address (compliance with codes)
 - Emergency equipment: Must be immediately available for use & appropriate for ASC's patient population
 - Typically an area for Medical Director to oversee & coordinate
 - Emergency personnel: Must have personnel trained in use of emergency equipment & CPR whenever a patient in the ASC

16

ASC Conditions for Coverage



- #6: Medical Staff (42 CFR § 416.45): Likely shared responsibility between Medical Director & ASC
 - Membership & clinical privileges: Qualifications of members of the medical staff
 - Reappraisals: Must periodically reappraise privileges & scope of procedures performed in the ASC
 - Other practitioners: Must have policies & procedures to oversee & evaluate clinical activities of other practitioners
- (On a practical basis, the Medical Director is usually the person called upon to deal with problems relating to Medical Staff members)

17

ASC Conditions for Coverage



- #7: Nursing services (42 CFR § 416.46): Less a Medical Director responsibility
 - Must meet nursing needs of patients
 - Must delineate patient care responsibilities for all nursing personnel
 - Must be an RN available for emergency treatment whenever a patient is in the ASC

18

ASC Conditions for Coverage



- #8: Medical records (42 CFR § 416.47): Likely shared responsibility between Medical Director & ASC
 - Must maintain complete & accurate medical records to ensure adequate patient care
 - ASC must have a system for collection, storage, & use of patient records
 - Form & content of record:
 - Must have medical record for each patient
 - Must be accurate, legible, and promptly completed
- Typically, will fall to the Medical Director to address failure of Medical Staff members to maintain proper records

19

ASC Conditions for Coverage



- Medical record must include at least the following:
 - Patient identification
 - Significant medical history & results of physical exam
 - Preop diagnostic studies (entered before surgery), if performed
 - Findings & techniques of the operation, including pathologist's report on all tissues removed during surgery
 - Any allergies & abnormal drug reactions
 - Entries related to anesthesia administration
 - Documentation of "properly executed informed patient consent"
 - Discharge diagnosis

20

ASC Conditions for Coverage



- #9: Pharmaceutical services (42 CFR § 416.48): Likely shared responsibility between Medical Director & ASC
 - Drugs must be prepared & administered acc'g to established policies & acceptable standards of practice
 - Adverse reactions must be reported to the responsible physician & documented in the record
 - Blood & blood products must be administered only by physicians or RNs
 - Orders given orally for drugs & biologicals must be followed by written order, signed by the prescribing physician

21

ASC Conditions for Coverage



- #10: Laboratory & radiologic services (42 CFR § 416.49): Likely shared responsibility between Medical Director & ASC
 - If ASC performs lab services, must meet CMS req'ts (42 C.F.R. Part 493)
 - Radiologic services may only be provided when integral to ASC services
 - Must meet hospital conditions of participation for such services (42 C.F.R. §§ 482.26(b), (c)(2), & (d)(2)), including
 - Proper safety precautions
 - Periodic inspection of equipment
 - Periodic check of radiation workers for radiation exposure
 - Personnel – who may use radiologic equipment & administer procedures
 - Records

22

ASC Conditions for Coverage



- #11: Patient rights (42 CFR § 416.50): Likely shared responsibility between Medical Director & ASC
 - Verbal & written notice of patient's rights (pre-surgery)
 - **Disclosure of physician financial interest or ownership in the ASC
 - **Advance directives – provide info on policies on advance directives & document in prominent part of record whether patient executed an advance directive
 - Submission/investigation of grievances
 - Exercise of rights: Be fully informed about a treatment or procedure & expected outcome before performed
 - Privacy & safety
 - Confidentiality of clinical records

** Emphasizing rights that may not immediately come to mind as a "patient right"

23

ASC Conditions for Coverage



- #12: Infection control (42 CFR § 416.51): Likely shared responsibility between Medical Director & ASC
 - Must maintain program to minimize infections & communicable diseases
 - Must maintain functional and sanitary environment
 - Must maintain ongoing program to prevent, control, & investigate infections & communicable diseases
 - Must be under direction of designated & qualified profession w/training in infection control
 - Be part of QAPI

24

ASC Conditions for Coverage



- #13: Patient admission, assessment, & discharge (42 CFR § 416.52): Likely shared responsibility between Medical Director & ASC
 - Ensure each patient has appropriate presurgical & postsurgical assessments completed & all elements of discharge req'ts completed
 - Patient assessment & admission: Identify those patients who require medical history & physical exam prior to surgery
 - Include timeframe for med history & physical exam
 - Specific factors to address, including:
 - Patient age, diagnosis, type & number of procedures to be perf'd on same surgery date
 - Planned anesthesia level

25

ASC Conditions for Coverage



- #13: Patient admission, assessment, & discharge cont'd:
 - Post-surgical assessment: Patient's post-surgical condition must be assessed by physician, qualified practitioner, or RN w/(at minimum) post-op care experience
 - Post-surgical needs must be addressed & included in discharge notes
 - Discharge: Must:
 - Provide written discharge instructions & overnight supplies
 - When appropriate, make follow-up appt
 - Ensure all pts informed – in advance of procedure or prior to leaving ASC – of their prescriptions, post-op instructions, & physician contact info for follow-up care

26

ASC Conditions for Coverage



- #13: Patient admission, assessment, & discharge cont'd:
 - Discharge: Also must:
 - Ensure each patient has a discharge order signed by physician who performed the surgery or procedure
 - Ensure all patients discharged in company of a responsible adult
 - Except those patients exempted by attending physician

27

ASC Conditions for Coverage



- #14: Emergency preparedness (42 CFR § 416.53): Likely shared responsibility between Medical Director & ASC
 - Must have emergency preparedness plan – reviewed & updated at least every two years – that:
 - Based on documented, facility-based & community-based risk assessment
 - Strategies to address emergency events
 - Address patient population & continuity of operations
 - Include process to cooperate w/local, state, & fed officials
 - Detailed req'ts of plan

28

ASC Conditions for Coverage



- #14: Emergency preparedness (42 CFR § 416.53) cont'd:
 - System to track location of on-duty staff & sheltered patients during emergency
 - Safe evacuation from ASC, including detailed requirements – e.g.,
 - Care & treatment needs of evacuees
 - Staff responsibilities
 - Means to shelter in place
 - Medical documentation to
 - Preserve patient info
 - Protect confidentiality
 - Secure & maintain availability of records
 - Many more details

29

ASC Conditions for Coverage



- The State Operations Manual contains the Interpretive Guidelines relating to the Conditions of Coverage (“CfCs”) for ASCs
- Far more detail
 - Details of the CfCs
 - Instructions for surveyors on what to review to assess compliance
- Topics often covered in more than one section – e.g.,
 - Informed consent is addressed in at least four sections:
 - Survey procedures
 - Surgical procedures
 - Medical records
 - Patient rights

30

Highlights & Examples: Anesthetic Risk & Evaluation

- In discussing ASA physical status classification, CMS states (Q-0061):
 As the ASA PS level of a patient increases, the range of acceptable risk associated with a specific procedure or type of anesthesia in an ambulatory setting may narrow. An ASC . . . might then consider, taking into account the nature of the procedures it performs and the anesthesia used, whether it will accept for admission patients who would have a classification of ASA PS IV or higher. For many patients classified as ASA PS level III, an ASC may also not be an appropriate setting, depending upon the procedure and anesthesia.

31

Highlights & Examples: Anesthetic Risk & Evaluation

- Post-anesthesia assessment
 - Before discharge from ASC
 - Not required for moderate or conscious sedation
 - By physician or anesthesiologist
 - Not by RN using a checklist
 - At a minimum, must include monitoring/assessment of:
 - Respiratory function
 - Cardiovascular function
 - Mental status
 - Temperature
 - Pain
 - Nausea & vomiting
 - Postop hydration

32

Highlights & Examples: QAPI

- CMS does not prescribe a particular QAPI program; it provides each ASC with the flexibility to develop its own program
 - Ongoing: Collection & analysis of quality data at regular intervals, updated records of actions taken to identify quality problems identified
 - Data-driven: Must identify what data will be collected, how data will be collected & analyzed, frequency of collection
 - Focus on high-risk, high-volume, & problem-prone areas
 - Will differ from ASC to ASC

33

Highlights & Examples: Informed Consent

- “A well-designed informed consent process” to include (Q-0162):
 - Description of proposed surgery, including anesthesia to be used
 - Material risks & benefits related to the surgery & anesthesia
 - “Material risks could include risks with a high degree of likelihood, but a low degree of severity, as well as those with a very low degree of likelihood, but a high degree of severity”
 - Treatment alternatives
 - Who will conduct surgical intervention & administer anesthesia
 - Whether other physicians will participate
 - Whether qualified nonphysician practitioners will perform important parts of surgery or administer anesthesia

34

Highlights & Examples: Informed Consent (2)

- Section on patient rights addresses informed consent for anesthesia (Q-0229)
 Given that ASC surgical procedures generally entail use of some form of anesthesia, and that there are risks as well as benefits associated with the use of anesthesia, ASCs should assure that their informed consent process provides the patient with information on anesthesia risks and benefits as well as the risks and benefits of the surgical procedure.

35

Potential Areas of Legal Exposure

36

Medical Director Areas of Responsibility



- Typically, the Medical Director is responsible for all of the above
 - Establishing policies and procedures (or working with others to establish them)
 - Implementing policies
 - Overseeing that training is done
 - Spot-checking for compliance
 - Preparing for and responding to surveys
- Serves as the “point person”: the “firefighter” who addresses the crisis du jour

37

Potential Legal Exposure



- The role is prone to potential liability
 - The Medical Director is in the hot seat
 - Fields all crises
 - Often – quick decisions needed
 - High stakes
 - Many responsibilities that require ongoing oversight/monitoring
 - Makes it easier for a ball to drop
 - To fail to carry out all responsibilities
 - Potential consequences for ASC accreditation/Medicare participation

38

Potential Legal Exposure



- With a wide range of responsibilities, many areas of potential legal exposure:
 - Noncompliance with CMS Conditions for Coverage
 - Likely a breach of the Medical Director agreement
 - Consequences for ASC accreditation/Medicare participation
 - Breach of contract – failure to comply with all duties of the position
 - Claims relating to credentialing
 - Failure to credential a physician
 - Termination of a physician’s privileges
 - Negligent credentialing

39

Potential Legal Exposure



- Additional areas of exposure:
 - Professional liability – if a patient is injured – whether due to
 - A failure to comply with Conditions for Coverage
 - A decision the Medical Director makes
 - Even if the decision is proper, potential for a legal challenge
 - Claims related to peer review
 - HIPAA
 - Fraud & abuse
 - Compliance with Stark – financial arrangements with physicians
 - Anti-kickback compliance

40

Strategies to Navigate Obligations & Minimize/Mitigate Legal Exposure



Strategies: Framing Duties: #1



- *Contractual:* Make sure Medical Director duties are:
 - Clearly outlined
 - Not overly broad
 - Take into account the ASC’s role in assuring compliance with ASC regulatory requirements
 - Duties must be realistic
 - ASC must provide staff to assist the Medical Director to carry out duties
 - (See below for the need to create a team)

41

42

Strategies: Framing Duties: #2



- *Contractual:* Frame obligations as “assisting in” and “overseeing,” rather than performing all of the tasks and ensuring an outcome
 - For example:
 - Original: “Ensure compliance with CMS Conditions for Coverage”
 - Reworded: “Work with ASC staff with the goal of promoting compliance with CMS Conditions for Coverage”
 - Cannot overcommit in “ensuring” or “guaranteeing” an outcome

43

Strategies: Training



- *Contractual:* The ASC should provide appropriate training for the Medical Director to equip the Medical Director to carry out the duties of the position
 - Can perform better with the proper tools
 - Learn from others who face similar challenges
 - Such time should “count” for purposes of the time commitment of the Medical Director
- *Updates/Staying informed:* Need support from ASC to stay abreast of changes to ASC req'ts

44

Strategies: Adequate Time



- *Contractual and operational:* Ensure that any Medical Director agreement allows the Medical Director sufficient time to perform the duties
 - Often, the time allocation is tied to a budgeted amount of money, rather than a realistic assessment of the time needed
 - Cannot do the job properly if do not have sufficient time

45

Strategies: Indemnification & Insurance



- *Contractual:* Want the ASC or ASC owner to indemnify the Medical Director against liability associated with the position, so long as the Medical Director acts in good faith
 - May also want to require that ASC/ASC owner purchase errors & omissions insurance to cover the Medical Director
 - Such agreement must survive expiration or termination of the Medical Director Agreement
 - This presentation is focused on the Medical Director, but such indemnification/insurance should extend to the anesthesia group & any group personnel who assist the Med. Dir. in carrying out duties

46

Strategies: Create/Foster a Team



- *Operational:* Need to have a good team in the ASC to serve as extensions of the Medical Director and to oversee all areas of ASC operations & obligations under the CMS participation agreement (as outlined above)
 - Not just the ASC Administrator, but all staff – from top to bottom
 - The Medical Director job is bigger than any one person

47

Strategies: Create Redundancy in the Team



- *Operational:* Cross-train ASC and group (if the anesthesia group is providing the Medical Director) personnel on different functions
 - Promotes continuity of the function
 - Allows for informed discussion & decision-making
 - Provides more people to assist in
 - Implementing policies
 - Monitoring compliance
 - Providing training

48

Strategies: Promote Culture of Compliance



- *Operational:* Create culture of compliance
 - Encourage staff to ask questions
 - Encourage ASC staff & Medical Staff members to
 - Offer suggestions
 - Think ahead to identify possible issues
 - Incorporate “training” into digestible units more frequently
 - To avoid overloading a single training session with more information than can be absorbed

49

Conclusion



50

Conclusion



- The Medical Director is the point person in the ASC
 - An administrative position that is inextricably tied to clinical decision-making
 - High stakes/high-risk position
 - Similar to anesthesia – may be straightforward much of the time, but when a problem arises, the Medical Director must make a quick & informed decision
 - Understanding the scope of the obligations & the potential risks – along with strategies to minimize exposure – can help a Medical Director navigate the position

51

HANDOUTS

Your Responsibilities as the Medical Director of an ASC - Pharmacy Regulations

Lea Schilit, PharmD, CPh, MS, RD
Panelist

01/23/2021

11:45-12:15pm Eastern (Q&A from 12:15-12:30pm Eastern)

What You are Responsible for as Medical Director: Pharmacy Requirements

Lea Schilit, MS, PharmD, CPh, RD
Assistant Vice President, Clinical Pharmacy Services, East Region
HCA Healthcare Ambulatory Surgery Division



1

Conflict of Interest

Disclosure statement: the following individual has the following to disclose concerning possible financial or personal relationships with commercial entities (or their competitors) that may be referenced in this presentation

- I have nothing to disclose

– Lea Schilit, PharmD, MS, CPh has nothing to disclose



2

Learning Objectives

- Discuss safe medication practices including how USP 797 and 800 apply in the ambulatory surgery center, use of compounded medications, identify processes to monitor for expired medication, review components needed for identification and labeling of high alert and confused name medications in your center, safe medication storage, documenting of medication errors and near misses, and tips for order sets
- Describe best practices surrounding handling, storage, and monitoring of controlled substances at your surgery center



3

USP 797

- If not administered immediately, the compounded sterile product is labeled appropriately, including the exact 1 hour Beyond Use Date (BUD) and time
- Simple transfer of not more than 3 commercially manufactured packages of sterile nonhazardous drugs or diagnostic radiopharmaceuticals
- Opened or needle punctured single-dose containers are to be used within 1 hour
- Open ampules should not be stored regardless of the environmental surroundings

Buchanan E.C, Cassano A.T. The ASHP discussion guide on USP <797> for compounding sterile preparations.
www.ashp.org/~/media/ASHP/Files/DrugGuide797-2008.pdf



4

USP 797- why one hour BUD?

- The rationale is that the 1-hour limit is expected to preclude microbial population increase when accidental contamination of such drugs occurs with small quantities of microorganisms
- Once microbial contamination occurs, the organism replication can begin within 1 to 4 hours with exponential growth occurring rapidly afterward

Dolan SA, Felizardo G, Barnes, S, Cox, TR, et al. APIC Position Paper: Safe Injection, Infusion, and medication vial practices in healthcare. American Journal of Infection Control. April 2010.



5

USP Chapter 800

- NIOSH maintains and updates a list of antineoplastic and other Hazardous Drugs
- More than just chemotherapy: Phenytoin, Spironolactone, Estrogen, Warfarin
- Drugs considered hazardous include those that exhibit one or more of the following six characteristics in humans or animals:
 - Carcinogenicity (cancer formation)
 - Teratogenicity or other developmental toxicity (embryo or fetus)
 - Reproductive toxicity (interferes with normal reproduction or fertility)
 - Organ toxicity at low doses
 - Genotoxicity (destructive effect on cell's genetic material – DNA/RNA)
 - Structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by the above criteria

USP General Chapter <800> Hazardous Drugs: Handling in Healthcare Settings. Reprinted from USP 40-NF35 Second Supplement (2017).
<http://www.usp.com/compounding/usp-general-chapter-800-hazardous-drugs-handling-in-healthcare-settings>
Accessed January 2nd 2021



6

USP Chapter 800

- Every center should have a designated Hazardous Drug Coordinator and a Hazardous Drug policy in their pharmacy P&P manual
- Every should have a customized Assessment of Risk (AoR) document that identifies the hazardous drugs on your formulary, the level of risk, required PPE, and special handling information
- The hazardous drug list should be posted where hazardous drugs are stored at the center and all hazardous drug(s) need warning labels, including in the anesthesia carts
- Every time a new medication is added to formulary it should be reviewed to see if it is on the NIOSH list of hazardous medications



7

Labeling of Syringes

- Unless the syringe or compounded sterile product is immediately and completely administered by the person who prepared it, or immediate and complete administration is witnessed by the preparer:
- The label **MUST** contain:
 - Names and amounts of all ingredients
 - Name or initials of the person who prepared it
 - The exact 1-hour Beyond use date (BUD) and time
- Pre-labeling syringes is not a recommended or accepted practice, as it easily allows for errors



8

Pre-Labeled Syringes



9

Unlabeled Syringes



10

Improperly Labeled Syringes



11

Compounded Medications

- Do you use compounded medications in your facility? Do you know which compounders are being used?
- Is there a process in place for vetting a potential compounder at your center? Has someone toured the facility?
- Have you checked the FDA for a 483 report?
 - <https://www.fda.gov/about-fda/ora-foia-electronic-reading-room/2020-pharmacy-inspections-and-related-records>
- Paperwork you should have available at the center: Pharmacy's state licensure, contract with center, insurance, warning letters and responses



12

Compounded Medications

- Are there commercially available medications that may be used in place of the compounded medication?
 - i.e. commercially available gemcitabine vs compounded mitomycin for instillation for bladder cancer
- State specific requirements? In FL centers have to document in the chart the lot number, BUD, name of compounded medication in the chart



13

Multi Dose and Single Dose Vials



- Multi dose vials (MDVs) once opened need a label with the date opened, 28 day expiration date and initials on the vial
- Multi dose vials should be kept and accessed in a dedicated medication preparation area
- Single dose vials (SDVs) do NOT contain a bacteriostatic agent
- Once a single dose vial is opened, it must be discarded



14

Medication Storage

- Room temperature medication storage must be kept within 59°F to 86°F
- Each drug should have its own medication bin
 - Different routes of administration (oral, injectable, topical)
 - Different strengths
- Alert stickers should be used to identify drugs with special warnings



15

Medication Storage: Refrigerated Medications

- Medication Refrigerators should be locked when center is closed/not in use
 - Controlled substances need to be double locked at all times
- When storing vaccines the refrigerator temperatures need to be recorded twice daily
- Refrigerator temperatures need to be monitored even when center is closed
- Make sure to document the out of range temperatures on the log and the actions/steps taken to correct the temperature along with notifying managers/pharmacist



16

Medication Storage: Expired Medications

- Expired Medications should be stored separately from non expired medications
 - There should be a process and policy in place how to remove expired medications at your center
- Expired Controlled Substance should be segregated from non expired controlled substances until returned using a 3rd party reverse distributor or being wasted on site per DEA and local state regulations
 - Expired controlled substances should still be counted per your center's controlled substances policies



17

Understanding Medication Expiration Dates



Expires August 31, 2016

Expires October 1, 2019

Many compounded medications expire mid-month

New formatting for medication labels will appear as YYYY/MM/DD or YYYY/MM



18

High Alert and Confused Medication Names

- High Alert medications and Confused medications should be identified at your center
 - Use the ISMP lists as reference but your list should be unique to your formulary
 - Labeling should be used to identify the medications with special warnings
- Lists should be posted where medications are stored and staff should know where the lists are posted



19



20



21

Near Miss/Medication Error & Adverse Drug Reporting

- Encourage reporting of medication errors, near misses, and adverse drug events
- Make sure forms to report are easily accessible and easy to use
- Where are forms being submitted? Where are they stored? Who is reviewing them?
- Are the findings shared out to the center staff and other centers (if applicable)?



22

Order Sets, MAR, and Medication Reconciliation Forms

- No range orders
- Only use approved abbreviations
- Consistency (i.e. all generic or all brand names)
- Indications for PRN use
- Appropriate pain scales and medication options
- Do you have a MAR (Medication Administration Record)?
- Medication Reconciliation- are the physician's signing off on the form?



23



24

Security of Controlled Substances

- Do you have a policy for controlled substances? Are all of anesthesia staff familiar with policy?
- How often are you changing out lock codes to anesthesia carts, boxes, and medication storage areas?
- Are controlled substances double locked when not in use?
- Does your facility have cameras? How often is the video reviewed?



25

Controlled Substances Ordering and Receiving

- Are you familiar with the process at your center for ordering and receiving controlled substances?
 - Who is doing the ordering and receiving?
 - Where are the drug deliveries left in the center?
- Is the DEA in your medical license or the center's?



26

Controlled Substance Record Auditing

- Is there a process in place for auditing charts for controlled substance use and documentation?
- Where are the findings being reported?
- How are they being followed up on? Are they being tracked and trended?



27

Leadership During a Diversion Event

- The presence of the Medical Director is very important during a diversion to help lead the investigation
- If it is a suspected anesthesia provider helping to assist in coordinating random syringe test sample or drug screening if needed
- Counseling of provider if needed
- Assistance with chart reviews
- Annual Diversion Education



28

Thank-you

Lea.Schilit@HCAHealthcare.com



29

References

1. Buchanan E.C, Cassano A.T. The ASHP discussion guide on USP <797> for compounding sterile preparations. www.ashp.org/s_ashp/docs/files/discguide797-2008.pdf . Accessed January 2nd 2021
2. USP General Chapter <800> Hazardous Drugs-Handling in Healthcare Settings. Reprinted from USP-40-NF35 Second Supplement (2017). <https://www.usp.org/compounding/general-chapter-hazardous-drugs-handling-healthcare>. Accessed January 2nd 2021
3. Dolan SA, Felizardo G, Barnes, S, Cox, TR, et al. APIC Position Paper: Safe injection, infusion, and medication vial practices in healthcare. American Journal of Infection Control. April 2010.



30

HANDOUTS

Creating and Maintaining a Patient-Centered Culture of Quality and Safety - Patients Satisfaction

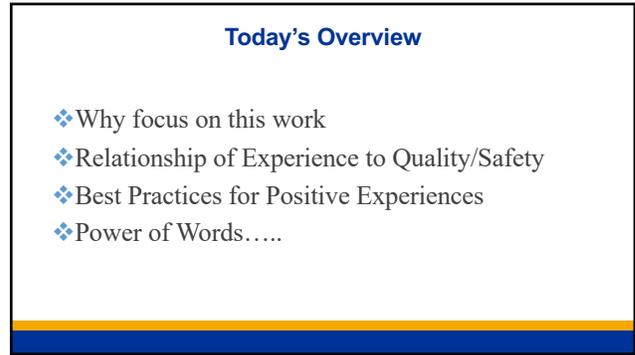
Jane Hyde, PhD
Panelist

01/23/2021

1:00-1:30pm Eastern (Q&A from 2:00-2:15pm Eastern)



1



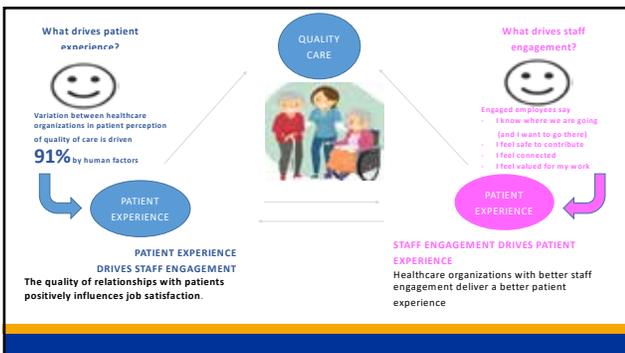
2



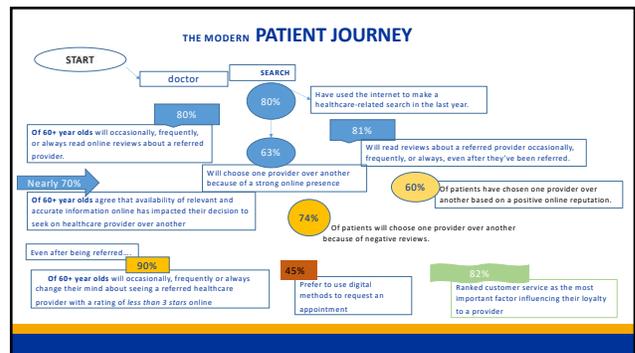
3



4



5



6

Caring

Quality includes a “Caring Relationship that facilitates health and healing”

(ANA, 2010, p.29)

7

Universal Expectations

Know Me: my care is a human interaction

Respect Me: my time and my need for information

Hear Me: involve me and communicate with me

Show Me: empathy and compassion in each encounter

8

Every Moment Matters



9

Best Practices for Best Experiences

*Know Me..... My Name, My Preferences, My Care History and Today

*Caring Encounters.....

*Communications... pre, current, and post – it all matters

*Teamwork..... Singing from the Same Sheet of Music

*Access and Sensitivity to Time.....Do procedures and policies reflect this sensitivity ?

10

See Me/Know Me



Breast Surgery
(Meet Elizabeth)
Diabetic
(45 years old, a mom, wife, sister)
Repeat breast cancer patient
(Professor of music; violinist; gardener; mother of twins)
(Hates needles, timid about her physical changes)

11

Relationship Based Care



12

Caring Encounter

An intentional process focused on getting to “know the patient” very early in the episode of care and sharing those learnings so that nurses can establish a strong healing relationship with the patient throughout their care in the acute care setting.

Clinical Excellence:
Connecting clinical excellence with patient experience and views of quality

Improved Patient Views & Operational Outcome
Increased HCAHPS scores

Caring Encounter

Culture Impact
Connecting mission, RBC with nurse communication and patient views

Caritas Processes:
Connecting caring with RN/Patient dialogue

13

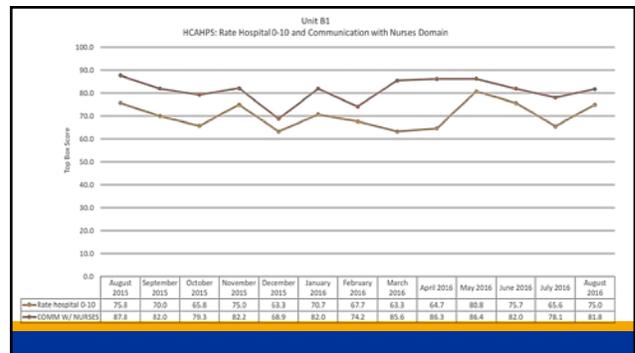
Encounter Development and Process

- ❖ Questions for Conversation:
 - Preferred name
 - Important partner in care
 - Concerns or goals for this episode of care
- Learn the patient’s story
- Please remember that I.....
- Communication Preference
- Gesture of Caring for Comfort

14



15



16

Qualitative Data Review

- Four Focus Groups:
 - ❖ Patient Family Experience Council
 - ❖ Patient Advisory group
 - ❖ Post Encounter Patient Group
 - ❖ Nurse Feedback Group
 - ❖ Patient comments/CFS

17

Qualitative Findings/Themes

- ❖ Encounter/Relationship Important to Care and Healing
- ❖ Ability to “live” the learnings
- ❖ Skill set to build trust imperative
- ❖ Caring is demonstrated through words and behaviors
- ❖ Trust equates to safe
- ❖ Listening to my feelings important
- ❖ Addressing my anxiety matters
- ❖ Nurse confidence in process lacking for some
- ❖ Encounter must be intentional and authentic (Caring Moments, Watson)

18

Summary:

The Patient's View of Caring Matters presentation overviews the strong alignment of experience with safety and quality and the need for all three aspects of care to intertwine. Evidence indicates in many cases the impact of experience on the patient's clinical outcomes and the importance of understanding the differences in understanding the patient's "satisfaction" versus the impact of their overall perception of the care experience. Simplifying the improvement of patient experience and a discipline to provide highly reliable expected experiences will be noted. Best practices and proven approaches for providing caring encounters and overall patient focused experiences in the ambulatory setting will be shared.

The Patient's View of Caring Matters

Presentation by Dr Jane Hyde

January 23, 2021

References:

Adboumatar, H., Chang, B., Hanna, M & Siddiqui (Eds). (2013, September). *Best Practices in Patient Centered Care*. Paper presented at John Hopkins University's Patient Centered Care Conference, Baltimore, MD. Retrieved from [http://www.hopkinsmedicine.org/armstrong_institute/files/documents/Best Practices in Patient Centered Care Proceedings.pdf](http://www.hopkinsmedicine.org/armstrong_institute/files/documents/Best_Practices_in_Patient_Centered_Care_Proceedings.pdf)

Baumblatt, G. (2013, May 21). Re: A sacred moment to improve the care process [Web log message]. Retrieved from www.emmisolutions.com/blog/2013/5/21

DiNapoli, P., Nelson, J., Turkel, M., & Watson, J. (2010). Measuring the caritas processes: Caring factor survey. *International Journal of Human Caring*, 14(3), 16-21.

Doyle, C., Lennox, L., Bell D. A systemic review of evidence on links between patient experience and Clinical safety. *BMJ open* 2013; 3(1): e001570.

Duffy, J. R., Baldwin, J., & Mastorovich, M. J. (2007). Using the quality-caring model to organize patient care delivery. *The Journal of Nursing Administration*, 37(12), 546-551. <https://doi.org/10.1097/01.nna.0000302382.45625.66>

Garten, M., Heard, J., Delrosario. Ambulatory Surgery Center Medical Director: A visionary leader. *Anesthesia Clin* 2019 June;37 (2): 389-400.doi.10.1016/j.anelin.2019.01.org

Gullick, J., Shimadry, B. (2008). Using patient stories to improve quality of care

[Abstract]. *Nursing times*, 104(10), 33-34. Retrieved from

www.nursingtimes.net

Ha, J. F., & Longnecker, N. (2010). Doctor-patient communication: A review. *The*

Ochsner Journal, 10(1), 38-43. Retrieved from

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/>

Hall, MF. Looking to improve financial results? Start by listening to patients.

Healthcare Financial

Management. 2008, 62 (10), 76-80.

Henderson, A., Van Eps, M., Pearson, K., James, C., Henderson, P., & Osborne, Y.

(2007).

‘Caring for’ behaviors that indicate to patients that nurses ‘care about’ them.

Journal of Advanced Nursing, 60(2), 146-153. 10.1111/j.1365-2648.2007.04382.x

Kennedy, Trevis, SE, Kent, KC. Is there a relationship between patient satisfaction and favorable?

Outcomes? *Ambulatory Surgery*. 2014; 260 (4): 592-600.

Tabler, J., Scammon, D. L., Kim, J., Farrell, T., & Tomoaia-Cotisel, A. & Magill, M.

(2014). Patient care experiences and perceptions of the patient-provider

relationship: A mixed method study. *Patient Experience Journal*, 1(1), Retrieved

from <http://pxjournal.org/journal/vol1/iss1/13>

Thies, J. (2012). "Small moments become sacred encounters." *Journal of Catholic Healthcare Association of the U.S. Health Progress*, 37-41

Watson, J. (1988). *Nursing. Human science and human care. A theory of nursing.*
New York, NY: National League for Nursing.

Watson, J. (2012). *Human caring science.* Sudbury, MA: Jones & Bartlett Learning,
LLC

Wazir, A; Shukla, A; Dutton, RP. Patient satisfaction in anesthesia:
Implementation, relevance &

Identification of meaningful measurement. *Advanced Anesthesia.* 2018; 36
(1):23-37.

Webster, A. (2011, September 28). *Easing patient fears can raise HCAHPS scores.*

Retrieved from <http://healthleadersmedia.com/page-1/MAR-271458/Easing-Patient-Fears-Can-Raise-HCAHPS-Scores>

HANDOUTS

Creating and Maintaining a Patient-Centered Culture of Quality and Safety - Safe and Just Culture

David Shapiro, MD
Panelist

01/23/2021

1:30-2:00pm Eastern (Q&A from 2:00-2:15pm Eastern)

Safe & Just Culture

Panel: Creating and Maintaining a Patient-Centered Culture of Quality and Safety

David Shapiro, M.D.

SAMBA
 ASC Medical Directors & Leaders
 Virtual Summit
 Saturday, January 23, 2021

1

Organizational Definition

A literature review didn't identify a consistent definition of just culture in healthcare; therefore, a nationally recognized training organization definition was utilized.

For this presentation, just culture was defined broadly as **organizational accountability for the systems they've designed and employee accountability for the choices they make.**

Just culture isn't a blame-free culture, rather a culture of balanced accountability. Safe patient care outcomes include organizational system design and individual behavioral choices.

2

Behavioral Definition

Another Definition:
 Just Culture is an atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior.

The concept has been applied to many settings, including:

- Aviation
- Industry
- Healthcare

Roadmap to a Just Culture – Flight Safety Foundation

3

Historic Applicability

In a landmark publication, Reason presented a detailed analysis of human error. Reason introduced his text by referring to the 1928 studies of Spearman but asserted that the decade prior to the publication of his book was characterized by public concern about the terrible cost of human error.

He lists the Tenerife runway collision in 1977, the Three Mile Island crisis in 1979, the Bhopal methyl isocyanate disaster in 1984, the *Challenger* and Chernobyl explosions of 1986, the capsizing of the *Herald of Free Enterprise*, the King's Cross tube station fire in 1987, and the Piper Alpha oil platform explosion in 1988 as causes for a collective impetus to address error.

Without doubt, it is clear that the nature and scale of such tragedies impacted wide geographic areas and generations of humans.

4

Errors v. Fault

People make errors. Errors can cause accidents. In healthcare, errors and accidents result in morbidity and adverse outcomes and sometimes in mortality.

One organizational approach has been to seek out errors and identify the responsible individual. Individual punishment follows. This punitive approach does not solve the problem. People function within systems designed by an organization. An individual may be at fault, but frequently the system is also at fault.

Punishing people without changing the system only perpetuates the problem rather than solving it.

5

Just Culture v. Blame Culture

Just culture is a concept related to systems thinking which emphasizes that mistakes are generally a product of faulty organizational cultures, rather than solely brought about by the person or persons directly involved. In a just culture, after an incident, the question asked is, "What went wrong?" rather than "Who caused the problem?"

A just culture is the opposite of a blame culture.

This is in contrast to a "blame culture" where individual persons are fired, fined, or otherwise punished for making mistakes, but where the root causes leading to the error are not investigated and corrected. In a blame culture mistakes may be not reported but rather hidden, leading ultimately to diminished organizational outcomes.

6

Just Culture v. Blame Culture

In a system of just culture, discipline is linked to inappropriate behavior, rather than harm. This allows for individual accountability and promotes a learning organization culture.

In this system, honest human mistakes are seen as a learning opportunity for the organization and its employees.

The individual who made the mistake may be offered additional training and coaching.

However, willful misconduct may result in disciplinary action such as termination of employment—even if no harm was caused.

7

Relationship to Patient Safety

A patient care system is obligated to collect productive investigative data that can be analyzed and acted upon to improve patient safety. This process is not possible unless members of the organization remain vigilant and mindful and maintain continuous surveillance.

Similarly, people within the organization must believe that they are obligated to report errors.

However, medical institutions cannot afford a blame-free culture: Some errors do warrant disciplinary action. Finding a balance between the extremes of punishment and blamelessness is the goal of developing a just culture.

8

Leap's Just Culture Considerations

Early Work in the Field:

Dr. Lucian Leape, a member of the Quality of Health Care in America Committee at the Institute of Medicine and adjunct professor at the Harvard School of Public Health

The single greatest impediment to error prevention in the medical industry is "that we punish people for making mistakes."

Leape indicated that in the healthcare organizational environment in most hospitals, at least six major changes are required to begin the journey to a culture of safety:

9

Leap's Just Culture Considerations

- We need to move from looking at errors as individual failures to realizing they are caused by system failures
- We must move from a punitive environment to a just culture
- We must move from secrecy to transparency
- Care must change from being provider-centered (doctor-centered) to being patient-centered
- We must move our models of care from reliance on independent, individual performance excellence to interdependent, collaborative, interprofessional teamwork
- Accountability must be universal and reciprocal, not top-down

10

Just Culture Considerations I System

People make errors, which lead to accidents. Accidents can ultimately lead to deaths.

The standard solution is to blame the people involved.

But if we find out who made the errors and punish them, are we solving the problems? No. The problem is seldom the fault of an individual; it is the fault of the system.

Changing the people without changing the system will perpetuate the problems.

11

Just Culture Considerations II Reporting

How can we change systems to encourage individuals to report errors and learn from their mistakes?

A just culture seeks to create an environment that encourages individuals to report mistakes so that the precursors to error can be better understood in order to fix the system issues.

Individual practitioners should not be held accountable for system failings over which they have no control. In a just culture, individuals are continually learning, designing safe systems, and managing behavioral choices.

Events are not things to be fixed, but opportunities to improve understanding of the system.

12

Just Culture Considerations III Administration

How do you get started with a just culture initiative and ensure that all staff members feel free to report errors?
 There needs to be an administration that supports the concepts of a just culture and encourages staff to report errors. Highly reliable industries foster mindfulness in their workers.

Mindfulness is defined by Weick and Sutcliffe (2001) as being composed of five components:

13

Just Culture Considerations IV Mindfulness

1. A constant concern about the possibility of failure even in the most successful endeavors
2. Deference to expertise regardless of rank or status
3. An ability to adapt when the unexpected occurs (commitment to resilience)
4. An ability to concentrate on a specific task while having a sense of the bigger picture (sensitivity to operations)
5. An ability to alter and flatten hierarchy as best fits the situation

14

Occurrence Reporting

A patient care system is obligated to collect productive investigative data that can be analyzed and acted upon to improve patient safety. This process is not possible unless members of the organization remain vigilant and mindful and maintain continuous surveillance.

Similarly, people within the organization must believe that they are obligated to report errors.

However, medical institutions cannot afford a blame-free culture: Some errors do warrant disciplinary action. Finding a balance between the extremes of punishment and blamelessness is the goal of developing a just culture. ↴

15

Occurrence Reporting

Nonblaming incident investigation is the first pillar in developing the foundation of just culture.

Healthcare institutions have adopted nonpunitive incident management structures to improve patient safety outcomes.

This ideally creates an atmosphere of trust between the employee and employer and has a positive impact on staff members' willingness to report outcomes when results aren't as expected.

16

Errors

In patient care delivery, individuals can make multiple inconsequential errors. These errors arise from conditions that exist within an organization's systems, such as staffing challenges, delays, and equipment failures.

Most clinicians have limited opportunity to change the systems in which they work. They need to be error identifiers to recognize and resolve system issues that may become mistakes.

This alert to leadership creates a safer organization. In this study, speaking up was defined as the willingness of individuals to communicate actual or potential error or event information upward to supervisors and hospital administrators.

17

Errors

Organizations often determine the response to an error based on its severity.

Errors causing no harm are minimized or ignored and those resulting in injury or death are highly punitive.

All types of error hold equal importance in a just culture, not just those with poor outcomes. To build trust, error identification and reporting are encouraged to provide opportunities for staff education and system redesign.

As an organization transitions to a learning environment through event disclosure, it fosters trust for improvement rather than mistrust from blame.

This is considered critical to becoming a highly reliable organization.

18

Three Types of Behaviors

Establishing a just culture at your organization requires building awareness, implementing and developing policies that support just culture, and building the tenets of just culture into daily work practices

There are three types of behaviors to be expected at any organization:

Human error – Inadvertently doing something wrong, a slip or lapse

At-risk behavior – Increasing risk where it's not recognized or where it's believed to be justified

Reckless behavior – Consciously disregarding a serious and unjustifiable risk

19

Practical Steps to Building a Fear-free, Accountable Culture

It starts with *how* you form performance expectations.

There is no easy answer to creating performance goals that stretch the organization to do its best, but not beyond. There is risk that goals developed from the “bottom up” will be too conservative and goals set from the “top down” will be too ambitious and fail to recognize the realities of the local environment. Consider a process in which goals are set through dialogue supported by as much data as possible, to help build shared commitment to aggressive but realistic levels of performance.

20

Practical Steps to Building a Fear-free, Accountable Culture

Start with inquiry, not blame.

As with issues of patient safety, the response to variation in performance starts with inquiry not blame.

The first level of inquiry should address whether the variation is in some way traceable to ineffectiveness on the part of the leader or if it is the product of other factors beyond the leaders real or perceived control.

If it is the latter, the work, together, is to address those factors.

If, for example, the root cause of patient experience scores on a nursing unit tracks back to delays in the emergency department, the organizational response should reflect that and establish a broader process to drive improvement.

21

Practical Steps to Building a Fear-free, Accountable Culture

Develop a system for ongoing monitoring of predictive indicators.

An organizational climate of healthy accountability embraces data as a tool for improvement. In it lies information with which to recognize and diagnose, early on, factors impeding progress toward performance goals. Ongoing vigilance around key indicators creates a platform for meaningful inquiry and dialogue to determine the root cause of variance so appropriate corrective action can be taken.

22

Practical Steps to Building a Fear-free, Accountable Culture

Maintain a timely, disciplined approach to addressing signs of performance variance.

The goal of a healthy accountability is improvement, not blame or explanation. In a just culture, information indicating variation from expected performance is addressed as soon as the organization becomes aware.

Too often, leaders hang back in the hopes that the situation will correct itself or believing a reasonable explanation after the fact will be sufficient to avoid blame.

This misses the point. The goal is to create a timely organizational response.

Leaders should be expected to come forward as soon as they see signs of unexpected variation, share their diagnosis and approach, seek support as needed, and work to adjust in time to correct or compensate for what has occurred.

23

Safe & Just Culture

Panel: Creating and Maintaining a Patient-Centered Culture of Quality and Safety

David Shapiro, M.D.

SAMBA
ASC Medical Directors & Leaders
Virtual Summit
Saturday, January 23, 2021

24

HANDOUTS

Managing Your ASC - Adding Service Lines

Robert Eisenberg, RN, MBA, CASC
Panelist

01/23/2021

2:15-2:45pm Eastern (Q&A from 3:15-3:30pm Eastern)

SAMBA ASC MEDICAL DIRECTORS & LEADERS VIRTUAL SUMMIT

Adding Service Lines to Your Ambulatory Surgery Center

Robert Eisenberg, RN, MBA
Administrative Director-Ambulatory Surgery Planning and Integration
reisenberg4@wellspring.org
717-812-2423

1

DISCLOSURE

I have no actual or potential conflict of interest related to this presentation.

2

Objectives:

- 1) Identify the financial, clinical, regulatory and operational considerations when evaluating the addition of a service line to your ASC.
- 2) Be able to put together an effective business plan for adding a service line.

3

Scenario:

You are an equity partner in an ASC and are on the Board. The center has two Operating Rooms and a Procedure Room. At present, the ASC performs Pain, ENT and General Surgery procedures. The volumes are such that one of the Operating Rooms sits idle nearly all week. You are approached by an orthopedic group who needs more outpatient operating room time.

How would you go about evaluating this opportunity?

Let's start with the four critical elements.

- Financial analysis
- Clinical considerations
- Regulatory challenges
- Operational excellence

4

Financial Analysis:

Information you will need to complete the financial analysis:

- 1) Anticipated volume by primary CPT code
- 2) Payer mix and reimbursement by payer by CPT
- 3) Direct case cost by procedure (personnel, supplies, implants)
- 4) OR time by surgeon and procedure type (Dr. X takes 90 minutes to complete a TKA)
- 5) Capital equipment and instrumentation investment needed

Financial analysis
Clinical considerations
Regulatory challenges
Operational excellence

5

Contribution Margin Worksheet

Primary CPT Code	Description	Reimbursement				Estimated Weighted Average Reimbursement	Annual Volume			Estimated Revenue		
		Commercial 1	Commercial 2	Commercial 3	SNR		Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
20057	Fluoro Guided Biopsy	\$356	\$391	\$1,141	\$713	\$604	250	250	250	\$251,000.00	\$251,000.00	\$251,000.00
44211	Cervical Intraoral Biopsy	\$395	\$395	\$1,270	\$707	\$365	350	350	350	\$351,750.00	\$351,750.00	\$351,750.00
28921	Skull Base Arthroscopy	\$1,244	\$1,498	\$2,094	\$1,206	\$1,311	750	750	750	\$983,250.00	\$1,198,500.00	\$1,413,750.00
20057	Biopsy	\$1,364	\$1,564	\$4,480	\$2,481	\$1,481	30	30	30	\$44,430.00	\$50,820.00	\$57,210.00
28921	Skull Arthroscopy	\$1,244	\$1,498	\$2,094	\$1,206	\$1,311	250	250	250	\$327,750.00	\$391,500.00	\$455,250.00
20057	Direct Biopsy of Brain	\$4,404	\$5,044	\$6,420	\$4,417	\$4,471	50	50	50	\$223,550.00	\$251,050.00	\$278,550.00
27274	Arthroscopy	\$1,364	\$1,564	\$4,480	\$2,481	\$1,481	100	100	100	\$148,100.00	\$170,100.00	\$192,100.00
20057	Biopsy	\$1,364	\$1,564	\$4,480	\$2,481	\$1,481	100	100	100	\$148,100.00	\$170,100.00	\$192,100.00
20057	Biopsy	\$1,364	\$1,564	\$4,480	\$2,481	\$1,481	100	100	100	\$148,100.00	\$170,100.00	\$192,100.00
44211	Transnasal Endoscopy	\$395	\$395	\$1,270	\$707	\$365	50	50	50	\$182,500.00	\$182,500.00	\$182,500.00
TOTAL										\$4,244,100.00	\$4,978,800.00	\$5,716,410.00

Primary CPT Code	Description	Direct Case Cost	Average OR Time (min)	OR Staff Cost per Hour	OR Personnel Cost	Total Cost per Case	Annual Volume	Year 1	Year 2	Year 3
20057	Fluoro Guided Biopsy	\$81	40	\$60	\$110	\$251	250	\$62,750.00	\$62,750.00	\$62,750.00
44211	Cervical Intraoral Biopsy	\$100	40	\$60	\$110	\$270	350	\$94,500.00	\$94,500.00	\$94,500.00
28921	Skull Base Arthroscopy	\$300	40	\$60	\$110	\$470	750	\$352,500.00	\$427,500.00	\$502,500.00
20057	Biopsy	\$1,450	100	\$110	\$110	\$2,670	30	\$80,100.00	\$90,900.00	\$101,700.00
28921	Skull Arthroscopy	\$300	40	\$60	\$110	\$470	250	\$117,500.00	\$140,500.00	\$163,500.00
20057	Direct Biopsy of Brain	\$2,450	70	\$60	\$110	\$3,020	50	\$151,000.00	\$170,500.00	\$190,000.00
27274	Arthroscopy	\$1,200	40	\$60	\$110	\$1,370	100	\$137,000.00	\$156,700.00	\$176,400.00
20057	Biopsy	\$6,000	90	\$110	\$110	\$6,220	50	\$311,000.00	\$351,100.00	\$391,200.00
44211	Transnasal Endoscopy	\$100	40	\$60	\$110	\$270	50	\$135,000.00	\$135,000.00	\$135,000.00
TOTAL								\$1,200,400.00	\$1,400,400.00	\$1,600,400.00

6

Key considerations for Financial Analysis:

- Have you negotiated favorable contract rates for the proposed CPTs? Implant reimbursement?
- Do you have a mechanism to fund the capital investment?
- Is the timeframe to reach breakeven acceptable? (In our example it would be about five months)
- Will a move to capitated reimbursement or bundled payments affect your assumptions?

CAPITAL EQUIPMENT

C-arm	\$140,000
Mini C-arm	\$80,000
Specialty OR Table	\$40,000
Arthroscopy Towers	\$200,000
Instrument sets and pans	\$200,000
Power equipment (saws, drills)	\$120,000
Cameras, Arthroscopes	\$80,000
Positioning Equipment	\$40,000
Stretchers	\$35,000
Monitors	\$15,000
Misc. equipment	\$50,000
Total	\$1,000,000

7

Clinical Considerations:

- 1) Does the staff have the necessary competencies for the proposed specialty?
 - a. What impact will these have on case volume?
- 2) Have clinically appropriate patient selection guidelines been created and communicated?
 - a. Resuscitation equipment, instrumentation
 - b. Medications
 - c. Biologics
 - d. Staff training
 - e. Hospital privileges
- 3) Contingency planning: What can go wrong specific to the proposed specialty?
 - a. Office, pre-op, intra-op, post-op
- 4) Do clinical pathways need to be developed?
 - a. Do they have experience managing the specialty?
 - b. Specific skill sets- i.e. peripheral nerve blocks
 - c. ERAS protocols
- 5) Anesthesia involvement in decision
 - a. Do they have experience managing the specialty?
 - b. Specific skill sets- i.e. peripheral nerve blocks
 - c. ERAS protocols

Financial analysis
Clinical considerations
Regulatory challenges
Operational excellence

8

Regulatory Challenges:

- 1) Have the planned procedures been approved to be performed in an ASC?
 - a. CMS ASC Approved Procedure List (APL)
 - b. By payers
 - c. State specific regulation- i.e. Need for Exception to perform TJR in PA
- 2) Will you need 23 hour stay capability? Is it allowed in your state?
- 3) Do you need to inform your accrediting body that you are adding a specialty?

Financial analysis
Clinical considerations
Regulatory challenges
Operational excellence

9

Operational excellence:

- 1) How will the ASC and practice work together to optimize communication and the patient experience?
 - a. Scheduling, patient teaching, pre-op testing, discharge instructions, follow-up appointments
 - b. Patient optimization or cancellation
- 2) Is the ASC staff well-versed in the clinical pathways?
- 3) Physical space for the new equipment
- 4) Sterile processing requirements, capacity, flow, timing
- 5) Pre-op and PACU space requirements, understanding patient flow
- 6) Adequate staffing for the specialty (this may also include non-clinical staff) and volume increase

Financial analysis
Clinical considerations
Regulatory challenges
Operational excellence

10

Summary:

Adding a new Service Line to your ASC can be a solid strategy to drive long-term success. Careful analysis, planning and execution are essential. Putting together a solid business plan will help inform decisions and help the center avoid costly missteps. Inclusion of the four critical elements in your plan is a good place to start. You may find elements unique to your situation to add to the plan.

Including various stakeholders from the beginning is critical. These may include your Medical Director, Anesthesia providers, Nursing leadership, Supply Chain and Business Office management. Ultimately, the opportunity will need to be presented to the ASC Board for consideration.

Thank you!!!

Please refer to the following attachments to help with your planning:

- 1) Contribution Margin Worksheet
- 2) Planning Sheet

11

Contribution Margin Worksheet

Primary CPT® Code	Description	Reimbursement				Estimated Weighted Average Reimbursement	Annual Volume			Estimated Revenue		
		Commercial 1	Commercial 2	Commercial 3	MCR		Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
26055	Trigger Finger Release	\$856	\$891	\$1,141	\$713	\$861	250	258	268	\$215,236.88	\$221,693.98	\$230,303.46
64721	Carpal Tunnel Release	\$956	\$996	\$1,275	\$797	\$962	250	258	268	\$240,594.38	\$247,812.21	\$257,435.98
29821	Shoulder Arthroscopy	\$1,543	\$1,608	\$2,058	\$1,286	\$1,553	150	155	161	\$232,926.75	\$239,914.55	\$249,231.62
29827	RCR	\$3,364	\$3,504	\$4,485	\$2,803	\$3,385	75	77	80	\$253,846.69	\$261,462.09	\$271,615.96
29881	Knee Arthroscopy	\$1,543	\$1,608	\$2,058	\$1,286	\$1,553	200	206	214	\$310,569.00	\$319,886.07	\$332,308.83
25607	Distal Radius Fx Repair	\$4,844	\$5,046	\$6,459	\$4,037	\$4,875	50	52	54	\$243,733.88	\$251,045.89	\$260,795.25
28298	Bunionectomy	\$3,364	\$3,504	\$4,485	\$2,803	\$3,385	100	103	107	\$338,462.25	\$348,616.12	\$362,154.61
27447	TKA	\$10,332	\$10,763	\$13,776	\$8,610	\$10,397	250	258	268	\$2,599,143.75	\$2,677,118.06	\$2,781,083.81
29888	Repair of ACL	\$4,648	\$4,841	\$6,197	\$3,873	\$4,677	100	103	107	\$467,664.75	\$481,694.69	\$500,401.28
64718	Transposition of Nerve	\$956	\$996	\$1,275	\$797	\$962	50	52	54	\$48,118.88	\$49,562.44	\$51,487.20
TOTAL										\$4,950,297	\$5,098,806	\$5,296,818

Primary CPT® Code	Description	Direct Case Cost	Average OR Time (min)	OR Staff Cost per Hour	OR Personnel Cost	Total Cost per Case	Annual Contribution Margin (Revenue per case - Total Cost per case) x Annual Volume	Year 1	Year 2	Year 3
26055	Trigger Finger Release	\$85	30	\$66	\$33	\$118			\$185,737	\$191,309
64721	Carpal Tunnel Release	\$180	45	\$66	\$50	\$230	\$183,219		\$188,716	\$196,045
29821	Shoulder Arthroscopy	\$386	60	\$66	\$66	\$452	\$165,127		\$170,081	\$176,686
29827	RCR	\$1,850	100	\$110	\$183	\$2,033	\$101,347		\$104,387	\$108,441
29881	Knee Arthroscopy	\$340	60	\$66	\$66	\$406	\$229,369		\$236,250	\$245,425
25607	Distal Radius Fx Repair	\$2,450	75	\$66	\$83	\$2,533	\$117,109		\$120,622	\$125,306
28298	Bunionectomy	\$1,200	60	\$66	\$66	\$1,266	\$211,862		\$218,218	\$226,693
27447	TKA	\$6,600	90	\$110	\$165	\$6,765	\$907,894		\$935,131	\$971,446
29888	Repair of ACL	\$1,950	90	\$110	\$165	\$2,115	\$256,165		\$263,850	\$274,096
64718	Transposition of Nerve	\$150	60	\$66	\$66	\$216	\$37,319		\$38,438	\$39,931
TOTAL									\$2,395,147	\$2,467,002

C-arm	\$140,000
Mini C-arm	\$80,000
Specialty OR Table	\$40,000
Arthroscopy Towers	\$200,000
Instrument Sets and pans	\$200,000
Power Equipment (drills, saws)	\$120,000
Arthroscopes	\$80,000
Misc. Equipment	\$50,000
Posiioning equipment	\$40,000
	\$950,000

HANDOUTS

Managing Your ASC - Staffing and Conflict Resolution

Rena Courtay, MBA, BSN, RN, CASC
Panelist

01/23/2021

2:45-3:15pm Eastern (Q&A from 3:15-3:30pm Eastern)

Staffing and Conflict Resolution

In the Perioperative Setting

Presented by Rena M. Courtay MBA, BSN, RN,
CASC
Solutions for Outpatient Surgery, Inc.




1

Objectives

Review	Review typical staffing models in the perioperative setting
Outline	Outline strategies for balancing productivity with patient safety and service excellence
State	State the definition of conflict and disruptive behavior in the perioperative setting
List	List examples of conflicts/disruptive behaviors and understand their effects
Discuss	Discuss strategies for resolving conflicts in the perioperative setting



2

Staffing and Scheduling

LONG TERM STAFFING – THE PROCESS OF PLANNING THE NUMBER AND TYPE OF WORKERS WHO WILL BE USED TO FILL A BUSINESS UNIT'S COMPLEMENT OF POSITIONS

DAILY STAFFING – THE PROCESS OF MAKING DAILY ADJUSTMENTS TO STAFFING

SCHEDULING – THE PROCESS OF PLANNING WHEN STAFF MEMBERS ARE TO WORK THEIR SHIFTS



3

Staffing Levels

Peak

- Peak Staffing Level – number of productive and paid FTE's needed to cover the highest volume of work

Average

- Average Staffing Level – staffing level needed for an average month

Core

- Core (Minimum) Staffing Level – number of productive and paid FTE's required by regulation or professional practice to open the doors



4

Traditional Staffing

	FTE Cases	Time
OR 1	3	8:00-10:30
OR 1	2	1:00-3:00
OR 2		
OR 3	1	9:00-10:00
OR 4		
GI #1	2	7:00-8:00am
GI #2	1	12:1-1:00pm
GI #2	2	2:00-3:00pm
Total	11	

Current Core	Status	Position
3	0.8	OR nurses
1	0.8	OR/Endo tech
1	0.8	ENDO nurse
2	0.1	ENDO nurse
1	0.1	OR/ENDO tech
1	0.1	OR tech
1	1	Nurse Manager
1	0.8	Pre/PACU nurse
4	0.6	Pre/PACU nurse
3	0.1	Pre/PACU nurse
1	0.8	Nursing Assistant

1-endo nurse
1-endo tech
2-OR nurses
2-OR techs
1-Nurse Manager
1-Pre op nurse
2-PACU nurses
1-nurse asst.



5

Flanagan, M. (n.d.). 'Clamp.' - 'So, staff shortages are getting serious.' [Cartoon]. Retrieved December 20, 2018, from <https://www.cartoonstock.com/cartoonview.asp?catref=mln3577>



6



Labor Expense

What should you be looking at?

- Case Volume
- OR schedule
- Acuity
- Pediatric patients
- Staffing ratios
- Worked hours per case target for your facility
- Lunch/Breaks
- Overtime
- ASPAN and AORN guidelines

SOCIETY FOR
SAMBA ULATORY
NESTHESIA

7



Balance Expense with Quality Care

- Hire personality
- Create and maintain a culture of service excellence
- Deliver the same message to all – set clear expectations
- Show that you care about them as people
- Attitude is everything
- Deal with the slackers and the naysayers

SOCIETY FOR
SAMBA ULATORY
NESTHESIA

8

Definition of Conflict in a Clinical Setting

Conflict is defined as “a state of disharmony between incompatible persons, ideas, or interests” (Dictionary.com)

SOCIETY FOR
SAMBA ULATORY
NESTHESIA

9

Types of Conflict



SOCIETY FOR
SAMBA ULATORY
NESTHESIA

10

Definition of Disruptive Behavior in a Clinical Setting

Disruptive behavior consists of a practice pattern of personality traits that interferes with a clinician’s effective clinical performance. The disruptive behaviors negatively impact the persons with whom the clinician interacts. (Journal of Medical Regulation, 2013)

SOCIETY FOR
SAMBA ULATORY
NESTHESIA

11

Examples of Disruptive Behavior

- Degrading comments or insults
- Discriminatory behavior
- Inappropriate joking
- Incompetence
- Physical assault
- Profanity
- Refusal to cooperate with others
- Refusal to follow established protocols
- Retaliation
- Spreading malicious rumors
- Substance abuse
- Throwing objects

SOCIETY FOR
SAMBA ULATORY
NESTHESIA

12

ADVERSE CLINICAL CONSEQUENCES OF DISRUPTIVE BEHAVIOR

Decrease in:

- Patient satisfaction
- Physician satisfaction
- Staff satisfaction

Quality of Care Issues:

- Patient Mortality
- Patient Safety
- Medical Error
- Adverse Event



13

ADVERSE PSYCHOLOGICAL CONSEQUENCES OF DISRUPTIVE BEHAVIOR

Stress Loss of Concentration Anger Frustration

Reduced Collaboration and Communication Reduced Information Transfer Impaired Providers



14

Best Practices



- Adopt professional behavior standards
- Recognize excellence
- Confront problem
- Empower the bystanders
- Learn to address behaviors as they occur



15

Corrective Feedback Steps with a Physician or Staff Member



- Inform him/her of the session ahead of time
- Provide private, respectful atmosphere
- Negotiate an agenda
- Have another leader there with you
- Ask for self-assessment
- Share observations; tie to values
- Ask for strategies for improvement



16

Key Points

- Nurses and physicians are often caught in workplace conflicts but are ill-prepared to deal with them
- Conflict is inherent to complex, large and multiprofessional organizations such as a hospital or surgery center
- Workplace conflict can arise from communication, structural or personal issues
- Understanding how you react to conflict can help you find more efficient ways to deal with it



17

Thank You

Rena Courtay RN, BSN, MBA, CASC
President and CEO
Solutions for Outpatient Surgery, Inc.
Rena.Courtay@gmail.com



18