Episode 205 - Latest News, Final 2024 CMS ASC Payment Rule and Focus on Pharmacy Compliance including an interview with Pharmacist John Karwoski - November 5, 2023

Welcome to Tire Discounters. Oh, hi, Athanum.

Hi, Mike. Hey. Do you like to save big bucks? I like big bucks. I cannot lie. And the other brothers can't deny? What? You know I don't have any siblings. Well, let's just say that right now, you can save big bucks on major brand tires.

I like big bucks, and you cannot lie. Why would I lie, Mike? Never mind. Stop by Tire Discounters and save up to 300 big bucks on select major Brands plus a free alignment with any 4 tire purchase.

At the Clinton School of Public Service, Students experience direct engagement and intensive experiential learning that goes beyond the traditional education model.

Equip yourself with the skills and tools you need to Create impact across various sectors and career paths all while leading on the ground change.

Discover how you can impact communities locally, Nationally and globally with a master of public service.

Apply now at clinton school dot u a s y s dotedu. At the Clinton School of Public Service, students experience direct engagement and intensive experiential learning that goes beyond the traditional education model.

Equip yourself with the skills and tools you need to create impact across various sectors and career paths, all while leading on the ground change.

Discover how you can impact communities locally, nationally, and globally with a master of public service. Apply now at clinton school dot u a s y s dotedu.

On this episode of the ASC podcast with John Gailey, we discuss the latest news, including the final 2024 CMS payment rule for ASCs and focus on the regulations related to pharmaceutical services, and we interview pharmacist John Kowalski regarding diversion.

Welcome to the ASC podcast with John Gailey, the longest running podcast specifically focused on the freestanding ambulatory surgery industry.

We would like to thank our sponsors, Surgical Information Systems, providing cutting edge information solutions for surgery providers, TriBalance.

TriBalance offers a comprehensive next generation ASC solution that optimizes Payment and supply chain performance enabling actionable data insights and ambulatory health care strategies, the nation's leading regulatory and accreditation compliance resource for ambulatory surgery centers.

For more information about our sponsors, please visit our website at ascpodcast. com. Welcome to episode 205 of the ASC podcast with John Gailey for November 5, 2023, Recording from our studios in Spencerport, New York.

This is Sue Cronkite, cohost of the ASC podcast with John Gailey, and operations manager for ambulatory health care strategies.

We'd like to remind our listeners that the ASC regulatory environment is a rapidly evolving landscape, And the material presented in this episode is based on the most current information available as of the date of recording.

As such, it's important to recognize that this information may be subject to change, and we advise all ASCs to stay up to date with the latest regulations and guidelines issued by their relevant regulatory bodies.

Joining me today is John Gailey, the owner of Ambulatory Healthcare Strategies and one of the most respected experts in the ambulatory surgery industry.

With over 30 years of experience, mister Gailey has authored over 10 books on the ASC industry, and he is a sought after speaker on regulatory accreditation and finance issues.

So we're recording on the Sunday after we finished up our, director of nursing boot camp. I thought we would, come back to the studio before we shut it down for a while here at, replace some of the equipment.

We're updating every constantly upgrading equipment in here just to make us sound better and be able to accommodate the many conferences we have. We got a lot of them coming up, don't we?

We do. And we actually thought Almost every day of the week this past week, we thought we'd come down after the boot camp, but we couldn't quite make it back down to record some more after doing the boot camp all day.

So Yeah. It was exhausting. Plus, we also had serve we had 2 surveys this last week. One was a surprise. And, unfortunately, for Sue and Amy, who are, a big part of the boot camp, it was their clients.

So I you know, it's almost like, You know, Murphy's Law there, like the Yeah. The worst possible time for, for one of our clients to have a, a survey, but, it was, it was an interesting week. We had a lot of fun with our our, listeners.

We had, some good feedback. You know, our, our, boot camps are are really becoming a very important, element of our our clients too. So about thirds of the people that were on it were, were clients of ours.

So there there's always a little bit more interaction because they know Yeah. You know, our people so well. But it was it was a lot of fun. And, the next, boot camp coming up will be in January for the, administrators boot camp.

Mhmm. I think with all of the turnover, it's, you know, it's just such a great thing to be able to put somebody new or even people that have been in either the Trader role.

Everybody that we have, they always say they learned something. Yeah. The new people, it it often seems somewhat overwhelming, but, You know, at least they know all the information.

They know where to start, and then they can join us on our Saturday sessions Right. And, you know, catch up a bit more. And they also get the recordings so they can always, You know, revisit that.

Yeah. And our our, we we do have an on demand version of of all 3 of our boot camps. We have the director of nursing boot camp, The administrator's boot camp, and I think it's gonna be in, March.

It's gonna be our next, business office managers boot camp, but they're on demand. There are on demand versions if, if you really can't wait for one of the live virtual ones. So, and then in November I'm sorry.

We're in November already, but, Later this month on 16th 17th, we have, on 16th, we're gonna have the, Finance and accounting 101 class, introduction to finance and accounting for ambulatory surgery centers 101.

That's, It's, that's gonna be a, a nice opportunity to kind of, get the basics of accounting, especially for, like nurses, in particular who are in the administrative role, and that's that's, Quite frequent, actually, actually.

Or if anybody is preparing for the CASC exam, this would be a good way to kinda get that financial section.

So That's on November 16th. And then the following day, in November 17th, we'll be, redoing our conditions for coverage and interpreted guidelines conference.

We did that last, I think it was about the same time they're about the same time in, September of I think it was in September of 2020 2021. Uh-huh. I think so. But there's been enough changes, and we're gonna have a lot of fun.

We actually have a very high, we have Quite a number of people signed up. We're close to that 50, and we haven't even really gotten into the month for both of those conferences.

So we, we expect to be well over a100 when we're we're finally done. So sign up quickly. It's, all that information is available at asccentralorascdashcentral.

Com, and you can, follow the links to sign up for that. And, I am busily working on our credentialing, privileging, and peer review conference, which is gonna be in January.

Not Not ready to announce the date yet, Sue. I do have to follow-up on a couple things, but, probably within the next 24, 72 hours, we'll be able to announce that, conference.

So we're gonna be we're gonna be kinda busy. We better get used to this, the studio down here. So, while the conference was going on Mhmm. CMS, released the final 2024, payment rules for HOPDs and ASCs.

So that was, interesting that we're gonna talk about that, in a few minutes, but that, was, a pleasant surprise, though, still didn't get everything we wanted, but, we definitely, made some strides.

But with that, why don't we start into some of the news, Sue? Okay. I have some information about cyberattacks. On August 15th, The joint commission released a sentinel event alert addressing the recent increase in cyberattacks.

According to the alert, The Department of Health and Human Services data revealed 707 data breaches in 2022, exposing at least 51,900,000 patient records.

The majority of these incidents involved hacking or another, IT incident often in email or on network servers.

These attacks have targeted large health care systems as well as small independent practices, so it's really hitting everybody.

The joint commission notes that the constantly changing methods of attack necessitate not only preventative measures, but also being fully prepared after a cyber attack.

Additionally, all personnel should be prepared for a cyber emergency, not just the IT staff. The Joint Commission recommends certain actions to both prevent cyber incidents and to be prepared in the event of an incident.

The center should evaluate the findings of its hazard vulnerability assessment and prioritize any services that are necessary for the center to continue operations.

These would include medical records, pharmacy services, and other services necessary for patient care and safety.

Recommend forming a downtime planning committee responsible for developing a plan for both preparedness actions and mitigations.

This committee should include representatives from IT, leadership, and personnel from admitting, nursing services, and any other departments that would be affected by the loss of electronic systems.

Your center should identify downtime resources and develop downtime plans and procedures. Plans and procedures should include When to declare the downtime, shut down electronic systems and or cancel procedures.

Downtime procedures may include access to a fax machine, paper and pen resources for charting and discharge paperwork, maintaining a hard copy drug guide to check for known drug interactions.

And additionally, the center should designate response teams responsible for evaluating the severity of an unanticipated cyber incident and determining what steps need to be taken.

All personnel and center leadership should be fully trained on the center's downtime procedures as Well, it's the types of incidents that would result in the need to initiate these downtime procedures.

This training should be part of employee orientation, And a comprehensive training program should include classroom training, tabletop exercises, workshops, and possibly a full scale disaster drill.

In the event of a cyberattack resulting in downtime procedures, the center should maintain good communication with personnel, patients, and families, including which systems have been affected, the clinical and nonclinical consequences of the attack, and what is being done to address the situation.

Center should provide frequent status updates. Finally, after an attack, the center should evaluate their response and make any necessary improvements.

This may include restoring electronic systems as you're able to, requiring center wide password resets, and or replacing factory resetting affected hardware.

For more information, please read the issue 67 of the Joint Commission Sentinel event alert. And we'll provide a link to that newsletter.

So this is wild. That that is an incredible number, and and we know just from our own clients in the last, it was 18 months, we've had 3 cyber events not always affecting the surgery center directly, but, indirectly affecting them.

Like, if they're part of a practice Yeah. And the practice was impacted, You know, the telephone systems, the emails going back and forth.

I think we related a story earlier about a hospital that a surgery center was connected with was not connected with, but, work with for preop and pathology, not being able to do anything for a long period of time.

Yeah. Not being able to access those results, and and that really slows things down. So so I took a couple things out of that. As you were reading it, I was like, you know, highlighting a couple things.

First of all, I did mention the hazard vulnerability assessment and how Important that document is we spent quite a bit of time during the boot camp last week talking about how to do, an HVA even though Many directors in nursing might not necessarily be directly involved in that Yeah.

Unless they they unless they are the administrator. Mhmm. But, we we really didn't spend a lot of time focusing on cybersecurity during that.

And Mhmm. This is a very good point that that is certainly one of those things that you are, not on that that there's a good chance that you're gonna be affected by it.

And it's not something everybody would know. I mean, everybody's done fire drills. Obviously, we have doing those, but Yeah.

You know, this is not something people just know common sense of of how to deal with, so really good to run through it. Well, it it struck me also as you were talking that, been talking about forming a downtime planning committee.

I mean, this isn't, when you think about downtime, there are other things even, you know, beyond, the cybersecurity that could cause your system to be down.

Once you move over to an EMR system, You know, you you could be in trouble if your software is down for whatever reason. You know?

They they could have a cybersecurity event, Or there could be a problem with your Internet Internet connection, or, you know, again, the the, the servers for your Internet provide or your Your, EMR provider could could have a problem.

Yeah. I remember at the hospital when, you know, once in a blue moon, we'd end up having to go back to paper charts.

And, I mean, I had started off with paper charts, but, boy, once you're Yeah. Doing electronic medical records for, you know, even a year or 2, it it's just so foreign to go back to.

Yeah. You don't wanna do it anymore. You really have to have to, you know, have some kind of a process to make sure you've got those forms so that people can be instructed how to use them.

So Well and then another thing that I mean, certainly one of the best ways to avoid these types of problems, One of the most important elements is making sure you have very strong passwords that everybody has, a password.

Those passwords are changed periodically.

You know, and also, you know, have a a regular, cybersecurity assessment done by a reputable, IT company here. Probably somebody other than your own vendor, just to make sure that you got some independence there.

So definitely start to, think about this a little bit more seriously and be prepared for this type of thing and and put it into your HVA as, as the Joint Commission recommended, have drills also.

Yep. And just some information on wrong site surgeries. Per recent article in Becker's, The joint commission noted that wrong site surgeries are most frequently attributed to orthopedic services.

It's 35. 3% Based on analysis of 68 wrong site surgery, closed claims from 2013 to 2020. Also important to note is compared to the inpatient setting, The severity of claims was generally lower in the ambulatory care facility.

The most common procedure associated with wrong site surgery claims is intervertebral disc surgery accounting for 22.

1%, followed by arthroscopy and muscle tendon surgeries. Nearly half of these claims resulted in the need for additional surgery. Researchers noted that failure to follow policy protocol was a contributing factor in 83.

8% of these incidents, followed by failure to review medical records noted to be a factor in 41. 2% of these incidents. For more information, refer to the May edition of the Joint Commission Journal on Quality and Patient Safety.

Those are frightening statistics, especially since, you know, the arthroscopy is in particular. It just seems Like, a a good time out would certainly avoid Mhmm.

That problem. And that's been our experience when we've done investigations after a wrong side surgery. It's It's very frequently the time out that that has been, the problem.

So, you know, you know, and and, you know, as a surveyor, I often go into centers, and it's very obvious that, you know, that they're doing a certain they're doing a time out while I'm there, but they're not doing They don't look comfortable doing it.

They don't look comfortable.

It's very rodent. Yeah. Yeah. I mean, it's very robotic. So you're not you're doing it for, safety purposes. It's not just something that is there for a regulatory purpose, and I I think that's that's an important takeaway.

So you as, the leadership in the surgery centers really need to make sure that your people, you know, are are doing this. Mhmm. You know, pop in periodically, do an audit. You know, include this in your monthly, checklist. Mhmm.

And, of course, empower everybody on that team, you know, from the surgeon to the anesthesiologist, to the charge nurse, to the techs, you know, the scrub techs and the the, you know, any other people that are in the room to stop the procedure to do this and and make sure they're they're not, you know, yelled at by the doctors or the surgical team Yeah.

When they do that. It is extremely important that you do this.

And you can back it up by, you know, with your policy and procedures. Like I said, most it looks like most people have the correct policies and procedures, but they just get lazy and aren't following them.

So if somebody has a complaint, you know, you can go back and point to your policy, and this is what we've decided to do.

Right. And we have to follow through for that. And and it really is a a sign of really poor quality when, you know, you have to do additional surgery because you did surgery on the wrong, you know, part of the body.

So, yeah, let's, let's all dedicate ourselves to trying to do, better timeouts and also checking the paperwork better.

So, Sue, I also saw that, validation surveys are about to restart. CMS has notified the accreditation organizations that The new process that we've talked about a couple times, is gonna be in place.

In the past, you might remember that a validation survey, was performed by the state agency, you know, about Anywhere up to 30 days usually after the accreditation organization did a team status survey.

And the the reason for these surveys is to validate, the work of the accreditation organization when they're doing a CMS, certification survey. And And, of course, the, on an annual basis, we, receive a report.

We talk about usually on the on the podcast here as to what, what the what CMS found with these validation surveys, how accurate, the various accreditation organizations were, and they score those accreditation organizations based upon, how many, you know, citations were were missed or or not accounted for during the, the accreditation organization survey.

So the the new process, though, is going to be, even more daunting because what's gonna happen is the CMS team who, Apparently, in the future, are not going to be the state agencies, but they're gonna be outside contractors contracting with CMS.

No information about what those, who those contractors would be, but they would contract with CMS to, show up at the same time that the accreditation surveyors are there with the same number of people that would be, with the accreditation surveyor.

So if you have 2 or 3 people on the, on the accreditate the deemed status Accreditation team, you're gonna have another 3 people, you know, 2 to 3 people showing up with the, accreditation surveyors.

So make sure you have plenty of space in your surgery center for for all these people.

Now unlike the previous process, the CMS surveyors are not going to be, issuing their own report. They're gonna be absurd well, They'll issue a report, but it won't be to the center.

So instead of you having 2, statements of deficiencies as was in the past, This report would go to the, to CMS from the, the individuals that are doing the validation survey. That's strictly surveying the other Surveyors, basically.

Correct. They're observing them, which speaking as a surveyor, if, if I'm one of those unlucky guys to have it, trust me, it's gonna be, You know, it's gonna be a different type of survey.

We're gonna be We're here. There's no way to avoid careful to get every look. That that's right.

You're not gonna wanna miss anything too. And, of course, CMS doesn't really like, You know, the fact that we're so consultative, and and we are Okay. You know, as an accreditation surveyor, we try to be as consultative as possible.

And I have a feeling that that part of the The experience for surgery centers is gonna be very different. So You just couldn't help but be a little bit tense. I don't you know? Yeah.

It's just always awkward. So, anyway, that's gonna be start starting up shortly. I don't have any more information about that. Apparently, the surveyors in the beginning at least will know that surveyor that, CMS is following them.

Then after that, it will be a surprise. So you could have 2 surprises. You're surprised by the surveyor showing up, and the surveyor is surprised by another team showing up, to watch over them.

And as we indicated earlier, the final 2024 payment rule was issued on November 2, 2023. And this is an update to the OPPS and the ASC payment rates as well as the, ASC quality reporting program.

I'm gonna go through, what the updates were. Some of this is right off of the the news release, and some is just some observations.

So in accordance with Medicare law, CMS is finalized in the OPPS. That's what they call payment rates for hospitals and ASCs that meet applicable quality reporting requirements, and they're increasing the rates by 3.

1%. This update is based on the projected hospital market basket percentage increase of 3.

3%, reduced by a 0. 2%, rate for the productivity adjustment. Now, you know, this is marginally, up from the proposed rule. You might remember in in July, we reported that the proposed rule showed 2. 8%. Now it went up to 3.

1%, a point 3% increase. And we're grateful for that increase, but it is still wholly inadequate given the cost of energy, the cost of, you know, the rising salaries for all of our staff, supply supply chain problems.

You know, a 4. 1% increase in the core consumer costs, as a full 1% higher than what, CMS is giving, to the surgery centers.

So and and hospitals actually get the same rate increase. So and and, of course, the the one of the problems with that core inflation rate number that we have for the consumer cost is it doesn't include energy, which is bizarre.

You know, energy is actually a big part of our cost increase because our organizations, you know, do use, electricity and, you know, natural gas as well as there's built in costs from the delivery of all the supplies that we get.

So it's too bad that those are not being taken into consideration. As we talked about in the interim rate, they did make some additions to, the, approved payment code.

So, for 2024 to address patient access issues for dental services under anesthesia in the ASC setting, and trying to encourage more dental procedures, to move to the, inventory surgery center, CMS is finalizing the addition of 26 separately payable dental surgical procedures to the ASC covered procedures list and 78 ancillary dental services to the list covered ancillary services.

We'll provide a link to all the files that that have the information on these rates. Now It's interesting. So we really didn't ask to have these things added.

Mhmm. But this was, I mean, it's something that has is important, I think. A lot of these procedures have been done in the surgery center, but it's almost like, as a, as a charity because, they're largely Medicaid patients, actually.

And, you know, there are some Medicare, you know, patients, obviously. That's why they're adding it to this. But the, CMS is hoping that they'll also flow Slow down into the states into the Medicaid program.

We did have a major win, though, in the industry, in that when CMS finalized, their rates for 2023. CMS did, add a total of 37 surgical procedure, which include the 26 dental procedures.

So there were 11 additional codes, and and the AIC Association fought hard to have some additions. This isn't a lot of codes. There's only 11. I'm gonna run through them quickly here.

They're they're they're not yeah. I mean, they're they're it's great. You know, we appreciate them being added, but, to again, there's so many more things that should be moving into the ASC environment.

So I'm gonna read the CPT code. Remember, the CPT code is a trademark of the American Medical Association.

All rights are reserved. Structure of the lower jaw with a graft, 21195, a reconstruction of the jaw without fixation. 23470 is of the shoulder joint as is 23472.

27006 is the incision of the hip tendons. 27702 is the reconstruction of the ankle joint. 29 868 is an arthroscopy, knee surgical men, meniscal, transplantation including arthrottomy for meniscal insertion, medial, or lateral.

And, 33289 is of a hemodynamic monitor. I don't know anything about that one. That's a that's a new one on me. 37192 is a transcatheter procedure on arteries and veins, other transcatheteral procedures.

60260 is repeat thyroid surgery, And c 9734 is a focused ultrasound ablation or therapeutic intervention. As I said, these are not close to what the ASC, association wanted, but it is, nonetheless, the a win for, you know, for ASCs.

Moving on to the finalization of the ASC quality reporting program in the 2024, Pay a final rule. They, reiterated 3 items.

The first one is COVID nineteen vaccination coverage among health care personnel. It's measured to align with the updated Centers For Disease Control, CDC National Healthcare Safety Network measure specifications.

And what this really means is that we still have to do the COVID nineteen, reporting to NHSN at least through 2024.

And the cataract's improvement in patient's visual function within 90 days following cataract surgery measure. They are continuing to, push this on the industry.

It will not, it will be voluntary at the current time. They are, looking to have this, implemented within the next couple years. We've been fighting this, you know, pretty, voraciously, in the industry.

But what they did do is they, they indicate they're gonna Acquire the use of 1 of 3 specific sir survey instruments to measure the change in visual function pre and to further standardize data collection and reduce facility burden.

It's a problem. I I it's interesting. So they're They're adding this to the requirement, and CMS has said, we're gonna make it easy for you by providing a tool.

But, nonetheless, the tool is not something that The nurses in the surgery center are are really gonna be very comfortable using because it has to do with, you know, optometry.

And, you know, but I guess we're gonna have to learn it because we're having a hard time fighting this with CMS.

Well, the ASC Association will continue to fight it. It makes no sense that this Be put as a burden on the ASCs when it really is, something that's gonna bounce back to the, you know, the ophthalmology surgeon Mhmm.

Who's gonna be doing this anyway? So, and then good luck trying to find these patients, you know, 90 days after the procedure.

That'll That'll also be challenging, especially in some of our areas. And then item number 3, the appropriate follow-up interval for normal colonoscopy and average risk patients measure.

They are aligning that with the updated clinical guidelines there. In addition, CMS is finally finalizing with modification the adoption of a of one new ASC, quality reporting measure.

The risk standardized patient reported outcomes following elective primary total hip and or total knee arthroscopy measure.

C n CMS indicated that this measure will provide specific insight to the quality of care of this common procedure.

CMS is finalizing the measure with modification to Extend the voluntary reporting period to a total of 3 years prior to requiring mandatory reporting in the 2028 reporting period for the twenty 31 payment determination.

So this is way off, but I'm actually very supportive of this.

I think this is a good way to demonstrate the high quality of care that we can provide, for these, total knee, procedures. You know, I yes. It's gonna be experimental for a while or at least a a trial for a while.

I'd encourage you to look into these things because I think this would be very beneficial to demonstrate to our patients, demonstrate to other doctors, and demonstrate to the, to the Medicare program and the insurance companies that indeed it it is safe to move those procedures into the ASC setting.

One other win is CMS is not finalizing the Proposal to readopt the hospital and outpatient and ASC facility volume data on selected outpatient surgical procedures, And this is based upon some quite a bit of feedback from the commenter saying that they did not really understand or see how, that information would be useful or whether it would have any relevance to providers, consumers, and interested parties.

So so at the present time or at least 2024, you're not gonna have to, report that volume data.

You know, Sue, we haven't talked about pharmacy in quite a while, so we decided in our focus segment to Talk about the pharmacy regulations and how to comply.

And, we also, found an interview that we did with, John Kowalski, in April, at the New Jersey Association of ASCs meeting, and I, frankly, kind of forgot to include this.

We'd actually did it in the New Jersey episode, but we didn't put it in this episode, so it was a good time to pull it out. And in that discussion, we're focusing a little bit more are more focused on diversion.

So let's take a short break, and when we come back, we'll talk about pharmaceutical services and the regulations. Some people take the straight path in life, But at Arizona State University, we respect your twists and turns.

They make our online students more driven to excel in their professional lives. That's why our personalized suite of services empowers you with innovative resources and staff that sticks with you.

Make your next Turn with one of our 300 plus programs at ASU, number 1 in innovation for 9 consecutive years. Visit us at asuonline dotaasu.

Edu to learn more. With the rapid changes occurring in the ASC industry, the exodus of experienced ASC administrators, nurse managers, and business office managers, There is an increasing demand for quality leadership education.

That's where our industry leading boot camps come in.

In 2021, we introduced our administrator boot camp and the director of nursing boot camp, and in 2023, the business office manager boot camp. These boot camps have become the industry standard for ASC leadership training.

And with over 225 graduates, lead the industry in mentored virtual training. Live virtual training for the administrator boot camp occurs every January July, and the director of nursing boot camp is October May.

Our new business office manager boot camp will continue in the spring of 2024. There are also on demand versions of each boot camp for those who simply I can't attend the live virtual programs.

All boot camps, including the on demand boot camps include access to resources, membership In the ASC central patron program, copies of John's latest books, access to credentialing conditions for coverage, and other recorded training grams and, of course, our regular drop in Zoom sessions where you can ask questions and interact with other patron and boot camp members.

Our programs also include those that are CASC certified, our programs are comprehensive and taught by the nation's leading ASC experts and are designed for all levels of leadership from experienced leaders who want to enhance their skills or pass the CASC exam or those who are new to the industry and wish to learn how to run an ASC.

For more information about our live virtual and on demand programs, visit asccentral@ascdashcentral.

Com, Or you can call us at 585-594-1167 or email us at info@ascpodcast. com for more information. So anytime we focus on a particular Torrey area, we always wanna go back to the actual conditions for coverage.

As we all know, those are the Medicare regulations that govern ambulatory surgery centers, and and you need to be in compliance with the conditions for coverage in order to maintain your certification as an ambulatory surgery center for Medicare payment purposes.

Also, most other insurance companies require you to have Medicare certification just to be able to build that insurance company.

So when we talk about pharmaceutical services, we focus on 416 dot48, condition for coverage pharmaceutical services.

And that states that the ASC must provide drugs and biologicals in a safe and effective manner in accordance with accepted professional practice and under of an individual designated responsible for pharmaceutical services.

Now we all know that the conditions for coverage really provide a very high level def, description of what the regulation is.

And CMS has provided us with interpreted guidelines, actually provided them to the surveyors, but fortunately, they're also published so that we know what the surveyors are gonna be looking for.

So I'm just gonna highlight some of the, interpreted guidelines related to 416 dot 48. And it does state the drugs and biologicals used within the ASC must be provided safely and in an effective manner.

And it notes that it has to be consistent with generally accepted professional standards of pharmaceutical practice and with the requirements specified in the standards within this condition.

The ASC has to designate a specific licensed health care professional to provide direction to the ASC's pharmaceutical service, And that individual must be routinely present when the ASC is open for business, but continuous presence is not required.

Now, Sue, this is one of those areas that we we talk to a lot of our our clients about, and we've mentioned it on the podcast that people have a tendency to kinda point toward their Pharmacy consultant, for this role, but it is very clear from the interpreted guidelines here that it has to be somebody that is there quite a bit of time.

And, of course, the pharmacy consultant might only show up quarterly or semiannually.

Generally, this individual, the person that's in charge is going to be The medical director or the director of pharmacy services, somebody, perhaps that might be that the light their license might be used to to purchase the the drugs.

And I think sometimes we forget to appoint them on the annual basis.

So make sure that in your governing body minutes, you do have an annual appointment of this individual and make sure that person is very aware of their responsibilities and that they indeed do have that role.

The interpretive guidelines also note that, ideally, the ASE Should have available a pharmacist who provides oversight and consultation on the ASC's pharmaceutical service, but that is not actually required By the federal regulation, it might be required by the state regulations.

Now the regulations go on to state that ideally the ASE should have available a pharmacist who provides Oversight or consultation on the ASC's pharmaceutical service, but that is not required by the regulation.

However, the state regulators may require that as part of their, regulations related to the, the organization's state license.

So I will add to this too that that pharmacy the pharmacist's Reports are extremely valuable. Even if you are in a state that does not require it, we highly recommend that you have available a pharmacist.

Even if they don't come in on a regular basis, I do recommend they do, but if, you know, if they don't come in on a regular basis, just having somebody that you can call up when you have a pharmacy related problem such as a diversion, questions about, alternative drugs.

That's become quite common recently when when drugs certain drugs are in short supply.

The pharmacist might be able to provide you some alternatives. Also, anytime that there is a drug interaction or a a drug problem, the pharmacist should be consulted.

So be prepared when the surveyor show up to, to do the phone. They're gonna ask the ASC's leadership for evidence that a qualified individual has been designated to direct Pharmaceutical services in the ASC.

They may wish to talk to that person, so make sure their prep desk to the types of questions they might have, which are really related to the way in which the pharmaceutical services overseen and and also making sure that the person in charge is well aware of all the documentation requirements, checks on those documents periodically.

Mhmm.

And, Sue, I think that is one problem is it does note in the regulations that, that the person in charge of pharmaceutical services, really should know what's going on there and should be aware of those reckon records and look at them.

Because if something happens, it is going to be that person who is gonna be held responsible for it.

And continuing with 41648, Administration of drugs. Drugs must must be prepared and administered according to established policies and acceptable standards of practice. And there are interpretive guidelines for this 41648 a.

Drugs and biologicals used within the ASC must be administered to patients in accordance with formal policies The ASC is adopted, and those policies in the ASC's actual practices must conform to acceptable standards of prac for medication administration.

So you should have some very comprehensive policies and procedures. Make sure that they are reviewed by somebody that is, familiar with medication management.

That would generally be a pharmacy Sultan. Now the interpreted guidelines go on to define accepted professional practice and acceptable standards of practice.

And this is very important because when you're looking for, when you're looking to develop the policies and procedures, you wanna make sure you're using the correct organizations.

And, also, these organizations do provide signs and other guidance on a regular basis.

So they have defined, the accepted professional practice and acceptable standards of practice to mean that drugs and biologicals are handled and provided in the ASC in accordance with applicable state and federal laws As well as standards established by organizations with nationally recognized expertise in the clinical use of drugs and biologicals.

And they pointed out a couple examples, which include the National Association of Boards of Pharmacy, the Institute of Safe Medication Practices or ISMP, and the American Society of Health System Pharmacists.

And they point out the ASC must have policies and procedures designed to promote medication administration consistent with acceptable standards of practice. So they should address issues including, but not limited to?

So the first one is a physician or other qualified member of the medical staff acting within their scope of practice must issue an order for all drugs or biologicals administered in the ASC.

And this is one thing that I've actually noted, and and, Lori Rodricks, my colleague also So on on the HS team has noted that we're finding orders to be a bit of a problem, both the standing orders and the orders issued during, the procedures, both making sure that they're there, that they're signed off by the doctor.

And most particularly, we've noticed that they're not always countersigned by the nurses when the orders have been carried out.

So look for that. Also, keep in mind that you need to, make sure that verbal orders are followed up in writing. And, again, that's one of those problems that we periodically find.

And you must follow the manufacturer's label, including the storing of drugs and biologicals as directed, disposing of expired medications in a timely manner, using single dose vials of medication for 1 patient only.

And, again, this is one of those areas that has been what problematic again?

We're always repeating the importance of reading the manufacturer's labels, you know, double checking before you're using any of these drugs, storing them in such a way that they're, easily identified, storing them in a safe manner.

And, if there is a temperature or you know, that's It has to be refrigerated, making sure you're following that very closely. Disposing of expired medications has been a problem also. There are a lot of different ways of doing that.

Make sure you follow the manufacturer's recommendations. And then using a single dose vials of medication for 1 ASC only, that has there's been an uptick in that. I think I've particularly seen it with regard to propofol.

The, anesthesiologist in many cases have been saying, well, why are we Why are we only using on 1 patient? I can safely use it on on multiple patients given how quickly these cases go, but it doesn't matter.

The instructions say that it can only be, You know, one use and violating that would result in a in a, immediate jeopardy situation if a survey were to come in.

And also would be a malpractice problem if indeed, you had a, a lawsuit related to that. So be very careful about those things. And you also want to avoid preparation of the medications too far in advance of their use.

For example, while it may appear efficient to predraw The evening before all medications that'll be used for the surgeries that has been scheduled the following day, this practice may, depending on the particular drug or biological, promote The loss of integrity, stability, and security of the medication as well as, you know, infection control issues.

And any prefilled syringes must be initialed by the person who draws it, dated and timed indicate when they were drawn and label as both content and expiration date.

Again, Sue, that is a very common problem I find when I am doing, surveys. And, Laurie, Roderick's our infection control expert.

She's always talking about, how we we need to make sure we're following standard infection control practices, whenever you use an injectable medications, including proper hand hygiene and, you know, scrubbing the septum, etcetera.

The interpreted guidelines for 41648 a continue to talk about the records, noting that records of receipt and disposition of all drugs listed in all the schedules, have to be maintained.

If the See, it uses any of these scheduled drugs. ASC's policies and procedures have to address the following. The accountability procedures to ensure Troll the distribution use and disposition of the scheduled drugs.

Records of the receipt and disposition of all scheduled drugs must be current and must be accurate, And records that trace the movement of scheduled drugs throughout the ASC have to be maintained.

And continuing, the ASC system is capable of readily identifying loss or diversion of all controlled substances in such a manner as to minimize the time frame between the actual loss or diversion to the time of detection and determination of the extent of loss or diversion.

Welcome to Tire Discounters. Oh, hi, Athanum.

Hi, Mike. Hey. Do you like to save big bucks? I like big bucks. I cannot lie. And the other brothers can't deny? What? You know I don't have any siblings. Well, let's just say that right now, you can save big bucks on major brand tires.

I like big bucks. And you cannot lie. Why would I lie, Mike? Never mind. Stop by Tire Discounters save up to 300 big bucks on select major brands, plus a free alignment with any 4 tire purchase.

So we've seen an uptick in the the amount of diversion recently. I think it's kind of a sign of the times. Seems to be a problem that has been escalated, not after the pandemic, but it was starting before the pandemic.

And I think ASCs are are likely, locations for this because Often, the security on an ASC is not as secure as in a hospital, which might be using things like the Pyxis units.

So we have to remain very vigilant about this, make sure that those drugs are properly stored, that records are maintained, and that anytime the Count comes off up wrong, that, some follow-up is immediately enacted.

If that means people have to stay late in order to be able to reconcile what's going on, With those numbers, that certainly is something that needs to be done.

And make sure your your staff, the providers, and the nurses, take seriously the signing off of you know, is, Medications are wasted.

When they have that double count that they need to really take that seriously and be responsible for what they write in there.

Yeah. That's a very good point. And I think one of the things that we've seen also is that, you know, that you develop such a level of trust with your colleagues.

And certainly, the doctors just don't wanna sit there and sign if they're if they're gonna have to be that secondary second signature.

They will probably just automatically, just by rote, Just sign it off without actually watching, and that really is a very dangerous procedure.

And keep in mind that it's your license that's on the line when you're signing off on that, and you don't wanna take those chances.

Let's just briefly mention what the surveyor is gonna be looking for when they're assessing your compliance with 41648 a.

They're gonna Trying to turn if there's any evidence in the medical records review that there was an order signed by a physician or other qualified practitioner for All the drugs and biologicals administered to the patient.

They also wanna make sure the drugs or biologicals are administered only by nurses or other qualified in individuals or under the direction of nurses or other qualified individuals as permitted by federal and state laws.

So be very careful about who you allow to administer those drugs. And then they're also gonna be checking for the labeling, make sure that they're properly labeled, that they're properly stored, and haven't expired.

And expirations, It still amazes me that this is one of those things that I almost always find when I go find when I that I always seem to find when I go on-site.

So, check regularly to make sure that any expired drugs are pulled. As part of the infection control survey tool that CMS uses, You also wanna make sure that the ASC employs safe injection practices.

And if the ASC uses scheduled drugs, their Surveyors are gonna be looking to determine if there's a record system in place that provides information on controlled substances in a readily retrievable manner.

They're gonna review the records to determine that they trace the movement of the scheduled drugs from when the drugs enter the facility to when they're finally disposed of or used.

And they'll want to determine if the licensed health care professional who is in charge of the ASC's pharmaceutical services is responsible for determining that all drug records are in order and that an account of all scheduled drugs is maintained and periodically reconciled.

And that is a problem because often those individuals that have been appointed in that position don't realize the responsibilities they're taking on.

So make Sure that whoever it is, and it's usually gonna be a doctor, you know, has an opportunity to review the records regularly.

And, again, the, surveyors are gonna check to make Sure that any losses are immediately identified and that there is a very quick process for identifying the cause of that loss or where those drugs ended up.

They're and they're gonna Review your policies and procedures to make sure that that the organization minimizes scheduled drug diversion.

416 dot48 a continues on, to note that adverse reactions must be reported to the physician responsible for the patient and must be documented in the record.

And the interpretive guidelines just note that any adverse Reaction or drug to a drug or biological is immediately reported to the physician so they can take whatever actions they need in order to assure the patient, recovers quickly.

And all adverse drug reactions experienced, by patients must be documented in the patient's medical record. And, of course, there has to be policies and procedures that incorporate all these requirements.

And then the surveyors, of course, will be interviewing clinical staff to determine, the steps that they would take with regard to an adverse reaction, or they'll be reviewing medical records that might have an example of that.

Continuing on 416 dot 48 a, section 3 says orders given orally for drugs and biologicals must be followed by a written order and signed by the prescribing physician, and we did note this earlier.

But, again, you wanna make sure that there is the the regular, process involved, which includes a readback and verification process whereby the nurse Receiving the order repeats it back to the prescribing physician who then verifies that it's correct, and that, of course, follows up with a written order.

And then they have to the prescribing physician must sign date and time the written order in the patient's medical record confirming that verbal order.

This is particularly a problem in ASCs because if you don't get that surgeon to do it right away, you might not be able to get them, you know, for quite a while afterwards. So, Again, make sure all of these are are occurring.

And the survey procedures for this is the surveyors, if they observe any verbal orders occurring while they're, watching a case. They'll keep an eye out for this being followed up in writing.

And then, of course, they'll interview your nursing staff to ask them how they would handle, verbal orders if they don't see them in the, in in the time that they're on-site.

They wanna make sure that the Practice conforms to the regulatory requirements.

So infection control is one of those issues, Sue, that we find during surveys and even, you know, with our own clients as we're getting Getting them ready for a survey.

Simple things like scrubbing the hub, scrubbing the septum on the Vial. Vial. And it was interesting. One of the doctors, that we had been working with said, I had never heard of this.

I just always assumed that, you know, when I clip flipped the top off, Mhmm. That it was sterile, and, and and he he had no problem, accepting that they needed to be done once he thought about it.

But Mhmm. Sometimes we just have to go back The basics and make sure that people, you know, who who have been doing these things for years understand some of the more basic requirements there.

And, of course, Hand hygiene when drawing up and administering drugs is vital.

Never forget USP 797, which allows for the mixing of up to 3 drugs. Anything beyond that would would have to be done by a compounding pharmacy. So another ongoing problem we have is the proper administration of multidose drugs.

The regulations require you to draw it up outside of the patient care area. And when we define a patient care area, that means anywhere a patient could be, which means that you can't avoid, this issue.

In other words, you can't drop a multidose drug while the patient is not in an operating room. You're still, It's still considered a patient care area even when the patient isn't there, and that could result in cross contamination.

So, just be very careful. Identify an area in your surgery center, that would be used for any, anytime that you'd roll up.

And if you do have to use a multidose vial in a patient care area, for example, in the operating room, it immediately becomes a single dose.

So make sure your policies and procedures follow that. And, of course, it goes without saying that you must follow manufacturer's instructions regarding whether a product is single or multidose.

And really for all other betters, always instructions for use. It's I have use for everything. Sue, I've been starting to save all the instructions for use in the house now too.

So, unfortunately, we don't have an instruction for use for our dog here who is sleeping contently between us. So drug diversion has become a major issue in health care.

Often, it is our own staff. So we need to keep an eye out, dispose the drugs properly, and have all wasting and have all wasting witnessed, and report any diversion immediately to the proper authorities.

As I mentioned earlier, during the April New Jersey State Association meeting, I had a chance to, Interviewed John Kowalski.

And and while we included this in the New Jersey special episode, we did not include in the, an episode about pharmacy so that This is our opportunity to bring it out now.

So, let's listen now to John Kowalski talking about drug diversion. At the Clinton School of Public Service, Students experience direct engagement and intensive experiential learning that goes beyond the traditional education model.

Equip yourself with the skills and tools you need to Create impact across various sectors and career paths all while leading on the ground change.

Discover how you can impact communities locally, Nationally and globally with a master of public service.

Apply now at clinton school dot u a s y s dot e d u. So this is John Gailey, and I'm here at the, New Jersey annual conference in April 2023, and I'm here with my friend, John Kowalski.

And, John, talk a little bit about your company first. Oh, it's great to be back with you, John. We talked, I guess, a few years ago at the New York meeting, and, You know, I like really, working with you and your team.

Just like you, working in throughout the country with consultant pharmacist services. Just celebrated my 20th anniversary starting JDJ Consulting, and we have a team of great pharmacists.

I'm speaking today at the conference on Our recent benchmarking, that we've completed on narcotic diversion, and I thought we could just chat a little bit about what we've seen over the years and, you know, Answer some questions you that you may see out in the field.

It's funny with narcotic diversion. You and I talk a lot about the risks in our centers and how we can, better improve things and educate people.

And the benchmarking pointed out a lot of areas that we see, need and maybe some that are getting better, but some Always can be better. Just this morning, got a call from a facility of mine that is worried about a potential diversion.

So It's always, present. We are, trying our best to help with, preventing it and, educating people to know when, In fact, it might be existing in our centers.

Yeah. And you have a number of our clients too. You cover what states do you cover? Pretty much 13 states right now are mid mid Atlantic states are our home base, New Jersey, Pennsylvania, new Delaware, Maryland.

We go as far as California, Mississippi, South Carolina, Nevada, and, I think people really our our, services and our reports that we generate for, you know, moving them forward in in best practices.

That's right. And, so when I speak of diversions, It actually hasn't been any of our mutual clients, but but we've, we've had and that's to be honest with you, that's probably it's not a matter of if.

It's almost a matter of when, unfortunately. I mean, you can set good systems up and, but even some of our best places, unfortunately, have had that.

So talk about because That's the point to be made is that, I mean, my experience, it's it's the least it's the person that you least expected to Do a diversion.

You and I did talk about how someone could show no signs and no exhibit no red flags.

It's very difficult, unless you're doing consistent audits and oversight of this area of of the centers, I sometimes think it's Too complacent with staff because they've all worked together.

They're comfortable with one another. Mhmm. And therefore, the guard is let down. The diversion call this morning was actually what I see happen a lot. The OR anesthesia cart was left unattended between cases.

The nurse CRNA returned back for her next procedure, and a vial count was incorrect. Yeah. And when you question the CRNA, the box wasn't locked. Yeah. And the and the cart wasn't locked, and no one was attending the room.

And we we see this quite frequently. As I know, you you see it, and you're right in investigations. Well, during the survey, it's probably one of the most common things we have, and a Comment will be made.

Well, somebody's always in the room. Well, that whoever is taking responsibility for those drugs, that's the person that should be, you know, locking it up or or or making sure it's being secured.

So let's, again, repeat. The, anesthesia card should always be locked whenever, the anesthesiologist is not in the room.

Probably the best tool for that tends to be those, the ones with the push buttons now, I think. Push push button combo. Yeah. Auto locking Part, really, the technology is there.

I actually have a few places that have a badge swipe entry into the card. You know, I think, we're at a point in the ASC industry where automation needs to really start to show its head.

Says an Omnicell, but we need real time devices that can manage controlled substances and track, usage of controlled substances.

As you know, when you go into these ASCs, very few have automation with narcotic control records. It's paper system. Yeah. When is the last time a health health system or a hospital dealt with narcotic papers?

Right. It's it's I mean, in in 20 years, we haven't seen it in in 20 years. But in surgery centers, it is paper, and we need to take the jump to automation to help us secure.

And You know what? It it the reports that you can get from these machines can generate red flags in in areas where you need to investigate.

I think that's my mission lately is is to is to educate people on the benefits of that sis systems that are out there. What do you think is the most common drugs that are being diverted right now? Injectable narcotics.

Yeah. Delauded, Fentanyl, c two narcotics are are very, physically addictive, and therefore, someone that is is Occasionally begins to use drugs, finds that they need more and more to satisfy that that, physical addiction.

And a lot of times, they catch themselves by failure to steal drugs. Putting sailing back in a vial.

Yeah. We just saw in one of our, emails from Becker's, that a nurse was found guilty of transferring Fentanyl out of a vial, putting saline in the vial, and thousands of doses were discovered at a center in in Florida.

I found that in my center occurring few years ago. So I think the injectable narcotics, although drugs like Percocet and Vicodin, are being repackaged and and and other drugs being put in.

The blatant stealing of of, of 10 vials is not something because it it'll just show up on account. Mhmm. But I think, there's also very sophisticated purchasing, methods that people have found to be diverting large quantities of drugs.

Mhmm. But, in the workplace, it's usually an injectable vial. And what that brings up an interesting question.

As part of our quality improvement program, as we're looking at incidences, we're looking at people that are complaining about pain, What types of things should we be watching for as a potential sign that a drug has been, diverted in such a way that they're, Yeah.

You don't readily, recognize, like you said, you know, in in inserting, sailing to replace what was taken out. Red flags.

We do a lot of education for our nursing staff centers and our benchmarking this year demonstrated that we more centers are requesting that education, and I think it is a key to allowing the staff to know What a red flag, you know, from a individual to a facility, management of of narcotics.

What if patients in the recovery room who were given pain medicine are are screaming in pain? Mhmm. That was discovered by a physician one time who was ordering, a narcotic for pain and recovery.

His patients the nurse said were administered. The patient never got the drug. Yeah. We discovered that saline was administered, and the nurse was injecting herself with with a narcotic.

So red flags there's multiple red flags. We wanna empower our nursing staff and our clinical staff to report anything that is not right in their eyes.

Mhmm. Because the bottom line we have to remember, John, is our patients are coming in for a procedure, wanting to be not have complications, Wanna have a surgical procedure and go home and recover.

How would you feel if they were harmed by Bloodborne pathogen by contaminated needle that that maybe an employee was using on themselves.

So we really take it personally with JDJ as as getting this education out and Empowering our nurses to report to their supervisors or even to me as their consultant pharmacist any worries they have.

I don't want a nurse going home at night worrying about what might be happening in their place, and and that's where we can really help out. Yeah.

You're you're getting to the heart of one of my ongoing concerns is that There's so many organizations that discourage incident reports being written up or the flips and and there there needs to be a recognition, Almost a reward for reporting things so that we can look into it.

Even if in the end, you know, let's say that you're reporting a patient or a pay a patient complaining about pain that was unresolved.

Even if in the end you determine that this is a patient that, you know, was given valid drugs, that's fine. But by reporting that and then over time seeing multiple cases You'll see the trends. That you'll see the trends.

But how are we gonna have those trends if we don't if we don't report every incident? It is important to document, to report, because they can really show trends that on an individual basis, You might not see anything.

Right. Right. But when you see the multiples, as you're saying, and now you're you're tracking things by a provider, by a particular nurse, And this is what automation can do for us.

The manager could run a report that shows usage by provider of of drugs.

Mhmm. And we had a place up in North Jersey that was using automation, and they called me and said, hey. Our 4 nurses in PACU pretty much administered the same amount of pain medicine.

1 nurse is way up over the over the standard norm, and we didn't see that unless we had that That data collection. Yeah. Whether it's incident reports, whether it's, automation that can generate reports.

Hospitals around the country do this, and the pharmacy departments Track these types of things. Right. And our ASC industry can really benefit and and keep our patients safe with this, ability to to look at trends.

So it gets, again, it gets to the heart of quality improvement of following up on instant reports and not just brushing them off.

And then what you're also talking about is that internal benchmarking where you're comparing, you know, the pain, unresolved pain, over a period of time, quarter to quarter, month to month, you know, what whatever time frame you choose, and then making sure that you do Look into any trends that are going in the opposite direction from what you expect.

Creating an action plan, doing a quality improvement study if you're a triple a c or, You know, performance improvement project, if you're a joint commissioner or or one of the others, those are what surveyors expect you to see, or to do.

Absolutely. I think, when you think about benchmarking, it's a really a continuous loop in in performance improvement.

You know, I have a definition that I'm gonna be presenting this afternoon, benchmarking a process of learning, adapting, and measuring best practices of an organization to improve performance.

It goes and cycles on and on. Our benchmarking recently this past fall was on narcotic diversion. We asked, facilities around the country to answer 60 questions Mhmm.

On Six areas of of narcotic, control, security, surveillance, documentation, education, resources, and, We think this type of benchmarking, we've done it 3 years in a row.

This will continue to allow centers to see what other other centers are doing Mhmm.

And maybe, enhance their own systems. I know the nurse this morning called with that discrepancy or that potential diversion. She was visit visibly on the phone very upset. Yeah.

Sure. Felt like she didn't do her job. Yeah. And that's a shame to put a nursing manager in that position. The other thing we do, John, is is our data, showed that we're improving on having policies for managers when there is diversion.

Right. You wanna have a nurse when someone comes to them with a question about maybe somebody diverting To be able to have a a step by step guideline so that they accurately can begin to track And investigate.

You can't leave it to inconsistency when a nurse has to track a potential diversion because people can, file lawsuits for false act you know, claims of of what you're doing.

We gotta be careful. We're gonna move toward towards testing, drug testing, and that's gotta go into legal.

So we really work hard for our centers to have a policy dealing with their steps they need to take when diversion is identified. So let's talk about what would be a good way to, to monitor this on an ongoing basis.

Seems to me like, a nurse and and rotating. It shouldn't be the same nurse all the time, but you have a, you know, some type of a checklist, for example, that somebody is rounding.

And this has To be I I guess, say, it's gotta be a weekly type thing, you know, or even daily if you end up with a situation where you're really concerned, and rounding.

So I'm just Thinking out loud, what types of things would we be looking for as part of that rounding? And, I use a slide, at our center and looking at a controlled substance from cradle to grave.

Mhmm. And the stop points along that From when its order is placed Mhmm. To when it's sent to the wholesaler, to when it's delivered to the center Mhmm.

To when it's unpacked, to when it's entered into inventory, to when it's signed out to an anesthesia provider or administered to a patient, to when it's administered, to when it's wasted if there's waste.

That continuum needs continuous auditing. Now as you said, things might be weekly. Things might be daily. Right.

When you think about witnessing for waste after a medicine is administered in the OR by anesthesia, What we want our nurses to do when they reconcile that sheet at the end of the day when it re gets returned, an anesthesia provider just can't throw it into a box and run out the door.

Mhmm. A nurse must Reconcile.

They're looking at a few items, and this is the daily audit. Does the count match what was administered and what was returned? If there's waste, was a witness present to sign? Mhmm. Is there any illegibility or numbers of writing over?

That's a daily thing That follows that continuum. Maybe weekly is a nurse's auditing charts, the interop record versus maybe the count sheet. Did that match, and we find discrepancies there.

Maybe monthly, the nursing administrator will run reports of utilization of drugs. So you see the continuum and the audits points can vary on a time frame, but we don't wanna miss any of this.

And our benchmarking did show that we're And and when you come to see the talk this afternoon from 19 2019 to 2022, all the audits in these areas have all increased by our centers.

And that makes me really proud that they understand the urgency just as we understand the urgency.

You and I know that we wanna have our centers be doing the best in this Serena, and this auditing is is part of that, and it gives them, peace of mind when they know that, you know, that's going on.

The other thing it does is It lets the facility staff know and the providers know that audits are taking place. Right. When you physically go out and monitor and and they see you monitoring.

Mhmm. And they call you and Yeah. Don't make this a secret shopper thing. It it should be obvious. Yeah. Good point. And and when you find a discrepancy, immediately Interact with the individual who had the discrepancy.

That puts them on notice. Good places have good employees. Mhmm. Bad places have banned employees. And it's a big part of our jobs, you and I, to enhance that message when we go and visit our facilities.

So before we started recording, we were talking about, incidents where, physicians who might be that 2nd signer on the, the drug counts will Just at the beginning of the day, just, you know I mean, you can't make this stuff up.

Right, Tim?

You know, just sign off as though he had been there and witnessed the the counts and how important it is to make sure that that sort of thing is not occurring, that you are, seriously taking that those those taking those counts seriously, and then the people that are I mean, off on it, our r and d doing what they're saying they're doing.

You know, we did a little data study that showed, when the count when the waste is actually witnessed.

Mhmm. And we see improvements from 2019 to 2022. We asked, is it done at the end of the procedure, Or is it done at the end of the day? We don't wanna see syringes with partial drugs left till the end of the day.

That went down from 9. 2 to 2% in centers that leave it till the end of the day. I want that to be 0. Right. Right. What we did see improved from 45% to 75% is wastages occurring at the end of the procedure.

So when the doctor shows the nurse in the room, hey. I got 1 ml of Fentanyl, and it's in the RX destroyer wasted and the empty syringes and the sharps, that nurse is the one that's gonna sign it at that moment or in that time frame.

Right. Right. The other thing automation would do is we could track when the when the waste was actually signed.

And one of my centers found that one CRNA had a 4 hour delay on when they were getting their cosignature for wasting on their automated device.

Isn't that amazing? Yeah. And the technology Gave that center that information. Yeah. Right. And and now we have a situation where syringes were maybe left unattended.

Yeah. Right. Now a nurse is signing for something that was a syringe. Maybe it was 4 hours. How do we know? Nurses get worried about their signing their name. Are they responsible to say it is Fentanyl in there or Deloitte?

Yeah. It's basically saying that you saw 1 ml of a substance wasted. Right. So You see, you and I, what we see together. Right? Yeah. Very common. Well, I had another one of my pet peeves. I I and it happens.

I swear it must be, like, 1 out of every 4 centers that I go into. You go and look at the big waste bin in the operating room, and there is a syringe half filled with usually, it's propofol, but there'll be other things.

Yeah. And and I guess that's another one of my concerns is I know propofol is not a controlled substance.

It can be harmful. And it can be very harmful. And that's the one where I'm finding centers are because it's not a controlled substance, they don't treat it as dangerously as a dangerous substance, and I see it left open.

Yeah. You know, on the counter, I see the syringes with it half filled. Relax in handling that medication because it's not deemed by the DEA as a controlled substance, but it is abusable Right.

By, pop by people, and people have been harmed by that. I did a newsletter. I was so frustrated with, noncompliance of the wasting of drugs and the sharps because I see it in 4 out of 5 centers.

Yeah. Yeah. That that I'd I did a newsletter last month, and it was called squirt it out before you throw it out. Yeah. I like it. And I've had managers post it around their site.

It's that little I'll send it over to you. I was gonna say, that sounds like a good sign there. But I'll tell you what. Send it over to me, and we'll link it in our, our show notes here It really was a big hit.

It was a big hit because everybody knows it's not what to do Right. And we still see it happening. So, John, let's talk security and ongoing surveillance activities.

And, again, John, our benchmarking has demonstrated An enhanced level of surveillance at ASCs that we cover, in 2019, for instance, even facility entrance front door Mhmm.

Surveillance went from 35 to 50%. We'd like to see surveillance being used more in the med room. Are you talking about, like, video surveillance?

Surveillance. Yeah. We're talking video surveillance, particularly with this question for our centers. When we open new centers now, we we recommend In the med room surveillance at the narcotic cabinet Yep.

We recommend in a med room a access panel that's badge swiped, not just a push button. We also recommend that med room door has an auto close lever, so it doesn't remain open.

Right. But surveillance has improved in our centers, and I think that gives centers we caught a diverter, a nursing supervisor, placing, Delauded in her pocket Rare.

And and and later bringing it back with something else in there, and it was found on video surveillance because we had surveillance at the cabinet.

I think I think it protects centers, and and the technology is not that cheap. Right. It's not that expensive right now. And, that's an area that I I have felt is, is a key component to minimizing, the diversion re risks.

And, again, physical, security, making sure you've got, good badge systems that you're updating those badges on a regular basis. When somebody leaves, make sure you take them out of the system.

I agree. You know, as much as possible, be moving away from the old keys. First of all, how many times have the the keys actually get put on a hook and, yeah, anybody can access it. Or left in the cabinet door.

Oh, you're right. Yeah. Pictures of that too. Right? Yeah. Yeah. The badge systems are not the the prices are dropping. They're becoming much, and and, again, think about what could happen if you had a, an actual diversion.

Yeah. Traceability of entry by the badge is a great tool for managers to identify. When we have a diversion call, we wanna narrow the window down of when We were knowledgeable of it not being a problem to when the count was wrong.

Right now, the center this morning has a 2 hour window that they have to follow. It's not like a 2 day or a one day 24 hour access.

So minimizing that time frame of a potential diversion, And if you had surveillance, watching a tape of that time frame that you knew it might have happened gives tools that we never had before.

Right. And you bring up, another important point here is that what do you do as soon as you, identify a possible diversion or you know a diversion has occurred?

So One thing is obviously contact your, your, your pharmacy consultant. If you're working, like, with a firm like ours, with regular consulting who's gonna be, right I'm sorry, regulatory, compliance oversight.

You're gonna wanna consult with them to make sure the investigation, the incident report's done. What else? What should be a component of that? Yeah. And, again, Pull out their policy Yeah.

Because we wanna make sure that they stepwise do everything accurately. Right. When diversion is suspected. Document, document, document. Whatever anybody said to you, whatever whoever you interviewed, time stamp it.

So historical information is important. This morning's call shit wasn't to me, and that was wonderful. We can't delay in calling the pharmacist because we can help moving you in a direction that won't cause more maybe diversion.

It could be as little as, you know, lock the place down until we get everybody's name and number or, you know, sequester what is whatever we're talking about. Maybe we need to send a syringe for testing, but, yeah, follow your policy.

If you don't have a policy, call us at JDJ Consulting. We can help with policy development. We really think it's the tool that managers need to protect them and their patients in the surgery center.

And from a surveyor standpoint, the Pharmacy is becoming a big issue now. I mean, we're doing a lot of citations. And keep in mind, that these could be immediate jeopardy.

I as a matter of fact, the version that is witnessed or is observed during or or unresolved, discrepancy could be something that would escalate immediately to an immediate jeopardy situation, in which case you'll have to shut down until you're able to resolve that.

And likewise, as you said, if you observe 1, or suspect 1, you immediately take actions, interview people individually, not together as a so that you can get their different stories.

And with a with a with a witness because Mhmm. That can lead to inconsistent Right. Government. There's always 3 sides to the story as we know. Yeah.

Yeah. And, again, like, we I I I cannot emphasize enough. You and I are are good friends. It is extremely important even if your state doesn't require you to have a pharmacy consultant. And I'm not just trying to sell your services.

I mean, There are so many services that a a pharmacy consultant could give you, to to help resolve so many of those, problems that you'll run into. We're seeing, some increases in, requirements by certain states.

Yeah. And I'm not sure if you realize in South Carolina, Physician practices require a quarterly pharmacy consultant visit. How about that? A physician practice because they're not regulated. Yeah. They have samples.

They've been caught, fill you know, writing prescriptions for, you know, pill mills. Yeah. And South Carolina mandates that a application with a pharmacist's name on it, licensed in the state, performs quarterly visits.

And we just started with 70 facilities in South Carolina offices. Yeah. Yeah. Pharmacists go in. It's a short visit, but we're auditing charts.

Yeah. We're auditing samples. The thing you know, the thing we see, John, is nurses wanna learn. They just need the guidance. Yeah. And we're already creating educational programs for nurses.

Somebody was wanting to give I'm Rosephin for, in his office practice, and they really were inconsistent on reconstituting the drug even. So we scripted that information for them, sample, tracks.

So I would like to see more states, adopt these, you know, oversights, and who better than a pharmacist or someone like yourself with a company that you've worked with for years to Right.

To help staff perform the best they can. Right. As always, John, it's great talking to you again, and, will have you back again, I'm sure, at, another, next opportunity, but I appreciate your time.

Thanks so much, John. And great to see you, and good luck with everything. And, hope you, continue to enjoy the program today.

In this segment, we provide an update on upcoming topics for the podcast, our upcoming virtual conferences, and upcoming speaking engagements for John and his staff and other events in the ASC industry.

We are, kinda way behind in getting episodes out right now.

We have a bunch of them scheduled, and, we fell little bit behind this week with the boot camp, but, stay tuned. We're gonna be ramping up a little bit and, and trying to get a lot of information out to you in a short period of time.

So, Sue, I'm heading out to the Washington Inventory Surgery Center Association's annual education conference and trade show, which is gonna be November 9th 10th, 2023 at the Tulip Resort and Spa in Tulip, Washington, and I'll be speaking there about benchmarking.

And if I have an opportunity, I'll, do a special episode up there. We tried last year, we weren't able to quite do it, but, we'll, we'll we'll make another attempt this year.

And our introduction to finance and accounting for ambulatory surgery centers It's November 16th, live, virtual, and it will be on demand after that date.

And on the following day, the ASC conditions For coverage and interpret guidelines conference will be November 17th, and it's also gonna be live and on demand after that date.

And ASCA 2024 will be at the Gaylord Palms Resort and Convention Center in Orlando, Florida, April 17th through 20th 2024.

The Georgia Society of ASCs and the South Carolina ASC Association's joint semiannual conference and trade show It'll be February 22nd 23rd, 2024 in Atlanta, Georgia at the Westin Atlanta perimeter north.

And they're gonna have another conference on August 15th to 16th at Hilton Head, South Carolina at the Marriott Hilton Head Resort and Spa.

And the Gulf States conference will will be June 11th through 13, 2024 in Biloxi, Mississippi at the Beau Rivage Resort and Casino.

I and the Florida Society of Inventory Surgical Center's quality and risk management conference will be April 4th through 5th, 2024 In Daytona Beach, Florida at the Hilton Oceanfront Resort and the annual, conference

and trade show will be July 17th through 19th, in Orlando, Florida at the Signia by Hilton Orlando Bonnet Creek.

And the Tennessee Ambulatory Surgery Center Association's conference is September 12th through 13, 2024 in Chattanooga, Tennessee at the Chattanooga.

Don't forget our upcoming boot camps. January 2024 cohort of the ASC administrators boot camp is January 23rd to 26th, and you can sign up for that at ASC Dash Central .

Com. And we will be having, another DON boot camp sometime in May, and the business officer Business office managers boot camp sometime probably in March.

We'll be announcing those very shortly. And all this, and information on all of these boot camps is avail atascdashcentral.

Com. Remember, on demand versions of the ASC director of nursing, ASC administrators, and business office managers boot camp are available on asccentral@ascdashcentral.

Com. And don't forget, we have a lot of prerecorded events all available on ascdashcentral.

Com, including the Credentialing conference recorded in 2020, medical director conference recorded in 2021. And also, in 20 in June of 2023, we did a a multistate conference, which is eligible for 16 AEUs and 4 IPCH credits.

So if you're looking for some relatively inexpensive AEU or IPCH credits, you can, get them at the website at asccentral. That's ascdashcentral. com. And we do wanna remind everyone to become a patron member of the podcast.

The patron member program, which is known as the ASC central patron program, is an exclusive membership website that provides a one stop ASC regulatory and accreditation compliance operations and financial management resource for busy administrators, nurse managers, and business office managers.

The resources include some of our virtual conferences, links, policies and procedures, forms, and fire and disaster drills.

Membership helps to defray the cost of producing this podcast, including the research staff, Travel cost to conferences, equipment cost, and production cost.

And for more information, you can visit ascdashcentral. com. That's it for this episode of the ASC podcast with John Galen.

If you found the episode informative, please share it with your friends and colleagues in the ASC industry, and Don't forget to hit that subscribe button so you never miss an episode.

We would love any feedback that you can give us by emailing us at Comments at ASC podcast. com. And we'd like to give a special thank you to our great team here at the podcast who make this podcast possible.

Our sound editor, Susan Cronkite, our executive producer, John Gailey, and our dedicated research team of Sue Cronkite, Jenna Alvarez, Judy D'Ambrosio, Alex Borneman, Zach Kalleraitis, Jim Masters, Amy Germano, Lori Rodricks, Kathy Fodi, Donna Macchio, and Christina Norman.

We truly couldn't do it without them. Our music is provided by MediaSushi and Mike Nolan, the ASC podcast with John Gailey has hosted on Podbean and is available on all major podcast platforms.

Thanks for listening. This episode of the ASC podcast with John Gailey is sponsored by Surgical Information Systems, TriValence and ambulatory health care strategies.

Surgical Information Systems provides cutting edge information solutions for surgery providers.

TriBalance offers a comprehensive next generation ASC solution that optimizes payment and supply chain performance, enabling actionable insights.

Ambulatory Healthcare Strategies is the nation's leading regulatory and accreditation compliance resource for ambulatory surgery centers. For more information about our sponsors, visit our website atasc podcast.

Com. This podcast is an educational and operational tool and is not intended to be a comprehensive resource for all rules, regulations, and standards Said an ambulatory surgery center must meet.

The advice provided should not be considered as nor does it constitute legal advice or opinion. When reviewing specific situations involving legal and regulatory issues, attorneys and other professionals should be consulted.

 If you're interested in advertising or sponsoring the ASC Podcast with John Gailey, Please email us at info@ascpodcast.

Com. We would love to hear your questions and comments. Please email us at comments atascpodcast. com. Ew. Gotta get rid of this old Backstreet Boys T shirt.

Tell me why. Because it stinks, boys. Tell me what. I've washed it so many times, but the odor won't come out. Tell me why. No. You tell me why I can't get rid of this odor. Have you tried Downey rinse and refresh?

It doesn't just cover up odors. It helps remove them. Wow. It worked, guys. Downy rinse and refresh removes more odor in one wash than the leading value detergent in 3 washes. Find it wherever you buy laundry products.