TESTIMONY OF THE

AMERICAN SURGICAL HOSPITAL ASSOCIATION

TO THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

MAY 17, 2006

PRESENTED BY JOHN M. HOUSE, MD

Mr. Chairman and Members of the Committee:

My name is John M. House, MD, a practicing urologist from Irving, Texas. I am a member of the Board of USMD hospital in Arlington and also one of almost 60 physician investors in that facility. USMD is a member of the American Surgical Hospital Association (ASHA), the trade organization for physician owned hospitals with specialized capabilities. I am testifying on behalf of ASHA today.

In addition to our physician partners, more than 200 doctors maintain privileges at our facility, providing a broad array of surgical services. In fact, our busiest surgeon is not an investor. He, like the others, is drawn to USMD because of the high quality of care and focus on patients that are the hallmark of our hospital and other physician owned facilities.

Texas Health Resources, the largest health care system in north Texas, is also a partner in USMD. Mat-Rx Development, LLC is another investor. As the Committee knows from earlier GAO reports, this type of mixed joint venture in not uncommon among specialty hospitals.

USMD opened in 2003. We have 18 inpatient beds and are in the process of expanding our space and our services. When completed as planned, USMD will have capacity for 80 beds, and ICU and be able to provide obstetrics, coronary care, oncology and neonatal intensive care in addition to the multiple surgical and medical services now offered. The

hospital is located in an area of rapid population growth and demand for our services is growing exponentially. Other hospitals are experiencing similar demand.

Our current inpatient capacity is similar to that of most ASHA members, except for cardiac hospitals that are usually much larger. The surgical specialties that use USMD and similar facilities have seen the site for their surgery move rapidly from inpatient service to outpatient setting. There is simply less inpatient surgery being performed in urology, orthopedics, general surgery, and ENT, to name a few, at all hospitals. This shift is not limited to surgery. Many diseases, such as pneumonia, that used to call for routine inpatient admission, are being managed by physicians on an outpatient basis, often in the patient's own home.

As a result of these changes, many general hospitals have downsized their inpatient service, converting the space to other use. Many new hospitals are designed with far fewer inpatient beds than would have been the case twenty five years ago. Much of this shift has been driven by payment policies of Medicare and other health plans. Improvements in anesthesia, surgical technique and equipment and drug therapies have played a significant role in altering the face of hospital medicine today.

As required by Texas law, USMD has an emergency department. Last year 30,000 people were seen in the USMD emergency facility. Our expansion of the physical plant is also driven by our need to support the increased ER activity.

Mr. Chairman, your letter of May 2, 2006, asked that ASHA provide information on the following topics:

- Background information on the benefits of physician-owned specialty hospitals,
- Information on the types of investment practices physician-owned specialty hospitals utilize to recruit and retain physician investors,
- Information regarding accreditation and other efforts to maintain a standard for patient safety and quality of care for patients receiving care at physician-owned specialty hospitals,
- Background regarding the different types of joint-venture arrangements that community hospitals are entering into with specialty hospitals.

I will address each issue in turn, but would like to first comment on two topics of very current interest. The first is the interim report on specialty hospitals that was released on May 9 by the Centers for Medicare and Medicaid Services (CMS). The second is the unfortunate death of Helen Wilson, following surgery at Physicians Hospital in Portland, Oregon.

CMS Interim Report

The CMS interim report, required by the Deficit Reduction Act, has two main parts. It addresses issues that CMS Administrator Mark McClellan raised in testimony before the House Energy and Commerce Committee in May 2005 when CMS filed its first report on

specialty hospitals, mandated by the Medicare Modernization Act. ASHA members have cooperated fully with CMS in both the MMA and DRA reports.

The CMS interim report also updates Congress on specific steps underway to meet the requirements for a strategic plan for specialty hospitals. The final report is expected in August.

Congress had also received a 2005 report from the Medicare Payment Advisory Commission (MedPAC) analyzing other issues in the specialty hospital debate. MedPAC recently looked at those questions again using a much larger Medicare database. It confirmed the original findings and shed additional light on some items, such as comparative costs, that could not be resolved in the original report because of sample size. Based on the more recent findings, MedPAC decided not to make any new recommendations regarding specialty hospitals. Importantly, their most recent work confirms that the presence of physician owned specialty hospitals in a community does not affect the overall profitability of the general hospitals. Nor do they lead to increased utilization of services that would be above the level that would be consistent with population growth.

As in the case with the CMS analyses, our members have fully cooperated with MedPAC staff, providing opportunities for site visits and responding to data requests from the Commission. In fact, in every one of the many government reports on specialty hospitals conducted since 2003, we have made every effort to work with the responsible agencies

when they have asked for our assistance. Our members have nothing to hide from the government, or anyone else, and have consistently offered full disclosure of data needed by investigators and analysts.

It is in that spirit of openness that ASHA is supporting the efforts of Congress and the Administration to achieve greater transparency in quality and price information available to patients. We know that there are circumstances, like emergency trauma, when price and quality comparisons are not possible. However, when patients are considering elective surgical and medical procedures, this information can have great value to consumers and help them receive better medical care.

As the Committee may recall, the 2005 CMS report found that, based on an analysis of claims data, cardiac specialty hospitals delivered high quality care that was as good as or better than their competitor hospitals. A similar assessment could not be made for orthopedic and surgical hospitals because of data limitations; however, the experience of ASHA members specializing in a variety of surgical disciplines, as measured by independent reviewers such as HealthGrades, is comparable to that found by CMS for cardiac facilities. Attached to our testimony are charts from the CMS report documenting the quality of care that was found.

CMS made four recommendations as a result of that report. First, in agreement with MedPAC, it recommended reform of payment rates for inpatient hospital services. Second, CMS called for changes in the reimbursement for services provided in

ambulatory surgical centers. Third, CMS planned to review if specialty hospitals met the Medicare definition of hospital. Finally, CMS planned to review the procedures it used to approve hospitals for participation in Medicare. CMS also announced that it would consider how provisions of EMTALA should apply to specialty hospitals.

ASHA had supported the MedPAC recommendation to make changes to hospital payments to better recognize severity of illness, and subsequently endorsed Medicare's first changes to cardiovascular DRGs. In the recently released proposed rule on the hospital inpatient prospective system, CMS lays out a much broader set of changes that would expand this notion to all DRGs in all hospitals. ASHA is reviewing the proposed rule to determine how it will affect our members and may offer comments on technical issues in the proposal. However, our primary goal is to assure that the changes apply equally to all hospitals, providing a level playing field for all. If the final rule meets that standard, then ASHA will continue to support the DRG reforms, even though CMS suggests in its impact analysis that specialized hospitals could see significant reductions in Medicare revenue.

ASHA likewise supports the CMS effort to make changes in the ASC payment system, which has not been updated in any significant way for more than 20 years. This step would help align payments across sites of service and address anomalies in rates that have developed over the last 20 years.

Regarding the definition of what is a "hospital" for Medicare purposes, the program has wisely remained flexible in its interpretation of the law, recognizing that medical care has evolved greatly since 1965. Evaluations have been made on a case by case basis as hospitals have applied for Medicare numbers or under other circumstances that prompted a review. ASHA members are licensed by their states as acute care hospitals as are general hospitals. It is rare that a state provides a different kind of license to a specialty hospital.

ASHA is gratified that CMS has decided to retain this flexibility and the current enrollment process, which has served the program well since its inception. Hospital services will continue to evolve and it is important that Medicare not be locked into a rigid definition of "hospital" that would preclude innovation.

The EMTALA Technical Advisory Group (TAG) carefully studied the relationship between physician owned specialty hospitals and EMTALA requirements at its October 2005 meeting. EMTALA is a broad law and covers all hospitals in one way or another. Our members are no different and their operating policies make clear the specific obligations each facility has under the law. The TAG considered and rejected a proposal that all hospitals be required to have an emergency department. As the Committee knows, a number of states do not require that licensed hospitals have an emergency department. All of the major hospital associations opposed the recommendation and CMS has concurred with the action of the TAG. ASHA agrees with this decision,

believing that the states are in the best position to determine the emergency care needs in their jurisdiction.

CMS has, in its proposed rule on hospital payment, clarified the obligations of hospitals with specialized capabilities to accept transfers consistent with the services provided at the facility.   We support this clarification in policy, consistent with our belief that federal laws and regulations should be fairly applied to all.

The balance of the interim report deals with CMS' efforts to examine physician investments and return on those investments, as well as levels of Medicaid and charity care provided.

Federal law places numerous requirements on the ways physicians can invest in hospitals and other health facilities. These laws also address returns on investment. Our members make every effort to comply fully with these requirements, relying on expert legal counsel as the investment is first organized. ASHA hospitals also maintain internal compliance programs to ensure that these financial arrangements with physician investors remain consistent with state and federal law. ASHA recently provided each member with information about these requirements as a reminder of the great importance of maintaining full compliance. That document is attached also.

ASHA members are working with CMS on the collection of data needed to complete the DRA strategic plan. Notwithstanding allegations by critics of specialty hospitals, we are

confident that CMS will find that our members are making every effort to stay within the boundaries of federal law.

The complexities of these laws, and the difficulties with compliance, are amply demonstrated by the fact that more than ninety general hospitals have entered into corporate integrity agreements or entered into settlement agreements with integrity provisions with the HHS Office of Inspector General. None of these facilities are, to the best of our knowledge, physician owned specialty hospitals.

Two of the largest for profit systems, HCA and Tenet, also have reached such agreements. In fact, Medicare is currently moving to disenroll a Tenet hospital in San Diego, another in a series of federal actions affecting the company.

HCA's own history with the enforcement of federal law is well known to this Committee. Given their history, we find their aggressive stance in opposition to physician owned specialty hospitals somewhat hypocritical. Not only was the company founded by physicians who purchased a hospital in Nashville, it continues to have multiple joint ventures with physicians. HCA, with annual earnings of over $1.4 billion, owns almost 100 ambulatory surgery centers, many in partnership with physicians. To us, this company's attacks on physician ownership are simply inexplicable.

This level of vigilance by the Inspector General, and the current political focus on physician ownership, force our members to be as conscientious as possible in maintaining

compliance with all relevant state and federal laws that govern these business arrangements.

We will continue to work closely and cooperatively with CMS as it completes the strategic plan and look forward to seeing their final report and recommendations.

Physicians Hospital, Portland, Oregon

The death last summer of Helen Wilson following surgery at Physicians Hospital in Portland, Oregon, is a tragedy to her family and friends. Indeed, any unanticipated death in a hospital is tragic. Unfortunately, such deaths occur in every hospital, despite efforts by physicians and hospitals to prevent them.

Neither ASHA nor this Committee is in a position to judge the actions of Physicians Hospital, the doctors or the staff that were involved in this case. Oregon state authorities, CMS and perhaps a court of law will be the ultimate determiners of responsibility and will take whatever steps are appropriate and necessary.

However, because her death has become so highly politicized, we do feel compelled to make some observations that will give Congress more context in which to evaluate this situation.

First, this Committee and others have made much of the fact that a physician was not physically present at the hospital at all times. However, Medicare does not require that

its hospitals provide such coverage, mandating only that physicians be available on call. The state of Oregon, like the states of Iowa and Montana, follows the same rule.

As noted, unanticipated and/or preventable death is all too common an occurrence in our nation's hospitals. In April 2006, HealthGrades released its third "Patient Safety in American Hospitals" report. This is the largest annual study of its kind. The statistics are sobering. According to their report, if "all hospitals performed at the level of the top 15 percent, 280,134 fewer patient incidents and 44,153 fewer deaths among Medicare patients would have occurred, saving $2.45 billion during the years 2002 through 2004." The HealthGrades eighth annual "Hospital Quality in America" study released last October reached similar conclusions.

These facts in no way diminish the loss to Mrs. Wilson's family and friends, but should serve as a wakeup call to Congress, the Administration and all of us who serve patients that much more is needed beyond the steps already taken or recommended to improve quality. Simply adopting the average nurse to patient ratios found in specialty hospitals (one nurse for every three and one half patients) in all community hospitals could significantly reduce errors and improve care. But community hospitals in California fought imposition of a much weaker standard, claiming it was too expensive to implement. Could it be that many of the nation's hospitals are unwilling to invest the time and money it takes to improve quality? Are they putting profits before patents?

Benefits of Physician Owned Specialty Hospitals

Before reviewing the benefits of these hospitals, it is important to understand why they are built in the first place. Since these are major undertakings, involving substantial financial risk to physicians and other partners, it is not a decision to be entered into lightly. Typically, the decision is driven by the behavior of general hospital management that has refused to listen to the concerns of surgeons about quality of care, scheduling, equipment and the like. In some cases, like in Sioux Falls, SD, hospital management made decisions that physicians would not accept. A few years ago, the new administrator of Sioux Valley Hospital decided that all physicians had to be employees of the hospital. The cardiovascular team was unwilling to accept that demand and created a heart hospital in partnership with the other general hospital in town. A similar situation occurred in Green Bay, Wisconsin, and many of the medical staff left to organize a physician owned general hospital. In both cases, the physicians' decision was provoked by management intransigence.

In Modesto, California, the Stanislaus Surgical Hospital was built after surgeons spent ten years trying to get other local hospitals to address their concerns. Incidentally, those physicians maintain their privileges at the other general hospitals in the area, a common practice among physicians who invest in specialty hospitals. In fact, the only physicians I know who do not maintain privileges at another facility are those who have been denied them because they invested in a "competing" entity. This "economic credentialing" is another example of general hospitals putting "profits before patients." Not long ago, Aberdeen, South Dakota, lost a promising young orthopedic surgeon due to economic

credentialing. ASHA wonders how general not for profit hospitals defend that result? Is it part of their much vaunted service to the community?

Another driving force is the increased specialization of medical care. Specialized physicians require specialized facilities, equipment, infrastructure and, most importantly, specialized staff. Frustration with the unwillingness of some general hospitals to meet these needs, so essential to good quality medical care today, also motivates physicians to find a better way.

For the elective surgical patient, the advantage of a physician owned specialty hospital is high quality care. For example, the infection rate in ASHA member hospitals is substantially below the rate in general hospitals. The 2005 CMS report to Congress previously established the fact that specialty hospitals provide high quality care and, recent studies in Pennsylvania have shown how an infection slows recovery and significantly increases medical costs. It raises an important question—given a choice, why would any surgeon admit an elective surgical patient to a hospital where the risk of infection is substantially higher than an alternative site?

Patients benefit from clinical staff that is expert in the areas in which they work. By specializing in surgical care, they have increased competence in patient management. As already noted, our average nurse to patient ratio is 1:3.5. This is far better than the 1:6 mandated by the state of California. Published research clearly demonstrates that hospital quality is closing linked to the level of nurse staffing.

Our hospitals also try to focus on the needs of the patient and family. For example, most of our rooms are single rooms that protect the patient's privacy, with comfortable facilities for family members to stay overnight in the room if they want to. We make an effort to provide food that is not only edible, but also truly palatable. I would point out that we achieve these results with payments that are no greater, and often less than, those received by general hospitals.

Physicians want the best care for their patients that can be provided. Our hospitals make every effort to meet that need. According to the 2005 CMS report, we have been successful. That report demonstrated very high patient satisfaction levels and a superior level of medical quality compared to general hospitals. After all, our names are on the door, and we have every motivation to provide the best care we can to our patients.

If you believe that hospital quality is not an issue, then why is CMS working so hard to improve it through reporting of quality measures? Why did 60 physicians in New York announce they would no longer use Catskill Regional Medical Center because of their concerns over poor patient safety standards? Why are physicians being urged to report quality measures?

Surgeons also want control over their schedules so that there is predictability for them and for their patients. In far too many general hospitals, elective surgery cases are bumped time and time again, with the result that the surgeon is not able to do the case

until much later in the day. That wastes the surgeon's time and also means that the patient has been waiting for hours, without food and water, to their great unhappiness. While some general hospitals manage to address this scheduling problem, too many others refuse to try. Perhaps this would cost the hospital more money, which they would rather put into executive salaries. Is this another example of general hospitals putting profits before patients?

As a physician, I understand that emergencies will bump elective procedures. However, why should my patient suffer if there is another facility well equipped to provide the care needed in an orderly manner? If hospital management does not want to accommodate the needs of its elective surgical patients, then they should not complain if I, and other surgeons, make better arrangements for them.

These qualities are attractive to physicians who are not investors. As I noted, more than 200 physicians practice at USMD. In a 2004 ASHA survey, we found that the average member hospital had 30 investors, but that more than 90 physicians had privileges. The use of these facilities by non investors has been corroborated by studies conducted by the Government Accountability Office (GAO). Clearly this is a model that works well.

The other great advantage of physician owned hospitals is the high level of satisfaction for the staff who work there. Nurses get to practice nursing, not pencil pushing. It has often been said that there is no shortage of nurses, simply a shortage of jobs that they want. ASHA member hospitals make every effort to create a climate that recognizes the

value of nursing personnel. Other clinical staff develop specialized expertise and we also make a point to value their contributions. At USMD every effort is made to focus on the needs of patients, physicians and the staff. This is the case at other surgical hospitals as well.

In sum, the benefits of physician owned hospitals are high quality care for patients, efficiency for surgeons and high staff satisfaction, which in turn contributes to the high quality of care provided.

Investment Practices

Physician investment in hospitals is governed by complex federal and state laws. We make every effort to assure that our financial relations with our physician partners meet the requirements of these laws. Our hospital, like all others, operates an internal compliance program to make sure that investments and distributions meet all legal standards.

Your letter, Mr. Chairman, asks us to "Provide information regarding the types of investment practices physician-owned specialty hospitals utilize to recruit and retain physician investors." However, I believe this reflects an inherent misunderstanding of the reason for physician investment in the first place. Remember that these hospitals arise out of unresolved conflict between general hospitals and their medical staff. If the physicians make the decision to build a hospital, they need to put their own money at risk before a bank or other financial partner will become involved. Since there is no

guarantee that a physician owned hospital will succeed, these doctors take a substantial financial risk. That risk can be diluted by increasing the number of partners, and, in fact, GAO found that the average physician investor had a very small ownership percentage.

If and when the hospital becomes profitable enough to make distributions to the investors, these distributions are strictly in proportion to their share of investment. Anything else would be illegal.

If USMD wanted to recruit a new surgeon as an investor, perhaps to replace a physician who is retiring or to expand the services that could be offered to patients, the physician would be offered shares in the hospital corporation. That doctor would have to assume risk for that money, as well as sharing in the liability for any borrowing that the hospital might do in the future. These transactions are arms length and based on fair market value. Physicians and hospitals that do not adhere to these standards do so at great risk.

Some specialty hospitals have prospered and the investors have received generous distributions, according to their share of investment. Many others have not reached that level and the distributions have either not been made or are very limited. The fact that most physicians have a small level of investment in the facility is also a limiting factor in terms of the size of the distribution any one investor might receive.

In some cases, a hospital seeks a new partner, like a general hospital or a corporate investor. Under those circumstances, existing shareholders may receive additional

distributions based on the amount of third party investment and the share held by the physician. A good example is taking place in Iowa right now. Mercy Medical Center in Sioux City is a partner with 43 physicians in the Siouxland Surgery Center in Dakota Dunes, SD. Mercy has decided to increase its share in the surgical hospital from 6% to 40%. Incidentally, the Dakota Dunes facility treats many Iowa residents and a number of physicians and staff who work there also live in Iowa.

I don't know if any of the physician investors will benefit financially from this transaction. However, it will certainly help support physician recruitment to the Sioux City area, maintain the existing coverage of Mercy's emergency room and enhance the services at the 80 rural outreach clinics in the tri-state area served by the specialty hospital.

It is also important to remember that the majority of physicians using specialty hospitals are not investors. They practice at these facilities for reasons quite independent of the possibility of any distribution.

Physicians invest in these hospitals to achieve goals that cannot be achieved elsewhere—better quality of care for their patients, efficiency for the surgeons and high quality staff and equipment.

Maintaining Quality of Care

ASHA member hospitals take many steps to maintain the quality of care that is provided in their facilities. All of them are Medicare certified, meeting the conditions of participation required by the federal government. Our members are licensed as general acute care hospitals, and as such must meet all state requirements relating to quality and patient safety. In addition, many of our hospitals, like USMD, are certified by JCAHO.

Each physician owned hospital, in common with general hospitals, is required to have numerous internal processes to maintain quality and address problems should they arise. Attached to this statement is the Sioux Fall Surgical Center 2006 continuous quality management/risk management strategic plan which covers all facets of the hospital's operations, down to assuring that the temperature of food delivered to patients meets state requirements. National Surgical Hospitals, Inc. is a corporate partner with physicians in ten hospitals and has an extensive program for continuous quality improvement in every facility. Details on their efforts can be provided to the Committee if the Members wish to have a better understanding of this well designed program.

Specialty hospitals that partner with general hospitals typically adopt the standards used by the general hospital that are relevant to the specialized services being provided.

Physicians who partner with corporate developers, like National Surgical Hospitals, operate within a rigorous framework of continuous quality improvement. In fact,

hospitals under the National Surgical Hospitals flag make every effort to establish standards that exceed accepted industry requirements. They emphasize communications at all levels within the hospital, through formal and informal processes.

Each specialty hospital has a comprehensive quality program, which involves the governing body, medical staff, clinical and non-clinical staff and patients. Each program is based on a written plan, which defines planned operations to assure the safe and effective delivery of patient care. These processes are constantly monitored and include state and federal regulatory requirements as well as the hospital's own standards of care. Responsibility for maintenance of quality starts with the hospital's board of directors and includes medical staff and other clinical and non clinical personnel. Regular surveys of patient satisfaction are also used to identify areas for improvement.

In many respects these are the same steps that general hospitals follow. However, we believe that physician ownership drives our hospitals to strive for even higher levels. It is like the difference between renting a house and owning it. An owner will pay much closer attention to details and outcomes than a mere tenant. Physician ownership brings active involvement by the doctors in all facets of the hospital's operations. This strengthens every aspect of our quality control efforts.

Joint Ventures with Community Hospitals

Despite the vitriol directed at specialty hospitals by competitors and other hospital trade groups, joint ventures between physician owned specialty hospitals and community

hospitals are common. In its first report on specialty hospitals in 2003, GAO noted that approximately one third of identified specialty hospitals had a general hospital partner. Our own membership surveys confirm that finding.

These joint ventures are guided by the same federal and state laws that govern any physician investment in a health facility. Great care is taken by all parties to ensure that the transactions, no matter how complex, are consistent with all legal requirements.

The nature of these ventures can vary widely, depending on community, hospital and physician need. The previously mentioned joint venture between Mercy and Siouxland Surgery Center involves a sharing of services, equipment and medical personnel, designed to strengthen both facilities and provide patients with choice of the site of care.

In some cases, general hospitals will partner with a specialty hospital to turn over entire service areas to the specialized facility. This is particularly true in cardiovascular care. Through specialization a new level of quality can be attained, while freeing up inpatient rooms and operating suites in the general hospital that can be put to use for other needed medical and surgical services.

Some of these ventures involve the general hospital, physicians and a corporate developer. Baylor Hospital, working with its physicians and United Surgical Partners International, has been a leader in this area.

The important point about the trend to establishing these ventures is that they signal the recognition of hospital managers that there is a better way to align hospital, physician and staff incentives to improve the services provided to patients.

ASHA considers these arrangements far superior to general hospitals employing physicians or buying practices and then restricting their referrals to the closed shop of the hospital and its staff, regardless of quality. Unfortunately this trend is all too common and ASHA believes that the arrangements serve no purpose except to allow hospitals to control their service area and maximize earnings. This is another example of general hospitals putting profits before patients.

Conclusion

The federal government has conducted numerous studies of physician owned specialized hospitals. Some have been mandated by law, while others stem from requests by this committee and others with jurisdiction. The net result is that no evidence has been adduced that ASHA members are harming general hospitals financially. There is no evidence of overutilization of services. Physician ownership does not lead to improper referrals or unnecessary medical services. It has been firmly established that our members provide high quality medical care, equal or superior to the best that general hospitals have to offer. It has been shown that our physicians do not abandon the community but continue to maintain privileges at local general hospitals. Our model is popular with other physicians who have no financial stake in the facility. These studies

have rebutted virtually every allegation that opponents of specialty hospitals have made over the last five years.

The American Surgical Hospital Association urges the Senate Finance Committee to recognize the reality about physician ownership, not the hype from opponents afraid of innovation and competition, and lay this issue to rest.

I would be pleased to respond to any questions the Committee members may have.

Study of Physician Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

(Charts Pulled Directly from the CMS Study)

Table 5.1
Cardiac Specialty Hospitals and Community Acute Care Hospital Competitors:
AHRQ Inpatient Quality Indicators, Mortality Rates among Select Surgical Procedures*
For the Population of All Specialty Hospitals and Their Competitors

	Specialty	Competitor
AAA repair		
Number of deaths	16	101
Population at risk	206	948
Observed rate	77.67	106.54
Expected rate	99.91	141.82
Observed/expected ratio	***0.78***	***0.75***
CABG		
Number of deaths	152	484
Population at risk	4,036	10,922
Observed rate	37.66	44.31
Expected rate	47.87	51.50
Observed/expected ratio	***0.79***	***0.86***
PTCA		
Number of deaths	93	469
Population at risk	8,925	24,706
Observed rate	10.42	18.98
Expected rate	14.70	19.71
Observed/expected ratio	***0.71***	***0.96***
Carotid endarterectomy		
Number of deaths	4	19
Population at risk	142	315
Observed rate	28.17	60.32
Expected rate	49.05	49.31
Observed/expected ratio	***0.57***	***1.22***

*NOTE: The data for observed and expected rates are per 1,000 discharges.

SOURCE: CY 2003 Medicare IPPS claims.

Observed/Expected ratios less than 1 indicate better than expected performance or fewer than expected deaths.

Table 5.2
Cardiac Specialty Hospitals and Community Acute Care Hospital Competitors: AHRQ Inpatient Quality Indicators, Mortality Rates among Select Medical Admissions*
For the Population of All Specialty Hospitals and Their Competitors

	Specialty	Competitor
In-hospital mortality rates		
CHF		
Number of deaths	95	1,408
Population at risk	3,001	30,859
Observed rate	31.66	45.63
Expected rate	76.39	76.92
Observed/expected ratio	***0.41***	***0.59***
AMI, without transfer cases		
Number of deaths	197	1,649
Population at risk	3,094	14,804
Observed rate	63.67	111.39
Expected Rate	91.78	128.51
Observed/expected ratio	***0.69***	***0.87***

* NOTE: The data for observed and expected rates are per 1,000 discharges.

SOURCE: CY 2003 Medicare IPPS claims.

Observed/Expected ratios less than 1 indicate better than expected performance or fewer than expected deaths

The overall mortality rates for inpatient, and for inpatient plus 30-day also indicate that the quality of care in specialty hospitals is good (***see Tables 5.3 – 5.5***). Across the three specialty hospital types, for both moderately ill (APR-DRG Minor or Moderate) and severely ill patients (APR-DGR Major or Extreme), the percentage of patients who died while hospitalized was significantly less for specialty hospitals than that for competitor hospitals, for all DRG groupings. This trend holds true for inpatient plus 30-day mortality rates. The t-test on the difference between the means (average) indicates that these differences are significant at the .1% ($p < 0.001$) level.

Table 5.3

Heart Specialty Hospitals and Community Acute Care Hospital Competitors: Overall Mortality Stratified by Patient Severity and by DRG Groupings (MDC=5) For the Population of All Specialty Hospitals and Their Competitors

	Inpatient Mortality						Inpatient + 30 day Mortality					
	Specialty			Competitor			Specialty			Competitor		
	# died	N	% died	# Died	N	% died	# died	N	% died	# died	N	% died
Moderate Severity												
Major Heart	16	3,326	0.48*	63	8,934	0.71	39	3,326	1.17*	147	8,934	1.65
PTCA, Etc.	19	8,046	0.24*	70	22,525	0.31	72	8,046	.90*	240	22,525	1.07
Other	39	6,690	0.58*	543	53,593	1.01	128	6,690	1.91*	1,886	53,593	3.52
Severe												
Major Heart	201	2,076	9.68*	935	7,810	11.97	279	2,076	13.44	1,245	7,810	15.94
PTCA, Etc.	27	1,125	2.40*	231	4,356	5.30	66	1,125	5.87	408	4,356	9.37
Other	157	1,912	8.21*	2244	20,848	10.76	299	1,912	15.64	4,000	20,848	19.19

* indicates the differences between specialty and competitor hospitals are statistically significant at a .1% level.
NOTE: Moderate Severity includes APR-DRG both severity categories Minor and Moderate; Severe includes APR-DRG both severity categories Major and Extreme
SOURCE: CY 2003 Medicare IPPS claims.

Table 5.4

Orthopedic Specialty Hospitals and Community Acute Care Hospital Competitors: Overall Mortality Rates Stratified by Patient Severity and DRG Grouping (MDC=8) For the Population of All Specialty Hospitals and Their Competitors

	Inpatient Mortality						Inpatient + 30 day Mortality					
	Specialty			Competitor			Specialty			Competitor		
	# died	N	% died	# died	N	% died	# died	N	% died	# died	N	% died
Moderate Severity												
Major Ortho	0	3,954	0.00*	124	40,192	0.31	5	3,954	.13*	660	40,192	1.64
Minor Ortho	0	1,614	0.00*	6	13,960	0.04	1	1,614	.06*	96	13,960	.69
Medical	0	79	0.00*	102	14,583	0.70	1	79	1.27*	620	14,583	4.25
Severe Severity												
Major Ortho	2	346	0.58*	526	14,178	3.71	4	346	1.16*	1228	14,178	8.66
Minor Ortho	0	24	0.00*	28	829	3.38	0	24	.00*	50	829	6.03
Medical	0	1	0.00	315	4,484	7.03	0	1	.00	830	4,484	18.51

* indicates the differences between specialty and competitor hospitals are statistically significant at a .1% level.
NOTE: Moderate Severity includes APR-DRG both severity categories Minor and Moderate; Severe includes APR-DRG both severity categories Major and Extreme

SOURCE: CY 2003 Medicare IPPS claims.

Table 5.5
Surgery Specialty Hospitals and Community Acute Care Hospital Competitors: In-Hospital and 30 Day Mortality reported by patient severity (MDC = 8, 12, 13) For the Population of All Specialty Hospitals and Their Competitors

	Inpatient Mortality						Inpatient + 30 day Mortality					
	Specialty			Competitor			Specialty			Competitor		
	# died	N	% died	# died	N	% died	# died	N	% died	# died	N	% died
Moderate Severity												
Major Surgery	0	191	0.00*	2	2,347	0.09	1	191	0.52*	22	2,347	0.94
Minor Surgery	0	253	0.00	0	877	0.00	0	253	0.00*	1	877	0.11
Severe Severity												
Major Surgery	0	38	0.00*	18	694	2.59	0	38	0.00*	40	694	5.76
Minor Surgery	0	1	0.00	1	8	12.50	0	1	0.00	3	8	37.50

* indicates the differences between specialty and competitor hospitals are statistically significant at a .1% level.

NOTE: Moderate Severity includes APR-DRG both severity categories Minor and Moderate; Severe includes APR-DRG both severity categories Major and Extreme

SOURCE: CY 2003 Medicare IPPS claims.

Complications During Hospitalization: The occurrence of adverse events and complications during hospitalization is another important aspect of health care quality. The Agency for Healthcare Quality and Research's (AHRQ) Patient Safety Indicators (PSIs) reflect the quality of care inside hospitals by focusing on potentially avoidable complications and iatrogenic events. They are not intended to be definitive quality measures as there are many factors that influence performance on quality indicators - some of which are independent of quality of care. However, high rates may indicate possible quality problems. Because no "right rates" have been established for most indicators, AHRQ suggests comparing rates among providers that are, ideally, as similar as possible in case-mix, socioeconomic status and other demographics (i.e., "peer groups"). We attempted to account for these differences by comparing the ratio of the observed to the expected complication rates, which focuses on performance of specialty and competitor hospitals given their patient mix. The tables below show only a sample of the PSI measures that were computed.

The PSIs indicate that, overall, cardiac specialty and competitor hospitals are performing better than expected in terms of in-hospital complications and adverse events in some PSIs and worse than expected in others ***(see Table 5.6)***. Note the PSIs where the observed/expected ratios are less than one, indicating that the cardiac specialty hospitals performed better than expected given the hospitals' case mix. For example, cardiac specialty hospitals have lower than expected rates of infections due to medical care, post operative hip fractures, post operative deep vein thrombosis and post operative sepsis. Both cardiac specialty and competitor hospitals have higher than expected rates of iatrogenic pneumothorax. Competitor hospitals have higher than expected rates on several other PSIs. A similar analysis of Patient Safety Indicators was also performed for orthopedic and surgery specialty hospitals. The small number of discharges prevented us from drawing strong conclusions concerning complication rates for these hospitals.

Table 5.6
Cardiac Specialty Hospitals and their Acute Care Community Hospital Competitors: Select AHRQ Patient Safety Indicators For the Population of All Specialty Hospitals and Their Competitors

Patient Safety Indicators (PSIs)		
	Specialty Hospitals	Competitor Hospitals
Iatrogenic pneumothorax		
Number of Cases	36	246
Population at risk	24,605	136,056
Observed Rate	1.46	1.81
Expected Rate	0.80	0.76
Observed/expected ratio	***1.83***	***2.38***
Selected infections due to medical care		
Number of Cases	39	539
Population at risk	28,562	137,988
Observed Rate	1.37	3.91
Expected Rate	2.42	2.94
Observed/expected ratio	***0.56***	***1.33***
Post-op hip fracture		
Number of Cases	4	33
Population at risk	19,549	58,853
Observed Rate	0.20	0.56
Expected Rate	0.36	0.41
Observed/expected ratio	***0.57***	***1.37***
Post-op pulmonary embolism or DVT		
Number of Cases	98	576
Population at risk	19,658	59,058
Observed Rate	4.99	9.75
Expected Rate	9.36	10.49
Observed/expected ratio	***0.53***	***0.93***
Post-op sepsis		
Number of Cases	22	165
Population at risk	3,848	11,791
Observed Rate	5.72	13.99
Expected Rate	8.53	13.62
Observed/expected ratio	***0.67***	***1.03***
Accidental puncture or laceration		
Number of Cases	174	630
Population at risk	30,704	155,441
Observed Rate	5.67	4.05
Expected Rate	4.47	3.07
Observed/expected ratio	***1.27***	***1.32***

* indicates the differences between specialty and competitor hospitals are statistically significant at a .1% level.

NOTE: Observed and Expected rates are per 1,000 cases.

SOURCE: CY 2003 Medicare IPPS claims.

The complete table is in the appendix as Table A1

Table 5.7
Cardiac Specialty Hospitals and Competitor Acute Care Hospitals: Readmission Rates Stratified by Patient Severity and DRG Grouping For the Population of All Specialty Hospitals and Their Competitors

	Specialty Hospitals			Competitor Hospitals		
	# readmissions	N	% readmissions	# readmissions	N	% readmissions
Moderate Severity						
Major Heart	278	3,326	8.36	536	8,934	6.00*
PTCA, Etc.	403	8,046	5.01	1.080	22,525	4.79**
Other	594	6,690	8.88	3.902	53,596	7.28*
Severe Severity						
Major Heart	305	2,076	14.69	860	7,812	11.01*
PTCA, Etc.	169	1,125	15.02	477	4,356	10.95*
Other	317	1,912	16.58	2,270	20,849	10.89*

NOTE: Comparisons are limited to patients in MDC 5; non-cardiac admissions are not included in this analysis.

*, ** indicates the differences between specialty and competitor hospitals are statistically significant at the .1% and 5% levels respectively.

SOURCE: CY 2003 Medicare IPPS claims.

In orthopedic specialty hospitals, the percentage of patients in the moderate severity category readmitted after treatment at a specialty hospital ranged from roughly 1.2% to 1.6% (***see Table 5.8***). The percentage of readmissions was slightly higher for competitor hospitals than for orthopedic specialty hospitals, ranging from, approximately, 1.8% to 4.3%. A t-test of the difference between means showed that the difference between orthopedic specialty and competitor hospitals is significant for all DRG groupings. The percentage of orthopedic patients in the severely ill category readmitted to the hospital in all DRG groupings was similar across hospital types. The t-tests showed that the difference in proportion between specialty and competitor hospitals were significant at the $p<0.05$ level only for major and minor orthopedic surgical procedures and not significant for medical procedures. This suggests that the competitor and specialty hospitals performed about the same with respect to severely ill orthopedic patients. However, as with moderately ill patients, the number of readmissions at orthopedic specialty hospitals was very small.

Table 5.8
Orthopedic Specialty Hospitals and Competitor Acute Care Hospital Competitors: Readmission Rates reported by Patient Severity and DRG grouping (MDC=8) For the Population of All Specialty Hospitals and Their Competitors

	Specialty Hospitals			Competitor Hospitals		
	# readmissions	N	% readmissions	# readmissions	N	% Readmissions
Moderate Severity						
Major Ortho	63	3,954	1.59*	1,008	40,193	2.51
Minor Ortho	22	1,614	1.36*	251	13,961	1.80
Medical	1	79	1.27*	638	14,584	4.37
Severe Severity						
Major Ortho	17	346	4.91**	843	14,179	5.95
Minor Ortho	1	24	4.17**	54	829	6.51
Medical	0	1	0.00	317	4,484	7.07

*, ** indicates the differences between specialty and competitor hospitals are statistically significant at the .1% and 5% levels respectively.

NOTE: Moderate Severity includes APR-DRG both severity categories Minor and Moderate; Severe includes APR-DRG both severity categories Major and Extreme

SOURCE: CY 2003 Medicare IPPS claims.

Readmissions to both surgical and competitor hospitals for patients in MDC 8, 12 and 13 were too few in number to draw any significant conclusions from the data (especially among severely ill patients). Readmission rates for moderately ill patients with a major surgical procedure were lower for specialty hospitals whereas rates for minor surgical were lower for competitor hospitals, however, these were not statistically significant. There were very few severely ill patients discharged from specialty hospitals and consequently, the numbers of admissions and readmissions for both DRG groupings are too small relative to competitor hospitals to allow us to have confidence in these results. We would need to repeat these analyses with multiple years of data to reach any reliable conclusions regarding differences in the quality of care provided in surgical specialty hospitals versus their community acute care hospital competitors on this measure.

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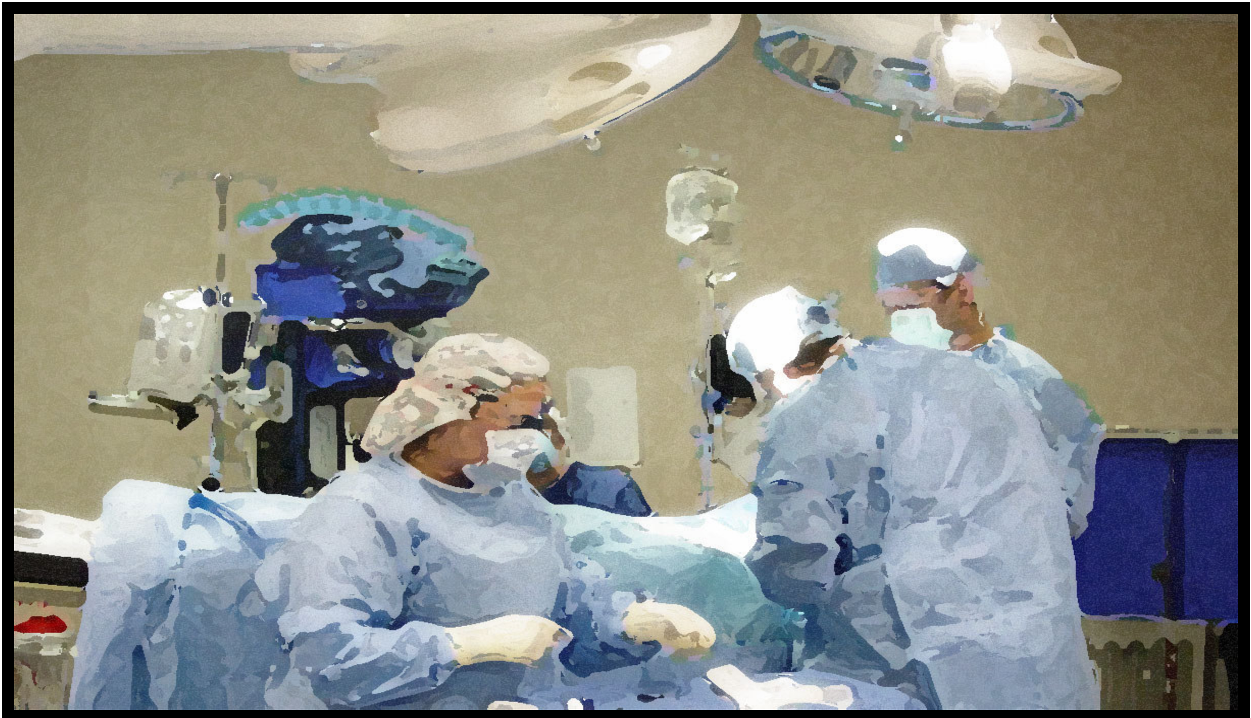

EXECUTIVE SUMMARY – THE APPLICATION OF THE FRAUD AND ABUSE ANTI-KICKBACK STATUTE AND EMTALA TO SPECIALTY AND SURGICAL HOSPITALS[1]

March 2006

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[1] This Executive Summary has been authored by Scott Becker and Nathan Kottkamp, each of McGuireWoods LLP, on behalf of the American Surgical Hospital Association.

I. Medicare/Medicaid Fraud and Abuse and Anti-Kickback Law

The Anti-Kickback Statute, 42 U.S.C. §1320a-7b, prohibits the offer, provision, solicitation, or receipt of any sort of remuneration in exchange for the referral of any service potentially reimbursable under Medicare, Medicaid, or other federal health program. There are several issues that are raised with regard to physician ownership of surgical and specialty hospitals under the Anti-Kickback Statute.

Each hospital is encouraged to consult with their own legal counsel as to issues arising under the Anti-Kickback Statute.

There is no safe harbor that provides comfort for the development of surgical hospitals. There does exist a safe harbor for certain investment interests in small entities. However, the safe harbor requires that investing physicians own no more than forty percent of the hospital and generate no more than forty percent of the volume of the hospital's business. Thus, it may not be applicable to many surgical and specialty hospitals. As no safe harbor protection exists for such investments, it is extremely important that the offering of shares in the development of the hospitals be done under carefully constructed prophylactic rules that help demonstrate that the investors are not given special terms or remuneration in exchange for referrals. These rules might include:

- Each investor will have an equal opportunity to purchase shares;
- Investors will pay fair market value for shares and will not pay more or less per share based on their ability to generate referrals for the hospital;
- No investor will receive financing from another investor or the hospital for the purchase of shares;
- All returns on investment will be based on ownership of shares and not on the referrals generated by the physician;
- Investors should be required to disclose to patients their ownership in the hospital;
- Physicians should not be expected to make any level of indirect referrals to the hospital;
- The hospital will not discriminate against Medicare or Medicaid or governmental health care program business;
- Services of the entity will be marketed or furnished to all persons in a manner that is the same (i.e., marketing of services will not be different based on who is an owner of the facility);
- The potential ownership group should not be differentiated or based on the volume or value of referrals;
- The center will not track or distribute referrals from investor owners to all members;
- The real estate lease for the hospital will be consistent with fair market value for the space leased;

- Shares should not be reallocated based on the volume or value of referrals;
- Hospitals should not develop elaborate “target” lists of investor physicians based on revenues or referrals;
- No physician should be offered special remuneration to encourage use of the facility; and
- Physicians should not be pressured to withdraw if they do not generate business for the hospital.

Finally, the Department of Health and Human Services’ Office of Inspector General (“OIG”) has expressed concerns in other contexts that should be carefully considered in this context. First, the OIG has commented negatively on arrangements that may enable investors to derive profits from the provision of indirect referrals. Specifically, in Advisory Opinion 98-12, the OIG outlined its concerns with respect to ambulatory surgery centers (“ASCs”) as follows:

> [T]his Office is concerned about the potential for investments in ambulatory surgical centers to serve as vehicles to reward referring physicians indirectly. For example, a primary care physician, who performs little or no services in an ambulatory surgical center in which he has an ownership interest, may refer to surgeons utilizing the ambulatory surgical center, thereby receiving indirect remuneration for the referral through the ambulatory surgical center’s profit distribution. Similarly, an investment by orthopedic surgeons in an ambulatory surgical center that is not equipped for orthopedic surgical procedures, or that is exclusively used by anesthesiologists performing pain management procedures on patients referred by the orthopedic surgeons, would be suspect.

As there is no specific safe harbor for surgical hospitals that invokes the extension of practice concept that exists in the ASC safe harbor, many parties have viewed surgical hospitals as providing an opportunity for the involvement of primary care physicians as owners in surgical hospitals. However, one should be aware of the OIG’s concerns regarding arrangements in which physicians who are indirect referral sources are brought in as owners. I.e., any such parties should be allowed to invest, for example, because they make a capital investment to the hospital and not to induce or encourage referrals.

II. EMTALA

This section provides background guidance on Emergency Medical Treatment and Labor Act (EMTALA) obligations for both hospitals with emergency departments and hospitals that do not have emergency departments. A good deal of the guidance contained herein is derived from guidance that CMS has provided to states survey agency directors pursuant to a memo related to EMTALA Interpretive Guidelines. Each hospital is urged to consult with their own legal counsel and review the regulations located at 42 CFR §§ 489.20 and 489.24.

Medicare participating hospitals, including specialty hospitals, must comply with the EMTALA statute and accompanying regulations in 42 CFR §489.24 and 42 CFR §489.20(l),(m), (q) and (r). EMTALA requires hospitals with emergency departments to provide a medical screening examination ("MSE") to any individual who "comes to the hospital" (including presenting on the hospital's campus) and to provide stabilizing medical treatment within its capacity. It also prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition (EMC). The term "hospital" includes specialty hospitals.

A dedicated emergency department is defined as meeting one of the following criteria regardless of whether it is located on or off the main hospital campus. The entity: (1) is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for EMC on an urgent basis without requiring a previously scheduled appointment; or (3) during the preceding calendar year (i.e., the year immediately preceding the calendar year in which a determination under this section is being made), based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely evaluated and treated for EMCs.

A. Requirements for Hospitals With Emergency Departments

Hospitals with dedicated emergency departments are required to take the following measures:

- Adopt and enforce policies and procedures to comply with the requirements of 42 CFR §489.24;
- Post signs in the dedicated ED specifying the rights of individuals with EMCs and women in labor who come to the dedicated ED for

health care services, and indicate on the signs whether the hospital participates in the Medicaid program;

- Maintain medical and other records related to individuals transferred to and from the hospital for a period of five years from the date of transfer;
- Maintain a list of physicians who are on call to provide further evaluation and/or treatment necessary to stabilize an individual with an EMC;
- Maintain a central log of individuals who come to the dedicated ED seeking treatment and indicate whether these individuals:
  - Were refused treatment;
  - Were denied treatment;
  - Were treated, admitted, stabilized and/or transferred or were discharged,
- Provide for an appropriate MSE;
- Provide necessary stabilizing treatment for EMCs and labor within the hospital's capability and capacity;
- Provide an appropriate transfer of an unstabilized individual to another medical facility, but only if:
  - The individual (or person acting on his or her behalf) after being informed of the risks and the hospital's obligations requests a transfer;
  - A physician has signed the certification that the benefits of the transfer of the patient to another facility outweigh the risks or
  - A qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed the certification after a physician, in consultation with that qualified medical person, has made the determination that the benefits of the transfer outweigh the risks and the physician countersigns in a timely manner the certification. (This last criterion applies if the responsible physician is not physically present in the emergency department at the time the individual is transferred.)

Additionally, prior to, and as part of the transfer, the transferring hospital must:

- Provide treatment to minimize the risks of transfer;
- Send all pertinent records to the receiving hospital;
- Obtain the consent of the receiving hospital to accept the transfer;
- Ensure that the transfer of an unstabilized individual is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures; and

- Provide the name and address of any on-call physician who refused or failed within a reasonable time to provide necessary stabilizing treatment.

- Not delay in the MSE and/or stabilizing treatment in order to inquire about payment status;
- Accept appropriate transfer of individuals with an EMC if the hospital has specialized capabilities or facilities and has the capacity to treat those individuals; and
- Not penalize or take adverse action against a physician or a qualified medical person because the physician or qualified medical person refuses to authorize the transfer of an individual with an EMC that has not been stabilized or against any hospital employee who reports a violation of these requirements.

B. Requirements for Hospitals that Do Not Have Emergency Departments

A hospital that does not have a dedicated emergency department, as defined by 42 CFR §489.24(b), generally does not have an EMTALA obligation to provide screening and treatment, and is not required to be staffed to handle potential EMC. Nevertheless, EMTALA, per 42 CFR §482.12(f), requires the hospital's governing body to assure that the medical staff has written policies and procedures for the appraisal of emergencies, initial treatment (within its capability and capacity, and makes an appropriate referral to a hospital that is capable of providing the necessary emergency services. (See Form CMS-1537, Medicare/Medicaid Hospital Survey Report). Such a facility must have policies and procedures in place for handling patients in need of immediate care. For example, the facility policy may direct the staff to contact the emergency medical services/911 (EMS) to take the patient to an emergency department or provide the necessary care if it is within the hospital's capability.

A hospital without an emergency department should review the bylaws, rules and regulations of the medical staff to determine if they reflect EMTALA requirements.

C. Hospital Signage Requirements

Hospital signage must at a minimum:

- Specify the rights of individuals with EMCs and women in labor who come to the emergency department for health care services; and
- Indicate whether the facility participates in the Medicaid program. Signs must also be clear and use simple terms and language(s) that are understandable by the population served by the hospital.

Furthermore, the sign(s) must be posted in a place or places likely to be noticed by all individuals entering the emergency department, as well as

those individuals waiting for examination and treatment (e.g., entrance, admitting area, waiting room, treatment area).

D. Call Responsibilities

As a requirement for participation in the Medicare program, hospitals that have an emergency department must maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. The on call list identifies and ensures that the emergency department is prospectively aware of which physicians, including specialists and sub-specialists are available to provide care.

A hospital can meet its responsibility to provide adequate medical personnel to meet its anticipated emergency needs by using on call physicians either to staff or to augment its emergency department, during which time the capability of its emergency department include the services of its on call physicians.

CMS does not have requirements regarding how frequently on call physicians are expected to be available to provide on call coverage. Nor is there a pre-determined ratio CMS uses to identify how many days a hospital must provide medical staff on call coverage based on the number of physicians on staff for that particular specialty. No physician is required to be on call at all times. In particular, CMS has no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide 24-hour/7 day coverage in that specialty. Instead, each hospital has the discretion to maintain the on call list in a manner that best meet the needs of the hospital's patients who are receiving services required under EMTALA in accordance with the resources available to the hospital, including the availability of one call physicians.

Call coverage should be provided for within reason depending upon the number of physicians in a specialty. A determination about whether a hospital is in compliance with these regulations must be based on the facts in each individual case. Surveyors will consider all relevant factors including the number of physicians on staff, the number of physicians in a particular specialty, other demands on these physicians, the frequency with which the hospital's patients typically require services of on call physicians, vacations, conferences, days off and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on call physician is unable to respond.

The best practice for hospitals, which offer particular services to the public, is that those particular services should be available through on call coverage of the emergency department.

Physician group names are not acceptable for identifying the on call physician. Individual physician names are to be identified on the list.

Hospitals have the ultimate responsibility for ensuring adequate on call coverage. Hospitals have an EMTALA obligation to provide on call coverage for patients in need of specialized treatment if the hospital has the capacity to treat the individual.

A determination as to whether the on call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician. The ER physician's ability and medical knowledge of managing that particular medical condition will determine whether the on call physician must come to the emergency department.

When a physician is on call for the hospital and seeing patients with scheduled appointments in his private office, it is generally not acceptable to refer emergency cases to his or her office for examination and treatment of an EMC. The physician must come to the hospital to examine the individual if requested by the treating emergency physician. If, however, if it is medically appropriate to do so, the treating emergency physician may send an individual needing the services of the on call physician to the physician's office if it is part of a hospital-owned facility (department of the hospital sharing the same Medicare provider number as the hospital) and on the hospital campus.

If a physician who is on call does not come to the hospital when called, but directs the patient to be transferred to another hospital where the physician can treat the individual, the physician may have violated EMTALA.

For physicians taking call simultaneously at more than one hospital, the hospitals must have policies and procedures to follow when the on call physician is not available to respond because he has been called to the other hospital to evaluate an individual. Hospital policies may include, but are not limited to procedures for back up on call physicians, or the implementation of an appropriate EMTALA transfer according to 42 CFR §489.24(e).

The decision as to whether the on call physician responds in person or directs a non-physician practitioner (physician assistant, nurse practitioner, orthopedic tech) as his or her representative to present to the dedicated ED is made by the responsible on call physician, based on the individual's medical need and the capabilities of the hospital and applicable State scope of practice laws, hospital bylaws, and rules and regulations. The on call physician is ultimately responsible for the individual regardless of who responds to the call.

On call physicians may utilize telemedicine (telehealth) services for individuals in need of further evaluation and/or treatment necessary to stabilize an EMC, as permitted by applicable State scope of practice laws, hospital bylaws, and rules and regulations. Individuals are eligible for telemedicine services only when, because of the individual's geographic location, it is not possible for the on call physician to physically assess the patient.

Physicians that refuse to be included on a hospital's on call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship while at the same time refusing to see other patients (including those individuals whose ability to pay is questionable) may violate EMTALA. If a hospital permits physicians to take calls selectively take call while the hospital's coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment.

E. Specialist Not Available

The medical staff by-laws or policies and procedures must define the responsibility of the on call physicians to respond, examine and treat patients with an EMC.

Physicians, including specialists and sub-specialists (e.g., neurologists) are not required to be on call at all times or required to be on call in their specialty for emergencies whenever they are visiting their own patients in the hospital. The hospital must have policies and procedures (including back-up call schedules or the implementation of an appropriate EMTALA transfer) to be followed when a particular specialty is not available or the on call physician cannot respond because of situations beyond his or her control. The hospital is ultimately responsible for providing adequate on call coverage to meet the needs of its patients.

F. Central Log

A central log on each individual who "comes to the emergency department", as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged. The provisions of this regulation apply to all hospitals that participate in Medicare and provide emergency services.

G. MSE Is Not Triage

A hospital must screen individuals to determine if an EMC exists. CMS has expressly stated that it is not appropriate to merely "log in" an individual and not provide a MSE. Individuals coming to the emergency department must be provided a MSE beyond initial triaging. Triaging is not equivalent to a MSE. Triage merely determines the "order" in which individuals will be seen, not the presence or absence of an EMC.

A MSE is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist.

A hospital, regardless of size or patient mix, must provide screening and stabilizing treatment within the scope of its abilities, as needed, to the individuals with EMCs who come to the hospital for examination and treatment.

H. Transfers

Under EMTALA, transfer is permitted if the individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's EMTALA obligations and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. Transfer is also permitted if a physician has signed a certificate that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based.

EMTALA requires an express written certification. Physician certification cannot simply be implied from the findings in the medical record and the fact that the patient was transferred.

The certification must state the reason(s) for transfer. The narrative rationale need not be a lengthy discussion of the individual's medical condition reiterating facts already contained in the medical record, but it should give a complete picture of the benefits to be expected from appropriate care at the receiving (recipient) facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer. The risks and benefits certification should be specific to the condition of the patient upon transfer. This rationale may be on the certification form or in the medical record. Certifications may not be backdated.

I. Requirements for a Proper Transfer

There are four requirements of an appropriate transfer:

First, the provision of treatment to minimize the risks of transfer is the first requirement of an appropriate transfer. If the patient requires treatment, it must be sufficient to minimize the risk likely to occur or result from the transfer.

Second, the receiving facility must have available space and qualified personnel for the treatment of the individual; and must have agreed to accept transfer of the individual and to provide appropriate medical treatment.

Third, the transferring hospital must send to the receiving facility all medical records (or copies thereof) related to the emergency condition which the

individual has presented that are available at the time of the transfer, including available history, records related to the individual's EMC, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer.

Fourth, the transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

SIOUX FALLS SURGICAL CENTER

QUALITY IMPROVEMENT / RISK MANAGEMENT PLAN

ORGANIZATION

Each patient has needs, including psychosocial, economic, spiritual and physical, which comprise the individual. Sioux Falls Surgical Center is responsible for meeting the patients' needs according to their individual state of health. We shall strive for optimal outcomes with continuous improvements that consistently represent a high standard of practice, minimize risks to patients and are cost effective.

MISSION

The Sioux Falls Surgical Center shall be the leader in providing the highest quality surgical, recovery care and diagnostic imaging services in an environment that is safe, convenient, and comfortable for our patients, their families, our employees and the health care practitioners who use our surgery, recovery care and imaging facility

QUALITY PHILOSOPHY

In accordance with our mission statement, administration, management, and all employees are committed to the continuous improvement of patient care. This commitment will be nurtured in an environment supportive of excellence, non-threatening in nature, open to suggestion and conducive to positive change. Administration, management, and staff will take an active part in a planned, systematic organization wide approach to the monitoring, analysis and improvement of performance and / or processes.

GOALS

A. Assure the delivery of patient care at an optimally achievable level of quality in a safe, professional, and cost-effective manner.
B. Improve the quality of care provided through ongoing, objective and systematic measurement, analysis and improvement of performance.
C. Maximize patient safety and minimize patient and organization risk of adverse occurrence.
D. Advance awareness and knowledge of continuous quality improvement among administration, management and patient care providers.
E. Educate personnel to facilitate and promote organization wide philosophical commitment to quality of care, service and leadership. Ensure that leadership and staff understand the tenets of quality improvement.
F. Respond proactively to customer expectations and feedback concerning the quality of care delivered.

G. Provide an efficient, competent and pleasant work environment for employees and physicians.
H. Meet the needs of third party payers and maintain requirements for regulatory compliance and accreditation

OBJECTIVES

A. Maintaining and monitoring an evaluation system to determine if providers of care and service are practicing optimally and identify opportunities for improvement.
B. Utilize appropriate quality tools to assist with problem identification and to ascertain improvement opportunities. Tabulate, aggregate, and summarize data and present in a meaningful format to assist in problem solving. Maintain a system of corrective action to assure problems or concerns are identified and resolved. Re-evaluation to determine that the corrective actions have sustained the desired result. If the problem or concern remains, alternative action will be taken to resolve the problem.
C. Proactively reduce the risk to patients by periodic review of resources, equipment and policies. Hold quarterly meetings of the Safety Committee, where safety issues are identified and researched.
D. Administration, management, as well as all departments will participate in continuous quality improvement activities. Ideas will be encouraged from all employees. Front line employees will serve on process improvement teams. Those who know the most about a specific process will be involved in the evaluation and submit recommendations for improvement.
E. QI training is incorporated in orientation. Comprehensive training for all employees at all levels of the organization will be completed annually.
F. Patient satisfaction questionnaires will be evaluated. All patients' comments will be assessed with individual follow-up. Patients concerns and comments will be tracked and trended for problematic areas and improvement opportunities.
G. Identification of problems or opportunities for improvement is encouraged from staff and practitioners. On site continuing education will be provided as well as ongoing inservicing of new equipment and surgical procedures. Physician and staff satisfaction will be assessed biannually.
H. Policies and procedure compliance will be randomly reviewed to ensure that all Federal, State, accreditation requirements are met and also to assure organization wide adherence with the compliance program.

QUALITY IMPROVEMENT / RISK MANAGEMENT COUNCIL

The Quality Improvement Council shall be comprised of, administrative, management, and direct patient care employees. Individuals within the team will represent the entire facility, providing a cross/functional group that possesses an overall knowledge and understanding of the surgical center as a whole. Members shall include, but not be limited to:

- Quality Improvement Director-Chairperson
- Medical Director, acts as representative from the Management Committee
- One representative from the Credentials Committee
- Two SFSC practicing physicians
- One representative from Anesthesia Department
- Two representatives from the Surgery Department
- Two representatives from PACU
- Two representatives from Recovery Care Department
- One representative from Admissions Office
- One representative from the Business Office
- Infection Control Nurse
- Risk Manager
- Director of Nursing

AUTHORITY AND RESPONSIBILITY

ALL MEMBERS

1. Meet quarterly; date shall be determined by the Quality Improvement Coordinator to coincide with the schedules of Council members and staffing needs of the Sioux Falls Surgical Center.
2. Assist in the preparation of the annual quality improvement strategic plan.
3. Evaluate the scope, organization and effectiveness of the quality improvement plan and make revisions as necessary.
4. Assist in the identification and monitoring of QI activities.
5. Coordinate a system of problem identification, problem resolution and re-evaluation.
6. Act as the organizational body responsible for risk management activities.
7. Evaluate trends of employee / patient / visitor occurrence reports.
8. Constantly evaluate quality and be on the lookout for ways to improve.

MANAGEMENT COMMITTEE

1. Is responsible for overall care at the Sioux Falls Surgical Center.
2. Provides one representative to the Quality Improvement Council.
3. Evaluates and approves the Quality Improvement and Risk Management Plan.
4. Receives and reviews Quality Improvement Council minutes and reports.
5. Participates in the review of credentials as well as quality of care issues and concerns of all active staff prior to their reappointment.

PHYSICIAN REPRESENTATIVES

1. Contribute to medical staff quality assurance activities.
2. Act as a resource in the development of Case Review protocol.
3. Provide input in the development of criteria to be monitored in order to evaluate the quality and appropriateness of clinical performance.

MEDICAL DIRECTOR

1. Is responsible for and accountable to the Management Committee for the facility's QI program.
2. Acts as a liaison between the Management Committee and organizational departments for matters affecting operations.
3. Reports improvement activities to the Management Committee.

QUALITY IMPROVEMENT DIRECTOR

1. Designs and implements the QI plan for the SFSC.
2. Initiates policy and procedure development for the QI department.
3. Conducts QI activities in a manner that complies with regulatory and AAAHC accreditation standards.
4. Educates new staff and provides ongoing educational activities for the facility to support quality activities. Facilitates and promotes organization wide philosophical commitment to quality.
5. Acts as Chairperson for the QI committee. Serves as the focal point of QI activities.
6. Directs prioritization of issues for assessment and improvement based on effect on patients and available resources.
7. Acts as a resource person to provide input to infection control activities.
8. Promotes and supports systems and processes to achieve safe, cost effective, high quality healthcare.
9. Reviews, tracks and trends employee/visitor / patient occurrence reports.
10. Coordinates events for QI activities. Provides guidance and organization to the activities of quality improvement.
11. Uses collaborative efforts and teams to study and improve specific existing processes.
12. Coordinates the activities of process improvement teams by providing guidance and instructions. Functions as a team facilitator as needed. Coordinates team efforts to monitor and evaluate patient care
13. Prepares and displays quality improvement reports and activities utilizing data in a meaningful format. Tabulates, aggregates, summarizes and displays pertinent data.

12\. Develops complete, timely reliable reports. Shares information with appropriate staff, including reports to the D.O.N., the Medical Director, and the Executive Director.

Submits QI reports and minutes to the Management Committee for review at their meetings.

RISK MANAGER

1. Supervises credentialing committee appointment and reappointment activities.
2. Investigates employee/visitor / patient occurrence reports.
3. Monitoring of surgical outcomes.
4. Acts as a resource person to provide input on all regulatory and compliance issues.
5. Provides input into employee health/risk management/ infection control / education and safety activities.
6. Promote process improvement for the ongoing prevention and reduction of risk.
7. Functions as liaison to liability insurance company.

INFECTION CONTROL NURSE

1. Responsible for the new employee orientation of infection control practices.
2. Responsible for the annual mandatory in-service of bloodborne pathogens.
3. Acts as a resource for employees and managers providing information and support as needed.
4. Investigates all surgical site infections and reports information to appropriate managers and the QI Director.
5. Conducts surveillance rounds addressing potential high-risk issues.

SAFETY OFFICER

1. Works with Risk Management personnel to develop and implement employee injury prevention strategies and programs. Monitors program effectiveness and makes adjustments as necessary.
2. Reviews all employee / visitor / patient occurrence reports.
3. Investigates occurrences regarding malfunctioning medical devices.
4. Promotes an atmosphere of "culture of safety" without blame.
5. Ensures compliance with all environmental health and safety standards promulgated by all local, state, and federal agencies.
6. With the Environmental Services Director, conducts building and grounds hazard surveillance surveys on a periodic and regular basis to detect code violations, hazards, and incorrect work practices and procedures.
7. Develops and recommends new procedures and approaches to safety and loss prevention based on reports of occurrences, accidents and other relevant information.

Members of the safety committee, which meets quarterly,

monitor safety issues. Findings/concerns will be submitted to QI and included in the quarterly report to Management Committee

DEPARTMENTAL REPRESENTATIVES

1. Actively participate in the identification of objectives for the annual specific plan.
2. Participate on specific process improvement teams as activities indicate.
3. Assist in data collection, analysis and finalizing reports to support departmental goals.
4. Responsible for reporting findings, actions and follow-up of activities to his/her department. Reports are to be reflected in unit meeting minutes.

EMPLOYEES

1. Are knowledgeable of and actively participating in and supporting the QI process.
2. Are involved in a daily search for improvements in all services, products and organizational processes.
3. Contribute to the achievement of improvement goals through individual action or in partnership with others.
4. Communicate and work together to achieve the mission statement, values and goals of Sioux Falls Surgical Center.
5. Develop a teamwork relationship with all customers and suppliers.
6. Focus on the QI process to exceed the needs and expectation of the customers, suppliers.
7. Are committing to making customer satisfaction and safety top priority.

CUSTOMER SERVICE AND SATISFACTION

Satisfaction evaluation will be utilized and completed to determine facility and staff strengths and weaknesses. Data will be analyzed to identify specific areas, which need improvement and /or trending patterns. Patient satisfaction will be assessed regarding care received and patient outcomes. Customer feedback will be utilized for providing direction for improvement opportunities.

QUALITY OF CARE PEER AND MEDICAL RECORDS REVIEW

Quality of care Peer and Medical Records review shall be completed to assist in credentialing as well as being a mechanism for evaluating the quality of patient care in an environment that is safe, convenient and comfortable. Evaluating the health care provided insures that the health care professionals are providing the quality of patient care that the SFSC makes every effort to achieve. Case review shall involve a continual, routine gathering

of information. Objective and systematic monitoring will be utilized in the evaluation of documentation and unexpected outcomes Staff members as well as physicians shall be engaged in this process. Case review information will be incorporated into the reappointment process.

CONTRACTED SERVICES

There is an ongoing collection of information from contracted services to assist in determining that the use of these services is consistent with the patient's needs. By evaluating the level of health care provided, we ensure that the contracted service is meeting the high level of care that the SFSC strives to achieve This monitoring of contracted services shall be comprehensive and shall utilize TQM tools in order to adequately address the full scope of services provided, identify and address any problem areas.

QUALITY IMPROVEMENT STRUCTURE

A. The review of patient care shall include the following characteristics:

1. Ongoing and Systematic Process
    a. Tracking data over time (Ongoing) and evaluation of this data determines what elements of patient care best reflect the overall care provided by the department, what kinds of information needs to be collected about these elements of care, and how often the information should be collected and evaluated. This approach is outlined in the yearly strategic plan and is evaluated and updated annually.
    b. A systematic process for data collection and evaluation means that information about various elements of patient care and clinical performance is collected as part of the daily functions of the department when appropriate. The information is collected at the various agreed on intervals of time and is representative of the practitioners involved and the type of service provided.
    c. Monitoring of care and outcomes shall be comprehensive, not limited to problem focused studies,

2. Problem Identification
    a. Methods of assessment, monitoring and problem identification shall include, but not be limited to:
        1. Observation
        2. Interview
        3. Record Review
        4. Concurrent Monitors
        5. Brainstorming
        6. Retrospective Monitors
        7. Benchmarking
        8. FMEA
    b. Identification of problems and/or opportunities may be revealed by utilizing the following sources:

1. Policies and Procedures
2. Standards of care
3. Guidelines for documentation
4. Current literature teaching
5. Cost of care

c. Other means of problem identification utilized in the continued effort to improve patient care include that which comes through:

Internal methods
- Medical Records
- Infection/Hospitalization follow up
- Management Committee
- Quality of care Peer and Medical Records Review
- Occurrence Reports

External Methods
- Regulatory Agencies
- Federal Legislation
- Professional Organizations
- Networking/ Benchmarking

d. Each department participates in the development and application of the objectives used to evaluate the care they provide. They shall identify problems that have an impact on patient care and outcomes, clinical performance and overall process. All staff will observe clinical performance and identify patterns or trends and be constantly on the lookout for ways to improve.
e. The primary approaches/methods of problem assessment and evaluation are:

Structure
Structure is the arrangement of the care system or elements that facilitate care; resources, staff, equipment, policies etc.; evidence of the facilities ability to provide care; the care environment.
Process
Refers to the method, means, sequence of steps or procedures for providing care and producing outcomes. There may be many or few processes directed towards the evaluation of activities carried out by health care personnel in the delivery of patient care.
Outcome
Directed toward the evaluation of a patient's health status as a result of patient care delivered, the end results of care. It is retrospective as the patient's chart is reviewed following discharge. The audit is done with a focus on a specific

problem or concern identified, or specific processes, as well as any potential problems that could affect the patient’s outcome.

3. Analysis

   Analysis of information about important aspects of patient care and patient outcomes shall utilize statistical methods and tools to interpret data accurately and produce meaningful information in order to adequately address the full scope of services provided including high risk, high volume, new procedures and problem prone areas.

   a. Analysis of ongoing data collection and/or identified problems may be completed by utilizing, but not limited to, the following tools.
      1. Process Improvement Teams
      2. Brainstorming
      3. Control Charts
      4. Flow Charts
      5. Pie Charts
      6. Pareto Charts

   d. If problems are suspected, problem focused studies may be performed to determine the cause, magnitude and impact of the problem.
   e. In some cases, a combination of any or all of the approaches/methods may be used. The type of problem identified determines the method chosen for monitoring/evaluation/improvements.
      1. Procedural (process-observation)
      2. Documentation (outcome / process record review)

4. Action

   Action is taken as appropriate when negative findings, trends, special cause variation, problems or opportunities to improve care are identified. Actions may include:

   a. Changes or modification of equipment/supplies.
   b. Process analysis and review
   c. Development / review / revision of policy, procedures, standards, and guidelines.
   d. Assessment and / or modification of contracted services.
   e. In-service education
   f. Employee / Practitioner counseling
   g. Re-evaluation of identified problems or concerns is performed to assure that the corrective measures have achieved and sustained the desired result.

h. Alternative corrective actions are taken as needed with continuing re-evaluation.
i. Documentation of findings, conclusions, recommendations, action taken and results of action taken will be documented in:
   1. Quality Improvement Committee meeting minutes.
   2. Reports and monitors to the Quality Improvement Council
   3. Reports and minutes to the CEO and Management Committee.
   4. Each department representative must submit a written or oral report of QI activities at his / her unit meetings. This report should be reflected in the unit meeting minutes.
j. Corrective actions take into account the following:
   1. Resources available
   2. Time involved
   3. Cost

MEASURES OF EFFECTIVNESS

The QI Director is responsible for the facilitation, documentation, and reporting of the day-to-day functions of the overall quality program.

The objectives, scope, organization and effectiveness of the activities of the Quality Improvement Program are evaluated at least annually and revised as necessary. Quality plans will be reviewed at the Management Committee meetings. This review of the overall quality plan and annual strategic plan evaluates the effectiveness of the program. Emphasis will be placed on areas monitored, evaluated, identified problems, opportunities for improvement, success of actions taken toward problem resolution and improvements made in patient care. Efficiency and cost-effectiveness will also be evaluated. Revisions to the program will be effective upon approval of the Management Committee.

CONFIDENTIALITY

All copies of minutes, reports, and worksheets will be handled in a manner ensuring strict confidentiality. These may be stamped or marked "CONFIDENTIAL". Results of quality assurance activities and reports will not contain identifiable client information. Information may be coded or reported in aggregate.

MEDICAL DIRECTOR DATE

SIOUX FALLS SURGICAL CENTER 2006
CONTINUOUS QUALITY MANAGEMENT / RISK MANAGEMENT
GOALS AND STRATEGIC PLAN

I. EMPLOYEE EDUCATION, CERTIFICATIONS, TRAINING

Comprehensive training of employees at all levels of the organization will be completed. QI training is incorporated into the new employee orientation. A facility wide QI educational week will be held annually. This week will include training sessions that will include an overview of our QI program as well as descriptions and clarifications of staff responsibilities. The program will be presented at various times during the week to accommodate the employees work schedules.
The program will include:

a. Quality awareness
b. Staff participation
c. The SFSC's mission statement and goals.
d. Customer Satisfaction
e. Employee Suggestions

In addition to the training sessions the week will include poster presentations, quality quizzes, and prize drawings.
Just in time training will be utilized for process improvement teams. Just in time training will include:

a. Definition of the team assignment.
b. Identification of the scope of responsibility of the team
c. Use of basic quality improvement tools.
d. Role of team leaders and facilitators

II. REGULATORY GOALS

- Remain compliant with the South Dakota Department of Health Hospital rules and HCFA regulations.
- Documentation for each year will be maintained and summary will be broken out per quarter. The supporting statistics will be maintained in a locked file cabinet.
- Policies and Procedures will be reviewed annually.
- Annual employee education will be provided.

III. BENCHMARKING

Comparison of key performance measures with other like organizations or with best practice of national or professional targets will be completed. Accurate facility historical data will be collected to be compared now and in the future.

- A procedure specific benchmarking study will be completed with like facilities.
- Comparative analysis from FASA will be utilized to determine best practice for benchmarking purposes.
- SFSC will participate in ASHA benchmarking activities.

IV. ONGOING EVALUATION OF PATIENT SATISFACTION

Satisfaction evaluation will be utilized and completed to determine facility and staff strengths and weaknesses. Data will be analyzed to identify trends and/or specific problem areas. Patient satisfaction will be assessed regarding care received. Patient feedback will be utilized for providing direction for improvement opportunities.

- Satisfaction survey and/or input received verbally via phone calls, letters, etc., will be dated when received.
- The numeric portion of the surveys will be entered into a data sheet for evaluation and trending by the quality department. This information will be incorporated into a graph and included with the monthly narrative report. Cumulative monthly ratings of individual questions will be tracked and trended on a run chart.
- Any survey with a numeric rating of 2 or lower in any area will be investigated and forwarded to SFSC management as deemed necessary by the quality department.
- The quality department will review all narrative comments. These comments will be compiled and shared with staff monthly.
- Patient's comments will be shared with individuals whose names were specifically mentioned on the survey.
- Target for follow up on patient comments/concerns will be two weeks from the time the patient survey is received.
- Monthly summaries of comments will be posted in a binder in the staff lounge.

V. SURGICAL COMPLICATIONS

Each month all surgeons performing cases will receive a Patient Outcome Survey listing their patients and procedures

- Infection Control
  - All patients who have a reported infection will be assigned a classification by the Infection Control nurse.
  - The Infection Control Nurse or designee will complete follow up on all patients sustaining a post-operative surgical site or other infection.
  - All reported infections will be tracked, trended, and investigated for commonalities.
  - All reported infections will also be tracked by specialty. Comparative analysis will be completed with data received from FASA and ASHA quarterly reports.
- Hospitalizations
  - Patients admitted to a hospital within 72 hours are designated on the returned survey.
  - A discharge summary will be obtained from the admission hospital.
  - All hospital admissions will be tracked and trended.
  - Comparative analysis will be completed with data received from FASA and ASHA quarterly reports.
- Complications
  - All complications will be investigated, tracked and trended.
  - Comparative analysis will be completed utilizing internal historical trends.

VI. REVIEW MEDICAL RECORDS AND STAFF PEER REVIEW FOR QUALITY OF CARE AND COMPLETENESS

- Chart assessment will be ongoing to assure completeness of routine documentation within 30 days. This review will be consistent with our goal to achieve and maintain optimal documentation of patient care.

VII. PHYSICIAN CREDENTIALING/PEER REVIEW

The physician members of the Board of Directors will review credentials as well as the results of quality management outcome measurements of all active staff prior to their reappointment. Outcome measures include but may not be limited to:

- Hospital transfers and admissions with-in 72 hours.
- Post-op surgical site, or other infections.
- Number of surgical procedures.
- Patient return to the Operating room.
- Surgical complications

The area under review and the method of chart selection will be outlined specifically in the Peer Review Plan. An annual profiling report including outcome measures will be placed in each physician's peer review folder.

VIII. QUALITY IMPROVEMENT/RISK MANAGEMENT COMMITTEE QUARTERLY MEETINGS

The Quality Improvement committee will provide organizational direction and oversee all of the continuous quality improvement activities. The committee will be utilized to sustain, facilitate, and expand the quality improvement activities based on the organization's mission statement and goals. There will be medical staff, management, and front line staff participation. The committee will strive to provide clear communication of quality measures throughout all levels of the organization. Department delegates will be responsible for communicating quality activities at his/her department staff meeting. Quarterly summaries will be posted in the employee lounge.

IX. MONTHLY TRACKING AND TRENDING OF EMPLOYEE AND / OR PT. VISITOR INCIDENT REPORTS

Tracking and trending of incident reports will focus on analysis of data and decision-making techniques to predict potential risk and to estimate financial impact on the facility. Reports will be prioritized by frequency, severity, and potential reduction.

- Ongoing evaluations of all incidents will take place. A report will be presented at the quarterly Quality Improvement meeting.
- Follow-up will be completed immediately on all contaminated exposures.
- The employee health nurse will complete an annual report including all employee-contaminated exposures.
- Comparative analysis will be completed utilizing internal historical trends and data received from like facilities and FASA.

- Ongoing tracking to identify trends will be completed.

X. FACILITY WIDE GOALS

IMPROVING FACILITY WIDE COMMUNICATION

- 2006 Quality focus will be on improving the communication at SFSC. Several communication models will be evaluated. After a model is selected we will trial, educate and implement the new communication model.

BAPTIST INSTUTUTE LEADERSHIP PROGRAM

- Achieving facility excellence by focusing on employee satisfaction, physician satisfaction, customer satisfaction, leadership development and accountability activities into a comprehensive method for focusing SFSC's culture on service and operational excellence.

XI. DEPARTMENTAL GOALS

A QI folder will be available to each department. The contents of this folder shall include the departmental goals and activities for the calendar year. Studies from the department and other pertinent QI information will be included. Patient confidentiality and privacy will be maintained at all times.

A. Front Desk

1. Evaluate process for forwarding Operative note to referring physicians. Identify problems and opportunities for improvement.
2. Evaluate patient use of web site pre registration. Identify ways of increasing patient awareness and use of web site.
3. Develop a method to survey family/friends of patients waiting in the lobby. Identify problems and opportunities for improvement.

B. Admission to the Pre-Operative Department

1. Evaluate pre-op time frame (wait), assess and trend. Identify problems and opportunities for improvement.

C. Operating Room

1. Surgical Indications Monitoring (SIMS) study for a high frequency procedure done at SFSC.
2. Assess patient wait time in the Operating room from time brought to OR to actual incision time. Identify problems and opportunities for improvement.
3. Decrease surgical delays by improving accuracy of scheduled operative times.
4. Improve the adherence in the completeness of preference cards, to assure accuracy of supplies.

D. PACU

1. Track and trend telephone advice calls.
2. Improve effectiveness of discharge planning and teaching. Form a process improvement team for the evaluation and improvement of discharge planning and teaching. Main focus would be crutch instructions and microdisc teaching.
3. Perform chart audits of staff to be utilized with performance reviews.
4. Increase quality and consistency of message to patient's with the development of scripted statements regarding 02 saturations and prior to pain medication administration.
5. Achieve PALS certification for all PACU nurses.
6. Follow up of Versed FMEA; evaluate any reports of problems after Versed administration.

F. Recovery Care

1. Ensure that patient food is being served in accordance with state regulations by monitoring food temperatures. A quarterly report will be submitted. Improve quality and selection of patient food.
   - Assess timeliness of dinner order receipt to assure delivery at 6 pm.
2. Tracking of unscheduled admits to Recovery Care, monitor admission diagnosis for trends.
3. Track patients' questions by phone, post discharge to assess areas that we may be able to improve.
4. Evaluate 100% of patient satisfaction questionnaires. The same guidelines listed above will be followed. Maintain or improve our present level of satisfaction.

G. Business Office

1. Focus on obtaining accurate patient and responsible party accurate demographic information.
2. Coding audits—internal x 2, external x 1.
3. Transcription—broaden the capability of the dictation system, restructure filing of specific patient dictation to allow easier location and electronic communication.

H. Regulatory affairs

1. Re-evaluate completion of medical records within 30 days.
2. Re-evaluate timeliness of H&P completion. Assessment of adequacy and timeliness will be based on state and federal regulations.
3. Compliance with HIPAA Security Rule requirements by April 20, 2006.
4. Improve current process for obtaining and tracking physician privileging. Research core privileging for physicians.
5. Improve occurrence reporting.
   a. Research and employ on-line reporting with the development of the intra-net service. (This will be a joint venture with the IS department)

I. Information systems

1. Implementation of the Network Recovery System
2. Development and implementation of an intranet.

J. MRI

1. Evaluate 100% of patient satisfaction questionnaires. The same guidelines listed above will be followed.

K. Safety

1. Conduct a FMEA (Failure Mode and Effects Analysis) on medication administration
2. Develop a team to look at the process for delivering medications – from taking the orders, signing off orders, and administering the medication. Evaluate process for opportunities to reduce medication errors.
3. Develop a team to evaluate the current patient handoff process for problem areas and improvement opportunities.
4. Research and evaluate potential new safety sharps devices.

XII. CONTRACTED SERVICES

Maintain a continuous effort by all members of our facility to meet the needs and expectations of the customer, the staff and the regulatory agencies. In our commitment to continuous quality improvement we include our contracted services in our QI program. This will assist us in determining if providers of a service are practicing optimally and identify opportunities for improvement.

A. Dietary Department

1. Assess patient satisfaction survey (incorporated into RCC Patient Satisfaction Questionnaires
2. Spot check – food temperature (RCC food temperature record)

B. Laboratory

1. Obtain CLIA certificate from contracted Labs. Obtaining certificate will insure that contracted laboratories are in compliance with regulatory standards.
2. Patient Satisfaction Questionnaires (any questionnaires with specific lab related complaints / concerns will be referred to the laboratory director)

C. Avera McKennan Hospital Radiology

1. Report of re-takes provided annually to the QI committee for review; a comparison of nationwide statistics will be made.
2. Report of integrity of X-ray aprons annually.
3. Ongoing review of chart completion to include radiology reports and/or physician note of use of radiology.

D. Pharmacy

1. Ongoing monitor of drug outdates.
2. All medication errors will be reported to the P & T committee for review
3. Copies of all adverse drug reactions will be reported to the P & T committee for review.
4. Copies of all adverse drug reactions will be forwarded to the QI department for tracking and trending.

E. Anesthesia

1. Re-evaluation and continuation of a written post-anesthesia evaluation with-in 48 hours of surgery and prior to patient discharge. Improve the compliance of postop visits to RCC by anesthesia personnel.
2. Re-evaluation of noting of pre-op orders. By completing all necessary documentation of pre-op orders we can insure that our patients are receiving the highest level of quality care in the most efficient, safe, and accurate way possible.
3. Track and trend all post-operative complications. Data will be collected via incident reports and / or monthly physicians' patient outcomes survey.
4. Development and implementation of an Anesthesia Peer Review Program.

F. Physical Therapy

1. Assure physical therapy visits / treatments are appropriately documented.

G. Laundry

1. Assure that the appropriate water temp. of 160 F (71 C) is being utilized on all laundry. If chlorine bleach is added to the laundry process to provide 10 parts per million or more of free chlorine the minimum hot water temperature may be reduced to 140 F (60 C). Spot checks of laundry temp will be completed. An annual written report will be submitted.

The quality improvement plan will remain flexible as other problems – suggestions for QI activities arise.

____ Medical Director Signature _________ date.

____QI Director