Welcome to the Arizona Ambulatory Surgery Center Association (AASCA) which was founded in 2008 and serves as the voice of the Arizona ambulatory surgery center industry. Providing a strong, unified voice on issues affecting freestanding ambulatory surgery centers in Arizona is mission critical for board members. The AASCA also provides a vehicle for the communication and dissemination of information regarding the ambulatory surgery center community among its members. Joining the AASCA benefits all Ambulatory surgery Centers in Arizona. Your participation assists with monitoring of state and federal legislation and applying strategic influence towards issues that impact all members. Joining the AASCA benefits all Ambulatory surgery Centers in Arizona. Your participation assists with monitoring of state and federal legislation and applying strategic influence towards issues that impact all members. Providing access to educational opportunities at reasonable costs to the members influences many issues that affect the quality of care we all provide in our individual setting. Interacting and collaborating with the national ASC association on federal issues, including current and proposed CMS reimbursement issues gives us the ability to promote a “Patient First” attitude toward the legal and regulatory environment. It is in the mutual interest of physicians and ASCs to provide quality care efficiently and cost effectively. The AASCA acknowledges that physicians, administrators, nurses, and other stakeholders all need to work together to be successful in this economic environment. Join your colleagues in Arizona and let your voices be heard.

Barbara Marco, RN
AASCA President
Arizona is the birthplace of the surgery center industry. Ambulatory surgery centers are revolutionizing the way surgical care is delivered, saving the nation billions of dollars annually. Increasing efficiencies mean that physicians have more time to spend in their practices and patients have lower costs and infection rates.

Like an ASC, our Association is a low cost, efficient organization that focuses on producing results for its members. Facility membership is open to Medicare and State certified ASCs.

Brenda Mastopietro, MS, RN, CNOR
Membership Chair

Our Mission and Goals

**AASCA exists to:**

- Promote acceptable standards of care and outcome benchmarks of ASCs in AZ
- Promote staffing effectiveness and efficiencies through professional development and skills assessment
- Promote a cost-effective health care delivery system of ASC facilities
- Promote benefits of ASCs among the public and medical communities
- Exchange information
- Explore and promote new technologies and treatment modalities
- Assess existing state laws and regulations, which apply to ASCs and make appropriate recommendations to regulatory agencies
- Collaborate with other health care organizations towards achieving common goals and meeting the needs of the health care consumer
Membership Benefits

BENEFITS TO A FACILITY MEMBERSHIP IN AASCA

ADVOCACY – Government is playing a bigger role in the healthcare (over 50%) and we need to speak with one voice and pool our resources to meet, lobby, and make recommendations with one voice. Currently we are working with AHCCCS for a more equitable distribution of the healthcare dollar and we are working on the interpretations of State regulations that affect every ASC. The various competing interests have their own lobbyists, and we need every ASC to become a member to demonstrate the benefits of ASCs.

COMPLIANCE – Information and awareness of State regulatory developments and their implications through membership newsletters and communiqués. The well being of your ASC is dependent on being able to interpret the State regulations. The cost a misunderstood interpretation of a regulation can cost an ASC are many multiples of the low membership fee. This information can be found in Membership Only Resources.

NETWORKING – AASCA provides a low cost way to build a community and develop your knowledge and careers. The opportunity to network and share information can be extremely valuable and well worth the cost of membership.

EDUCATIONAL – Attend meetings at member rates and receive continuing education opportunities. Get up to date clinical and managerial information that affects physicians, nurses, and administration in the outpatient surgery setting.

ASSISTANCE IN RUNNING OR IMPROVING YOUR ASC – Access to vendors you may not have heard about, remain current on ASC news, receive a quarterly newsletter, post job openings, be current on issues that could seriously affect your ASC, receive advice on running your ASC better, participate in forums/blogs to share ideas, etc. Be on an email list for any alerts, discounts, or updates.

MARKETING – Link your website to the Associations which provide a unified promotion of ASC benefits to the public and policy makers.

JOIN NOW FOR ONLY $300!

Submit your membership form on our website at www.arizonaasc.org or email to Evelyn Bloomhart at evelyn@arizonaasc.org
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Spring Legislative Update

I am one of the new “kids” on the AASCA Board and am excited to share regular updates with you regarding State and Federal legislative issues that impact our healthcare industry. I am the Administrator of St. Joseph’s Outpatient Surgery Center and Recovery Care Center and am best contacted via email at PAlice@USPI.com or my direct office line 602.406.4652. Please feel free to communicate with me regarding your questions and concerns. I may not have all the answers, but have many resources to get us to the conclusion we are looking for!

Patti Alice, RN
Legislative Chair

To summarize our recent ASCA Publication:

Due to a delay by CMS in updating the surveyor interpretive guidelines, there has been some confusion during surveys regarding notification of ASC patients of their rights, advance directives, and physician investors. In Dec 2011 it was determined that ASCs could provide these important items to their patients on the day of surgery. The surveyor’s guidelines had not been updated to reflect the change which caused some centers to be incorrectly cited for non-compliance. A memo is available at the website for use in the event this unfortunate circumstance occurs at your center.

Two new committees have been formed at the ASCA:

State Affairs Committee to foster better communication and coordination between the ASCA and state associations.

Government Affairs Committee will oversee the Office of the Government Affairs Department.

State Legislation:

Electronic Medical Records statute change to include prescriptions for controlled substances in schedules II, III, IV, and V to be electronically transmitted. Also, Health Care Directives access change to allow entities with a Business Associate Agreement to access the registry. Passed House and held by Senate.

Unemployment Insurance change to current statute which requires an employer to issue a final check to a terminated employee within three days, requirement now is check issuance by the end of the next regular pay period. Passed House and Senate.

Certified Registered Nurse Anesthetists repeals existing statutes relating to administration of anesthetics. Allows the Board of Nursing to certify an RN as a CRNA and allows a CRNA to administer anesthetics under the direction of and in the presence of a physician or surgeon in certain specified settings.

Federal legislation:

House Bill 3630 to extend payroll tax relief, unemployment benefits, and the Medicare Physician Fee schedule through the end of 2012 passed the House and Senate. The component of House Bill 3630 that provided for specialty hospitals under construction to restructure their ownership to include physicians and to allow existing hospitals to expand to meet community needs did not pass the Committee.

HOW DO I FIND INFORMATION ABOUT THE STATE AND GOVERNOR?

ARIZONA’S OFFICIAL STATE WEBSITE IS HTTP://AZ.GOV/
REMANDER

Have you reviewed and revised your internal plans lately? Remember, facilities are required to review and revise their Emergency Management Plan, Infection Control Plan, Quality Plan, and Risk Management Plan at least annually.

AHCCCS Fee Schedule Update

Upholding reimbursement to a reasonable level has been the focus of both the 2011 and 2012 AASCA board of directors. As most of you know Medicaid rates were adjusted again February 1st, 2012. Although the AASCA did not endorse or agree with the new methodology to include the implant with the procedural code, we felt that if we were able to provide data and be included in the process we could at least work with this model to be certain our costs were covered. This has not been the case. Therefore at the beginning of March the Board regrouped and sent another letter to Mr. Thomas Betlach, Director of AHCCCS. After reviewing the topic with our membership, more feedback was provided, and we reached out to Mr. Betlach again to share our concerns that we have identified with the ASC Fee Schedule dated Feb 1, 2012. See the letter on the next page.

FOR YOUR INFORMATION

CMS regulations state that every facility must designate, in writing, a qualified licensed healthcare professional to lead the Infection Control Program. This individual must have training and established competency in Infection Control practices and methodologies, and is required to have documented ongoing training regarding Infection Control practices, standards, and concepts.

RATES AND CODES RESOURCES

Ambulatory Surgical Center (ASC) FFS Rates & Codes can be found at:


RESOURCES
February 15, 2012

Mr. Thomas Betlach, Director of AHCCCS
801 E. Jefferson Street
Phoenix, AZ 85034

Dear Mr. Betlach:

On behalf of the membership of the AASCA (Arizona Ambulatory Surgery Center Association) we wish to thank you and your department for your efforts related to the most recent iteration of the ASC Fee Schedule effective February 1, 2012. We appreciate the many challenges faced by the AHCCCS program. As we have attested to on multiple occasions, we feel that AHCCCS has yet to fully realize the benefits of the ASC industry, not only from a quality perspective but also the cost savings opportunity.

In working with Mr. Schwarz we have made some strides in addressing the shortcomings of the fee schedule dated October 1, 2011. Although the AASCA did not endorse or agree with the new methodology to include the implant with the procedural code, we felt that if we were able to provide data and be included in the process we could at least work with this model to be certain our costs were covered.

Our membership has provided feedback, we are reaching out to you to share our concerns that we have identified with the ASC Fee Schedule dated Feb 1, 2012.

Procedural Codes (CPT) With Missing Implant Provisions. As you are aware, we have spoken to you at great lengths about implants. These are hard costs that are used for items that are implanted in the patient for a surgical repair; for instance a plate and screw used to repair a fracture.

In review of the fee schedule we have identified codes that typically require the use of implants and no payment was allotted for the implant within the CPT code. We provided Mr. Schwarz with a list of codes that include implants; however the new fee schedule did not include all the CPT codes that we identified as having implants.

Reimbursement Below Costs. We have identified multiple CPT codes in which the reimbursement does not cover our costs. This applies not only to CPT codes that have implants but also specific specialties primarily GI endoscopy.

All Providers 5% reduction. According to Laws 2011, Chapter 31 AHCCCS was given the authority to reduce rates for all providers up to 5%. This went into effect October 1, 2011.

The Association wishes to raise some concerns regarding the data and process in which the ASC Industry was subjected to the 5% reduction. Until October 1st ASC’s were provided separate reimbursement for implants, in addition to the CPT code. We speculate that the data used to arrive at the 5% reduction included paid data, which included implant reimbursement. When the October 1st fee schedule was made public, we identified that the implant reimbursement was no longer reimbursable in the fee schedule, coupled with a 5% CPT code reduction. These 2 reductions, the removal of the implant reimbursement and the 5% CPT reduction, resulted in a far greater reduction than the 5% that was authorized. As a result of these 2 reductions, the revenue the ASC’s once received is now retained by the AHCCCS plans. Essentially, the AHCCCS plans received additional revenue, which we feel was not the intended effect.

ASC vs. HOPD Rates. The difference in reimbursement for the same procure done in an ASC vs. Hospital Outpatient Department (“HOPD”) is estimated to be between 30-40%. This difference is based on reimbursement at 100% of Medicare. The current AHCCCS ASC fee schedule is approximately 85% of the ASC Medicare rate, further widening the gap between the ASC vs. HOPD rates. We understand that AHCCCS has implemented measures to advise the insurance plans to utilize ASC to realize this cost savings. However, we are unaware of any ASC noting an increase in the AHCCCS cases as a result of their initiatives. As tax payers, it’s difficult to understand why a governmental agency is willing to pay 30-40% more for the same service. We feel that the efforts thus far have failed to capitalize on this savings. We strongly support this initiative and want to participate to whatever extent possible, with consideration that the above issues are appropriately addressed. We certainly do not want to sign up to do more cases at a loss.

We sincerely wish to continue to provide services to those that are in need. The new fee schedule certainly includes many procedures that cover costs; however we want to level the playing field and only feel it is only reasonable to cover costs for all procedures.

Our association would like to extend an invitation to you to speak to our membership in hopes of hearing from you directly regarding the challenges facing AHCCCS to allow our membership to understand how we can work together to achieve a win-win outcome. The meeting is scheduled for June 29th in Sedona.

Respectfully,

Barbara Marco
AASCA President

c: The Honorable Janice K. Brewer, Arizona Governor
   Representative John Kavanagh, District 8
   William Prentice, ASCA Executive Director
   Herb K. Schultz, US Department of HHS, Office of IES, Regional IX Director
Join Us At Our Annual Conference in Sedona!

Thursday, June 28th to Saturday, June 30th

Sedona, Arizona

Our Annual Conference is Right Around the Corner

It’s that time again… The Arizona ASC Association’s Annual Conference will be held in the enchanting town of Sedona. Sedona is known for its captivating views and its majestic vibes. We invite you to take this opportunity to spend time enjoying the scenery while learning what’s new in the ASC world. This year’s conference will be introducing educational opportunities for your entire staff; offering a Saturday morning session event catered to your facility’s Infection Control Program. Not only are we offering up the same great educational opportunities that we have in the past, but this year we encourage you to invite your Infection Preventionists, Infection Control Coordinators, Central Processing Department staff members, Nurses, Scrub Techs, Environmental Services staff members, and any other staff members that participate in your facility’s Infection Control Program to our Saturday session.

We will be presenting information on a variety of topics that will help your Infection Control plans and activities be more compliant and able to withstand your next accreditation survey.

In addition to the first-rate educational sessions, the conference will be offering fun filled networking events, door prizes, Vendor sponsored prize drawings, and much, much more. Please join us in our continued efforts to promote the ASC industry, while enjoying the beautiful surroundings, and charming feel of Sedona. We look forward to seeing you there!

Tracy Kruse, RN, CASC
Conference Chair

Learning is like rowing upstream, not to advance is to fall back.
Chinese Proverb
SEDONA. THE LOCATION IS SIMPLY MAGICAL AND HAS BEEN CALLED "THE MOST BEAUTIFUL PLACE IN AMERICA"

The Hilton Sedona Resort is located just 90 minutes north of Phoenix, Arizona and the Grand Canyon is a scenic 2.5 hours drive away.

219 beautifully appointed guest rooms and guest suits, featuring Wireless Internet Access, Hilton Serenity Collection Bed, Crabtree & Evelyn Bath amenities, cozy Gas Fireplaces, Flat Panel LCD TV's, and Private Balcony or Private Patio.

Golfers of all skill levels will enjoy our Onsite 18-Hole Championship Golf Course set among the beautiful Red Rocks of Sedona. Sports enthusiasts will enjoy the Award-Winning Clubhouse, a challenging game of Tennis or our full service Fitness Center.

Come relax and rejuvenate your mind and body with one of our many Spa Treatments and Salon Services at The Spa at Hilton Sedona.

Just minutes away from Shopping, Dining and over 40 Art Galleries. Enjoy Sedona’s gorgeous scenery up close with over 200 miles of Hiking and Mountain Biking Trails, Horseback Riding or take an exciting Jeep Tour.

Experience Northern Arizona’s Wine Country with a Wine Tour of Award-Winning Verde Valley Wine Producers.

Hotel guests will receive complimentary access passes to the beautiful Hilton Sedona Spa.
There are 300 patients seen in ambulatory settings for every one person admitted to a hospital, according to CMS. That is about to change sometime in fiscal year 2012.

A value-based purchasing program for ASCs, similar to those outlined for inpatient and outpatient hospital care, is on the way, the agency said. "CMS intends to propose in CY 2012 rulemaking implementing an ASC quality measure reporting program under section 109(b) of the Medicare Improvements and Extension Act of 2006," it said.

New VBP rules for ASCs based on performance, however, require several steps. Among these, the HHS Secretary needs statutory authority from Congress to establish a VBP program and allow for performance-based payments. At present, the law "permits the Secretary to implement a quality reporting system for ASCs in a manner so as to provide for a reduction in any annual update for failure to report on quality measures. However, the authority limits the Secretary to reducing the annual update for failure to report -- not based on performance."

Among some of the specifics, it may reduce annual payment updates "for failure (of an ASC) to report on quality measures" and structure payments based on the centers' rates of the following types of events:

1. A patient burn.
2. A patient fall.
3. Wrong site, wrong side, wrong patient, wrong procedure or wrong implant.
4. Appropriate timing of intravenous prophylactic antibiotic.
5. Appropriate hospital transfer and/or admission.
6. Appropriate surgical site hair removal.
7. Surgical site infection.
8. Medication administration variance.
9. Medication reconciliation; and

In its report, which HHS was required to prepare according to the Patient Protection and Affordable Care Act, CMS highlighted the importance of reducing these errors in light of the fact that these ambulatory care facilities are the fastest growing type of hospital reimbursed by Medicare.

Second, new quality measures are needed to expand the set now available.

Ambulatory quality is going to be a tough process to measure, to be sure, because it means monitoring outcomes from much less invasive procedures over the long haul. But the drive to keep outpatients out of the hospital, in much lower acuity settings, must also police itself better, to make sure errors in care don't become mishaps that force these patients back in.

**HELPFUL HINT**

Using your Microsoft Outlook Calendar feature to set reminders can be very useful to your day to day operations. You can set your computer calendar to remind you of your required quarterly Fire/Evacuation Drill, your annual Cardiac/Respiratory Arrest Drill, and your annual Malignant Hyperthermia Drill, as well as any other recurrent tasks.
ASCA Offers Special Introductory Rate to New Members

Individual ASCs that have never been members of the national Ambulatory Surgery Center Association (ASCA), and those that have not been members since 2008 or before, are invited to become members at ASCA’s new $500 introductory membership rate.

To take advantage of this offer, go to www.ascassociation.org/ASCA/Membership/MemberTypesBenefits/FacilityMembership. There, you can see a list of the benefits ASCA members receive and download the membership application you need to apply.

Want more help or information? Call 703.836.8808 or contact Mykal Cox at mcox@ascassociation.org.

Understanding the 2012 Measures is reprinted with the permission of the Ambulatory Surgery Center Association.
Quality Reporting

The Centers for Medicare & Medicaid Services (CMS) recently announced that it would begin implementing an ASC quality reporting program on October 1, 2012—nine months later than the January 1 date proposed originally.

MEDICARE’S NEW QUALITY REPORTING PROGRAM FOR ASCs

The Centers for Medicare & Medicaid Services (CMS) recently announced that it would begin implementing an ASC quality reporting program on October 1, 2012—nine months later than the January 1 date proposed originally. ASCA had requested such a delay to allow ASCs to receive details about and prepare to participate in the new program.

Despite this welcome modification, ASC operators will have a fair amount of work to do to ensure that their facilities are complying with the new reporting requirements.

How to Report the New Quality Measures

2012 Measures

Beginning on October 1, 2012, ASCs will be required to report data on the following five quality measures:
1. Patient Burn
2. Patient Fall
3. Wrong Site, Side, Patient, Procedure, Implant
4. Hospital Admission/Transfer
5. Prophylactic IV Antibiotic Timing

Each of these measures was developed by the ASC Quality Collaboration, a group composed of members of the ASC community that focuses on improving quality. The five measures are also endorsed by the National Quality Forum, a national consensus-based standard-setting organization that works to improve the quality of American health care by supporting the development and implementation of a national strategy for health care quality measurement and reporting. CMS decided not to finalize two measures it had proposed—surgical site hair removal and surgical site infection—which, as ASCA pointed out, would have been difficult for ASCs to report.

ASCs will report the five measures identified above beginning in 2012 by including quality data codes (QDC) on the CMS-1500 health insurance claim forms that ASCs already submit to CMS. On each claim form, ASCs will need to include a code that will indicate whether the Medicare patient experienced an event that one of the five measures assesses. For example, if a Medicare patient did not sustain a fall while at the ASC to undergo cataract surgery, the ASC would include the code corresponding to “no fall” on the reimbursement claim it sends to CMS for that patient’s cataract procedure.

CMS is expected to release the list of QDCs in April 2012. It is important to note that these initial five measures apply only to Medicare patients that an ASC sees during 2012. ASCs will not have to include QDCs on other payers’ claim forms.

2013 Measures

2013 will usher in the addition of two more measures: Safe Surgery Checklist Use in 2012 and the 2012 Volume of Certain Procedures. The reporting mechanism for these two procedures will differ from the mechanism used to report the initial five measures. ASCs will report both of these measures through CMS’s QualityNet web site (qualitynet.org) rather than on the Medicare claim forms. This site has not yet been updated to allow ASCs to register to submit data.

In 2013, ASCs will be required to go to the CMS QualityNet web site between July 1 and August 15 and report whether they used a safe surgery checklist for all patients in 2012, not just those covered by Medicare. Because CMS is not dictating that ASCs use a particular checklist, ASCs are free to select a checklist that meets their individual needs as long as it meets CMS’s broad...
## CMS’s Current Quality Measure Implementation Plan

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reporting Period</th>
<th>Payments Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Burn</td>
<td>Begins October 1, 2012</td>
<td>2014</td>
</tr>
<tr>
<td>2. Patient Fall</td>
<td>Begins October 1, 2012</td>
<td>2014</td>
</tr>
<tr>
<td>4. Hospital Admission/Transfer</td>
<td>Begins October 1, 2012</td>
<td>2014</td>
</tr>
<tr>
<td>6. Safe Surgery Check List Use in 2012</td>
<td>July 1 thru August 15, 2013 (measures use 1/1/12–12/31/12)</td>
<td>2015</td>
</tr>
<tr>
<td>7. 2012 Volume of Certain Procedures</td>
<td>July 1 thru August 15, 2013 (measures use 1/1/12–12/31/12)</td>
<td>2015</td>
</tr>
<tr>
<td>8. Influenza Vaccination Coverage Among Health Care Workers</td>
<td>October 1, 2014 thru March 31, 2015</td>
<td>2016</td>
</tr>
</tbody>
</table>

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### Medicare Payment Analysis Proposed 2012 Rates

**How is your ASC likely to be affected by the changes in Medicare’s ASC payment rates proposed to take effect in 2012?**

This file, now available free online, will tell you.

**Also includes**
- Comparison of 2012 proposed ASC Payments to
  - Current Payments
  - Proposed 2012 HOPD Payments
- CPT Code-Specific Data
- Specialty Data

To get a copy of the report, go to ascassociation.org/medicare2012 or call 703.836.8808.

---

**2014 Measures**

In 2014, one additional measure, Influenza Vaccination Coverage Among Health Care Workers, is slated to be added to the list of quality measures CMS will expect ASCs to report. This goals (see these goals in the box titled “2013 and 2014 Measures” on page 43). Several organizations, including the World Health Organization and the Association of periOperative Registered Nurses (AORN), have developed boiler plate checklists that can be adjusted to suit the needs of a particular ASC. To see several of these sample checklists, go to ascassociation.org/ascqualityreporting.

It is also important to note that, although CMS uses the name safe “surgery” checklist, the measure applies to all ASC procedures, including those that are generally considered to be diagnostic and pain management procedures (e.g., certain endoscopies and injections for controlling pain).

ASCs will also be required to go to the QualityNet web site between July 1 and August 15, 2013, to report the 2012 volume of procedures that relate to several specific CPT codes. A list of these codes can be found in the box at the bottom of page 43. The patient volume ASCs will be expected to report will be the ASC’s total patient volume, including both Medicare and non-Medicare patients. Note that ASCs will be required to report 2012 volume in 2013. This means that ASCs must have a system in place on January 1, 2012, that will enable them to record their procedure volume for the CPT codes CMS has specified so that, in 2013, they can report that information.
Top 10 Deficiencies

The AASCA reached out to the AZDHS to provide our membership a list of the Top Ten State and Federal Deficiencies.

In an effort to provide our membership with a better understanding of the specific types of State deficiencies, I reviewed most of the 2011 survey findings and included them for reference. The actual centers are not named.

Elizabeth Hakal, RN

<table>
<thead>
<tr>
<th>Rule</th>
<th>Statue</th>
<th>Specific Types of Survey Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>R9-10-1707.B.</td>
<td>Admission</td>
<td>Within 30 days prior to admission, a medical staff member shall complete a medical history and physical examination of the patient. The individual responsible for performing the operative procedure shall document the pre-operative diagnosis and the procedure to be performed.</td>
</tr>
<tr>
<td>R9-10-1706.A.</td>
<td>Nursing Services</td>
<td>Developing and implementing written nursing and patient care policies and procedures, including medications administration, storage, and disposal;</td>
</tr>
<tr>
<td>R9-10-1704.D.</td>
<td>Personnel</td>
<td>Employees who provide direct patient care shall:</td>
</tr>
<tr>
<td>R9-10-1711.A.</td>
<td>Environmental Standards</td>
<td>Administrators shall ensure that written infection control policies and procedures are established and implemented for the surveillance, control, and prevention of infection which shall include the following:</td>
</tr>
<tr>
<td>R9-10-1711.A.</td>
<td>Storage, maintenance, and distribution of sterile supplies and equipment; and</td>
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</tbody>
</table>
### Top 10 Deficiencies continued

<table>
<thead>
<tr>
<th>Rule</th>
<th>Rule</th>
<th>Statue</th>
<th>Specific Types of Survey Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>R9-10-1711.B.</td>
<td>Environmental Standards</td>
<td>The administrator shall ensure that housekeeping and maintenance services are</td>
<td></td>
</tr>
<tr>
<td>R9-10-1711.A.1</td>
<td>Environmental Standards</td>
<td>The administrator shall ensure that written infection control policies and sterilization methods;</td>
<td></td>
</tr>
<tr>
<td>R9-10-1711.C.2</td>
<td>Environmental Standards</td>
<td>The administrator shall ensure that equipment is operational, inspected and maintained in accordance with the facility's policies and procedures which shall include the following: 2 Maintaining records documenting service and calibration information;</td>
<td></td>
</tr>
<tr>
<td>R9-10-1702.A.3</td>
<td>Administration</td>
<td>The governing authority shall consist of 1 or more persons responsible for the organization and administration of the outpatient surgical center. The governing authority shall:</td>
<td>Grant or deny clinical privileges of physicians and other members of the medical staff and delineate, in writing, the clinical privileges of each medical staff member; and</td>
</tr>
<tr>
<td>R9-10-1702.B.c.vi</td>
<td>Administration</td>
<td>The governing authority shall appoint an administrator who shall have authority and responsibility to manage the facility. The administrator shall:</td>
<td>Develop and implement written administrative policies and procedures governing:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Infection control, housekeeping, and maintenance;</td>
</tr>
<tr>
<td>R9-10-1708.C.</td>
<td>Quality Manage- ment</td>
<td>The administrator shall maintain a record of quality management activities and ensure that any conclusions and recommendations on findings of quality management activities are reported to the governing authority.</td>
<td></td>
</tr>
</tbody>
</table>

**LEARNING CORNER**

Did you know that it is required that facilities provide at least 6 hours of continuing education each year to their employees; which does not include initial hire orientation or CPR training?
Our Association relies on the support of our business partners to put on our annual conferences. We thank them for their willingness to partner with us!

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