What Joint Commission’s alert on infections means for ORs

Are hospital-acquired infections a sentinel event? The Joint Commission says they are if the infection is linked to a patient death or major impairment. The commission issued a sentinel event alert in January saying it wants such incidents to be reported so it can build a database and monitor trends.

JCAHO says it is asking for the information because only 10 infection-related incidents have been reported since its sentinel event program started in 1996, too few to allow for any conclusions or recommendations.

Some think JCAHO is feeling pressure because of criticism in the media that it hasn’t been doing its job. A blistering article by the Chicago Tribune last fall charged, among other things, that JCAHO continues to give high accreditation scores to hospitals that have serious problems, including higher infection rates. JCAHO responded that it has been an advocate for quality and continues to upgrade its survey process.

Sentinel event alerts don’t affect accreditation. But JCAHO surveyors will want to know whether your facility is aware of the alert and its recommendations. If an infection meets the definition of a sentinel event, the Joint Commission standards require a root cause analysis to be conducted.

The sentinel event alert raised ques-

Continued on page 7

Patient safety

Top 100 Hospitals

What’s working at the top-performing hospitals

Even in tough times, some hospitals find a way to treat more and sicker patients, achieve good outcomes, maintain a higher nurse-to-patient ratio, and still keep a positive bottom line.

In response to our readers’ request for what’s working, OR Manager is interviewing surgical services leaders at some of the Top 100 Hospitals that have been identified as top performers three or more times. In a new series, we ask the leaders to describe a successful project in one of three areas:

• recruitment and retention of OR staff
• cost management
• quality improvement.

The article on p 10 features 98-bed Wellstar Douglas Hospital in Georgia. Read more about the Top 100 Hospital study on p 9.
Rebirth of a surgical icon.
The all digital Bovie.

Introducing the Bovie IDS-300

• FDFS™ (Fast Digital Feedback System) Monitors in real time the tissue impedance at the active electrode and adjusts the output to maintain set power.
• 300 Watts Cutting Power
• 2 Cut Modes
• 10 Levels of Blend
• 10 User Definable Presets
• Digital Error Detection (DED™)
• Discreet Outputs (FCFS™)
• Pad Sensing (BovieNEM™)

Bovie
MEDICAL

7100 30th Ave. N. • St. Petersburg, FL 33710-2002
U.S. Phone 1-800-537-2790 • Fax 1-800-323-1640
Intl. Phone +1-27-384-2323 • Fax +1-27-384-9144
www.boviemedical.com • info@boviemedical.com
Creating a just culture

What’s your role in creating a culture where employees who make errors are willing to come forward so all can learn?

New energy modalities

New devices using RF energy, ultrasound, cryotherapy, and other wave forms are arriving in the OR. What you need to know to manage the new technology.

Physician buy-in

Advice from a national study on getting physicians involved in your cost reduction projects.

Reinforce that preventing infection is ‘Job One.’

Hospital-acquired infections are a patient safety issue. The Joint Commission on Accreditation of Healthcare Organization underlined that fact in January when it issued a sentinel event alert asking organizations to report nosocomial infections linked to a patient’s death or major impairment.

You can read about the alert and reaction to it in this issue.

How will an organization decide if an infection meets the definition? Will it decide to report? What will we learn from those reports?

You may hear your infection control professionals debating these issues.

At first, we were surprised by the alert. We usually think of patient safety in connection with errors like wrong-site surgery or an incorrect medication dose.

But as we talked to infection control experts, we found that, though they have questions about when an infection should be reported, they agree that serious infections are a patient safety issue.

“Absolutely they are,” says Barbara Soule, president of the Association for Professionals in Infection Control and Epidemiology (APIC). “We’ve always seen infection as a patient safety risk.”

Questioning conventional wisdom

The patient safety movement is bringing safety advocates and infection control experts together to learn what each can contribute to improving care.

Traditionally, the focus has been on keeping a hospital’s infection rates at or below norms of the Centers for Disease Control and Prevention’s (CDC) National Nosocomial Infections Surveillance (NNIS) system.

If a hospital’s rates meet those benchmarks, individual infections might not be subject to an in-depth analysis. It has been accepted that some serious infections are inevitable because many patients are at high risk. They have underlying conditions such as older age, chronic diseases, and cancer. They are subjected to all kinds of invasive treatments that can be routes for microorganisms.

The focus is on keeping infections that cause “substantial harm” or are linked to a patient death.


What’s the OR’s role in this?

Some suggestions for OR directors are on page 8.

The main one—reinforce with your staff and physicians that infection prevention is “Job One.”

Stay in touch with your infection control professionals. Attend meetings of the infection control committee, or send a representative. Find out what strategies your organization is planning for improving patient safety by preventing infections.

—Pat Patterson

OR Manager salary/career survey

Look for our annual salary/career survey, which will be sent to a sample of our subscribers in May. The survey, now in its 13th year, tracks trends in staffing, skill mix, salaries, benefits, span of control, and other issues focused on OR management.
The Surgical Table Choice
That’s Always Right for You!

Skytron’s 6600 Series Surgical Table sets NEW BOUNDARIES for Full Body Imaging Flexibility, Weight Capacity and Surgeon Access, including optional fully CARBON FIBER, REMOVABLE BACK and LEG SECTIONS. Not to mention EXCLUSIVE 210° Top Rotation.

You’re gonna love what this table can do for you!

3500 Series
21” Top Slide, Specialty/General Purpose
500 lb. Capacity
Optional Voice/Touchscreen Activation

6002 Series
Top Rotation, General Purpose
600 lb. Capacity
Optional Voice/Touchscreen Activation

6500HD Series
Top Rotation, Bariatric/General Purpose
1,000 lb. Lift, 850 lb. Articulation
Optional Voice/Touchscreen Activation

3000 Series
Specialty Imaging, optional 4-Way Top Slide
500 lb. Capacity
Vascular, Cardiology, Urology, Pain Mgt.

3500 Series 21” Top Slide, Specialty/General Purpose 500 lb. Capacity Optional Voice/Touchscreen Activation

6002 Series Top Rotation, General Purpose 600 lb. Capacity Optional Voice/Touchscreen Activation

6500HD Series Top Rotation, Bariatric/General Purpose 1,000 lb. Lift, 850 lb. Articulation Optional Voice/Touchscreen Activation


Skytron 5000 36th St. S.E.
Grand Rapids, MI 49512
1-800-SKYTRON (759-8766)
E-mail: sales@skytron.us

Focusing on Quality Since 1972

Removable Carbon Fiber Back Section

6600 Series Features:
- 1,000 lb. Lift 600 lb. Articulation Capacity
- Advanced Full Body Imaging Coverage
- Optional Fully Carbon Fiber, Removable Back and Leg Sections
- User-Friendly One Touch, Back-Lit Pendant Control

Exclusive 210° Top Rotation
Implant prices see largest jump since 1992

Prices for hip and knee implants continue to climb. Strategies like standardizing implant vendors and capping prices haven’t made much of a dent.

List prices for hip and knee implants rose 9.5% between 2002 and 2003—the largest jump since 1992 when it began collecting data, Orthopedic Network News (ONN) reported in January.

Since 1991, the cumulative cost increase for implants has been 115%. Hospital Medicare payments for hip and knee replacement rose only 14% for the same period.

Most dramatic of all, physician payments for joint replacements have fallen 40%, to the point where the sales commission for an implant by about $450, notes ONN’s editor and publisher, Stan Mendenhall. That refers to the 20% that goes to the sales organization, not necessarily to the individual rep, he added.

Mendenhall is speaking on managing an orthopedic implant program at the OR Business Management Conference June 4 to 6 in Washington, DC, sponsored by OR Manager, Inc.

Medicare pays for about two thirds of total hip and knee procedures.

Mendenhall blames Wall Street for the continuing price pressure. As publicly traded companies, orthopedic implant vendors demonstrate their worth to investors through their share price. Their ability to attract investors is based on whether they meet targets for share earnings.

Mendenhall is particularly critical of Wall Street analysts who set targets for share earnings and trumpet the news of any company that misses the target, even by as little as a penny a share. Then the stock price takes a beating.

To meet analysts’ projections, companies must increase revenue or decrease expenses. Increasing revenues means raising prices, encouraging use of more expensive products, and trying to expand the number of procedures performed.

The intense focus on share price is a major driver of rising costs, he believes.

Joint strategies have mixed results

In a survey of 61 hospitals, Mendenhall found 58% paid more for hip and knee implants in 2002 than in 2001.

Efforts to standardize implant vendors and set ceiling prices have not made much of a difference in costs, the report found. Nor does orthopedic surgical volume make much of a difference.

The largest orthopedic programs (over 1,000 joint cases a year) paid an average of $4,390 for a hip implant, not much different than the $4,110 average paid by the smallest programs (less than 250 procedures). The most favorable pricing ($3,990) was at hospitals performing 500 to 1,000 procedures. For knee implants, large programs paid a little less on average than small ones, with hospitals with 251 to 500 cases achieving the best pricing.

Standardizing vendors has had mixed results. Though hospitals that standardized to a single vendor had the lowest overall average costs per case for knee implants, that wasn’t true for hips. For hips, hospitals using three vendors had almost the same implant cost per case as those using a single supplier. On the other hand, 2001-2002 prices did not increase as much for those using fewer vendors.

These findings are borne out by the Yankee Alliance, a group of 34 hospitals in the Northeast that participated in the

Continued on page 6
“For our organization, size, volume, or standardization doesn’t seem to matter,” comments Val Giordano, RN, the alliance’s vice president for perioperative services. Comparing data for alliance hospitals, which range from 40 to 600 beds, she found that contrary to popular belief, the biggest don’t get the best discounts. She also found implant prices for five members that had standardized to one vendor didn’t differ much from those that hadn’t limited vendors.

Capitated pricing also seems to have fizzled.

Only a few hospitals (8%) in the ONN survey used ceiling pricing, which caps what the hospital will pay for certain types of prostheses. She also found implant prices for five members that had standardized to one vendor didn’t differ much from those that hadn’t limited vendors.

Capitated pricing also seems to have fizzled.

Only a few hospitals (8%) in the ONN survey used ceiling pricing, which caps what the hospital will pay for certain types of prostheses. The problem, Mendenhall says, is that manufacturers negotiate “carve-outs,” or exceptions, to the ceiling prices. Physicians often aren’t committed to enforcing the ceilings with vendors, and the burden of administering the program tends to be greater than the value gained.

Two Yankee Alliance members that adopted capitated pricing found similar pitfalls.

“When you write a capitated contract, you want to include all of the technology, but they didn’t do it for all of the categories,” Giordano notes. “If a sales rep comes in with a Generation Z implant, the physician is not going to say, ‘That’s not in the capitated agreement.’”

That’s not to say ceiling pricing can’t work.

A third Yankee Alliance hospital that adopted ceiling prices brought its average implant cost down from $5,100 to $3,600 over 18 months. “It took a lot of fortitude and was led by the OR director, the materials management director, the financial officer, and the chief medical director,” Giordano says. “This one was successful because they had physician support and set stringent criteria.”

Rather than ceiling prices, Mendenhall thinks “ceiling targets” are a more useful approach. The targets are price standards a hospital sets internally and monitors on an ongoing basis.

“This eliminates the need to set arbitrary standards that are often subverted by the hospital’s business partners,” Mendenhall says. For targets to be successful, the hospital must have a good process for monitoring costs.

Overall, the prices hospitals are able to get for implants depend on their individual ability to negotiate prices, the mix of technology they use, and the backing they get from their physicians.

Prices are going to continue to climb, Mendenhall says, “until we get the vendors to talk to Wall Street and say implant prices can’t grow to the sky. “And it’s even worse for spine.”

More information about Orthopedic Network News is at orthopedicnetworknews.com

For information on the OR Business Management Conference, call 800/442-9918 or visit www.ormanager.com

---

**Orthopedic implant price increases 1991-2003**

<table>
<thead>
<tr>
<th>Year</th>
<th>Implant price change</th>
<th>Hospital payment change</th>
<th>Physician payment change</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-92</td>
<td>+115%</td>
<td>+14%</td>
<td>-40.3%</td>
</tr>
<tr>
<td>92-93</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>93-94</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>94-95</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95-96</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96-97</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>97-98</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>98-99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99-00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00-01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01-02</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02-03</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A patient safety approach will require a change in attitude.

In analyzing this case, the team could look at several areas, she suggests:
- Was aseptic technique used in inserting the urinary catheter?
- What was the staffing level? Lower staffing ratios have been associated with urinary tract infections.
- Might the patient have been a candidate for an anti-infective-coated catheter, such as one with a silver alloy? Research suggests such catheters, though about $5 more than a regular catheter, can be cost-effective in high-risk patients.

Another expert, John Burke, MD, from LDS Hospital in Salt Lake City, points out in the New England Journal of Medicine that there are accepted infection prevention measures clinicians can take, even in compromised patients. Leading the list—complying with hand hygiene guidelines.

Among others:
- avoiding use of invasive devices when there are alternatives, for example, condom catheters
- shortening the time invasive treatments such as mechanical ventilation are used, if appropriate.

Root cause analysis a good tool

Patrice Spath, BA, RHIT, who writes and lectures nationally on patient safety, thinks root cause analysis can be a useful tool for probing for causes of infection. She notes that infection control professionals, with their training in epidemiology, have skills that lend themselves to improving safety.

“Getting to the root cause is something they learn in their training,” she says.

But taking a patient safety approach will also require a change in attitude by everyone, she says, including physicians, administrators, managers, and clinical staff.

If a patient dies from a nosocomial infection, the organization will have to admit the patient care experience was flawed in some way,” Spath observes.

Most common complication

APIC strongly agrees that nosocomial infections are a patient safety issue, says Soule.

Infections are the most common complication in hospital patients.

An estimated 2 million patients acquire an infection in US hospitals each year, and 88,000 die as a result. Nosocomial infections add $4.5 billion to health care costs a year, the CDC estimates.

In fact, surgical site infection was the second largest category of adverse events in the well-known Harvard study published in 1991. That study is one source for the Institute of Medicine’s estimate that 44,000 to 98,000 patients die in hospitals each year from medical errors.

Still, taking a patient safety approach to infections isn’t easy.

Root causes are hard to trace because of the interplay between the patient’s underlying health and the complex treatment hospitals give. Many patients come to the hospital with multiple underlying risk factors: advanced age, cancer, chronic diseases, and obesity, among others. They are subjected to a host of invasive procedures, from drawing blood to surgery. Aren’t some infections to be expected given the risks?

A quality improvement approach to infections

Some experts say we need to rethink the idea that a certain number of infections are inevitable.

Facilities shouldn’t be satisfied if their infection rates fall within ranges identified by the CDC’s National Nosocomial Infections Surveillance (NNIS) system, suggests CDC Director Julie Gerberding, MD, MPH, in the Annals of Internal Medicine. NNIS is the nation’s major system for tracking infections acquired in health care.

She advocates taking a quality improvement approach, much like that taken for medication errors. She suggests infection-control teams consider doing a root cause analysis if they suspect an infection was preventable, even if the patient’s condition is complex.

She describes the example of a 78-year-old man with lung cancer and chronic obstructive pulmonary disease who died of pneumonia after developing several infections during a 14-day hospital stay that included palliative brain surgery for metastasis.

In analyzing this case, the team could look at several areas, she suggests:
- Was aseptic technique used in inserting the urinary catheter?
- What was the staffing level? Lower staffing ratios have been associated with urinary tract infections.
- Might the patient have been a candidate for an anti-infective-coated catheter, such as one with a silver alloy? Research suggests such catheters, though about $5 more than a regular catheter, can be cost-effective in high-risk patients.

Another expert, John Burke, MD, from LDS Hospital in Salt Lake City, points out in the New England Journal of Medicine that there are accepted infection prevention measures clinicians can take, even in compromised patients. Leading the list—complying with hand hygiene guidelines.

Among others:
- avoiding use of invasive devices when there are alternatives, for example, condom catheters
- shortening the time invasive treatments such as mechanical ventilation are used, if appropriate.

Root cause analysis a good tool

Patrice Spath, BA, RHIT, who writes and lectures nationally on patient safety, thinks root cause analysis can be a useful tool for probing for causes of infection. She notes that infection control professionals, with their training in epidemiology, have skills that lend themselves to improving safety.

“Getting to the root cause is something they learn in their training,” she says.

But taking a patient safety approach will also require a change in attitude by everyone, she says, including physicians, administrators, managers, and clinical staff.

If a patient dies from a nosocomial infection, the organization will have to admit the patient care experience was flawed in some way,” Spath observes.

**Continued from page 1**

There are going to be challenges because nosocomial infections are multifactorial, and it’s sometimes very difficult to determine a root cause,” says Barbara Soule, RN, MPA, CIC, president of the Association for Professionals in Infection Control and Epidemiology (APIC).

She added that APIC supports the concept of using the sentinel event process to look at causes of unexpected deaths or impairments from infections.

Asked whether it was considering revising the alert to clarify which infections are sentinel events, a JCAHO spokesman would say only that its new infection control panel “is reviewing many issues.”

JCAHO appointed the 20-member panel to recommend changes in its infection control standards and develop ways to help ensure facilities are complying.

The alert’s major recommendation, in addition to reporting, is to comply with the new hand hygiene guidelines from the Centers for Disease Control and Prevention (CDC) issued in October 2002 (www.cdc.gov). The guideline recommends more widespread use of alcohol-based handrubs in addition to gloving and washing hands. (See December 2002 OR Manager.)

Most common complication

APIC strongly agrees that nosocomial infections are a patient safety issue, says Soule.

Infections are the most common complication in hospital patients.

An estimated 2 million patients acquire an infection in US hospitals each year, and 88,000 die as a result. Nosocomial infections add $4.5 billion to health care costs a year, the CDC estimates.

In fact, surgical site infection was the second largest category of adverse events in the well-known Harvard study published in 1991. That study is one source for the Institute of Medicine’s estimate that 44,000 to 98,000 patients die in hospitals each year from medical errors.

Still, taking a patient safety approach to infections isn’t easy.

Root causes are hard to trace because of the interplay between the patient’s underlying health and the complex treatment hospitals give. Many patients come to the hospital with multiple underlying risk factors: advanced age, cancer, chronic diseases, and obesity, among others. They are subjected to a host of invasive procedures, from drawing blood to surgery. Aren’t some infections to be expected given the risks?

A quality improvement approach to infections

Some experts say we need to rethink the idea that a certain number of infections are inevitable.

Facilities shouldn’t be satisfied if their infection rates fall within ranges identified by the CDC’s National Nosocomial Infections Surveillance (NNIS) system, suggests CDC Director Julie Gerberding, MD, MPH, in the Annals of Internal Medicine. NNIS is the nation’s major system for tracking infections acquired in health care.

She advocates taking a quality improvement approach, much like that taken for medication errors. She suggests infection-control teams consider doing a root cause analysis if they suspect an infection was preventable, even if the patient’s condition is complex.

She describes the example of a 78-year-old man with lung cancer and chronic obstructive pulmonary disease who died of pneumonia after developing several infections during a 14-day hospital stay that included palliative brain surgery for metastasis.

In analyzing this case, the team could look at several areas, she suggests:
- Was aseptic technique used in inserting the urinary catheter?
- What was the staffing level? Lower staffing ratios have been associated with urinary tract infections.
- Might the patient have been a candidate for an anti-infective-coated catheter, such as one with a silver alloy? Research suggests such catheters, though about $5 more than a regular catheter, can be cost-effective in high-risk patients.

Another expert, John Burke, MD, from LDS Hospital in Salt Lake City, points out in the New England Journal of Medicine that there are accepted infection prevention measures clinicians can take, even in compromised patients. Leading the list—complying with hand hygiene guidelines.

Among others:
- avoiding use of invasive devices when there are alternatives, for example, condom catheters
- shortening the time invasive treatments such as mechanical ventilation are used, if appropriate.

Root cause analysis a good tool

Patrice Spath, BA, RHIT, who writes and lectures nationally on patient safety, thinks root cause analysis can be a useful tool for probing for causes of infection. She notes that infection control professionals, with their training in epidemiology, have skills that lend themselves to improving safety.

“Getting to the root cause is something they learn in their training,” she says.

But taking a patient safety approach will also require a change in attitude by everyone, she says, including physicians, administrators, managers, and clinical staff.

If a patient dies from a nosocomial infection, the organization will have to admit the patient care experience was flawed in some way,” Spath observes.

**Continued on page 8**
Patient safety

Continued from page 7

And as with other patient safety issues, confronting that possibility means overcoming fear and shame. It means being open to looking at an infection as the result of larger system problems, and that will take leadership and courage, she notes.

How can OR directors get involved?

“This whole patient safety movement has refocused the OR on infection prevention, and that’s a good thing,” comments Barbara Gruendemann, RN, MS, FAAN, CNOR, of Dallas, a perioperative nurse who writes and lectures on infection prevention.

“Probably 80% of OR practice is related to infection control, either directly or indirectly. It is a huge overriding issue.”

Her suggestion for OR directors? “Use infection prevention as your mantra. Get back to the basics, like cleanliness—clean hands, clean instruments,” she says. Recent headlines on endoscopes underline the importance of cleaning as the foundation for infection prevention.

Some additional ideas:

• Stay in touch with your infection control professionals. Ask to join the infection control committee or appoint a representative, if you haven’t already.

Know your facility’s surgical site infection rates and how surveillance is done. Ask the infection control professional to inform you if infection rates change.

• Reinforce with the staff the need for clear, accurate documentation. The patient’s chart would be a key source of information in any root cause analysis. In particular:
  —Is wound classification documented correctly? Inaccurate documentation can skew surveillance statistics.
  —Is documentation accurate and complete on use of catheters, drains, and other devices associated with infection?

• Make sure sterilization cycles are documented appropriately and logs kept.

• Educate the staff and physicians about the CDC’s new hand hygiene guideline. Make sure they know, for example, that the CDC strongly recommends against long fingernails and artificial fingernails in units like the OR and ICU. Long nails and artificial nails have been linked to infection, including an outbreak in a neonatal intensive care unit.

• Monitor for strict adherence with reprocessing protocols for flexible endoscopes. There are continuing reports of infections because of failure to follow reprocessing guidelines.

• Find out what your organization is doing to monitor and improve compliance with protocols for prophylactic antibiotics.

Improving antibiotic use

Proper use of antibiotics is a widely accepted strategy for reducing surgical infection risk. Wrong timing is associated with a two- to six-fold increase in surgical infections for procedures for which prophylaxis is recommended. Many hospitals are conducting QI projects in this area.

Antibiotic prophylaxis is also emerging as a measure of hospital quality. It was one of two infection control practices readily accepted by the federal Agency for Healthcare Research and Quality (www.ahrq.gov) in an analysis of scientific evidence for patient safety practices. The other was use of sterile barriers during placement of central venous catheters.

The National Quality Forum lists selection and timing of prophylactic antibiotics among 31 indicators of hospital quality (www.qualityforum.org). JCAHO is conducting a study of 40 hospitals to try to identify best practices for antibiotic prophylaxis.

Another issue that’s likely to be more widely discussed is improving infection surveillance after outpatient surgery. Studies have shown surveillance of surgical site infection with confidential feedback to surgeons reduces risk of infection. Yet surveillance after outpatient surgery has been difficult to achieve.

JCAHO’s Sentinel Event Alerts are on its web site at www.jcaho.org. Look under Sentinel Events.

References


Web site has info on herbs and botanicals

A new web site from Memorial Sloan-Kettering Cancer Center in New York City features up-to-date information on 135 herbs or supplements.

The site explains conditions the agents treat, adverse effects, and potential drug interactions. It also provides warnings about whether the agent should be discontinued before surgery and for what length of time it should be discontinued.

Although use of herbs and related agents has grown in popularity, current information about the agents hasn’t been readily available.

The site’s home page directs users to an alphabetical listing of herbs and botanicals. A click on the herb links to an unbiased monograph citing the scientific literature bolstering or refuting the agent’s purported clinical properties. A “News and Alerts” section offers the latest information from the Food and Drug Administration and other sources.

—www.mskcc.org/aboutherbs
Top hospitals have better outcomes, lower costs

For 9 years, the Top 100 Hospitals study has identified hospitals that outperform their peers clinically as well as financially.

These benchmark hospitals adapt quickly to external pressures, provide high quality care in an efficient manner, and are maintaining their financial viability, according to Solucient, the data management company that conducts the study.

If all hospitals performed at this level, 57,000 more patients would survive each year, and $9.5 billion could be saved. The number of patients having complications would drop by 18%, Solucient says.

In a new series starting in this issue, we spotlight what perioperative services leaders at some of the Top 100 Hospitals have done to help their organizations perform at a high level. (See p 10.)

The Top 100 study doesn’t attempt to identify the contribution that surgical services makes to successful outcomes. But because surgery is a major cost and revenue center, it seems logical to assume surgical services plays a role in their success.

Highlights of new study

In the latest study released in December 2002 based on 2000 data, the Top 100 Hospitals had:

- **Lower mortality rates.** Though patients at top-performing hospitals were sicker and had more complex conditions, the survival rate for the Top 100 was about 1% higher than for hospitals in general. Though patient deaths for all hospitals have moved upward slightly since 1996, the increase has been less for the Top 100.

- **Lower costs.** Adjusted expenses for top performers were 19% lower than peers’. Top performers’ costs have gone up more slowly, by 4% a year from 1996 to 2000 versus 13% a year for peers.

- **Higher overhead.** Interestingly, Top 100 Hospitals are spending more on overhead than peer hospitals. Solucient says further research is needed to determine why.

- **Leaner staff.** The number of FTEs per adjusted average daily census is lower for the Top 100 than for peer hospitals. The difference is even more striking after patient-severity and wage adjustments are made. Top 100 Hospitals tend to maintain a higher RN staffing level, however.

- **Higher wages and benefits.** Top 100 Hospitals paid $1,990 more per employee in salary and benefits than peer hospitals, after adjusting for regional wage variations. Adjusted median wage and benefits expense for top performers was about 5% higher than for peers, a difference that has continued through the years. Solucient thinks this may reflect a difference in skill level.

“These increases, coupled with the tendency to maintain leaner staffing ratios, suggest that hospitals are not trying to recoup their losses by cutting salaries but are instead focusing on fewer numbers of the best possible employees,” the report said.

- **Better profitability.** At 8.81, the Top 100s’ median total profit margin is more than 5 percentage points higher than the median for peers.

Best of the best

The new Top 100 report identified a group of 57 hospitals that have been top performers four or more times.

Solucient says it has documented some of the ways these facilities perform differently from other hospitals. Not only do they have higher survival rates and fewer complications at lower costs, but they also are more efficient, sending patients home sooner, expanding their outpatient settings, and being early adopters of proven new technology.

“To achieve that level of performance in even a single year is a significant accomplishment,” the report says. “To consistently achieve it over a number of years indicates a higher level of management excellence and consistency.”

Solucient says these facilities also emerge as exceptional performers in unrelated studies using different data sources.

The company plans more research to identify what makes these facilities consistently able to perform at a high level.

About the study

The Top 100 study recognizes hospitals in five groups: major teaching and teaching hospitals as well as small, medium, and large community hospitals.

For the first time in the new study, the Northeast had the highest percentage of benchmark hospitals, 7% of all hospitals in the region. The region lagged in the study’s early years, probably because states in the area were heavily regulated, diluting the influence of managed care. The South, though it still has the most benchmark hospitals, has lost ground since 1995 when almost half of the Top 100 Hospitals were from that region. The number of top performers from the West also has dropped off.

Solucient measures hospitals on eight measures of clinical quality, operations, and financial management using data from hospitals’ Medicare cost reports plus Solucient’s own database. The company claims to have information on more than 800 data elements for over 6,000 U.S. hospitals. The Top 100 Hospitals report has been produced yearly since 1993.

For more information on the Top 100 study, visit www.solucient.com
Hospital’s culture values employees

Wellstar Douglas Hospital’s reputation as a good place to work helps it attract and hold on to nursing staff.

Despite the scarcity of experienced OR nurses, “we can fill positions for the day shift easily,” says Anne Medlin, RN, BSN, CNOR, manager of surgical services. Of 40 employees in surgical services, there currently is one vacancy on the 3 to 11 pm shift. Five of the OR’s ten staff nurses have been at the hospital for 20 or more years.

Medlin thinks the hospital’s policy of treating employees well is a major reason. For example, full-time employees get a 3 to 11 pm shift. Five of the OR’s ten staff nurses have been at the hospital for 20 or more years.

We try to be an ‘employer of choice’

“Th...
Patient privacy and implant tracking

Do you automatically give manufacturers a patient’s name, address, telephone number, and Social Security number when one of their products is implanted in that patient? Most OR managers have done this automatically for years.

With implementation of the patient privacy regulation of the Health Insurance Portability and Accountability Act (HIPAA), OR managers are beginning to challenge such requests.

The Food and Drug Administration (FDA) provided in its 1993 tracking regulations a list of permanently implantable devices it believed should be tracked. The scope of the FDA’s tracking authority changed in 1998.

Now, the FDA may by “order” require a manufacturer to track a device. There is no statutory requirement to track a device unless the FDA has issued an order. The FDA may add or remove devices from the list of devices to be tracked.

Presently, only 12 implantable devices are subject to tracking orders issued by the FDA (sidebar).

**Protecting privacy**

To protect patient information and comply with the HIPAA privacy regulations, the Nebraska Health System (NHS) in Omaha is sending a letter to manufacturers explaining why companies will no longer be receiving patients’ individually identifiable health information on devices the FDA doesn’t require to be tracked (see letter on p 14).

Maureen Moluf, RN, manager in perioperative services, and Sheila Wrobel, JD, MBA, privacy officer for NHS, developed the letter. The letter will be sent to companies requesting patient information related to implant use.

“I believe manufacturers have the right to know we have implanted their device in someone, but they don’t need to know individually identifiable patient information,” says Wrobel.

With the de-identified information, manufacturers can still conduct product recalls, replacements, and look backs. They would know to contact NHS and ask for further information, but they would not be able to contact the patient directly.

“We will release protected health information for devices on the FDA tracking list.

We will only release protected information for devices on the FDA tracking list.”

**Implants subject to tracking**

Implantable devices subject to tracking orders issued by the FDA:
- Temporomandibular joint prosthesis
- Glenoid fossa prosthesis
- Mandibular condyle prosthesis
- Implantable pacemaker pulse generator
- Cardiovascular permanent implantable pacemaker electrode
- Replacement heart valve (mechanical only)
- Automatic implantable cardioverter/defibrillator
- Implanted cerebellar stimulator
- Implanted diaphragmatic/ phrenic nerve stimulator
- Implantable infusion pumps
- Dura mater
- Abdominal aortic aneurysm stent grafts.

Source: Food and Drug Administration

Changing policy

NHS began the policy change by amending its implantable-device tracking policy to match the current FDA list of trackable devices.

A paragraph was added to the policy saying that if a device is not on the FDA list, the hospital will fill out only the device identification (lot, batch, model, or serial number); the date the device was implanted; the hospital name; and the surgeon’s name.

“We hope this middle ground will satisfy the manufacturers,” says Moluf.

“Under HIPAA, we ask vendors why they are requesting the protected health information to determine whether the disclosure is permissible without the patient’s individual authorization,” says Wrobel. Is the information for health reasons, marketing purposes, or both?

Breast implant and intraocular lens manufacturers have written them patient information. She has not received further requests for information.

“We can provide them with any patient information they would need if there is a defect in the implant or a recall, but otherwise they have not justified why they need that information,” she adds.

Generally, in the past the onus for recalls and look backs has been on the hospital to contact the surgeon and patient, Wrobel notes. Moluf was involved in a notice of defective orthopedic implants. The manufacturer told her the lot numbers and catalog numbers, and the hospital tracked the patients and contacted the surgeons.

“The only involvement from the manufacturer was letting us know they had discovered issues with some of the screws, nuts, and bolts. It was on our shoulders to make the contacts,” says Moluf.

Continued on page 14
So you can’t fly,
smash evil robots,
or melt stuff with your eyes.

Still, he feels safer with you than anyone.

And unlike cartoon heroes,
you really do protect people for a living.
Sample letter to implant vendor

Dear Vendor:

I am in receipt of your request for patient information related to
_______________.

Under the Health Insurance Portability and Accountability Act (HIPAA), Nebraska Health System (NHS) may not disclose patients’ health information (protected health information, or PHI) to vendors unless:

- Disclosure is mandated by Nebraska or federal law (ie, FDA-regulated device required to be tracked; responding to product recalls, repairs and replacement; or reporting adverse events, product defects, or problems); or
- Disclosure is for purposes of providing services to NHS involving treatment, payment, and health care operations pursuant to a business associate agreement.

If one or both of these two exceptions do not apply, then the patient must specifically authorize the disclosure to the vendor in writing.

If you believe disclosure of patient information you are requesting is mandated by Nebraska or federal law, please provide us with a specific citation to the law that would provide us with the authority to release the protected health information you are seeking. Please attach a copy of the citation as well.

Statutory citation permitting disclosure of PHI:

If you have questions regarding this policy, please contact the NHS HIPAA privacy officer at [phone number]. We appreciate your assistance with maintaining the privacy of patients’ health information.

Sincerely,

Source: Nebraska Health System.

Nominate OR Manager of Year

A s surgical services managers and directors juggle departments, cope with staffing, and strive to keep quality of patient care high, they deserve to be recognized.

Each year at the Managing Today’s OR Suite conference, a manager or director is named OR Manager of the Year.

This year’s conference will be held Sept 17 to 19 in San Diego.

The OR Manager of the Year will receive an expense-paid trip to the meeting, including air fare, hotel, meals, and registration.

In recognizing an individual manager, the award honors all OR nurses for their important role. It is a way of celebrating nursing management in surgical services.

Readers of OR Manager are invited to nominate a manager for the award. Simply write a letter of about 300 words describing what makes the manager deserving of the award.

**Specific accomplishments**

Address specific accomplishments such as leading the staff, inspiring others, improving recruitment and retention, stimulating quality improvement, and encouraging collaboration among disciplines. The letter may be accompanied by letters from colleagues, including physicians, administrators, staff, and other managers.

Send the letter to OR Manager, Inc, OR Manager of the Year Award, PO Box 5303, Santa Fe, NM 87502-5303. The deadline for entries is July 1.

Nominations are judged by members of the OR Manager advisory board. The winner will be notified in August.

Expect to receive the Managing Today’s OR Suite conference brochure in a few days. The brochure is being mailed separately because of postal regulations. The brochure is also online at www.ormanager.com

**Resources**

- The FDA’s list of trackable devices is at www.fda.gov/cdrh/devadvice/353.html#link_2
- The FDA’s “Guidance on Medical Device Tracking” is at www.fda.gov/cdrh/modact/tracking.pdf

The Department of Health and Human Services Office of Civil Rights has published frequently asked questions on the privacy rule that can be useful in interpreting the privacy regulation. Visit www.hhs.gov/ocr/hipaa

—Judith M. Mathias, RN, MA

Fuzzy information

The FDA’s information could use clarification on disclosure of patient information, Wrobel comments.

The Nebraska Hospital Association and American Hospital Association have asked the FDA to provide more guidance on what information can be disclosed and to give more examples.

“We feel we have a very compliant approach and are providing the needed information,” says Wrobel.

“We believe providing manufacturers with a minimum amount of information necessary to enable recalls, look backs and other safety-related activities meets our goal of ensuring patient safety and privacy.”

Heads up on HIPAA

Continued from page 11

Expect to receive the Managing Today’s OR Suite conference brochure in a few days. The brochure is being mailed separately because of postal regulations. The brochure is also online at www.ormanager.com

OR Manager Vol 19, No 4

April 2003
How is block time reviewed and revised?

Part 3 of a three-part article

This part of the series on block scheduling focuses on the ongoing management of blocks, in particular, how block time is reviewed and how requests from new surgeons are handled.

Participating are four directors of surgical services and the leading researcher on surgical scheduling.

The directors are from two community hospitals, Munson Medical Center in Traverse City, Mich, and Poudre Valley Hospital in Fort Collins, Colo, and two academic medical centers, Northwestern Memorial Hospital in Chicago and the University of Wisconsin Hospital and Clinics in Madison. Three of the four directors were nominated for OR Manager of the Year in 2002.

The research perspective is provided by Franklin Dexter, MD, PhD, of University of Iowa Health Care, Iowa City, who has published numerous studies on OR scheduling and related subjects.

Part 1 of the series, in the February issue, focused on initial setup of blocks. Part 2, which appeared in March, discussed block release time.

Q1. What cases count toward a surgeon’s utilization of block time?

Munson: Any case scheduled by 5 pm on the workday prior to surgery (eg, Friday for Monday) is counted toward the surgeon’s elective block time need. This includes elective surgery they do in the released time from someone else’s block.

Northwestern: Any cases that are performed during regularly scheduled block time (7 am to 5 pm). We do not differentiate between elective, add-on, or emergency cases.

Poudre Valley: Scheduled elective cases are counted toward utilization. Surgeons aren’t penalized for time that is released and used by others, but they don’t get credit for it either. Add-ons outside the block don’t count. If a surgeon is increasing volume and is always extending beyond the block, we will see if he needs additional time. But if a surgeon’s block is on Thursday, and he does a lot of cases on Tuesday outside the block, he doesn’t get credit.

University of Wisconsin: All cases within prime time (7:30 am to 5:00 pm in our institution) are counted toward utilization.

What the research says

Dr Dexter: Suppose OR staffing and scheduling decisions are made based on four guiding principles, listed in order of importance: safety, access to OR time on Any Workday, maximizing OR efficiency, and minimizing patient delays on the day of surgery. Then allocation decisions are not based on utilization alone. (See Part 1 in the February OR Manager, Questions 1 through 4).

The reason is that overutilized hours (ie, the hours that ORs run longer than the regularly scheduled OR hours) (Strum, Vargas, and May, 1999) are more costly than underutilized hours of OR time.

The allocation that serves to maximize OR efficiency provides the optimal balance between allocating too many OR hours, resulting in underutilized OR time, and allocating too few OR hours, resulting in more expensive overutilized OR time. (Dexter, Epstein, and Marsh, 2001; Strum, Vargas, and May, 1999; Dexter, Macario, 2002).

Whether a case is finished during regularly scheduled hours does not affect its impact on future OR allocations for the surgeon. If a surgeon does many of his or her cases after the end of the regularly scheduled workday, then more OR time is subsequently allocated to the surgeon. At a surgical suite wanting cases, overutilized hours are curtailed not by setting rules on surgical case scheduling (eg, by not counting those hours of cases toward fewer allocations of OR time). Instead, future overutilized hours are prevented by changing staffing and by allocating more OR time (Dexter, Traub, 2002).

The Any Workday system of OR scheduling

Three types of elective case OR scheduling systems have been described (Dexter, Macario, 2002).

The system most widely used in the US, referred to as the Any Workday method, is based on the strategy that the surgeon and patient choose the day of surgery and cases are not turned away for lack of OR time, provided the case can be done safely, even if the case likely will be performed in overutilized time.

Because there are a limited number of ORs, the facility may not be able to provide a convenient start time to the surgeon and patient. Provided, however, that the case can be performed safely on the day chosen by the surgeon, the facility will perform the case. Often the facility will force the surgeon to call these cases “add-on” or “urgent” cases, but in the end, the cases get done. In such surgical suites, the objective in allocating OR time should be to maximize OR efficiency. This method and others have been studied in the references listed at the end of the main article.

—Franklin Dexter, MD, PhD
University of Iowa

Q2. Do you allow surgeons to switch patients within their block time? If so, what is the time frame in which this is allowed and still have the case count towards block utilization?

Munson: We do allow them to switch. We would prefer to have a longer release time—48 hours is short to allow access to released time. If a surgeon can fill the time with his own case, we will let him do it up to the day before. We ask surgeons not to rearrange cases after the schedule is published. It is a huge dissatisfier to patients to change their OR time.

Northwestern: Yes, only if the surgeon still has control of his or her block.

Continued on page 16
OR efficiency

Interview participants

Munson Medical Center
Traverse City, Mich
Mary Murphy, RN, BSN, CNOR
Director of surgical services
Robert Cline, MD
Medical director of surgical services
323-bed regional tertiary care center; staffed 24 hours
ORs: 13 (inpatient and outpatient)
Surgical volume: 18,000 cases
Types of surgery: Most types, including open heart, except transplants and complex pediatrics
Schedule blocked: 7:15 am to 5 pm

Northwestern Memorial Hospital
Chicago
Karen Anderson, RN, MSN, MBA
Director of surgical services
500-bed academic medical center
ORs: 35
Surgical volume: 29,000 cases
Types of surgery: All specialties including transplants
Schedule blocked: 7 am to 5:30 pm

Poudre Valley Hospital
Fort Collins, Colo
Robin Ramsey, RN, BSN, CNOR
Administrative director, surgical/radiology services
236-bed community nonprofit hospital
ORs: 12 (11 + cysto)
Surgical volume: 11,000 cases
Types of surgery: All specialties except transplant
Schedule blocked: 7 am to 3 pm
(Orthopedic rooms blocked until 5 pm)

University of Wisconsin
Madison, Wis
Barbara Pankratz, RN, MSN
Director of surgical services
471-bed academic medical center
ORs: 22 inpatient, 9 outpatient
Surgical volume: 20,711
Types of surgery: All services, including Level 1 trauma, transplant, oncology, and burns
Schedule blocked: 7:30 am to 5 pm

Does a new partner automatically get block time?

Continued from page 15

For example, if the surgeon’s block releases 72 hours prior to the day of surgery, and the surgeon calls 48 hours prior to that date, he or she will not be allowed to switch patients. Surgeons must make the switch before the automatic release time for the surgeon.

Any case that is done will count toward the utilization, regardless of the time it was booked.

Poudre Valley: Yes. Surgeons get credit for everything done in the block. The schedulers call the physicians’ offices the day before to reconfirm the procedures booked and the order of the cases.

University of Wisconsin: Changes can be made only up to the point of block time release. If a case is cancelled after block time is released, patients on the add-on list are slotted in. If there are no add-on cases or special circumstances, a switch would be approved.

What the research says

Dr Dexter: Suppose staffing and case scheduling decisions are made based on the four principles mentioned in Question 1. Then this is not an issue. If a case is cancelled and another case is scheduled, so be it. However, there is a time up to the day before surgery when new elective cases (ie, the substituted case) can no longer be scheduled. Then subsequent cases would be considered to be urgent and would no longer apply to future OR allocations for elective cases.

Up to when can elective cases be scheduled? As explained in Part 1, Question 1 in the February issue, on the day of surgery, maximizing OR efficiency is synonymous with minimizing overutilized OR time (ie, the hours that rooms run late) (Dexter and Traub, 2002). Thus, at surgical suites aiming to maximize OR efficiency, elective cases can be scheduled up to the time when a safe, full preoperative evaluation can be performed without increasing expected overutilized OR time (ie, producing a delay that may reduce OR efficiency).

Q3. How do you review block utilization?

Munson: We review it quarterly. We are a little seasonal here.

Northwestern: The OR Management Committee will review block time monthly. Recommendations for service changes are made every 6 months. The department chairs can make changes in individual surgeons’ allocations at any time. The surgical administration will provide the appropriate detail to assist them in making these decisions.

Poudre Valley: Every 6 months.

University of Wisconsin: Block time is reviewed quarterly.

What the research says

Dr Dexter: This is an unsolved scientific question. It is known that performance is best when OR allocations are calculated with 9 to 12 months of data (Dexter and Traub, 2002). Consequently, doing calculations more often than quarterly is not necessary for purposes of allocating OR time.

Still, there may be benefits to calculating OR allocations more often. It is my experience from consulting that some surgical suites choose to run analyses every other month. This is not because results are expected to be different but as a method of organizational education. Whether such a process is beneficial is unknown.

Q4. How does a surgeon request block time—new or adjusted?

Munson: In our situation, our ORs are full and so is the hospital; new beds are under construction. Overall, our OR utilization is 82%. For the moment, a new surgeon would need to have an existing surgeon give up time or would plan to use Saturday time. We run one to two rooms on Saturday for urgent and emergent cases; some cases might be done electively. We have small pieces of time on Friday and every fourth week all day, but it is not enough.

Northwestern: Surgeons initially request it from the department chair. They can appeal to the OR Management committee if needed.
What the research says

Dr. Dexter: What to do when all ORs have already been allocated is well understood for surgical suites that aim to maximize OR efficiency, but the answer is too long for a brief explanation. The topic is covered in articles by Dexter, Epstein, and Marsh (2001) and Dexter and Macario (2002).

Provided that this is not a problem, the surgeon requesting allocated OR time can provide data from other facilities for how many hours of cases he or she expects to do on a day of the week. That estimate is then used to calculate the allocation expected to maximize OR efficiency. (See Part 1, Question 4 in February issue.)

If the OR usage initially is expected to be too low for an OR allocation, the surgeon would not be allocated OR time. However, the surgeon still would be guaranteed access to OR time on Any Workday. At least one OR is planned every workday for such cases. (See Part 1, Question 5.)

Q5. What parameters must be met for surgeons to maintain current block time?

Munson: We have a rule in our utilization guidelines that says they must maintain 65% of their block time to keep it. We’ve used this rule a few times to take away block time but not often. If a surgeon does not have a lot of time that is unutilized, it is not useful to take it away. In general, it doesn’t help us to take 1 hour away. We count all cases scheduled by 5 pm the day before surgery. This way, we are counting many cases that are urgent enough to be done the next day and would not be delayed until the surgeon’s next block time.

Our utilization rule states that surgeons must be available during their block time. We don’t want them to be, say, scheduling endoscopy cases or to be in their office. When we do reallocate blocks, we coordinate with their other demands.

Northwestern: The surgeons must release time appropriately to maintain a level of utilization that is close to their peers. We do not have an established individual threshold. We do establish a threshold for services. Any service that consistently is two standard deviations below the average utilization for all services will lose block time.

Poudre Valley: 60% utilization.

University of Wisconsin: Overall, we look at all utilization under 70%, although blocks allocated to urgent case-loads (ie, orthopedics, trauma, and transplant) are evaluated by different criteria.

What the research says

Dr. Dexter: Suppose that OR staffing and case scheduling decisions are made based on the four guiding principles listed in Question 1. Then a surgeon with personally allocated OR time maintains the allocated OR time so long as providing him with allocated OR time serves to maximize OR efficiency (Dexter, Epstein, and Marsh, 2001; Strum, Vargas, and May, 1999; Dexter, Macario, 2002).

If a surgeon’s usage drops below the threshold such that estimated OR efficiency would be greater by not allocating the surgeon OR time, then the surgeon continues to have guaranteed access to OR time on Any Workday, provided the case could be done safely. The surgeon schedules cases into other first-come, first-served nonblocked OR time. (See Part 1, Question 5.)

Q6. Who is responsible for reviewing and revising the block schedule? When is this done? How are surgeons notified of a change in their schedules?

Munson: The Block Utilization Committee meets quarterly. When we do make changes, there is a negotiation with the surgeon(s) involved. The changes generally start 4 to 6 weeks later to allow for scheduled cases to be done without change and for surgeons to change their office or clinic schedules as necessary.

The Block Utilization Committee has five physician members, including the chief of anesthesia (or a delegate), the chief of surgery (or a delegate), and two other physicians appointed by the chief of surgery, such that there are no fewer than two surgeons and two anesthesiologists on the committee. Also on the committee is the director of surgical services; the OR manager and manager of the eye surgery center attend when invited.

Northwestern: The OR Management Committee reviews the block time monthly. Services changes are made every 6 months, and the chief of surgery is responsible for communication to the department chair. If the changes are made within the services, the department chair is responsible for notifying the individual surgeons.

Poudre Valley: Review and revisions are conducted by the management team, and surgeons are notified in writing.

University of Wisconsin: A subgroup of the OR Committee, the Surgeon Advisory Group, reviews all block time utilization and recommends changes in allocation. If utilization is below the threshold, the division chair receives written notification that the block utilization will be reviewed again in 3 months and will be reduced by half if utilization remains low. When block time is decreased, the division chair receives notification in writing.

What the research says

Dr. Dexter: The best organizational structure for OR time allocation is an unsolved scientific question. Recently, it has been my informal experience from consulting that organizations aiming to allocate OR time to maximize OR efficiency have outsourced the statistical analysis. Then an OR committee reviews the analysis but rarely alters decisions that are based on historical data. Whether this approach is “best” is unknown.

Q7. What do you do with a new partner who joins an office? Does the partner automatically get block time? Do you grant individual block time to a new surgeon? Or do you wait until he or she has established practice?
The O.R. is the last place you want to be distracted by what you’re wearing. So DuPont has created a family of innovative O.R. fabrics that go beyond increased protection and safety to offer you new comfort and control. They incorporate advances in technology and materials to help you stay cool and comfortable, move more freely and work relaxed. They even feel good when you touch them. From splash protection to a breathable impervious barrier fabric that adjusts to your body to reduce fatigue and keep you fresh. Our O.R. fabrics provide the confidence and comfort you need to stay in control and focused on what you do best.
Continued from page 17

**Munson:** When we had enough open time, we would tell new surgeons to schedule into open time and establish a track record.

We have had a couple of surgeons join a group without informing surgical services. We had to tell them there was no time. They got a room when we opened a new OR, but until then they did their cases at night. Surgeons are supposed to meet with the medical director of surgical services or the Block Utilization Committee for education before they join the staff.

A Professional Resources Committee reviews a new surgeon’s application to join the staff. The committee’s job is to use data to determine a quota of specialists and determine whether the staff will be open or not.

**Northwestern:** It is at the discretion of the individual department chairman for the allocated service block. The chairmen can reallocate within their block and assign time. The OR Management committee, however, will not increase the service’s allocation unless the service’s utilization is consistently two standard deviations above the average utilization for all services.

The scheduling guidelines allow individual surgeons with no block time to access open time before individuals with block time. This system has allowed new surgeons to establish themselves. Surgical administration will then provide the department chair with individual surgeons’ utilization, volume, and release data. Reallocation recommendations are provided only if requested.

**Poudre Valley:** We usually tell a new physician that we don’t automatically assign block time. We will do a periodic review of volume. It could be 12 months before we assign a block. In addition, we will not automatically purchase new instrumentation for 6 months to 1 year unless it is for a new procedure.

**University of Wisconsin:** A service is expected to work internally to find time for the new surgeon to schedule. As utilization for the service increases, new time is then allocated to the service as it becomes available.

**What the research says**

**Dr Dexter:** Suppose that the OR staffing and case scheduling decisions are made based on the four guiding principles listed in Question 1. Then the surgical suite does whatever is expected to maximize OR efficiency. (See Part 1, Questions 2 and 4 in February.)

The decision would be based on expected workload. If a new partner is not bringing existing work to her new practice but will be growing a practice slowly, then likely she would initially schedule cases into first-come, first-served open OR time. Alternatively, if the practice has its own allocated OR time, she should initially schedule her cases into the practice’s OR time. The surgeon would be guaranteed access to OR time on Any Workday for her cases.

**Q8. What do you do when new technology comes along that takes more time to perform? Do you adjust blocks accordingly?**

**Munson:** This came up recently with bariatric surgery. We have two surgeons who want to start. The decision is on hold because of a lack of ORs and beds.

**Northwestern:** Not at this time.

**Poudre Valley:** Not at this time.

**University of Wisconsin:** This is a challenging situation. If we had more anesthesia and nursing personnel, we would consider that option. At this time, we work with the surgeon to track the surgeon’s historical time and identify how many cases can fit within the allocated block. As the case time decreases, we increase the number of cases that can be scheduled. We limit our elective schedule to prime-time hours.

**What the research says**

**Dr Dexter:** Suppose that OR staffing and case scheduling decisions are made based on the four guiding principles listed in Question 1. Then as new technologies progressively change each service/group/surgeon’s total hours of elective cases including turnover times, OR allocations need to change to assure that OR efficiency is maximized. (See Question 3.) If more OR time is used, then more OR time is allocated, because otherwise cases will be completed in expensive overutilized OR time.

**References**

Dexter F. A strategy to decide whether to move the last case of the day in an operating room to another empty operating room to decrease overtime labor costs. Anesthesia & Analgesia. October 2000;91: 925-928.


Dexter F, Macario A. Changing allocations of operating room time from a system based on historical utilization to one where the aim is to schedule as many surgical cases as possible. Anesthesia & Analgesia. May 2002;94:1272-1279.


Dexter F, Traub RD. How to schedule elective surgical cases into specific operating rooms to maximize the efficiency of use of operating room time. Anesthesia & Analgesia. April 2002;94:933-942.

Epstein RH, Dexter F. Statistical power analysis to estimate how many months of data are required to identify operating room staffing solutions to reduce labor costs and increase productivity. Anesthesia & Analgesia. March 2002; 94:640-643.

A new enzyme in the spore coat of the commonly used indicator relies on around for several years. The most assurance, optimizing throughput, and with new options for improving quality recognition by AAMI provides you capital Practice: Steam Sterilization and Sterilization & Infection Control American National Standard Good Hos
ers and Class 5 chemical integrators are included in the new edition of the American National Standard Good Hospital Practice: Steam Sterilization and Sterility Assurance, AAMI/ANSI ST-46 from the Association for the Advancement of Medical Instrumentation (AAMI). This recognition by AAMI provides you with new options for improving quality assurance, optimizing throughput, and in some cases reducing expenses.

Early read-out indicators have been around for several years. The most commonly used indicator relies on an enzyme in the spore coat of the Geobacillus stearothermophilus live spores in the indicator vial. If the spore is still alive, the enzyme produces florescence when placed in the special reader that comes with the product.

Though this form of monitoring has gained wide acceptance, national standards for sterilization practices had not recognized this new technology until the revised AAMI steam sterilization standard was issued late last year. The standard endorses use of the enzyme-based results from early-readout BIs for routine monitoring and release of all loads, including loads containing implants.

Class 5 another option

There is another option for rapid assessment of sterilization conditions. You may not be familiar with the term “Class 5 chemical integrator.” This indicator has a response that highly correlates with the response of a BI across a specific range of conditions that are or may be present in a steam sterilization cycle. Class 5 integrators go beyond the more familiar “integrator” that responds to conditions needed for sterilization but does not make the claim of correlating well with the response of biological monitoring. Class 5 integrators and conventional integrators may look similar. The difference is in the label claims substantiated in submissions to the Food and Drug Administration (FDA).

According to the new AAMI steam sterilization standard, Class 5 chemical integrators can be used for routine monitoring and product release for all loads except those containing implants. The AAMI working group thought there was not yet enough experience with these indicators to permit their use in release of implants. For AAMI to change its position, studies are needed on Class 5 integrators’ reliability and comparability to biological monitoring results in real-world situations, just as studies were done for the enzyme indicators.

Quicker results

The major advantage of both early read-out BIs and Class 5 chemical integrators is the ability to obtain almost instantaneous results, letting you know of failure to reach sterilization conditions at the site where the indicator was placed. Of course, neither can ensure that all items in the load are sterile. That depends on the design of the devices in the load and the loading patterns you used.

But if you use one of these products for routine daily monitoring, you will know of an unacceptable end-point response at the start of the day. For routine monitoring of loads, you can use the satisfactory end-point response as one of the factors in making a decision to release the product at the end of cool down, with greater assurance that sterilization conditions were met.

Flash sterilization

The AAMI steam standard covers only steam sterilization of wrapped items. AAMI has not yet taken an official position on use of these indicators in flash sterilization. But it stands to reason that you could extend these technologies to flash sterilization if the product label claims support that. Here the Class 5 indicators would have the edge, because there is no waiting. And we know how the surgical team abhors waiting for flash-sterilized items. The result can be seen and interpreted immediately. However, the Class 5 indicators should not be used for implant release following flash sterilization until they demonstrate reliability and comparability to BIs in studies yet to be done.

These two options for early or immediate readout differ not only in technology but also in cost. The early readout enzyme-based product is a true BI and therefore costs more than the Class 5 indicator. Because these two are not fully interchangeable, you may want to consider having both available—use the enzyme product when you are processing implantable devices, and use the Class 5 for routine monitoring of all other loads.

When to use conventional BI testing

The enzyme product also allows you to run conventional BI testing by continuing to incubate the product after the enzyme response had been determined. AAMI recommends there are several situations in which you should do this:

- When you are installing or relocating a sterilizer. Three consecutive cycles should be monitored, and the sterilizer should not be used until all results are known and satisfactory.
- After a major repair to the sterilizer or the steam distribution system. In this case, one cycle should be sufficient.

Continued on page 22
AAMI steam standard discusses home laundering of uniforms

The revised steam sterilization standard from the Association for the Advancement of Medical Instrumentation (AAMI) addresses a hot topic—laundry of scrub suits and other uniforms at home.

“The issue of hospital- versus home-launched attire was very controversial. We felt we had to address it,” says Barbara Goodman, RN, BS, CNOR, a perioperative nursing consultant who co-chaired the AAMI steam sterilization working group with Martin Favero, PhD.

Consistent with Occupational Safety and Health Administration (OSHA) standards, the AAMI standard says clothing that is grossly soiled or visibly contaminated must be laundered in the health care facility. But the question about where to launder clothing that is not visibly contaminated is unresolved. There is no scientific data on home laundering of uniforms, and the Centers for Disease Control and Prevention has not taken a stand. “Each facility must decide what is best for its own setting,” says Goodman, including whether the policy can be met and whether it can be monitored by managers. A large hospital with an on-site laundry might want to continue providing laundered uniforms, while an ambulatory surgery center that must send laundry out might choose a different solution.

Minimum criteria

If home laundering is allowed, AAMI outlines minimum criteria provided by Robert Garcia, BS, MT (ASCP), CIC, assistant director of infection control at Brookdale University Medical Center in Brooklyn, NY:

- As required by OSHA, uniforms with visible blood or body fluids must be laundered by the facility, not at home.
- Home laundering should utilize an automatic washer and hot-air dryer.
- While not absolutely necessary, hot water (110°F to 125°F) is recommended to assist inactivation of organisms.
- Chlorine bleach should be used unless the manufacturer specifically recommends against it on the garment label. If chlorine bleach is contraindicated, oxidizing bleaches such as those containing hydrogen peroxide should be used.
- As a matter of good personal hygiene, hands should be washed after placing laundry in the washer.
- Detergent should be used according to the manufacturer’s recommendations.
- Uniforms should not be laundered with underwear, because underwear is a significant source of microorganisms.
- To facilitate removal of soil and microorganisms, uniforms should be completely submerged in the washer throughout the wash and rinse cycles.
- The door or lid of the washing machine should be kept clean and sanitary to reduce the possibility that laundered clothing will be contaminated as it is removed from the washer.

“If OR directors decide to allow home laundering, they might want to control it by saying that uniforms are donned in the facility, not before leaving home, and they are contained during transit [like in a plastic bag] to prevent contamination,” Goodman suggests.

Continued from page 21

- When doing periodic quality assurance of your actual load configurations, as described in section 7 of the AAMI steam standard. In this case, multiple BI might be placed throughout the load, in the most-difficult-to-sterilize locations within the packages selected for monitoring.

And don’t forget to run a control BI. This should be done at least daily for every day that a BI is used and anytime you begin a new lot number of the BI product. Growth of the test organism in the unexposed control verifies that the spores are still alive, not having been damaged in manufacturing or by storage conditions. This may mean running a control more frequently than you are used to or than your BI manufacturer has suggested in the past, but it is in accord with good laboratory practices and recommended in the latest edition of the AAMI steam standard.

Obviously, switching from conventional biological indicators to either an enzyme/biological product or a Class 5 chemical integrator requires planning. Determine how you will use this product.

Even though the AAMI standard has expanded its recommendation to include these two new products, you need to decide if it is beneficial to continue to use BIs for product testing or switch to these alternative products. Next, you should develop an algorithm for dealing with unacceptable end-point responses. This will be different than your existing recall policy, because you will know results much sooner. Finally, the whole decision needs to be reviewed and approved by either the infection control committee or risk management committee or both.

And don’t forget to check those outdates on the traditional BIs if you plan to continue using them as part of your monitoring scheme.

Now that you are not using them so frequently, they could outdate! ❖

—Marimargaret Reichert, RN, MA
Olmsted Falls, Ohio

—Janet K. Schultz, RN, MSN
Denver

Marimargaret Reichert and Janet K. Schultz are consultants well known for their expertise in sterilization and disinfection.

The American National Standard Good Hospital Practice: Steam Sterilization and Sterility Assurance, AAMI/ANSI ST-46 can be purchased from AAMI at www.aami.org or by calling 800/332-2264 ext 217. Price is $50 AAMI members, $95 non-members.
Proposal calls for little or no increase in Medicare payments

As expected, a Medicare advisory panel recommended to Congress hospital payment updates for 2004 that are lower than the rate of inflation. Ambulatory surgery centers (ASCs) would receive no update.

Congress must act for the proposals to take effect.

Advocacy groups, including the American Hospital Association and the Federated Ambulatory Surgery Association (FASA), vowed to fight the proposals on Capitol Hill.

In a March report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended:

- An inpatient payment update equal to the marketbasket index less 0.4%, which is below inflation.
- A hospital outpatient payment update equal to the marketbasket index less 0.9%, also below inflation.
- A zero update for ASC payments.

According to MedPAC, ASCs’ growth in volume and number of providers “suggests payment is more than adequate.”

MedPAC originally planned to recommend reducing payments to ASCs for 358 procedures for which ASCs are paid a higher rate than hospitals. But MedPAC modified that to recommend that the government compare the bundles of services included in those procedure codes before determining whether ASC payments should be reduced.

Reducing ASC payments for all of these procedures would lower ASC Medicare payments by 7%.

A long-expected update in the Medicare list of procedures approved for payment in ASCs had not been issued as of March 12. The update is still expected this spring, with a possible effective date of July 1.

FASA is offering a diskette ASCs can use to calculate the impact of the suggested cuts on their centers. For information, phone 703-836-8808.

HHS Inspector General advocates uniform outpatient rates

The Health and Services Office of Inspector General (OIG) issued a report in February that also would reduce outpatient payments. The OIG said Medicare could save $1.1 billion if it paid only the lower of ASC or hospital outpatient rates for procedures where there were differences. The effect would be to reduce payments to both hospitals and ASCs.

Since hospital and ASC payments are based on different statutes, the OIG also advised that the Center for Medicare and Medicaid Services develop a whole new outpatient payment system with uniform rates, a huge undertaking that is unlikely to happen soon.

Congress would have to act for these recommendations to take effect. The Inspector General, Janet Rehnquist, resigned in March over other issues, and it is not clear what impact her leaving will have on the proposal.

For the latest information on the financial management of the OR, join your colleagues at the 4th annual OR Business Management Conference

June 4-6, 2003
Capital Hilton, Washington, DC

The conference opens with a welcoming reception June 4. The two-day conference will be June 5 and 6.

Special tracks
- Materials Management
- OR Construction and Design
- Finance

The brochure is available on the OR Manager web site www.ormanager.com or phone 800/442-9918.
Top ten safety issues with medical devices

A quarterly column on technology trends for surgical services.

Surgical suites are overwhelmed with technology. New devices are introduced weekly, if not daily, that physicians and staff must learn how to operate safely and effectively.

Though technology has improved patient care, technology also can present patient safety hazards. This is particularly true if the technology hasn’t been carefully planned for and if physicians and staff haven’t been properly trained.

ECRI, a nonprofit organization, has been conducting medical device evaluations for over 30 years. From this experience, we have compiled a list of the “top ten” devices that are most likely to present patient safety issues. These are devices that are more likely than others to be associated with serious injuries. And though the incidence of problems is fairly low, the consequences are serious. Not surprisingly, most of these devices are used in surgery.

If you’re looking at improving patient safety, a review of these devices is a good place to start.

1. Infusion pumps

The most common problems we see are overdoses from programming errors, or from infusion pumps that do not have free-flow protection.

The Joint Commission on Accreditation of Healthcare Organizations has received a significant number of reports of adverse outcomes resulting from free-flow of a drug when the control of the pump is lost. That is why JCAHO made free-flow protection on all infusion pumps one of its six National Patient Safety Goals for 2003.

At a minimum, you need to review your inventory to see if you have any pumps without free-flow protection and to remove those from service. ECRI has published a list of products with known free-flow problems. Contact ECRI for information on how to obtain the report.

2. Ventilators and anesthesia systems

The most common problems are related to breathing circuit leaks and disconnections, specifically, the failure to set alarms properly to detect problems.

3. Patient monitors

Most of the problems with patient monitors stem from improper settings. The majority of these incidents involve alarms, but adverse events also result from setting monitors at unrealistic physiological levels.

4. Defibrillators

Defibrillators are the most common device associated with patient deaths in the Food and Drug Administration’s medical device reporting database. Obviously, this is due in large part to the severity of illness of patients being treated.

Though defibrillators themselves are not necessarily a problematic technology, they are devices we would recommend making a high priority for standardization. Use of defibrillators requires split-second timing. Patients can’t afford to wait for clinicians to find the right button to push or the right dial to turn because they are confused about which device they are using.

5. Electrosurgical unit and laser burns and fires

ECRI continues to receive reports of fires associated with these devices. In many cases, the clinical staff can prevent problems by limiting use of supplementary oxygen.

6. Heart-lung bypass and circulatory assist devices

Problems include perforations and leaks from intra-aortic balloon catheters. This situation is not easily prevented, but serious consequences from the leaks can be prevented. Bad outcomes ECRI has seen in its investigations typically happen because the staff failed to detect the leak early or, if they did detect the leak early, failed to take the appropriate action.

7. Catheters and needlestick prevention devices

The problem with the needlestick prevention devices is not so much their design as the fact they are not being used. Managers and directors need to make sure the clinical staff supports safety products that are acquired. We hear from some nursing staffs that they feel the products were shoved down their throats.

Another problem we see is shearing when a catheter is inserted in a vessel. As the catheter is being inserted, it splits or breaks, and a fragment may remain in the patient. This is one of the most common catheter-related problems we see. Possible complications are foreign-body reactions, infection, and need for surgery to remove the fragments. There should be a plan in place for inspecting catheters before they are inserted, retrieving the catheter and fragments in case it shears, and replacing the catheter if necessary.

8. Trocars and staplers

Incidents we have seen principally involve injury to vessels. In one case, we were asked to investigate an event where an artery was stapled accidentally. We have also seen instances where staplers jammed and where trocars perforated blood vessels or bowel. Our general recommendation is to make sure the staff and the physicians understand the equipment they are using.

9. Reprocessing of endoscopy instruments

Plenty of infection issues still are
reported related to endoscopes. Generally, this is because some part of the reprocessing protocol was not followed, such as cleaning the scope or rinsing it appropriately. For example, there have been reports of “chemical colitis” caused by glutaraldehyde that was inadequately rinsed from endoscopes’ internal channels. Also, in many cases, the staff does not understand the design of the endoscope well enough to make sure it is effectively cleaned.

10. Magnetic resonance imaging

It is well known that you shouldn’t have metal objects in the MRI suite. Incidents with metal objects are unusual but high profile. In one widely reported case, an oxygen tank left in the MRI room became a projectile and killed a young boy. We also reported on a police officer who was a patient and was brought into the MRI unit with his gun still in his belt. The gun went off after it was attracted to the MRI’s magnet. Fortunately, no one was hurt.

For further information on ECRI’s reports, visit our web site or call the number below. Also check with your risk manager or biomedical engineering department, which may already subscribe to ECRI publications.

—Jim Keller
Director, Health Devices Group
ECRI, Plymouth Meeting, Pa

Jim Keller can be reached at jkeller@ecri.org

ECRI, a nonprofit organization sometimes called the Consumer Reports of health care, is known for its objective approach to medical device evaluation. Visit www.ecri.org or phone 610/825-6000.

OR Manager’s Toolbox

Check our web site for practical help on personnel evaluation, codes of conduct, and patient assessment. Go to www.ormanager.com. Look under The OR Manager’s Toolbox.

Drug resistance on rise

Resistance of Streptococcus pneumoniae to both penicillin and erythromycin is increasing faster than strains singly resistant to either, according to the March 10 online issue of Nature Medicine.

Measuring antibiotic resistance in eight states from 1996 to 1999, researchers based at Harvard School of Public Health, Boston, found Strep strains resistant to penicillin rose from 21.7% in 1996 to 26.6% in 1999, and strains resistant to erythromycin rose from 10.8% to 20.2%.

They predicted that by July 2004, nearly 41% of pneumococci at the Centers for Disease Control and Prevention’s active surveillance sites will be resistant to both penicillin and erythromycin taken together, with 5% resistant to penicillin only and 5% to erythromycin only.

Vaccines against S pneumoniae are recommended for infants and the elderly, the two groups most likely to get the infection.

—www.nature.com

April 2003    OR Manager  Vol 19, No 4
Are you doing all you can to treat your patients’ pain? Pain control is one of surgical patients’ leading concerns.

Yet pain is not always assessed and treated adequately.

About 30% to 40% of patients may have moderate to severe pain during the first 24 to 48 hours after surgery. Poorly controlled pain can deprive patients of sleep, interfere with functioning, and delay recovery. Along with postoperative nausea and vomiting, pain is the main cause of delayed discharge and hospital admission, with increased costs. Patients may not know what can be done to treat their pain. They may hesitate to ask about pain relief, or they may not know what to ask.

Three ambulatory surgery centers (ASCs) in Florida took steps to improve their pain management process and saw patients’ satisfaction with pain control rise.

The 18-month performance improvement (PI) project conducted in HealthSouth’s Florida Northeast Region by surgery centers in Melbourne, Jacksonville, and St Augustine, Fla, helped reinforce patient education, assessment, and documentation for pain management.

HealthSouth owns more than 200 surgery centers nationwide.

The centers decided to start the project after they noticed inconsistencies in the way they were assessing and documenting pain. Also, two of the centers’ patient satisfaction scores for pain were lower than the HealthSouth average.

Among issues they identified:

- Pain assessments were not always documented before surgery. Nurses did not necessarily ask patients about types of pain they might already have before surgery, such as arthritis pain, that could have implications for positioning or other aspects of their treatment.
- All of the centers did not document pain assessment during the postoperative phone call.
- The centers decided to work together to strengthen their programs. They also wanted to develop a more consistent approach to complying with pain standards of the Joint Commission on Accreditation of Healthcare Organizations. JCAHO’s pain standards, which were effective in 2001, require facilities to assess pain for all patients, record assessments so caregivers can follow progress in pain control, and be sure the staff is competent in pain assessment and pain management, among other things.

A work team of nurses and physicians from the three centers was organized to work on the project. The team began by conducting a root cause analysis to help them better understand the factors that affected pain management. Major factors they identified were:

- **Patients and families:** Inability to communicate pain level effectively
- **Health care team:** Lack of appropriate tools to educate
- **Documentation:** Inconsistent forms and lack of a consistent pain scale.

The team also reviewed JCAHO’s pain standards to be sure the improvement strategies they developed would meet the commission’s requirements.

**Identifying solutions**

The project yielded three solutions the team decided to implement:

- Develop a brochure the staff could use as an educational tool to teach patients and families.
- Conduct in-service education with the staff about using the brochure and the pain scale to help ensure the staff was providing consistent preoperative and postoperative pain assessment and education.
- Provide the brochure to physicians’ offices to aid in the education effort.

The brochure, entitled *Understanding Pain Management*, is the centerpiece of the PI effort.

“*The brochure helps the staff teach patients that they can be more in control of their pain management and can be participants in their care,*” Lee Rocque, RN, administrator of HealthSouth Melbourne, told OR Manager.

The brochure explains in clear, understandable terms:

- what pain is
- patients’ right to pain relief
- questions patients can ask before and after surgery
Pain information to give before discharge

- Explain that 20% to 40% of patients have moderate to severe pain at home and it can last 2 to 4 days.
- Advise patients on how to manage pain (which drugs and how often) and side effects of analgesic drugs.
- Provide (or prescribe) breakthrough analgesic (and antiemetic) to last 2 to 4 days.
- Advise patients to take analgesic before the effect of single-dose local anesthetic wears off.
- Encourage parents to use a pain assessment tool to optimize pediatric pain control.
- Explain that postoperative tiredness and drowsiness are common and in some patients may last several days.
- Provide telephone number and pager number of physician to be contacted if necessary.
- Inform the patient that the surgeon or nurse will make a follow-up call after surgery.


- what to do at home
- Nondrug pain relief measures such as relaxation and imagery.

The brochure has a pain scale with both pictures and verbal descriptions that nurses can use to show patients how they can describe their pain. There is also a pain management survey patients can fill out before surgery to help them to communicate with the preoperative nurse about any pain they may already have.

“The brochure gives the whole team the same frame of reference,” notes Cinda Hoover, RN, CNOR, director of nursing at HealthSouth Melbourne.

“It gives patients the ability to understand the terms we use so they can communicate better with the nurses, and vice versa.”

Patients receive the brochure at their doctor’s office, during their preoperative appointment, or when they arrive at the surgery center on the day of surgery. About 40% of patients are seen at the center prior to the day of surgery, and the remainder are assessed by phone.

“We assure patients we will have something to give them in their IV as well as orally for pain control,” says Hoover. “We tell them not to wait until the pain is too great to ask for relief. We reassure them that it is not a sign of weakness to take pain medication, and we explain that it can speed their recovery.”

The centers hope to have the brochure translated into Spanish.

The PI project seems to have made a difference. Since the brochure and other improvements were introduced, the three centers have seen their patient satisfaction scores for pain control rise from an average of 85% to 93%. Compliance with documentation is much improved, rising from 30% to 70%. The centers are continuing to perform chart audits to ensure documentation stays on track. Compliance also will be part of nurses’ peer evaluation.

A copy of the patient education brochure is on the OR Manager web site at www.ormanager.com. Look under OR Manager’s Tool Box.

This project was originally described in the Source, a newsletter from Joint Commission Resources, Inc.

Advice on improving pain control

Tips from the HealthSouth centers for improving pain management:

- Remember pain control is number 1 for patients. How well your center manages pain has a major impact on patient care and patient satisfaction. When nurses assess pain before surgery and discuss pain management with patients, patients feel you are attending to one of their major concerns.
- Strive for consistent education and communication with the staff about pain control. This is especially challenging if you have per diem staff. Follow up to make sure the staff continues to use the improvements you put in place.
- Enhance communication with physicians’ offices so they become part of pain management assessment and education.


Resources


What’s best way to market your ASC?

Q. Is it a good idea to hire a consultant to develop a marketing plan? Or is this something you can do on your own?

A. The short answer of course (and sadly) is “No.” You do not need a consultant to figure out how to attract more surgeons to your center. You or your staff should be able to figure that out better than anyone you can bring in from outside the organization.

Let’s make sure we are all talking about the same thing, though. To whom do you plan to market the center? If you are talking about a market plan directed to patients, why would you want to do that? Let’s be a little controversial here—what do patients bring to your center? Not much. They occupy space, mess up the stacks of three-year-old magazines in the lobby, and let their kids run wild in the hall. I know I have upset some of you with my response. But patients don’t walk in off the street for surgery, just like a car doesn’t drive into the repair shop to get fixed. They are directed to the center or taken there by the surgeon or the owner of the car. That is who we market to in this industry. If we don’t take care of the patient in the best possible way, or don’t fix the car properly, we will not have the chance to see the surgeon or the owner of the car again.

I know some of you will get upset about this, but health care is a business—a huge business—and we as professionals need to start treating it as such or someone else will.

The entire reason there are surgery centers to begin with is because hospitals didn’t know the surgeon is the target market—not the patients or the staff. If you are still unsure about this, please call me, and I will be delighted to charge you a fee to do your marketing plan to patients.

Q. Would you give us some pointers on marketing? What is the best method: TV, newspaper, billboards? Or is it best to rely primarily on professional networking?

A. As in the first answer, the target of your marketing needs to be the physician. And, as most of us know, they can be difficult to reach.

If you want to really cut to the chase after you have told the surgeon how wonderful you are, how well you take care of his or her patients, and what his or her return on investment in the ASC will be, you need to bypass them and get to the worker bees. Usually, this is the physician’s office manager. (Well, it is really the scheduler, but she is tough to get to without following the office chain of command.)

Your marketing goal here is not to have the office manager tell you about complaints she has heard from patients the office has sent to your center before. The most common complaint is that patients felt rushed out (Hooray! They should be rushed out!), or the staff was rude to them (There is never an excuse for that—fire rude people on the spot, in front of the patients if you can), or the doctor’s case was late getting started (even if it was the doctor who was late). One of your best marketing strategies is for the office manager to see only happy, smiling faces of patients who’ve had surgery at your center and come back to the office for the follow-up checkup. If your center made her doctor look bad, you can forget getting new patients from her.

Next is getting to the scheduler. This is the real meat of the action. Hers is the desk the charts get flipped onto to schedule the cases. If you have marketed your center well, all she will have to do is make a single phone call to a human being (No, not a menu-driven phone system.)

Life’s lessons learned here? Get the best. Your scheduler is someone you want to be able to handle many phone calls at a time without anyone feeling hurried.

If the physician’s office needs to make more than one call to your center, you are doing it wrong. Remember when the fast food chains were fast? Notice they aren’t anymore? Did you also notice that the largest chain (it starts with “McD”) lost something like $245 million dollars last month? There is a consequence for poor service.

Which is the best form of marketing? Forget TV unless you can do it during the Super Bowl, and your center somehow includes beer. Billboards do nothing unless you are starting a new service like pain management or a breast center of excellence that the center participates in. Billboards, TV, radio, and newsprint are all good for what I call “feel-good advertising.” This type of advertising is really directed to the staff of the center to make them feel good about the service they provide to the public.

There is nothing wrong with this—in fact, I think a well-placed ad in the local paper periodically that talks about your center’s statistics is a good thing. It raises awareness of the industry. It
does nothing to attract new business, but it looks good, especially if you are in a small community of under 30,000.

Q. Are there any data on which marketing methods are most effective for ASCs?

A. Not that I know of. In my experience, the most effective method is historic results. Try this: Put down on one sheet of paper a list of your accomplishments, such as:

98: Percentage of cases that start on time at the Earnhart Surgery Center.
99: Percentage of patients who say they had a good experience at the Earnhart Surgery Center.
8: Average turnaround time in minutes at the Earnhart Surgery Center.
99: Percentage of staff retention over the past 3 years.
0.001 : Percentage of infections at the Earnhart Surgery Center.
0.002 : Percentage of admissions from the Earnhart Surgery Center to local hospital.
58: Return on investment for current physicians at the Earnhart Surgery Center. (OK, leave that one out—tacky.)

You get the drift. Work with results. Everyone says what their center can do—show what you have done if you want to market yourself effectively.

Do not spend lots of money on brochures and pamphlets. They are a waste of money, and no one reads them anyway. I have been in business for 18 years and have never printed a single brochure.

If you feel you must print something, print an in-house newsletter and send it to prospective physician users. These may end up in odd places, like the local pizza parlor, so don’t print anything that would not look good out of context.

The most creative ideas I have ever had have come from someone else—so ask your staff to help you “market” your center—they are much cheaper than a consultant!

—Stephen W. Earnhart

Stephen W. Earnhart is president and CEO of Earnhart & Associates, Inc, Dallas. He can be reached at searnhart@earnhart.com

Earnhart & Associates has benchmarks from hundreds of facilities across the country. To find out how to receive free benchmarks, visit www.earnhart.com

If you’d like to submit a question for the column, please e-mail it to ppatterson@ormanager.com.

Who can you turn to for independent, unbiased answers when a medical device or technology harms rather than helps?

Turn to ECRI.

When an accident occurs in your facility, you need a thorough, unbiased, and objective investigation, an accurate conclusion, and timely recommendations. For more than 30 years, we have helped organizations react quickly and knowledgeably to restore operations and maintain confidence. Experts in ECRI’s Accident and Forensic Investigation Group offer the highest level of independent judgment and depth of experience in the world, supported by extensive databases and testing capabilities.

For more information, contact ECRI by telephone at +1 (610) 825-6000, fax at +1 (610) 834-1275, or e-mail at accidents@ecri.org.
Maxxim files for bankruptcy

Maxxim Medical, a medical and surgical product company based in Waltham, Mass, filed for Chapter 11 bankruptcy protection in February. The company said it was “organizationally sound” and would continue to operate without layoffs but had an excessive level of debt.

Medline, DuPont team up on apparel

Medline Industries, Mundelein, Ill, and DuPont Medical Fabrics announced a new marketing agreement in March. DuPont will provide fabrics for Medline’s Proxima line of disposable surgical apparel and protective products. Proxima products are sold both separately and in custom packs.

AmerisourceBergen acquires Bridge Medical

The pharmaceutical supply chain company AmerisourceBergen of Valley Forge, Pa, announced in January it bought Bridge Medical, Solana Beach, Calif, which provides bar code software used for reducing medication errors and tracking costs.
Sixteenth Annual

Managing Today’s OR Suite

The Premier Conference on OR Management

San Diego
September 17-19, 2003
Manchester Grand Hyatt San Diego

Discover, discuss, debate the latest in OR management

All-day workshops, general sessions, breakout sessions, exhibits, and networking provide you with the information you need to manage your OR today.

Highlights:
• Track for those who manage an ambulatory surgery center
• Track for those involved with purchasing for the OR
• Track for new managers

Expect to receive your conference brochure in a few days. It is being sent separately because of postal regulations. The brochure is also at www.ormanager.com
Duke describes steps for improving organ procurement

In a Feb 21 letter to the United Network for Organ Sharing, Duke University Medical Center describes circumstances that led to the blood-type incompatibility error in the heart-lung transplant of 17-year-old Jesica Santillan. Jesica died Feb 22, 2 weeks after receiving the wrong organs in her first transplant at Duke and then suffering brain damage and complications after a second transplant.

The letter says the medical center conducted a root cause analysis and found a lack of redundancy in validating blood-type compatibility. From now on, validation of ABO compatibility and other key data on the donor and recipient will be performed by:
— the transplant surgeon
— the transplant coordinator and
— the procuring surgeon.

The letter describes steps to be used in the verification process. The letter is posted on the OR Manager web site.

JCAHO calls wrong-site surgery summit

The Joint Commission on Accreditation of Healthcare Organizations is holding an invitation-only summit in May to try to reach consensus on processes for preventing wrong-site surgery. A possible outcome might be a “universal protocol” for preventing these events.

During 2002, wrong-site surgery rose from the fourth to the third most often-reported sentinel event.

The audience will include the Joint Commission’s corporate members plus the American Academy of Orthopaedic Surgeons. The summit will focus on:
• the scope of the problem
• why these problems still occur
• what has been done already to eliminate these problems
• what can be done in the future.

The commission believes the growing number of such cases necessitates the summit.

Eliminating wrong-site, wrong-procedure, and wrong-person surgeries is one of JCAHO’s 2003 National Patient Safety Goals, which were effective in January.

New web site for quality measures

The federal Agency for Healthcare Research and Quality launched a new web site in February as a clearinghouse for evidence-based quality measures.

The user-friendly site has summaries of the measures, a way to compare measures side by side, and access to full-text measures or information on ordering the documents. The site also has a search feature, discussion forum, and guidance on using evidence-based measures.

Fifteen measures are listed for surgery, such as mortality rates for coronary artery bypass and surgery rates for hysterectomy and laminectomy or spinal fusion.

Final HIPAA standards issued

The Department of Health and Human Services issued the last of regulations to carry out the Health Insurance Portability and Accountability Act (HIPAA).

The final security standard, published Feb 20, requires health care providers and others to take steps to protect electronic patient information. The compliance deadline is April 21, 2005.

The security standard goes hand in hand with the HIPAA privacy standard, which will be enforced this year starting on April 14. The security standard is more limited because it protects electronic information, whereas the privacy standard covers all kinds of patient information, such as conversations, paperwork, trash, and so on.

Also issued was another rule that modifies the electronic transactions and code sets standard. This standard is intended to achieve uniformity in transactions such as insurance claims.

Antibiotic cement reduces total knee infections

Bone cement mixed with the antibiotic cefuroxime lowers risk of deep infection in diabetic patients having total knee replacement, according to a study from the Center for Hip and Knee Surgery, Mooresville, Ind, presented at the American Academy of Orthopaedic Surgeons meeting in February in New Orleans.

With the antibiotic-cement mixture, deep infections were 0.7% in the nondiabetic group and 1.2% in the diabetic group. Though this difference was not statistically significant, much higher incidences have been reported in diabetic patients in other studies.

The study involved 5,220 primary total knee replacements, 6% involving diabetic patients. Investigators followed outcomes at 8 weeks, 6 months, 1 year, then every 2 to 3 years.