The Joint Commission on Accreditation of Healthcare Organizations announced on May 16 it is modifying scoring of its recommendation for surgical site marking effective immediately. The changes followed a May 9 summit on wrong-site surgery. Under the new policy, organizations will still be required to mark the site in cases involving:
- right/left distinction
- multiple structures (such as fingers or toes)
- levels (such as the spine).

But JCAHO will no longer require marking the site for other types of procedures, including midline sternotomies for open-heart surgery, cesarean sections, laparotomy and laparoscopy, and interventional procedures for which the insertion site is not predetermined, such as cardiac catheterization.

JCAHO also will not require marking of teeth prior to surgery for extraction, having reached consensus on this issue with the American Dental Association.

JCAHO is working on a draft of a “universal protocol” for prevention of wrong-site surgery. A draft will be posted on its web site and presented to the JCAHO board for approval in July. A national symposium is planned for the fall.

 Fifteen years ago, the main direct-ed-energy modalities used in the OR were electro surgery and lasers. Now there is an explosion of modalities: radiofrequency (RF), microwave, ultrasound, and cryoablation. They promise to make care less invasive and surgery less traumatic. Patients go home sooner and recover faster. But they don’t necessarily make life easier in the OR. Managers must keep the staff up to date on a bewildering array of new generators, probes, and accessories. Specialties compete for the latest equipment, taxing the OR budget.

A disposable ultrasonic scalpel enables surgeons to dissect safely around vital structures. But it raises the supply cost of a laparoscopic cholecystectomy by $105 to $341, according to a report by OR Benchmarks. Use of an arthroscopy “wand” increased the cost per case by $129 to $299 in another OR Benchmarks study. The three facilities using the wands had the highest supply cost per case of the eight participants.

Over the next 5 years, use of direct-ed-energy techniques in major specialties where they apply is expected to grow by 7% annually—with sales revenue growing at an even higher rate of 9% a year, according to MedTech...
Please see the ad for MEDLINE INDUSTRIES in the *OR Manager* print version.
What you can do to improve retention

Specific advice backed with data from exit interviews with staff who left.

Growing role of specialty coordinators

This key role is growing to help meet needs for staff education and technology management.

Joint ventures

What you need to know if your organization is embarking on a joint venture with physicians.

If you know anyone who’s making money on AAA endo grafts, let me know. I’d like to talk with them,” one of our readers said.

Now we know the answer—almost nobody is. For most hospitals, the DRG payment falls far short of the cost of repairing an abdominal aortic aneurysm using one of the popular percutaneous grafts. That was demonstrated in a study led by a surgeon at the University of Pittsburgh. The results are described on p 26.

AAA grafts are just one example of the technology dilemma facing surgical services departments—how do you provide patients and surgeons with the best technology without busting the budget?

The answer isn’t easy. The incentives aren’t in the hospital’s favor. Surgeons want the new technology but don’t have to pay for it. Manufacturers sell to the surgeons. Hospitals write the checks. Too often, the OR director is caught in the middle.

Questions beyond cost

New technology raises questions beyond cost. How do you keep the staff up to speed so they know how to operate the technology safely? For example, with all of the new devices that use radiofrequency energy, does the staff know how to protect patients from electrosurgical burns? Does your central reprocessing staff know how to handle complex, delicate reusable items?

Companies tout their devices as user friendly and say their sales reps provide training. But is the training sufficient and consistent? OR education provides patients and surgeons with the best technology. The monthly publication OR Manager (USPS 743-010), (ISSN 0889-9106) is published monthly by OR Manager, Inc. 1807 Second St, Suite 61, Santa Fe, NM 87505-3499. Periodicals postage paid at Santa Fe, NM and additional post offices. POSTMASTER: Send address changes to OR Manager, PO Box 5303, Santa Fe, NM 87502-5303.

OR Manager is indexed in the Cumulative Index to Nursing and Allied Health Literature, the Hospital Literature Index, and the National Library of Medicine’s Health Planning and Administration Database.

Copyright © 2003 OR Manager, Inc. All rights reserved. No part of this publication may be reproduced without written permission.


Editorial Office: PO Box 5303, Santa Fe, NM 87502-5303. Tele: 800/442-9918 or 505/982-0510. Fax: 505/983-0790. E-mail: ppatterson@ormanager.com

Advertising Manager: Anthony J. Jannetti, Inc East Holly Ave/Box 56, Pitman, NJ 08071. Telephone: 856/256-2300; Fax: 856/589-7463. John R. Schmus, national advertising manager. schmus@ajj.com

OR Manager is a monthly publication for personnel in decision-making positions in the operating room.

Elinor S. Schrader: Publisher
Patricia Patterson: Editor
Judith M. Mathias, RN, MA: Clinical editor
Billie Fernsebner, RN, MSN: Consulting editor
Janet K. Schultz, RN, MSN: Consulting editor
Kathy Shaneberger, RN, MSN, CNOR: Consulting editor

OR Manager  Vol 19, No 6

June 2003

OR Manager is a monthly publication for personnel in decision-making positions in the operating room.

Elinor S. Schrader: Publisher
Patricia Patterson: Editor
Judith M. Mathias, RN, MA: Clinical editor
Billie Fernsebner, RN, MSN: Consulting editor
Janet K. Schultz, RN, MSN: Consulting editor
Kathy Shaneberger, RN, MSN, CNOR: Consulting editor

OR Manager  Vol 19, No 6

June 2003

OR Manager is a monthly publication for personnel in decision-making positions in the operating room.

Elinor S. Schrader: Publisher
Patricia Patterson: Editor
Judith M. Mathias, RN, MA: Clinical editor
Billie Fernsebner, RN, MSN: Consulting editor
Janet K. Schultz, RN, MSN: Consulting editor
Kathy Shaneberger, RN, MSN, CNOR: Consulting editor

OR Manager  Vol 19, No 6

June 2003

OR Manager is a monthly publication for personnel in decision-making positions in the operating room.

Elinor S. Schrader: Publisher
Patricia Patterson: Editor
Judith M. Mathias, RN, MA: Clinical editor
Billie Fernsebner, RN, MSN: Consulting editor
Janet K. Schultz, RN, MSN: Consulting editor
Kathy Shaneberger, RN, MSN, CNOR: Consulting editor

OR Manager  Vol 19, No 6

June 2003

OR Manager is a monthly publication for personnel in decision-making positions in the operating room.

Elinor S. Schrader: Publisher
Patricia Patterson: Editor
Judith M. Mathias, RN, MA: Clinical editor
Billie Fernsebner, RN, MSN: Consulting editor
Janet K. Schultz, RN, MSN: Consulting editor
Kathy Shaneberger, RN, MSN, CNOR: Consulting editor

OR Manager  Vol 19, No 6

June 2003

OR Manager is a monthly publication for personnel in decision-making positions in the operating room.

Elinor S. Schrader: Publisher
Patricia Patterson: Editor
Judith M. Mathias, RN, MA: Clinical editor
Billie Fernsebner, RN, MSN: Consulting editor
Janet K. Schultz, RN, MSN: Consulting editor
Kathy Shaneberger, RN, MSN, CNOR: Consulting editor

Editorial

Too often, the OR director is caught in the middle.

If you know anyone who’s making money on AAA endo grafts, let me know. I’d like to talk with them,” one of our readers said.

Now we know the answer—almost nobody is. For most hospitals, the DRG payment falls far short of the cost of repairing an abdominal aortic aneurysm using one of the popular percutaneous grafts. That was demonstrated in a study led by a surgeon at the University of Pittsburgh. The results are described on p 26.

AAA grafts are just one example of the technology dilemma facing surgical services departments—how do you provide patients and surgeons with the best technology without busting the budget?

The answer isn’t easy. The incentives aren’t in the hospital’s favor. Surgeons want the new technology but don’t have to pay for it. Manufacturers sell to the surgeons. Hospitals write the checks. Too often, the OR director is caught in the middle.

Questions beyond cost

New technology raises questions beyond cost. How do you keep the staff up to speed so they know how to operate the technology safely? For example, with all of the new devices that use radiofrequency energy, does the staff know how to protect patients from electrosurgical burns? Does your central reprocessing staff know how to handle complex, delicate reusable items?

Companies tout their devices as user friendly and say their sales reps provide training. But is the training sufficient and consistent? OR education provides patients and surgeons with the best technology.

Top 100 Hospitals, on p 7.

• Present a united front. Make technology acquisition a team approach. Munson calls its four-member team the CCC—cost containment committee. “No matter who comes to us, they get the same answer from all four,” says Barb Peterson, the OR manager.

• Develop a systematic capital acquisition process. Insist that purchases above a certain cost threshold be justified with evidence of the clinical benefits, a complete cost and reimbursement analysis, and a business plan, if appropriate. This obviously requires strong physician and administrative backing.

• Factor staff education into the acquisition cost and process.

Mission St Joseph’s Hospital in Asheville, NC, includes the cost of training in its total equipment cost and depreciates the whole cost over the lifetime of the equipment.

• Set up a vendor access program to help short-circuit the chummy relationships that make it difficult to keep track of what products are entering the system and what is authorized for payment.

You can read about Pinnacle Health’s product-entry process on p 24.

These strategies—with backing from your administrators—give you a fighting chance of making sure your OR can withstand the technology blizzard and provide a safe environment for patients.

—Pat Patterson
Please see the ad for ADVANCED STERILIZATION PRODUCTS in the OR Manager print version.
Nurture yourself to succeed, speaker advises

Ready to have your batteries recharged? Keynoting the Managing Today’s OR Suite conference Sept 17 to 19 in San Diego is Dan Clark, an expert on human potential. Clark is an internationally known speaker, songwriter/recording artist, and the primary contributing author to the Chicken Soup for the Soul series. His keynote is sponsored by Kimberly-Clark Health Care.

OR managers must nurture continual growth themselves and with their staff if they are to succeed in today’s stressful health care environment. What we need to succeed is inside us, Clark suggests.

“Change from the outside in is reactive and creates pressure and stress,” he says. “Change from the inside out is proactive change that creates power. We take charge and change because we can—it’s our choice.”

Clark will address the harm in misjudging one’s own potential and ways to cope with pressure. “No one can exceed his or her potential,” he says. “We only misjudge the potential. However, we can exceed expectations. Pressure is not something that is naturally there. It is created when we question our own abilities. When we know what we can do (through education and perfectly practiced, spaced repetition), there is never any question.”

Hard-won lessons

An award-winning college athlete, Clark looked forward to a career in professional football, but a paralyzing injury changed his life. He managed a full recovery after 2 years of self-examination and therapy. He brings the lessons he learned to his work today. “Pain is a signal to grow, not to suffer,” he says. “In rehab, you have to stretch before you strengthen. All the strengthening occurs in the area past the point of discomfort.”

Clark says his program helps people find out what matters most and how they can maximize their potential in their work. “What would happen if we approached each day as a songwriter?” he asks. “There are only 12 notes in music. The only difference between one song and another is the arrangement of the notes. And the only difference between a great songwriter and an average songwriter is the same as the difference between a great manager and an average manager—passion, creativity, and imagination.”

Clark’s keynote opens the two-day conference on Thursday and Friday, Sept 18 and 19. Other general sessions include:

- An Update on Recruitment and Retention and What You Can Do About It, with Greta Sherman of JWT Specialized Communications Health-care Group
- Making Health Care Economics Almost Riveting, with Paul Solman of the News Hour with Jim Lehrer, a special lecture and reception by Cardinal Health, Medical Products and Services
- Bioterrorism: What You Should Know, with Martin Favero and Cynthia Spry, presented by Advanced Sterilization Products
- Your Mission, Your Mantra, Your Legacy, with DeNene Cofield, director of surgical services at Medical Center East, Birmingham, Ala.

The conference also offers 32 breakout sessions with practical information for OR managers and directors, including tracks for materials management and ambulatory surgery.

In addition, eight all-day seminars will be held on Wednesday, Sept 17, preceding the two-day conference.

For a conference brochure or to register visit www.ormanager.com or phone 800/442-9918.

Advisory Board

Gail Avigne, RN, BA, CNOR
Nurse manager
Shands Hospital at the University of Florida, Gainesville

Mark E. Bruley, EIT
Director
Accident & Forensic Group, ECRI
Plymouth Meeting, Pa

Judith Canfield, RNC, MNA, MBA
Associate administrator of surgical services
University of Washington Medical Center, Seattle, Wash

Michele Chotkowski, RN, MSHA
Director of perioperative services
Lawrence Hospital/HealthStar Network
Bronxville, NY

DeNene G. Cofield, RN, BSN, CNOR
Director of surgical services
Medical Center East
Birmingham, Ala

Larry Creech, RN, MBA, CDT
Vice president, perioperative services
Clarian Health System
Indianapolis, Ind

Cheryl Dendy, RN
Administrative director, Ambulatory Satellites, St John Hospital and Medical Center, Detroit

Franklin Dexter, MD, PhD
Associate professor
Department of Anesthesia
University of Iowa, Iowa City

Aileen Killen, RN, PhD, CNOR
Director of nursing, perioperative services
Memorial Sloan-Kettering Cancer Center
New York City

Robert V. Rege, MD
Professor and chairman
Department of Surgery
UT Southwestern Medical Center
Dallas, Tex

Marilyn Reichert, RN, MA
Administrator, Surgical Care Center
Southwest General Health Center
Middleburg Heights, Ohio

Kathy E. Shaneberger, RN, MSN, CNOR
Director, perioperative services and ortho/neuro service line
Mercy General Health Partners
Muskegon, Mich

Shelly Schwedhelm, RN, BSN
Director, perioperative services
Nebraska Health System
Omaha

Robert Walker, RN, BA, CGRN
Baptist Physicians Surgery Center
Lexington, Ky

Allen Warren
Business manager, surgical services
Mission St Joseph’s Hospital
Asheville, NC

Anny Yeung, RN, MPA, CNOR, CNAA
Assistant vice president for perioperative services & associate hospital director
SUNY Downstate Medical Center
New York City
Please see the ad for
BOVIE MEDICAL
in the OR Manager print version.
A full-court press on OR’s supply costs

A series featuring ideas from perioperative leaders at Top 100 Hospitals.

A
fter supply costs increased by $131 a case in 1 year—amounting to $2.4 million—OR leaders at Munson Medical Center knew they had to get more aggressive with cost management.

Like other hospitals, Munson, a regional referral center in northern Michigan, has been buffeted by rising costs and the technology explosion in surgery. A strong performer in Solucient’s Top 100 Hospital study, Munson is in a select group that has been on the Top 100 Hospital list four or more times because of clinical and financial performance.

The OR leaders set out to save $600,000 in supply costs during fiscal year 2003. Nine months into the fiscal year, they are projecting they will actually save $1 million.

These were steps they took to meet their budgetary goals.

Provide education

In June 2002, the OR leaders organized a crash course on the hospital’s financial situation for the staff, surgeons, and anesthesiologists before the new fiscal year began.

All of Munson’s top leaders attended. The system’s president kicked off the event with a description of the big picture in health care, with rising costs, shrinking reimbursement, and more uninsured. The COO followed with a discussion of Munson’s financial pressures, including new technology and the tight employment market.

Mary Murphy, RN, BSN, CNOR, director of surgery, brought the discussion to the OR level, discussing surgical volume and increases in cost.

“I showed, for example, how our lap cholecystectomy reimbursement had declined by 49% while our costs had increased by 77%,” Murphy says.

The OR’s medical director, Robert Cline, MD, outlined the new cost-saving process.

Get physicians involved

Once cost consciousness was raised, the leaders worked to get physicians actively engaged.

“Our focus is to get the surgeons involved in negotiating with the suppliers,” says Jennifer Willis, a supply consultant Munson brought in under a 1-year contract to help with cost management projects. Willis, who came from a regional supply alliance, reports to Murphy.

“In my experience, when the surgeons are educated, you can be successful in negotiating on total joints, for example. Once they are involved, it is fun for them, and they have the power to get better pricing.”

Willis’s office is located in the OR where she is accessible to physicians. She dresses in scrubs and meets with them on their own turf.

Good information helps.

“When information is presented to them on our costs and how much the hospital is losing, the surgeons are more tuned in.” Willis adds.

The hospital’s decision support department employs an RN with an MBA who provides cost analyses and other data.

On spinal implant procedures, which lose money, as they do for many hospitals, Murphy went to the neurosurgeons and told them the price the hospital needed on the implants in order to break even. The surgeons, in turn, went to the companies for better pricing and won reductions of 30%.

Murphy has proposed making Willis’s position permanent.

“She is part of our team. She’s not seen as an outsider trying to cut costs,” Murphy says.

Get tough on new purchases

To get a better handle on new instruments and equipment purchases, the OR leaders formed the CCC—Cost Containment Committee. Members are Murphy; Willis; Dr Cline, and the OR manager, Barb Peterson, RN, BS, with surgeons as ad hoc members.

The CCC’s principal strength is that it presents a unified front with a fast response.

“Now no matter who comes to us, they get the same answer from all four of us. Before, it might have been inconsistent,” says Peterson. “Now the process is established, and they can’t get around it.”

The CCC introduced two major initiatives:

1. A review process for purchases under $3,000, the cutoff amount for capital equipment.

Anyone requesting a purchase or trial must submit a form to the CCC. Peterson reviews the forms, following up with the submitter to make sure the committee has all the information it needs. She involves team leaders and coordinators to find out why the item is needed and what it would replace.

“Since we formed this committee, we aren’t getting as many requests,” Peterson observes. “I think people are asking themselves, ‘Why do we need this?’”

The committee aims for a rapid turnaround, with an answer if possible within a week.

2. An annual instrument budget for each specialty.

Each specialty manages its own

Continued on page 9
Please see the ad for
OLYMPUS ENDOSCOPY
in the OR Manager print version.
Be relentless on conversions

Applied to the capital equipment budget at the end of the fiscal year is with the CCC. All of what is left in the spending. ”People realize it’s like their checkbook, and they keep track of what they are spending, “ says Murphy. “Once surgeons are involved, it’s fun for them.”

Be systematic about capital purchases

The OR has put in place an objective process for evaluating capital equipment led by Dr Cline. The process applies to equipment costing from $3,000 to $50,000; equipment over $50,000 is reviewed by a hospitalwide committee.

Section chiefs submit their capital requests once a year, then meet to review the requests. Surgeons requesting items are asked to make a 1-minute presentation per item plus answer questions. Chiefs score each item, and the scores are ranked to set priorities for purchases.

Simultaneously, the hospital set up a Clinical Operations Committee to consider new programs or procedures that carry a significant technology price tag. Any program with a projected cost of more than $10,000 requires a business plan, including a literature review, if applicable; a cost analysis; and the expected reimbursement. Criteria examined are net present value, operating efficiency, customer satisfaction, health outcome, and new business activity.

Reviewing AAA grafts

Among technologies the committee has reviewed are endovascular grafts for abdominal aortic aneurysms (AAA), cervical cages for spinal fusion, bariatric surgery, and left ventricular assist devices.

Serving on the committee are administrators, physicians, and department directors. Murphy and Dr Cline represent the OR.

If a program gets the green light, the committee conducts a follow-up after about 6 months to compare actual with predicted utilization and costs.

A recent reassessment of AAA grafts found the price of the grafts had gone up, and the hospital was losing money. Though the decision was controversial, the committee decided the hospital should keep doing them because it is a “center of excellence” for that service. The number of patients has been fewer than projected, however.

Though the clinical operations process doesn’t make managing technology costs any easier, it does give leaders a forum for evaluating technologies more systematically than they might otherwise.

“We constantly struggle with the issue of what we should be doing at this institution,” says Murphy. “It’s a very difficult issue.”

For more information about the Top 100 Hospital study, go to www.100tophospitals.com
Are specialty hospitals a healthy trend?

The debate over specialty hospitals is heating up as heart hospitals and orthopedic hospitals spring up across the country.

Advocates say these “focused factories” provide high quality, patient-friendly care. They say specialized facilities enable physicians to be more efficient and share in the profits. Opponents, particularly community hospitals, say specialty hospitals skim the cream of the best-paying procedures, depriving community hospitals of revenue to cover the uninsured and procedures that aren’t as well reimbursed.

Though the U S has a long tradition of some types of specialty hospitals, such as rehab, children’s, and eye and ear hospitals, facilities focused on cardiac care and orthopedics are new. An estimated 50 to 100 such hospitals are operating, with more being built.

Policy makers, including Congress, are taking notice. Should policy makers take steps to curb growth of specialty hospitals or take a wait-and-see approach?

A report from the General Accounting Office (GAO), expected in a couple of months, should give a better picture of the trend. The report was ordered by the influential chair of the House Ways and Means Committee, Bill Thomas (R-Calif).

In the meantime, pros and cons were aired at an April 15 conference in Washington, DC, hosted by the nonpartisan Center for Studying Health System Change. The conference followed release of the center’s new report on specialty hospitals.

Specialty hospitals can be owned by national for-profit companies, general hospitals, or a combination. Physicians or medical groups can have an interest ranging from 15% to 50%.

In some areas, depending on state law, specialty hospitals must provide a full range of emergency services, while in others they need only handle the specialties they serve.

Driving the trend

What’s driving the trend? Three major factors were outlined by the report’s author, Kelly Devers, PhD:

- Relatively high profit margins for some specialties, such as cardiac and orthopedic services, make specialty hospitals an attractive investment.
- Physicians say they can be more efficient in a facility focused on one type of surgery.
- Physicians invest in specialty hospitals to shore up declining incomes. “Certain procedures are more profitable than others, and everyone is trying to get a piece of that,” Devers observed.
- Medicare formulas have tolerated these payment differences because they help cross-subsidize other services. As specialty hospitals focus on high-profit specialties, it raises questions about the impact on the rest of the system.

For physicians, specialty hospitals help make up for declining revenue. Specialists saw their incomes drop 4% during the 1990s while income for other professions rose, Devers pointed out.

Physicians also like an environment tailored to their needs. “Orthopedics is nuts and bolts intensive,” commented a conference panelist, William Greene, CEO of the medical practice OrthoArkansas. “It drives [surgeons] crazy not to have a staff that’s familiar with a full tray of multisize screws and nuts and bolts. They want somebody who knows what’s there and how to use it.” That can be difficult in a general hospital where orthopedists share the same OR with general surgery, OB, and a host of other specialties.

Another driver—the decline in tightly managed care. “More decisions are being placed in the hands of consumers. As consumers get more choice, they may see specialty hospitals as more convenient,” Devers noted. The facilities are smaller, easier to get in and out of, and may feel more like a hotel than a hospital.

Orthopedic and cardiac services are attractive to investor-owned companies because of the revenue potential and strong growth, commented another panelist, securities analyst Gary Taylor.

Hospital-based cardiovascular services amount to $150 billion a year, and the hospital orthopedic market is $100 billion. That compares to about $20 billion annually for the outpatient surgery market. So far, cardiac and orthopedic hospitals only have about a 1% market share, so there is a lot of room for growth.

Worries for community hospitals

Community hospitals worry whether they’ll be able to continue to serve community needs if high-paying specialties go away.

“Unlike the boutique hospital, the local community hospital is part of the essential fabric of our communities,” argued William Petasnick, CEO of Froedert Hospital in Milwaukee.

In some organizations, cardiac services provide 25% to 40% to the bottom line that can be used to help pay for less well reimbursed services.

There’s also concern scarce nursing staff will be spread thinner still.

“We have already lost a couple of our very skilled nurses to these specialty hospitals. Part of it is work hours. Part of it is select coverage,” Petasnick said.

What’s the impact?

There’s not much evidence yet whether the claims of either side are true. Solid evidence about the impact of specialty hospitals on quality, cost, price, and access to services is sparse, notes the report.

Questions policy makers are struggling with:
- Will specialty hospitals improve quality by focusing on one area of medicine, or will they lead to similar or poorer quality by spreading patient volume over more facilities?
- Will there be more utilization of some services, such as more heart surgery, as both specialty hospitals and general hospitals try to fill their beds?
- Will physicians’ ownership in facilities create a conflict of interest, encouraging them to perform more
procedures to generate more income?
- Will adding more facilities to the system make health care more cost-effective, or will it add cost? Will there be enough demand to fill the additional capacity specialty hospitals create?
- Will specialty hospitals provide consumers with more choices or limit access by jeopardizing community hospitals’ ability to offer less profitable services like burn care and psychiatric care?

“Specialty hospitals might succeed not by improving quality and reducing cost but by selecting better paying services, better paying patients, and relatively healthy patients,” Devers said.

Fighting back

Devers outlined three ways community hospitals are fighting back:
- Hospitals are opening their own specialty hospitals, offering physicians the same advantages they’d have in a competing specialty facility.

In Indianapolis, when MedCath, a company that develops heart hospitals, began talking to physicians’ groups, two of the city’s four hospital systems joint ventured with physicians and built their own cardiac hospitals. The other two systems built heart hospitals without physician ownership.

- Hospitals use “economic credentialing,” which means they try to deny admitting privileges to physicians who have an ownership interest in a competing surgery center or specialty hospital. Some courts have upheld these actions; other cases are pending. The Health and Human Services Inspector General’s office said in December it would seek public comment for a guidance about “economic credentialing.” Hospitals also try to discourage health plans from contracting with competing facilities.

More regulation?

Some think the answer is more legislation and regulation.

Two Democratic congressmen, Pete Stark (Calif) and Jerry Kleczka (Wis), have introduced a bill that would prohibit physicians from referring patients to hospitals in which they receive a special share of the profits.

Stark is the namesake for earlier legislation that prohibits physicians from referring to entities covered by Medicare and Medicaid if they have a financial interest in the entity. The current Stark law allows physicians to invest in whole hospitals. Stark and Kleczka say this is a “loophole” they would like to close. The bill would still allow physicians to invest and refer patients to hospitals in which they invest but only if investment was also opened to the general public.

If the legislation passes, and physicians’ ability to invest is limited, some experts say the specialty hospital industry would dry up. In a Republican-controlled Congress, that may be unlikely.

Also unlikely is an overhaul of Medicare payment. The Medicare payment system is so complex that adjusting one part creates other distortions elsewhere.

So far, specialty hospitals pose questions that don’t have easy answers.

In Petasnick’s opinion, the big question is: Is health care a business or a social service? If high-paying procedures move out of community hospitals, who will support their social mission?

On the other hand, specialty hospitals are a way of redefining the traditionally awkward relationship between doctors and hospitals. In traditional hospitals, physicians are neither employees nor owners. Specialty hospitals give doctors a stake in the business, better aligning incentives. But this new relationship raises more questions about the impact on the rest of the health care system.

Retain the best staff.

Make the work environment as attractive as possible. Stay competitive in wages, bonuses, and work hours. Help your CEO understand that staff retention is a competitive issue.

Communicate your strengths to the public.

Not all specialty hospitals have emergency rooms or timely physician coverage. “If I were a patient, that’s something I would want to know,” Devers says.

Keeping your hospital competitive

Are you hearing rumblings about specialty hospitals in your community? Here are suggestions about keeping your OR competitive, offered by Kelly Devers, PhD, of the Center for Studying Health System Change:

Demonstrate your results.

Specialty hospitals say that as “focused factories” they can be superior to general hospitals that serve a variety of specialties. Look at your own surgical volume and outcomes. If you have high volumes and good outcomes, demonstrate that. If not, continue to build your programs and improve.

Create a “focused factory” within your main OR.

Froedert Hospital in Milwaukee carved out ORs for orthopedics, with a specialized nursing staff. “We actively involve our orthopedic physicians in the operation of those ORs, and in referring to entities covered by Medicare and Medicaid if they have a financial interest in the entity. The current Stark law does allow physicians to invest in whole hospitals. Stark and Kleczka say this is a “loophole” they would like to close. The bill would still allow physicians to invest and refer patients to hospitals in which they invest but only if investment was also opened to the general public.

If the legislation passes, and physicians’ ability to invest is limited, some experts say the specialty hospital industry would dry up. In a Republican-controlled Congress, that may be unlikely.

Also unlikely is an overhaul of Medicare payment. The Medicare payment system is so complex that adjusting one part creates other distortions elsewhere.

So far, specialty hospitals pose questions that don’t have easy answers.

In Petasnick’s opinion, the big question is: Is health care a business or a social service? If high-paying procedures move out of community hospitals, who will support their social mission?

On the other hand, specialty hospitals are a way of redefining the traditionally awkward relationship between doctors and hospitals. In traditional hospitals, physicians are neither employees nor owners. Specialty hospitals give doctors a stake in the business, better aligning incentives. But this new relationship raises more questions about the impact on the rest of the health care system.

CRNA salaries soar

The average salary for certified registered nurse anesthetists (CRNAs) jumped 9.5% to $129,000 last year, topping off at $180,000, according to an annual review by Dallas-based health care staffing firm Allied Consulting.

The firm conducted more searches for CRNAs in 2002 than for any other allied health care professional, replacing pharmacists, who had the most searches since 1999.

Demand for CRNAs is growing for several reasons. The Centers for Medicare and Medicaid Services rescinded a rule requiring CRNAs to be supervised by anesthesiologists, and several states now allow CRNAs to work without direct supervision. Anesthesiologists are in short supply and difficult to recruit. The number of inpatient and outpatient surgical procedures is rising, and CRNAs provide a lower cost alternative to anesthesiologists.

—www.allied-consulting.com
Sharps safety

Safety devices reduce injuries; ORs lag

Sharps injury rates have dropped substantially as safer devices have been adopted.

The overall injury rate fell by 51% from 1993 to 2001, according to the International Healthcare Worker Safety Center at the University of Virginia, which tracks sharps injuries.

Sticks from disposable syringes, which cause the largest share of injuries to nurses, dropped by 59%. Big declines were also seen for other types of conventional needles.

“This is very good news for health care workers. It shows safety devices are really making a difference,” says Jane Perry, MA, of the center.

“The data are encouraging for everyone who’s been working hard to get safety devices in place.”

Injury prevention received a big push from the Needlestick Safety and Prevention Act, which has been enforced since 2001, and revised compliance guidelines from the Occupational Safety and Health Administration.

The findings should send a message to clinical areas and hospitals that so far haven’t focused on safety issues, she adds.

In OR, lower use of safety devices

In the OR, the injury rate dropped by 50%.

But the data suggest that safety devices haven’t caught on as readily as they have in other areas.

Blunt-tipped suture needles, for example, are yet to be accepted by most surgeons. Suture needles were the only device category that did not show a marked decline, with injuries falling by only 5%.

Data from 2001 show OR personnel have a much lower proportion of injuries from safety devices (7%) than workers in other units, even though the OR has a high proportion of the overall injuries (29%), another indication use of safety devices is lower in the OR, Perry notes.

For scalpels, a drop in injuries from reusables still is more than twice as high as from the disposables:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reusables</td>
<td>21.0%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Disposables</td>
<td>0.2%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

Not surprisingly, scalpels cause more serious injuries than suture needles and carry a higher risk of blood-borne pathogens transmission. In all, 69% of scalpel injuries reported in 2000 and 2001 were moderate or severe, compared with 41% of injuries from suture needles.

“One thing we recommend as a means of reducing injuries from scalpels is to use alternative means of cutting, such as blunt electrosurgical devices or lasers,” Perry says.

Hands-free passing?

Are ORs adopting hands-free passing of sharps? Though the center doesn’t collect data specifically about sharps passing, patterns of OR injuries may give some indication:

• 94% of scalpel injuries were to the hands.
• 41% of injuries from scalpel blades occur between steps in a multi-step process, much higher than the overall rate of 6%.
• Written comments submitted on OR injuries indicate a high percentage occurred during passing.
• Most injuries from scalpels (56%) were to the right hand, which for most would be the receiving hand in passing.
• 58% of OR injuries were not to the original users of the device, nearly double the rate overall.

One recommendation is for OR staff who do not require fine dexterity to wear a protective glove, such as one made of Kevlar.

Making sure safety features are used

Though the decline in injury rates is encouraging, residual injuries from safety devices are still occurring. A continuing problem is that staff don’t activate the safety feature.

“When we look at the data specifically for safety devices, we find a fairly large percentage of the injuries occur after use, which wouldn’t be the case if the devices were properly activated,” Perry says. “This speaks to the need for better training.”

Some hospitals check disposal containers to see how many safety devices have not been activated. Then they follow up to reinforce training.

“This doesn’t necessarily mean there is a problem with the safety devices,” Perry adds. “There may be some design flaws, but we can say with confidence that overall safety devices have decreased worker injuries.”

The Healthcare Worker Safety Center developed the EPINet needlestick surveillance program used by hospitals. There is a version of EPINet specifically for ORs. For information, visit www.med.virginia.edu/epinet.

Decline in nurses’ injury rates: 1993 and 2001

<table>
<thead>
<tr>
<th>Conventional device</th>
<th>% decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disposable syringes</td>
<td>59%</td>
</tr>
<tr>
<td>Needles on IV lines</td>
<td>100%</td>
</tr>
<tr>
<td>IV catheters</td>
<td>55%</td>
</tr>
<tr>
<td>Prefilled syringes</td>
<td>62%</td>
</tr>
<tr>
<td>Phlebotomy needles</td>
<td>70%</td>
</tr>
<tr>
<td>Winged steel needles</td>
<td>55%</td>
</tr>
<tr>
<td>Lancets</td>
<td>87%</td>
</tr>
<tr>
<td>Suture needles</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: International Healthcare Worker Safety Center, University of Virginia.
Insight, Irvine, Calif, a market research firm. The fastest growing procedure, endometrial ablation, is projected to increase by 27% by 2006. Most of the other growth will be in orthopedic, aesthetic, urologic, ophthalmic, and cardiovascular surgery.

For ORs, this rapidly developing technology presents challenges, including:

- cost
- safety for patients and staff
- physician credentialing
- staff education.

So much to know

“There are so many energy modalities and so much for the staff to know for each one,” says DeNene Cofield, RN, BSN, CNOR, director of surgical services at Medical Center East, Birmingham, Ala.

“Each has its own brand-specific cords and disposables. Each is re-processed in a different way—some are disposable, some are reusable, and some are reposable.” That makes it difficult for central processing personnel to keep up to date.

Staff training is also an issue, especially when OR education budgets have been cut. Staff must have an orientation and competency check on each new device as well as ongoing reviews.

“Safety and nurse education go hand in hand. It’s pretty stressful. We have new devices coming in almost every day, and the surgeon might want to use it the next day,” says Mark Emodi, RN, OR manager for the Nebraska Health System in Omaha.

Modalities for every specialty

There seem to be modalities for every specialty and even specific procedures.

In one promising development, RF energy is being used to ablate unresectable tumors percutaneously. Though the treatment isn’t a cure, it can extend survival and usually can be done on an outpatient basis under IV sedation. Patients may be able to go home within hours with minimal pain. A small needle with an electrode on the tip is inserted directly into a tumor using imaging guidance. The energy "cooks" the tissue, killing tumor cells. The treatment takes 10 to 30 minutes.

RF ablation is being performed for liver tumors and is being studied for kidney tumors and for pain relief from bone metastases in breast cancer.

“It is more rapid than surgery—we even had one patient who went kayaking the day after he underwent the procedure,” said Bradford J. Wood, MD, of Johns Hopkins, who has treated kidney tumors with the technique.

Microwave devices for tumor ablation are being tested in Asia.

Similar innovations are taking place with other forms of energy.

There are RF and cryogenic approaches to excessive menstrual bleeding that vendors claim will take the place of many hysterectomies. Nova-Sept, Palo Alto, Calif, received FDA clearance in March for its NovaSure endometrial ablation procedure using bipolar RF energy. CryoGen, San Diego, has a cryogenic technology called Her Option for the same purpose. The government approved a "new technology" APC code 980 for cryo endometrial ablation last year.

Several technologies focus on cardiac arrhythmias. CryoCath’s Surgifrost treats arrhythmias during coronary artery bypass or mitral valve surgery. Boston Scientific has an RF technology for arrhythmias.

Patients who snore can get relief with RF treatment of the soft palate in a technique known as Somnoplasty. Facial wrinkles are smoothed with another RF technique.

A start-up company called Silhouette Medical is conducting animal studies on a minimally invasive RF treatment of obesity. RF energy is delivered to the gastric antrum to modify tissue with the goal of reducing food consumption and gastric emptying.

What’s driving the new technology?

“There’s definitely a trend toward minimally invasive percutaneous procedures,” says Susan Levine, DVM, PhD, of the technology assessment firm, Hayes, Inc, Lansdale, Pa.

Advances in technology enable companies to make smaller, computer-controlled, user-friendly devices. But to what extent some of the devices are a scientific advance is a question.

“In general, there are alternatives to these, like conventional electrosurgery. So it’s hard to say when these become an innovation or are just another tool,” she says.

Money is also a motive.

Most of the devices consist of a control unit plus disposable probes, which is where companies make their money. RITA Medical Systems, which sells a tumor ablation system, says in its annual report that in 2001, disposables accounted for 78% of its sales.

Arthrocure, which sells a variety of devices using its proprietary Coblation technology, says its strategy includes providing control units at substantial discounts and generating future revenue from disposables.

“In many cases, the facility is convinced of the need by the sales force. Then you discover after the fact that you need disposables and perhaps extra staff,” says Jim Keller of ECR, a nonprofit organization in Plymouth Meeting, Pa, that evaluates health care technology.

Best strategies

The best strategy for surviving the technology blizzard—have a systematic process for making purchasing decisions. Start with a needs assessment, Keller and Levine recommend. Make sure people who participate represent a range of opinion, including skeptics as well as advocates. Areas to address in the needs assessment:

Is this a valid technology for this application?

- Can the device be used for a variety of applications or is it specialized?
- How will the new technology affect other technologies already in use?
Please see the ad for
CTC CARDINAL HEALTH
in the OR Manager print version.
Please see the ad for CTC CARDINAL HEALTH in the *OR Manager* print version.
Please see the ad for
KARL STORZ ENDOSCOPY-AMERICA
in the OR Manager print version.
### OR technology

#### Examples of directed-energy devices

<table>
<thead>
<tr>
<th>Type of energy</th>
<th>What it does</th>
<th>Advantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Argon beam coagulator</strong></td>
<td>Achieves rapid hemostasis.</td>
<td>Rapidly stops bleeding with less charring, tissue destruction, and formation of necrotic tissue than with conventional spray coagulation.</td>
</tr>
<tr>
<td>Uses a beam of ionized argon to conduct a high-frequency electrical current to stop bleeding.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Applications</strong></td>
<td>Situations where large areas of vaporization or coagulation are necessary.</td>
<td></td>
</tr>
<tr>
<td><strong>Examples of devices</strong></td>
<td>ConMed (conmed.com)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Valleylab (valleylab.com)</td>
<td></td>
</tr>
<tr>
<td><strong>Coblation</strong></td>
<td>Removes tissue.</td>
<td>Dissolves soft tissue rather than burning or charring as in conventional electrosurgery.</td>
</tr>
<tr>
<td>Proprietary type of low-temperature bipolar radiofrequency (RF) energy. Name is derived from “controlled ablation.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Applications</strong></td>
<td>Arthroscopy, spine/neuro, ENT, cosmetic, urologic, gynecology, laparoscopic/general surgery.</td>
<td></td>
</tr>
<tr>
<td><strong>Manufacturer</strong></td>
<td>Arthrocare (arthrocare.com)</td>
<td></td>
</tr>
<tr>
<td><strong>Cryotherapy</strong></td>
<td>Delivers extremely low temperatures.</td>
<td>Destroys tissue selectively while avoiding damage to healthy tissues.</td>
</tr>
<tr>
<td>“Cold energy.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Applications/Examples of devices</strong></td>
<td>Cardiac arrhythmias. CryoCath: SurgiFrost, Freezer (cryocath.com)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gynecology: Endometrial ablation. CryoGen: Her Option (cryogen-inc.com)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urology: Breast fibroadenomas: Sanarus: Visica (sanarus.com)</td>
<td></td>
</tr>
<tr>
<td><strong>Laser</strong></td>
<td>Tissue effects vary according to wavelength.</td>
<td>Precise and controlled destruction of tissue.</td>
</tr>
<tr>
<td>Narrow, intense beam of light.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Applications/Examples of devices</strong></td>
<td>Cardiology: Transmyocardial revascularization: CardioGenesis: Ho:YAG (eclipsesurg.com)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urology: Benign prostatic hyperplasia: Ethicon: Indigo Laser System (indigomedical.com)</td>
<td></td>
</tr>
<tr>
<td><strong>Microwaves</strong></td>
<td>Uses microwaves to destroy excess tissue. In cardiology, creates lesions to block atrial fibrillation.</td>
<td>Less invasive treatment.</td>
</tr>
<tr>
<td>Microwaves.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Applications/Examples of devices</strong></td>
<td>Cardiology: Atrial fibrillation. Afx (afx-inc.com)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urology: Benign prostatic hyperplasia. Urologix: Targis/Cooled ThermoCath (urologix.com)</td>
<td></td>
</tr>
</tbody>
</table>
Please see the ad for DUPONT MEDICAL FABRICS in the OR Manager print version.
Please see the ad for DUPONT MEDICAL FABRICS in the *OR Manager* print version.
OR technology

<table>
<thead>
<tr>
<th>Type of energy</th>
<th>What it does</th>
<th>Advantages</th>
</tr>
</thead>
</table>

**Radiofrequency energy**

Radiofrequency energy creates heat that has a variety of tissue effects. Devices deliver controlled levels of energy.

**Applications/Examples of devices**

**Cardiology:** Boston Scientific, EP Technologies (bostonscientific.com)

**Surgery:** Hemostasis. TissueLink (tissuelink.com)

**Vascular surgery:** Valleylab. Ligasure. (valleylab.com)

**Tumor ablation:** Berchtold. HiTT Electrotome (berchtoldusa.com)

**Surgery:** Boston Scientific (bostonscientific.com)

**Radionics. Cool-tip (radionics.com)**

**RITA Medical Systems (ritamedical.com)**

**Urology:**

Benign prostatic hyperplasia. Medtronic.

**TUNA (transurethral needle ablation) (medtronic.com)**

**Ultrasound**

Electrical energy is converted into mechanical energy or ultrasonic waveforms vibrating at a frequency of 55,500 Hz.

Vibration of blade denatures proteins to form coagulum so that cutting and coagulation occurs simultaneously. Cuts and coagulates at lower temperature than electrosurgery or lasers.

**Applications/Examples of devices**

**Surgery:**

- Ultrasonic welding of tissues. Axya Medical (axya.com)
- Cutting, coagulating of soft tissue:
  - Ethicon. Harmonic Scalpel (ethiconendo.com).
  - Olympus. SonoSurg (olympus.com)

**What will the volume be?**

- How many procedures will the device be used for? Will it bring in new business?
- Will the device be used for enough cases to justify the direct and indirect expense? Or is it a toy only a few will use?

**What is the reimbursement?**

Much reimbursement is fixed or discounted, so there is limited ability to charge for new technology. Is the Medicare inpatient DRG or outpatient APC payment sufficient to cover the cost? Does the technology qualify for a pass-through payment or as a new technology under APC payment?

**What is the impact on staff training and competency?**

Consider training and safety as part of the decision-making process, advises Keller.

- What will it cost to train employees to use the new technology safely?
- What are the hidden costs? These might include training and monitoring competency of central reprocessing personnel, tracking inventory, and paying for maintenance and repairs.

As education budgets have been cut, ORs have relied more heavily on companies for staff education.

“‘But manufacturers’ in-services may not be sufficient,’” Keller says. “Some companies are open about the risks [of the technology], but there may be an incentive to downplay the risks to make a sale.”

One-time education is not adequate. Ongoing training is needed for new employees, temporary personnel, and off-shift staff.

At Mission St Joseph’s Hospital in Asheville, NC, the cost of training is built into the acquisition cost.

“We include the cost of training in with the total equipment cost and depreciate the whole cost over the lifetime of the equipment,” says Al Warren, business manager for surgical services. This is not done for replacement technology the staff already knows how to use.

Mission St Joseph’s has an emerging technology committee at the senior level that includes physicians as well as administrative personnel.
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

You may register online. For a conference brochure, visit www.ormanager.com or phone 800/442-9918.
We include the cost of training in the total equipment cost.

Equipment fast facts
As a short refresher, include a list of “fast facts” for staff using a piece of equipment:
- List steps in using the equipment in as few words as possible.
- Limit the list to one side of a card no bigger than one sheet of paper.
- If additional information is needed, for example, about power settings for different procedures, place an asterisk by that step and write additional information on the back of the card.
- Laminate the card, punch a hole in the upper left corner, and tie the card to the equipment with a plastic locking tie.
- Include important safety tips in a different color, if applicable.

These fast facts should never replace adequate training for the equipment but just serve as a reminder for staff who use the equipment infrequently.

—Kathy Shaneberger, RN, MSN, CNOR
Director, perioperative services and ortho/neuro service line
Mercy General Health Partners
Muskegon, Mich

We have a good understanding of the technology. For devices to be used safely, the staff needs a basic understanding of the energy modalities and their effects. That’s particularly important with RF energy.

“All RF energy is not the same,” points out Judy Eagan, RN, clinical education coordinator for Valleylab, Boulder, Colo, a manufacturer of electrosurgical units and other RF devices for tumor ablation and pain management.

In certain applications, RF energy can generate significantly more power over a longer time than conventional electrosurgery.

“Traditionally, we have thought you couldn’t get a burn if you were using a generator with return-electrode contact quality monitoring. But you can if current is used for a long enough activation period, as in liver ablation or prostate vaporization,” Eagan says.

“If the device is delivering lots of current, you need more surface area for the patient return electrode to disperse the current safely. There can be severe adverse effects if the depressive electrode does not have enough area to match the amount of current being delivered.”

ECRI published a report in 1998 of a 65-year-old patient whose thigh was burned at the return-electrode site during monopolar electrosurgery for transurethral vaporization of the prostate using a rollerablation electrode. Saline was used as the distention/irrigation medium.

“When inadequate surgical effect was noted by the surgeon, the ESU output power was increased, and a burn resulted,” ECRI reported in its journal, Health Devices (June 1998;27:233-235).

No ESU alarms were reported at any time during the procedure. ECRI concluded that a combination of factors was involved. One factor was use of an incorrect distention/irrigation medium—using an electrolytic solution instead of a nonconductive solution such as sorbitol, dextran 10, dextran 70, or glycine may make monopolar electrosurgery less effective because electrolytic solutions conduct and disperse electrical current away from the intended ablation site. Other factors were high current output of the ESU, and an ablative procedure with a rollerablation electrode, which may require long activation periods to destroy a mass of tissue.

ECRI is investigating another serious burn incident involving another RF device.

Whenever RF energy is used, Eagan suggests, the staff needs to know:
- Is the current bipolar or monopolar? Bipolar current has fewer safety risks because the current doesn’t flow through the patient’s body and has a lower voltage, but its clinical applications are more limited.
- Is the device high or low voltage?
- Does the treatment require short activation or long activation with a lot of current?

“All of these affect the risk,” Eagan says.

—Pat Patterson

Call for abstracts for poster display
Posters are invited for the Managing Today’s OR Suite conference Sept 17 to 19 at the Manchester Grand Hyatt, San Diego. Topics suitable for posters include research studies, process improvement projects, and clinical innovations.

If you are interested in displaying a poster, please submit an abstract to OR Manager, Inc, by July 15.

For more information, including abstract submission forms, check the OR Manager website at www.ormanager.com or call 800/442-9918.
Please see the ad for SKYTRON INC in the *OR Manager* print version.
Vendors have seen hospitals as an open market where they can come and go freely promoting their products and services. They spend time in lounges and lobbies hoping to catch a physician or nurse manager to talk with. They offer samples to the OR staff with the hope the product will end up on the shelf.

Lack of control over vendors leaves gaps in the procurement process that make it difficult to keep track of what is entering the system and may mean having to pay for items that find their way on to the shelf.

Hospitals are taking a closer look at their product-entry practices, especially in light of patient safety concerns and the Health Insurance Portability and Accountability Act (HIPAA).

Not only is there a safety risk in allowing products to be used that haven’t been properly introduced into the system but also patients’ privacy may be violated if unauthorized sales personnel are in the operating room with a new piece of equipment.

Vendors can no longer roam freely or bring unscreened products into the four hospitals in the PinnacleHealth System based in Harrisburg, Pa.

Under Pinnacle’s supplier relations program, any new product must undergo screening by a committee before it can be used. This policy and others are communicated to sales personnel at a vendor certification class that all reps must attend if they want to do business with the system.

Reining in reps

PinnacleHealth began limiting access of sales personnel after a merger brought the four hospitals together in January 2001. Gaining more control over the supplier community was one priority for the centralized supply chain management department.

Before the merger, suppliers were required to sign in and wear badges when they were in the hospital. This would have been impractical after the merger because sales personnel would have had to go to a central location to sign in before traveling to the individual hospitals.

Though the hospitals had their own policies for vendors, the policies had loopholes and weren’t entirely effective.

The supply chain department decided to develop a new systemwide supplier relations program that includes:

• an orientation/certification class for sales reps
• photo identification badges
• an appointment-only policy
• a purchase order requirement.

Screening purchases

Before a new product can be used at PinnacleHealth, it must go through a department-specific screening committee. The surgical services screening group includes specialty coordinators, the OR director, and an appointed surgeon representative.

If a surgeon is interested in using a new product, the specialty coordinator gives the surgeon a form to fill out and sign. The form is sent to the materials management department, and the item is added to the agenda for the next meeting of the surgical services group.

The group reviews the information presented and weighs the financial impact with the clinical applications. The group also considers the impact on other products currently used, including contract obligations and policies and procedures.

Staff in the contracting department are available to help sales personnel navigate the supply review process.

Attending class

All sales personnel are required to attend a 1-hour certification class and complete a written exam about the system’s policies and procedures as well as regulations such as the HIPAA privacy rule. Reps do not receive an ID badge until they have completed the class and scored 100% on the exam.

Classes are held once a month. Sometimes suppliers are given temporary rights to make appointments for a month until the class is held.

Badges are assigned to each individual, not the company, and have the person’s photo on bright yellow background. If a salesperson changes companies, he or she is still certified and able to make appointments without taking the class again.

Managers and staff have been educated to look for this badge. If salespeople arrive in the operating room without a badge, the manager does not meet with them but directs them to the materials management department, which will sign them up for the orientation class.

To visit the OR department, reps must have an appointment with a specific person. After completing their appointments, they must leave the area and not visit with other staff or physicians.

Staff and reps are given a hot-line number for corporate compliance and urged to call if they are approached for any unapproved purchase or witness questionable business practices. This way, vendors keep an eye on each other, and it sends the message that business is being conducted aboveground, notes Stephen Tambolas, former director of materials management at PinnacleHealth, who developed the supplier relations program.

During the program’s first year, more than 1,000 reps attended the class—a higher number than expected—and they continue to enroll.

The key to compliance, says Jonathan Herb, PinnacleHealth’s contact manager, is for OR managers and their staffs to see themselves as part of enforcement for the program and to keep in touch with the materials management department.

OR managers “love the program,” he adds, noting they have seen a big reduction in pages from the lobby, telephone calls, and drop-ins from salespeople.
No PO, no pay

The purchase order requirement stipulates that vendors will not be paid for a product that does not have a purchase order.

“If somebody sends us an invoice that does not have a purchase order number on it, they get a form letter that basically says, ‘Thank you for your donation,’” says Herb.

When the company receives the letter, Herb usually gets an immediate phone call. Depending on the circumstances, he may agree to pay the invoice that time, but after that he stands by the policy.

“After vendors get bitten by the policy once, they are very careful to have purchase orders,” he says.

The surgeons have been supportive of the program. Occasionally, Herb hears from a surgeon who wants a product, such as an orthopedic implant, brought in at the last minute. In that situation, he pre-issues a purchase order specific to that patient so the vendor has the purchase order ahead of time. Once the implant is inserted, the purchase order is completed with information about the specific components used.

Building a vendor database

A side benefit of this program is it allows the hospital to build a vendor database. PinnacleHealth can now contact directly every rep who does business at its hospitals.

Hospitals learned how important vendor contact information was when they were gearing up for Y2K several years ago. As hospitals tried to contact companies, they realized they didn’t know how to get in touch with the sales personnel, says Tambolas. When they sent Y2K letters to companies’ offices, the letters sometimes didn’t reach the individual reps for 45 to 50 days.

Now when salespersons come in for the certification class, they fill out a data form including their e-mail addresses, postal addresses, and phone numbers, which are added to the vendor database.

Anyone in the hospital can get information from the database to use in contacting a rep.

Tambolas says the reps are happy being in the database because their customers can reach them in a hurry if they need a product.

Talking things over

As part of the supplier relations program, PinnacleHealth conducts vendor roundtables that include hospital decision makers and staff. Roundtables are scheduled when an issue arises that affects a number of vendors.

“At the roundtables, we try to get the issue out in the open and use them as a brainstorming session,” says Herb. A roundtable usually results in a policy to address the issue.

One roundtable focused on orthopedics, with individuals attending from orthopedic companies, nursing, accounts payable, and materials management. They discussed how implants were brought into the system and how orthopedic instruments are returned to the sales reps by the OR staff. Vendors said instruments were being lost, and it was taking a long time to be paid for them. They wanted to be paid immediately. Materials management responded that most lost instruments were found within 30 days and suggested the vendors be paid in 60 days. The group compromised on a policy that says vendors will be issued a purchase order in 30 days if an instrument isn’t found.

A place to meet and work

To compensate sales reps for the loss of access to lounges, Tambolas set up a procurement area where vendors can meet and work between appointments. Many travel from other cities like Baltimore, Philadelphia, and Pittsburgh to Harrisburg and had nowhere else to wait when they weren’t on sales calls. They are invited to use this area whether they have business with PinnacleHealth or not.

“The vendors are happy because they have a place to hang out,” he says, “and we are happy because when we need one of them, I often have to go no further than the procurement area.

For the future

“I now see the supplier relations program as a basic piece of our responsibility to the patient. It means we now have control of our business,” Tambolas says.

PinnacleHealth continues to look at future enhancements to the plan such as health screening and ongoing education for sales personnel. For example, the system has held vendor education programs on HIPAA.

They have discussed TB screenings but are investigating the legal aspects of such a policy before making a decision on implementation.

—Judith M. Mathias, RN, MA

Copies of PinnacleHealth’s product request form and product trial evaluation form are on the OR Manager web site at www.ormanager.com. Look under OR Manager’s Tool Box.

Smallpox-vaccinated caregivers pose risks

Hospital patients may face an increased risk of complications from contact with smallpox-vaccinated health care workers, according to the March 26 JAMA. The smallpox vaccine is made with a live virus that can infect those who come into contact with people who have been vaccinated.

Those at increased risk include patients with immune system diseases, with skin conditions including eczema, those who are on immune-suppressing medication, and newborns. Researchers in New York estimated that half of the state’s hospitalized patients are at increased risk for serious complications. The Centers for Disease Control and Prevention (CDC) says no vaccinia transmission to contacts has been reported in the health care setting in a voluntary nationwide program in which more than 21,000 health care workers have been vaccinated since January.

The CDC recommends daily inspection and bandaging of the vaccination site, meticulous hand washing after contact, and administrative leave if vaccination-related complications develop.

—www.cdc.gov

Stemming losses from AAA endografts

Though endovascular grafts are an established method for treating abdominal aortic aneurysms (AAAs), they create a financial challenge for hospitals.

A recent study in the Journal of Vascular Surgery confirms that most hospitals lose money on these cases.

Analyzing costs and reimbursement for 221 cases from seven hospitals, the researchers found an average net loss of $3,898 for hospitals reimbursed by Medicare DRGs. Most of the patients—93%—were covered by Medicare.

The graft was the single greatest expense, accounting for 57% of the cost with overhead. Graft prices ranged from $12,100 to $15,400. The mean cost without overhead was $10,500. Other supplies, including vascular stents, wires, and catheters amounted to an additional $3,600. In all, 86% of the cases used the Guidant graft, and 14% used the Medtronic product.

Endovascular AAAs are reimbursed under two DRGs: 110 for procedures with comorbidities and 111 for procedures without comorbidities. The mean net loss was significantly higher for DRG 111 ($9,198) than for DRG 110 ($2,200).

The four community hospitals in the study lost from $12,100 to $15,400. The mean cost without overhead was $10,500. Other supplies, including vascular stents, wires, and catheters amounted to an additional $3,600. In all, 86% of the cases used the Guidant graft, and 14% used the Medtronic product.

The authors told Pittsburgh Medical Center, one of the hospitals making a profit of $530 to $1,800, and one had a loss of $1,900. The differences owe to the DRG mix and adjustments between DRG 111 and 110. You must be sure you aren’t missing comorbidities,” comments another author, Robert Zwolak, MD, an attending vascular surgeon at Dartmouth Hitchcock Medical Center, Lebanon, NH.

From 70% to 80% of candidates for AAA endografts have comorbidities and should fall in DRG 110, the study showed.

Coders often rely on histories and physicals submitted by primary care doctors. The best thing hospitals can do is to help ensure the H&P is thorough. If the H&P isn’t complete, the case may be improperly assigned to DRG 111, and the hospital can end up with only half the appropriate payment, he says.

Not much more can be done to reduce length of stay, which averages 2.4 days for an endovascular AAA.

Competition might help bring costs down somewhat as more grafts enter the market. Grafts are currently marketed by Guidant, Medtronic, and Gore. Cook may soon have a product cleared by the Food and Drug Administration, and Cordis, a Johnson & Johnson company, is waiting in the wings.

Unless the picture changes, community hospitals in particular may have a tough time sustaining AAA endograft programs.

As an alternative to AAA grafts, some surgeons are using a minimal access procedure.

William Turnipseed, MD, a surgeon at the University of Wisconsin, Madison, says the minimal access approach has a length of stay and morbidity rates “almost identical” to the endograft procedure. He recently completed a comparison of the two approaches in high-risk patients.

The procedure is done through a 10 cm incision without a laparoscope. The hospital has done a comparison of endografts with the minimal incision approach in its business plan and found it could save $500,000 a year if it converted 40% of endografts to minimal access procedures, Dr Turnipseed notes. He has a video of the procedure available, and the university has applied for a patent.

In addition to the low DRG payment, there are significant startup costs, such as the costs of providing fluoroscopy. Dr Zwolak also noted that hospitals launching an endovascular AAA program may be required to purchase a startup inventory of grafts and for emergency backup.

**Vascular implants are stents, stent grafts, and prosthetics other than endografts.

| Mean costs of endovascular AAA graft by cost center including overhead |
|--------------------------|-------------------|-------------------|
| Endograft* | $13,191 |
| Vascular implant** | $1,116 |
| Med-surg supplies | $2,498 |
| OR | $2,651 |
| Patient room | $1,331 |
| Pharmacy, lab, blood | $1,122 |
| Radiology | $943 |
| Other | $307 |

Total | $23,159 |

* Hospitals assigned varying overhead costs to endograft.
** Vascular implants are stents, stent grafts, and prosthetics other than endografts.

Reference

Running a surgical suite is a tough job. Who are the leaders who make it happen? This series profiles some nominees for the 2002 OR Manager of the Year, the largest field ever.

When Gail Avigne, RN, BA, CNOR, fainted in the OR as a nursing student, she emerged from the experience determined to work in the OR.

It’s typical of her outlook: “If someone tells me I can’t do something, that’s what I want to do,” she says.

Overcoming adversity has driven Avigne’s 23-year career at Shands Hospital at the University of Florida, Gainesville, where she is nurse manager for the operating rooms.

In college, Avigne earned a bachelor’s degree in sociology and an associate degree in nursing.

Studying social work has been one of the most beneficial things for me—understanding people and being able to work for people is probably the most important element of my job,” she says.

Avigne was an OR staff nurse and a charge nurse before applying for a supervisor position, for which she was passed up three times.

“When I didn’t get it, I decided I could either help the person who did get to succeed, or I could leave—there was no in-between. I chose the former, knowing it would help me succeed.”

Avigne passes her positive outlook on to her staff.

“With failures, maybe you don’t get exactly what you want at the time, but you get something—a result that will be better if you view it positively. It’s really the failures, rather than the successes, that give you the opportunities to reach an even higher goal.”

Shands entered a growth phase while Avigne was supervisor from 1987 to 1994. Surgical volumes since have doubled from 7,000 per year to 14,000, and nine ORs have expanded to 23 plus two cysto suites and a burn unit.

A team-based culture

When Avigne became nurse manager in 1994, she assumed responsibility for the ambulatory surgery unit and the recovery rooms as well as the OR. With this came one of the management initiatives Avigne is proudest of—15 OR teams.

The aim was to bring efficiency and cost management projects closer to the front lines and empower the staff so they felt they could make a difference in the department’s performance.

“When 150 people and lots of procedures, you couldn’t just say, for example, everybody’s going to have a 20-minute turnover time,” she says. “I thought we needed to break it down into smaller groups to succeed.”

Teams are led by an RN, a surgeon, an equipment specialist, and an anesthesiologist.

Unlike other team plans, RN team leaders at Shands are included in the numbers for daily staffing. Equipment specialists, who are surgical technologists (STs), are not part of the staffing numbers. Shands has three levels of STs—entry level, certified level, and the equipment specialists, who participate in team leadership. Though the equipment specialist is not a management position, it is respected and draws many applicants.

Avigne acts as a coach for the teams, asking them to formulate goals and measurements, monitor data, and come up with action plans. Team goals and data are posted every day, an idea Avigne borrowed from manufacturing.

When teams reach goals, she posts kudos along with the names of every team member. Quarterly luncheons and dinners are held for teams that attain goals or show marked improvement.

“I find the RNs and techs getting stronger and making decisions independently,” she says. “The value is in giving people autonomy. As a manager or leader, you have to let go. You don’t have to control every decision or every idea they have.”

To further help her monitor performance in the large organization, Avigne established the position of team leader coordinator. The coordinator travels through the services daily to determine what’s going wrong and what’s going right.

Though employees initially were suspicious of the coordinator’s role, they now seek her out.

Through the years, Avigne has assembled a strong management team of individuals who complement one another.

“I’ve been careful not to put people on the management team who are too much like me,” she says. “We try to stay goal driven. We work to have a culture of believing in people.”

Data is one of Avigne’s passions. One of her long-term goals is for Shands to be a national leader for measuring and monitoring data.

“Data is objective. Surgeons are scientists, so they respond to data,” she says.

Eventually, by the end of a case, Avigne would like to be able to give the surgeon a report with a detailed cost per case.

Building bridges

In recruitment and retention, Avigne emphasizes flexibility. The department currently has no RN or ST openings.

“When people need time off, I try not to say no, and it’s rare that we can’t accommodate people,” she says.

Continued on page 28
The staff is diverse.

To help build bridges among the various groups, Avigne created a diversity committee 3 years ago when she sensed a certain iciness in the workplace.

“It took almost a year before I could get this group of volunteer RNs and techs to tell me the truth about what was going on,” she says. “Sometimes we work side by side, but do we really know what makes us tick? The thing that’s hard is to make yourself vulnerable and to recognize that perhaps you don’t know what to do, but if you come from the heart, you’ll figure it out together.”

The committee meets monthly. In addition to talking about issues, the committee holds celebrations and has a bulletin board with information of interest at the hospital or in the community.

Managing costs

Avigne and a surgeon chair a unit value analysis committee organized about a year ago. The committee, which was informal in the past, now has membership requirements, goals, policies and procedures, a mission statement, and request forms for new products.

Cost savings have been achieved through contract negotiations and standardization. The committee has helped decrease overall expenses by more than $3 million over the past several years. Standardizing hip and knee replacement and reducing the number of primary vendors from four to two saved about $300,000. They also have standardized spinal implants, gloves, perfusion contracts, and instrument repair contracts.

“If we have what we think is a good idea, and we can’t move it, we can bring it to the Resource Utilization Committee, which is chaired by the chief of staff, the COO, and several other prominent physicians and administrators,” says Avigne. The committee reviews initiatives that have not achieved consensus at the unit value analysis committee.

One issue the Resource Utilization Committee addressed was intraluminal grafts for abdominal aortic aneurysms (AAA). After a profit-and-loss statement was prepared on the procedures, the committee asked the practicing physician to present data on the procedure.

The members decided referrals resulting from the AAA procedures raised surgical volumes enough to outweigh losses from the grafts. The committee will review the decision at a later date.

Surgeons are particularly interested in coming before the committee if there is a question about a program continuing. They also are asked to appear to discuss why they should or shouldn’t move on a process.

“We’re trying to educate surgeons to understand that they can have a powerful role in negotiations and in the cost of doing business,” Avigne says.

Avigne believes that one of her greatest strengths is her creativity. Several years ago she set a personal goal of maintaining balance by exercising, leaving the unit to have lunch when possible, and taking time off to keep her ideas flowing and be with family, her husband of 24 years and two teenage college daughters. “Family is like glass, she says. “You have to take care of them, or they will break.”

She has earned the respect of her colleagues for both her business acumen and her people skills. Says Dave Paulus, MD, of the Shands Department of Anesthesiology, “Gail is the best resource the OR has.”

Health Policy & Politics

Illinois bill would register surgical techs, assistants

The Illinois House was considering a bill (SB 354) in May to offer registration to surgical technologists and surgical assistants. The bill passed the state’s Senate overwhelmingly in April.

The bill is for title protection only, not licensure. The legislation would create a voluntary program to protect the titles “registered surgical technologist” and “registered surgical assistant,” limiting their use only to persons registered with the state. To register, a person would have to complete an education program approved by the state and be certified in surgical technology and/or surgical assisting.

“We feel there will be more qualified people out there if we give them an incentive to keep their certification up,” said Margaret Vaughn, a lobbyist for surgical technologists and surgical assistants.

Sue Clark, a lobbyist who monitored the bill for the Association of peri-Operative Registered Nurses, said she believed the original intent was to pass licensure legislation that would allow for direct reimbursement.

Under SB 354, people still could use the titles “surgical technologist” and “surgical assistant” without being registered, and hospitals would not be required to use registered techs or assistants. The bill does not prohibit nurses, physicians’ assistants, and others who are licensed from carrying out surgery-related tasks. Medical students and residents could assist at the discretion of an operating physician without being registered.

—www.legis.state.il.us. Search by bill number.

Federal nurse-to-patient ratio bill in the hopper

Sen Daniel Inouye (D-Hawaii) kicked off National Nurses Week May 5 by introducing S 991. The bill would amend the Medicare conditions of participation to require minimum staffing ratios. Rather than setting forth numbers, the bill would require staffing systems to ensure a number of RNs on each shift on each unit to provide “appropriate staffing levels.” Specifically, the staffing system would have to:

- be created with input from direct-care RNs
- be based on the number of patients and level and intensity of care to be given
- account for the design of the environment and available technology
- reflect preparation and experience of those providing care
- reflect staffing levels represented by specialty nursing organizations
- provide that RNs not be assigned to float to units without having established the ability to provide professional care on that unit.

Hospitals would have to post their staffing numbers daily, specifically noting the number of RNs. The bill also would provide whistle-blower protection for RNs and others who file complaints on staffing.

—www.nursingworld.org
Getting physicians to schedule cases at your ambulatory surgery center (ASC) instead of a competitor’s depends a great deal on how your ASC is viewed by the physician’s office scheduler and staff.

What are ASCs doing to build good relations with physicians’ schedulers?

Here are some ideas from ASC directors who have found ways to create positive relations between offices and ASC staff. Whenever planning a social event or gifts, keep in mind whether these might be construed as an inducement to referrals under anti-kickback laws. See the legal tips in the sidebar.

Build relationships

“I want the office scheduler to think of me first when she has a case to schedule,” says Barbara Harmer, RN, BSN, MHA, senior consultant, HealthCare Consultants International, Celebration, Fla.

“She may have six different ASC numbers in front of her, and I want her to call me. I want her to remember me and my facility in a nice way.”

The first thing Harmer does when introducing her ASC to an office scheduler is to take a jar filled with candy and set it on the scheduler’s desk. The jar has the ASC’s logo and phone number on it. The hope is that the scheduler will see that logo on the candy jar daily and think of the ASC. The scheduler may be more apt to call the number on that candy jar first when she has a case to schedule.

Another idea is to give the center pens and Post-it notes with the ASC’s name and phone number.

“This is so inexpensive and such an easy way to keep your ASC visible in that office,” says Harmer.

“What is important is making a connection. You need a personal touch,” she says.

Though her center used to publish newsletters for offices, they were too impersonal. They also held wine and cheese parties after office hours, but they had a hard time getting office staff to attend because most had family commitments. To avoid anti-kickback issues, it would be a good idea to give the wine and cheese party as an open house for all physician offices. It would not be a good idea to give the party at a physician’s office.

Breakfast get-togethers can work well. The ASC can either provide breakfast in its conference room or reserve a space at a nearby restaurant.

“We have found that the office staff will come to a breakfast because they are on their way to work anyway, and they can have a nice breakfast on us,” says Harmer. She suggests giving the office staff a little gift at the breakfast as something to remember the ASC by.

One evening event that did attract office staff was a dinner and a fashion show. The ASC asked vendors for donations to help pay for the buffet dinner and asked department stores in the area to do the fashion show. Vendors donated door prizes and items for a raffle.

Another well-attended event was a mother-daughter tea scheduled around Mother’s Day. Vendors sponsored tables and decorated them. A prize was given for the best decorated table.

“All of the ideas help build relationships. That is the bottom line,” says Harmer.

Organize an office-of-the-month club

The Harmony Ambulatory Surgical Center in Fort Collins, Colo, chooses an office a month. The center caters a lunch for the office’s staff and gives small gifts.

The center also holds a luncheon meeting for schedulers once a year at its facility. At the luncheon, Barbie Thelen, RN, BSN, BA, CPAN, director of operations, and Johanna Nichols, business office manager, meet with all of the schedulers to see if the communication process can be improved. They go over
Give tours of the center

Another way to build relationships is to hold a workshop after hours. At the workshop, take the office staff through the center as if they were patients, suggests Donna Quinn, RN, MBA, CPAN, CAPA, director of the Orthopaedic Surgery Center, Concord, NH.

Register them and take them through the preoperative area, ORs, recovery room, and discharge areas. This gives the ASC staff the opportunity to review with the office staff why they need certain information at the time of scheduling.

The office staff also gets a first-hand look at what a patient goes through so they are better able to educate patients and answer their questions before surgery. This is a good opportunity to provide the office with preadmission packets that they can give to patients when the decision for surgery is made. After the tour, provide a dinner buffet with a chance to socialize.

—Judith M. Mathias, RN, MA

Are gifts to office staffs legal?

There are legitimate business reasons to meet with the ASC’s referral sources, such as to iron out any scheduling or admitting difficulties. Because of busy schedules, these types of meetings often occur during a lunch period. ASCs should understand, however, that providing anything of value to a potential referral source could, in certain circumstances, implicate federal and state anti-kickback laws.

For example, the federal anti-kickback statute prohibits a health care provider from knowingly and willfully providing or receiving, directly or indirectly, any cash or item to induce referrals of items or services reimbursed by Medicare or Medicaid. This criminal liability applies to both parties in an impermissible “kickback” transaction.

The decision whether to prosecute is discretionary and depends on the specific facts and circumstances.

Gifts and prizes should be permissible as long as they are infrequent, of nominal value (not cash or cash equivalents, like gift certificates), and the gifts do not vary based on the amount of referrals received from the physicians. This is true even if the physician participates in these events. The Health and Human Services Office of Inspector General (OIG) in its “Compliance Guidance for Individual Physicians and Small Group Practices” states that soliciting or accepting any gift or gratuity from those who would benefit from the physician’s referral of federal health care program business is a risk factor only if it is of more than nominal value. The OIG defined “nominal” to mean no more than $10 per item or $50 in the aggregate on an annual basis.

It is also important to look to the state where the ASC is located to see if it has laws similar to the federal anti-kickback laws.

—Lorin E Patterson, JD
—Kimberly Gibbens, JD
Shook, Hardy and Bacon
Kansas City, Mo

New York hospital to pay millions in sex-harassment lawsuit

Brooklyn’s Lutheran Medical Center will pay more than $5.4 million to settle complaints by dozens of female employees that a doctor sexually harassed them during pre-employment physical exams, according to the April 10 New York Times.

The federal Equal Employment Opportunity Commission pursued the complaints after eight workers complained that physical exams required of new employees turned into bouts of physical and verbal sexual abuse. These eight will divide nearly $2 million; the other $3.4 million will be divided among 43 other workers.

The plaintiffs said the doctor touched their breasts and genitals and made comments about their sexual and dating habits. He also told them that if they did not consent to everything he asked, they would not be hired.

Lutheran now offers training for employees on how to spot and prevent sexual harassment and has started an anonymous employee hot line. Female chaperones are now required to be in the room during all employment-related exams of women. The hospital handbook now states that breast and gynecological exams should not be part of a pre-employment screening.

What’s the law on discounts and waivers?

Two attorneys answer questions ambulatory surgery center managers ask about courtesy discounts, waivers, and physician distributions.

Q. Is it legal for an ambulatory surgery center (ASC) to give professional or “courtesy” discounts to family and friends of physicians who operate at the center? What about spouses of investors in the center? If so, how should these accounts be handled?

A. The phrase “courtesy discount” has several different meanings. Traditionally, it denoted the practice by a physician of waiving all or part of the fee for services provided to the physician’s office staff, other physicians, or their families. Recently, it has also come to mean the waiver of any portion of the fee for services not covered by insurance or other third-party payer, including any “out-of-network” penalties that would otherwise apply.

Although some courtesy arrangements may be permitted in certain situations, they may also implicate a number of federal and state prohibitions. For example, the Health Insurance Portability and Accountability Act (HIPAA) has an anti-patient inducement provision that makes it unlawful to offer any benefit (including a discount) to a patient eligible for Medicare or Medicaid when the provider should know the inducement would likely affect the patient’s choice of a provider. The waiver of a co-payment or deductible can be such an inducement. Because a patient, including a physician’s family and friends, would likely choose the ASC over other providers to avoid the co-payment, an ASC risks a civil money penalty for waiving the co-payment with Medicare- or Medicaid-eligible patients.

HIPAA does allow the waiver of co-payments or deductibles for patients eligible for Medicare or Medicaid as long as it:
• does not occur on a routine basis
• is not advertised, and

mas is preceded by reasonable collection efforts or a finding of financial need.

If a patient was told in advance that he or she was not really expected to pay the co-payment or deductible, the subsequent collection effort might not be considered “reasonable.” Failure to report the discount on the Medicare claim form could also lead to scrutiny under the federal False Claims Act.

Private insurance

Private insurance contracts generally require collection of co-payments and deductibles. Some contracts may allow the ASC to waive the co-payment and deductible on a case-by-case determination of need, but rarely will the contract allow routine waivers. There is a risk that the insurer will deny the whole claim if the ASC’s participation agreement with the insurer prohibits waiver of co-payments or deductibles. As is the case with Medicare or Medicaid, the insurer could argue that the patient did not have the proper incentive to seek treatment.

An insurer could also accuse the ASC of fraudulent behavior in that the ASC submitted a claim for the total charge for the service, which was then reduced by the amount of the discount. This would result in a claim for the total amount, say $100, when the actual charge for the service was the total amount minus the waived co-pay, say 20%, or $80. The insurer would argue that it should only have paid 80% of $80, or $64, and that the ASC has defrauded the insurer out of $16.

HIPAA also authorizes criminal sanctions specifically directed toward misrepresentation of this type in connection with the delivery of or payment for health care services under a public or private insurance plan. One could argue that this misrepresentation constitutes either fraud or a false statement within the meaning of HIPAA.

MD discounts an anti-kickback concern

The federal anti-kickback statute is also a concern regarding courtesy discounts given to physicians or their families. This practice could be viewed as an attempt to induce these physicians to refer patients to the ASC. Obviously, the extension of professional courtesy discounts is common in the medical community, and the decision to prosecute is discretionary. The decision will be based on the individual facts and circumstances.

If the ASC chooses to grant courtesy allowances to physicians or their families, other than the waiver of the co-payment or deductible, the discounts should be infrequent and the amount reasonable. For example, it could cause closer scrutiny if the ASC waived the surgery cost instead of a smaller portion of its fees. This practice is also much more defensible when extended to all physicians and not merely those who happen to refer patients to the ASC.

The ASC should also have policies to guide its staff on appropriate use of discounts. The policies should state:
• who is eligible for the discount
• what the discount will be
• how the ASC came to this determination (ie, board resolution or facility administrator).

The decisions cannot be connected in any way to a physician’s referral of patients to the ASC. The policies should also describe the system used to record the discounts given. The record should show why the patient was entitled to the discount (ie, spouse of an ASC

Continued on page 32
The ASC should have policies to aid the staff.

Q. Is it legal to waive the co-pay or a higher deductible a patient would pay for using our center if it is out of the patient’s insurance network?

A. There is no question that waiver of co-pays for “out-of-network” patients is both common in the ASC industry and frequently problematic on a legal basis. The reasons are largely described in the answer above. Perhaps most significant is that certain states, such as Colorado, have enacted legislation with the specific intent to curb such “out-of-network” practices (Colo Rev Stat Sec. 18-13-119). Consultation with the ASC’s local attorney is crucial to reduce exposure when business is conducted on an “out-of-network” basis.

In jurisdictions where this practice is not expressly prohibited, steps can be taken to reduce exposure to an ASC. Such steps include:

- clearly informing managed care organizations (MCOs) of the waivers
- sharing any “discounts” the ASC provides as a result of its “out-of-network” waiver policy with the MCOs (the MCOs may argue that these “discounts” arise because the ASC submitted a claim for the total amount when the amount charged was actually less)
- avoiding advertising that waivers will be made for “out-of-network” patients.

As in the answer above, even if these precautions are taken, an ASC may still face risks in waiving co-pays for “out-of-network” patients. For example, there is case law that upholds an MCO’s right to withhold payment altogether under such circumstances.

Q. We have a surgeon who would like to operate at our center. The surgeon seems to meet the “one-third test” because at least one-third of his practice income would be from procedures he would perform in the ASC. However, the surgeon belongs to a group practice, and the other members would not be participating in the center. The group practice would collect the fees for the procedures he performs in the center. Is this permissible?

A. Under these circumstances, the ASC should inquire into how the professional fees collected by the surgeon’s group practice will be distributed among its members. This situation is very similar to that addressed by the Health and Human Services Office of Inspector General (OIG) in Advisory Opinion #02-9 dated June 21, 2002. In that case, a GI physician was the sole owner of an ASC and belonged to a GI group practice. The other members of the group practice would not participate in the ASC but would collect the professional fees generated from it. Once the fees were collected, however, all of the fees from services performed within the ASC were passed directly through to the GI physician owner. As a result, the other group members were not “improperly incentivized” to refer to the facility as “passive referral sources.” The OIG concluded that this arrangement satisfied the federal Anti-kickback Statute’s ASC investments safe harbor.

Otherwise, the ASC should inquire about the nature of the nonparticipating group members’ practice. For example, in an OIG Advisory Opinion #03-02 dated Jan 21, 2003, many members of a group practice investing in an ASC did not perform enough outpatient surgery to satisfy the investments safe harbor, but they did receive at least one-third of their practice income from performing procedures that required either an ASC or hospital OR setting. In these circumstances, the OIG indicated that while the safe harbor was not satisfied because the other surgeons would not likely be passive referral sources, it was unlikely that the anti-kickback statute would be violated.

Advisory opinions admittedly protect only those parties who actually apply for them. Because these opinions are felt to express the OIG’s views on the arrangements, however, they are closely monitored by the health law community because they are thought to express the OIG’s views on particular fact patterns.

—Lorin E Patterson, JD
—Kimberly Gibeaux, JD
Shook, Hardy and Bacon
Kansas City, Mo

This article contains general information and is not legal advice. No action should be taken relying on information in this article without obtaining advice of legal counsel.
Looking to recognize employees?
Some of the most-wanted items, according to a survey by Vault, Inc, a New York career company, reported in the Wall Street Journal:
• a Palm Pilot
• gift certificates to retailers, restaurants, or movie theaters
• tickets to sporting events or concerts
• fine wine
• flowers
• cash.

Not so appreciated—giving the corporate mission statement on a laminated card, a jar of jelly beans, or a gift certificate to McDonald’s for vegetarians.

CEOs are staying put
Hospital CEO turnover is at its lowest point in years, according to the American College of Healthcare Executives’s annual survey of CEO turnover.
In 2002, turnover was 14%, the lowest since 1994 and slightly higher than the all-time low of 13% reported in 1983 and 1990.
Reasons cited are the sluggish economy and better board support.
Harder economic times, a bearish stock market, and a different environment since Sept 11, 2001, are keeping some executives from moving. Hospital boards are not as trigger-happy and are giving CEOs more time to improve performance at their facilities.

Fewer nurses, more adverse events
Pennsylvania hospitals with a higher proportion of registered nurses and licensed practical nurses had significantly lower incidences of pneumonia and decubitus ulcers in the 1990s, according to a new study by Lynn Unruh, PhD, RN.

Unruh used a sample of all Pennsylvania acute care hospitals from 1991 and 1997 to assess the relationship of licensed nursing staff with hospital patient problems sensitive to nursing care: lung collapse, decubitus ulcers, falls, pneumonia, posttreatment infections, and urinary tract infections.
The study also found that patient acuity increased 21% during this time period, while licensed nursing staff per 1,000 acuity-adjusted patient days of care fell 14.2%.
—Unruh L. Medical Care. January 2003;41:142-152.

Scholarship applications due
Applications are due June 30 for nursing scholarships offered under the Nurse Reinvestment Act. Awards will be made by Sept 30. Recipients must agree to serve 2 years in a critical shortage area.
—http://bhpr.hrsa.gov/nursing/reinvestmentact.htm

Please see the ad for LCCST SURGICAL TECH in the OR Manager print version.
Premier, Novation settle with Retractable Technologies

Two of the largest group purchasing organizations, Premier and Novation, settled an antitrust lawsuit May 7 brought by Retractable Technologies, Inc (RTI), Lewisville, Tex, maker of Vanishpoint needle safety devices. Tyco Healthcare Group, which was also sued, joined in the settlement, leaving BD as the only remaining defendant. The lawsuit, filed in 2002, alleged that the defendants engaged in anticompetitive conduct to prevent RTI from selling its needles to hospitals. The defendants denied the allegation. Terms of the settlement reportedly included cash payments and other provisions that will make it easier for RTI to sell its products to hospitals.

Sterion sells container line to Steris

Minneapolis-based Sterion announced May 8 it had sold certain of its sterilization container assets to Steris Corporation, Mentor, Ohio. Sterion said it would focus on other areas of its business, such as negative pressure wound therapy and related surgical drains.

SRI/Surgical Express teams with Aesculap

SRI/Surgical Express, Tampa, Fla, has renewed its rela-
tionship with Aesculap for ten years. Under the agreement, the two companies will jointly market SRI’s procedure-based delivery of instruments with Aesculap’s instrument sets.

Please see the recruitment ad for GIBSON FISHER LTD in the OR Manager print version.

Please see the recruitment ad for YALE NEW HAVEN HOSPITAL in the OR Manager print version.
Please see the ad for KIMBERLY-CLARK CORPORATION in the OR Manager print version.
**Drug-eluting cardiac stents could erode volume of bypass surgery**

Ushering in what some call a new era in coronary artery disease treatment, the Food and Drug Administration approved April 24 the first drug-eluting stent. The Cypher stent made by the Cordis Corp, a Johnson & Johnson company, is intended to reduce restenosis in treated coronary arteries. Restenosis is one of the greatest challenges in long-term treatment of cardiac patients. The company says the new stent will cover the majority of stent cases performed. The stent gradually releases a drug, sirolimus (Rapamune) that prevents scar tissue growth, which can lead to blockages. The Cypher’s list price is about $3,200, much more than conventional stents. Medicare approved added reimbursement for drug-eluting stents in August, in anticipation of FDA approval, but payments are expected to fall short of the cost. Drug-eluting stents are likely to mean less coronary artery bypass surgery, cutting into hospital revenues.

—www.cypherusa.com

**FDA issues safety alert on adhesion prevention product**

The FDA alerted users April 16 to immediately stop using Gynecare’s Interigel Adhesion Prevention Solution from Gynecare, a unit of Ethicon, Somerville, NJ. The company is voluntarily withdrawing the product from the global market. Intergel is used in gynecological surgery to reduce postoperative adhesions. There have been reports of adverse events including late-onset postoperative pain and repeat surgeries following pain, noninfectious foreign body reactions, and tissue adherence. In some patients, a residual material was observed during repeat surgery. Gynecare is requesting that all Gynecare Intergel product and samples be returned to Gynecare.


**JCAHO surveyors not to look for MRSA clinical path as part of infection sentinel event alert**

Joint Commission on Accreditation of Healthcare Organizations surveyors won’t expect to see a clinical path for methicillin-resistant Staph aureus (MRSA) in connection with the January Sentinel Event Alert on nosocomial infections. The alert has only two recommendations:

- comply with the Centers for Disease Control and Prevention’s new hand hygiene guideline
- manage as sentinel events all deaths and major permanent loss of function attributed to nosocomial infections.

The Joint Commission issued the alert because few such events have been reported to the sentinel event database. An MRSA clinical pathway was mentioned as one example of a strategy that hospitals have used to reduce infection risks. But this is not one of the alert’s recommendations, Rick Croteau, MD, of JCAHO told OR Manager.

—www.jcaho.org

**What is optimum OR utilization?**

The most efficient OR is one in which patients are waiting when the OR is available. But the most patient-friendly OR is one that has a room ready when the patient arrives. Optimum utilization results when these two factors are balanced.

These are the findings of researchers from the Children’s Hospital of Philadelphia and George Mason University, Fairfax, Va, who used an OR simulation to enumerate the important factors in optimum utilization. They set operational goals of having cases start within 15 minutes of the scheduled time and end no more than 15 minutes past the scheduled end of the day.

Within these goals, they found the OR is most efficient with a utilization between 85% and 90%. When utilization increased to more than 90% to 95%, late minutes and delays increased beyond the 15-minute target.

Decreasing the variability of case duration allowed increased utilization without exceeding the 15-minute target.

Increasing the variability of case duration decreased the utilization that can be achieved within these targets.