Fine-tuning the block schedule? Now could be the right time

If you want to fine-tune the block schedule, now may be the time. A silver lining of the recession is that surgeons and staff may be more accepting of changes to the schedule than they might be otherwise.

With the decline in elective surgery from the economic downturn, surgeons are less able to leverage one hospital against another.

In all, by the end of March 2009, 59% of hospitals were seeing a moderate or significant decrease in elective procedures, the American Hospital Association reports.

“This is allowing hospitals to make changes that are more politically challenging,” observes William Mazzei, MD, medical director of perioperative services and clinical professor of anesthesiology at the University of California, San Diego.

“What is important to surgeons is good use of their time at one facility rather than playing one facility against another. They don’t have the business to do that any more.”

Facilities may be able to enforce stricter rules to improve OR utilization, he says. With more OR time available, they may be able to en-

Continued on page 8
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Editorial

Why are costs so much higher?

What McAllen does has more of are services—more testing, hospital treatment, surgery, and home care.

Dr Gawande observes there also seems to be a higher prevalence of physicians in McAllen who see their patients as a revenue stream.

As he talks with physicians and executives, he hears that something began to change in McAllen about 15 years ago—“the medical community came to treat patients the way subprime-mortgage lenders treated home buyers: as profit centers.”

In most communities, he observes, physicians have a mix of attitudes about money; some place a lot of emphasis on revenue while others see it as secondary to patient care and clinical interests. McAllen’s medical community, on the other hand, tends to be “at one extreme” in their focus on finances.

Dr Gawande then looks at communities and organizations that have controlled costs and achieved higher quality. Among these are the Mayo Clinic; the city of Grand Junction, Colorado; and Intermountain Healthcare in Salt Lake City.

The contrast between them and McAllen, he believes, “is a battle for the soul of American medicine.” To him, the question the nation needs to ask is “whether the doctor is set up to meet the needs of the patient, first and foremost, or to maximize revenue.”

—Pat Patterson

Dr Gawande’s article is free at www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande
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The webinar series for new managers will begin on October 22 and continue through December.
Managing the Lean way, keeping employees engaged, stopping bad behavior, improving patient flow, and getting the most out of the sterile processing department are among topics for 8 all-day seminars being offered Wednesday, Oct 7, at the Managing Today’s OR Suite Conference. The conference runs Oct 7 to 9 at Caesars Palace in Las Vegas.

Especially for new OR managers, a seminar on financial skills will provide tools managers need to make and support good decisions.

S-1: Operational Excellence: Using Lean in the OR
Jenn Lingenfelter, Pamela Murphy
Weeding waste out of OR processes will be the focus of this seminar focusing on Lean manufacturing, pioneered by Toyota.

S-2: Orientation, Onboarding, and Employee Development
Judy Pins
Lessons from a progressive new hospital about bringing employees on board successfully and keeping them engaged throughout their careers.

S-3: Financial Skills for New Managers
Sherry Church, Gina Brennan
This session will help managers learn the vocabulary of finance and acquire financial skills needed to understand reports and make good management decisions.

S-4: Moving Beyond the Double Doors: A Journey on Improving Patient Flow
Christina Dempsey, Sherron C. Kurtz, Kenneth G. Murphy
A hospital shares its journey to optimize flow, resulting in less wait time for urgent patients, better block utilization, reduced case time after 5 pm, and more.

S-5: Management Strategies to Stop Bad Behavior for Patient Safety
Grena Porto
The speaker offers a road map for recognizing bad behavior, setting behavioral standards, and developing a code of conduct to improve patient safety.

S-6: Appreciative Leadership: Focus on What’s Going Right
Jo Manion
In this energizing session, the speaker explores elements of appreciative leadership and concrete, positive approaches for addressing issues in the work environment.

S-7: SPD and the OR: Different Issues, Common Goals
Cynthia Spry, Martha Young
The speakers will offer strategies for building a foundation so both departments can understand each other’s needs and improve processes.

S-8: Magic of Frontline Leadership: Secrets of Accountability and Engagement
Brian Lee
An expert on employee satisfaction teaches about creating incentives to improve productivity and offers practical tools for creating world-class patient, staff, and physician satisfaction.

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Settlement on kyphoplasty billing

In the first settlement of a national investigation, HealthEast Care System agreed in May to pay the federal government $2.28 million to settle allegations that 3 of its hospitals overbilled Medicare for kyphoplasties.

Some 100 hospitals are under investigation, according to the legal expert who represented HealthEast. The investigation is being led by the US Attorney for the Western District of New York in Buffalo.

The settlement involves kyphoplasties performed from 2002 through 2007 at St Paul, Minnesota-based HealthEast’s St Joseph’s Hospital, St John’s Hospital, and Woodwinds Hospital.

The investigation stems from a whistleblower lawsuit filed in 2006 by 2 former employees of Kyphon, Inc, the company that developed balloon kyphoplasty.

Kyphoplasty, a treatment for spinal fractures caused by osteoporosis or cancer, involves using a balloon catheter to create a cavity in the fractured bone and filling the cavity with bone cement.

The suit alleged that Kyphon conducted a fraudulent marketing campaign that induced hospitals to bill Medicare for kyphoplasty as an inpatient procedure even though the procedure can be performed safely as an outpatient procedure.

“By keeping patients overnight, hospitals could seek greater reimbursement from Medicare and make much larger profits on kyphoplasty,” said Kathleen Mehltretter, acting US Attorney in Buffalo.

HealthEast says it “cooperated fully” with the investigation, and no penalties are involved.

In 2008, the government reached a $75 million settlement with Medtronic Spine LLC, which acquired Kyphon in 2007. The company did not admit wrongdoing.

Whistleblower allegations

The whistleblowers’ original complaint, filed against Kyphon and a Buffalo hospital and recently unsealed, alleged Kyphon started in 1999 to develop a marketing scheme “to exploit high reimbursement under inpatient DRGs to persuade hospitals to perform kyphoplasty.”

Kyphon was highly profitable, according to the court filings, with the profit margin on its products ranging from 87% to 92%.

DRGs that Kyphon recommended paid hospitals about $6,000 to $10,000 depending on the area of the country. That compared with outpatient reimbursement of about $2,000 in 2005, according to the court filing.

Billings for unnecessary inpatient admissions are considered false claims, which are illegal under the federal False Claims Act (sidebar).

Among allegations are that Kyphon representatives met with coders and medical record departments to explain how to code and bill the charges to ensure payment under the DRGs.

Court documents also say sales reps would be present in the OR during kyphoplasty and were taught to ask the OR nurses whether the patient had been admitted for an inpatient stay. If not, the sales rep allegedly would arrange for the physician to sign orders for inpatient admission in the OR.

Also part of the allegedly fraudulent scheme was to market an instrument for performing bone biopsies during kyphoplasties. The company, according to the whistleblower suit, advised physicians they had to perform bone biopsies on every patient regardless of medical history or condition.
Only the beginning

The HealthEast settlement is only the beginning, says Ronald H. Clark, PhD, JD, the legal consultant who represented HealthEast and an expert on the False Claims Act. “Basically, every hospital performing kyphoplasty could potentially be a subject of this investigation,” he says.

He says HealthEast ran into problems despite having what he calls “the best compliance plan I have ever seen in a hospital. This shows you no compliance plan will catch everything.”

The settlement holds lessons for hospitals and OR leaders, not only on billing for kyphoplasty but for any new technology introduced in a hospital.

The immediate lesson—if the US Attorney comes calling, cooperate, Clark advises. Kyphoplasty billing problems are easy to uncover, says Clark, who was formerly a senior counsel in the Civil Fraud Division of the US Department of Justice. Investigators can simply run a computer report on a hospital’s claims. If most kyphoplasties come up as inpatient, that’s a red flag.

He says HealthEast came out reasonably well because it cooperated fully with the US Attorney.

Clark outlines the approach hospitals should take in his blog at http://fcaexpert.blogspot.com/2009/02/new-national-kyphoplasty-enforcement.html

For those who don’t cooperate, he says penalties can be much more severe. The government can assess $5,500 to $11,000 per each piece of paper associated with a false claim plus treble damages.

Best defense

Clark says a hospital’s best defense is to invest in a “top-notch compliance plan.

“Have your plan reviewed. Make sure it is effective, supported with adequate resources and that you have a good compliance officer,” he advises managers.

The settlement holds other lessons. Be sure the hospital has a policy stating that contact between employees and outside vendors and independent physician groups must be authorized, he advises. Compliance officers need to be aware of whom employees have contact with because under the law, the hospital will be treated as though it was fully aware of what was going on.

Also, though nothing precludes a salesperson from being in the OR to make sure a device is used correctly, “the danger is that in many hospitals in which kyphoplasty was performed, sales personnel were giving billing advice,” he says. “That can work its way into becoming a billing rule, and that becomes a problem.”

Another lesson: Include the compliance officer in the product evaluation process to make sure procedures involving new products are billed appropriately.

Educate employees

Employees and managers need to be educated about the compliance plan, Clark adds. They should know who the compliance officer is and feel comfortable going to the officer with any concerns. Employees who feel comfortable reporting concerns and know their concerns will be addressed are less likely to consider filing a whistleblower suit.

One way he judges if a hospital has a good compliance plan is to ask any employee, “Who’s your compliance officer?” If he gets a blank stare, he knows something is lacking.

Every employee should have easy access to pertinent parts of the compliance plan. Two ideas are to provide color-coded notebooks or post information about the plan on the hospital’s intranet.

“The consequences of not being proactive for hospital management are severe,” he says. “It can mean huge amounts of money, affect your Medicare eligibility, and if you have a building project, it can affect any bonds that require approval from HHS.”

Ronald Clark’s website is at http://fcaexpert.com

C difficile infection rising in hospitals

Clostridium difficile is more prevalent in hospital patients than previously estimated. The majority of cases appear to be health care associated, finds a new survey.

The survey, completed by 648 hospitals, found 13 in 1,000 inpatients were either infected or colonized with C difficile—a rate 6.5 to 20 times higher than previous estimates, which the authors say is a minimal estimate. William Jarvis, MD, the principal investigator, said preventing C diff development and transmission should be a top priority for every institution.

OR throughput

Continued from page 1

courage surgeons to stay at the fa-
cility longer than they might have in ordinary times.

For example, if the OR has al-
lowed some surgeons to have half-
day blocks, which is not optimal for utilization, it may be easier to make these full-day blocks.

If the surgeons object, the facility might respond by saying it will convert these blocks to open time into which anyone can schedule cases. In this environment, most surgeons will accept the change, says Dr Mazzei, who is also with Surgical Directions LLC, Chicago-based consultants.

It may also be easier to match staffing more closely to the surgical schedule, he notes. In a down economy, staff may be more accepting of scheduling changes.

The business of blocks

With fewer cases, ORs need to pay close attention to how surgeons’ block time is affecting their business, comments Jerry Ippolito, MBA, MHSA, of consultants OR Efficiencies LLC, Naples, Florida.

When a surgeon asks for block time, he suggests the question should be: “What are you going to bring us?” How will the surgeon’s cases benefit the hospital? He advises posing the same question to surgeons who already have block time.

The block time analysis should include not only how much of their block time surgeons are using but also the contribution margin of their cases. (Contribution margin = revenue – variable costs, such as implants and specialty staffing). The contribution margin should be calculated before indirect costs are allocated and should include revenue and expenses for the surgeon’s patients hospitalwide, not just for the OR, he adds.

The literature includes a num-

number of studies on OR time allocation, including use of contribution margin (related article, p 11).

Good governance

Nothing is more important to effective block scheduling than strong, active leadership, these experts say. The block scheduling system must be governed by policies and procedures endorsed by the medical staff and enforced by the OR’s governing body. Policies must be transparent.

“The system must be scrupu-
lously fair. If there is any fa-
voritism, the surgeons will sniff it out, and it will never work,” stresses Tom Blasco, MD, MS, an anesthesiologist and intensivist at Advocate Lutheran General Hospital, Park Ridge, Illinois, and a con-
sultant with Surgical Directions LLC.

“The OR governing body must be committed to ongoing measurement and evaluation,” Ippolito adds. “Many organizations allocate block time to a surgeon and never look at it again, whether the sur-
geon uses it or not.”

When blocks are poorly man-
aged, surgeons have bad ex-
periences and may end up rejecting block scheduling all together. (For more on OR governance, see the July 2008 OR Manager.)

Communication is a corollary

Communicating with surgeons about their blocks is essential in managing the block schedule, says Stephanie Davis, RN, MS, CNOR, assistant vice president, surgical services for the HCA Clinical Services Group of HCA Inc, the national health care company based in Nashville, Tennessee.

The surgeon’s office often schedules the cases. The office may be scheduling some cases outside the block because these other times are more convenient, she notes.

“If we are not transparent with surgeons about their utilization, they may not know they are not meeting the target. They may vol-
unteer on their own to adjust their block,” she says.

Open communication is also part of customer service.

“If you have a good relationship with your surgeons, they will trust you to manage blocks fairly,” says Davis, who has assembled a block scheduling toolkit for HCA Inc’s 165 hospitals (related article, p 9).

Starting a conversation

Good relationships make it easier to start a conversation if a sur-
geon’s block utilization is not what is expected. Davis says that when she was a perioperative director, she talked to the surgeons about low utilization as soon as she found out.

She might say, for example, “Dr Smith, I hope you got your letter about block utilization. Did you re-
alize you were only running about 35%? Do you want to move your block to a different day? What can I do to help you get your utilization where it needs to be?”

Efforts to manage the block schedule can be worth it because everyone benefits, Dr Mazzei ob-
serves.

“The workday is more enjoyable for physicians and staff alike in hospitals that have completely full...
A toolkit for managing block scheduling

HCA Inc, the national health care company, has developed a block scheduling toolkit for its 165 hospitals. The toolkit includes decision points, algorithms for managing blocks, and sample policies.

Here are HCA Inc’s 10 decision points for block scheduling.

1. Is this the right time for block scheduling?

About 75% to 80% of HCA Inc’s hospitals use block scheduling, estimates Stephanie Davis, RN, MS, CNOR, assistant vice president, surgical services for the HCA Clinical Services Group, Nashville, Tennessee, who developed the toolkit.

If an OR isn’t using block scheduling, she suggests asking: “What are the reasons for not offering this service? Are those reasons still valid in today’s environment?”

Not every OR decides to use block allocations. “If you don’t have a lot of volume and are trying to get every case you can, you might not want to rock the boat with the medical staff,” she notes.

In some parts of the country, “surgeons are really anti-block,” says Jerry Ippolito, Jerry Ippolito, MBA, MHSA, director of perioperative services and pain management business development, Southeast Anesthesiology Consultants, Charlotte, NC.

That can happen if they have had a bad experience. To some, block scheduling means “preferential treatment.” Surgeons may be more receptive to another term, such as “reserved time,” he suggests.

An OR schedule with all open time has its own problems, he adds. Open time favors surgeons who perform mostly elective cases, such as ENT and ophthalmology, and can schedule far in advance.

Even in an OR with all open time, surgeons tend to establish patterns that are, in effect, like block time.

Leaders may have success getting the surgeons to accept block scheduling if they show them data demonstrating that their cases already fall into regular patterns, he suggests.

How much time should be blocked? Typically, 55% to 80%, though how much open time to offer depends on the situation, Ippolito says. A high-volume trauma center can’t allocate as much time as an OR with a more predictable caseload. How much time to leave open is also a strategic issue. A more mature setting may have 80% to 85% of its time blocked, while a facility trying to attract new surgeons will want more open time available.

2. Does your block scheduling policy include key elements?

Davis suggests key elements of the policy should include:

- A block utilization rate is calculated monthly and reported to each surgeon quarterly. The toolkit recommends a block utilization rate of 70%. But there is no hard-and-fast rule, Davis says. “It’s up to our facilities to set the level they think is appropriate.”

Suggested block release times

<table>
<thead>
<tr>
<th>Service</th>
<th>Release Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn service (inpatient)</td>
<td>1 day</td>
</tr>
<tr>
<td>Cardiac</td>
<td>1 day</td>
</tr>
<tr>
<td>General surgery</td>
<td>7 days</td>
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<tr>
<td>Gynecology</td>
<td>7 days</td>
</tr>
<tr>
<td>Head and neck</td>
<td>7 days</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>4 days</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>7 days</td>
</tr>
<tr>
<td>Orthopedics (joint)</td>
<td>14 days</td>
</tr>
<tr>
<td>Orthopedics (spine)</td>
<td>3 days</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>7 days</td>
</tr>
<tr>
<td>Plastic (cosmetic)</td>
<td>14 days</td>
</tr>
<tr>
<td>Radiology</td>
<td>3 days</td>
</tr>
<tr>
<td>Vascular</td>
<td>2 days</td>
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<tr>
<td>Thoracic</td>
<td>3 days</td>
</tr>
</tbody>
</table>


Davis says monitoring of blocks requires discernment: “Your OR governance team has to look at each situation and be able to back up its decisions with facts.”

(From a scientific point of view, adjusting blocks according to utilization isn’t the best choice, notes a leading researcher, Franklin Dexter, MD, PhD. See related article, p 11.)

- Automatic block release times are stated and enforced consistently for all surgeons. In a general OR with a lot of specialties, a 72-hour release is appropriate, Davis says. “Some will argue 48 hours is better; others will argue 1 week. You have to decide with your group what fits.” One option is release times by specialty (sidebar).
- The policy states that if a surgeon notifies the OR in advance...
to release block time, unused time will not count against the surgeon in the block utilization report. Advanced notice allows other procedures to be booked into the unused time.

3. **Is there a physician champion?**

Blocks are best managed by an executive committee made up of the OR director, the administrator responsible for surgery, the chief of surgery, and the chief of anesthesia.

“Everyone on the committee has a vested interest in making block scheduling work,” Davis notes.

The physician champion helps to monitor and enforce the block schedule and communicate with the surgeons.

“Communication goes over better if the surgeon receives it from a peer,” she notes.

The physician champion, with the OR director, should be willing to sign letters to the surgeons informing them of their block utilization.

4. **Is there a grace period?**

The block scheduling policy allows surgeons a 3-month grace period to improve their block utilization once informed of their utilization rates, the toolkit advises.

“Our plan is to inform surgeons of their block utilization once a quarter but to tell them we will wait one more quarter before doing anything to their block to allow for variances,” Davis says.

5. **How is the utilization rate communicated?**

“It’s important to communicate with every surgeon. If they have a block, you communicate with them once a quarter, regardless of their utilization,” Davis says.

The toolkit recommends a tiered approach to communication. For example:

- A letter of congratulation is sent to surgeons with a block utilization rate of 70% or greater.
- Surgeons with utilization of 70% to 50% are informed they have not met the threshold and asked to decrease the time blocked or to consider changing their day or time to improve usage.
- Surgeons whose utilization falls below 50% are informed they are well below the threshold, and if they do not bring their utilization to 70% or above by the end of the next quarter, they will lose the privilege of having a block.

6. **Are at least 1 or 2 ORs reserved for first-come, first-served booking?**

“Having open rooms allows new surgeons to book occasional cases in your OR and allows for recruitment of new business,” Davis notes.

7. **Do you have 1 OR for add-ons, emergencies, and flip-flopping of cases?**

“In small ORs, this might not be possible, but in medium to large ORs, it is effective,” Davis says.

Open rooms provide flexibility to move cases and add cases. There may be exceptions for facilities such as eye centers where routines are well established. The rule is not rigid; the point is to have flexibility. Providing an add-on room for urgent and emergent cases enabled St John’s Regional Health Center, a regional trauma center in Springfield, Missouri, to increase its surgical volume by 5%, increase surgeon revenue by 4.6%, reduce the need for ORs after 3 pm, and reduce overtime. The project was part of an effort to smooth patient flow throughout the hospital. (See November 2003 and January 2005 OR Manager.)

8. **Is the schedule accurate?**

Are your OR analyst and schedulers making sure the schedule is accurate so utilization reports will reflect accurately each surgeon’s block use? Accurate data is critical when reporting block utilization to surgeons.

9. **Are you willing to enforce the block scheduling policy fairly?**

Effective block scheduling requires maintenance and enforcement of rules, Davis says. The HCA Inc toolkit provides a sample policy for block scheduling.

10. **Will the administration support the block scheduling policy?**

Effective block scheduling always comes back to good governance. The administration must support the surgical executive committee that reviews the block allocations and not overturn their decisions.

**References**


Smoothing OR schedule can ease capacity crunches, researchers say. *OR Manager.* 2003;19(11):1, 9-10.
The research on OR time allocation

What criteria should be used to make decisions about adjusting block time? Traditionally, OR committees have used surgeons’ utilization of blocks. But OR utilization isn’t the best way to make this decision, the research shows.

The method to use depends on why block time is being adjusted, notes Franklin Dexter, MD, PhD: Are blocks being adjusted for operational reasons; that is, to match staffing to the existing OR workload? Or are blocks being adjusted for tactical reasons, such as to provide more convenient access to OR time for some surgeons?

Consider these scenarios:

**Scenario 1: Tactical decision**

A group of neurosurgeons has 91% utilization of their block time. They’re recruiting a new spine surgeon and need more OR time. Dr Jenkins, a vascular surgeon, has 60% utilization of his block. It seems that he could use less time. Should the OR committee take some of Dr Jenkins’s block time and give it to the neurosurgeons? This is a tactical decision.

**Scenario 2: Operational decision**

The neuro service has a block allocation of 3 ORs on Mondays from 7:15 am to 3:30 pm. They have little underutilized time and often have overutilized time (ie, run late). How many nursing staff should be assigned for 8 hours and how many for 10 hours? This is an operational decision.

**Tactical decisions**

For tactical decisions like Scenario 1, decisions increasingly are being made at least partly to meet financial goals, Dr Dexter says. The OR committee might, for example, look at the contribution margin for spinal surgery to decide if giving the neurosurgeons more block time would help the hospital financially. (Contribution margin = revenue – variable costs.) More spinal surgery might or might not be a good idea, depending on the implant costs and the reimbursement.

Tactical decisions also include strategic issues. Dr Dexter says “revenue” should be considered from a long-term perspective and should include not only reimbursement but also the intangible value of adding more cases in a focused strategic area. For example, executives decide your hospital is going to be a regional pediatric center. Of course, you will give your pediatric surgeon a great deal of block time, the cost and reimbursement issues aside. In this case, each additional pediatric patient has an intangible value, known in economics as utility, Dr Dexter explains.

**Utilization not best choice for tactical decisions**

Utilization is not the best choice for making tactical decisions on block time, Dr Dexter says, citing 5 reasons from the literature:

1. Utilization does not help to reduce patient waiting times, which is usually a goal of patients as well as clinicians and administrators.
2. Utilization is poorly related to contribution margin. A surgeon or service with high utilization can still lose the hospital money if reimbursement for these cases doesn’t cover costs.
3. Efforts to increase utilization can actually reduce margins. For example, the hospital signs an insurance contract hoping to increase surgical volume, but not many of the patients have surgery, and the contracted rates are too low to cover costs.
4. Utilization is poorly related to variable costs. Surgeons with equal utilizations can have different variable costs. For example, 2 surgeons have 70% block utilization. The first surgeon performs outpatient breast surgery, which has low variable costs per OR hour. The second surgeon performs joint replacements, which have high variable costs per OR hour.
5. For surgeons with low utilization, it is questionable whether utilization can be estimated sufficiently precisely for this purpose. A 2003 study found, for example, that if during 1 quarter, Surgeon 1 had a block utilization of 65%, and Surgeon 2 had a block utilization of 80%, statistically, the difference may be due to random chance. For surgeons with low utilization, the study found it would take more than 10 years of data to measure block utilization accurately enough to be of practical value in making block-time decisions.

**Operational decisions**

Operational decisions should be made to improve OR efficiency, according to research findings. For
this purpose, OR efficiency is defined as a balance between underutilized and overutilized OR time. If time is underutilized, revenue isn’t coming in while the OR is incurring labor costs. Overutilized time means clinicians have to work late, which is a dissatisfier and can be costly if overtime is needed.

Achieving OR efficiency involves matching the staffing allocation as closely as possible to the existing workload.

In Scenario 2, depending on the details of the neuro service workload, a decision based on OR efficiency might be to increase the neuro service’s OR allocation (or block) from 7:15 am to 6 pm in 2 of the 3 ORs. The anesthesia providers and nurses gain by having more predictable work hours (ie, fewer overutilized hours).

The purpose of this block adjustment is not to encourage more neurosurgery because the neurosurgeons are already getting their cases on the schedule. Rather, the purpose is to achieve a better balance between underutilized and overutilized time.

“Generally, what surgeons care about are tactical decisions: ‘How can I grow my practice?’” Dr Dexter says. “What anesthesiologists and nurses generally care about are decisions on the day of surgery: ‘Will I finish on time?’”

More information on Dr Dexter’s research and consulting is at www.FranklinDexter.net

References


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Joint Commission’s perspective

On April 15, 2009, the Joint Commission posted a response on its website to a question about standards that address vendor representatives in clinical areas. The commission says it does not have specific standards or credentialing requirements in this area because accepted national standards on competence for vendor reps are lacking.

But the commission notes, “...some organizations are recommending general credentialing requirements for these individuals” and refers readers to AdvaMed’s website (www.advamed.org).

The commission also cites several standards relevant to any person who enters a health care organization and affects the quality and safety of patient care.

—www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/09_FAQs/HR/hc_industry_vendor_representatives.htm

More is needed to reduce confusion.

In 2006, SMI took a step to help end the patchwork quilt of credentialing requirements by publishing Management Guidelines for Vendor Access (www.smisupplychain.com).

“We identified the need for vendor management from a safety and quality standpoint,” says Hughes.

New joint best practices

AORN and the Advanced Medical Technology Association (AdvaMed), which represents medical device manufacturers, recently took another step toward consistency, releasing Joint Best Practices Recommendations for Clinical Health Care Industry Representative Credentialing at the AORN Congress in March 2009. The recommendations include credentialing criteria representing best practices from 11 organizations and are designed to provide guidance for streamlining vendor credentialing.

Perner says the organizations hope the recommendations will help OR managers establish a vendor credentialing policy.

“It’s also important to determine how to implement the policy and communicate it to others so it’s followed,” he adds.

Some hospitals have used medical credentialing as a template for vendor credentialing, but Terry Chang, MD, director of legal and medical affairs for AdvaMed, says there’s a difference. “With physicians, it makes sense to have primary source verification such as graduation from medical school. That kind of rigor makes sense because of the risk. But the risk [from what a vendor does] is not the same as practicing medicine.”

Who’s on first?

More is needed to reduce confusion. “Suppliers are asking who’s on first, who’s on second,” says Hughes. “What are we supposed to be doing for each system?”

Vendor credentialing requirements vary because individual hospitals interpret risk, industry expectations, and infection control practices differently.

“Some hospitals ask for vaccinations, and some don’t ask for any,” says John Wills, founder and president of Status Blue, LLC, a third-party credentialing verification organization (CVO). Companies like Status Blue use databases and software to manage sales rep credentialing; vendors pay an annual processing fee to be included.

Reciprocity needed

“In a perfect world, you do the paperwork once and be squared away for all the hospitals,” says Wills. In essence, there would be reciprocity. Variations in hospital requirements make reciprocity difficult.

“The notion of there being a ‘one size fits all’ industry guideline and documentation repository sounds good in principle but is difficult to conceptualize in real-world practice,” says Wills. “Best practices and industry guidelines are important, and we need more consistency with vendor credentialing, but if clinicians have to meet different requirements and medical staff expectations for each facility so they can be on staff or have privileges, why would the industry operate differently for vendors?”

The good news is most third-party CVOs allow sales representatives access to all the hospitals in a single system rather than charging the system for each hospital.

“Reps can log on and send their profile with their credentials attached to whomever they want,” says Wills. “It’s the equivalent of sending an email with a link.” That includes other CVOs the vendor might want to register with.

The AORN recommendation encourages hospitals to “institute a policy of reciprocity,” which, along with a coordinated credentialing process, could save resources. CVOs

Continued from page 1
Who bears the cost?

Not efficient,” given the amount of work involved. He says hospitals typically charge $100 to $250 per sales rep, although one system charges $400 per rep.

The second option is for vendors to pay CVOs. Wills sees his and other companies as time savers for the hospital.

“Everyone is busy enough so why not log into a system that other hospitals in your area are using?” he says. “You can monitor and track visitors. It’s apparent to the staff this person isn’t an employee. If they have the badge on, then it’s thumbs up.”

Hughes says the drawback of this option for vendors is, “an annual fee, even though 90% of work is done in the first year. It’s like the Energizer Bunny for cash flow.” He also worries that larger manufacturers, which can better afford the fees, have an unfair advantage over smaller companies.

“Of 3,000 manufacturers, about 20 make up 60% to 70% of business,” Hughes says. “But you’re still dealing with nearly 3,000 manufacturers who deserve access to present their products. It needs to be managed carefully.” He also wonders if antitrust charges by smaller companies could be a possibility in the future.

Fee structure varies

The fee structure for CVOs can vary. The Independent Medical Distributors Association (IMDA) recommends the universal membership model, defined as “a single annual fee good for all installations of the same branded service solution,” in which a vendor representative’s membership grants access to unlimited hospitals for one fee.

CVOs deny fees are out of line, citing costs of annual updates needed to meet hospital requirements for TB testing and liability insurance, adding new hospitals, and technology costs.

“Nearly all vendors find our business model to be fair and equitable compared to alternative business models or hospitals charging individually,” says Wills.

Hughes proposes a novel third option: funding by group purchasing organizations (GPOs) such as Novation, Premier, MedAssets, and others. The cost to fund credentialing would come from the administrative fee (typically up to 3% of total volume) GPOs can charge. He believes this option would lower the number of credentialing companies down to “3 or 4,” also reducing the number of companies a vendor must register with.

What’s next?

Perner says the recent joint recommendations are, “a living document. More organizations can join, and we welcome input.”

Hughes at SMI also welcomes AORN’s involvement, saying, “Their involvement is powerful. They cast a large net.” He also cautions, “Guidelines are not standard; there will always be variation.” The goal is to cut down on the variation, while still moving forward. “In health care everyone wants it to be perfect so they don’t do anything. No matter what the solution, it won’t solve everything.”

—Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer in Columbia, Maryland.
An effective plan to manage vendors is crucial for any OR, but designing such a system for a large health system is complex. Nurse leaders at the Sisters of Mercy Health System, based in St Louis with 19 hospitals in 4 states, have collaborated with their colleagues to craft a policy that works.

The policy is at the heart of the system’s Vendor Access Program, a credentialing process for vendors to manage access in the hospital.

“Our number-one driving force is a safe environment for patients, coworkers, and vendors,” says Ruth Damron, RN, BSN, clinical resource manager for ROi Performance Consulting (the operating division of Sisters of Mercy Health System), who coordinated the task force charged with developing the program. The program also helps the system manage potential risks of vendors in the OR and adhere to professional guidelines such as those from AORN and regulatory requirements such as the Health Insurance Portability and Accountability Act (HIPAA).

Unified approach, local flexibility

“In the past, each hospital had its own vendor policy. The rules were different at different hospitals, making it confusing for vendors,” Damron says.

For the task force, she pulled together key stakeholders including representatives from materials management, pharmacy, security, clinical engineering, capital management, facilities management, support services, the OR, and any other areas where vendors interact with staff.

The task force tapped into work by the Strategic Marketplace Initiative (SMI), which published Management Guidelines for Vendor Access in 2006 (www.smisupplychain.com).

“We used the SMI guidelines as a starting point and adapted them to our hospitals,” says Damron. This approach gave Mercy the consistency it needed while allowing for some individual approaches to implementation at the hospital level.

For several months, the task force held a weekly conference call to develop the program. “We hashed out what would work for all of our facilities and different areas,” says Melissa Castleberry, RN, BSN, OR supervisor for St Edward Mercy Medical Center, Fort Smith, Arkansas, part of Sisters of Mercy Health System, which averages about 5,500 cases per year.

After implementation, the task force met biweekly to share issues and best practices and now meets as needed.

Program details

Sisters of Mercy Health System classifies vendors as Level 1 (non-clinical) or Level 2 (clinical), based on proximity to patients (sidebar, p 18). Level 2 vendors must meet more stringent requirements.

“Most companies already have the needed training in place,” says Damron. “They either provide it themselves or use a third party.”

Mercy’s legal, risk management, and infection control departments reviewed the courses to be sure they provide the necessary information.

Vendors covered

The vendor access program applies to all vendors, except those involved in capital construction, which is covered by another policy, and vendors who visit physician offices and clinics.

The program outlines responsibilities of the director of materials management, the vendor, department directors, and medical and administrative staff.

During the registration process, vendors sign off on the required areas as they complete them.

“By doing this, they acknowledge and accept the guidelines established in Vendormate,” says Castleberry.

Vendors who don’t comply face escalating consequences. First violations are documented, vendors receive a verbal warning, and the policy is reviewed with them.

For a second violation, the director of materials management or the applicable department director notifies the vendor’s regional or corporate office of his or her company. In the case of a third violation, the vendor is suspended from further business with Mercy. Repeated violations by vendors from the same company may result in a ban of all the company’s vendors for a specified period or permanently.

Spreading the word

Sisters of Mercy Health System targeted 3 primary groups for education—staff, physicians, and vendors—before launching the program. Strategies included webinars, e-mails, signs in the physician...
and staff lounges and on bulletin boards, letters to vendors and physicians, presentations at meetings, education programs, and articles in newsletters and on websites.

“The directors of materials management at the hospitals were the champions,” says Damron. She provided education kits that included a PowerPoint presentation and supporting materials.

Mercy’s leaders, including the CEOs of each hospital, received talking points so they could answer questions. Damron also presented to the CEO council.

E-mail and phone scripts were used to inform vendors. Employees were given a sample script for how to approach a vendor who did not have a badge. The staff was armed with postcards for vendors that explained what they needed to do to register.

3, 2, 1—liftoff!

The vendor access program was launched on July 1, 2008, with an e-mail and letter to vendor companies.

“Identifying which reps need to be included is a huge undertaking,” says Damron. Some smaller hospitals had vendor information only on a card file, so the information had to be entered into a database.

National account representatives for companies with a Mercy contract were asked to disseminate the information. Materials management had to inform local companies.

By the Sept 1, 2008, deadline, only a small number of vendors were compliant, so Mercy set Nov 1 as a “hard” deadline and started to deny access to vendors without the required information.

“Some vendors were unhappy with the new system because they had been doing the same thing for years,” says Cynthia Sharp, surgical ancillary services supervisor at St Edward Mercy Medical Center.

“We felt we had more control because reps have to sign in every day,” adds Sharp. “We liked the services and how they manage point of entry.”

Mercy does not pay any fees to Vendormate. Instead, fees are calculated based on the type and amount of business each vendor conducts with Mercy and an assessment of each company’s potential legal risk. The fees, which vendor companies pay directly to Vendormate, are assessed per company, not individual sales representatives. Responsibilities of Vendormate and Mercy are defined in writing to avoid confusion.

New vendor representatives receive a card explaining what they need to do for credentialing. The vendor creates an online account that includes documentation of training and immunizations.

Checking in

On-site, the vendor checks in at a kiosk or department computer to receive a daily badge. After the visit, the vendor signs out and returns the badge holder. Log-ins are password protected.

New vendors have a month to complete the application. When a vendor plans to be in an operating room, the physician’s office calls to notify the OR inventory staff.

During normal business hours, vendors sign in through Vendormate’s automated system. Damron says determining the sign-in points can be eye-opening. “One hospital found they had 19 points of entry for its new tower.” The hospital worked to improve security before implementing the vendor access program.

At St Edward Mercy Medical Center, badge readers are located at all entrances to the OR. If vendors don’t have the appropriate access code on their badges, they are not allowed into the restricted area.

In the case of emergency surgery, trauma representatives have “contract” badges that allow them access to the OR.

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Sample vendor access requirements

Level 1 (nonclinical) vendors
1. Meet insurance requirements
2. Written statement from the company that documents the health care industry representative’s competencies:
   • Company’s products
   • General hospital safety training
   • Patient confidentiality
   • Business ethics
3. Picture identification that is time sensitive
4. Disclose any apparent or potential conflict of interest
5. Personnel changes

Level 2 (clinical) vendors
Meet all the Level 1 access requirements plus:
1. Undergo a criminal background check
2. Corporate information including regional and corporate supervisory contacts
3. Must be accompanied by hospital-designated staff when in patient care areas
4. Provide information on company’s products
5. Demonstrate FDA approval when requested
6. Licensing for biologicals (tissue banking & distribution)
7. Possess evidence of annual instruction in:
   • Confidentiality, patient rights, and HIPAA
   • Product complaints and medical device reporting (MDR) requirements
   • Aseptic principles and techniques
   • Infection control
   • Bloodborne pathogens
   • Fire, electrical, and other safety and emergency protocols
   • Appropriate conduct in the clinical environment
   • Hospital vendor rules and visitation policy
   • The medical system, device, product, procedure, or service they will be delivering and/or operating
8. Business ethics, including disclosure of any financial relationships with the institution, physicians, or other staff; and code of conduct expectations
9. Education and training documents
10. Hospital product standardization program
11. New product introduction processes
12. Product recall processes
13. Written proof of immunization status:
   • TB testing
   • Hepatitis vaccination
   • Measles, mumps, and rubella (MMR) vaccine
   • Chicken pox vaccination
   • State-required vaccinations (varies by state; refer to hospital-specific protocol)

Source: Sisters of Mercy Health System. Reprinted with permission.

“In the future, we’d like to see the access program set up so these vendors could log in,” says Sharp.

The Vendormate system can generate an electronic, searchable log of all visitors, including company name; vendor’s name and e-mail address; meeting contact, location, and purpose; and sign-in/out dates and times.

Helpful tips
As with most large projects, communication is key.

“When you think you’ve communicated enough, you’ve forgotten something. Over-communicate and don’t overlook stakeholders,” says Damron, who also recommends tapping into the corporate communications department, which can add a vendor resource link to a hospital’s web page and help disseminate information.

The information technology (IT) department is also important. Although the Vendormate tool is web-based, IT has to supply printers so reps can print their badges. Damron recommends starting the process as soon as possible because of the many priorities facing IT departments.

Worth the effort
Creating a systemwide vendor access system is worth the effort.

“It has proven to be an efficient and helpful tool to help the entire system to track who is in our facility,” says Sharp. “It has helped us to be able to monitor who is following the rules and who is not.”

Damron adds an unexpected benefit. “It helped all of us be better collaborators.”

―Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer in Columbia, Maryland.
A
fter some delay, Medicare’s program to have outside companies audit claims is getting underway. The companies, called recovery audit contractors (RACs), will be checking to see that claims filed by hospitals, physicians, and other providers follow Medicare policies and procedures.

OR Manager asked Keith Siddel, MBA, an expert on health care business operations, to give readers an introduction to RACs. Siddel is CEO of HRM Consulting, Creede, Colorado.

Q: Why did the government decide to go with the RAC approach?

Siddel: The RAC program was mandated by Congress in 2006. Medicare decided to use third-party companies to see if by paying incentives, the RACs could do a better job of identifying claims problems than fiscal intermediaries (FIs). (FIs are private companies that process Medicare claims and perform other services.) Over the years, the FIs have become more focused on adjudicating claims and addressing medical necessity than on targeting areas to audit.

RACs, which were selected by competitive bidding, will be paid a contingency fee for finding claims that were overpaid and underpaid. For the most part, the RACs are not health care companies but companies that audit businesses like grocery stores or Home Depot.

In a 3-year pilot study of RACs in 6 states (California, Florida, New York, Massachusetts, South Carolina, and Arizona), the government says it collected over $900 million in overpayments and identified nearly $38 million in underpayments.

Q: What is the status of RACs?

Siddel: The RAC program was held up by a protest over the contract awards. The final protests were settled in February 2009. The program is now going forward and is being expanded to all 50 states. The country has been divided into 4 regions with a RAC for each one. A map and other information are at www.cms.hhs.gov/RAC

Outreach in all 4 regions is being conducted this spring and summer. About half the states were to be phased in by March 1, 2009, with the rest to follow.

Q: How will RACs look for problem claims?

Siddel: RACs take basically 2 approaches. The first approach is to data mine. They take millions of claims and analyze them using computers to look for trends and problem areas. On the basis of the analysis, they will do an audit.

The second approach is to send hospitals a letter asking for copies of a certain number of medical records that the RAC will examine for problems. RAC auditors can go back only to October 2007.

During the pilot study, hospitals protested that the record requests were burdensome. Medicare has now restricted the number of records a RAC can request in a 30-day period based on the hospital’s volume of patients.

Q: What will happen when a RAC finds a problem?

Siddel: If a problem is found, such as coding for wound care, where the RAC believes it can recover money, it may contact all of the hospitals in the area asking for these types of records.

If the RAC determines the case is clear-cut, and the hospital shouldn’t have been paid, it will request that the money be taken back and will not bother requesting the records. The hospital will then get a letter from the FI saying it has taken the money back on a group of claims and explaining the reason. The hospital then has a certain period of time to appeal the RAC’s decision.

Q: What types of surgical issues are the RACs looking at?

Siddel: The problems deal mostly with coding. There have been some coding issues with inpatient-only procedures. These are procedures that are supposed to be done on an inpatient basis but slip through and are done in the outpatient setting. Most of the time, the FI catches this but not always.

Documentation is an area to focus on because coding is supported by documentation. OR managers will want to make sure nursing documentation conforms with hospital policy and regulatory requirements.

It also makes sense to make sure coding guidelines are coordinated between your hospital’s health information management (HIM) department and the physicians’ offices. Inconsistent coding between

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hospitals and physician practices will become easier to spot as Medicare transitions from FIs to Medicare Administrative Contractors (MACs). The MACs will handle claims for both Part A and Part B, so there will be an easy place for Medicare and RACs to go to see if there is consistency between hospital and physician claims.

Q How should we be getting ready?

Siddel: Every hospital should have a RAC team. The team should identify where RACs were successful in taking payments back during the pilot study and review claims in those areas. If the team identifies a problem, let’s say with pneumonia coding, the team should do an audit and resubmit the claims so the hospital doesn’t have to deal with RAC auditors.

One caution—there are a lot of vendors trying to sell databases and tracking software. You have to be careful where you spend money. There is software that will track all of your claims and send you a daily report on which claims are at risk based on the RAC demonstration project. What it doesn’t tell you is that some of the information from the demonstration may have been overturned or shown to be wrong. I would caution about spending a lot of money on software until the RAC program really gets going, and the hospital can see what best fits its needs.

Q Medicare rules on coding and claims are complicated and sometimes unclear. How will these issues be resolved?

Siddel: We saw in the demonstrations that in these cases, the RAC would say, “This is our interpretation.” Then the hospital had to fight it. There is supposed to be education. But it is not really in the RACs’ interest to tell you quickly what your problems are. They make money by taking payments back when you haven’t solved the problems.

So the education has to come from within the hospital and the hospital industry. With the first notice you get from a RAC saying, “We want these 10 accounts,” your RAC team should be saying, “Ah ha. This is what they are looking for.” Then the RAC team should gather the forces and tackle the problem.

Q What are the penalties for claims problems?

Siddel: The RACs will not per se assign penalties. They will just request the money back. But the fact that the RAC has identified a problem area means it would be naive to think that the Health and Human Services Office of Inspector General or whistleblowers would not grab that issue and perhaps argue for penalties. This action would not come specifically from the RACs, but it certainly is a potential effect from the RAC process.

More about the RAC program is at www.cms.hhs.gov/RAC/

The draft guideline is at www.cdc.gov/ncidod/dhqp/pdf/pc/cauti_GuidelineApx_June09.pdf


The guideline, which updates and expands the CDC’s 1981 guideline, addresses prevention of catheter-associated UTI for pediatric and adult patients needing short-term or long-term catheterization in any type of health-care setting.

The guideline addresses 3 key questions:

1. Who should receive urinary catheters?
2. What are the best practices for those who require urinary catheters?
3. What are best practices for preventing infections associated with obstructed urinary catheters?

The CDC says catheter-associated UTI is the second most common health care-associated hospital infection, accounting for just under one-third of the more than 28,000 infections reported to the CDC’s surveillance system in 2006-2007.

The infections are associated with increased morbidity, mortality, hospital cost, and length of stay.

Surgery recommendations

Among recommendations pertaining to surgery:

• Urinary catheters should be used in surgical patients only as necessary, rather than routinely.
• Indwelling catheters should be removed as soon as possible after surgery, preferably within 24 hours unless there are indications for continued use.

The draft guideline is at www.cdc.gov/ncidod/dhqp/pdf/pc/cauti_GuidelineApx_June09.pdf
Educating patients on SSI prevention

Though the Joint Commission is in the midst of revising its National Patient Safety Goals, organizations are expected to continue plans to meet the goals by Jan 1, 2010. Proposed revisions were issued May 12 for a 6-week field review. Final goals are expected in October.

The commission is conducting a comprehensive review of the safety goals during 2009 and will introduce no new goals for 2010. Complying with some of the goals has been “a struggle” for some organizations, the commission acknowledges.

“We want to make sure not only that our guidance is up to date but also that [all of the requirements] are still worthy of that type of focus and that everything being required truly adds to patient safety,” Louise Kuhny, RN, MPH, MBA, CIC, senior associate director of the Joint Commission’s Standards Interpretations Group, told OR Manager.

Preventing SSIs

Of particular interest to OR leaders, NPSG 7, which focuses on reducing the risk of health care-associated infections (HAI), is being expanded from 1 to 5 subgoals, including surgical site infection (SSI). There is a 1-year phase-in of the new requirements with full implementation expected by Jan 1, 2010. In the field review, the Joint Commission proposed deleting 1 new subgoal: NPSG.07.02.01, manage as sentinel events HAI-related deaths or permanent loss of function.

Four subgoals remain:
• NPSG.07.01.01: Comply with hand hygiene guidelines.
• NPSG.07.03.01: Implement evidence-based practices to prevent HAI due to multi-drug resistant organisms.
• NPSG.07.04.01: Implement best practices or evidence-based guidelines to prevent central line-associated bloodstream infections.
• NPSG.07.05.01: Implement best practices for preventing surgical site infections (SSI) (sidebar).

As a guide to evidence-based practice, Kuhny suggests referring to the compendium of strategies for preventing HAI in hospitals from the Society for Healthcare Epidemiology of America and other organizations (www.shea-online.org/about/compendium.cfm).

Educating patients on SSI

One specific element of performance (EP) under the SSI subgoal is to educate patients who are having a surgical procedure and their families about SSI prevention.

Kuhny notes the requirement has a tie-in to other patient education standards.

“We have always had a significant patient education requirement,” she says. “Patient education often affects safety, and we obviously want patients to be as much a part of their care as they can be.”

In preparing to meet the EP, she advises managers to refer to these other standards:

Provision of Care

Two standards in the Provision of Care chapter are relevant to patient education on SSIs:

• PC.02.03.01 requires patient education and training based on the patient’s needs and abilities. A key requirement is EP 25:
The hospital evaluates the patient’s understanding of the education and training it provided. The intent is to make sure the patient understands the education provided, Kuhny says. This can be done in a number of ways, such as having the patient repeat back what was heard.

PC.03.01.03 EP 4 has an obvious link to education on SSIs: “The hospital provides the patient with preprocedural education, according to his or her plan for care.”

It’s up to the organization whether to use printed patient education information. The Joint Commission does not require that, Kuhny says. (Examples are in the sidebar.)

Record of Care

Documentation is addressed in the Record of Care chapter:
- RC.02.04.01 EP 3 requires documentation in the medical record of information provided to the patient and family.

“There needs to be some indication in the record that education occurred,” Kuhny says, adding that the type of documentation “is totally up to the organization.” Examples are placing a copy of the education form in the patient’s chart; making a brief progress note such as, “Education provided on preventing surgical site infection;” or having a check box in the patient’s record to say education was provided, and the patient verbalized understanding.

Rights of the Individual

The chapter on Rights and Responsibilities of the Individual under RI.01.01.03 requires the hospital to respect a patient’s right to receive information in a manner he or she understands.

That applies to patients who speak another language as well as to those who have vision, speech, hearing, or cognitive impairments.

What will surveyors look for?

One way surveyors are likely to assess compliance is to include patient education on SSI prevention in a patient tracer, says Kuhny, who is also a surveyor.

In a tracer, a surveyor selects a patient and using the patient’s record, traces care the person received. The purpose is to assess the organization’s systems for providing care and services.

In a tracer involving a surgical patient, for example, Kuhny says she would talk with the patient and some of the care providers, observe the education process, and ask the patient about the education received. She would also ask caregivers about the education chosen for the patient and how they knew the patient understood what they were trying to teach. In addition, she would ask about the organization’s policies on patient education.

“I would look at the policies to see what the organization would expect for documentation,” she notes. Though the approach to patient education is up to each organization, she adds, the organization needs to define how it will document education. In a tracer, “I would compare the documentation in the patient’s record with what the policy required,” she says.

Kuhny encouraged managers to proceed with their plans for meeting the requirements on preventing SSIs. Though there may be some revisions, many of the requirements are in other standards hospitals already are addressing.  

—Pat Patterson

Have an idea?

Do you have a topic you’d like to see covered in OR Manager? Have you completed a project you think would be of help to others? We’d be glad to consider your suggestions. Please e-mail Editor Pat Patterson at ppatterson@ormanager.com
Process improvement

Applying the Surgical Apgar Score

“T

his patient is a 10. Everything went well.” Or “This patient is a 5. She will need close monitoring.” Before long, physicians and nurses may be using a numerical score like this when transferring patients from the OR to the next level of care.

Researchers have validated a 10-point Surgical Apgar Score that can be used to provide a quick report on how well a patient fared during surgery and the risk for major postoperative complications.

Patterned after the familiar Apgar score for newborns, the Surgical Apgar Score is derived from 3 intraoperative variables:

• estimated blood loss
• lowest mean arterial pressure
• lowest heart rate.

“With these 3 pieces of information, you can make a pretty good guess at how a patient might do in the first 30 days after the operation,” says Scott Regenbogen, MD, MPH, of the Harvard Medical School and Massachusetts General Hospital, Boston, the lead author of a report in the Archives of Surgery.

Predictors of complications

After evaluating dozens of variables, the researchers determined these 3 were the only independent predictors of 30-day major complications. The Surgical Apgar Score is intended to be a useful tool that can be used in “any setting without a lot of cost or difficulty,” Dr Regenbogen told OR Manager.

The study involved a sample of 4,119 general and vascular surgery patients from the National Surgical Quality Improvement Program (NSQIP) database at Massachusetts General Hospital.

An analysis showed that of 1,441 patients with scores of 9 or 10, only 72 (5%) developed major complications, and 2 (0.1%) died within 30 days of surgery. In contrast, of 128 patients with scores of 4 or less, 72 (56%) developed major complications, and 25 (19.5%) died within 30 days. The researchers found the 3-variable Surgical Apgar Score achieved C statistics of 0.73 for major complications and 0.81 for deaths.

Ready to use

The tool is ready for clinical use, Dr Regenbogen says. The article outlines a number of applications. Surgical teams could use the Surgical Apgar score to give immediate feedback on a patient’s condition. The score can aid communication between surgical teams and the postanesthesia care unit and nursing unit. It could be used to assist in decisions about admitting patients to the ICU.

At one Boston teaching hospital that participated in the study, Dr Regenbogen says, residents and nurses use the Surgical Apgar Score when transferring a patient after surgery.

“It’s a shorthand way of communicating the overall stability of the patient and success of the operation,” he says.

The score is being validated for other types of surgery, including total hip and knee replacement, radical cystectomy, and colon and rectal resection. A poster presented at the American Academy of Orthopaedic Surgeons meeting in February 2009 reported the Surgical Apgar Score is “strongly predictive” of major postoperative complications after total joint replacements. Data on colon and rectal resections presented at the American Society of Colon and Rectal Surgeons meeting in May 2009 shows the score also predicts which patients are likely to develop a late complication after they leave the hospital.

A quality improvement tool

The Surgical Apgar score can be

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used as an outcome measure for quality improvement and safety efforts, Dr Regenbogen notes.

For example, a surgical division chair might choose to review every elective operation with a score of less than 5 to try to understand what is going on with those operations. Or the chair might look at patients with scores of 8 or more who go to the ICU to see if that was an appropriate use of resources. The score does not allow for comparison among institutions, the authors note.

To evaluate its broader applicability, Surgical Apgar Scores were collected for all patients enrolled in the World Health Organization study of the Surgical Safety Checklist in 8 countries. Use of the checklist was shown to be linked to lower patient deaths and complication rates (March 2009 OR Manager). A report on the study’s results for the Surgical Apgar Score is being reviewed for publication.

“We have always looked at this as a way that hospitals with relatively low resource availability for quality monitoring might have a useful tool for their ORs,” Dr Regenbogen says. “The idea is that it can be used both by surgical teams in their care and by the administration in quality audits or attempts to make improvements.”

—Pat Patterson

References


OR business conference in Chicago opportunity for ideas, networking

Participants attending the 2009 OR Business Management Conference in May in Chicago heard speakers address issues challenging OR leaders today, from implementing Lean principles in perioperative settings to managing implant costs. Discussions in and out of the sessions supplemented speakers’ presentations and gave attendees the opportunity to exchange ideas, opinions, and strategies.

OR directors, OR business managers, materials managers, and others interested in the business side of surgery chose among 3 all-day seminars and 8 breakout sessions and spent time networking with exhibitors.

The keynote address focused on 3 worries—money, patient safety, and talent shortages—keeping health care leaders awake at night. “What’s important to the boss drives the agenda,” said Connie Curran, RN, EdD, FAAN, president of Curran Associates, a health care management consulting firm and editor emeritus of Nursing Economics, in explaining the need to understand concerns of upper management. Curran noted what OR leaders could do to address each worry.

What, me worry?

In setting the stage for money concerns, Curran said US health care spending is now 17% of our gross domestic product (GDP), with a projected increase to 19.2% by 2013. That compares to the 7% to 8% average in the United Kingdom, Canada, Australia, and Germany. Despite spending more than twice what those countries spend, Curran said, “We don’t have extraordinary outcomes. We don’t have the highest life expectancy, at least 45 million are uninsured, and our infant mortality is number 35 in the world.”

Although Curran said 2007 was a “very good year” for hospitals, 2008 reflected the changing economic scene. “Charitable gift giving slowed, elective surgery dropped, credit ratings were downgraded, increased unemployment resulted in increased uncompensated care, and there was declining reimbursement from Medicare and Medicaid,” she summed up.

Troubles continue in 2009. The construction boom has ended, and unionization is a growing force.

To counteract money concerns, Curran advised participants to “seek out profitable service lines and surgeons. Determine where you are making money, and where you are losing money.”

Patient safety worries

On patient safety, the second worry, OR leaders are especially concerned about wrong-site surgery and what Curran called “surgical souvenirs”: Items left behind after surgery in about 1 in 5,000 cases.

A retained object is a “never” event, defined as an identifiable, preventable occurrence with seri-
ous patient consequences. Examples of other never events are catheter-associated urinary tract infection, pressure ulcer, and surgical site infection after coronary artery bypass graft surgery. The Centers for Medicare and Medicaid Services (CMS) no longer pays for certain never events acquired in the hospital, and private payers have followed suit.

Nurses: A source of revenue

Curran noted the focus on patient safety translates into a focus on nursing. “Nurses can drive money and be a source of revenue,” she said and recommended nurses get involved in quality initiatives.

“Use a balanced scorecard and try to improve every year even if it’s just 2%.”

Despite recent hospital layoffs, Curran said the shortage of health care workers, including nurses, will continue, making it leaders’ third worry.

The average age of a nurse is 47, but an OR nurse’s average age is even higher at 52 years. “We’re a chronologically gifted profession,” said Curran. Two-thirds of nurses worked less than full time last year but enough hours so they qualified for benefits.

In the current recession, nurses are staying in the workforce, but as Curran said, “The recession will end,” leaving a shortage of nurses to care for an aging population. Another factor affecting workforce is nurses’ exiting hospitals because of dissatisfiers such as inadequate compensation and excessive paperwork.

Curran sees a silver lining in the recession cloud. “It’s a good time to clean house,” she said. “Get rid of [sub-performing personnel]. Invite them to update their resumes and free up their future. You can be picky.”

Supply chain insights

Jamie Kowalski, MBA, FACHE, FAAHC, FAHRRM, who has been in the supply chain field for more than 35 years, sums up the current state of affairs as, “I’ve never seen anything like it. It’s like a perfect storm.” The storm includes economic recession, reduced volumes and revenues, proliferation of technology, and lack of access to capital. Kowalski is vice president of business development for Owens & Minor, Inc, a health care distributor and supply chain management company. He and Carl Natenstedt, CPA, also of Owens & Minor, discussed how OR leaders can manage supply chain more effectively, particularly because the OR has a significant impact on the hospital’s bottom line.

“Supplies is the fastest growing expense category in a hospital,” said Kowalski. “Cardiovascular and orthopedic supplies are driving the spend growth by a big amount.”

Supply chain strategy

Unfortunately, the OR supply chain is often not optimized; for example, the typical OR writes off 30% of charges. Managing the supply chain yields large benefits. For instance, Natenstedt said, “Increasing inventory turns from 2 to 4 frees up an average $5 million in capital.”

Kowalski advised working with all elements of the supply chain, from evaluating products to charging. “They are interdependent,” he said. “You can create a [negative] ripple effect by only focusing on one thing.”

Managing supply chain begins with a strategic plan. Kowalski recommended writing down the steps in the chain and analyzing how to improve each one.

Supply chain strategy

“Focus on opportunities with the biggest rewards,” said Kowalski. That usually means physician preference items, which represent the largest (45%) piece of the supply chain pie.

A total supply chain solution should include spend analytics, distribution and inventory management, contract management, charge capture, and clinical utilization. At the center are metrics. “If you can’t measure it, you can’t manage it,” said Kowalski.

Both speakers emphasized that OR leaders don’t have to do this work in isolation.

“Use your partners,” said Kowalski, including, “suppliers, consultants, and purchasing companies.”

Cynthia Saver is a freelance writer in Columbia, Maryland.

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Seek out profitable service lines.
Ambulatory surgery centers (ASC) have been getting more attention from regulators and health policymakers over the past year, and not all of it has been welcome.

From quality reporting legislation to Medicare payment issues, ASCs have been under review. That is due in part to efforts by hospitals to curtail what they see as unfair competition from physician groups with access to the most profitable patients and procedures, without the added strains of emergency and uninsured care.

It is time to address these issues, speakers and attendees agreed during the April annual conference of the Ambulatory Surgery Center Association in Nashville, Tennessee.

The association’s president, Kathy Bryant, urged members to communicate with legislators, regulators, and their own communities about the contributions they make and the hardships some of the new regulations will cause.

“We have to stay on message,” she warned. “It’s important that we’re all saying the same thing.”

Payment disparities
Changes in Medicare reimbursement levels for 2009 show ASCs are losing ground on payment for high-volume procedures. Payments will decline up to 22% (for paravertebral procedures for pain management). Other declines include:

- cataract surgery: -1%
- upper GI endoscopy: -7%
- diagnostic colonoscopy: -6%
- lesion removal during colonoscopy: -6%.

Because of differences in the way adjustments are calculated, hospital outpatient departments do not face such serious cuts. For example, the Medicare Payment Advisory Commission (MedPAC), the advisory panel for Medicare, recommended an inflation update factor of 3.6% for hospitals but only 0.6% for ASCs. Bryant noted MedPAC’s original recommendation was a factor of 0% for ASCs until intensive industry lobbying succeeded in raising it to a positive level.

The reason, she said, is that MedPAC and other federal agencies have been listening to hospitals. A MedPAC report to Congress in March defends the lower reimbursement rate by claiming advantages that ASCs have.

It states, “Physicians have greater control and may be able to perform more surgeries per day in ASCs because they often have customized surgical environments and specialized staffing.” The panel also appeared to conclude that because volumes and revenues had risen in preceding years, ASCs were thriving.

Until 2003, according to ASC As-
CMS allows exception on advanced notice

In late May, ASCs celebrated news that Medicare will allow an exception in its new ASC Conditions for Coverage (CfCs) that reflects one of their concerns about the patient notification rule. The CfCs took effect May 18, 2009.

The exception came in interpretive guidelines for state survey agencies issued May 15 by the Centers for Medicare and Medicaid Services (CMS). The guidelines allow an exception in certain cases to the rule that a patient must receive written notice of patient rights and ASC ownership at least a day in advance of surgery.

The exception applies to situations in which the patient is referred for surgery on the same day the procedure is scheduled, and the referring physician states in writing that the procedure is medically necessary that day and is appropriate for an ASC.

The ASC Association lobbied CMS for relaxation of the advance notice rule, which they say presents a hardship in many cases. Association president Kathy Bryant said of the change, “We appreciate CMS’s willingness to reconsider its decision. This is a great example of the impact ASCs can have when we work together on issues like these.”

She noted the exception is unlikely to occur often because ASCs normally perform elective procedures and rarely schedule them on the same day.

More information is at http://ascassociation.org/coverage/

Ambulatory Surgery Centers

MedPAC’s argument, according to its January meeting transcript, is that lower rates for ASCs are appropriate because ASCs have lower costs than hospitals, which may be because they have less complex patients and fewer regulatory requirements than hospitals. MedPAC also expressed concern that as the number of ASCs increases, the volume of outpatient surgery will grow and increase Medicare spending.

The ASC Association has argued to MedPAC that one goal should be to get 60% to 70% of services now performed at hospitals at a higher cost into the “most cost-effective, clinically apt place” where they can be performed.

Regulatory hardships

The changes that took effect this year in Medicare Conditions for Coverage also cause concern, despite some modifications. “Overnight stay,” for example, now means “24 hours,” rather than “continuing past 11:59 pm,” a change that permits more procedures beginning later in the day. Still, Bryant noted, an ASC cannot schedule a procedure that would include, as a matter of treatment protocol, subsequent transfer to a hospital. “If you do,” she says, “you are risking your certification, not just the payment.”

Another sore point is the 24-hour notice requirement for advising patients of their rights and the ownership status of the surgery center because it forces some patients to wait longer than necessary for treatment, just to wait out the notification period (sidebar).

In response to quality reporting requirements that penalize nonparticipants with decreased reimbursement, the association has sponsored a collaboration that generated 11 quality measures for surgery centers, of which 6 have been approved by the National Quality Forum.

As with other requirements, Bryant says of performance measures, “We want to share our data. But we want to share our data in a fair way.”

‘Playing the charity card’

One of the main reasons regulators have tended to sympathize with hospital protests is that hospitals play the charity card in what ASCs believe is a misleading way, Bryant says. ASCs, especially those affiliated with hospitals, often provide charity care as a public service or to comply with hospital policy.

Hospitals that say they are losing needed revenues to ASC competition also are misrepresenting the case, Bryant noted.

She maintained that the physicians who provide uncompensated care in their own surgery centers really do make a personal sacrifice of time and money.

Hospitals that say they are losing needed revenues to ASC competition also are misrepresenting the case, Bryant said.

Between 2003 and 2006, hospital outpatient volume nationwide grew by 2.1%. However, revenues from outpatient procedures increased by 9.3%, meaning those

Continued on page 29
Testing practices need a closer look

Is too much preoperative testing being done for ambulatory surgery patients? New research suggests testing practices may need a close look.

“If anesthesiologists are just ordering tests as a routine, they need to look at our study and re-examine what they’re doing,” advises Frances Chung, FRCPC, a well-known researcher in ambulatory anesthesia.

In the new pilot study, Dr Chung and her colleagues evaluated whether preoperative testing can be eliminated in healthy ambulatory surgery patients without an increase in adverse events. Savings for the health care system could be significant. About 65% to 70% of surgery is outpatient, and preoperative testing in the US is estimated to cost more than $18 billion a year.

First randomized trial

Though preoperative testing for ambulatory surgery has been debated for almost 30 years, the study is the first prospective, randomized, controlled trial to assess if such testing can be eliminated for ambulatory surgery patients.

An American Society of Anesthesiologists (ASA) 2002 practice advisory states that preoperative tests should not be ordered routinely but may be ordered, required, or performed selectively to guide or optimize perioperative management.

Case series reports have suggested that even indicated testing may be unnecessary in healthy ambulatory surgery patients. An indicated test is one ordered for a specific clinical indication or purpose.

Because the new study is small (1,026 patients), Dr Chung says results should be considered preliminary. In addition, the study had strict exclusion criteria and did not include patients with major medical issues, especially related to cardiac and respiratory disease, such as patients who had a myocardial infarction within 3 months before surgery.

Still, the findings add another important piece of evidence on the merits of preoperative testing.

Study protocol

The researchers randomized the 1,026 patients to 2 groups:
• indicated testing: 527 patients
• no testing: 499 patients.

The testing group had a complete blood count (CBC), electrolytes, blood glucose, creatinine, electrocardiogram (ECG), and chest x-ray, as indicated by the Ontario Preoperative Testing Grid, consensus guidelines used by hospitals in Ontario, Canada.

No tests were ordered for the no-testing group. Patient age, gender, type of surgery, anesthesia, and ASA physical status were similar for the 2 groups. Most patients were ASA P1 or P2, and 12% of patients in each group were ASA P3.

No significant differences

No significant differences were found between the groups in rates of perioperative adverse events within 7 and 30 days after surgery. Most events were not serious. More patients in the testing group returned to the hospital within 7 days. The main reasons were severe pain, infection, and urinary retention.

In the no-testing group, none of the adverse events was associated with patients not having preoperative testing.

Cost savings were US $14,800 ($30.90 per patient) in the no-testing group.

Little need for testing

Because of the sample size, the findings aren’t strong enough to warrant changing preoperative testing protocols, notes Dr Chung, who is professor of anesthesiology at the University of Toronto and medical director of the ambulatory surgical unit and combined surgical unit at Toronto Western Hospital.

The authors say their findings justify a large multicenter study, which is not underway at this time.

Because most study patients were ASA P1 and P2, the findings apply primarily to those 2 groups, though Dr Chung says the findings can also apply to stable patients with higher ASA classifications. The testing decision also depends on the type of surgery. For example, she says testing is not ordered for cataract patients even if they are ASA P3 or P4.

Toronto Western Hospital has changed its practice since the study, she notes, though some pre-
operative testing is still being done. For example, chest x-rays are not ordered for all patients who are heavy smokers and have pulmonary disease. ECGs aren’t ordered for all patients over age 45 with a cardiac history or hypertension.

“We should encourage anesthesiologists to consider changing their practice in preoperative testing. This study helps them in understanding that there is not a lot of need for testing,” she says. —Judith M. Mathias, RN, MA

**References**


Both listen and speak up, she urged. “It is critically important for ASCs to be informed, and don’t hesitate to write your members of Congress. I think the challenge is to make sure our voice is heard.”

Time to speak up

The association’s chair, Alsie Sydness-Fitzgerald, CASC, agreed that ASCs need to speak up more. “Speaking as a nurse, I don’t understand, if we perform, say, an arthroscopy, why we get paid less for it than a hospital.”

She noted that when the first ASCs emerged during the 1970s, they were seen as a source of more personalized care but faced little controversy. It has been their success in recent years that led to greater regulatory scrutiny, and she said it now is time to confront the misconceptions that have arisen. “We’ve been around a long time,” Sydness-Fitzgerald said. “The reason people don’t know about us is we’ve been very quiet.”

—Paula DeJohn

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At a Glance

Surge in nurse employment —but it won’t last

With the recession, the RN shortage has eased or even ended in many parts of the country, a new study finds. Older nurses have delayed retirement or returned to work, and part-time nurses have become full time in response to the economy. The increase has been stunning—in 2007-2008, RN employment in hospitals increased by 243,000, or 18%.

But the relief will be temporary. A new shortage will loom in the next decade, with a shortfall developing about 2018 and growing to about 260,000 by 2025. The data is from Peter Buerhaus of Vanderbilt University.


Cost-effectiveness of preventing retained sponges

New technologies can substantially reduce the incidence of retained sponges at an acceptable cost, researchers have found. They compared standard sponge counting with new technologies for preventing retained sponges using a model they developed to compare cost-effectiveness of the methods.

Findings showed standard counting prevents 82% of retained sponges. Bar-coded sponges and radiofrequency-tagged sponges prevented 97% of retained sponges. X-rays were most costly but less effective than bar-coded sponges. Bar-coded sponges were the most cost-effective of the methods studied.


Doubts raised over hip resurfacing

Enthusiasm is waning for hip resurfacing after recent studies show the procedure is no better than the newest types of total hips at helping patients resume an active lifestyle, according to the June 4 Wall Street Journal. Studies also show women are more likely to suffer complications after resurfacing compared with total hip.

Hip resurfacing has been touted as an alternative to total hip replacement for younger, more active patients. The surgeon replaces the socket but preserves the femoral head after smoothing away the arthritic damage.

Hip resurfacing is more difficult, takes more OR time, and requires longer incisions than total hips, according to the Journal. Both procedures cost $30,000 to $50,000 and generally are covered by private insurance and Medicare.

—www.wsj.com

Las Vegas hepatitis C outbreaks spur 5 new state laws

Nevada has passed 5 new state laws in response to hepatitis C outbreaks in 2 Las Vegas endoscopy centers last year, the Associated Press reports. The outbreaks led to the largest patient notification in US history. More than 50,000 patients may have been exposed to bloodborne diseases because of reuse of syringes and vials of anesthetic drugs. Nine patients contracted hepatitis C, and more than 100 cases may be linked to the now-closed centers.

One law requires ASCs to have unannounced inspections yearly. Another requires that a nurse accompany all inspection teams. A third law puts more teeth in protections for whistleblowers because some nurses reportedly were afraid to step forward about the problems for fear of losing their jobs. Two other laws are intended to bridge gaps in communication during a public health crisis.