Will a ‘perfect storm’ help control rising orthopedic implant costs?

It may well take the perfect storm of federal investigations, legislation, unprecedented hospital and surgeon cooperation, and voluntary changes in manufacturers’ business practices to control rising hip and knee implant costs, say experts interviewed by OR Manager.

But many believe once the storm is over, hospitals will begin to see relief from ever-rising implant costs. Once money-makers for surgery departments, hip and knee implant procedures at many hospitals now have margins that are slim, nonexistent, or bright red, experts say.

From 2003 to 2004, implant prices climbed 9%, while Medicare reimbursement rose only 2.4%, according to Orthopedic Network News, which tracks implant costs (related article, p 13).

Some developments during the first half of 2005 that may help hospitals on implant prices:
- In February, the Office of the Inspector General (OIG) of the Department of Health and Human Services issued 6 advisory opinions that seemed to give the green light to certain types of gain-sharing arrangements—programs that financially reward physicians for participating in hospital supply cost-containment projects. (See www.oig.hhs.gov/fraud/advisoryopinions/opinions.html. Read opinions 05-01 to 05-06.)
- In March, the US Department of Justice (DOJ) issued subpoenas to large orthopedic implant manufacturers, seeking information about

More ORs call for financial disclosure with product, equipment requests

A surgeon asks for an expensive new piece of equipment. The request is forwarded to the value analysis committee.

Before considering the purchase, the committee would like to know whether the surgeon has financial ties to the company that sells the product. Is the surgeon consulting with the company? Is he or she conducting a company-sponsored clinical trial? Does the physician own company stock?

Financial disclosure is the trend. More organizations are requiring physicians who make product requests to sign a conflict-of-interest statement. In some cases, physicians must sign a disclosure to be allowed to vote on a purchasing decision. Disclosure also is the norm for employees, including administrators, managers, and sometimes staff.

“In this day and age, with Enron, WorldCom, Tyco, and other corporate scandals, as well as what we’ve seen in health care, conflict-of-interest policies and disclosures are not only a best practice but a necessity,” says Lisa Murtha, JD, of the Health Care Compliance Association.

In organizations Murtha has consulted with, physicians are expected to sign
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**What’s your turnover time?**

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**The battle over safety scalpels**

OSHA expects ORs to implement safety scalpels, but many surgeons find they’re not acceptable. Are there solutions?

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**L**ittle things mean a lot. ORs are working hard to improve care and safety. They’re tackling complex processes like administration of prophylactic antibiotics. But sometimes the simplest things determine how patients judge their care. Rushed doctors and the nursing shortage have made the stress of being a patient more severe, even if the clinical care is first-rate.

Many times, it’s the simple indignities patients find distressing. A patient’s call button is placed just out of reach. Caregivers come and go without introducing themselves.

These discourtesies can be magnified when a person feels ill and vulnerable.

**Walk the patient’s path**

We asked Jeanne Kennedy, who for 25 years was director of community and patient relations at Stanford Hospital and Clinics, what OR directors can do to help ensure their patients are treated humanely:

- **A smile makes all the difference.** “Everything is trumped by someone who is kind and pleasant,” she says. “Almost everyone working in your facility cares about patients and wants to do a good job. A smile and friendly conversation convey this. Most caregivers don’t realize how important this is.”

- **Walk the patient’s path.** "If you’re in a large hospital, one day park where the patients park, see if you can find your way using signs, walk up to the front desk and see how you are greeted. If you’re too well known to pull this off, consider having a friend do it and give you a report.

- **Who’s greeting patients?** Receptionists, often the lowest paid and least trained of employees, are the first to see patients and have a big impact on their experience. The same is true for admissions clerks.

- **Can patients read staff name tags?** Do caregivers introduce themselves? Patients can feel they’re being cared for by a parade of anonymous people. Caregivers should introduce themselves clearly by their first and last names. Ask what the patient prefers to be called. “One thing that frosts me is the doctor saying, ‘Hello, Jeanne. I’m Dr Jones,’” says Kennedy.

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The OR team should introduce themselves, or reintroduce themselves, in the OR. “Smile,” she says. “Even with a mask, they can see it in your eyes.”

- **Be careful about conversations.** If the OR team is laughing and joking, watch the subject matter and bring the patient into the conversation. Patients may worry the team is laughing at them or isn’t paying attention to their work. “Hearing is the last sense to go when you’re being anesthetized,” she says.

- **Explain what’s being done,** such as positioning the patient’s arm on an armboard. This is routine for the staff but might be startling to a patient.

- **Consider families in the waiting room.** Keeping them informed is essential. Some creative things facilities are doing are providing massage therapists and offering CDs and CD players.

- **If your facility allows significant others in the recovery area,** bring the person in as soon as possible. It is comforting to have a familiar person there when you are emerging from anesthesia.

“None of this is rocket science,” Kennedy says, “But why is it these basics so often are not attended to?”

In today’s hurry-up environment, it’s more important than ever. Caring doesn’t need to take a lot of time. Kennedy recalls that when she had a procedure recently, “They raced me through, but I didn’t mind at all because they were so kind about it. But it is scary when someone is rushing you and isn’t nice about it. “Clinicians need to focus on their people skills in addition to their professional expertise,” she says.”

—Pat Patterson
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VHA Inc, the health care alliance, announced Oct 5 it has acquired Goodroe Healthcare Solutions, a consulting firm that has developed databases on outcomes, cost, and quality for cardiac care and orthopedic surgery.

Gainsharing is known for its gainsharing model, which won 6 favorable rulings from the government earlier this year.

Health and Human Services Office of Inspector General (OIG) said the Goodroe projects passed muster because there were ways to measure practice patterns before and after the projects to make sure savings didn’t compromise care.

VHA says it acquired Goodroe not just because of gainsharing but as part of a strategy “to help physicians and hospitals work together on supply chain issues,” Jeff Hayes, VHA’s senior vice president for research and development and acting COO of Goodroe, told OR Manager in an interview.

Goodroe’s databases are what VHA found attractive, Hayes said.

“Gainsharing is one tool in the toolbox,” he said. “The data allows for a lot of uses. It really depends on hospital-physician relations and other things they have already tried. It is a matter of getting hospitals and physicians together to examine the data and decide on an appropriate strategy.”

The firm’s CEO, Joane Goodroe, says her company’s proprietary software enables comparisons of both practice patterns and supply usage. The firm claims to have data on more than 1 million cath lab and open-heart procedures. She says the company also is working on orthopedics and neuroscience, including spinal implants.

Goodroe says her system can be used both by ORs that have information systems and those that do not. The system pulls data partly from hospital information systems and partly uses Goodroe’s software.

“Gainsharing is known for its gainsharing model, which won 6 favorable rulings from the government earlier this year.”

“The key is to make sure we don’t have the staff duplicate their work,” she says.

Hospital-physician projects could take a variety of forms, she says, from sitting around a table to compare clinical practices and costs to embarking on gainsharing.

“Some people will do gainsharing. Other hospitals will find other ways to use the data to get alignment with their physicians. Gainsharing is one form of alignment,” Goodroe says.

She added that her firm’s data is intended to be used internally by hospitals and physicians and would not be shared with other institutions.

“Gainsharing is known for its gainsharing model, which won 6 favorable rulings from the government earlier this year.”

“Our systems are not built to do price comparisons. It is more to enable you to look at products and overall cost. We are not in the business of releasing pricing by individual vendor,” she said.

Where does gainsharing stand?

With the OIG opinions, is Goodroe confident enough to proceed with gainsharing projects without further OIG review?

“That is a decision made by each hospital’s counsel,” she told OR Manager.

“There are attorneys who don’t believe their clients need to seek opinions, so we are not seeking opinions on their behalf, as long as they stick to the exact model we have had approved. There are some that want to be conservative and go for another opinion.”

The same is true on the issue of whether gainsharing arrangements violate the Stark ban on physician self-referral. That also should be reviewed by hospital counsel, she says.

She notes that the Centers for Medicare and Medicaid Services, which is responsible for Stark, reviewed the OIG opinions before they were released but did not comment on them.

Goodroe will continue operating from its offices in Norcross, Ga, and will continue working with hospitals that are not VHA members, Hayes says. Goodroe said the firm has about 150 clients.

VHA Inc, based in Irving, Tex, has about 2,400 member health care organizations nationally. More information on Goodroe is at www.goodroe.com.

Read about the OIG opinions in the April 2005 OR Manager.
Please see the ad for MEDI-FLEX INC.
in the OR Manager print version.
Katrina teaches disaster planning lessons

Murray Couey, RN, was driving out of town with his wife, Connie, on Friday, Aug 26, 3 days before Hurricane Katrina hit the Gulf Coast, when he was summoned back to West Jefferson Medical Center (WJMC), Marrero, La.

“I got a call from a colleague and was told, ‘Don’t leave town.’ (Katrina) was coming, and we would be initiating our hurricane plan Saturday or Sunday,” says Couey, who is senior director of nursing for surgical services at the 462-bed community hospital, located about 10 minutes south of downtown New Orleans.

As part of West Jefferson’s hurricane plan, all essential employees were notified they would be needed at the hospital within 48 hours.

“Our plan includes getting all the food, water, and medical supplies we need for 4 to 5 days,” he says. “I told the weekend staff to go through our inventory and make sure we had everything we needed. Extra supplies were brought in.”

Couey spent Saturday boarding up his house and Sunday morning sent his family to Georgia to be with relatives.

At 6 pm Sunday, West Jefferson officially activated its hurricane plan.

“We didn’t have to evacuate patients because we felt we had adequate time, staff, and supplies to discharge patients who could be discharged and care for the remainder,” Couey says. The discharges reduced the hospital’s census from about 400 patients to 150.

During Sunday night, Couey and the OR staff secured supplies and made bedding arrangements.

“Some staff got empty patient rooms, but most were assigned vacant offices and space in the preanesthesia holding area. We took a couple of ORs not used for surgery and converted those to 4-bed rooms,” he says.

So far, everything was going according to plan.

“A lot of people spent most of the night watching and waiting for the storm,” Couey says.

Early Monday morning, Katrina hit full force with 145-mph winds. Surgery was cancelled Monday; on Tuesday several inpatients required minor procedures.

On Wednesday, 3 levees broke in New Orleans. “That is when all hell broke loose,” he says. “The civil disobedience started, the shooting and the looting, and we started seeing gunshot wounds.”

Scrambling to stay open

During the first 3 days after the hurricane, Couey says the OR staff and hospital officials scrambled to keep the facility running. During the height of the storm early Monday morning, the hospital lost its main power. Emergency generators kept lights and essential equipment running but were not enough to run the air conditioning system. The building began to heat up. By Tuesday morning, the temperature on many nursing units exceeded 100 degrees.

At this point, the hospital’s hurricane plan started to crumble because of the failure of outside agencies, Couey says. The hospital began to improvise to obtain additional supplies.

“With no help coming from agencies such as FEMA or the Red Cross, (West Jefferson) management and employees improvised by working with private companies such as Wal-Mart, Lowe’s, and Home Depot to obtain water, plywood, batteries, food for patients, extra personal effects for employees, fans, and countless other essential items,” says Jennifer Steele, RN, the hospital’s chief spokesman, in a statement.

Wal-Mart allowed hospital pharmacists access to their pharmacy for items such as insulin. West Jefferson also contacted hospitals in other parts of the state for blood products and pharmaceuticals.

“A CEO from a small hospital (in Raceland, La) personally drove 40 miles via convoy to WJMC to deliver every bottle of water in his community for (our) staff and patients,” Steele says.

This was not part of the plan. “We had to take care of ourselves at this point,” Couey says.

What would they do differently?

Like all accredited hospitals, West Jefferson has a disaster plan. Hospitals also must stage mock disasters at least twice a year.

But practice often is different than the real thing. Despite having a solid plan, Couey says his staff identified 3 things they will do differently next time.

“We didn’t collect enough water to wash the floors,” he says. The plan calls for storing nonpotable water in containers to clean floors and flush toilets.

“We used 2 trash cans to collect the water, and they ruptured because of the weight,” he says. “We created our own flood. We used alcohol and peroxide when we ran out of cleaning water.” The hospital plans to purchase stronger containers to store wash water.

Communication was another issue.

Continued on page 9
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Hurricane Katrina

Continued from page 7

“We need more hand-held walkie-talkies that are more powerful to get through cement and steel,” he says. “Communication within the hospital was difficult in the beginning.”

“We relied on our feet to get word between ER and OR,” he says. “We overrode the fire notification system to make announcements, and that helped us coordinate calls.”

He estimates the hospital needs about 40 to 50 walkie-talkies, including at least 10 for the OR.

“People also learned to help themselves more in this disaster than ever before,” Couey says. “We found that doctors can clean floors and take out the trash. We have a picture of our chief of surgery hauling a big red trash container outside.”

Lessons from 2004 hurricanes

Jeff Prescott, spokesman for HCA, says one lesson the Nashville, Tenn.-based for-profit hospital chain learned from the 2004 hurricanes is the need to purchase satellite phones.

“Land lines and cell phones will not work,” Prescott says. “Our satellite phones worked reasonably well.” HCA owns in a joint venture Tulane University Medical Center in New Orleans, which was evacuated, and 2 other hospitals affected by Katrina.

Another lesson was to have plenty of linens handy. “When you have broken windows, you will use whatever you have to remove water, and linens are all you have,” Prescott says.

While some question whether “just-in-time” inventory works in a disaster, Couey says the hospital’s delivery system worked well enough to get the hospital through.

“We order 48 hours in advance normally. We will look at our supply amount, maybe increasing it a little, but not a significant amount,” he says.

“We had the 3 days of advance notice (before Katrina hit) to resupply, plus 2 days of supplies on the shelf, and we have custom packs we could use,” he says.

A sluggish response

The 3 biggest unexpected events were:

• Supply trucks that were initially turned around several days after the storm hit.
• The failure of federal and state officials to respond for more than 7 days. The disaster plan envisioned outside help within 3 days.
• “It was never envisioned that so many hospitals would close,” Couey says.

Another unexpected event was that a supply truck headed for the hospital was stopped by Louisiana state police. “Our CEO (Gary Muller) and parish people looking into that,” Couey says. “It is a major issue, and we don’t want this to happen again.”

But the biggest disappointment for West Jefferson officials was failure of the Federal Emergency Management Agency (FEMA) to send help within 3 days, Couey says.

“Federal help came 7 days late,” he says. “That was the one thing we needed the quickest that took the longest to get here.”

Muller met with FEMA officials in Washington on Sept 28 to discuss the issue. FEMA arrived at West Jefferson on Sept 19, more than 2 weeks after Katrina. “We had 3 or 4 FEMA people here to collect applications for relief. They couldn’t answer our questions,” he says.

Other hospitals also were critical of the response to Katrina.

“Various government agencies didn’t do what they were supposed to do, from our standpoint,” says Prescott.

Despite limited federal assistance, Prescott says HCA prepositioned materials—plywood, diesel fuel, water, medications, batteries, and food—in the region to supply its 3 hospitals before the storm hit.

“We were ready for everything except the flooding when the levees broke,” Prescott says. “We had no plan for that.”

Based on FEMA’s response, Couey says the hospital will probably adjust its hurricane plan to expect a 7- to 8-day federal response.

“We cannot wait for the cavalry to ride in. We will have to do this ourselves next time. I hope there is not a next time, but you never know,” he says.

The aftermath

In the weeks after the storm, West Jefferson was using 9 of its 15 ORs during the day and 2 at night, Couey says.

“We converted staff to 12-hour shifts to meet 24/7 needs.”

Not as many physician offices have reopened as expected. “There are not many people here in Jefferson Parish. About 270,000 normally reside here, and I guess maybe 80,000 to 100,000 are here now. It grows every day.”

While surgical procedures are down about 75%, the OR was making plans for volume increases in the next several weeks.

“We are only one of 3 hospitals open,” Couey says. “Once people get back, they will need a hospital to turn to. We will be there.”

—Jay Greene

Jay Greene is a freelance writer in St Paul, Minn.

JCAHO issues emergency guide

The Joint Commission on Accreditation of Healthcare Organizations has issued a step-by-step guide, Standing Together: An Emergency Planning Guide for America’s Communities, that suggests 13 steps communities can take to respond to all types of emergencies. Among topics covered are:

• safeguarding data and systems
• linking with federal and state mental health resources
• ensuring culturally sensitive communications
• identifying appropriate community partners.

The guide can be downloaded for free on JCAHO’s web site at www.jcaho.org/news+room/news+release+archives/em_planning_guide.htm.
their financial relationships with orthopedic surgeons.

- In April, AdvaMed (the Advanced Medical Technology Association), a trade association for medical device manufacturers, issued updated ethical guidelines on the interaction between vendor representatives and health care professionals. The additions primarily cover gifts and appropriate payment for services. (See www.advamed.org/publicdocs/coe_with_faqs_4-15-05.pdf.)

- In May, Senators Charles Grassley (R-Iowa) and Max Baucus (D-Mont) introduced specialty hospital legislation that included a provision to allow gainsharing, or “coordinated-care incentive arrangements,” between hospitals and doctors. The Medicare Payment Advisory Commission (MedPAC) in February also endorsed the concept of gainsharing.

“...gainsharing and the device manufacturers’ subpoenas will have the dual effect of helping hospitals lower prices,” says Gadi Weinreich, chairman of the national health care group in the Washington office of Sonnenschein Nath & Rosenthal.

“The tables are starting to turn toward hospitals,” he says. “It is not the beginning of the end; rather, it is the starting point of a long process. Solutions need to be found, but these subpoenas will lead to a number of changes in the number and content of financial arrangements among device manufacturers and physicians. This, in combination with the continued evolution of gainsharing, may jump-start the movement toward lower prices.”

“The latest and greatest”

From 1991 to 2004, orthopedic implant prices jumped 132% while hospital reimbursements rose only 16%, according to Orthopedic Network News.

In 2004, knee implants cost a typical orthopedic program $4,200, an increase of 42% from about $3,000 in 2000, says Dan Piro, senior vice president of Aspen Healthcare Metrics, an Englewood, Colo.-based consulting firm. In 2004, hip implants cost about $5,600, up 60% from about $3,500 in 2000, according to Aspen data.

“The data shows there were very few programs with positive margins. For primary hips and knees, it is difficult to make money, and it is getting worse,” Piro says.

The biggest reason why hips and knees do not make money is the difference between reimbursement and costs, he says. “To a lesser extent, there is the competitive problem of business lost to ambulatory surgery centers,” he says.

Bill Anton, BA, RRT, business director of surgical services at the University of Washington Medical Center, Seattle, says patients and surgeons drive some of the implant cost increases.

“The American public wants the latest and greatest, no matter what it costs,” Anton says. “Surgeons also want the best for their patients, and that costs the most.”

According to Anton, these are some reasons costs have escalated and margins have declined:

- Vendor relationships with surgeons that tend to drive up the cost of implants.
- A disconnect between surgical procedures that pay surgeons high professional fees and hospitals’ low facility fees. The result is the hospital loses money on certain procedures.
- Lack of incentives for surgeons to reduce hip and knee implant costs.
- Rapid introduction of new implants and other products into the market.
- Lack of a rigorous value analysis process for new products coming into the hospital.

Adds Piro: “Price increases are fueled because (orthopedic implant) companies are publicly traded, and there is pressure from Wall Street to meet and exceed expectations.”

But there are steps hospitals can take to reduce implant costs. “The most important thing you can do first is have a meaningful dialogue with your surgeons,” Piro says.

What can hospitals do?

Three main strategies hospitals have used to control costs are:

### Knee-deep in costs

**Costs included in total knee replacement**

<table>
<thead>
<tr>
<th>2000</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>($ in thousands)</strong></td>
<td><strong>($ in thousands)</strong></td>
</tr>
<tr>
<td>All fixed costs</td>
<td>$3,653</td>
</tr>
<tr>
<td>All other direct costs</td>
<td>$2,487</td>
</tr>
<tr>
<td>Medical, surgical, Rx</td>
<td>$1,368</td>
</tr>
<tr>
<td>Implant cost</td>
<td>$2,966</td>
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<tr>
<td><strong>Total costs</strong></td>
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</tr>
<tr>
<td><strong>All fixed costs</strong></td>
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</tr>
<tr>
<td><strong>Total costs</strong></td>
<td><strong>$13,290</strong></td>
</tr>
<tr>
<td><strong>All fixed costs</strong></td>
<td><strong>$4,615</strong></td>
</tr>
</tbody>
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### Source:

Materials management

• collecting cost and quality data and sharing it with physicians to encourage efficient use of resources
• standardizing implant products with a few vendors to get better pricing and management control
• capitulating implant prices to fixed procedural costs.

“Some hospitals don’t share data with physicians because they don’t trust their data,” Piro says. “You need to (find ways to) collect the data, open the kimono, and share it with your surgeons.”

Anton says, “Once the doctors understand how much procedures cost and what the reimbursement is, many times they will cooperate for the overall benefit of the hospital.”

In exchange, hospitals should be prepared to make efficiency and quality improvements in the OR. “Surgeons are making a lot less money on (Medicare) cases, and if a hospital can make life easier in the OR, you will get cooperation from doctors,” Piro comments.

The next step is standardizing implants. “It makes it easier to negotiate with vendors because they base their discounts on market share and spending,” Anton says. “Doctors will object, and sometimes hospitals will stop short because of political considerations.”

Surgeons generally don’t want to standardize because they have developed brand loyalty and built strong relationships with vendor representatives, Piro says.

Capping implant prices

One way to avoid wide-scale standardization is to negotiate capitated implant contracts with vendors, Piro says.

“Capitating implants, or setting price matrixes, preserves surgeon choices,” Piro says. “Many doctors look at specific knee and hip implant constructs as homogenous products. When they see that what the hospital pays for similar products is all over the board, they often believe it is fair (to capitulate).”

Vendor companies don’t like capitation, he notes. “It doesn’t increase their market share; it just lowers their price,” Piro says.

Still, capitulating implant costs can be a winning strategy, Piro says. But it requires complete buy-in from surgeons and the administration. “It is a difficult strategy unless you have complete support,” he says.

Effective product entry processes require a hospital administration willing “to take the heat from physicians,” Anton says.

Each week, Anton receives 1 to 2 new product requests from surgeons. The approval process can take from 3 to 4 days for emergency cases to as long as 6 to 12 weeks, depending on whether the FDA has approved the device and how long price negotiations with vendors take.

Meanwhile, “the surgeon is stewing,” Anton says. “The worst case is the surgeon will schedule a case (before the implant is approved for use at the hospital). This puts us in a bad position. We have to go fast to set up billing, and we may not get the best prices.”

Still, using the hospital’s implant product evaluation committee, Anton says he has saved $243,000 in surgical implants over the last 12-month period. “If we didn’t have that process, it could add $300,000 to $400,000 in additional costs,” he says.

Where is gainsharing going?

The financial disconnect between surgeons and hospitals is one of the drivers of implant costs. Gainsharing is designed to connect incentives. While details are complex, the concept is quite simple: Cost savings on supply costs are shared between physicians and the hospital.

In 1999, gainsharing programs fell off the map when the OIG stated in an opinion that they probably violated the Civil Monetary Penalty (CMP) statute that prohibits direct or indirect payments to physicians for reducing or limiting items or services to Medicaid or Medicare patients.

But based on the OIG’s new encouraging gainsharing opinions, HCA, the Nashville, Tenn-based for-profit hospital chain, began in June to implement a gainsharing project for hip and knee implants at its 160 hospitals, says spokesman Jeff Prescott. Although the OIG hasn’t issued an opinion on the project yet, Prescott says HCA is signing up physicians and offering them financial incentives.

“We will hold (the savings) in escrow until we get (OIG) approval,” he says. “If the surgeons use the implants, the savings are allocated back out, aggregated by division, and based on procedures they will do.”
A missing piece

Most experts believe gainsharing will eventually become commonplace.

“This year we had a revival in the concept of gainsharing,” Weinreich says. “Each OIG opinion was slightly different because the protocols were different. But the common feature is that hospitals would work with physicians to standardize certain high-cost medical supply and device items, and manufacturers would give hospitals a better price based on increased sales volume.”

While the OIG said these arrangements still would probably violate the CMP statute, the OIG also said it would not impose sanctions because of clinical and product safeguards incorporated in the specific programs, Weinreich says. “This opinion is limited to the requesters of the opinion,” he adds.

The opinions cite reasons why the OIG would not pursue violations of the CMP law. Among them were establishing baseline thresholds beyond which no savings would be shared with physicians and distributing incentives on a per-capita rather than on an individual basis.

One missing piece of the equation, however, is how gainsharing affects the Stark anti-kickback law that prohibits physician self-referrals, Weinreich says. “The OIG correctly observed that it is not authorized to comment on Stark,” he says. “That analysis is important because Stark is a strict liability law. It is unclear whether gainsharing models violate Stark.”

The Centers for Medicare and Medicaid Services is the principal regulatory agency on Stark, and Weinreich says CMS has not voiced an opinion on gainsharing yet. “CMS has a historic interest in gainsharing,” he says. “CMS sought to work with hospitals in a pilot project in New Jersey, but that was halted due to some competing hospitals that got a judge to enjoin the program.”

One way to resolve the issue, he says, is for federal legislation to be approved. “The bill proposes safe harbors for gainsharing that would be permitted under Stark,” he says.

Weinreich says he is aware many hospitals are working on gainsharing programs. “You must tell your client gainsharing could well violate the law unless you have a specific opinion from the OIG,” he says. “There is no question that the advisory opinions have started something that can’t be put back in the box.”

Weinreich says the OIG’s opinions show there is recognition within government that gainsharing can be a good thing. “We need to get there somehow, and a legislative fix is coming eventually,” he says.

What is DOJ looking for?

Another development that may give hospitals leverage to reduce implant costs is the subpoenas issued to large implant manufacturers.

Weinreich says the DOJ is looking for improper payments to orthopedic surgeons from vendors. Some services like research or testing are legitimate, he says, and if paid at fair market may not raise any problems. However, the DOJ may find kickbacks are part of these agreements, he says.

Nothing is directly known about the subpoenas because defense lawyers for the companies aren’t talking, Weinreich says. It could take 2 to 3 years before details of the subpoenas are revealed, and some action is taken by the DOJ, he says.

“My understanding is that the subpoenas are very broad,” Weinreich says. “They seek all contracts and financial arrangements with any orthopedic group or individuals who are orthopedic surgeons. The DOJ wants to look at consulting agreements, speaking engagements, and personal services between manufacturers and surgeons who use those devices.”

He says it is possible that the investigation may identify a number of arrangements the government may deem worth additional scrutiny and enforcement action. The short-term effects of the subpoenas, says Weinreich, could lead individual companies to tighten ethical standards.

“We are likely to see that even companies with good compliance might bolster their efforts, and companies with looser controls about the agreements they enter might use this series of events to tighten their controls,” he says. “Those who are unscrupulous will probably try to continue.”

The impact on surgeons will most likely initially chill relationships with vendors, he says. “Physicians will change some conduct and ask more questions about relationships and financial dealings,” he says.

As a result, the subpoenas will create an incentive for physicians to work with hospitals like they never have before, Weinreich says. “The real opportunity to reduce prices will come in conjunction with gainsharing.”

West Nile infections in organ recipients

The West Nile virus (WNV) infection was found in September in 3 out of 4 transplant recipients who received organs from a New York City resident, according to the Oct 5 MMWR Weekly Report by the Centers for Disease Control and Prevention.

The recipients were given the liver, kidney, and lungs at transplant centers in New York City and Pittsburgh. Two recipients developed neuroinvasive disease, one recipient had asymptomatic WNV infection, and a fourth recipient was not infected.

Investigators determined the donor had lived near an area that had mosquitoes positive for WNV. His wife said he had spent time outdoors and felt febrile before receiving his fatal head injury.

This is the second report of WNV transmission in organ transplantation. The first report was in August 2002. In that case, the donor had received a transfusion of WNV-positive blood 1 day before organ recovery.

Clinicians should be aware of the potential for transplant-associated transmission of infectious disease, the CDC says. Organ recipients have a risk about 40 times greater than the general population of developing neuroinvasive disease after WNV infection.

—www.cdc.gov/mmwr
Mix shifts toward high-demand implants

One factor behind rising orthopedic implant costs is the shift to more elaborate and expensive implants.

In 2004, high-demand hip implant systems made up 60% of the constructs used for total hip replacement, up from 39% in 1999. In contrast, hybrid systems accounted for 20%, down from 55% in 1999. So-called high-demand hip systems have a coated stem and coated acetabular cup, while hybrid systems have an uncoated hip stem and coated acetabular component.

If you count the newer ceramic-on-ceramic and metal-on-metal implants in the high-demand category, 79% of implants in 2004 were high demand.

Overall, the average hip and knee implant cost rose 8% to $4,981 between 2003 and 2004, according to a survey of 42 hospitals by Orthopedic Network News (ORN). Total hip costs increased 8% to $6,167, and total knees increased 8% to $4,764.

These hospitals, designated as the Orthopedic Research Network (ORN), are monitored year to year for their implant selection and costs. The costs include the metals, plastics, bone cement, bone graft substitutes, and other instruments and devices sold by orthopedic implant vendors.

In addition to the mix of implants, other factors contributing to cost increases are steady increases in manufacturers’ prices and the fact that, until 2004, discounts offered to hospitals have not been enough to offset the increased costs.

The newer metal-on-metal and ceramic-on-ceramic systems accounted for 19% of the hip systems in 2004. The 2005 list price of Stryker’s ceramic-on-ceramic hip system with a Secur-Fit stem, ceramic head, and Trident shell and liner, at $11,000, is well over the average Medicare DRG 209 payment of $10,109 in FY 2005.

Other total hip findings

Among the other findings for total hips:
• 19% of the femoral heads are large, over 32 mm in diameter. These are designed to decrease dislocation but have a higher cost.
• Ceramic heads increased to 15% of femoral heads sold in 2004, up from 6% in 2003. The average ceramic femoral head cost $1,287 in 2004; the average metal head cost $543.
• The average coated femoral stem cost $3,100, up 8% from 2003, while the average uncoated femoral stem cost $1,568, up 12% from 2003.
• Cross-linked polyethylene liners accounted for 62% of acetabular liners; metal/ceramic liners accounted for 13% of the liners in total hips.
• Conventional polyethylene accounted for 24% of liners sold to hospitals. In 1999, cross-linked polyethylene accounted for less than 10% of liners sold.

Total knees

Almost twice as many knees as hips were replaced, both nationally and within the ORN. In 2004, in ORN, there were 7,111 primary knees and 3,441 total hips.

The types of prostheses used in knees have not changed as dramatically as those used in total hips. In all, 78% of total knees in the ORN used uncoated femurs and uncoated tibias that were cemented in place. The average price of these systems was $4,657, up 7% between 2003 and 2004.

Unicondylar knees accounted for 5% of knee replacements in 2004, down from 6% in 2003.

Hybrid (coated femur or coated tibia) or fully coated knee systems accounted for 16% of knee systems in 2004.

New DRGs for joints

For FY 2006, the Centers for Medicare and Medicaid Services (CMS) has split DRG 209 into 2 DRGs:
• DRG 544 for primary hips and knees, with a payment of $10,120
• DRG 545 for revision hips and knees, with a payment of $12,791.

The change was made at the recommendation of the American Academy of Orthopaedic Surgeons. In the past, the primary and total hips were lumped together in DRG 209.

With this change, primary hip and knee replacements will see an increase of $11, or 0.1%, up from $10,109 in FY 2005. Revision hips and knees will see an increase of 26.5%.

To bolster Medicare’s ability to monitor the types of revisions being performed, CMS introduced a number of new ICD-9-CM codes to differentiate the types of bearing surfaces for total hips and the types of components being replaced for hip and knee revisions. This means coders will need to be more cognizant of the materials being used for implants and how these are reflected in the ICD-9-CM codes. ♦

—Stan Mendenhall
Editor, Orthopedic Network News
Mendenhall Associates, Ann Arbor, Mich

For more information, go to www.OrthopedicNetworkNews.com.
Please see the ad for
OLYMPUS ENDOSCOPY
in the OR Manager print version.
A matrix that spells out what the hospital will pay for hip and knee prostheses has helped rein in orthopedic implant costs for a Florida hospital. The matrix lists levels of payment for total joint and bipolar hip procedures.

“Implant costs kept rising to an unacceptable level, and something had to be done,” says Kathie Ottavinia, RN, OR materials manager at 157-bed, nonprofit Jupiter Medical Center, Jupiter, Fla. The hospital has 9 ORs and 8 orthopedic surgeons who perform about 500 total joint replacements a year. The majority of these patients are covered by Medicare.

When the idea of a matrix was first introduced, there were concerns that surgeons would leave, and companies would refuse to do business with the hospital—but that didn’t happen, Ottavinia says.

“All of the surgeons and companies are still here, and we are not using any different products than we did before,” she says. The matrix has been in effect for a little over 3 years.

The team

The matrix was developed over 6 months by a team headed by the chief operating officer. The team evaluated and discussed data that had been collected about insurance reimbursement, cost accounting, and patient stay by the information systems, finance, and management care departments.

Beth Suriano, RN, director of surgical services, and Ottavinia gathered information on case and surgeon volume and implant costs. Jupiter’s surgeons use implants from about 6 companies, with most of the volume going to 3 manufacturers.

All of the orthopedic surgeons were invited to participate. A few did and were shown all of the figures collected on the reimbursement, volumes, and the costs that implants were consuming, Ottavinia notes. Although most of the surgeons stayed on the sidelines, she says those who participated understood the hospital’s position after seeing the data.

“It was hard for them to argue when they saw the figures, and I think most of them felt confident the companies would stay with us,” Ottavinia says.

The vendors were also asked for their input. “One company in particular was quite helpful and surprisingly supportive, along with the surgeon who used its implants,” she notes.

Implant levels

The payment levels on the matrix were based partly on implant types and partly on whether the implant is cemented, partially cemented, or not cemented (eg, porous) (illustration on page 16).

“Basing the matrix predominantly on cement made it easy. It’s clear cut, and there’s no guessing game,” Ottavinia says.

The payment levels were set with the hospital’s goal of paying a certain amount of the DRG reimbursement for the total joint prosthesis. The levels of payment include all implant components, including screws, holding pins, restrictors, and so forth. The hospital would not disclose its pricing.

If a surgeon wastes a component, the hospital pays an agreed-upon percentage of the list price. Revisions are not included on the matrix; these are not high-volume procedures at Jupiter. Revisions also are paid according to an agreed-upon percentage of the implant list price. If a surgeon cemented in a porous implant, the hospital still pays only the matrix price for a cemented implant. Ottavinia thinks that makes the companies more vigilant about what the surgeon is using.

CFO signs off

After the matrix was finalized, it was presented to the chief financial officer, who evaluated, approved, and then signed off on it.

About 5 weeks before the effective date, the hospital sent a certified letter with a copy of the new matrix pricing to every orthopedic company that it did business with, or might in the future. The letter stated that as of the effective date, the hospital would pay only the matrix prices for implants, without exception. The surgeons received a copy of the same letter.

No signature or response from the companies was required.

“We didn’t ask for their agreement,” Ottavinia notes. “If the companies came in, it meant they had agreed to honor the matrix pricing.”

Monitoring pricing

Ottavinia monitors the pricing. After each implant case, the company representative must drop off the paperwork in her office. The next morning, she reviews the paperwork and compares it with the OR implant record. If all is satisfactory, she issues a requisition, and the company gets its purchase order number, usually within 24 hours.

Not everything went smooth initially. One company in particular continued to submit either incorrect pricing on its paperwork or no pricing at all, Ottavinia notes.

Eventually, after numerous phone calls, conversations with reps, and some delays in payments, she says the situation was resolved.

Teams build loyalty

One factor that has kept the surgeons at Jupiter, Ottavinia believes, is an experienced OR orthopedic staff. The hospital provides RN first assistants (RNFAs) for all total joint procedures. For the most part, surgeons work with the same RNFAs and OR team.

“That’s the number-one surgeon satisfier,” she says.

Ottavinia also thinks allowing all companies to participate instead of limiting surgeons’ choices to 1 or 2 was crucial in neutralizing a major surgeon issue. No surgeon wanted to switch from the company he was using at the time.

With multiple vendors, the staff has to be skilled on a number of implant systems.

“Our staff has the experience, and our

Continued on page 17
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SPECTRUM SURGICAL INSTRUMENTS
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**Materials management**

### Orthopedic implant matrix

<table>
<thead>
<tr>
<th>Total knee matrix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very high</strong></td>
</tr>
<tr>
<td><em><strong>Emerging technology</strong></em></td>
</tr>
<tr>
<td>Prior approval needed (price to be negotiated on a per-case basis)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total hip matrix</th>
<th>Bipolar hips</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very high</strong></td>
<td><strong>High</strong></td>
</tr>
<tr>
<td>Examples include metal-on-metal &amp; ceramic</td>
<td>Total press-fit noncemented femoral stem &amp; shell/cup</td>
</tr>
<tr>
<td><em><strong>Prior approval REQUIRED on a per-case basis</strong></em></td>
<td>Any poly liner</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

1. Matrix pricing includes all screws, plugs, holding pins, etc.
2. Any and all items not listed on above matrix will require prior approval.
3. Percentage off list price on all “wasted” (not implanted) implants.
4. Percentage off list price on all revision components.
5. Shipping fees only if less than 48-hour case-booked time.
***Any approval needed must be obtained from the OR materials manager or the director of surgical services.***

Source: Jupiter Medical Center, Jupiter, Fla. Reprinted with permission.

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**Fewer delays, cancellations with clinic visit**

Cancellations and delays were significantly lower for patients who had a visit to an anesthesia preoperative clinic than for patients who did not, according to a new report.

The authors reviewed charts for all cases during a 6-month period at the University of Chicago Hospitals. They cross-referenced cases with delays and cancellations with a database of patients who had a clinic visit. A total of 6,524 eligible cases were included.

In same-day surgery, 8% of patients evaluated in the clinic had cases cancelled compared with 16% who did not. In the general ORs, 5% of clinic-evaluated patients had cases cancelled versus 13% without a clinic visit.

In both areas, patients seen in the clinic entered the OR earlier than those who were not seen.


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RNFAs deserve much of the credit for keeping everything going smoothly,” Ottivinia says. The major vendors keep instrument sets in house, and there is always a rep on hand for cases and consultations.

“The matrix has worked well for total joints, but pricing remains a challenge,” she says. “Nothing is ever completely settled, and as changes occur, individuals from all areas of the hospital will re-evaluate the data to determine if any changes should be made.”

Continued from page 15
When Judy Patterson, RN, BSHA, CNOR, arrived in July 2003 as director of surgical services at 105-bed Hannibal Regional Hospital in Hannibal, Mo, she quickly discovered the hospital had an orthopedic implant purchasing problem.

“We had no IT system, no data, and physicians were unaware of pricing of implants,” Patterson says. A sensitive issue was that one vendor was a brother and the other a brother-in-law of 2 orthopedic surgeons. “It was hard to know which direction to take,” she says.

One of the first steps Patterson took was implementing a directive that all implant invoices must come through her before a purchase order is issued. “This gave me the opportunity to get acquainted with the vendors, implants, and the pricing as well as to collect data for the physicians,” she says.

She began using a data tracking system and collected information from St Louis-area hospitals. She also began sharing information with the physicians for the first time. “All of these strategies were instrumental in supporting our efforts in cost reduction,” she says.

### Setting goals

In her cost review, Patterson found the hospital lost $1,200 on every total hip replacement case. During fiscal 2003, the hospital lost $340,000 on its total hip cases. With fiscal 2004 fast approaching, Patterson’s goals were to reduce implant costs, standardize, and improve inventory management.

Curtis Burton, MD, one of Hannibal’s 3 orthopedic surgeons and brother of one of the vendor reps, said he was surprised when he heard the news. “I thought I was doing the hospital favors by performing so many surgeries,” he says. “The hospital would have lost less money if I had played golf.”

After going over the cost data with the surgeons, Patterson called a meeting with the representative of the company that supplied the total hip prostheses, who is Dr Burton’s brother. “We asked the company for 50% off, they offered 20%, and we settled for 35%,” Patterson says. “We thought we did well.”

Like all participants, Patterson’s team, which included the CFO, materials management director, pharmacy director, and orthopedic coordinator, attended the meetings, developed a storyboard of progress, set goals, kept in touch with other participants, and learned OR process improvement techniques.

Patterson says she expected to go to the first breakthrough meeting in September and show what the team had done. “We were very proud of getting those discounts,” she says. “We learned we didn’t do as well as we thought. We needed to go back and get organized.”

She also learned the hospital needed to use the CFO as the driver of the process and to include the orthopedic coordinator as part of the team.

After the meeting, Patterson talked with the surgeons about standardizing to one vendor to save money, but not surprisingly, they didn’t want to do that. “We were on Premier pricing contracts for knees, but that needed to be adjusted,” she says.

### Moving to capitated pricing

During the second meeting in December, Patterson learned about capitated pricing—a strategy of setting a flat rate for implants. “We told the 2 vendors what we would pay for each hip and knee implant, including screws, pins, bits, and trocars,” she says. “We knew what other hospitals were paying based on the breakthrough series.”

Jane Anders, RN, MHA, MBA, SSM’s contract manager of surgical services, says SSM’s 8 participating hospitals saved a total of $1.5 million, mostly in the orthopedic area. “Most of the hospitals have gone to a capitated pricing arrangement and have done well,” she says.

After the second session, Patterson says Hannibal was able to negotiate a 47% discount using capitated contracts that locked in prices for hips and knee implants for 2 years. “We gave the vendors the contract, and it was revised 5 or 6 times but not on pricing,” she says. “Any new technology has to be approved by me, the staff has to be trained on it, and everything had to

### Small hospitals can get discounts like larger hospitals.

She says she later learned that although the company was giving the hospital a 35% discount on implants for which it had negotiated a price, vendor representatives were recommending that surgeons use more expensive implants. “The vendor would come back and add a $650 to $700 up-charge to the implant. It was a way to get their discount back,” she says. “They also charged us for freight, something that was not that unusual a few years ago.”

### Joining a collaborative

During the summer of 2004, Patterson was invited by SSM Health Care, a St Louis-based health system, to participate in Premier’s Supply Chain Collaborative Breakthrough Series. Hannibal is an SSM affiliate.

Over about 8 months, teams from some 35 hospitals or hospital systems participated in the fourth annual series, says Gay Wayland, RN, MBA, vice president of Premier’s supply chain knowledge transfer. Hannibal was the smallest hospital in terms of beds participating in the implant project. “Smaller hospitals can get just as large discounts as larger hospitals,” Wayland says. “It is a myth that there is a correlation between volume and price. It is how well you can engage physicians and get them involved in the negotiations.”

Wayland coaches hospitals not to start talking with physicians about standardization. “Try to offer to make their life better at the hospital by offering benefits, such as investing in capital equipment if they will help bring the cost per case down,” she suggests.
be consigned. No freight charges.”

The contracts became effective in January.

“Some hospitals may have lower prices than us, but we locked it in for 2 years,” she says. “Hips and knees went up 8% this year, and probably will go up 8% or more in 2006.”

From September 2004 through March 2005, Hannibal saved $261,781 on hips and reduced costs by more than $1,000 per case, Patterson says. Though there’s further to go, she is pleased with the progress so far.

“We ended up playing one vendor against the other, a common practice in business,” says Dr Burton. “There was a lot of resistance from the vendors. I made it clear the prices were too high.” One vendor was opposed to changing the price. We told them we were going to the other vendor to purchase both types, and the first vendor came around.”

Patterson says that despite the family relationships, the surgeons “never let that be an issue. They became our partners in reducing costs.”

**Partnering with physicians is key**

Patterson also learned the importance of working with physicians on process improvement in the OR and marketing the hospital to increase referrals.

“We had already started to work with the surgeons on pricing, but improving the process was just beginning,” Patterson says. She also formed a partnership with materials management to educate staff on cost reduction strategies.

She and the staff worked to reduce turnover time for joint replacement surgery from about 45 minutes to about 20 minutes. One strategy is to have patients prepared as much as possible in the holding area before they are taken to the OR. The hospital also has provided the surgeons with another room with laminar flow and bought new instruments and equipment.

She also learned the value of using the surgeons to make outreach visits to the community. “We called on clinics to talk about improvements at the hospital to get more referrals,” she says.

As a result, Hannibal increased orthopedic volume overall by 22% and total joint procedures by 10%.

“I couldn’t be happier,” says Dr Burton, a partner with Midwest Orthopedics Specialists. “I had a busy practice before, but because the hospital OR is more efficient, I can get done by 1 or 2 pm or add another surgery. Before, I was there all day. This is my reward.”

Burton says he often was frustrated when he thought he was helping the OR, but the rewards weren’t coming back to him.

“A well-run organization rewards you for bringing in business by making your life easier or by getting better technology,” he says. “I feel the hospital is doing that now.”

—Jay Greene

Jay Greene is a freelance writer in St Paul, Minn.

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a conflict-of-interest disclosure as part of the credentialing process.

“Typically, the doctors are the ones who are most familiar with the technology,” says Murtha, who has served as compliance officer for the University of Pennsylvania, Children’s Hospital of Philadelphia, and other institutions.

“Often, sales people with the technology companies contact the clinical people first to get them charged up about a piece of equipment they ought to buy,” she notes. “Because of the relationships that develop, it’s critical for doctors to complete a disclosure form. That way, it’s clear whether they have a relationship with the company that would somehow compromise their business judgment in purchasing that piece of equipment.”

No disclosure, no vote
At Swedish Medical Center, a 3-hospital system in Seattle, physicians who want their vote included in a purchasing decision must sign a conflict-of-interest statement, a requirement of the value analysis process.

“They must sign, or their vote doesn’t count. It’s not an option anymore, and it’s been accepted quite well,” says Allen Caudle, vice president of supply chain management. He notes that Swedish has a “robust” value-analysis system, which has been in place for about 5 years.

Under the hospital’s conflict-of-interest policy, those who must sign statements, in addition to corporate officers and administrators, are members of the pharmacy and therapeutics committee, value-analysis teams, and institutional review board. The policy gives Caudle responsibility for coordinating disclosures for the value-analysis teams. In addition, the director of corporate compliance coordinates disclosure for all those covered by the policy.

Decisions on high-stakes physician-preference items such as orthopedic implants are made by an ad hoc committee of physicians from that specialty. Swedish performs about 2,000 hip and knee implants a year, and some of its surgeons design implants for orthopedic companies.

When a vote is taken, physicians submit their votes in writing to the department chair, who opens them along with the vice president in charge of that value-analysis team. If a vote does not have a matching conflict-of-interest form, it is not counted.

Caudle explained how the process will work for a new contract Swedish is negotiating for knee implants. The goal will be to select 2 primary knee implant vendors, which Swedish has already achieved for spinal surgery. The vendors will be selected by an ad hoc committee of 15 of the 60 orthopedic surgeons chosen by the department chair. The ad hoc committee sets the criteria for who can vote, which include performing at least 20 knee implants in the past year and signing a disclosure statement.

As part of the deliberations, Caudle will present data to show the hundreds of thousands of dollars that can be saved by consolidating to 2 vendors rather than using 3 or 4 companies.

“The physicians have been pretty upfront” about disclosing any financial ties, Caudle says. “Their colleagues know about their relationships, and it isn’t a big secret. It’s not that they can’t have those relationships. It’s just that they have to document them and let us know about them if they want to vote.”

The medical staff is increasingly aware of the legal reasons for disclosure, says Kate Rogers, RN, MSN, CNOR, Swedish’s director of surgical services. “They understand and are accepting the way business is done here.”

Rolling out a new policy
Two organizations that recently added physician financial disclosure to their product-evaluation process are Spectrum Health, a 7-hospital system based in Grand Rapids, Mich, and OSF Saint Francis Medical Center, Peoria, Ill, one of the nation’s largest Catholic hospitals, with 710 beds.

Spectrum Health’s new policy asks physicians to complete a disclosure statement prior to bringing a product request to the value-analysis committee. The 1-page statement asks the physician to fill in the name of the product being evaluated, sign his or her name, and list any financial arrangements with companies or other parties related to the product. The statement is backed by an administrative policy mandating use of the statement.

“We aren’t saying they can’t have these arrangements. We just want to know if they are doing it and if that could influence their decision,” Christopher Baskel, director of supply chain management, says.

Gail Greco-Bieri, Spectrum’s equipment, materials, and instrument coordinator, adds, “Our bottom-line goal is to provide the best product to our patients and to be fiscally responsible. To do that, we need to understand why a doctor believes so strongly that a product is the best one out there.”

Baskel proposed the disclosure statement to Spectrum’s risk and compliance department when the conflict-of-interest policy was up for renewal. The disclosure applies to “agents” of the hospital, such as physicians who are not employees and participate in product evaluations.

The policy was piloted by a group of obstetricians led by Donald Heggen, MD, and they have signed off on it. The new policy is being communicated to the rest of the medical staff by the director of medical affairs. It will apply not only to products being considered for surgery but to the institution as a whole, including radiology and the cath lab.

“We found that once you explain the policy, and the physicians understand it, they don’t seem to have a problem with it,” Baskel says.

His advice for others who want to introduce financial disclosure for physicians: “Work with your risk and compliance and your legal departments. Get some political clout behind you.”

Disclosure part of new technology process
At OSF Saint Francis, disclosure is an expectation of the new technology assessment process, rolled out last fall. All members of the technology value-analysis committee, employees and
physicians alike, must sign a disclosure form annually. Committee members who have a financial relationship with a company whose product is being evaluated are expected to refrain from voting.

In addition, physicians who submit a product request are expected to sign a disclosure statement on the back of the new product/technology request form.

The statement says, in part: “This information is shared with committee members and is considered when discussing your request. A potential conflict-of-interest issue does not disqualify someone from requesting the product/technology. The committee recognizes that many departments and members of the medical staff have relationships with manufacturing companies. Physicians with expertise in this area have often received research grants or other support from companies. However, the committee feels it is important to disclose these relationships.”

The form asks physicians to indicate whether they:
- have a proprietary interest in the company that makes the product being evaluated
- own stock in the company (excluding mutual funds)
- serve on the company’s board of directors
- expect to (or currently receive) royalties from the company.

The form also asks if the physician or department has received financial support from the company, including research funding, support for continuing education, travel support, or other funding.

So far, physicians have accepted the policy, says Rita Menold, RN, technology value analyst for surgery and allied services. “As long as their requests are still considered, they are OK with the disclosure,” she says.

Disclosure by managers, staff

It’s the norm for hospitals to require administrators, managers, and sometimes staff to sign conflict-of-interest disclosures, Murtha says. Generally, the policy applies to those with contracting authority but may also apply to employees at lower levels, such as those in the purchasing and billing departments.

Swedish, Spectrum, and OSF Saint Francis all require administrators and managers to sign an annual disclosure policy.

The Swedish policy spells out the rules on gifts and favors from vendors. Basically, an employee may not accept anything more than a token gift, such as a calendar or pen, Caudle says. He personally does not go out to dinner with vendors or accept other favors. When invited, he responds, “Why don’t we have a meeting in my office during business hours?”

OSF Saint Francis has a strict policy on what vendors may bring in, notes Anne Kanaby-Krup, RN, director of surgical services. Any food brought in by vendors must be purchased from the hospital’s catering service. Other than that, “the only thing we accept is education,” she says. “I would much rather have the vendors focus on education than anything else.”

A copy of OSF Saint Francis’s new technology assessment form is in the OR Manager Toolbox at www.ormanager.com

ICDs may be cost-effective

Expensive implantable cardioverter-defibrillators (ICDs) may be worth the cost for high-risk patients, according to a study in the New England Journal of Medicine.

The study found that costs associated with implanting the devices fall in a range considered acceptable because patients generally live longer after the procedure. The researchers determined that the defibrillators cost from $34,000 to $70,200 per “quality-adjusted life year,” which considers quality of life as well as an increase in life expectancy from the procedure.

The authors, led by Gillian D. Sanders, PhD, of Duke University, developed a model of the cost, quality of life, survival, and preventive effect of the device based on results of 8 clinical trials.

The researchers compared patients who had an ICD implanted with a group that did not and used a model to project what happened to the patients during their lifetimes, including medical costs and deaths. Based on the results, “this would be considered a good value for the money,” Dr Sanders told the Wall Street Journal. The study was not funded by the device makers.

ICDs convert episodes of ventricular fibrillation and ventricular tachycardia to sinus rhythm, potentially averting sudden death from cardiac causes.

ICDs pose a big challenge to policy makers. The government estimates that up to 500,000 Medicare beneficiaries might be eligible for an ICD. Piper Jaffray & Co estimates the costs could reach $5.6 billion next year. Medicare pays about $30,000 to implant an ICD, according to the Wall Street Journal.

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A strategy for review of new products

Product standardization is a key to controlling OR costs. Children’s Hospital of Pittsburgh has developed a successful product standardization strategy using a New Products Committee.

The committee, in existence for 18 months, was initiated because too many new products were entering the OR without going through the proper channels. Our purchasing manager and I, as the director of perioperative services, decided a committee was needed to oversee how and when new products could be brought into the OR.

Hospital executives approved our request to set up a committee with a charter to review, evaluate, and approve or deny all new product requests. The review process considers clinical, quality, and financial outcomes as well as regulatory and contractual issues.

The New Products Committee is co-chaired by the purchasing manager and me. Other members include representatives from the nursing, medical, finance, infection control, materials management, and education departments as well as regulatory and contractual issues.

The New Products Committee reports to the Executive Standardization Committee.

New product requests

A surgeon who wants to bring in a new product must first complete a New Product Request form. Information on the form includes:

- Type of request (ie, trial product, new product, or change existing product)
- Clinical justification for the product and how the product would improve patient care
- Description of how the product will be used
- Educational requirements for end users
- Identification of similar products currently being used
- Potential elimination of another product if new product is approved
- Estimated annual use of the product in the cost-benefit analysis.

Before the form is sent to the committee, it must be reviewed by the purchasing manager and me. For example, if a plastic surgeon wants to try a new tissue expander for breast reconstruction, but we already use another brand, I ask the chief of plastic surgery if he supports the request and if the plastic surgeons all would use this new expander.

Criteria used by the New Products Committee to approve or deny requests are in the sidebar.

Requests for products not on GPO contracts typically are not approved. Requests for a product or type of product that has already been standardized are not approved at this level but can be taken to the Executive Standardization Committee and then to the chief executive officer.

The OR had one unsuccessful standardization project involving endomechanical devices. The endomechanical vendor we standardized with did not have all of the pediatric sizes of devices our surgeons needed. In the end, we made some exceptions to allow certain products from another vendor for specific cases.

Standardization initiatives

The Executive Standardization Committee is responsible for approving or denying standardization initiatives. It also serves as a level of appeal for surgeons whose new product request is denied by the New Products Committee.

Members of this committee include executive staff from operations and quality as well as clinical nursing directors, the purchasing manager, and the contract compliance specialist. Members are appointed by the medical director, chief financial officer, and chief nursing officer, who serve as the co-chairs.

Decision-making criteria used by this committee include:

- Ensuring quality of care is maintained
- Reducing the number of products and vendors
- Enhancing contract utilization
- Achieving cost savings through better pricing and contractual rebates.

For the most part, the Executive Standardization Committee supports the decisions of the New Products Committee while serving a dual role of assessing products for standardization.

Items to be standardized do not go through the New Products Committee because they are not new products. An example is standardizing central line catheters from 4 different types to 1 type.

Standardization of spinal implants

One of the most successful initiatives the Executive Standardization Committee has accomplished is standardizing spinal implants. The OR performs about 100 spinal procedures a year with a large cost impact averaging $10,000 to $15,000 per procedure.

Prior to standardization, the OR had used a variety of spinal implant trays, all with big price tags. We knew significant savings could be achieved by having the orthopedic surgeons use one spinal implant vendor.

The decision-making process began with the purchasing manager and me meeting with the division chief of orthopedic surgery. We determined whether there were any quality issues associated with standardizing to one vendor. We then developed a financial analysis comparing costs by procedure and surgeon. We have not compared cost by level of spinal fusion yet, but hope to work with the chief of orthopedics to accomplish that because he has already compiled data for each level.

All of the orthopedic surgeons agreed to use one vendor except one who

Continued on page 24
The OR uses a savings tracking tool, which is presented to the standardization committee for all standardization initiatives. The tool shows current product expenses versus new product expenses along with any rebates to show total savings of the initiative.

Strategies for success
To achieve success in standardization, it is important to focus first on quality and then on the financial gains of using a sole vendor. Increasing overall awareness of an organization’s contractual agreements with vendors also helps support the strategic goals of product standardization.

Successful standardization strategies include:
- executive and medical support and focus on standardization initiatives
- organizational awareness of standardization opportunities
- physician and nurse buy-in
- financial support to perform cost-benefit analyses on products
- a knowledgeable purchasing manager to partner with vendors and negotiate contracts for the best pricing
- strong partnership between the OR director and purchasing manager.

At Children’s Hospital, product standardization is an ongoing process. The combination of a strong, committed medical director holding the surgeons accountable, along with a purchasing manager who continuously identifies opportunities for the OR, helps ensure success in standardization initiatives.

—Diane Hupp, RN, MSN
Executive Director, Nursing and Surgical Services Lines
Director of Perioperative Services
Children’s Hospital of Pittsburgh

The Children’s Hospital tracking tool for monitoring current and new product expenses is in the OR Manager Tool Box at www.ormanager.com
Officials for the ambulatory surgery center (ASC) built by Children’s Medical Center of Dallas faced a tough decision in the months leading up to its March 2003 opening: Should they hire OR nurses from the main hospital?

Initially, Matt Chance, MHA, CHE, business manager of surgical services at Pavilion Surgery Center, said the answer was no. Pavilion wanted outside OR nurses to staff the new 6-OR ASC.

“We decided early on that we would have a dedicated staff at the ASC,” Chance says. “We couldn’t take staff away from our main OR, where it was full. We needed to be up and running on Day 1. We also didn’t want to import nurses with inpatient mindsets. Surgery centers have different operational needs than main ORs.”

As volume increased to about 450 cases per month, Patty Crabb, RN, BS, Pavilion’s director, says the ASC has since hired 5 nurses from the main hospital to staff preoperative and recovery units.

“I only hired one nurse from the OR, and she is not here anymore,” Crabb says. “It is a big change in mindset here compared with the main OR. We are a single self-contained unit where turnovers are fast. We have little down time.”

**Hiring the ‘right staff’**

In the fast-paced and competitive realm of ambulatory surgery, patients spend the majority of their time with nurses, surgical technologists, and support staff. Hiring the right staff can build a reputation of great patient care that can make the difference between a winning and losing ASC, experts say.

Hiring staff for freestanding or hospital-affiliated ASCs can be one of the most sensitive decisions managers make. Some hospital-affiliated ASC managers say hospital politics become a factor in hiring decisions—at least in the beginning when an ASC opens. But most ASC managers say the decision to hire an OR nurse is purely an operational one that is made on a case-by-case basis.

Some ASCs prefer not to hire OR nurses who have spent years working in inpatient environments because the pace, duties, schedules, cost-control responsibilities, and patient and physician interactions are different. Yet ASC managers say they keep an open mind when interviewing and hiring.

“You want the best person for the job, regardless of where they come from,” says Sue Weides, RN, CAPA, former manager of the Ambulatory Surgery Center at Lutheran Advocate General Hospital, Park Ridge, Ill. “Turnover is quick in ASCs. Most main-OR nurses come over and are surprised how many cases we do in such a short time. Some aren’t used to the pace. This is the biggest obstacle over here.”

Weides, who now is clinical coordinator of presurgical testing at Lutheran Advocate General, says more than half of the 20 nurses currently at the 6-OR ASC transferred over from the hospital’s main surgery department.

Two other changes inpatient OR nurses may face when moving into the ASC arena are the wide variety of cases each day and the need to have a customer-friendly attitude toward patients, families, and surgeons.

“Our patients are not as sick. (OR staff) can be involved in an ear tube for 10 minutes and then move to a laparoscopy for 90 minutes,” Weides says.

She says providing good customer service to surgeons is very important at ASCs because there generally is a small core of surgeons that regularly work at the ASC.

“We have probably 250 surgeons on staff, but we have a strong core of about 20 whom we work with consistently,” she says. “It is important that OR nurses

Continued on page 26
work well with the surgeons because they see them every day.”

**Asking the right questions**

When hiring nurses for an ASC, Ann Geier, RN, MS, CNOR, CASC, vice president of operations at Ambulatory Surgical Centers of America, Norwell, Mass, says asking the right questions in interviews can help identify best candidates.

“Nurses might not have ASC or outpatient experience, but you want nurses with the right attitude,” Geier says. “Ask them situational-type questions. For instance, you might ask a nurse to describe a typical work day. If they work in the OR, they might tell you they have cases scheduled, and they do those, restock, and go home.”

This is a red flag, she says, noting that in ASCs, nurses often are reassigned to other units later in the day, depending on work flow.

“Ask them what other responsibilities they have. Have they been on a CQI committee? This is important,” Geier says. “Everybody in an ASC is expected to do other duties.”

Geier says identifying those nurses who are able to deliver customer-friendly service is crucial to make an ASC successful.

“Ask them to describe the worst confrontation they ever had with a MD. This will tell you their customer service orientation,” she says. “Ask them what they do if a surgeon tells an off-color joke. When you hear the answer, you can tell if they would make things worse or be able to defuse the situation.”

Geier, who has worked in both inpatient ORs and ASCs, says hospital ORs are doing a better job at delivering customer service to surgeons. “I still would rather hire the hospital nurse who has ASC experience. It is difficult sometimes trying to change the inpatient nurse’s mentality. They recognize they need to change, but many do not do anything about it,” she says.

Rebecca Craig, RN, CNOR, CASC, administrator at Harmony Surgery Center, Fort Collins, Colo, says she and her clinical director, Catherine Seiler, RN, ask 2 questions that tend to identify a nurse’s flexibility and attitude. Harmony is a joint venture between surgeons and nearby Poudre Valley Hospital.

“I have my toilet question,” Craig says. “I ask, ‘Are you willing to clean a toilet if necessary?’”

Also, Harmony does a lot of GI endoscopy procedures. “We may need that done. Some nurses are versatile and willing; some are not. The answer helps us judge how flexible a nurse is.”

Other questions frequently asked are:

“What is your favorite part of your (current or last) job? What is your least favorite?” Craig says. “We have been weeding out a lot of people with this question. Some say their least favorite was that they were so busy. They wouldn’t be able to work in our environment.”

Of Harmony’s approximate 36 part-time and full-time nurses who staff its 4 ORs and 2 GI and pain management rooms, about half originally came from a hospital inpatient OR.

“We had a lot of turnover the first 2 years when we opened, but we have very little turnover now,” she says. “Some may have started out as inpatient nurses, but everyone working here now is an ambulatory nurse.”

Weides agrees interviews are critical, but they only tell part of the story.

“One of the questions is ‘Have you felt like your skills are not being used?’” she says. “If someone worries about that, we may not hire them.”

Weides says Lutheran’s ASC employs 3 nurses with the “can-do” attitude who are willing to learn new duties and responsibilities, says Donna Slosburg, RN, BSN, LHRM.

CASC, senior vice president of quality initiatives at HealthSouth. In Slosburg’s experience, some OR nurses may lack the experience to carry out multiple duties required of ASC nurses.

**Doing what it takes**

“In a hospital, you have a lot of support staff. ASCs have limited staff, so everybody has to be flexible and willing to do whatever it takes,” Slosburg says.

For example, ASC nurses in the OR are expected to staff procedures and then clean up the room between cases. “We don’t typically have housekeepers or orderlies like hospitals,” she says. “You may be scrubbing, ordering supplies, cleaning instruments, working on PI projects, as well as picking up the trash.”

In past interviews she has conducted, Slosburg, who is based in St. Petersburg, Fla, says OR nurses typically think ASCs are easy places to work because they don’t have night shifts and call responsibilities.

“Some nurses know all the right answers. I liked to get recommendations from people they worked with. I always had staff or the leadership team interview candidates. I would get everybody’s feelings afterwards,” she says.

Most ASCs want OR nurses with a “can-do” attitude who are willing to learn new duties and responsibilities, says Slosburg.

Weides says Lutheran’s ASC employs

Continued on page 28
Please see the ad for STERIS CORPORATION in the OR Manager print version.
A few surgical technologists as scrub techs, but “most OR nurses have to scrub and circulate.”

Crabb says OR nurses primarily are dedicated to surgery, but they are also expected to participate in quality assurance and process improvement projects. “If needed, (OR nurses) also work in Phase 1 and Phase 2 recovery rooms and sterile processing,” she says.

Attention to costs

Many ASCs are profitable, and managers say much of this is attributable to efficient operations and attention to costs. Staff nurses are expected to pay rigorous attention to cost containment.

“Because our reimbursement is on a flat-fee basis (Medicare ASC groupers), we have to be efficient with time and costs. We don’t open everything on the preference card. We just open the necessities, and nurses will wait and ask the physician,” says Crabb.

Since Dallas Children’s Pavilion opened, Chance says per-case supply costs have dropped to under $750 per case from about $1,000 per case in 2003.

Crabb says OR nurses learn quickly how much items cost and how to query surgeons who order expensive supplies.

“Nurses learn to ask if (the surgeon) knows how much an item costs before they open it. Most times the doctor doesn’t know and will offer an alternative or not use it.”

Nursing shortage affects hiring

ASC managers say the nursing shortage sometimes makes it difficult to find experienced nurses who are willing to take an ASC’s sometimes lower pay, fewer benefits if they work part-time, and less vacation time in exchange for what is a more flexible schedule and a more open working environment.

“The main hospital trains new nurses,” Geier says. “ASCs don’t have the staff development budget hospitals do. In a way, we have a Catch-22 type situation. We don’t hire new graduates because they are not experienced. The experienced nurses are at the hospitals, and they are in great demand, and hospitals have deeper pockets than ASCs.”

Do your patients understand their care?

A Spanish-speaking woman walks out of the hospital just before surgery when it is finally communicated clearly to her that tubal ligation is permanent and not a temporary method of birth control.

A diabetic patient’s case is cancelled even though they have signed them. The figures are sobering. Studies show that even after patients agree to care or receive:

- 18% to 45% are unable to recall the major risks of surgery
- many cannot answer basic questions about services or procedures they agreed to have
- 44% don’t know the exact nature of their operation
- 60% to 69% don’t read their consent forms, and 60% do not understand them even though they have signed them.

Lack of true informed consent is a common basis for malpractice cases. It also increases the chance of an error and disproportionately affects patients who have difficulty understanding information, such as those with limited English or low literacy.

Try “teach-back”

How can health professionals help?

Ask each patient or legal surrogate to recount what he or she has been told during the informed consent discussion, the National Quality Forum (NQF) recommends.

This “teach-back” strategy is part of NQF’s national consensus standard for informed consent, also known as Safe Practice 10.

NQF issued a user’s guide in September to help health professionals carry out this and other recommendations, including having consent forms written in simple sentences in the patient’s primary language and engaging the patient in a dialog about the procedure.

Though there’s concern “teach-back” takes more time, NQF reports that 4 months after starting to use it, one hospital dropped its surgical cancellation and delay rate from 8% to less than 1%.

The NQF user’s guide can be downloaded for free at www.qualityforum.org

We don’t open everything on the preference card.

For example, some OR nurses who would be good candidates for an ASC may have seniority with 6 weeks’ vacation at the hospital. “We can only offer 2 weeks,” Geier says. “Nurses who come to us want the challenge of working in an ASC. They like the smaller staff and more intimate settings and are willing to make adjustments.”

Geier says other benefits to working at an ASC are: a family atmosphere, teamwork and cross-training, convenient parking, work autonomy, and less of a hierarchy.

Once the decision has been made to hire OR nurses, Geier recommends hospital-affiliated ASCs advertise within the hospital first and then advertise externally after a few weeks. Advertising in local and national publications works well, she says. But word of mouth within the local nursing community is the most effective.

“When you hire from outside—that brings resentment. But you need to be careful during your interviews to make sure nurses don’t bring the hospital mentality and a lot of baggage that needs to be undone,” she says.

— Jay Greene

Jay Greene is a freelance writer in St Paul, Minn.
A plan for managing problem employees

Lisa Cooper, RN, BSN, BA, CNOR, knew a lot about perioperative nursing but little about managing a staff when she was promoted to a managerial role in an ambulatory surgery center (ASC) 8 years ago.

One of the first supervisory challenges Cooper faced was managing problem employees, many of whom she inherited.

“I counseled people as I would want someone to talk to me,” says Cooper, clinical director at El Camino Surgery Center in Mountain View, Calif. “I expected others to work as I had worked. But this one-dimensional approach wasn’t effective—managing people is far more complex.”

Because she didn’t learn supervisory skills in nursing school, she read management books, learned from mentors, and observed the approaches of both ineffective and effective managers and administrators.

“Management is only somewhat by instinct,” she says. “It’s a learned science of how to treat people the way they need to be treated and how to watch the bottom line.”

Three-part plan

Based on her experiences and interactions with what she says are exceptional managers, Cooper developed a 3-part plan to manage problem employees who bleed productivity and positive morale from her ASC:

1. Identify the problem and counsel the employee.
2. Determine what motivates the employee.
3. Consider the legal ramifications of your actions.

“Whenever possible, these 3 steps should be completed before sitting down with the employee for counseling,” Cooper says. “But sometimes the information you gain from the counseling process itself may affect steps 2 and 3.”

Step 1: Identify the problem

The first step in counseling is defining an employee’s problem, Cooper says.

“Basically, there are 3 types of problem employees: Those with performance problems, those with personal problems, and those you simply do not want working for you anymore because of the seriousness of their behavior.

“Generally, those with performance problems can be divided into 2 categories—a lack of motivation or a lack of ability—and this matters when working out a plan to address the problem.

“The second is personal problems, such as substance abuse, family, or workplace violence. These are tough ones to handle because you’re often dealing with an unstable employee.

“The third is the employee you just don’t want around anymore. Maybe they gossip too much, bring down morale, or don’t have the work ethic you need.”

Is it really a problem?

Even after categorizing an employee’s problem, managers need to ask themselves if it’s a real problem or just a nuisance.

“If the employee excels and doesn’t interfere with operations or morale, then just help the employee continue to excel,” Cooper advises. “Don’t focus on employee’s weaknesses or problems. Work around them.”

But don’t ignore the problem either, she says. “If it’s a small issue, don’t make it an issue,” Cooper says. “If it’s a performance issue, and they need training, then give it to them. If it is affecting their co-workers, tell the employee in a matter-of-fact manner, such as ‘Listen, I know you give more than 110% every day, but when you take extra time for your lunch in front of your co-workers, you should realize it causes some tension and hard feelings.’

“Give your star employees key information and trust they will do right.”

In the management bestseller, First, Break All the Rules (Simon & Schuster, 1999) authors Marcus Buckingham and Curt Coffman report that great managers focus on employee strengths, not weaknesses.

Working for the Gallup organization, the authors interviewed thousands of managers who echoed the same insight: “People don’t change that much. Don’t waste time trying to put in what was left out. Try to draw out what was left in. That is hard enough.”

Counseling

When employee behavior does interfere with operations or morale, counseling is necessary. Cooper approaches the process like a research scientist: observing, asking questions, hypothesizing, interviewing, analyzing, and then making a conclusion. Other tips:

• Document problem behavior. Always try to witness misconduct firsthand. “If you get a report that someone is not wearing her mask properly in the OR, ask your charge nurse to page you when it is happening and then go into the room yourself to witness it,” Cooper says. “Often just being ‘caught’ by a manager can cause a change in behavior.”

• Meet in a private, quiet space when counseling.

• Always ask employees their side of the story, even if the purpose of the meeting is to terminate them. “It is important to hear what they have to say,” Cooper says. “It usually can be used to help support whatever direction you need to take them.”

• Ask open-ended questions, such as, “I heard some details about what happened the other day. I am interested in understanding your perspective. Can you explain to me what happened?” Do not guide the employee.

Continued on page 30
down a path you have guessed to be the answer. “Let them tell you in their own words what they see is the problem and what they think will help,” she says. “Your employees may admit their actions in their own words. Give them time to talk, and often they will assist in your documentation.”

• Thank them and ask them to leave. “I can’t stress how important this is,” Cooper says. “When you take time to reflect, you avoid being irrational or emotional about a situation. You show respect to your employee by demonstrating that you actually care about what they had to say and will keep it in mind as you make your final decision.”

**Step 2. Determine what motivates the employee**

The second part of Cooper’s approach is finding out what motivates employees to achieve a desired behavior.

“Your employees know best what will motivate them to improve their performance,” she says. “Listen to their explanations or get informal feedback from peers, and you might hear what it will take to help them resolve the problem.

“We had a situation where the preop nurse repeatedly neglected to make sure the patient’s consent form was signed,” Cooper relates. “Each time, we would listen to her explanation of why it happened. Then we told her we’d talk to her later after we considered what she said. We called her back in and told her this was a problem, and it needed to be solved.

“First, we tried motivating her by saying that being a professional nurse means handling this important issue with diligence. That didn’t work.

“Then we tried the approach of explaining that this was a liability issue, and the patient could hold us responsible for assault if the patient is not fully informed before the surgery. That didn’t work.

“Finally, after talking informally with one of her co-workers, I found out that money and job security were extreme motivators for her. So we wrote a clear warning that if this incident occurred again within the next 6 months, we would terminate her employment. It never happened again.”

Cooper notes that employees’ internal motivation varies. “Motivation is the inner force that drives employee behavior,” Cooper says. “Most often, people tend to search for meaning, not money, to motivate them.”

**Step 3. Consider legal implications**

Because most ASCs do not have in-house legal counsel, Cooper says it is important to approach employee counseling with the question, “What would my lawyer say about this?”

She recommends the following points to avoid potential employee litigation:

• Have clear and consistent written policies.

• Act fairly.

• Communicate with problem employees frequently and candidly.

• Document behavior and discussions thoroughly.

• Seek legal advice when necessary.

• Have a legitimate business reason for all decisions.

Most states have “employment at will” laws, which allow employers to fire an employee at will, though there are important exceptions. But Cooper says even though the letter of the law may support the practice, “you have to consider what the 12 people you see at the potential jury pool.

“Your reasons for termination have to fit the gut check of treating people in a fair and reasonable matter,” she says. “You really need to justify why you fired someone, even if the law doesn’t say you have to.”

She adds that managers need to pay special attention to possible claims of discrimination or retaliation, the most common reasons employees take employers to court.

When firing is required, Cooper says managers must be willing to act with the conviction that the termination is a necessary and essential part of keeping an organization productive.

**Correcting mistakes**

Sometimes during the counseling process, managers learn the employee is right.

“When this happens, you need to stop and recognize your error, then fix it,” Cooper says. “Don’t keep going down the wrong path. One wrong decision ignored will lead to another wrong decision.”

She shares an example of a 90-day evaluation she conducted with the employee’s direct supervisor. The supervisor gave strong feedback on issues the employee needed to address. However, the supervisor had not shared with the employee in advance the issues Cooper and the supervisor were documenting.

“I’m a strong believer that nothing should be a surprise in a written evaluation,” Cooper says. “But what do we do now? The evaluation is in front of us for her to sign. To admit we made a mistake might undermine management’s credibility. But it was a risk I had to take. I couldn’t go down that path because I knew what would happen if we didn’t get off that path.

“I called the employee on my day off and explained that we would not be including the constructive comments in her evaluation because we should have met with her beforehand. Therefore, she shouldn’t have a negative mark because of a mistake on our end.

“I told her we would meet in a few weeks to go over the issues, and if she hadn’t worked on a plan to address them, we would need to discuss at that point how we would go forward.”

Cooper adds that changing an evaluation after getting all the facts is a sign of a healthy manager.

“I’m not afraid to tell employees I’ve changed my mind after meeting with them,” she says. “It lets them know I have faith and confidence in what they have to say, what they have to give, and what they will continue to offer the company.”

—Leslie Flowers

Leslie Flowers is a freelance writer in Indianapolis.
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Risk no greater with 1-step sterilization wrap, study finds

Wrapping sterile items in 1-step sterile wrap carries no greater risk of bacterial contamination than double-wrap methods and may save in both labor and materials costs, an Australian study has found.

The independent study, conducted under actual hospital conditions, compared 400 packs containing 1,119 items, half wrapped in cloth and sterile wrap and half wrapped in 1-step sterile wrap; both wraps were from Kimberly-Clark. The packs were stored in 4 areas of the hospital and periodically tested for shelf life. Time to wrap and unwrap the packs was also measured. Bacteria were cultured from 20 (1.7%) of the 1,157 items tested; no differences were found between the wrap methods. The double-wrapped packs took longer to wrap and open.

The authors concluded that using the 1-step wrap had no greater contamination risk and could result in cost savings.


Glucose-control protocol reduces sternal wound infections

A team from a Boston teaching hospital tightened glucose control of cardiac surgery patients and reduced the rate of sternal wound infections, a new article reports.

The authors describe use of an insulin protocol in the OR and ICU. Good control was defined as glucose less than 130 mg/dL for more than 50% of the measured time. During the study, 737 of 818 (90%) of patients having coronary artery bypass received insulin; 57 patients did not have a preoperative diagnosis of diabetes. The authors from Beth Israel Deaconess Medical Center say the factor most highly predictive of well-controlled glucose was a protocol with a 110 mg/dL trigger for insulin. During the study, the rate of mediastinitis decreased from 1.6% to 0%.


Conflicts between surgeons, device companies

A page-one article in the Sept 22 New York Times examines relationships between surgeons and medical device companies, such as orthopedic implant manufacturers. The article says the relationships are a “central issue” in the upward cost spiral of implants and are a place where “many of the checks and balances that govern health care costs do not apply.”

“Hospital officials and health care experts say the companies have used their relationships with doctors and a climate of secrecy to ensure that their products remain unusually profitable,” says the article by Reed Abelson.

—www.nytimes.com

Hospitals using less mercury

Hospitals have significantly reduced the amount of mercury and waste from patient care, according to a survey by the American Hospital Association and Hospitals for a Healthy Environment (H2E). The survey found:

- 97% of hospitals recognize problems of mercury use and have taken steps to eliminate mercury found in fluorescent bulbs and thermometers
- 72% of hospitals have inventoried and replaced all mercury-containing devices or labeled them for proper handling
- 80% of hospitals have an overall waste reduction policy.

The survey is part of hospitals’ commitment to meet a 2005 goal of virtually eliminating mercury.

“The market for mercury-containing medical products has been all but eliminated, and the amount of mercury entering health care has sharply decreased,” says H2E.

—www.aha.org
—www.h2e-online.org

Kits for do-not-use abbreviations

Joint Commission Resources is offering a Spell it Out! Toolkit to help reduce use of dangerous medical abbreviations, acronyms, and symbols. The kit includes posters, quick-reference cards, and other materials.

The kit is intended to help organizations meet the Joint Commission’s National Safety Patient Goal of improving communication and standardizing a list of abbreviations that are not to be used. The kit is $49.

Order code KAB-05BHM.