OR nursing leaders are facing a worsening shortage of staff, particularly RNs, according to the 2007 annual OR Manager Salary/Career Survey. In the survey’s seventh year of including staffing issues, the number of open positions and vacancy rates rose in contrast to last year, when the shortage seemed to be easing. Nearly two-thirds (65%) of respondents said it was difficult to recruit experienced OR nurses, and the average number of open RN positions more than doubled.

The OR Manager Salary/Career Survey was mailed in May to 800 OR Manager subscribers in hospital OR management positions, with 346 returned for a response rate of 43%. Most of the OR leaders who responded to the survey (74%) work in community hospitals. A separate survey was sent to ambulatory surgery centers (see page 12). Results from the remainder of the survey, including salaries and benefits, will appear in the October issue.

**Technology in surgery**

**Orthopedic navigation: Questions about long-term results and costs**

Like a car’s global positioning system (GPS), computer-assisted surgical navigation helps orthopedic surgeons get their bearings. A navigation system receives and transmits data about joint surfaces and placement of implants, displaying the information on a computer screen where the surgeon can view it.

Computer-assisted surgical navigation systems became commercially available in the US in 2001. The systems allow surgeons to digitize the patient’s anatomy at the beginning of surgery without any preoperative imaging.

First used in neurosurgery, navigation systems later became available for total joint replacement. Anterior cruciate ligament (ACL) reconstruction also is being performed with navigation systems, improving accuracy of the tunnel position for the ACL, leading to improved outcomes. But the technology is young. It’s estimated fewer than 10% of orthopedic surgeons are currently using navigation.

Hospitals considering this technology face questions about whether navigation improves surgeons’ performance or contributes to longer-lasting joint replacements. So far, there is not enough evidence to answer these questions. Currently, the only large prospective clinical studies comparing conventional techniques with computer-assisted navigation are for total knee arthroplasty. Some data on cost-effectiveness of navigation systems is beginning to emerge (sidebar, p 17).
Please see the ad for
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What are OR leaders earning?

Learn how your salary and management role compare with your peers in our annual OR Manager Salary/Career Survey.

Is your job too big?

People management, financial issues, multiple departments—is the OR nurse director’s role realistic?

**Editorial**

By now, the nursing shortage statistics are distressingly familiar—the total number of nurses is expected to begin declining after 2010, just as the baby boomers need more health care. Nursing schools are receiving more applications, but a growing number of qualified applicants are being denied admission. The main reason is a shortage of faculty.

Nurse vacancy rates are running 7% to 10%. In a 2005 study, 75% of RNs said they believe the nursing shortage presents a major problem for the quality of their work life and patient care.

The OR is seeing its own staffing challenges. OR vacancy rates and use of travelers are up in this year’s OR Manager Salary/Career Survey. The staffing results are reported in this issue.

The staffing crunch is certainly on the radar screen for nurse leaders. OR directors are seizing the initiative to prepare the next generation of staff—55% now accept new graduates, a practice that was much less common 15 years ago.

A disconnect

But senior hospital executives aren’t placing workforce issues at the top of the priority list. Many are in denial about the situation in their own institutions, according to a new report from PricewaterhouseCoopers.

In a survey of 240 hospital execs, many said they knew the nurse workforce in general was dissatisfied—but almost none thought it was a “very significant” problem in their own organizations. Other issues are seen as more pressing.

This disconnect could start to affect hospitals’ other strategic initiatives, the report says. For example, many hospitals are building more OR space. But are they planning how they will staff these new rooms?

PricewaterhouseCoopers outlines 4 key strategies for addressing the workforce shortage:

- Develop public-private partnerships.
- Encourage technology-based training.
- Design flexible roles.
- Establish performance-based metrics.

Most require broad-based support and investment.

But there are steps OR directors can take to encourage senior executives to move human capital higher up on the priority list.

- Nurses will be “rainmakers.” Point out that nurses play a critical role in clinical quality and patient satisfaction, both of which will have a bigger impact on Medicare reimbursement. Nurses and physicians will become “rainmakers” as quality and patient satisfaction begin to drive more revenue, says the PricewaterhouseCoopers report.

- Nurses and physicians want better work-life balance. Nurses want flexible schedules. Physicians increasingly want to be employed and insist on subsidies for taking call. Organizations that focus more on work-life balance “will have a competitive edge in recruiting and retaining top talent,” the report says.

- Realize staff vote with their feet. Weak front-line managers and disruptive behavior, whether by staff or physicians, drive nurses away. Organizations that don’t address these issues will have a tough time attracting and keeping clinicians.

- Develop a human capital dashboard. Labor costs account for 49% of total costs for most hospitals, and an estimated 30% of employees are nurses. Your hospital no doubt has a dashboard to track its key metrics. Does the dashboard include staffing trends like nurse turnover, vacancy rates, and use of travelers? (Sample metrics are posted on the website of the National Association for Healthcare Recruitment at www.nahcr.com.)

Staffing shortages and workforce issues are urgent issues that need to be at the top of every leader’s priority list. ✤

—Pat Patterson

The PricewaterhouseCoopers report is at www.pwc.com/extra/pwcpublications.nsf
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Outpatient quality reporting slated

Hospitals would have to report on 10 outpatient quality measures to get a full update in their 2009 outpatient payments, under a proposed Medicare rule issued July 16. Two of the measures affect surgery:

- timing of antibiotic prophylaxis
- selection of antibiotic.

Other quality measures apply to acute myocardial infarction, pneumonia, and diabetes.

Hospitals have been reporting on inpatient quality measures since 2005, a program Centers for Medicare and Medicaid (CMS) says has been “overwhelmingly successful.”

The measures are part of a proposed update to the outpatient prospective payment system (OPPS) for 2008. Hospitals overall would receive a 3.3% inflation update in their outpatient payments.

Comments are due by Sept 14. A final rule will be issued later this fall.

CMS says it is concerned about the increase in outpatient spending, which accounted for one-third of the increase in the 2007 Medicare premium. Hospital outpatient payments overall are expected to increase by 10.5% in 2008.

To help curb the increases, CMS says it is moving toward “value-based purchasing” by requiring more quality reporting and bundling more services into a single APC payment. The quality reporting is required by Congress under a 2006 law.

Bundling more services

CMS says the proposed bundling is intended to “encourage efficient resource use.”

Intraoperative services is one of 7 categories slated for package payment. CMS proposes a list of 40 HCPCS codes that would be bundled into intraoperative APC payments and billed on the same claim. Examples are:

- 95955: EEG during surgery
- 73530: X-ray exam of hip
- 74300: X-ray of bile ducts/pancreas
- 93320: Doppler echo exam, heart
- 93609: Map tachycardia, add-on
- 93621: Electrophysiology evaluation.

The packaging wouldn’t have much of an impact on payments, at least for 2008. Urban hospitals, for example, would see a slight decline of 0.1%, and rural hospitals would see a small increase of 0.4%. CMS also proposes 2 “composite APCs,” with one bundled payment for several major services:

- low-dose rate prostate brachytherapy
- cardiac electrophysiologic evaluation and ablation.

Currently, these are paid under several codes, and each component is paid separately under different APCs. CMS is proposing a single payment. There would continue to be separate payment for brachytherapy sources, however, as required by law.

Inpatient payment update

Medicare’s final inpatient payment rule for 2008 was issued Aug 1, finalizing a draft released in April. Overall, hospital payments for inpatient services will increase by an average of about 3.5% for fiscal 2008.

The rule revamps the DRG structure to account more fully for each patient’s severity of illness, CMS notes. The rule creates 745 new severity-adjusted DRGs, replacing the 538 current DRGs. Payments will increase for hospitals that serve more severely ill patients and decrease for those that serve those who are not as ill. The new DRGs will be phased in over 2 years, rather than 1 year as proposed.

CMS says the rule means payments for inpatient services will be “more accurate and better reflect the severity of patient’s condition.”

CMS also took the controversial step of making adjustments to account for changes in how hospitals document and code for patients’ severity of illness. Without the adjustments, the agency said, the new system would cost Medicare more, though it is supposed to be budget neutral.

The American Hospital Association (AHA) blasted the move, saying the adjustments would result in more than $20 billion in “backdoor budget cuts” based on a “guess” by CMS. AHA said there was no evidence that the adjustments are necessary.

The rule also has provisions to ensure Medicare no longer pays additional costs for some preventable conditions acquired in the hospital, such as certain infections. In addition, CMS is expanding the list of publicly reported quality measures and reducing payment when a hospital replaces a device that is supplied at no or reduced cost.

The inpatient rule is at www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf

The proposed outpatient rule is at www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.

A fact sheet is at www.cms.hhs.gov/apps/media/fact_sheets.asp.

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Tensions increased from 1.9 in 2006 to 4.1. The previous high was 2.2 in 2001 and 2002.

The news was slightly better for surgical technologists (STs). The average vacancy rate rose from 7% in 2006 to 9% this year, but the average number of open positions stayed about the same (1.5 in 2007 vs. 1.1 in 2006).

Open positions also stayed vacant significantly longer than 2006: an average of 15 weeks (compared to 13 weeks in 2006) for RNs and 12 weeks (compared to 9 weeks in 2006) for STs.

The percentage of hospitals with no openings was 41% for RNs and 58% for STs.

Trouble areas

The average number of open RN positions was highest in the South (5.4) and Northeast (4.3), compared to the West (3.5) and Midwest (3.0). Community hospitals had a higher percentage of open RN and ST positions compared with teaching facilities, with community hospitals reporting an 11% vacancy rate for RNs versus 8% for teaching hospitals.

The West and the South have the highest RN vacancy rates. The West reported 13% and the South 11%, both higher than the national average. The West had a higher percentage of open ST positions compared to the other regions.

The West also claimed the most average weeks positions have been open—21.3 for RNs and 18.4 for STs. The Northeast was next, following by the Midwest and the South.

Salary/Career Survey

<table>
<thead>
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<th>Region</th>
<th>Response</th>
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</tr>
<tr>
<td>Midwest</td>
<td>33%</td>
</tr>
<tr>
<td>South</td>
<td>31%</td>
</tr>
<tr>
<td>West</td>
<td>19%</td>
</tr>
</tbody>
</table>

Hospitals with no open OR positions

| Positions | RNs (41%) | STs (58%) |

How difficult is it to recruit experienced OR nurses?

- 1 (not difficult) 2%
- 2 10%
- 3 22%
- 4 29%
- 5 (very difficult) 36%

Overall difficulty in recruiting experienced OR nurses

| Average |

| How often does your OR use overtime to staff its ORs? |

- Always or almost always
- Occasionally
- Rarely
- Never
- No answer

What percent of total nursing staff are agency or travel nurses?

Respondents who use agency or travel nurses

- None 16%
- 1%-9% 49%
- 10%-24% 25.5%
- 25%+ 9%

Note: Number responding was 98.
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GETINGE/CASTLE INC.
in the OR Manager print version.
Salary/Career Survey

Average number of open positions in ORs

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Region</th>
<th>Northeast</th>
<th>Midwest</th>
<th>South</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td></td>
<td>4.3</td>
<td>3.0</td>
<td>5.4</td>
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</tr>
<tr>
<td>STs</td>
<td></td>
<td>1.9</td>
<td>0.8</td>
<td>1.8</td>
<td>1.7</td>
</tr>
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</table>

<table>
<thead>
<tr>
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<th>Northeast</th>
<th>Midwest</th>
<th>South</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td>4.1</td>
<td>3.4</td>
<td>6.3</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td>1.5</td>
<td>1.3</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>Teaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What percent of budgeted FTE positions are open?

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<th>Type of facility</th>
<th>Region</th>
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<th>South</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td></td>
<td>8%</td>
<td>9%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>STs</td>
<td></td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Region</th>
<th>Northeast</th>
<th>Midwest</th>
<th>South</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td>10%</td>
<td>11%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td>9%</td>
<td>9%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Teaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average number of weeks positions have been open (turnover)

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Region</th>
<th>Northeast</th>
<th>Midwest</th>
<th>South</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td></td>
<td>15.9</td>
<td>13.2</td>
<td>12.8</td>
<td>21.3</td>
</tr>
<tr>
<td>STs</td>
<td></td>
<td>15.5</td>
<td>10.5</td>
<td>9.1</td>
<td>18.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Region</th>
<th>Northeast</th>
<th>Midwest</th>
<th>South</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td>15.2</td>
<td>15.7</td>
<td>14.3</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td>12.2</td>
<td>12.5</td>
<td>12.4</td>
<td></td>
</tr>
<tr>
<td>Teaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Turnover was defined as the percent of staff who have left and been replaced in the past year.

Continued from page 7

More trouble for the West came in the number of open management positions. The national average was 0.5, and the West had the highest number (0.8) followed by the South (0.6), Northeast (0.4), and Midwest (0.3).

Turnover rates rise

The average turnover rate (percentage of staff who left and were replaced in the past 12 months) for RNs rose from 7% in 2006 to 8% but was lower than 2001’s 13%. The average turnover rate for STs stayed at 7%, down from a high of 10% in 2001.

The West had the highest RN turnover rate at 11%, more than double that for the Northeast (5%) and nearly double that for the Midwest (6%).

In 2006, the total turnover rate for the South was 7%, but 2007 saw higher rates for both RNs (10%) and STs (9%). In fact, the South had the highest turnover rate for STs in the country. The West claimed the second-highest rate (8%), followed by the Midwest (6%) and Northeast (6%).

Continued on page 10

Trends in OR nurse staffing

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2003</th>
<th>2005</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of open positions in the OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNs</td>
<td>2.2</td>
<td>1.7</td>
<td>1.9</td>
<td>4.1</td>
</tr>
<tr>
<td>STs</td>
<td>1.8</td>
<td>1.1</td>
<td>1.1</td>
<td>1.5</td>
</tr>
<tr>
<td>Open positions as a percentage of budgeted FTEs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNs</td>
<td>9%</td>
<td>5%</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>STs</td>
<td>12%</td>
<td>7%</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Average number of weeks positions have been open</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNs</td>
<td>14</td>
<td>12</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>STs</td>
<td>14</td>
<td>11</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Average staff turnover rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNs</td>
<td>13%</td>
<td>7%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>STs</td>
<td>10%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Routinely use agency/travelers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>19%</td>
<td>25%</td>
<td>23%</td>
<td>32%</td>
</tr>
</tbody>
</table>
Turnover rates in community hospitals for RNs were about 1% higher than in teaching hospitals.

Temporary help
Given the staffing woes, it is not surprising the use of agency and travel nurses increased from 25% in 2006 to 32%. Although the difference was not statistically significant, it is the highest percentage since the survey began.

Teaching hospitals (38%) were more likely than community hospitals (31%) to use agency or travel nurses. Use of contract staff remained highest in the West, up from 46% in 2006 to 54% this year. The Northeast was next, coming in at 37%, slightly higher than the South (30%). Only 19% of hospitals in the Midwest reported using contract nurses.

Solutions vary
Staffing solutions varied from using overtime to hiring new graduate nurses or RNs without OR experience. More than half of hospitals (52%) occasionally use overtime to staff the OR, and nearly one-third (30%) use overtime always or almost always. A fortunate 3% of OR leaders never use overtime. Teaching hospitals and hospitals in the West and South were most likely to use overtime.

More than half of ORs (55%) hire new graduate nurses, a dramatic shift from 1991, when only 34% did. As in 2006, teaching hospitals (67%) were more likely than community hospitals (51%) to employ new grads.

The Northeast and South were the most likely to hire new grads (60% for each region), followed by the West (52%) and the Midwest (49%). Two-thirds (66%)
### OR skill mix remains steady

The ratio of RNs to surgical technologists in hospital ORs remains steady at 64:36 in this year’s OR Manager Salary/Career Survey.

Federal regulations say surgical technologists (STs) may circulate with an RN in the room or immediately available. Currently, 34 states specify an RN as the circulator, according to AORN.

The percentage of hospital respondents who have STs circulating with an RN in the same room remained low at 7% this year. None reported that STs circulate on their own, and only 1 reported that STs circulate with an RN immediately available.

Of the 25 hospitals that said STs circulate, either with an RN supervisor in the same room (24) or immediately available (1):

- 16 are community hospitals
- 10 are large departments with 10+ ORs
- 4 are small with 1 to 4 ORs
- 11 are in the Midwest, and 9 are in the South.

A small number of respondents (2%, or 8 hospitals) reported having a 100% RN staff, and 18% reported 75% to 99% RNs. The most common percentage was 50% to 74%, reported by 217 hospitals (67%).

### Skill mix in ASCs

ASCs reported an average skill mix of 66% RNs and 34% STs, compared to 62% to 38% in 2006.

The percentage of ASCs that allow STs to circulate either with an RN in the room or immediately available is 14% (n=36), down from 18% in 2006, but still higher than the 11% reported in 2005.

Of the 36 ASCs that allow STs to circulate, 33 have fewer than 5 ORs; 17 are physician owned, and 10 are joint venture facilities. No ASCs reported that STs circulate on their own.

### Ratio of RNs to surgical techs

<table>
<thead>
<tr>
<th>Year</th>
<th>RNs to Surgical Techs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>64:36</td>
</tr>
<tr>
<td>2005</td>
<td>64:36</td>
</tr>
<tr>
<td>1995</td>
<td>69:31</td>
</tr>
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</table>

### Do surgical techs circulate?

#### Hospitals

<table>
<thead>
<tr>
<th>Option</th>
<th>2007</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>92%</td>
<td>86%</td>
</tr>
<tr>
<td>Yes, RN in room</td>
<td>7%</td>
<td>12%</td>
</tr>
<tr>
<td>Yes, RN available</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>On their own</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

#### Ambulatory surgery centers

<table>
<thead>
<tr>
<th>Option</th>
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</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>82%</td>
</tr>
<tr>
<td>Yes, RN in room</td>
<td>9%</td>
</tr>
<tr>
<td>Yes, RN available</td>
<td>5%</td>
</tr>
<tr>
<td>No answer</td>
<td>3%</td>
</tr>
<tr>
<td>On their own</td>
<td>0%</td>
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</tbody>
</table>

### Help on SCIP measures

Need practical help on the Surgical Care Improvement Project? The OR Manager SCIP supplement sponsored by Kimberly-Clark Health Care has articles from your peers on these SCIP measures:

- antibiotic administration
- glucose control
- appropriate preop hair removal
- keeping patients warm
- setting up a beta blocker protocol
- preventing venous thromboembolism.

For free printed copies, e-mail shesch@ormanager.com or call 800/442-9918. Or download a PDF of the SCIP supplement at www.ormanager.com.

Cynthia Saver is a freelance writer in Columbia, Maryland.
OR nurse leaders in ambulatory surgery centers (ASCs) have fewer open positions and lower turnover rates than hospitals, but recruitment of experienced OR staff remains a challenge.

Those are some findings from the 2007 annual OR Manager Salary/Career Survey. The survey was mailed in May to 1,000 nurse managers of ambulatory surgery centers, with 249 returned for a response rate of 25%. Results of the management portion of the survey, including salaries and benefits, will appear in the October issue.

Mixed staffing news

Overall, staffing is strong for ASCs. More than two-thirds (68%) report no open positions for RNs, and 81% have no surgical technologist (ST) open positions. The average number of open positions is only 0.8 for RNs and 0.3 for STs. Turnover is low: 7% for RNs and 8% for STs.

Despite this good news, ASC leaders struggle to fill vacancies. Only 10% of leaders say that, in general, they have no difficulty recruiting experienced OR nurses.

How difficult is it to recruit experienced OR nurses?

Overall difficulty in recruiting experienced OR nurses

<table>
<thead>
<tr>
<th>Overall difficulty</th>
<th>Percentage</th>
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<tr>
<td>Not at all difficult</td>
<td>10%</td>
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<tr>
<td>Somewhat difficult</td>
<td>40%</td>
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<tr>
<td>Difficult</td>
<td>49%</td>
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</tbody>
</table>

How often do you use overtime to staff your ASC ORs?

<table>
<thead>
<tr>
<th>Overtime frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>14%</td>
</tr>
<tr>
<td>Rarely</td>
<td>35%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>43%</td>
</tr>
<tr>
<td>Always/almost always</td>
<td>8%</td>
</tr>
</tbody>
</table>

The average number of open positions is only 0.8 for RNs and 0.3 for STs. Turnover is low: 7% for RNs and 8% for STs.

Despite this good news, ASC leaders struggle to fill vacancies. Only 10% of leaders say that, in general, they have no difficulty recruiting experienced OR nurses. Leaders fare better when it comes to STs. In the past year, only 32% said recruitment of STs was difficult, compared to 45% for RNs. On average, the open time for RN or ST positions was 11 weeks.

Missed opportunities?

Most ASCs use overtime occasional-
Salary/Career Survey

In the past year, how difficult has it been to recruit OR staff?

**RNs**

- Somewhat or not difficult: 55%
- Difficult: 45%

**STs**

- Somewhat or not difficult: 68%
- Difficult: 32%

About the ASCs

Most of the OR leaders who responded to the survey (43%) work in a physician-owned ASC, followed by joint venture facilities (37%), then hospital-based ASCs (7%).

Most of the ASCs (61%) are multispecialty. Of the 38% single specialty ASCs, the top 3 specialties were ophthalmology (29%), gastroenterology (24%), and orthopedics (20%).

Most facilities are accredited by the Accreditation Association for Ambulatory Health Care (47%), followed by the Joint Commission (25%). Only 2% are accredited by the American Association for Accreditation of Ambulatory Surgery Facilities. Of the remainder, 16% were not accredited, and the rest were accredited or approved by some other entity.

More than half (51%) are located in suburban settings. Urban areas had 33% of ASCs, with rural areas at 16%.

The average case volume per year was 4,390.

Some ORs that hire RNs without OR experience

<table>
<thead>
<tr>
<th></th>
<th>Hospitals</th>
<th>ASCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hire RNs without OR experience</td>
<td>83%</td>
<td>47%</td>
</tr>
<tr>
<td>Hire new graduate nurses</td>
<td>55%</td>
<td>19%</td>
</tr>
<tr>
<td>Hire neither of these</td>
<td>14%</td>
<td>49%</td>
</tr>
</tbody>
</table>

Do you offer OR training for nurses?

- No: 19%
- Yes: 81%

Thank you

OR Manager thanks its subscribers who generously took time to complete this year's survey. We appreciate your part in gathering this information, which will be useful to your colleagues around the country.
National nursing shortage: A snapshot

**RNs working in hospitals**

In 2006, the average RN working in a hospital was:
- 48 years old
- worked 3.7 days per week and 35.8 hours per week
- worked 5.2 overtime hours per week
- earned $32.10 per hour


**The nursing workforce is increasingly older and foreign born**

In the past 4 years:
- RNs over age 50 have been the fastest growing part of the RN workforce, expanding by 11% annually. Employment growth for middle-aged and younger RNs declined.
- Foreign-born RNs accounted for nearly one-third (30.5%) of the growth in the nursing workforce. In 2005, 14% of the RN workforce was foreign-born RNs.


**National nurse staffing metrics**

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacancy rate (by FTE)</td>
<td>10.1%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Turnover rate (by FTE)</td>
<td>11.3%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Days to fill</td>
<td>NA</td>
<td>57.6</td>
</tr>
<tr>
<td>Days to start</td>
<td>NA</td>
<td>59.3</td>
</tr>
<tr>
<td>*Cost per hire</td>
<td>$2,895</td>
<td>$6,029</td>
</tr>
</tbody>
</table>

NA = not available.
*May not include all fixed and variable costs.


**RNs’ top 5 reasons why there is a nursing shortage**

**RNs’ perceptions have changed:**

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary and benefits</td>
<td>58%</td>
<td>32%</td>
</tr>
<tr>
<td>More careers for women</td>
<td>44%</td>
<td>30%</td>
</tr>
<tr>
<td>Faculty shortages in nursing school</td>
<td>*</td>
<td>26%</td>
</tr>
<tr>
<td>Undesirable hours</td>
<td>38%</td>
<td>24%</td>
</tr>
<tr>
<td>Nursing not seen as rewarding career</td>
<td>*</td>
<td>21%</td>
</tr>
</tbody>
</table>

*Options not presented to respondent.


**Schools turning applicants away**

Though interest in nursing careers is strong, access to BSN programs is becoming more difficult. Most schools say faculty shortages are the reason.

Source: American Association of Colleges of Nursing. www.aacn.nche.edu
How navigation works

The navigation system is a computer workstation with a screen, software, a positioning/tracking system, and surgical instruments. The positioning and tracking system is composed of small reflective spheres that are attached to the patient and tracked by an optical camera to register the location of the anatomical structures. The computer then develops a model of the joint and projects the image onto a monitor.

The surgeon touches parts of the patient’s anatomy with a pointer so the computer can identify and register those points in its memory, including specific bone structures, the anatomy, the motion and alignment of the patient’s normal anatomy, and the optimal joint alignment.

With this information, the computer can guide the surgeon in making the bone cuts for the implant. The computer knows the angle of the cut relative to the shaft of the femur or tibia, for example, and can tell the surgeon how many degrees he is off.

“It’s almost like playing a video game. The surgeon is looking at a screen and trying to balance the bone cut and the ligaments based on real-time feedback the computer is giving on its screen,” Thomas P. Vail, MD, spokesperson for the American Academy of Orthopaedic Surgeons (AAOS), told OR Manager.

“The computer helps us in aligning all the jigs we normally use for total knee replacement,” says Michael R. Marks, MD, MBA, an orthopedic surgeon and chief of staff at Norwalk Hospital, Norwalk, Connecticut. “It is amazing how you can change a knee from being internally rotated to externally rotated with just a few millimeters of motion. These are the things we used to look at and say, ‘It looks pretty good.’ Now, with navigation, we’re able to come within 1 or 2 degrees of correction. That’s really the incredible part of this.”

Benefits of navigation

A leading advantage of navigation in knee surgery is that it eliminates the need for an intramedullary rod. In conventional surgery, a rod is inserted up the length of the femur and used as a reference to determine proper knee implant alignment in relation to the hip joint.

Compared to the use of an intramedullary rod, navigation techniques have been shown in randomized studies to increase the accuracy of bone resections to within 1 degree. Not having to insert an intramedullary rod also reduces the risk of fat embolism and blood loss during surgery. Over the past few years, total knee replacement has evolved into less invasive surgery with smaller instruments. Dr Marks says computer-assisted navigation can be used through these smaller incisions, ensuring more accurate bone resection and better alignment. These modifications appear to shorten recovery and time in physical therapy.

Impact on OR time

Navigation adds OR time to a knee replacement. There is a learning curve for the surgeon using the system, but time goes down as the surgeon becomes more accomplished, says Dr Vail, who is an orthopedic surgeon at the University of California, San Francisco.

Because navigation gives surgeons the ability to check their cuts, they spend more time ensuring bone cuts and alignment are perfect. Navigation also allows them to evaluate each step of the procedure and make changes if necessary, which also takes more time. But patients may benefit later on if the possibility of a revision is less.

Dr Marks, who has used navigation for about a year, says the technology added about 45 minutes to his first case, but after about 10 cases, the extra time was down to about 15 minutes. “To add...
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Technology in surgery

Are navigation systems cost-effective?

Computerized navigation systems make orthopedic surgery more costly. Do they also improve results? So far, the literature is mixed.

For computer-assisted total knee replacement, some reports show computer assistance allows for better alignment of the prosthesis than mechanical guides, with fewer outliers, or cases outside the acceptable range. Other reports find that for experienced surgeons, navigation systems provide no real benefit—mechanical guides and extensive experience are about equal to the computer. But on balance, more studies have found the computer reduces outliers, notes Kevin J. Bozic, MD, MBA, assistant professor of orthopedic surgery and health policy at the University of California, San Francisco.

What isn’t yet known is how computer assistance ultimately affects outcomes, such as function of the knee, pain relief, and long-term survival of the implant.

Cost-effectiveness analysis

Dr Bozic and his colleagues recently completed a cost-effectiveness study of navigation in total knee surgery. Publication is forthcoming. In the study, they used a decision model to look at:

• what the literature says about outliers and their effect on survival of implants
• what reducing outliers would mean for reducing revision rates long term
• what upfront costs could be justified for this technology.

Factoring in the fixed costs of the hardware, the variable costs of the disposables, costs of additional OR time, and the number of revisions avoided due to improved alignment associated with computer navigation, they found the threshold for achieving cost savings over the lifetime of the patient (due to avoiding future revision surgery) was an additional $650 per case.

Dr Bozic predicts that in the future, navigation will become simpler to use, less expensive, and eventually will be incorporated into most practices.

References


—Judith M. Mathias, RN, MA

Costs and reimbursement

A navigation system for joint replacement can cost from $150,000 to $300,000 and can be leased. How much navigation adds to the cost of a case depends on the volume of cases and whether the facility purchases or leases the system.

Before purchasing a system, Dr Marks recommends that a hospital review its volume of total knee cases, figure out the cost per case, and ask whether it believes a system is worth the cost to achieve better outcomes and fewer revisions.

To date, there is no Level 1 CPT code for orthopedic computer-aided navigation and no additional reimbursement for use of navigation for Medicare patients who have total joint replacement. Dr Marks says most insurers do not reimburse for use of the system, or if they do, it is very little.

The AAOS and specialty societies are working on getting a CPT code for orthopedic navigation.

An evolving technology

Dr Vail says not enough is known about the technology yet to say it is ready for general use.

“Data is beginning to emerge to suggest navigation is beneficial for the surgeon and the patient,” he says. “But to translate that into general use, we’re not quite there yet for the majority of orthopedic surgeons doing knee surgery.”

He thinks the software will evolve so navigation not only will help with alignment but also with the balancing of ligaments. He thinks more surgeons will be ready to adopt navigation when they are able to pinpoint what parts of the procedure are the most important to navigate, where the computer really provides an advantage, how it benefits the patient, and whether it saves costs.

Dr Marks says that though he and his partners had good results with the conventional technique, results are better using navigation, and they have learned a lot in the year they have been using the technology. They are now able to compare results for patients who have had one knee replaced in the conventional manner and one replaced using navigation.

Empirically, it makes sense to use computers in surgery, he adds.

“Computers have better brains than we have and can do things much better than we can with our hands. We know there are more changes in navigation technology coming. Because we are already familiar with the technology, it will be that much easier to learn.”

There is no question that computerization is the way of the future, notes Dr Vail. “I think computer navigation will give us more and more information. Surgeons will determine which bits of information are most important and when it’s time to use navigation in their practice.”

—Judith M. Mathias, RN, MA

Continued from page 15

15 minutes to a case for what potentially could be a much greater outcome, I think is well worth it,” he says.

Nurses also need additional time to bring the navigation camera and computer screen into the OR and set them up. The circulating nurse, who controls the computer and monitor screen during the case, needs to know how to push the buttons on the screen as the surgeon moves from one area to the next. Nurses attend training sessions to learn the system and how to troubleshoot it, which Dr Marks says is not difficult to learn.

Costs and reimbursement

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Getting good data to guide decisions

Do you judge your reports by the pound? Many OR leaders aren’t lacking for data—they often receive stacks of reports every month. But they may lack good information, a plight some call DRIP—data rich but information poor. How can leaders avoid DRIP and get useful reports to guide decision making?

“I think the most important thing is first to ask: ‘What is it I want to know, and why do I want to know that?’ says David Wyatt, RN, MA, CNOR, director of perioperative services, University of Kansas (KU) Hospital, Kansas City. “Often, we just run reports or do what the person in the position before us did. I think you’re much better off deciding what you want to know and focusing your energy on the information you need to make intelligent decisions.”

These are suggestions from a recent KU project to improve the use of information for managing the perioperative process.

Ensure the data are unimpeachable

Ensure a high level of confidence in the data that is collected.

KU’s perioperative leaders wanted to make sure their data was accurate. Having accurate data keeps the quality of the data from being a focus for arguments, which can stall improvement efforts.

To help with the project, the university brought in Navigant Consulting, Inc, which assigned a team to review and validate a year’s worth of data from hundreds of patient charts.

“Perioperative services is essential to quality surgical care, but perioperative leaders must have quality data to make decisions and for surgeons to believe it,” says Mary Jane Edwards, RN, MHSA, CNOR, Navigant’s national director of perioperative and interventional services.

To enable better data reporting in the future, KU plans to implement new software from Epic that will cover the perioperative continuum.

“One thing we identified is that this can’t just be about the OR—it’s has to be about all of perioperative services,” says Wyatt.

The software will have an electronic record covering the perioperative period from the preop clinic through the postanesthesia care unit (PACU).

“That way, we’ll be able to pull information from the clinic directly into the patient’s record in the OR,” says Wyatt. Data will also be available from the PACU, which currently isn’t automated, to gain better insight into patient flow.

Decide what is important to measure

Select the key metrics that will help you understand how perioperative services is performing.

Metrics KU measures are:

- first case on-time starts
- utilization of ORs: prime time (Monday-Friday, 7:30 am to 5:00 pm and overall)
- turnover time
- case volumes and hours
- PACU length of stay
- PACU holding time (measured as part of patient flow issues).

Agree on definitions

Reach consensus on definitions for the key metrics.

Agreeing on definitions is necessary before data reporting will be meaningful, Wyatt notes. The definitions must be developed by a credible group with decision-making authority, such as the surgical services governance committee, and the definitions must be in writing.

“Once the definitions are agreed upon, the data are reported according to the definitions. “Then you can move away from arguing about the data, and start using the data to make intelligent decisions,” says Wyatt.

Set the bar

Set targets to work towards.

Though KU participates in external benchmarking, it doesn’t simply adopt those benchmarks as its targets. “Benchmarking information is good to have, but it’s not necessarily where you set the bar,” Wyatt says.

Among benchmarking services KU participates in are the AORN PNDs dashboard, the University Health-Systems DRIP and get useful reports to guide decision making?
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Consortium, and Solucient HBSI.

But KU also considers what targets are appropriate for its facility. For example, the 50th percentile for turnover time for a specific procedure might be 40 minutes. But that doesn’t mean KU would simply adopt that as a goal.

In setting their targets, Edwards says organizations first need to consider what is good patient care. “Is it good for cases to be delayed because the preoperative process isn’t working?” she asks. “Also, patient care isn’t well served when PACU patients have met discharge criteria but experience a prolonged PACU stay because there is no way to monitor and correct this aspect of patient flow.”

Also consider the business perspective. Can you afford to spend more than a half hour on turnover time between cases because people can’t work out a more efficient process?

“You need to define how to make the facility healthy, profitable, and deliver great patient care—that should be the benchmark to pursue,” she says.

Let facts speak for themselves

Once you decide on the key metrics, definitions, and calculations, monitor the metrics. A regular, concise report enables leaders to track their progress. KU reports its data in a dashboard called the Perioperative Compass, a short report with the metrics and definitions (illustration).

Decide who will respond to the data

Who will be responsible and accountable for using the data to make decisions?

At KU, the OR’s decision-making body is the Perioperative Governance Committee, a 14-member group that includes surgeons, anesthesiologists, Wyatt, the chief nursing officer, and chief operating officer. The committee meets monthly, and the dashboard is always the first item on the agenda.

Meeting frequently is important to keep the momentum up. Says Wyatt, “The more infrequently you meet, the more ground you lose. Even if you’ve taken action, if you don’t meet often, you don’t know how it’s affected the data.”

Edwards adds, “You want leaders to anticipate seeing the dashboard each month. In 4 weeks, you can pilot improvements and report back on progress at the following month’s meeting.”

Being able to get data on a timely basis is also crucial.

“You don’t want to hold meeting after meeting without unimpeachable data to work with,” she says. “You also don’t want to have to postpone meetings because data isn’t available.

Once you have the data, put it to work. For example, KU’s perioperative team has used the data on PACU holds to work with the inpatient units on patient flow strategies. One strategy was to open an extended recovery unit for patients needing observation or extended recovery.

“We will be assessing our data to see how this strategy helps with patient flow in perioperative services,” Wyatt says.

Physicians are more apt to be engaged if the data is clear and definitions consistently reported, Edwards notes. “It helps them take ownership for making improvements. They’re no longer the victims or the dissatisfied customers. The data are the foundation of making that work.”

Don’t depend on a single person to keep data

Engage 2 or 3 people to be keepers of the management reporting system.

Having only one person who knows how to mine data and produce reports is risky. You’re stuck if that person leaves or goes on vacation. At KU, the reports are managed by information systems personnel rather than OR staff.

“You need people who understand the reports you are generating and can check whether they’re accurate,” says Wyatt. At the same time, they should be objective. That’s more likely if they are not employees who are being evaluated on those metrics.

The value of reports is measured not in how much paper can be generated but in what story the data can tell.

Since this article was written, David Wyatt has accepted a new position as vice president for perioperative services at Presbyterian/St Luke’s Medical Center, Denver.

David Wyatt and Mary Jane Edwards will present a session titled “An Effective Approach to Block Scheduling” at the Managing Today’s OR Suite conference Oct 3 to 5 in San Diego.
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The keynote address and general sessions feature nationally known speakers who have important messages for surgical services directors. If you wish to suggest a general session speaker, please obtain as much information about the person as you can, such as the speaker’s title, organization, address, and phone number.

**The deadline for proposals and suggestions for both conferences is Nov 1**

Fax or e-mail proposals to Judy Dahle, RN, MS, education director, OR Manager, Inc, at 714/545-0180 or jdahle@earthlink.net. (Please do not send PowerPoint presentations.) For questions, please call 877/877-4031.

A good home for OR supplies, used equipment

REMEDY, Inc, a nonprofit program to salvage medical supplies for impoverished countries, has added a website to help match supplies with facilities in need.

The site, named Med-Eq and modeled after eBay, allows organizations to post supplies and equipment so charities can claim them for overseas missions. Recent examples are hospital beds, an x-ray machine, a cardiac monitor, and an ambulance.

Founded by Yale anesthesiologist William Rosenblatt, MD, in 1991, REMEDY has aided the recovery of $84 million in supplies and equipment, according to the New Haven Register.

REMEDY’s goal is to provide international medical relief while reducing solid waste from US hospitals. Sample protocols and frequently asked questions are on the REMEDY website.

—[www.med-eq.org](http://www.med-eq.org/)
—[http://remedyinc.org/](http://remedyinc.org/)
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Ambulatory surgery centers (ASCs) see pluses and minuses in Medicare’s final rule for a revised ASC payment system, released July 16. The new system, mandated by Congress to take effect by Jan 1, 2008, will for the first time base ASC payments on the hospital outpatient prospective payment system (OPPS).

In a big minus, surgery centers would receive only about 65% of what hospital outpatient departments (HOPDs) receive for the same procedures. Though this rate is up from the 62% proposed last year, it is far lower than what ASCs had hoped. An ASC industry analysis showed a 73% rate was justified and could remain budget neutral to Medicare, as Congress required.

“Because CMS is still setting the rate so low, payments for some procedures will be cut significantly,” said FASA President Kathy Bryant, referring to the Centers for Medicare and Medicaid Services.

Moreover, the rule postpones payment updates for 4 years, which she said “is likely to mean that some procedures now performed in ASCs will be forced back into hospitals, where those procedures will ultimately cost Medicare and its beneficiaries more.”

Craig Jeffries, executive director of the American Association of Ambulatory Surgery Centers, said the final rule “will force many centers to make difficult choices about whether to continue offering certain services in their ASC.”

The impact on your ASC will depend largely on the procedures you perform. Those specializing in orthopedics will do well. But those focused on GI and pain management will see a drop (chart, p 26). The system will be phased in over 4 years, which CMS says should give ASCs time to adjust, for example, by bringing in other types of procedures.

The American College of Gastroenterology termed the cuts in endoscopy payments “draconian,” saying they could severely limit use of colorectal screening for Medicare beneficiaries. This year, the national average payment for a diagnostic colonoscopy in a freestanding GI center is $448, the college says. In 2008, it would be $427.78, falling to $373 in 2011 when the new system is fully implemented.

Gastroenterologists say it’s impractical to bring in other types of cases because their centers are often closely tied to their practices, and some state certificate of need rules don’t allow it.

CMS says the reason GI procedures are taking a hit is because current payments are close to HOPD rates now, so they will come down, while rates for other ASC procedures have been lower.

During a July 31 CMS audio conference, one GI physician said that with the new rates, by 2011, he would no longer be able to perform colonoscopies and endoscopies in his ASC.

“Those will have to go to the hospital, at substantial difficulty for the patient, increased costs for the patient, increased costs to Medicare, and a tremendous loss in efficiency and access. I think that’s a serious problem for CMS, and I don’t think you have seriously considered it,” he told the officials.

The plus side
There are some bright spots. FASA expressed support for parts of the rule that:

- expand the list of procedures Medicare will pay for in an ASC
- allow Medicare payments for radiology services when integral to a surgical procedure
- provide payment for implants and other devices in a manner consistent with HOPD payments

Continued on page 26
phase in the new system over 4 years, rather than 2 as proposed. In the meantime, ASCs will be paid a blend of the current and new rates. As expected, some 790 procedures will be added to the ASC list. When a few additional procedures are added this fall, the list will total about 3,300 procedures, compared with about 2,500 now.

The downside is that many of the added procedures are performed primarily in physicians’ offices. To avoid creating an incentive to move those to the more expensive ASC setting, Medicare will cap payments to ASCs at the physicians’ practice expense amount. (This will not affect the physician’s fee.)

Medicare is also shifting its approach for determining which procedures are eligible for ASC payment. Until now, Medicare used a complex set of criteria to decide which procedures to add to the ASC list, and updates lagged. The final rule allows payments to ASCs for any surgical procedure except those that CMS determines are not safe to perform in an ASC or require an overnight stay.

Though the list is improved, the ASC industry says it still lags behind what commercial insurers will cover in freestanding surgery centers.

Action on high-cost devices
ASCs have been worried about how the new payment system would pay for expensive implants and other types of devices. In some cases, they note, the proposed 62% rate would not cover the cost of the implant, let alone other services provided.

In response to comments, CMS modified its approach so ASCs will be able to bill for these items generally in the same way HOPDs do. Jeffries called it a “strong signal that CMS is trying to level the playing field between ASCs and hospitals.”

But Bryant said it’s important to realize that “very few implants that aren’t currently paid for separately will be paid for separately” under the new system. “It’s not really true that ASCs will get implant payments when they didn’t in the past.”

What is important, she adds, is that CMS policy now treats ASCs and HOPDs virtually the same way with respect to implants, though the payment rates may differ.

The new approach is explained in a CMS fact sheet and a briefing by the law firm of McDermott Will & Emery (www.mwe.com):

• In general, CMS will continue its current policy of packaging into the ASC facility payment the direct and indirect costs related to a surgical procedure, including use of the facility, staffing, supplies, drugs not eligible for separate payment, anesthesia supplies, and so forth.

• CMS will no longer make separate payments to ASCs for implantable prosthetic devices and implantable durable medical equipment (DME). Instead, payment for most implants will be bundled into the APC payment, as it is for hospitals.

• Some exceptions will allow additional payment for certain high-cost devices and ancillary services if they are “integral” to surgical procedures. Among these are:
  —radiology services
  —brachytherapy sources
  —drugs and biologicals.

• Medicare will provide ASCs with separate payment for devices that have “pass-through” status under OPPS, meaning they qualify for additional reimbursement beyond the APC rate. For 2008, only 2 devices will continue on pass-through status:
  —C1821: implantable interspinous process device (eg, the X-STOP)
  —L8690: auditory ossintegrated device. The auditory device currently is payable in the ASC setting. The

**Imperial of revised ASC payment system**
Examples of impact with and without 4-year phase in

<table>
<thead>
<tr>
<th>Procedure</th>
<th>2008 Percent Change</th>
<th>2008 Percent Change without Transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>66984: Cataract surgery</td>
<td>-40</td>
<td>-20</td>
</tr>
<tr>
<td>43239: Upper GI</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>66821: After-cataract laser</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>62311: Inject spine</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>29881: Knee arthroscopy</td>
<td>60</td>
<td>80</td>
</tr>
<tr>
<td>28285: Hammer toe</td>
<td>80</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare and Medicaid Services.

Continued from page 25
pass-through list is updated quarterly, so more codes may be added in the future.

- Medicare will also provide a separate payment for “device-intensive procedures.” These are defined as ASC-covered procedures where the device cost is more than 50% of the median APC cost. There are 25 such procedures on the 2007 ASC list, and 15 more will be eligible for payment in 2008.

For these procedures, CMS will separate the payment into 2 parts—the device portion and the service portion. For the device portion, ASCs will be paid on the same basis as HOPDs; only the service portion will be discounted to 65%.

- Current examples of device-intensive procedures are insertion of a pacemaker system, cryoablation of the prostate, and implantation of a spinal infusion pump. Examples of procedures to be added for 2008 are insertion of a pacemaker and upgrading of a pacemaker system.

- CMS is proposing to revise Stark law definitions for imaging and outpatient prescription drugs so physicians would be permitted to refer these to ASCs, and ASCs could bill for them without violating self-referral prohibitions.

Getting ready

Medicare’s OPPS system with its 200-plus APCs is more complicated than the 9 grouper rates ASCs are used to. What should they do to get ready?

Education is the first thing, says Bryant. FASA and AAASC are both holding seminars on the new system this fall.

“There are a lot of misunderstandings about how the hospital system works,” she notes.

ASCs will need to upgrade their computer systems to reflect the new system.

Bryant thinks the basics of billing and coding generally will be straightforward. ASCs will continue to bill by CPT code and use form CMS 1500, which they do now.

“More than ever, it’s important to make sure coders “are completely up to speed,” she advises. With more payment groups, any errors in coding could be more costly to the ASC. Coding correctly for radiology services will also be critical because of the changes in payment for some of these services.

A bigger question is whether Medicare carriers will be ready.

“In the past, they haven’t been so good,” she says. “It’s concerned that when ASCs call the carriers for information, they might not get the right answers.”

Bryant encourages ASCs to call FASA instead. If FASA staff cannot answer the question immediately, they will research the answer. They can also spot trends in calls reporting incorrect answers from carriers. Bryant says she can then report the problem to CMS so they can correct it.

“Calling FASA not only allows us to help members but identifies ways in which Medicare can help us,” she says.

Seeking legislation

The ASC industry continues to pursue legislation to address what it sees as shortcomings in the final rule. HB 1823 has been introduced in the US House, and a Senate sponsor is being sought.

“The rule falls far short of offering Medicare beneficiaries the same kind of access that the bill provides,” Bryant says. “The payment rate of 65% is woefully inadequate. These are issues we are talking to members of Congress about.”

AAASC is holding a conference Sept 10 in Washington, DC, which Jeffries says is an opportunity for ASC leaders to meet with legislators and seek support for raising the 65% conversion factor.

“CMS has made its decisions, and absent specific direction from Congress, we will see no improvement,” he says.

Will Medicare carriers be ready?

Resources

American Association of Ambulatory Surgery Centers
Medicare 2008 payment resources.
Phone 423/915-1001
—www.aaasc.org

Centers for Medicare and Medicaid Services

• CMS-1517-F: Revised payment system policies for services furnished in ASCs beginning CY2008.
  —www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp

• CMS-1392-P: Proposed changes to the hospital prospective payment system and CY 2008 rates.
  —www.cms.hhs.gov/HospitalOutpatientPPS/HORD/

  —www.cms.hhs.gov/apps/media/fact_sheets.asp

FASA National Office
Phone 703/836-8808
—www.fasa.org/

McDermott Will & Emery

For ideas on how to prepare your ASC for the new system, see the July OR Manager.

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Rhode Island Hospital cited for wrong-site surgery

The Rhode Island Department of Health on Aug 2 ordered Rhode Island Hospital in Providence to hire a consultant to review its practices after a neurosurgeon operated on the wrong side of a patient’s head on July 30. The hospital suspended the privileges of the surgeon, J. Frederick Harrington, Jr, MD, who voluntarily agreed to stop performing neurosurgery while the state medical board investigates.

The operation was an emergency craniotomy on an 86-year-old man with a subdural hematoma. The surgeon initially operated on the wrong side, then immediately operated on the correct side after the error was discovered.

The state issued an “immediate compliance order” to the hospital, indicating the problem required immediate action.

The state said the wrong-site procedure was the hospital’s second this year and the third in 6 years. The other incidents also involved neurosurgery.

The state ordered the hospital to have 2 physicians sign and document the site prior to surgery. The consultant will evaluate other safeguards for neurosurgery and make recommendations.

The health department also said licensing boards would investigate whether to take disciplinary action against any other professionals involved, including supervisors.

A media release on the case is available on the department’s website. ☞

—www.health.ri.gov/media/070802.php
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Washington State hospitals report wrong surgery, retained objects

Hospitals in Washington State reported 30 wrong surgeries and 36 instances of retained foreign objects from June 2006 through July 2007.

Four hospitals had 2 or more instances of wrong surgery. One reported 3 such incidents and another reported 4 (3 on the same date). For retained objects, 11 hospitals reported 2 or more events, with 4 hospitals reporting 3 incidents.

One medical center reported 3 retained object incidents and 4 wrong surgeries during the time period.

In 2006, the state began requiring hospitals and other health care facilities to report when they have any of 28 events identified by the National Quality Forum as ones that should never happen. The state provided the information, which is not published, to OR Manager. Facilities must also complete a root cause analysis, which is not reportable.

Wristband color standard adopted in Ohio

An Ohio initiative is encouraging health care facilities to adopt standard colors for patient wristbands. A survey of hospitals in the state found 19 different colors with 28 different meanings are being used, the Ohio Hospital Association reports.

The Ohio Patient Safety Institute recommends these standard colors:
- White/clear: Patient identification
- Red: Allergy
- Yellow: Fall risk
- Green: Blood product.

The color for do not resuscitate is undergoing review, and the institute is not making a recommendation for that at this time.

The institute believes standardization is important because many physicians, nurses, and other practitioners work in more than one facility. The ultimate goal is to eliminate wristbands in favor of electronic tracking systems.

The institute is working with providers across the state to help them implement the new standard beginning Sept 1.

—www.ohiopatientsafety.org/

Fewer complications at specialty orthopedic hospitals

Compared with general hospitals, specialty orthopedic hospitals serve healthier Medicare patients. Medicare patients who have hip or knee replacements at specialty orthopedic hospitals have a 40% lower risk of complications after surgery than those at general hospitals, in a study from the University of Iowa and Department of Veterans Affairs Iowa City Health Care System.

“The findings were somewhat surprising and important,” said Peter Cram, MD, the study’s lead author. “We suspected that specialty orthopedic hospitals were selecting low-risk patients for admission, and that is what our analysis found.

“But we also found that complications were less common in specialty hospitals even after accounting for the types of patients each hospital admitted.”

The investigation, published in the Journal of Bone and Joint Surgery, was based on records of Medicare beneficiaries who had total joint replacements between 1999 and 2003. The researchers said the study needs to be replicated in populations other than Medicare patients and using other approaches than claims data.


Orthopedic procedures on rise

The number of orthopedic procedures being performed rose 24% from 1997 to 2005, according to the Agency for Healthcare Research and Quality. Spinal fusion increased the most at 73%.

Though the volume of inpatient fusions continues to rise, procedures are shifting to the outpatient setting. Knee arthroplasties rose by 69%, and hip replacements were up 32%, with the demand for knee and hip replacements projected to double in the next 20 years.

—www.hcup-us.ahrq.gov/reports/statbriefs/sb34.pdf