The monthly publication for OR decision makers

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Health care and the economy

Economy hits hospitals hard, but impact on surgery still emerging

The economy is hitting hospitals hard. For elective surgery, the picture is only starting to emerge. Hospitals’ median total margins shrank to near zero in the third quarter of 2008—unprecedented low, according to a Thomson Reuters analysis of data from 439 hospitals. This was primarily because of a drop in investment income.

Though there were plenty of anecdotes that elective surgery was off, the data available in March hadn’t yet shown a trend.

Thomson Reuters data for key elective procedures hadn’t broken from historic trends through December 2008. That was true both for hospitals and physician activity (sidebar, p 7).

Some high-volume outpatient procedures like knee arthroscopy and cataract surgery seemed to be off for hospitals, but physician volume for those procedures had not let up, suggesting the decline was because more procedures were shifting to surgery centers and physician offices, the company said.

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Patient safety

Getting surgical teams on board for OR checklists and briefings

There’s evidence that using a surgical checklist makes a difference in patient outcomes. A worldwide pilot study at 8 hospitals, published in January, found patient deaths and complications lower after OR teams used the World Health Organization’s Surgical Safety Checklist.

Yet some OR teams struggle to consistently perform the surgical site verification process required by the Joint Commission’s Universal Protocol.

How do you bring about the culture change needed for successful timeouts and briefings? One model ORs have used is aviation. LifeWing Partners, founded by pilots and physicians, works with hospitals around the country to help them build team-based cultures.

OR Manager interviewed LifeWing’s President Steve Harden, a former US Navy Top Gun instructor, and Steve Montague, a 26-year aviation veteran, about getting surgical teams on board.

Harden will keynote the Managing Today’s OR Suite Conference Oct 7 to 9 at Caesars Palace in Las Vegas. His talk will be titled From Aviation to Health Care: A Culture of Safety.

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A Leaner surgical suite

Learn how Toyota’s long successful Lean manufacturing methods are helping ORs improve performance.

Cesareans in the OR

Read how colleagues manage staffing and standards for performing cesarean births.

Editorial

Has your OR joined the Surgical Safety Checklist Sprint? The goal is to try the World Health Organization (WHO) Surgical Safety Checklist at least one time with one OR team by April 1. The Institute for Healthcare Improvement (IHI) hopes every hospital in the country will reach that goal.

The WHO checklist rolled out in 2008 is a set of 19 critical elements for patient safety. Surgical teams are encouraged to use the checklist during 3 phases of a case: sign in, timeout, and sign out. The checklist gives team members a chance to check in with each other and confirm such items as the patient’s identity, surgical site, allergies, and estimated blood loss.

Earlier this year, the checklist got a major push with the report of a worldwide pilot study in the Jan 29, 2009, New England Journal of Medicine. (Download the article for free at www.nejm.org) Results from 8 hospitals around the globe showed patient death and complication rates fell after the checklist was introduced. (See March OR Manager.)

A sprint for adoption

As of March 10, 533 hospitals had signed on to the sprint, and 210 had already completed their test, IHI reported in a conference call.

If the sprint succeeds, it will be an unprecedented leap forward.

“We are pushing the envelope,” IHI’s president and CEO Donald Berwick, MD, said during the call.

On average, he noted, it takes 17 years for an evidence-based change to take root in health care, citing a figure from the Agency for Health Care Research and Quality.

He gave 3 good reasons to adopt the checklist now:

• It’s backed by human factors theory—the checklist standardizes information and builds team cohesiveness.
• It’s logical—it makes sense to think that it is a safer practice to pause before a case to check on items that pose the greatest hazards to a patient during surgery.
• It’s evidence based—with the New England Journal report, evidence that the checklist makes a difference has now been published in a prestigious journal.

“If we can get this done for the country, not only will we be protecting patients—we might be proving something to ourselves: that even in this difficult time for our economy and health care, we can make a change when it counts.”

Plan to join the Surgical Safety Checklist Sprint. For help and resources, check the IHI website at: www.ihi.org/IHI/Programs/ImprovementMap/WHOSurgicalSafetyChecklistSprint.htm

—Pat Patterson

A new look for OR Manager

OR Manager has a new look. With the economic downturn, our advertising has decreased. We have made some changes that don’t affect the quality of the publication but reduce our costs. We have eliminated color from some of the publication and changed the font size to make the publication more readable in its online digital edition.
Full Page Ad
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(Pickup)
With the tough economy, perioperative departments are pressed to reduce costs and make the most of OR time and other resources.

The OR Business Management Conference May 20 to 22 at The Drake Chicago offers strategies and tools for improving OR costs and performance.

OR business managers see this as their conference, with opportunities to network and get information on improving financial management.

Seminars

Four all-day seminars are planned for Wednesday, May 20.

- **Lean Principles for the Perioperative Environment.** The seminar will cover principles to weed out waste and foster a culture of continuous improvement. Lean can be applied to any number of OR processes, including case cart assembly, on-time starts, and more.
- **Planning for Technology in Tough Times.** With less money for capital purchases, how can ORs keep technology planning on track? The seminar will address ways to align capital investments with strategic needs.
- **A Collaborative Journey to a Surgery Pavilion for the Future.** This new facility, with 18 surgical suites, is the result of a collaborative team process that achieved an exceptional facility.
- **Improving Patient Flow—Data, Processes, and Sustainability.** The speakers will demonstrate a proven 3-phase approach to improving flow, with examples of data analysis and real-life outcomes.

Business-focused breakouts

Twelve breakout sessions address financial issues OR leaders face. Highlights include:

- **Improving the OR Revenue Cycle.** The session will cover how to improve charging practices so OR charging is integrated with the organization’s revenue cycle.
- **New Ways to Manage Total Joint and Spine Implant Costs.** The session will include 3 successful principles for implant cost management and 3 types of reports to support decision making and hospital-physician alignment.
- **Taming the Charge Description Master.** Issues the speaker will address include OR time charges, recovering equipment costs, and managing implant charges.
- **Developing an Anesthesia Program.** Managing needs of surgeons and anesthesia providers is a balancing act. The speaker will discuss critical components for developing an anesthesiology program that supports marketable perioperative services.
- **Improving the OR Supply Chain.** The presenter will highlight key cost-saving opportunities, such as improved inventory management, information systems, and charge capture. He’ll describe metrics for measuring performance.
- **Aligning OR Players to Develop a Prospering Surgery Program.** The speaker will describe how to align stakeholder objectives, strengthen OR governance, and encourage physicians to become part of the solution.

Download the conference brochure and register at www.ormanager.com
An online survey

In a survey by Novation, 44% of hospitals said they are seeing a reduction in surgical procedures. The results are based on a 12% response to an online survey of 546 CFOs and materials management executives.

It’s hard to know what to make of the data yet. Year-over-year variations of 5% to 10% in elective procedures are not that unusual, says Gary Pickens, PhD, chief research officer for Thomson Reuters.

“If you are looking at one time period and comparing it with the previous year, you may not be getting an accurate picture,” he says. “On the other hand, if the pattern continues for 3, 6, or 9 months, it probably is an issue.”

There are anecdotal reports from around the country that elective surgery is off.

State hospital association surveys found elective procedures down for some members. Elective surgery is one of the few areas that provides revenue growth.

In California, 30% of hospitals reported volume had decreased for elective procedures, the California Hospital Association said in January. In Pennsylvania, 44% of hospitals reported a moderate to significant decrease in elective procedures in the first month of the year. Elective procedures were said to be down by 2% to 20% for 60% of New Jersey hospitals in a poll.

In one large nonprofit health system that has hospitals in 20 states, elective surgery is said to be down considerably for most of the facilities. Some hospitals have reduced the number of staffed ORs, and most have frozen open perioperative positions except those deemed critical. Managers have been instructed to stop use of agency staff.

In California, there were reports from OR directors of hiring freezes, new grads and other RNs not being able to find work, reduced hours for clinical staff, and some layoffs.

Some surgery up

For other organizations, surgery is stable or even up. At Massachusetts General Hospital in Boston, surgical volume has increased a bit. Surgery at Yale-New Haven Hospital in New Haven, Connecticut, in February was up about 3% from last year, mostly in outpatient care.

“We have not had to furlough staff in the OR as yet, but we are managing how we use overtime and staff when we may not be as busy in the afternoons,” says Ena Williams, RN, MBA, MSM, nursing director of perioperative services.

Consultants say they are hear-
How are hospitals faring?

Hospitals’ median total margin fell to 0% in the third quarter of 2008—an unprecedented low. But data for January 2007 through December 2008 had not shown a trend in patients deferring elective procedures, either in or out of the hospital, according to a Thomson Reuters report released in February. The data is from a cohort of 150 hospitals.

Findings on surgery:

- Cardiovascular surgery was within historical ranges for the period.
- Orthopedic surgery inpatient admissions showed no sign of a decrease in this set of hospitals.
- Hospital-based outpatient surgery showed no evidence of breaks in volume trends following the start of the recession in late 2007.
- Major outpatient surgery varied within the historic range. There is some evidence of downward trends in cataract surgery and knee arthroscopies. But the trends are consistent with the movement of key procedures out of the hospital.
- For physicians, activity was within the historic range for three procedures: colonoscopy, arthroscopy, and cataract surgery.

Surviving the downturn

Providers who weather the recession the best will be those who adjust to the new conditions, says Jeff Peters of Surgical Directions, LLC, Chicago.

“If you develop an effective mechanism to use your capacity, manage your costs, and capture the business other people are losing, you can adjust and do OK,” he says.

ORs may find surgeons are more receptive than in the past.

“What I’m saying to surgeons is, the entire economy is in a transformation,” he says. “Hospitals can’t afford to run their ORs as they have in the past where a surgeon had 6 hours of block time, used only 4, and no one could follow him.”

Approaches his clients are taking:

- Manage OR capacity effectively. “They want to be sure while they’re reducing OR capacity, they’re not hurting access for surgeons,” he says. This calls for a strong governance model with an organized program for managing the block schedule.
- Seek ways to reduce labor and nonlabor costs.
- Develop a business development strategy. They are prepared to capture volume as other facilities close or reduce OR hours. “They have dedicated people going around talking to surgeons,” he says. “They are saying, ‘What are your problems? What are your needs? How can we address them?’”

Layoffs mostly avoid direct-care staff.

As the economy sours, there have been scattered reports of hospital layoffs, some involving direct care staff.

Mass layoffs, defined as those involving 50 or more people at a single employer, in health care sur-
Health care and the economy

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passed the 10-year average, according to the Bureau of Labor Statistics (BLS). Twenty percent of the mass layoffs were at hospitals.

In the Novation survey, 47% of respondents said they foresee staff cuts, and 68% expect cuts for clinical staff.

On the other hand, BLS figures showed employment at the nation’s hospitals rose by 0.14% in February and was up by 131,800 over a year ago.

Two large job losses were reported by the University of Pittsburgh and University of Chicago Medical Centers. The latter announced restructuring in February that would eliminate 450 jobs, about 5% of its workforce.

In hard-hit Michigan, at least 1,320 employees were laid off at 15 hospitals, including Beaumont Hospital in Royal Oak, which shed 500 jobs, and St John Health in Detroit, which eliminated 400, according to press reports. The Michigan Nurses Association said there had been a few RN layoffs, though most nursing job cuts were through attrition.

In Minnesota’s Twin Cities, local hospitals have shed more than 1,000 workers since last year, the Star Tribune reported Feb 2. Health care is a key part of the state’s economy. But last year, health care employment grew more slowly at 2.9%, down from 4.1% in 2007. Rural hospitals were doing better because many are designated as “critical access” and receive higher Medicare reimbursement.

Massachusetts has seen some nurse layoffs. “It’s not a large number, but there have been reductions in hours and a shifting of resources. ORs have been protected because that’s where the money is,” says David Schildmeier of the Massachusetts Nurses Association.

How is the economy affecting your OR?

Is your elective surgery down? Or is it unaffected? Are you reducing staff hours? Or are you recruiting new perioperative staff? Has your facility down-sized its management staff?

OR Manager would like to hear from you. Contact editor@ormanager.com
What are the pitfalls of getting the timeout in place and practiced appropriately?

Harden: One of the biggest pitfalls is that many people have never seen the timeout done correctly. So they don’t have a vision of what it should look like when it’s done properly and what they should be striving for.

Sometimes the timeout becomes longer and more involved than it should be. If it slows the workflow, you definitely won’t get the support of the physicians.

Also, if people don’t know how to do it well, you may not prevent the very thing you are trying to prevent—wrong site surgery. When this happens, everyone becomes demoralized.

They say, “We had a wrong surgery, but we were doing the timeout.”

Embedding the checklist in your workflow is nothing short of a culture change. Changing the culture is primarily a leadership issue.

When we go into a hospital, an initial reaction we often hear from physicians and nurses is that leadership dropped the checklist on them and said, “Here it is. Do it.” Then they walked away, assuming it would be done. Leadership didn’t persistently follow up to make sure it was used correctly.

How can you get past the pitfalls?

Harden: When administrators want to use a checklist for the Universal Protocol, many go and get a checklist from another institution. That never works. Checklists need to be developed by the people who will use them. As long as you comply with the Joint Commission’s requirements, there’s a lot of freedom in how you structure the checklist in your culture. The people who actually will use the checklist are the ones who should create it and are responsible for making sure it gets accomplished.

Montague: If physicians and staff understand the “why” of a preprocedure checklist, it’s much easier to embrace. They’ll understand that this is not an external requirement. They’ll want to do it because their life is going to be better, and they are going to be more effective as a team. As pilots, we can say, “My life is better as a professional because we do this.”

But don’t people already understand why they should use a checklist? The Joint Commission says you have to do this to prevent wrong surgery.

Harden: Most of the hospitals we work with aren’t using a checklist when we begin our work. Most are trying to do the required steps from memory, and there is a great deal of variation from team to team. It’s the variation that allows fertile ground for errors. Most OR teams do not understand the benefits they can gain from adopting a checklist approach.

One complaint is that a team briefing with a checklist takes too much time. What have you seen?

Harden: We’ve had success by pointing out the efficiencies to be gained. Teams are investing a minute to a minute and a half on the front end of the case but are likely to gain 5 to 10 minutes and maybe more on the back end. Over time, that can a considerable gain. Data from our clients shows decreases in the number of cases with unexpected delays. Case lengths also improve. The efficiency gains are what get the physicians on board. But a checklist can’t be completed in minute to a minute and a half unless the tool is well designed, aids the workflow, and was designed by the people who actually use it. The people who use it must also constantly tweak it to make it better.

Montague: In the literature, there are reports that cases are disrupted when you don’t have all of the needed people in the OR, the equipment isn’t ready, and the circulator has to make trips out of the OR to find missing items. If you ask people, “Does this happen in your OR?” They say, “It happens all the time.”

This inefficiency has been accepted as a way of doing business. With a team briefing, there is a way to discuss these things in a concise format. It’s an investment. You are reducing time in the long run and reducing the risk to the patient.

Over time, the timeout can become rote, and team members tend to tune out. How do you avoid that?

Montague: We offer 2 specific suggestions. One is responsibility. Everyone in the OR is responsible for making sure it gets accomplished.
for ensuring the checklist is done correctly. Just as important is designating one person with the final responsibility and accountability. There should be a policy in writing that says: “You have to make sure the briefing or checklist is done correctly. You have the power and responsibility to ‘stop the line’ if it is not being done correctly.”

The second suggestion involves proper communication. The person leading the checklist needs to ask questions instead of making statements. When you ask questions, it is a dialog, and others are expected to respond. You want to make it interactive as much as possible. Everyone on the team should have a speaking role; this keeps the team tuned in.

Who leads the checklist? Is it typically the physician, the circulating nurse, or someone else?

Montague: It’s probably evenly split between the physician and the circulating nurse. When the circulating nurse leads it, we think it’s essential to do the prompt to make sure the surgeon, the anesthesiologist, and others in the room are taking an active role.

My experience is that physicians are like pilots—we sometimes feel we’re invulnerable. We don’t think we are going to have an accident or a wrong-site surgery. I think you’re more successful engaging physicians if your checklist helps to fix the routine things they experience every day. Is the antibiotic on board? Do we have the equipment ready?

If your checklist helps fix everyday frustrations, it’s easier to get them to lead it and use it. That also gets into the last piece—the culture change.

Culture change seems like world peace. Everyone would like to get there, but how do you bring it about?

Harden: You change culture by changing what happens at the hundreds of moments of truth every day. For example, when it’s time to do the Universal Protocol, do you do it from memory, or use a checklist? That’s a moment of truth. Are you paying attention and focused, or are you half-listening? That’s another moment of truth.

We change what happens at the moment of truth by changing what people think at the moment of truth through good training. We reinforce the desired actions by using good tools like checklists. Ultimately, with training and tools we create good habits. Habits determine our character. The character of the team determines the culture. So the formula for changing culture is to change character by creating good habits through use of effective tools and good training. That’s exactly the model we followed in aviation.

How do you make it safe for everyone on the team to speak up if they see a problem? That’s key for patient safety.

Harden: I have never worked in a hospital where I did not hear a nurse say, “This is never going to fly with Dr S. Are you going to hold him accountable? Or is he going to bite my head off?”

Quite simply, this is a leadership issue. Behavior that gets rewarded gets repeated. Behavior that has negative consequences gets changed. This fear is going to persist until folks see something different happen. Words are not sufficient; they have to see different behavior. They have to know that Dr S has had a “performance coaching session” with the vice president for medical affairs about negative behavior.

Those who speak up also need to be rewarded. Someone needs to say to Nurse J, “I noticed that you spoke up during that case. A note is going into your personnel file to document that you have shown exactly the kind of behavior we want.”

When we work with a hospital, we spend a third of our time working with the leadership team, making sure they understand what is required and what standards they need to enforce.

Teamwork training can be difficult to achieve in a busy OR. How do you get everyone to attend?

Montague: To create a good checklist process, we strongly believe you must lay the groundwork with teamwork and communication training. That is one of the prerequisites for working with us. If you are not trained in how to listen and how to build a team, the checklist tool is not going to work.

If folks want to do it the right way, they need to make training happen. We do whatever it takes to work around the OR schedule. We have started as early as 6:30 am and as late as 7 pm, and we have done training on weekends.

We’ve had success in getting physician participation in training sessions. Once they hear from their peers that it is worthwhile, provides CME, and their attendance can earn them up to a 10% discount in their malpractice premiums, most physicians want to participate.

It seems like mistakes happen not in routine cases but in situations where there is an aberration. The patient’s position has been changed, or there is an emergency. How can a checklist help?

Harden: Our philosophy is that

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Where to look for supply savings

As one of the hospital’s biggest revenue and cost centers, ORs are a big target for expense reduction in these tough economic times. Supply costs are always a focus, but OR business managers say they’re redoubling efforts.

The biggest opportunities are in physician preference items like orthopedic implants—also the thorniest because of surgeons’ brand loyalty. And the greatest savings potential is in product utilization; in other words, changing physician behavior.

“Utilization, changing behavior to consume less or use alternative products, is where you have the opportunity to save the most. It is also the hardest part because it requires the alignment of all stakeholders,” notes Gary Dowling of Huron Consulting Group’s Wellspring nonlabor practice.

On the plus side, hospitals may find surgeons are more interested in collaborating.

“It’s early, but we are seeing physicians becoming more receptive. They understand the economic conditions because they’re seeing it in their own practices,” adds Hazel Seabrook, RN, MBA, of Huron’s Wellspring practice.

One health system they work with has even named a surgeon as medical director of supply chain management. His time will be split 50-50 between his practice and working with physicians on cost savings.

Here’s a look at supply cost issues and how ORs are tackling them.

New climate of openness

The public airing of the cozy financial arrangements between physicians and device and drug companies is starting to create a new climate of openness.

Under an agreement with the Department of Justice in 2007, the major orthopedic implant companies are now posting consulting arrangements on their websites. The American Academy of Orthopaedic Surgeons and the North American Spine Society have adopted more stringent conflict of interest policies. AdvaMed, the Advanced Medical Technology Association, a trade group, recently strengthened its ethics guidelines.

Seabrook says one of the first questions clients ask is what arrangements their physicians have with industry. “I’m finding more hospitals are seeking advice on how to get proactive physician disclosures so they are aware of relationships physicians have with vendors,” she says.

Keeping data out front

Accurate, complete data is essential to working with physicians on supply costs. That’s still a challenge for most ORs, Seabrook says. A root problem is incomplete and out-of-date preference cards, which many rely on for reports on cost per case. Cleaning up preference cards is a major step toward better data.

Cost per case is reported monthly to the OR’s clinical managers at St Joseph Hospital in Orange, Calif. Managers are expected to review the report and share trends with physicians in their service.

“We have always shared cost per case,” explains Terry Wooten, director of business and material resources for surgical services and endoscopy. With a recently upgraded information system, “we can now show the true cost without additional items like the overhead.” Physicians can see exactly what their preferences cost. “Some are shocked,” he says.

Adamant about value analysis

Value analysis is a mainstay for supply decisions at St Joseph.

For continuity, the value analysis team meets monthly, even if no items are on the agenda. Staff and physicians requesting new products are told, “Wait for the next value analysis meeting.” Exceptions are allowed only for unusual situations.

The St Louis-based Sisters of Mercy Health System, with 19 hospitals, is taking value analysis to the next level to focus on utilization. A systemwide value analysis committee guides decisions on

Physician preference savings opportunities

• Price improvement: 5% to 10%  
• Standardization (fewer companies or brands): 20% to 25%  
• Utilization (changing consumption behavior): 65% to 75%

Source: Wellspring Partners.

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Cost management

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new products requested at the system’s hospitals.
Cardiac rhythm management is the focus of one utilization initiative, notes Marita Parks, RN, MHA, vice president for performance consulting for the system’s supply chain arm, ROi (Resource Optimization and Innovation).
A physician committee is examining use of high-tech devices such as pacemakers and implantable cardioverter defibrillators (ICDs) and developing algorithms to guide use of the devices. After the algorithm is adopted, the committee plans to monitor use of the algorithm and any related cost reduction. A similar approach is planned for total joint implants.

The challenge of spine

If you ask OR directors and business managers about their biggest supply cost challenge, the answer is resounding: “Spine.” The bewildering array of hardware and biologicals make costs tough to manage.
Capitated pricing and/or reducing the number of implant vendors are the most common strategies. In capitation, ceiling prices are set for categories of implant constructs. Which approach is best depends on local market dynamics, Seabrook observes. Hospitals need to balance the need to reduce costs with the risk of losing surgeons if their preferred brand is eliminated.
“Reducing vendors generally is not well received,” she says. Capitation may seem easier, but it’s not a panacea because capped pricing requires close monitoring.

Capping implant prices
Mission Hospital in Asheville, North Carolina, has pulled off the feat of capitated pricing for trauma and spinal surgery implants, a program that took almost a year to develop, notes the surgical services business manager, Allen Warren. Capitated pricing has been in place for about 5 years for spine and about 1 year for trauma. The hospital, which has 43 ORs at 3 sites, performed more than 2,400 spinal surgery cases in fiscal 2008.
For trauma, one of the trauma orthopedic surgeons worked with materials management to determine a capitated price for the plates, screws, and other supplies used for an orthopedic trauma case.
Mission presented the capitated pricing to the vendors, and 2 signed on. The previous supplier elected not to participate, which meant the trauma surgeons had to change brands.

Capping prices for spine
For spinal surgery, Mission’s 11 orthopedic and neuro spine surgeons agreed to limit implants to 2 vendors that met the capitated pricing. The surgeons recently merged into 1 group. The schedule of 38 constructs was originally based on one developed by Premier that has been modified over time to fit new technology.
The participating vendors must comply with the capped pricing unless the surgeon has a specific reason for using components outside the pricing agreement. The program is enforced by a committee that includes spine surgeons, and they must approve exceptions.

Occasionally, a product has to be supplied free if a company circumvents the process.
In a strategy that helped gain physician buy-in, a portion of cost savings from the capitated pricing program is dedicated to Mission’s spine program, including education for staff and purchase of new instruments.

Managing “new technology”
The biggest challenge with capitated pricing is managing the loopholes, Warren says. Mission is seeking to address that issue as it negotiates its fourth capitated contract for total joint prostheses. One issue is determining what is “new technology.” A company might say a product is “new technology” and should be paid for outside the capitated agreement. Sometimes a part number is changed, and the change is defined as “new technology.”
The shift of implants toward the high-tech category is a national trend. Orthopedic Network News (ONN) reports that in 2007, 85% of total hip constructs fell in the most expensive category, compared to about 40% in 1999 in its national network of hospitals.
New technology should be addressed as part of the implant contract, Seabrook advises. “You need to put in a solid process for how any new technology is brought in,” she says. She suggests engaging the surgeons in determining whether the product is really new, saying, “It is often easier for the surgeon to put pressure on the vendor than it is for the hospital.”
One way to address “construct creep” is to require a vendor to provide the 510(k) clearance from the Food and Drug Administration to document a new technology, suggests Orthopedic Network News editor, Stan Mendenhall. He says
the issue has become more complicated, particularly in spine, as more startup companies enter the market. A single component from different vendors can vary widely in price, and identifying the original manufacturer can be difficult.

One hospital system includes a clause about new technology in its implant contract. The clause states that the company must provide a formal invoice before a new technology is offered for use in its facilities, with documentation that the product is defined as new technology by the FDA and/or third-party experts. The price must be mutually agreed upon in writing before the product is used. The contract states that products invoiced without prior approval for amounts over the capitated price will be paid at the capitated amount.

**Potential in gainsharing?**

Does gainsharing hold promise as a way to aid savings on physician preference items? Gainsharing is a formal and highly structured collaboration between hospitals and physicians in which the two parties agree to share savings from clinical projects. Gainsharing is subject to scrutiny by the Health and Human Services Office of Inspector General (OIG) because of the risk these projects might create incentives to cherry-pick healthier patients or stint on care. About a dozen such arrangements have passed muster with the OIG, all from one firm, Goodroe Healthcare Solutions, a unit of VHA.

Seabrook says hospitals she’s talked with are cautious about gainsharing, finding it complex and cumbersome. And savings may not be enough to interest physicians. Moreover, because of legal requirements, a new savings objective must be set each year. “A big question hospitals have is, ‘How do you sustain a model like that year after year?’” she says.

**Checklists**

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the more complex the case, the greater the need for a briefing. It is going to slow you down a bit, and that’s OK. That’s the time when you avoid harm. We in aviation say, “Once you get out of your normal behavior pattern, you are probably going to make a mistake.”

In an emergency, we use a different checklist; we may only review certain steps. You may only review 5 steps rather than the usual 10 steps. Then you go back when things slow down to review the other steps.

The important thing is to analyze those emergency steps on the front end, not to make it up as you go.

Montague: A hospital CEO told me, “When we have had an incident, we were slightly out of the normal pattern.” That’s what you need to build into your checklist and briefing: A pause to look around the room. Look people in the eye and say: “This is not what we normally do. These are the risk factors. I need you to watch for them.” It is essential to put a placeholder in the briefing to hold these kinds of discussions.

**Total joint demand may outpace number of orthopedic surgeons**

The number of patients needing total joint replacements could soon outpace the number of surgeons who can operate on them if trends continue, according to reports at the American Academy of Orthopaedic Surgeons meeting in Las Vegas in February.

**More younger patients**

More than 700,000 primary total joint replacements are performed in the US each year. Demand is expected to double in the next 10 years. A major reason is the increase in younger patients.

Among findings reported:

• In 2016, 46% of needed hip replacements and 72% of needed knee replacements will not be able to be performed.

• By 2011, more than 50% of patients needing hip replacements are expected to be younger than 65, and by 2016, that will be true for knee replacement patients as well.

The fastest growing group of patients is age 45 to 54.

“I was somewhat shocked at the shortfall [in surgeons] that we predicted,” said Thomas K. Fehring, MD, one of the researchers. The researchers are calling on policy makers to reconsider reimbursement rates for the surgery, which has declined as costs of care have risen.
With a new type of sterilization monitor, the Class 6 emulating indicator on the market, managers are asking how the new device fits into their sterilization quality assurance programs.

Two companies recently had Class 6 indicators cleared by the Food and Drug Administration for sale in the US: Steris Corp of Mentor, Ohio (Verify SixCess brand), and Steritec Products of Castle Rock, Colorado (Emugraph brand).

Managers will need to be armed with knowledge to sort out the new information and differing opinions.

A different approach

Class 6 indicators use a different approach than biological indicators (BIs), which have been used for years in sterilization monitoring. BIs are defined as having a known number of microorganisms with known resistance to the sterilization process. BIs need to be incubated to verify that all of the microorganisms have been killed.

In contrast, Class 6 indicators use a chemical ink formulated to change abruptly when the indicator reaches the "stated value(s)" for that sterilization cycle. The "stated values" correspond to critical variables the sterilizer manufacturer has defined for the sterilization process.

A Class 6 indicator, for example, can be set to have a stated value of 4 minutes at 270° F (132° C), the standard dynamic air removal steam sterilization cycle, notes Lon Bruso, vice president of Steritec Products. Thus, when this Class 6 indicator shows a pass result, it means the indicator was exposed to conditions that met those parameters.

Whether that is equivalent to a sterility assurance level (SAL) of 10^-6 is a question. By definition, an SAL is based on the chance that a given number of microorganisms will remain viable after being subjected to a sterilization process. Chemical indicators do not contain microorganisms.

In another difference, Class 6 indicators are designed and validated for specific sterilization cycles. In general, a different Class 6 indicator is needed for each type of cycle to be monitored. This also means Class 6 indicators can be designed to monitor the longer times needed for extended cycles, which have become more common with large, complex instrument sets.

A Class 6 indicator could be matched to each cycle.

On the other hand, 3M, which sells BIs and Class 5 indicators, maintains that Class 5 indicators have an advantage because, in mimicking BIs, they can detect types of sterilization process failures, such as air-steam mixtures and inadequate air removal, not detected by physical monitors or other types of CIs, including the Class 6.

3M refers to AAMI’s steam sterilization standard for health care facilities (ANSI/AAMI ST79:2006). Both are covered in the Association for the Advancement of Medical Instrumentation (AAMI) manufacturer standard for chemical indicators (ANSI/AAMI/ISO 11140-1:2005). The standard defines classes of indicators and performance requirements and/or test methods for CIs.

Under the standard, the response of Class 5 CIs is required to correlate to a BI at 3 times and temperatures. The response of Class 6 indicators is not required to correlate to a BI. That is an advantage or a disadvantage, depending on your point of view.

Steris says Class 6 indicators have an advantage, giving the example of a 270° F sterilization cycle, which has several variations: 3 minutes for metal or nonporous items (no lumens) in a flash sterilization cycle, 4 minutes for wrapped items in a prevacuum cycle, 10 minutes for metal items with lumens in a flash gravity cycle, and 15 minutes for a wrapped item in a gravity cycle. A Class 5 indicator, which is timed to match a BI, can indicate that 2 minutes of steam have been delivered but can't indicate that for 3, 4, 10, or 15 minutes. A Class 6 indicator could be matched to each cycle.

What is role of the Class 6 indicator?

The indicator is specific to the cycle.
and A1:2008), which states, “Biological monitoring provides the only direct measure of the lethality of a sterilization cycle.” Martha Young, MS, CSPT, senior technical service specialist for 3M adds: “Neither Class 5 nor Class 6 CIs contain spores and thus do not directly measure the lethality of a sterilization process.”

She adds: “Both sterilizer manufacturers and medical device manufacturers use BIs to validate their sterilizers and devices to ensure there is sufficient lethality to produce the desired sterility assurance level (SAL) for the device, typically 10⁶. CIs cannot be used to determine the SAL.”

Role in sterilization monitoring?
What role would Class 6 indicators play in current sterilization monitoring? Professional guidelines do not yet address this question, and opinions differ.

Bruso of Steritec Products says Class 6 indicators can monitor that the sterilization process met conditions beyond the 2 minutes where BIs are typically killed, as in the full 4-minute 270° F steam cycle.

But Chuck Hughes of SPS Medical, an independent lab that conducts validation testing for sterilizer and medical device manufacturers, questions whether that higher degree of resistance means a Class 6 indicator is better than a BI. SPS Medical also makes BIs and Class 5 indicators.

“I would throw out the question: ‘Do we need something more resistant than the BI or Class 5 indicators, which are cleared by the FDA as equal to a BI?’” Hughes says.

He notes that 1 to 2 minutes of saturated steam is what is needed to kill the most resistant microorganisms, as presented by a BI. He says the 4-minute cycle actually is 100% overkill beyond what is needed to kill a BI, which is a requirement of the FDA.

“There is no question that you can make a chemical indicator more difficult to pass than a biological indicator,” Hughes says. “But is more resistant better?” He adds, “The only value I see in that is in monitoring a prion cycle,” which is an extended cycle of 18 minutes at 270° F in a prevacuum sterilizer. Currently, indicators are not available in the US for prion cycles.

He maintains that users looking for the convenience of a CI that is as accurate as a BI but that does not require incubation can use Class 5 indicators, as recommended by AORN and AAMI ST79.

Monitoring extended cycles
An area where Class 6 indicators might be helpful is for monitoring sterilization cycles, such as extended cycles of 8 minutes or 20 minutes at 270° F.

“It would be nice to have a Class 6 indicator that is cycle specific for some of these extended cycles,” says Cynthia Spry, RN, MSN, CNOR, an independent consultant.

A drawback is that extended cycles have not been standardized. Under FDA rules, indicators can be released only for currently validated cycle parameters. These are not necessarily the same as some of the manufacturers’ extended cycles.

Manufacturers have been working with the FDA to resolve this issue. AAMI has a new technical information report that addresses extended cycles titled Process Challenge Devices/Test Packs for Use in Health Care Facilities (TIR31). The report requests that manufacturers standardize their cycles, which would allow indicators to be developed for those cycles.

“Class 6 emulating indicators lend themselves perfectly to extended cycles,” says Richard Schule, MBA, FCS, FAST, director of clinical education for Steris. “The goal of extended cycles is to lengthen the exposure of complex sets or devices, allowing every surface to contact steam.” He said a Class 6 indicator can demonstrate that the sterilizer achieved these conditions, adding that Class 6 indicators are the “only indicators capable of targeting the specific exposure time requirements for extended cycles.”

Hughes says he does not think Class 6 indicators are necessary for monitoring extended cycles. The issue, he says, is making sure the BIs and Class 5 indicators are in the right locations in the tray; that is, where the steam is least likely to penetrate. The purpose is to verify that all of the tray’s nooks and crannies are exposed to 2 minutes of saturated steam.

The reason for extended cycles, Hughes says, is that when a company is validating a tray for sterilization, the process may take 5 minutes or more to ensure steam has reached all parts of the tray. Under the FDA’s overkill requirements, the cycle must then be doubled to 10 minutes for the FDA to clear the tray for marketing.

Hughes says, in his view, steam

Continued on page 16
penetration can be monitored by locating BIs and Class 5 indicators in the hardest-to-reach areas of the tray.

Load release

The burning question is whether Class 6 can be used for the release of sterilizer loads containing implants. Current professional guidelines recommend use of a BI for every load containing an implant, with items quarantined until the BI result is negative. It is also recommended that a Class 5 indicator be used within the BI process challenge device. The guidelines include those from AORN, AAMI (AAMI ST79), and the Centers for Disease Control and Prevention (CDC).

Information from Steris says its Class 6 indicators “may be used to release all loads.” That creates a quandary for OR and central services (CS) managers.

Standards and guidelines

Managers rely on professional guidelines in setting policies for sterilization monitoring. The Joint Commission’s infection control standards (JC.02.02.01) require hospitals to use reprocessing methods “consistent with regulatory and professional standards.”

AORN, AAMI ST79, and the CDC’s newly revised Guideline for Disinfection and Sterilization in Healthcare Facilities do not yet address the Class 6 indicator.

AAMI’s steam sterilization hospital practices working group is waiting for published scientific evidence before providing guidance on the Class 6 in AAMI ST79, says Spry, the working group’s cochair.

To date, independent published research on the Class 6 indicator is lacking.

“A Class 6 emulating indicator is not a BI. They both have application,” Sprys says. “The question is, what is the most appropriate use in the US market?” Class 6 indicators have been used in some European countries, most notably in France, where all steam cycles are 18 minutes. Class 6 indicators are available in Europe to match the 18-minute prion cycle.

Like AORN and AAMI ST79, the CDC guideline continues to recommend monitoring with a BI for every load with implants, quarantining the items whenever possible until the BI is negative. The guideline was finished before the Class 6 indicators entered the market.

In a comment to OR Manager, the CDC guideline’s senior author, William Rutala, PhD, MPH, said Class 6 indicators “are not a substitute for a biological indicator.” He added: “No professional organization has recommended the use of Class 6 emulating indicators as a substitute for biological indicators, and there are no data (to include our own data) that demonstrate that a Class 6 indicator mimics a biological indicator at suboptimal sterilization times.” He has completed a study that has not yet been published.

How to proceed?

Until more evidence is available, Spry suggests that managers can use the AORN Recommended Practices for Product Selection in Perioperative Practice Settings as a framework for decision making. The recommended practices outline a general process for product selection.

OR and central service managers interviewed by OR Manager say they are interested in the new Class 6 indicator technology but find the competing claims confusing. They say they would like to see published scientific evidence on the Class 6. They also are waiting for guidance from the professional standards, though these can take years to be updated.

—Pat Patterson

References


Check our website for the latest news, meeting announcements, and other practical help.

www.ormanager.com
Tips for taming the OR chargemaster

Second of a 2-part article.

The OR consumes the most expensive and often the highest volume of supplies in the hospital. OR managers want to make sure their chargemasters are up to date so patient bills will accurately reflect services provided. They also want to make sure they are complying with the complicated billing and reimbursement regulations.

In this series, Keith Siddel, MBA, an expert on health care business operations, answers questions about charging in surgical services. He is CEO of HRM Consulting, Creede, Colorado.

Part 1 addressed OR time charges. This part focuses on maintaining the chargemaster and charging for supplies.

Q What do you suggest as best practices for maintaining the OR chargemaster?

Siddel: There are 2 philosophies. One philosophy says, “Our OR charges are only departmental operations charges.” Under this philosophy, supplies are seen as a function of the central supply or materials management department, and that department is responsible for setting up and managing those charges. The OR then uses the same supply numbers and charge tickets as any other department. Accountability rests with central supply or materials management.

The other philosophy is that each department stands alone and is its own revenue center. The OR orders its own supplies, maintains its own inventory, and is responsible for assigning charges.

It doesn’t matter which philosophy is used as long as accountability is there. There should be also a standard process for categorizing supplies and assigning a markup regardless of where the accountability rests.

Q What is your advice on managing the charging process?

Siddel: The first step in charging is to assign the new device to a category. The second step is to apply the markup to set the price, and the third step is assigning the correct revenue code and CPT/HCPCS code. This can be a challenge, and a mistake at any point can result in lost revenue.

Managing the process needs to involve several departments and takes coordination. The business office assigns the revenue code and often the general ledger code. The health information management department (HIM) assists in assigning the correct CPT or HCPCS code. This can be a challenge, and a mistake at any point can result in lost revenue.

CMS is beginning to focus on the markup.

Q How do you decide when an item is separately chargeable and/or separately billable?

Siddel: Ever since I have been in health care, we have begged CMS to use a code to use. I caution clients not to accept what vendors say carte blanche. That is not to say vendors are misleading, but often they are no more qualified to assign a code than you are without the right information, and they often pick the code that reimburses the most because it looks good for the sales process.

Regarding the markup, historically, hospitals have not marked up high-cost items as much as low-cost items. Let’s say a hospital buys a supply for $10; it may not have a problem charging $100 for that. On the other hand, if a device costs $25,000, the hospital won’t mark it up by 10 times. This is a situation CMS (Centers for Medicare and Medicaid Services) is trying to rectify. In the final IPPS (inpatient prospective payment system) rules for 2009, CMS indicated that it is beginning to focus on the cost markup for supplies. Remember, CMS uses a generic formula to ascertain your costs for supplies. An example is the $10 item for which you may be charging patients $100. CMS would look at your overall cost-to-charge ratio, which may be 40%. Under the formula, CMS would assume the $100 item really costs you $60 rather than $10. To solve this problem, CMS now requires providers to designate “high-cost supply items” from all other supply items. Most important—this is only the first step in this initiative.

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Continued on page 18
and other payers to come out with a list of what is chargeable. Unfortunately, there is no hard-and-fast list. Therefore, you need to go by broad categories.

There are things that are not chargeable—you can’t even put them on the bill—and things you can put on the bill but won’t be paid for. Generally, you won’t be paid for 80% of supplies anymore, but that doesn’t mean you shouldn’t charge for them. I will explain why later.

These are the broad categories of items that are not separately chargeable. (See the sidebar for descriptions of chargeable, billable, and other common charging terms.)

**Routine supplies used for the staff**

Any supplies used by the staff in providing services may not be separately charged or billed. That includes items like gowns, gloves, and hats.

**Routine supplies used by the patient**

The general rule is that any item used 70% of the time for most of your patients is not separately chargeable or billable. A lot of commercial payers say that if you don’t document an item, you can’t charge for it.

You also can’t charge for personal items given to patients, such as Kleenex. I tell providers this includes anything a hotel wouldn’t charge you for, like shampoo or toothpaste.

In the OR, this can get tricky. For example, you would not charge for a cover on a light handle because that is routine. But what about items used only when you perform a particular procedure? Most providers and CMS have never defined routine as being an item “routinely” used only for a certain type of procedure. When considering whether something is routine, look at the general patient population in a particular care area.

**Capital equipment**

Most capital equipment is not separately chargeable because these are items that are depreciated on the cost report.

**Why should you charge for an item if you know you are not going to be paid?**

**Siddel:** In today’s world, you have to know your costs. If you don’t know your costs, you won’t know where your problem areas are or where you need to grow or shrink your business. Unless you have a good cost-accounting system, charging for items is the only way you will know what you have used on a patient. You also need to know how much it costs, for example, for Dr X to perform an appendectomy.

In deciding whether to charge for an item, you also need to weigh the cost of the charging process. There is a cost associated with the process of tracking, monitoring, and assessing the charge. A lot of facilities say that if an item costs less than $100, they will not charge for it because it costs too much to generate and capture the charge.

**Chargeable versus billable**

What is chargeable versus billable? Here are a few terms.

**Chargeable**

Chargeable means each patient will be charged for the item. Remember, just because something is chargeable doesn’t mean it will show up on the patient’s bill. Often charging is used for decision support because providers want to know where an item is being used and on what kind of patients. Some charges are set up as statistical or zero-charge items for internal tracking purposes. I recommend keeping these to a minimum.

**Billable**

Billable means an item can be billed on the patient’s claim. The item may or may not be covered by the third-party payer or even by a patient, but it is acceptable to allow the charge to cross to the claim.

**Bundled**

These are items for which no separate payment will be made.

They may or may not be billable. For example, Medicare recommends billing most of your bundled items either separately or ensure that the cost is included in the patient charge.

When these items are billed, Medicare assigns a status indicator “n,” meaning no separate reimbursement is made for that item. The problem is that many providers fail to bundle the charge or bill separately. This results in under-reporting to Medicare of procedure costs, and future reimbursement is reduced.

**Noncovered**

Noncovered means the third-party payer does not pay for that item or service. In some instances, these items are statutorily noncovered, which means you can bill them to the patient. If the item is noncovered for a unique reason, and you have notified the patient upfront that it is noncovered for them, it can be billed to the patient.
**What are the risks of charging for an item that is used off-label?**

**Siddel:** This brings up the issue of medical necessity, which is a two-fold issue. The issue starts with the physician, who must decide what is medically necessary based on the patient’s condition. The payer also decides what is medically necessary. More and more, Medicare and other payers are drawing the line on medical necessity.

If a physician knowingly uses or prescribes something you believe may not be covered or appropriate, you need to have the patient sign an ABN (advanced beneficiary notice). An ABN notifies the patient that Medicare may not pay for the item. Then if Medicare doesn’t pay, you can bill the patient.

You also need your compliance and legal departments to sign off. That’s not to say the patient shouldn’t get the item. What you need to tell the patient is, “Your physician believes this is medically necessary. Your insurer may or may not believe it’s medically necessary. If they decide it’s not, you will need to pay for it.” Then you have the patient sign the ABN. (There are complex regulations regarding the ABN. This is a brief simplification.)

**Have a question on the OR revenue cycle?**

Keith Siddel will respond to questions in a regular column. Send your questions to Pat Patterson, Editor, at ppatterson@ormanager.com. He is speaking at the OR Business Management Conference, May 20 to 22, in Chicago, on the OR revenue cycle and chargemaster.

You can reach Siddel at ksiddel@hrmlc.com

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**Forum**

**To the editor:**

The article entitled “Set the clock for OR on-time starts” in the March 2009 issue includes an account of impressive process improvements at Memorial University Medical Center (MUMC) in Savannah, Georgia. I am surprised, however, that “the hospital didn’t have a way to specifically measure the results in financial terms.” After all, the article also states that a business analysis of the situation before the project was undertaken “showed significant loss of revenue from late starts ($1.7 million in 2006).” If the hospital was experiencing a loss in revenue, one would presume that late starts were forcing a reduction in the number of cases that could be scheduled. If that was indeed the case, then it should have been possible to measure the increase in case volume as first-case-start performance improved.

If, on the other hand, the presumed $1.7 million dollar “loss of revenue” was calculated by multiplying the number of minutes of delay by the average cost of an OR minute, then the potential financial benefits were incorrectly estimated. Here’s why: Saving a few minutes here and there doesn’t translate into a financial impact unless cases are added or staff is eliminated. It’s possible there was some reduction in overtime at MUMC, but it’s likely to have been minor. I estimate that the average lateness of the first cases was reduced by about 10 to 20 minutes, not enough to make a substantial dent in overtime payments. Perhaps that’s why no financial impact was observed.

Working to improve first-case-start performance is a popular improvement project, but it may not represent wise investment of a hospital’s resources. Start with the popular metric for assessing improvement: “percent on-time starts.” While the metric sounds “right,” it fails to provide a complete picture of the improvement.

**A more useful metric**

A more useful metric is “average minutes late.” It affects directly the expected duration of the day’s schedule, which is the sum of the expected values of all the time intervals, including the delay at the beginning of the day.

Unfortunately, most projects aimed at improving first-case-start performance are probably not as successful as the one at MUMC. They likely save no more than 15 minutes of a day’s schedule, thus making little impact on a hospital’s overtime payments.

Hospitals could realize much greater financial benefits by working to reduce nonoperative times between short cases, as noted in our 2008 article (see reference). By doing so, they might be able to routinely add a short case. Since one additional short case produces an incremental margin improvement of about $2,000, doing so every day offers the potential to improve the bottom line by $500,000 annually. But even this route to financial improvement must be carefully examined before launching an effort to reduce non-operative times. The hospital must expect to grow its load of short cases to capitalize on the “found” capacity, or it must plan to close one or more operating rooms and reduce staffing levels.

—Dan Krupka
Managing Principal
Twin Peaks Group, LLC
Lexington, Massachusetts

**Reference**

Making your GI unit more efficient

You know meticulous instrument care and handling can reduce your GI endoscopy repair costs. But did you know that the organization and design of your GI unit can also affect your daily operations as well as your repair costs? Rethinking the layout of your setting is an opportunity to manage resources cost-effectively, improve the unit’s flow and function, and potentially reduce repair expenses. Here are key issues to consider.

**Assess your inventory**

Maintaining an optimal scope inventory is fundamental to keeping repair expenditures at a minimum. Monitor the size and age of your endoscopes and balance your scope inventory against your current and forecasted procedural requirements. Do you have the right scopes to meet current and predicted case-mix demand?

Too many of the wrong scopes can lock up excessive capital; too few of the right scopes may delay procedures. This can lead to patient and physician dissatisfaction, unplanned staff overtime, and increased scope handling-related repairs.

Data from the Olympus benchmarking program for 2008 showed that endoscopes per procedure room averaged:
- 2.0 of the most often used upper scopes
- 3.1 of the most often used lower scopes
- 0.2 and 0.3 specialty scopes for upper and lower procedures

Benchmarking data can help you evaluate your own scope mix, ensuring you get the most mileage out of your capital equipment budget. You can also look at the number and frequency of procedure-start delays and cancellations resulting from unavailable equipment. This will provide a good indicator of whether your inventory is sufficient to meet your typical procedural load.

It’s also important to evaluate the age of your inventory. If you keep a frequently used scope for too long, repair expenditures may start to climb while your technology edge plummets. The benchmark data for 2008 shows the median age of all endoscopes as 2.6 years, with the overall average ages reported as: colonoscopes (3.0 years), EGD scopes (3.1), ERCP scopes (3.0) and EUS scopes (2.4).

**Manage the design of your unit**

A workspace that aids operational throughput may mean less rushing and fewer incidents of damage. Most important, achieving optimal efficiency allows more time to ensure proper protocols are followed. The most efficient and cost-effective units have considered the dynamics of staff, equipment, and workspace. A few questions to think about:
- Do you have an appropriate number of prep and recovery bays to meet the needs of your case mix and volume? Benchmark data in 2008 finds the ratio of prep and recovery bays to procedure rooms as 4:1 in both single-specialty ambulatory surgery centers and nonteaching hospitals and 3:1 in teaching hospitals.
- Do your workspaces follow a dirty-to-clean flow? Is the reprocessing room close to the procedure room? This is important not only for infection control but also to ensure scopes and staff move through the space efficiently.
- Does the procedure room have adequate space to protect endoscopes before, during, and after procedures?
- Does your facility have dedicated clean scope storage separate from accessories?

**Rearrange your reprocessing**

Equally as important as a well-designed facility, the GI unit must structure reprocessing protocols, processes, and workspace to maximize throughput of scopes while minimizing risk of damage.

**Location**

The Society of Gastroenterology Nurses and Associates 2008 Standards of Infection Control in Reprocessing of Flexible Gastrointestinal Endoscopes state: “Reprocessing of contaminated patient equipment should be done in an area designated and dedicated for this function. This should be a room separate from where endoscopic procedures are performed.” (www.sgna.org)

Proper cleaning of endoscopes is essential to safe reprocessing. As mentioned, this dedicated area ideally should be located close to the procedure rooms. Additional time spent moving scopes to remote...
sites may present infection control risks associated with delayed reprocessing and make scopes more vulnerable to damage. Always check with your original endoscope manufacturer (OEM) for instructions on delayed reprocessing.

In addition, to expedite transport to remote reprocessing areas, staff may be more tempted to tightly coil and stack scopes together or scopes and accessories together in the same transportation bins. Such shortcuts make scopes more vulnerable to kinks, cuts, punctures, and other damage.

**Time**

Allow staff adequate time to complete all cleaning, disinfection, and sterilization (CDS) steps in accordance with OEM guidelines. The schedule can get hectic. But the more rushed the reprocessing technician is, the more opportunity there is to omit steps, causing endoscope damage and downtime. Insufficient or improper leak testing can result in accidentally missing a small leak, which left unchecked can escalate into a major repair. Failure to inspect the water-resistant cap before attaching it to the scope or forgetting to attach it before immersing the scope into the basin of water can also cause damage and additional repair work.

On average, 2008 benchmark reprocessing time data showed 8.2 minutes were required for leak testing and mechanical cleaning, 32.5 minutes for automated endoscope reprocessors (AER) cycle time, and 6.4 minutes for postautomated time, for a total of 47 minutes from start to finish. Compare your average scope turnaround time. Faster time is not necessarily better. Factor in sufficient time to cover all of the necessary reprocessing steps.

**Protocols and processes**

Make sure to complete precleaning in the procedure room. Precleaning removes bioburden before it has a chance to harden, avoiding the need for more aggressive cleaning and potential damage to the scope. Check the integrity of the water-resistant cap, making sure it is dry, and attach it to the scope at bedside. Transport scopes to the reprocessing area in covered containers. Then in the reprocessing room, always perform leak testing prior to moving on to manual cleaning and high-level disinfection. Consistent leak-testing practices can help avoid fluid invasion damage to the scope, which is the number-one cause of expensive, refurbishment-level repairs.

**Space**

The reprocessing room should be of adequate size with proper ventilation. Check the sink drain and work areas to ensure they are free of sharp edges. Remove all unnecessary objects that might damage the endoscope. Leave ample counter space for leak testers, basins, flushing pumps, and so forth so there is room to maneuver the scopes without stacking or bumping them into other equipment.

**Sinks**

Use a sink large enough to avoid crimping the instrument during leak testing and manual cleaning. The sink should be deep enough to allow full immersion of the endoscope. Never use sinks to stack scopes waiting for leak testing and manual cleaning.

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**Endoscope inventory per procedure room**

<table>
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<th>Single-specialty ASC</th>
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**About the benchmarking study**

The benchmarking study is conducted by Olympus Endosite Consulting as a quarterly web-based subscription service.

- The data is from the 2008 Quarter 3 survey.
- The number of participants was 79.
- Data is reported directly by participants.
- The data is segmented by facility type and volume.
- The data is based only on reporting by participants for the period and is not aggregated over multiple periods.
- The survey is not limited to Olympus customers, though it is likely most participants are.
- Olympus says it publishes the de-identified results regardless of whether they appear favorable to the company or not.

[www.olympusamerica.com/consulting](http://www.olympusamerica.com/consulting)
GI endoscopy

Continued from page 21

Automated reprocessors

If your facility uses AERs, make sure you have the appropriate number and types of machines for your volume of scopes. Benchmark data for 2008 shows the average number of scopes that can be reprocessed at once per endoscope procedure room is 1.3.

It is also a good idea to design enough space to allow access for planned and unplanned maintenance and repairs. Make sure you are using an AER that is appropriate for the types of scopes at your facility. Also, use only FDA-approved liquid chemical germicides (LCG) recommended by the endoscope manufacturer to protect your equipment from chemical damage. LCG potencies should be tested and recorded prior to every cycle. Staff can avoid chemical damage to the scope as well as cross-contamination risks by adhering to the detergent and/or disinfectant/sterilant manufacturers’ instructions.

Safety-proof your storage

To safeguard endoscopes when not in use, store them in clean, dry, well-ventilated cabinets maintained at an ambient temperature. Store endoscopes without valves and caps; they can trap moisture in the channels and promote unwanted microbial growth. A well-ventilated storage cabinet reduces the chance of microbial contamination.

Proper storage of the endoscope should support the control body. The insertion tube and universal cord should hang in a vertical position, with the distal tip hanging freely. Finally, to prevent stretched or broken angulation wires, place the angulation locks in the unlocked position.

Never store endoscopes in their carrying cases. Use appropriate carrying cases or shipping containers for transporting endoscopes to and from repair facilities. Do not pack the scopes with accessories to prevent further damage during transport.

Practice prevention

An ounce of prevention can greatly influence your repair expenditures. Fix minor damage quickly before it escalates. This includes ensuring regularly scheduled preventive maintenance checks, checking instruments and equipment for wear, and documenting postrepairs of all returned endoscopes. Track and trend scope repairs by individual scope serial number. This data will help point to aspects of reprocessing that need improvement. Finally, keep staff trained on handling, operating, and reprocessing practices and protocols.

Delegate duties

Every member of your staff, from physician to technician, needs to understand the direct correlation between proper endoscope care and handling and repair expenditures. This is particularly true of reprocessing staff. Facilities with the lowest rate of repairs tend to have highly trained, dedicated reprocessing staff members who have been given ownership of the reprocessing responsibilities. These staff members comprehend that skipping and/or ineffectively performing reprocessing steps, or failing to follow OEM instructions, can adversely affect patient safety and directly increase the incidence and cost of repair.

All staff working with endoscopes need proper training and to keep current on handling, operating, and reprocessing protocols. Proper handling and CDS protocols go a long way toward maintaining properly operating equipment, reducing repair expenditures and supporting positive infection control outcomes. Seek the support and resources of your scope manufacturer to help with training.

Encourage certification

A new Certified Flexible Endoscope Reprocessor exam was introduced in the US in February 2008. All reprocessing staff should be encouraged to take this test. The exam provides uniform guidelines and standards for evaluating the knowledge and skill set necessary for this critical reprocessor position. (More information is at sterileprocessing.org)

In summary, a well-organized and efficiently designed GI unit that enables careful equipment handling, preventive maintenance, and proper storage protocols can eliminate the need for many repairs and ensure continued delivery of safe, cost-effective quality care.

— Nancy Vacante, RN, BS
Director of R&D
Olympus Business Development Group, Center Valley, Pennsylvania

More information is at olympusamerica.com/cds, olympusamerica.com/endoscopecare, olympusamerica.com/reprocessing, and olympusuniversity.com
The principles of informed consent are well known—patients have the right to make informed decisions about their care, including surgery. The primary purpose of informed consent is to ensure that the patient has the information necessary to make a decision before agreeing to any treatment.

The responsibility for informed consent is the physician’s. Informed consent is a dialogue between the patient and physician in which the patient learns and understands about the proposed treatment, including the risks, benefits, and alternatives. The patient also has an opportunity to ask questions and agree about what is to be done.

Though these principles may be understood, the details of informed consent raise a lot of questions. OR Manager asked David Balfour, an attorney with DiCaro, Coppo & Popcke, APLC, Carlsbad, California, a law firm that specializes in medical and health care law, to respond to frequently asked questions from readers.

Q How critical is the physician’s signature on the consent form? We sign the surgery consents with a nurse witness and the patient. This is a convenience and customer service issue for the surgeons. The physician is required to document risks, benefits, and alternatives on the history and physical or dictated note. Do we need to change our process?

Balfour: While the physician’s signature is not required on the informed consent form, requiring the physician’s signature serves as an important double-check for the facility. The patient and a qualified, competent health care provider must personally interact for the requisite exchange of questions and answers. A physician is required to obtain consent from the patient for a surgical procedure after informing the patient about the procedure.

Informed consent is a process, not a signature on a form. The informed consent discussion cannot be delegated to the staff. Staff can assist in the process by providing educational materials such as pamphlets, brochures, videos, and online materials about the procedure generally (materials provided should be documented). But a physician must conduct the discussion with the patient about the expectations of risks, benefits, and alternatives for the procedure for that specific patient. Inappropriate assurances (or even guarantees) made by staff members may subject the doctor and facility to additional liability based on the inappropriate information given.

Informing the patient
Whatever format the informed consent form takes, it should not be signed before the physician’s discussion with the patient. A patient should be informed verbally, in nontechnical terms, about all of the following:

- a description of treatment procedures/products/devices/medications to be used
- a description of any attendant discomfort and risks to patient that can reasonably be expected from such treatment
- an explanation of any benefits to the patient that can reasonably be expected
- an explanation of any appropriate alternatives to procedures/products/devices/medications that might be advantageous to the patient, and their relative risks and benefits
- an offer to answer any inquiries concerning the treatment involved.

Documenting the consent
The physician should document the consent discussion in notes separate from the consent form. The more ironclad the documentation, the more likely the consent will be confirmed by anyone reviewing the case, including the patient’s attorney should anything go wrong unexpectedly. In litigation, the adequacy of a written consent is a factual issue to be determined by a jury, and the mere existence of a signed written informed consent is not conclusive proof that informed consent was given.

Countless surveys and articles relating to medical malpractice actions have shown the majority of lawsuits arise due to poor communication between physicians and patients. The informed consent discussion is one of the most important conversations between doctor and patient and should not be minimized. In both the short and the long runs, improved patient-physician-facility communication minimizes the likelihood of medical errors and liability exposure. In the long run, the surgeons will thank you.

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**Ethics**

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**Q** Do nurses witness the signature only or give their signature to verify patients’ understanding? (Nurses never seem to get this right.)

_Balfour:_ At a minimum, nurses or other care providers witnessing the signature should be confident the patient himself or herself is signing the consent, and the patient is competent to sign. The nurse should make sure the patient is not impaired by medications in agreeing to the procedure. Competency can also relate to age; for example, the nurse should ensure minor patients’ consents are signed by the responsible parent(s) or guardian.

While the responsibility for informing the patient and obtaining consent rests with the physician, witnessing the patient’s signature on the consent is the optimum time to ensure the patient has had all questions answered about the procedure. While the nurse may not be, the doctor is required to verify the patient’s understanding and consent. (Sometimes doctors don’t get this right.) The nurse asking, “Has the doctor answered all of your questions about the procedure?” is a good step. If not, the consent process is not complete, and the doctor should be sought out before the surgery to get the questions answered. Nurses should be careful, though, not to offer advice about the risk/benefit calculations; such calculations and advice should be left to the doctors.

The contemporaneous signature of a witness serves 2 purposes. First, it impresses upon the patient the importance of the document the patient is signing. Second, it documents a part of the informed consent process, namely the patient’s agreement to undergo the procedure. The facility benefits from the nurse assuring the patient’s comprehension. The nurse is not required to verify the patient’s comprehension of and consent to the procedure to protect his or her own liability, but the nurse’s doing so helps to protect the facility from liability, both by assuring that the patient has consented and continuing good open communication with the patient.

**Q** Who can witness an informed consent (family member, surgical team member, housekeeper, etc)? This is a debate among physicians and nurses.

_Balfour:_ Any adult may sign as a witness on the consent form. Given that consent forms are typically pre-drafted forms with handwritten entries describing the procedure and the name of the physician(s), the form will generally be interpreted in favor of the patient’s interpretation and against the interpretation of the facility. For this reason, it is preferred that the witness to a consent be either a noninterested employee of the facility or a family member, friend, or escort of the patient.

Because informed consent is a process, the best person to witness the patient’s signing of the informed consent form is the person who has witnessed the most of the informed consent process. If at all possible, it is helpful to have someone who has heard the physician discuss the risks, benefits, and alternatives with the patient.

**‘Reasonable patient’ standard**

In some states, the adequacy of the consent is determined using a “reasonable patient” standard. In those states, whether the consent is valid is determined by whether the patient was informed of all a reasonable patient would expect to be told, and in a way a reasonable patient could understand to assess the relative risks and benefits of undergoing the procedure. In these “reasonable patient” states, the physician must explain the procedure using nontechnical terms the patient can understand. In these states, having a family member or friend of the patient witness the consent can help to support the comprehensibility of the information given in the consent process. Inquiry should be made of the family member or friend to ensure all of their questions have been answered as well as those of the patient.

**‘Reasonable physician’ standard**

In other states, the standard for determining whether informed consent is appropriate is the “reasonable physician” standard, which looks at whether the physician gave all information a “reasonable physician” would have provided. In these states, it might be preferable to have a witness who is familiar with the process and who might note if all the parts of the procedure were covered in the informed consent discussion.

**Failure to advise of risks**

The failure to fully and adequately advise of the risks of a surgery to which the patient has consented is generally categorized as negligence. But performing a surgery that the patient has not consented to, or which is substantially different than what was con-
sented to, is battery, an intentional tort. Intentional torts are, by their nature, uninsurable, so malpractice coverage will typically not cover the exposure created. Moreover, in states with malpractice litigation protection statutes, battery will destroy the protections of the statutes for the offending physician.

Without regard to the standard used in your state, prudent practice requires that the patient undergoing this procedure has been fully informed about the procedure and has freely made the choice to proceed, and the informed consent process was witnessed and documented.

Q Should we have separate surgical and anesthesia consent forms?

Balfour: Anesthesiologists should be having a conversation about the risks of anesthesia with the patient apart from the conversation of the risks and benefits from the surgical perspective. While the surgery consent should be obtained prior to the day of surgery, frequently the anesthesiologist’s discussion with the patient takes place the same day as surgery. Anesthesia risks should be discussed generally in any discussion of the risks and benefits of surgeries involving anesthesia. Requiring the anesthesiologist to obtain informed consent for the anesthesia specifically is good practice because it helps to ensure that the process happens.

Q In our ambulatory surgery center (ASC), not all physicians have seen the patient in the office and had an informed consent discussion. This is especially true for GI endoscopy and pain management. The ASC staff must then present the informed consent form to the patient and get the signature. Rules do not allow the patient to be brought into the procedure room until the form is signed. So the physician must either come out to have the discussion with the patient, or the rules must be broken to allow the discussion to take place in the procedure room. Either way, this is not the best time to have an informed consent discussion. Do you have any suggestions?

Balfour: A consent obtained in the operating room could be later found invalid. It would at least face severe questioning on review. As with most contracts, the patient might be excused from having signed the form because of the pressure, known legally as duress, of the situation. The surgeon, the surgery team, and the facility could all be viewed as counting on the patient to undergo the procedure, and the patient could not want to “disappoint” them. The patient might fear, for example, that he or she would have to pay for the setup time for the surgeon and the facility if he or she were not to undergo the procedure. The patient’s decision to consent to the procedure must be freely made without such pressures.

Consent should be obtained after the surgeon discusses the risks, benefits, and alternatives with the patient, and prior to the patient making the final decision to undergo the procedure. The earlier the consent discussion and the less the pressure during the consent discussion, the better. Given that most of the procedures performed in ASCs are elective, at least in their timing, the facility would be wise to require the informed consent discussion to take place before the patient arrives at the facility on the day of the surgery.

Surgery centers frequently have the referring physician’s office complete a surgery scheduling sheet with patient demographics, type of procedure, equipment to be used, etc. This sheet could require physicians’ offices to indicate whether the patient has given consent for the procedure, and the surgery center could require a copy of the signed consent to be forwarded to the surgery center before the surgery date.

If the same-day consent is all that is practicable, the surgeon must go out and have the informed consent discussion with the patient before the patient signs the consent.

DiCaro, Coppo & Popcke is a law firm serving the medical and health care communities with services including malpractice defense, peer review, and medical board and hospital board issues.

OR Manager introduces new digital version

Super Subscribers now have access to a new digital version of OR Manager. You will be able to:

- turn pages with a click of your mouse
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- search the issue for topics of interest
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- print the issue
- save as a PDF.

You can review a demo of the October issue on our website, www.ormanager.com
Ambulatory surgery centers (ASCs) are about to find themselves more deeply connected with the communities they serve than ever before.

Under the latest Centers for Medicare and Medicaid Services (CMS) rule setting out conditions for coverage, ASCs must join their hospital colleagues in publishing disaster preparedness plans.

The Medicare rule, which takes effect May 18, goes beyond fire drills and patient transfer agreements. ASCs must work with state and local emergency management authorities to determine where each facility and organization fits in with its community’s response plan.

One option: shut the doors

Many surgery centers, especially those in locations at risk for hurricanes, fires, earthquakes, and other recurring dangers have long had emergency response plans. The 3 surgery centers owned by BayCare Health System, Tampa, Florida, have a simple plan: shut the doors and release staff to help in the main hospitals.

That is still fine under the new rule, according to Jerry Gervais, an engineer with the Joint Commission. “In an ASC, it is common in large-scale disasters to simply shut down,” he says. “We will accept that, as long as it has been reviewed with the community.”

However, the updated Medicare rules and the Joint Commission other guidelines that followed provide an opportunity for ASCs to rethink their policies regarding disaster preparedness. Many will decide to participate more fully in protecting the communities they serve by offering to share their facilities, skilled staff, and supply stores when disaster strikes.

The Joint Commission encourages that choice as well. “We’d like to see ASCs work closely with hospitals,” Gervais says. “It represents a unique opportunity to them to be of service to their community.”

The new condition for coverage is simple and short: Under Subpart C, Section 416.41, it states: “The governing body...develops and maintains a disaster preparedness plan.”

The section specifies the components of an ASC disaster plan, which must include:
- provision for emergency care of patients, staff, and visitors
- coordination with state and local emergency response authorities
- annual drills to test the plan’s effectiveness and revise it as necessary.

The Joint Commission standards are more comprehensive, filling a 16-page chapter in the 2009 Standards for Ambulatory Care. The Accreditation Association for Ambulatory Health Care (AAAHC) was expected to issue its 2009 standards by the end of February. In general, the AAAHC standards require a written emergency plan.
What is an emergency?

An emergency can be anything from a temporary power failure to the Sept 11 terrorist attacks, from an ice storm that keeps staff from getting to work to a hurricane that destroys an entire city.

For an ASC or hospital, an emergency can result in loss of the ability to serve its own patients or in added demand for its resources from other facilities. When an emergency is so severe or widespread that the local community can no longer deal with it and must ask for outside help, it has become a disaster.

The Joint Commission standard also spells out the steps an ASC should take in designing its plan. First, the top leadership must participate. In this and other critical policy issues, experience has shown that if development is left to a lower-ranking committee, the plan will collect dust on a shelf and be useless when the time comes for implementation or the annual drills that now are required.

What are your vulnerabilities?

Next comes what many experts term the “hazard vulnerability analysis.” Working with community emergency management officials, the ASC considers what kinds of incidents are most likely to affect it. In addition to the obvious perils of hurricanes in Florida and earthquakes in California, more subtle hazards should be identified. In large cities, for example, there may be a threat of urban unrest or street violence. The Department of Homeland Security has compiled probability studies that indicate which cities and regions are most at risk for terrorism, whether by bombing or chemical or biological attacks, and has shared the information with communities throughout the nation.

Other vulnerabilities include location near a nuclear power plant or chemical plant, toxic waste site, or, as fire-ravaged western states have learned in recent years, a forest or grassland in a dry climate.

In mountainous or very rural areas, roads blocked by flood or avalanche may prevent supplies and emergency vehicles from getting to or from a surgery center. Agricultural areas, already ill-served by health care facilities, face disasters from hazardous materials spills on the farm or in transportation accidents.

In the third step, planners take the list of possible emergencies and prioritize them. In the deep South, “snowstorm” might be at the bottom, while in Minnesota “blizzard” might top the list.

Participating in community response

The fourth step is to decide to what extent the ASC wishes to participate in the community response plan. By “community,” the Joint Commission means the city, county, state, or even region where the ASC is located and that has its own response plan.

That decision will determine the details of the ASC’s own plan: Will it accept overflow patients from nearby hospitals? Will it be a decontamination or quarantine site? Will it close and let the staff don first responder badges and report to the actual disaster site? Will it provide blankets and bandages to community shelters?

In working with community officials, the ASC must communicate its own capabilities and needs. The general public is not aware of the limits of health care providers, Gervais notes.

“Citizens have an expectation that if there are desperately injured or ill, they will simply report to the nearest hospital,” he says. “Anyone who works at a hospital or an ASC understands what their capabilities are. But communities don’t. There’s a disconnect.”

Lessons from Katrina

Gervais saw the problem firsthand when he made the first of many trips to the region devastated by Hurricane Katrina. “People were trapped in buildings, including hospitals.” Evacuees later were sent to shelters in other states, and some have never returned.

“It impacted the whole country,” he says. “It was our first test of a nationwide response.”

As it turned out, no amount of planning would have covered all contingencies, he says, because there were so many unexpected events.

In New Orleans, the city was prepared for the hurricane itself but not for the breach of levees or the breakdown of law and order.

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with police and firefighters unable to respond effectively.

“It was total anarchy,” he says. “There was no 911. Many things happened there that were not anticipated. The Joint Commission calls it a catastrophe, defined as an event that immobilizes a whole community. We spent 2½ years de-briefing, and the lessons we learned are already in the 2008 standards.”

Among those lessons is the importance of having emergency power available. In New Orleans, hospitals with backup generators on the first floor lost them immediately when flooding occurred. That meant no air conditioning in temperatures up to 110°F.

Without functioning water and sewer systems, sanitation became a problem.

Another lesson was the vulnerability of the supply chain. Most hospitals use just-in-time delivery, with 90% of supplies delivered by truck. Supplies had to be brought in by helicopter, a very expensive alternative.

“Emergency management in health care must be an all-hazards approach,” Gervais says.

**Designing the plan**

According to the Joint Commission standard, which is based on best practices developed in other industries and organizations, ASC plans should address the following areas:

- communications
- resources and assets
- safety and security
- staff responsibilities
- utilities
- patient care.

A good plan, according to the standard, will be “scalable” so that, for example, a communication network that works for a minor emergency will also perform in a major disaster. In addition, the components of the plan should be generic enough to apply in any type of emergency. The Joint Commission calls this the “all hazards” approach.

“Although emergencies have many causes,” it states, “the effects on these areas of the organization and the required response effort may be similar.”

Karen Ketchie, RN, PMD, uses the all hazards approach when helping clients design emergency plans. She is president of Disaster Management Consultants, Jacksonville, Florida, and team commander of a state medical response team and of a Florida-based unit of the National Disaster Medical System (DMAT).

“There are certain elements that you do no matter what kind of event it is,” Ketchie says. “An example is a flood. It would affect staffing and utilities. Look at the big picture.”

While the standard contains detailed criteria for each of the standards (backup utilities, for example) it devotes the most space to staff responsibilities.

In emergency mode, staff may be assigned responsibilities that have nothing to do with their job titles. The office manager could be assigned to escort patients.

**A role for volunteers**

The issue of volunteers becomes critical for a health care facility because any volunteer giving patient care must have appropriate credentials. In the confusion of an emergency, determining who may legally perform what services can be difficult. The standard encourages use of precredentialing through agencies such as the Emergency System for Advance Registration of Volunteer Health Professionals, a division of the Health Resources and Services Administration, and the Medical Reserve Corps.

Volunteers whose credentials are not proven can be used if their services are considered critical, but the ASC must perform detailed checks, including performance supervision and evaluation, and document their efforts to be sure patients are treated only by qualified caregivers.

Once on the job, staff and volunteers should be easily identified by color-coded hats, wristbands, badges, or similar means.

Ketchie says ASC staff not needed on site would be good candidates to serve on emergency response or DMAT teams. “During planning, they should encourage staff to register in one of the programs that would precredential them.”

For ASCs that opt to stay open in an emergency, the Joint Commission standard calls for including in the plan a procedure for re-
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stocking medications and other patient supplies. It also calls for establishing backup communications in case normal methods, such as cell phones and fax machines, are not operable.

As part of their responsibility to maintain safety and security, ASCs need to outline specific responses to chemical and biological emergencies. A separate Joint Commission standard identifies criteria for dealing with outbreaks of infectious diseases.

**Writing the plan**

Ketchie advises using spreadsheet software such as Microsoft Excel for drafting the plan.

“The standards tell you every critical element they’re looking for. List the standards and what it takes to be in full compliance. Use it as a checklist.”

In separate columns, she says, planners should indicate for each standard whether the ASC is already in compliance and if not, who is responsible for compliance. “That way, everybody is on the same page—literally.”

Whoever will be responsible for approving the plan, such as the CEO, should take part in writing it, with input from nursing and all other departments, she adds.

An ASC looking for a model plan to copy will not get one from the Joint Commission.

“We don’t give out plans per se,” Gervais says. “Look at the services you give and decide what you want to continue if there is a disaster. Planning and analysis are most important. The key to success is planning, planning, planning.”

—Paula DeJohn
Paula DeJohn is a freelance writer in Denver.
At a Glance

**S aureus infection risks after cardiac surgery**

In an 8-center study, 205 (1.3%) of 16,386 patients developed a *Staphylococcus aureus* infection after elective cardiac surgery. Preoperative risk factors identified for bacteremia or chest wound infection were:

- body mass index >40
- chronic renal failure
- chronic lung disease.

But the majority of patients who developed infection did not have any risk factors. Only 8 patients had all 3 risk factors. The authors say prevention should not be restricted to a group of patients but should address the whole patient population.


**Eliminating preop testing does not affect outpatient outcomes**

Eliminating preoperative testing in ambulatory surgery patients does not increase adverse events, according to a new report.

In a randomized study of about 1,000 patients, Canadian researchers found no significant differences between testing and no-testing groups for adverse events within 7 and 30 days after surgery. Hospital revisits within 7 days were higher in the testing group. Cost savings for the no-testing group were US $14,800, or $30.90 per patient.


**Teaching hospitals’ postop mortality lower for whites but not blacks**

Medicare patients having surgery at major teaching hospitals have better survival rates than at nonteaching hospitals. But the better survival rates occur in white patients, not blacks, a study has discovered.

The racial disparity was found not only across different hospitals but for white and black patients in the same hospitals. The study analyzed Medicare claims for 4.6 million patients at 3,270 hospitals. The research relied on Medicare claims data and not detailed medical records that might have shed light on the reasons, the authors say.


**Feds to crack down on surgeons who accept kickbacks**

Within a few months, federal prosecutors plan to file civil and criminal charges against a number of surgeons who they say demanded profitable consulting agreements from device companies in exchange for using their products, the March 3 *New York Times* reported.

If convicted, the surgeons, besides jail time and fines, could lose their licenses for a time and be excluded from Medicare and Medicaid programs. In plea agreements, federal officials have required drug and device makers to post on their websites payments made to physicians who serve as consultants or speakers.

—www.nytimes.com/2009/03/04/health/policy/04doctors.html?_r=2&emc=eta1

**Medicare to cover bariatric surgery for morbidly obese diabetics**

Medicare will now cover bariatric surgery for beneficiaries who have a body mass index (BMI) of 35 or more and type 2 diabetes, according to a Feb 13 decision from the Centers for Medicare and Medicaid Services.

The decision expands Medicare’s coverage of 4 types of bariatric surgery for morbidly obese patients with at least 1 obesity-related comorbidity.

viewdecisionmemo.asp&id=219&