JCAHO answers questions on new surgical site-marking stand

The Joint Commission on Accreditation of Healthcare Organizations revamped its expectations for surgical site marking following a May 9 summit meeting on wrong-site surgery in Chicago.

The invitation-only summit was called because the Joint Commission is concerned that despite two Sentinel Event Alerts, wrong-site surgery continues to happen, with five to ten cases reported to the commission a month.

“Our surveys showed inconsistent implementation of the recommended procedures, not just the site-marking requirement,” says Richard Croteau, MD, JCAHO’s executive director for strategic initiatives. JCAHO thought that achieving consensus among the major professional organizations related to surgery would get better results.

About 60 people attended representing more than 30 professional organizations, including among others the American College of Surgeons, the Association of periOperative Registered Nurses, and the American Society of Anesthesiologists.

The site-marking requirements took effect in January as part of the JCAHO’s National Patient Safety Goal 4, which is intended to eliminate wrong-site, wrong-patient, and wrong-procedure surgery.

In more than 600 announced sur-

Strategies for involving physicians in a product conversion project

Most ORs have wrung costs out of commodity supplies through group purchasing. The next level of savings must come from physician preference items such as orthopedics, endomechanicals, and even suture.

Aligning the hospital’s incentives with physicians is a challenge. ORs are caught between physicians who may have strong product preferences and hospital CFOs who pay the bills.

In a recent study, VHA Inc, the health care alliance, canvassed its members to learn the most successful strategies for involving physicians in cost management. Surgical services leaders at St Cloud Hospital, part of central Minnesota’s CentraCare system have put the strategies to work as they engaged surgeons in cost-saving projects on orthopedic soft goods, urologic supplies, and an arduous conversion of endomechanicals. The endomechanical project yielded about $300,000 in savings for the 18-OR department, which performs about 13,000 procedures a year.

The six success factors include:

1. Make a compelling case for change.

Quality gurus call this the “burning platform”—a situation where not taking a risk could lead to certain death or

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Please see the ad for MEDLINE INDUSTRIES in the *OR Manager* print version.
Meeting staffing challenges

Is your OR suffering from “gaposis”—surgeons want to operate late in the day but staff want to go home? What strategies can help?

How to improve retention

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

Growing role of specialty coordinators

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

A

re OR charges at some hospitals too high? You would think so if you’ve read the papers in recent weeks.

The California Nurses Association, a union, and a related policy institute issued a report in May highlighting “the 100 most expensive ORs.”

CNA compiled the data from Medicare cost reports for 4,500 hospitals for 1999 to 2000, the most recent data available.

Investor-owned hospitals and large hospital systems led the list. For-profit hospitals accounted for 61 of the top 100 most expensive ORs, with 44 owned by the two largest investor-owned systems, Tenet and HCA. Multi-hospital systems made up 79 of the top 100.

The average overall OR markup was 220%. For the top ten, OR charges were far higher—from 818% to 1,020%. Number one was Tempe St Lukes Hospital of Tempe, Ariz, owned by Iasis Healthcare.

Why single out ORs?

CNA spokesman Charles Idelson told us this is the third study the union has done on hospital pricing. “Part of what attracted us to do this is that we have identified major areas that generate more revenue and greater profits,” he said.

The findings may come as a surprise to OR directors, who mainly hear about the losses their hospitals incur from payers.

Are charges even relevant, we asked Idelson. Most payments to hospitals are fixed by government programs or discounted fees negotiated with private payers. The report did not examine hospitals’ margins on OR services or discuss the fact that margins on some services are used to subsidize others that are money losers.

Idelson said charges are relevant because they become the asking price in contract negotiations, like the list price for a car. Charges also are factored into the formula for determining outlier payments and can drive those payments upward. CNA maintains that for these reasons OR charges help fuel health care inflation.

More to the story

It’s important to know what is going on behind the scenes. The study is about more than health care economics. It is partly an ideological dispute about for-profit and market-driven health care. It’s also about union politics.

CNA officials are upfront in saying they favor a national health care system based on a single-payer model. They oppose the current market-driven approach, believing “it has failed,” according to Idelson.

Also, CNA has long been a foe of Tenet. The animosity escalated recently when Tenet formed an alliance with CNA’s rival, the Service Employees International Union.

CNA tells RNs the alliance is Tenet’s scheme to “force you to join a non-RN union.” CNA says Tenet is seeking to replace RNs with LVNs (who could fill slots as “professional nurses” when California’s mandatory staffing ratios go into effect next year.)

As a union, CNA’s primary audience is the staff nurses in California they seek to organize. If the union can convince nurses that hospitals are making large profits—even though the report doesn’t address that issue—nurses might decide they need a union to help them get better pay.

It’s hard to know whom to favor in this battle. CNA, known for its militancy, has few admirers among managers in California. And Tenet and HCA don’t exactly have unblemished records for financial dealings. Tenet is under federal scrutiny to find whether its outlier payments were excessive. Tenet more than doubled its outlier payments in 2 years by raising its gross charges.

Knowing the background may help put the study in context.

Managers in California say nurses mainly are just confused.

—Pat Patterson

The report is on CNA’s web site at www.calnurse.org
Please see the ad for
KIMBERLY-CLARK CORPORATION
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An engaging look at health care’s big questions

Will technology costs keep outpacing reimbursement? How can we continue to provide devices like the life-extending $25,000 internal defibrillator that the public clamors for but doesn’t want to foot the bill for?

Are we doomed to a health care system of “boutiques” for the wealthy and Wal-Mart (or a bankrupt K-Mart) for the poor and middle class? Will the Baby Boomers stand for a two-tier health care system? Will they be willing to pay the freight after decades of a seemingly free ride? Or will they vote to pay the freight after decades of a health care system? Will they be willing to support a massive surge of retirees. That’s the view of Paul Solman, business and economics correspondent for the NewsHour with Jim Lehrer.

How successful your surgical services department is in the years to come depends heavily, he believes, on the answers.

Solman will explore some of health care’s big questions at the Managing Today’s OR Suite conference Sept 17 to 19 in San Diego. His special lecture, Making Health Care Economics Almost Riveting, on Thursday, Sept 18, followed by a reception, is sponsored by Cardinal Health, Medical Products and Services.

Solman, who has been with the NewsHour since 1985, has been demystifying money matters (and other subjects) for 25 years. His varied career— including being a taxi driver, management consultant, and kindergarten teacher as well as a journalist—gives him the perspective to take a sober subject like health care economics and make it comprehensible and fun.

He’s used all kinds of devices to engage his audience—like a “magic wand” and disappearing dollars to teach the tricks of Enron’s “accounting alchemy.” He developed “The Hostile Takeover Game” while teaching at the Harvard Business School’s Advanced Management Program.

Solman’s work has been recognized with a Peabody award and several Emmys, most recently for his reporting on Microsoft. He is coauthor of the book, Life and Death on the Corporate Battlefield.

Solman likes to participate with his audience as much as possible. As he does before many of his lectures, he plans to meet with a group of OR directors to hear about issues they face.

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**Bigger conference has more offerings**

This year’s Managing Today’s OR Suite Conference will be bigger and better than ever with more offerings:

- Eight all-day seminars will be held on Wednesday, Sept 18.
- Tracks are provided for ambulatory surgery and materials management.
- A total of 32 breakout sessions are offered, with some being repeated. A few of the breakout topics are: Reducing Costs for Lumbar Fusion, Bariatric Surgery: Outcomes and Return on Investment, and the Road to Safe Surgery.

For a conference brochure or to register visit www.ormanager.com or phone 800/442-9918.
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surveys conducted between Jan 1 and March 30, surveyors found 8% of hospitals were not in compliance.

Immediately after the summit, JCAHO announced it was revising scoring for surgical site marking based on consensus reached at the meeting. In addition, JCAHO said it will work toward a “universal protocol” for surgical site verification. The first draft was sent to meeting participants for review in late May. The draft will be posted on JCAHO’s website, probably in mid-June, with plans to have a final draft approved by JCAHO’s board of commissioners in July. The protocol would most likely take effect in July 2004.

OR Manager talked to Dr Croteau, a general surgeon by background, for an update on the changes and answers to specific questions about what JCAHO expects.

Q. What changes did JCAHO make in its surgical site-marking requirements as a result of the summit?

Dr Croteau. Based on what seemed to be clear consensus at the summit, we have modified the survey process for the recommendation in Goal 4 to “implement a process to mark the surgical site, and involve the patient in the process.” Under the modifications, organizations still will be required to mark the surgical site in cases involving:

• right-left distinction
• multiple structures (such as fingers or toes)
• levels (such as the spine).

This requirement will continue to be scored. However, JCAHO will no longer require marking the site for other types of procedures, including midline sternotomies for open-heart surgery, cesarean sections, laparotomy and laparoscopy, and interventional procedures for which the insertion site is not predetermined, such as cardiac catheterizations.

If your organization is not marking the site in these cases, it will not be scored noncompliant with the surgical site-marking recommendation as long as you are consistently marking the sites involving right-left distinction, multiple structures, or levels.

We would add that it is not wrong to continue to mark all sites, but we will only survey for compliance with site marking as stated above.

It is also important to note that the other components of the Patient Safety Goal for surgical site verification remain in place. These include:

• having a process for preoperative verification
• conducting a time-out in the OR before the procedure begins.

Q. Is there also a change in the requirement for marking of teeth?

Dr Croteau. Yes. The Joint Commission supports the position of the American Dental Association (ADA) that dental procedures should be exempt from the site-marking requirement. This position is based on the realization that there is no reliable way to mark teeth directly. This also was the consensus at the summit.

A caution: We want to be clear that we have not abandoned the requirement for verifying teeth to be extracted or treated. In lieu of directly marking teeth, the JCAHO and ADA recommend these steps:

• Review the dental record and indicate the numbers of teeth to be treated or mark the teeth on the dental radiograph or dental diagram in the patient’s record.
• Ensure the radiographs are properly oriented and visually confirm that the correct teeth or tissues have been charted.
• Conduct a “time-out” to verify the patient, tooth, and procedure.

Q. Regarding surgical site verification, JCAHO has been emphasizing two principles: standardization and redundancy. You said previously that marking of all sites was needed because the surgical site needs to be verified in more than one way. Now JCAHO is allowing for more exceptions.

JCAHO’s site-marking “no nos”

Marking the surgical site “No” or using a band to indicate the side to be operated on are not acceptable ways to meet the surgical site-marking requirement, the Joint Commission on Accreditation of Healthcare Organizations said May 28.

The two methods were proposed alternatives for meeting the site-marking requirement in the National Patient Safety Goal for eliminating wrong-site surgery. But JCAHO found these methods were not appropriate.

Marking “No” is not acceptable because wrong surgery is not just a “lateral confusion” issue, JCAHO says. Surgical site verification is a process that also includes identifying the right patient and right procedure.

Also not acceptable is placing a band on the patient’s extremity to identify the side of the body to be operated on. Some organizations place a surgical site band, which is removed by the circulating nurse only after verification is complete.

Among the reasons for rejecting this alternative was that, again, site marking is intended not only to identify the right side but the right patient. Also, marking is meant to tell the surgeon not just if he is in the right place but to tell others they are in the wrong place. Some organizations accomplish this with a policy of “no mark, no surgery.” In other words, if the team sees no mark on the site, they call a halt until the site and patient are verified. JCAHO was also concerned that using a band would exclude the surgeon from the site verification process. Also, the band might have an error or might not be seen.
Please see the ad for
KARL STORZ ENDOSCOPY-AMERICA
in the OR Manager print version.
## Time-out tip

OR staff of the Nebraska Health System, Omaha, found a simple way to remind surgical teams to do a “time-out” in the OR before a case to confirm the correct patient, procedure, and surgical site.

“The staff came up with a great and inexpensive idea,” says Joyce Soule, RN, manager of surgical services.

Here’s the process:

- The words Time-Out are printed in large letters (24 pt) on bright yellow paper. This is printed about 16 times on one side of the paper and cut in strips 4 inches by 1 1/2 inches.
- A yellow strip is placed in every instrument set that has a knife handle in it. The strips are sterilized in the set with the count sheet.
- When setting up for the case, the scrub nurse lays the yellow strip over or beside the knife on the Mayo tray. This reminds everyone at the field to call time-out before the surgeon is handed the knife.
- Any team member can call the time-out. It doesn’t have to be the circulating nurse. But the circulating nurse is responsible for documenting that the time-out is done.

“It has been working great,” says Soule. Just seeing the bright yellow paper is enough to make the team stop for the time-out. She believes the yellow strips will only be needed for a few months until everyone is used to the new practice.

—Judith M. Mathias, RN, MA

### We recognize that this is a controversial area.

This was seen as a significant barrier to the overall objective of eliminating wrong-site, wrong-procedure, and wrong-patient surgery. Rather than sacrifice the greater goal, the decision was made and supported at the summit to limit the requirements for marking.

**Q.** In view of the changes, how does the Joint Commission recommend marking right-side, possible left-side procedures (e.g., hernias)?

**Dr Croteau.** We don’t have a specific requirement. Methods that have been used are to mark the sites 1 and 2 or to mark “start here.”

**Q.** How do the changes affect the previous exemption of marking for natural body orifices? For example, what should be done about marking the ear, which could be considered a natural body orifice yet has a right/left distinction?

**Dr Croteau.** With the changes, most issues regarding natural body orifices become irrelevant. Regarding ears, we haven’t taken an official position, but it is certainly reasonable to consider marking the external ear when a procedure is to be done in the ear canal, such as insertion of a tympanostomy tube. We have had cases of kids who were scheduled for tubes who had a tonsillectomy instead because the wrong patient was operated on.

**Q.** Would you please clarify if there is an exemption for genitalia? What about procedures involving one testicle? Shouldn’t these be marked?

**Dr Croteau.** Genitalia are excluded from the site-marking requirement. But that doesn’t mean an organization can’t have its own policy for marking a site in a particular situation. When an organization develops a policy, however, it should be implemented consistently throughout the organization. If the policy is not consistent, it is confusing for the staff and overlooks the importance of the team function.

**Q.** What is the definition of an invasive procedure that occurs outside of the OR? Saying procedures that are of “more than minimal risk” is too vague and does not provide needed guidance to hospitals.

**Dr Croteau.** The 2003 Comprehensive Accreditation Manual for Hospitals has a definition for “invasive procedure”: “Any procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.”

We have explicitly stated that venipuncture, routine peripheral IVs, NG tubes, and Foley catheter insertions do not require site marking. But most other procedures will be marked.

We have posted a statement on our web site, however, saying there will be an exemption to site marking for procedures, such as those performed at the bedside, where the practitioner is in continuous attendance from the time the decision is made to perform the procedure through the consent process until the procedure is performed. But if the practitioner leaves at any time, such as when the nurse is setting up for the procedure, the site must be marked. An example is insertion of a chest tube for a pneumothorax. We have several cases in our database where the practitioner left for a time, and the chest tube was inserted on the wrong side. That’s a life-threatening situation.

**Q.** How, specifically, does the JCAHO want marking of the site to be done?

**Dr Croteau.** Our two expectations are:

- The patient will participate whenever possible. This doesn’t mean the patient must do the actual marking but that the patient is involved in knowing where, why, and what surgery will be done.
- The mark will be visible in the OR after the patient is prepped and draped.

Continued from page 7

Would you please explain this change in position?

**Dr Croteau.** The reasons for marking the site remain valid. They include not only identifying the site but identifying the patient as well. However, we recognize that this is a controversial area. There has been significant pushback from practitioners who disagree with the value of marking all sites, specifically those that do not involve a right-left distinction or multiple structures or levels.

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Specialty hospitals’ patients not as sick, says government report

Specialty hospitals tend to treat patients who aren’t as sick as patients with the same diagnosis treated by general hospitals, according to a preliminary report by the General Accounting Office (GAO) released in April.

The GAO identified 92 hospitals that focus on cardiac, orthopedic, surgical, or women’s care, less than 2% of all acute-care hospitals nationwide. Another 20 are under development.

In an in-depth examination of 25 specialty hospitals, the GAO found 21 treated lower proportions of severely ill patients than general hospitals in their areas. For example, at an urban cardiac hospital in Arizona, about 17% of patients with the most common diagnoses were severely ill compared with 22% at general hospitals in the same area. For the other 4 specialty hospitals, patients were just as sick or sicker than those at general hospitals.

In all four types of specialty hospitals in the study—cardiac, orthopedic, surgical, and women’s—the median percentage of severely ill patients was lower than that for hospitals, according to the GAO.

Specialty hospitals, which have tripled in number since 1990, provide care in niches such as cardiovascular and orthopedic care. The GAO defined specialty hospitals as those having two thirds or more of their inpatient claims—cardiac, orthopedic, surgical, and women’s—the median percentage of severely ill patients was lower than that for hospitals, according to the GAO.

Surgical hospitals groups also criticized the GAO report for using too small a sample.

The GAO is planning a comprehensive report for later this year.

The American Hospital Association (AHA) said the GAO report “illustrates the negative impact” niche providers could have on access to care.

AHA is calling for regulators to close what it calls a loophole in the Stark law that allows physicians to invest in niche hospitals. AHA also wants requirements for physicians to disclose their ownership interests, for specialty hospitals to have transfer agreements if they don’t have full-time ERs, and for specialty hospitals to have the same quality standards that are applied to other hospitals.

Meanwhile, the Centers for Medicare and Medicaid Services’s regulatory agenda for this year, issued May 27, includes plans to propose a rule to further limit physician referrals to entities like specialty hospitals in which they have an ownership interest.

The GAO’s report is at www.gao.gov

OR Manager’s Toolbox

Check our web site for practical help on personnel evaluation, codes of conduct, and patient assessment. Go to www.ormanager.com. Look under The OR Manager’s Toolbox.
some other dire outcome.

The burning platform might be the hospital’s survival, even the threat of bankruptcy.

For CentraCare, the burning platform was the ability to invest in new technology and maintain its presence in that part of the state.

“The message we sent was that if we have a decent margin, we will be able to invest in more new technology. If physicians want us to be able to afford new technology, they need to work with us on costs,” says Beth Honkomp, RN, MS, MBA, CNAA, director of St Cloud’s Care Center for Surgical and Special Care Services.

The message needs to be delivered—and repeated—to everyone in the organization. At CentraCare, the message was delivered by a physician who understood the hospital’s situation. The message seems to have gotten through, at least for some.

“We now hear physicians in meetings saying they need to be careful about spending because they want money left over for a new procedure, and they want the hospital to remain viable,” says Honkomp, adding, “You have to explain, show documentation, and discuss the cost differences. It isn’t easy when there are strong preferences.”

2. Bring data.

Dedicate enough resources to gather, analyze, and communicate information about the hospital’s financial situation, VHA advises.

St Cloud’s leaders spent a great deal of time analyzing surgeons’ current end mechanical usage to determine specifically which devices they would be able to convert and which they could not.

“We had to be convinced that the cost savings the vendor projected could actually be achieved and would be worth the effort to make the conversion,” Honkomp says.

The hospital’s team charge leader for general, vascular, and thoracic surgery, Dianne Schendzielos, RN, CNOR, acted as the point person for the project, working closely with a supply chain consultant from Novation, VHA’s supply arm. Together they performed an item-to-item match to see if each device had an equivalent from the vendor that would perform exactly the same tasks for each of the procedures. Schendzielos reviewed each device’s product insert to determine if there was a match. They then determined what percentage of devices could be converted.

Three important lessons from this effort:

• They needed to keep the number of nonconverted devices as low as possible to up compliance with the Novation contract.
• They would have to pay list price for any products they could not convert, which could sharply cut into the cost savings.
• It was important to perform their own cost analysis rather than just accept the vendor’s data.

3. Senior management is involved.

Administrators can act as facilitators, negotiators, communicators, and monitors, VHA notes. They provide data, resources, and support. They help set the tone and coordinate relationships with physicians and suppliers. They recruit key physicians for cost management projects, work to keep suppliers from sabotaging the effort, and stay visible. They are prepared to handle any physicians who may attempt to subvert the initiative.

St Cloud set the tone by calling a meeting where VHA officials presented the plan for the supply chain initiative. Attending were CentraCare’s and St Cloud’s presidents, the vice president for medical affairs, and other physicians, including James Lundeen, MD.

Participants realized that when certain physicians left, costs per case would go down because often these physicians were less cost-effective than their peers. If physicians do leave, they’re likely to find any other organization they join faces similar cost challenges.

Myth: A large commitment of resources is needed for success.

Many organizations participating in the study were successful with no additional resources.

Source: VHA. Engaging Physicians in Supply Cost Reduction.
4. Involve physicians.

Engage physicians in all phases of the cost reduction effort—from serving on product selection committees to communicating with peers. Consider their perspective in planning each component, especially data, VHA advises.

A key step in St Cloud’s conversion was to set criteria for acceptance of the new devices and have the surgeons sign off on it. (Examples of the criteria are in the sidebar.)

“We shared the criteria at clinical department meetings. General surgery was the hardest hit, so we talked closely with them,” says Schendzielos. Every surgeon who uses endomechanicals had an opportunity to review the criteria and provide feedback. That tactic increased ownership of the criteria and made it difficult for a surgeon to say the conversion was affecting quality of care.

“The comment, ‘I just can’t use this,’ wasn’t good enough,” Honkomp adds. When the team heard that comment, they asked a sales person to meet with the surgeon to find out if the issue was the learning curve or the product itself.

The vendor also was required to sign off on the criteria to acknowledge that products that truly did not meet the criteria would be exempt from the contract.

Another important strategy—providing the surgeons with strong staff support. Thirteen staff members were identified by specialty teams to receive intensive training on the new devices. They in turn trained the other staff and served as resources to the surgeons and staff.

“This was a key step,” Honkomp says. “We asked these 13 to give 100% to learning the new products so they could teach others. That’s so important because the physicians count on the staff in the rooms to troubleshoot.” The 13 met one on one with the sales reps until they felt comfortable teaching the rest of their teams.

- **Criteria: Conventional surgical products**

Examples of criteria St Cloud Hospital used in its endomechanical conversion:

**Circular staplers**
- Must provide leak-proof anastomosis
- Should provide adequate lumen size
- Must provide adequate hemostasis
- Must be able to be removed easily
- Should provide controlled tissue compression to accommodate varying tissue thicknesses
- Tissue margin at staple line should ensure integrity of anastomosis.

**Ligation clip appliers**
- Must securely seal vessels
- Applier must load clip easily without dropping or damaging clip.
- Premium clips should close from distal to proximal.

**Linear cutters (GIA)**
- Forks must close parallel for consistent staple formation.
- Must provide leak-proof staple line
- Cartridges must incorporate safety lockout so inadvertent refiring of cartridge is not possible.
- Staple line must exceed cut line to adequately achieve hemostasis.
- Knife blade must meet standard criteria for blade replacement, ie, replace when blade has cut through a staple line, replace when blade has cut through tumor tissue, replace when blade could cause cross-contamination (bowel to clean tissue).

**Linear staplers (TA)**
- Should provide parallel jaw closure for consistent staple formation
- Should provide automatic and manual placement of the tissue retaining pin
- Should provide adequate hemostasis
- Must provide leak-proof staple line
- Must be able to be used on vascular tissue
- Should be adequately sized to provide manipulation, control, and exposure

**Roticulators** (Universal GIA instrument)
- Should roticate at handle-head junction
- Should be adequately sized to provide manipulation, control, and exposure
- Should provide parallel jaw closure for consistent staple formation
- Should provide automatic and manual placement of the tissue-retaining pin
- Should provide adequate hemostasis
- Must provide leak-proof staple line

**Skin staplers**
- Should be ergonomic to accommodate smaller hands
- Should permit easy firing and release
- Should allow good visibility of staple placement
- Postfire, should result in good skin approximation
Tips for a successful conversion

Tactics that helped St Cloud achieve its endomechanical conversion:

- leadership by team charge nurses who have close relationships with surgeons
- phased rollout of the conversion
- an item-by-item comparison of devices from the former and current vendors
- specific acceptance criteria agreed upon by surgeons and the vendor
- demonstrated backing from senior management
- intensive training of key staff to support surgeons and teach others
- sales personnel on hand daily for the first month and regularly thereafter.

Other steps that helped set the stage:

- Rolling out the conversion in phases:
  - easy to convert
  - more difficult to convert
- Starting with devices that were easy to convert so the project could score a success before moving on to the more difficult products
- Making the products available, along with sales personnel, daily for 3 weeks before each phase of the conversion so the surgeons and staff could become familiar with the new devices
- Maintaining a close relationship between the OR buyer, supply assistants, and sales reps so all knew the status of the project
- Going “cold turkey” by removing all products to be converted on the first day of each phase.

5. Involve suppliers.

Consider the needs and motivations of suppliers and how they can contribute to the effort. Suppliers can provide data, help highlight opportunities for change, and provide product demonstrations.

At St Cloud, sales personnel were closely involved in the conversion, providing support for the surgeons and training for the staff. They were on hand daily for the first month or so after the new products were introduced and continue to meet with the surgeons when issues arise.


Consider incentives that will motivate all three parties—hospital, physicians, and suppliers, VHA recommends. Physicians often ask, “What’s in it for me?” Some hospitals have developed incentive plans to share the savings.

At St Cloud, the incentive was for the hospital to be able to afford new technology, but the hospital is considering financial incentives for the future.

Says Sandy Schmitt, VHA’s vice president for consulting services, “Physician incentives are more the exception, but our consultants say organizations are interested in exploring this option.” To be legal, incentives must be structured in a way that is not considered an inducement to referrals and is not tied to individual physicians’ compensation. Two common ways of doing this:

- Share 50% of the savings identified in a cost management project with a surgical department to use for capital equipment or FTEs.
- If the hospital projects saving a certain amount, say $500,000, through switching to an alternative product, and the physicians aren’t interested, they are expected to find equivalent savings elsewhere. (An article on creating physician incentive plans was in the June 2002 OR Manager, pp 20 and 22.)

For suppliers, the motivation might be a higher committed volume of products.

Many organizations are introducing stricter vendor relations policies as part of their cost management initiatives.

“Not only are they excluding them from participating in the contract, they’re excluding the company from doing any business with the facility,” Schmitt says.

To these six strategies, Honkomp adds her own: commitment, compromise, and persistence.

“You can’t just draw a line in the sand. It takes commitment on both sides and a lot of give and take.”

Bioterrorism: What you should know

If there were a bioterrorism attack in your community, would your hospital and your OR be ready?

Two expert speakers at the Managing Today’s OR Suite conference Sept 17 to 19 in San Diego will help provide basic knowledge ORs need to prepare for such an event.

Speaking at a special luncheon Friday, Sept 19, sponsored by Advanced Sterilization Projects (ASP), Irvine, Calif, are:

- Martin Favero, PhD, director of scientific and clinical affairs for ASP
- Cynthia Spry, RN, MS, MSN, CNOR, international clinical consultant for ASP

Favero, a former director of the Centers for Disease Control and Prevention’s Hospital Infections Program, will talk about the organisms that could be used in a bioterror attack and their consequences. Favero was honored in June as the first recipient of the Martin S. Favero Lectureship Award by the Association for Professionals in Infection Control and Epidemiology.

Spry will discuss the impact of bioterrorism on the OR and the steps ORs can take to prepare.

A conference brochure is available at www.ormanager. You may register online or phone 800/442-9918.
Total knee replacements with a 63-minute procedure time, 20-minute turnover time, and two OR staff per case.

With these results, Saint Thomas Hospital, part of Akron, Ohio’s Summa Health System, stood out as a best performer in a recent study by OR Benchmarks, a service of OR Manager, Inc. In the study, 18 facilities measured their performance on a total of 74 total knee cases.

Strong teamwork, good rapport among physicians and nurses, and a specialized staff contribute to the good performance, notes Ken Peters, RN, the orthopedic coordinator. With eight rooms, the department is small enough to be cohesive. Summa has about 12 surgeons who perform a total of 825 total knee replacements annually. The hospital’s total surgical volume is 6,500 cases a year.

“We have the advantage of being specialized in orthopedics,” he says. Everyone on the staff knows how to perform all of the procedures the department does, which provides for flexibility in staffing.

The department also has a veteran staff.

“Almost no one leaves,” says Peters. “We’ve had almost the same team for 10 years. Some of those who’ve left have asked to come back.”

Peters and the OR manager, Joyce Berardi, RN, are both hands-on managers.

“If you aren’t spending time in the rooms, you get isolated,” Peters says.

Saving on supply costs

With a total supply cost of $3,348 including the knee implant, Saint Thomas’s supply costs were below the study’s median of $3,843. The hospital’s prosthesis costs ranged from $2,628 to $3,045, compared with the study’s median of $2,917.

Saint Thomas doesn’t limit the number of implant vendors because several of the surgeons develop technology for different companies.

“We don’t cut anyone out,” says Peters. “But we do hammer on the cost. The vendors compete because we’re a big orthopedic program, and they want the business.”

Though the hospital doesn’t adhere to a rigid demand-matching protocol, surgeons select prostheses to match the patient’s health status and activity level.

“We want to put in what the patient needs, but not more,” he says. Neither does the hospital impose a ceiling price by type of implant, as some institutions have done. But Berardi tracks costs closely, and vendors are expected to keep prices at about the same level for types of prostheses.

“If we’re buying a certain type of knee implant for $2,600, we don’t expect them to come in at $2,800 or $2,900,” he says. “That approach works pretty well.”

For a number of years, the department has compared physicians’ cost profiles, under the leadership of the section chief, J. Patrick Flanagan, MD. If one doctor’s costs are higher than others’ for the same procedure, Dr Flanagan subtly goes to the physician and says, “We need to get the cost to this level.” Doctors do a good job of policing themselves, Peters notes.

The staff have done a good job of keeping custom packs lean, he adds. “They’ll let us know if we have an extra drape sheet or towels.”

On other supplies, Saint Thomas’s cost for saw blades is below the study’s median of $37.31, again because of the hospital’s volume. Surgical teams don’t wear environmental “space suits,” which eliminates another cost. Instead, they wear personal protective equipment recommended for such cases, including boots, face shields, and high-filtration masks. In the study, space suits were worn in 40% of the cases, with a median cost per case of $140.70.

Procedure time fast

With a procedure time of 63 minutes, Saint Thomas was the best performer in the total knee replacement study where the median procedure time was 94 minutes. The fast procedure time contributed to a low labor cost.

A smooth machine

Saint Thomas keeps labor costs low at $183 by limiting staff: one surgical technologist (ST) and one RN or two RNs per case. In the study, labor costs ranged as high as $803 with a median of $395.

Some physicians at Saint Thomas use a resident to assist; others rely on the two OR staff members. A couple of physicians have their own physician’s assistants.

One well-oiled team helps set the tone. The surgeon performs the cases...
**OR efficiency**

with his private scrub person, along with the RN circulator.

“It’s just the two of them. They’re a smooth machine. That puts pressure on the others,” Peters observes.

Instead of having a staff member to hold the leg, surgeons have become adept at using positioning devices and sandbags. Though some surgeons request an assistant, “we try to accommodate them when we can, but the general expectation is they don’t need an extra person,” he says.

To keep the busy schedule from becoming too taxing, Peters and Berardi make sure the staff get breaks and lunches, usually providing the relief themselves. Not only does this keep the staffing numbers down, but it keeps the managers in touch with the surgeons and staff.

**Tackling turnover time**

Saint Thomas was the best performer in setup time, cleanup time, and overall turnover time. OR Benchmarks, because it is measuring the costs associated with a specific procedure, defines turnover time as the setup and cleanup time associated with a specific procedure.

Saint Thomas had the fastest setup time at 14 minutes, the fastest cleanup time at 6 minutes, and the fastest turnover time at 20 minutes. The median turnover time for the study was 55 minutes.

Though staffing is lean, the scrub and circulator stay in the room at the end of the case to help with cleanup. They are aided by two support staff.

“If you have four people working together, it really speeds things up,” Peters notes. “You can’t have people leaving the room at the end of the case. Then you get friction.”

For turnover time to be efficient, he adds, all members of the team need to collaborate. “You also need the surgeon to get back to the room, the residents who will help with positioning, and anesthesiologists who know how to work with our turnover time.” Berardi may grab a mop. Peters often steps in to a room to set up for the next case.

“If something needs doing, we do it—that’s our philosophy,” he says.

**Workplace**

**Shortages affect financial outlooks**

Staffing is inflating expenses and is one of the biggest uncertainties in assessing credit quality of health care organizations, according to Fitch Inc, a firm that rates credit worthiness of businesses.

Shortages of RNs and other health care personnel are increasingly widespread despite strategies for workforce development and government programs to provide financial support. The problem is, the benefits of these programs may not be realized for years.

Providers will continue to experience growing salary and benefit expenses as well as increased use of temporary staffing. Supply and demand imbalance will worsen as retiring nurses outstrip replacements.

Some hospitals believe special designations will help recruitment. Nearly 70 hospitals in the US and the United Kingdom have achieved magnet status from the American Nurses Credentialing Center. Of these, 12 systems have outstanding bonds ratings by Fitch.

—www.fitchratings.com (look under US Public Finance, then click on Special Reports)

**Two more states allow CRNAs to give anesthesia independently**

Certified registered nurse anesthetists (CRNAs) in Kansas and Colorado can now administer anesthesia without physician supervision. Governors from both states asked state officials to allow nurse anesthetists to practice independently because of a shortage of anesthesiologists in their rural communities.

Six other states have made use of a 2001 rule from the Centers for Medicare and Medicaid Services that allows a governor to notify CMS in writing of the state’s desire to opt out of the supervision requirement for CRNAs, according to the American Association of Nurse Anesthetists.

Opposing anesthesiologists in Colorado sued the state this spring to block the move, arguing that giving CRNAs such autonomy will endanger patients. The case is pending, according to the May 22 Denver Post.

—www.denverpost.com
—www.aana.com

**What would help shortages?**

What’s the number one thing nursing must change to attract more people to the profession? Nurses invited to participate in an online survey gave the following responses:

• Compensation: 28%
• Professional and personal respect: 26%
• Perceptions of the profession: 23%
• Staffing/workload: 19%
• Workplace issues, eg, management: 5%
• Benefits: 3%.

Surveyed RNs selected work schedules, growth opportunities, and commuting distances as the primary reasons for choosing their present employer.

Most RNs quitting left because they feel employees were not valued, typified by such issues as overwork, lack of growth potential, lack of respect, and lack of confidence in management to address such issues.

The survey was conducted by the Bernard Hodes Group and Nursing Spectrum.

—Copies of the survey are available by e-mailing healthcare@hodes.com

**Surgical mortality not affected by type of anesthesia provider, says AANA study**

Patients who receive anesthesia from CRNAs and anesthesiologists working independently are just as safe as those receiving anesthesia from CRNA and anesthesiologist teams, according to findings of a study by Chicago researchers. Examining more than 400,000 cases in 22 states from 1995 to 1997, researchers found surgical death rates were essentially the same whether anesthesiologists, CRNAs, or teams provided the anesthesia. Hospitals where CRNAs were the only anesthesia providers had similar rates to hospitals where anesthesiologists were involved.

The study included only cases with clear documentation of the type of anesthesia provider. The study was funded in part by the American Association of Nurse Anesthetists Foundation.

A PI project to turn around morale

Performance improvement (PI) is an accepted method for addressing a variety of issues in the OR, such as turnover time, case delays, and preoperative chart preparation. Can PI also help with an intangible issue like staff morale?

After surgical services managers at Blake Medical Center in Bradenton, Fla, undertook a PI project with concrete steps to measure and improve morale, staff turnover declined sharply and satisfaction increased.

Before the project began, the OR was losing about 10 of its 63 employees a year, a turnover rate of 16%. In the past year, only 3 employees, or 5%, have left.

Moreover, “the environment in the OR has significantly improved,” says David Grohs, RN, MS, CNOR, Blake’s director of surgical services.

The morale problem came into focus about 3 years ago when Grohs and his team conducted a staff survey. They already knew morale was not the best.

“The productivity was poor, teamwork was weak. It wasn’t the most conducive work environment,” he says candidly.

One item on the survey was a general question about the staff’s interactions with peers.

“After compiling the data, we realized there was an underlying tone that indicated something was going on,” he says.

To gather more details, they conducted a second ten-item survey to zero in on specific staff behavior issues. The staff marked on a five-point scale whether they strongly agreed to strongly disagreed with statements such as:

- My coworkers are cooperative and friendly.
- I feel I can go to the charge nurse with difficulties and get assistance.
- I feel I can go to the OR director with difficulties and get assistance.
- I feel I am treated with respect by my coworkers.
- I like my job.

Survey responses were anonymous, and written comments were invited.

The responses were blunt: The staff was distressed about negative comments by their peers as well as mistreatment of equipment, work avoidance, and staff members who refused to speak to others if they were angry. The staff also was not happy about the way managers were handling the situation.

Though sobering, the results gave the management team more solid information about behaviors that needed to be addressed. Based on the findings, Grohs and his team developed a series of strategies targeted at improving staff interactions and morale.

A surgical services pledge

So everyone would know the standard of behavior that was expected, the department created a surgical services pledge defining professional demeanor.

“Employees have to have someone to go to,” Grohs says. “There were some suspensions and counseling. Employees realized they either had to change or leave. We did have to stick to our commitment.”

An open-door policy

Grohs made sure employees and managers understood they could come to him to discuss issues with staff interaction.

“Employees have to have someone to go to,” Grohs says. His office is off the OR corridor, and he encouraged staff and managers to stop in and made time to listen.
Former employee sues Steris Corp

A former employee of Steris, Larry J. Joslyn, filed suit in Ohio in May against the Steris Corporation and some of its officers. Joslyn alleged he was “wrongfully dismissed” by Steris after “voicing complaints” about the company’s Steris System 1.

A Steris spokesman termed Joslyn’s claims “unsubstantiated” and said the company will vigorously contest the claims.

Joslyn joined the company in 1997 after Steris bought the company he founded, Joslyn Sterilizer Corporation.

In court filings, Joslyn alleges he complained to the company that System 1 products “do not sterilize per label claims.” After raising concerns, Joslyn alleges he was told by company officials not to discuss or raise issues about “liquid sterilization limitations or problems” with System 1. The suit also alleges that “upper management was aware of the problem.”

Joslyn referred questions to his lawyer, Steven Sindell of Cleveland. When Sindell was asked why Joslyn didn’t report his concerns to the Food and Drug Administration (FDA), Sindell said, “It was already in the FDA. It would have been duplicative.”

Joslyn is seeking compensatory and punitive damages as well as fees and costs.

Why OR time shouldn’t be allocated based on surgeons’ utilization

A new study shows why OR time should not be allocated and why OR resources should not be planned based on utilization.

Have you ever had a surgeon who has a low utilization and claims: “I didn’t do anything different? I don’t know why my numbers dropped—it just happened.” Then later they’re busy. It is true that this is purely because of random error.

Many surgical suites allocate operating room block time to individual surgeons. If block time is allocated to services, yet the same surgeon invariably operates on the same weekday, for all practical purposes, block time is being allocated to individual surgeons.

Organizational conflict occurs when a surgeon with a relatively low OR utilization has his or her allocated block time reduced. The researchers studied potential limitations affecting whether a facility can accurately estimate the average block time utilizations of individual surgeons performing low volumes of cases.

The study found neither 3 months nor 1 year of historical data were enough to be able to identify surgeons who had persistently low average OR utilizations. For example, with 3 months of data, the widths of the 95% confidence intervals for average OR utilization exceeded 10% for surgeons who had average raw utilizations of 83% or less. If during a 3-month period, a surgeon’s measured adjusted utilization is 65%, there is a 95% chance that the surgeon’s average adjusted utilization is as low as 38% or as high as 83%. If two surgeons have measured adjusted utilizations of 65% and 80% respectively, there is a 16% chance that they have the same average adjusted utilization.

The point is that average OR utilization cannot be estimated precisely for low-volume surgeons based on 3 months or 1 year of historical OR utilization data. The solution is to allocate OR time based on OR efficiency, which considers not just underutilized OR time but also overutilized OR time. That combination doesn’t have these statistical problems.


Building skills for managers and staff

Grohs got actively involved in coaching both front-line managers and staff on behavior issues. When a staff member came to him with a complaint, he would pull the appropriate manager into a meeting with the staff member, and they would address the issue together.

“We would say, ‘We are not going to condemn you, but we need to see action to correct this.’” The staff’s reaction was positive as they saw situations were being addressed.

Shift bonuses for current staff

With its Florida location, Blake’s caseload is seasonal as it cares for the area’s large population of snowbirds. To help even out staffing, the hospital was willing to pay bonuses to its current staff who would work extra shifts during the busy winter season. Those who agree to work 4 or more additional hours per 2-week pay period between Dec 29 and May 1 receive a $1,500 bonus. Twelve members of the OR staff volunteered for the plan.

“Our staff was able to get the money that travelers or contract employees would have received, and it has improved employee satisfaction,” Grohs says.

Remeasuring staff satisfaction

After implementing the program, managers surveyed the staff again at 3 months and found “vast improvement,” Grohs says. Another survey 3 months later found improvement had continued. Though physician satisfaction hasn’t been measured directly, comments from surgeons indicate they also have noticed the difference. That, in addition to the improved retention, indicate that morale has turned around.

OR Manager “super subscription”

OR Manager is offering a new option—the “super subscription.” You can continue to receive the print version of OR Manager every month, plus an early electronic version, which will be available 2 to 3 weeks before your print copy. You will also have access to OR Reports, our monthly review of the latest studies on the OR environment, and regular e-mail bulletins with news you need. The price: $129 a year.

If you wish, you can continue to subscribe to the print copy only for $86 annually.

Check our web site for the latest news, meeting announcements, and other practical help. www.ormanager.com

For more information about the Top 100 Hospital study, go to www.100tophospitals.com
Selecting video cameras that will stand up

Video technology—3-chip digital—is pretty standard as far as visualization for the surgeon is concerned. But the technology is not very standardized when it comes to selecting a camera that will withstand cleaning and sterilization while keeping repair bills to a minimum.

Life expectancy

Cameras’ multiple materials and complex designs pose significant life expectancy issues. Most manufacturers provide 1- to 2-year warranties; a few go as long as 3 years. Is that a good deal? That depends on the number of times the cameras will be processed during that period. Materials degradation is rarely time related. The more important question is, “What assumptions about the number of uses did the manufacturer use to determine the life expectancy?” If your hospital turns over the camera inventory at least 3 times per week, a 3-year life expectancy is realistic. If you use the cameras less often, you should expect your cameras to last longer, so find out about an extended warranty.

Materials compatibility

No camera is universally compatible with steam, ethylene oxide, gas plasma, and liquid peracetic acid processes. That’s a change from the first cameras, which were designed to be “hand washed” and sterilized with ethylene oxide. The lenses, adhesives, and polymers for coating and sheathing were all tested for compatibility with ethylene oxide.

The first alternative low-temperature technology, liquid peracetic acid, presented new challenges for device manufacturers. Adhesives and polymers needed to be changed to endure this highly oxidative liquid process. Color-coding for distinguishing between models was bleached out. Still, advantages of rapid turnover in reprocessing were driving the market to new, faster sterilization technologies.

Hydrogen peroxide-based plasma sterilization systems were introduced in the early 1990s. Exposure to highly oxidative vaporized hydrogen peroxide coupled with the vacuum excursions inherent in the process degraded the polymers and rubber-based materials typically used in cabling. When the even shorter cycle was introduced recently, the device manufacturers had yet another challenge. The double injection vacuum coupled with twice the exposure to the reagents meant additional testing and possibly new designs were needed to ensure a reasonable life expectancy. Users had to plan for the fact that devices compatible with one generation of this sterilizer could not be assumed to be compatible with others.

While steam sterilization avoids chemical incompatibilities and allows for rapid, relatively inexpensive processing, cameras that can be steam sterilized present different challenges. Designs have to be modified to shield the electronics from damage by heat, moisture, and vacuum excursions without compromising the quality of the video. The user must take care that the areas between the camera head, coupler, and scope are completely dry before use to prevent fogging or distorted video. The user must also allow for a sufficient cool-down period for proper function and use life.

Price isn’t everything

During a recent evaluation process to purchase new cameras, one hospital asked manufacturers to provide information on three questions (sidebar). The hospital sent requests for proposal to five manufacturers.

Only one company responded with the appropriate information. Two companies stated, “We don’t provide this information. You are the only one who has asked for this.” The other two sent incomplete information. For example, one company used only 100 cycles in testing the camera for material or performance degradation, rather than the number of cycles a camera would be subjected to in its warranty period. The other company did not provide materials degradation data on the upgraded cycle for gas plasma sterilization.

After careful analysis, the hospital selected the supplier that provided data supporting its sterilization and warranty claims, even though the acquisition cost of the cameras was higher.

Questions when buying video cameras

1. Does the company have a testing protocol and results to verify the cameras could be cleaned effectively using the technology and products available?
2. Do the testing protocol and results validate at least a $10^{-6}$ sterility assurance level (level of kill) when exposed to the sterilization process recommended by the manufacturer?
3. Has the company analyzed the materials degradation associated with the cleaning and sterilization method that would be used?

Need to investigate

After purchasing cameras, how would you prove expensive repairs were the result of foreseeable materials degradation rather than “user problems”? You could request the information noted in the sidebar, do an analysis of your usage patterns, and hope for a favorable response from the manufacturer.

We’ve found it is a lot easier to do this work up front. As the potential purchaser, you are in a strong position to demand information prior to purchase that not only could affect your buying decision but also could save significant repair costs later.

—Marimargaret Reichert, RN, MA
Olmsted Falls, Ohio

—Janet K. Schultz, RN, MSN
Denver

Marimargaret Reichert and Janet K. Schultz are consultants well known for their expertise in sterilization and disinfection.
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Do dot-com mergers mean tighter supply chain?

When the Internet-based e-commerce tidal wave crested 3 years ago, many observers expected the majority of active dot-com companies to crash, leaving a few larger exchanges to conduct business online.

Global Healthcare Exchange’s recent acquisition of Medibuy seems to prove those predictions weren’t far off the mark.

Today, by and large, three major Internet exchanges handle the bulk of online transactions for health care products and services:
- Global Healthcare Exchange LLC (GHX), Westminster, Colo
- Neoforma
- Broadlane Inc’s BroadLink operation.

Neoforma and BroadLink, which is used primarily by Broadlane members, both have strategic partnerships with GHX.

GHX briefly considered a similar alliance with Medibuy, but the companies decided to merge instead.

“We discovered we complemented each other pretty well,” says Kevin Ruffe, GHX’s vice president of operations.

Will the consolidation make the supply chain more efficient for hospitals and ORs?

Though some may argue that the merger eliminates competition, GHX maintains the larger company will be able to offer hospitals better technology for Internet purchasing. GHX also is large enough to help drive the movement for supply chain standards, such as use of Universal Product Number formats.

Even with these steps, many of the major challenges to supply chain efficiency for many hospitals and ORs continue to be internal. Many ORs need more fully developed inventory systems and better integration with materials management systems.

In driver’s seat

Ruffe says acquiring Medibuy will bring down barriers the companies faced on their own.

“Our goal is to be a neutral utility and [to] support both providers and suppliers versus a company that’s only focused on one part of the industry,” he says.

GHX, launched in 2000 by five leading health care manufacturers, attracted such GPOs as AmeriNet Inc, JPC (now an affiliate of MedAssets HSCA), Pharmaceutical Buyers Inc, and a smattering of integrated delivery networks. Medibuy brings to GHX Premier Inc, the nation’s second-largest GPO in annual purchasing volume, and HCA, the nation’s largest investor-owned hospital chain, along with HCA’s GPO, HealthTrust Purchasing Group, which includes about a dozen other for-profit chains.

“When you look at GHX, they’re pretty much in the driver’s seat,” says Michael Davis, vice president and research area director for the healthcare industry at Gartner Group, a Stamford, Conn-based information technology research and consulting firm.

“They started with a number of major manufacturers, then they bought HealthNexis, which brought in major distributors. Now Medibuy brings in the providers, including big groups like Premier and HPG. Everybody’s protected.”

Rachel Foerster, principal of Rachel Foerster & Associates, a Beach Park, Ill-based e-business consulting firm, indicated that the paring down was inevitable and necessary. “The dot-coms came out of the woodwork several years ago, and there were just too many of them, so this is just a continuing rationalization of the marketplace that’s needed,” she says. “Still I’m not yet sure I see the real bottom-line benefits for the providers.”

Davis sees potential to accelerate supply chain efficiencies as well as boost Internet-based e-commerce, particularly as GHX establishes relationships between the three customer groups.

“They have to create a lot of linkages to improve supply chain efficiency,” he says. But building infrastructures for these linkages is not as easy as it sounds.

What’s complicating the transition? “Everybody is re-engineering the processes as they go,” Davis says.

Providers want accurate pricing and catalog information, which will help them focus more on evaluating products and less on ordering manually, he says.

Following the numbers

The new GHX facilitates Internet-based e-commerce between 1,463 hospitals and 140 supplies in the US. Prior to the merger, GHX represented approximately $1.5 billion to $2 billion in dollar volume from its participants. With the Medibuy acquisition, the exchange anticipates adding at least another $1 billion in purchasing volume, Ruffe notes.

Currently, on average, providers connected to GHX conduct approximately 10% to 15% of their medical and surgical supply purchasing via the exchange, with some providers pushing that to 50% to 70%. The amount depends on a hospital’s willingness to expand its e-commerce capabilities and on how many of its trading partners are connected with the exchange.

Ruffe steadfastly stands behind the veracity of the dollar-volume data GHX collects.

“We measure confirmed orders. We measure what orders have gone through the system, focusing on live orders we’ve actually seen in the last 30 days,” he says.

Technology attraction

GHX plans to combine the best technology of both companies and phase out the rest, according to Ruffe.

GHX retains its AllSource electronic catalog, which is maintained and verified by suppliers. Medibuy didn’t develop an electronic catalog of its own. GHX also retains its Content Intelligence tool that automatically identifies and corrects inaccurate product data in purchase orders, then sends correct POs to suppliers. GHX keeps track of these changes and notifies the hospitals so that they can update their internal product files and item masters.

Medibuy products that particularly...
impressed GHX were its Commerce One-based requisition software and Quovadx-based integration engine, or “cloverleaf,” which Medibuy used to connect with hospitals. GHX now calls it Connect Plus.

Says Ruffe, “It was very reliable, and they had good success in being able to monitor it. We’re going to continue that and try to migrate more people to using that technology.”

GHX enables hospitals to connect to its exchange through a number of vehicles, including simple dial-up, according to Ruffe. But GHX wants to standardize the way customers connect, moving as many as possible away from dial-up and toward Connect Plus and Internet pipelines with materials management information systems (MMIS) and enterprise resource planning systems (ERPs).

“We’re definitely going to be reducing our use of various connection methods,” he said. “We’ll be incorporating some of our browser functionality and our direct-order ability through the Web site to the Reqs product.” Reqs is the trademarked name of GHX’s browser-based requisition software tool.

OR managers should be interested in Reqs, Ruffe says, because it allows them to order products electronically and maintain an item master even if their computer systems aren’t connected to an MMIS or if they’re not equipped with electronic order capabilities.

**Why ORs should be interested**

As a result, OR managers won’t have to delay decisions to order electronically because they’re waiting to replace or upgrade their computer systems.

Another benefit of GHX’s technology tools, he says, is they don’t overly burden a hospital’s information technology staff.

“We try to make it look like it’s another EDI [electronic data interchange] connection for them,” he said.

The Connect Plus option with Quovadx simply involves hooking up a Dell Computer processor with preconfigured software. That enables the hospital to communicate with its MMIS provider and for GHX to monitor content and transactions. GHX offers another similar solution that doesn’t require a box.

GHX emphasizes that hospitals don’t have to rely on EDI or sophisticated computer systems to conduct business via the Internet.

Ruffe notes, “You have a lot of people who are still using systems that are based on DOS operating systems or early versions of Windows.

“What we’ve done is try to be flexible. If you can create EDI, we’ll take it.” GHX can then convert it on its side, work it through it system and pass it on to other suppliers in a computer format they can use.

GHX gladly will accept XML [extensible markup language] transactions and even flat files, which it will convert, then process and transmit them to their final destinations.

Continued on page 22
At the same time, GHX says it isn’t looking to supplant the software companies, just augment and complement their offerings.

“We’re not going to be an MMIS,” he says. “We want to present hospitals with more functionality than what they may have now and not prevent them from upgrading their systems in the future. Without a doubt, we’re going to be eliminating a lot of manual effort and saving people a lot of time,” Ruffe adds.

But Davis dismisses the notion that all that is needed is a simple computer and not complex MMIS and ERP systems.

“You’re only looking at one component of Internet-based e-commerce—purchasing and catalogs,” he said. “If you really want true return on investment, the payback is beyond that.” It’s making sure transactions move from front-end systems to back-end systems used to manage internal operations, such as materials management and accounts payable.

**Key player on standards**

By maintaining an open, neutral exchange and generating a critical mass of users and order volume, GHX positions itself as a key player in promoting standards for hospital and supplier identifiers, product nomenclature, and supply chain transactions beyond EDI and bar coding.

GHX sits on the board of the Coalition for Healthcare eStandards (CHEs at www.chestandards.org), an organization comprising GPOs and e-commerce companies to adopt and promote data standards.

“Our goal is really to accelerate the adoption of standards,” Ruffe says. “We’re working with CHEs to identify standards that make sense for the industry and then adopt them into our process and work with our [users] to adopt them as well.” For now, it means that GHX has to provide a great deal of cross-referencing in the programming.

GHX supports such standard identifiers as the Health Industry Business Communication Council’s Health Industry Number (HIN), the Uniform Code Council’s Global Locator Number (GLN), and the two Universal Product Number (UPN) formats from the HIBCC and the UCC.

**Our goal is to accelerate the adoption of standards.**

Ruffe admits trading partners in health care continue to struggle with how to identify customers and products, so it’s focusing on those areas before pushing transaction standards. Simply put, providers and suppliers may apply different numbers to each other and also refer to identical products with different numbers. So GHX creates costly and time-consuming cross-referencing programs to support the current standards. In late March, GHX announced it will support the United Nations Standard Products and Services Code (UNSPSC) as the primary means for classifying products in its AllSource catalog.

“What’s interesting is that everybody wants to categorize the products and have the right categories for the products. But then nobody has the same identifiers for products within the categories, too,” he said. “You can find one product with five different identifiers.

“But we are going to support the UNSPSC taxonomy so people will be able to browse our products that are available through the exchange by the taxonomy. We’re going to be working with our suppliers to classify products to that taxonomy because we don’t classify it for them. The AllSource catalog is their data. We’re just the stewards of that data.”

Ruffe realizes some suppliers are reluctant to be grouped with competitors and to have their products classified within similar categories, fearing buyers will find products interchangeable and compare only on price. That’s why the standards allow suppliers to assign attributes to their products that will distinguish product features.

Rachel Foerster concurs that cross-referencing consumes a huge amount of resources.

“Custom programs cost money to write,” she said. “You don’t want to build horrendously expensive cross-referencing programs.

“A standard semantic is necessary, but everybody wants to call their products by their own names. That’s why I don’t see health care embracing standards like other industries have. That probably means there’s still too much money in health care, despite all of the cost problems, like declining reimbursement.”

GHX’s merger with Medibuy merely gives it the muscle to push for standards, according to Davis. “GHX gets nervous when I say that because they don’t want to be seen as Big Brother. But they can be a great catalyst for this. The industry has to either get smart and do this on its own, or the government will do it for them.”

Added Foerster: “Providers should be pushing for this, but they are at the mercy of suppliers and payers who have invested in traditional EDI formats and don’t want to move away from them. That’s understandable.”

Health care is a victim of fragmentation, she concludes.

“The health care industry desperately needs administrative simplification,” she said. “Providers should be applying new IT tools to cut costs and become more operationally efficient, but they really aren’t investing in the appropriate enabling software to do this.”

—Rick Dana Barlow

Rick Dana Barlow is a northwest suburban Chicago-based freelance writer specializing in health care supply chain management topics.

**Have an idea?**

Do you have a topic you’d like to see covered in OR Manager?

Have you completed a project you think would be of help to others?

We’d be glad to consider your suggestions.

Please e-mail Editor Pat Patterson at ppatterson@ormanager.com
So your organization is planning a joint venture with physicians to build a new ambulatory surgery center (ASC). As the surgical services director, you may be called on to participate in launching this new enterprise. You may be asked to provide data, prepare the staff, and join in decisions that will affect the new venture’s success. You’ll need strong diplomatic skills and command of information about your current business.

“This can be a real eye-opener of an experience,” comments Cheryl Dendy, RN, administrative director of ambulatory satellites for the St John Health System in Detroit, which has been negotiating with physicians to convert a hospital-owned surgery center into a joint venture. Surgeon colleagues will now be business partners, and they will want a say in decisions that may not have concerned them before. Rumors will fly among your staff. A host of issues will be on the table, from who will provide anesthesia services to who will provide the housekeeping.

Tips on joint ventures were shared by Dendy; Stephen Earnhart, CEO of Earnhart & Associates, Inc, Dallas; and Joan Dentler, principal of ProNet Healthcare Strategies, LLC, Austin, Tex.

Earnhart and Dentler specialize in development of joint ventures.

What’s motivating the MDs?

“Motivations for doctors are not what most people think—the money,” says Earnhart. “The need for time efficiencies is the number one motivator for surgeons. While profitability is important to all the investors, the goal for surgeons is not the profits but the time value.” Since most of surgeon’s revenue is from performing cases, their revenue increases if they can perform more cases a day.

Contrary to popular belief, the physician partners aren’t going to get rich. Doctors may think the return on their investment will be 50% to 60%. While there are centers that achieve that, he says, there are just as many where the return is around 15% to 20%.

Five things Earnhart says physicians want from the hospital in a joint venture:

• capital to support the deal
• credibility in the community
• an easy path down the certificate-of-need trail
• contracting capability with insurers
• a share in the profits.

Physicians are often surprised by how much effort setting up a surgery center entails. “Some of them will say, ‘I don’t want to work this hard,’” he notes.

Negotiating a deal can tax the relationship between the hospital and physicians.

“It’s got to be a win-win,” Earnhart says. “You can’t have one party more successful than the other. Both are scared the other will get the upper hand. Unless you can put together a win-win, don’t even consider it.”

There a variety of legal issues, including compliance and self-referral issues, that it will take a consultant and attorneys to sort out.

What’s in it for the hospital?

Keeping business is the major motivator.

“Hospitals know that if they don’t join in, they will lose 100% or 80% of their business in a specialty. If they partner with the physicians, they feel they can capture at least 50%,” says Earnhart.

Hospitals actually can do better financially with a 50-50 partnership with high-earning MDs than they can with 100% ownership, he says. “That’s because you have your physicians actively working with you to keep your staffing costs and supply costs down and keep your revenue up, even though the reimbursement is lower in an ASC than in a hospital.”

Continued on page 24
Time efficiency is the number one motivator for surgeons.

**Pros and cons of leasing staff**

Should you lease your staff from the hospital or hire your own?

Some advantages and disadvantages of leasing were outlined by Susan Hollander, MBA, FACHE, of Aspen Healthcare, Boulder, Colo, at the Federated Ambulatory Surgery Association meeting in May in Boston:

**Advantages**

- No need for ASC to have human resources expertise such as payroll and benefit management
- Staff have flexibility to transfer without loss of seniority, which they may see as a benefit. This can also be a disadvantage if they leave, and you have to replace them.
- Leasing saves you the time and resources to develop your own system.

**Disadvantages**

- The center still has control over employees’ performance and accountability.
- The ASC loses control over the salary and benefit plan. Market rate adjustments are out of the ASC’s control.
- If the hospital is unionized, ASC staff may also have to be unionized.
- The ASC doesn’t have as much flexibility to create bonus or incentive plans as it would if it hired its own staff.
Some ASC benchmarks

When planning a joint venture ASC, you may be asked for benchmarks to use in planning. Benchmarks are available from several sources. The Federated Ambulatory Surgery Association (FASA) provides some benchmarking information to its members. Consultants keep their own proprietary databases. There also are subscription services such as the Surgical Outcomes Information Exchange.

Whatever source is used, you need to understand how each benchmark is defined and whether it applies to your situation, advises Paul Davis, a consultant with Health Inventures, Superior Colo. Health Inventures is a new company formed in a buyout from J&J Consulting and Services, Ambulatory Surgery Division.

Surgical volume per OR per year

1,100 to 1,200

“This is a planning number used in the industry,” Davis comments. It applies to a multispecialty ASC operating from 7:30 am to 3 pm without extended hours.

Be aware, however, that the number will vary depending on the types of cases a center performs. An ASC with a large volume of GI endoscopy cases will likely perform more cases per OR than one performing a large volume of longer orthopedic cases.

--- Source: Health Inventures

Supply cost per case

| Low: | $83 |
| Mean: | $217 |
| High: | $408 |

“This is a mixed bag. You really need to take the numbers in context,” Davis cautions. “The cost depends on your mix of cases. To be pure, you need to compare like facilities with a similar mix of procedures.”

Supply cost for pain management may be less than $20 a case, while supplies for an orthopedic case with implants can cost more than $2,000.

--- Source: Health Inventures

Inventory turns

| Low: | 2 turns |
| Mean: | 5 turns |
| High: | 11 turns |

Inventory turns are a measure of how often the supply inventory turns over. To calculate, divide the total medical supply expense, including pharmaceuticals, by the value of the medical supply inventory on hand.

“Inventory turns are slow in healthcare in general,” says Davis. Again, the numbers vary depending on each center’s situation. Centers with a high number of specialty items and physician preference items, such as orthopedic implants, typically have fewer inventory turns than centers performing routine cases that have standardized supplies. The ideal is a just-in-time inventory where supplies are delivered as needed based on the surgical schedule.

--- Source: Health Inventures

Paid clinical nonphysician hours per case

| Overall median: | 8.41 |
| Multi-specialty: | 8.58 |
| Single-specialty: | 7.48 |
| Gastroenterology: | 4.39 |
| Ophthalmology: | 6.95 |
| Orthopedic: | 10.62 |

--- Source: FASA

Block utilization

There is no formal benchmark for the utilization surgeons should be expected to achieve to keep their block time in an ASC.

The rule of thumb is 75%, according to Davis. “If a surgeon is consistently below 75%, many centers would look at that and perhaps cut back the amount of block time.”

--- Source: FASA

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--- Source: FASA

Additional surgeons once the structure was formed. Additional shares were set aside for future marketing efforts. There was also discussion about whether to require specific volumes for surgeons and whether to consider their involvement in other joint ventures within the hospital system’s market.

To avoid self-referral issues, physicians who invest in the center should be those who plan to do their work there. They should meet the one-third, one-third tests set forth in the “safe harbor” rules for the federal anti-kickback statute. That is, they should perform one-third of their procedures in the ASC and derive at least one third of their practice income from procedures performed in the ASC.

Should we hire a management company?

In a partnership it is always preferable to have both partners “sit at the same side of the table.” Having an outside management company allows for that. The hospital and physician partners should jointly select the management company, and both should be involved in the ongoing evaluation of its services. Often, the partners may believe they can run things on their own. That may be the case, but outside management can provide a safety net for the new business, at least initially. Outside management can provide the physicians with the confidence that the ASC will not be run like an extension of the hospital, a common concern of physicians. A quality management company should be working itself out of a job. The company should be training and evaluating the staff as it goes so the partnership is not paying management fees forever.

Make sure meeting minutes are kept

Minutes are important when it comes time for licensure and Medicare certification. Licensing officials will look for evidence that your executive committee approved key decisions, which they will expect to find in the meeting.

Continued on page 26
minutes. There is nothing more embarrassing than to have a licensure application fail because the executive committee failed to keep minutes of meetings.

Know your business
As a surgical services director, you may be asked to supply the venture’s executive committee with key facts about the hospital’s surgical business. If the joint venture will be formed from an existing hospital-owned surgery center, as was the plan for Dentler’s project, she suggests gathering these facts:

- The tax structure
- Value of the surgery center’s real estate
- Capital equipment inventory and assessed value
- Current overhead
- Current contracts for purchased services
- Value of your supply inventory
- Payer mix and contract status for all payers
- Current bottom line: Is your current ASC profitable? If not, why not?

Know the key benchmarks for your business
You may be asked for benchmarks used in the ASC industry (sidebar). Be aware that you need to take benchmarks in context. Always ask how the benchmark is defined, what types of centers it applies to (eg, multi-specialty, size, and mix of procedures), how many facilities are in the database, and how the data are collected and analyzed. For example, supply cost per case and clinical hours per case vary depending on the type and mix of procedures. A center doing primarily GI endoscopy or pain management cases will have quite different numbers from one with a large volume of orthopedics. You want to be sure you are being compared fairly and setting realistic expectations.

Who will provide anesthesia services?
Anesthesia services can make or break a surgery center. Dentler suggests that the hospital and physician partners work together to choose the anesthesia provider for the ASC.

“For the hospital partner, this may be a welcomed opportunity to make a change from the status quo,” she says. The partnership should issue requests for proposal (RFPs) for anesthesia services, keeping in mind the scope of services and delivery terms that will optimize the ASC’s efficiency and profitability. All potential anesthesia providers should be interviewed by the partnership. Anesthesia providers should understand that they will work under a service contract with a finite term and provisions for termination if service delivery fails to meet expectations. An ASC anesthesia contract can generate substantial revenue for an anesthesia provider, and it should be respected and treated as something of value, reminds Dentler.

Who will provide the staffing?
Will the staff be leased from the hospital, or will they be employees of the joint venture?

Earnhart recommends that the ASC hire its own staff. This will avoid any inducement or anti-kickback issues. For the hospital OR staff, moving to the surgery center has trade-offs. Nurses may like the surgery center’s week-day hours and no call. But if they become employees of the partnership, they will have to give up their seniority and perhaps other benefits from the hospital.

“Most surgery centers can’t afford the heavy layer of staffing with 10 to 15 years’ seniority,” Earnhart comments.

Be prepared to negotiate new contracts
As a separate business from the hospital, the joint venture will have its own contracts for services. There likely will be 25 to 30 contracts to be negotiated. Among these are contracts for business office functions, information systems, laboratory, radiology, anesthesia, and pathology. Some contracts might be with the hospital, “but they will have to be at fair market value,” Earnhart advises. An example is housekeeping. The hospital might offer to provide housekeeping services for $7.50 a square foot, but an outside vendor might offer to do it for $2. That becomes the fair market value.

Prepare the staff
Inform and educate the hospital’s surgical services staff at the first inkling that a joint venture may be formed, Dendy advises. The staff needs to understand why the hospital is investigating a joint venture and the potential advantages and disadvantages.

Don’t wait for the rumors to start to fly. There may be tales about what business will be leaving the hospital, which nurses surgeons prefer to hire for the ASC, and some staff losing their jobs at the hospital if business departs. All of this is hard on morale if the director doesn’t share information proactively.

“One way to educate the staff is to select a successful joint venture and provide a side-by-side comparison with your facility,” Dendy suggests. “Encourage dialog that includes exciting prospects, such as greater surgeon participation and enthusiasm. Together think about the potential for growth and change.”

Keep the staff in the loop with frequent updates. Include the planned joint venture as a standing item on the agenda for staffing meetings and develop a formal rumor control plan.

“Above all, remain positive and enthusiastic with your staff,” Dendy stresses.

Be prepared for uncertainty
Opening a new facility will affect your OR’s business and maybe your own posi-
tion. This can be unsettling. Be prepared, be confident, keep an open mind, and be willing to listen, Dendy suggests.

“You can rest assured that what the surgeons love and hate about your facility will be debated,” she says. The purpose of this discussion is to determine what kind of governance to establish and how much potential there is for change.

As the primary creator of the ASC that was being considered for a joint venture, Dendy felt a great deal of ownership of the facility.

“Given that, I was not prepared to have it dissected before my very eyes,” she says. “However, it was not all bad, and I even learned a little. The point is, you must know your facility, processes, policies, and procedures inside and out.

“Be prepared to defend them, and be prepared to listen. There are many ways of accomplishing most things. Try to stay objective—this will win you votes in the end.”

This may be a time for some soul searching as well. How well do you embrace change? Can you work with the physicians who want to take your business in a new direction? Will you be able to work with the joint venture’s board? Can you remain positive with your staff and lead the change? Are you prepared possibly to work harder than you are now?

“In this new model, the facility will demand the best of you,” she says. •

Health costs of obesity rival those of smoking

About 9% of the nation’s annual health care bill goes for care related to being overweight or obese, comparable to the cost of treating smoking-related illnesses. More than half—54%—of those covered by insurance are overweight or obese, with a higher percentage for Medicare patients (56%). Obesity is a major risk factor for diabetes, hypertension, and heart disease and should be addressed as aggressively as smoking, the researchers advise.

Health care for overweight individuals costs 37% more than care for persons of normal weight.

The authors say their analysis points out how much of the cost is borne by government health programs such as Medicare and Medicaid.

**Health Policy & Politics**

**HHS awards $3.5 million to promote nursing diversity**

The Department of Health and Human Services in June awarded grants to 16 schools to support nursing education for persons from disadvantaged backgrounds. The grants will fund scholarships or stipends as well as provide help for pre-entry preparation and retention. Minority students in the nursing schools receiving grants average 38%, nearly double the national average of 19%.


**Do away with ASC list, FASA urges**

The Federated Ambulatory Surgery Association urged the government to abandon its list governing which procedures can be performed for Medicare patients in ambulatory surgery centers.

Medicare pays a facility fee to an ASC only if a procedure is on the list, which FASA says denies Medicare beneficiaries access to ASCs. That is true, FASA argued, despite ASC’s strong safety record, high efficiency and customer satisfaction, and lower costs.

FASA also asked the government to address inconsistent Medicare payment for implants used in surgical procedures, saying the bundle of services covered needs to be more clearly defined. FASA was commenting on the updated ASC procedure list published March 28. FASA advocated adding 31 additional codes to the list and opposed deleting 14 procedures. Complete comments are on FASA’s web site.

—www.fasa.org/press.html

**ANA “outraged” as OSHA drops TB standard**

The American Nurses Association sharply criticized the Occupational Safety and Health Administration’s withdrawal May 27 of a rule to protect workers from occupational exposure to TB.

ANA chided OSHA for its decision to “simply abandon the rule without adequate explanation.”

ANA says the lack of an enforceable regulation might lead to decreased vigilance, which might lead to more cases.

But the American Hospital Association advocated withdrawing the rule, saying hospitals had spent considerable time and resources developing TB control programs, and added requirements would be an undue burden.

—www.nursingworld.org

**Surgeons advocate more support for trauma care**

Federal and state governments need to up their efforts to develop and improve trauma services. That is especially important at a time when communities need to strengthen emergency preparedness, the American College of Surgeons said at a press conference May 28.

New data from the National Trauma Data Bank reveal some surprising findings. It has been thought most injuries involve “young men who crash and older women who fall.” But early data identified some “troubling areas,” including the “surprising risk of suicide” in mid-aged men and the sharply rising risk of injury-related deaths with aging, according to the College.

—www.facs.org/news

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Please see the ad for SPECTRUM SURGICAL INSTRUMENTS in the OR Manager print version.
In Business News

Kimberly-Clark Health Care acquires patient-warming business

Kimberly-Clark, Roswell, Ga, agreed to acquire the patient-warming business of Medivance of Louisville, Colo. Medivance makes the Arctic Sun system, which is used to prevent hypothermia during complex surgical procedures.

Owens & Minor signs with HealthTrust

Richmond, Va-based distributor Owens & Minor has signed a 5-year distribution agreement with HealthTrust Purchasing Group, a Nashville, Tenn-based group purchasing organization. HPG, with 900 member facilities, has a current contracting volume of more than $5.5 billion. Among HPG’s members are facilities from HCA, HMA, Triad, Lifepoint, and others.

Surgical robotic companies to merge

Two major makers of surgical robotic systems, Intuitive Surgical, Sunnyvale, Calif, and Computer Motion, Santa Barbara, Calif, have announced a merger. Intuitive Surgical makes the daVinci system, and Computer Motion is developer of the Zeus platform, which includes Hermes and Aesop. The companies say their complementary technology should help to further surgical robotics.

Please see the ad for MARY WASHINGTON HOSPITAL in the OR Manager print version.

Please see the ad for LCCST SURGICAL TECH in the OR Manager print version.
Please see the ad for BOVIE MEDICAL in the *OR Manager* print version.
CDC issues recommendations for environmental infection control

The Centers for Disease Control and Prevention (CDC) issued final recommendations June 6 as part of its Guidelines for Environmental Control in Health-Care Facilities. The guidelines, which make final a 2001 draft, address preventing infections associated with air, water, surfaces, and other environmental aspects in health care facilities. Included is advice for facility construction, demolition, renovation, and repair. Among topics of interest to ORs are room ventilation and cleaning, TB precautions, and cleaning recommendations for Creutzfeldt-Jakob disease. A summary of the recommendations will be in the August OR Manager.

—www.cdc.gov/ncidod/hip/enviro/guide.htm

Guidant unit pleads guilty to problems with AAA graft delivery system

The EndoVascular Technologies division of Guidant Corporation pleaded guilty June 12 to 10 felonies, admitting it lied to the government and hid thousands of serious health problems, including 12 deaths, caused by its Ancure Endograft System. The system is used to treat abdominal aortic aneurysms.

The company agreed to pay $92.4 million in criminal and civil penalties, the largest ever imposed on a device maker for failing to report problems to the federal government, the June 13 New York Times reported.

—www.guidant.com
—www.nytimes.com

Higher mortality associated with office surgery

Surgery performed in offices is associated with a more than 10-fold greater mortality rate compared with surgery in ambulatory surgery centers in Florida, the University of South Florida, Tampa, reports.

Researchers examined the first 2 years of mandatory adverse incident reports filed with the Florida Board of Medicine. A review of 182 adverse incident reports showed 13 surgically related deaths occurred in 141,404 office procedures compared with 18 deaths in 2.3 million ambulatory surgery center procedures.

Despite strict Florida regulations requiring credentialing for surgeons, accreditation of office surgery facilities, and qualifications of anesthesia personnel, only 84% of office-based surgeons were board certified, 38% of offices were accredited, and 15% of offices had a dedicated anesthesiologist.


Medicare bonuses for superior care?

Medicare is planning a pay-for-performance trial that will reward hospitals that provide superior care, the May 27 Wall Street Journal reports.

Under the 3-year pilot, hospitals would submit data on Medicare patients with stroke, heart attack, hip surgery, pneumonia, and heart failure. Hospitals with top quality scores would get a 1% to 2% bonus in addition to regular Medicare payments. The lowest performers’ payments would not be affected, though the White House Office of Management and Budget has insisted that low performers lose a small portion of their funds in the third year.

Some worry that data collection on hospital performance isn’t yet sophisticated or ample enough to use as a basis for reimbursement.