Ensuring a comparable standard of care for cesarean deliveries

Your facility is having a baby boom. The number of cesarean births is exceeding the obstetrical unit's capacity. Administrators want the OR to perform the overflow cases. What plans do you make for patient safety and care of both mother and newborn?

The cesarean birth rate has risen by more than 25% in this decade. Cesareans accounted for 31% of births in 2006, the latest figure available from the Centers for Disease Control and Prevention. That places a strain on many obstetrical units and creates a need for closer collaboration with perioperative services.

A surgical services director faced this situation recently. Her hospital, with 460 beds and 11 ORs, has a large and growing obstetrical volume. In the OB unit, cesarean births were staffed with one circulating nurse. But the director thought 2 RNs were needed: one to circulate for the mother’s surgery and the second to care for the newborn.

She asked what nursing practice standards and guidelines apply, a question other OR directors may also be asking.

Continued on page 5

How could ORs benefit from the government’s health IT funds?

The federal government is providing $19 billion in grants and loans for health information technology (IT). Will ORs be able to capture some of the funding to improve their systems?

The funding comes under the American Recovery and Reinvestment Act signed by President Obama in February 2009.

Financial incentives will be available to hospitals and physicians to promote health IT, particularly the electronic health record (EHR). The ultimate purpose is to improve health care efficiency and improve quality. Payments will start in 2011 and scale down (sidebar, p 9).

There are big catches. To be eligible, hospitals must already have invested in IT and be “meaningful users” of “certified EHR technology,” terms to be defined by the Secretary of Health and Human Services later this year. In general, a qualified EHR will need to have patient information such as demographics, a medical history, and

Continued on page 9
Surgical Instrument Inspection Textbook

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Editorial

It’s happened again—endoscope reprocessing errors. More than 10,500 veterans have been notified they may have been exposed to contaminated equipment at 3 Veterans Affairs (VA) facilities (see page 19).

Several errors were found: A wrong connector was used. One tube wasn’t being reprocessed between patients. Other parts weren’t always discarded at the end of the day as intended. And flushing of the scope’s water system wasn’t always performed.

The VA is not alone. The VA’s national patient safety director, James Bagian, MD, says manufacturers tell him as many as 9 of 10 facilities aren’t processing scopes correctly.

The risk is considered low. The incidence of infection from GI endoscopy procedures is estimated at 1 in 1.8 million (Schembre D B, Gastrointest Endosc Clin N Am. 2000; 57:695-711). Still, endoscopes have been associated with more outbreaks than any other type of device.

A different approach?

The remedies are familiar—follow manufacturers’ instructions to the letter, provide more education, check competency.

These steps are deceptively simple. Endoscopes are complex. Re-processing requires dozens of steps that vary by type and brand of scope. Technicians who do the work earn entry-level pay, and there is pressure to turn around cases quickly.

“This whole system is set up to fall apart,” one expert told us.

Are these remedies enough? Or is it time for a different approach?

Should endoscope reprocessing be thought of in the same way as medication safety, as a complex system prone to errors where failsafe measures need to be built in?

It used to be when a medication error occurred, the response was to search out the person who made the mistake and drum in more education. Then patient safety experts pointed out the system itself was the problem.

Facilities started doing high-level assessments of the risk of errors from underpaid staff, multiple parts, easy-to-confuse connections, hard-to-clean devices, and unclear or conflicting instructions.

That kind of assessment and the remedies would take resources. But the cost of testing 10,500 veterans isn’t small either, in dollars or the mass anxiety created.

In the meantime, experts we spoke with stressed these points:

- Organize the reprocessing area with safety in mind. That includes good lighting and minimal distractions.
- Develop a system for storing parts so it’s easy to select the right ones.
- Instruct staff to verify in writing informal instructions from company representatives.
- Focus on why each step is critical—staff who understand why steps are needed may be less likely to take shortcuts.

A comprehensive patient safety approach is long overdue.

—Pat Patterson

Upcoming

SCIP: What’s the status?

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A related and larger question: How can you help ensure a comparable standard of care throughout the organization? This is a growing need as invasive procedures expand to GI endoscopy, interventional radiology, the cath lab, and other departments. Joint Commission standard LD.04.03.07 requires that “patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.”

At Yale-New Haven Hospital in New Haven, Connecticut, a collaborative task force has developed policies and procedures that apply across departments (sidebar, p 7).

**What guidelines apply?**

Professional associations have recommendations applicable to cesarean births.

AORN’s staffing guidelines, which apply to any surgical procedure, specify 1 RN per patient per OR in the role of circulating nurse. Other AORN recommended practices also apply, such as counts and maintaining a sterile field. The count recommendations specify a sponge count before closure of a cavity within a cavity, such as the uterus.

The American Academy of Pediatrics (AAP) and the American College of Obstetrics and Gynecology (ACOG) Guidelines for Perinatal Care recommendation for circulating for the intrapartum phase is a 1:1 RN-to-patient ratio.

“That means the circulator is responsible for only the role of the circulator until mom and baby reach the recovery area,” says Catherine Ruhl, CNM, MS, associate director for the Association for Women’s Health, Obstetric, and Neonatal Nurses (AWHONN). The association does not issue standards on staffing ratios.

“Therefore, the role of your circulator can be no different than the role of the circulator in your general OR,” says Ruhl, referring to the requirement for a comparable standard of care. Thus, “One nurse (or scrub tech) must be available to scrub, one nurse must be available to circulate, and one nurse must be available for the infant.”

About 1 in 10 newborns require some assistance with breathing at birth, and about 1% require extensive resuscitative measures, according to the AAP.

Guidelines for neonatal resuscitation from the American Heart Association and the AAP state that at every birth “there should be at least 1 person whose primary responsibility is the newborn.”

This person must be capable of initiating resuscitation, with someone else immediately available to perform a complete resuscitation. With careful assessment, most newborns who will need resuscitation can be identified before birth, the guidelines note.

**What experts say**

When polled, most members of the OR Manager Advisory Board said that when cesareans are performed in the OR, in addition to the RN circulator, the OB unit sends a nurse and/or a pediatrician to care for the infant.

One advisor, Kathleen Miller, RN, MSHA, CNOR, senior clinical consultant for Catholic Health Initiatives, Denver, says she has addressed this situation a number of times as an OR manager and director.

“In the OR, the circulating nurse as well as the anesthesia provider can only be responsible for one patient.”

Continued on page 6
We emphasize surgical safety.

Fathers have been able to attend cesarean births in the OR unit for some time, Simpson notes. The mother sometimes requests another person as well. A teenage mother may want her mother to be present, for example, and such a request is often granted.

At the same time, there is a more rigorous focus on safety.

“Being mother and baby friendly does not preclude safety,” Simpson says.

The ACOG statement on surgical patient safety issued in 2006 addresses issues such as prevention of wrong surgery, the need for adequate personnel, and the need to minimize distractions during the surgery.

“We constantly emphasize surgical safety, such as no interruptions during counts,” Simpson says. Time-outs before cesarean births are a way of life, as they are for any invasive procedure. At St John’s, counts are conducted as recommended by AORN, including calling for an x-ray if a discrepant count cannot be resolved.

A director’s solution

In a follow-up e-mail, the director who asked the question about staffing says her concerns are being addressed. She had shared her concerns with the hospital’s physicians and anesthesia group, who discussed them with the medical staff leadership. She says they have now adopted the AORN standards for counts.

For cesarean births in the OR, the staffing plan will include a per diem nurse cross-trained for the OB unit from the postanesthesia care unit (PACU), or the OB unit will send a nurse to care for the baby.

Because this second nurse will be needed for only 30 to 45 minutes, there will not be a big impact on productivity. The OB unit was also considering how to provide a second staff member routinely.

The hospital’s education department will provide education for the OB nurses on counts and other surgical practices, with assistance of veteran perioperative nurses.

Concern about retained items

There’s reason to be concerned about counts during cesarean births. The director says she knows of 2 incidents of retained objects that may be associated with cesareans performed in the past at other hospitals.

In one case, 2 sponges were discovered in a woman’s uterus after she went to another hospital with abdominal pain not long after her cesarean. In the second case, a woman who had a CT scan performed after a fall was found to have 2 size 0-Vicryl suture needles in her abdomen. Her history included previous laparoscopic surgery and 2 cesarean births. Size 0-Vicryl suture needles are used for closing deep layers and could have been left during a cesarean.

Vaginal birth is the most common type of procedure with a retained foreign object, accounting for about one-fourth of such cases, in data from Minnesota’s statewide adverse event reporting system. Hospitals in the state are conducting a Safe Count campaign to prevent retained objects in vaginal deliveries. More information is at
The collaborative effort at Yale-New Haven Hospital to harmonize standards for cesarean births began when a senior nursing VP asked the OR management to consult with the labor & birth (L&B) unit.

“We had collaborated over the years, but we wanted to put a more formal structure in place,” says Ena Williams, RN, MBA, MSM, nursing director for perioperative services. Yale-New Haven’s main campus, with 940 beds, has 37 ORs; the L&B unit has 3 ORs. Williams began with a 2- to 3-week assessment of L&B. “We looked at the patient populations and recognized they had similar requirements,” she says. “The patients need similar intraoperative management and postoperative care. There are regulatory issues in common, such as the National Patient Safety Goals.”

These are steps the units’ leadership teams took to harmonize practice between the 2 departments. The collaborative model has since been applied to other departments, including interventional radiology, the GI endoscopy unit, and a freestanding ambulatory care facility that joined the system.

Form a leadership team

A multidisciplinary task force was formed to oversee the project. As much as possible, the leaders tried to match representatives from both departments, including physicians, nurses, managers, educators, and support services.

The team set a goal: To ensure that the ORs in L&B maintain similar standards to the ORs in perioperative services “to optimize patient safety, quality, and service excellence.”

Identify focus areas

The task force identified 7 focus areas common to the OR and L&B:

• National Patient Safety Goals, such as eliminating wrong surgery, improving handoffs, and medication reconciliation
• infection control, including flash sterilization
• environment of care, such as standardizing cleaning protocols, establishing a latex-free environment, and performing daily checks of emergency equipment
• policies and procedures, including surgical counts, malignant hyperthermia management, and sterilization protocols
• central sterile supply, including a system for equipment refurbishment and an audit process for surgical kits
• patient safety, such as blood availability and fire safety
• staff development, including orientation for L&B RNs to the perioperative department; consistent staffing for cesarean births; and education in high-risk, low-occurrence cases.

Develop a work plan

A work plan was devised to address the focus areas, and an L&B manager partnered with Williams to implement the plan.

“The first goal was to standardize practice,” Williams says. The second was to prepare the L&B staff so that if a problem occurred, such as a patient having a cesarean

Continued on page 8
Clinical management

Continued from page 7

who required a hysterectomy, the L&B staff would be prepared.

Staff from L&B spent time in the OR with the perioperative GYN staff so they could become more familiar with surgeons they might work with in an emergency. OR staff also go to the L&B unit to support the staff and act as a resource when an unexpected situation occurs.

The 2 staffs also worked together to standardize cards for emergency cases. The L&B unit’s emergency cart was redesigned to support situations the unit may experience.

Harmonize policies and procedures

Comparable policies were developed for relevant aspects of L&B and perioperative services. These included policies such as counts, management of emergency procedures, and postoperative care. Documentation forms were standardized as much as possible.

A staffing model was developed for cesareans in the OR and L&B. Current practice is to provide an RN circulator plus a nurse for the baby. “We now have a model where a second circulator is available to support the baby during a c-section so the circulating nurse can stay focused on the surgical procedure,” Williams says.

A uniform count policy includes a procedure for addressing discrepant counts, including x-rays. “When there is a count discrepancy, they follow the same exact standards. Nobody questions it any more,” Williams says.

She explains this is no longer a nursing policy but a hospital policy agreed upon by the medical and the nursing staff.

“You can’t fight this battle on your own,” Williams says. You have to get buy-in from the medical staff.”

Keep up the collaboration

To maintain the collaboration, a clinical leader from L&B was identified to become the unit’s “perioperative leader.” She is the go-to person for perioperative aspects of labor and delivery and related staff development and is mentored by the OR’s clinical leader for GYN surgery.

Williams says the position reinforces the bond between OB and the OR. “For us, it’s no longer how you do things versus how we do things. Now there is a standard. The collaborative leadership structure has eliminated lines between departments.”

Stay prepared for surveys

Be prepared for questions on a comparable standard of care from the Joint Commission and state surveyors, Williams advises.

“They will go from unit to unit and location to location. They will ask about your policies, so you had better be practicing the same way,” she says.

A collaborative team can also be a good resource for managers on standards and practice. Yale New-Haven’s team continues to meet every 4 months to address questions, practice issues, and policy development.

“We have come a long way,” she says. “It no longer feels like we are working in silos. We are discussing ways to expand this across the health system because many of our surgeons practice in other facilities.”

Nominate OR Manager of Year

The July 1 deadline is fast approaching for nominations for OR Manager of the Year.

Each year at the Managing Today’s OR Suite conference, a manager or director is named OR Manager of the Year.

This year’s conference will be Oct 7 to 9 in Las Vegas, Nevada.

The OR Manager of the Year will receive an expense-paid trip to the meeting, including airfare, hotel, meals, and registration.

In recognizing an individual manager, the award honors all OR managers for their important roles. It is a way of celebrating nursing management in surgical services.

Readers of OR Manager are invited to nominate a manager for the award. Simply write a letter of about 300 words describing what makes the manager deserving of the award. Supporting letters may also be sent.

Send the entry to OR Manager, Inc, OR Manager of the Year Award, PO Box 5303, Santa Fe, NM 87502-5303.

Submit the entry for your deserving manager by July 1.

Nominations are judged by the OR Manager advisory board.

A conference brochure can be downloaded at www.ormanager.com

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
problem lists plus be able to:
- provide clinical decision support
- support physician order entry
- capture quality information
- exchange and integrate health information from other sources.

Carrot and stick
Besides a carrot, there is also a stick. Hospitals that aren’t “meaningful users” by 2015 will be subject to Medicare payment penalties unless they show significant hardship.

There is a long way to go. Only 1.5% of US hospitals have a comprehensive electronic records system. More than 90% did not even meet the requirement for a basic system, according to a report in the April 9, 2009, New England Journal of Medicine (www.nejm.org). Finances were cited as the major barrier.

Positioning the OR
How can OR leaders position themselves to take advantage of some of the funding?
To start with, hospitals are likely to need 2 functions in place to qualify as a meaningful user—baseline documentation and robust quality reporting, says Mikael Ohman, senior vice president of strategy and business development for McKesson Technology Solutions.

“What if I were an OR director, I would make sure anything relating to quality reporting was top notch,” he says. For hospitals that are already pretty advanced, “this is a great opportunity to take some of the final steps,” he says, which might include systems needed to improve OR throughput, patient charging, and inventory management.

OR automation could use a boost. Though the majority of departments have automated OR scheduling, fewer than half have a fully developed perioperative system, according to the HIMSS Analytics Database (charts).

The last frontier
OR leaders can make a strong case for more robust IT systems. The OR touches on key goals identified for health IT—clinical documentation, quality reporting, and greater efficiency, says Jason Hess, general manager of clinical research for KLAS Enterprises, which conducts user surveys of health care information systems.

Integration continues to be a big need. To contribute to these goals, ORs need to be more closely tied with the hospital’s core IT systems. ORs are often the “last frontier for integration,” Hess says. Despite being a major cost and revenue center, “ORs are nowhere near where the lab, pharmacy, and some other areas are.”

In the most recent KLAS report on surgery management information systems in 2007, 64% of users named essential clinical or financial information that is not interfaced. Leading the list were inventory/materials management and clinical information, both critical to OR throughput and quality reporting.

The preoperative process, with the need to coordinate patient assessments, testing, and consultants, could also benefit from automation and integration (related article, p 11).

Equally as important as software but often overlooked is the personnel needed for clinical and...
Some types of surgical site infections are no longer reimbursed by Medicare. These include mediastinitis after coronary artery bypass and infections following some orthopedic procedures and bariatric surgery.

Software is a major boon to infection preventionists, replacing reams of paper. They can spot trends more quickly, including surgical site infection outbreaks. If they can’t get electronic reports from the OR easily, that’s a big gap, Hess notes.

Though chief information officers will have a big to-do list, OR directors can make a strong argument that more robust and better integrated perioperative information systems are instrumental in helping their institutions and the nation achieve health IT objectives.

—Pat Patterson

Heated debate over virtual colonoscopy

Whether Medicare should pay for virtual colonoscopy is the subject of a heated debate in Washington, DC, the April 18 Los Angeles Times reports. Virtual colonoscopy is less expensive and more comfortable than traditional colonoscopy, but consensus is lacking on its effectiveness.

Proponents say virtual colonoscopy will increase the number of people screened. Critics contend it could inflate health care spending because a traditional colonoscopy is required if there is a finding from virtual imaging. The decision on Medicare coverage is expected soon.

—www.latimes.com/business/la-na-colonoscopy18-2009apr18,0,4333525.story
Preparing patients for the day of surgery can mean chasing faxes and other documents that are easily misplaced. Missing information can lead to surgical delays and cancellations, not to mention frustrated physicians and staff.

If ever a process was ripe for automation, this is it. With the government’s funding for electronic health records (EHR), the preoperative process is one area hospitals and physicians may be looking at.

One option is to harness the Internet. Preoperative documentation is submitted through a secure web portal where physicians, nurses, and other authorized users can access it easily.

OR Manager spoke with users and representatives of 3 companies that offer web-based systems for managing preoperative information.

**Presurgical Care Management System**

Advocate Lutheran General Hospital in Park Ridge, Illinois, has been using an automated preoperative evaluation system for about 5 years.

“We almost never cancel a case anymore because a patient hasn’t been prepared appropriately preoperatively,” says Mary Kay Bissing, DO, chair of anesthesia and perioperative medicine. “And we don’t have to get last-minute consultations, which we were doing almost daily.” She estimates the software has reduced the cancellation rate from missing paperwork on the day of surgery from about 5% to near zero.

The Presurgical Care Management System was developed by David Young, MD, Advocate Lutheran General’s medical director of presurgical testing. The software collects patient information, processes it into risk scores and treatment plans, and generates reports. The system is now owned by DocuSys, Inc, Atlanta (www.docusys.net). Dr Young is the company’s medical director of presurgical care.

**Web-based questionnaire**

Patients access the automated questionnaire at home or through kiosks in surgery centers and physician offices using an identification number.

The questionnaire, developed by the Cleveland Clinic and used by the Clinic and Advocate Lutheran General, focuses mainly on pulmonary, diabetes, and cardiac issues.

Patients answer the yes or no questions phrased in layman’s terms. Yes answers trigger further questions. A nurse always verifies the completed questionnaire with the patient and asks more questions if needed, Dr Young notes.

The software converts the patient’s responses to medical terminology. For example, the questionnaire asks: “Do you have shortness of breath at night that requires sleeping on more than 2 pillows?” If the patient enters “yes,” the program reports that the patient has “nocturnal dyspnea.”

Once the information is entered and verified, the software compares the findings with the surgery the patient will have and determines the lab testing and any further evaluation needed. The system then creates different reports for the patient, surgeon, preop evaluation clinic, primary care physician, and anesthesiologist.

**My Medical Files**

Automation has helped end the paper chase at Christiana Care Health System, Wilmington, Delaware, which in September 2008 adopted a web-based system from My Medical Files (MMF from MMF Systems, Inc, New York City, www.mmf.com)

Before, a blizzard of faxes led to “many delays on the day of surgery and physician dissatisfaction,” says Andrea Rodriguez, RN, BSN, CNOR, manager of surgical services for Christiana Care.

MMF indexes, tracks, and notifies clinicians of missing information without the involvement of hospital staff.

**How it works**

With MMF, patient information is faxed to a central number. The incoming faxes are received by fax services, which digitize and store the documents in a database. The documents are then made available over MMF’s secure web servers in Virginia and California. Users are given a password to the MMF website.

The digitized documents then go to trained personnel in India who index patient information around the clock, making it available on the MMF website minutes after receiving it, explains Jose Barranco, MMF’s vice president for market development and compliance. He says the company can...
Information systems

**Preop automation costs**

Presurgical Care Management System  
*DocuSys*

The price is based on the hospital’s annual surgical cases. The software is available as a site license or on a per-case basis. There is a one-time implementation fee and annual maintenance fee.

For a hospital with 5,000 cases a year, the base one-time license fee is about $80,000 plus implementation services and an annual maintenance fee of $15,000.

For a surgical center with 2,000 cases per year, the base one-time license fee is about $25,000 plus implementation and an annual maintenance fee of $5,000.

Alternatively, the system is offered for a per-patient fee of $2.50 to $6.50, depending on volumes and configuration.

—www.docusys.net

My Medical File  
*MMF Systems*

Fees are based on the number of procedures a facility performs.

For indexing 10,000 cases a year, MMF charges $4,000 a month. Include in the request for proposal the number of representatives the company will provide for training and for how long, advises Andrea Rodriguez, RN, BSN, CNOR, of Christiana Care, Wilmington, Delaware, which uses MMF.

—www.mmf.com

One Medical Passport  
*Medical Web Technologies*

Pricing varies based on the configuration, modules purchased, and surgical volume.

A community hospital with a standard configuration, for example, could expect to pay about $1,000 to $2,000 per month.

—www.onemedicalpassport.com

Eliminating the paper shuffle

The day before surgery, the OR staff prints out a hard copy of the patient’s folder.

“We still need a hard copy of the patient’s chart. But we have eliminated 60,000 pieces of paper we were shuffling each month,” says Rodriguez, noting physician satisfaction with MMF is high.

Anesthesia providers print out the patient’s information because the anesthesia department does not have an automated information system yet. The goal is to go paperless.

One Medical Passport

One Medical Passport (Medical Web Technologies, Scituate, Massachusetts) is a different approach, giving patients a free portable health record. Individuals can set up a “medical passport” on the company’s website (www.onemedicalpassport.com) and keep it for their records.

“Patients have a tremendous interest in creating a personal health record, and One Medical Passport is a great tool for doing this. There is no charge to patients,” says Stephen Punzak, MD, an anesthesiologist who is the company’s founder and CEO.

Health care facilities and physician offices pay a fee to access a patient’s One Medical Passport information, with the patient’s permission.

Geared for first-time users

Typically, patients find out about One Medical Passport when they schedule surgery with a hospital or surgeon who uses the system. The surgeon gives the patient a card with the surgery date, type of surgery, and how to access the website. The patient logs on at home, creates a user name and password, and fills out the online questionnaire. Patients cannot skip questions and can review the information before it is submitted.

“The system is geared for people who have never used it before and for those with limited computer experience,” says Dan Short, Medical Web Technologies’s vice president of sales.

The completed passport data is stored in the company’s secure storage facility and can be downloaded by any provider a patient has granted access to. The information either is displayed in a report format that can be printed or in an electronic format that can be interfaced.

Power of the passport

The power of the One Medical Passport

Continued on page 14

—www.docusys.net

Continued from page 11

provide an entire patient folder within 30 minutes of receiving a patient’s documents.

None of the data actually travels to India, Barranco notes. Personnel have read-only access to the documents that remain in the secure web servers.

Missing information is tracked down by MMF staff based in Panama (who speak fluent English), who phone surgeons’ offices.

Patients’ folders can be accessed by Christiana Care clinicians and office staff. Patients do not have access to the file.

“I can’t tell you how much the tracking service has changed the quality of life at the points of service,” says Rodriguez.
MANAGING TODAY’S OR SUITE

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Managing Today’s OR Suite

Practical tools for building staff loyalty

With the recession, it might be tempting to put staff recruitment and retention on the back burner. Employees may be staying in place for now because jobs are scarce. But these efforts are more important than ever, says Brian Lee, CSP, an expert on staff loyalty and leadership.

“The recession has not solved the staffing crisis,” he says. “There is still a shortage of nurses. And there are not enough seats in nursing schools to solve the problem.”

The focus should not be on “warm bodies” but assembling the best possible team.

“Basically, you succeed or fail based on the quality of staff you have,” says Lee. That’s increasingly true as managers are pressed for higher productivity, quality, and patient satisfaction.

A popular speaker from last year, Lee will present 2 sessions at the Managing Today’s OR Suite Conference Oct 7 to 9 at Caesars Palace in Las Vegas:

• an all-day seminar on Wednesday, Oct 7, titled “Magic of Frontline Leadership: Secrets of Accountability and Engagement”
• a general session on Thursday, Oct 8, titled “Thriving on Multiple Priorities: Proven Strategies for Work/Life Balance.”

In the all-day seminar, Lee will teach skills and share practical tools, such as 3 “loyalty-smart questions” to discover whether staff are thinking about leaving and “resignation recovery,” ways to save a person who’s already decided to depart.

He’ll also address what to do about the “whiners and slugs,” employees who have left mentally without letting anyone know.

“That can be a danger for some hospitals with low turnover, particularly small rural hospitals,” he says.

Finding a balance

In his general session, Lee will suggest how managers can find a balance as they manage multiple priorities.

He’ll describe strategies for identifying and setting priorities, keeping others from wasting your time, and identifying problem areas that block managers from achieving their goals.

Lee is CEO and founder of Custom Learning Systems, Calgary, Alberta, Canada. He is author of Keep Your Nurses and Health Professionals for Life and Satisfaction Guaranteed, both from Mastery Publishing.

Learn more about Lee at www.customlearning.com

Automation

Continued from page 12

Passport technology is not only in the data collection but also in what it does with the data, Dr Punzak says. Rather than simply printing out the patient’s information, the system routes the information to the clinician who needs it.

An Assessment Checklist module lists tasks and forms that need to be completed for each patient. As information comes in, the system automatically takes the task off the list. An audit trail shows who indicated the task was completed and when.

A document manager module automatically scans documents, alerts the facility the documents have been submitted, and automatically alerts the surgeon’s office if documentation is missing.

More accurate information

A surgery center that has used One Medical Passport for about a year finds the system has improved the accuracy of patient information.

Patients can fill out the online questionnaire from their homes in a relaxed manner, which helps ensure the information is correct and complete, says Gina Espenschied, RN, BSN, CNOR, administrator of The Surgery Center at Brinton Lake, Glen Mills, Pennsylvania, which performs about 500 to 600 cases a month.

“In the past, when preoperative nurses called patients, they often caught them in the car or at work with little time to focus on the questions,” she says. As a result, the information sometimes wasn’t complete or differed from what the patient gave on the day of surgery.

Espenschied says the document manager module has decreased surgery cancellations caused by missing paperwork by nearly 15%. Presently, about 70% of patients complete the Passport compared to 20% when the program was introduced.

— Judith M. Mathias, RN, MA
Computed tomographic (CT) colonography for colorectal cancer screening and diagnosis

OR leaders are striving to make evidence-based decisions about new technology. OR Manager, Inc., and ECRI Institute have joined in a collaboration to bring quarterly supplements with summaries of the Institute's technology assessment reports to OR Manager readers. ECRI Institute is an independent nonprofit organization that researches best approaches to improving patient care. It does its work by analyzing the research literature and data on clinical procedures, medical devices, and drug therapies.

Technology description

Computed tomography (CT) colonography uses 16- or 64-slice CT with software designed to construct a series of cross-sectional images (slices) of the interior surface of the colon into two-dimensional (2-D) or three-dimensional (3-D) images. CT colonography is intended for colorectal cancer (CRC) screening of asymptomatic individuals or as a diagnostic tool for symptomatic individuals who cannot or choose not to undergo conventional colonoscopy. CT colonography avoids some of the disadvantages of colonoscopy (i.e., invasiveness, increased risk of bowel perforation, need for sedation) and has been promoted as a way to increase patient compliance with CRC screening. Both procedures require the same bowel preparation.

Clinicians performing CT colonography can obtain images of the entire colon in 20 to 30 seconds. When scanning is complete, reconstructed 2-D or 3-D images are displayed on a workstation. Interpretation takes 15 to 60 minutes. If the interpreter recommends polyp removal or investigation of a suspicious lesion, same-day colonoscopy may be possible.

Regulatory status

The U.S. Food and Drug Administration (FDA) regulates CT systems, workstations, and image processing software under the 510(k) process as Class II devices. Numerous manufacturers have received FDA clearances for systems, workstations, and software used to perform CT colonography.
Hospital impact
A successful CT colonography service requires primary care physicians, radiologists, and gastroenterologists to collaborate. Because CT colonography is relatively new, patient inquiries and education can be time-consuming. A program coordinator may be helpful to coordinate staffing and equipment purchasing and to monitor clinician and patient education.

Credentialing/training
CT scanning is typically performed by technologists and interpreted by board-certified radiologists. Disagreement exists within the medical community regarding which clinicians are most appropriate to interpret CT colonography scans. Specialty societies are developing standards on instruction and qualifications considered necessary for proficiency in interpreting CT colonography. There is no consensus on the best training program.

Effect on other technologies
Several technologies can be used as an adjunct to CT colonography, including fecal “tagging” (including barium solution), iodine-containing contrast agents, and computer-generated “virtual reality” images to remove fecal matter from CT images.

CT colonography competes with conventional colonoscopy, the gold standard method of screening for polyps and evaluating symptomatic patients. However, because suspicious polyps can only be viewed but not removed during CT colonography, CT colonography will not replace conventional colonoscopy.

Phase of diffusion
CT colonography is widely available throughout the United States in hospitals and freestanding clinics. The addition of CT colonography to the American Cancer Society’s 2008 guidelines for CRC screening and surveillance has spurred adoption of this technology.

Device costs/procedure charges
Generally, CT colonography is performed using 16-slice or 64-slice CT scanners. The average list price for a new 16-slice CT scanner base system ranges from $700,000 to $900,000. The list price for a 64-slice CT scanner system ranges from $1.8 to $2.4 million. The price typically includes the scanner unit, control console, and acquisition and processing workstation configured with appropriate software packages for image review and postprocessing capabilities. As hospitals are upgrading to 32- and 64-slice CT scanners, secondhand 16-slice scanners are becoming available for $500,000 to $600,000.

Typical charges for CT colonography, including practitioner and facility fees, range from $567 to $895 per exam.

Reimbursement/coding/payment
The U.S. Centers for Medicare & Medicaid Services (CMS) has not issued a national coverage determination (NCD) for CT colonography. However, in February 2009, CMS determined that there is inadequate evidence to classify CT colonography as an appropriate CRC screening test. CMS expects to issue a final NCD in May 2009.

The American Medical Association has assigned two category III Current Procedural Terminology codes for CT colonography: one for screening and one for diagnostic.

According to the 2009 Hospital Outpatient Prospective Payment System, the CMS payment rate for diagnostic CT colonography is $191.78. Physician fees are carrier priced and at the discretion of local carriers, which base payment on a per-case basis following documentation review.
**Cost considerations**

ECRI searches identified eight cost-effectiveness analyses published in the peer-reviewed literature (Sonnenberg et al., 1999; Heitman et al., 2005; Arnesen et al., 2007; Hassan et al., 2007; Pickhardt et al., 2007; Vijan et al., 2007; Lansdorp-Vogelaar et al., 2008) and a January 2009 Agency for Healthcare Research and Quality evidence report.

An improvement in CT colonography accuracy, a reduction in cost, and/or an increase in compliance rates were identified in the eight reviews as factors that could make CT colonography more cost-effective.

**Key clinical questions/findings**

The clinical questions and findings are

- Does the rate of development of CRC, patient-survival, or quality of life differ between CT colonography and colonoscopy when used for CRC screening or diagnosis? No sufficient follow-up data were available to address this question.

- What is the sensitivity and specificity of CT colonography for detecting clinically important polyps and cancer when used for CRC screening or diagnosis? CT colonography appears most promising for screening average-risk asymptomatic individuals. Our meta-analysis found the sensitivity estimate to be 91% (95% confidence interval [CI]: 86% to 95%). We could not accurately estimate specificity due to differences among study findings. For screening high-risk asymptomatic individuals, the results of our meta-analysis suggest that large polyps and cancer may be missed in many patients. The estimate for sensitivity was only 72% (95% CI: 60% to 80%). For diagnosing symptomatic patients, the sensitivity was 88% (95% CI: 76% to 95%), and the specificity was 99% (95% CI: 96% to 100%). The posttest probability of disease with a positive test was 92% (95% CI: 73% to 98%), and the probability of disease with a negative test was 1% (95% CI: 1% to 3%).

- Do patients prefer CT colonography or colonoscopy? Data from nine studies indicated that most patients preferred CT colonography, although the proportion of patients favoring CT colonography ranged widely—from 37% to 90%.

- What adverse events are associated with CT colonography? Adverse events were infrequent and generally minor, but longer follow-up is needed to assess those attributed to radiation exposure. Studying greater numbers of patients may detect rare events.

- Does offering CT colonography for CRC screening increase compliance with screening recommendations? No conclusions can be drawn due to the insufficient quantity of evidence.

Excerpted with permission from ECRI Institute’s TARGET database of evidence reports on emerging technologies. The complete report can be purchased from ECRI Institute’s Health Technology Assessment Information Service at htais@ecri.org.

ECRI Institute is an independent nonprofit health services research agency designated as an Evidence-based Practice Center by the U.S. Agency for Healthcare Research and Quality. The Institute maintains the strictest conflict-of-interest standards in the healthcare industry to protect against bias and ensure the integrity of its information.

**SELECTED REFERENCES**


SELECTED REFERENCES


Quantity of Evidence Base (High)
The evidence base consists of 17 studies that assessed 7,460 patients. Of these studies, 6 assessed 5,857 asymptomatic patients, and 11 evaluated 1,603 symptomatic patients.

Quality of Evidence Base (High)
ECRI Institute analysts used an assessment tool to formally examine factors of study design that may have the potential to reduce the validity of conclusions.

Consistency of Evidence Base (Low)
When possible, ECRI Institute analysts used statistical tests to determine the consistency of the evidence base. No study compared patient survival or quality of life of patients who underwent computed tomographic colonography to that of patients who underwent colonoscopy for colorectal cancer screening or diagnosis. Sensitivity was consistent among studies on asymptomatic, average-risk individuals and symptomatic individuals but was not consistent among studies on asymptomatic, high-risk individuals. Consistency was not evaluated for other outcomes due to a paucity of evidence.
Endo reprocessing lapses at the VA

Follow the published manufacturer’s instructions—that message is being hammered home once again following errors in the setup and reprocessing of endoscopy equipment at 3 Veterans Affairs (VA) facilities. The errors involved use of a wrong connector and failure to follow reprocessing instructions for tubing, according to the VA.

The incidents have messages for all GI labs, says James Bagian, MD, director of the VA’s National Center for Patient Safety.

“This is not just a problem for the VA,” he told OR Manager. “Manufacturers tell us as many as 9 out of 10 facilities they see are not reprocessing this equipment correctly.”

Testing offered

The VA has notified more than 10,500 veterans who may have been exposed to cross-contamination during endoscopy at VA facilities in Murfreesboro, Tennessee; Augusta, Georgia; and Miami during periods ranging from April 2003 to March 2009.

Dr Bagian says it’s not clear when the problems first arose, but the VA took a conservative approach in offering testing.

As of April 27, 2009, 6,687 veterans had received their test results, the Department of Veterans Affairs said. In all, 8 had tested positive for hepatitis B, 25 for hepatitis C, and 5 for HIV. Results do not necessarily indicate any relationship to the endoscopy procedures, the VA said. An epidemiologic investigation is being conducted to check for any such relationship.

The risk of hepatitis transmission through endoscopy is “extremely small,” the VA notes. HIV transmission through endoscopy has never been reported.

What happened?

The first error reported was use of a wrong connector to attach the auxiliary water tube to the endoscope’s irrigation source (illustration).

“Somebody apparently disassembled one tube and put the connector on another tube,” Dr Bagian says. He said the action shows “a lack of appreciation for the fact that medical devices should not be modified by clinical personnel without consultation with the appropriate authorities.”

The wrong connector has no valve. The correct connector has a 1-way valve that prevents fluid from flowing backward and contaminating the irrigation filter and tubing. Both connectors are green, but the incorrect connector has 1 wing, and the correct one has 2 wings.

Other errors surface

As other VA facilities reviewed their practices, more lapses surfaced:

• In some facilities, the auxiliary water tube wasn’t being reprocessed between patients, as the manufacturer recommends. The auxiliary water tube must be reprocessed each time it is used, according to alerts from the VA and Olympus, the endoscope manufacturer.

• The irrigation tube and its filter weren’t always being discarded at the end of the day, as instructed by the manufacturer.

• The auxiliary water tube was not always primed and flushed as directed.

These errors are described in a VA Patient Safety Alert (www.patientsafety.gov/alerts.html).
AORN Works provides fresh eyes with a fresh perspective of your operating room operations. Our renowned team of master's prepared clinical consultants have walked in your shoes and know how your O.R. should run...and how to enhance it. Our operational assessments will help to improve your processes and our never events evaluation techniques will ensure that you've incorporated the best practices into your operating room. AORN Works has the systems, people and tools you need to get your perioperative arena not only up to speed, but ahead of the rest.
OR Manager to launch webinar series

OR Manager, Inc, is launching an educational webinar series to provide the latest information on OR management to 3 key audiences:
• OR directors and managers
• OR business managers
• new OR managers.

“OR Manager is the premier provider of information and education relating to management of the OR,” said OR Manager President Elinor S. Schrader.

“We want to make our information more accessible. With the economic downturn, hospitals are restricting travel, which makes it difficult for some managers to attend educational events.

“With webinars, you can participate in an education program without leaving your office. For a single fee, others can also participate,” Schrader said.

“Ways of learning and accessing information are changing rapidly, and OR Manager is adding this technology to our electronic information, which includes the digital edition of OR Manager.”

OR directors

Starting in June, V. Gerard Ippolito will present 4 webinars on surgical services business development and planning. He is president of OR Efficiencies, LLC. Christina Dempsey, RN, MBA, CNOR, senior vice president of clinical operations, Patient Flow Press Ganey, will offer a webinar on improving patient flow.

Business managers

In July, several sessions from the recent OR Business Management Conference will be offered. Connie Curran, RN, EdD, FAAN, who keynoted the conference in Chicago in May, will present a webinar on how OR leaders can deal with the key issues of money, quality, and manpower.

New OR Managers

In the fall, a series of webinars designed to help new managers learn basic OR management skills will be offered. These will be valuable for OR nurses who want to move into management positions.

For more information, go to www.ormanager.com

Endoscopy

Continued from page 19

VA stresses that the alert applies to all flexible endoscopes and accessories, regardless of the manufacturer or model.

Many facilities thought they were doing the right thing but weren’t, Dr Bagian says. He emphasized the need to follow manufacturers’ written instructions explicitly for each component in the endoscopy setup.

Relying on diligence alone “is not enough,” he says. He advocates a quality control approach similar to that aviation employs for its mechanics, including detailed standard operating procedures, frequent training, testing, and accountability.

“The airlines understand if you don’t do a process meticulously, accidents happen, and people die,” he says.

His advice for GI labs:
• Make sure all procedures are consistent with manufacturers’ instructions. Locate instructions for all components and do a side-by-side comparison with your procedures.
• Develop standard operating procedures. Make sure the procedures are posted where they can be easily seen and are followed. “No one can accurately perform 48 reprocessing steps from memory every time,” he says.
• Instruct personnel to verify any advice given by company sales representatives. If a rep says, “Sure, you can do this,” require the rep to show where that instruction is written in the manual or to provide the instruction in writing, Dr Bagian advises.
• Test personnel on standard operating procedures.
• Conduct informal observations. Walk in and watch scopes being reprocessed. If some personnel aren’t capable of following directions consistently, “they need to be in different jobs,” he says.

Physicians and nurses share in the accountability, he adds. All clinicians should know the equipment and how to use it correctly. They should hold one another accountable. For example, if one clinician observes another is not flushing the endoscope when necessary before inserting it in the patient, “the clinician is obligated to speak up,” Dr Bagian says. “It’s just like telling someone to wash their hands or change gloves.” If the person doesn’t comply, a supervisor should be notified.

Standards for endoscope reprocessing are posted on the Society of Gastroenterology Nurses and Associates website at www.sgna.org

What is needed to be ready for a Joint Commission survey with regard to sterilization practices, both now and in the future? Experiences with recent surveys were shared by 20 operating room managers with responsibility for the OR and sterile processing department (SPD) at an all-day session on sterilization at the AORN Congress in March in Chicago. The managers identified issues the surveyors were concerned about, departments they visited, and questions they asked.

In the past, though surveyors often asked to see documentation of OR and SPD services, they did not always don scrubs and walk through the operating room or the sterile processing department. It appears this has changed. Participants reported that surveyors walked through both departments, visiting the decontamination, prep and pack, and storage areas in SPD and the instrument processing and sterilization areas in the operating room.

None of the issues surveyors looked for were surprises. They were issues that should be included in routine quality assurance audits, such as flash sterilization, pack integrity, sterilization process monitoring, and whether practice is consistent with policies and procedures.

Interestingly, except for checking to see that documentation of flash sterilized items identified the patient involved, none of the participants said the surveyors included instrument processing in patient tracers. In the tracer process, a surveyor selects a patient and, using the patient’s record, retraces the “specific care processes that an individual experienced.” The purpose of a tracer is to assess an organization’s systems of providing care and services.

It may be only a matter of time before the tracer process is expanded to include the ability to trace instrument sets to specific patients. The tracer methodology and instrument traceability seem to go together. Although SPD does not provide patient care, it does provide services that affect the quality and safety of care. In fact, one surveyor specifically asked if the department could track instruments to patients but did not pursue this further.

**Flash sterilization**

Regarding flash sterilization, managers said surveyors wanted to know the flash sterilization rate, what was being flash sterilized, and how often. Eye instruments were of particular concern. Several managers reported having to purchase eye instruments as a result of the survey as well as concern about reports of TASS (toxic anterior segment syndrome). TASS, an acute, noninfectious inflammation of the eye’s anterior segment, is a complication of surgery on the anterior segment, such as cataract extraction.

Surveyors asked to see the policy for flash sterilization to determine if practice reflected the policy. They also inspected flash sterilization documentation records for completeness and traceability to the patient.

**Documenting flash sterilization**

Managers need to monitor how well flash sterilization documentation is being maintained. The AORN recommended practices for sterilization state that flash sterilization documentation should include:

- item being processed
- patient receiving the item
- cycle parameters used (e.g., temperature, duration of cycle, and the date and time the cycle is run)
- operator information
- reason for flash sterilization.

Flash sterilization records should be neat, well organized, and legible; anything else suggests carelessness. One suggestion is to use a 3-ring binder with one page for one flash sterilization cycle, with a preprinted designated space on each page for the sterilizer printout (or printout information entry). The printout should fit into the space and not overlap the page. Any excess paper on the printout should be removed. Tethering a pair of scissors and a stapler to a site next to the log book can help accomplish this.

Documentation should be protected from water splashes. A flash sterilization log kept next to a sterilizer located near a sink is a prime target for splashes and stains, which can result in a messy and crinkled log that suggests sloppy practice. Plastic page covers may be used to protect the documenta-
Monitor flash sterilization documentation.

But BI monitoring is not optional for loads containing implants.

Considering the mix of most loads in high-volume facilities, monitoring every load with a BI makes sense. Monitoring every load ensures that any set containing an implant (screw, wire, plate, etc) will not inadvertently be released without a BI having been run with the load. It makes it easy to answer the Joint Commission surveyor wanting to know when and why a BI is run.

Tracers in the future?

Joint Commission surveyors may not include instrument sets in tracers right away. But managers should be aware that is a possibility for the future.

Traceability is addressed in the steam sterilization standard from the Association for the Advancement of Medical Instrumentation (AAMI ST:79), which states, “Ideally, cleaned medical devices should be traceable to the patients on whom they are used... Ideally, every processed device, especially an implant, should be fully traceable to the patient on whom it is used and in whom it is implanted.” The word “ideally” is used because the AAMI committee responsible for writing this guideline recognizes that many facilities do not yet have automated tracking systems that allow traceability. In addition, most tracking systems permit traceability to a particular instrument set but not to individual instruments.

Is it only a matter of time before surveyors ask to see documents that can identify the instruments used on a particular patient? Facilities with low surgical volumes may be able to track instruments manually, but for large-volume facilities, a computerized instrument tracking system would be needed to meet the AAMI recommendation for instrument traceability. If in the future, the Joint Commission incorporates instrument processing into the tracer methodology, an automated tracking system would serve the facility well.

—Cynthia Spry, RN, MA, MSN, CNOR
Independent Clinical Consultant

References


Do you have a question on sterilization and infection control?

Send questions to Pat Patterson, editor, at ppatterson@ormanager.com. We’ll consider them for the column.
GPO purchasing of implants lags

On average, hospitals purchase 73% of their materials through group purchasing organizations (GPOs), with a wide range from 30% to 90%. But fewer—19%—purchase expensive orthopedic implants through GPO contracts, a new survey finds.

Eugene S. Schneller, PhD, a business professor at Arizona State University, Tempe, and a supply chain consultant, surveyed 28 systems representing 429 hospitals about their commitment to group purchasing, including savings, satisfaction, and perceived value. The study was financed by the Health Industry Group Purchasing Association (HIGPA), a GPO trade group.

GPOs are organizations that buy on a large scale and negotiate discounts from vendors. They also provide services like consulting and performance improvement efforts.

Survey highlights:
• Overall average savings attributed to GPO contracts: 18.7%.
• Percent of general med-surg supplies purchased through GPO: 82%.
• Average hospital supply expense as percent of net revenue: 18.5%.

On the labor impact of group purchasing, findings indicated the average hospital would have to hire 9 FTEs to replace services GPOs provide.

The average hospital in the study had 380 beds, 20,000 annual inpatient admissions, and $62 million in supply spending.

From the findings, Schneller projected that GPOs save the US over $36 billion in direct health care costs annually. More savings would be possible if GPOs were more widely used, he added.

He and others speaking at an April 29 news conference called GPOs “key players in health care reform” and said greater use of group purchasing could aid hospitals, which have been heavily hit by the recession.

Implant purchasing lags

For items such as total joint prostheses, pacemakers, and cardiac stents, group purchasing has not penetrated far (table, p 25).

These items, driven heavily by physician preference, are more difficult to consolidate for group buying than bulk supplies.

They are also a big cost challenge, accounting for about 60% of a hospital’s total materials spend, according to a 2007 report by Schneller and his coauthor Kathleen Montgomery.

For hospitals that do purchase these items through GPO contracts, estimated average savings are:
• 15% for orthopedic implants
• 17% for cardiac devices.

It’s hard to compare these savings with savings hospitals can get on their own because of the nondisclosure clauses in their contracts, Schneller notes.

The most common way hospitals use GPOs for physician preference items, employed by 50%, is as a starting point for negotiations, the survey found.

Over a third (37.5%) say they have a strategy to use GPOs for implant purchasing, even though only 19% buy their hip, knee, and spine implants mainly through GPO contracts.

The findings suggest many hospitals indicated they would like to go further, with over half (56%) saying they want to improve their GPO contract participation for these items.

Why the gap?

Why the gap between intentions and behavior on physician preference items? Schneller suggested several reasons: Some may believe there is an advantage in doing their own contracting, using GPO pricing as a benchmark, or they may be working with their GPO on custom contracting.

Schneller told OR Manager he sees collaboration increasing among orthopedic makers, hospitals, and GPOs, though that was not part of the survey.

“As some orthopedic suppliers have had issues with the Department of Justice and are less able to reach physicians, they have tended to collaborate more with hospitals,” he says.

He was referring to the Justice Department’s 2007 agreement with major implant manufacturers. In the deal, the companies avoided criminal prosecution and paid more than $300 million to settle claims over charges they had paid physicians kickbacks for use of their brand of implants. As part of the deal, companies were required to post on their web sites lists of consulting arrangements with physicians.

There have also been calls for stricter conflict of interest policies for physicians and industry, most recently by the Institute of Medicine.
Schneller says he has been “fairly vocal” about the need for transparency in implant pricing as well as a national registry to track implant use and outcomes. The outcomes data could be used to compare the effectiveness of various types of implants. Attempts to set up a registry have been slowed by questions about funding, how to encourage participation, data privacy, and who would manage and own the data.

**Supply expense per discharge**

In the overall findings, hospitals with lower use of GPO contracts are likely to have higher expenses per adjusted discharge than hospitals with high GPO contract use, especially for general medical products, housekeeping, and other clinical products.

All of the reasons for this difference aren’t known, but Schneller says hospitals that aren’t making high use of their contracts “would be wise to review their current strategies.”

For every 1,000 admissions, a hospital underperforming in this area could save as much as $400,000, and a system could save almost $900,000, he noted.

In addition, he notes, hospitals give a high value to other services GPOs provide besides pricing, such as monitoring the market for drug shortages, identifying safety products, and managing suppliers’ failure to adhere to terms and conditions.

**Collaboration with implant vendors is increasing.**

GPOs’ role in physician preference items

<table>
<thead>
<tr>
<th></th>
<th>% principally use GPO contracts</th>
<th>% have GPO assist in local negotiation</th>
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<td>15.4</td>
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New report advises stronger policies on conflict of interest

The Institute of Medicine (IOM) recommends voluntary measures to curb conflicts of interest between physicians and industry.

The report, released April 28, 2009, calls on Congress to require companies to report on a public website payments to physicians, researchers, and others.

Recommendations address disclosure of financial ties, limits to company payments and gifts, and removing industry influence from medical education and practice guideline development.

The report advised medical centers, professional societies, and others to establish or strengthen their conflict of interest policies.

The IOM committee said it found a great deal of variation in conflict of interest policies and adherence with them.

**Reference**

The economy is taking its toll on ambulatory surgery centers (ASCs) and other outpatient facilities.

In all, 60% of ambulatory care organizations in a new survey have seen demand for their services fall over the past 12 months. For 11%, the decline was 20% or more. About one-fourth (27%) have seen no change.

Most of the survey participants (76%) were ASCs, 9% were office-based surgical centers, and the rest were other outpatient organizations. The majority (64%) are physician owned.

“A number of ASCs are hurting from the economy, though it really varies. If they have not been impacted, they are getting ready. Almost everyone is in some form of watchful waiting,” says Naomi Kuznets, PhD, of the Accreditation Association for Ambulatory Health Care Institute for Quality Improvement (AAAHC Institute). The institute invited 4,000 AAAHC-accredited organizations to participate in the online survey in March, with 985 responding (25%).

Declines in volume were highest in the Midwest, the Southeast, and the Southwest.

For 57% of organizations, elective procedures were declining faster than nonelective procedures. And for just over half (51%), self-pay procedures were dropping faster than procedures reimbursed by third-party payers.

Basic services affected

The recession’s effect is being felt not only on self-pay and elective services like cosmetic surgery but also on basic services such as general surgery, ENT, and pain management, Kuznets says (sidebar, p 27).

Three-fourths (76%) of respondents reported a negative impact on patients’ ability to pay their co-pays and deductibles.

Some facilities said they had seen an increase in patients who are delaying, canceling, or not showing up for procedures. Among reasons were the higher copays and deductibles or fear of losing work because of illness or taking time off.

In response, facilities are tightening their belts. Even those that have not had a decline in volume are taking steps to conserve resources. Two-thirds (67%) reported the economic downturn had had negative effects including:

- making capital purchases (44%)
- purchasing supplies (31%)
- hiring or retaining staff (29%)
- purchasing services (12%)
- floating payroll expenses (9%).

In addition, 2% said the economy had affected decisions to give raises or bonuses, and 2% said it had affected staffing hours or wages (1%).

Staffing changes

“Most didn’t say they are reduc-
ing the number of staff,” says Kuznets. “It’s more that they are redistributing hours and keeping salaries where they are.”

Reports on changes in the number of RN staff over the past 12 months varied widely, from -14 to +35, with a median of 0.

A number of centers commented that they were reducing staff hours and freezing hiring and pay.

Some said their benefit costs are rising, perhaps because staff members are adding spouses who have lost their jobs or insurance.

**Some add staff**

Not everyone was tightening up. One ASC had added 30 RNs over the past year. The facility was focused mostly in orthopedics, podiatry, and pain management, which are paid for by Medicare and workers’ compensation, Kuznets notes.

Several other centers that reported they were hiring more nursing staff were also performing podiatry, pain management, and orthopedic cases.

She says most centers are likely to follow similar strategies by shifting their mix of cases to specialties where more patients are covered by government payers such as Medicare and workers’ comp.

**How are ASCs adjusting?**

Some centers are going after more volume, with 28% reporting they have stepped up their marketing efforts in the past year. But almost none (91%) said they have lowered their prices in response to the economy.

Perhaps because of the greater numbers of patients who must pay for more of their care out of pocket, 40% of centers said they have increased their collection practices, while only 12% have reduced these efforts.

Kuznets says the institute plans to repeat the survey in 6 months.

**Hardest hit specialties**

Percentage of facilities reporting declines:

- Cosmetic surgery (76%)
- General plastic surgery (73%)
- General surgery (72%)
- Vascular surgery (71%)
- Podiatry (68%)
- ENT (67%)
- Pain management (66%)
- Gastroenterology (66%)
- Pediatrics (65%)
- Urology (65%)
- Orthopedics (64%)
- Obstetrics/gynecology (63%)
- Ophthalmology (62%)

Source: AAAHC Institute.

**Some are going after more volume.**

**Change in volume in past 12 months**

<table>
<thead>
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<th>Change in Volume</th>
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<tr>
<td>Minus 30% or more</td>
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<tr>
<td>Minus 20%-30%</td>
</tr>
<tr>
<td>Minus 0-20%</td>
</tr>
<tr>
<td>Increase 12%</td>
</tr>
<tr>
<td>No change 27%</td>
</tr>
</tbody>
</table>

Source: AAAHC Institute.

**Are elective procedures decreasing faster than nonelective procedures?**

- 57% Yes
- 29% No
- 14% Don’t know

Source: AAAHC Institute.

**Reference**


Test-drive the new digital OR Manager at www.ormanager.com.

It’s included with the Super Subscriber subscription. You can upgrade to a Super Subscription by calling 800-442-9918.
Electronic commerce, slow to come to hospitals, has been even slower to reach ambulatory surgery centers (ASCs). Part of the reason is that large, distributor-hosted ordering systems were impractical for small clients such as ASCs. Even most Internet-based systems, now in common use, were designed for high-volume transactions.

That is changing.

In January, Cardinal Health, Dublin, Ohio, joined a growing number of distributors supporting a software package called SourcePlus Purchase Connection (PCX), which provides order management and supply chain forecasting through an electronic data interchange (EDI) connection using a web portal. Three other distributors currently link to PCX: Medline Industries, Mundelein, Illinois; McKesson Corporation, San Francisco; and Blue Medical, Jacksonville, Florida.

SourcePlus was designed specifically for ASCs by SourceMedical, Wallingford, Connecticut.

The system allows users to submit supply orders to participating vendors and to have a single computer-based record of their ordering, receiving, and spending. Vendors do not need to make any modifications in their own systems to work with it.

Using SourceMedical’s software and a distributor’s ordering system, SourcePlus also gives surgery center customers rapid order confirmations and price updates. Customers pay a monthly subscription fee for access to the web portal.

The company recently introduced an advanced version that coordinates just-in-time (JIT) distribution and another that posts payments electronically to other business systems.

Purchasing is only one ASC function for which automation technology is becoming available. Since the beginning of 2009, the choice of ASC-dedicated systems has expanded, often as a result of joint ventures between SourceMedical and smaller companies seeking access to its customer base of about 2,250 ASCs and 65 surgical hospitals.

According to president and chief operating officer Scott Palmer, “Because we have by far the greatest market share, we get to pick the best companies to partner with.”

New products include One Medical Passport, an online patient registration system developed by Medical Web Technologies (related article, p 11); AutoPost, the payment system, from ZirMed; Business Intelligence, a reporting system used by multi-facility ASCs, created by MediBis; Edge Survey, a physician satisfaction measure from CTQ Solutions; and SourcePlus Elite, the JIT version, developed with IOS Corporation.

SourceMedical is one of many automation vendors an ASC may consider. The large software companies such as Lawson, PeopleSoft, and McKesson have hospital systems with multiple components, such as materials management, financial, and clinical, that a large ASC might be able to afford and use.

Some distributors provide hardware to set up direct e-commerce ordering and payment but only for products that distributor sells.

At the other end of the scale, smaller companies offer systems designed for physician practices. The catch, say experts, is that those systems are not designed to meet the specific needs of ASCs with their focus on high surgical volumes, small staff, and cost containment.

Software “timeshare”? Mike Cummins, senior vice
president and chief information officer of the hospital alliance VHA, Irving, Texas, who has watched the evolution of e-commerce and electronic data processing at hospitals for the past decade, believes ASCs may be better off with the big companies but under agreements that allow them to avoid major investments.

“They run on a much thinner shoestring in terms of profit,” he says of ASCs. “If you’re small, you can’t afford Lawson. However, you don’t have to buy a whole system. You can go to software suppliers and in effect lease time on a server. Lawson or PeopleSoft [among others] do that.”

In fact, Cummins says, that model may be the trend for ASC automation.

**Trends**

“There are 2 things I think will happen,” he says. “First, I see an evolving group of small companies that will try to service [ASCs]. Most will be software ASP (application service providers, or software accessed online) services.

“Second, we will see ASCs and even hospitals using a model that was discarded in the past. They will go back to software services, integration, and fewer data centers within the organization to avoid the cost of maintenance and staff.”

The rapid pace of technology advancement will only make the “rent” option more attractive, Cummins notes.

Most hospitals buy equipment and software, which they must maintain, upgrade, and integrate with other systems. Cummins predicts many hospitals will return to the days when they let a vendor provide and maintain the system in return for a monthly lease payment.

“What I’m seeing is, hospitals are not interested in owning a system,” he says. “That allows them not to use capital. They pay for access to the system owned by someone else, the big software company, like a time share.” Reliability and security are the vendor’s responsibility, he adds.

“It depends on your philosophy: Do you buy and own or pay as you go?”

He believes they will even prefer this model to new web-based systems. “A web system can be as hard to talk to as an owned system. They must conform to standards, but not all do.”

**A different path**

The “time-share” model would seem ideal for ASCs. But the recent expansion of products custom-made for ASCs may set some on a different path.

Stephen Punzak, MD, CEO of Medical Web Technologies, Scituate, Massachusetts, notes about 45% of the ASC market has already invested in SourceMedical products. “An electronic health record system will be the key to bringing together technology and workflow to achieve these results.”

For SourceMedical clients, the ASC-specific product will be the Vision series of upgraded systems that will automatically transfer new data to an embedded EHR.

Palmer maintains ASCs need dedicated products because of their purpose and structure.

“By its very mission,” he says, “an ASC is a lean facility, focused on quality, convenience, and low cost. If you look at that model, can you put in a hospital system? No, because it doesn’t support being lean.”

Unlike hospitals, with many functional departments, ASCs need a unified system, he explains. “There are no modules. You buy the whole system, and you don’t need an IT department; it is run by a nurse administrator, typically.”

The cost of such an integrated system is about $40,000, Palmer says, and adding an EHR component currently adds $40,000 to the cost.

**Virtual procedure trays**

One of SourceMedical’s new products aids sterilization record-keeping. Currently, sterilizers print out data tapes that must be reviewed and stored. The new Instrument eManager system, part of the company’s AdvantX series, follows the process from receiving used instruments from the OR, into the sterilizer, through preparing new trays for the next procedure. It connects with the sterilizer and creates an electronic report of sterilization results. It shows a “virtual tray” on the screen, so the technologist can see which instruments

Continued on page 30
are needed in assembling the actual tray.

“It’s harder for the tech to make a mistake,” Palmer notes. “Having a picture is a big benefit. There’s a training effect and no more tracking of sterilizer tapes.”

**Conditions converging**

Conditions are converging to make automation almost inevitable. The American Recovery and Reinvestment Act of 2009 (the so-called stimulus package) makes technology use, especially EHRs, a priority in the effort to improve health care quality (related article, p 1).

Even without the new rules, Dr Punzak says there are good economic reasons to choose electronic processing.

“The economy is going to cause surgical facilities to review more closely how they can maximize their investment dollars and take advantage of technologies that will streamline efficiencies and reduce costs,” he notes.

Besides, Palmer adds, physicians appreciate the convenience as well as cost-effectiveness of automation.

“There is going to be increasing pressure on margins. How do you combat that? With good information and technology.”

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**Electronic**

Continued from page 29

Consumer group cites progress on surgical infections

Hospitals have made progress in preventing surgical infections, but too many patients fail to get the right care, according to a new Consumers Union report.

Analyzing data from the government’s Hospital Compare website, the group estimated that for 2007-2008:

- 90.8% of patients received an antibiotic within 1 hour before surgery
- 95.4% received the appropriate antibiotic
- 87.1% had antibiotics stopped within 24 hours after surgery.

The report shows how hospitals are performing by state.

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**Medical Director for Outpatient Surgery Center**

The Department of Anesthesiology and the Perioperative Services division at the Dartmouth-Hitchcock Medical Center are seeking a physician leader to serve as Medical Director of a new outpatient surgery center. This is a faculty position with the Dartmouth-Hitchcock Clinic and Dartmouth Medical School, a collegial physician-managed group practice that values clinical care, administrative ability, education, and research. It is anticipated that the appropriate candidate would collaborate extensively with Perioperative Services leadership in addition to committing some time to active clinical practice and scholarly activities. Dartmouth-Hitchcock Medical Center is a state-of-the-art facility located in the Upper Connecticut River Valley of New Hampshire, a scenic area of Northern New England with cultural, academic, and recreational activities readily available. It is essential that candidates be Board Certified or Board Eligible. Academic title and compensation will be consistent with experience and Dartmouth-Hitchcock Clinic policies.

Please refer to our website for further information:

http://www.dhmc.org/dept/anesthesiology

Please fax or send your curriculum vitae to:

Thomas M. Dodds, MD
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Chairman, Faculty Search Committee
Dartmouth Medical School
Dartmouth-Hitchcock Medical Center
One Medical Center Drive, Lebanon, NH 03756
Fax: (603) 650-8980

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**Share your success!**

Has your ambulatory surgery center made major strides? Have you improved care or found ways to be more efficient? Share your success with your colleagues.

Contact Pat Patterson, editor, for a possible interview at ppatterson@ormanager.com

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How do you feel this textbook will assist institutions with their perioperative education goals?

“This book is ideal to be incorporated into any safety, standards or quality class, especially at the graduate level. It can also be easily incorporated into any surgical services department. The organizational focus of the book lends itself to looking at the patient from a systems approach as they proceed through the Perioperative milieu. This should allow the Perioperative Educator to tailor a plan for individuals and meet both the nurse and the organization’s needs. As a reference book the Perioperative community will be able to support educational offerings with evidence and rationales that will give validity to surgical nursing interventions.”

How can this textbook benefit perioperative professionals preparing for the CNOR® certification?

“This book would be an ideal companion book to be used with AORN Standards and Recommended Practices to provide a comprehensive data base to prepare for the CNOR® certification. The Perioperative nurse with two years of experience will be able to take the knowledge in this book and synthesize it into practice type situations. This will allow the nurse to prepare for application-based questions that are important in assessing not only knowledge but competency.”

How does this textbook compare to similar textbooks already in the market?

“The safety focus of this textbook is definitely what separates it from its comparative counterparts. The Perioperative systems based approach starts by taking an upper-level view of the surgical environment. The bird’s-eye view allows us to examine the system and breaks the situation down into Microsystems all the while keeping patient safety in the forefront. Then the book leads us into specialty scenarios that are similar to the organization of other texts. I especially like the combination of graphics and photos to support the information that is provided in text format.”

Who would you recommend this book to and why?

“I would and have recommended this book to be utilized at many different levels of Perioperative education. Novice nurses that are gaining Perioperative knowledge will be able to utilize this textbook to provide them with a strong foundation of Perioperative skills. Nurses that have spent at least two years refining their skills will be able to take this text and utilize it to gain surgical knowledge and synthesize it to allow them to be successful with knowledge in application-based assessment techniques that are incorporated in both the CNOR® and CRNFA® assessments.”

Theodore J. Walker, RN, BSN, MSN, CNOR®, ACNS, BC Major, USAF, NC is a Perioperative Clinical Nurse Specialist with the Mike O’Callaghan Federal Hospital in Las Vegas, Nevada. He has been a perioperative nurse for 15 years.

For information on how to purchase Competency for Safe Patient Care During Operative and Invasive Procedures, visit the CCI website at www.cc-institute.org/land_patientCare_ORM.aspx. Or call 888.257.2667.
Economic crisis takes toll on patients, hospitals

Nearly half of 1,078 hospitals responding to a survey by the American Hospital Association released April 27, 2009, have cut staff, and 9 in 10 have made cutbacks to address economic challenges. Highlights:

- 59% have seen a decline in elective procedures, with 18% seeing a significant decline.
- 65% have seen a decrease in total margins in 2009 over 2008, with 39% reporting a significant decrease.
- Hospital employment is no longer growing.
- The number of mass layoffs for hospitals in February, at 23, was double the 12 in February 2008.

More than 40% expected losses in the first quarter, up from 26% for the first quarter of 2008. Some 80% reported cutting capital spending for facilities upgrades and technology.


Meta-analysis:
Supplemental oxygen lowers SSI rate

Perioperative supplemental oxygen has a significant effect on the prevention of surgical site infections (SSIs), finds a meta-analysis in the April Archives of Surgery. The analysis included 5 randomized, controlled studies involving 3,001 patients.

The data showed a 12% infection rate in the control group and a 9% infection rate in the supplemental oxygen group, for a relative risk reduction of 25% and an absolute risk reduction of 3%. The benefit was greater in colorectal procedures.


Bariatric surgery outcomes no better for centers of excellence

Designation as a bariatric surgery center of excellence does not ensure better patient outcomes nor does annual procedure volume, according to a report in the April Archives of Surgery.

Researchers compared outcomes of 19,363 patients who had bariatric surgery in 253 hospitals. About 28% had the procedures at centers of excellence. Outcomes were equivalent at centers of excellence and hospitals without this designation. The average cost at centers of excellence was $11,527, compared with $10,984 at other hospitals.

Since 2006, Medicare has paid for bariatric surgery only at centers of excellence.


Study backs electrophysiologists implanting cardioverter defibrillators

Patients who have cardioverter defibrillators implanted by cardiologists trained in electrophysiology have fewer serious complications than patients who have the devices implanted by other cardiologists, thoracic surgeons, or other specialists, according to a study in the April 22/29 JAMA.

A review of more than 110,000 patients who received defibrillators found the rate of heart attacks and internal bleeding during implant was lowest (1.3%) when the procedure was performed by an electrophysiologist. The highest rate of serious complications (2.5%) occurred when the implant was performed by thoracic surgeons.