A health system’s experiment with 90-day warranty for CABG

When you buy a car, you can get a 5-year warranty. A refrigerator and washer and dryer come with a 1-year guarantee. But if a patient has heart bypass surgery and develops a sternal wound infection, not only is there no guarantee, but the patient’s insurer will probably be charged more for treatment of this bad result.

There are accepted ways to prevent infections and other complications, but they aren’t always followed. With extra reimbursement available to treat complications, some say physicians and hospitals don’t have a financial incentive to improve results.

A Pennsylvania health system is taking a new approach—a 90-day warranty for elective coronary artery bypass surgery (CABG). Under the warranty, called ProvenCare and thought to be the first of its kind, the Geisinger Health System charges a flat fee that covers the surgery and 90 days of follow-up treatment. Geisinger pledges not to charge extra for postop infections or other complications directly related to CABG.

The warranty really is Geisinger’s pledge to offer evidence-based care and stand behind the results, explains Alfred Casale, MD, surgical director of the Geisinger Heart Institute.

Geisinger has identified 40 evidence-based steps that should be part of care.

Planning for the worst: OR director shares lessons from the Gulf Coast

How would your OR manage if the hospital was on emergency power for 3 days, there was no running water, and supplies were dwindling? You didn’t know when help would arrive. Still, sick and injured patients kept arriving, and families were flocking to your doors.

After Hurricane Katrina in 2005, the staff at West Jefferson Medical Center in the New Orleans suburb of Marrero, Louisiana, found themselves in that situation.

With an active hurricane season forecast this year, the hospital has fine-tuned its disaster plan. The hospital’s director of nursing for surgical and critical care services, Murray Couey, RN, shared with OR Manager what the hospital would do the same and what it plans to do differently. Many of the lessons apply to any facility that might find itself challenged by a catastrophic event.

Located on higher ground that wasn’t flooded, West Jefferson was one of only 3 hospitals in the area to stay open through the storm and its aftermath, performing surgery on all but 2 days. It was flooded with patients and provided shelter for families and special-needs people from the community.

When government help failed to arrive, hospital leaders pieced together their own safety net. They called on the Rotary Club to help transport dialysis patients. They asked the CEO of a hospital 60 miles away to round up bottled
Please see the ad for MEGADYNE in the OR Manager print version.
Editorial

Thirty-day outcomes have improved

You may have heard this one: An electrician comes to do work at a surgeon’s house. When the electrician tells the surgeon the hourly rate, the surgeon exclaims, “That’s more than what I make.” The electrician responds, “Yes, but I warranty my work.”

The warranty is now coming to surgical care. The Geisinger Health System in Pennsylvania introduced a 90-day warranty, called ProvenCare, last year for its elective coronary artery bypass graft (CABG) surgery (article, p 1). Geisinger charges a flat rate for the surgery and 90 days of postop treatment and says it will not charge extra for complications directly related to the CABG.

The warranty is a pledge to follow 40 evidence-based steps for every CABG patient. It is limited, applying only to:

- members of Geisinger’s own health plan
- coronary artery bypass surgery
- physicians who are part of the Geisinger corporation.

Geisinger also has the advantage of a mature electronic health record that aids in coordinating care.

Since the warranty program went into effect, Geisinger says 30-day outcomes have improved.

ProvenCare has attracted notice. After a report at a surgical meeting in April, The New York Times lets picked it up.

The warranty is part of the bigger picture of cost and quality in health care.

Geisinger has introduced ProvenCare. After a report at a surgical meeting in April, The New York Times lets picked it up.

Pennsylvania is one of the most advanced in public reporting. In June, the state reported on what hospitals are being paid for CABG, along with some of their outcomes. The results are displayed like Consumer Reports, with circles filled in to show how they did on mortality and readmissions.

The report found high costs don’t necessarily buy better care. Of the state’s 60 hospitals performing CABG, the best paid received an average of $100,000, while the least paid received less than $20,000—yet both had comparable lengths of stay and mortality rates. You can read the report from the Pennsylvania Health Care Cost Containment Council at www.phc4.org.

The public can also look up new hospital quality data on Medicare’s Hospital Compare website (www.hospitalcompare.hhs.gov). You can find death rates for hospitals in your area for heart attack and heart failure.

So far this data is of limited value. When you look up hospitals on heart failure, for example, you’re likely to find all have checkboxes in the middle column—“no different from the national average.”

The reason? CMS isn’t completely confident of its mortality adjustments and decided to define “average” in a very broad manner. It’s like in Lake Wobegon—all the children are above average.

The Hospital Compare site has other information we think is more useful at this point—you can see how well hospitals say they are following surgical infection prevention recommendations. For the 12 hospitals in the Denver area, we learned the range of those giving antibiotics on time is wide, from 56% to 94%.

If I were facing surgery, that’s something I’d want to know.

It’s also becoming easier for the public to check up on care hospitals are giving.

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It’s hard to say if warranties will catch on. But Geisinger is out in front with a concept that captures the public’s growing demand for more information and more accountability.

It may not be long before patients start saying to their surgeons, “Hey, Doc, are you offering a warranty with that?”

—Pat Patterson
Please see the ad for
KARL STORZ ENDOSCOPY-AMERICA
in the OR Manager print version.
Universal Protocol won’t change for now

The Joint Commission isn’t making immediate changes in the Universal Protocol for surgical site verification. But revisions could be coming. One issue being discussed is who should mark the surgical site.

Joint Commission officials discussed the protocol in a June 21 audioconference as a follow-up to a wrong-site surgery summit in February. The protocol, which took effect in 2004, outlines steps accredited facilities must follow in verifying the correct patient, site, and procedure prior to surgery.

Despite the protocol, the Joint Commission says reports of wrong surgery persist at the rate of 5 to 8 a month. States with mandatory reporting haven’t seen a decrease either.

A new report from Pennsylvania says 427 reports of wrong surgery and near misses were received in the 30 months from June 2004 through December 2006, a rate of about 1 every 2 days (related article).

No one is sure whether the reports are persisting because there are more incidents or better reporting.

Though communication problems continue to be a leading cause of wrong-surgery events, surveyors started noticing in 2006 that procedural compliance was also a factor; that is, not following the Universal Protocol, noted Peter Angood, MD, Joint Commission vice president and chief safety officer.

In the audioconference, the Joint Commission reviewed findings for the February summit, noting that the 50-some organizations represented agreed the protocol is effective, though not to the extent they would like, and supported maintaining it. They also discussed possible revisions.

For the time being, there won’t be any changes. But proposed revisions will be sent to the Sentinel Event advisory group for review in the next few months, Dr Angood said.

Some issues discussed at the summit included:
• Does the protocol need to be more specific and routinized?
• There should be “zero tolerance” for lack of compliance with the protocol.
• Incidence of anesthesia- and radiologic-associated events has been increasing. It was reemphasized that the protocol applies to procedures performed outside the operating room.
• Strong support was voiced for a public awareness campaign.
• In response to resistance to the protocol and complaints about time pressures, Dr Angood said, “a strong message needs to go out” that in institutions that have been successful, the protocol has improved efficiency overall.
• Each organization’s leaders need to support the protocol and be engaged in developing policies and procedures and monitoring compliance.

Dr Angood noted that the World Health Organization (WHO) will be testing a detailed correct-site protocol internationally but said the Joint Commission isn’t pushing in that direction at this time.

He and Paul Schyve, MD, Joint Commission senior vice president, then spent the next 45 minutes of the audioconference answering questions, most of which asked for clarification of the protocol.

Who should mark site?

A lingering question is who should mark the surgical site. In response to a question from a listener, Dr Angood said the marking should be done by a member of the surgical team who will be performing the case such as the surgeon, surgeon first assistant, or resident, not by a medical intern or member of the “OR environment.”

Later someone asked if he saw the Joint Commission moving toward using “must” instead of “should” in the statement about the person performing the procedure marking the site. He said, “We clearly are considering the must’ in our deliberations,” but that the Universal Protocol currently stands as written, and no immediate changes are being made. ✤

A transcript of the conference will be posted at www.jointcommission.org in the next few months. Requests for clarification of the Universal Protocol can be submitted through the website. Look under Standards, then Online Question Form.

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Please see the ad for
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in the OR Manager print version.
No single step prevents wrong surgery

No single step, whether the time out before the incision or surgical site marking, is adequate to prevent wrong surgery. Rather, site verification needs to be a package of activities that involves the team—the nurse, patient, surgeon, and anesthesia provider—as well as an accurate OR schedule and consent and a review of all the patient information.

That’s what the Pennsylvania Patient Safety Authority concluded after analyzing 427 events reported to the state over 2½ years, a rate of about 1 every 2 days. Of these, 41% reached a patient, and 59% were near misses; 18 facilities had more than 1 wrong incision in 12 months.

The surgeon’s involvement is particularly important. Having the surgeon involved preoperatively was a net benefit in preventing events. But having the surgeon involved in site verification only in the OR was a net detriment—that is, it was implicated in more events than it prevented.

“We had several events in which the time-out was completed, yet the wrong site was operated on,” says Janet Johnston, RN, MSN, JD, of the authority’s reporting system, which collected and analyzed the data.

“Utilizing one part of the verification process does not seem to be associated with fixing the problem. The whole site verification process is complex, and our data seems to indicate that doing one small part of that process is not really adequate.”

Hospitals and surgery centers in Pennsylvania are required to report wrong-surgery events as well as near misses. Pennsylvania is the only state that mandates reporting of near misses.

From the data, the agency identified factors that contributed to wrong-site events that reached a patient as well as factors that resulted in a “save.”

Factors implicated in patient contact
Activities of surgeon in OR: 53%
Failure of time-out: 34%
Failure of anesthesia provider in OR (eg, blocking wrong site before time-out): 17%
Failure to verify with consent: 13%
Failure to verify with patient information: 13%

Failure to verify position/prep: 11%
Factors in a “save”
Patient/family: 23%
Surgeon involved preop: 19%
Consent: 17%
Patient information: 16%
Office records: 13%
Preop nurse: 12%

“The surgeon’s involvement preoperatively seemed to have a strong association with actually promoting recovery from a wrong-surgery event,” Johnston tells OR Manager.

“Another interesting thing had to do with the physician’s office records.” Having the patient’s office records available in the surgery setting seemed to aid prevention. But not having records available was one factor associated with wrong-surgery events that reached the patient.

A strong contributing factor in wrong surgery was the scheduling of the case by the physician’s office, Johnston noted. Sometimes the incorrect procedure was scheduled, the wrong site was identified, or the surgical site was ambiguous.

Two case examples
Two cases illustrate the surgeon’s role in ensuring correct surgery. In the first example, the surgeon participated in site verification only in the OR. In the second, the surgeon was involved preoperatively.

Surgeon involved only in OR
A patient was admitted for left knee surgery. The patient was properly identified, and the site was properly marked. After the patient was brought to the OR, the physician elevated the patient’s right leg for the procedure. The nurse prepped and draped the patient. During the time out, no one recognized the wrong leg had been prepared. The procedure was performed on the incorrect leg.

“Because the surgeon inadvertently lifted the wrong leg for the prep, the surgical team assumed it was the correct leg,” Johnston notes.

Surgeon involved preoperatively
The patient was in the holding area. The permit and scheduled procedure indicated the left side was to be operated on. The patient, however, stated the right side was to be done. The surgeon reviewed all of the paperwork, the physician’s notes, and the current x-ray, spoke to the patient, and confirmed the right side was the correct side. The surgery proceeded.

A report on the analysis appears in the June 2007 issue of the Patient Safety Advisory published by the Pennsylvania Patient Safety Authority. An article on the project has been accepted for publication in the Annals of Surgery.

Download the Advisory at www.psa.state.pa.us/psa/. Look under Advisories and Related Resources. View a video about the findings by clicking on Resources Associated with Patient Safety Advisory Articles. Scroll down to Other Resources.
A 'dramatic change'

Geisinger’s leaders say the warranty is a “dramatic change” from the usual way care is given and paid for. They point to research showing rates of surgery and other treatments vary widely, depending on where people live and who treats them. Studies have also found that more intensive and expensive care doesn’t necessarily mean better outcomes.

Pennsylvania has documented these variations through its mandatory statewide reporting system. The data shows, for example, that CABG rates vary by more than 100% around the state. In the Wilkes-Barre area, the rate is nearly 8 in 1,000 Medicare enrollees, whereas in the York area, it is 3.5 per 1,000. There’s also a wide variation in CABG outcomes, with mortality ranging from 0.4% to 3.0% in 2004, according to the Pennsylvania Health Care Cost Containment Council.

A new report shows higher payments to hospitals don’t necessarily relate to better CABG outcomes. In fact, 2 of the highest paid hospitals in the Philadelphia area had higher-than-expected mortality rates. The highest paid hospital received nearly $100,000 on average and the lowest about $20,000. (The report is at www.phc4.org/.)

Key elements of warranty

Care process
The process of care:
• supports patients as active participants in their care
• systematically applies evidence-based care
• relies on electronic health records and decision support tools for collecting data, providing feedback, and analyzing outcomes.

Global payment
• Geisinger will accept a global payment for all related services and follow-up care, including hospital and physician payments (applies only to care by Geisinger providers).
• Geisinger won’t charge for complications related to the procedure that occur within 90 days.

Source: Geisinger Health System.

Hard-wiring the process
A work group was set up to map the 40 steps into the process of care. With the support of an IT team, the work group “hard-wired” the process into the electronic record, order sets, and OR time-outs. The group decided on sources of data for monitoring compliance, who would be accountable for the steps, and what tracking method would be used, notes Karen McKinley, vice president of clinical effectiveness.

As the new process was put in place, she and her team abstracted data as close to the time of care as possible, giving feedback to the QI team and to clinicians who were not compliant.

“If we found the process was not performing as designed, we would quickly redesign that portion of the process, run
## Quality improvement

### Evidence-based steps for CABG

#### Preadmission documentation:
- ACC/AHA indication
- Screening for and consultation regarding IMI (inferior myocardial infarction)/RV (right ventricular) involvement
- Treatment options and patient preference
- Need for warfarin—anterior MI (myocardial infarction) or WMA (wall motion abnormality)
- Current user of clopidogrel or warfarin?
- Screening for stroke risk
- Carotid doppler (if indicated)
- Vascular surgery consultation (if indicated)
- Ejection fraction
- Screening for need to use intra-aortic balloon pump
- Screening using epiaortic echo (as indicated)
- Patient withheld clopidogrel/warfarin for 5 days preop?

#### Operative documentation:
- Patient received correct dosing of beta blocker (preop)
- Correct use of intra-aortic balloon pump (preop → postop)
- Preop antibiotics (within 60 min of incision; vancomycin within 120 min)
- Blood cardioplegia (on-pump patients)
- Epiaortic echo of the ascending aorta and peer consult
- Intraoperative hyperglycemia screening
- Correct insulin management (as indicated; per protocol)
- Use of LIMA (left internal mammary artery) for LAD (left anterior descending) grafting

#### Postoperative patient documentation:
- Anteroapical MI within prior 7 days; postop echo
- Monitoring for atrial fibrillation for >48 hrs
- Anticoagulation therapy (as indicated)
- Antibiotics administered (postop for 24-48 hrs)
- Aspirin (6 hrs postop or 24 hours postop)
- Beta blocker (within 24 hours postop)
- Statin administered (postop)
- Surgical debridement and revascularization of any sternal wound infection
- Plastic surgery consult regarding ongoing management of sternal wound
- Tobacco screening and counseling

#### Discharge documentation:
- Referral to cardiac rehab
- Discharge medications (eg, beta blocker)
- Discharge medication: aspirin
- Discharge medication: statin

#### Postdischarge documentation:
- Patient correctly taking beta blocker?
- Patient correctly taking aspirin?
- Patient correctly taking statin?
- Patient correctly administering anticoagulant?
- Did patient resume smoking?
- Patient enrolled in cardiac rehab?

Source: Geisinger Health System, reprinted with permission.

a small test of change, and incorporate the new changes,” she says. An outcomes analysis was done at 8 and 12 months.

### Setting the package price

Meanwhile, a reimbursement team set about developing pricing for CABG surgery. They determined there would be a package price for the CABG episode of care, including the surgical preoperative, intraoperative, and postoperative care. The price would also cover smoking cessation counseling for patients, cardiac rehab, and management of all postop complications within 90 days of surgery. The global fee includes a 50% share of the cost of historical readmission rate. Geisinger is protected from outlier or catastrophic events by reinsurance. Geisinger hopes to expand the program to other insurers and employers. Its executives say outside insurers and employers have indicated Geisinger would need to add 5 to 10 more procedures in its plan before enough employees would be affected to make it worthwhile for them to sign up, according to the Times.

Other procedures on the drawing board include total hip replacement, cataract surgery, and coronary angioplasty with stenting.

### Getting patients involved

As part of the warranty program, par-

Continued on page 10
ticipating employers are encouraged to get their employees actively involved in their care. Patients must choose to enroll and agree to be active participants, for example, by complying with their medications, completing cardiac rehabilitation, stopping smoking if applicable, and managing their weight.

Outcomes
Before the program began in February 2006, Geisinger estimates only about 60% of its CABG patients received all of the evidence-based aspects of care. Within 3 months, compliance had improved to 100%, and it remained above 90% through February 2007. In the first 6 months of the program, 30-day outcomes had improved, and the reduction of complications was approaching statistical significance, reported Dr Casale and his colleagues in April at the American Surgical Association conference.

Reference

Special conference offer for OR materials managers
Would you like your materials manager to be able to spend time at the exhibits at Managing Today’s OR Suite?

We are offering a special one-day registration for materials managers and OR purchasing staff to attend Managing Today’s OR Suite on Thursday, Oct 4. The conference will be Oct 3 to 5 at the Manchester Grand Hyatt in San Diego.

The exhibit includes over 100 companies that provide OR supplies and equipment.

Materials managers are invited to attend all education programs, including 2 general sessions and 2 breakout sessions. They will be welcome at the gala reception Thursday evening as well as the continental breakfast and luncheon.

To register, materials managers should go to www.ormanager.com and look for the special offer registration form.

The Carrot Principle: A low-cost, high-return employee motivator

“...When you recognize people for what they do well, they actually do better.”

Max Brown will speak on The Carrot Principle at a luncheon on Friday, Oct 5, at the Managing Today’s OR Suite Conference Oct 3 to 5 in San Diego. He is with the Carrot Culture Group, a division of O.C. Tanner Company.

The luncheon and special presentation are sponsored by Advanced Sterilization Products.

The Carrot Culture Group trains managers in methods advocated by Adrian Gostick and Chester Elton in their books The Carrot Principle: The 24-Hour Manager and A Carrot a Day. The basic Carrot Principle is that humans, including employees, respond better to constructive praise and meaningful rewards than to constant criticism.

Using the Carrot Principle is justified as much by a desire for better productivity as by an urge to be more humane, Brown says. The methods are based on a study involving more than 200,000 workers over 10 years, which found that the number 1 reason people leave their jobs is lack of appreciation.

Brown’s enthusiasm for the Carrot Principle is infectious.

“It is amazing,” he told OR Manager. “I fly nearly 200,000 miles a year speaking to thousands of people, and the single most important thing we can do is to help them feel good about who they are and how they contribute.

“We’ve all seen employees who are engaged. They’re people who care. They know there’s a lot of pressure; they know everything’s not going to be perfect. But they’re still committed to doing the best job they can,” he says.

“Some people are just self-motivated, but in most cases, an employee like that believes what she or he is doing is recognized and appreciated.”

Brown says when he first went into an OR as a consultant, he was told, maybe jokingly, “The screamers are not the patients. The screamers are the surgeons.”

“That contributes to high turnover among OR nurses,” he responded.

Quality care comes from a quality team. In an OR, this isn’t just about employee satisfaction. A well-run health care facility saves more lives.

More engaged employees
The Carrot Principle does not mean ignoring things that go wrong, he says.

But a supervisor actively looks for things employees do right and praises those behaviors.

“I believe recognition is one of the most underutilized and misunderstood pieces in a manager’s toolkit—the low-cost, high-return solution to achieving better results in employee motivation and production,” Brown adds.

Brown advises his management trainees to ask themselves what an employee has to do to be appreciated in their workplace, and then ask themselves what their goals are for the employee program—a certain set of behaviors and values, better safety in the OR, a new efficiency target?

Brown acknowledges that he sometimes meets resistance among managers.

“People say to me, ‘I wasn’t praised, and I don’t see why I should have to do that.’” They say they don’t have time to praise their employees. “My answer, of course, is ‘How much time does it take to criticize them?’

“...Aside from making a more positive workplace, employee recognition creates more engaged employees, which makes for a more productive workplace,” Brown says. “Researchers have learned that when you show you care as a leader, you’re more respected and trusted. And when you have more respect and trust, you get better results.”

—Kate McGraw

Kate McGraw is a freelance writer in Santa Fe, New Mexico.

Disaster planning

Continued from page 1

water. Wal-Mart opened its doors to provide necessities like diapers, formula, and personal care items. Home Depot and Lowe’s provided wood and glass to make repairs.

Some days later, a government DMAT (Disaster Medical Assistance Team) set up tents on the front lawn and stayed for 6 weeks to provide triage and front-line care—a godsend,” Couey says. He and his staff worked 20-hour shifts during the 3 days right after the storm and long hours for many days thereafter.

In May, Couey and his staff were gearing up again. Staff were signing up for the activation team, which stays at the hospital if the disaster plan is activated.

Licensed for 451 beds, West Jefferson is currently staffed for about 380.

One of the biggest challenges after the storm was restaffing. About 50% of the staff did not come back. The 14 ORs are now fully staffed, and all contract positions were eliminated this spring.

“This is the first time I’ve ever used contract staff in the OR in my 30 years in surgery,” he says. “I was impressed with the quality of the people we were able to get.” Some staff from the local area who worked on contract after the storm decided to become permanent employees.

Surgical volume is about 20% above prestorm levels because the rest of the health system still has not fully recovered.

To recruit for med-surg and critical care, which still have vacancies, the hospital changed its salary structure and added incentives like tuition reimbursement and stipends.

This is Couey’s advice about disaster planning.

Get the staff involved

“You need to get your staff involved in looking at everything you need,” he says. “Your staff is the most valuable resource you have.”

The disaster plan calls for staffing by 4 or 5 OR teams who rotate on duty, off duty, and sleep time.

Consider arrangements for families

In one policy change, West Jefferson will discourage families of staff and patients from seeking shelter in the hospital. Instead, the staff will be encouraged to have their families evacuate.

“In Katrina, we had an overwhelming number of people in the hospital,” Couey says. “Keeping the families here created a hardship, not only for the facility but for the families.” Accommodations weren’t optimal, and it was hard to meet families’ needs and keep everyone safe.

“If you evacuate your family, you don’t have to worry about them,” he adds. “It can lessen the stress on the caregivers who elect to stay during the crisis.”

Reduce the census

In another policy change, the hospital decided to be aggressive about discharging patients starting 72 hours before a hurricane to lessen the load on the facility and prepare for patients who are on tube feedings or confined to bed.

In 2005, these patients were allowed to come to the hospital if they brought their own caregiver. But many caregivers weren’t adequately prepared and couldn’t provide basic care for their patients.

Instead, the hospital is working with local and state officials on a plan to remove these patients from the area.

Upgrade the physical plant

West Jefferson has upgraded its emergency infrastructure, a project that was underway before the storm. Four big diesel generators have been installed 20 feet above ground level, with tanks containing 36,000 gallons of fuel—enough to sustain power, including all lights and air conditioning, for 7 days. Two deep wells can provide water.

To aid communication, which was hampered during Katrina, a new command center is equipped with satellite and microwave phones; digital, analog, and hrm radios; marine radios; and satellite TV.

Partner with the community

West Jefferson has formalized its relationship with local businesses, which proved to be of great help during Katrina. An agreement has been worked out that designates key individuals to go to the businesses if the hospital needs items like bottled water or generators, ensuring an orderly process.

Disaster planning resources

Agency for Healthcare Research and Quality
Training of Hospital Staff to Respond to a Mass Casualty Incident. —www.ahrq.gov/clinic/epcsums/hospmcisum.htm

AHRMM: Association for Healthcare Resource & Materials Management

American Hospital Association
Emergency readiness resources. —www.aha.org/aha/issues/Emergency-Readiness/resources.html

VHA Health Foundation
Resources to help health care executives assess their emergency preparedness and identify areas for development. —www.vhalff.org/vhalff

Make a plan to get supplies

During Katrina, suppliers’ trucks were stopped by law officers out of concern they would be attacked by looters. Since then, West Jefferson has worked out arrangements with the authorities and its major distributor, located in Baton Rouge.

“In the event of an impending storm, we’ve provided them with a list of supplies we want delivered immediately prior to the storm,” he says.

Major suppliers have been identified to law enforcement. If there’s a problem with law and order, “we have worked it out so law enforcement will get us the supplies by whatever means they choose,” he notes.

Think about staffing after the disaster

Getting restaffed after the storm was difficult. Because many employees had homes damaged or destroyed by the
hurricane, West Jefferson granted an immediate 90-day personal leave to anyone that requested it. “That was a huge mistake,” Couey says. Some employees took the leave even though their homes weren’t damaged, and the hospital had trouble getting them to come back before the 90 days were up.

The new policy is a 30-day leave. Though the hospital wanted to be empathetic with its employees, “we also had a crisis here,” says Couey. “Employees need to know that their family members and loved ones will be coming to the hospital for care. It’s difficult for us to provide that care if we don’t have our staff back who probably can be working.”

So employees can get past checkpoints, the hospital is directing them to carry their hospital IDs. If they evacuate before the storm, they also will be given a placard to display in their vehicles so they will be allowed back in as soon as the roads are opened.

Learning from the worst
Couey feels the hospital is more prepared now than it was before Katrina. “We know we’ve been through the worst. We know we can get through it, and we know we can depend on each other,” he says. “You come together as a community, pull yourself back together, lift yourself up, and get moving.”

Checklist for hospital disaster preparedness

This checklist was developed with the aid of hospitals in Florida and the Gulf Coast after the 2005 hurricanes to help in disaster planning. To remain operational, hospitals should take the following steps:

- Arrange to address employees’ cash needs with cash on hand during the disaster.
- Bring in tanker trucks with a 10-day supply of potable water, diesel fuel for generators, and gasoline for employee use.
- Establish an in-house general store so employees can obtain dry goods, cleaning supplies, and donated items. Staff the store with volunteers. Set up laundry service for employees.
- Set up an on-site day care or make arrangements with other childcare providers to care for children of hospital employees during the disaster and for an extended period afterwards.
- Obtain satellite phones for management and emergency team members for external communications as well as radiophones for internal communications.
- Establish a Hurricane Team as well as a Relief Team to support the Hurricane Team after the initial rush. Remind employees clearly about expectations for relief staffing. If necessary, set up a transportation service to pick up employees.
- Videotape or photograph all hospital assets as proof to FEMA about the “as was” condition of the building, grounds, and assets. This documentation will be needed when applying for damage reimbursement. Pass out cameras to department directors.
- Place supplemental emergency generators in areas not prone to flooding.
- Work with the National Guard to determine plans for crowd management and protection of the facility, supplies, patients, and staff.
- Set up a 24-hour materials management and receiving department and stock a 10-day supply of important items including: water; ice; food (MREs); linens; IV sets and solutions; oxygen concentrators; disinfectants; gloves; medications such as insulin, heart drugs, antibiotics, and anti-diarrhea remedies; blankets, pillows, and cots for staff; hand sanitizers; scrubs; personal hygiene items; nicotine patches; and equipment and supplies for dialysis and chemotherapy.
- Do not rely on information stored electronically: Update hard-copy lists of emergency contacts. Have a hard-copy contact list of administrators, clinical staff, and leaders of other local hospitals who may be able to assist during a crisis.
- Develop/update recovery plans for business information systems.
- Purchase plywood and window repair supplies.
- Establish relationships with corporate and community partners that might provide supplies and food during a disaster.
- Establish on-site pet kennel for employee pets.
- Anticipate patient load increases in dialysis, oncology, and radiology.


Help on SCIP
Need practical help on the Surgical Care Improvement Project? The OR Manager SCIP supplement sponsored by Kimberly-Clark Health Care has articles from your peers on these SCIP measures:
- antibiotic administration
- glucose control
- appropriate preop hair removal
- keeping patients warm
- setting up a beta blocker protocol
- preventing venous thromboembolism.

For free printed copies, e-mail shesch@ormanager.com or call 800/442-9918. Or download a PDF file of the SCIP supplement at www.ormanager.com.
What progress are ORs making in automating their supply chains?

The 2007 Most Wired Survey by Hospitals & Health Networks provides a glimpse of how OR automation is advancing. The survey assesses hospitals’ progress in information technology. Some findings of the supply chain portion of the survey were shared with OR Manager.

Electronic purchasing

Paperless purchasing is a huge time and labor saver. Nearly half (49%) of respondents purchase half or more of surgical supplies using electronic data interchange (EDI). Fewer have moved to online purchasing of physician preference items. Only 18% say they buy more than half of their physician preference items online, and a third (34%) aren’t buying any of these items electronically.

“EDI is fairly common for commodity items, but with implantables, it’s more complex,” says Karen Conway, spokesperson for the health care e-commerce exchange, GHX, Westminster, Colorado.

Because many physician preference items are on consignment, software adjustments are needed to handle these items. Nancy LeMaster, vice president for supply chain operations at BJC HealthCare in St Louis, is on a GHX team that is working on a solution.

“The vision is that we could scan an implant bar code and be able to generate a purchase order, create the implant log, communicate with the manufacturer’s system to decrement the inventory, and re-order the product,” LeMaster says.

Instrument tracking

Instrument-tracking systems, which keep tabs on trays as they move through reprocessing, haven’t caught on as rapidly as other materials management technologies.

About a third (36%) have a tracking system. In contrast, 83% use automation for drug dispensing, and 91% have software for supply management.

Hospitals with instrument tracking systems say they wouldn’t be without them. But it can be hard to come up with the numbers to justify the cost, particularly in medium-sized and small ORs.

Still, managers say the systems have many benefits (related article).

About the survey

The survey was conducted during March by e-mail and fax, with 4,093 invited to complete the survey. Responses were received by 804, for a return rate of 23.8%. Complete results will be published in H&HN and Materials Management in Health Care.
Is it time to add instrument tracking?

ORs probably have as much money tied up in their instrument inventory as in surgical supplies, from $1 million to $5 million. Yet automation for instrument tracking is much less common than other materials management technologies. (See related article.)

The need for keeping track of your instrument dollars is “similar to keeping track of your supply dollars,” says Jean Sargent, CRCST, CMRP, FAHRMM, who implemented instrument tracking for 6 surgical sites at UCLA Medical Center.

Managers who use tracking systems say the systems help improve instrument utilization and service to the OR. But the systems take time to implement, and it can be difficult to demonstrate a return on investment, particularly in medium-sized and small ORs. To be able to make a good decision, managers need to be clear about what they expect a system to achieve (sidebar).

Benefits of tracking

Typically, in an instrument tracking system, instrument sets are bar coded. Technicians then scan the sets as they move through the reprocessing cycle and back to the OR. Here are some benefits a tracking system can provide.

Finding trays quickly

When trays are scanned, any tray can be found quickly, saving frantic, time-consuming searches.

“If we don’t find a tray on the shelf, we can look in the system and find out where it is,” says Aaron O’Neill, OR business manager at the University of Washington, Seattle, with 21 ORs, which has had a system for 6 or 7 years.

In an emergency, finding trays quickly can be a patient safety issue, particularly if an OR has only 1 or 2 trays of a specific type, adds Sargent, who is currently director of materials management for University of Kentucky Healthcare, Lexington.

Reducing loss of damaged instruments

The staff can keep track of instruments essential to a particular tray.

“You can set up the system so when you scan a set into decontam, it will give you a popup that says, ‘Look for X instrument,’” Sargent notes. If the instrument is missing, the staff can immediately go to the OR to retrieve it before the trash and linen are dumped.

Sets can also be flagged for maintenance.

“We are able to determine when to send a set out for maintenance rather than just saying, ‘Oh, these have been used enough,’ or waiting for a doctor to complain,” says Susan Nielsen, RN, MSA, CNOR, director of central processing at William Beaumont Hospital, Royal Oak, Michigan. Nielsen says the system has been a boon for managing the myriad sets needed to serve Beaumont’s huge volume of more than 55,000 cases a year, which are heavily orthopedics.

UCLA included endoscopes in its tracking system, Sargent notes, enabling managers to see which scopes were being broken the most often and how. Then they could educate the staff or take other steps to avoid expensive repairs.

Easier updating of count sheets

In an automated system, set contents can be updated easily, enabling the system to produce accurate count sheets. That, in turn, means more accurate tray assembly and better service to the OR.

Producing reports

Tracking systems can produce a variety of reports that aid in instrument management.

“You can run reports on your tray utilization,” says O’Neill. “If you have duplicates or unused trays, the reports will show you that.”

Those trays can then be broken down and instruments distributed among trays that are used more often.

Nielsen uses reports to monitor unit and individual productivity, set utilization, and set error rates, among others.

Set contents can be updated easily.

Issues to consider if you’re considering an instrument tracking system.

- Determine what functions you want the system to perform. Do you want only to locate trays? Do you want any individual instruments to be tracked? Do you want to monitor employee productivity?

- What reports do you want from the system? Most systems produce standard reports. Will you need custom reports? Will there be a charge for these?

- Look at 2 or 3 systems. Have the companies provide demonstrations.

- Go on site visits. “That is really the only way to get a handle on how a system is used,” says Susan Nielsen, RN, MSA, CNOR, director of central processing at William Beaumont Hospital, Royal Oak, Michigan.

- What is the cost of the software? If you are paying for a license, what is the charge for upgrades? Is there an additional charge if you implement the system at more than one location?

- What hardware will you need? Will the vendor provide that, or will you buy it separately?

- Who will maintain the hardware, including the bar code scanners and printers?

- What is the availability of technical support? What is the cost?

- What shape is your instrument database in? How much work will be needed to clean it and update it? If the vendor does that, what is the charge?

- If you are purchasing several modules, how will the implementation be phased?

- Does the system interface with your OR information system? If so, what is the cost of writing and maintaining the interface?
Avoiding scheduling conflicts

Increasingly, managers want a tracking system to interface with the OR information system. Then a manager could find out, for example, how often cases had to be rescheduled because there weren’t enough instruments. The system could also flag conflicts. Say you have 5 major sets, and 5 cases are scheduled. When the sixth case is scheduled, an alert would pop up to say there are not enough instruments.

Anticipating regulatory requirements

Sargent says she expects regulators in the future to require instrument trays to be traced to individual patients.

The Association for the Advancement of Medical Instrumentation (AAMI) currently recommends, “Ideally, every reprocessed medical device, especially an implant, should be fully traceable to the patient.”

If an implant is flash sterilized—a practice AAMI does not recommend—the load should be full traceable to the patient (Comprehensive Guide to Steam Sterilization, ST79, 2006, 10.3.1, p 79). At present, most ORs keep these records manually.

Beaumont’s system has a module that allows the staff to scan information on loads with biological indicators (BIs) into the computer.

Rather than reviewing a handwritten log or stacks of sterilizer printouts, “all we have to do is print a report,” Nielsen says. “It shows you all of the BIs, when you did them, and what the results were. That’s one of the reasons the staff likes it—it has reduced the amount of handwriting they have to do.”

Monitoring employee productivity

Beaumont uses its system to monitor employee productivity, a feature that requires management sensitivity and time to implement.

“I caution people about this,” Nielsen says. “My employees were very aware there was a productivity module, and they were nervous about us using it.

“You have to understand it’s a tool,” she adds. “You can’t use it as the only measure of employee performance.” The productivity goal is 70%, which she and her team thought was doable.

If an employee is severely under the goal, a supervisor can review the individual scans to see what the issue might be. The system provides documentation in case there’s a need for discipline or termination.

Productivity measurement is also useful during orientation to see how a new employee is progressing, which sets the person has processed, and which he or she still needs experience with.

Implementation

The implementation curve for a tracking system can run from a couple of months to a year or more, depending on the size of the facility and number of functions selected.

A major factor is how complete and accurate the hospital’s instrument database is to begin with.

“If you have good information, your implementation will go much quicker,” Sargent says.

Beaumont’s implementation took about a year. A time-consuming aspect was developing the labor standards for the productivity system. To set a labor standard for each set, the system must know how long it takes on average to reprocess each major type of set. This required each employee to process and scan each set several times.

“That part was tedious,” Nielsen says. “We had to make sure people did that. We kept telling them, ‘It’s going to get better.’”

Nielsen’s tip for success is to involve CS employees in the process long before the tracking system is introduced.

“We asked for their input about what activities we should scan, where we should put the workstations, and so forth,” she says.

“We tried to include them as much as we could so by the time the system was ready, they were prepared for it and had already done some scanning.”

Justifying the cost

Though a tracking system may have benefits, the CFO will probably want you to pin down the potential savings to offset the investment, says Michael Frisina, PhD, administrative director at Tuomey Healthcare System, Sumter, South Carolina. He says he evaluated systems a couple of years ago but wasn’t able to justify the cost, which was about $150,000. Tuomey has a volume of 8,500 to 9,000 cases a year.

The problem is that most ORs and CS departments don’t have good baseline data on the costs of instrument problems, Frisina notes. How much OR time is wasted, for example, from delays caused by missing or broken instruments? How much was spent on repairs that could have been avoided if a tracking system were able to flag sets for preventive maintenance? These costs can be hard to quantify.

“We tried to factor savings per year but never could get it to a break-even point,” Frisina says. Instead, he and his team looked for ways to achieve the same objectives without a tracking system.

From another perspective, Nielsen, in her high-volume facility, has found the reports she is able to get alone have made it worth purchasing the system.

“Originally, we thought, ‘We will know where our trays are,’ and that’s true, but there’s more to it than that,” she says. “For example, you have data for making decisions about purchasing instruments or sets. You’re not making decisions based on gut feelings.”

She was also able to use the system’s data to justify her budget request for CS staff and instruments several years ago when Beaumont opened a new 16-OR tower that has a high orthopedic volume. From the tracking system, she knew how many sets on average orthopedic cases use (9 then and up to 14 now), and she knew from the labor standard how long it took to reprocess a set.

Though it might be difficult in the beginning to prove that an instrument tracking system will save money, she says in the long term, she believes it does.
Joint Commission’s 2008 safety goals

The Joint Commission has made 2 major changes to the National Patient Safety Goals for 2008, requiring organizations to:

• take steps to reduce harm from anticoagulant therapy.
• develop a method to enable caregivers to request help when a patient’s condition seems to be worsening.

The new requirements will be phased in, with full implementation required by Jan 1, 2009. Milestones must be met along the way (sidebar).

In a less demanding change, under the goal of reducing the risk of infection, organizations can choose to comply with the World Health Organization’s hand hygiene guidelines instead of the Centers for Disease Control and Prevention hand hygiene guidelines.

Anticoagulant risks

The Joint Commission notes that anticoagulants are a high-risk treatment and a widely acknowledged patient safety problem. Among the issues are complex dosing, monitoring the drugs’ effects, and making sure patients comply with outpatient therapy. The commission expects organizations to put in place a defined anticoagulant management program that will individualize the care given to each patient who receives anticoagulants.

The goal has 11 Implementation Expectations, which require, among other things, using only unit doses and premixed infusions, when available; using approved protocols; getting a baseline International Normalized Ratio (INR); and using programmable infusion pumps.

Rapid response

The new Goal 16, which requires a plan for rapid response to a patient’s worsening condition, was added because it’s estimated that critical events such as cardiac and respiratory arrest happen in 4% to 17% of inpatients. Often, there are warning signs for 6 to 8 hours. The Joint Commission says having a plan so caregivers can directly request help by a specially trained person or team might prevent arrests and save lives.

One requirement is being retired as a safety goal. Under Goal 3 (medication safety), the requirement to limit and standardize drug concentrations will be surveyed as part of the Medication Management standards. ♦

Changes to 2008 National Patient Safety Goals

Goal 3: Medication safety

New requirement 3E

Reduce likelihood of patient harm associated with use of anticoagulation therapy.

Applies to: Ambulatory care, hospitals, critical access hospitals, and others.

One-year phase-in with full implementation by January 2009. Milestones include:

• As of April 1, 2008: Leaders assign responsibility for oversight and coordination of development, testing, and implementation of requirement.
• As of July 1, 2008: Implementation work plan is in place.
• As of Oct 1, 2008: Pilot testing underway in at least one clinical unit.
• As of Jan 1, 2009: Process is fully implemented across organization.

Goal 7: Health care-associated infections

Amended requirement 7A

World Health Organization (WHO) Hand Hygiene Guidelines can be used instead of Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

Applies to: All accredited programs

Goal 16 (new): Response to patient’s condition

Improve recognition and response to changes in a patient’s condition.

One requirement: Select a method that enables staff to directly request assistance from a specially trained individual when a patient’s condition appears to be worsening.

Applies to: Hospitals, critical access hospitals

One-year phase-in with full implementation by January 2009. Milestones include:

• As of April 1, 2008: Leaders have assigned responsibility for oversight and coordination of development, testing, and implementation of requirement.
• As of July 1, 2008: Implementation work plan in place.
• As of Oct 1, 2008: Pilot testing underway in at least one clinical unit.
• As of Jan 1, 2009: Process is fully implemented across organization.

The 2008 goals are at www.jointcommission.org. Look under Patient Safety.

Read the Joint Commission news release and access the updated goals.
OR business management

OR analyst: A support for periop leaders

Perioperative directors have seen their jobs expand, with growing demands for financial analysis, operational efficiency, and quality monitoring.

To help provide support, HCA Inc, one of the nation’s largest health care providers, developed the role of OR analyst. It’s estimated more than 50% of HCA’s 173 hospitals now have such a role, which includes supporting the OR’s electronic nursing documentation, being responsible for charging and billing, and producing reports.

Analysts hone their skills at a 2-week OR Analyst University provided at HCA’s corporate headquarters in Nashville, Tennessee.

“Surgical directors have so many responsibilities today. The business of surgical services coupled with the human resource issues and customers is complex and often overwhelming,” says Sherry Church, RN, BC, MSN, MBA, clinical director of surgical services in the HCA Quality Group.

The OR analyst position represents HCA’s effort to develop a business management role for the OR. In an analysis last year, OR Manager found the role varies widely across the country, having evolved to fit the needs of each organization (sidebar).

Major aspects of the HCA role, formally titled “OR clinical systems analyst,” are to:

- assist the OR staff in optimal use of computer system applications
- be responsible for billing and charging
- produce financial reports
- provide statistical reports and data.

Specific performance standards are in the sidebar.

HCA has a model job description, which has been adopted as an HCA Best Practice in Surgical Services.

Though every HCA hospital is considered to need an OR analyst, Church says the role would look different in a hospital with 4 ORs than in one with 40 ORs. In a small hospital, for example, the OR analyst might also be the perioperative educator, whereas a large hospital might have more than one analyst or an analyst with assistants.

Qualifications

In HCA, perioperative RNs with a BSN are preferred for the OR analyst position, says Church, who estimates about 80% of the OR analysts are RNs.

The reason for RNs? A major part of the analyst’s role is monitoring nurses’ electronic documentation.

The analysts “are deep into the building and maintenance of our system,” says Church. “We think if you’re an RN and have been a circulator or scrub, you’ll have more insight into the documentation as well as the system’s end users. But we also feel experience is more important than education. So there can be—and are—exceptions to the RN qualification.”

The position also requires the ability to use database, spreadsheet, and word processing software and the ability to educate staff.

Reporting structure

HCA recommends that its OR analysts report to the perioperative director with a dotted line to the IT department.

“We believe they should have all of the IT access any IT person would have,” says Church. “We know surgical services areas are often underserved by the IT department. It’s no one’s fault; the services and activities behind the closed doors are intimidating to some. We feel the OR analyst is the best one to build the menus and regulate access.”

OR Analyst University

The idea for the “university” was born because “we wanted to create the position in a robust fashion across a large enterprise,” says Church. The curriculum, which she says started out to be “huge,” was condensed to 80 hours, delivered in 2 1-week sessions. The curriculum was developed by Church with colleagues Robyn Dang, RN, and Steve Gillis, RN.

So far, 80 students have completed the course.

OR analyst position

Job-specific standards for HCA Inc’s OR analyst include:

- creates and maintains all software dictionaries, forms, queries, and responses related to OR documentation and billing
- responsible for the surgical revenue cycle; completes billing/charging on a daily basis, creating supply-item add requests and reconciling ancillary charge reports
- produces cost reports and revenue reports for end-of-month reporting
- creates and maintains surgical menus for all perioperative staff; sets up PIN numbers
- creates and/or maintains standard software screens
- trains new employees on use of the OR module; informs all involved staff and managers of changes to the system and teaches as needed
- supports hospital staff as requested and coordinates with other departments as they interface with the OR’s software (admitting, revenue integrity, supply chain, etc)
- works with IT staff to coordinate installation of the computer system for OR documentation in new or reorganized surgical services departments
- creates reports to provide statistics/data for administration, quality improvement, finance, surgical services, and special projects
- in conjunction with the appropriate OR director/manager and management engineer, participates in the performance improvement/quality improvement program for surgical services.

Source: HCA Inc.

Continued on page 19
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course, which comes with a diploma. Students attend on paid time and receive 68 CEUs.

“To have 40 people here for 2 weeks and have to replace them is a huge investment,” she says. She and her team are considering taking the course on the road and offering an abbreviated version.

They are also working on a return-on-investment analysis to document whether the formal training for OR analysts saves the hospitals money.

“We believe it does, but it is hard to quantify,” she says.

Church says her own experience provides evidence that close attention to OR billing does capture revenue. The hospital where she previously worked, which has 10 ORs, garnered $14 million in additional gross revenue in 1 year by improving its OR billing process.

Consider the example of a 6-hole plate used in an orthopedic case, she suggests. During the case, the nurse might write 4 screws were used. Yet, the holes are rarely left empty. An OR analyst might know to say to the nurse, “Sue, did you really use only 4 screws?” The answer would probably be no, 6 were used.

“Is an untrained person going to catch that?” she asks. “I suspect most ORs leave money on the table because of that kind of thing. Every patient’s bill should be as perfect as we can get it. It must be right for the patient as well as the business. That’s the right thing to do.” The OR analyst’s role includes setting up a process so OR nurses can document supply use easily and accurately without taking their attention away from the patient. ♦

OR business manager role varies

There is no uniform job description. Highlights:

• 10 of the 13 positions required a business degree; 2 also required an RN license.
• 6 of the 13 positions reported to the OR nurse manager or director, with the rest reporting to a senior administrator such as a vice president or director of the surgical service line.
• The OR business managers had an integral role in financial aspects of the department, such as preparing or contributing to preparation of the budget; managing the budget; charging and billing, cost analysis; and cost management.
• Most had roles in purchasing, working with vendors, and product evaluation.
• Many had a role in information technology, but the roles varied widely.

The role of OR business manager varies widely, OR Manager found in a 2006 analysis of 13 job descriptions.


By number of ORs

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New major study on surgical outcomes

The American College of Surgeons (ACS) reported in June on a 3-year surgical outcomes study involving nearly 185,000 patients in 142 centers. Results from the ACS National Surgical Quality Improvement Program (NSQIP) are reported in 20 articles in the June Journal of the American College of Surgeons.

One article describes how NSQIP data was used to develop a new risk index for surgical site infection (SSI), which the authors say is more accurate than that used by the Centers for Disease Control and Prevention (CDC). Other articles describe risk models for other surgical complications, including respiratory failure, cardiac events, venous thromboembolism, and complications after liver resection. For example, the study on cardiac complications concludes that a patient’s risk for a heart attack is associated less with the more common cardiac risks such as angioplasty, angina, or hypertension than it is with other conditions, such as high white cell count or diabetes.

How 3 hospitals used data to improve

A case study by Rowell et al discusses how 3 hospitals used their NSQIP data to reduce postoperative complications. The Salt Lake City Veterans Affairs Medical Center, which found it had a high rate of wound complications in general surgery, reviewed charts and found a pattern of closing contaminated or clean-contaminated wounds when other risk factors for wound complications were present. After a new protocol was put in place, the wound infection rate for those procedures fell from 5.5% to 2.9%.

The University of Virginia used its NSQIP data to reduce SSIs in patients having abdominal surgery by 36%. It found patients having colorectal surgery who developed an SSI had a higher body mass index (BMI) on average than patients who did not. One step was to use wound wicking (placing a piece of dry gauze in the wound to wick exudates away from the area) for colorectal surgery patients with a BMI >25 kg/m².

Massachusetts General Hospital, discovering morbidity slightly higher than expected in vascular surgery patients, identified one factor was a high rate of urinary tract infections (UTI). Several preventive steps were adopted, including use of silver alloy urinary catheters. The vascular UTI rate dropped from 7.0% to 1.8%.

SSI risk index

The risk index for SSI, described by Neumayer and colleagues, identified 14 independent risk factors—age over 40 years, diabetes, dyspnea, steroid use, alcoholism, smoking, recent radiotherapy, ASA class 2 or higher, and certain lab values. Risk was also related to characteristics of the surgery, such as emergencies, complex cases, type of procedure, and wound classification.

The authors say this index, though more complex, is more accurate than that of the CDC’s National Nosocomial Infections Surveillance System (NNIS).

The authors say they envision a system where patients’ risk factors will be entered in their records as part of their history, physical, and preoperative evaluations.

Benchmarking clinical outcomes

NSQIP is an outcomes benchmarking program that ACS says uses validated, risk-adjusted clinical data. Participating hospitals must use trained RNs to collect preoperative, operative, and 30-day morbidity and mortality data on a sample of patients having major surgery. The data are submitted to NSQIP, and benchmarking reports are fed back to the member hospitals so they can compare their results with peers and national averages. If a hospital’s patients have significantly more problems than would be expected, the hospital can use the NSQIP database to investigate why.

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Surgical Site Infection Risk Index

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<tr>
<td>Aneuysrm, blood vessel repair, and others (35001-37799)</td>
<td>1</td>
</tr>
<tr>
<td>Thoracoabdominal aneurysm and others (33001-34900)</td>
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<tr>
<td>Integumentary and musculoskeletal (10000-29999)</td>
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<tr>
<td>Respiratory system and others (30000-32999, 38000-39999)</td>
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<tr>
<td>Mouth, palate, and others (40000-43499)</td>
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<tr>
<td>Hernia, endocrine, and others (49491-49611, 60000-60999)</td>
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</tr>
<tr>
<td>Condition</td>
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</tr>
<tr>
<td>Work RVU &gt;17</td>
<td>4</td>
</tr>
<tr>
<td>Work RVU 10-17</td>
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</tr>
<tr>
<td>Contaminated or infected wound</td>
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</tr>
<tr>
<td>ASA Class 2-5</td>
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<tr>
<td>Emergency surgery</td>
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</tr>
<tr>
<td>Clean/contaminated wound</td>
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<td>Diabetes</td>
<td>1</td>
</tr>
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<td>Smoker</td>
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<tr>
<td>Dyspnea</td>
<td>1</td>
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<tr>
<td>Steroid use</td>
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<tr>
<td>Serum albumin &lt;3.5 g/dL</td>
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<tr>
<td>Age 40 years or over</td>
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<tr>
<td>Bilirubin &gt;1.0 mg/dL</td>
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<td>Radiotherapy for malignancy in last 90 days</td>
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<td>&gt;2 alcoholic drinks/day</td>
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<td>Work RVU &lt;10</td>
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</tr>
<tr>
<td>Clean wound</td>
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<td>ASA Class 1</td>
<td>0</td>
</tr>
<tr>
<td>Age under 40</td>
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</table>

Risk index scores:
Low (risk score 1-5). Medium (risk score 6-8). High (risk score >8).

Note:
ASA = American Society of Anesthesiologists
RVU = relative value units
Reprinted with permission.
While hospitals that aren’t enrolled in NSQIP can learn from the published results, “the real strength of being in NSQIP is that the hospital has its own data to compare,” notes Clifford Ko, MD, FACS, of ACS.

The annual fee for NSQIP is $35,000. Each hospital must identify a surgeon champion and dedicate an RN to collecting the data. The nurse receives training and support from ACS to make sure the data is entered consistently using standard definitions. ACS also provides software, audits the data, and provides customer support.

Originally developed by the Department of Veterans Affairs in the 1990s, NSQIP has 155 participating hospitals, including community hospitals and academic medical centers.

**Strength of NSQIP**

Dr Ko says NSQIP has strengths compared with other outcomes reporting systems that use administrative databases.

“NSQIP uses clinical data, whereas administrative data is for billing or administrative purposes,” he says. “NSQIP is much more detailed and can give better insight into outcomes and what can be learned from the data.”

In NSQIP, for example, one of the biggest predictors of how patients do is their albumin level, which administrative databases don’t collect.

NSQIP has a tie to the Surgical Care Improvement Project (SCIP), a national quality improvement project focused on 4 types of surgical complications: infection, venous thromboembolism, cardiac, and respiratory.

Participating hospitals can use NSQIP to report their SCIP data to the Centers for Medicare and Medicaid Services (CMS).

“They can also learn more about their SCIP outcomes by having data to help them compare whatever their rates are,” Dr Ko says.

Twentieth Annual
Managing Today’s OR Suite
San Diego
Manchester
Grand Hyatt

October 3 to 5, 2007
Online registration available at www.ormanager.com
Please see the ad for CARDINAL HEALTH in the OR Manager print version.
You must know your equipment.

Four letters that strike fear into the heart of any administrator of an ambulatory surgery center (ASC) are T-A-S-S, or toxic anterior segment syndrome.

This complication of cataract surgery has been around for years, but news of an outbreak in 2006 brought it to the forefront.

A new report of a TASS outbreak at a community hospital in Maine was reported June 29 by the Centers for Disease Control and Prevention.

A TASS outbreak brings difficult decisions about whether to close a facility, negative effects on staff and surgeon morale, and, most important, pain and suffering for patients (sidebar).

Prevention is the best defense. The American Society of Cataract and Refractive Surgery (ASCRS) and the American Society of Ophthalmic Registered Nurses (ASORN) developed the Recommended Practices for Cleaning and Sterilizing Intraocular Surgical Instruments, which outline prevention strategies. Here are suggestions from those guidelines and experts in the field.

Follow the manufacturer’s guidelines

It may seem like common sense, but too often, ASCs don’t follow the directions for use (DFU) from instrument manufacturers when it comes to cleaning. In general, recommendations include using a neutral pH solution with low sudsing properties and thoroughly rinsing the solution off the instrument.

Some experts recommend not using enzymatic detergents because they are difficult to rinse properly.

“Residual enzyme is one of the more common causes of TASS, in my opinion, particularly if it is present within the lumen of a cannula or I/A [irrigation/aspiration] or phaco hand piece,” says David F. Chang, MD, clinical professor at the University of California, San Francisco, and chair of the ASCRS Cataract Clinical Committee. “If instruments are thoroughly flushed with sterile water immediately after the case is completed, I would question why enzyme is necessary in the first place.”

Vikki Pearce, RN, BSN, clinical director at the Peninsula Eye Surgery Center in Mountain View, California, says her center does not use detergents because their use may lead to TASS. The center performs 4,000 eye cases a year.

But Barbara Ann Harmer, RN, BSN, MHA, president of MedAssist Consultants, Inc, in Celebration, Florida, and a member of the ASCRS/ASORN guidelines development team, disagrees: “Let’s put this enzymatic issue to bed. You don’t have to stop using enzymatic detergent; you just need to use it correctly,” Harmer has been involved in TASS education for nearly 7 years and notes that during the 2006 outbreak, facilities that didn’t use enzymatic detergent still had cases of TASS.

Using detergent correctly means thorough rinsing per the manufacturer’s DFU. “Even when you take a shower, you make sure you rinse adequately and don’t leave any soap residue on your skin or in your hair,” says Harmer. Similarly, rinsing removes detergent so it does not build up in the instrument.

Ramona Conner, RN, MSN, CNOR, manager for standards and recommended practices at AORN, agrees enzymatic detergents are fine as long as they are used at the correct dilution and thoroughly rinsed off. Conner also participated in the development of the ASCRS/ASORN recommended practices. She says the committee didn’t ban enzymatic detergents because they are helpful for removing viscoelastic, which dries quickly and is difficult to remove.

Continued on page 26
**Snapshot of TASS**

TASS is an acute inflammation of the anterior chamber of the eye after cataract surgery. Signs of TASS, such as blurred vision and severe inflammation, typically occur 12 to 24 hours after surgery. Topical corticosteroid eye drops are used to treat the condition. Patients with mild cases of TASS tend to improve quickly, but severe cases can result in permanent damage.

Causes can be broken into 3 categories:

**Extraocular**

An example is talc from surgical gloves.

**Products**

Products inserted into the anterior chamber during surgery can be involved, such as anesthetic agents, preservatives, or miomycin-C.

**Irritants**

Irritants may be on the surfaces of surgical instruments due to poor instrument cleaning.

Continued from page 25

Whatever the choice of cleaning agent, instrument care procedures must be written, based on the manufacturer’s DFUs, and kept in a binder or online, where staff can easily refer to them.

**Reduce the number of instruments**

Thorough cleaning requires time, a precious commodity in an ASC. To reduce this time, Harmer recommends cutting back on the number of instruments used for cataract surgery.

“People have too many instruments on the tray,” she says. “You should have no more than 5 to 10 instruments.” Some ASCs have as many as 45, driving up cleaning time. Often, the high number is simply the result of the OR manager and surgeon failing to pare down what is needed.

Taking that time pays off. Harmer estimates it takes only 4 to 6 minutes to clean 5 to 10 instruments.

A common question is how many sets of instruments are needed. “If you have 1 OR, you need a minimum of 3 trays; if you have 2 ORs, you need a minimum of 5 trays,” says Harmer. This breaks down to 1 set in use, 1 being reprocessed, and 1 ready for use (terminally sterilized); in the case of 2 ORs, the 1 set ready for use can be shared between the 2 rooms.

That’s just the minimum, Harmer emphasizes. The ASC manager should check how long it takes to clean the instruments between cases. If you have a high volume of cases, such as 4 in 1 hour, you may need an additional tray. This means money in an era of tight budgets, but consider that if TASS occurs, the ASC may have to close its doors while the cause is found.

**Prepare cleaning space appropriately**

ASCs must have adequate room to decontaminate and clean instruments and a ready supply of sterile distilled water or sterile deionized water. Use of one of these water types is recommended for the clean-

**Consistent, repeated education is key.**

More tips include:
- Do not allow viscoelastic solution to dry inside instruments. Wipe instruments with a lint-free cloth and place in sterile water.
- Flush phacoemulsifier hand pieces with BSS before removing them from the operative field.
- Use disposable cannulas and tubing whenever possible.
- Avoid flash sterilization.
- Clean ophthalmology instruments separately from other instruments.
- Thoroughly dry instruments by using filtered compressed air that is free of oil and water.
- Do not use glutaraldehyde for sterilizing intraocular instruments.
- Read the Recommended Practices for Cleaning and Sterilizing Intraocular Surgical Instruments from the American Society of Cataract and Refractive Surgery and the American Association of Ophthalmic Registered Nurse (see references).
- Tap into education resources. An online continuing education program about TASS is available at www.tassfacts.com.

Know your equipment

“You must know your equipment,” says Harmer. “Managers assume the people they hire know it, and they often don’t.”

For example, ultrasonic cleaners should be cleaned at least daily and preferably after each use, and a tabletop sterilizer contains distilled water that must be cleaned on a regular basis. Sterilizer function should be checked daily, and the results documented in a log. The quality of the water supplying a steam sterilizer should be checked annually.
Provide education and staff

Consistent, repeated education is key to ensure staff clean instruments properly. Harmer advises OR managers to designate someone who spot checks cleaning and verifies correct technique by observing the staff. This designated person needs to have training to ensure that correct knowledge starts at the top.

“Education for new staff is done one-on-one,” says Pearce, who acknowledges that staffing can be a challenge in an environment with shortages of health care workers. She created her own solution, hiring a technician who had 17 years’ experience with caring for instruments to spearhead cleaning efforts. The technician also helps out in the preoperative holding area and postanesthesia care unit when time permits.

“You have to look at your risk-benefit analysis and your options, then choose what works best for your situation,” says Pearce.

Regular competency assessment is important, although the ASCRS/ASORN recommended practices don’t specify a frequency. Conner says an annual assessment is reasonable in ASCs with a stable staff.

Pearce adds that TASS must remain top of mind for surgeons and staff. “You have to remember it’s always a possibility, so you always need to be vigilant,” she says. “It’s like malignant hyperthermia: it’s out there, and it can be dangerous.”

Partner with surgeons

The ASC manager should work with surgeons to encourage reporting and establish a reporting mechanism.

Nick Mamalis, MD, directs a voluntary reporting program for TASS, based at the Intermountain Ocular Research Center, Moran Eye Center, University of Utah in Salt Lake City, which can be reached at 801/581-6586. The ASCRS/ASORN guidelines recommend a surveillance system for detecting TASS. The CDC says TASS outbreaks should be reported to state and local health departments. Assistance in investigating outbreaks is available from the CDC’s Division of Healthcare Quality Promotion at 800/893-0485.

“Ideally, surgeons should report any suspicions to the OR manager,” says Dr Chang. He notes that sometimes surgeons are reluctant to report a possible case of TASS because they are not sure what the diagnosis is, or they may want to avoid the stigma of having a “complication” no one else has had.

Dr Chang adds, “Reporting can even be done confidentially at first if the surgeon so desires. Communicating such suspicions to a central source can facilitate earlier rather than later recognition of a facilitywide pattern. Of course, definite cases need a more formal investigation that the OR manager will spearhead.”

Pearce says prompt reporting is crucial. “If there are any signs of inflammation on the first postop day, the surgeon should notify the OR manager and not wait until the monthly report.” The reason is twofold. First, the national TASS database tracks lot numbers, which are not normally recorded in the patient’s medical record. Pearce says if she knows soon enough, she can track down the lot number. Second, the cause of a TASS outbreak is often difficult to pinpoint, so the investigation needs to start promptly.

Pearce says her medical director sent a letter to all surgeons explaining surgeons are expected to contact Pearce if there is any question of TASS.

“Signs of TASS need to be part of organizations’ and surgeons’ routine screening,” says Conner. Harmer suggests wording the question on the reporting form to state, “Have you had any recognized inflammatory reactions (TASS, TECD [toxic endothelial cell destruction])?” because these are not infectious processes.

Do it right every time

The right equipment, the right staff, and the right space add up to the right prevention plan for TASS. Ongoing awareness is also key. “Whether I’m the director or the staff nurse, I have to assume the position of patient advocate, delivering the best quality of care to patients so they can have a good outcome,” says Harmer. “You need to do due diligence for every patient.”

—Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer in Columbia, Maryland.

References


Forum

This letter refers to the article, “Timeout: It’s as easy as apple pie!” in the July OR Manager.

To the Editor:

At Sharp, after the University of California, San Francisco, gave us permission to use the slogan, we made boards for each OR, introduced this on Time Out Day and served apple pie to the staff on breaks.

This has been a hit. The surgeons now, instead of calling for a time-out, ask, “Who’s ready for apple pie?”

It’s always nice to have a little fun at work!

—Mary Diamond, RN, MBA, CNOR

Director, surgical services Sharp Healthcare, San Diego

Mary Diamond recently took a new position as director of surgical services at Tri-City Medical Center, Oceanside, California.
Please see the ad for
RF SURGICAL SYSTEMS, INC.
in the OR Manager print version.
An ASC’s relentless focus on savings

No cost is too small to escape the eyes of managers at Evansville Surgery Center in Evansville, Indiana, which shaved about $100,000 from its supply budget in the past year as part of an overall $417,000 reduction in variable costs. Evansville has 2 multi-specialty surgery centers that perform about 9,900 procedures a year, about 40% in orthopedics. The centers are owned 50-50 by physicians and the hospital.

These are strategies Evansville used to manage its supply costs.

Track savings

The most valuable tool in tracking savings is a spreadsheet titled the “direct expense reduction report,” which Laura Murphy, Evansville’s director of operations, uses to track savings.

“Every time we find an item that will save us money or renegotiate a contract, I do a projection of the savings,” adds LeeAnn Puckett, the materials manager.

Murphy presents a savings status report to the board of directors quarterly.

“It’s one thing to say to your board, ‘We anticipate saving $140,000 this year in direct expenses.’ But it’s another to be able to show them specifically where you are saving,” she says.

Standardize relentlessly

Evansville places a major emphasis on standardization.

“We look at the top 3 or 4 procedures we do in each specialty,” says Murphy. She identifies a physician champion from each specialty to partner with. For each procedure, she develops a spreadsheet listing the surgeons who perform that procedure and the supplies each uses with the associated costs. She and the physician champion then meet with the surgeons in that specialty in an attempt to standardize supplies.

“We ask what each of them can do to be cost-effective,” she says.

All of the orthopedic surgeons use the same major vendor for shoulder and knee procedures. When the 3-year contract was up, Evansville bid it out to 3 companies.

“Once the contract is negotiated, the center doesn’t go outside the contract unless the vendor doesn’t make a specific product.

If a surgeon requests an item such as a suture anchor from another vendor, the center first goes to the primary vendor to see if there’s an acceptable alternative. They keep the staff in the loop.

“We let the staff know if we’re trialing an item, to get their support. Often, the staff can make it or break it for us with a new product,” she notes.

Use your GPO

Group purchasing organizations offer more than price negotiations. They can provide pricing audits and reports of your buying patterns to see if you’re making the most of their contracts.

Don’t be afraid to shop around

“You can’t be afraid to switch vendors and negotiate new contracts with someone else,” says Puckett. “I think a lot of organizations tend to stick with their GPO for all of their purchases. But if someone has a better price, we are going to shop there.”

Evansville isn’t partial to big companies. Puckett says she takes the time to listen to sales reps from new small companies entering the market.

“If they have a quality product and the cost is less, we’ll trial it, and we may switch—we have found brand names are not always indicative of the highest quality and certainly not the lowest prices,” she says.

Do sweat the small stuff

At Evansville, every expense is scrutinized.

Murphy says, “We eliminated unnecessary duplication of relatively inexpensive products, such as surgical masks, bouffant hair covers, and surgical hand scrubs.

“Our purchasing coordinator posted the cost of each brand of hand scrub so the surgeons could compare, and the most expensive brand was eliminated.”

Similar posters compared the cost of screws for anterior cruciate ligament repair and ice wraps for knee and shoulder procedures.

“A lot of surgeons don’t realize the cost of these items, she notes. “Once you make them aware of it, they’re usually willing to consider alternatives. A lot of times, it’s just a matter of pointing it out to them.”

Adopt a strict vendor policy

Under Evansville’s vendor policy, no salesperson can be in the ORs without first reviewing a PowerPoint presentation on the policy and signing forms outlining the requirements.

The physicians must support the vendor policy for it to be effective, Murphy adds.

Under the policy, vendors must give advance notice of plans to be in the OR and must check in with Puckett. If access is granted, reps are permitted only to show a physician a specific item.

Vendors are informed that if they open a product in the OR that has not been approved, “we will consider it a donation to our organization. We will not pay for it,” says Murphy.

If a physician wants a salesperson to bring in a product for a case, the rep must bring the item to Puckett first so she can research it, determine the price,
and see if the center already stocks a similar item. If so, the device is not allowed unless it offers the same or superior quality at a lower cost.

Get the physicians on board
“Our physicians have gotten very much in tune with costs. Hardly a day goes by when a physician isn’t asking about the cost of some item,” Murphy notes.

Cost information is shared regularly at physician investor meetings.
“We provide them with cost and reimbursement information for commonly used supplies. That’s really an eye opener. I think physicians sometimes believe that whatever we use, we can bill and be paid for.”

If the center is considering a new product that will save money, “We ask them to at least try it,” she says. “We stress the importance of quality, but we encourage them to have an open mind if the cost savings are significant.”

Recently, a new venous access system was trialed although the same brand had been used for a long time.
Puckett sent the surgeons a letter telling them a new brand was being considered, and the rep would be available for 2 or 3 days to show them the product and answer questions. The surgeons were asked to complete an evaluation form.
One day, Puckett was talking with 2 surgeons. When one complained about the trial of a new device, the other commented, “If it’s a cost savings, and the product is good, we have to look at it.” The new product was adopted. Later, the surgeon who had complained recommended the product to 2 hospitals where he also practiced.

Murphy acknowledges that cost management projects are often easier in a surgery center than a hospital because many of the surgeons have an ownership interest.

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Form a value analysis team
Evansville recently formed a value analysis team. In value analysis, a team uses a systematic process to consider whether a new purchase is warranted. Team members include Murphy, Puckett, the controller, the administrator, and the purchasing coordinators. Physician investors participate in decisions concerning their specialty.
The committee has been instrumental in keeping unapproved products from entering the OR, Murphy says. But the process works both ways. The committee has also approved new products with a higher cost because they were considered better for patient care.

Reference
Making value analysis work in an ASC.
Please see the ad for INTEGRATED MEDICAL SYSTEMS in the OR Manager print version.
Needlestick injuries common but unreported by surgical residents

A survey of nearly 700 surgical residents in 17 US medical centers found that by their final year of training, 99% said they had had a needlestick injury; for 53%, the injury involved a high-risk patient. Of the most recent injuries, 51% were not reported to the employee health service.

The researchers say most resident respondents falsely believe that reporting and getting timely medical attention will not prevent infections and that reporting takes too much time and interrupts their work. The authors say hospitals need to develop systems to improve prevention and reporting.


When should patients be ready on day of surgery?

If patients arrive early on the day of surgery and have to wait NPO until afternoon, their satisfaction is diminished. But if patients don’t arrive early enough, they may not be ready if their case is moved up.

Researchers report on a new method for choosing the earliest possible start time of a case. The method does not rely on knowledge of the preceding case, surgeon, and/or procedure. Instead, the method uses the scheduled and actual start times of historical cases, classified by surgical suite, service, and day of week. The authors say the method is easy to implement and does not require complex modeling.


CDC revises isolation guideline

The Centers for Disease Control and Prevention (CDC) has issued its long-awaited new Guideline for Isolation Precautions. The guideline, updated from 1996, is expanded to cover settings such as ambulatory facilities, infusion services, and special environments such as pediatrics, ICUs, and burn units. New focuses are on administrative support for infection control programs, nurse staffing levels, and using masks when performing procedures involving spinal canal punctures such as epidural anesthesia. New sections have been added on multi-drug resistant organisms, gene therapies, and bioterrorism.

—www.cdc.gov/ncidod/dhqp/gl_isolation.html

Study exposes MRSA threat

A survey of more than 1,200 US health care facilities found 46 in every 1,000 patients carried or were infected with Methicillin-resistant Staphylococcus aureus (MRSA), reports the Association for Professionals in Infection Control and Epidemiology (APIC). This number is nearly 10 times the rate previously estimated. Past studies looked at incidence of MRSA in specific patient groups. This is the first study to sample a larger and more diverse set of health care facilities in all 50 states.

—www.apic.org

CDC infection-tracking system now in all states

A secure, web-based reporting system that tracks healthcare-associated infections is now available to all health care facilities in all 50 states. The National Healthcare Safety Network has options for data analysis and information sharing within and outside a facility or to the public if the facility wishes. The system builds on the CDC’s National Nosocomial Infection Surveillance (NNIS) system, developed 30 years ago.

The CDC says it is already partnering with dozens of facilities, including Department of Veterans Affairs hospitals, to use the new system to track Methicillin-resistant Staphylococcus aureus.

—www.cdc.gov/ncidod/dhqp/nhsn.html

Medicare’s pay for reporting for MDs began July 1

The first national, voluntary program linking physician payment to the reporting of quality data became effective July 1. Medicare providers can report quality data on 74 designated performance measures through the CMS claims processing system. The American College of Surgeons has posted a variety of materials on the program.

—www.facs.org/ahp/pqri/index.html