### Bonus trends

**Will your facility be paid more if it has quality outcomes and lower costs?**

Medicare and some big health plans are setting up bonus plans that reward doctors and hospitals for controlling costs and improving quality. Some are giving physicians incentives to use lower-cost settings like ambulatory surgery centers (ASCs).

Policy makers see these new “pay for performance” plans as the best hope to help control health costs. Hospitals are a target because they account for a major chunk of health care spending.

“Surf’s up. I think we’ll see more not less of these plans, perhaps with Medicare in the lead,” Don Berwick, MD, quality improvement guru with the Institute for Healthcare Improvement, Boston, said in an audioconference April 27.

Though your facility may not be affected yet, it’s a good reason to keep focused on cost management and quality.

### Patient relations

**Recovering from an ‘oops’:**

**Best ways to make amends**

The patient was sobbing. After being instructed to use a restroom in a high-traffic public area wearing only a hospital gown, the woman returned to the preoperative holding area in tears.

“She told me she had never been so embarrassed in her life,” says Diane Goligoski, RN, a staff nurse at Sharp Memorial Hospital in San Diego.

Goligoski practiced service recovery with the patient, a series of behaviors to make an “oops” better or prevent one from happening.

Goligoski apologized profusely and told the patient this would not happen to anyone else. Then she immediately contacted her manager, Mary Diamond, RN, MBA, CNOR, director of surgical services, to help console the patient. After the procedure Goligoski gave the woman flowers from the hospital gift shop, using a coupon from her service recovery toolkit.

“These bathrooms had always been the place where we directed patients before surgery,” says Diamond, who manages 21 ORs at Sharp Memorial Hospital and Sharp Mary Birch Hospital.

Continued on page 9
Please see the ad for
MEGADYNE
in the OR Manager print version.
Editorial

Here’s a phrase you will be hearing a lot—pay for performance. Experts say it’s the wave of the future for reimbursement.

Employers and policymakers think it could be one answer to the rising cost of health care.

Everyone agrees the current payment system is broken.

“Our country spends 40% more on health care than any other country in the world,” said quality guru Don Berwick, MD, of the Institute for Healthcare Improvement (IHI, www.ihi.org), and there’s a lot of concern we’re not getting our money’s worth.

The idea behind pay for performance is that doctors and facilities that perform better should be paid more, and that will motivate them to keep improving care while controlling costs.

It’s a strong and growing movement. Some big players are involved—Medicare, the Institute of Medicine, the Leapfrog Group, and large insurers like UnitedHealthcare.

You can read about the trends in this month’s lead story.

More of a zoo

A lot of pilot projects are going on—about 100 by one count. “This isn’t one animal. It’s more of a zoo,” Dr Berwick commented in a recent IHI audioconference, with many formats for tying payment to performance.

Much of the focus is on physicians now, but hospital pay for performance is fast approaching.

“My own view is that the possibilities and value of this kind of system for hospitals exceed what it would be for physicians,” Dr Berwick said.

Details aren’t nailed down. So far only a fraction of a percent of payments is in play. It’s hard to say how much of a hospital’s or doctor’s payments might eventually be at stake: a token 1% to 2% or as high as 5% or even 10%.

No big effort like this can go on without questions and controversy. Some of the issues were traced by Bob Galvin, MD, director of global health care for General Electric, who also participated in the audioconference:

• Will providers tend to “manage to the measure”—focus on what is being measured rather than patient care as a whole?
• Will doctors shy away from patients who might jeopardize their results, such as those who aren’t compliant in taking their medications?
• Will pay for performance be hard on morale? Will providers suffer from “measurement fatigue”?
• Don’t expect more overall funding for the future for reimbursement.

What can managers expect?

What will the impact be on surgical facilities?

Pay for performance may not affect your facility for some time. But keep your eyes on the horizon. These are some possible effects:

• Measurement will become a way of life, even more so than it is now.
• Many of the measurements, like adhering to guidelines for prophylactic antibiotics for surgical patients, will require multidisciplinary effort.
• Good information systems will be essential to gather and track data and report results. That’s one area where Drs Berwick and Galvin particularly want policymakers to focus attention and resources.
• Don’t expect more overall funding for pay for performance. The whole point is to get better value out of the health care system. Employers and Congress already feel health care costs are out of control. ♦

—Pat Patterson

Paying staff for performance

Who provides rewards for staff, and how well do they work?

Winning the Baldrige award

A 200-bed hospital wins one of the nation’s most prestigious quality awards.

Upcoming

Saving nurses’ backs

The latest on ergonomics, a key to retaining senior staff.

Paying staff for performance

Who provides rewards for staff, and how well do they work?

Winning the Baldrige award

A 200-bed hospital wins one of the nation’s most prestigious quality awards.
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Fire marshal bans alcohol-based preps

The Nebraska State Fire Marshal wrote the state’s hospitals and ambulatory surgery centers (ASCs) March 31 saying they may not use alcohol-based surgical prep solutions when cautery or electrosurgery is planned.

Though the ruling applied to Nebraska, the Centers for Medicare and Medicaid Services (CMS) agreed with the ban, meaning it could spread to other jurisdictions. If that happens, experts worry about the risk for surgical infections.

Health care organizations, led by the American Society for Healthcare Engineering (ASHE), are working to address the situation. ASHE submitted a proposal to the National Fire Protection Association (NFPA) in April asking it to amend NFPA 99, the fire code for health care facilities.

In the meantime, ASHE advised hospitals and ASCs to discuss the issue with their patient safety leaders and decide how to respond if cited by CMS.

The fire marshal’s letter stemmed from a surgical fire at a hospital in Omaha, in which a woman was severely burned.

“We found they were using a flammable germicide during surgery, and that is apparently what caused the fire,” the assistant state fire marshal, Bruce Neemann, told OR Manager. The patient later died, though it is not clear she died of fire-related injuries, he said.

In the letter, the fire marshal said use of flammable germicides (such as alcohol-based prep solutions) in conjunction with cautery and electrosurgery violates NFPA 99 13.4.1.2.2 (2003 edition), which states: “Liquid germicides used in anesthetizing locations, whenever the use of cautery or electrosurgery is contemplated, shall be nonflammable.”

The letter says the fire marshal conferred with regional and national CMS offices, and CMS officials concurred with the ruling, which applies to any “flammable liquid germicide” such as DuraPrep, Prevail, and alcohol. A spokesman at CMS headquarters in Baltimore confirmed that.

ASHE is not aware of facilities outside Nebraska that have been cited by CMS for use of alcohol-based prep solutions.

What should OR managers do?

ASHE advises managers to carefully review their practice for surgical prepping. If they continue to use alcohol-based preps, they should strictly adhere to the product labeling, says Dale Woodin, ASHE deputy executive director. That includes making sure the solution is thoroughly dry and not allowing it to pool.

Managers should also review ASHE’s proposal to NFPA, termed a technical interim amendment (TIA). The TIA outlines how flammable germicides and antiseptics can be used safely and gives a rationale for use of alcohol-based surgical preps. The TIA is posted at www.ashe.org.

If cited by CMS, a facility can file an application for a waiver, Woodin notes. An application can be filed if a facility believes complying with a rule would be a financial hardship or have “unintended consequences.” In its application, a facility could use the rationale in the TIA to explain why it believes continued use of alcohol-based preps is justified and how the facility intends to manage the fire risk.

Amending NFPA 99 is a long process. If NFPA approves the amendment, it then must be considered by CMS, which could take months.

A time-out for preps

One recommendation in the TIA is to have a time-out before any surgical procedure that uses flammable solutions to:

• verify the site is dry before it is draped and an ignition source is used
• make sure pooling has not occurred or has been corrected
• remove any solution-soaked materials from the OR.

The time-out would be similar to that required by the Joint Commission on Accreditation of Healthcare Organizations for surgical site verification.

Other recommendations in the TIA include:

• applying an alcohol-based skin prep from a unit-dose type container
• emphasizing the need for dry time before a heat source is used
• recommending a periodic hazard assessment of surgical procedures and the OR environment.

Continued on page 7
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Fast facts

Surgical fires
- 50 to 100 surgical fires occur each year, with 1 to 2 fatalities.
- An estimated 10% to 15% of surgical fires in the US involve alcohol-based prep solutions.
—ECRI

Surgical infections
- About 500,000 surgical site infections (SSIs) occur annually in the US.
- Surgical infections are developed by:
  —2% to 5% of patients having clean extra-abdominal operations
  —up to 20% of patients having intra-abdominal operations.
- Compared to patients without an SSI, patients who develop SSIs are:
  —up to 5 times more likely to be admitted to an intensive care unit
  —5 times more likely to be admitted to the hospital
  —up to 2 times more likely to die.

Worries about surgical infection
Experts were concerned about implications for surgical infection if alcohol-based surgical preps are banned. The skin is the most important source of organisms that contaminate surgical wounds. An estimated 500,000 surgical site infections occur annually. There are about 50 to 100 surgical fires each year, with 1 to 2 fatalities, according to ECRI, a nonprofit organization that researches health care technology.

As the TIA explains, alcohol is the “gold standard” prep for preventing surgical site infection because it kills microorganisms quickly. Aqueous solutions without alcohol take much longer to dry, and even with aqueous formulations, alcohol is used during skin cleaning.

No studies have adequately compared the most common skin prep agents (povidone-iodine, alcohol-containing products, and chlorhexidine gluconate), the Centers for Disease Control and Prevention notes in its Guideline for Prevention of Surgical Site Infection 1999.

Perhaps 10% to 15% of fires involve alcohol.

Complete removal of alcohol would “constitute an unacceptable risk for increase surgical site infection and has never been attempted,” ASHE points out in the TIA.

Telling ORs to remove alcohol-based preps essentially amounts to “conducting an uncontrolled clinical trial under fiat,” maintains Judene Bartley, MS, MPH, CIC, who has worked on the issue with ASHE on behalf of the Association for Professionals in Infection Control and Epidemiology, Inc (APIC). Al de Richemond, a veteran surgical fire investigator with ECRI, in an interview with OR Manager said, “Alcohol has associated dangers, as do all flammable antiseptics and medications, most of which are permitted in surgery.” He also noted that alcohol-based preps aren’t prohibited by NFPA 99 when lasers are used, even though they also are an ignition source. For that reason, he says, the logic of citing facilities for use of flammable preps with electrosurgery “is flawed.”

Alcohol is involved in perhaps 10% to 15% of surgical fires in the US, ECRI estimates. Such fires typically happen when an alcohol-based prep solution is used improperly—is not allowed to dry or pools under the patient. Vapors can accumulate under the drapes and drift to the surgical site, where they can be ignited by an electrosurgical electrode.

De Richemond described a 2002 case in New Zealand that led to a similar call for a ban. The fire happened after a woman needed an emergency cesarean section was prepared with a large amount of alcohol, which ignited when electrosurgery was applied. She received third-degree burns to 11% to 12% of her body; the baby was not harmed. Instead of a ban, New Zealand authorities issued a safety alert on proper use of prep solutions (Tooher R, et al. Aust New Zealand J Surg. 2004;74:382-383).

The State of Texas also has issued a position statement on use of alcohol-based surgical preps. Even though the state’s hospital licensing rules say flammable germicides shall not be used as preps, the state health department said it recognizes the efficacy of alcohol-based preps in preventing surgical infections. Until the rule can be revised, the state said that facilities should not be cited for a violation if they meet a series of conditions for proper use of the preps. The position statement applies only in Texas.

What should OR managers do?
Here are some steps to take on use of alcohol-based surgical prep solutions:
- Read the proposed amendments to NFPA 99 (the TIA) from the American Society for Healthcare Engineering (www.ashe.org).
- Discuss safe use of alcohol-based surgical prep solutions as part of your facility’s patient safety process.
- If you continue to use alcohol-based preps in procedures involving cautery or electrosurgery, adhere strictly to the product directions.
- If your facility is cited by CMS for a violation of NFPA 99 because of use of alcohol-based surgical preps, consider filing an application for a waiver. The application comes with the citation notice.

Weight-loss surgery effective in larger patients
Surgery is more effective than nonsurgical treatment for weight loss and control of some comorbid conditions in patients with a body mass index of 40 or greater, according to a meta-analysis in the Annals of Internal Medicine. More data is needed to know if surgery is effective for patients who are less severely obese.

Surgery resulted in weight loss of 20 to 30 kg (44 to 66 lbs), which was maintained for up to 10 years. Gastric bypass resulted in more weight loss than gastroplasty.

The mortality rate for bariatric procedures is less than 1%, and adverse events occur in 20% of cases.
Please see the ad for
BFW, INC.
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Physicians who provide higher-quality, low-cost care, according to its criteria—and kicking up controversy.

Here’s a look at the trends.

The affordability crisis

Health costs have been charging upward, and hospital costs are leading the way.

“We’re seeing an affordability crisis in health care,” said David Ormerod, MD, of Blue Shield of California, who traced trends at the American Association of Ambulatory Surgery Centers (AAASC) meeting in March in Reno, Nev.

Health care costs have been climbing by about 5% a year since 1997 after slowing in the mid-1990s.

“Because hospitals account for so much of the health care dollar, that’s really where the concern is,” Dr Ormerod said. Physicians' costs are rising, too, but are a smaller percentage of the expense. Prescription drug cost growth has been consistent (chart).

As costs rise, fewer people can afford insurance, and the healthiest tend to be the ones who drop their coverage. That leaves the insured population with a larger percentage of sick patients, which boosts costs and premiums further.

Paying for better results

In April, Medicare introduced Hospital Compare, where the public can see data on nearly 4,200 hospitals for 3 conditions—acute myocardial infarction, heart failure, and pneumonia. (www.hospitalcompare.hhs.gov or www.medicare.gov). Hospitals that don’t report are docked 0.4% in their annual Medicare update. In all, 98% of eligible hospitals are participating.

The early returns from Medicare’s 3-year demo with Premier found the 274 participating hospitals improved their quality significantly during the project’s first year, Centers for Medicare and Medicaid Services administrator Mark McClellan, MD, PhD, announced in May. The project tracks hospital performance on 34 indicators for 5 conditions (www.cms.hhs.gov/researchers/demos/phqi/default.asp). Two conditions involve surgery—coronary artery bypass graft (CABG) and hip and knee replacement. Hospitals are being rated on indicators such as using the internal mammary artery for CABG and starting and stopping prophylactic antibiotics on time.

During the first year, median performance was up 7.5%, indicating “financial incentives to reward better quality care work,” Dr McClellan said.

When data analysis is complete, hospitals scoring in the top 10% will receive a 2% bonus over their DRG payments for patients with the relevant conditions. Hospitals in the next 10% will receive an extra 1%. In the third year, hospitals that don’t meet a quality target will have their payments reduced. Medicare is expected to pay out $21 million in bonuses over the 3 years.

Hackensack University Medical Center in New Jersey is one of the pilot participants. In looking at its practices, the hospital noted a couple of problem areas, such as the use of antibiotics after total joint surgery, according to an article in The New York Times (April 15). Under guidelines based on clinical trials, antibiotics are to be discontinued 24 hours after surgery. Evidence has shown that giving them longer is not effective and can contribute to antibiotic resistance. Yet the hospital found a quarter of surgical patients were kept on antibiotics for more than 24 hours. The surgeons solved the problem by issuing a standing order to stop IV antibiotics after 24 hours.

“Within a week, 94% of patients had their antibiotics withdrawn on time,” the article said.

To surgeons who protested, the chairman of the department of orthopedic surgery would say, “You’re entitled to your opinion, but there’s no validity to it.”

Bonuses for physicians

A Medicare pilot involving 10 large physician groups covering about 200,000 patients will pay bonuses to MDs who improve care for patients with chronic diseases like congestive heart failure, cardiac disease, and diabetes. About 100 such programs have been created by other insurers and employers, The Times noted. The Medicare Payment Advisory Commission (MedPAC) recommends that Medicare start paying all physicians differently based on how they perform.

A UnitedHealthcare (UHC) pilot “performance program” has elicited strong reactions from physicians and hospital systems. Underway in 13 areas, the pilot designates physicians who UHC says provide higher-quality, lower-cost care, according to its criteria. Some self-insured employers such as General Motors and Daimler Chrysler are giving employees incentives, such as lower copayments, to use these physicians, The Wall Street Journal reported (March 29). In the St Louis area, the pilot applies to about 1.5% of the 900,000 people UHC covers.

Doctors and hospitals are pushing back, saying the pilot is ill-conceived and unfair. BJIC Healthcare, a 10-hospital system, is threatening to terminate its UHC contract, saying just 18% of its physicians and only a handful of doctors at Washington University would qualify for the performance network. Patients would be forced to pay higher out-of-network rates if they wanted to continue to see these physicians. Officials of

### Why do some hospitals have higher ‘sticker prices’?

### Elements of health cost growth, 2004

<table>
<thead>
<tr>
<th>Source</th>
<th>Percent change</th>
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<tbody>
<tr>
<td>All services</td>
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<tr>
<td>Hospital</td>
<td>3.5%</td>
</tr>
<tr>
<td>Physician</td>
<td>2.2%</td>
</tr>
<tr>
<td>Rx</td>
<td>1.8%</td>
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Sources: Center for Studying Health System Change (December 2004) and America’s Health Insurance Plans.
another system, St John’s Mercy Health Care, called the plan “ill-conceived, poorly planned, and hurriedly implemented,” according to the St Louis Business Journal. The Medical Group Management Association (MGMA) asked UHC to stop the program, saying it had “serious design flaws,” which made it “unethical” and “misleading to consumers.”

Patients pay more at costlier hospitals

Blue Shield of California made headlines in 2003 when it set up 2 tiers of hospitals based on quality and cost. Hospitals in the first tier are considered “preferred,” with higher quality and lower cost, according to Blue Shield’s criteria.

Patients who choose second-tier hospitals pay more—sometimes significantly more. A patient who had a $1,000 copay in a first-tier hospital might pay twice as much out of pocket to use a second-tier hospital. The program applies only to elective admissions, not emergencies. The program has saved Blue Shield about 3%

Blue Cross and Blue Shield of Minnesota is rolling out a 2-tier hospital plan for one of its networks, set to go into effect in January. The tiering is based on both cost and quality measures. As in California, patients in the network will pay higher co-pays to use second-tier hospitals.

Pushing hospitals on cost and quality

Calpers, the nation’s third largest purchaser of health care benefits, is pushing hospitals on cost in California. Last spring, Calpers voted to exclude 38 hospitals from its Blue Shield network. Some later rejoined, but 23 are still out.

“Premium increases exceeding 50% in the past 3 years are simply unsustainable. Almost half of the cost increases are driven by hospital charges,” Calpers’ board president said.

Calpers spokesman Clark McKinley told OR Manager, “There’s a wide disparity in the ‘sticker prices’ in hospital chargemasters, and it doesn’t seem to make much sense. You might see a $14,000 charge for a surgery at one hospital and half that at another.

“We know hospitals have to make their margin, and we want them to be healthy, but we believe there has to be a more sensible way to reimburse them for their costs.”

Calpers is forming a coalition to look at hospital pricing and quality measures and expects to have a plan in place next year.

Encouraging use of surgery centers

Some insurers have incentives to encourage physicians and patients to use less expensive ambulatory surgery centers (ASCs) instead of hospital outpatient departments. But payers expect to see a significant difference in cost. Without a big cost differential, insurers are unlikely to choose ASCs based only their claim of higher quality, Dr Ormerod said.

Some pilots pay physicians higher fees for taking their procedures to ASCs, he notes. Though the success of these programs is not yet clear, more insurers may consider such arrangements if they are successful.

Another incentive is to give medical groups a target for what percentage of their surgical procedures, say 33%, are appropriate for an ASC versus a hospital.

“We’ve been getting this information out to physician groups to see how they compare with this benchmark,” Dr Ormerod said.

Physicians get detailed reports about the cost difference between the 2 types of facilities.

A study by the Moran Company commissioned by the Federated Ambulatory Surgery Association found that, on average, Medicare paid $320 more for a claim in a hospital outpatient department than in an ASC.

When physicians see the cost difference, Dr Ormerod said, “the light goes on, and they say, ‘Gee, maybe we should start to shift some of our services there.”

We can actually drill down to the procedure level and begin working with them to channel more of their procedures to the cost-effective settings.”

Patients might be rewarded as well. Their copay might be $500 in a hospital but $200 or $300 in a surgery center. The difficulty is that for many patients, the decision about where to have surgery is already made before they are aware there is a difference in the copay.

Cardiac outcomes in specialty, general hospitals

Lower mortality rates in specialty cardiac hospitals can be accounted for by their healthier patients and higher volumes, according to findings of a study from the University of Iowa College of Medicine, Iowa City. The study examined whether general and specialty cardiac hospitals in the same region with similar volumes would have similar outcomes.

The research, reported in the New England Journal of Medicine, retrospectively examined 42,737 Medicare beneficiaries who had percutaneous coronary intervention (PCI) and 26,274 who had coronary artery bypass grafting (CABG) during 2000 and 2001 in specialty cardiac hospitals and general hospitals in the same markets.

Specialty hospital patients were less likely to have coexisting conditions and were less likely to have had an acute myocardial infarction than general hospital patients.

The better health of specialty hospital patients compared with those in general hospitals was reflected by the lower mean predicted risk of death—2.1% vs 3.1% for PCI and 5.0% vs 5.8% for CABG.

Mean volumes of PCI and CABG procedures were higher in specialty hospitals than in general hospitals.

Though the unadjusted rate of death was lower in specialty hospitals, stratified analyses comparing specialty and general hospitals with similar volumes did not find a significant difference in mortality, the researchers noted.

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for Women. “But a new garage opened, and traffic increased. She was the first patient to complain.”

And the last. Freep patients now use another bathroom not in a public corridor.

Service standards

Sharp introduced service recovery almost 2 years ago as part of the “Sharp Experience,” the system’s journey to become the best place to work, receive care, and practice medicine.

Service recovery is the handling of customer dissatisfaction, complaints, problems, or difficulties. Sharp says service recovery is initiated “when a customer has received less than excellent care.” This service culture has 12 standards of behavior, and one is service recovery.

“These aren’t suggestions—they’re standards, especially for managers,” says COO David Tew.

Working with the Studer Group (www.studergroup.com), a consultant based in Gulf Breeze, Fla, Tew sought to make service recovery fun. For instance, at an employee rally, Tew dressed up as one of the Village People and introduced Service recovery by singing “Sharp A-C-T” to the tune of “YMCA.”

ACT is an acronym for:

• Acknowledge and apologize
• Correct
• Take it forward and track it.

Acknowledging and apologize

Acknowledging a patient’s fears or complaints is the most important piece of service recovery, Tew says.

“The ability to say, ‘I hear you; I’m sorry this happened to you,’ is so significant, Tew says. “Nothing soothes faster than the words, ‘I apologize.’”

Acknowledgment also works to calm physicians, Diamond adds. “The one thing that I always say when I have an angry surgeon who says everything has gone wrong since he got out of bed is, ‘What can I do right now to make it right?’” Diamond says. “Usually, it is nothing. I have done what I needed to do: I let them vent.”

Correct

After acknowledging a person’s issues, empathize and let the person know that how he or she feels is important to you, Diamond says. For instance, a nurse can say to a patient’s waiting family, “This must have been frustrating for you.”

Compensation also eases the pain, Diamond says. Sharp has empowered staff to give patients gifts if their service expectations were not met. The gifts, stored in a purple envelope on the unit, include vouchers for the hospital gift shop, cafeteria, and coffee shop and local restaurant certificates.

In addition to the flowers for the woman who had the embarrassing bathroom experience, Diamond learned the patient’s favorite restaurant was one in the toolkit. She gave her 2 coupons and a note that said, “When you go home and you feel better, have dinner on us as our way of saying I’m sorry this happened. Thank you for taking the time to tell us.”

The most frequent reasons for toolkit gifts are when patients and their families have had long waits, are from out of town, or have complaints about a department. OR nurses also give physicians coffee vouchers when they’ve had unusual waits.

Tew’s advice for hospitals seeking to assemble toolkits is to “ask what your frontline staff can do—not your director or managers but the person who has the first opportunity to turn the situation around. What can you do to empower them?”

Take it forward

The final step in service recovery is to take it forward and track it.

For the customer service blunders the staff can’t handle with kind words and coupons, staff is encouraged to “manage up.” For instance, Diamond speaks to unhappy patients and families. She follows them throughout their stay to make sure their service expectations are met.

“I will say to the patient, ‘My colleagues told me that you have this issue. My name is Mary Diamond, and I’m the director of surgery. I am here to follow up with you.’

“I tell them we’re sorry, what we’re going to do, and see if there is anything else that we need to do.”

If you or your staff hear about a problem with another department, there is a way to handle that under service recovery. For instance, instead of saying, “It must be that imaging department again. Not my problem. It wasn’t on my shift,” you would say, “That’s unfortunate you had that experience. Chris is probably one of the kindest persons I’ve met, and she is certified. I am sorry that happened.”

At first, some managers were concerned that by acknowledging mistakes, they would be encouraging malpractice claims, Tew notes. But he says that hasn’t been the case.

The T in ACT also stands for track it. When the staff dispenses a toolkit item, that is recorded on a tracking form. Nurse managers submit these tracking reports monthly to the Service Recovery Action Team. Tracking identifies costs as well as recurring problem areas to be addressed, such as wait times, parking, or a particular department or unit.

Preventive medicine

Service recovery also is about preventing service errors and anticipating complaints. For instance, in perioper-
**Service recovery scripting**

The key to service recovery is listening without becoming defensive and acknowledging without assigning blame. Sharp Healthcare provided scripting to help OR nurses know what to say during service recovery opportunities.

<table>
<thead>
<tr>
<th>Don't say</th>
<th>Do say</th>
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<tr>
<td>General apology</td>
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<tr>
<td>“I am sorry you’ve reached the wrong number, but I can’t help you.”</td>
<td>“I’m sorry you’ve been transferred a number of times. Let me give you the telephone number before I transfer you.”</td>
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<tr>
<td>Angry people</td>
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<tr>
<td>“I am not responsible for the way your other call was handled. What do you want me to do about it?”</td>
<td>“I apologize that this situation has left you feeling angry. I understand you’re upset about the way your previous call was handled. How can I help you now?”</td>
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<tr>
<td>Delayed procedure/waiting</td>
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<tr>
<td>“I have no idea when we can respond; we have a 4-hour delay.”</td>
<td>“I apologize no one has responded. I know your waiting is inconvenient. We didn’t meet your expectations. I will have someone call you back within the hour who can answer your questions. Here is my name and number; please call me if you don’t receive a call back.”</td>
</tr>
<tr>
<td>Complaints about other departments</td>
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<tr>
<td>“It’s not my fault that I’m overloaded with work; if they would just hire more people then I could get things done.”</td>
<td>“I apologize that the service you requested was not performed in a timely manner, and we did not meet your expectation. Thank you for bringing this to my attention. I will make sure your request is completed immediately.”</td>
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Tew related a call he received from a circulating nurse in the OR who was “managing up” a potential service disaster. “She said, ‘David, I want to let you know about a situation. Mrs Smith has been NPO all day. She is scheduled to have surgery at 2 pm. We just had a heart and two traumas. It’s not going to happen at 2 pm. We will try to work it into the schedule for 7 pm or potentially in the morning. Would you mind going and talking to her?’”

Tew went to the patient unit and talked with the charge nurse, who was aware of the situation. He asked her to come to see the patient with him so there would be continuity.

“I walked in and said, ‘Mrs Smith, Dr Schwartz, your surgeon, and you are fortunate to have him, has just been called in to do 2 trauma cases. As a result, the elective surgery you were going to have at 2 pm will have to be delayed.’”

“I stopped; I didn’t say anything. I wanted to see what she had to say, both verbally and nonverbally. “She said, ‘I really trust Dr Schwartz. I’m grateful that you have come up. It’s not what I had planned. I have family here from out of town. They are quite hungry. They are going to be back in a few minutes.’”

“So the first clue was, ‘I have family members who are hungry.’ How can I use service recovery for them? I told her the charge nurse had some food coupons she would bring in. I told her we were really sorry about this delay, and this is what we are going to do for her family. Then I said, ‘Is there anything more we can do for you? We have the time.’”

Tew notes that this woman gave the hospitals all 5s (the highest score) on her discharge survey.

“Didn’t meet her expectations, but we were able to anticipate her issues,” he says.

Other ideal service behaviors he suggests include asking people who look lost if they need help finding their designation and escorting them there, as well as lending a helping hand to new employees.

**Competitive environment**

Satisfied customers and physicians are especially important in Sharp’s competitive San Diego area. Half of Sharp’s visits are covered by capitated payments. That means patients are covered by plans that pay a per-member, per-month fee to their physicians.

Physicians are independent and shop for the best hospital.

“The number one reason customers are dissatisfied and decide to go somewhere else is the indifferent attitude of staff,” Tew says. “One satisfied customer will share with at least one other person. One really dissatisfied person will tell 20 others, and if they have access to the Internet, it could be 1,000.”

Start-up costs for service recovery were $115,000 for supplies and training, he says. He does not have figures on how much Sharp has spent fixing errors, but he says problems have gone down significantly. “Remember, it costs a lot more to replace a customer than to retain one,” he says.

**Training the staff**

Diamond trained the staff to implement the ACT of service recovery with a video and competency guide and worksheet. She started by training 30 to 40 of the frontline staff, then eventually all the OR staff.

Continued on page 14
**Being open about errors is norm at Children’s Hospital**

During a procedure, the surgeon asked for an instrument. While getting it, someone placed a hot fiberoptic cord tip on the patient’s abdomen, resulting in a first-degree burn.

Immediately after the procedure, the surgeon explained to the family exactly what had happened and ensured them the hospital would take steps to prevent it from happening again.

Full disclosure of accidents and mistakes to patients and their families is the policy at Children’s Hospitals and Clinics in Minneapolis.

“The concept of disclosing medical accidents and near misses with families is a departure from the comfort zone of many providers,” says Julianne Morath, RN, MS, chief operating officer and vice president of care delivery. “But the greater risk lies in not communicating.”

**A defining moment**

Children’s began developing its full disclosure policy even before the Institute of Medicine’s landmark 1999 patient safety report To Err is Human.

The hospital commissioned 19 focus groups across departments and disciplines, including families. Hospital officials learned what patient safety meant to them, what they had seen and experienced with accidents and errors, and what they thought were barriers to patient safety.

As with any hospital initiative, top leadership support was necessary. The hospital’s board of directors endorsed integrating patient safety monitoring and progress into the hospital’s strategic planning.

“When an error occurs or an accident happens, it is a defining moment. How such events are viewed and managed expresses and shapes the culture of the organization,” says Morath, who also is on the board of the National Patient Safety Foundation and co-author of the new book To Do No Harm: Ensuring Patient Safety in Health Care Organizations (Jossey-Bass, 2004).

**Shifting away from blame**

To shift away from the blame, secrecy, and lawsuit prevention historically associated with hospital accidents, Children’s has created a culture of safety, which includes open disclosure, analysis, learning, prevention, and face-to-face accountability, Morath says.

“We focus on system failures now, not people failures,” says Gloria Drake, RN, MSN, CRNA, clinical services director of surgery. “If someone makes an error, there were several gaps or vulnerabilities in the system that allowed that error to happen.”

In fact, Children’s uses a slice of Swiss cheese as the logo for its full disclosure policy. Swiss cheese signifies that for an error to occur, a series of holes in the system have to line up.

After an accident, a root cause analysis is performed to examine each part of a system that failed. A quality improvement project is then undertaken to improve the system.

**Supporting staff**

When disclosing an incident to families, physicians tell everything that happened except the name and job function of the staff involved.

“Asking who did it is a natural question parents have,” Drake says. “But who did it doesn’t matter. Their identity isn’t as important as the hospital learning from it, apologizing for it, and fixing it so it never happens to another patient.”

“Getting accidents out in the open is as therapeutic for the caregiver as it is for the family, she adds.

“Mistakes take a terrible toll on health care workers,” she says. “They come to work to care for people. Full disclosure allows people to process events rather than carry around blame or secrecy. Energy goes into fixing the system rather than hiding the error.”

**Blameless reporting**

Installing a blameless reporting system is one of the first steps Children’s took to create a patient safety culture. The staff can report accidents or near misses anonymously through a phone hotline, electronic reporting, or paper reporting.

“We built an indicator for reporting... at Children’s Hospital.”

Continued on page 16
Please see the ad for ADVANCED STERILIZATION PRODUCTS in the OR Manager print version.
continued from page 14

into our key performance indicators, with a reward for increased reporting,” Morath says. “The traditional incident reporting form was recast as a Safety Learning Report. We went from check-offs and coding to telling stories about what happened, what the conditions were, and what people think could prevent the incident from happening again.”

The narratives help identify patterns of risk, such as gaps in communication and information sharing during hand-offs.

For instance, at 11:05 am every day in the OR there is a new team. An OR safety action team examined and reinforced ways for OR staff to quickly, efficiently, and competently hand over care.

Stop the line

In addition to blameless reporting, staff and families are invited to “stop the line” of care when they are concerned about patient safety.

“Anyone in our organization, including families, can stop the action to reestablish safety if they perceive that what is taking place would put a patient at risk of harm,” Morath says. “We tell parents, ‘if it looks wrong, it is wrong.’ So if a parent sees a medication that is a different color or a fluid that looks different, we don’t try to reassure them; we go back and confirm that the appropriate action is being taken. Families have interrupted near misses.”

Staff does not need to fear retaliation for reporting errors or potential errors at Children’s, she says. When physicians are granted privileges at Children’s, they sign a code of conduct that does not tolerate retaliation.

“The chief of surgery told my staff that reporting is not only their right, it’s their responsibility,” Drake says.

Patient safety rounds

To further accident prevention, senior leaders make monthly patient safety rounds to query staff on their concerns.

“I always ask staff what keeps you up at night worried?” Drake says. “What they tell me is the accidents waiting to happen.”

Morath suggests additional revealing safety questions to ask staff:
• What are you doing to create safety?
• What do you see as the barriers to safety?

Does ‘sorry’ work for errors?

The Sorry Works! Coalition, a not-for-profit group of doctors, lawyers, insurers, and patient advocates is trying to restore trust in the health care system, where accidents can and will happen.

Sorry Works! advocates a formal apology program for errors as a middle-ground solution.

“Sorry Works! comes down to very basic human interactions and returns us to what we were all taught in kindergarten—when you make a mistake, apologize and make it right,” says coalition spokesperson Doug Wojcieszak, who started the organization after his older brother died from medical errors, he says.

Full disclosure benefits patients and caregivers, Wojcieszak says. Patients and their families get immediate answers to their questions about what went wrong. They also can avoid protracted legal wrangling and receive prompt compensation.

“Malpractice trial lawyers will tell you that most of the people who come to their offices are just looking for answers because nobody at the hospital will talk to them,” Wojcieszak says.

“The whole deny-and-defense strategy has been tried and failed.”

For physicians, full disclosure allows them to maintain control of the situation and maintain a relationship with their patient, Wojcieszak says. “Doctors get into medicine to treat and care for their patients, not to see them as potential litigators.”

Sorry Works! is lobbying for legislation in Illinois to implement a pilot program in which hospitals can practice full disclosure risk-free. The state will pick up the tab for liability that exceeds the average. “If we’re right, the hospitals will save money, and the state won’t pay,” he says.

Data is still scant to prove the cost-effectiveness of full disclosure.

However, the litigation costs of Veterans Affairs Medical Center in Lexington, Ky, which began investigating incidents and offering patients settlements up front in 1987, compare favorably to other VA hospitals.

According to a study in the Annals of Internal Medicine, the Lexington facility pays for more claims, but the average claim is smaller.

Wojcieszak says other hospitals that have developed full-disclosure policies include the University of Michigan Health System in Ann Arbor, Johns Hopkins Hospital and Health System in Baltimore, and Children’s Hospitals and Clinics in Minneapolis.

And what if sorry doesn’t work?

“Honest physicians make lousy targets in the courtroom,” Wojcieszak says. “They go to court looking like the good guy.”

—Leslie Flowers

For more information, visit SorryWorks.net.

Reference

Five-star service in an endoscopy unit

When a customer walks into a 5-star hotel, they expect service. Not good service, but fabulous service.

That’s what Pam Parmelee, BSN, BA, MSHA, had in mind when she was hired to open and operate the Sharp Memorial Outpatient Pavilion in San Diego. The pavilion, owned by Sharp HealthCare, houses outpatient surgery, endoscopy, laser vision surgery, diabetes, imaging, radiation oncology, infusion, and community health services. The outpatient surgery center has 10 ORs and 2 pain procedure rooms.

When the doors opened 2 years ago, Parmelee said to herself, “I’m going to do this right. Our focus is going to be patient and physician satisfaction.”

The hotel industry inspired her to create a 5-star experience for patients. She charged each department to create an atmosphere where patients and physicians feel special and important.

“I told managers to think outside the box,” she says. “They could do anything they wanted to make their area stand out.”

Silver-platter service

The team in the endoscopy area hit the ground running. In fact, the department was the first in the pavilion to achieve 99% Press Ganey patient satisfaction scores just 4 months after it opened, and it has maintained those scores. Thirteen full-time RNs and 2 administrative assistants manage 300 cases a month.

“Patients don’t usually think favorably of endoscopy,” says manager Midolie Loyola, RN, BSN, CGRN. “They’re anxious, and not feeling so hot because of the at-home prep for the procedure. We wanted to provide an environment where we give excellent service and patients are comfortable.”

Loyola and her staff brainstormed to create a patient experience with these features:

• Patients are treated as honored guests. A welcome sign and administrative assistant greet them. When it’s their turn to go to the procedure room, rather than calling their names, the nurse enters the reception area, shakes their hand, and escorts them back.
• Each staff member who has contact with a patient signs a thank you card, which is attached to the patient’s chart, and addresses the envelope by hand. This is a requirement throughout the pavilion, Parmelee says.
• Framed art and CD stereo systems are in each procedure room, and patients choose their music.
• Nurses offer patients warm blankets and gowns, and booties await them on the bed.
• Framed art, silk floral arrangements, and a vanity stand adorn the bathrooms. Loyola adds amenities, such as flushable premoistened personal wipes, a basket with feminine pads, and potpourri and air freshener.
• Children receive teddy bears and other small toys.
• After the procedure, nurses serve crackers and juice, if allowed, in plastic stemware on a silver tray.
• Loyola places her business card with her pager number at the front desk so patients can call with questions or concerns following the procedure.
• Nurses call patients the day after the procedure to ask how they are feeling.

Hire enthusiasm

When interviewing, Parmelee and Loyola say they look for candidates who are supportive of the outpatient center’s philosophies and priorities of 5-star care.

“We look for smiling faces, enthusiasm, and energy,” Parmelee says. “We ask them to demonstrate how they would handle an angry patient or physician.”

Because she has hired the right people, Loyola says taking customer service to a superior level has not been difficult.

“At first, the nurses were a little hesitant to shake a patient’s hand, only because it was a different approach, but now they love it,” Loyola says.

She adds that the 5-star philosophy doesn’t get stale, and the endoscopy department’s consistently high patient satisfaction scores energize staff.

A 5-star work environment

The staff is expected to uphold standards that become a 5-star experience at Sharp Memorial Outpatient Pavilion in San Diego:

• Give their best to those around them.
• Maintain a positive attitude.
• Maintain a calm, professional environment.
• Take pride in their work and have fun.
• Maintain a clean environment, keeping walls free of memos, notices, or flyers and not having food or drink in work areas.

Endoscopy manager Midolie Loyola, RN, BSN, CGRN, says employees also are treated like customers. Before a new employee’s first day on the job, she calls and sends a welcome letter. The employee’s preceptor also sends a welcome card. On the first day, the employee meets with Loyola for the first half hour and receives a care package from co-workers with lunch coupons, notebooks, and snacks.

“It’s just as important that employees feel welcomed and are acknowledged in a positive manner,” Loyola says. “What they do makes a difference, and we appreciate them from the start.”

As a result, she reports a turnover rate of 0.2% and employee satisfaction survey numbers averaging 4.85 out of 5. “If employees leave, it’s because they’re moving,” Loyola says. “We have nurses waiting to work here.”

And not just because of the free massages. As a thank you for meeting 5-star expectations, employees in the pavilion can get 15-minute head and neck massages, with a limit of 2 per week.

Continued on page 18
we’re just doing this for the scores. I say, ‘Wouldn’t you rather work in an environment that you’re proud of and happy to be in?’”

**Little things mean a lot**

The outpatient pavilion is a new building with abundant light, plants, and artwork. Though it’s beautiful, Parmelee stresses that you don’t need a new building to provide 5-star service.

“It’s the little things you do for patients that matter,” she says. “It doesn’t have to take a lot of time or money.”

For example, a paid concierge greets visitors to the building. A Sharp volunteer then escorts them to their department if it is their first visit. All front-end employees wear the same blue jacket emblazoned with the Sharp logo.

If employees are not meeting 5-star expectations, Parmelee says they are immediately counseled. For example, Press Ganey scores were not as high as Parmelee wanted for registration staff in some departments. So she took them on a field trip. In one afternoon, they hit 5 ritzy hotels in the San Diego area and observed the behavior of the front desk staff. Each Sharp employee had to fill out a questionnaire describing language hotel employees used to greet customers, their facial expressions, and if they said the same things to every customer, Parmelee says.

Back at Sharp, she videotaped the registration employees in role-playing exercises so they could see if they smiled and how they looked while talking to patients. “It was very effective,” she says.

“Treating patients this way is mandatory,” Parmelee says. “We set our expectations high and hold people accountable. Physicians feel this place is different, and patients give incredible feedback.”

Indeed, volume in the outpatient surgery center increased 225% in the first 15 months of operation. More than 900 procedures take place a month, compared to 335 in the first months, Parmelee says.

Patient satisfaction scores measured by Press Ganey show the laser vision center at 99%, and outpatient surgery is between 91% and 94%. Turnaround time for ambulatory surgery cases averages 13 minutes, comparable to a freestanding for-profit facility, Parmelee reports.

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**Poet helps leaders explore key conversations at work**

When you step into management, much of your job is about people and helping them to work well together.

On many days, your task involves bringing key constituencies—nursing staff, doctors, materials managers, suppliers, assistants, and others—together in a common effort.

One art in achieving this is the ability to engage others in “real conversations where everyone feels they’re necessary, and their voice is heard,” notes poet David Whyte.

For more than 20 years, Whyte has been bringing poetry into the corporate world to help managers think creatively about their vocation as part of their life’s journey. Poetry, he says, can be a way to get in touch with your core values and cut through the underbrush of everyday stress and frustration.

Whyte will present a special lecture at the Managing Today’s OR Suite conference Oct 19 to 21 in San Diego. The lecture, Courage and the Creative Life: New Conversations in the Workplace, is sponsored by Cardinal Health, Medical Products and Services.

One of Whyte’s themes is “courageous conversations.”

“I would say most people don’t realize how foundational conversation is to their work,” he notes. “You usually find mistakes are made because of a breakdown in communication—a breakdown in conversations.”

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**Risk low for low-grade prostate cancer**

A new study in the *Journal of the American Medical Association* may shed light on the controversy over how to treat early-stage prostate cancer.

Researchers found that men with localized low-grade prostate cancer who forgo aggressive treatment are unlikely to die of the disease, even after 20 years.

The researchers followed 767 men diagnosed with prostate cancer from 1971 through 1984 and treated with either observation or androgen withdrawal therapy. They found the risk of dying depended on the aggressiveness of the prostate cancer as measured by a rating system called the Gleason score.

Men with a low Gleason score of 2 to 4 had a very low chance of dying during the 20-year follow-up, while men with scores of 8 to 10 had a high likelihood of death from prostate cancer.

Meeting JCAHO’s new tissue standards

L ast year, for the first time, rabies was diagnosed in 4 organ transplant recipients who died. The infection was traced to the donor, an Arkansas man. But there was a delay while officials tracked down who received the diseased tissue and who else might have been exposed.

In 2001, a 23-year-old Minnesota man died after receiving a knee allograft contaminated with Clostridium sordellii. There was a nationwide scramble as officials tried to find out who else might have received grafts from the same donor.

New tissue handling standards from the Joint Commission on Accreditation of Healthcare Organizations, effective July 1, are intended to help ensure that organizations have a well-coordinated system for managing tissues they implant. The standards cover 3 major areas:

• standardized processes for tissue handling (PC.17.10)
• traceability of tissue from source to recipients (PC.17.20)
• investigation of adverse events (PC.17.30).

The standards are new for hospitals, critical access hospitals, ambulatory care organizations, and office-based surgery and have been updated for laboratories.

Megan Sawchuk, MT(ASCP), associate director of JCAHO’s Standards Interpretation Group, responded to questions about the new standards.

Q What types of tissue do these new standards cover?

Sawchuk: The standards apply to any cellular-based elements, including synthetics. Examples are bone, corneas, skin, heart valves and conduits, tendons, fascia, dura, bone marrow, veins, arteries, cartilage, sperm embryos, eggs, stem cells, cord blood, and synthetics. Regarding synthetics, the standards apply to artificially prepared nonhuman products made from coral but do not apply to synthetic tissue products derived from plastic.

Q How have these standards changed from previous versions?

Sawchuk: The standards are much more specific than in the past. Also, the new standards have been moved from the laboratory manual to the manuals for hospitals and other facilities.

Q What do the standards say about selecting a tissue supplier? Are there requirements on what to look for?

Sawchuk: Under PC.17.10, EP 2 says you must validate that tissue suppliers are registered with the US Food and Drug Administration (FDA) and licensed by state agencies, if that is required in your state. Tissue suppliers must comply with 3 FDA standards:

• “Good Tissue Practices” final in November 2004
• registration of tissue establishments
• donor screening (www.fda.gov/cber/tiss.htm).

Q What type of process do we need for tissue handling?

Sawchuk: This is covered under PC.17.10, which has 10 EPs. Essentially, there needs to be a coordinated process for ordering, receiving, storing, and issuing tissue throughout the organization. This includes verifying packaging integrity, logging the tissue in, handling it according to written directions, monitoring and recording storage temperatures, providing for alarms and emergency backup, and complying with state and federal regulations.

Q Does JCAHO say who should oversee tissue handling?

Sawchuk: That is up to each organization to determine. You may have physicians in different specialties and locations who implant tissue. We want to see organizations develop a unified, coordinated effort that addresses the needs of these. Typically, we see someone like the OR manager having a level of responsibility, with a physician having the ultimate oversight, but that arrangement isn’t specifically required.

Q What do we need to do about how tissue is transported to our facility by the vendor? Do the standards address this?

Sawchuk: Under PC.17.10, EP 10 requires verifying the package integrity and checking that temperatures during transport were controlled and acceptable. If the package comes through the normal shipping process, you can check the packaging, open the box, take the temperature, and check any indicator that may be included. If tissue is kept in the trunk of a vendor’s car, that would be more dubious.

When selecting a tissue provider, one criterion should be that the tissue will be transported and delivered in an acceptable condition.
**Continued from page 19**

**Q What kind of recordkeeping do we need for storage temperatures?**

**Sawchuk:** Standard PC.17.10 has 3 EPs related to this:
- Maintain continuous temperature monitoring for storage refrigerators and freezers.
- Maintain daily records to show that tissues were stored at the required temperatures.
- Storage equipment has functional alarms and emergency backup.

There has been a lot of confusion about how we are going to look at temperature. If tissue is stored at room temperature, such as freeze-dried bone, you would need to record the room temperature once a day. There is no requirement for continuous monitoring or alarms for room-temperature monitoring.

If you are storing tissue in refrigerators and freezers, the temperature has to be monitored continuously but only has to be recorded once a day. Also, the continuous monitor must be linked to an alarm.

**Q Please explain what is expected for alarms and emergency backups.**

**Sawchuk:** The alarm needs to be monitored 24/7, including weekends, with a backup plan in case the power fails or the temperature is not maintained. If your organization needs help implementing this, I suggest talking to the blood bank because they have similar requirements. Often, the alarm can be set up to be monitored somewhere else in the organization if no one will be in your unit to hear it.

**Q What do we need to do for tissue tracking?**

**Sawchuk:** Essentially, under PC.17.20, you need to be able to track tissue from the moment it enters your organization until it is implanted or disposed of. You need to map out each step in the process. This includes documenting the storage and lot number of any products used to reconstitute or process tissue. Organizations must also send the tissue usage information cards back to the source facility. Important to note, records must be kept for 10 years rather than the current 5 years.

This is an exercise you can do to see if your process is adequate: Take a medical record for a patient who has had a tissue implant. See if you can trace back through your system everything that happened to that tissue, back to the donor facility. Also see if you can track the tissue in the other direction: If the donor facility notifies you of a recall, will you be able to figure out who received the tissue? This is key. In the rabies case last year, there were some traceability issues that delayed determining who had received the tissue.

When selecting a vendor, ask what kind of tracking tools the vendor provides. The FDA’s Good Tissue Practices require tissue manufacturers to have a labeling method that facilitates effective tracking. Some vendors are better than others at providing tracking and reporting systems. Seek out those who will make compliance easier.

**Q How will surveyors look at tissue handling? Is this likely to come up during the tracer process?**

**Sawchuk:** Everyone should expect surveyors to pick patients who have had tissue implanted for tracers. They will take a medical record and talk to the staff who cared for the patient, starting with admission. Eventually, they will end up in the OR, where the staff will walk them through the process. They might ask the staff, for example, “What did you do with the tissue when it arrived in your organization?” The staff member would pull out the log and say, “The tissue for this patient arrived on Jan 3. It was logged in by Margaret Jones. It was kept frozen. We record that temperature daily.”

The new tissue standards were published in the February Joint Commission Perspectives. For questions, contact JCAHO’s Standards Interpretations Group at 630/792-5900, option 6.

The third standard deals with investigation of adverse events. Is this new?

**Sawchuk:** This is not new. But it has been one of the most frequently cited standards in the lab manual. We are working on FAQs [frequently asked questions] to post on our web site about this. This standard is in concert with the FDA’s Good Tissue Practices, which require tissue providers to report adverse events.

This needs to be a bidirectional process—that is what many organizations miss. First, you need a policy to investigate suspected problems with tissue reported to you by the donor facility, the so-called “look-back” or recall process. This includes not only hepatitis and HIV but also other infectious agents.

The other piece, which is often missing, is to have a mechanism for physicians to report back to your facility if a patient develops an infection after the surgery or has another complication related to the tissue. Your organization also needs a process to investigate this and report back to the donor facility.

There are a variety of methods to accomplish this. We don’t define the mechanism, but we do want a comprehensive process in both directions. For example, some organizations send a letter to their physicians each month asking them to report any tissue complications. This information might be forwarded to the appropriate person, such as the quality assurance coordinator or infection control professional, for investigation, action, and reporting to the donor facility. There are a variety of methods to accomplish this. We don’t define that. But we do want a comprehensive process in both directions.

Call for abstracts for poster display at conference

The Managing Today’s OR Suite Conference to be held Oct 19 to 21 in San Diego will include a poster display of research studies, process improvement projects, and clinical innovations.

If you would like your poster to be considered, please submit an abstract by July 15.

More information, including an abstract submission form, is available at www.ormanager.com or by calling 800/442-9918.
Building bridges with physicians and bringing its group purchasing organization (GPO) to the table helped a North Dakota hospital make progress on one of the toughest cost management issues—orthopedic implants.

St Alexius Medical Center in Bismarck saved $500,000 on its total joint replacement procedures, $250,000 of that from implants—in its latest contract negotiations. The new contracts are for 3 years.

The hospital performs about 5,500 procedures a year in its main ORs, 43% of which are in orthopedics. Of those, about 600 are hip or knee replacements.

These are some strategies that helped St Alexius achieve its results.

**Lay a foundation**

Teamwork with physicians, cultivated over several years, is a major reason the project was successful, says John Schreier, director of purchasing. “We didn’t start by going after orthopedic implants,” says Schreier, who was the OR manager before taking his current position. “Obviously, implants are the area everyone focuses on. But that’s also where the doctors get defensive.”

By working with the physicians on less sensitive projects first, the St Alexius team built collaboration and trust. At the same time, the team worked internally to present a united front. Schreier is closely allied with the director of surgical services, Claudia Dietrich, RN, MSN. They meet weekly, along with Elaine Mather, director of central service. The orthopedic clinical coordinator, Bryon Hoff, RN, BSN, is also a key ally because he works with the surgeons on the front lines.

**Areas the team addressed early were blood wastage, antibiotics, and preoperative education.**

On antibiotics, for example, pharmacists noted the surgeons did not all use the same antibiotics or regimens, but there were no differences in infection or complication rates. The pharmacists began persuading the surgeons to standardize their routines.

**Share cost information**

Sharing data was a common theme in these projects, says Schreier. “We began giving the doctors the data, and pretty soon they were giving us ideas,” he says. “We got them to standardize in several areas and built credibility to take it to the next level.”

Previous implant cost management projects had focused on negotiating better pricing and contract terms with the vendors. To move the project forward, Hoff began providing cost information to the surgeons so they could see how much implant procedures were costing and how much reimbursement the hospital received. The team encouraged the surgeons to challenge the data and kept refining it. The surgeons were asked not to share the information with the vendors.

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**Orthopedic implant cost crunch**

In the past 13 years:

- Total joint prosthesis prices have risen 119%.
- Hospital payment for DRG 209 has risen 4.5%.
- Physician reimbursement has fallen 38%.

**Orthopedic procedure costs**

<table>
<thead>
<tr>
<th>Implant costs</th>
<th>Other costs</th>
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<td>50% - 75%</td>
<td>25% - 50%</td>
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Source: Amerinet.

“Orthopedic implant was a common theme.”

Source: Amerinet.

“Nationally, the total joint prosthesis represents 50% to 75% of a hospital’s total reimbursement,” says Barrow. In the past 13 years, the cost of a total joint implant has risen 119%, while hospitals’
Medicare payment for DRG 209 has increased just 4.5%. Meanwhile, physicians’ reimbursement has fallen by 38%.

“If we don’t close the gap, by 2030 when many of us reach retirement age, hospitals aren’t going to be able to afford to do these implants,” she says.

Hospitals are caught between Medicare’s limited reimbursement and the implant vendors, who need revenue growth to satisfy their stockholders.

Compounding the problem, companies are marketing newer, more expensive technology directly to consumers. “People see Jack Nicklaus in an ad playing golf when he’s 70 years old. They say, ‘If that ceramic-on-ceramic hip is good enough for Jack, it’s good enough for me,’” Barrow notes.

St Alexius already had the main ingredient for tackling implant costs, she says—a good relationship with its surgeons. “They had already taken on a whole cost management project, but they got caught up on the implants, which is typical of what we see,” Barrow says. “They needed an unbiased third party to help get the physicians off the block.”

Enlist surgeons as allies

To get the ball rolling, St Alexius called a dinner meeting with the surgeons and invited Barrow to present her data. “I think the surgeons were astounded at some of the numbers,” says Dietrich.

The team gave the surgeons spreadsheets showing procedure-specific costs for total joint cases by physician and discussed the data with them. The next step was to enlist the surgeons’ help in the contracting process.

“We asked the surgeons if they would be willing to work with us on achieving our outcomes with the new contracts,” Schreier says. The team asked the surgeons when approached by the vendors to refer the vendors back to the hospital.

They also asked the surgeons to agree to commit 80% of their business to the 2 or 3 vendors that were awarded contracts. The other 20% would allow surgeons to choose products for revisions or new technology for specific patients.

The team asked the surgeons which vendors they wanted to invite to the table. They explained which vendors were in the region, what kind of relationship they had with the hospital, and how willing the vendors were to work with the team. Though orthopedic implant companies have traditionally negotiated directly with hospitals for total joint implants, Amerinet says it has had some success working with vendors.

The surgeons selected 3 vendors to receive requests for proposals (RFPs). The 3 companies were invited to separate 1-hour meetings, with Frank Kilzer, St Alexius’s director of materials management, Schreier, and Barrow. The vendors were asked to send not only the local rep but also the regional manager or other decision maker. The team reviewed the RFP process with the vendors and shared data about the hospital’s costs and reimbursement rates.

“We told them that if we continue to lose money, they are going to lose our account because we won’t be able to continue on this path,” Schreier notes.

In the end, 3-year contracts were awarded to 3 vendors in November 2003. The physicians later decided to drop 1 vendor, and 2 remain.

As a spin-off, other surgeons, including the cardiovascular group, are showing strong interest in learning about costs. “Now that we’ve had some success in orthopedics, the cardiovascular group is saying, ‘I guess we’re willing to play in that ballgame, too. That’s a huge success for us,’” Dietrich says.

Nominate OR Manager of 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 19 to 21 in San Diego.

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.

To nominate a manager, write a letter of about 300 words describing what makes the manager deserving of the award.

Send the letter to OR Manager, Inc, OR Manager of the Year Award, PO Box 5303, Santa Fe, NM 87502-5303. Deadline is July 1.

Nominations are judged by the OR Manager advisory board.

Average implant cost for total knee by physician

<table>
<thead>
<tr>
<th>Physicians</th>
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Source: St Alexius Medical Center.
Please see the ad for SKYTRON in the OR Manager print version.
Technology in Surgery

Best practices for device recalls, alerts

Do notices get into the proper hands?

The media reports on 2 patients who died in a cath lab after receiving anesthetic gases instead of oxygen. A staff person had misconnected the gas line, overcoming the specific fittings.

The state health department issues an alert on endoscope reprocessing after lapses compel facilities to offer hepatitis and HIV testing to thousands of patients.

The Centers for Disease Control and Prevention (CDC) issues an advisory not to use a medication linked with bacterial infections.

When notices like these arrive in your facility, do they get into the proper hands?

Every facility needs a process to make sure that device-related information, including recall notices and hazard alerts, doesn’t fall through the cracks, says Jim Keller, director of the Health Devices Group at ECRI, an independent nonprofit organization that researches health care technology.

All of the above incidents actually happened. The cath lab case, reported in early 2002, occurred in a New Haven, Conn, hospital. The endoscope alert came in October from the California State Department of Health Services after 8 facilities notified over 5,000 patients about problems with endoscope reprocessing. The CDC advisory, issued in April, concerned magnesium sulfate solution from PharMEDium Services, a line, overcoming the specific fittings. The key is to have reprocessing instructions for 2 new Olympus scopes, notes Jim Keller, head of the Health Devices Group at ECRI, a nonprofit organization that researches health care technology.

The risk of disease transmission was low, and the state health department had not identified any cases linked to the colonoscopies.

The new colonoscopes, purchased in late 2004, had a water-jet channel that was not in the hospital’s previous scopes. Technicians did not recognize the difference and failed to disinfect the water-jet channel, ECRI reported.

The same is true for devices with software: Is that information technology’s responsibility? Or is it biomedical engineering or the department using the device?

The information isn’t confined just to recalls, Keller cautions. Some of the most serious problems are never classified as recalls. There also are advisories, alerts, articles from the clinical literature, notices from device manufacturers such as updates to reprocessing instructions, and even newspaper articles about patients harmed by a device-related accident.

“Say your hospital has a problem after a widely publicized story in the lay press. Just imagine what the headlines would be like if your hospital has to admit it wasn’t aware of the previous incident or didn’t take action,” he says.

Keller offered these 5 best practices for managing device-related information:

1. Have clearly defined roles and responsibilities.

There should be a process for handling device-related information consistently throughout the organization.

“You need a coordinator or administrator of device-related information who decides what information needs to be processed and disseminated. This person should also be responsible for forwarding the information to the relevant departments,” he says.

Often the responsibility is assigned to the materials manager, the biomedical engineer, the risk manager, or a person designated by the Patient Safety Committee.

“You also need a formal, centralized list of devices used in your institution, with a corresponding list of department heads or other staff assigned to each device category,” Keller says. They should receive the safety notices for devices on their list. For example, the OR manager would receive notices about surgery lasers or pneumatic drills.

Some common areas that can be overlooked:

• not including devices used at satellite facilities, such as an ambulatory surgery center or clinics
• failing to assign responsibilities for rental equipment, equipment on loan, and physician-owned equipment
• not assigning responsibilities for “cross-over devices,” such as drug-eluting stents and computer-based devices.

“If you ask the pharmacy, ‘Who is responsible for hazards and recall notices for drug-eluting stents?’, they might say, ‘That’s a device. That’s materials management’s responsibility,’” says Keller. “But if you talk to the materials manager, they might say, ‘That has drugs in it, so the pharmacy takes care of that.’”

The same is true for devices with software: Is that information technology’s responsibility? Or is it biomedical engineering or the department using the device?

“You need to communicate about who is going to handle these cross-over devices,” he advises. “Get a list together and make sure people are assigned.”

2. Have a consistent naming convention and an inventory for your devices.

What is an electrosurgical unit called...
Recall notices and alerts

This is how the US Food and Drug Administration defines recalls and alerts.

Recall and field correction

Action taken by a firm to either remove a product from the market or to conduct a field correction. Recalls may be conducted on a firm’s own initiative, by FDA request, or by an FDA order.

- **Class I recall:** There is a reasonable probability that use of a product will cause serious adverse health consequences or death.
- **Class II recall:** Use of a product may cause temporary or medically reversible adverse health consequences, or the probability of serious adverse health consequences is remote.
- **Class III recall:** Use of product is not likely to cause adverse health consequences.

Medical device notification or safety alert

Any communication by a manufacturer, distributor, or other responsible party or FDA to inform health professionals or others of a risk of substantial harm from a medical device in commercial use. Notifications are issued at the request of FDA. Safety Alerts are voluntary.


in your facility—a Bovie, a cautery, an ESU, or all of these?

“If you get a notice about a problem with an ESU—the formal name for this technology—but your facility calls it a cautery, you might not find the relevant devices in your inventory.” Keller notes. It is not uncommon for a hospital to have 6 different names for some types of devices, and even more names for some medical device vendors.

“The problem can be even worse for hospital systems, especially when each hospital in the system manages its own inventory,” he says.

Ideally, the inventory should be accessible from a centralized location and cover the full range of devices used in the organization.

Check to see if your organization is using consistent, up-to-date terminology. ECRI has a naming convention called the Universal Medical Device Nomenclature System (UMDNS), promulgated by the World Health Organization and used in more than 40 countries. The system has standardized device names, definitions, and manufacturers’ names that can be applied to your inventory to help resolve inconsistent naming. The UMDNS is harmonized with the nomenclature of the US Food and Drug Administration (FDA).

Nonprofit organizations, government agencies, and device manufacturers can download a UMDNS file with device and vendor names free of charge if they sign a licensing agreement and abide by certain conditions. Information is at www.ecri.org under Products and Services.

Downloading the file is just the first step. “To get it right, you have to match each item in your inventory with the nomenclature,” Keller says. “Unfortunately, there isn’t an easy, automated way of doing this data cleaning.”

3. Have an approved, comprehensive source of information.

There needs to be an approved list of sources for recall notices, hazard alerts, and other device-related information. Sources can include device manufacturers, regulatory agencies such as the FDA, the clinical literature, and hazard and recall notification services. ECRI provides a clearinghouse for this type of information through its Health Device Alerts program.

“The information you use should be clear and accurate with specific action steps to help your staff decide how to resolve reported problems,” Keller says.

“If your hospital uses a clearinghouse, it would be a good idea to gather the data from multiple sources, analyze the significance of the reported problems, and verify the accuracy of information from original sources.”

“We find that as many as 25% of the recall notices in the FDA’s enforcement report need to be corrected,” says Keller. For example, there may be a missing or incorrect model number, or information may be lacking on how to resolve the reported problem.

Verifying the information can save time and avoid the risk of having critical information slip through the cracks, he says.

4. Have a reliable and consistent process for dissemination.

“You need to have a process to make sure device-related information is forwarded to the right people,” Keller says.

As a test, he suggests managers check their databases to see if they have a record of the cath lab incident in New Haven, Conn. Is there documentation that the information was forwarded to the cath lab and other relevant departments? ECRI wrote a report about this incident and recommended specific training for cath lab professionals.

Is there evidence the recommended training was done? If your institution decided more training wasn’t needed, was that decision documented with justification? If not, there may be gaps in your notification process that need to be addressed.

5. Have follow-through and accountability.

Your notification process should include an easy method for departments to acknowledge that they received the notices and either removed the devices from service or implemented the corrective actions or recommendations.

In addition to this mechanism, “we have suggested that the hazard and recall notice process needs high-level support,” he says. “That way, the managers and staff who receive the reports know they are being overseen. I think that gives them a greater incentive to follow through.”

Information on ECRI is available at www.ecri.org or by calling 610/825-6000.
physician peer review is critically important to safe care, but it can be difficult to get physicians involved. It’s also problematic for standards compliance. "It is very hard to get the physician staff to understand that this is something that needs to be done and is protective for them and the facility,” says Sheryl Walker, MD, a surveyor and member of the accreditation committee for the Accreditation Association for Ambulatory Health Care (AAAHC). She is also medical director and chief of anesthesia at The Surgicenter of Baltimore, Owings Mills, Md. AAAHC standards require organizations to have “an active and organized process for peer review that is integrated into the quality management and improvement program.” The standards also say that peer evaluation is used in credentialing and privileging.

Dr Walker and 2 nurse managers described how their facilities manage the peer review process. Jerry Henderson, RN, MBA, CNOR, CASC, is executive director of The Surgicenter of Baltimore, a freestanding, multispecialty center with 5 ORs serving 112 physicians and performing about 13,200 procedures a year. Marilyn Christian, RN, BSN, CNOR, CASC, is chief operations officer for Special Surgery of Houston, a 4-OR physician-owned multispecialty ASC. Procedures performed include orthopedics, podiatry, interventional pain management, and reconstructive plastic surgery. The center has about 20 physicians and performs about 2,200 procedures a year.

Who is on your peer review committee?

Christian: Our peer review process is guided by our medical review board, which consists of a physician from each specialty in our center, including anesthesiology. At a minimum, the committee has an orthopedist, a podiatrist, a plastic surgeon, a pain management physician, and the medical director, who is an anesthesiologist.

Henderson: We have a peer review committee, which consists of 6 physicians representing various specialties, including anesthesia. The committee is chaired by one of the physician owners, a pathologist. Physicians rotate membership.

Please describe your peer review process.

Christian: We review 5% of each provider’s charts each quarter, or 3 charts, whichever is greater. This is a random selection. In addition, a focused review is conducted if there is an unusual occurrence. That is our standard of practice.

For the randomly selected charts, physicians on the committee conduct a medical review for the following components, which are part of the State of Texas and Medicare guidelines:
• treatment consistent with clinical impression
• history and physical present
• operative note present
• pathology report present
• adverse events.

The same charts are also reviewed for anesthesia services. These items include:
• Was the ASA [American Society of Anesthesiologists] score consistent with bylaws?
• Was a consultation obtained when indicated?
• Was the preoperative anesthesia assessment completed?
• If indicated, was medical clearance obtained?
• If complications occurred, were they managed appropriately?
• Did the record reflect the patient’s course or change in condition and results of treatment?
• Was the anesthesia outcome satisfactory based on the diagnosis and treatment plan?
• Was postoperative pain management adequate?

Also, for our own internal audit, we ask whether there are any suggestions for improvement. In addition, the surgeons are asked to complete an infections and complications report every month, and we monitor the responses through the committee. If there were a complication, that
would trigger a focused chart review.

**Henderson:** We have a quality indicator sheet that goes with every patient. The sheet, an alphabetical list of about 250 items, includes all kinds of issues that can occur, from operational issues like late starts to patient complications such as a hospital admission, bleeding, aspiration, and so forth.

The circulating nurse circles any items that apply to a particular case. The sheet has a place to explain the incident; who reported it; who witnessed it; whether the incident was referred to the surgeon, anesthesiologist, or a nurse; and what the findings were. The sheet then comes to me as well as to the medical director and nursing director.

Certain complications and all sentinel events are automatically referred to the peer review committee for immediate attention.

The information then is logged into our AdvantX computer system in a section for quality indicators. This enables us to track information and print out reports by physician, staff member, or types of occurrence.

We also do random chart audits on every physician who does cases in our center. Before the charts go to the peer review committee, nurses review them for documentation, completeness, accuracy, and appropriateness of care. Two nurses are assigned this responsibility. They do the chart reviews during down time from their other duties. We have regular meetings of the peer review committee where the charts are reviewed.

**Q** The AAAHC standards say you will collect data in an ongoing manner and identify trends that affect patient outcomes. Could you give an example of how you do this?

**Henderson:** Our indicator sheet and computerized information enable us to do this easily. We can run reports on any item in our indicator list. For example, if we have an ENT doctor who has a patient with unusual bleeding, we could do a search to see what percentage of his patients have had that problem. This enables us to see trends or problems with any particular physician. The reports go to the peer review committee and are used in the recredentialing and privileging process.

**Q** Should peer review data be kept electronically?

**Should peer review information be kept in your surgery center’s information system? Or is it safer to keep peer review documents only on paper? Would electronic peer review data be discoverable by plaintiff’s attorneys in case of a lawsuit?**

“Information gathered solely for peer review proceedings should be labeled as such. If the files are electronic, they should be electronically secure and should not be co-mingled with other information,” says Michelle Marsh, an attorney with the firm of Waller Lansden Dortch & Davis, Nashville, Tenn.

Typically, information routinely gathered but later used in peer review is not discoverable from the peer review file, she says. But the information may be discoverable from the original source if it was gathered in the course of “customary operations.”

For example, suppose an unusual event occurred during a procedure, and a staff member noted the event in the patient’s medical record. The patient’s case was then reviewed by the peer review committee, and a summary of the analysis (including copies of pages from the record) became part of the committee’s files. The summary prepared only for peer review and kept in the peer review file would not be discoverable. But the medical record would be discoverable in accord with state and federal medical records privacy laws.

Also, some states require certain quality information to be reported. Depending on state law, this information could be publicly available.

The federal Health Care Quality Improvement Act (42 USC § 11101) is the basis for many of the restrictions on availability of information in peer-review files. In addition, each state has its own privilege and peer review immunity protections.

Marsh provided these 3 tips:

1. Don’t treat electronic information with less concern than you treat paper documents. If the document should be in a locked cabinet and marked “privileged and confidential peer review information,” take steps to accomplish the same thing electronically by segregating and securing the information.

2. Follow your facility’s policies and procedures regarding maintaining privileged peer review information regardless of the medium. Failure to follow your own standards is one of the easiest ways to get into trouble.

3. Discuss with an attorney familiar with your state’s laws and federal law any concerns you have about your facility’s policies or security of documents used in peer review, whether stored electronically or on paper.

**Q** How do you tie peer review to recredentialing and privileging?

**Christian:** Our reappointments are done every 2 years, which is required in Texas. For some states, it is 3 years. AAAHC allows 3 years. At the time of reappointment, we examine each physician’s confidential peer review file along with the reappointment application and primary and secondary source verifications of credentials.

The file would include any practice issues that are out of the norm and have been reviewed by the Medical Review Committee. The reports and recommendations are forwarded to the governing board for final endorsement.

Also in each physician’s file are

Continued on page 28
AAAASAF to launch on-line peer review

The American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASAF) plans to introduce web-based physician peer review this month.

The new system will allow each facility to create and register a web-based physician peer review group. The group will review reports that facilities submit to meet AAAASAF’s quality improvement standards. The peer group could consist of physicians from accredited facilities or from outside.

Under AAAASAF standards, accredited facilities must submit electronically at least 6 cases per surgeon, or 2% of cases in a group practice, every 6 months. If a surgeon has performed fewer than 6 cases during the reporting period, all of the cases must be submitted.

Facilities must also submit all unanticipated operative sequelae occurring within 30 days of surgery. This includes, for example, unplanned hospital admissions; unscheduled returns to the OR for complications; or untoward events such as infections, bleeding, wound dehiscence, or inadvertent injury to a body structure.

The data are aggregated and analyzed by the association as an overall quality check on its 1,200 accredited facilities. The system was developed in the 1990s when questions were raised about outcomes of surgery performed in office-based facilities.

The first report of the aggregated data, published by Geoffrey R. Keyes, MD, and associates in Plastic and Reconstructive Surgery in May 2004, covered more than 400,000 procedures. Incidence of unanticipated sequelae was 0.34%. The death rate was 1 in 51,450 procedures, or 0.002%.

AAAASAF monitors to see that facilities are submitting their peer review data in a timely manner, explains communications director Jaime Trevino.

This is also checked during a reaccreditation self-review and by AAAASAF inspectors, who review charts.

If an inspector sees a red flag or there is a delay in reporting the random cases or sequelae, the facility receives a deficiency. Recurring problems or other standards violations are referred to an investigative committee.

Information about AAAASAF is available at www.aaaasf.org or by phoning 888/545-5222.

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Q Do you pay your physicians to review charts?

Henderson: No. I don’t think you should pay anybody to do reviews. I believe it is part of their duty to keep up the quality of their profession.

Dr Walker: I think they probably should be paid if they are not owners or investors. I think this indicates that you really value this activity and want it done correctly.

Q Do you have a problem getting physicians to complete their chart reviews?

Dr Walker: I think it is a matter of education. Many physicians think an accident can never happen to them. I just gave a lecture for physicians and nurses in our center where I cited some actual malpractice cases that happened in 2003 and 2004. We dissected the cases and discussed what went wrong. In one case, a woman had a trocar placed in her abdomen for a laparoscopic cholecystectomy when she was actually having a shoulder repair. Case review is a good exercise and really gets people’s attention.

Christian: Most of the time when there are obstacles, I find it is because physicians are unaware of the requirements. I sell them on the importance of this. I explain it is a requirement and is part of doing business.

I also try to make it easy for them. All of our charts, when completed, are automatically scanned into our system. I have the ability to randomly select charts, de-identify them, and burn them onto a CD. I then hand-deliver the CD, a hard copy, and the forms to the physicians who will be reviewing them. When they have completed the review, the CD and documents are returned to the committee.

We have chosen to keep our peer review records on paper in a confidential file rather than electronically because of discoverability issues.

Henderson: As in any group, you have some who work harder and more consistently than others. Everybody takes a turn on the committee because that is part of running a center. We have about 20 owners, so the duties can be rotated. Our physicians take this pretty seriously.

Q Do you have physicians from different specialties review each other’s charts?

Christian: The AAAHC standard advises that at least 2 physicians be involved in peer review but does not say they have to be from the same specialty.

Continued on page 30
Please see the ad for SPECTRUM SURGICAL INSTRUMENTS in the OR Manager print version.
We prefer to have a specialty evaluate its own specialty.

**Henderson:** Yes. The physicians on the committee are not necessarily from the same specialty as the charts they are reviewing. I think that distances them a bit. Others who are in single-specialty or single-doctor centers have to have someone else do their peer review. They need to have an arrangement with another physician, whether in their specialty or in another specialty.

**Dr Walker:** I think it’s fine and maybe even a little better to have a physician from a different specialty review charts. A person from a different specialty may be more likely to say, “What’s going on here? This doesn’t seem right to me.” The bar may be a little higher.

**Q:** How do you manage peer review for nonphysician professionals such as certified registered nurse anesthetists (CRNAs)?

**Christian:** Anesthesia services provided by CRNAs are evaluated by the anesthesiologists.

**Henderson:** The CRNAs are reviewed through the peer review committee using the same process as for physicians. Any incidents are captured on the indicator sheet, and their documentation is audited in the chart review. If we see a trend, such as deficiencies in documentation, we are able to present this evidence to them during their evaluation. Nurses’ documentation is reviewed in the same way.

**Q:** What are the advantages and disadvantages of outsourcing peer review?

**Christian:** An outside review is an advantage if your facility is small or your medical review board feels it is too personally involved in a situation. The state medical association usually has a committee that will review charts for a fee. Some specialty associations also provide this service. You may also be able to arrange for peer review with another center, such as one operated by the same management company. Charts need to be de-identified before they are sent out.

**Henderson:** We do not outsource peer review. I think the advantages are that you get an unbiased review. The disadvantage is that it may be hard to find someone who is willing to do it without added expense.

**Dr Walker:** For a small center or a solo practitioner, it may be necessary to send charts out for review. It provides objectivity and takes a burden off the person who is in the center. Also, if an outside reviewer runs across something that is inappropriate or unethical, it would be easier for them to take the proper action, such as reporting to the licensing board or the peer review body of the medical society.

The AAAHC standards are available at www.aaahc.org or by phoning 847/853-6060.

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**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
Please see the ad for MEDLINE INDUSTRIES, INC. in the OR Manager print version.
APIC questions hospital-infections report

Are hospital infections rising, and if so, by how much? HealthGrades, a Lakewood, Colo-based company, made headlines in May with a report saying hospital-acquired infections rose 20% in the US from 2000 to 2003, accounting for 9,522 deaths and costing $2.6 billion. The report analyzed Medicare data using 16 patient safety indicators developed by the federal Agency for Healthcare Research and Quality. The report included a list of the “best-performing” hospitals.

But the Association for Professionals in Infection Control and Epidemiology Inc (APIC) termed “misleading” the HealthGrades methodology, which used administrative codes and billing data to identify infections. APIC said another study reported in April showing a wide disparity in the number of infections identified through billing records versus those validated through surveillance.

APIC, along with the Centers for Disease Control and Prevention and others, are seeking funding to develop a national standard for reporting of hospital-acquired infection data.

—www.healthgrades.com
—www.apic.org

Medicare updates ASC list

The Centers for Medicare and Medicaid Services (CMS) on May 4 issued an update to the list of procedures eligible for a Medicare facility fee when performed in an ambulatory surgery center (ASC).

The interim final rule, effective July 5, adds 65 procedures to the 2,464 procedures already on the list, many more than the 25 CMS proposed adding last fall. CMS also decided to delete only 5 procedures, compared to 100 it proposed deleting. CMS noted that deleting most of these procedures would have moved them into physicians’ offices, which public comments said would have been risky for patients with more complicated health conditions.

Under the new list, Medicare will cover bronchoscopies and some other endoscopies in ASCs but not laparoscopic cholecystectomies.

More information is at www.cms.hhs.gov/suppliers/asc/

JCAHO posts new H&P FAQ

The Joint Commission on Accreditation of Healthcare Organizations posted a new frequently asked question (FAQ) on the patient’s history and physical on its web site April 18.

The FAQ addresses requirements for the update to the patient’s condition. JCAHO says the H&P must be performed within 24 hours of the inpatient admission or up to 30 days before admission for inpatient or outpatient services. When using an H&P performed before admission, Standard PC.2.120 EP 7 says an update is required at the time of admission. This is different than in 2003 when the update was needed only when there were significant changes or the H&P was 8 to 30 days old, as required by the Centers for Medicare and Medicaid Services. The update must be performed by a licensed independent practitioner with privileges to perform H&Ps.

If the patient is having surgery within the first 24 hours of admission, there must be an update on the patient’s condition prior to surgery.

—www.jcaho.org. Go to Top Spots, then Standards FAQ. Scroll down to Comprehensive Accreditation Manual for Hospitals and click to see list of FAQs.

Medtronic to pay $1.35 billion to surgeon inventor

Medtronic, the Fridley, Minn-based medical device maker, said it would pay $1.35 billion to a surgeon turned inventor to gain ownership of patents related to spinal surgery and to settle litigation between them, according to The New York Times (April 23).

A federal jury ruled last fall that Medtronic should pay $559 million to the inventor, Gary K. Michelson, MD, and his company, Karlin Technology. Medtronic agreed to $550 million to settle the lawsuit and another $800 million to acquire the patents, the Times reported.

The deal will also give Medtronic rights to virtually all the spine-related inventions Michelson makes in the next 15 years. The deal will also end the threat that Medtronic would be stopped from selling spinal products because of infringement.

—www.nytimes.com