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OR Manager Conference

Conference equips OR leaders with critical management skills

More than 1,500 registrants from the perioperative nursing community representing 49 states and 10 countries gathered in Long Beach, California, in September for the 27th annual OR Manager Conference.

Attendees chose from an education menu of preconference seminars, general sessions, and breakout sessions, as well as numerous company-sponsored CE programs.

The brand new CCI Certificate Program for Surgical Services Management, a 2-day preconference program, included speakers from several different healthcare facilities and offered the opportunity to obtain more than 25 con-

tact hours upon completion.

The comprehensive OR Manager Conference program, which included presentations by more than 65 speakers, had tracks devoted to business management, the new OR manager, and ambulatory surgery centers. In addition, a masters series track debuted this year with presentations designed to bring high-level education to experienced leaders.

The various tracks allowed attendees to tailor their education and earn 11.7 contact hours. The conference program also was approved for 16 hours of AEU credit.

Continued on page 11

Salary/career survey

Business manager role evolving with challenging times

The percentage of healthcare facilities with a business manager has remained roughly the same over the past several years, and most tend to work in teaching hospitals, according to the 24th annual OR Manager Salary/Career Survey. However, business managers' education and experience seem to vary widely, as do their areas of responsibility.

Opinions about what constitutes the ideal background are mixed, but business managers who spoke to OR Manager agree that the abil-

ity to analyze data, keep up with the latest technology, and understand the clinical staff's needs are the keys to success.

About the survey

Data for the OR Manager Salary/Career Survey were collected from April to May 2014. The survey list comprised 800 OR Manager subscribers who are directors (or equivalent) of hospital ORs. The survey was closed with 138 usable responses—a 17% response

Continued on page 14



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Editorial

If you skipped this year's OR Manager conference, you missed an opportunity to learn about the evolution of healthcare delivery and the changes you should be making at your facility.

Improving the patient's experience of care was an underlying theme. We've all heard about the shift from volume-based to value-based measures of performance and how that will affect payment. But according to keynoter Tim Porter-O'Grady, DM, EdD, ScD(h), APRN, FAAN, senior partner, Tim Porter-O'Grady Associates, Inc, Atlanta, many nurse leaders are still trying to figure out what needs to be done differently to meet the new measures.

In Wednesday's preconference session, "Improve Your Scores: SCIP/HCAHPS/Core Measures," two experienced leaders connected the dots between perioperative services and patient satisfaction.

Mary H. Diamond, MBA, RN, PMP, CNOR, senior director of nursing, Tri City Medical Center, Oceanside, California, and Jerry W. Henderson, MBA, BSN, BSPA, RN, CASC, CNOR, executive director, perioperative services, Chippenham Hospital, Richmond, Virginia, took the audience back to basics. They revisited the importance of individualized care and attention, and they sent attendees home with tools to enhance communication between staff and patients.

"Patient experience matters," Henderson said. "Hospitals scoring in the top quartile of satisfaction reported more than two times the margin of those at the bottom, so it makes a big difference in how you're getting paid." In the hospital where she worked previously, she said, HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores were part of performance evaluations, and those who failed to

meet HCAHPS goals lost out on getting an increase.

The Centers for Medicare & Medicaid Services recently announced that it will add HCAHPS Star Ratings to its Hospital Compare website in April 2015. Star Ratings, which aim to help consumers more easily compare hospitals, include HCAHPS measures related to communication with staff, pain management, discharge information, and care transition, along with an overall hospital rating and recommendation.

About a year ago, I had surgery for a tumor that turned out to be benign. Although I had an excellent surgeon and an excellent facility, I was nervous and scared. My case was delayed by about an hour, but the OR staff kept me informed and comfortable. During the nearly 4-hour procedure, my husband likewise was informed of my progress. I was discharged the following morning in a timely manner, and my recovery went well.

An elderly friend who underwent surgery at a different hospital in our area had a very different experience. Long wait times pre- and postoperatively with little to no information increased her level of anxiety and discomfort. During her recovery, she developed infections requiring emergency treatment, which she received at a different hospital.

For both of us, choice of surgeon mattered more than choice of hospital. But next time, we would not choose her hospital. Websites like Hospital Compare influence patients' decisions about their care, so proven delivery of value-based care is important. Attending the OR Manager Conference just might help you deliver that care, so next year, I hope to see you there. ❖

—Elizabeth Wood

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Staff vacation gridlock eased by innovative allocation system

Developing a vacation selection process that is fair to everyone can be a daunting challenge for OR managers. The right balance between flexibility and adequate coverage can make or break staff satisfaction.

Having time away from the hospital is important for all OR personnel, but perhaps none more so than those who work day in and day out with oncology patients.

"Vacation selection was an annual issue," Shokjean Yee, MA, RN, CNOR, perioperative charge nurse at New York City's Memorial Sloan-Kettering Cancer Center (MSKCC), told OR Manager. "We would hang up a vacation request grid in June for vacations starting the following January, and it would not be finished until November or December. Vacations were granted according to seniority, and changes were rampant."

After many years of confusion

“
**Create rules
that are fair
to everyone.**
”

and staff dissatisfaction, a committee was formed to develop a new vacation selection process. The group collected staff suggestions and held multiple brainstorming sessions.

The vacation selection process now separates vacation allotments into specialty service cores and shifts worked, and a random sequence generator is used to ensure equity.

In addition to Yee, Elizabeth S. Pincus, MSN, MBA, RN, ACNS-BC, CNOR; Kristen A.

Crookes, BSN, RN, CNOR; Dawn Pamas, BSN, RN; and Carole Cass, MSN, RN, CNOR, were also on the committee.

Core, shift designation

MSKCC's main OR has 21 rooms and is staffed with approximately 120 RNs and surgical technologists. Staff members are separated into five cores: genitourinary/thoracic (GU/Thor), hepatopancreatobiliary/gastric mixed tumors (HBS/GMT), gynecology/colorectal (GYN/CR), orthopedic/neurosurgery (Ortho/Neuro), and head & neck/plastic/pediatrics (HN/PL/PED). The evening shift is separate from the day shift and is allotted vacation time as if it is a sixth core.

Nurses and surgical technologists are assigned primarily to one core, but they also can rotate out and work in multiple services.

Shifts include 7 am to 3 pm, 7 am to 5 pm, 7 am to 7:30 pm, 11 am to 7 pm, 11 am to 9 pm, and 9:30 am to 10 pm. Staff don't rotate shifts, and there is a call team after 10 pm. Because MSKCC is not a 911 receiving hospital, the OR is not staffed 24 hours.

Anyone who works up until 7:30 pm is considered day shift, and those who work until 9 or 10 pm are considered evening shift.

Staff suggestions prompted separation of the evening shift's vacation requests from the day shift's requests.

"It used to be that staff would not only have to compete with people within their core based on seniority, they also would have to compete with senior evening staff," says Crookes. "The entire staff believed the day and evening

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Human resources

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vacation selections should be independent of each other."

Random sequence generator

To determine the number of vacation slots a core gets each week, the total amount of vacation weeks for the staff within that core is calculated and divided over 52 weeks.

However, the number of vacation weeks a core is entitled to is

not always spread evenly throughout the year, so some weeks need more slots than others.

Because there is always a question of fairness and how it's perceived when allotting time off, says Yee, they decided to try a new strategy.

The committee used a random sequence generator (<http://www.random.org/sequences/>) to determine in a blinded fashion which weeks would have the extra slots.

"All a random sequence generator does," says Pincus, "is to take a series of numbers and put them in a random order. If you give it 1 through 5, it will give you back something like 4, 3, 1, 2, and 5."

Vacation selection process

Every September, 2 weeks are designated for vacation selection for the following year. A vacation grid is plotted out on an Excel spreadsheet showing the number of people who can take off each

| Week of | GU/THOR | GU/THOR | GU/THOR | HBS/GMT | HBS/GMT | GYN/CR | GYN/CR | ORTH/NEUR | ORTH/NEUR | HN/PL/PED | HN/PL/PED | EVENINGS | EVENINGS |
|----------|---------------|------------|-----------|-------------|-------------|-----------|-----------|------------|---------------|-------------|--------------|-------------|-------------|
| 1/5/14 | Dubai | Venice | XXXX | | XXXX | Columbia | XXXX | Allentown | Bogata | | | Scotland | |
| 1/12/14 | | | | | XXXX | | | | | | | Africa | Boston |
| 1/19/14 | Trenton | Canton | | York | XXXX | | XXXX | | | Denver | XXXX | Ohio | |
| 1/26/14 | | Canton | | Maryland | XXXX | | XXXX | Seattle | XXXX | Denver | Tampa | Austria | Toronto |
| 2/2/14 | St Louis | | Trinidad | | XXXX | London | XXXX | | Boise | | Rome | Austria | Wisconsin |
| 2/9/14 | Venezuela | Maine | | Carlsberg | | | XXXX | Mexico | | | XXXX | Austria | Wisconsin |
| 2/16/14 | Hawaii | Madrid | Mansfield | Turkey | XXXX | | XXXX | Virginia | XXXX | Idaho | XXXX | India | Lisbon |
| 2/23/14 | Washington | Estonia | | | XXXX | Phuket | XXXX | | | Las Vegas | XXXX | Switzerland | Cozumel |
| 3/2/14 | Savannah | Texas | XXXX | | | Nigeria | XXXX | Australia | | | XXXX | Italy | Manila |
| 3/9/14 | Dubai | Texas | XXXX | Oahu | Jersey | Jamaica | XXXX | Bogata | | | Hampton | Denmark | |
| 3/16/14 | Burbank | Austria | Anchorage | Green Bay | XXXX | Genoa | XXXX | Nassau | Boise | Lincoln | XXXX | Hawaii | |
| 3/23/14 | St Louis | Burbank | XXXX | Austin | Charleston | Korea | Allentown | Virginia | XXXX | Georgia | XXXX | | Toronto |
| 3/30/14 | Germany | Lyon | Hungary* | Madrid | XXXX | Iran AORN | XXXX | Paris AORN | Hampton AORN | Denmark | Burbank AORN | Scotland | Oregon |
| 4/6/14 | Israel | St Louis | Trinidad | Poconos | XXXX | Peru | XXXX | Kenya | Tampa | Miami | XXXX | Ohio | Singapore |
| 4/13/14 | Israel | Kenner | XXXX | Maryland | XXXX | Asia | XXXX | San Jose | Hampton | Miami | XXXX | Cuba | Boston |
| 4/20/14 | Kenner | Singapore | XXXX | China | Green Bay | Nigeria | Eire | Texas | XXXX | Miami | Jamaica | Africa | Milan |
| 4/27/14 | Kenner | Georgetown | London | Mansfield | XXXX | Genoa | XXXX | Dallas | XXXX | | Las Vegas | California | San Diego |
| 5/4/14 | Madrid | Texas | | Turkey | XXXX | | XXXX | Key Largo | XXXX | | | Manila | Haiti |
| 5/11/14 | Dubai | Venice | Mexico | New Orleans | XXXX | Iran | XXXX | Nassau | Bogata | | XXXX | | |
| 5/18/14 | | Dubai | | York | | Iran | XXXX | Key Largo | | | XXXX | Vienna | |
| 5/25/14 | Moscow | | | | | | XXXX | | XXXX | | XXXX | Florida | Boston |
| 6/1/14 | | San Juan | XXXX | | | Peru | XXXX | | XXXX | | XXXX | Florida | Hawaii |
| 6/8/14 | Hawaii | San Juan | XXXX | Oahu | XXXX | Rome | XXXX | New York | | | XXXX | Qatar | Wisconsin |
| 6/15/14 | | | XXXX | Oahu | Austin | Rome | XXXX | Seattle | XXXX | | Prague | Austria | Haiti |
| 6/22/14 | Trenton | Fresno | XXXX | Austin | XXXX | Jamaica | XXXX | | | | Prague | Las Vegas | Cuba |
| 6/29/14 | Germany | Savannah | | Poconos | Lima | | XXXX | Allentown | XXXX | Anchorage | xxxx | Italy | |
| 7/6/14 | Germany | Venice | St Louis | Mansfield | XXXX | Genoa | XXXX | Nigeria | Dallas | Denmark | XXXX | Africa | Switzerland |
| 7/13/14 | Moscow | San Juan | XXXX | Carlsberg | XXXX | | XXXX | Nigeria | Hampton | Denmark | | Ohio | Switzerland |
| 7/20/14 | Charleston | Georgetown | Canton | New Orleans | XXXX | Finland | London | Mexico | XXXX | Idaho | | Romania | Emirates |
| 7/27/14 | Texas | Georgetown | Canton | Green Bay | XXXX | Japan | XXXX | Key Largo | XXXX | Idaho | XXXX | India | Milan |
| 8/3/14 | Madrid | Hungary | Trinidad | China | XXXX | Eire | Paradise | Texas | XXXX | Tampa | XXXX | Scotland | Milan |
| 8/10/14 | Madrid | Fresno | XXXX | Croatia | XXXX | Eire | XXXX | Kenya | XXXX | Tampa | Burbank | Africa | Toronto |
| 8/17/14 | Seoul | Dubai | Jersey | Maryland | XXXX | Asia | XXXX | Kenya | Allentown | Las Vegas | Mansfield | Singapore | Qatar |
| 8/24/14 | Venice | Venezuela | Trenton | Maryland | XXXX | Asia | Peru | Virginia | XXXX | Jamaica | XXXX | | Vienna |
| 8/31/14 | Hungary | Venezuela | XXXX | Poconos | XXXX | | XXXX | Hampton | Atlantic City | Miami | Anchorage | Italy | Boston |
| 9/7/14 | Maui | Estonia | Alaska | Austin | New Orleans | Iran | XXXX | New York | XXXX | Idaho | XXXX | Italy | Milan |
| 9/14/14 | Lyon | | XXXX | York | Texas | Iran | XXXX | Denmark | New York | Prague | XXXX | Oregon | Italy |
| 9/21/14 | Lyon | Canton | Israel | Oahu | XXXX | | XXXX | Allentown | XXXX | Burbank | XXXX | Vienna | Wisconsin |
| 9/28/14 | Lyon | | | | XXXX | Japan | XXXX | | XXXX | | | Austria | India |
| 10/5/14 | Germany | Israel | | China | XXXX | Japan | XXXX | Texas | Kenya | | | Cozumel | Toronto |
| 10/12/14 | Fresno | Hawaii | Trenton | Carlsberg | XXXX | Asia | XXXX | | XXXX | Las Vegas | XXXX | Switzerland | Austria |
| 10/19/14 | Fresno | Hawaii | XXXX | Turkey | XXXX | London | XXXX | Mexico | Peru | Georgia | Moscow | Manila | |
| 10/26/14 | Fresno | Hawaii | Columbia | Poconos | XXXX | Jamaica | XXXX | Georgia | | Tampa | XXXX | | |
| 11/2/14 | Jersey | St Louis | | | XXXX | Paradise | XXXX | Hampton | XXXX | Columbia | XXXX | Scotland | Ohio |
| 11/9/14 | | | | | XXXX | | XXXX | | XXXX | | | | |
| 11/16/14 | Atlantic City | | | | XXXX | Phuket | XXXX | Boise | | Columbia | XXXX | | |
| 11/23/14 | | | Burbank | Boise | XXXX | Genoa | XXXX | Nassau | XXXX | Aruba | Paris | Wisconsin | |
| 11/30/14 | Venezuela | Hungary | Canton | New Orleans | XXXX | Peru | XXXX | Key Largo | XXXX | Aruba | Mansfield | Switzerland | Hawaii |
| 12/7/14 | Venice | Germany | XXXX | Oahu | Georgetown | | XXXX | | XXXX | | Philippines | | India |
| 12/14/14 | Seoul | | XXXX | Charleston | York | Asia | Eire | London | XXXX | Philippines | Idaho | Africa | Singapore |
| 12/21/14 | Maui | Texas | Australia | China | XXXX | Negri | XXXX | Mexico | XXXX | Philippines | Miami | California | Toronto |
| 12/28/14 | Maui | Charleston | XXXX | Turkey | XXXX | Japan | XXXX | Nassau | Dallas | Philippines | Denver | Manila | Romania |

| | |
|------|--|
| XXXX | SLOT IS CLOSED |
| NAME | PRIME WEEK |
| NAME | INDIVIDUAL GRANTED WEEK OUT OF SERVICE |
| NAME | INDIVIDUAL HAD THIS WEEK LAST YEAR |
| NAME | INDIVIDUAL HAD THIS WEEK >2 YEARS |
| NAME | EVENING SHIFT |

OR staff vacation request grid, Memorial Sloan-Kettering Cancer Center, New York City. Used with permission.

week in each core and e-mailed to each staff member. Empty slots on the grid are available; slots with Xs are blocked (sidebar).

A lock box is provided for staff to submit requests. Using a form that lists all weeks of the year, they check off the ones they want. Staff members are eligible for 4 to 5 weeks of vacation depending on title and years of service.

"At the end of the vacation selection period, we start putting in all of the requests and plot them out on a copy of the grid," says Pincus. "Usually two or three members of the vacation committee work together so we can double check each other," she says.

The first thing the group does when granting vacation requests is look at whether the person had that week off last year. Staff members cannot have the same week off 2 years in a row. "This way, a senior person can't get Christmas off every year if someone else wants it," says Pincus.

From there, requests are granted according to seniority. A maximum of 2 weeks can be taken during prime times, such as holidays and summer, unless more time is needed for a special occasion. "The nurse leader has to give special permission for this, but weddings and honeymoons are always granted," Pincus says.

When the grid is finished, there will be open slots in various cores. If a staff member from one core is also competent to work in another core that has an open slot, that person can take that open slot. However, day staff can only take day slots, and evening staff can only take evening slots.

A color coding system is used to signify prime weeks and evening shift slots. The system also helps keep track of individual vacation information that is used

when allotting vacation time in subsequent years.

After the initial publication of the grid, the request for an open slot is granted on a first come, first served basis by the nurse leader.

"We had an issue with people changing a lot of weeks or turning them back in, so one of our rules now is a person can only return 2 weeks and can only trade with someone once," says Crookes.

Once the grid is done, it is posted in the nurse manager's office, and it is also posted online on the OR's shared drive. Only the nurse manager can make changes after posting.

"The process is nonpreferential across the board," says Crookes. "Even those of us who plot the grid have to submit our vacation requests on the first day. We can't change our own requests or move our own requests around while we are working on the grid. We have to wait until it is posted like everyone else."

Survey affirms process

"It was a long and sometimes difficult process to develop, but we all grew together and staff input

was key," says Pincus.

Several years after the new vacation selection process was implemented, the committee randomly distributed a five-point questionnaire to 52 staff members to get their perceptions. Results were favorable:

- 67% believed the process was fair
- 84% thought the separation of day and evening shifts improved the process
- 82% said they received at least 2 of the weeks they requested
- 67% believed the process had been improved by staff input
- 65% said annual staff input and feedback about the process were important.

"There is something to be said for consistency and knowing that rules are staying the same and are fair to all," says Pincus. "It may seem a confusing way to do it, but to us it is perfectly logical." ♦

—Judith M. Mathias, MA, RN

Reference

Pincus E S, Yee S, Crookes K A, et al. A staff driven collaborative vacation process. Poster session, 2014 AORN Surgical Conference & Expo.

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Former pilot applies aviation skills to perioperative nursing

As a Navy veteran, airline pilot, and flight nurse, Lisa Reeves, RN, performed safety checklists for nearly 15 years.

When Reeves became a perioperative nurse 2 years ago, she was pleasantly surprised to find she would continue to use checklists and that ORs had been studying aviation safety practices.

"The aviation and OR environments are so similar, I felt like I was right back at the airline," Reeves told OR Manager.

Among the similarities:

- Both are high-risk occupations, where one mistake can cost a life.
- Both involve complex, multistep procedures.
- Both are associated with accidents or events that usually are caused by a chain of events.

Breaking the error chain

Surgical and aviation checklists both help to break the error chain and encourage all team members to speak up. "We have learned in aviation that a chain of events usually leads up to an accident, and that several people along the way could have broken the chain if they had spoken up," says Reeves. The same holds true for the OR.

Checklists create a culture that encourages communication and contributions from all team members. "Checklists help us back up ourselves and each other to stop errors before they happen," she says.

In both fields, there is a desire to fit as much as possible into a day, says Reeves, but people still have to be safe doing that. "The checklist is a good way to ensure safety because it makes sure that in the desire to be fast and efficient, important considerations aren't overlooked," she notes.

Same steps, different outcomes

A surgical case is similar to a flight in that the basic steps are always the same, but no two flights and no two surgical procedures are exactly alike, says Reeves.

"You can fly between the same two cities twice in a row, and they will be different," she says. The number of passengers on board adds to the weight of the plane. This affects how much runway is needed to take off and how much fuel is needed. The weather is another variable.

In the OR, the surgical team can perform the same procedures back to back, but every patient is different in size and age, and has comorbidities that can affect the outcomes. "You have to think of every case and every flight as unique and take into account the differences," says Reeves. "If you get complacent, you could have a bad outcome for the patient or the flight."

Turnaround parallels

Turnarounds between surgical cases and airlines flights are another parallel Reeves sees between the OR and aviation. The airline focuses on on-time departures and fast flight turnarounds. The OR focuses on on-time case starts and fast room turnarounds.

If the first flight of the day or the first case of the day is late, it can affect the schedule for the entire day. If flight or case turnarounds are excessively long, the schedule can be delayed further.

The airlines have a goal of 30 minutes or less for the time planes spend at the gate in between flights (door open to pushback). OR staff aim for 20 minutes or less for the time the room is empty in between



Lisa Reeves, RN, flight nurse with the North Carolina Air National Guard, performs safety checklist.

patients (wheels out to wheels in).

"In the OR, you're cleaning up the room after the patient is out, bringing in new instruments, and setting up the next case. In the airplane, you are cleaning up the garbage the passengers left behind, bringing in new snacks and drinks, and refueling," says Reeves. "In both, there is a lot to do in a short amount of time, and there is a team of people working together to make it happen," she says.

Similar duties

Reeves also sees similarities between the work of pilots and circulating nurses. "Their tasks are different, but the workflows are so similar," she says.

For a long flight, pilots are very busy getting the plane ready, setting up the flight instruments, performing a flight control check, checking the flight plan, and then taking off. While they are cruising, they aren't too busy except for monitoring the flight. Then when it is time to land, they are busy again.

Human resources

In a long surgical procedure, the circulating nurse is very busy at the beginning of the case, setting up the room and equipment, getting the patient positioned on the OR bed, doing counts, helping the surgeon and anesthesiologist, and assisting in the safety checklist. During surgery, the nurse does charting and monitors the case and team, but isn't as busy. At the end of the case, the nurse is busy doing counts, getting the patient's bed ready for transfer to the postanesthesia care unit or intensive care unit, and assisting the anesthesiologist.

Short flights and short cases also are similar because pilots and circulating nurses are very busy the entire time, she says.

Bringing the past and present together

"I have been so lucky to have the careers I have had," says Reeves. "It's been a lot of fun."

Reeves "got the urge to fly" in high school and joined the Navy so she could be a fighter pilot. As it turned out, she was too short to fly for the Navy, but this didn't stop her. While in the Navy, she took flying lessons wherever she was stationed.

After fulfilling her commitment to the Navy, she started flying for US Airways, and she was a pilot for 7 years.

About 5 years ago, she decided to become a nurse. When she graduated, she joined the cardiac/thoracic/vascular surgical

team at Carolinas Medical Center, Charlotte, North Carolina.

Thanks to a nursing school classmate's suggestion, Reeves joined the North Carolina Air National Guard after graduation.

"I thought being a flight nurse was a perfect way to bring my past and present together," says Reeves. "It allows me to still be on airplanes and do nursing."

Reeves recently struck out on a new adventure. She now works in the emergency department.❖

—Judith M. Mathias, MA, RN

Reference

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OR Manager Conference

Continued from page 1

General sessions fueled thought-provoking ideas about the future of healthcare delivery, changing roles and responsibilities for peri-operative services teams, and suggestions for coping with today's fast-paced working environment.

A record number of exhibitors showcased the latest innovations in surgical equipment and services, along with a wealth of educational material. New this year, a hybrid OR on the exhibit floor gave attendees an opportunity to see all of the specialized equipment in one place and to learn about the components from participating companies.

New research was reflected in the dozens of posters on display, and many attendees talked with the authors about their work.

As always, a highlight was the OR Manager of the Year luncheon and award presentation, which this year went to Nancy Daughety, RN, from St Francis Hospital, Inc, in Columbus, Georgia.

Despite a busy schedule, attendees made time to party aboard the legendary Queen Mary ocean liner, where they enjoyed a rare opportunity to tap their inner creativity by fashioning hats for themselves.

A new world

Tim Porter-O'Grady, DM, EdD, ScD(h), APRN, FAAN, who spoke at the inaugural OR Manager Conference, delivered an inspirational keynote address. As Dr Porter-O'Grady, senior partner of Tim Porter-O'Grady Associates, Inc, in Atlanta, celebrates his 44th year as a nurse, he told participants, "Although the world is shifting, who we are and what we are is going with us into this new world, although the language of it will be different."

As an example of this new world, Dr Porter-O'Grady said, many nurses learned how to care



Dr Tim Porter-O'Grady inspired the audience during his keynote address.

for patients who stayed in the hospital for an average of 7 to 9 days, whereas now most patients stay a matter of hours.

That shift demands that nurses approach patients differently. The philosophy should now be: "Because I care about you, I'm going to do everything in my power to be sure you're not here 1 second longer than you need to be."

To enter this new world, nurses must leave some things behind, a task many find challenging. Dr Porter-O'Grady suggested leaders have a monthly staff meeting with the sole purpose of discussing what is not going to be done anymore. "You can't do everything forever," he said.

Dr Porter-O'Grady showed the Choluteca Bridge in Honduras, now known as the "bridge to nowhere" because in 1998 Hurricane Mitch changed the course of the river it crossed. "The river is moving," he said. "You are leading people to a land you will not occupy. It's not a worse place, it's just a different place."

Dr Porter-O'Grady identified several drivers or "rivers" of change:

- The economics of healthcare is moving from volume to value. "Value asks a different set



Closer Juliet Funt's "WhiteSpace" philosophy, along with some old "Candid Camera" clips, sent everyone home on a high note.

of questions," he said. "Did it make a difference? Did something happen?" The shift is from being responsible for the process of work to being accountable for the product of the work.

- Interdisciplinary clinical service models are becoming increasingly important.
- Healthcare driven by patients, families, and communities is stimulating the movement to create value around the point of service. Dr Porter-O'Grady noted that decision-making should be made as close as possible to the point of service.
- The focus is on advancing the triple aim—improving the patient experience of care, improving the health of populations, and reducing per-capita healthcare costs. "You now have to be able to demonstrate the convergence of these three metrics," Dr Porter-O'Grady said.

Building physician relationships

Success in this changing world depends on good physician relationships. "Physicians are your

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OR Manager Conference

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customers,” said general session speaker Marian McCann, EMBA, BSN, RN, CNOR. “You cannot forget that because they bring your patients to you.”

McCann, CEO of Hoku Consulting in Los Angeles and OR director at Long Beach Memorial, tied understanding a typical surgeon’s characteristics and emotional development to success in building a relationship. For example, surgeons are intelligent, analytical, passionate, production minded, and opinionated individuals with perfectionistic ideas who face business pressures. Yet, their emotional development differs from a nurse’s, she said.

“In medical school, they generally don’t work and are competing with each other,” McCann said. Surgeons lack the same socialization experiences most nurses have, and when they graduate, she noted, “They suddenly have a huge amount of responsibility and adoration right and left...that’s very heady.”

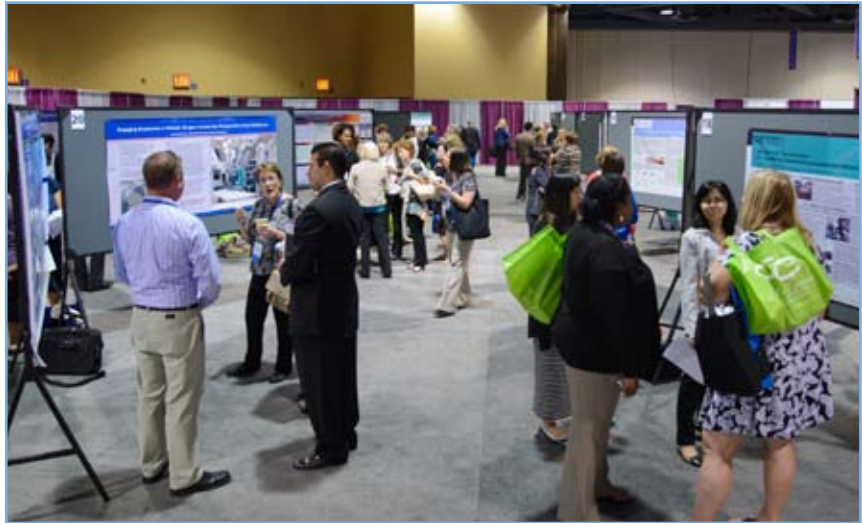
To manage the physician relationship, McCann said, know your audience, give up control, relate with grace, balance power (for instance, include others in decision making), and focus on mutual goals.

“Control what you can and only what you can,” she advised the audience. “Seek counsel by talking to the CNO, COO, or chief of staff.”

It’s important to “keep your word, be responsible, and take accountability,” she added.

“Make sure your data is clear and well presented,” she advised, and after the presentation, allow time for the audience to absorb and reflect on what you have said.

McCann summarized her strategies as follows: know your audience, know yourself, know your goal, know your data, and keep your eye on the prize.



Attendees flocked to the poster session on Thursday.



OR Manager of the Year Nancy Daughety, RN (left), was nominated by many colleagues, including Deborah Saylor, MSN, RN (right).



Several companies showcased their equipment in the special hybrid OR exhibit.

OR Manager Conference



Self-styled party hats created a celebratory mood for the special reception aboard the Queen Mary ship.

Turbulent times bring challenges

"You are in turbulent times," said Kent Bottles, MD, faculty at the Thomas Jefferson University School of Population Health, Philadelphia, and chief medical officer for PYA Analytics, Knoxville, Tennessee.

Dr Bottles reviewed national healthcare trends to show the source of that turbulence, expanding on some of the trends of the triple aim Dr Porter-O'Grady had discussed—improving patient experience and population health, and cutting costs.

Bringing value to healthcare depends on changing the focus from "sick care" to "population health," Dr Bottles said. "You have to reach out and touch people before they come into the hospital."

He noted that sick care is centered on providers who work in silos, but population care focuses on the patient and uses provider networks.

The turbulence has taken a toll on independent physician practices. "More than one-half of physicians are now employed by systems," Dr Bottles said.

Physicians aren't the only ones who are struggling. "People are in the middle, straddling the first curve and the second curve," he noted. This first curve refers to

traditional practice such as fee for service, and the second curve refers to new trends such as value-based payment.

Dr Bottles covered three areas of particular interest to leaders in turbulent times: conflict, feedback, and trust.

He said leaders should welcome conflict because that's what is needed to create robust solutions to problems. He advised them to encourage feedback and outlined several strategies for more effective feedback from the 2014 book, *Thanks for the Feedback: The Science and Art of Receiving Feedback Well*, by Douglas Stone and Sheila Heen. Finally, Dr Bottles said, building trust is essential and requires forgiveness, listening, and honoring commitments.

Reclaim your WhiteSpace

"Our time is under attack," announced conference closer Juliet Funt, founder of WhiteSpace® at Work, a custom training and consulting firm based in Los Angeles. "When was the last time you caught someone thinking at your place of work?" she asked. With all of the pressures and time constraints imposed by schedule overloads in their professional and personal lives, many people

find it difficult, if not impossible, to think strategically, said Funt.

She defines WhiteSpace as "a strategic pause between activities that will make you more confident and calm," and she presented it as a strategy that can help leaders cope in high-pressure situations. WhiteSpace differs from meditation in that it's more of a "tuning in" than a "tuning out."

Funt, the daughter of Allen Funt, who hosted the funny, popular TV show "Candid Camera," used clips from the show to illustrate some of her points. She also provided two key strategies for obtaining WhiteSpace: redistributing effort, for example, putting yourself on an email diet, and redistributing excellence, for example, understanding when good is good enough.

Take a WhiteSpace moment now and mark your calendar for next year's OR Manager Conference, scheduled for October 7-9, 2015, at Gaylord Opryland in Nashville, Tennessee. Early registration discounts are available; for more information, visit www.ormanagerconference.com. ❖

Cynthia Saver, MS, RN, is president of CLS Development, Inc, Columbia, Maryland, which provides editorial services to healthcare publications.

Salary/career survey

Continued from page 1

| Average annual salary (n=43) | |
|---------------------------------|-----|
| Mean = \$86,000 | |
| Median = \$87,500 | |
| \$100K+ | 21% |
| \$90K-\$99,999 | 14% |
| \$80K-\$89,999 | 14% |
| \$70K-\$79,999 | 7% |
| \$60K-\$69,999 | 2% |
| <\$60K | 12% |
| Don't know | 30% |

| Number of direct reports | |
|--------------------------|-----|
| 10 or more | 9% |
| 5 to 9 | 40% |
| >5 | 28% |
| none | 23% |

rate. To ensure representation of the target audience, results were filtered to include only the 131 respondents who work full time as a manager or director. The margin of error is ± 7.9 percentage points at the 95% confidence level.

Survey results on staffing and salary data for OR directors and managers, as well as articles about the impact of healthcare reform on hospitals and ambulatory surgery centers, appeared in the September and October issues of *OR Manager*.

Trends and qualifications

About a third of OR leaders reported having a business manager, essentially the same as last year and comparable to 37% in 2009. Nearly two-thirds of business managers work in teaching hospitals, a trend that is consistent with last year's results and reflects an increase from the 54% from 5 years ago.

Most survey respondents (58%)

Data analysis abilities are essential.

require business managers to have a bachelor's degree, and more than a third require a master's.

The percentage of hospitals that require a clinical background for a perioperative business manager, however, has declined significantly, from 78% in 2009 to only 28% this year.

"Not having a clinical background is like working with one arm tied behind your back," says Paul Rhodes, RN, operating room business manager at Maricopa Integrated Health System in Phoenix, a level 1 trauma center with 11 ORs and the second largest burn center in the country.

"It's hard to understand the critical needs of surgeons and staff without the clinical background," Rhodes says. For example, someone without clinical experience might not appreciate the immediate need for a microscope cover that is on "back order."

"A clinical background has some definite advantages," agrees Michael Holder, MHA, who started his career as a recreational therapist before moving into business operations.

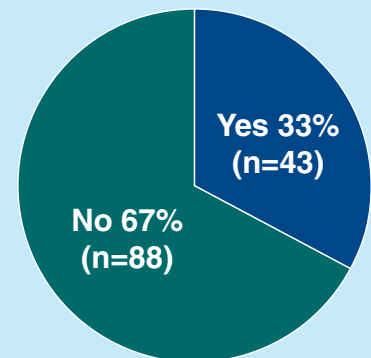
When he became business manager for surgical services at New Hanover Regional Medical Center in Wilmington, North Carolina, he made a point of spending time in the OR, learning about equipment and processes. Holder is responsible for a total of 35 ORs at three locations.

But not having a clinical background can yield its own advantages. "There are a lot of times I wish I had that clinical background, but it's good to have someone outside looking at things a different way," says Robin Main, MHA, business manager for UF Health in Gainesville, Florida, which has an annual volume of 31,000 cases for its 47 ORs at four sites.

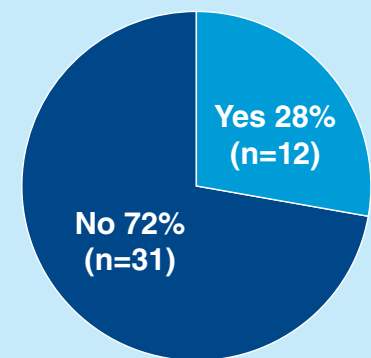
She works closely with the assistant vice president of surgical services, who has clinical expertise. "It's a good partnership because we complement each other."

Main was an industrial engi-

Does your OR have a business manager?



Is a clinical background required for a business manager position?



Salary/career survey

Facilities with business managers

By number of facilities

| | |
|----|----------|
| 1 | 23% |
| | (n = 23) |
| >1 | 63% |
| | (n = 17) |

By facility type

| | |
|-----------|----------|
| Community | 23% |
| | (n = 23) |
| Teaching | 65% |
| | (n = 20) |

Degree required

| | |
|----------------|-----|
| Bachelor's | 58% |
| MBA | 21% |
| Other master's | 14% |
| Other | 5% |
| None | 2% |

neer before moving into the business world. To ensure she is not overly focused on the business perspective, Main spends some time watching cases in the OR.

"It brings me back to why we're here; we're here for the patients. They are scared, they are sick, and they are nervous. We're here for them," she says.

Business managers must be good problem solvers, have good critical thinking skills, and be able to support processes that are patient centered, she notes.

Salary

The average annual salary is

Integrate cost and quality performance.

\$86,000, up from \$78,600 in 2009 and slightly higher than last year's \$83,900. The median reported annual salary for business managers was \$87,500.

Those in the Northeast earn the highest average salary (\$110,000), followed by the Midwest (\$92,800), South (\$71,600), and West (\$68,400).

Interestingly, the type of hospital (community vs teaching) and number of facilities (one vs more than one) had minimal impact on average salary. However, the fact that 30% of respondents answered "don't know" to this question may have skewed the results.

Scope of responsibility

Nearly half of business managers have five or more direct reports, and only 23% have none. Filling those reporting roles isn't always easy.

"It's hard to find staff with the skill to manage the supply chain process in the OR," Rhodes says. "You often have to educate clinical staff to help them evolve into management and to understand

the tie between the clinical and business worlds." In addition to business management, he oversees the OR schedulers and is responsible for block time.

According to the survey, some areas of responsibility for business managers have evolved. For example, in 2009, 71% of business managers were responsible for billing and reimbursement, compared to 47% this year. Other areas of significant decline (10 or more percentage points) were financial analysis and reporting, materials management, surgical services information systems, and quality improvement.

Responsibilities have increased in only two areas, according to the survey: value analysis and product selection, and purchasing OR supplies and equipment. However, given the wide variation in how the role is enacted, it's difficult to make general conclusions.

Rhodes, who has been a business manager for 7 years, has seen the role evolve into a more formal process that includes balancing multiple responsibilities related to accounting, finance, and revenue management.

"Setting up a charge structure is so crucial," he says, adding that it's also important to understand contracts and have the ability to pull together clinical needs, billing, and contracting.

Main, who has been a business manager for 6 years, says she has seen an increase in collaboration with physicians and administrators. "Surgeons are now involved and engaged in decisions, and that's dramatically improved the relationship," she notes.

Main also has seen business managers become increasingly

Comparison of 5-year data

| | 2014 | 2009 |
|---|----------|----------|
| Respondents who have a business manager | 33% | 37% |
| Average salary | \$86,000 | \$78,600 |
| Clinical background required | 28% | 78% |
| 4+ direct reports | 49% | 51% |
| Teaching hospitals with business managers | 65% | 54% |

Continued on page 16

Salary/career survey

Continued from page 15

involved in high-level administrative decisions. "We now have more data available for making better decisions because of EHRs [electronic health records] and other sources," she says. "People are demanding data."

Problems and solutions

"The biggest challenges of the role are supply issues [such as product conversions], physician relations, dealing with new technology, managing capital investments, and trying to grow volume," Holder says.

"Our ideas of quality in the hospital can be different from the surgeons," says Holder. "They are patient focused, and we have

to be both patient and financially focused." Holder offers the following advice:

- Learn negotiating skills.
 - Know the clinical staff; one benefit is they will come to the business managers with cost-saving ideas.
 - Understand that surgeons have their own business to manage, so their perspective differs from that of the OR business manager.
 - Be open and honest with surgeons. Sometimes you can't make the decision they want, so this will pay off in the long run.
 - Don't get caught between clinical and nonclinical administrators (Holder reports to both). If they disagree, get them both in the same room to discuss the issue.
- Main says that staying on the

cutting edge of technology while controlling costs is difficult: "There is a lot of new technology out there, and of course it costs more than the old technology."

She cites the example of the transcatheter aortic valve replacement (TAVR) procedure. "TAVR valves cost a lot of money, so we have to weigh whether to do these procedures and, if so, how we are going to control costs. You have to make it clear to surgeons that your most important goal is patient safety and patient satisfaction," she explains. She adds the following tips:

- Interact with the staff so you understand their perspective. For example, spending time in the OR can help identify why implant charges aren't being captured correctly.

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What are the OR business manager's responsibilities? (n = 43)

| | 2014 | 2009 |
|--------------------------------------|------|------|
| Value analysis/product selection | 67% | 60% |
| Financial analysis/reporting | 81% | 92% |
| Purchasing OR supplies/equipment | 60% | 52% |
| Materials management | 47% | 57% |
| Billing/reimbursement | 47% | 71% |
| OR scheduling | 30% | 35% |
| Strategic planning | 40% | 42% |
| Surgical services information system | 33% | 44% |
| Quality improvement | 7% | 17% |
| Other | 9% | 6% |

- Understand how clinical documentation works.
- Have excellent Microsoft Excel, report writing, and computer skills.

"You have to have a good foundation in the clinical and business environments before you get started," says Rhodes.

His advice:

- Understand spreadsheets, markups, and the differences between buying directly from the manufacturer, the distributor, or through a group purchasing organization (GPO). Knowing these differences helps business managers to ask the right questions. For example, asking "Can the requested surgical supply be purchased through our GPO?" establishes the foundation for moving forward with negotiations and provides a starting point for setting the product's price.
- Understand add-on fees on premium-priced surgical products from distribution centers.
- Build spreadsheets to analyze supply costs and present operational data. Rhodes provides

monthly variance notes for the budget report that is shared with the chief operating officer.

Future directions

According to Todd Nelson, MBA, director of healthcare finance policy and operational initiatives at the Healthcare Financial Management Association in Westchester, Illinois, key trends are as follows:

- The shift from volume-based payment (fee for service) to value-based payment (capitation or bundled payment).
- The continued effects of electronic health records on operations, ie, how they change the workflow and how they can be used to enhance patient outcomes and financial results.
- An emphasis on business intelligence; business managers must be able to understand, analyze, and report on data derived from many areas of the facility to ensure the success of both clinical and financial systems.

Holder expects business managers to be spending an increasing amount of time on contract negotiations with vendors and GPOs, as

well as service line development. Rhodes agrees that GPO involvement will increase, and he anticipates that technology will continue to grow and improve.

"Working with the staff and having discussions with surgeons about the latest technology and equipment in the operating room is a key component to improving patient care," Rhodes says. "Having the clinical background and experience in the operating room allows me to work as a team member and make intelligent choices when investing hospital funds for capital equipment," he adds.

Another trend, Rhodes notes, is the development of increasingly sophisticated computer systems that will allow for more detailed analysis.

Success of the business manager position in the OR has sparked interest in adding this position to other areas of healthcare facilities.

"I've seen the role expand here and throughout the US," Holder says. "It can be taken across multiple service lines. We now have [a business manager] for oncology, for care of women and children, and for cardiac services."

Nelson says the business manager role is needed to integrate the cost and quality performance of an organization.

"The future for the business manager role is looking bright as a key to success from a cost and productivity perspective, as well as a financial and data management perspective," he says. ♦

Cynthia Saver, MS, RN, is president of CLS Development, Inc, Columbia, Maryland, which provides editorial services to healthcare publications.

Co-management agreements thrive in a culture of responsibility

Most hospitals are experimenting with ways to collaborate better with physicians. An alignment model that is particularly relevant for hospital ORs is the surgical services co-management agreement (CMA).

Under a CMA, surgeons receive compensation for helping to manage a service line. Several leading ORs have used CMAs to engage surgeons in efforts to improve quality, increase efficiency, reduce costs, and achieve strategic goals. However, establishing a successful CMA requires careful planning and ongoing management attention.

We talked to several OR experts who have helped establish and run CMAs.

Goals and targets

Clearly defining the objectives of the agreement is critical for creating organizational focus and is necessary for legal compliance.

According to Dana Regnier, MHA, RN, vice president of ambulatory services at the University of Arizona Health Network in Tucson, CMA goals can run the gamut of OR quality, efficiency, and safety objectives. From 2010 to 2012, Regnier was executive director of a cardiovascular services CMA at MacNeal Hospital in Berwyn, Illinois. The agreement encompassed several service lines with participation from cardiovascular surgeons, vascular surgeons, and cardiologists.

"Goals and performance metrics should be based on the specialties represented," Regnier says. "Our metrics focused on outcomes such as ventilator times, pulmonary complications, primary PCI [percutaneous coronary intervention] within 90 minutes of arrival, and patient satisfaction." Other perfor-

“
**Service contract
easier than
joint venture.**
”

mance metrics addressed readmission rates, block time utilization, compliance with care pathways, and cost reduction. "We also had program development metrics because one of our top goals was to develop an arrhythmia center."

Other CMAs have targeted improvement in on-time starts, turnover time, preference card costs, and other hot-button issues. As much as possible, CMA goals should be formulated in terms of concrete performance targets. For example, instead of just "improve surgical safety," specify "increase Surgical Care Improvement Project compliance to 98% or above."

Another common CMA objective is care standardization. Lynette Wilkos-Prostran, MSN, RN, is executive director of the musculoskeletal service line at Loyola University Health System in Maywood, Illinois. From 2009 to 2013, she served as service line director of orthopedics and then as vice president of perioperative services at Weiss Memorial Hospital in Chicago, where she helped launch and lead an orthopedic service line CMA. "One of the major goals of the Chicago Center for Orthopedics was to improve clinical outcomes by standardizing care pathways and order sets," she says.

Activities and valuation

Once the goals of the CMA are

established, the next step is to determine physician duties under the agreement and the value of these services.

"Required management activities could include things like board participation and traditional medical director responsibilities," Regnier says. All activities should be defined in terms of the specific time contribution and performance objectives. For example, an agreement might require surgeons to devote 6 hours per month to work on a process standardization goal, including committee work and preparation.

The next step is to determine the valuation of the services. According to Tina Brinton, executive vice president/chief operating officer of Dynafios, a healthcare consulting firm in Issaquah, Washington, the most common approach to CMA valuation is the market approach.

"In the market approach, you take the set of physician management duties and compare it with standard remuneration in the local market," she says. The less common approach is cost-based valuation. "Under the cost approach, you would use medical group or physician executive cost benchmarks to establish a value for services."

Fees and incentives

The CMA valuation drives physician compensation. Most CMA compensation structures have two components—a base management fee and an incentive payment. The base management fee is often distributed as a monthly stipend. "Typically, this base fee is about 20% to 30% of the total potential compensation amount," Brinton says.

Incentive payments represent

the bulk of CMA compensation, and they are usually paid at year-end. The final distribution amount depends on surgeons' achievement of performance goals. Under many agreements, surgeons will have basic "level I" goals and "level II" stretch goals. If participants achieve level I performance, they receive 75% of the incentive dollars. Meeting the level II performance threshold secures the final 25% of the incentive.

Brinton discourages any attempt to assign different weights to different performance goals. "Dividing the incentive equally over all the indicators sends the message that all the goals are equally important," she says. "What you don't want is for people to start arguing over which objectives are more or less valuable. When you put barriers in the way in terms of nuances, it wastes valuable time."

Organizational structure

A CMA can be structured as either a joint venture company or an all-party management services contract. According to Brinton, the contract model is simpler and produces the same results as a more complex joint venture. "The trend is toward eliminating the joint venture structure," she says. "Once physicians hear about the contractual model, they usually don't see a need to create a separate joint venture entity."

A CMA "org chart" typically includes a leadership board and an array of operational teams. Within an operational team, surgeons and hospital personnel work together to achieve the CMA's specific performance goals. One operational team might focus on quality, another on efficiency improvement, a third on pharmacy costs, etc.

Get top leaders engaged in the process.

The CMA leadership board monitors and directs all activities under the agreement. This group should hold monthly meetings to review current performance metrics, receive operational team updates, discuss problems, and establish priorities.

Successful CMA enterprises are typically managed by a hospital-employed administrator, often the director of the surgical service line. Administrator responsibilities include coordinating surgeon meetings, assisting with data capture and analysis, and ensuring that participating surgeons maintain progress toward goals.

As executive director of the MacNeal cardiovascular CMA, Regnier actively managed the agreement down to the operational team level. "It's important to be engaged with the physicians," she says. "As administrator, it was my responsibility to set agendas for operational team meetings, attend all sessions, and report back to the leadership board on team progress and metrics."

Challenges

"For a co-management agreement to be successful, hospital executives need to be engaged and visible," Regnier says. "The governing board of our cardiovascular services CMA included the CEO, COO, CFO, and CNO of the hospital. They took the initiative very seriously, and I think it made a

difference for the physicians to know that executives were very invested."

Another problem is surgeon commitment. "Not all physicians will have the same level of commitment to the agreement," Wilkos-Prostran says. The solution is ongoing attention and communication. "If physicians are struggling or there is no movement on performance indicators, you need to initiate a discussion about the obstacles and what support or resources are needed to achieve the goal."

Even among committed participants, maintaining focus over the long term can be difficult. "During the first year of the agreement, participants received a sizable bonus for achieving the stretch goals. But during the second year, performance becomes more difficult as you need to sustain the goals of the first year and develop goals for the second year," Wilkos-Prostran says.

Strong CMAs are able to sustain progress because they create a culture of responsibility. "Surgeons hold each other as well as leadership and staff responsible," Wilkos-Prostran says.

A good tool

Surgical services CMAs offer several benefits to OR leaders, the most important of which is improving surgery department performance.

The Weiss CMA, for instance, reduced length of stay (LOS), cost per case, and readmission rates for orthopedic patients.

At MacNeal Hospital, the cardiovascular services CMA reduced LOS, cut postoperative infections, and improved protocol compliance. It also decreased

Continued on page 27

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Awareness during anesthesia: A rare but disturbing complication

According to the American Society of Anesthesiologists (ASA), intraoperative awareness with recall occurs “when a patient becomes conscious during a procedure performed under general anesthesia and subsequently has recall of these events” (ASA). Patients remember sounds, voices, tugging, and pain.

Even without painful sensory perceptions, being awake but unable to communicate with the surgical team can cause severe distress and lasting psychological damage, including posttraumatic stress disorder (PTSD). Some patients describe awareness with recall as their “worst hospital experience” (Joint Commission).

Awareness with recall is thought to occur in approximately 1 to 2 cases per 1,000 in the general population undergoing general anesthesia (Mashour et al. 2011) or about 21,000 to 42,000 cases annually in the United States (Joint Commission).

In high-risk cases, such as cesarean sections, it is 10 times as common. Because not all patients who experience awareness with recall report it, the true occurrence may be even higher.

Patient outcomes

A literature review of 271 cases of awareness with recall between 1950 and 2005 found a variety of patient complaints, most commonly auditory and tactile perceptions rather than pain. For example, in one study, 72% of the patients reported tactile perceptions (such as pressure or tugging) and 70% reported auditory perceptions (such as sounds or voices), followed by feelings of acute fear, helplessness, and panic

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(58%, 56%, and 43%, respectively). Less than half of the patients experienced pain (Ghoneim et al.).

Half of patients who have an episode of awareness with recall experience some degree of mental distress, and 40% to 60% of patients may require extended psychological or psychiatric care (AANA).

“Later occurring psychological symptoms” include severe anxiety and PTSD and, in some instances, may not occur until years later (AANA).

The damaging psychological effects of awareness with recall should not be underestimated and, in at least one instance, are alleged to have caused a man to kill himself 2 weeks after the occurrence (James).

Lawsuits

Approximately 2% of the anesthesia medical malpractice claims in the ASA’s Closed Claims Project database were for awareness-with-recall claims. Although no single cause of awareness could be found in 35% of the claims, 37% were for light anesthetic and 28% were for anesthetic delivery problems. The median payment amounts for awareness claims was about \$25,000 for claims from 1999 and earlier and \$71,500 for more recent ones (Kent).

The mere fact that anesthesia with recall has occurred does not mean an anesthesiologist has

been negligent or deviated from the standard of care (Domino et al.). Even if anesthesia was appropriately administered but the patient nonetheless awoke and the anesthesiologist knew, or should have known, that the patient became aware, the anesthesiologist and surgical team have a duty to address the problem. For example, in one case that settled for \$400,000, the anesthetic gas vaporizer was found to be empty and the patient was “bucking during the procedure,” an obvious indication that the patient was feeling pain (Thomas).

ASA standards

ASA has standards for basic anesthetic monitoring that apply to all anesthesia care (except in emergency situations). In addition, according to an ASA statement on the documentation of anesthesia care, medical records should include anesthesia history and intraoperative record keeping should note any “unusual events,” which could include awareness with recall. ASA standards do not specifically address awareness with recall or awareness monitoring.

Action plan

One researcher suggests that awareness with recall can be reduced by half through audit and education and that merely drawing attention

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and improving understanding is an important preventative measure (Goddard and Smith). OR managers and other clinical and nonclinical staff can take additional steps, detailed below, to reduce the likelihood of awareness with recall.

Develop a clear policy

Having a comprehensive awareness policy in place is the first step in protecting patients, responding to adverse public relations in the event of media attention, or, in a worst-case scenario, preparing a legal defense.

The Joint Commission recommends that an anesthesia awareness policy address the following (Joint Commission):

- Education of clinical staff about awareness and how to manage patients who have experienced awareness with recall.
- Identification of patients at higher risk for intraoperative awareness and discussion with such patients, before surgery, of the potential for awareness with recall.
- Effective application of available anesthesia monitoring techniques, including the timely maintenance of anesthesia equipment.
- Appropriate postoperative follow-up of all patients who have undergone general anesthesia, including children.
- The identification, management, and referral of patients for counseling who have experienced awareness with recall.

American Association of Nurse Anesthetists (AANA) recommendations are similar; they state that the policy should include the following (AANA):

- Methods for identifying and managing an occurrence of awareness with recall.

Identify at-risk patients before surgery.

- Mitigation strategies for preventing awareness-with-recall events.
- Requiring a perioperative team debriefing when an awareness event occurs.

Identify high-risk patients

A key component of the facility's awareness policy is the identification of higher-risk patients (sidebar). ASA also recommends interviewing patients to assess level of anxiety and specifically asking about any history of awareness and previous experiences with anesthesia (ASA).

Reduce the risk of awareness with recall

Having identified the higher-risk patients, the anesthesiologist can take extra precautions. Medical staff leadership should develop clinical protocols for reducing the risk of intraoperative awareness. A clinical checklist could include items such as avoiding or minimizing administration of muscle relaxants, setting alarms for low anesthetic gas concentrations, considering treatments for hypotension other than decreasing anesthetic concentration, and redosing IV anesthesia when delivery of inhalation anesthesia is difficult, such as during a long intubation attempt or during rigid bronchoscopy (Mashour et al. 2011; ASA).

ASA recommends using multiple modalities to monitor depth of anesthesia during the operation,

including the following (ASA):

- Clinical signs, such as checking for purposeful or reflex movement, although neuromuscular blocking drugs may mask purposeful or reflex movement.
- Conventional monitoring systems, such as electrocardiogram, blood pressure, heart rate, ETAC, and capnography monitoring.
- Brain function monitoring—while not routinely indicated for general anesthesia patients, the individual practitioner may decide to use it for selected patients, such as those receiving light anesthesia.

Awakening during a procedure does not mean a patient will remember the experience; the patient must be awake long enough (thought to be at least 30 seconds) to form a memory. If awareness is noted, the patient should be given more anesthesia immediately. The anesthesiologist may also administer a benzodiazepine, which may help increase the likelihood that the patient will not recall the event. ASA recommends that this decision be made on a case-by-case basis.

Ask the patient

Whenever awareness is suspected or known to have occurred, patients should be asked about it. The Brice protocol is a well-established set of questions that may be considered (Aranake et al.):

1. What is the last thing you remember before falling asleep?
2. What is the first thing you remember after waking up?
3. Do you remember anything between going to sleep and waking up?
4. Did you have any dreams during your procedure?
5. What was the worst thing about your operation?

The answers to these questions

should be recorded and placed in the patient's medical record. Episodes of awareness with recall that are discovered as a result of these questions should be acted on.

Act on reports of awareness with recall

Reacting sympathetically and doing everything necessary actions to lessen the impact of awareness with recall is the best way to deter patients from taking their case to the courts or media.

Both ASA and the Joint Commission recommend speaking with patients who report episodes of awareness with recall to get details of the event. When the patient is a minor, parents should be asked about signs or symptoms of awareness with recall that the child displays. It is important to let the patient describe the experience in his or her own words, to listen sympathetically, and to get all the details that a patient can remember; thus, ASA recommends that a questionnaire or structured interview may be necessary. Questions could include the following (Wennervirta et al.):

- What did you remember (e.g., sounds, voices, tactile sensations, visual perception, pain, paralysis)?
- Did you feel something in your mouth or throat?
- What was going through your mind during this experience (e.g., fear, distress, dread)?
- Did you think you were dreaming?
- How long do you think this experience lasted?
- Did you try to alert anyone during your surgery or procedure?
- What was your state of mind before the surgery or procedure?
- Have there been any consequences of awareness?
- How do you feel now?
- Did you inform any healthcare

Risk factors for intraoperative awareness

Patient risks

- Past history of awareness during anesthesia.
- Comorbidities such as ASA class 4 or 5, reduced cardiovascular reserves, or hemodynamic instability.
- Genetic or acquired resistance to anesthetic agents, such as the following: frequent users of benzodiazepines or opiates; habitual alcohol drinkers; users of drugs that affect metabolism of benzodiazepines or opiates; and the need for more inhalation anesthetic among patients with mutation of the melanocortin-1 receptor gene.
- Use of antihypertensive drugs and beta blockers.
- Gender (some studies indicate that women are more susceptible).
- Age (children and the elderly have a higher awareness incidence).
- Airways that are difficult to intubate, which may increase the use of muscle relaxants.
- Obesity, which can make it difficult to estimate the pharmacokinetics of IV anesthetic agents.

Procedure-associated risks

- Cesarean section.
- Cardiac surgeries, mainly where cardiopulmonary bypass is used.
- Emergency trauma surgery.
- Night surgery.

Anesthetic technique risks

- Use of muscle relaxants or paralytics.
- Total intravenous anesthesia.
- Failure to give benzodiazepines (which have amnesia-inducing effects).

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workers of this experience after you woke up?

Facilities may also wish to be able to categorize the nature of the awareness-with-recall episode for their own quality improvement, risk management, or other purposes, a practice that both ASA and AANA recommend. Everything that a patient describes should be recorded and made part of the medical record, but using a classification scheme will make it easier for everyone to quickly un-

derstand the nature of the event.

Perhaps the most important thing that this questioning can do is identify patients likely to have later-occurring psychological symptoms, such as severe anxiety or PTSD.

The Joint Commission, ASA, and AANA all recommend referring the patient to a psychiatrist or psychologist if necessary, and the Joint Commission notes that early counseling has been found

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to reduce the risk of PTSD. Clinical psychologists or psychiatrists trained in the diagnosis of PTSD should perform the psychological assessment. One recent study recommends three psychological assessments whenever an awareness-with-recall episode is suspected: at 2 to 6 hours, at 2 to 36 hours, and at 30 days (Aceto et al.). Even patients who are not likely to develop PTSD may need counseling, and organizations should ensure that those patients receive it. ❖

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Focused competencies give anesthesia technicians a leg up on the efficiency ladder

Demand for anesthesia technicians is on the rise, according to a recent Chicago Tribune headline.

The article touts the position as a way to “work in the operating room without going to medical school.” Although this description may be an overreach, it does help raise awareness of the growing and valuable role of the anesthesia technician.

According to the American Society of Anesthesia Technologists and Technicians' Standards of Practice, there are three levels of practice: anesthesia technician, certified anesthesia technician, and certified anesthesia technologist.

The extent of the responsibilities associated with each role de-

“
Annual skills days include 10 stations.
”

pends on individual expertise, education, and certification (sidebar below). Certification is not mandatory.

Anesthesia technician responsibilities

Barnes-Jewish Hospital in St Louis employs 40 anesthesia technicians to cover more than 60

ORs on two campuses. Anesthesia technicians assist anesthesia providers in obtaining and preparing equipment and supplies, and they must be knowledgeable about anesthesia techniques, instruments, and technology.

“Our anesthesia technicians are pivotal to the smooth running of the OR,” says Gail Davis, MSN, APRN-BC, CCRN, manager of perioperative education and development.

Their preoperative responsibilities include:

- setting up the anesthesia gas machine
- checking to make sure the appropriate gas lines are attached and on

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ASATT definitions and qualifications for anesthesia technicians

Anesthesia technicians have not met the requirements to apply for the American Society of Anesthesia Technologists and Technicians (ASATT) national certification examination, or have met the requirements but choose not to pursue certification.

The anesthesia technician:

- assists anesthesia providers in various settings
- performs duties under the direct supervision of an anesthesia provider and/or RN
- provides support for surgical cases by assisting in the preparation and maintenance of patient equipment and anesthesia delivery systems before, during, and after anesthesia
- performs first-level maintenance on anesthesia equipment
- cleans, sterilizes, disinfects, stocks, orders, and maintains routine anesthesia equipment and supplies.

Education

Educational requirements to work in the role of an

anesthesia technician are at least a high school education. In some cases, a 2-year degree in healthcare may be required.

Competencies

The anesthesia technician demonstrates proficiency in:

- basic life support
- purpose, use, and care of physiological monitors relating to the administration of anesthesia
- ethical and legal issues and responsibilities
- biologic hazards, infection control, and standard precautions
- fire, electrical, laser, and explosion hazards in the OR and other anesthesia-related areas
- storage, use, and safe handling of bulk and cylinder gases
- structure, function, and care of all components of anesthesia delivery systems
- sterile technique and principles of aseptic practice
- use of common anesthetic gases
- type and indications for local, regional, and general anesthesia and monitored anesthesia care
- principles of purchasing and supply levels
- communication skills.

Source: The American Society of Anesthesia Technologists and Technicians Standards of Practice.

Human resources



Barnes-Jewish Hospital
 Perioperative Services-2014 Anesthesia Technician Skills Day
 Competency Checklist: Jet Ventilator

Name: _____ Employee # _____ Date: _____

| PERFORMANCE CRITERIA | Validator' s Initials/Date |
|--|-------------------------------|
| Manual Jet Ventilation | |
| 1. Identifies location of Emergency Manual Jet Vent Bag within the division | |
| 2. Demonstrates hook up for connection of oxygen to appropriate receptacle on boom & wall | |
| 3. Demonstrates attachment of yankeur suction (obtained from nursing) | |
| 4. Demonstrates Initiation of use of Jet Vet on patient | |
| Automatic Jet Ventilation | |
| 1. Identifies location of Emergency Manual Jet Vent Identifies "ready" reading displayed by pump for completion of priming | |
| 2. Demonstrates hook up for connection of oxygen to appropriate receptacle on boom & wall | |
| 3. Demonstrates hook up for connection of air to appropriate receptacle on boom & wall | |
| 4. Demonstrates attachment of yankeur suction (obtained from nursing) | |
| 5. Dials appropriate settings to initiate Automatic Jet Ventilation | |

Comments: _____

Validator: _____ Validator initials: _____

If assistance is required, your Clinical Nurse Manager or Educator will develop an action plan with you.

Action Plan: _____

Review/revise date: _____ Author or person reviewing/revising _____

Checklist used with permission from Barnes-Jewish Hospital, St Louis.

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- setting up and laying out the appropriate equipment and supplies for intubation, central lines, and capnography
- priming and prepping rapid infusers
- helping to bring the patient to the room.

Intraoperatively, one anesthesia technician will typically cover two to three rooms—running for supplies and taking blood work to the lab. Anesthesiologists have

the technicians' cell phone numbers and can call them at a moment's notice. In between cases, anesthesia technicians clean the anesthesia equipment and provide appropriate maintenance such as changing the soda lime in the filter.

The anesthesia technicians have their own manager, who is an RN. He does daily assignments and helps train them on the equipment and supplies needed for all of the different specialties.

Skills day participation

"Though Barnes-Jewish has employed anesthesia technicians for about 15 years, the uniqueness of our program came 4 years ago when we decided to align their competencies like we do for nurses and surgical technicians," Davis told OR Manager. "Doing so added a standard of professionalism," she says.

To ensure competency, the anesthesia technicians now participate in annual skills days with the RNs and surgical technicians. Skills days

are scheduled on two weekends and include 10 stations, each with a competency checklist (sidebar, p 26). Some stations are run by RNs, including cardiopulmonary resuscitation, malignant hyperthermia, 12-lead ECG placement, and central line setup.

Anesthesia technicians also run specific stations, such as setup and function of the difficult airway cart, jet ventilator, transcutaneous capnography, soda lime, and rapid infuser.

All RNs, surgical technicians, and anesthesia technicians have to show competency at all 10 stations.

"Every year we look at which pieces of equipment or processes have the highest use and which have the highest potential for mistakes," says Davis. "We make sure those are included in the skills days to ensure competency and standardization."

Davis says they also assess the competency checklists each year that are at each station, and update them if necessary. "We have developed competency checklists for each station to guide us and to make sure the teaching steps are standardized," she says. "I may always teach ECGs the same way, but someone else might put in an extra step. We want everyone to go through the same steps."

The competency checklists also provide a baseline for information used in orientation of new anesthesia technicians.

Training on the job

Because there are very few anesthesia technician training schools in the St Louis area, the majority of them are trained on the job, notes Kimberly Dick, MSN, RN, CNOR, clinical nurse educator.

The OR education staff give them information during orien-

tation to get them ready to go in the rooms. Once in the rooms, they have hands-on training with other anesthesia technicians that is overseen by their manager, and then they have preceptors who are experienced anesthesia technicians.

Typically, anesthesia technicians are in training for 6 weeks before they are allowed to be on their own.

The anesthesiologists love having these technicians to assist them, and the skills day participation has really helped build their teamwork with the surgical technicians and nurses, says Dick.

When the anesthesia technicians were first included in the skills days, the head of anesthesia did a survey of all the anesthesia providers to see if the additional training increased their efficiency.

According to Davis, the overwhelming response was that the rooms run more smoothly as a result of the training, and the equipment and supplies that they needed were more readily available.

Standardizing the processes into a checklist format, they said, was key to the increased efficiency. ♦

—Judith M. Mathias, MA, RN

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Co-management

Continued from page 19

costs. "Our direct costs decreased by about 9% overall for the service line, so profitability increased," Regnier says.

Wilkos-Prostran believes that CMAs help keep physicians loyal to the hospital. "Surgeons gain satisfaction in improving their time management to grow their practices and, more importantly, happy patients who are satisfied with their care," she says. "In addition, the surgeons understand that if they want to make things better in the OR, they need to be present there on a regular basis to work with the multidisciplinary teams on improving outcomes."

Surgical services co-management can be an important part of a comprehensive effort to engage physicians in OR leadership. "Co-management agreements are a good tool for achieving initial alignment between surgeons and the OR," says Bob Dahl, chief operating officer of Surgical Directions. "Getting surgeons involved in this range of issues can set the stage for more robust collaboration through a surgical services executive committee."

Dahl also believes that co-management can be a good way to introduce surgeons to value-based payment. "CMAs provide a platform for getting surgeons focused on performance metrics and allowing them to self-organize to hit performance targets, all within an incentive structure." ♦

This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow revenue, control costs, and increase department profitability.



Ambulatory Surgery Centers

Sharpen coding skills and reimbursement strategies during ICD-10 delay

The Centers for Medicare & Medicaid Services (CMS) once again has extended the deadline to begin using International Classification of Diseases-10 (ICD-10) billing codes. Implementation has been set for October 1, 2015, and a growing number of billing, technology, and clinical specialists agree it is time to move ahead with adoption of the new coding system. Ambulatory surgery centers (ASCs) are no exception.

For ASCs, the transition will be less complicated than for hospitals because there will be fewer new codes to adopt, but lack of hospital-sized resources may mean ASCs will need to provide more staff flexibility or depend on outside help.

Coders have been gearing up for more than a year to learn the new codes, and they will likely use the latest extension to practice applying the new formats, even though they must still submit claims using ICD-9. Clinicians, insurers, and software specialists likewise will have an additional year to perfect their skills and programs.

"I'm grateful for the delay, but now I would say I'm ready; let's just do it," Raecal Martin, CPC, CAPC, says. Martin is one of 126,400 members of the American Academy of Professional Coders (AAPC) in Salt Lake City. AAPC certifies medical coders, billers, auditors, and practice managers. Martin specializes in ASC coding and provides outsource services through The Coding Network, LLC, in Eugene, Oregon.

Most of her clients, she says, have developed readiness plans, trained staff, and prepared to begin testing.

Financial concerns linger

ICD-10 codes provide more detail than the ICD-9 codes currently used in the US. The data they contain will improve quality measurement and ensure more accurate reimbursement, according to a CMS statement announcing the new deadline.

"ICD-10 codes will provide better support for patient care and improve disease management, quality measurement, and analytics," CMS

administrator Marilyn Tavenner says in the announcement.

Still, industry observers warn there will be added costs and reduced productivity during the implementation period. They note the experience of European and Canadian physicians during their conversion to ICD-10 during the 1990s.

"There is reason to be concerned," according to Patrick Campbell, product manager at MedAptus, a Boston company that designs coding technology. "When Canada made the transition, physician productivity dropped." While learning the new process, he explains, the physicians had less time to spend with their patients.

As several online commenters have noted, in the US there is also concern because the reimbursement system is based on diagnosis and procedure codes; in Europe, they serve mainly as statistical data points.

Although Medicare is the primary source of revenue for many ASCs, some managers have ex-

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pressed concern that private insurers may not be ready to accept ICD-10 claims, so ASCs may have to use both code sets or they will see claims denied.

Sue Bowman, MJ, RHIA, CCS, FAHIMA, thinks that is an “urban myth.” As senior director, coding policy and compliance, of the American Health Information Management Association (AHIMA) in Chicago, Bowman has been working closely with insurers, hospitals, and physicians on the technical side of the changeover.

“Most payers are more ready than providers,” she says. “With any go-live situation, there will be glitches, but if organizations prepare well, there shouldn’t be any major problems.” In fact, she notes, all organizations covered by the Health Insurance Portability and Accountability Act (HIPAA) must complete the transition by October 1, 2015.

Preparation is key

“Unprepared organizations may take up to 5 years [after conversion] to get back to their previous cash flow rate,” Campbell estimates. All the more reason to be prepared, he notes. In fact, he says, it is now financial managers who are pushing for conversion to ICD-10.

If preparation is the key to success, it should have begun long ago, but some ASCs may have made ICD-10 a lower priority—after conversion to electronic medical records (EMRs), for example. It is not too late to start the preparation timeline, Campbell says, but expect to devote staff, time, and money to the effort.

Physicians and nurses as well as billing and coding personnel will



Expect loss of accuracy during transition.

need education, and systems will need to be upgraded and made compatible with EMRs, hospital systems, and claims processors.

“We’ve got a full year,” he says. “Smaller organizations like ASCs can move faster to implement ICD-10, so they’re still OK.” As large hospitals make the transition, they do so one department at a time, he notes.

Sources of help include IT providers like MedAptus, professional organizations like AHIMA, and government agencies like CMS. The World Health Organization created the codes. CMS has adopted them and provides its ICD-10 manual online. Outsource coding specialists may take over much of the work, but clinicians will need to modify procedure documentation to accommodate the new code structure.

According to Bowman, the main difference between ASCs and hospitals will be one of scale. The process is the same for every healthcare organization, even physician practices. The AHIMA website provides a detailed checklist of milestones and timelines that could apply to any organization.

In one way, however, the transition will be simpler for ASCs: Fewer procedures are performed in ASCs, and only the diagnostic ICD-10 codes will be used, whereas hospitals will use both diagnostic and procedure codes.

When CMS announced the latest deadline for conversion to ICD-10, AHIMA had long since rolled out an implementation plan; the planning phase was to begin in 2009. The new deadline simply allowed for a later “go-live” date and an extended follow-up period.

The AHIMA recommended schedule has four phases:

- plan development and impact assessment
- implementation preparation
- go-live preparation
- post-implementation follow-up.

Expect an impact

Do not skimp on the first phase, AHIMA warns; be sure all management and staff members are aware of the impact the project will have on their jobs and the facility’s operation: “Delayed completion of the impact assessment will jeopardize an organization’s ability to complete all ICD-10 implementation tasks by the compliance date, risking claim rejections and payment delays.”

Appoint a steering committee representing all departments that will be affected and a project manager to be a “positive change agent.” Develop a communication strategy so that every participant will hear the same message. In addition, establish a plan for educating staff and management in use of ICD-10. At the same time, discuss the conversion with vendors, especially software providers, and insurers to be sure all systems will be able to accept the new codes. Some ASCs may need to purchase additional computers or monitors.

Because most ASCs do not have IT departments, they will most

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likely depend on outside vendors. Many have already outsourced coding and billing functions, and others are considering doing so to help in the conversion.

Campbell's customers are mostly large hospitals with or without ASCs, and he says MedAptus products illustrate the relationship between care delivery and final charges. The company has two software programs that translate clinical functions into codes; Pro is for physician services, and Tech is for nurses in the outpatient setting.

"Both products focus on charge capture," Campbell explains. Instead of filling out a charge ticket to give the billing department, physicians now can choose a code from the screen on a smartphone. They know which procedure they did, so they select it on the computer screen and it generates a code." The same is true for nurse activities such as giving vaccinations.

There are additional checks and balances, Campbell notes. Clinicians are legally responsible for accurate charges on claims, and coders verify the charges based on coding rules. Instead of spending time on data entry, coders now can find and solve problems.

The MedAptus products are able to produce both ICD-9 and ICD-10 codes. They use a database maintained on the company's servers, and users have secure access through the Internet.

ASCs and other facilities adopting less advanced technology must be sure that clinical documentation contains the level of detail required for ICD-10 codes. Physicians may have to modify the way they describe procedures.

“
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”

How codes will look

A CMS guideline for physicians offers an example of ICD-10 codes for treatment of pain. The codes are more specific than ICD-9 codes, meaning there will be more choices to identify a given diagnosis. For example, ICD-9 has one code for injections to alleviate pain in extremities: 719.46 for knee pain and 729.5 for limb pain.

ICD-10 features the following six codes:

- M25.561: pain in right knee
- M25.562: pain in left knee
- M79.601: pain in right arm
- M79.602: pain in left arm
- M79.604: pain in right leg
- M79.605: pain in left leg.

In a presentation to brief physicians on the changes, Patricia Brooks, RHIA, senior technical advisor for the CMS Hospital and Ambulatory Policy Group, explains why the current codes are no longer adequate. A coding system, she says, needs to be flexible enough to add emerging diagnoses and procedures, yet exact enough to identify elements precisely. "ICD-9-CM is neither of these," she adds.

In her example, a patient fractures his left wrist and is treated. A month later, the same patient fractures his right wrist, and that is treated. "ICD-9-CM does not identify left versus right, so the claim requires additional documentation." ICD-10-CM,

on the other hand, has distinct codes for left versus right, initial encounter versus subsequent encounter, and routine versus delayed healing.

"ASCs have an advantage," Bowman notes. "They don't have to learn the new procedure coding system, PCS, which is hugely different from ICD-9 but applies only to inpatient hospital procedures."

Specifically, ASCs and physician practices, like all healthcare providers, will use ICD-10-CM diagnosis codes, but only hospitals will use ICD-10-PCS codes for inpatient procedures. Current CPT codes for outpatient procedures will not change.

Organize implementation

With a plan in place, there is still a long way to go before flipping the switch to ICD-10. Expect problems during the transition, and prepare now to alleviate them, AHIMA advises.

Among problems to address before they occur are decreased coding productivity and decreased coding accuracy. Both conditions will be reflected in accounts receivable backlogs, claim denials, and declining revenue during the transition. Expect some interruption, and take steps to minimize it.

Before the transition, eliminate current coding backlogs and bring in outsource coders as necessary. Ensure that all affected personnel have adequate training in using the new codes. Do not depend on a class or two, but encourage practice and advanced training as needed.

AHIMA recommends that coders complete ICD-10 education between 6 and 9 months before the compliance date, October 1, 2015. Coders in ASCs and other outpa-

tient facilities will need about 16 hours of education because ASCs will use only ICD-10-CM codes. Hospital coders will need more education to become familiar with codes for both ICD-10-CM and ICD-10-PCS codes.

Review medical records for adequate documentation. Revise those lacking sufficiently detailed documentation for reporting under ICD-10. Work with vendors to be sure EMRs are compatible with ICD-10 and with the ASC's other systems.

Also, AHIMA advises, have a backup plan if there is a system failure or other unexpected event at the time of implementation. Are other staff, equipment, or facilities available?

Test and revise

Before the start date for the new system (the go-live date), take time to review and double check preparations. Test new systems and consult with vendors to make needed adjustments. Confirm that coders are adequately trained. Keep senior management up to date about the transition. Maintain communication with vendors and payers, and be sure they are ready to work with the new codes.

Remember that after the deadline, there is no grace period; non-compliant claims will be rejected for all services performed on or after October 1, 2015.

However, CMS has organized a series of tests that ASCs may participate in. During test periods, Medicare will receive codes using ICD-10 and review the test claims for accuracy.

At press time, the scheduled test periods were November 12-21, 2014; March 2-6, 2015; and June 1-5, 2015. By September 15, 2015, at the latest, all participants

should be ready, according to the AHIMA checklist.

After implementation

ASCs should begin tracking results as soon as they start to use the new codes. Identify changes in reimbursement, claim denials, and coder productivity. The steering committee should continue to meet and assess reports, determine corrective action, and share any lessons learned from the experience.

Because the new codes differentiate more clearly among procedures, some ASCs will see changes in their case mix index and reimbursement groups. Communicate with insurers about how these changes could affect reimbursement schedules or payment policies. Provide feedback and education to increase awareness of the effect of the new codes on financial areas and clinical data.

Tide is turning

If some healthcare industry segments—such as ASCs—have been reluctant to move forward with ICD-10, those concerned with data, such as AHIMA, have not.

A statement to members on AHIMA's website reports, "We've heard from many of you that you're concerned about the possibility of another delay in the future. AHIMA hears your concerns. Like you, the last thing we want to see is another ICD-10 delay."

AHIMA now is advocating with legislators to counter any pressure for further delays. The organization is also working to change any lingering doubts among healthcare professionals. It is developing outreach and education programs for physician groups as well as for news media, to promote un-

derstanding of and support for ICD-10.

Bowman encourages ASCs to get on board as well. CMS, AHIMA, and many professional associations are offering classes, guides, and webinars to bring coders up to speed and keep managers up to date.

An ASC with several coders may find it most economical to send one or two of them to a train-the-trainer seminar, and then let them train their colleagues. AHIMA, Bowman says, offers academies that include online preparation followed by intensive classes in various locations.

The delay, then, is less a relieve than a chance to practice new skills and avert revenue shortfalls by making sure codes are accurate from Day 1. "The advantage of the delay is more time to test ourselves," Martin says. "There's no time like the present to begin practical coding." ❖

—Paula DeJohn

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At a Glance

Higher risk of postop complications linked to OSA

Diagnosis of obstructive sleep apnea and treatment with continuous positive airway pressure therapy before surgery were tied to fewer postoperative cardiovascular complications in a study.

For both diagnosed and undiagnosed patients, OSA severity, type of surgery, age, and other comorbidities also were important risk modifiers.

The authors also reported that patients with OSA, even those who received CPAP, were two times more likely to experience surgery-related respiratory complications compared with those without OSA.

—Mutter T C, Chateau D, Moffatt M, et al. *Anesthesiology*. 2014;121(4):707-718.

Shorter length of stay tied to lower postop readmission rates

A retrospective study using 10 years of Veterans Affairs Surgical Quality Improvement Program and administrative discharge data finds a link between decreasing 30-day readmissions and a decline in postoperative length of stay.

Of the nine surgical specialties assessed, seven were found to have

significant declines in readmission rates. Postoperative length of stay decreased for each specialty except for thoracic and cardiac, which remained unchanged.

Postoperative infection was the most common readmission diagnosis in seven specialties and the second most common in two. Urinary tract infection and digestive system complications also were common readmission diagnoses.

—Soonhee H, Smith T S, Gunnar W. *JAMA Surg*. Published online September 17, 2014.

Fall prevention strategies help total knee patients, but risks remain

Implementation of a multi-intervention fall prevention strategy reduced the incidence of falls after total knee arthroplasties in a study.

Despite prevention efforts, however, patients continued to have a high risk of falling if they were of advanced age; in the intermediate phase of recovery (postoperative day 1 to day 3); or were in the bathroom, going to and from the bathroom, or using the bedside commode.

Most patients who fell were not considered high risk, and 23% of falls were associated with morbid-

ity, including seven return visits to the OR and two new fractures.

Clinicians should provide fall-prevention strategies to all patients (especially the elderly) and reinforce practices that will monitor patients in their hospital rooms, the authors say.

—Johnson R L, Duncan C M, Ahn K S, et al. *Anesth Analg*. Published online September 10, 2014.

Bariatric surgery center accreditation linked to better outcomes

Bariatric surgery center accreditation is associated with improved rates of patient survival and fewer postoperative complications, a study finds. The findings conflict with the Centers for Medicare & Medicaid Services' 2013 decision to lift its requirement for facility accreditation for coverage of bariatric surgery, the authors say.

Medicare patients had a significant reduction of in-hospital mortality (0.56% vs 0.23%) and serious morbidity (9.92% vs 6.98%) after implementation of the 2006 CMS accreditation requirement for coverage, compared with before.

—Young M T, Jafari M D, Gebhart A, et al. *J Am Coll Surg*. 2014;219(3):480-488.