The OR of Tomorrow
What piece of capital equipment do you see in your future?

Dan O'Connor, Editor-in-Chief

Surgical facility managers have wish lists (must have) and shopping lists (will have) when it comes to purchasing capital equipment. Often the only difference between what you want and what you need is building consensus among surgeons and finding room in the budget — and neither is an easy thing to do.

Lou Estay, RN, director of surgery at Terrebonne General Medical Center in Houma, La., requires surgeons to write letters justifying their equipment requests. Nancy Wyrebek, RN, BS, of HealthAlliance Hospital in Leominster, Mass., says that buying capital equipment is a two-year process. She's making recommendations now for fiscal year 2008 to 2009. "This involves lots of research into projections, where we're going and what the needs are," she says.

To find out what pieces of equipment will be added to tomorrow's ORs, we surveyed 158 of our readers and asked them to name the one piece of equipment that their ORs, their surgeons and their staff just can't do without.

Pecchant for high tech
OR managers certainly have an affinity for the sleek, the sophisticated and the state-of-the-art. The four items most cited when we asked, "What are you currently shopping for?" were:

- high-definition displays (23, 14.5 percent);
- intraoperative imaging (20, 12.7 percent);
- LED lights (11, 7 percent); and
- centralized OR controls (11, 7 percent).

Why are HD displays in such high demand? "Better visualization leads to shorter OR times," says Bob Balduf, administrator of the Parkway Surgery Center in Toledo, Ohio.

"You theoretically improve the speed of the case when you improve the surgeon's ability to see," says Mike Pankey, RN, MBA, of the Ambulatory Surgery Center of Spartanburg in Spartanburg, S.C.

"Our OB-GYN and general surgeons will definitely like the benefit of HD over our traditional video systems," says Leann Puckett, materials manager at the Evansville Surgery Center in Evansville, Ind.
Notably, nine of our survey respondents say they're not planning on adding any new capital equipment — at least not for a little while. "Nothing at this time until payment changes are finalized," says one administrator, referring to Medicare ASC payment rates for 2008, which Medicare released this month.

Two readers made a point of specifying that they were only in the market for refurbished equipment, one adding that it must be from a source "with a proven record of quality and warranty service."

Other pieces of equipment our readers say they're shopping for: flexible scopes (10), surgical scopes (9), ENT video towers (7), location/tracking systems (7), OR tables (6), phaco units (6), anesthesia machines (5), autoclaves (4), patient monitors (4), OR lights (3), electronic medical records (3), arthroscopic towers (2), fluid waste management (2), radiofrequency generators (2), C-arms (2), orthopedic instruments (2), robotics (2), electrocautery units (2), video headlights (2), booms (1), pain management tables (1), patient warming units (1), case carts (1), laparoscopic cameras and scopes (1), supply storage systems (1) and retina surgical equipment (1).

Linda Phillips, RN, the administrator for Castleman Eye Center in Taylor, Mich., is the one in the market for $100,000 to $150,000 worth of retina surgical equipment. "It will allow me to bring in a whole other specialty and add complete ophthalmology surgical services," she says. "[Retina cases] will follow cataract surgery, so our ORs won't sit idle."

Equipment planner Kelly Spivey says it's a safe bet to add minimally invasive equipment. "It's relatively easy to install in an existing OR — there's not much needed unless you want to hang monitors from the ceiling, but it can be done from the cart," she says.

**Are You Overpaying for Capital Equipment?**

Hospitals across the nation overpay by $3.5 billion to as much as $5 billion annually for capital equipment purchases, says VHA, the national healthcare alliance, which analyzed capital purchasing patterns for its 1,400 member hospitals.

"Hospitals suffer from a lack of information, automated tools and staff resources to focus on strategically managing capital spending, which limits their effectiveness when it comes to capital purchase planning," says Nik Fincher, senior director of capital asset services for VHA. Mr. Fincher says hospitals can save up to 30 percent on capital equipment purchases if they:

- develop a strategic long-term capital plan;
- use automated budgeting tools;
- develop a budget development process;
- access accurate pricing information;
- leverage group purchasing organization (GPO) contracts;
- obtain current supplier information;
- look at purchases as opportunities to aggregate value over time rather than treating purchases as single events;
- develop a standardization plan;
- use a functional negotiation process; and
- focus on life-cycle costs versus price.

**Equipment encourages efficiency**

Most of our survey respondents were concerned about one thing: how their next purchase would improve OR efficiencies. More than 88 percent of our respondents strongly agreed or agreed somewhat with the following statement: Before purchasing a new piece of equipment, we generally insist on hard evidence that it will pay for itself.
on an ongoing basis, either in increased revenue or increased efficiency.

Cheryl Laverty of NGB Health in Charlotte, Mich., has a lengthy wish list: orthopedic equipment, drill locking sets, camera boxes and camera heads. "We'll be able to open two rooms instead of one for better service," says Ms. Laverty, who also plans on outfitting a new endoscopy suite.

United Surgical’s Carolyn Perez plans to purchase intraoperative imaging equipment that "will be dependable and state-of-the-art."

Steven Smith of the Wisconsin River Orthopedic Institute in Wisconsin Rapids, Wis., has his sights set on fiber optic intubation equipment. "This will make difficult intubations easier and there will be less chance of trauma to the patient," says Mr. Smith. Plus, he says, there will be "less chance of canceling surgery due to a difficult airway."

Traci Albers of High Pointe Surgery Center in Lake Elmo, Mont., says her anesthesia machines need to be replaced because of age. Her other purchases — monitors, microscope, CO2 laser — will hopefully help her grow case volume by recruiting additional surgeons, she says.

At the Surgery Center at Mt. Zion in Morrow, Ga., any capital investment must address one or more of the following for it to be considered. In the words of administrative director Melody Mena, a new piece of equipment must:

- improve efficiencies over the current process;
- create a new line of revenue;
- have a return on investment of more than 60 percent; and
- be more cost effective.

"Safety," she adds, "trumps everything." Our survey seconds that opinion: 78 percent of our respondents say they’d be likely to purchase a new piece of equipment that they're convinced will improve quality of care, regardless of whether it’s cost-justified.

Before purchasing a new piece of equipment, do you generally insist on hard evidence that it will pay for itself on an ongoing basis, either in increased revenue or increased efficiency? When we asked our survey respondents this question, 88 percent either strongly agreed or agreed somewhat. Slightly more than 11 percent disagreed.

When we asked if capital equipment purchases are shared decisions, with surgeons and the facility management team holding relatively equal influence, 78 percent of respondents agreed that the process is collaborative. Sixteen percent disagreed somewhat and 7 percent strongly disagreed.

Reader Survey

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<th>How Much Do You Plan to Spend On Your Next Equipment Purchase?</th>
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<tr>
<td>Less than $50,000</td>
<td>27.7%</td>
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http://www.outpatientsurgery.net/2007/11/print&id=6350
"I respect the opinion of my surgeons and in our collaborative relationship, it is my job to find a way to make their requests profitable," says Monica Ziegler, MSN, CASC, administrator of Physicians Surgical Center in Lebanon, Pa. "If they are not, I approach the MD and describe my struggles. If their requests are valid, my MDs have been open to alternative suggestions on how to approach the same goals. We work as a team. I do the research — we both make suggestions on what is best for the center and work together to achieve the desired goals: quality care, efficiency of work and profitability."

When we asked how often capital equipment purchases have come about primarily as a result of a surgeon's request, 26 percent said more than 60 percent of the time; 43 percent said 30 percent to 60 percent of the time; 20 percent said 10 percent to 30 percent of the time; and 9 percent said less than 10 percent of the time.

When we asked how often the surgeons' requests for equipment were accepted and the equipment was purchased, 33 percent said more than 60 percent of the time; 43 percent said 30 percent to 60 percent of the time; 18 percent said 10 percent to 30 percent of the time; and 5 percent said less than 10 percent of the time. We asked our readers if they would acquiesce to surgeons who threaten to take cases elsewhere if they don't get the equipment they want, even if the purchase is not cost-justified. Sixty-one percent said they wouldn't make the purchase, while 25 percent said they might.

Once you have the green light to buy, some of our respondents say there's no better place to shop for equipment than an exhibit hall, where you can "test-drive" the equipment you're considering. "Several years ago, my associate and I were able to look at instruments, sterilizers, furniture, OR lights, OR tables, accessories and future OR designs," says Kathy Romero RN, MA, CNOR, director of surgical services at Blount Memorial Hospital in Maryville, Tenn. "It was a very valuable trip, and ultimately saved us time in making decisions."

"We try to demo or ask for a loaner before making a capital purchase to ensure the equipment meets the needs of the service," adds Maureen Spangler, RN, CNOR, director of perioperative services at Lexington Medical Center in West Columbia, S.C.

It typically takes from one to six months from the time a piece of capital equipment is requested to the time that it can be used, according to 67 percent of our respondents. Another 24 percent say it takes longer, from six months to a year. For a few, the process can be very quick (6 percent say it takes less than a month) or very long (4 percent say it takes more than a year).

"We always try out a piece of equipment with more than one physician actually using the equipment or
instrumentation," says Stuart Katz, FACHE, CASC, executive director of the Tucson Orthopaedic Surgery Center in Tucson, Ariz. "This can be done quickly depending on the specific item, what it is used for and how many of these procedures are scheduled. If they are done infrequently, the acquisition time can be extended until we have enough data to decide whether we want the new item."

**In the budget?**

Finding the funds for new equipment has always been a challenge for facility managers. "I feel that our surgery department doesn't get an equal share in the monies to purchase new or used equipment for the outdated things," says an OR manager who didn't want her name used.

Retinal specialist Murray Erasmus, MD, wants a new retinal microscope and camera. Very badly. The one he uses at the Royal Jubilee Hospital in Victoria, British Columbia, was purchased in 1993. "It's like having a 14-year-old computer, it works ... but it takes longer and it's a little bit more stressful," Dr. Erasmus recently told Victoria's Times Colonist newspaper.

The new operating microscope he wants costs $130,000 to $200,000, with necessary accessories totaling another $50,000. The scope comes with video capabilities so that student nurses and doctors can see on a flat-panel monitor what the surgeon is viewing through his microscope.

"We're equipment-dependent and this is the primary piece of equipment we use to visualize what's going on," says Dr. Erasmus. "If I can see better, the chance of being able to repair those tissues is improved."

The hospital's fundraising partner is trying to raise money for the new scope. "Every year the needs of the medical staff outweigh the funding available," says Melanie McKenzie, the executive director of the Victoria Hospitals Foundation.

### Reader Survey

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<th>How Would You Describe the Profitability Impact of the Last Piece of Equipment That a Surgeon Requested?</th>
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<td>Very profitable</td>
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<td>Not at all profitable</td>
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**SOURCE:** Outpatient Surgery Magazine Reader Survey, October 2007, n=158

### Of the many reasons to buy

As one survey respondent says, buying capital equipment is a never-ending cycle. When Yvonne Campbell, the materials/facility manager at Winter Haven Ambulatory Surgical Center in Winter Haven, Fla., helped open her facility 10 years ago, much of the equipment was refurbished.

"Naturally, after this period of time, we're having to upgrade to newer equipment. Companies no longer repair, or you can no longer buy parts for, the equipment that is more than 10 years old," she says. "For example, some of our
cautery units are now obsolete, so we are having to upgrade to something newer. Or we’re purchasing the newest machine on the market. Everyone in our business knows it never ends, and you will always be upgrading to something newer that companies put out.”

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