

Ambulatory Surgery Centers

ASC section on page 19.

In this issue

Flu advice is stressing vaccinations.....	5
MANAGING TODAY'S OR SUITE. A leader's passion for patient safety.....	7
ECONOMIC TRENDS. Hospital bottom lines recover in Q1.....	9
STERILIZATION & DISINFECTION. Reprocessing safely in all settings.....	16
AMBULATORY SURGERY CENTERS. ASCs: A third feel the economic pinch.....	19
AMBULATORY SURGERY CENTERS. Ready for an infection control survey?.....	25
AT A GLANCE.....	32

Conference issue
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Salary/Career Survey

OR leaders face tightened budgets, loss of benefits in wake of recession

OR leaders say the economic downturn has hit surgical services, according to results of the 19th annual *OR Manager* Salary/Career Survey. Nearly two-thirds (63%) of OR managers and directors have been asked to cut their annual operating budget in the past 6 months. In all, 79% are

Related editorial, page 3

reconsidering or postponing capital expenditures, and 84% report new limitations on funding for attending educational events.

About 1 in 5 (19%) has lost at least some benefits, and nearly half (44%) are postponing retirement.

Despite these challenges, both hospital and ambulatory surgery center (ASC) OR leaders like their jobs, scoring their satisfaction an average of 4.0 (out of a possible 5) for those in hospitals and 4.2 for those in ASCs.

The average total compensation package for OR managers and directors is \$129,000, compared with \$124,000 in 2008.

The *OR Manager* Salary/Career Survey was mailed in April 2009 to 800 *OR Manager* subscribers who are directors or managers of hospital ORs; 323 were returned for a response rate of 40%. The margin of error is ± 4.7 at the 95% confidence level. A separate survey was sent to ASC managers (see page 19). Results from the staffing portion of

Profile of the typical OR nurse leader

The typical head of a hospital OR in the *OR Manager* Salary/Career Survey:

- Earns an annual salary of \$151,000 for an administrative director, \$123,000 for a director, and \$90,000 for a nurse manager
- Received a raise of 3.7%
- Holds the title of administrator/administrative director (31%) or director (42%)
- Works in a community hospital (72%) with an average of 15 staffed ORs
- Manages 5.9 departments
- Oversees 102 clinical and 25.1 nonclinical FTEs
- Is responsible for an operating budget of \$24 million
- Is 52 years old and plans to retire in 2021.

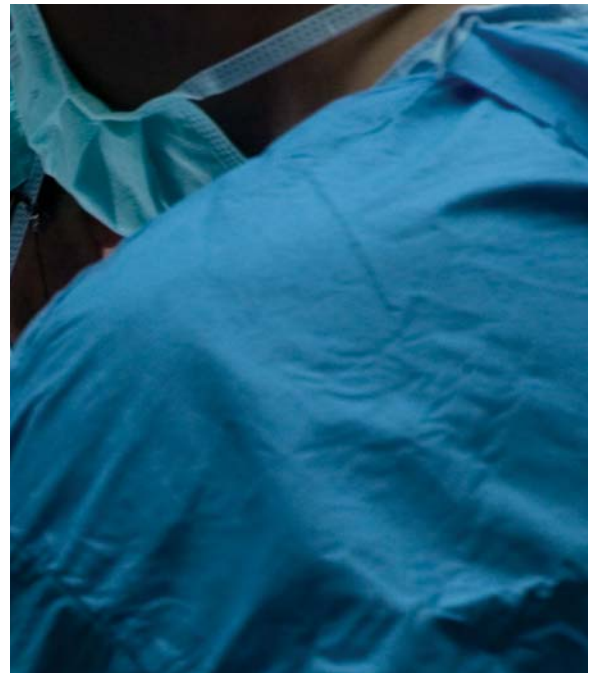
the survey appeared in the September *OR Manager*.

Weathering the storm

Economic concerns are playing out in several ways.

Budget cuts. Money is top of mind for everyone. Comments included: "[We're] focused on cutting costs more than ever," "no spending unless critical," and "there is no room for purchases, improvements.

Continued on page 10



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Upcoming

Preventing retained items

What can technology add to efforts to prevent this rare but stubborn problem?

Taming MRSA infections

How one OR conquered an outbreak of MRSA surgical site infections.



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Editorial

After taking a hit in the last half of 2008, hospitals' bottom lines recovered somewhat in the first quarter, according to Thomson Reuters data. One reason—aggressive cost cutting, described as “astonishing” by one of the report's coauthors (see p 9).

Comments from the 2009 *OR Manager* Salary/Career Survey tell us about the part our readers have played in that effort. Results on salaries and benefits are in this issue. Results on staffing were published in September.

Three-fourths of the respondents, 233 in all, sent written comments telling us how the economy has affected management of their ORs. A few, 27, said they had seen no impact, and a few said volume was up. You can read some of the comments in the article, but we thought you'd like to see what others said.

Pressure on staffing

In the survey, only 3% reported layoffs of direct care staff. But pressure on staffing is evident. More than half (58%) of the comments mentioned effects such as salary freezes, hiring freezes, and an intense focus on productivity targets. The insecurity was taking a toll on morale.

Some examples:

- “It is making flexing staff to volume exceptionally important. Any variance in the flex budget is scrutinized closely.”
- “Very hard to staff based on low volume. Very disgruntled staff.”
- “Have to ask staff to take up to 8 hours off per pay period. All have lost some benefits.”
- “Experiencing staff tension regarding going home early due to decreased schedule.”
- “Asking staff to voluntarily take off on slow days. Watching OT [overtime] closely. No travelers. No RN training class this year for new/inexperienced RNs.”

The economy's impact on ORs.

- “People are afraid they will be laid off. There is a lot of pressure to provide hours when the cases are not there to do.”

Supplies, capital spending

In the OR's other big budget category, 38% of comments described cutting supply costs and capital spending.

Among the comments:

- “It has made us much more concerned about the price of implants and other materials management issues.”
 - “No capital spending unless absolutely necessary.”
 - “Slower to purchase new technology; renegotiating implant contracts.”
 - “More difficult to replace broken instruments and equipment.”
 - “We are having trouble meeting budget due to increased cost of implants.”
 - “Administration/finance are becoming more involved in supply chain management.”
- Some have seized the opportunity to take a new look at how they do things. They are working on Lean and Six Sigma projects, increasing the staff's awareness of fiscal stewardship, and working with surgeons to decrease par levels for supplies. “Able to make changes which were difficult in the past—incentive for everyone to be more efficient and effective,” one person wrote. ♦

—Pat Patterson

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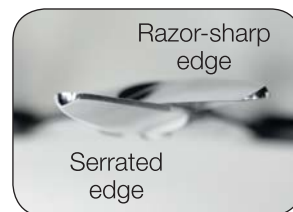
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Flu advice is stressing vaccinations

The government and health care system are gearing up for an outbreak this fall of the H1N1 virus in addition to seasonal flu. Officials offered advice in an August 20, 2009 call hosted by the Department of Health and Human Services.

Health care workers are among 5 initial target groups for the H1N1 vaccination program to begin around October 15. The groups in no order of priority are:

- pregnant women
- household contacts and caregivers for infants <6 months of age
- health care and emergency medical services personnel
- persons aged 6 months to 24 years
- persons aged 25 to 64 with health conditions placing them at higher risk of flu complications.

Contraindications are the same as for the seasonal flu vaccine.

The government is making the vaccine and related supplies available to providers at no charge.

“
**Stay home
when sick.**
”

Get flu shots, clean hands

The Centers for Disease Control and Prevention (CDC) is emphasizing the need for health care workers to be vaccinated for both H1N1 (2 doses) and seasonal flu (1 dose). The Joint Commission is challenging facilities to reach a vaccination rate of 65% to 90%—much better than the 42% in 2005-2006. The commission requires hospitals to offer flu vaccine on-site (www.jcrrinc.com/FLUChallenge/).

Some states are taking an aggressive stance. New York State is requiring health care workers to be vaccinated, saying it is a “patient safety issue.” In California, health care workers who opt out of flu shots must

sign a form declining the vaccine.

Hand hygiene is another major focus, both in health care and in the community.

Employers are encouraged to tell their health care workers to stay home when sick. In communities with H1N1 flu, the CDC says health care personnel with a fever and respiratory illness should stay out of work for 7 days or until symptoms resolve.

Infection control

The CDC’s interim infection control guidance for H1N1, issued in May 2009, was still in effect in late August. An updated guidance is expected, but when is not known.

The interim guidance considers H1N1 a “novel” flu virus. The CDC is still studying whether H1N1 is spread primarily through droplet transmission (ie, by sneezing and coughing) like seasonal flu or also via the airborne route. The flu is also spread by contact with contaminated surfaces.

For that reason, the interim guidance is conservative, recommending fit-tested N95 respirators for workers entering rooms of patients isolated for H1N1 flu and for aerosol-producing procedures like bronchoscopy, which should be performed in a negative-pressure room.

The updated H1N1 guidance is expected to place more emphasis on other precautions and less on respirators, a CDC official said during the call. Among other measures are screening patients for signs and symptoms and separating those with respiratory conditions. ❖

Flu websites

www.flu.gov

Main site for the health care community, employers, and others.

www.cdc.gov

Click on the H1N1 link at the top of the page.

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A leader's passion for patient safety

Creating a culture where patient safety is valued as the top priority by all and fostering an atmosphere of open dialogue. Those are twin passions of Elena Canacari, RN, CNOR, this year's OR Manager of the Year.

For 6 years, Canacari has been director of perioperative services at 621-bed Beth Israel Deaconess Medical Center, a Level 1 trauma center and Harvard teaching hospital in Boston. Her scope of responsibility spans 2 campuses and includes 40 ORs, 3 postanesthesia care units, preadmission testing, OR scheduling, central processing, and a business unit with a total of more than 500 FTEs. She came to New England Deaconess Hospital in 1970 and later worked at Beth Israel. The two hospitals merged in 1997.

Integrity and trust

The 14 nominating letters from colleagues describe a leader who has "an innate sense of professionalism, team leadership, even-handedness, and equity at all times," as the chief of general surgery, Mark P. Callery, MD, wrote.

"I simply could not do my job without Elena's advice, tutelage, expertise, wisdom, skill, sweat equity, and business savvy," wrote Malcolm M. DeCamp, MD, the chief of cardiothoracic surgery. He describes Canacari as "the 'glue' that holds the entire surgical enterprise together."

"Elena's every word and action is grounded in integrity and trust. She offers strength and support during change with a clear focus and direction," said Barbara DeTullio, RN, BSN, MA, nurse manager of the East and West ORs, and Susan Dorian, RN, MSN, nurse manager of the perianesthesia areas.

"No one does this alone," says



Elena Canacari, RN, CNOR

Canacari, who credits a strong team of staff, managers, and physicians with helping her to manage such a huge job skillfully. She also cites experience gained through a range of major projects. A few examples are moving acute care services from one campus to the other, standardizing and integrating procedure-based delivery systems and preference lists for the merged organization, and opening 3 new ambulatory surgery units. Adding to her background are a National Patient Safety Leadership Fellowship, contributions to national position statements for AORN, and service with the local AORN chapter.

A 'burning platform'

Asked what she is proudest of, Canacari cites the department's response to a wrong-site surgery a year and a half ago. That event, she says, created a "burning platform" that renewed efforts to create a united effort on patient safety.

"Elena took charge, rallying the entire hospital community to improve community and safety," wrote David S. Chapin, MD, of the Department of Obstetrics & Gynecology.

Marsha Maurer, RN, MS, senior vice president, patient care services, and chief nurse, says Canacari "helped spearhead substantial changes to our time-out process," including implementing a standard "scripted" time-out throughout perioperative services. Part of that was making sure the entire team is engaged and pauses for a "moment of reverence" before the incision.

Among other safety initiatives Canacari has fostered:

- a weekly huddle with the chiefs of each surgical division and senior administrators to bring up safety issues
- a patient safety task force, including anesthesia providers, surgeons, and OR staff
- quarterly patient safety grand rounds attended by some 450 anesthesia providers, surgeons, and staff.

Attributes of leadership

What attributes does Canacari think have served her best in managing her complex responsibilities? She says it's important to take time to listen and reflect.

"I've been thoughtful before assuming a new role and have made sure I had the full support of my family," she says.

Day-to-day, she tries not to be reactive to situations but "to listen, think, and be reflective" before taking action.

Canacari holds a diploma in nursing from Cambridge City Hospital, Cambridge, Massachusetts. Her perioperative nursing career began more than 40 years ago when, as a new graduate nurse, she was assigned to the OR. She learned that she loved it and has risen to become a successful perioperative leader. ❖



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Hospital bottom lines recover in Q1

Hospital finances rebounded in the first quarter of 2009, according to one source. Thomson Reuters data reported in August 2009 found total margins were up. About 30% of hospitals were in the red, which though still bad, was a big improvement from 50% in the third quarter of 2008.

The median total margin rose to 3.1% in the first quarter from 0.17% in the third quarter.

Hospitals, like the rest of the nation, faced a financial crisis last year, with large drops in investments, difficulty obtaining credit, and worries about a decline in volume.

In response, they pulled back on spending.

The cost control has been “astounding,” David Koepke, PhD, coauthor of the Thomson Reuters report, told *OR Manager*. “As far as the data go back, we do not show the extent of cost control that is happening now.”

Spending increases were held to near 0 for the first quarter. Labor cost increases were below inflation, and supply costs were up a fraction.

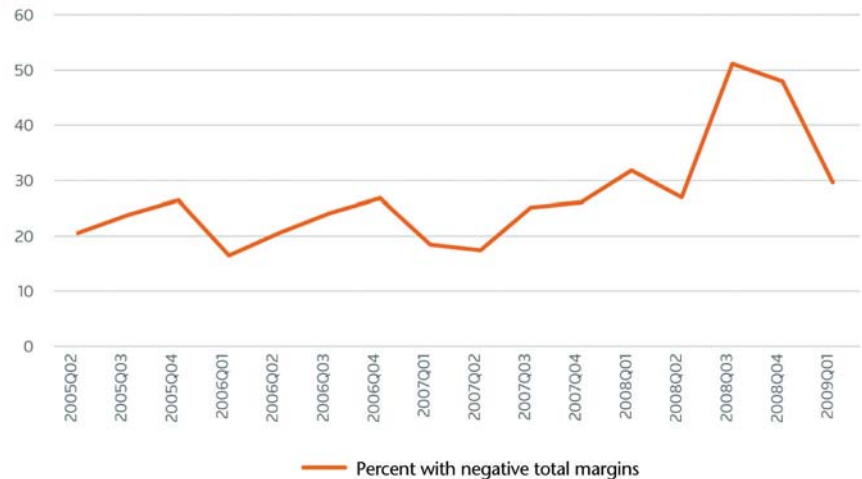
Still, “I don’t think we’re out of the woods,” commented Richard Gundling, vice president of the Healthcare Financial Management Association.

Cost cutting, including layoffs and other savings, may have improved bottom lines, but “I’m not sure that’s sustainable,” Gundling said.

Thomson Reuters found wide variations in hospitals’ financial health. Those in the bottom quartile had total margins of -1% or less, while the top quartile had margins of 7% or more.

The data are from 522 acute-care hospitals that submit benchmarking, with results weighted to be rep-

Percent of hospitals with negative total margins, Q2 2005-Q1 2009



US hospitals’ total margins, which plunged to historic lows in the last half of 2008, recovered substantially in the first quarter of 2009. Half of hospitals had negative margins in the third quarter of 2008, declining to around 30% in the first quarter of 2009. Source: Thomson Reuters, August 2009. Reprinted with permission.

resentative of US acute-care hospitals in general. The report does not collect data specifically about surgery.

Effect on elective surgery?

So far, other Thomson Reuters databases have not shown the recession has had much effect on elective surgery.

Only recently, in June and July, has the company seen a downward trend in volume for elective procedures such as screening colonoscopy and knee arthroscopy. “Though hospitals are claiming big decreases in the popular press, this is the first time we have seen real evidence,” Koepke said.

In contrast, the American Hospital Association in a March 2009 survey of its members found 59% had seen a moderate to significant decrease in elective procedures compared with 2008.

In the 2009 *OR Manager* Salary /

Career Survey, 30% of respondents reported a decrease in surgical volume, compared with 24% in 2008 (related article).

Earlier in the year, a consumer survey by Thomson Reuters found that quite a few people said they were deferring care. That did not show up in the data until this summer. Even then, Koepke said the trend was not strong.

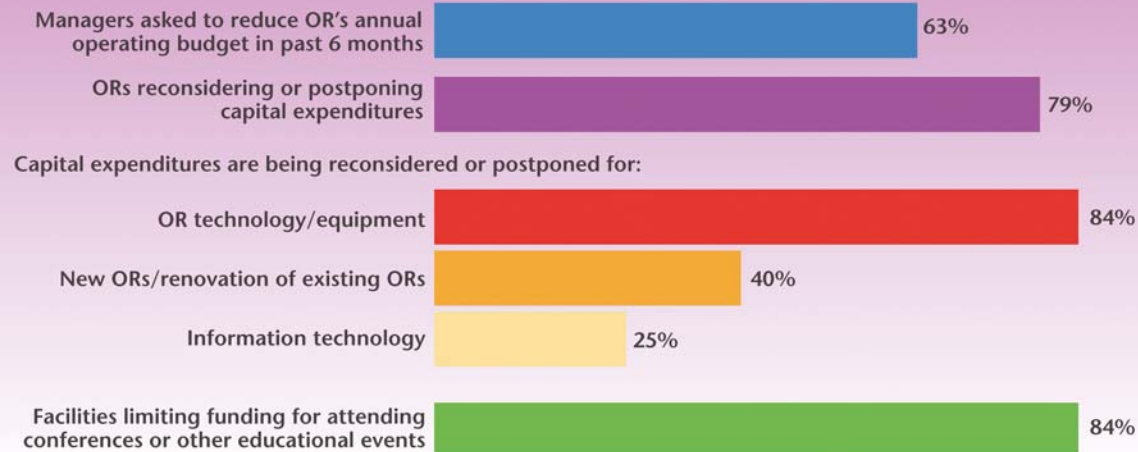
Nor has the data on bad debt shown much change. Charity care was up, but that trend started before the recession. Bad debt and charity care were expected to rise as more people lost their jobs and insurance coverage.

There was some decline in inpatient volume, but Koepke said a trend was hard to discern.

The benchmarking data are reported overall and for 5 classes of hospitals: small, medium, and large community hospitals and 2 groups of teaching hospitals. ❖

Salary/Career Survey

OR impact of economic downturn



Respondents to hospital survey

Region	Response
Northeast	13%
Midwest	42%
South	30%
West	16%

Continued from page 1

Much pressure to reduce costs—variance meetings very intense.”

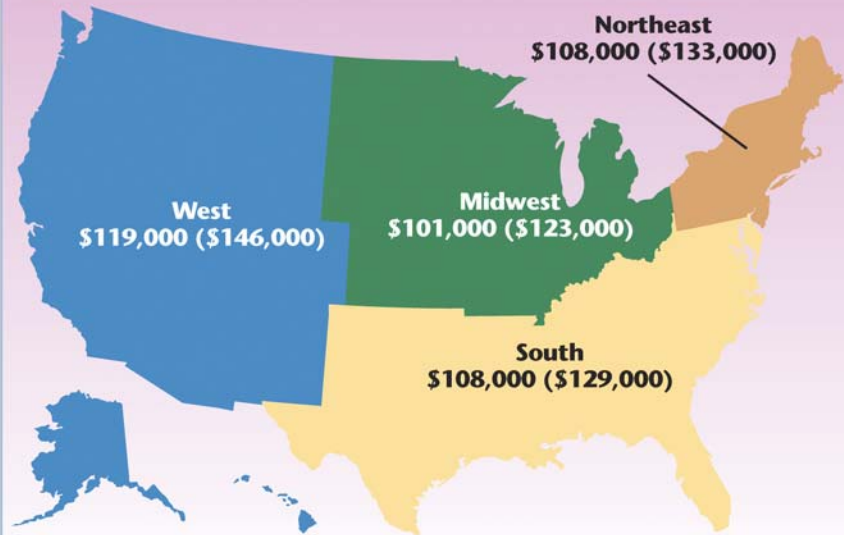
For the 63% of respondents who were asked to cut their annual operating budget, the average reduction was 7%.

Those who manage more ORs were significantly more likely to have had to make cuts (66% of those who manage 10+ ORs and 67% for those responsible for 5-9 ORs) compared with those who manage 1-4 ORs (48%).

Not everyone has financial difficulties. “The hospital has had good OR margins in the past few years and [the margins] are financially good at this time,” one nurse leader commented.

Purchasing cuts and delays. Capital equipment budgets have

Average annual salary (and total compensation) by region



Note: Total compensation includes wages/salary plus bonuses, insurance, pension, etc.

been targeted. “Not able to order needed capital equipment,” said one OR manager. “We are postponing...some needed acquisition of capital assets, ie, anesthesia machine, autoclave,” said another.

Those managing 10+ ORs were significantly more likely (87%) to be reconsidering or postponing capital purchases compared with those responsible for 5 to 9 ORs (73%) or 1 to 4 ORs (67%).

OR technology/equipment suf-

ferred the most from belt tightening, cited by 84%, followed by OR renovation and new construction (40%), and information technology (25%).

Loss of benefits. For the 19% who lost benefits, the loss was fairly consistent by job title, number of ORs managed, type of hospital, and geography. Benefits affected were compensation, retirement contributions, insurance benefits, and education.

Several reported their pay has

Salary/Career Survey

OR managers' purchasing clout

Do you influence the selection and purchase of...

OR supplies/equipment	90%
OR capital equipment	82%

been reduced. Others said raises or merit increases were being held. Bonuses either weren't paid or were harder to earn for some.

A number said employers' contributions to 401(k) or 403(b) retirement funds were reduced or eliminated, at least for this year. Some said health insurance premiums and copays have been raised.

Education is also suffering. Managers reported loss or suspension of tuition reimbursement and travel for meetings.

"[We] have freezes on travel for staff, management," wrote one person. Another reported no educator resources, including "no educator, no CNS [clinical nurse specialist], no approval for conferences."

Larger facilities (89% for 10+ ORs and 88% for 5-9 ORs) were significantly more likely to have limited funding for conferences or other educational events, compared with facilities with 1-4 ORs (62%).

Salary facts

Hospital-based OR managers and directors now earn an average salary of \$107,000, compared with an average of \$102,000 in 2008 and \$99,000 in 2007. Salaries are highest in the West (\$119,000). Those in teaching hospitals earn an average of \$18,000 more than their community hospital counterparts.

OR leaders with a more senior title continue to earn more, with

Average annual salary and total compensation

By number of ORs	Annual salary	Total compensation
1-4 ORs	\$86,000	\$103,000
5-9 ORs	\$102,000	\$124,000
10+ ORs	\$118,000	\$143,000
By facility type		
Community	\$102,000	\$124,000
Teaching	\$120,000	\$144,000
By title		
Admin/admin director	\$125,000	\$151,000
Director	\$101,000	\$123,000
Nurse manager	\$90,000	\$109,000

administrators and administrative directors earning an average of \$125,000, compared with \$101,000 for directors and \$90,000 for managers.

The average salary increase was 3.7% (4.3% in 2008 and 2007).

Salary increases by region

West	4.3%
South	3.9%
Northeast	3.6%
Midwest	3.3%

Total compensation

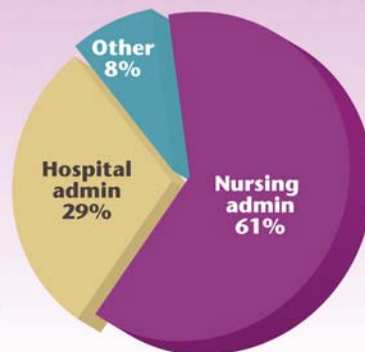
Once bonuses, insurance, pension, and other benefits are added, the average compensation is \$129,000 (\$124,000 in 2008; \$121,000 in 2007). More than one-fourth (29%) earn between \$100,000 and \$124,999, while 19% earn between \$150,000 and \$199,999. Only 6% earn more than \$200,000, and less than 1% are paid less than \$70,000 a year.

Benefits

The most common benefits are:

Health insurance	94%
Dental insurance	90%
Life insurance	87%

To which office or department do you report?



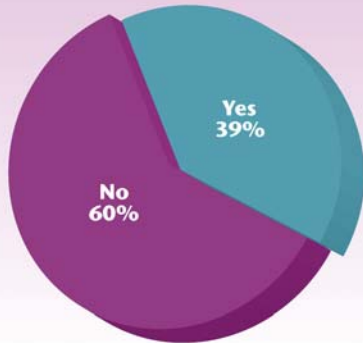
401 (k) retirement plan	86%
Tuition reimbursement	84%
Disability insurance	82%
Dependent health insurance	71%
Eye care	70%
Educational benefits	58%
Pensions	48%

All respondents receive paid time-off, with an average of 29.9 days.

Continued on page 12

Salary/Career Survey

Did you receive a monetary bonus or profit sharing during the past 12 months?



Continued from page 11

A total of 39% receive bonus or profit sharing as part of their total compensation, with an average amount of \$6,440. Monetary incentives are most common in the West, with 48% of respondents reporting them, compared with 30% in the South, 34% in the Midwest, and 46% in the Northeast.

Vacancies and job hunts

Though vacancies for OR managers and directors are perceived to be high, only 6% of respondents report management positions are vacant. The average length of a vacancy is 8.9 months.

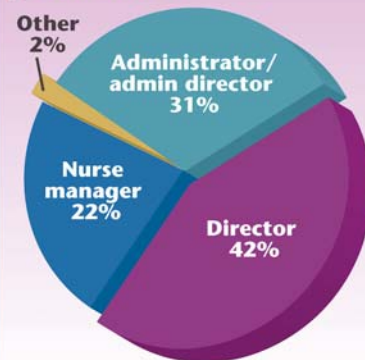
Only 4% are actively seeking a new job, and 15% are considering a new job search. OR leaders in teaching hospitals are significantly more likely to want to stay put: 92% aren't considering a job search, compared with 77% for those in community hospitals.

Nurse managers are significantly more likely than directors (22% vs 9%) to be considering a new job search, with 15% of administrators or administrative directors considering this option.

Where you work

Most (72%) respondents work in

What best describes your title?



community hospitals, with 24% in teaching hospitals. The average number of licensed beds per hospital was 288.

Hospital location for respondents is evenly split:

Suburban	34%
Rural	33%
Urban	32%

About your role

Here is a closer look at titles, reporting structure, and elements reflecting span of control.

Title and work area. Most respondents report their title as director (42%), followed by administrator or administrative director (31%) and nurse manager (22%).

Most (52%) administrators or administrative directors refer to the area they oversee as perioperative services, followed by surgical services (45%) and operating room (3%). Director titles are evenly split (42% each) between perioperative services and surgical services, followed by operating room (17%). Nurse managers' titles more frequently (45%) include the term "operating room," followed by surgical services (39%) and perioperative services (16%).

Organizational structure. About two-thirds of respondents (61%) report to nursing administration,

Which other departments report to you?

Postanesthesia care	76%
Central processing	65%
Outpatient/same-day surgery	65%
Preadmission services	57%
GI/endoscopy	55%
Anesthesia support personnel	49%
Materials management for OR	45%
Perfusion services	19%
Pain management	18%
CRNAs	11%
Cardiac cath lab	4%
Inpatient unit	4%
Emergency room/trauma services	3%
ICU	2%

Others mentioned: Scheduling (2%), preop unit (2%), and wound care (2%).

while 29% report to hospital administration. Those who manage 10+ ORs are significantly less likely to report to nursing administration.

OR leaders reporting to nursing administration

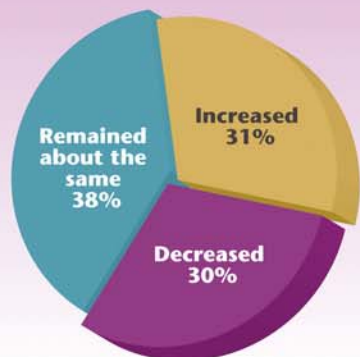
10+ ORs	52%
5-9 ORs	78%
1-4 ORs	67%

Those in community hospitals are more likely (65%) to report to nursing administration compared with those in teaching hospitals (49%).

Scope of responsibility. More than three-quarters (77%) have responsibility for the OR and other departments within one hospital; 14% oversee only the OR in one hospital, and 9% manage the OR and other departments at multiple facilities.

Salary/Career Survey

Has surgical volume increased?



The 5 most common departments managed are postanesthesia care, central processing, outpatient/same-day surgery, preadmission services, and GI/endoscopy.

Money talk. OR leaders' financial responsibilities remain impressive. On average, respondents oversee an annual operating budget of \$24 million, with 32% reporting \$10 million or more.

Administrative directors managed the highest budget levels, followed by directors, and managers.

Average annual OR budget managed

Operating	\$24 million
Capital	\$1.8 million
Personnel	\$5.3 million

Surprisingly, many respondents did not know the size of their budget or chose not to answer this question.

People power. OR managers and directors directly or indirectly oversee an average of 102 clinical and 25.1 nonclinical FTEs, with a total average of 127 FTEs.

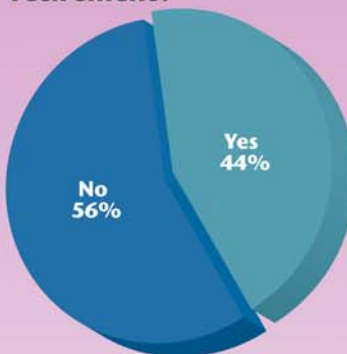
Long hours. Considering the workload of respondents, it's not surprising that respondents report working an average of 52.7 hours a week. About a fourth (23%) say their workweek is 60 hours or

Continued on page 14

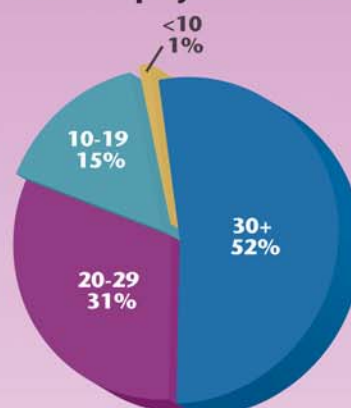
Nearly half postpone retirement

The economic downturn has led to second thoughts about retirement. Four in 10 survey respondents are putting off their plans to stop working. Still, more than half plan to be out of the job market in 10 years.

Has the economic downturn caused you to postpone retirement?



Years employed in nursing

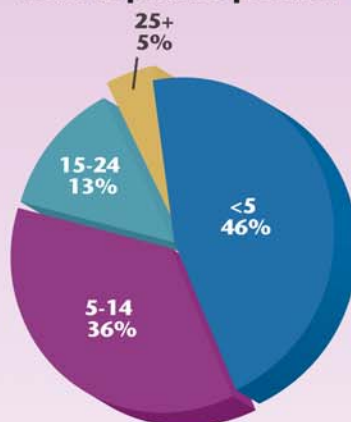


Average = 28.6

In what year do you plan to retire?

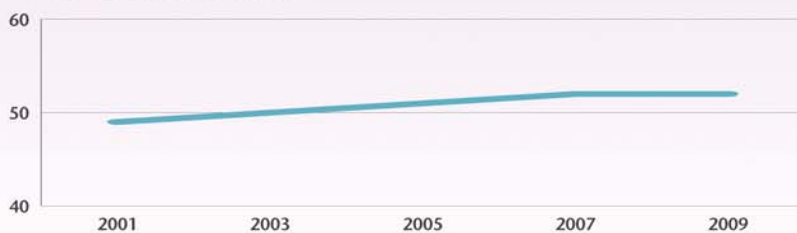


Years in present position



Average = 8.3

Average age increases



Salary/Career Survey

How many clinical FTEs are under your span of control?

	By type of facility		By number of ORs			By title		
	Community	Teaching	1-4	5-9	10+	Admin director	Director	Manager
Clinical	80.0	171.1	30.0	59.0	157.0	150.0	91.0	55.0
Nonclinical	18.0	46.4	11.8	10.4	39.0	36.2	21.9	15.6

What is the annual budget for the ORs (in millions)?

	By type of facility		By number of ORs			By title		
	Community	Teaching	1-4	5-9	10+	Admin director	Director	Manager
Operating	\$19.2	\$30.1	\$6.0	\$8.8	\$36.8	\$36.7	\$18.3	\$13.8
Capital	\$1.1	\$3.5	\$0.3	\$0.9	\$2.7	\$2.1	\$1.6	\$1.2
Personnel	\$4.2	\$8.0	\$1.4	\$2.9	\$7.5	\$7.7	\$4.3	\$3.1

Continued from page 13

more. Only 7% of respondents work an average of 40 to 44 hours.

Purchasing power. All of the OR managers and directors who responded to the question about purchasing influence wield significant power, with 90% reporting they influence the selection and purchase of OR supplies and equipment and 82% influencing capital equipment decisions.

Most involvement is through membership on a decision-making committee or team (55%) or a value-analysis team (44%). Value-analysis teams are significantly more common for those managing 10+ ORs (64%) compared with those who manage 5-9 (57%) or 1-4 ORs (22%).

In all, 36% of respondents say they are the primary decision maker on purchases, and 33% serve in an advisory capacity. Those in community hospitals are significantly more likely than teaching hospital counterparts to be primary decision makers (40% vs 22%).

About your OR

Respondents manage an average of 14.7 ORs, with administra-

How many sites do you manage?

	By title		
	Admin director	Director	Nurse manager
OR only within one hospital	5%	9%	31%
OR & other depts within one hospital	76%	81%	69%
OR only at multiple sites	1%	0%	0%
OR & other depts at multiple sites	15%	9%	0%

tors and administrative directors responsible for significantly more (20.7 ORs) than those with other titles: 11.4 for directors and 12.9 for nurse managers.

The average annual case volume is 9,120 and, not surprisingly, size correlates with volume.

Annual surgical volume by number of ORs managed

1-4	3,610
5-9	5,840
10+	13,140

Increases in surgical volume have slowed, with 31% reporting a higher number of cases in the past 12 months compared with 39% in 2008 and 40% in 2007. Nearly a third (30%) report a decrease, com-

pared with 24% last year, and 38% report volume stayed about the same (36% last year).

Incentives to improve the bottom line. About a fourth (24%) of OR managers and directors say their facility has a plan for rewarding the staff financially for performance improvements or cost reductions. Teaching hospitals are more likely to have these plans than community hospitals (28% vs 23%).

About you

Women continue to dominate the field of OR management (87%), as do RNs (97%).

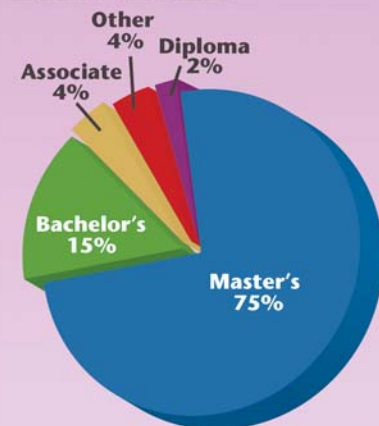
Age and retirement. At 52.3 years, the respondents' average age is unchanged from 2008. Only 14% are 44 years old or younger.

The average year planned for re-

Salary/Career Survey

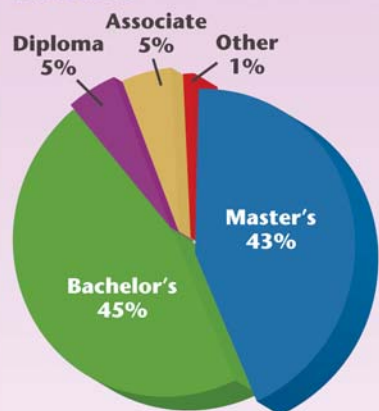
Highest degree

Admin directors



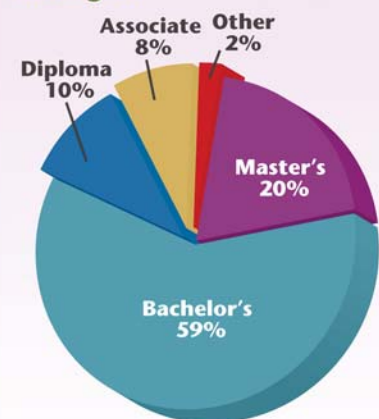
Note: n = 82

Directors



Note: n = 116

Managers



Note: n = 61

tirement is 2021, compared with 2018 in 2008. OR leaders remain a seasoned cadre, with an average of 28.6 years in nursing and 8.3 years in their current positions.

Education. Managers and direc-

tors are most likely to have a master's degree as their highest level of education, with 24% reporting an MS or MSN, and 11% reporting an MBA.

Most (78%) managers and directors say a specific degree is required for their position. The most common degree required is the bachelor's (58%), but title and location play a role.

Most common degree required by position

Admin/admin dir:	Master's 63%
Director:	Bachelor's 66%
Nurse manager:	Bachelor's 89%

Teaching hospitals are significantly more likely than community hospitals (59% vs 34%) to require a master's degree.

A final thought

OR leaders face challenges in these harsh economic times, but one respondent had this perspective: "[The] economic downturn is only a small part of my OR's opportunities—everyone needs to be smart and prudent in their financial spending. Would you do any less at home?" ♦

—Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer in Columbia, Maryland.

Thank you

OR Manager thanks the respondents who took time to complete this year's survey. We appreciate your part in gathering this information, which will be useful to your colleagues around the country.

Proposals invited for 2010 conferences

Share your successes at the 2010 OR Manager conferences:

Managing Today's OR Suite

September 29 to October 1, 2010, Orlando

OR Business Management Conference

May 12 to 14, 2010, San Francisco

Submit your proposal for a 75-minute breakout or a full-day preconference seminar at www.ormanager.com

Deadline is Nov 2. Questions? E-mail Judy Dahle, RN, MS, education coordinator, at jdahle@ormanager.com or call 1-877/877-4031.

Honor colleagues with a donation

Honor the perioperative professionals on your surgical team. November 8 to 14 is Perioperative Nurse Week, a week set aside to recognize and honor perioperative nurses for their important role and commitment to safe patient care. The AORN Foundation suggests honoring colleagues by making a donation to the Foundation in their name. An acknowledgment note will be sent to each colleague honored through a donation to the Foundation.

The AORN Foundation is the philanthropic arm of AORN. The Foundation advances surgical patient safety by supporting nurses through education and research.

Make your honorary gift online at www.AORN.org/AORNFoundation or contact 800/755-2676 ext 230.

Reprocessing safely in all settings

Procedures requiring sterilized or high-level-disinfected instruments are performed daily in a variety of settings—hospitals, freestanding and hospital-affiliated ambulatory surgery centers (ASCs), physicians' offices, clinics, endoscopy suites, and dental facilities.

Accreditation surveyors are looking closely at reprocessing in these facilities.

Medicare's new ASC interpretive guidelines for surveyors issued in May 2009 have detailed guidelines on infection control, supporting the updated ASC Conditions for Coverage (CfCs). Also, the Joint Commission recently said it will scrutinize the entire process of steam sterilization rather than focusing mainly on flash sterilization.

Sterilization & Infection Control



This article includes observations about how ambulatory facilities can adapt the major sterilization standards and recommended practices to their settings. We also offer considerations based on our consulting experience.

Two constants

Like hospitals, many ambulatory facilities have been designed to facilitate efficiency and comply with standards and recommended practices. They may have state-of-the-art instrument processing equipment and be staffed with experienced and competent sterile processing personnel.

Others are converted offices, homes, or apartments that have

Consider how to organize work flow.

limited space, and staff have little or no experience in instrument processing. Cleaning is done manu-

Related article, page 25

ally, sterilization is usually accomplished in a table-top gravity steam sterilizer, and high-level disinfection is not automated.

Two factors, however, are constant regardless of the setting:

- Personnel want to provide safe patient care using instruments that have been properly processed.
- The standards and recommended practices for high-level disinfection and sterilization do not differentiate by practice setting but are adaptable to facility resources.

That is true for the Association of PeriOperative Registered Nurses (AORN) Standards and Recommended Practices and the Association for the Advancement of Medical Instrumentation (AAMI) *Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities*. For example, AORN's Recommended Practices for Sterilization state, "Policies and procedures will reflect variations in practice settings and/or clinical situations that determine the degree to which the recommended practices can be implemented."

Adapting your facility

For instance, a facility with

space for only one instrument processing area will not be able to dedicate one room under negative pressure to decontamination processes and another under positive pressure for packaging and sterilization. But it is possible to separate the decontamination and disinfection or sterilization functions by time and space.

Separation by time is accomplished by not decontaminating and sterilizing or disinfecting at the same time. Instruments should be sterilized or high-level disinfected during a time when decontamination is not being done.

To separate these functions by space, the work flow should flow from dirty or contaminated to clean; eg, cleaning followed by packaging followed by sterilization. For example, if there are 2 countertops in the instrument processing area, one should be dedicated to decontamination and the other to packing and sterilization. If there is only one countertop, the end near the sink should be dedicated to decontamination, and the other end should be dedicated to packaging and sterilization. Ideally, the sterilizer should be located at the end of the counter farthest from the sink and after the packaging area.

To separate the decontamination area from the clean area, a Plexiglas partition may be installed on the countertop. Decontamination can be carried out on one side of the partition, and instruments can be packaged and sterilized on the other side.

Key areas to check

These are the more common knowledge deficits and areas needing improvement or education this

Sterilization & Disinfection

consultant has observed. They are not all-inclusive. Consult the AAMI and AORN documents for a thorough understanding of standards and recommended practices.

Key considerations:

- Personnel cleaning instruments should wear personal protective equipment; ie, a liquid-resistant covering, utility gloves, and eye protection. This applies when cleaning even one instrument.
- The sink used for cleaning instruments should not be used for handwashing.
- Contaminants should be contained—used instruments should be transported or carried to the decontamination area in a covered container marked with a biohazard label or at least contained in a towel or drape.
- Instruments should be disassembled where appropriate and washed as soon as possible. If unable to clean immediately after a procedure, spray instruments with presoak solution and store them in a covered metal tray or other closed container also marked with a biohazard label.
- Wiping instruments or containment devices with a germicidal wipe is not a substitute for cleaning. Instruments and containment devices should be washed with a detergent intended for this purpose, and the detergent should be prepared strictly according to manufacturer's instructions.
- Household cleaners are not suitable for instrument cleaning.
- Instruments should be thoroughly dried before they are packaged.
- A chemical indicator should be placed inside all packages. If the inside indicator is not visible from the outside, a chemical indicator should be affixed to the

Surveyors will look at reprocessing.

outside as well. The external and internal indicators are different. The external indicator should be a Class 1 indicator. The internal one should be either a Class 3 or 4 indicator or preferably a Class 5 integrating indicator or a Class 6 emulating indicator. The AAMI standard has detailed recommendations on indicators.

- Chemical indicators do not demonstrate sterility. Class 1 indicators are designed to indicate that the package was processed. Class 3, 4, 5, and 6 indicators are designed to indicate that some or all of the parameters have been met.
- Packages should be labeled with the date of sterilization. When a marking pen is used on a peel pouch, the writing should be on the plastic side only.
- The efficacy of the sterilizer should be monitored at least weekly using a biological indicator (BI) appropriate for the sterilizer and cycle. A BI is different from a chemical indicator. A BI is a test system containing viable microorganisms providing a defined resistance to a specified sterilization process (eg, steam sterilization). The test system is subject to a sterilization cycle and then incubated. No growth indicates the sterilizer is effective. Instructions for use guide the user through the process of monitoring.
- A biological indicator must be

used with all loads containing an implant.

- Companies that sell chemical indicators and BIs can be located on the internet. Some ambulatory facilities contract with an outside company that will incubate the BI and provide the results.
- BI monitoring results should be documented.
- There should be a written policy and procedure describing actions to take when a BI test indicates sterilization failure.
- High-level disinfection is not the same as sterilization. It should not be referred to as "cold sterilization." High-level disinfection kills all microorganisms (except prions) but does not kill high numbers of spores. Sterilization kills all microorganisms (except prions) and kills high numbers of spores.
- High-level disinfection is appropriate for flexible GI endoscopes but not for surgical instruments used in a sterile procedure or for instruments that are intended to contact normally sterile areas of the body.
- Processing of GI endoscopes is a complex process. Instructions for processing should be readily available—preferably with an instructional DVD and a laminated poster in the processing area.
- Personnel responsible for processing must have demonstrated competency.
- High-level disinfectant solutions should be labeled with the date the solution was activated or poured into the container and the date it expires.
- High-level disinfectant solutions should be tested before each use to determine that the minimum effective concentration is present.

Continued on page 18

Sterilization & Disinfection

Continued from page 17

- Strips used for testing must match the product being tested. Strips are not interchangeable. Some test strips require that a quality control test be performed on each package/bottle of strips prior to using them. Results of the quality control testing should be documented.
- Although a high-level disinfectant may pass the minimum effective concentration test after the expiration date, the solution should be discarded once the expiration date is reached.
- Results of high-level disinfectant testing should be documented.
- An eye-wash station should be present and an eye-wash station sign posted in any facility using high-level disinfectants.
- Processed GI endoscopes should be stored by themselves in a closet or other closed-off area. They should be stored hanging, not coiled.
- Sterilized packages/items should be stored only with other sterile items. If storage space is extremely limited, sterile items may be stored on one shelf of a cabinet and clean supplies stored on another shelf.
- Supplies should be stored away from potential sources of contamination such as sinks, pipes, and window sills. Nothing should be stored on the floor. Sterile items should be stored at least 8 inches above the floor and at least 18 inches below the ceiling or sprinkler heads.

Reviewing these areas as well as the complete standards and recommended standards will help ambulatory managers not only to prepare for surveyors but also to confirm that their practices for sterilization and disinfection are state of the art. ❖

“
**Nothing should
be stored on
the floor.**
”

—Cynthia Spry, RN,
MA, MSN, CNOR

Independent Clinical Consultant

References

Association for the Advancement of Medical Instrumentation. *Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities*. ANSO/AAMI ST79:2w006, Arlington, VA: AAMI, 2006, 2008. www.aami.org

Association of periOperative Registered Nurses. *Perioperative Standards and Recommended Practices*. Denver: AORN 2009. www.aorn.org

Centers for Medicare and Medicaid Services. CMS Manual System. Pub 100-07 State Operations Provider Certification. Revised Appendix L. *Interpretive Guidelines for Ambulatory Surgery Centers*. Ref S&C-09-37. Available at <http://ascassociation.org/coverage/>

Joint Commission. Steam Sterilization: Update on the Joint Commission's Position. June 15, 2009. www.jointcommission.org/Library/WhatsNew/steam_sterilization.htm

**Do you have a question
on sterilization and
infection control?**

Send questions to
Pat Patterson, editor, at
ppatterson@ormanager.com.
We'll consider them
for the column.

Invitation: Surgical supply chain study

An academic study, “Supply Chains and the Surgical Suite: Measuring the Impact of Best Practices on Financial and Operational Performance,” is being conducted by two business professors.

The study examines supply chain implementation, best practices on reducing costs, improving efficiencies, and maximizing throughput in the surgical suite.

The study is in the data collection phase. Hospitals are being recruited to participate in assessments through November 2009.

Study measures

The study includes measures that identify the degree to which a hospital surgical suite has implemented a portfolio of supply chain practices such as clinical collaboration, process automation, case cart management, surgical tray and instrumentation tracking, inventory monitoring, off-site sterile processing, surgical suite information systems, order tracking, custom procedure packs, inventory systems, and distribution models.

Leading the study are Vicki Smith-Daniels, PhD, of Arizona State University, Tempe, and Dwight Smith-Daniels, PhD, of Wright State University, Dayton, Ohio.

To participate, 2 informants—one from supply chain and the other a clinical surgical manager—complete an online survey that takes 45 to 60 minutes.

Participating hospitals receive a benchmark report and copies of other publications.

If you are interested, please contact Vicki Smith-Daniels at vicki.smith-daniels@asu.edu or 480/229-4202. ❖



Ambulatory Surgery Centers

Salary/Career Survey

ASCs: A third feel the economic pinch

Though many managers of ambulatory surgery centers (ASC) report their facilities are feeling the pinch from the economic downturn, salaries are stable or slightly higher than 2008, according to results of the 19th annual *OR Manager Salary/Career Survey*.

Nearly a third (31%) of managers say the recession has caused financial difficulties for their ASC, and 32% have been asked to cut their annual operating budget. Almost half (44%) are reconsidering or postponing capital expenditures, 42% have seen cuts in education funding, and 9% have lost some benefits in the past 6 months.

On the plus side, ASC managers' salaries are slightly up from last year—the average total compensation package is \$98,600, compared with \$93,200 in 2008. Managers also score their job satisfaction high—an average of 4.2 out of a possible 5.

Those are highlights from the 19th annual *OR Manager Salary/Career Survey*. The survey was mailed in April to 1,000 ASC managers, including *OR Manager* subscribers and an external list, with 259 returned for a response rate of 26%. The margin of error is ± 5.3% at the 95% confidence level. Readex Research conducted the survey. Any significant changes in the data reported here have a confidence level of 95%. Results from the staffing portion of the survey appeared in the September issue.

Economic effects

ASCs have not been affected by the economic downturn as severely as hospitals. Of the 31% of managers who report financial difficulties, there is little variation by geography, type of ownership, and number of ORs. One exception: more than half (56%) of hospital-owned ASCs report financial troubles, compared with 38% for corporate-owned, 29% for physician-owned, and 23% for joint-venture facilities.

How impact is being felt. Of the 80 respondents who reported financial difficulties, 90% have had declines in elective surgery, 39% have seen changes in Medicare reimbursement, and 13% noted the lack of available credit. The results were consistent across location, type of ownership, number of ORs, and single vs multispecialty.

Budget. Of the 84 managers who have been asked to reduce their annual operating budget, nearly half of those (42%) cut it by 10% or more; 37% did not specify a percentage.

Slightly less than half (44%) of ASCs are reconsidering or postponing capital expenditures, with OR technology/equipment the area most frequently (75%) affected, followed by information technology (34%).

Education. Many ASC managers who report not having financial difficulties are still experiencing the economic pinch when it comes to spending on education.

Respondents to ASC survey

Region	Response
Northeast	15%
Midwest	26%
South	38%
West	20%

Managers' span of control

Clinical FTEs	19.4
Nonclinical FTEs	4.2
Total FTEs	23.6

Nearly half (42%) of facilities have limited funding for attending educational events.

More than half (54%) reported reduced funding for education, 27% cited elimination of funding, and 29% noted a ban on travel.

Salary numbers

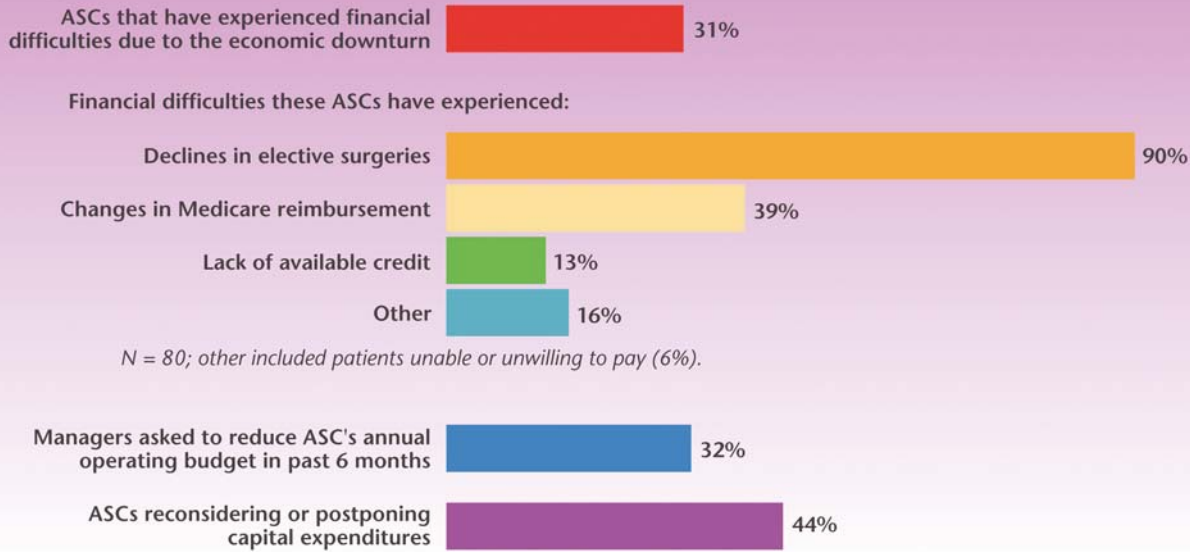
ASC managers earn an average of \$82,000, less than the \$107,000 average for hospital OR managers and directors. Salaries are slightly higher than last year and are highest in the West and the Northeast.

As in 2008, managers working in hospital-owned ASCs report the top average salary (\$94,100), and those in physician-owned ASCs report the lowest—\$74,200 compared with \$92,200 for both corporate-owned and \$86,000 for joint-venture centers.

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Salary/Career Survey

Impact of economic downturn on ASCs



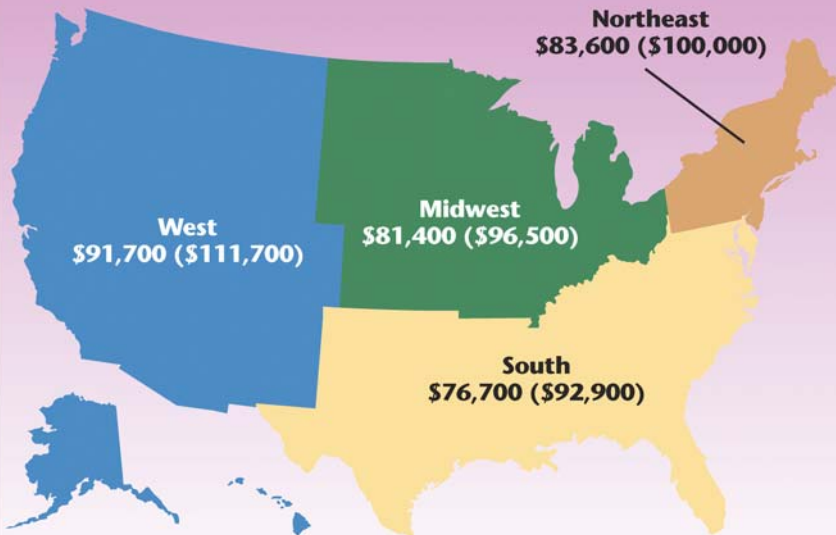
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Size still matters but not as much as in 2008. ASC managers in centers with 5 or more ORs earn an average of \$90,900, compared with \$79,000 for those in centers with fewer than 5 ORs, a gap of \$11,900 vs a gap of \$14,200 in 2008. The average salary for managers in multi-specialty ASCs was \$87,100, compared with \$74,000 for single-specialty centers.

On average, the ASC manager's total compensation package is \$98,600, with the highest reported in the West (\$111,700), followed by the Northeast (\$100,000), Midwest (\$96,500), and South (\$92,900).

As with salary, total compensation is higher in ASCs with 5 or more ORs (\$110,800) compared with those with fewer ORs (\$94,600). Multispecialty ASC managers earn more than single-specialty ones (\$103,800 vs \$90,500).

Average annual salary (and total compensation) by region



Note: Total compensation includes wages/salary plus bonuses, insurance, pension, etc.

ASC managers received an average increase in salary of 4.7%, higher than the 3.7% for hospital OR directors but slightly less than

Salary/Career Survey

Purchasing power

Do you influence the selection and purchase of...

OR capital equipment	73%
OR supplies/equipment	90%

What best describes your involvement in purchasing decisions?

Member of committee	46%
Primary decision maker	37%
Advisory capacity	31%

the ASC raises of 5% in 2008 and 5.1% in 2007. For only 11%, the increase was a result of a promotion or change in job responsibilities. Just 14% of respondents had not received a raise from their current employer.

Benefits

Benefits packages for ASC managers are leaner than for hospital OR managers. Only 54% of ASC managers, for example, have disability insurance, compared with 82% for hospital OR managers and directors.

	ASC	Hospital
Paid time-off	99%	100%
Health ins	86%	94%
401(k) plan	86%	86%
Life insurance	66%	87%
Dental ins	73%	90%
Disability ins	54%	82%
Eye care	54%	70%
Dependent health ins	46%	71%

In the past 6 months, the ASC's volume has...

	2009	2008	2007
Increased	19%	34%	45%
Decreased	30%	15%	14%
Remained about the same	51%	49%	39%

Average annual salary and total compensation

	Annual salary	Total compensation
By number of ORs		
<5 ORs	\$79,000	\$94,600
5+ ORs	\$90,900	\$110,800
By ownership		
Hospital-owned	\$94,100	\$109,400
Physician-owned	\$74,200	\$89,700
Corporate-owned	\$92,900	\$108,800
Joint venture	\$86,000	\$105,700
By title		
Administrator/admin director	\$92,300	\$114,200
Clinical director	\$84,400	\$99,900
Nurse manager	\$71,100	\$83,100

Education benefits	42%	58%
Tuition reimb	33%	84%
Pension	15%	48%

ASC managers have an average of 26.3 days off per year, including vacation, sick time, and holidays. More than three-quarters (79%) have bonuses or profit sharing as part of their total compensation—a considerably higher percentage than hospital OR managers and directors (39%).

Those who received monetary bonuses or profit sharing in the

past 12 months (70%) reported an average payment of \$6,640.

The manager's role

ASC managers oversee an average of 3.8 ORs, varying by type of ownership. Those in single-specialty centers oversee an average of 2.6 ORs, compared with 4.5 for those in multispecialty ASCs.

ASC managers supervise an average of 23.6 FTEs, including an average of 19.4 clinical FTEs and 4.2 nonclinical FTEs. Just under a third (30%) hold the title of admin-

Continued on page 23

WANTED

Seeking ORs for 48 hour installation of boom and integration system. Must be willing to eliminate ceiling construction.

Position includes: freedom from trip hazards, reduced neck strain and fatigue, plus increased OR efficiency. Small ORs and low ceilings are welcome.

All qualified applicants please call to schedule a trial at (800) 448-8439.



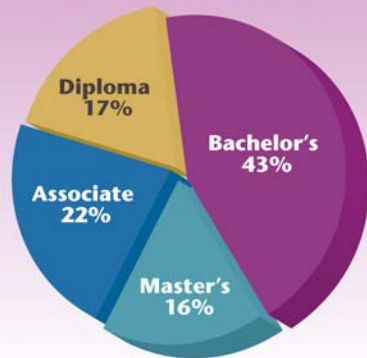
NuBOOM® is an all-in-one equipment management and visualization system that will change the way you think about upgrading ORs. With NuBOOM your current ORs can quickly become integrated MIS surgical suites. Reclaim critical floor space, even small rooms with low ceilings can now become integrated MIS ORs. Our Perfect Placement® installation process will ensure the HD monitors are positioned exactly where they are needed for every case.

Schedule a TRIAL! Call us today at **800 448 8439** to learn more, or you can also visit our website at nuboom.com to view video testimonials and see the NuBOOM in action.

 **CompView Medical**

Salary/Career Survey

Highest degree completed



Continued from page 21

istrator or administrative director, 24% are nurse managers, and 40% are split evenly between clinical director and director of nursing, with the remainder having another title.

Most report to administrators (41%), followed by physician owners (18%), medical directors (12%), board of directors (12%), and the corporate office (3%). ASC managers continue to work hard—an average of 48 hours a week, with 16% reporting working 55 hours or more.

Purchasing influence

Nearly all respondents (98%) participate in selecting and purchasing decisions. Most are members of a decision-making team or committee (46%), while 37% are the primary decision makers, and 31% serve in an advisory capacity. Nurse managers are significantly less likely to be the primary decision maker or to influence selection and purchase of capital equipment compared with those with other titles.

ASC managers influence pur-

Areas for reconsidering or postponing capital expenditures

OR technology/equipment	75%
Information technology	34%
Other	14%

N = 113

chasing decisions for OR supplies and equipment (90%) and for OR capital equipment (73%). Fewer in corporate-owned ASCs (80%) influence decisions related to capital equipment compared with other forms of ownership.

Surgical volume

The average surgical volume is 4,520 per year, ranging from less than 1,000 (9%) to 19,999 (7%). Economic conditions are likely behind the continuing trend toward lower patient volumes. Only 19% said their surgical volume increased in the past 6 months, a dramatic difference from the 34% who had increases in 2008 and 45% who had higher volumes in 2007. Thirty percent reported a decrease in surgical volume; for half of these, the decrease was 10% or more. The remainder (51%) said their volume remained about the same in the past 6 months, compared with 49% in 2008 and 39% in 2007.

About your ASC

Most respondents (46%) work in physician-owned ASCs, followed

by joint venture (27%), corporate-owned (16%), and hospital-owned centers (7%). Nearly two-thirds (62%) work in multispecialty centers. The top 4 single specialties reported are ophthalmology (33%), gastroenterology (27%), cosmetic/plastic surgery (12%), and orthopedics (11%).

The average ASC annual operating budget is \$5.6 million.

ASC budgets by ownership

Hospital-owned	\$8.8 million
Corporate-owned	\$6.7 million
Joint venture	\$5.7 million
Physician-owned	\$4.1 million

About you

Nearly all respondents (93%) are women, and 96% are RNs. The average age is 52 years, with an average of 27.3 years in nursing (only 3% reported fewer than 10 years) and 9.9 years in the current position. The highest level of education for ASC managers is the bachelor's degree (43%), followed by an associate degree (22%), diploma (17%), and master's degree (16%).

Fewer than half of ASC managers (44%) say their employer requires a specific degree for their position. The most common degree required is a bachelor's (67%), followed by a master's degree (17%), and an associate degree (13%). ♦

—*Cynthia Saver, RN, MS*

Cynthia Saver is a freelance writer in Columbia, Maryland.

Creating A Sustainable Competitive Advantage

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Does your operating room cause more pain than it cures?

Ready for an infection control survey?

Infection control in ambulatory surgery centers (ASCs) is under the microscope. The Department of Health and Human Services announced in July 2009 it is funding infection control surveys in more than 125 ASCs in 12 states by September 30, 2009. Additional funds were coming in October.

Surveyors will be armed with detailed new guidelines from the Centers for Medicare and Medicaid Services (CMS). The guidelines are intended to help them assess compliance with the revised ASC Medicare Conditions for Coverage (CfCs) effective in May 2009.

The Accreditation Association for Ambulatory Health Care (AAAHC) is expanding its infection control standards. Proposed revisions for its 2010 accreditation handbook include a dedicated chapter on infection control (www.aaahc.org).

What to expect

The CMS interpretive guidelines include 11 pages of infection control requirements plus a 16-page worksheet for surveyors to use in judging compliance.

In the major requirements, surveyors will check for an organized infection control program based on national guidelines and directed by a trained health care professional (sidebar, page 29).

Surveyors will check for compliance primarily by observation. They will also interview staff. In some cases, the guidelines state, the interviews may provide sufficient evidence for citing a deficiency. Surveyors will observe at least 1 surgery during the site visit, unless no procedures are sched-

Best advice: Know the guidelines.

uled during that time. If the facility does mostly short procedures, such as colonoscopy, surveyors may observe 2 procedures.

They will also conduct patient tracers like those in accreditation surveys. In a tracer, the surveyor identifies at least one patient and follows the case from admission through discharge to observe practice.

The best way ASCs can prepare is to know the major infection control guidelines. "And make sure you have someone in the role of infection control coordinator who has been trained," advises Lynn Cromer, RN, MT, CIC, chair of the communications committee for the Association for Professionals in Infection Control and Epidemiology (APIC) and a consultant with the Duke University Infection Control Outreach Network, Durham, North Carolina.

What type of training?

The interpretive guidelines say the person who directs the infection control does not need to be certified in infection control but must have documented training. The guidelines are not specific about the training. Cromer says surveyors are likely to look for 2 major aspects:

- Has the designated person been specifically trained in infection control?
- Does the person know what an infection control program should include, and is the person implementing that program?

APIC and others offer basic courses. (See Resources, p 27.)

How much time the person should devote to infection control depends on the size and complexity of the facility.

"There is no cookie-cutter infection preventionist role," Cromer says.

Often, smaller ASCs rely on a nurse who also has other responsibilities. A large facility or one with multiple sites may need a full-time infection control director.

Educating staff

Managers also need to make sure the staff is educated about the latest infection control guidelines. Staff need to follow the guidelines consistently and be prepared to be questioned by surveyors. Education must include not only nursing staff but also the medical staff, other direct-care staff, sterilization and disinfection personnel, and cleaning staff. Education must be conducted on hire or on granting of privileges and in regular refreshers.

Making sure the staff has the latest information is a challenge because most ASCs can't afford a dedicated educator, says Bruce Bardall, RN, BSN, MS, CNOR, national director of clinical services for National Surgical Care, an ASC management company based in Dallas.

Continued on page 27

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What's behind the surveys?

The Government Accountability Office (GAO) recommended in a February 2009 report that HHS develop a plan for random infection control surveys in ASCs. The report outlined several concerns.

First, 43% of surgery in the US is performed in ASCs, yet the GAO noted there is no national infection reporting mechanism for freestanding facilities.

Second, though experts consider infection risks in ASCs to be low, a few widely publicized incidents have occurred, such as reuse of syringes and medication vials in an endoscopy center in Nevada, reported in 2008. Thousands of patients were tested for HIV and hepatitis, with 6 cases identified.

In addition, the GAO says pilot surveys in Maryland, Oklahoma, and North Carolina in 2008 found some "serious lapses," such as failures to reprocess equipment properly. The findings have not been published.

The ASC Association says the reason surgery centers have not been a focus for government surveys in the past is because they have been considered low-risk.

"We have to keep educating policy makers that the rate of infections in ASCs is extremely low. All of the data from our outcomes monitoring shows that," the association's president, Kathy Bryant, said at the group's annual meeting in the spring. She urged ASCs to demonstrate their quality and safety in the surveys.

Surveyors will interview staff.

Continued from page 25

Internet-based training is a good option, he says, because the staff can complete it as they have time. One source is www.claritynet.com, which has programs that can be customized.

At Lakeshore Surgicare in Chesterton, Indiana, Donna Tang, RN, BSN, CNOR, the quality improvement coordinator, finds it's helpful to focus on one infection control topic each month and give contact hours. She's offered an APIC program on DVD as well as regular "lunch and learn" sessions.

How do you make sure the staff is ready for a survey? Bardall suggests making rounds to observe practice.

"I like to observe every day for breaks in practice," he says. Any lapses can be addressed immediately and the staff member coached on the spot. He prefers that approach to having the staff practice tracers because the staff is likely to exhibit model behavior during a practice session rather than what they do every day.

Monitoring for infections

An essential element of the infection control program is a system for identifying infections that may be related to the ASC's procedures. Surveyors will ask:

- how the ASC obtains information on infections

- whether infection tracking is documented
- whether the ASC has a policy and procedure for complying with state notifiable-disease reporting.

There are multiple ways of tracking for infections, Cromer notes. Some ASCs send surgeons a monthly letter listing the patients they have treated in the past 30 days. The letter may have checkboxes to mark Yes or No for any in-

Continued on page 29

Infection control resources

ASC Association

*Conditions for Coverage
Compliance Resources*

Spiral-bound book with Medicare's interpretive guidelines, a document highlighting changes in the revised Conditions for Coverage, and more.

\$55. Phone 703/836-8808 or download order form at: <http://ascassociation.org/Publicationsorderform.pdf>

Association for Professionals in Infection Control and Epidemiology (APIC)

- Ambulatory care resources —www.apic.org
Look under Member Services, then Ambulatory Care.
- Training course: Infection Prevention for Ambulatory Care November 6-7, 2009, Dallas. —www.apic.org
Look under Education & Certification.

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Medicare guidelines: Infection control

Under Medicare's interpretive guidelines for state surveyors who will review compliance with the ASC Conditions for Coverage, the infection control program must have these elements:

- provide a functional and sanitary environment for surgical services to avoid sources and transmission of infections and communicable diseases
 - be based on nationally recognized infection control guidelines
 - be directed by a designated health care professional with training in infection control
 - be integrated into the ASC's quality assurance/performance improvement (QAPI) program
 - be ongoing
 - include actions to prevent, identify, and manage infections and communicable diseases
- include a mechanism to immediately implement corrective actions and preventive measures that improve the control of infection within the ASC.

Infection control guidelines

Surveyors will check that the ASC has considered these nationally recognized guidelines for its infection control program:

- CDC/HICPAC Guidelines:
 - Guideline for Isolation Precautions
 - Hand hygiene
 - Disinfection and Sterilization in Healthcare Facilities
 - Environmental Infection Control in Healthcare Facilities
- AORN: Perioperative Standards and Recommended Practices
- Guidelines from surgical specialty societies and organizations.

Infection control and related practices

The surveyor worksheet includes specific questions in the following areas:

- hand hygiene
- injection practices
- single-use devices, sterilization, and high-level disinfection
- environmental infection control (such as cleaning of ORs, high-touch surfaces, and decontamination of gross spills of blood)
- point-of-care devices (ie, blood glucose meters).

Source: CMS. Interpretive Guidelines for Ambulatory Surgical Centers. The guidelines are available at <http://ascas-society.org/coverage/>

The CDC guidelines are at www.cdc.gov/ncidod/dhqp/index.html

Continued from page 27

fections and include a self-addressed stamped envelope. Any infections are recorded by the infection control coordinator and investigated. Other ASCs call patients 30 days after surgery to ask for this information.

Depending on the facility's size, Cromer says, surveillance may include all patients or target different groups, for example, focusing on a different procedure or specialty each month.

The right focus?

Some ASC managers question whether the focus on infection control surveys is misplaced. They think ASCs should be judged on

their outcomes, such as low infection rates, rather than on following every infection control guideline to the letter. They worry changes needed to comply could affect their efficiency and cost-effectiveness. They are also concerned state surveyors might not understand clinical practice.

Said one manager, "We have the evidence to say we don't have an infection control problem," noting the center's rate is less than 0.1%. "But we are starting to feel that this evidence doesn't matter. We will have to go back to practices we used years ago."

The ASC Association reports that the majority of ASCs in its voluntary Outcomes Monitoring Pro-

ject routinely report infection rates of less than 1%. For the first quarter of 2009, 651 ASCs submitted infection data. There are an estimated 5,000 ASCs in the US.

Know the guidelines

An example of a practice that may have to change is using Diprivan (propofol) vials labeled for single use for multiple patients, even though the drug is drawn up aseptically using a sterile needle and syringe for each patient. Another example is spiking IV bags and setting up tubing the night before for the next day's cases. Both help save minutes and dollars.

Cromer responds: "I understand what ASCs are saying from a cost

Continued on page 30



ADMINISTRATOR OF PERIOPERATIVE SERVICES
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Lehigh Valley Health Network (LVHN), located 60 minutes north of Philadelphia and 90 minutes west of NYC, has an immediate opening for an experienced perioperative leader to oversee operational and clinical activities. Responsibilities include leading performance improvement initiatives, development of departmental policies and procedures, strategic planning, staff recruitment and leadership development, medical staff interaction, involvement in clinical research activities and departmental budget development and compliance. Position reports to the Vice President of Orthopedic and Perioperative Services.

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Continued from page 29

and efficiency standpoint. But there are cases in the literature for things being done in a certain way." She added that managers can get more buy-in from the staff and physicians when they share the literature supporting a recommendation and explain the rationale.

Diprivan, for instance, is labeled by its manufacturer, AstraZeneca, for single-patient use. The product insert notes that propofol has no preservatives and can support growth of micro-organisms. There have been reports in the literature of postoperative infections. The Centers for Disease Control and Prevention issued its Safe Injection Practices in 2007 after investigating 4 large outbreaks of hepatitis infection in outpatient clinics. The main breaches were reinsertion into multi-dose vials or using a single

needle or syringes to give IV medications to multiple patients. A 2008 report cited more than 600 reports of hepatitis C transmission in health care settings over 15 years, most from unsafe injection practices.

Cromer reiterates that knowing the infection control guidelines and their rationale is one of the best ways managers can prepare for surveys. That can help them respond to a surveyor who does not seem to understand clinical practice. It's also one of the best ways to ensure the ASC's practice is safe. ❖

—Pat Patterson

The CMS Interpretive Guidelines for Ambulatory Surgical Centers are available at <http://ascassociation.org/coverage/> The infection control worksheet is Exhibit 351, located at the end of the guidelines.

References

Alter M. Healthcare should not be a vehicle for transmission of hepatitis C virus. Editorial. *J Hepatology*. 2008;48:2-4.

Centers for Disease Control and Prevention. *Safe Injection Practices to Prevent Transmission of Infections to Patients*. www.cdc.gov/ncidod/dhqp/injectionSafetyPractices.html



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Special bulletin

Safety goals, Universal Protocol revised

The Joint Commission released its revised Universal Protocol for surgical site verification September 9, 2009, along with changes to the National Patient Safety Goals.

No new safety goals are being issued for 2010. Instead, the commission spent this year reviewing and revising the 2009 goals. Some changes are effective immediately; others will be effective January 1, 2010.

Many of the changes proposed in a May 2009 field review were adopted, though some have been modified. In general, wording is simpler, and some specifics that caused confusion are reworded or deleted.

Two changes in the safety goals of particular interest to perioperative leaders:

- **Perioperative medications (NPSG. 03.04.01):** Requirements for labeling medications on and off the sterile field remain in the safety goals. There is a more specific list of what labels must include.
- **Health-care associated infections (NPSG 7):** By January 1, 2010, organizations are expected to have fully implemented the requirements set forth in the 2009 goals.

These include requirements related to hand hygiene, prevention of infections due to multidrug-resistant organisms, prevention of central line-associated bloodstream infections, and prevention of surgical-site infections.

Universal Protocol changes

Among the revisions to the surgical verification process and time-out:

Verification (UP.01.01.01)

Specific times when verification has to occur have been deleted. Also deleted is the requirement to use a checklist. Instead, facilities must use a "standardized list" to verify specific items. Use of the list does not have to be documented for each patient.

Site marking (UP.01.02.01)

Who may mark the site is modified from the field review. The revision states: "The procedure site is marked by a licensed independent practitioner [LIP] who is ultimately accountable for the procedure and will be present when the procedure is performed." In limited situations, the LIP may delegate site marking. But requirements are specific.

Alternatives for site marking (UP.01.02.01)

The language is revised to give facilities more latitude in adopting alternative processes for site marking.

Time-out (UP.01.03.01)

The major changes to the time-out:

- The revision states: "Conduct a time-out immediately before starting the invasive procedure or making the incision." Language about conducting a time-out before anesthesia is deleted.
- The number of items to check during the time-out is reduced to 3:
 - correct patient identity
 - correct site
 - procedure to be done.
- The requirement to suspend other activity during the time-out is removed.
- Regarding documentation, the revision states: "Document the completion of the time-out. Note: The hospital determines the amount and type of documentation."

The prepublication 2010 National Patient Safety Goals and Universal Protocol are on the Joint Commission website. ❖

—www.jointcommission.org

All the Right Moves: How Data Helps Top Performers Take Action — and Get Results

Management guru Peter F. Drucker said: “Checking the results of a decision against its expectations shows executives what their strengths are, where they need to improve, and where they lack knowledge or information.”

The observation – coined by an expert in leadership and management – can be poignantly applied to operating room performance. Certainly, healthcare providers cited in the 2009 OR Benchmarks® Collaborative (ORBC) Top Performer Recognition Program (see lists on page 3) frequently echo the sentiment when they reflect on the performance improvements they have made in their operating rooms.

These top performers have catapulted their operations to new levels by accessing – and then leveraging – data from the ORBC, a vendor-neutral benchmarking service provided by McKesson in partnership with OR Manager Inc. The ORBC provides monthly trend data on 20 key performance indicators including start-time accuracy for the first case of the day and subsequent cases, estimated case-duration accuracy, prime-time utilization, and day of surgery add-on cases. Users enter information and access both internal and national trends through an online dashboard with multiple options for generating and accessing data based upon various factors such as procedure or surgeon.

The service enables operating room managers to measure performance by making comparisons to similar organizations; uncovering insight into performance improvement opportunities through user-friendly, drill-down analysis. It also reports and shares OR performance and operational trends in a three-dimensional fashion to better align goals and outcomes.

A recent study on a sample of 122 subscribers between May 2007 and April 2009 demonstrated that routine access to dynamic, interactive business intelligence contributed to consistent gains in efficiency and effectiveness across subscribers. This gain was evidenced by the average 7.8% increase in first case start-time accuracy accompanied by an average 2.7% increase in subsequent case start accuracy, an average 3.2% increase in scheduling accuracy/estimated case duration accuracy and an average 5% increase in prime time utilization.

Empowering Staff

Melanie Zabeth, clinical manager at **Emory Clinic**, an ambulatory surgery center in Atlanta, attests to the value of leveraging data to improve operations.

“We use the ORBC data for everything,” Zabeth says. “It gives consistent information to make decisions. It makes everything we do very data driven, which is good because surgeons are very data driven. And, the data gives validity to the changes we implement.”

Turning data into knowledge helps the OR team at **St. Joseph’s Health Care-London**, Ontario, zero in on making specific improvements, says **Karla Haist**, data analyst.

“We share the ORBC data with the executive committee every two months to identify areas of opportunity,” she says.

Similarly, **Cookeville (Tenn.) Regional Medical Center** frequently uses ORBC data to help direct performance improvement initiatives, according to **Darla Cline**, clinical manager.

“With ORBC, you can put your money where your mouth is,” Cline says. “With good data, we are able to make changes and develop the processes to operate more efficiently. We are able to work smarter, not harder.”

“With good data, we are able to make changes and develop the processes to operate more efficiently. We are able to work smarter, not harder.”

Having access to the data – the cold hard facts, per se – also helps operating room managers justify the value of the performance improvement initiatives that they implement. **Christine Cochran**, surgical services program manager at **St. Mary’s General Hospital**, Ontario, for instance, routinely uses ORBC data to illustrate how performance improvement initiatives are producing results.

“ORBC gives us the ability to demonstrate to surgeons and staff that hard work and initiatives on performance programs are paying off,” Cochran says. “Displaying the data from ORBC is a great visual reaffirmation.”

Empowering Comprehensive Change

Although leveraging data in meaningful ways typically helps organizations improve performance on specific metrics, comprehensive transformation is likely to follow as well. Using the ORBC service, for example, has helped **Kaiser Permanente ASC, San Diego**, winner of the ambulatory surgical center award for scheduling accuracy, reinvent its work culture all together.

“Before participating in the OR Benchmarks Collaborative, Kaiser Permanente ASC, San Diego was a place where people

simply worked,” explains **Beverly Roling**, director of perioperative services. “Now, it is a place where there is a real team spirit.”

Staff members have become more aware of how they compare to similar organizations — and, as a result, have become keenly focused on performance.

“[The service] has given us a chance to look outside Kaiser and see what the rest of the world is doing,” she adds. “Because we are a large organization, we tend to look internally. ORBC data gives us a good idea of what we need to improve on and what we are performing well in.”

Perhaps most importantly, though, the focus on performance helps Kaiser shine a light on common goals. This, in turn, rallies the staff around a central mission, making them perform with the grace of a finely tuned championship team.

“Before, it was like herding a bunch of cats,” Roling says. “Prior to using ORBC, everyone did their job — but they did not act as a team. I didn’t realize how much our staff wants to do well until I gave them data that compares them to others. They truly want to see how well they are doing and it gives them a great incentive.”

Here’s how the ORBC service typically comes into play at Kaiser. The data, which is displayed in easy-to-read dashboards, is reviewed at least weekly — and then discussed at staff meetings. Armed with insight from the data, the surgery center team gets to work.

For example, when the team decided to work on turnover times, staff members realized that they needed to go beyond simply trying harder. Instead, they took a very methodical approach to improvement. A member of the financial staff strapped a stop watch to his wrist, immersed himself in the operating room for a few days to time how long it took each staff member to complete every task, from preparing a bed to unwrapping a surgical tray.

“Prior to using ORBC, everyone did their job — but they did not act as a team. I didn’t realize how much our staff wants to do well until I gave them data that compares them to others. They truly want to see how well they are doing and it gives them a great incentive.”

Problem areas and best practices were identified — and, most importantly, all staff members gained insight into what they had to do to improve.

With this approach, the team has been able to improve turnover significantly — the surgery center now performs 10 additional surgeries each day.



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And, while the turnaround has resulted in increased satisfaction and a healthier bottom-line, perhaps what’s most impressive is how it has transformed the work culture at Kaiser Permanente ASC.

“Previously, surgeons did not want to schedule their procedures at the surgery center. With ORBC in place, surgeons like going there and staff members like coming to work. There is a new morale and team spirit,” Roling says.

Empowering Effective Leadership

While ORBC data helps to empower the Kaiser Permanente team, the service is also a lifeline for leaders. Case in point: When **Caroline Kornutik** took over as the director of perioperative services in the operating room at **Saint Barnabas Medical Center**, Livingston, N.J., she quickly realized that ORBC could be her greatest ally.

“I just log into my computer and all the information is right there at my fingertips,” Kornutik says. “The data is all right there in a dashboard so it is easy for me to break it down and turn it into meaningful information. Without this tool, I had to run a report to get the information and it would just take too much time.

“We had piles and piles of data and pages to compile before we could even begin to affect a process change. Being able to present data in a user-friendly format has been huge in implementing new processes.”

With ORBC, Kornutik just clicks her mouse and immediately identifies any problem areas. From there, she drills down and determines exactly what is contributing to the problem — and most importantly, gets to work on a solution.

The information also helps Kornutik work with staff members to identify what exactly needs to be addressed, instead of taking more random shots at performance improvement.

“Nurses tend to go off our gut, so having data to drive conversations is a big improvement,” she observes.

For example, if there is a problem with on-time starts, Kornutik clicks on a bar and immediately realizes if the problem rests with a specific day of the week, specialty or physician.

After identifying the problem, Kornutik rolls up her sleeves and starts to implement a solution.

“Then, I can develop an intervention, put it in place and see if it makes a difference or not,” she says.

The remedy might be something as simple as talking to a handful of doctors who are having trouble with on-time starts.

“Just speaking to them about the problem could be enough to improve performance. It’s sometimes a simple fix, but without the information, the problem would persist,” she says.

With the ORBC service in place, Saint Barnabas has been able to take specific actions that led to improved performance. For example, the academic medical center has improved operating room on-time starts by:

- Implementing staggered start times. Instead of having all

(continued on page 4)

2009 ORBC Top Performers

Best Overall Performer, Ambulatory Surgical Center

*GMH Outpatient Surgery
– United States*

*Mt. Sinai Hospital
– Toronto, Canada*

Best Overall Performer, Academic Hospital

*Saint Barnabas Medical Center
– United States*

*Kingston General Hospital
– Canada*

Best Overall Performer, Non-Academic Hospital

*Kaiser Permanente Woodland
Hills Medical Center
– United States*

*Riverside Healthcare Facilities
– Canada*

Honorable Mention Overall Performer

*The Ottawa Hospital
Corporation – General Eye
Institute*

The Hospital for Sick Children

*Lennox and Addington
County General Hospital*

*Lake of the Woods
District Hospital*

*Surgicenter of Greater
Milwaukee*

Emory Clinic

Carle Foundation Hospital

Hospital of Saint Raphael

*Cookeville Regional
Medical Center*

2009 ORBC Top Performers Category Winners

Canada – Ambulatory Surgical Center	Scheduling Accuracy	The Ottawa Hospital Corp – General Eye Institute
Canada – Ambulatory Surgical Center	Start Time Accuracy	St. Joseph's Health Care – London – Cataract
Canada – Ambulatory Surgical Center	Case Time Effectiveness	Mt. Sinai Hospital – Toronto – Outpatient
Canada – Ambulatory Surgical Center	Turnover	Mt. Sinai Hospital – Toronto – Outpatient
Canada – Ambulatory Surgical Center	Utilization	Trillium Health Centre – West Toronto
Canada – Academic Hospital	Scheduling Accuracy	Kingston General Hospital
Canada – Academic Hospital	Start Time Accuracy	St. Joseph's Health Care – London
Canada – Academic Hospital	Case Time Effectiveness	Sunnybrook – Holland Orthopaedic and Arthritic Centre
Canada – Academic Hospital	Turnover	University Health Network – Princess Margaret
Canada – Academic Hospital	Utilization	Mt. Sinai Hospital – Toronto
Canada – Non-Academic Hospital	Scheduling Accuracy	Trillium Health Centre – Mississauga
Canada – Non-Academic Hospital	Start Time Accuracy	St Mary General Hospital
Canada – Non-Academic Hospital	Case Time Effectiveness	Huron Perth Healthcare Alliance – Clinton Public Hospital
Canada – Non-Academic Hospital	Turnover	Trillium Health Centre – Cardiac Services
Canada – Non-Academic Hospital	Utilization	St. Thomas Elgin General
US – Ambulatory Surgical Center	Scheduling Accuracy	KP San Diego ASC
US – Ambulatory Surgical Center	Start Time Accuracy	GMH Outpatient Surgery
US – Ambulatory Surgical Center	Case Time Effectiveness	Surgicenter of Greater Milwaukee
US – Ambulatory Surgical Center	Turnover	Loma Linda ECOR
US – Ambulatory Surgical Center	Utilization	Emory Clinic
US – Academic Hospital	Scheduling Accuracy	Saint Barnabas Medical Center
US – Academic Hospital	Start Time Accuracy	Jewish Hospital
US – Academic Hospital	Case Time Effectiveness	Danbury Hospital
US – Academic Hospital	Turnover	Brigham and Women's Hospital
US – Academic Hospital	Utilization	Loma Linda University MCOR
US – Non-Academic Hospital	Scheduling Accuracy	KP Woodland Hills Medical Center
US – Non-Academic Hospital	Scheduling Accuracy	St. Joseph Medical Center – Orange
US – Non-Academic Hospital	Start Time Accuracy	Longmont United Hospital
US – Non-Academic Hospital	Case Time Effectiveness	St. Jude Medical Center
US – Non-Academic Hospital	Turnover	Petaluma Valley Hospital
US – Non-Academic Hospital	Utilization	KP Woodland Hills Medical Center



SAINT BARNABAS HEALTH CARE SYSTEM

Saint Barnabas Medical Center

Pictured are members of the Saint Barnabas Medical Center Perioperative Services Team (R to L): Cynthia Thompson, OR Scheduling Manager; Jean Inzirillo, RN, BSN, CNOR; Lynette Pearson, RN, CNOR; Irma Dumapit, RN, BSN; Denise Nesfield Limes, RN, MSN, CNOR; Caroline Kornituk, RN, MSN/ED, CNO, Director of Perioperative Services

(continued from page 2)

operating rooms kick off the day at 7:30 a.m., each operating room starts at a distinct time, say 7, 7:30 or 8 a.m.

- Making sure all patient charts are in a state of readiness prior to the beginning of each surgery.
- Scheduling surgery times according to each individual doctor's history. Because the ORBC data reveals exactly how long it typically takes each surgeon to complete specific types of surgeries, the operating room team can allot the exact amount of time needed for each procedure, thereby eliminating bottlenecks down the road.

"If a surgeon says he can do a hysterectomy in 1.5 hours and we look in the database and know that his average time is 2 hours, then we won't let him schedule it for less than that," Kornituk explains. "We have the data to know exactly how much time to schedule to keep everything on track throughout the day."

By implementing these interventions, Saint Barnabas has improved on-time starts significantly. In a recent month, on-time starts went from 53% to 68.5%.

Such results illustrate just what Peter Drucker referred to when he spoke of measuring against an expectation to determine strengths and areas of improvement. As the healthcare organizations recognized in the ORBC program clearly illustrate, it is possible to use data to continually evaluate strengths and weaknesses — and then take the action required to elevate performance to the next level.

About the Top Performer Recognition Program

The Top Performer Recognition Program is an annual awards program highlighting organizations that have used ORBC data to achieve significant results. The program honors member hospitals that exemplify the transformational value actionable data can bring to the OR. By recognizing the accomplishments of these hospitals, the ORBC can share with member organizations best practices and proven strategies for improving OR utilization.

Join the ORBC Today

If you are looking to leverage benchmarking to help improve your OR performance, then sign up for the OR Benchmarks Collaborative today at our Web site (www.orbenchmarking.com) and complete the Intent to Purchase form.

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