Salaries keep pace, but are they enough for high-pressure jobs?

Salaries for perioperative nurse managers and directors are keeping pace. But is the pay high enough to keep them in these high-pressure positions?

An OR manager makes on average $85,485 this year compared to $81,694 in 2003, according to the 14th annual OR Manager Salary/Career Survey. For 1 in 5, pay tops $100,000.

But the average salary may not be sufficient to attract leaders to run stressful OR suites with multimillion-dollar budgets. Recruiters say it is increasingly difficult to fill directors’ jobs (related article below). As managers get older—the average age is 50—they are less likely to want to relocate to take a new position or deal with the stress.

Continued on page 12

Recruitment & retention

Periop director positions harder to fill as talent pool is shrinking

The nursing shortage isn’t affecting only the staff—it’s reaching into the perioperative director’s office.

In talking with recruiters across the country, OR Manager heard that 10% to 25% of OR director positions may be open, though they did not have data.

This year’s OR Manager Salary/Career Survey found 16% of respondents have openings in OR management, but the survey didn’t ask specifically about the director position.

“I can tell you, other than the CNO or VP of nursing, the director of surgical services or OR is the most difficult position to recruit for,” says Debra Borheck of Management Recruiters International, Indialantic, Fla.

Another recruiter, Greg Zoch, in the health care practice of Kaye/Bassman International, Plano, Tex, says, “We have a serious, almost critical, shortage of..."
Please see the ad for
CTC CARDINAL HEALTH
in the OR Manager print version.
**Upcoming**

**Block scheduling: A strategic issue**
More than ever, block time is a strategic issue. Advice from experts on managing this key resource.

**Attracting and keeping the mature worker**
Learn how meeting the needs of older workers is helping combat the staffing shortage.

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**Editorial**

**There's no time to breathe and regroup.**

There’s a lot of focus today on quality of work life for nurses. Finally, hospitals have realized that to attract and keep a qualified workforce, they must support nurses to keep them from fleeing in droves.

They’re doing more in the way of flexible schedules, better pay, and even childcare and concierge service.

Now what about perioperative leaders?

It’s time to focus on their quality of life.

Perioperative director positions are getting harder to fill.

As we talked to interim managers and consultants for the article in this issue, we heard an earful about why these jobs go begging.

“People don’t want these jobs because they are so difficult,” says Linda Slezak, RN, MS, FAAN, a veteran perioperative nursing director who is an independent consultant and interim OR director.

**Support lacking**

There is constant stress, and too often the support isn’t there.

Managers wrote about some of their challenges in responses to the 2004 OR Manager Salary/Career Survey reported in this issue—dwindling reimbursement; scarce capital dollars; lack of physician cooperation on supply standardization; and, increasingly, competition from their own physicians as they set up surgery centers and specialty hospitals.

It’s also clear that, given the right circumstances, being a director can be satisfying. Three out of four survey respondents say they receive good support from administrators, and almost all say they have a positive relationship with their physicians.

But when an organization is troubled, the director’s shoes can be hard to fill.

A lot of directors wonder where the next generation of leaders will come from.

They see too little attention paid to this by top executives. Organizations must put resources into leadership development if they expect to have new managers ready to step up once today’s managers and directors—average age 50—begin to hang up their business suits.

**What to fix**

These are some things Slezak thinks need fixing to make director positions more attractive:

- **Higher pay.** “Salaries are extremely low for what are high-level executive positions,” she says. OR directors manage a significant business—with an average budget of $14.4 million, according to the Salary/Career Survey.

- **More stature and power.** Too many hospital administrators expect OR directors to make tough changes, including taking on physician issues, without enough backup. A manager can’t take on orthopedic implant costs or more efficient surgery scheduling without administrators who will stand behind them.

- **More resources.** Directors need support for information technology—not just software but also enough resources to turn data into decision-making tools. They also need clinical educators to prepare new nurses who don’t have an OR background and keep the rest of the staff up to speed with technology. They need funding to attend conferences and other events so they can expand their knowledge and get new ideas. “For too many people, there’s no time to breathe and regroup,” Slezak observes.

Organizations must realize that investing in their leaders is every bit as critical as investing in high-tech equipment, recruiting new physicians, and attracting and keeping more nurses.

—Pat Patterson
Please see the ad for ADVANCED STERILIZATION PRODUCTS in the *OR Manager* print version.
G
t purchasing organizations (GPOs) are in the headlines again.

On Aug 21, The New York Times reported that the U.S. Department of Justice has opened a “broad criminal investigation” into the medical-supply industry, apparently to determine whether hospitals and other providers are “fraudulently overcharging Medicare and other federal and state health programs for a wide array of goods.”

The report said “more than a dozen” companies had received federal subpoenas. The investigation appeared to be centered on Novation, an Irving, Tex-based GPO that serves VHA and the University HealthSystem Consortium. Companies served with subpoenas, according to The Times, were Merck, Bristol-Myers Squibb, Genentech, GE Healthcare, BD, and Cardinal Health. No subpoenas to hospitals were reported.

The central issue of the current investigation, according to the Times’s industry sources, is whether use of rebates, discounts, and refunds to hospitals and other providers “means that Medicare and Medicaid are being charged higher prices for products than the hospitals are actually spending.”

A hearing was scheduled for Sept 14 before the Senate Judiciary Committee’s antitrust subcommittee, the same panel that held hearings on GPOs in 2002. A possible outcome might be a call for greater federal oversight for health care group purchasing. GPOs have said they will oppose any legislation for further regulation, saying self-regulation “is the most effective tool.”

Safe harbor

GPOs are allowed to collect fees from suppliers and give discounts and rebates to hospitals and other providers under a federal “safe harbor” and antitrust exemption. Without these protections, the payments could be considered kickbacks.

One question in the current investigation may be whether the discounts and rebates hospitals receive from GPOs are reflected in their cost reports to Medicare, says Lynn Everard, a Ft Lauderdale, Fla-based consultant and critic of GPOs.

“Discounts and rebates have the effect of reducing costs,” he says. If hospitals’ cost reports don’t reflect those lower costs, Medicare might consider that to be equivalent to filing a fraudulent cost report. He was not aware of hospitals being investigated by the Department of Justice, however.

“What this all comes back to is that if a hospital is a shareholder in a GPO, and if that GPO does something wrong, the hospital could share responsibility,” Everard says.

He encouraged OR managers and directors to follow the proceedings and be aware of purchasing practices in their organizations. “If you’re involved in purchasing at any level, ask questions and find out if there’s anything you need to be doing differently,” he says.

Large national GPOs face a number of other questions. Among them are how GPOs account for their fees and whether contracting practices such as sole-source agreements and bundling unfairly exclude small companies. GPOs defend their practices, saying they are not anticompetitive.

### Advisory Board

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amy Bethel, RN, MPA, CNA</td>
<td>Executive director, surgical services</td>
<td>Iowa Health, Des Moines</td>
</tr>
<tr>
<td>Mark E. Bruley, EIT</td>
<td>Vice president of accident &amp; forensic investigation, ECR</td>
<td>Plymouth Meeting, Pa</td>
</tr>
<tr>
<td>Judith Canfield, RNC, MNA, MBA</td>
<td>Associate administrator of surgical services</td>
<td>University of Washington Medical Center, Seattle</td>
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<tr>
<td>Christy Dempsey, RN, BSN, CNOR</td>
<td>Vice president</td>
<td>St John’s Regional Health Center Springfield, Mo</td>
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<tr>
<td>Franklin Dexter, MD, PhD</td>
<td>Associate professor, Department of Anesthesia</td>
<td>University of Iowa, Iowa City</td>
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<tr>
<td>Mary Diamond, RN, MBA, CNOR</td>
<td>Director of surgical services</td>
<td>Sharp Healthcare, San Diego</td>
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<td>Marion L. Freehan, RN, MPA/HA, CNOR</td>
<td>Nurse manager, main operating rooms, Massachusetts General Hospital, Boston</td>
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<tr>
<td>Jo Harbaugh, RN, BS, CGRN</td>
<td>Administrator, Digestive Disease Consultants</td>
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<tr>
<td>Mary J. Mazzei, MD</td>
<td>Medical director, perioperative services, University of California, San Diego</td>
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<tr>
<td>Mary M. Murphy, RN, BSN, CNOR</td>
<td>Director, surgical services</td>
<td>Munson Medical Center Traverse City, Mich</td>
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<tr>
<td>Barbara Pankratz, RN, MSN</td>
<td>Director, surgical services</td>
<td>University of Wisconsin Hospital &amp; Clinics, Madison</td>
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<tr>
<td>Robert V. Rege, MD</td>
<td>Professor and chairman</td>
<td>UT Southwestern Medical Center Dallas</td>
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<tr>
<td>Mariam Margaret Reichert, RN, MA</td>
<td>Administrator, Surgical Care Center Southwest General Health Center Middleburg Heights, Ohio</td>
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<tr>
<td>Kathy E. Shaneberger, RN, MSN, CNOR</td>
<td>Director, perioperative services and ortho/neuro service line</td>
<td>Mercy General Health Partners Muskegon, Mich</td>
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<tr>
<td>Allen Warren</td>
<td>Business manager, surgical services</td>
<td>Mission St Joseph’s Hospital Asheville, NC</td>
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Please see the ad for DUPONT in the OR Manager print version.
Manager of Year mentors the staff to lead


These are phrases used to nominate Gail Avigne, RN, BA, CNOR, this year’s OR Manager of the Year.

As nurse manager for the ORs, surgery center, recovery rooms, and preadmission testing area at Shands Hospital at the University of Florida, Gainesville, Avigne oversees 26 ORs with a volume of 16,000 cases a year. She’s responsible for a $188 million revenue budget and a $40 million operating budget. Over the past 2 years, she and her colleagues have reduced expenses by more than $3 million, Georgiann Ellis, Shands’s vice president for operations, wrote in her nomination letter.

But Avigne’s nomination is about more than numbers. The staff and top executives referred to her optimism, perseverance, and people skills.

Ellis notes the OR has a low staff turnover rate and, unlike other hospitals in the area, has not had difficulty recruiting.

“Gail is an employee advocate who is always striving to improve conditions for staff and physicians,” wrote Theresa N. Daly, RN, BSN, CNOR, teams coordinator for surgical services.

Nicholas J. Cassisi, DDS, MD, chief of staff for Shands Health Care, who has known Avigne since she was a graduate nurse, added: “She has marvelous problem-solving skills. No problem appears to be too big.”

Dave Paulus, MD, medical director of the OR, called Avigne, the “best resource the OR has.”

Avigne will be honored at the Managing Today’s OR Suite conference Oct 6 to 8 in Chicago.

What keeps her in the pressure-filled job?

Asked how she copes with the pressure of managing an OR, Avigne named two things: Being able to mentor the staff and support from her superiors to “think outside the box.”

They’re the same things that help retain the staff, she adds—giving people an opportunity to lead and giving them the freedom to be creative.

One of the most rewarding aspects of her job is encouraging other nurses to be leaders.

The structure she established for the OR supports that. There are 16 team leaders who “have a lot of autonomy and creativity,” Avigne says. The structure is lean: Team leaders report to 1 clinical coordinator who reports to Avigne. Team leaders select and lead their teams. They also learn to set goals, measure their progress, and post the results.

In hiring team leaders, she seeks qualities that show a potential for leadership, such as being open-minded, having good people skills, and being willing to take risks. Team leaders include both veteran nurses and nurses in their 20s. The opportunity to be a team leader has given younger nurses the ability to attract and keep nurses. They are measuring staff satisfaction after the policy goes into effect to see if it makes a difference.

Three innovative programs

Asked what achievements she is proudest of, Avigne named 3, all of which contribute to a positive working environment:

Exercise program for staff

In a new exercise program developed with the physical therapy department, surgical services staff can meet with an athletic trainer before or after work for $35 a month. Their progress is tracked for blood pressure, EKG, and cholesterol. Avigne is also monitoring whether the program makes a difference in productive hours worked and in retention. Two nurses who were being recruited by a surgery center decided to stay, in part because of the exercise program.

“We have found the staff is really energized by this,” she says. “If we can keep doing things like this, it really helps us have a positive work environment.”

Nurse-physician relations

A program Avigne has been developing for 6 years for the OR has been adopted as a hospitalwide protocol. The protocol was developed after a staff satisfaction questionnaire found only 50% to 60% of nurses felt respected by physicians.

The program includes a policy and algorithm for managing difficult behavior. Recently added is a course in interpersonal relations based on Daniel Goleman’s book, Emotional Intelligence.

Avigne and other managers have met with over 200 physicians to talk about the protocol and the impact of physicians’ behavior on the hospital’s ability to attract and keep nurses. They are measuring staff satisfaction after the policy goes into effect to see if it makes a difference.

Diversity program

To help build bridges among various groups, Avigne created a diversity committee 4 years ago when she detected tension among the staff.

“It took almost a year before I could get a volunteer group of RNs and techs to tell me the truth about what was going on,” she says. She found it took time, patience, and the willingness to be vulnerable to get people to start talking to her and to each other.

A 4-hour diversity course Avigne and her team developed now is offered to all orientees. The hospital also has adopted another OR innovation—a cultural celebration once a quarter that focuses on African-American, Native American, Hispanic, or Asian cultures. The celebrations weave in food, music, and art as well as education on health issues common to each culture.

Still, she acknowledges, diversity is a fragile issue. “It lies beneath the surface,” she says. “But if you are aware it’s there, that’s half the battle.”

Candidates for OR Manager of the Year are nominated by their colleagues. The winner is selected by the OR Manager Advisory Board.
Please see the ad for MEDLINE INDUSTRIES INC. in the OR Manager print version.
Recruitment & retention

Continued from page 1

good perioperative directors. Those who are retiring have to be able to train their replacements, and right now they are pulled in too many directions.”

Neal Marshall of the search firm Witt/Kieffer, who has been a recruiter for 10 years, says OR directors have always been difficult to find. Now they are “extra difficult,” and compensation continues to rise. One position he recruited for had a base pay rate of $130,000 to $150,000 for an urban hospital with 400 to 500 beds and 18 to 20 ORs.

Expectations high

Even with a large number of vacancies, employers’ expectations are high. And some think salaries haven’t caught up.

Hospitals looking for directors “want you to be master’s prepared with a business degree, but then they want to pay you $90,000. It’s not very smart,” one director observes.

Borheck sees a lot of hospitals upping requirements for education and certification. Employers are looking for a minimum of a BSN plus certification for surgical services management positions. Larger hospitals typically want a master’s degree. That is increasingly true as more hospitals apply for “magnet” certification, a program intended to aid nurse recruitment and retention.

Opting out

Recruiting leaders is difficult for a number of reasons.

First, perioperative nursing leadership faces the same demographic forces as nursing in general—and then some.

Most nursing schools haven’t offered OR preparation for years, and with an aging cohort of OR RNs, the talent pool is shrinking.

As more directors move toward retirement, “a lot are opting out, retiring early, and even going back to staff positions,” says Dan Warmack, RN, MA, CNAA, senior vice president with Soyring Consulting, St. Petersburg, Fla.

Older managers also are less likely to want to relocate, which most senior positions require.

“You only have 15% to 20% who will consider moving,” which limits the talent pool further, notes Marshall.

Stress is another big factor.

“There are so many pressures to provide excellent service, grow the business, and cut costs at the same time—you are constantly pulling your hair out,” observes Paul Wafer, RN, MBA, of Alpha Consulting Group, Manhattan Beach, Calif, who has been a surgical services director as well as a COO and CNO.

He has found being director of surgical services is just as stressful as senior executive roles, and the pay isn’t as high.

Directors notice that staff nurses who take call and work some overtime make about as much as they do, leading many to ask whether management is worth the headaches.

Though pressures are high, many organizations haven’t given managers the resources they need to make the kinds of decisions that are required.

“I still go into ORs that do not have an information system or decision support. How can you quantify your outcomes and defend changes you plan to make if there is no decision support?” asks Susan Bisol, RN, MSN, CNOR, vice president of operations for the Consulting and Services business of Cardinal Health.

Yet another factor—more surgical management position doesn’t take as long as filling a staff nurse or surgical technologist slot.

But finding the right person can take a long time—30% had been searching for more than 10 weeks.

Leadership funds at many hospitals have been slashed.

Continued on page 11
Please see the ad for SKYTRON INC. in the OR Manager print version.
Consistent supply use by surgeons and a dedicated bariatric team contribute to good performance in laparoscopic gastric bypass for DePaul Health Center in St Louis in a recent study by OR Benchmarks, a service of OR Manager, Inc.

Three surgeons perform about 300 laparoscopic gastric bypass operations per year at DePaul, which has a surgical volume of 12,000 cases a year. Nearly all of the scheduled procedures use the laparoscopic Roux-en-Y approach, with a few being Lap-Band procedures. DePaul’s total mean supply cost of $2,214 is the second lowest of 9 facilities participating in the study. DePaul also had the shortest procedure time and low labor costs.

Mindy Manley, RN, BS, CNOR, director of surgical services, commented on how the hospital achieves its strong results:

- **Standardized custom pack.** A custom pack for bariatric surgery is standardized for the 3 surgeons and purchased through a GPO contract. Surgeons use reusable graspers, scissors, and forceps. They also use an ultrasonic scalpel.

  “We reduced our cost per case by $70 by having a standardized pack,” Manley says. “All 3 of our surgeons do the procedure in the same manner and help each other, so it’s easy to get them to agree. They also are conscientious about costs.”

- **Stapler reloads.** Surgeons use 1 stapler and 6 to 8 reloads per case. Reloads are a major cost driver, the study found. In the study, the range was from 2 to 10 reloads for the facility with the lowest total supply cost to 16 to 19 reloads for the facility with the highest supply cost. DePaul’s surgeons oversew the staple line and do not use reinforcing material, another costly item.

- **Staffing.** DePaul’s dedicated bariatric surgery team typically consists of 1 RN, 1 surgical technologist, and 1 surgical assistant employed by the hospital. The team is one reason why the procedure time is the lowest in the study, Manley notes. The team has decreased OR time by 24 minutes since the hospital began performing the procedure. The short procedure time is also the reason why labor costs are low.

- **Turnover time.** DePaul’s turnover time is at the median. The team expedites the flow of patients by using 2 ORs. As the surgeon finishes one case and goes out to see the family, the next patient is brought into the second operating room.

  “This approach is more efficient for them and for us,” Manley comments.

The original report on the benchmarking study is in the July OR Manager.

<table>
<thead>
<tr>
<th>Laparoscopic gastric bypass</th>
<th>Range</th>
<th>Median</th>
<th>DePaul</th>
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<tr>
<td>Total supply costs</td>
<td>$1,918-$8,603</td>
<td>$3,269</td>
<td>$2,214</td>
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<tr>
<td>Procedure time (incision-close)</td>
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<td>51 min</td>
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<tr>
<td>Turnover time (setup + cleanup for same procedure)</td>
<td>39-83 min</td>
<td>44 min</td>
<td>44 min</td>
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<tr>
<td>Labor costs (wages + benefits for direct caregivers)</td>
<td>$184-$722/case</td>
<td>$353</td>
<td>$302</td>
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</table>

Source: OR Benchmarks. www.orbenchmarks.com

Managers can take on the mentoring role and have an ongoing relationship with the hospital to assist in developing new talent,” he says.

Demand for interim management is growing, and so is the length of engagements. Cardinal Health’s interim management engagements, which used to be 6 months, are becoming 12 months, says Bisol.

Kim Boerner, RN, general manager of AORN Management Solutions, says, “We probably get 15 calls a week from hospitals wanting interim or permanent managers. It’s not from one area; it’s all over the country.”

Both of Botsford’s interim positions were longer than planned. A 3-month position at an academic medical center in the Midwest stretched to a year, and the position still wasn’t filled. She then accepted a 3-month interim position in southern California. When she left at 6 months, the position was still open. When there is a gap in leadership, it can have a far-reaching effect.

“Without good leadership, you start to bleed in human resources, and then the staff starts to leave,” says Bisol. “It’s important that you plug those holes as soon as possible before the vision gets lost and people start wondering, ‘Where are we going? Who’s in charge?’”

—Pat Patterson
Some of the biggest challenges for OR directors, according to the survey, are the relentless need to reduce costs; find capital for new technology; enforce policies; and increasingly, meet competition from surgery centers and specialty hospitals.

Yet, despite the pressure, most managers find their jobs satisfying, particularly their relationships with physicians and the staff. They’re less happy with their pay and the recognition they receive.

The survey was mailed in May to 1,229 OR Manager subscribers and had a return rate of 34% (418). A separate survey was conducted for ambulatory surgery centers. The staffing portion of the survey was reported in the September issue.

Salaries and raises

The average salary for an OR director is $86,043, and the average for a manager is $73,957. The majority (52%) make over $90,000, and 20% are into 6 figures.

Salaries over $100,000 are most common in the West (36%) and in teaching hospitals (30%). A few (7%) earn under $60,000. This is most common in the South and in small ORs (1-5 rooms).

The vast majority (85%) of managers received a raise in the past year, averaging 4.1% over their base. Raises varied little by region and type of hospital. Managers of smaller ORs received smaller increases:

- 1-5 ORs: 3.7%
- 6-9 ORs: 4.5%
- 10+ ORs: 4.1%

The highest earners are in the West, where the average of $93,656 is almost $12,000 over the Central region, which had the lowest average at $81,718.

The highest pay goes to those in teaching hospitals, managing 10 or more ORs, and with multisite responsibilities. For comparison, hospital heads of nursing services earn a median base salary of $147,000, according to Modern Healthcare.

Bonuses

Despite the constant financial pressure, only 39% of managers are paid an
### Salary/Career Survey

#### How many clinical FTEs are under your span of control?

<table>
<thead>
<tr>
<th>By facility type</th>
<th>By number of ORs</th>
<th>By title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community</td>
<td>Teaching</td>
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<tr>
<td>Clinical</td>
<td>69.4</td>
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<tr>
<td>Nonclinical</td>
<td>19.9</td>
<td>36.6</td>
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#### What is the overall annual operating budget (in millions)?

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<thead>
<tr>
<th>By facility type</th>
<th>By number of ORs</th>
<th>By title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community</td>
<td>Teaching</td>
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<tr>
<td>For all ORs managed</td>
<td>$10.0</td>
<td>$26.6</td>
</tr>
<tr>
<td>For all departments managed</td>
<td>$13.8</td>
<td>$44.4</td>
</tr>
</tbody>
</table>

#### What is your role in purchasing decisions?

- Committee member: 47%
- Primary decision maker: 35%
- Advisory: 18%

#### Do you have an OR business manager?

In all, 24% (98) of respondents have a business manager for the operating room. This varies by the size and type of the facility. Those with business managers:

- By number of ORs
  - 1-5 ORs: 15%
  - 6-9 ORs: 5%
  - 10+ ORs: 79%

#### To whom do you report?

- Hospital admin: 22%
- Nursing admin: 72%
- Other: 7%

#### Average annual salary by scope of role

- OR only: $75,955
- OR+ other depts: $84,252
- Multiple sites: $90,657

#### Benefits

Benefits have remained fairly stable over the past 5 years, though fewer directors report retirement plans, and more are receiving dental and eye care. Some reported higher copayments and deductibles for health insurance.

Incentive bonus, though that rises to half in larger departments. By title, 45% of directors get bonuses, while 20% of managers do. On average, the bonus was 7.9% of base salary.

#### Those receiving bonuses by size of OR

- 1-5 ORs: 23%
- 6-9 ORs: 46%
- 10+ ORs: 50%

Continued on page 15
Please see the ad for MOLNYCKE HEALTH CARE INC. in the OR Manager print version.
Salary/Career Survey

Skill mix in OR remains stable

Do surgical techs circulate?

Hospitals

2004

Yes, RN in room 5%
Yes, RN available 2%
No 93%

1999

Yes, RN in room 13%
Yes, RN available 4%
On their own 1%
No 82%

Ambulatory surgery centers

Yes, RN in room 9%
Yes, RN available 5%
No 86%

ORs do not appear to be filling staffing gaps by having surgical technologists (STs) circulate in the operating room. Federal and state regulations say that STs may circulate with an RN in the room or readily available.

The ratio of RNs to STs in hospitals, at 64:36, has not wavered in the past 5 years.

The percentage of respondents who have STs circulating has declined in the past 5 years, from 18% in 1999 to 7% this year. No hospitals report that STs circulate on their own.

Of the 28 facilities where STs circulate, 27 are community hospitals, and 15 are in the South. A small number of hospitals, 7% (n=27), have a staff that is 90% or more RNs. Twenty are small ORs, and 14 are in the Central region.

Ambulatory surgery centers

The staffing ratio in surgery centers is about the same as that in hospitals: 65:35 RNs to STs.

A higher percentage of ASCs than hospitals have STs circulating (14%) (n=19), but none has them circulating on their own.

In all, 19% (n=25) of ASCs have a staff that is 90% or more RN.

Ratio of RNs to surgical techs

<table>
<thead>
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<th>Year</th>
<th>RNs:STs</th>
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<td>2004</td>
<td>64:36</td>
</tr>
<tr>
<td>2003</td>
<td>64:36</td>
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<td>2001</td>
<td>62:36</td>
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<td>1997</td>
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<td>69:31</td>
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<table>
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<th>1999</th>
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<tr>
<td>Health insurance</td>
<td>99% 99%</td>
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<tr>
<td>Dependent health insurance</td>
<td>81% 79%</td>
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<tr>
<td>Life insurance</td>
<td>94% 95%</td>
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<tr>
<td>Retirement plan</td>
<td>89% 95%</td>
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<tr>
<td>Dental insurance</td>
<td>92% 89%</td>
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<tr>
<td>Disability insurance</td>
<td>83% 81%</td>
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<tr>
<td>Paid time off</td>
<td>99% 100%</td>
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<tr>
<td>Tuition reimb</td>
<td>88% 85%</td>
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<tr>
<td>Eye care</td>
<td>62% 52%</td>
</tr>
</tbody>
</table>

About your organization

Three-fourths of respondents (76%) are from community hospitals, 23% are from teaching hospitals, and the rest are from other types of organizations.

About your role

Title and work area. The majority of respondents have the title director (61%), followed by nurse manager (26%), and other titles.

Most titles refer to the work area as surgical services (58%), followed by perioperative services (24%), and operating room (14%).

The term “perioperative services” is more common than in 1999, when 12% had that title.

Reporting structure. Typically, respondents (72%) report to the nursing administration, while 22% report to the hospital administration, and the rest to another structure.

The larger the department, the more likely the director is to report to the hospital administration:
- 10+ ORs: 57%
- 1-5 ORs: 12%

Management scope

How many sites do you manage?

<table>
<thead>
<tr>
<th>2004</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR only within one hospital</td>
<td>16% 13%</td>
</tr>
<tr>
<td>OR &amp; other depts within one hospital</td>
<td>84% 72%</td>
</tr>
<tr>
<td>OR only at multiple sites</td>
<td>1% 2%</td>
</tr>
<tr>
<td>OR &amp; other depts at multiple sites</td>
<td>9% 5%</td>
</tr>
</tbody>
</table>

Continued on page 16
Reporting by facility type

**Community**
- Nursing: 76%
- Admin: 20%

**Teaching**
- Nursing: 58%
- Admin: 26%

Managing beyond the OR. Managers wear many hats—90% manage departments besides the OR, and 12% manage beyond the hospital walls.

The largest group (79%) manages the OR and other departments within one hospital.

These managers and directors have an average of:
- 6 departments
- 10 ORs
- 77 clinical and 20 nonclinical FTEs.

They are responsible for an overall annual operating budget of $20.7 million.

Purchasing power

OR managers and directors have considerable clout in purchasing.

Nearly 100% say they have influence in selecting and purchasing both OR capital equipment and surgical supplies. And the vast majority—80%—say their decision-making involvement increased in the past year.

In all, 35% are the main decision maker, and 47% serve on the decision-making committee or team; only 18% say they serve in an advisory capacity only.

The smaller the OR, the more likely the manager or director is to be the primary decision maker.

<table>
<thead>
<tr>
<th><strong>Purchasing influence by size of OR</strong></th>
<th>1-5 ORs</th>
<th>6-9 ORs</th>
<th>10+ ORs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary decision maker</strong></td>
<td>45%</td>
<td>33%</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Member of team</strong></td>
<td>39%</td>
<td>46%</td>
<td>54%</td>
</tr>
<tr>
<td><strong>Advisory</strong></td>
<td>16%</td>
<td>21%</td>
<td>19%</td>
</tr>
</tbody>
</table>

About the operating room

Surgical volumes. The average surgical volume is 7,971.

- 1-5 ORs: 3,017 cases
- 6-9 ORs: 6,334 cases
- 10+ ORs: 12,963 cases

The rise in surgical volume appears to have slowed. Though a majority (51%) say their surgical volume rose in the past year, the increase was not as high as in past years. Most in the East (53%) and in teaching hospitals (54%) reported increased volumes.

Percentage reporting increase in surgical volume

- 2004: 51%
- 2003: 69%
- 2002: 58%
- 2001: 63%

Number of ORs. Those with the title “director” manage an average of 11 ORs, while those with the title “nurse manager” are responsible for an average of 8 ORs.

Continued from page 15
Please see the ad for CARDINAL PYXIS PRODUCTS in the OR Manager print version.
Salary/Career Survey

Annual budget. Managers and directors run multimillion-dollar businesses. On average, respondents are responsible for an annual OR operating budget of $14.4 million.

Average annual OR budget managed
Director $13.5 million
Nurse manager $11.5 million

Has surgical volume increased?

There’s a building boom in surgery departments as facilities tool up for an aging population and the needs of technology.
About 1 in 3 surgical departments is adding new operating rooms, and 1 in 4 is renovating. The average number of ORs being added is 4, and these are about evenly split between inpatient and outpatient rooms.

Information systems: More support needed

The main reasons for adding new ORs:
• increase capacity (70%)
• accommodate new technology (40%)
• replace an old facility (30%).
The major reason for renovating is to provide for new technology, named by 77%.

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Please see the ad for ADVANCED STERILIZATION PRODUCTS in the *OR Manager* print version.
Please see the ad for
SANDEL MEDICAL INDUSTRIES
in the OR Manager print version.
Despite the relentless pressure of running an OR, respondents generally are satisfied with their positions. Satisfaction with support and communication seems to be higher in ambulatory surgery centers (ASCs) than hospitals, perhaps because communication is easier in a smaller facility.

Though working with physicians can be stressful, nearly all managers say they have a positive relationship with their MDs. Teamwork among the staff also is strong.

But managers are not as satisfied with their salaries and recognition they receive. A slim majority say their pay is adequate, and 40% of hospital managers and 30% of ASC managers would like more recognition for their efforts.

Managers’ satisfaction varies with the type and size of hospital and, not surprisingly, by how much they are making.

- **Continuing education.** Managers in larger ORs (10+ rooms) (82%) and earning over $80,000 (79%) are happiest with their continuing ed opportunities. In contrast, in the smallest ORs (1-5 ORs), 63% are satisfied.

- **Salary.** Managers think a salary under $60,000 is not adequate for running an OR today—only 19% in that salary category are satisfied with their wages. Only 7% earn less than $60,000, and most are in small ORs. In contrast, 66% of those earning $80,000 or more are happy with their pay. The majority in this year’s survey are at that pay level.

### Do you believe...

<table>
<thead>
<tr>
<th>Question</th>
<th>Overall</th>
<th>Hospitals</th>
<th>ASCs</th>
<th>Community</th>
<th>Teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>... you receive adequate support from upper management?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes 77%</td>
<td>Yes 82%</td>
<td>73%</td>
<td>84%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>... you receive adequate communication from your administration?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes 74%</td>
<td>Yes 81%</td>
<td>74%</td>
<td>76%</td>
<td></td>
<td></td>
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<tr>
<td>... you have adequate opportunities for continuing education?</td>
<td></td>
<td></td>
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<tr>
<td>Yes 74%</td>
<td>Yes 82%</td>
<td>72%</td>
<td>85%</td>
<td></td>
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<tr>
<td>... your salary structure is commensurate with your position?</td>
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</tr>
<tr>
<td>Yes 56%</td>
<td>Yes 60%</td>
<td>58%</td>
<td>48%</td>
<td></td>
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</tr>
<tr>
<td>... you have a positive relationship with your physicians?</td>
<td></td>
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</tr>
<tr>
<td>Yes 97%</td>
<td>Yes 99%</td>
<td>96%</td>
<td>99%</td>
<td></td>
<td></td>
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<tr>
<td>... your staff works together as a cohesive team?</td>
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<tr>
<td>Yes 87%</td>
<td>Yes 96%</td>
<td>88%</td>
<td>84%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>... you receive adequate recognition for your achievements?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes 59%</td>
<td>Yes 69%</td>
<td>59%</td>
<td>62%</td>
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</tbody>
</table>
“Golden scalpel” awards cite OR achievements

If your OR could receive a “golden scalpel” award this year for an accomplishment, what would it be for?

Many responding to this question in the Salary/Career Survey simply said “recruitment and retention.” Others pointed to patient safety, quality improvement, and OR construction projects.

Here are some of their comments:

- **Recruitment and retention.** With experienced OR nurses hard to find, managers are trying new strategies.

One organization had set up an elective in perioperative nursing for credit at the local university. Another would give the award to the orientation team, who created a “positive, progressive, orientation program” that keeps new employees interested. A manager from Arizona said the OR actually has a waiting list and morale is high, especially with a new unit-based council.

- **Dedication of staff.** A manager whose hospital has been under regulatory scrutiny wrote, that despite a couple of trying years, the OR “has a wonderful retention rate and a great case turnover time.” Another said the staff continues to be cohesive and give “excellent patient care in the face of diminished numbers and benefit reductions.”

One manager of a 6-room OR was proud that her facility has achieved “total cross-training of all RNs” to be able to work intraoperatively as well as postoperatively for the same-day surgery unit. Central service and surgical techs were also cross-trained to sterile processing.

- **Process improvement.** Managers cited improvements in patient flow, block utilization, decreased turnover time, and a better record of on-time case starts. One OR improved its on-time start rate from 35% to 92%.

- **Patient safety.** Most often mentioned was the much-publicized correct-site surgery initiative of the Joint Commission on Accreditation of Healthcare Organizations. The director of a 45-room OR in a teaching hospital termed “miraculous” the OR’s 99.8% compliance with the time-out policy for surgical site verification. “That includes nurses, surgeons, anesthesia providers, and residents,” she said.

- **Information technology.** Brief comments belie the time and effort of bringing a new automated system “live.” “The award should be for putting our half-million-dollar supply inventory on a computer system with par levels,” one manager commented. This 4-OR facility had also built case carts so supplies are charged for, decremented, and automatically reordered.

“The challenge is trying to manage the supplies with the new computer system with no nonclinical support staff,” this manager added.

- **Construction and renovation.** Among projects that managers said they had shepherded were renovation of 10 ORs for new technology and construction of an integrated surgical suite. One community hospital had become the first such facility in its state in 30 years to establish an open-heart program.

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**Salary/Career Survey**

Continued from page 18

Directors who typically manage departments in addition to the ORs on average oversee an overall annual budget of $22 million for all departments.

**About you**

**Age and gender.** The age of OR managers has crept past 50. The average director is 51, and the average manager is 49. Five years ago, the average age was 48.

Consistent with past years, 90% of managers are female. Only 1 respondent was not an RN.

**Education.** For those with the title “director,” master’s and bachelor’s degrees run neck and neck as the highest degree (36% and 37%, respectively). The bachelor’s is the most common degree for nurse managers (52%).

The most common master’s is an MS or MSN (41%), with MBAs accounting for 29% and other master’s degrees for 30%.

Most (71%) say their employer requires a specific degree for their position. When a degree is required for directors, it is usually a bachelor’s (58%) or a master’s (41%); 2 facilities (1%) require a doctorate. For nurse managers, the most common requirement is a bachelor’s (77%), with a few requiring a master’s (11%), and the rest specifying a diploma, associate degree, or other education.

—Billie Fernsebner, RN, MSN

—Pat Patterson

Thank you

**OR Manager** thanks its subscribers who generously took time to complete this year’s Salary/Career Survey. We appreciate your part in gathering this information, which will be useful to your colleagues around the country.

**Salary/Career Survey director**

Billie Fernsebner, RN, MSN, education director for OR Manager, Inc, has coordinated the **OR Manager** Salary/Career Survey for the past 8 years.
Please see the ad for 3M HEALTHCARE in the OR Manager print version.
Should RNs be giving propofol in GI lab?

Should RNs be giving propofol (Diprivan) for sedation in the GI lab? It’s a hot issue.

Advocates point to propofol’s advantages—patients can be sedated quickly, awakened quickly, and discharged sooner than with conventional sedation. One study found an average time of 18 minutes from the end of the procedure to discharge. Most patients preferred propofol to the usual sedatives because they don’t have a hangover and feel they are back to normal sooner.

Three outcome studies with more than 11,000 patients have found no major complications. Though moderate sedation is still the norm in the GI setting, advocates would like to expand nurse-administered propofol sedation (NAPS), saying it not only is safe but is less costly than using an anesthesia provider.

But opinion is sharply divided.

Critics note that the package insert says propofol should be given only by persons trained in general anesthesia. Patients can slip into deep sedation more easily than with the usual drugs used in endoscopy, and it takes expertise to monitor them and respond to any complications.

“It’s great, but it’s a tricky drug, and you need to know what you’re doing,” says Beverly K. Philip, MD, a professor of anesthesiology at Harvard, who has been working on the issue for 2 years as chair of the Ambulatory Surgical Care Committee of the American Society of Anesthesiologists (ASA).

Statements in conflict

Gastroenterology and anesthesia societies have issued conflicting statements.

In July, the American Society for Gastrointestinal Endoscopy (ASGE) and the Society of Gastroenterology Nurses and Associates (SGNA) posted a joint statement outlining the role of RNs in managing patients during sedation, including deep sedation with propofol.

Three gastroenterology societies issued a statement pointing out there is data “to support the use of propofol by adequately trained nonanesthesiologists” with adequate supervision.

In contrast, a joint statement by ASA and the American Association of Nurse Anesthetists (AANA) echoes the package-insert warning that only persons trained in general anesthesia should administer propofol.

The gastroenterology and anesthesia communities are holding high-level discussions on the issue, but those involved would not discuss specifics.

Guidance for nurses

SGNA decided to join ASGE in making the statement because it recognized some nurses are working in GI labs where propofol is given and need guidance, says Jo Harbaugh, RN, BSN, CGRN, immediate past president of SGNA.

“We want to make sure there is a safe environment for all patients regardless of the setting and to have protocols in place if they are going to give propofol,” notes Harbaugh, who is administrator of Digestive Disease Consultants and executive director of the Digestive Disease Endoscopy Center, Normal, Ill. Nurses in her endoscopy center do not administer propofol.

Some key points in the ASGE/SGNA statement:

- Each endoscopy unit should have sedation policies that spell out the responsibilities for each member of the team.
- A nurse who gives sedation does so under the direct order of the physician.

Continued on page 26
Please see the ad for CERTIFICATION BOARD OF PERIOPERATIVE NURSING in the OR Manager print version.
Studies examine NAPS outcomes

Swiss researchers compared outcomes for 1,370 high-risk patients (ASA III and IV) and 642 patients (ASA I and II) who had NAPS during gastroscopies and/or colonoscopies. There were no major complications, though oxygen desaturation occurred in 3.6% of the ASA II and IV patients versus 1.7% of the ASA I and II patients. Four patients in the ASA III and IV group needed mask ventilation versus 1 in the ASA I and II group. The authors concluded NAPS during GI endoscopy is safe even for high-risk patients with careful monitoring.


Researchers randomized 80 ASA I and II patients to have either propofol or midazolam plus meperidine given by a nurse supervised by an endoscopist in a hospital outpatient GI lab. In all, 4 patients on midazolam plus meperidine had minor complications compared with 1 on propofol. Patients who received propofol expressed greater satisfaction. After 1 hour, 88% of propofol patients had been discharged compared with only 42% of patients on midazolam and meperidine.


A study of 9,152 endoscopies in an ambulatory surgery center in Medford, Ore, followed outcomes of a NAPS protocol developed by an anesthesiologist. There were 7 cases of respiratory compromise (3 prolonged apnea, 3 laryngospasm, and 1 aspiration requiring hospitalization), all with upper GI endoscopy. In all, 5 patients required mask ventilation, but none required intubation. Patient satisfaction was high. Mean time from end of procedures to discharge was 18 min.


Continued from page 24

• A nurse who gives deep sedation is responsible for monitoring the patient and should have no other responsibilities.

• Management of complications is the responsibility of the physician.

• Physicians and nurses should have “adequate training” for sedation; for deep sedation, this includes additional training in airway management and treatment of cardiovascular complications.

NAPS faces obstacles

Though advocates say outcome data for NAPS is strong, they acknowledge there are barriers to expanding the practice.

Douglas K. Rex, MD, a professor of medicine at Indiana University, president of the American College of Gastroenterology, and author of one of the outcome studies, has been a leader in developing a protocol for NAPS.

“We developed this program as a potential alternative to expand use of propofol without an enormous increase in costs,” he says. Using anesthesia providers for most GI procedures would be cost prohibitive, he and others say.

“I personally believe [NAPS] is safe if people are properly trained and patients are properly selected,” he adds. Nevertheless, because of obstacles, he doesn’t view NAPS as feasible now for most GI units.

Among the obstacles:

The package insert

The package insert’s statement that propofol should be administered by those trained in general anesthesia is a medical-legal barrier. SGNA considered the package insert in developing the statement, but because administering propofol is within the Nursing Practice Act in some states, SGNA thought it needed to provide direction. Harbaugh explains.

Dr Rex thinks the package insert is outdated.

“I don’t think there is an evidence base to support the package insert,” he says. “In fact, the evidence would suggest the package insert is outdated and needs to be reevaluated.” But that can be done only by the company that owns the drug, AstraZeneca.

The package insert creates civil liability problems for nurses and physicians who aren’t anesthesia providers and give propofol sedation, comments a nurse attorney, Deborah Krohn, RN, JD, of Baltimore, who works part-time as an endoscopy nurse.

The package insert “would be part of a plaintiff attorney’s arsenal” if there were a lawsuit involving injury to a patient in a case where a nurse gave propofol sedation, Krohn says. The attorney would likely refer to the insert as one element defining the standard of care for patients in these cases. She describes how a nurse’s deposition might go:

“Susan, can you read? Do you think these package inserts are throw-aways? Or do you think they provide real information and guidance?”

Patchwork of state laws

State boards of nursing are split on the issue.

In an informal survey of state boards earlier this year (chart), Krohn found 21 boards prohibit RN-administered propofol for procedural sedation, and 22 say it is permissible or have no prohibition. The other 7 did not have a clear statement, had not made a decision, or did not respond.

A number of states use broad language, making it hard for nurses to know where they stand. There also are nuances. Some say it is all right if there is anesthesia support. Some say it is permissible in the ICU for intubated patients but not for procedures.

“I think the debate is in its infancy,” says Krohn.

Financial issues

There are financial issues on both sides of the issue. The reimbursement picture is mixed.

According to the ASA, Medicare considers sedation given by an endoscopist to be bundled into the procedure and does not reimburse for sedation separately.

Medicare does cover anesthesia for endoscopy, however, when it is given by an anesthesia provider and considered “medically necessary.” That is determined by each Medicare carrier.

Actually, anesthesia-delivered propo-
Please see the ad for KARL STORZ ENDOSCOPY-AMERICA in the *OR Manager* print version.
A NAPS protocol

Nurses have been giving propofol sedation in the GI lab at Indiana University Hospital for about 4 years under a deep-sedation protocol developed in collaboration with anesthesiologists. This protocol for nurse-administered propofol sedation (NAPS) also applies to RNs who give propofol in the hospital’s bronchoscopy lab and electrophysiology labs.

Key features of the protocol:

Patient selection
Patients are excluded from NAPS if they are at risk of aspiration, might be difficult to intubate (such as patients with sleep apnea using CPAP machines and those who are extremely overweight), or are ASA class III and higher because of cardiac or pulmonary disease. Patients having upper GI endoscopies are more likely to be excluded because they are more likely to desaturate because of weight, among other reasons.

Training of nurses
Training involves a series of steps.
1. Nurses review written material and take a written exam.
2. Nurses observe trained nurses giving propofol. They then administer propofol under supervision for 2 to 3 weeks until deemed ready to begin giving it independently under supervision of an endoscopist. Training does not include advanced cardiac life support (ACLS), which nurses and endoscopists are already expected to have.
3. Data is collected on all NAPS procedures to monitor the safety record.

Staffing
The staffing pattern for NAPS includes:
- the endoscopist
- the RN who administers the drug and monitors the patient as his or her only responsibility
- a technician to assist the endoscopist.

The endoscopist is expected to manage any complications that occur.


Continued from page 26

MDs and RNs giving deep sedation to have, besides training for moderate sedation, additional training in “advanced airway management and treatment of cardiovascular complications.”

That goes beyond ACLS, she says, though ASGE and SGNA endorse ACLS.

“ACLS alone is not sufficient. There also has to be the ability for anyone administering deep sedation to rescue a patient who slips into a deeper level of sedation that can progress to general anesthesia,” she says.

That should include intubation, pharmacology of sedatives and reversal agents, and patient monitoring as well as recognition and drug management of complications.

At Indiana University, training for NAPS is outlined in a protocol developed in collaboration with anesthesiologists (sidebar). Finding someone to give the training can be difficult if anesthesia providers do not want to be involved.

Not surprisingly, Dr Philip, as an anesthesiologist, believes “adequate training” entails being prepared as an anesthesia provider or being credentialed by the organization to manage patients under general anesthesia. The way to assess whether there is “adequate training,” she notes, is to ask whether the organization would grant someone with that training privileges to administer general anesthesia as required by its accrediting organization.

Dr Philip is concerned not only about the content of the training but also whether clinicians will use their skills enough to maintain proficiency.

“You have to know how to manage patients who are having acute medical complications and how to intubate. These are tough skills to keep up unless you are doing them regularly,” Dr Philip says. “They may have bits of the right skills, but to pull them all together at the right time in an emergency takes a lot of ongoing practice.”

Enough data?
Though advocates say the outcome studies show nurse-administered propofol is safe, Dr Philip has reservations.

In the largest published study, by John A. Walker, MD, and colleagues from Medford, Ore, which involved more than 9,000 patients, Dr Philip noted there were 7 cases of significant respiratory compromise, all of which occurred in a subgroup of 1,830 upper-GI endoscopy patients. Of these, 3 developed prolonged apnea accompanied by hypoxemia, 3 developed laryngospasm, and 1 was a 74-year-old man who aspirated and was hospitalized. None of the patients required intubation, laryngeal mask airway, or rescue by an anesthesiologist.

In a study published by Dr Rex and his colleagues in 2002 reporting on their initial 2,000 cases of NAPS, Dr Philip notes 4 patients had desaturation to less than 85%, which the authors attributed to excessive administration of propofol and apnea; there also were 11 episodes of desaturation between 85% and 90%. These cases occurred despite administration of oxygen at 4 L per min. No patients were admitted or had other long-term problems.

Though there were no long-term complications, she asks, “Is that OK? That would be up to the cautious consumer.”

She questions whether there is enough data.

“Mortality for general anesthesia in healthy patients is about 1 in 300,000. This 11,000 cases is a fantastic beginning,” she says. “Is that OK? That would be up to the cautious consumer.”

She questions whether there is enough data.

“Mortality for general anesthesia in healthy patients is about 1 in 300,000. This 11,000 cases is a fantastic beginning, but we don’t know enough yet.”

For their part, gastroenterologists say...
Please see the ad for INTEGRATED MEDICAL SYSTEMS in the *OR Manager* print version.
they are not aware of evidence that establishes that propofol for endoscopy is safer when given by anesthesia specialists than by RNs supervised by physician endoscopists.

The debate is likely to continue for some time. —Pat Patterson

References


American Society for Gastrointestinal Endoscopy, Society of Gastroenterology Nurses and Associates. SGNA position statement: Role of GI registered nurses in the management of patients undergoing sedated procedures. www.sgna.org


Workplace

Docs’ disruptive behavior often involves conflict with nurses, study finds

When problems arise with physician behavior, most often they involve conflicts with nurses or other staff, according to a survey by the American College of Physician Executives (ACPE).

A third of the more than 1,600 respondents said they observe “problems with physician behavior” daily (3%), weekly (14%), or monthly (18%).

When there are problems, 70% said they nearly always involve the same physician(s). The most common behavior problem—disrespect.

Typically, problems with physician behavior at my organization involve:

- Refusal to complete tasks or carry out duties 52%
- Physical abuse (including throwing items) 9%
- Insults 37%
- Disrespect 83%
- Yelling 41%
- Other 16%

Most (78%) said their organization has a written code of behavior. But they were split on how the code is enforced—46% said it was enforced uniformly, while another 46% said it was enforced selectively. The rest said it was not enforced at all.

The survey report is in the September-October Physician Executive and is on the ACPE web site. —www.acpe.org

Nurses find change a pain in the neck

The more change in an organization, the more likely nurses were to report a neck problem, according to research published in the American Journal of Public Health.

Nurses who reported more than 6 system changes were more than 4 times as likely to have a neck disorder compared with nurses who reported 0 or 1 change. “The odds ratios for neck, shoulder, and back musculoskeletal disorders showed a consistent and increasing trend with the level of reported health care system change,” say the authors. Though many of the disorders were associated with the physical workload, there was also an association between changes and injuries that was independent of workload.

In all, 65% of nurses reported an increase in patient loads, and 65% reported an increase in acuity. Only one fourth reported their job was “very satisfying” and “security is good.”

The authors surveyed more than 1,000 nurses in Illinois and New York State, who were asked about musculoskeletal injuries and health care system changes such as staffing levels, patient acuity, and increases or decreases in the level of nursing care. —Lipscomb J, Trinkoff A, Brady B, et al. Am J Public Health. August 2004;94:1431-1435.

Hospitals using more contract labor

Hospitals’ use of contract labor, such as agency nurses and travelers, grew steadily as a percentage of total personnel expense, from 4.7% in 1997 to 8.1% in 2002. For-profit hospitals used a higher percentage of contract personnel (12.7%) than not-for-profit (7.7%) and government hospitals (7.5%). There was little difference between teaching and non-teaching hospitals.

Because pay rates for contract labor are often twice what staff employees are paid, avoiding use of temporary employees could save about $8 billion, according to the analysis, which used data from Medicare cost reports. The report was by American Hospital Directory, Inc, and Norton Healthcare. —www.ahd.com

Controversial new overtime rules in effect

New rules from the Department of Labor defining criteria for overtime went into effect Aug 23. Under the rules, RNs meet the test for “learned professionals,” who if salaried and making over $23,660 a year, can be considered exempt from overtime pay. The government says this is not a change from the previous rule because RNs have been considered exempt since 1971. Unions say the rules do not do enough to protect nurses who are paid hourly, however. The government counters that market forces have a bearing on how nurses are paid, and with the nursing shortage, employers are unlikely to withhold premium pay for overtime. The rules were published in the April 23 Federal Register. —www.dol.gov

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**Orthopedic Implant Trends**

**Hip and knee implant prices increase 9%**

A column on orthopedic implant costs and reimbursement.

In what has become old news to OR managers, implant costs are up because of shifts to new technology, particularly for hips. And Medicare payments are flat.

The average price paid for hip and knee implants by U.S. hospitals increased 9% between 2002 and 2003, according to data compiled by Orthopedic Network News (ONN). The data was compiled from 34 hospitals that submit data to ONN for its annual survey of hip and knee implants.

The average hip or knee implant system cost $4,346, an increase of 9% over $3,997 in 2002. Total hips increased 12% to $5,341 per procedure, partly because of a shift to more expensive coatings of femoral components. The percentage of total hip implants in this survey that use coatings increased from 57% of cases in 2002 to 67% in 2003. A total hip system with a porous stem averaged $5,615 in 2003, while a cemented total hip system averaged $4,389.

Total knee prices increased 8% to $4,141 in 2003. The vast majority of total knee systems (74%) are those in which both the femoral and tibial component are cemented.

The price of partial hip systems, used mostly in fracture patients, increased 16% to $2,447. This increase reflected the shift toward higher technology bipolar hips (58%) and away from the modular or one-piece endoprostheses (35%), which cost significantly less than bipolar implants.

**New hip products carry higher prices**

In the past couple of years, there have been a number of new total hip products, all designed to decrease the amount of polyethylene wear debris from a total hip joint. All of these systems carry significantly higher prices to hospital customers.

Under the moniker of “alternative bearing surfaces,” they include:

- cross-linked polyethylenes with wear resistance greater than traditional polyethylenes.

From the ONN survey, the metal and/or ceramic liners captured 7% of the market, while cross-linked polyethylene liners accounted for 59% of the total hip liners, and traditional polyethylenes were used in 34% of the total hips. The average selling price of a ceramic liner was $1,914 in 2003, while a metal liner was $1,246, a cross-linked poly liner was $910, and a traditional poly liner was $600 in the survey.

Although the ceramic, metal, or cross-linked liner is the most obvious of the additional costs of these systems, other costs are associated with their use, such as ceramic heads for use with the ceramic liners, and special acetabular shells designed for the ceramic or metal liners. Coupled with the reluctance of manufacturers to discount “new” technology, an alternative bearing total hip system can be double the price of a traditional hip system from several years ago. For example, the list price for Stryker’s ceramic-on-ceramic total hip system is over $10,000.

**Big push for unicompartmental knees**

The big marketing push last year in knee systems was unicompartmental knees, which replace either the lateral or medial condyle of the knee joint. A number of manufacturers have released (or re-released) their unicompartmental knee systems partly in response to the need for “minimally invasive” surgery.

In the ONN survey, unicompartmental knees accounted for 5% of the knees, although it has been noted that some hospitals perform unicompartmental knees for 25% of their patients, while others do not use them at all.

**Scant increase from Medicare**

Though hospitals have been paying higher prices for joint prostheses, there is little increase in Medicare payments. The Centers for Medicare and Medicaid Services (CMS) released new payment rates Aug 2. Included was a 2.4% increase for hospitals treating DRG 209, the payment category most frequently used for hip and knee implants in the Medicare population. The average hospital will receive $10,073 for Medicare discharges with total joints beginning Oct 1.

In FY 2003, ONN estimated that Medicare paid more for total joint procedures than any other category of procedure, at $4.4 billion. This surpassed payments for tracheostomy ($3.6 billion); heart failure ($3.3 billion); rhythm management, including pacemakers and defibrillators at $3.2 billion; and coronary stents at $2.9 billion.

—Stan Mendenhall
Editor, Orthopedic Network News
Mendenhall Associates Inc
Ann Arbor, Mich
Ambulatory surgery center (ASC) managers count among their accomplishments a staff with “zero turnover and a waiting list”; high patient satisfaction; and projects to achieve greater efficiency, better patient flow, and reduced waiting times.

They’re also working hard to balance clinical practice with the demands of running a competitive business and meeting expectations of owners, managers wrote in response to the 2004 OR Manager Salary/Career survey.

As more ASCs open, rivalries are heating up, and in some areas, hospital lobbies are trying to curb ASC growth.

One center survived the opening of a new surgery center that took 60% of its surgeons and nurses within 4 weeks. But this bruised ASC recovered quickly.

“We regained a positive bottom line in less than 3 months, were within budget, and had a Press Ganey (patient satisfaction survey) score of 96%,” the manager said.

They face challenges from owners as well.

“My achievement was surviving corporate bankruptcy,” one manager responded.

Another told of “walking a fine line with corporate partners,” who she felt did not adequately recognize the facility’s reputation or the knowledge of its personnel.

Like hospitals, ASC managers struggle to keep up with new surgical techniques and equipment “without breaking the budget,” as one manager put it.

The 14th annual OR Manager Salary/Career Survey polled 583 ASC managers, with 136 returned (23%).

ASC managers represent a diverse

Continued on page 34

Profile of the typical ASC manager

The typical manager of an ambulatory surgery center in the OR Manager Salary/Career Survey:

- Earns $75,674 in annual base salary
- Received a raise in the past year averaging 4.3% of base salary
- Holds the title of director (33%), nurse administrator (23%), or nurse manager (30%)
- Works in a joint venture (38%) or physician-owned (30%) facility in an urban (42%) or suburban (43%) locale.

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Respondents to ASC survey (n=136)

<table>
<thead>
<tr>
<th>Region</th>
<th>Distribution</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>69 (12%)</td>
<td>17%</td>
</tr>
<tr>
<td>South</td>
<td>202 (35%)</td>
<td>23%</td>
</tr>
<tr>
<td>Central</td>
<td>141 (24%)</td>
<td>24%</td>
</tr>
<tr>
<td>West</td>
<td>171 (29%)</td>
<td>35%</td>
</tr>
</tbody>
</table>
While the base salary averages $75,674, salaries range from $60,000 to $150,000 a year. Managers run centers with from 2 rooms to 13 rooms.

Most survey respondents are from ASCs owned by joint ventures (38%) or physicians (30%), followed by corporations (18%) and hospitals (12%).

Raises

Raises in this year’s survey, averaging 4.3%, are close to the 4.1% increase for hospital-based managers and a little higher than the 3.9% in 2003. The increases compare favorably to inflation.

ASC managers in the Central region received the highest raises, averaging 4.4%.

Physician-owned and hospital-owned facilities gave the greatest boosts, at 7.4% and 6.1% respectively. The number of managers receiving salary increases, at 84%, is almost the same as last year.

What ASC managers are making

This year’s average base salary of $75,674 compares to $73,213 last year. Hospital-based OR managers average 13% more, at $85,485. But only about $1,000 separates salaries of ASC and hospital-based managers who supervise 5 or fewer operating rooms: $71,728 for hospitals and $70,698 for ASCs.

ASCs with 5 or more ORs pay about 13% more than facilities with fewer than 5 ORs.

The South lags behind other regions. An ASC manager in a southern state averages 12% less in salary than an eastern counterpart.

Hospital-owned ASCs pay the most, followed by facilities owned by corporations, joint ventures, and physicians.

Bonuses

In all, 38% of ASC managers are eligible for bonuses, about the same as hospital-based OR managers (39%). The average bonus for an ASC manager was 8.6%, a little higher than the 7.9% paid to hospital OR managers.

Bonuses were most generous in the Central region (12%), followed by the West (7.9%), the South (7.5%), and the East (5%).

Benefits for ASC managers

Health insurance 99% 99%
Paid time off 99% 99%
Depen health insur 68% 81%
Dental insurance 82% 94%
Life insurance 82% 95%
Disability insurance 72% 83%
Tuition reimbursement 60% 88%
Retirement plan 79% 89%
Eye care 58% 62%

About the ASC

Number of ORs, volume. On average, managers oversee 6 operating rooms. The average surgical volume is 5,170 cases. Most ASCs saw their volume rise this year, with an average increase of 10%.

Budget. The average overall annual operating budget for an ASC is $5.0 million. The average is $3.9 million for ASCs with fewer than 5 ORs and $6.3 million for ASCs with 5 or more ORs.

Recovery-care capability. In all, 27% (n=36) of ASCs offer stays of overnight or greater. Overnight stays are most preva-
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How many FTEs does it take to run an ASC’s business office?

The average number of FTEs is 7.1 for ASC respondents to the OR Manager Salary/Career Survey.

<table>
<thead>
<tr>
<th>Business FTEs by number of ORs</th>
<th>&lt;5 ORs</th>
<th>5+ORs</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2 (n=56)</td>
<td>9.2 (n=50)</td>
<td></td>
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</table>

There is no agreed-upon formula for how many FTEs the business office should have. The number varies not only by surgical volume but also with business functions performed, workload, and skill sets of employees.

The range of FTEs ranges widely by surgical volume (chart).

Ownership has a lot to do with business functions performed and FTEs needed. For example, in the survey:

- 79% of physician-owned and 82% of joint-venture facilities do their own billing and claims processing, while only 46% of hospital-owned ASCs do.
- About 70% of physician-owned facilities and 80% of joint ventures do their own accounts payable and receivable, while about 30% of hospital-owned ASCs do.

But FTEs vary even for ASCs performing the same number of business functions. For example, 3 ASCs responding to the survey with a volume of 3,000 to 3,999 procedures a year each performed 15 out of 18 business functions listed in the survey questionnaire, but their business office FTEs ranged from 5 to 11. The size of the response did not permit further analysis.

Workload can also vary independent of case volume, ASC managers note. For example, two ASCs perform 5,000 cases a year, but one outsources physician credentialing while the other credentials 100 MDs. Or one administers 5 insurance contracts while another has 30. Accreditation also makes a difference: An accredited center may need more FTEs to meet standards for quality improvement and the like.

Among issues to consider in planning for business office staffing, suggests Barbara Harmer, RN, MHA, of HealthCare Consultants, Inc, Celebration, Fla, who consults with ASCs:

- ownership and structure
- surgical volume and complexity of the organization
- hours of operation
- skill set of individuals
- internal versus outsourced functions.

How efficient an office is starts with employee selection, Harmer notes. The more cross-training a center can do, the fewer FTEs it will need. She recommends looking for candidates who can multitask and either have ASC experience or are familiar with the ASC environment. For example, in an ASC she managed, the receptionist position was job-shared—the first person reported at 5:45 am and worked at the front desk until the second person arrived at 9 am. The first person then became the medical records clerk, plus relieved other staff for lunch. Similar arrangements can be made for other functions.
lent in the West (23 facilities), compared to the Central region (7), the South (5), and the East (1).

About your role

Titles. Most respondents hold the title of director, except for those from hospital-owned ASCs, where nurse manager is most common.

Other titles include clinical director, director of nursing, supervisor, executive director, or operations manager.

Reporting. More than half (58%) of respondents report to the ASC administration, followed by the board of directors, medical director, or corporate office. A variety of other arrangements includes reporting to the executive committee of the board of directors, clinical coordinator, hospital chief nursing officer, managing partner, executive director, CEO, or vice president of patient services.

Scope of role. Most respondents manage a single facility (58%), while 42% are responsible for multiple sites.

Purchasing power

ASC managers influence purchasing decisions—40% are the primary decision maker, and 22% say their involvement increased in the past year. Nearly all have a say in capital equipment and OR supply purchases.

About you

The average age of an ASC manager is edging closer to 50. It’s 49.6 to be exact, up from 48 last year, and 39% are between the ages of 50 and 59. Males make up 10% of the managerial pool.

Education.

Most ASC managers (95%) are RNs, and 65% hold a bachelor’s degree or higher. Master’s degrees and doctorates have been achieved by 18%.

In all, 41% of ASCs require a specific degree for the respondent’s position. When a degree is required, for 68% it is a bachelor’s and for 13% a master’s, with the remainder requiring at least an associate degree or diploma. All of the hospital-owned ASCs requiring a degree call for a bachelor’s degree, while 65% of joint ventures, 60% of corporate-owned centers, and 56% of physician-owned facilities specify a bachelor’s.

❖

—Billie Fernsebner, RN, MSN

—Leslie Flowers

Share successes At 2005 meetings

Share your successes with your colleagues at the conferences of OR Manager, Inc. Send proposals of about 500 words describing the session you wish to present. Sessions are approximately 1 1/2 hours long.

Managing Today’s OR Suite

Oct 19 to 21, 2005, San Diego

Managing Today’s OR Suite focuses on practical topics related to management of surgical services, such as achieving greater efficiency, management of information, leading and developing staff, and keeping costs under control.

The keynote address and general sessions feature nationally known speakers who have important messages for surgical services directors. If you wish to suggest a general session speaker, please obtain as much information about the person as you can, such as the speaker’s title, organization, address, and phone number.

OR Business Management Conference

May 2 to 4, 2005, Tampa, Fla

The OR Business Management Conference emphasizes financial management, materials management, OR technology/equipment management, and OR design and construction.

The deadline for proposals and suggestions for both conferences is Nov 1.

Fax or e-mail proposals to Billie Fernsebner, RN, MSN, education director, OR Manager, Inc, at 303/442-5960 or bfernsebner@ormanager.com. If you have questions, please call 303/442-1661.
Health Policy & Politics

Will hospitals be competing with drug companies for Medicare payments?

Adding a drug benefit to Medicare is projected to boost federal spending on the program 30.6% between 2005 and 2007, the Congressional Budget Office (CBO) said in its September economic update. According to the CBO, Medicare spending will reach $297 billion in 2005, up 8% over 2004.

The drug benefit could put a squeeze on hospital payments, say analysts. “We’re wondering if this means pharmaceutical companies and hospitals will be in direct competition for the Medicare dollar,” one analyst told *Modern Healthcare.*

—www.cbo.gov

California bill would require “lift teams”

California nurses were urging Gov. Arnold Schwarzenegger to sign the nation’s first law requiring 24-hour “lift teams” to help move patients.

The fate of the bill (AB 2432) was uncertain. The bill passed the legislature in late August. Kaiser Permanente, the state’s largest private hospital operator, supported it, but virtually every other hospital in the state opposed it, according to the Sept 3 *San Francisco Chronicle.*

“We have the highest rate of back injuries among professions, and that includes truck drivers,” said a spokeswoman for the California Nurses Association, which picketed hospitals in support. But most hospitals said the bill is too restrictive.

—www.sfchronicle.com

New council to look at coverage for new medical technologies

The Centers for Medicare and Medicaid Services (CMS) are setting up a new Council on Technology and Innovation to look at clinical benefits of new technologies. One aim will be to look at merits of new drugs and technologies to make their transition to Medicare coverage “as predictable and fast as possible,” said CMS administrator Mark B. McClellan, MD, PhD. CMS also wants to provide for more public input.

—www.cms.hhs.gov

Scales tipping against tax-exempt hospitals

Non-profit hospitals are under increasing pressure to defend their tax-exempt status, *USA Today* reported Aug 24. Nonprofits, which make up 85% of the nation’s hospitals, have come under scrutiny because they are expected to provide community benefits, including charity care, in exchange for not paying taxes.

Pressure is coming from several fronts. Congressional committees are investigating how hospitals charge the uninsured, saying some of them badger low-income patients to pay full price while they give insurance companies discounts. More than 40 class-action lawsuits have been filed since June by high-profile law firms against nearly 400 not-for-profit hospitals over the way hospitals handle bills for the uninsured.

—www.usatoday.com

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OR costs growing faster than drug costs

Operating room costs grew at a faster rate—32%—than drug costs, which increased by 22%, between 2000 and 2002. Cost also climbed for diagnostic imaging (36%), intensive care (27%), and medical supplies (26%), according to Solucient, a data management company. The database used to analyze the costs included about 20 million discharges a year from about 2,500 hospitals.

—www.solucient.com

New project on reducing surgical site infections

The nonprofit Institute for Healthcare Improvement begins a collaborative this month on surgical site infection prevention. Areas of focus are: appropriate hair removal, perioperative glucose control, supplemental oxygen, normothermia, and an improved OR culture. The collaborative is intended to help participants develop a system for significantly reducing surgical infections.

—www.ihi.org

Bariatric surgery complications “acceptably low,” study finds

National outcomes for obesity surgery are similar to those in specialized centers, a new study finds.

Using data from the National Hospital Discharge Survey, researchers found the complication rate was 9.6%, comparable to that in centers that specialize in bariatric procedures. A total of 8.6% of patients had a length of stay longer than 7 days. The most common preoperative comorbidities were: hyper-tension (34%), arthritis (27%), gastro-esophageal reflux disease (22%), sleep apnea (22%), and diabetes (18%).

The researchers concluded that though the number of bariatric procedures is increasing rapidly, complication rates remain “acceptably low.”


Orthopedic surgeons issue advice on prophylactic antibiotics

The American Academy of Orthopaedic Surgeons has issued a statement with evidence-based recommendations for antibiotic prophylaxis for primary total joint replacements. The recommendations address three areas:
• selection of the antibiotic
• timing and dosage of antibiotics
• duration of antibiotics, which is recommended not to exceed 24 hours postoperatively.

—www.aaos.org

Most hospitals to get full Medicare update

Nearly all eligible hospitals have begun reporting quality data to the government, entitling them to a full update in Medicare payments, the Centers for Medicare and Medicaid Services (CMS) announced Sept 2.

Although reporting is voluntary, under a new law, acute care hospitals that do not report will have their update reduced by 0.4 percentage points. CMS said 98.3% of hospitals met all requirements and will receive the full update.

Quality data are reported on three conditions: acute myocardial infarction, heart failure, and pneumonia.

Hospital quality data will be available to consumers starting in 2005.

—www.cms.hhs.gov

JCAHO votes to up its survey fees

The board of the Joint Commission on Accreditation of Healthcare Organizations voted Sept 7 to increase triennial survey fees to hospitals by about $2,700 in 2005, an 11.7% rise over the average $23,000 fee for 2004, Modern Healthcare reported. Individual hospitals’ increases will range from 5% to 12%, depending on their size and complexity. Also, hospitals of 200 beds or more will pay an extra $3,500 for adding an engineer to the survey team to assess compliance with the Life Safety Code and physical plant requirements.

Survey fees also will go up for other accredited organizations, including ambulatory care organizations, which will pay $810 more, and critical access hospitals, which will pay an additional $300.

—www.jcaho.org

AAAHC to seek comments on proposed standards revisions

The Accreditation Association for Ambulatory Health Care planned to open a 30-day comment period at the end of September on proposed revisions to its standards for ambulatory facilities, including surgery centers. New standards will be adopted in November to take effect in March 2005. The proposed revisions will be posted on-line.

—www.aaahc.org