OR managers’ salaries increase, but so do their responsibilities

Over the past 10 years, OR managers and directors have seen their average annual base salary rise substantially, from $64,543 in 1998 to $102,000 in 2008, but their span of control has also expanded, from an average of 59.5 clinical FTEs in 1998 to 98.9 FTEs this year.

OR managers and directors now receive an average total compensation package of $124,000 and oversee an average annual operating budget of $21.8 million.

Most leaders in both hospital ORs and ambulatory surgery centers (ASCs) like their jobs, scoring their satisfaction an average of 3.9 (out of a possible 5) for those in hospitals and 4.1 for those in ASCs. Retirement still looms large for a management workforce with an average age of 52.3 years for managers and directors in hospitals and 51 years for managers in ASCs.

Those are highlights from the 18th annual OR Manager Salary/Career Survey. The survey was mailed in April to 800 OR Manager subscribers in hospital OR management positions, with a response rate of 39%. The margin of error is ± 4.8 at the 95% confidence level.

A separate survey was sent to managers in ASCs (see page 31 for a complete report). ReadexResearch conducted both surveys. Results from the staffing portion of the survey appeared in the September OR Manager.

Hospital-based OR managers and directors entered the realm of the 6-digit salary this year by earning an average of

Continued on page 9

ORs add business manager role and see responsibilities grow

More ORs are adding a business manager role—and seeing responsibilities expand. More than one-third (38%) responding to this year’s OR Manager Salary/Career Survey have an OR business manager, up from 20% in 2003. This year’s survey asked more questions about this position.

The average salary reported for OR business managers is $73,000, ranging from over $100,000 to less than $60,000. Salary information was provided by 83 of the 114 respondents who have an OR business manager.

Most often, business managers (77%) report to the OR director. For about three-fourths (73%), a specific degree is required. Two-thirds (66%) do not have a clinical background.

Their top 5 responsibilities are:
- financial analysis/reporting
- annual budget
- billing/reimbursement

Continued on page 16
Please see the ad for MEGADYNE in the *OR Manager* print version.
Editorial

Take me to the nearest emergency room.” That’s what most people would say if they have chest pain or any other alarming symptom. The emergency department (ED) may no longer be so near.

Our country is seeing an erosion of its emergency medical system—even while it is a safety net to many.

Emergency visits are rising, but the number of emergency departments is falling.


You may have seen this in your own hospital, with the ED reaching capacity, ambulances diverted, and patients waiting for beds.

No one likes to think about what would happen with a flu epidemic or other major disaster. The Trust for America’s Health (http://www.trustealth.org/) in its yearly assessment of emergency readiness concluded:

• 25 states would run out of hospital beds in 2 weeks with a moderate pandemic flu outbreak.
• 40 states face a shortage of nurses.
• At least 6 states have cut their public health budgets.

Surgeons have backed away from taking emergency call. The American College of Surgeons cites a number of reasons, including the call burden, the number of surgeons opting out, and the risk of being sued. An underlying factor is that the shortage of surgeons, expected to grow in the future, is hitting trauma centers and EDs first.

An ED crunch

Emergency physicians say the ED crunch is likely to worsen.

“Millions more people each year are seeking emergency care, but emergency rooms are continuing to close, often because so much care goes uncompensated, which is the real economic issue in emergency medicine today,” said Linda Lawrence, MD, president of the American College of Emergency Physicians.

She said the CDC report is worrisome because the aging population of baby boomers is growing. And the second highest percentage of emergency visits for serious illnesses was among people ages 75 and older, which, she said, “could mean catastrophic overcrowding in a few years.”

OR can stress resources

The OR has a role in ED crowding. Research has shown artificial peaks and valleys in the elective surgical schedule place stress on resources throughout the hospital and cause patient backups in the postanesthesia care unit, the OR, and the ED. Smoothing the elective schedule can help alleviate that stress.

The Institute of Medicine took a comprehensive look at emergency care earlier in 2006, finding the system was overburdened, underfunded, and highly fragmented.

A lot of the health care reform talk is about prevention and better care for chronic diseases like diabetes and asthma—that’s as it should be. But these reforms are years off.

“In the meantime, emergency departments are providing a health safety net for everyone,” Dr Lawrence said.

Emergency physicians are urging Congress to pass the bipartisan Access to Emergency Medical Services Act. The bill would create a national commission to examine access to emergency care. It would also increase physician payments and call on the government to collect data on ED crowding so guidelines and standards can be developed.

Emergency physicians are urging the presidential candidates to address the ED crisis as part of their health care reform proposals.

The Institute of Medicine, the American College of Surgeons, and the American College of Emergency Physicians have all sounded the alarm.

Is anyone listening?  
—Pat Patterson
Please see the ad for
KARL STORZ ENDOSCOPY-AMERICA
in the *OR Manager* print version.
Scrub robot transfers to CS department

Penelope, the first surgical robot able to hand instruments and assist at surgery is transferring to another department—central sterile reprocessing—and her name will be Penelope CS.

Penelope, named for Ulysses’s wife in the mythic Odyssey by Homer, was invented by Michael R. Treat, MD, associate professor of clinical surgery in the College of Physicians and Surgeons of Columbia University in New York City.

Penelope’s software brain allowed her to focus on surgical instruments, count them, know where they were, and hand them to the surgeon. Penelope also could unpack instruments, arrange them, pick up an instrument, and put it back.

Thus, it wasn’t much of a stretch to move Penelope into CS and use her to clean, sort, inspect, and count instruments and repack them to go back to the OR.

A ‘brain transplant’

Penelope CS’s arm can be heavier and more versatile than the OR robot’s because she won’t have to work so closely with people. Instead, Penelope will be in a 5 feet-square Plexiglas enclosure surrounded by stations for cleaning, inspecting, counting, and repacking instruments.

The cubicle has a panel door that can be lifted to push in dirty instrument trays and retrieve clean ones.

“Penelope CS is more of a manufacturing process that doesn’t involve a lot of sensitive issues. We designed Penelope’s OR robotic arm to be extremely lightweight so it couldn’t hurt you if it bumped into you,” Dr. Treat told OR Manager.

With the help of robot manufacturer Adept Technology of Livermore, California, Penelope CS is a combination of a stockier robot with a heavier arm plus a magnetic hand and software brain with some adjustments.

“We are doing what I call a brain transplant,” says Dr. Treat.

Doing the dirty work

Penelope CS will not need Food and Drug Administration approval because “she won’t be working among people,” says Dr. Treat. “Unlike the original Penelope, this one you might say is just a sophisticated dishwasher.”

Dr. Treat and his colleagues at Robotic Systems & Technologies Inc, a company he founded in 2002 to develop smart medical devices, are in the process of completing the transplant of Penelope’s OR software brain into the heavier armed Adept robot.

There will be some tasks Penelope CS won’t be able to do right away, like take apart a trumpet valve, but if she can do the bulk of the work, like minor, major, and orthopedic trays, that’s already a good thing, he says.

Less worry about splashing

One of Penelope’s champions is a pediatric orthopedic surgeon at New York’s Hospital for Special Surgery who believes a robot will be accurate in making sure all of the screws, spacers, and inserts are always on his trays.

“A robot is capable of putting together a tray of instruments perfectly, just as a robot puts together our cars that we drive,” says Dr. Treat.

Another plus is that Penelope CS can take the worry of splashing and bloodborne pathogens away from humans who now clean instruments.

“We’re using a machine to do the dirty work and also maybe do it faster and more accurately. It is a winner for everybody,” he says.

—Judith M. Mathias, RN, MA
Please see the ad for
SPECTRUM SURGICAL INSTRUMENTS
in the OR Manager print version.
Managing Today’s OR Suite

OR Manager of Year ‘a total team player’

Barbara McKinnon, RN, BSN, CNOR

Barbara is not afraid to take educated risks to make a difference. Barbara will challenge the status quo and is open to change. She is a true team player, always able to look at the big picture.”

That is an excerpt from one letter sent on behalf of Barbara McKinnon, RN, BSN, CNOR, this year’s OR Manager of the Year. McKinnon is nurse manager of the operating rooms at New England Baptist Hospital in Boston, where she oversees 12 ORs with a staff of 80 FTEs at one of the nation’s leading hospitals for orthopedics.

McKinnon will be honored at the Managing Today’s OR Suite Conference to be held Oct 29 to 31 in Washington, DC. As OR Manager of the Year, she receives an expense-paid trip to the conference.

In the letter, Gail Sebet, RN, BSN, CNOR, New England Baptist’s director of perioperative services and a colleague of McKinnon’s for 30 years, also noted McKinnon’s commitment to patient safety, leadership, and compassion for patients, among other qualities.

The nominating letters portray a leader with a strong emphasis on patients and staff.

“Barbara has never lost focus on why she became a nurse. She engages her staff to work as a team, be respectful of coworkers, be efficient, and most importantly, practice safe perioperative nursing,” wrote the OR educator, Sherry L. Gomes, RN, BSN, CNOR, ONC.

A few of McKinnon’s accomplishments:

- training of new graduates and inexperienced RNs for the specialty orthopedic hospital
- 100% compliance with the Universal Protocol for surgical site verification and medication labeling in the OR
- education in safety measures during major construction for the OR, central sterile reprocessing, preoperative area, and postanesthesia care unit (PACU).

RNs connect with families

One of McKinnon’s achievements is gaining approval for an additional RN position to serve as surgical liaison for patients and families.

“These nurses go and talk to the families,” she explains. They go into the OR to check on the status of cases and let families know when patients will be going to their rooms. The nurses not only provide support for families but help reduce phone calls to the OR. They may be one reason New England Baptist rates in the 99th percentile for patient satisfaction with Press Ganey.

A pep rally for staff

McKinnon has also been an advocate for the staff. Last year, when 11 staff members suddenly left to relocate, retire, or respond to the lure of higher pay, McKinnon was looking for a way to shore up morale.

It was football season, and Perioperative Nurse Week was approaching, so McKinnon decided to hold a “pep rally.” She got decorations and invited physicians and senior administrators.

She asked the manager of central sterile reprocessing, Mark Duro, CRCST, to help her put together a PowerPoint to recognize every staff group, including the “rookies” (orientees), the “defense” (nurses who monitor patient safety practices), and “coaches” (managers). After the cheers, everyone gathered for a “tailgate party.”

Duro wrote: “I have worked with over 11 different OR managers in my years, and Barbara is my favorite. This is because she has always been fair, insightful, and a total team player.”

McKinnon managed to fill the staff vacancies within a short time.

During the long winter months, realizing the staff needed a lift, she came up with creative, short-term benefits at no cost to the hospital, a popular program that “was talked about for months,” wrote Ann Callahan, RN, a clinical resource nurse.

Keeping the OR moving

At an orthopedic hospital, with complicated instrumentation and setups, turnover times are always a challenge. McKinnon instituted a “turnover team” to expedite the process. When a case is finishing, the staff calls for the team. The teams, facilitated by an RN and a surgical technologist, clean the room and prepare for the next case while the circulating nurse finishes documentation and goes to see the next patient.

Patient safety measures

Like other ORs, McKinnon and her team have worked to achieve compliance with patient safety goals. With an orthopedic caseload, the hospital has always been focused on right-site verification.

“I think we were a little ahead of the game,” she says.

The attending surgeon has traditionally signed the site, and McKinnon herself monitors compliance.

Persistence also drove compliance with medication labeling on the sterile field.

“We had observers go around, and they would report to the staff on their compliance,” she says. When compliance plateaued at 90% to 95%, monitors went underground to spot where improvement was needed.

“Everyone finally realized we were checking on them,” she says.

McKinnon admits that she originally didn’t like change.

“When I realized that in order to grow and get better, I had to change,” she says. “But I also wanted to do it safely and make sure the staff was involved.” When new ORs were planned, the staff nurses had a big role in planning, as they do when new policies are developed.

“People are always stopping in my office to make suggestions, or just to vent,” she says.

She admits that when she read the nominating letters, she was taken aback.

“This is the manager I strive to be but didn’t know I had become,” she says.
Please see the ad for
SKYTRON, INC.
in the OR Manager print version.
Salary/Career Survey

Profile of the typical OR manager

The typical head of a hospital OR in the OR Manager Salary/Career Survey:
- Earns an annual salary of $115,000 for an administrative director, $100,000 for a director, and $87,000 for a nurse manager
- Received a raise of 4.3%
- Holds the title of administrator/administrative director (30%) or director (41%)
- Works in a community nonteaching hospital (73%) with an average of 13.6 staffed ORs
- Manages 5.9 departments
- Oversees 98.9 clinical and 21.9 non-clinical FTEs
- Is responsible for an operating budget of $21.8 million
- Is 52.3 years old and plans to retire in 2018.

Respondents to hospital survey

<table>
<thead>
<tr>
<th>Region</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>17%</td>
</tr>
<tr>
<td>Midwest</td>
<td>39%</td>
</tr>
<tr>
<td>South</td>
<td>30%</td>
</tr>
<tr>
<td>West</td>
<td>15%</td>
</tr>
</tbody>
</table>

$102,000, up from $99,000 in 2007. Salaries are highest in the West ($112,000), with the other regions of the country similar to each other. Those in teaching hospitals earn an average of $16,000 more than their community hospital counterparts. Salary increases as the number of ORs managed increases and when managers and directors oversee multiple departments at more than one facility.

Those with the title of administrator or administrative director make an average of $115,000, directors average $100,000, and nurse managers $87,000.

Respondents report their last salary increase averaged 4.3%, the same as in 2007, with the West and the Northeast receiving slightly more.

Changing profile of OR managers

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The typical OR manager or director in a hospital . . .</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*is paid an average annual base salary of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reports to nursing administration</td>
<td>66%</td>
<td>73%</td>
<td>66%</td>
</tr>
<tr>
<td>is eligible for incentive bonus</td>
<td>34%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>manages more clinical FTEs</td>
<td>59.5</td>
<td>72.0</td>
<td>98.9</td>
</tr>
<tr>
<td>has a master's degree</td>
<td>31%</td>
<td>37%</td>
<td>40%</td>
</tr>
</tbody>
</table>

*Overall average for OR directors and managers. Source: OR Manager, Inc.

Average annual salary (and total compensation) by region

<table>
<thead>
<tr>
<th>Region</th>
<th>Average Annual Salary</th>
<th>Total Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>$112,000 ($130,000)</td>
<td></td>
</tr>
<tr>
<td>Midwest</td>
<td>$99,000 ($120,000)</td>
<td></td>
</tr>
<tr>
<td>South</td>
<td>$102,000 ($127,000)</td>
<td></td>
</tr>
<tr>
<td>Northeast</td>
<td>$100,000 ($119,000)</td>
<td></td>
</tr>
</tbody>
</table>

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

Raises by region

<table>
<thead>
<tr>
<th>Region</th>
<th>Raise</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>4.5%</td>
</tr>
<tr>
<td>Northeast</td>
<td>4.5%</td>
</tr>
<tr>
<td>South</td>
<td>4.3%</td>
</tr>
<tr>
<td>Midwest</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

Total compensation

When bonuses, insurance, pension, and other benefits are added, the average compensation is $124,000 ($121,00 in 2007). Nearly one-fourth (22%) of respondents earn total compensation of $150,00 or more, while 3% make less than $70,000. The most common benefits include:

- Health insurance: 95%
- Life insurance: 93%
- Dental insurance: 90%
- 401(k) retirement plan: 88%
- Tuition reimbursement: 84%
- Disability insurance: 80%
- Eye care: 66%
- Educational benefits: 66%
- Dependent health insurance: 66%
- Pensions: 53%

Continued from page 1

Continued on page 10
All respondents receive paid time off, including vacation, sick time, and holidays, with an average of 30.3 days. Health insurance coverage for dependents was significantly lower than last year’s 75%.

Half of OR managers and directors receive either bonus or profit sharing as part of their total compensation package. In all, 40% received a bonus or profit sharing in the past 12 months, with an average amount of $6,030.

Nearly one-quarter (23%) of these monetary awards were $10,000 or above, with 3% of respondents taking home $25,000 or more. Monetary incentives are more common for administrators and for those overseeing a higher number of ORs.

Only about a third (34%) were eligible for an incentive bonus in 1998, compared to 40% in 2008. That jump is less impressive than it appears, because 40% were also eligible for bonuses 5 years ago.

Vacancies for OR management

Though there are anecdotal reports of large numbers of vacancies for OR managers and directors, only 6% of respondents report management positions are vacant. The average length of a vacancy is 9.3 months. Just 3% say an interim person fills the manager or director position, with an average tenure of 8.9 months.

In all, 6% are actively seeking a new job, while 18% are strongly considering a job search. This is consistent by job title and the number of ORs managed. OR managers and directors in teaching hos-
Has surgical volume increased?

- Increased 39%
- Remained about the same 36%
- Decreased 24%

Which other departments report to you?

- Postanesthesia care 75%
- Central processing 67%
- Outpatient/same-day surgery 64%
- GI/endoscopy 59%
- Preadmission services 54%
- Anesthesia support personnel 51%
- Materials management for OR 45%
- Pain management 22%
- Perfusion services 16%
- CRNAs 12%
- Cardiac cath lab 6%
- Inpatient unit 5%
- Emergency room/trauma services 3%
- ICU 3%

Others mentioned: Scheduling (2%), respiratory (2%).

Has surgical volume increased? OR managers and directors are a veteran group. By the end of 2014 (only 6 years away), 36% expect to be retired. More than half in this year’s survey have been in nursing for 30 or more years, and 56% have been in their position for 5 years or more. In all, 38% are 55 or older, with only 12% under 45.

About your role

OR managers and directors continue to have a wide scope of responsibility. 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 (41%), followed by administrator or administrative director (30%), and nurse manager (26%).

The title of the managed work area varies. Most administrators or administrative directors (16%) oversee “perioperative services,” while most directors (20%) manage “surgical services,” and most nurse managers (14%) oversee the “operating room.”

Reporting structure. Two-thirds of respondents (66%) report to nursing administration, while 30% report to hospital administration.

Those in community hospitals are more likely (68%) to report to nursing administration compared with teaching hospitals (56%).

Beyond the OR. Most OR managers and directors have responsibility beyond the OR, with 77% of directors and 62% of nurse managers managing the OR department and other departments in one hospital. Just 7% manage OR depart-

Continued on page 12
How many clinical FTEs are under your span of control?

<table>
<thead>
<tr>
<th>By type of facility</th>
<th>By number of ORs</th>
<th>By title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Teaching</td>
<td>1-4</td>
</tr>
<tr>
<td>Clinical</td>
<td></td>
<td>82.0</td>
</tr>
<tr>
<td>Nonclinical</td>
<td></td>
<td>17.2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>By type of facility</th>
<th>By number of ORs</th>
<th>By title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Teaching</td>
<td>1-4</td>
</tr>
<tr>
<td>Operating</td>
<td></td>
<td>$16.1</td>
</tr>
<tr>
<td>Capital</td>
<td></td>
<td>$1.5</td>
</tr>
<tr>
<td>Personnel</td>
<td></td>
<td>$4.0</td>
</tr>
</tbody>
</table>
Average number of ORs managed by title

Administrator/administrative director 19.7
Director 10.6
Nurse manager 11.2

The average annual case volume is 9,470 and, not surprisingly, size correlates with volume.

Annual surgical volume by number of ORs managed

<table>
<thead>
<tr>
<th>ORs managed</th>
<th>Surgical Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>3,220</td>
</tr>
<tr>
<td>5-9</td>
<td>6,250</td>
</tr>
<tr>
<td>10+</td>
<td>13,760</td>
</tr>
</tbody>
</table>

Surgical volume continues to increase for many ORs, with 39% (40% in 2007) of respondents reporting a higher number of surgical procedures in the past 12 months. About a fourth (24%) report a decrease, while 36% say volume has stayed about the same. The growth in volume is slower than in years past; increases of 71% were reported in 2000 and 69% in 1999.

Staff incentives. More than a fourth of OR managers and directors (26%) say their facility has a plan for giving its staff financial rewards for performance improvements or cost reductions. Community hospitals are more likely to have these plans than teaching hospitals (27% vs 20%). Surprisingly, organizations with 1 to 4 ORs are more likely to offer financial rewards (33%) compared to larger organizations (16% for 5-9 ORs and 28% for 10+ ORs).

About you

The vast majority of OR managers and directors are women (86%) who are RNs (96%).

Age and retirement. The aging management workforce continues to be a concern, with an average age of 52.3 years. That's 5 years older than the 47.1 reported in 1998 and 2 years older than in 2003.

Continued on page 14
**Salary/Career Survey**

**Most adding or renovating ORs**
As in 2007, nearly half (46%) of respondents are adding new ORs or planning to add ORs within the next 12 months. More than half (53%) are renovating or plan to renovate in the next 12 months. Leading reasons for adding ORs are to increase capacity or accommodate new technology. Top reasons for renovating are to update the facility, accommodate new technology, improve efficiencies, and add capacity/space.

**Are you adding or planning to add new ORs?**

<table>
<thead>
<tr>
<th>Reasons for adding ORs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase capacity</td>
</tr>
<tr>
<td>Accommodate new technology</td>
</tr>
<tr>
<td>Replace old facility</td>
</tr>
<tr>
<td>Other reason</td>
</tr>
</tbody>
</table>

**Are you currently renovating or planning to renovate ORs?**

<table>
<thead>
<tr>
<th>Reasons for renovating ORs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update facility</td>
</tr>
<tr>
<td>Accommodate new technology</td>
</tr>
<tr>
<td>Improve efficiencies</td>
</tr>
<tr>
<td>Add capacity/space</td>
</tr>
<tr>
<td>Add new services</td>
</tr>
<tr>
<td>Meet structural requirements</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

**Do you influence selection and purchase of OR capital equipment and supplies/equipment?**

- Yes, OR supplies/equipment: 91%
- Yes, OR capital equipment: 83%

**Incentives for staff**
More than one-fourth of respondents have a plan for rewarding their staffs financially for aiding performance improvement or cost-savings efforts. These plans are most common in community hospitals (27%) and in ORs with 1 to 4 rooms (33%).

**Do you reward staff financially for improving performance or reducing supply costs?**

- Yes: 26%
- No: 74%

**Continued from page 13**

Only 12% are 44 years old or younger.
The average year planned for retirement is 2018, a mere decade away. In all, 44% of the respondents will retire between 2010 and 2019. Leaders who retire will take along years of experience. Managers and directors have been in their current positions an average of 7.3 years.

**Education.** Managers and directors are most likely to have a bachelor’s degree as their highest level of education, while administrators and administrative directors typically have a master’s degree. Graduate education has risen over the past years. In all, 40% of respondents report their highest degree as a master’s, compared with 37% in 2003 and 31% in 1998. The most common master’s degree is the MS/MSN (22%), followed by an MBA (6%) and other master’s (22%). Just 1% of respondents have a doctorate in nursing.

**Most common degree required by position**

- Administrator/administrative director: Master’s 63%
- Director: Bachelor’s 71%
- Nurse manager: Bachelor’s 85%

*—Cynthia Saver, RN, MS*

*Cynthia Saver is a freelance writer in Columbia, Maryland.*
What’s your OR’s greatest achievement?

OR managers and directors have a lot to be proud of. Upgraded facilities and equipment led the list of achievements for survey respondents, followed closely by safety and quality improvements, better operational effectiveness, and efforts to develop the staff. Here is a sampling of comments.

Hospital OR managers and directors

What are you most proud of in your OR?

1. Upgraded facilities and equipment
   - $27.9 million OR redesign with electronic communication, improvement of throughput, increased patient and MD satisfaction.
   - Renovation/new construction of 5 digital state-of-the-art ORs.
   - Improved instrument tracking and turnaround by replacing 3 sterilizers and deploying tracking system.
   - Implemented a new computer system that includes all surgical areas: Preop, PACU, GI, etc.

2. Improved patient safety and quality
   - Surgical site infection rate is 0.9%. 100% compliance of surgical site marking by only physicians. 100% timeout compliance and documentation. Crew resource management for some specialties.
   - Going to 100% on SCIP compliance from 50%.
   - Introduction of highly reliable surgical teams, briefings/debriefings.
   - Two mechanisms to improve communication: (1) with PACU families of endoscopy patients and (2) morning report in OR.

3. Better-functioning ORs
   - Improved block scheduling, which has increased surgeon satisfaction and allowed for arrival and OR time for 5 new surgeons.
   - First-case on-time starts from 20% to 80%.
   - Decreased turnover times by 45%; increased physician satisfaction.

4. People power
   - No use of travelers. OR training program for new grads and RNs without OR experience has brought staffing to zero vacancies.
   - Recruitment/creative scheduling to reduce call requirements.
   - Developed specialty teams. Improved room turnover time from 47 to 28 minutes.

. . . and what do you hope to achieve this year?

1. Expand, upgrade facilities and equipment
   - Add additional capacity through addition of new advanced endoscopy and neurosurgical ORs.
   - Renovation, growing volumes. Become MIS (minimally invasive surgery) center of excellence.
   - Successful planning for renovation of 14 current ORs and addition of 11 more, with 11 “shelled in.”
   - Add robotic surgery.

2. Develop people
   - Staff incentive program for meeting growth, efficiency, decrease material costs.
   - Achieve magnet designation; develop staff to look more into evidence-based practice and AORN standards to change their practice.
   - I’m retiring but wish my successor well since I’ve trained him for 3 years and laid the foundation.
   - Cross-train team within the department and with 2 other departments.

3. Meet strategic goals
   - Want to add more surgeons to the staff, especially general.
   - Regain market to improve volume by 15% over last year.
   - Continue to build volume. Continue to develop new product lines.

4. Better-functioning ORs
   - Working to see that senior management sees the significance surgical care plays in the hospital’s bottom line.
   - Implement “fast tracking” to decrease turnover time between back-to-back cases.
   - Improve efficiency in OR to increase volume and decrease turnover time.
Business managers

Continued from page 1

• value analysis/product selection process
• materials management.

OR Manager interviewed 7 OR business managers to learn more about their roles.

Business managers see themselves as a link between the clinical and business sides of surgery.

“Today the business functions are critical to our survival,” says Cara Mueller, business manager for surgical services for the 14 ORs at Memorial Hospital of South Bend in Indiana.

“Ten years ago, you didn’t see many OR business managers. Now you see the role being expanded,” she says, as some organizations elevate the role to the director level.

At Inova Mount Vernon Hospital in Alexandria, Virginia, the role grew out of a materials management position. With the advent of computers, “IT became a big responsibility, and the materials manager took on this role,” Kate Holmberg, RN, OR business manager, wrote in an e-mail. A materials coordinator was hired to manage purchasing and stocking of supplies.

“As computers became a mainstay, the materials manager position turned into the business manager,” she said. More finance and budget responsibilities have been added since.

Eclectic titles, responsibilities

Titles reflect a range of responsibilities.

At Scott & White Hospital in Temple, Texas, which has 24 ORs and is expanding, Gerry Collier is director of supply chain management for surgery. Originally a respiratory therapist, Collier was previously the hospital’s director of value analysis. His role was created to guide supply chain improvements following a consulting engagement. Though Collier focuses on supply chain, he reports directly to the chief nursing officer.

Courtney Gorgone, MBA, project and strategic manager for perioperative services at Geisinger Medical Center, Danville, Pennsylvania, moved over from the health system’s business planning department. She oversees the perioperative information system, materials management, and operational and capi...
with surgery. Monreal says she speaks both languages, clinical and finance.

Allen, both an RN and CPA, was clinical manager for cardiovascular services and got her accounting degree because she was interested in the subject.

Her experience as an RN “probably adds credibility,” she says. “I can say to the nurses, ‘I’ve been where you are. I know what it’s like.’”

Though Gorgone does not have a clinical background, she does not see that as a disadvantage. Her undergraduate degree was in political science and anthropology, and she has an MBA.

“My mother is a nurse. I wear scrubs every day and am seen in the department,” she says. When challenged that she is not a clinician, Gorgone responds, “Talk to me about your concerns. I keep an open mind. I’m here to make the department a financial success but first and foremost a success for patients.”

Holmberg, who will soon receive her master’s in nursing, thinks a business degree would be helpful.

“Balancing budgets and variance reporting are important; the ability to read and process finance reports is necessary,” she says. Understanding reimbursement and coding is very important, as I am responsible for ensuring the bills can get paid.”

—Pat Patterson

### Best places to work in health care

Aurora Health Care in Milwaukee; Baptist Health in Jacksonville, Florida; HealthEast Care System, St Paul, Minnesota; and Palomar Pomerado Health, San Diego, are among the 100 Best Places to Work in Healthcare, according to a new awards program from Modern Healthcare.

The program recognizes workplaces “that enable employees to perform at their optimum level to provide patients and customers with the best possible care and services,” according to Modern Healthcare. About 238 health care organizations and companies volunteered to participate in the surveys conducted by the Best Companies Group, Harrisburg, Pennsylvania.

The 1 to 100 rankings will be announced in a Modern Healthcare supplement to be published Oct 27.

### Salary/Career Survey

#### Is a specific degree required for business manager?

- No: 27% (n=30)
- Yes: 73% (n=81)

#### Degree required

- Bachelor’s: 65%
- Master’s (any): 17%
- MBA: 17%

#### Is a clinical background required for business manager position?

- No: 66% (n=75)
- Yes: 34% (n=39)

#### How many direct reports does the business manager supervise?

- None: 14% (n=16)
- 1-3: 36% (n=41)
- 4+: 50% (n=56)

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October 2008

OR Manager Vol 24, No 10
Please see the ad for
AORN WORKS
in the *OR Manager* print version.
**Cost management**

### Is gainsharing starting to gain ground?

For the first time, the government has issued a favorable ruling on a spinal-fusion surgery gainsharing arrangement between a hospital and physicians.

In the ruling, issued July 31, the Health and Human Services Office of Inspector General (OIG) explains why it won’t impose sanctions for the arrangement, which could potentially violate the law. The ruling was the 11th on gainsharing for Goodroe Healthcare Solutions, a unit of VHA, Inc. The other opinions have been in cardiovascular and anesthesia services.

Gainsharing is a structured plan in which a hospital and physicians agree to share savings while demonstrating they are not “cherry picking” healthier patients, inducing referrals, or stinting on patient care.

In the project, the Goodroe group studied the surgeons’ historic practice patterns and identified 36 cost-saving opportunities. The hospital and surgeons then decided which changes to adopt. The opportunities were in 2 major categories:

- Limiting use of bone morphogenic protein (BMP) to an as-needed basis, following clinical indicators. Before the project, BMP was used in 15% of cases. The physicians determined usage could be reduced to 11% without an adverse effect on patient care.
- Standardizing spinal fusion devices and supplies where medically appropriate. To pass muster with the OIG, the hospital had to make available the same selection of devices and supplies as before. Savings had to come, not from limiting devices and supplies, but from decisions about “clinical and fiscal value.”

Data were monitored to ensure savings came solely from the project, and patients had to be informed about the project.

### Direction set by MDs

It’s critical that direction for the project is set by the physicians, Joane Goodroe, founder of Goodroe Healthcare Solutions and VHA senior vice president of innovation, told OR Manager.

**“It’s not about getting down to certain vendors,” she says. Instead, the project focuses on examining how the surgeons perform the procedures, assembling the data, and having the surgeons compare notes on their practice.**

“The data piece is probably the most underappreciated part,” Goodroe adds, because the analysis involves more than looking at the cost of individual items. The project might, for example, focus on a 2-level fusion, gather data about how the surgeons perform that procedure, determine the costs, show the data to the surgeons, and have them discuss their practice patterns. The savings stem from their discussions.

One of the biggest learning curves for the physicians is how much effort the project involves, Goodroe notes. Some decide they want to spend the time, while others do not.

She estimates administrative costs of a project are about 10% of the total savings.

**Does every gainsharing project require an OIG opinion?**

That’s up to the lawyers, Goodroe responds. Some legal teams believe they have enough guidance from previous opinions and don’t need an opinion, whereas others still feel they do.

Each project the Goodroe group has done follows the same model, she notes. She says VHA has over 30 such projects underway.

**What difference does gainsharing make?**

A new study examines the effects of 13 gainsharing programs in coronary stent patients using the Goodroe model. Compared to other hospitals, gainsharing hospitals reduced costs by 7.4% per patient. Most of the savings, 91%, came from lower prices on drug-eluting stents, with 9% from reducing utilization of stents and other products. The average payout to physicians was $17,000.

The findings indicated gainsharing didn’t change physician referral patterns nor did it seem to limit patients’ access to stents. Gainsharing also seemed to improve physicians’ compliance with evidence-based practice, such as use of anti-thrombotic therapy. The study by Ketcham and Furukawa is in the May-June 2008 *Health Affairs.*

### Catching on?

Is gainsharing catching on?

The government is looking at creating an exception in the physician self-referral law to allow incentive payments and “shared-savings programs.” The Centers for Medicare and Medicaid Services (CMS) asked for comments on the idea in the physician payment rule published in July. But the government has been considering gainsharing for more than 10 years, and it’s not clear whether there will be action this time.

The American Hospital Association (AHA) supports the exception but says the CMS proposal is too complex and costly. Instead, AHA says CMS should allow hospitals and physicians to use protocols and evidence-based practices already developed as part of gainsharing.

Whatever the specifics, Goodroe says health care must make headway on eliminating waste and variability. With predictions that Medicare will be out of funds by 2018, “we’ve got to get waste out of the system. Waste isn’t bringing benefit to patient care.” She says the model her group has developed is one that has been shown to work.

OIG Advisory Opinion No. 08-09 is at www.oig.hhs.gov/fraud/advisoryopinions.html.
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Performance improvement

OR tops the chart for MD satisfaction

What does it take for an OR to get to the top of the chart in physician satisfaction?

Baptist Medical Center Beaches, a 146-bed hospital serving the coastal communities of Jacksonville, Florida, scored in the 99th percentile for physician measures in a Press Ganey survey, one of the highest scores the survey firm has seen.

Nationally, Press Ganey found surgeons are among hospitals’ least happy physicians in a Press Ganey survey, one of the six investigations of Jacksonville, Florida, scored in the 99th percentile for physician measures in a Press Ganey survey, one of the highest scores the survey firm has seen.

Surgeons are among hospitals’ least happy physicians, according to the survey firm. One of the six investigations of Jacksonville, Florida, scored in the 99th percentile for physician measures in a Press Ganey survey, one of the highest scores the survey firm has seen.

At that time, surgeons were dissatisfied with late starts and inconsistent turnover times. Only about 1% of first cases of the day were starting on time, and cases were being lost to surgery centers that offered predictable block schedules.

Today, things are different. The incision is made promptly at 7:30 am for 81% of first cases of the day, and 79% of turnover times are within 15 minutes, up from only 42% previously.

Says Slyter, “I have physicians coming in my office saying, ‘I’m done at noon or 1 pm instead of 3 or 5 pm before.’ They are thrilled.”

He credits the surgeons, anesthesiologists, and nurses with leading the change.

“Some of the physicians had been working in surgery centers that were performing better and more consistently. They felt we could do a better job,” he says, adding, “This is a tight-knit community, and we have a medical staff that truly cares about the hospital.”

About 50 surgeons use the facility, which has 7 main ORs and 2 OB-GYN ORs. The hospital performs about 6,500 procedures a year and is served by one anesthesia group.

The payer mix is about 45% managed care and 40% Medicare, with the rest self-pay, Medicaid, and other coverage.

Block committee

A key step was setting up a “block committee” separate from the OR Committee that established policies and agreed to enforce them. Block committee members include 2 orthopedic surgeons, a general surgeon, an OB-GYN physician, the lead anesthesiologist, and Slyter.

The hospital also brought in consultants from GE Healthcare Performance Solutions, who gathered and analyzed data and helped set up policies.

The biggest improvements were:
- establishing a block schedule
- setting consistent start times with clear definitions—start time is defined as the incision, and any start after 7:30 am is considered late
- achieving more consistent turnover times.

Block policies

These are some of policies the block committee developed:
- Blocks are allocated by individual surgeon, not groups. A surgeon may allow a partner to use the block, but the hospital didn’t want to have to police who uses a block.
- Policies are clear about release of unused block time. Release times are set by specialty. For example, orthopedics has a voluntary release time of 5 days prior to the day of surgery with an automatic release time of 48 hours. For most other specialties, voluntary release time is 10 days, and automatic release is 5 days. (Voluntary release means unused time doesn’t count against the surgeon’s block utilization.)
- Surgeons must maintain 70% utilization of their blocks. If utilization falls below 70% for 3 consecutive months, some block time can be removed.

Surgeons are monitored on 2 data points:
- block utilization above 70%
- on-time arrival for cases.

Reviewed use of blocks

Every month, the block committee reviews use of block time, OR utilization, turnover times, and start times and sends each surgeon a letter. If the surgeon’s block utilization meets the 70% target, the letter is a thank you. If utilization falls below that level, the letter reminds the surgeon of the 70% target and says he or she could lose some block time if that is not maintained. The letters are signed by the chair of the block committee and Slyter.

Surgeons who don’t meet the criteria consistently can lose the ability to schedule for the first hour of the day, something the committee so far has not had to do, Slyter says.

Tightening up on turnovers

To better manage time between cases, a turnover improvement team examined each part of the case process, from the time the patient arrives in the facility until the patient arrives in the OR. They set up a data collection sheet to track each time element, aided by the GE consultants.

The data is collected daily for each case on paper. On the sheet, the staff records times for each phase of the case, for example, when the patient arrives, surgeon arrives, patient assessment is complete, and so forth. If there is a delay, they must indicate a reason.

“We ask the surgeons to be here by 7:10 am and have the patient ready to go to the OR by 7:15,” explains Donna Bowen, RN, BSN, C-NE, director of surgical services.

If the surgeon arrives late, the staff circles “surgeon late” on the sheet. If the patient isn’t on the way to the OR by 7:15, a reason must be recorded, such as the surgeon wanted more time to talk to the family, or the anesthesia block was not complete. If the patient arrives late in the OR, and no reason is marked, the staff is held accountable for the delay.

“At no point do we want to rush a patient or a doctor,” Bowen stresses. “But we need to have a reason why a case is late.”

To help avoid missing preop paperwork, physician offices now fax documents to the hospital via computer. That way, if the printed copy is missing, the staff can simply print a new copy.

Bowen compiles the data each day.
Please see the ad for
3M HEALTH CARE
in the OR Manager print version.
Surgeons among hospitals’ least happy

Some surgeons who are the hospital’s biggest revenue generators are also the least happy physicians, according to a report by Press Ganey. Of the 5 least satisfied specialties, 4 were in surgery—thoracic, vascular, cardiovascular, and general surgeons. Also dissatisfied were anesthesiologists.

The report is based on responses of 27,671 physicians at 302 hospitals and other facilities during 2007.

Physicians and administrators are still having trouble seeing eye to eye, the report notes. Though physicians rated hospitals relatively high on patient care and ease of practicing, they were significantly less satisfied with their relationships with administrators.

The communication gap is a “call to action,” Press Ganey says. Failing to partner with physicians could have a major impact on a hospital’s fiscal health if referrals fall off.

### Issues in the OR

Surgeons are the least satisfied with the operating room, particularly their ability to schedule surgery and tests/therapy, the survey found.

The biggest issue for surgeons is being able to coordinate their practice hours with the OR schedule, says Debbie Paller, a Press Ganey vice president. How quickly surgeons can get patients on the schedule is important for patient care as well as practice revenue.

A good strategy for addressing surgeon satisfaction, she suggested, is to prioritize surgeons by their volume, revenue per case, and social influence.

“Then you can sit down with these priority surgeons and the staff to see what can be done to better accommodate their cases.”

### Closing the communication gap

The communication gap between surgeons and administrators is challenging partly because of the way surgeons practice, she notes.

“Surgeons tend to have more unpredictable schedules, and it’s harder for administrators to get face time with them. They feel less engaged with the administration, and that definitely is a factor in their satisfaction.”

Surgeons also tend to spend less time in the hospital than other physicians and interact less with the general staff.

In addition, surgeons, who are used to making intense, quick decisions, can be frustrated with the consensus-driven, slower process of hospital administration.

Still, the stakes for forging better relationships are high. Not only do surgeons bring patients but they also have more choices of where to operate, including surgery centers and even their own offices.

“When there is competition, you tend to be more critical,” Paller says. Plus, physicians who have their own office OR or surgery center can influence decisions more readily than they can in the hospital, so they tend to be less satisfied and engaged with the hospital.

### MDs as business partners

Hospitals used to think of physicians as customers. “That needs to shift to seeing them as business partners,” Paller says. “That means developing trusting and deep relationships with your critical surgeons.”

Developing good relationships with key surgeons stores up good will to draw on for addressing sensitive issues.

“It’s also critical to deliver on basic expectations, rather than just offering a ‘wow’ factor every once in a while,” she says.

In other words, it doesn’t do much good to hold a fancy retreat if the hospital isn’t addressing basics like use of the block schedule and on-time starts.

The Hospital Check-Up Report: Physician Perspectives on American Hospitals can be downloaded at www.pressganey.com.

### Physician satisfaction with the OR

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and enters it into an Excel spreadsheet for tracking and analysis. Turnover times are reported weekly.

### Keeping up the momentum

Results have been sustained for about 1 year.

The first 6 months after the consultants left were a control phase. A committee of lead nurses and physicians met weekly with Slyter to help cement the changes.

“We would bring up snags, such as not having enough equipment,” he says. “Then we could make decisions on the fly to fix the problem.”

Regular reporting of data and enforcement of scheduling policies by physician peers keep up the momentum.

Start-time reports are posted in the department with reasons for late starts and names of those involved.

“As long as the numbers stay up, we just report the results and give accolades—‘You were here at 7:10. That’s great!’” Bowen says. “When we have an issue, the staff will suggest ideas for how to address it.

“This is becoming a way of life,” Bowen adds. “We are always going to be looking at it. Now it is becoming hard wired.”

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October 2008  OR Manager  Vol 24, No 10  23
Staff evaluations: More than a formality

Fifth article in a series on performance management.

This article builds on the first 4 articles in this series, published in the June, July, August, and September issues. The first article gave an overview of the performance management process. The next 3 articles covered the job description, initial competencies, orientation, goal setting, on-going competencies, and coaching and mentoring. This article discusses the actual performance evaluation, including peer evaluation and self-evaluation, as a part of performance management.

An effective performance evaluation system must evaluate the work being done without causing job dissatisfaction for the staff. The system must also provide fair, honest, objective feedback to the staff while avoiding invading the privacy rights of the person being evaluated. With all of that, it must meet legal and regulatory requirements.

Ideally, employees will come out of the performance evaluation process with a good understanding of what is expected of them, how they can improve, how they have met the goals they have set, and what new goals they can strive for. Though managers and employees may see performance evaluation as a formality and a chore, if used skillfully, it helps employees renew their commitment to the job and the organization.

The evaluation form

The performance evaluation form may either be a part of the job description or a separate form that mirrors the functions and behaviors in the job description. (A sample is in the OR Manager Toolbox at www.ormanager.com. Look under “Performance management for perioperative staff.”)

In either case, the evaluation statements need to be objective and measurable. Objective descriptors that work well include: accuracy, timeliness, performance of duties, technical ability, and quality of work. Less objective descriptors to avoid include: friendliness, creativity, adaptability, and motivation.

Similar to the job description, the performance evaluation form has an area for evaluating both essential functions of the job and behavioral characteristics expected by the organization. The form should also include areas to record goals for the next year and evaluate goal attainment for the previous year.

Measuring performance

Most performance evaluation systems use a scale with numbers or words that measure success. For example, performance may be ranked from 1 to 5, with 5 being exemplary, or by using words from “exemplary” to “does not meet.”

The measures should be clearly defined so they can be assigned consistently. For example, the definition of a score of 3 or “meets” might read, “Consistently performs in a timely, accurate, effective, and/or appropriate manner with little or no direct supervision. Recognizes the need for and seeks guidance when appropriate.”

Many forms also include a weight for each performance item so departments can adjust the weights if a generic form is used. For example, when a generic RN job description is used for circulating RNs in the OR, the criteria relating to discharge planning may have a low weight because circulating nurses generally aren’t involved in discharge planning, while the weight may be higher for RNs on a medical-surgical unit.

The scores for each criterion on the evaluation are then multiplied by the weight and added to determine a total score.

The form also has an area for feedback for each job function and behavioral aspect being evaluated.

Preparing for a staff member’s yearly performance evaluation takes several steps culminating in a face-to-face meeting:

- self-evaluation
- peer evaluation
- manager evaluation

Self-evaluation

Self-assessment is part of a good evaluation system. Staff members feel more involved in the assessment process if their input into their own work style is sought and included in the evaluation.

The self-evaluation form can be a copy of the formal evaluation form, or it can be a different form that includes the evaluative statements from the formal evaluation.

The staff member should be given a copy of this form with a brief memo outlining the process for filling out the form, returning it to the manager, and scheduling the evaluation session. This memo might also contain a statement about the value of self-evaluation, such as, “This is the time for you to ‘toot your own horn’ and make sure I know what you’ve achieved this past year so I don’t miss any of your accomplishments in the evaluation.”

Continued on page 27
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Please see the ad for ZYMogenetics in the OR Manager print version.

Share successes at 2009 meetings

Share your successes at the conferences of OR Manager, Inc. Submit your proposal online at www.ormanager.com.
Submit a proposal for a 75-minute breakout session or an all-day seminar. Ideas for general sessions are also welcome.

OR Business Management Conference
May 20 to 22, 2009
Drake Hotel, Chicago
The conference emphasizes financial management, materials management, OR technology/equipment management, and OR design and construction.

Managing Today’s OR Suite
Oct 7 to 9, 2009
Caesars Palace, Las Vegas
The conference focuses on practical topics on management of surgical services, such as achieving greater efficiency, management of information, leading and developing staff, and controlling costs.

The keynote 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, and contact information.

The deadline for proposals is Nov 3.
Questions? Phone or e-mail Judy Dahle, RN, MS, education coordinator, OR Manager, Inc, at Jdahle@ormanager.com or 877/877-4031.

Future meeting dates

OR Business Management Conference
May 20 to 22, 2009
Drake Hotel, Chicago

Managing Today’s OR Suite
Oct 7 to 9, 2009
Caesars Palace, Las Vegas

Sept 29 to Oct 1, 2010
The Walt Disney World Swan and Dolphin, Orlando

Sept 28 to 30, 2011
Hyatt Recency Chicago
Managing people

Continued from page 24

It’s best to give the staff member a relatively short time to complete and return the form. Two weeks usually works well. Given a longer time, the staff member may put the form aside and forget to complete it in time.

What if a staff member doesn’t fill out the self-evaluation? Or it’s obvious because of a lack of detail that the person has spent no time filling out the form? One successful tactic is to give the staff member the blank form at the beginning of the formal evaluation session and require him or her to fill it out then before the evaluation takes place. Or you might have the person complete the evaluation on each point as the evaluation progresses. This staff member should then receive a low score on a criterion that addresses commitment to the job. One goal for the next evaluation period might be for the person to keep a log of successes and turn in a complete self-evaluation on time.

Peer evaluation

The literature takes two different stances on peer evaluation. Some experts feel evaluation by peers is an essential part of a performance evaluation. The Magnet Recognition Program for nursing excellence expects hospitals seeking Magnet Designation to perform peer review. One element for applicants to the Magnet Recognition Program states, “Describe the formal and informal performance appraisal processes used in the organization, including self-appraisal, peer review, and 360° evaluation (as appropriate) for nurses at all levels in the organization.”

On the other hand, T. C. Timmreck, who writes on health care human resource issues, asserts that peer evaluation is ineffective. Timmreck states, “Peer evaluation usually is either conducted in such a manner that the performance appraisal process violates the dignity, self-worth, and motivational process of the worker or becomes a waste of time due to the unwillingness of peers to comment on others’ work.”

Some organizations use peer evaluations only for the developmental portion of the performance evaluation, not for any review used to determine a pay raise. Staff members have been found to be less honest in review of fellow workers if they think their statements will affect someone’s raise.

If your organization includes peer review as a part of performance evaluation, there are a few things to take into account. First, the form used for peer evaluation should be essentially the same as the form for self-evaluation. This allows you to compare how a staff member sees herself or himself compared with how peers see the staff member.

Second, you need to determine how to choose the peers to review each staff member. A good approach is to have the staff member being evaluated choose a portion of the peers, while the manager also chooses a portion. Another approach is to make peer selection random. This approach removes bias in the choice of peers for the evaluation.

The peer evaluation forms should be distributed at the same time as the self-evaluation, again with a short memo stating when the forms are to be returned and a statement about the value of peer review to the staff as well as to the rest of the department.

The manager’s evaluation

When writing the formal evaluation, the manager needs to compile all of the information about the staff member being evaluated. Information comes from the self-evaluation, peer evaluations, and from the manager’s performance log kept throughout the year about each employee. (See the July OR Manager for a sample performance log.) Each functional area and behavioral criterion needs to be addressed individually and all information considered before a score is selected for that area. You may choose to average all of the scores provided by peers, by the person being evaluated, and your own score, with or without adding a weight to individual scores. Then add a statement of feedback for the criterion.

Is peer evaluation effective?

Some managers complete the entire evaluation form before the face-to-face meeting with the staff member, and some complete the evaluation form while the meeting is taking place. Either strategy works effectively.

Information from peer evaluations must be included in a way that protects the identity of the peer who provided the information. Comments from peer evaluations can be included in the feedback section in quotes, because often these comments from peers are very meaningful.

Notes on performance should be shared between the manager and the employee during the face-to-face meeting. Any discrepancies can then be used as a starting point for discussion concerning strengths, weaknesses, areas for needed training, and goals that can be set for the next year.

An effective performance evaluation meeting can move from welcome and “small talk” about the staff member’s family, hobbies, the weather or some other topic to a review of each criterion on the evaluation, finishing with goal setting for the next evaluation period.

No negative feedback should be given during this session that has not already been brought to the staff member’s attention. Negative information that is unexpected by the staff person can have a detrimental effect on the person’s job performance, affect the manager’s credibility, increase turnover, and hurt unit morale.

Encouraging employee growth

This whole process of performance evaluation takes time and commitment on the manager’s part. But if the performance evaluation system is handled well, the process can provide personal and professional growth for both the manager and the staff member. The result of a well handled performance
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A group of California nurses is leading an effort to recognize nurses at the 2013 Tournament of Roses, the annual New Year’s Day event in Pasadena, California, that features the Rose Parade and Rose Bowl Game.

In 2012, Sally Bixby, RN, MS, will be president of the Tournament of Roses. Bixby is director of surgical services at the City of Hope National Medical Center, Duarte, California.

**Float to honor nursing**

In recognition of Bixby’s presidency and to honor all nurses, a group from the Operating Room Nursing Council of California is raising money to build a float honoring the nursing profession for the 2013 Rose Parade. Bixby, only the second woman to lead the event, has been a Tournament of Roses volunteer for 20 years.

The nurses have formed a nonprofit organization, Bare Root, Inc, as a grassroots effort to raise money to build the float.

“...There are millions of people whose lives have been touched in a positive way by nurses,” says Monica Weisbrich, RN, Bare Root president.

Weisbrich encouraged nurses and those who have been helped by nurses to contribute to the effort through the website, www.flowers4thefloat.org.

Those who visit the website are asked to contribute by recognizing a nurse who has touched their life or simply to make a contribution. Contributors can send an e-bouquet or e-card.

Weisbrich says all funds raised will go to developing the parade float and maintaining the website. Any excess funds will be used for scholarships and grants to qualifying organizations.

Bixby will be introduced at the Managing Today’s OR Suite Conference Oct 29 to 31 in Washington, DC, and the group will have a table in the conference registration area.

For more information, contact Weisbrich at monica@flowers4thefloat.org.
Please see the ad for
SURGERY MANAGEMENT IMPROVEMENT
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ASC managers more satisfied; salaries flat

Ambulatory surgery center (ASC) managers responding to the 2008 OR Manager Salary/Career Survey are more satisfied with their jobs than hospital OR managers, despite salaries that are flat compared to last year and lower than their hospital counterparts.

ASC managers report an average score of 4.1 out of 5 for job satisfaction, compared to 3.9 for hospital OR managers. An impressive 41% of ASC managers say they’re very satisfied with their jobs (a score of 5), with 37% reporting a score of 4. Still, many managers are on the move: 4% are actively seeking a new job, and 16% are strongly considering a new job search.

Managers in ASCs may be less satisfied when it comes to their salaries, which are essentially unchanged from last year. However, ASC managers are more likely than hospital OR managers to receive a bonus or profit sharing as part of their compensation package.

Those are some of the highlights from the 18th annual OR Manager Salary/Career Survey. The survey was mailed in April to 1,000 OR Manager subscribers and an external list of nurse managers of ASCs, with 265 returned for a response rate of 27%. The margin of error is ±5.4% at the 95% confidence level. ReadexResearch 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 OR Manager.

Salary data across the country

ASC managers earn an average of $79,900, lower than the $102,000 for hospital OR managers. Salaries are stable from last year and remain highest in the West and Northeast.

Managers working in hospital-owned ASCs report the top average salary ($87,800), while those in physician-owned ASCs report the lowest—$73,400 compared to $84,200 for both corporate-owned and joint-venture centers.

Size matters when it comes to salary.

<table>
<thead>
<tr>
<th>Region</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>15%</td>
</tr>
<tr>
<td>Midwest</td>
<td>26%</td>
</tr>
<tr>
<td>South</td>
<td>38%</td>
</tr>
<tr>
<td>West</td>
<td>20%</td>
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</tbody>
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Continued on page 32
ASC managers in centers with 5 or more ORs earn an average $14,200 more a year than those in centers with fewer than 5 ORs. Managers working in multispecialty ASCs make an average of $12,200 more than those in single-specialty facilities.

The average total compensation package for ASC managers is $93,200. As with salary, the West ($108,100) and Northeast ($98,400) report the highest packages, and the South the lowest ($83,100). Differences in compensation by number of ORs and specialties mirror those seen with salaries. Managers working in ASCs with fewer than 5 ORs receive total compensation averaging $22,000 less than centers with 5 or more ORs. Those in single-specialty ASCs make an average of $16,000 less than those in multispecialty centers.

ASC respondents reported their last salary raise averaged 5%, similar to 5.1% in 2007, and higher than the 4.3% average reported by hospital OR managers. In all, 10% of ASC managers received the increase as a result of a promotion or change in job responsibilities. Only 21 respondents (8%) hadn’t received a raise from their current employer.

**Bonuses/profit sharing**

The pay difference between ASC and hospital OR managers shifts when bonuses and profit sharing are considered. More than three-quarters (78%) of ASC managers receive one of these as part of their compensation package, significantly higher than last year’s 64%. In comparison, only half of hospital managers receive bonuses or profit sharing.

In the past 12 months, more than two-thirds (69%) of ASC managers received a monetary bonus or profit sharing, compared to only 40% for hospital OR managers. The average amount received for ASC managers was $5,880, and those in the Midwest reported the highest average ($7,290).

**Benefits**

Benefits packages for ASC managers are leaner than for hospital OR managers, with insurance, educational, and pension benefits less common.
decision team or committee, and 29% serve in an advisory capacity.

Managers are most likely to be the primary decision makers in physician-owned (52%) or joint-venture (46%) ASCs. Those who work in a hospital-owned center are more likely to serve on a team or committee.

ASC managers influence purchasing decisions for OR supplies and equipment (91%) and for OR capital equipment (76%). More managers in multispecialty ASCs (82%) influence decisions related to capital equipment than those in single-specialty centers (68%).

Surgical volume

The average surgical volume is 4,350 per year, ranging from less than 1,000 to 20,000 or more. Joint-venture and multispecialty ASCs report higher average volumes.

Growth in patient volume slowed this year. For the past 12 months, about half (49%) of ASC managers said their volume of surgical procedures remained about the same, significantly higher than 2007, when it was 39%. Still, more than one-third (34%) reported increased volume, and only 15% reported a decrease.

About your ASC

Most respondents (45%) work in physician-owned ASCs, followed by joint-venture (24%), corporate-owned (22%), and hospital-owned centers (6%). In all, 57% work in multispecialty ASCs, with 43% in single-specialty facilities.

The average annual operating budget is $5.0 million. Hospital-owned ASCs have the largest operating budget, averaging $7.1 million, followed by joint-venture ($6.4 million), corporate-owned ($3.6 million), and physician-owned ($2.4 million) centers.

ASCs high on accreditation

The Accreditation Association for Ambulatory Health Care (AAAHC) leads the pack of accrediting agencies with 36% of respondents. The Joint Commission is in second place (20%), followed by Medicare and state governments (11%), and the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) (2%).

Only 6% of ASCs are not accredited.

Information, please

Just over half (53%) of ASC managers report having a computerized information system (IS). Of those, 36% have a computer in each OR. Single-specialty centers, physician-owned centers, and ASCs in the South are least likely to have an IS.

All about you

Nearly all respondents (93%) are women, and 98% are RNs.

The average age is 51 years, slightly lower than the average hospital OR manager’s 52.3 years.

ASC managers have been in their current positions an average of 9.1 years, and in nursing an average of 26.6 years.

Most respondents report their highest level of education as a bachelor’s degree (42%), followed by an associate degree, diploma, and master’s degree.

Fewer than half of respondents (44%), say their ASC requires a specific degree for their position. The most common degree required is a bachelor’s (64%).

—Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer in Columbia, Maryland.
What’s your ASC’s greatest achievement?

Growing the ambulatory surgery center’s business and upgrading facilities and equipment top the list of achievements and goals for next year, according to respondents to the OR Manager Salary/Career Survey. Also leading the list were efforts to harness the strength of the staff.

What was your ASC’s greatest improvement?

1. Upgraded facilities and equipment
   - Electronic medical record for nursing notes and physician dictation. It captures coding for billing.
   - Update of equipment—same in all ORs.
   - Implemented a custom pack system for many of our case specialties.
   - Better control of IOL (intraocular lens) consigned inventory/logs, etc, via use of free software and hardware system.

2. Growing the ASC’s business
   - Increased volume by 10% in 1 year by adding orthopedic program.
   - Increased volume and turned around negative cash flow.
   - Additional interventional pain/spine procedures.
   - Becoming a multispecialty facility for bariatrics and minimally invasive spine surgery.
   - In addition to increasing surgical cases, we have opened a pain clinic that is doing very well.

3. People power
   - Established staffing pattern that matches our volume to decrease need to furlough staff on daily basis.
   - Working more as a team and being multifunctional. Able to perform several tasks.
   - We have continued to cross-train our staff so we can use staff more effectively and creatively.
   - Replaced a "drama queen"/bully.

4. Quality & efficiency
   - New culture of patient safety by following TeamSTEPPS patient safety program.
   - Improved turnover time with minimal staffing changes.
   - We are at 90% capacity in the OR—very busy and successful ASC.
   - We maintained 95% and greater each month in our patient satisfaction scores.

... and what do you hope to achieve this year?

1. Grow the ASC’s business
   - Increase volume; hire new surgeons and possible expansion.
   - Addition of orthopedics; recruitment of third ENT physician.
   - We are hoping to open a new ASC by 2009.
   - Increase volume; bring new services in.
   - Opening third outpatient surgery center north of town—expansion will provide more jobs and increase total ORs I manage to 19.
   - Finish planning and breaking ground on an addition—due to success of current center.

2. Upgrade, add new equipment
   - Purchase new endoscopes and processors.
   - Equip our 4th room with an equipment boom and upgrade arthroscopy equipment.
   - Cost reduction with reports from our new OR EHR (electronic health record).
   - Add high-definition video cameras.
   - Decrease overnight shipping needs by improved communication and planning.

3. People power
   - Improve staffing numbers and add part-time staff.
   - Profit sharing with employees.
   - I would like to see them encourage and promote certification of nurses.
   - Reduce use of agency to zero.

4. Improve efficiency
   - Decrease overtime by spreading cases out during the day.
   - Increase time management to decrease patient wait times.
   - Increase room utilization and attract more MDs.
Please see the ad for INTEGRATED MEDICAL SYSTEMS in the OR Manager print version.
Are routine x-rays cost-effective after emergency surgery?

Emergency surgery carries a 9-fold increased risk for retained surgical sponges. Researchers from Vanderbilt University and the Tennessee Valley VA Medical Center concluded that routine x-rays after emergency surgery are a cost-effective way to reduce the occurrence of retained surgical sponges.

In a study, they found routine x-rays cost $705 per patient compared with $1,155 for surgical counts. Results indicated routine x-rays were the preferred strategy as long as the sensitivity of surgical counts was less than 98%, and legal costs associated with retained sponges were more than $44,000 per case.


Is obesity a risk factor for admission after ambulatory surgery?

Researchers from the Mayo Clinic, Rochester, Minnesota, found obese patients (BMI >40) did not have a significantly higher frequency of unplanned hospital admissions after ambulatory surgery than normal-weight patients. This was true even though obese patients had more comorbidities. In the study of 470 patients, 26% of obese patients and 22% of control patients were admitted (odds ratio, 1.3; 95% confidence interval).

The researchers concluded that obesity is not a significant independent risk factor for unplanned admission after ambulatory surgery, despite the comorbidities.


More revisions with new joint replacement methods

Newer methods for hip and knee replacements, such as hip resurfacing and unicompartmental knee replacement, need revisions at a higher rate, according to a study in PLoS Medicine.

British researchers found 1 in 75 joint replacement patients needed revisions within 3 years, a rate of 1.3%. Those who had hip resurfacing had a revision rate of 2.6%, and those with unicompartmental knee replacements had a revision rate of 2.8%. Revision rates were higher in women after hip resurfacing and strongly decreased with age after unicompartmental knee replacement. The researchers recommend using hip resurfacing only in male patients and using unicompartmental knee replacement only in elderly patients.


Setback for coronary stents

A study aimed at boosting the case for coronary stents in the sickest patients failed—finding bypass surgery was better, according to the Sept 2 Wall Street Journal.

The study included 3,000 patients who had blockage either in 3 vessels or in the critical left-main coronary artery. About 100,000 of these patients receive stents each year.

The study showed that after 1 year, 18% of stent patients had died, had a stroke or heart attack, or had to return for surgery, compared with 12% of bypass patients. The biggest difference was a higher need for repeat procedures in stent patients.

The study, funded by stent-maker Boston Scientific, was reported at a cardiology meeting in Munich.

— http://online.wsj.com

Stanford limits industry funding of MD education

Effective Sept 1, Stanford Medical School in California is prohibiting new commercial funding for specific continuing medical education, including monetary contributions, loan or donation of equipment or supplies, and other services.

Companies will no longer be able to fund specific courses. Any industry support has to be directed to the Office of Continuing Medical Education, which will distribute the funds.

Stanford is the sixth major medical school to take this approach to shield faculty from commercial influences, The New York Times reports. The policy is described in the Aug 25 Stanford Dean’s Newsletter.

— http://deansnewsletter.stanford.edu/archive/08_25_08.html