Managing biologics

Help for understanding and managing bone allografts

Musculoskeletal tissue is a gift from donors and their families to patients. These biologic materials are also complex to purchase and manage.

Bone allografts in particular have a host of applications and come in an array of forms—putties, pastes, and chips, to name a few. How can OR teams select allografts that not only are safe for patients but also are clinically efficacious and cost-effective?

This series, a collaboration of OR Manager and the Musculoskeletal Transplant Foundation (MTF), offers information to assist in this complex area. The series leads off in this issue on page 18 with an overview of tissue donation, donor screening, and processing/sterilization. Future articles will offer guidance and tools for understanding, categorizing, and evaluating bone allografts.

Continued on page 9
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How many staff?

How many staff do ORs assign to a total joint replacement? A laparoscopic surgery? Read results of our new survey.

Scheduling: The next level

Taking scheduling to the next level of safety and customer service.

Editorial

Chips, pastes, putties, gels, powders, wedges, DBM, BMP, and assorted kits—the list of bone allografts and substitutes is long and confusing. These biologic materials have a big impact on the OR budget, but they are more than just another line of surgical supplies.

Biologics originate with a family’s decision to donate a loved one’s tissue. From there, they may pass through many hands until they are brought to the operating room in a form that promises to help a patient heal a defect caused by injury or disease.

In making decisions about which biologics to acquire, OR teams have to sort out a variety of issues:
- Is the tissue safe from pathogens that could carry disease? Many grafts cannot be sterilized like conventional medical devices.
- Who is supplying the tissue? Tissue is handled by a complex network of suppliers, including recovery organizations and non-profit tissue banks as well as medical device companies for which biologics are a competitive business.
- How is the tissue regulated? What agencies and organizations oversee tissue safety?
- What are the surgeons’ preferences for the grafts they use?
- What is the clinical efficacy? Published evidence may be fragmented or incomplete.
- How is tissue tracked and monitored after it arrives in the facility?
- How much inventory should the OR maintain? How much of it overlaps, and what is the cost?

Managing bone biologics

In a series starting in this issue, OR Manager is publishing information to help in managing this complex area. We believe we have found the right partner in the Musculoskeletal Transplant Foundation (MTF).

Over the next few months, OR Manager and MTF will bring you a series of articles intended to help you and your team better understand and manage bone biologics. The series will then appear as a special supplement in 2011.

The series begins with an overview of the tissue donation process and donor screening. Upcoming articles will feature:
- a guide to understanding the types of bone biologics and their role in healing
- a discussion of how tissue is regulated
- an explanation of tissue processing and sterilization
- an evaluation tool to aid decisions about biologics, including questions to ask suppliers
- a case study from an organization that has developed a process for evaluating and managing these complex materials.

We are interested in talking to others who also have good processes for selecting and acquiring bone biologics. I invite you to contact me if you have an effective process. We may want to interview you and write about your program.

Given the complexity of this area and its importance to physicians and patients, there’s a great need to share knowledge.

—Pat Patterson

Please contact me at ppatterson@ormanager.com if you would like to share your process.
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A call for mandatory flu vaccinations

Flu vaccinations should be a condition of employment or privileges for all health care personnel, two infection control societies advocate.

Being vaccinated is a “professional and ethical responsibility” and not complying with a facility’s vaccination policy should not be tolerated, the Society for Healthcare Epidemiology of America (SHEA) said in August.

The position was endorsed by the Infectious Diseases Society of America (IDSA).

Last year, 39% of health care professionals said they had no intention of being vaccinated despite the concern about H1N1 flu, a RAND Corporation survey found.

“Health care providers are ethically obligated to take measures proven to keep patients from acquiring influenza in health care settings,” said SHEA’s president, Neil Fishman, MD.

The position applies to all health care personnel in all health care settings whether they have direct patient contact or not. It also applies to students, volunteers, and contract workers.

The only exemptions should be for medical reasons, such as allergy to eggs. SHEA does not support exceptions for religious, personal, or philosophical reasons, saying failure to be vaccinated is an unacceptable risk to patients and other personnel.

Last year’s flu season, one of the worst in the nation’s history, highlighted the need for stronger policies, especially in light of low vaccination rates, SHEA says.

Richard Whitley, MD, IDSA president, said: “Vaccination of health care personnel saves patients’ lives and reduces illness,” adding that it helps to keep workers from falling ill during flu outbreaks and missing work, which further affects patient care.

Dr Fishman called mandatory vaccination the “cornerstone” of a program to prevent spread of flu that also includes identification and isolation of infected patients, hand hygiene and cough etiquette, use of protective equipment, and restriction of ill workers and visitors in a facility.

SHEA notes that otherwise healthy adults, such as health care personnel, are routinely infected with the flu virus and are likely at increased risk because of their contact with infected patients. Infected personnel may shed virus before development of symptoms.

Several studies have shown that vaccinating personnel reduces patient mortality and absenteeism.

Mandates effective

Mandatory vaccination is the single most effective strategy to increase health care worker vaccination rates, achieving coverage of more than 95%, SHEA reports.

A number of organizations already have mandatory vaccination policies, including the Department of Defense; HCA, Hospital Corporation of America; BJC Healthcare in St Louis; and Maryland-based MedStar Health, with medical and religious exemptions. BJC’s vaccination rate was over 98% for its nearly 26,000 employees, with 8 terminated for failure to comply.

SHEA’s position paper is posted at www.shea-online.org

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Synergy in Operation
Collaborative and hands-on—those are common themes in letters nominating Lorna Eberle, RN, BSN, CNOR, as the 2010 OR Manager of the Year.

As director of perioperative services at Providence St Peter Hospital (PSPH) in Olympia, Washington, Eberle manages, in addition to the 11-room OR, 8 other departments with a total of 190 FTEs.

The 12 letters from all levels of the hospital praised Eberle as forthright, honest, and calm, embodying the mission of the faith-based Providence Health & Services system, which has 27 hospitals in 5 states.

‘A skilled skipper’

PSPH’s medical director of perioperative services, Bryan D. Wales, MD, called Eberle “a skilled skipper” who “navigates the rocky shoals of a dangerous shore, yet manages to keep the ship afloat.”

He told of one example in which Eberle worked with him to provide care for an autistic child who was brought to the OR to be sedated for routine lab tests. The family had traveled a great distance, and no one else had been able to provide this care.

Chris N. Griffith, MD, chair of the surgery department, wrote: “She is excellent at building bridges and is very quick to resolve issues before they become larger issues that threaten our institutional integrity.”

Eberle is particularly strong in interfacing with surgeons, he noted, citing the OR’s smooth transition to a formal time-out before surgery, though significant pushback had been expected.

He attributed the good outcome largely to Eberle’s “care and concern,” noting that she took time to call each surgeon the day before his or her scheduled block to explain the process and make sure each one understood the intentions. During the first week, Eberle was at the control desk each morning as the surgeons arrived to remind them of the initiative. She also backed the staff as the time-out was introduced.

Eberle says the respect reflected in the letters is mutual.

“It’s very much a collaborative environment. We all work as a team. The interpersonal relationships are very good,” she says.

She adds that the hospital’s core values are strong—“you feel them when you walk in the door.” Part of her success, she says, is that “I feel I have incorporated those into my daily practice and my interactions.”

A sense of calm

Bonny Melby, RN, MS, assistant manager and educator for the short-stay unit, commented that Eberle “has that balance of confronting a sensitive incident assertively yet with sensitivity” and “always conveys a sense of calm.”

Eberle was also recognized for supporting the staff.

“I firmly believe I am the nurse I am today from the support, direction, and confidence she has helped me maintain,” wrote Carol Cairone, RN, CNOR, OR staff nurse and laser resource nurse.

Last year, Eberle pitched in washing instruments and assembling sets when part of the OR staff and all of the sterile processing staff went out on a one-day strike. The OR ran a full surgical schedule.

“Lorna spent 2 days working hands-on in this department,” so patient care could continue uninterrupted, said William Sjolin, RN, BA, CNOR, CRNFA, assistant clinical manager of perioperative services.

Others commended Eberle’s stewardship of resources.

The surgery manager, Lorie Khorsand, RN, BSN, CNOR, noted that Eberle has led major supply chain initiatives as co-chair of the Providence system’s Perioperative Resource Council, tackling projects to standardize suture and endomechanicals, drapes and gowns, and orthopedic implants for the system’s 27 surgical departments.

Jumping in as a new grad

Eberle began her career at Providence St Peter the Monday after graduating from nursing school in 1976, thinking she’d stay a year or two. But PSPH has become her home. After a year on a nursing unit, she moved to the OR, having learned in a nursing school rotation that “that is where my heart is.”

Why does she stay in the high-stress OR environment?

“I love my job, and I work with great people,” she says. “We have great relationships with our surgeons and anesthesiologists and our staff.”

She also embraces PSPH’s mission. “We care for everyone—it doesn’t matter who they are,” she says. It’s all about treating the person with respect and compassion.”
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there isn’t much time to replace current expertise.

This year’s survey also highlights a decade of change for OR directors. In the past 10 years of the survey, the average age has risen to 53 years, up from 48 in 1999, and half of respondents now have a master’s degree, compared with 35% in 2000. The term “perioperative services” has steadily gained popularity, with 36% claiming that as their work area, a big increase from 14% in 2000.

The OR Manager Salary/Career Survey was mailed in March to 800 OR Manager subscribers who are directors or managers of hospital OR departments; 294 usable surveys were returned for a response rate of 37%. The margin of error is ± 4.6 at the 95% confidence level. A separate survey was sent to nurse managers of ambulatory surgery centers (see page 19). This is the tenth year the staffing questions have been asked and the second year for the economic questions. Results from the staffing portion of the survey appeared in the September OR Manager.

**OR economics**

The good news on the economic scene is that fewer (62%) respondents reported reconsidering or postponing capital expenditures, down from 79% in 2009. Like last year, OR technology and equipment were the capital projects receiving the most second looks (77% vs 84% in 2009). The number of hospitals reconsidering or postponing OR construction or renovation stayed about the same (41% vs 40%).

“[We survived] a renovation/construction of 3 new ORs without...”

continued on page 10
shutting down services and [while] maintaining customer service scores,” noted one respondent. Other capital projects that respondents mentioned were opening a second campus, creating a new central sterile processing area, and installing an electronic medical record system. Another respondent said, “increased profitability: 13 PI [performance improvement] projects to match TJC [The Joint Commission] requirements.”

But other news isn’t so positive. An OR derives its economic health from surgical case volume, and more than a third (36%) of directors and managers reported their volume dropped over in the past 6 months, compared with 30% in 2009 and 24% in 2008.

The percentage of those reporting an increase in volume was 32%, nearly the same as last year but slightly lower than the 39% in 2008. Increases were most common in urban hospitals and in the West. Several directors and managers commented about their higher volumes, such as “OR volume increased 6% over previous year,” “17% volume growth,” and “a 5% increase in business despite the economic climate.”

Most respondents (44%) reported their operating budget had stayed the same in the past 6 months, 30% experienced an increase, and 25% saw their budgets decrease.

Directors and managers continue to work on the bottom line. “Supply management enhancements have reduced expenses considerably, and charge capture revisions have increased revenue,” noted one respondent. Another

### Impact on ORs of economic downturn

**ORs that have decreased their operating budget in the past 6 months**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>25%</td>
</tr>
</tbody>
</table>

**ORs reconsidering or postponing capital expenditures**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>62%</td>
</tr>
<tr>
<td>2009</td>
<td>79%</td>
</tr>
</tbody>
</table>

**Facilities limiting funding for attending conferences or other educational events**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>79%</td>
</tr>
<tr>
<td>2009</td>
<td>84%</td>
</tr>
</tbody>
</table>

### Average annual salary and total compensation

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual salary</th>
<th>Total compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>By number of ORs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4 ORs</td>
<td>$88,000</td>
<td>$108,000</td>
</tr>
<tr>
<td>5-9 ORs</td>
<td>$105,000</td>
<td>$126,000</td>
</tr>
<tr>
<td>10+ ORs</td>
<td>$124,000</td>
<td>$150,000</td>
</tr>
</tbody>
</table>

| **By facility type**            |               |                    |
| Community                       | $105,000      | $127,000           |
| Teaching                        | $125,000      | $154,000           |

| **By title**                    |               |                    |
| Admin/admin director            | $127,000      | $155,000           |
| Director                        | $104,000      | $125,000           |
| Nurse manager                   | $89,000       | $108,000           |
cited cost control as an additional benefit of quality improvement programs, saying, “Cutting down costs and improving patient care through the help of SCIP [Surgical Care Improvement Project].” Other strategies included implementing perpetual inventory, third-party re-processing, improving efficiencies, and applying the Lean management process.

**Compensation**

Patterns for annual salary and total compensation, which includes bonuses, insurance, pension, and other benefits, were similar.

Hospital-based OR directors now earn an average salary of $104,000 and OR managers earn an average of $89,000.

Respondents in the West earn the most ($127,000 salary/$155,000 total compensation), and respondents in the Midwest earn the least ($98,000/$121,000).

**Management scope**

**How many sites do you manage?**

<table>
<thead>
<tr>
<th>By title</th>
<th>Admin director</th>
<th>Director</th>
<th>Nurse manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR only within one hospital</td>
<td>2%</td>
<td>6%</td>
<td>28%</td>
</tr>
<tr>
<td>OR &amp; other depts within one hospital</td>
<td>73%</td>
<td>86%</td>
<td>66%</td>
</tr>
<tr>
<td>OR only at multiple sites</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>OR &amp; other depts at multiple sites</td>
<td>23%</td>
<td>7%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Not surprisingly, hospitals with more ORs compensate more: The average salary for those who manage or direct 10 or more ORs is $124,000, and average total compensation is $150,000. Respondents in teaching hospitals earn more than their community counterparts ($125,000 vs $105,000) and receive greater compensation ($154,000 vs $127,000).

**Raises and bonuses.** The average raise was 3.5%, down from 3.8% in 2005 and 4.4% in 2000.
Only a third of respondents received bonuses or profit sharing in the past 12 months, comparable with 39% last year and 40% in 2008. Those in the South and West were more likely to receive this benefit compared to other regions. 

Average bonuses for past 3 years

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$8,060</td>
</tr>
<tr>
<td>2009</td>
<td>$6,440</td>
</tr>
<tr>
<td>2008</td>
<td>$6,030</td>
</tr>
</tbody>
</table>

Benefits. All respondents receive paid time off, including vacation, sick time, and holidays, totaling an average of 29.6 days. Other common benefits include:

- Health insurance: 97%
- Dental insurance: 91%
- Life insurance: 89%
- 401(k) retirement plan: 86%
- Tuition reimbursement: 78%
- Disability insurance: 78%
- Dependent health insurance: 69%
- Eye care: 68%
- Educational benefits: 55%
- Pensions: 48%
- Bonus/profit sharing: 46%

Like last year, 19% reported losing benefits in the past 6 months. 
Only 27% of hospitals have a plan to reward staff financially for helping to improve performance or reduce supply costs.

About your role

Here is a closer look at directors’ and managers’ roles and responsibilities.

Where you work. Consistent with last year, more respondents work in a community hospital instead of a teaching hospital (76% vs 20%) and in a rural (41%) rather than a suburban (35%) or urban (22%) setting. The average number of licensed beds was 252, and 90% of respondents work for nonprofit hospitals. The average annual case volume is 8,110.

Title and work area. Most respondents report their title as director (41%), followed by admin...
About the operating room

How many clinical FTEs do you supervise directly or indirectly?

<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>
</tr>
<tr>
<td>Clinical</td>
<td>75.0</td>
<td>155.7</td>
</tr>
<tr>
<td>Nonclinical</td>
<td>15.7</td>
<td>37.2</td>
</tr>
</tbody>
</table>

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

<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>
</tr>
<tr>
<td>Operating</td>
<td>$14.1</td>
<td>$31.0</td>
</tr>
<tr>
<td>Capital</td>
<td>$1.0</td>
<td>$1.8</td>
</tr>
<tr>
<td>Personnel</td>
<td>$3.8</td>
<td>$9.3</td>
</tr>
</tbody>
</table>

Collaborating with physicians

OR managers and directors give physicians high marks for their willingness to collaborate. Collaboration was rated higher in some areas than others. Physicians are most apt to collaborate on efforts to improve patient care quality and safety, say respondents to the OR Manager Salary/Career Survey. They are less apt to be on board when it comes to increasing OR throughput or controlling costs.

In your OR, in what areas do the majority of physicians collaborate with OR management?

<table>
<thead>
<tr>
<th>By number of ORs</th>
<th>1-4</th>
<th>5-9</th>
<th>10+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving patient care quality/safety</td>
<td>82%</td>
<td>83%</td>
<td>87%</td>
</tr>
<tr>
<td>Increasing throughput</td>
<td>47%</td>
<td>72%</td>
<td>73%</td>
</tr>
<tr>
<td>Controlling costs</td>
<td>57%</td>
<td>49%</td>
<td>62%</td>
</tr>
</tbody>
</table>

Scope of responsibility. As last year, 77% of respondents have responsibility for the OR and other departments within one hospital. Just 9% oversee only the OR in one hospital, and 11% manage the OR and other departments at multiple facilities.

OR directors and managers are responsible for an average of 12.1 ORs and 6.5 departments or services. The most common departments and services that report to these OR leaders have been consistent over recent years: postanesthesia care, central processing, outpatient/same-day surgery, GI/endoscopy, and preadmission services.

Continued on page 14
Budget numbers. OR leaders’ fiscal responsibilities are impressive.

**Average annual OR budget managed**

- Operating: $17.8 million
- Capital: $1.2 million
- Personnel: $4.9 million

Many respondents said they did not know their budget or chose not to answer this question. Budgets are getting a high level of scrutiny: “zero budget variances,” said one respondent.

Funding for conferences and education events remains a target for budget cuts, but fewer respondents reported funding restrictions this year compared with 2009 (79% vs 83%). Of these, about a quarter (24%) of hospitals have eliminated funding for conferences or other educational events, significantly fewer than last year’s 35%, and 29% have banned travel.

Purchasing power. Respondents wield significant purchasing power in their hospitals. Most participation is through membership on the decision committee/team (57%) or value-analysis team (52%). More than one-third (39%) reported being the primary decision maker, and 30% serve in an advisory role.

One respondent reported developing a value-analysis team (VAT), and explains the team is “made up of nurse managers and materials experts on the management level. Our director of surgical services reports to and sits on the administrative VAT that includes upper level [administrators] and physicians.”

Most (92%) participated in selecting and purchasing OR supplies and equipment, with 89% doing so for capital equipment.

Staff supervision. OR directors and managers directly or indirectly oversee an average of 111 clinical
and nonclinical FTEs. As expected, administrators and administrative directors supervise significantly more employees than their counterparts at an average of 161 FTEs compared with 95 FTEs for directors and 63 FTEs for nurse managers.

The average number of clinical FTEs that respondents oversee has increased over the past decade, from 79 in 2000 to 81 in 2005 and 90.9 this year.

Directors and managers are involving staff in operations. “Shared governance has matured and is very active,” said one respondent. “Letting staff become more involved in decision making,” reported another.

Long hours. Given the increase in scope of responsibility and number of FTEs, it’s not surprising that respondents are working hard, putting in an average of 53 hours a week. Only 6% work 40 to 44 hours, and 6% work 65 hours or more.

In spite of the long hours, directors and managers are squeezing in outreach programs. “We are holding our second OR open house for 5th and 6th graders—very rewarding,” said one respondent.

Satisfaction. OR directors and managers are satisfied with their positions despite the challenges, with an average of 3.9 on a 5-point scale (5 equals being very satisfied, and 1 equals not satisfied at all). More than a quarter (27%) reported being “very satisfied,” and 48% reported a satisfaction level of 4. Those in the Northeast are significantly less likely to report they are very satisfied compared to other areas of the country.

Vacancies and job hunts. Only 6% of respondents report vacant OR manager or director positions, unchanged from 2009. The average length of a management vacancy is 7.3 months.

Only 5% are actively seeking a new job, and 21% are considering a new job search, compared with 4% and 15% in 2009. Given the lower satisfaction rates in the Northeast, it’s not unexpected that 15% are actively looking for a job compared to much lower rates in other geographic areas.

About you

Directors and managers remain an experienced group whose expertise will be missed when they retire.

Age, experience, and retirement. The average age of OR directors and managers has steadily risen through the decade, from 50 years in 2002 to 53 in 2010; in 1997, the average age was 47. According to the US Health Resources and Services Administration, the average age of a nurse in 2008 was 47.

OR directors have a wealth of experience. More than half (56%) have 30 or more years’ experience in nursing, and only 1% have fewer than 10 years.

Respondents are a loyal group: The average tenure in their current positions is 8.5 years, with 38% in their positions for fewer than 5 years.


Continued on page 16
Use of safety checklists is up

Nearly all—93%—of respondents to the OR Manager Salary/Career survey say they have adopted surgical safety checklists, up from 86% in 2009. (The question was not specific to the WHO Surgical Safety Checklist.) But there hasn’t been much change in those who are using preoperative briefings—52% this year vs 51% last year—and postoperative debriefings—28% this year and 30% last year.

Has your OR implemented safety checklists?

<table>
<thead>
<tr>
<th>By facility type</th>
<th>Community</th>
<th>Teaching</th>
</tr>
</thead>
<tbody>
<tr>
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<td>93%</td>
<td>93%</td>
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</table>

<table>
<thead>
<tr>
<th>By number of ORs</th>
<th>1-4</th>
<th>5-9</th>
<th>10+</th>
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<tbody>
<tr>
<td>Yes</td>
<td>88%</td>
<td>99%</td>
<td>92%</td>
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</table>

Has your OR implemented preoperative briefings/postoperative debriefings to improve patient safety?

<table>
<thead>
<tr>
<th>By facility type</th>
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<tr>
<td>Preop briefings</td>
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<td>60%</td>
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<td>Postop debriefings</td>
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<table>
<thead>
<tr>
<th>By number of ORs</th>
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<th>5-9</th>
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<tr>
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<tr>
<td>No</td>
<td>57%</td>
<td>43%</td>
<td>38%</td>
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</tbody>
</table>

Most (76%) directors and managers say a specific degree is required for their position. The most common degree required is a bachelor’s (57%), followed by a master’s (42%). Respondents with the title of administrator or administrative director and respondents who manage 10 or more ORs are significantly more likely to be required to have a specific degree. Rural hospitals are significantly less likely to require a degree.

Storm clouds or clear skies?

Although the economic forecast is slightly better than last year, clear skies aren’t likely to be around the corner. OR leaders, who carry with them years of wisdom, plan to exit the workforce by the end of the next decade. Leaders will need to act quickly to disperse the human resources storm clouds, a task that might prove difficult in a still struggling economy.

—Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer and president of CLS Development, Inc, in Columbia, Maryland.

References


Thank you

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

OR managers and directors had an opportunity to savor their successes over the past year. Here is a sampling of comments from the OR Manager Salary/Career Survey in response to the question: “In the past year, what is the greatest improvement that your OR has accomplished?” The categories are in order of frequency.

### Hospital OR managers and directors

#### 1. Improved patient safety
- Improved Surgical Care Improvement Project (SCIP) scores (cited by about one-third of respondents).
- Implemented World Health Organization (WHO) Surgical Safety Checklist.
- Online scheduling in physician offices: decreased issues/errors with posting cases, legibility enormously improved.
- Briefing and debriefing on every case.
- Nurse-to-nurse handoff from pre-op to OR.
- Increased patient safety by staff/surgeon communication improvement and creating a culture of awareness.
- Going back to the basics of patient safety first.

#### 2. Revving up efficiency/cutting costs
- OP unit staff were combined with PACU staff and cross trained. This added staff for getting first cases ready in a more expedient manner and added to the labor pool for PACU and call.
- Increased utilization between surgery and gastroenterology volume by 40%.
- Decreased supply inventory by 25%.
- Patient-centered online health history for pre-admission testing has helped improve screening.
- 3.5% reduction in FTEs, implementation of EMR [electronic medical record], and setting benchmarks for hours worked per patient volume or surgical minutes.
- Converted entire hospital to computer documentation.
- Decreased turnover time.
- Formed surgical executive committee with physician buy-in & participation to improve throughput, decrease inefficiencies, and decrease cost.

#### 3. Construction, renovation, and equipment
- Constructed new 6-room OR suite.
- Added a new surgery suite with some new equipment; new central service area, new outpatient rooms, new recovery room.
- Renovation of urology suite, purchase of PACS [picture archival and communications system] units; purchase of new anesthesia machines.
- Construction of new 4 room operating suite that includes full video integration in all suites.
- Integration of rooms, hybrid design.
- Video endoscopy upgraded to HD [high definition].
- Renovations that put all OR patients on one floor.
- Moved 2 hospitals into a new one.

#### 4. Power to the people
- Raised patient satisfaction scores by 50%.
- Maintaining patient satisfaction in the top 10% of Press Ganey survey while keeping morale high in a downturned economy.
- Doing a higher volume of cases with the same amount of staff.
- Zero vacancy and 100% oriented staff.
- Graduated 6 nurses from Periop 101 [referring to AORN’s core curriculum].
- Created second shift to reduce overtime.
- Joint biannual meeting with physicians and nurses.
- Maintaining permanent staff—we have completely eliminated all agency staff in 2.5 years!
- All of our surgical teams are certified.
Like organ donation, tissue donation is an end-of-life gift that can save or enhance the lives of 50 people, often many more. Donated human tissue, also called allografts, can be used in a variety of replacement, reconstructive, or regenerative surgical procedures. Beginning with an individual’s decision to donate, each step in the process of recovering, preparing, and distributing tissue is intended to ensure its safety for the recipient. Perioperative nurses are often involved with both sides of tissue donation—first, as tissue donation occurs in the operating room and then as tissue is transplanted.

**What can be donated?**

Bone, corneas, hearts for valves, ligaments and tendons, skin, and veins and arteries can be donated after death. Many organ donors may also be cornea and tissue donors; in these circumstances, tissue and eye recovery is performed immediately following organ recovery. Unlike organs, which must be transplanted within hours of donation, most tissue is prepared and preserved for later use.

**The tissue donation process**

Federal regulations require hospitals to report all deaths to their local Organ Procurement Organization (OPO) and to have an agreement with at least one eye and tissue bank. In most states, the OPO also serves as the tissue recovery agency, although tissue banks also provide these services. Once a referral is received, preliminary screening occurs, and a preliminary determination of donor eligibility is made. Factors such as age; cause of death; evidence of systemic infection; or evidence of risk factors for diseases such as HIV, hepatitis, syphilis and Creutzfeldt-Jakob disease (CJD) are considered (diagram).

Each state has an Anatomic Gift Act that governs how donation may occur and who may make a gift of an organ or tissue. More than 86 million Americans have registered to be donors after their death (www.donatelife.net). In cases where the potential donor has not registered, the next of kin or other authorized person may give permission for donation.

In either situation, a trained individual obtains information from a potential donor family about their loved one’s medical and social history.

The American Association of Tissue Banks (AATB) has standards for obtaining authorization for donation as well as for properly screening potential donors and for processing and distributing donated tissues. The standards emphasize the importance of compassionate care for family members as well as the need to eliminate any possibility of transmission of infectious diseases from donated tissue.

**Quality assurance is built in.**

Although the Food and Drug Administration and AATB have established donor screening guidelines, each tissue processor or tissue bank establishes its own donor criteria standards. It is important for perioperative nurses to be aware of the criteria used by the tissue bank that provides their facility with tissue.

**Tissue recovery**

Tissue recovery is performed using aseptic technique according to AORN recommended practices. The recovery takes place in an operating room or an OR-like environment such as a recovery suite at the local OPO or tissue bank. On occasion, recovery may take place in a medical examiner’s or coroner’s office or a funeral home.

Quality assurance protocols are built into recovery procedures to avoid cross contamination of tissues. All tissue is cultured, labeled with a unique identifier, and packaged separately before being transported to the tissue processor.

**Tissue donation fast facts**

- Thanks to the generosity of more than 30,000 donors and their families, over 2 million life-saving and life-improving tissue grafts were distributed in the US in 2009.
- In comparison, there were 14,631 organ donors, including 8,021 deceased donors and 6,610 living donors, resulting in 28,465 total organ transplants, an average of 2 transplants per donor.
An essential part of the recovery process is the reconstruction of the donor. All donors are reconstructed with great care utilizing customized prosthetics and with great consideration of the family’s wishes.

**Final review of suitability**

When tissue arrives at the tissue processing facility, it is held in quarantine until the final suitability review occurs. This final review consists of an evaluation of the pertinent medical information, records, serology tests, autopsy reports, and tissue and blood cultures as well as an examination of the medical and social history of the donor. All information is reviewed by the medical director of the tissue bank, and final suitability is determined.

It is always a good practice to know where the tissue recovered in your institution will be sent for processing and to learn as much as possible about the donor criteria, processing protocols, and whether the supplier provides priority access to tissues from your hospital or region.

**The gift of life**

Donation affects everyone. OR managers are directly aware that families often offer donation—the gift of life—at a painful time in their lives. The donor family remains at the heart and soul of the entire process of recovery, preparation, and distribution of tissue, and OR personnel need to be educated about all aspects of donation.

—Martha Anderson
Executive Vice President, Donor Services, Musculoskeletal Transplant Foundation

**References**


Screening of tissue donors is a critical step in ensuring tissue safety. Screening is a complex, multidisciplinary process that begins every time a family says “yes” to the option of donation and ends when tissue is released for transplant. Tissue banks vary in what is considered a suitable donor.

Regulating tissue banks

The Food and Drug Administration (FDA), the primary regulatory body for the tissue banking industry, sets mandatory standards related to donor suitability. The FDA’s primary focus is to prevent the transmission of communicable diseases associated with use of donated tissues. The FDA’s Good Tissue Practices, effective in 2005, include the Donor Eligibility Rule, which requires all tissue banks to screen for communicable diseases such as HIV, hepatitis, syphilis, and Creutzfeldt-Jakob disease. These regulations set the baseline for donor suitability that all tissue banks must follow.

The American Association of Tissue Banks (AATB) is a voluntary association dedicated to ensuring that human tissues intended for transplant are safe and free of infectious disease, of uniform high quality, and available in quantities sufficient to meet national needs. The AATB not only requires donor screening and testing similar to the FDA but also focuses on the operational and organizational aspects of tissue providers. More information is at www.aatb.org.

Additional donor criteria

Tissue banks can also set their own donor criteria above those required by the FDA and AATB. Examples of criteria that may differ among tissue banks are donor age, evidence of osteoporosis, and malignancies, among others. In selecting a tissue bank, it is important to know and understand the differences in donor criteria and the effect these differences may have on the safety and quality of tissue. An example is donor characteristics that could affect the structural integrity of bone allografts, such as the donor’s age, steroid exposure, and osteoporosis. A recent study published in *Spine* found that 50% (7 of 14) of tissue banks that process structural bone allografts accept donors with a diagnosis of osteoporosis, and 43% (6 of 14) have no upper age restriction for these types of grafts.

Tissue donation coordinators

Also important to understand is who is involved in the donor screening process within a tissue bank and the experience of the medical director responsible for the final decisions. Some banks employ experienced critical care RNs as tissue donation coordinators to assist with the review of donor records and the initial suitability process. These coordinators are responsible for authorizing the recovery of tissue from potential donors who meet the criteria for donor suitability. The coordinators have 3 main functions: to support the preliminary screeners, to protect the recovery team, and to honor the gift of the tissue.

Preliminary screening

The preliminary screeners are employed by a recovery or screening organization and are trained to obtain complete medical and social histories and consents. Preliminary screening is challenging. It is not easy to speak with the family who has experienced a recent unexpected death of a loved one. Because the screeners are often individuals in
entry level medical positions, such as EMTs or college students, the coordinator’s role is to make sure all information to determine if the donor is suitable is collected.

Another aspect of the coordinator’s role is to reduce the risk of disease transmission to the recovery teams. Generally, serology testing is performed after tissue recovery. Recovery teams rely on the discussion between the screener and the tissue bank coordinators to uncover potential high-risk behavior in donors that could increase the odds of serologies being positive for pathogens.

**Honoring the gift**

A major component of donor screening is “honoring the gift.” When a family consents to donation, the intent is for the tissue from their loved one to provide life-changing grafts for recipients. The tissue bank coordinators want to accept as many donor referrals as possible. They work to maximize the chances that a donor for whom consent has been obtained will complete the screening process and provide transplantable grafts. “Honoring the gift” also means that sometimes coordinators need to explain to families the rationale for why the tissue bank is unable to accept the potential donation.

—Judy Torgerson, BSN, CTBS
Associate Director of Donor Screening, Musculoskeletal Transplant Foundation

**References**


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**Human resources**

**Onboarding: OR observation, the interview, and job offer**

Second in a series on selecting and hiring perioperative nurses and integrating them into the staff.

It has become increasingly evident that ORs need to train their own circulators. St Luke’s Boise Medical Center in Idaho has developed a 14-step onboarding program that helps to recruit and retain qualified RN circulating nurses. The program has achieved a long-term retention rate, and 50% of the present perioperative clinical RN staff are a product of this process. In the past year, the training program attracted over 100 applicants.

The onboarding program has 14 steps in 3 categories:
- identification
- integration
- perpetuation.

The first article in September 2010 covered Steps 1-4: developing selection criteria, advertising, initial screening, and the phone interview. This article covers Steps 5-9, from OR observation through the interview and job offer.

St Luke’s Boise has 17 ORs and a perioperative staff of over 160 who support the daily schedule of 55 to 80 cases. The ORs are staffed around the clock.

**5. OR observation**

After the initial screening, the next stage in ensuring a candidate makes an informed decision is 4 to 8 hours of OR observation. In most RN education programs, students at best get 1 to 2 days of observation, which doesn’t give them a realistic view of the circulator role.

There are some essential aspects of the observation. I have the candidate arrive at least 5 minutes early and sit in the lounge awaiting our morning report. The goal is for the candidate to observe the interactions of the employees: Are they happy? What are they talking about? Are they grumbling? Do they greet the newcomer?

At morning report, the candidate is introduced as someone who is exploring the OR as a potential next stop in their career. I direct the candidate to the locker room with basic expectations of how to dress. We check in at the front desk, look at our patient load for the day, and choose a room. I’m looking for the right combination of surgeon, surgery, and circulator while reminding the candidate that the goal is to observe the RN circulator and imagine being in this role.

As we walk to the room, I measure whether the person keeps up. Does he or she have the energy for this fast-paced environment? I see the whole spectrum of in-
terest from candidates. Some are looking for me after 2 hours of observation, wanting to find the locker room. If I had signed them up without this experience, they would have been my first casualties. Others are so engaged that they neglect breaks or lunch until I arrive to take them to the next stage of onboarding.

6. The conversation

After about 4 to 5 hours of observation, at an agreed-upon time, I return to their room to retrieve them. I evaluate how they communicate with the staff in the room. Do they simply leave, or have they built a relationship to the point that they at least thank the circulator or even the surgeon? I’ll double back later to get feedback from the circulator.

On the way back to my office, I ask some routine questions. “How did it go? Can you see yourself doing this? Tell me about the surgery.”

Upon arriving at the office, I ask them to reflect on their morning and describe the role of the circulator. This tells me a lot about whether they got the essence of the job.

I restate the training program process and ask if they have questions. I direct the conversation to small talk to further evaluate their communication skills and assess their passion. Why the OR? What has prepared them for this? What got them through those tough moments in RN school when fellow classmates quit? When you get to that point when you say you are never going back to that job again, what makes you go back anyway?

A tested process

I talk of the obstacles they will encounter, balanced with the great benefits of an OR career. They will be their own worst critic. They will not feel like quitting in the first few months but will likely question their choice in about month 5 when they realize what they do and don’t know.

I then direct them to class photos of the past 10 years and talk about successes. In all, 85% who joined this program completed at least 2 years in our OR. Over 50% of our present clinical staff are graduates of this program. Several have gone on to leadership roles. I affirm that they will be part of a tested process where successes build on each other. Preceptors volunteer to mentor new people because they know the likelihood of success.

Addressing the vulnerability of adult learners, I cap this off by stating that if they are selected for the program, the screening process is over, and we are into success. But this depends on them making an informed choice. Their response leads me to an important question: “On a scale of 0 to 10, how badly do you want to be an OR circulator?” I value a qualified 7 or 8 more than a flippant 10. Based on the outcomes of this conversation, I may or may not invite them to the next stage of onboarding, the official interview.

7. Behavioral interview

Many facilities rely on the manager or director to interview potential candidates and make a job offer. I was hired by an interim director on a Saturday as I was traveling through the state! When that candidate does not work out, the staff legitimately points to the manager for making poor choices.

Our process now is interdisciplinary. While this may seem expensive to productivity, the discerning leader also sees the long-term benefits of reduced attrition and increased morale. On some occasions, I have asked the staff on the interview panel: “Would our staff rather pick up the slack with extra call and added shifts or hire this individual to fill those gaps for us?” Their willingness to pick up the slack has saved us from hiring bitter or dysfunctional individuals even in times of desperation.

Our interview process uses a uniform tool designed to provide consistency for each candidate. The tool itself is a behavioral interview. While we include fun questions like: “What 3 things in your car would tell us about you?” we also include other scenario-based questions. Here is a sample:

• “Describe a time when you were misunderstood in something you said, wrote, or did. What steps did you take to clear up the misunderstanding?”
• “You may need to take a step back in your job confidence as you learn this new role. What keeps you coming back?”
• “Describe a time in which you were new to a situation or skill and had to observe a colleague. How did you feel about being the ‘student’? How did you learn from that situation?”
• “A doctor yells at you and uses less than professional vocabulary to describe what he thinks of your abilities. How do you respond?”

They will be part of a tested process.

Human resources

Continued from page 21
The interview team

I introduce the tool to the candidate, indicating that there isn’t necessarily a right or wrong answer. The goal is to get to know each other. Around the table are a variety of individuals including an RN circulator, a supervisor, a certified surgical technologist, a previous program participant, and an unlicensed assistive person as well as myself. The goal is to have the same individuals present for all interviews to give consistency to the scoring tool.

The scoring tool has a 0-5 point scale. Each answer is scored. The result is a total score that is averaged and entered into a comparative spreadsheet. Some may question whether you can measure an answer to a question such as: “Do you have any questions for us?” Every question has a purpose, including this one. It tells me the level of preparation of the candidate. Some open a binder with typewritten questions and, in essence, begin their interview of us. Others are quick to state they have no questions.

Though a group interview may be intimidating, our goal is to use a friendly approach with introductions, humor, and icebreaker questions. The interview aims to ascertain whether the individual has a passion for this career, willingness to return to the novice role, and suitability to our culture. We know the person’s attitude today will likely resemble his or her attitude 10 years from now, though the skill set will be much different.

Our goal is to have a conversation allowing candidates to ask questions as well. They need to get to know us as much as we need to get to know them.

The end of the interview

At the end of the interview, candidates are informed that the next contact will come through human resources after our decisions have been reached, although they are free to call if they have further questions.

After the candidate leaves, the group spends a few minutes finishing the scoring on the interview tool before briefly listing the pros and cons of including this individual. At the end of the interview tool, I include 6 subjective questions. The last question holds a lot of weight. It asks the interviewers to sum up the interview by ranking on the scale of 0-5 their “confidence that candidate is likely to succeed in the perioperative training program.” The averages of this indicator are included in the overall scoring spreadsheet. These numbers are telling when we get to the next stage of onboarding.

8. Evaluation and analysis

At the conclusion of the interview, I work through the scores on a spreadsheet and reassemble the group for deliberations. Often, the top and bottom candidates are quickly identified. The ones in between take the majority of our discussion. Unless we approach this conversation openly, not campaigning for a particular candidate, we will not arrive at unanimous decisions or at least a consensus. It has amazed us how we come to solid group decisions on which candidates to invite to the training program.

9. Job offer

As part of a health system, our department competes for candidates with other surgical departments. If more than one department wants to make a job offer, the offers are combined through HR, and the final choice belongs to the candidate. Again, observation time is indispensable in drawing the right person to the right department.

The offers are coordinated and emailed to the HR recruiter, who contacts the desired candidates, holding some in reserve and sending polite emails to those who will not be considered this year.

On several occasions, we have had an individual take 10 days to 3 weeks to respond to the job offer. In both cases, these individuals did not last through the initial training. We strongly believe that if, after going through the first 8 steps of this process, a person is not able to make an affirmative decision within the first 3 days, we will withdraw the offer. Those who accept sign a 2-year agreement with a prorated financial obligation. The financial amount is not a reflection of the cost of training but a measure of the depth of their commitment to proceed with the specialty training. Now that we have arrived at a 2-way commitment, it is time to move to the second phase of onboarding, integration.

—Reuben J. DeKastle, RN, MHSA, CNOR
Clinical Educator
St Luke’s Boise Medical Center
Boise, Idaho

The third article will explore the integration phase of onboarding. The first 2 articles addressed screening of candidates. The rest of the series focuses on ensuring success for the new employee.
Financial difficulties are challenging more managers of ambulatory surgery centers (ASC) this year, according to results of the 20th annual OR Manager Salary/Career Survey.

Much of the change can be attributed to reduced case volume and changes in Medicare reimbursement for ASCs.

More than a third (34%) of respondents reported lower volume, compared with 15% 2 years ago, and elective surgery is down, too. In all, 43% reported financial difficulties because of the current economic condition. More than two-thirds attributed those difficulties to changes in Medicare reimbursement.

“We’ve seen the end of the 4-year transition phase for Medicare changes, which sheltered some of the higher volume procedures from drastic cuts in years past,” said Marie Edler, director of reimbursement policy for the ASC Association.

As a result, the survey found many managers are reconsidering or postponing capital expenditures, particularly for OR technology.

The OR Manager Salary/Career Survey was mailed in March to 1,000 OR Manager subscribers and an external list of nurse managers of ASCs, with 182 usable responses for an 18% response rate. The margin of error is ±6.7% at the 95% confidence level. Results from the staffing portion of the survey appeared in the September issue.

### Average annual salary (and total compensation) by region

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<th>Region</th>
<th>Average Annual Salary</th>
<th>Total Compensation</th>
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<tr>
<td>West</td>
<td>$98,900 ($117,000)</td>
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<tr>
<td>Midwest</td>
<td>$82,200 ($104,000)</td>
<td></td>
</tr>
<tr>
<td>South</td>
<td>$81,400 ($98,000)</td>
<td></td>
</tr>
</tbody>
</table>

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

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The 43% of ASCs that have experienced financial difficulties from the economic downturn is significantly higher than last year’s 31%. The most common source of those difficulties is a decline in surgical volume, reported by 81% of respondents, compared with 90% last year. Edler attributes the decline to the weak economy, which is causing people to postpone elective surgery, and the increase in high-deductible plans being chosen by employers, causing many patients to put off or decide not to have procedures.

ASCs experiencing problems with changes in Medicare reimbursement jumped dramatically from 39% last year to 68% in 2010, and 8% reported a lack of available credit.

More than one-third (36%) reported a decrease in overall surgical volume in the past 6 months, with those reporting an increase or a steady volume both at 32%.

Respondents note they are fighting back on volume. “Adding on new doctors,” said one. “We must be the ‘partner of choice.’” Some report success, as the manager who noted, “maintaining patient volume with decreasing revenue.” Another said, “increased net income despite decreased case volume.” Other respondents have

Continued on page 26
even expanded services.

For respondents (40%) who are reconsidering or postponing capital expenditures, areas hardest hit are OR technology and equipment (78%) and information technology (50%, significantly more than the 34% in 2009).

Despite economic constraints, many ASCs are moving forward with new projects, with some reporting expansion. “Opened 3 new centers [in] 3 new markets,” said one respondent.

**Compensation by the numbers**

On average, ASC managers earn less than their hospital OR counterparts.

**ASC** | **Hospital**
--- | ---
Salary | $86,700 | $109,000
Total compensation | $105,000 | $132,000

ASC managers in corporate-owned facilities earn the most, followed by those in joint-venture and physician-owned centers.

**Benefits.** Across the board, ASC managers consistently have fewer benefits than hospital OR managers and directors.

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<td>Paid time-off</td>
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<td>Health ins</td>
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About 8 in 10 (79%) reported having a bonus/profit sharing program compared with less than half (46%) of hospital OR managers and directors. In all, 10% reported losing benefits in the past 6 months, lower than the 19% for hospital OR managers and directors.

The average raise for ASC managers was 3.7%, comparable with 3.5% for hospital OR managers and directors. But the 2 groups saw a marked difference in the number who received bonuses or profit sharing during the past 12 months—70% for ASC respondents versus 33% for hospital OR managers and directors.
respondents. ASC managers’ bonus amounts were lower, however, averaging $6,530, less than the $8,060 for hospital OR directors and managers.

ASC managers have an average of 26.1 days of paid time off a year.

About the manager role
More than half (52%) of respondents’ ASCs are in suburban areas, followed by urban (31%) and rural (15%) locales. The average annual case volume is 4,410.

As in previous years, most respondents (45%) work in physician-owned ASCs. A quarter work in joint-venture ASCs, a fifth in corporate-owned facilities, and only 8% in hospital-owned centers. Nearly two-thirds (63%) of respondents work in multispecialty centers. Most single specialty ASCs were physician-owned (75%), while multispecialty ASCs were fairly evenly split between joint-venture (34%), hospital-owned (27%), and physician-owned (26%) facilities.

The top specialties for single-specialty ASCs were ophthalmology (37%), orthopedics (19%), gastroenterology (16%), and cosmetic/plastic surgery (10%).

Facility size. ASC managers oversee an average of 3.7 ORs, basically the same as last year’s 3.8, with variations according to type of ownership. Those in single-specialty centers oversee an average of 2.5 ORs, compared with 4.5 for those in multispecialty ASCs, and respondents in physician-owned centers oversee 2.7 ORs, compared with 4.5 for other types of ownership.

Scope of responsibility. ASC managers supervise an average of 23.7 FTEs, including an average of 19.5 clinical FTEs and 4.2 nonclinical FTEs. That’s much less than the average of 111 FTEs for hospital OR directors and managers.

One-third of respondents report their title to be administrator or administrative director, with the remainder split fairly evenly among director of nursing (22%), nurse manager (19%), and clinical director (16%).

More than a third (36%) report to administration, 20% to physician owners, and only 14% to a board of directors.

Budget. The average ASC annual operating budget is $4.7 million. More than half of respondents, primarily those with the title of nurse manager, didn’t know.

Physician $2.5 million

Although more than half (54%) of respondents said their budgets stayed the same in the past 6 months, 14% experienced a decrease, and 13% reported an increase.

Budgets remain a primary focal point for managers. “We made budget in a tight economy,” said one respondent. Another reported “cost and payroll savings of 6.5% of net revenue.”

Purchasing influence. About 9 out of 10 managers influence the selection and purchase of OR supplies and equipment (85%) and OR capital equipment (73%). Nearly half (48%) are members of the decision committee or team, 37% are the primary decision maker, and 28% serve in an advisory capacity.

Work hours/satisfaction. Respondents work an average of 49.1
hours a week, with 35% working between 50 and 54 hours. On a scale of 1 to 5, with 1 being “not at all satisfied” and 5 being “very satisfied,” respondents report a mean of 4 for satisfaction with their current position, and more than a third said they were very satisfied.

About you

Like their hospital counterparts, ASC managers are a seasoned group. More than half (56%) have been employed in nursing for 30 years or more. They have been in their current positions an average of 10.1 years.

The average age has steadily increased over the years, from 47 years in 1997 to 53 in 2010, the same trend as for hospital OR directors and managers.

Nearly half of ASC managers (48%) have a bachelor’s as their highest degree, followed by 21% with an associate degree, and 14% with a master’s. That pattern differs from hospital OR leaders, half of whom have a master’s degree.

Nearly half (47%) of respondents’ employers require a specific degree, compared with 76% for hospital OR respondents. The bachelor’s is the most common degree required for ASC managers, followed by associate and master’s degrees.

What will 2011 bring?

“Medicare reimbursement will remain a challenge for many ASCs if CMS [Centers for Medicare & Medicaid Services] doesn’t alter its policies that continue to cause a divergence of hospital outpatient departments and ASC rates, such as the inflation update differences,” says Edler. CMS uses different inflation indexes for hospitals and ASCs. ASC inflation updates are based on the consumer price index for urban consumers, while hospital updates use a market basket representing goods and services purchased by hospitals. ASCs contend their updates should also use the hospital market basket because they face the same inflationary pressures as hospitals in retaining nurses and purchasing supplies.

Edler adds that the productivity adjustment made as part of health care reform negated the inflation ASC payment update for 2011. “Other facets of health care reform may impact ASCs in the long term, but this is the most significant for 2011 reimbursement.”

The good news for ASCs, she says, is that under health care reform, more people will have insurance (though many will be on Medicaid). Another possible upside for patient volume is the coverage, with no copays or deductibles, of some screening services such as colonoscopies.

—Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer and president of CLS Development, Inc, in Columbia, Maryland.
When malignant hyperthermia (MH) surfaces in an ambulatory surgery setting, minutes count—the patient needs to be stabilized immediately and transferred to a hospital. But will the ambulance service have the right equipment and medications? Which hospital unit will receive the patient? Will the anesthesia provider go with the patient?

These are some of the issues that need to be addressed in advance. New MH transfer guidelines from the Ambulatory Surgery Foundation and the Malignant Hyperthermia Association of the United States (MHAUS) are intended to help ambulatory surgery centers (ASCs) develop such a plan.

The final guidelines, issued in the form of a colorful poster, were developed by a multidisciplinary task force of ASC, MH, and emergency medicine experts. The guidelines are similar to those posted for public comment in late 2009.

Patients need to be transferred because ASCs typically aren’t equipped to treat MH beyond stabilizing the patient, notes Henry Rosenberg, MD, president of MHAUS and director of medical education and clinical research at Saint Barnabas Medical Center, Livingston, New Jersey, and a member of the task force.

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<th>New guidelines help planning.</th>
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<td><strong>Plan needs to be ASC-specific</strong></td>
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<td>The transfer guidelines aren’t prescriptive but outline issues each ASC needs to consider to develop a transfer protocol to fit its situation, Dr Rosenberg explains. “We learned there is so much variation in ASC staffing, distance to the hospital, and arrangements for transport that we couldn’t be more specific. These guidelines are more to stimulate a thought process,” he says.</td>
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Plan needs to be ASC-specific

- The receiving hospital’s capabilities, patient data to be reported, and transport team’s capabilities
- Timing of the transfer
- Notification of the receiving hospital and coordination of communication.

For example, who will take care of the patient initially and ultimately—the emergency department, the ICU, or the postanesthesia care unit?

Transport capabilities

Learning about transport capabilities is also key.

The task force learned there are all levels of emergency responders, Dr Rosenberg says, depending on the state, locale, and ambulance service. Some are limited to such tasks as giving oxygen and taking vital signs. Others can intubate patients, defibrillate, and give IV medications.

Another question that often arises: Should the anesthesia provider go with the patient? Again, that depends. If the anesthesia provider can’t go, should another clinician go? Should the hospital send over an anesthesiologist? Should the surgeon go?

Blood gas analysis is another consideration. If the ASC doesn’t have that capability, will samples be sent to a lab? Should the facility buy a machine to perform blood gas analysis?

Advice for nurses

The nursing staff should be part of an MH response and transfer plan. That includes annual training...
In 2011, the OR Business Management Conference will be combined with the Managing Today’s OR Suite Conference, September 28 to 30, at the Hyatt Regency Chicago.

The decision to combine the conferences was made following the OR Business Management conference in San Francisco in May.

Because of the current economic environment, health care facilities are continuing to reduce funding for educational events and to ban travel for conferences.

Participants at the San Francisco conference were asked for their input, and most supported the decision in light of the economy.

At the Chicago conference in 2011, business managers and others involved in the financial management of the OR will have a special track of preconference seminars and breakouts. ❖

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Combined conference in 2011

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Proposals invited for 2011 conference

Share your success at the 2011 Managing Today’s OR Suite conference, September 28 to 30 in Chicago.

Submit your proposal for a 75-minute breakout or a full-day preconference seminar at www.ormanager.com/mtors/abstract/submittal-form.htm

The conference focuses on practical topics related to surgical services management, such as OR throughput, staffing, and cost management.

The conference will include a track related to business management of the OR. A separate OR Business Management Conference will not be held in 2011.

Deadline is October 15, 2010. Questions? E-mail Judy Dahle, RN, MS, education coordinator, at jdahle@ormanager.com or call 1-877/877-4031.
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At a Glance

**WHO surgical checklist saves money, improves care**

Using the World Health Organization Surgical Safety Checklist is a cost-saving, quality improvement strategy, finds a new study. Researchers found implementation of the checklist in one US hospital over 1 year:

- saved $103,829 annually for a hospital that performs 4,000 non-cardiac surgical procedures per year, a savings of $25.96 per procedure.
- resulted in net savings of $8,652 for every complication averted.

If at least 5 major complications are prevented within the first year of use, a hospital would realize a return on investment within the same year.

Checklist implementation costs ranged from $6,318 to $25,270, primarily for time spent by the implementation task force.


**Most BMP use off-label; CMS plans meeting**

At least 85% of the principal procedures using bone morphogenetic protein (BMP) are spinal fusions for which BMP use has not been approved by the Food and Drug Administration, finds a study. From 2002 to 2007, use of BMP more than quadrupled.

BMP is approved for use in anterior lumbar interbody fusion with interbody cage, revision posterolateral spine fusion (PSF), or treating long bone fractures. The principal procedures for off-label use are posterior lumbar interbody fusion, transforaminal lumbar interbody fusion, cervical fusion, primary PSF, and thoracolumbar fusions.

Because of safety concerns and the risk of complications with certain off-label uses, the authors say further research is needed to define appropriate indications.

The Centers for Medicare and Medicaid Services scheduled a meeting for Sept 22 on the on-label and off-label use of BMP.


**Consumer Reports rates cardiac surgery programs**

No longer limited to TVs and digital cameras, *Consumer Reports* posted its first ratings for surgeons Sept 7. The ratings give 1 to 3 stars to 221 cardiac surgical groups from 42 states for outcomes on coronary artery bypass surgery. Scores are based on data from the Society of Thoracic Surgeons registry. The *New England Journal of Medicine* called reporting of the data “a watershed event in health care accountability.”


**Elderly benefit from minimally invasive rotator cuff repair**

Arthroscopic rotator cuff repair provides significant improvement in pain and function in patients aged 70 years or older, researchers report.

Many surgeons are reluctant to perform shoulder surgery on the elderly because of fears of complications, but the findings show that these patients should not be excluded, according to *HealthDay News*.

Significant pain reduction was reported by 96% of patients, along with major improvements in shoulder function, range of motion, and muscle strength. Complication rates were low.