

Ambulatory Surgery Centers

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Salary/Career Survey

Average manager's salary tops \$92,000; raises pace inflation

The average salary for OR nursing leaders tops \$92,000 this year. A third of the leaders are making more than \$100,000 a year. Raises in the past year ran neck-and-neck with the Consumer Price Index, averaging 4%. But OR managers and directors did better on salary increases than managers and professionals in the nation as a whole, who averaged raises of 2.8%, according to the US Department of Labor.

OR managers and directors have major budgetary responsibility in surgery, overseeing on average operating budgets of \$19 million. They continue to have clout in purchasing decisions, saying they are closely involved and often take the lead.

These are results from the 2006 annual *OR Manager* Salary/Career Survey.

The survey was mailed in May to a random sample of 1,200 *OR Manager* subscribers with 266 returned for a rate of 22%. A separate survey was sent to ambulatory surgery centers (see p 29). Results on purchasing power will be in the November *OR Manager*.

Salaries and raises

The average annual salary for all respondents is \$92,680. The highest salary is \$180,000, reported by a director from a community hospital in the South who manages multiple departments. The lowest, \$40,000, is from a community hospital in the Central region. The East had the highest average salary—\$97,010.

Directors at teaching hospitals and the largest ORs (10+ rooms) reported

Continued on page 9

Managing people

Bad behavior in OR threatens patient safety, stresses teams

Surgeon speaking abusively to operating room personnel during procedure. Less attention to patient because of stress—more chance of error.

Failure of MD to listen to RN regarding patient's condition. Patient had postoperative pulmonary embolism.

Disruptive language/action and so on from surgeons and nurses' negative attitudes are worse. It all feeds off of each other and continues to get worse as case and day goes on.

Bad behavior like this is not uncommon in the perioperative setting. It's not only hard on morale. It's a threat to patient safety. In a new

study, 19% of respondents said they knew of a specific adverse event that happened as a direct result of disruptive behavior. Yelling, being disrespectful, using abusive language, and berating a coworker in front of others were the most frequent types of bad conduct.

Bad behavior takes a toll in stress, frustration, loss of concentration, ineffective communication, and impaired relationships.

"The most disturbing outcomes of the study were the impact on staff relationships, teamwork, and clinical outcomes of care," say authors Alan H.

Continued on page 19

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Upcoming

Five Commandments of Counts

A health system reinvigorates its counting practices with input from human factors experts.

Reuse of single-use items

The Food and Drug Administration analyzes 434 events reported to its database—and finds little to worry OR managers.



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for OR decision makers

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Editor's Note

Ever thought of a second career? There's a place that could really use you—schools of nursing. Schools are crying for faculty.

Last year, baccalaureate and graduate programs turned away close to 42,000 qualified applicants because they did not have enough teachers or other resources.

A few other figures:

- There are about 2 faculty vacancies for each 4-year and graduate program, according to the American Association of Colleges of Nursing (AACN).
- The faculty vacancy rate is 7.9% in baccalaureate and higher degree programs—up 32% since 2002—and 5.6% for associate degree programs, the National League for Nursing reports.
- Almost two-thirds of full-time faculty are 45 to 60 years old and likely to retire in the next 5 to 15 years.

It's true that teaching isn't as lucrative as management. Master's-prepared nursing professors earned an average of \$69,340 in 2005, AACN figures show. In contrast, the average OR director or manager earns \$92,680, according to the *OR Manager* Salary/Career Survey. But teaching has its own rewards.

We asked AACN's associate executive director, Robert Rosseter, what teaching has to offer OR managers.

Q Why should an OR director consider teaching?

Rosseter: Teaching provides an outlet for OR directors to share their expertise and perspective with the next generation of nurses. Many nurses who teach and maintain a clinical practice are energized by their interactions with new nurses and understand the important role they play in keeping the nursing workforce healthy. Others enjoy having access to a new pool of potential nurse recruits whom they can educate to practice in their particular setting.

Q What resources are available to help nurse managers qualify for teaching?

Rosseter: Most schools of nursing will work with clinicians interested in teaching by providing the education needed to be an effective teacher. Schools often provide a mentor for the new instructor who will answer questions and provide support.

What does teaching have to offer OR managers?

Many practice settings will reimburse nurses for getting an advanced education.

Though the doctoral degree is the preferred credential for a full professor, most states allow master's-prepared clinicians to teach independently. Baccalaureate-prepared nurses sometimes teach clinical courses under the direction of a graduate-prepared faculty member.

Q What's being done to address faculty salaries?

Rosseter: Many hospitals are partnering with local schools of nursing to provide funding to boost faculty salaries and hire new instructors. Several states like Illinois and Kansas have introduced programs that will augment faculty salaries. Nursing schools are also working to make the case to their school's central administration that nursing faculty salaries must be raised to levels commensurate with the faculty teaching in other health professions.

Tools that can help

We're seeing some creative approaches emerge:

- **AACN CareerLink for faculty.** This web-based clearinghouse has job postings, financial aid opportunities, and faculty development programs. www.aacn.nche.edu/CareerLink.
- **Troops to Nurse Teachers (TNT).** This new program, added to the Department of Defense authorization bill, would set up a pilot to help military nurses with a master's or doctorate transition to faculty positions. If Congress funds the program, it could start accepting applications in 2007.

Think about teaching. It could be the perfect solution if you're ready for the next stage in your career. ♦

—Pat Patterson

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NY governor vetoes RN circulator bill

New York State Governor George Pataki vetoed a bill (A 7837) Aug 16 that would have required an RN circulator in each OR for the entire operation.

The governor said he vetoed the measure because the state health department advised him “the vast majority of hospitals in the state already employ RNs as circulators,” but the department thought it was premature to impose a mandate “pending a review of the available workforce.”

New York regulations

Pataki said there was concern some rural hospitals in upstate New York might not be able to find enough RNs. The bill had passed both houses of the Legislature overwhelmingly. Overriding the veto would be difficult because the Legislature has recessed until after the fall elections, observers said.

New York’s current regulations say licensed practical nurses and surgical technologists may assist in circulating under the supervision of an RN who is immediately available to respond to emergencies.

New York is one of 10 states where the Association of periOperative Registered Nurses (AORN) is pursuing legislation to strengthen circulator language. The others

“
Labor supply in rural hospitals is a concern.
”

are Florida, Georgia, Maryland, North Carolina, Ohio, Virginia, Pennsylvania, South Carolina, and Washington.

According to AORN, about 20 states currently require an RN circulator in each OR, though AORN thinks some regulations could be stronger. (An update on state regs is on the AORN web site at www.aorn.org. Look under Government Affairs.)

Pataki’s concern about a nursing shortage has been the state’s “response to any of our proposals related to staffing,” said Nancy Webber, spokesperson for the New York State Nurses Association, which supported the bill. “They may have perceived this as another staffing mandate.” Like other state associations, NYSNA is seeking legislation to mandate nurse-to-patient ratios.

The state’s latest workforce study, conducted in 2002, found there was a nursing shortage in every county in the state, and 20% of nurses said they planned to leave within 5 years.

OR directors say supply adequate

OR directors *OR Manager* contacted in upstate New York say they are not having problems recruiting OR RNs, though they are in rural areas.

Recruiting OR RNs “is not an issue” at Samaritan Medical Center in Watertown, NY, near the Canadian border, says Susan Gornall, RN, MSN, CNOR, interim OR director. With a large military base and a school of nursing, the area’s labor supply has been adequate, she says. Across the state in Plattsburgh, NY, an OR director says her OR has no vacancies.

As elsewhere, lack of faculty is hurting the ability to prepare RNs. At a tea for 40 nursing students from the nearby community college, Gornall said it was announced that 3,000 candidates could not get into nursing schools in New York because there are not enough teachers.

New York’s Legislature recently approved \$4 million in new funding for scholarships and loans for RNs who plan to teach nursing.

OR staffing in rural hospitals

ORs in rural hospitals face challenges similar to all hospitals, staffing results from the *OR Manager* Salary / Career survey show (September *OR Manager*.) (See p 7.)

Fewer rural hospitals report an OR nursing shortage, but more say they are having a difficult time recruiting RNs. Rural hospitals also report a somewhat higher vacancy rate and a longer time to fill vacancies.

But very few rural respondents—4%, fewer than respondents overall—said surgical technologists (STs) or licensed practical or vocational nurses (LPNs or LVNs) were circulating, either with the RN in the room or immediately available. None reported STs, LPNs, or LVNs were circulating on their own. In comparison, 8% of all respondents said STs, LPNs, or LVNs were circulating with an RN in the room or immediately available. ♦

Information about New York Bill A 7837 is at <http://assembly.state.ny.us/leg/?bn=A07837>

See charts on page 7

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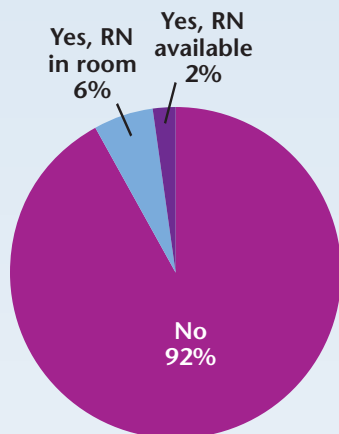
Nursing director, perioperative services, Yale-New Haven Hospital, New Haven, Conn

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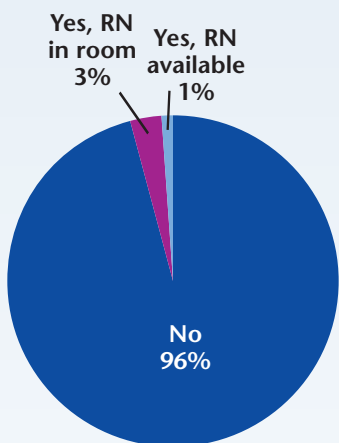
OR staffing in rural hospitals

Do surgical techs circulate?

Overall

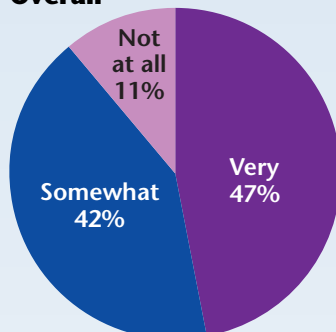


Rural hospitals

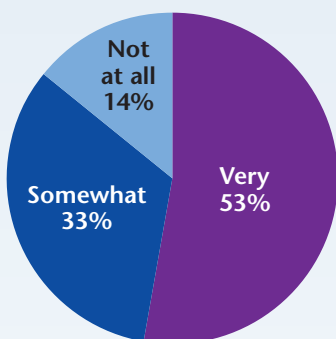


Is recruiting experienced OR nurses difficult?

Overall



Rural hospitals



Do not have an OR nursing shortage

Overall	37%
Rural hospitals	48%

	Overall	Rural
Percent of budgeted FTE positions open	7%	9%
Average number of weeks positions have been open	12.6	16.9
Average staff turnover rate (Percent of staff who have left and been replaced in past year)	7%	7%

Source: OR Manager Salary/Career Survey, 2006.

Conference sessions extend beyond the operating room

Surgical services directors today juggle many hats—77% manage the OR plus other departments in the same hospital, according to the *OR Manager Salary/Career Survey* reported in this issue. Leading the list are the:

- postanesthesia care unit
- outpatient surgery
- central processing
- GI endoscopy
- preadmission services.

Sessions at the Managing Today's OR Suite conference recognize this broader role. The conference is scheduled for Nov 8 to 10 in Orlando, Fla.

Offerings that will help managers and directors balance their multiple roles:



All-day seminars

Managing the Beginning and End of the Perioperative Continuum

Three veteran managers offer advice on managing the preadmission area and postanesthesia care unit.

Value-Analysis Teams for Cost-Savings Strategies and Technology Management

An OR business manager and surgical services leader cover the essentials of managing materials costs for surgery, including the value-analysis process.

Breakout sessions

Sessions that address other units directors commonly manage include:

- **Current Issues in Managing a GI Suite.** Staffing, infection control, and medication management will be among the issues covered.
- **Materials Management for the New OR Manager.** Mastering one of the costliest aspects of surgical services.
- **Implementation and Benefits of an Instrument Tracking System.** How automation in central processing can help measure employee productivity, manage instrument turn-around, and make budgeting decisions for new instrumentation. ♦

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Salary/Career Survey

Profile of the typical OR manager

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

- Earns an annual base salary of \$94,890 for an OR director and \$80,870 for an OR nurse manager
- Received a raise of 4% of base salary
- Holds the title of director of surgical services
- Works in a community nonteaching hospital (68%) with an average of 11 staffed ORs
- Manages 6 departments
- Oversees 82.7 clinical and 21.1 nonclinical FTEs
- Is responsible for an operating budget of \$19 million.

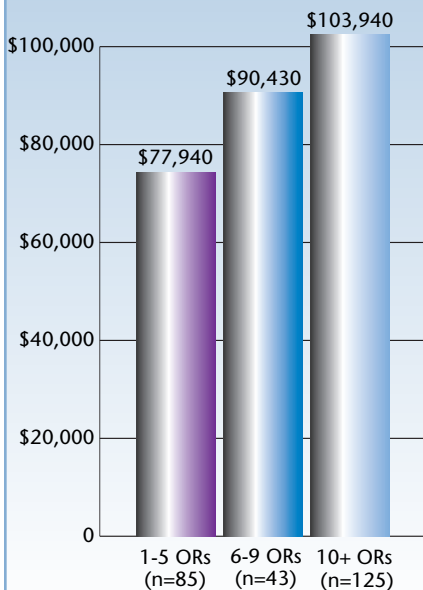
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average salaries of over \$100,000.

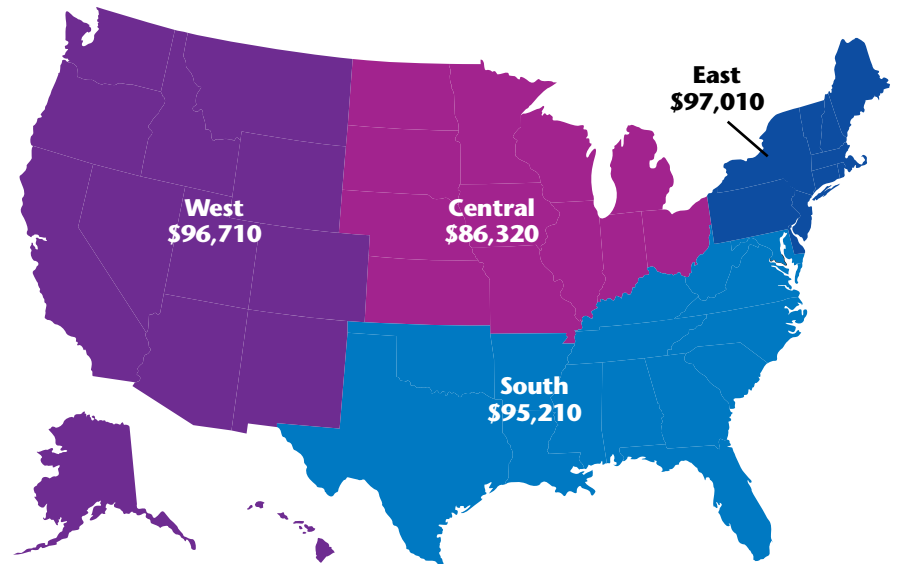
A few (13%) earn less than \$70,000. This is most common in the Central states and in small ORs with 1 to 5 rooms.

Nearly all respondents (92%) say they received a salary increase in the past year. At 4%, the average raise didn't quite match inflation, which ran 4.3% for the year ending in June, and just barely

Average annual salary by number of ORs



Average annual salary by region



edged out last year's average of 3.8%.

Raises varied little by region or type of facility. Leaders of the largest ORs had the highest average increase.

Raises by size of OR

1-5 ORs	3.8%
6-9 ORs	3.7%
10+ ORs	4.3%

Bonuses

Forty percent reported they are eligible for an incentive bonus or profit sharing, little changed from 39% 5 years ago.

The average bonus was 8% of base salary.

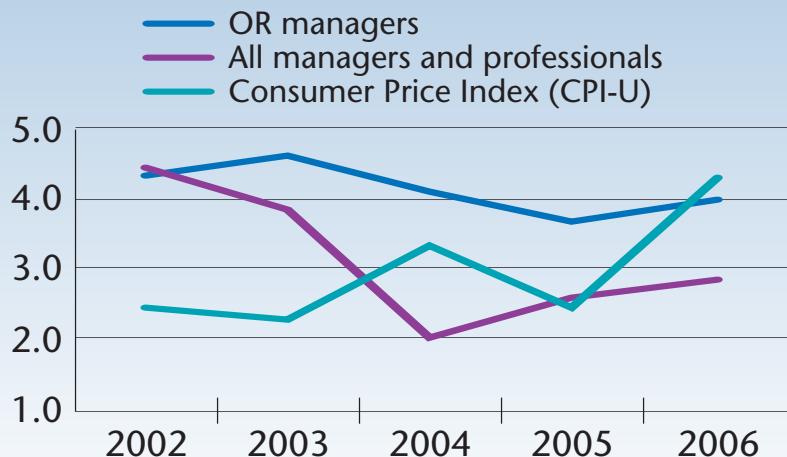
Of those eligible, respondents from the Central states (40%) and the South (48%) were the most likely to report being eligible for an incentive bonus.

Leaders are more likely to receive a bonus if they manage the ORs plus other departments (41%) and have the title director (41%) rather than nurse manager (23%). The amount of the bonus was higher for those managing the ORs plus other departments, at 8% (n=69), than for those managing the OR only, at 6% (n=4).

Half of directors of large ORs are eligible for a bonus.

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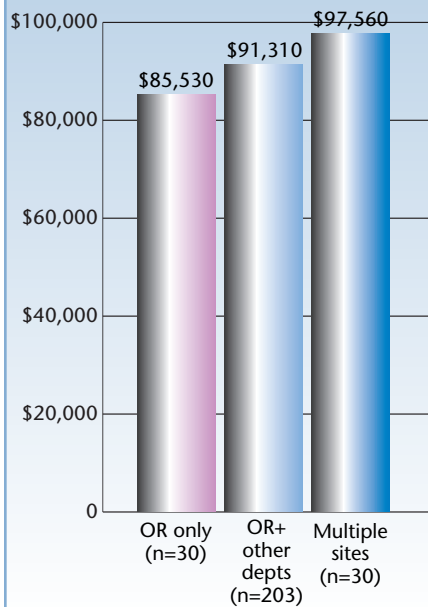
How OR leaders' raises compare



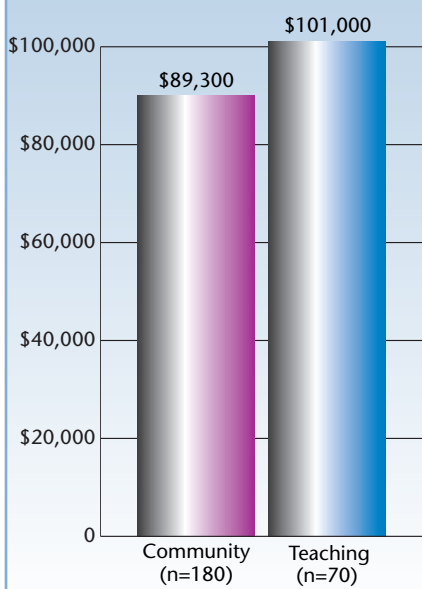
Source: *OR Manager, Inc.*; U S Department of Labor, *Employment Cost Index, Wages and Salaries, Consumer Price Index.*

Salary/Career Survey

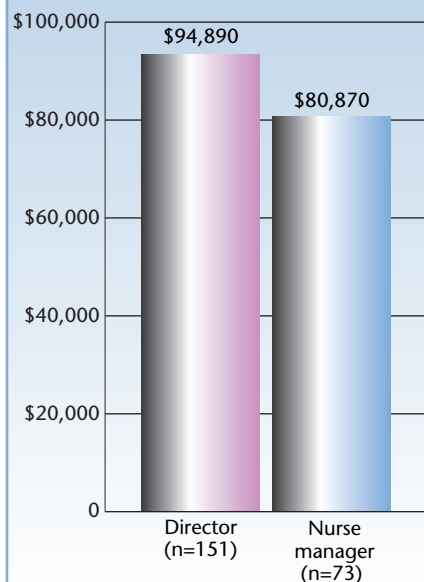
Average annual salary by scope of role



Average annual salary by facility type



Average annual salary by title



Continued from page 9

Those receiving bonuses by size of OR

1-5 ORs	31%
6-9 ORs	34%
10+ ORs	50%

Benefits

Benefits have changed little in the past 5 years. Two benefits that are more common are dependent health insurance and eye care.

Many report they are paying a higher portion of their insurance premiums or have higher copays or deductibles.

Among other benefits in addition to those listed are a concierge service, flexible spending accounts, 401k plans, and bonus plans for long-term employees reaching their 15-, 20-, and 25-year employment anniversaries.

	2006	2001
Health insurance	99%	99%
Paid time off	99%	97%
Life insurance	97%	96%
Retirement plan	94%	91%
Dental insurance	95%	93%
Tuition reimb	91%	90%
Disability ins	86%	85%
Dependent health insurance	83%	79%
Eye care	77%	56%

Changing profile of OR managers

The typical OR manager or director in a hospital...

	2006	2001	1996
is paid an average annual salary	\$92,680	\$79,555	\$59,720
reports to nursing administration	69%	64%	62%
is eligible for incentive bonus	40%	39%	34%
manages an OR with a management information system	91%	82%	66%
manages more clinical FTEs	83%	79%	56%
has a master's degree	40%	39%	34%

Source: OR Manager, Inc.

About your organization

Most of the survey's respondents (68%) work in community hospitals, while 27% are in teaching hospitals, and the remainder in another type, such as military, Veterans Affairs, or specialty facilities. Respondents are about equally divided among urban (33%), suburban (32%), and rural (36%) locales. In all, 87% are employed by not-for-profit organizations, and 13% are in for-profit facilities.

About your role

Title and work area. The most com-

mon title for respondents is director (58%), followed by nurse manager (28%).

In their titles, most refer to their work area as surgical services (51%), followed by perioperative services (28%), and the operating room (14%).

Reporting structure. Most respondents (69%) report to the nursing administration, with about one-fourth (26%) reporting to the hospital administration, and the remainder to some other entity.

Leaders in teaching hospitals are much more likely to report to the hospital administration than those in commu-

Salary/Career Survey

Do you have an OR business manager?

In all, 28% of survey respondents have an OR business manager. The position is most common in larger ORs and teaching hospitals.

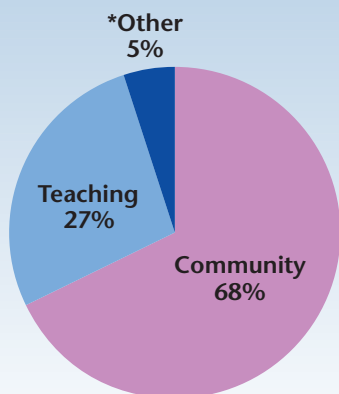
By type of facility

Teaching	Community
49%	21%

By number of ORs

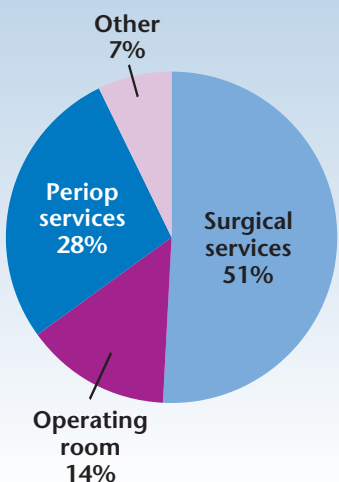
1-5	6-9	10+
6%	14%	48%

What is your organization type?



*Other types of facilities include specialty, military, and Veterans Affairs hospitals.

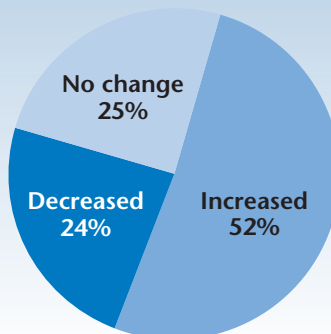
In your title, what is your work area?



How many sites do you manage?

	By title	
	Director (n=153)	Manager (n=73)
OR only within one hospital	5%	32%
OR & other depts within one hospital	85%	63%
OR only at multiple sites	0%	1%
OR & other depts at multiple sites	10%	4%

Has surgical volume increased?



nity hospitals, 41% versus 20%. The larger the department, the more likely the director is to report to the hospital administration:

10+ ORs:	37% (n=47)
6-9 ORs:	21% (n=9)
1-5 ORs:	9% (n=8)

Managing beyond the OR. For most respondents, their role extends beyond the OR and even the facility. The largest group (77%) manages the OR and other departments in a single hospital. These leaders oversee on average:

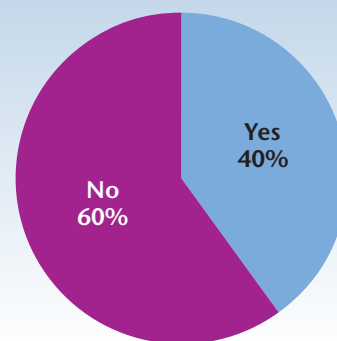
- 10 ORs
- 5 departments
- 76 clinical and 18 nonclinical FTEs
- an annual OR budget of \$15.7 million for operating expenses, \$1.3 million for capital, and \$4 million for personnel.

Another 11% of respondents manage multiple departments at more than 1 facility.

About the operating room

Surgical volume. The average annual surgical volume for respondents is 8,404 cases. A little more than half (52%) say their volume has increased, the same as

Are you eligible for a bonus or profit sharing?



in 2005 but lower than the 63% in 2001. On average, volume had increased by 8%.

Surgical volume by size of OR

1-5 ORs	2,589
6-9 ORs	5,807
10+ ORs	13,317

Number of ORs. Those with the title "director" manage an average of 11 ORs, while those with the title "nurse manager" oversee an average of 10 ORs.

Annual budget. Surgical services directors have a large financial responsibility, overseeing for all of the ORs they manage an average:

- operating budget of \$19.0 million
- capital budget of \$17.4 million
- personnel (salary) budget of \$4.9 million.

Average annual operating budget managed

Director	\$18.3 million
Nurse manager	\$10.5 million

About you

Age and gender. The average age of

Continued on page 12

Salary/Career Survey

How many clinical FTEs are under your span of control?

	By facility type		By number of ORs			By title	
	Community	Teaching	1-5	6-9	10+	Director	Manager
Clinical	65.7	129.7	27.0	53.5	130.5	81.1	51.2
Nonclinical	18.2	29.6	5.7	14.2	32.5	19.3	12.6

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

	By facility type		By number of ORs		
	Community	Teaching	1-5	6-9	10+
Operating	\$11.7	\$35.4	\$3.3	\$10.5	\$30.8
Capital	\$0.9	\$3.8	\$0.4	\$0.6	\$2.8
Personnel	\$3.0	\$9.9	\$0.8	\$2.4	\$8.1

Which other departments report to you?

	2001	2006
Postanesthesia care	92%	87%
Outpatient surgery	81%	75%
Central processing	74%	68%
GI/endoscopy	70%	61%
Preadmission services	60%	56%
Anesthesia support personnel	NA	57%
Perfusion services	NA	19%
Materials management for OR	NA	39%
Inpatient unit	NA	5%
Cardiac cath lab	6%	4%
Emergency room/trauma services	3%	3%
ICU	NA	3%

NA = not asked. Among other departments managed are scheduling, pain management, office staff, wound care/ostomy, IV therapy, dialysis, and the family waiting area.

Continued from page 11

respondents is now 51.4 years, up from 49 in 2001, and 60% are over 50.

In all, 15% of respondents to this year's survey are male, up from 11% 5 years ago. Only 5 (less than 1%) are not RNs.

Education. Of all respondents, 40% have master's degrees, and 37% have bachelor's degrees as their highest degrees. The remainder have a diploma (12%) or an associate degree (11%).

Types of master's degree reported are:

- MS or MSN: 51%
- MBA: 26%

- Another master's: 23%.

Of those with bachelor's degrees, 71% have a BSN, and 29% have another type of bachelor's.

Over half of those managing large ORs have master's degrees.

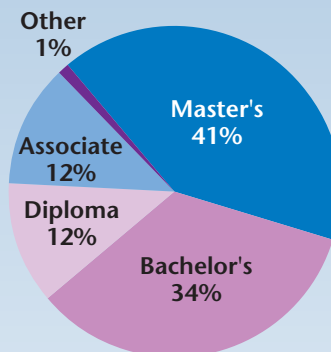
Highest degree for those running 10+ ORs

Master's	54%
Bachelor's	37%
Associate	4%
Diploma	4%
Doctorate	1%

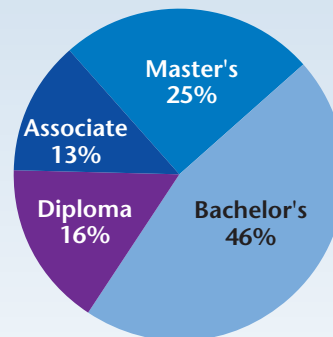
Nearly two-thirds (63%) of directors

Highest Degree

Directors



Managers



Average age

2006	51
2004	51
2002	50
2000	48

and nurse managers say their employer requires a specific degree for their position. For both directors and managers, the required degree is most likely to be a bachelor's.

Required degree

	Bachelor's	Master's
Directors	71%	28%
Nurse managers	89%	7%



Majority have computers in each OR

The majority of hospital ORs (58%) now have a computer in each operating room. That reaches 76% for teaching hospitals. Less than 1 in 10 do not have an automated information system. The top three uses of the computers in each OR are:

- patient documentation
- laboratory data
- order entry.

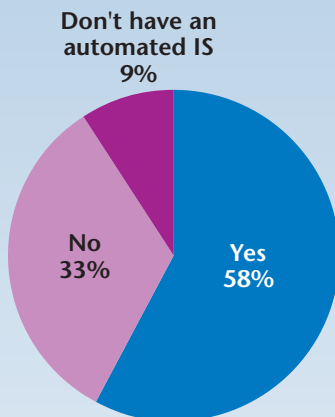
Fewer than 1 in 5 uses OR-based computers for inventory control.

The majority (53%) have a dedicated information specialist to help manage their system. For 66% of these, the specialist is in the OR department rather than the IT department.

The computer in each OR is used for . . .

Intraop patient documentation	78%
Laboratory data	72%
Order entry	60%
PACS (imaging)	54%
Patient charges	48%
Policy & procedure manual	47%
Inventory control	17%

Is there a computer in each operating room?



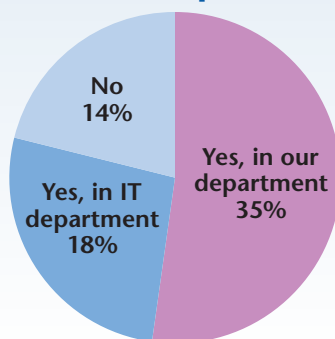
By type of facility

Teaching	76%	Community	51%
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By number of ORs

1-5	49%	6-9	54%	10+	67%
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Does the OR have a dedicated IS specialist?



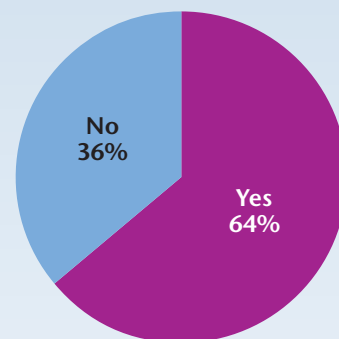
A building boom for ORs

The building boom for ORs is rolling along. Nearly two-thirds (64%) of survey respondents say they are adding or planning to add new ORs—a jump from 54% last year. The top reasons for building:

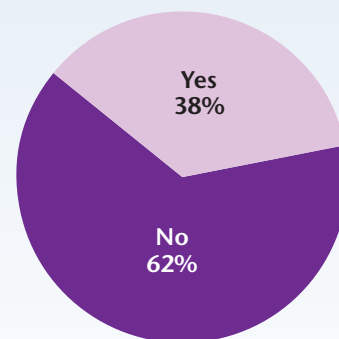
- increase capacity: 58%
- accommodate new technology: 45%
- replace an old facility: 35%.

More than one-third (38%) are renovating. The main reason, named by two-thirds, is to accommodate new technology. Another 25% are remodeling to meet structural requirements, and 33% are doing so for other reasons.

Are you currently adding or planning to add new ORs?



Are you currently renovating or planning to renovate ORs?



Hospital respondents to survey

Region	Distribution	Response
East	219	15%
South	369	27%
Central	372	36%
West	240	21%

The response percentage in the September issue was incorrect. These are the correct figures.

Thank you

OR Manager thanks its subscribers 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.

Salary/Career Survey director

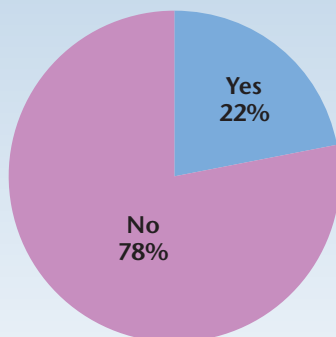
Billie Fernsebner, RN, MSN, education specialist for OR Manager, Inc, has coordinated the OR Manager Salary/Career Survey for the past 10 years.

Rewarding the staff

More than 1 in 5 (22%) of survey respondents have a plan that rewards the staff financially for helping to improve performance or reduce supply costs. That's up from 18% last year when the question was first asked. Respondents described a variety of rewards:

- \$100 gift card for identifying savings over \$10,000
- possible bonus based on guest satisfaction scores
- a fund separate from the main hospital fund that is used for education, parties, and food
- cash bonus for ideas that improve patient safety
- gainsharing based on the hospital's financial performance
- percentage payout for achieving certain goals.

Does your facility reward staff financially for helping improve performance or reduce supply costs?



By type of facility		
Teaching	Community	
21%	22%	
By number of ORs		
1-5	6-9	10+
17%	23%	24%

Management positions tougher to fill

It's taking longer to find managers for the OR. On average, management vacancies take 14 weeks to fill, compared to 10 weeks in the 2005 survey. Recruitment takes longest in the West (15 weeks).

Only about 1 in 5 (19%) of respondents

have management openings. The average number of openings is 0.3.

While 44% filled their openings in 4 weeks or less, 47% said it took more than 4 weeks—with 27% saying it took more than 16 weeks.

Average number of weeks management positions have been open

Type of facility			Region			
Overall	Community	Teaching	East	Central	South	West
14	14	14	11	14	14	15

Share successes at 2007 meetings

Share your successes at the conferences of OR Manager, Inc. Send proposals of about 500 words describing the session you wish to present. Sessions are approximately 1¼ hours long.

**Managing Today's OR Suite
Oct 4 to 6, 2007
San Diego**

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

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

**OR Business Management
Conference
May 9 to 11, 2007
Savannah, Ga**

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

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

Fax or e-mail proposals to Billie Fernsebner, RN, MSN, education director, OR Manager, Inc, at 303/442-5960 or bfernsebner@ormanager.com. (Please do not send PowerPoint presentations.)

If you have questions, please call 303/442-1661. ❖

Central service benchmarking study launched

The American Society for Healthcare Central Service Professionals (ASHCSP) of the American Hospital Association has started a benchmarking survey in central service and sterile processing.

The survey targets staff and compensation; staff functions; resources used; and expenses for purchases, maintenance, and out-of-house processing.

Among functions surveyed are clean-

ing, decontamination, case cart assembly, instrument processing, sterilization, inventory stocking, implants, and housekeeping for the department.

The society says the study will be sent to all central service and sterile processing departments in the US. As a benefit for participating, the society says each survey participant will receive a free customized salary report.

Initial results are expected in October,

and the data will be continuously updated as more surveys are received. Reports will be available for purchase.

The society estimates the survey will take 3½ hours to complete online, including time to gather the necessary information.

Participants also have the option of completing the survey for single functions, such as decontamination, if they don't want to complete the entire survey. ❖

—www.ashcsp.org

Nineteenth Annual

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OR managers cite year's achievements

Supply cost savings, performance improvement, and recruitment and retention led the list of OR managers' important accomplishments in this year's *OR Manager Salary/Career Survey*. The survey asks open-ended questions about both challenges and accomplishments.

One of the biggest challenges—maintaining or growing surgical volume, especially when an ambulatory surgery center opens in the area. Building or renovating ORs and expanding services were challenges for several. Staffing challenges included finding experienced cardiovascular nurses and designing internships for RNs and surgical technologists.

Saving on supplies, inventory

Inventory control and cost containment were major achievements for both large and small ORs. Orthopedic and spinal implants were specifically mentioned.

- The manager of a 3-room OR and GI facility in rural Michigan said her team had moved all of its orthopedic and pain management supplies and implantable mesh to a consignment basis, saving money and reducing inventory.
- In Illinois, a 24-OR department reduced its orthopedic vendors from 6 to 3 and capitated pricing for implants, saving \$180,000 annually.

Other accomplishments were implementing automated systems for preference cards, patient charging, and inventory. Standardization of supplies and controlling product entry were also mentioned.

Improving performance

OR efficiency and infection prevention were the focus for performance improvement (PI) projects.

- One facility boosted on-time starts from 14% to 81% in 10 months, while another improved from 28% to 72%.
- One manager became a systems director for 3 campuses, increased OR utilization, improved on-time starts, decreased turnover time, and reduced cancellations—not surprisingly, these were also her biggest challenges.
- Many had met goals of the Institute for Health Care Improvement's (IHI) 100,000 Lives Campaign, which aims to prevent avoidable patient deaths by

“**Recruiting MDs can be as difficult as attracting nurses.**”

adopting proven practices, and the Surgical Care Improvement Project (SCIP), a nationwide effort to prevent complications. A number had improved on administration of prophylactic antibiotics, maintaining patients' temperatures, and meeting protocols for preventing deep vein thrombosis.

Recruitment and retention

Respondents described steps that have boosted staff satisfaction, with the goal of retaining their experienced staff:

- revised the on-call schedule to have one team that works weekends only and is paid for 80 hours every 2 weeks, improving physician and staff satisfaction by 20%
- had 4 positions approved for nights and weekends for a 5-room OR suite so the staff doesn't have to take as much call
- adjusted staffing in a 10-room OR suite by increasing ancillary staff and reducing the number of RNs in one room.

Several reported adding support personnel, including a full-time educator, business manager, bariatric services coordinator, and information system coordinator.

Recruiting physicians can be as difficult as attracting nurses. For rural hospitals in particular, the arrival or departure of 1 or 2 surgeons can mean the gain or loss of an entire program. The manager of a 3-room OR in rural Tennessee said her major accomplishment was keeping staff with decreased volume. Another in rural Texas said her principal accomplishment was staying operational with enough FTEs to operate safely, decrease overtime, and reduce hours on call.

Also in Texas, the manager of a 3-room suite wrote that her accomplishments were an increased number of cases and surgeons, expanded endoscopy services, and successful RN recruitment.

A manager of a 3-room OR in rural Texas said she was able to hire 2 obstetrical/gynecological physicians to replace one who left. She also counted as an accomplishment successfully completing 1 year with a new orthopedic surgeon.

Building for service

Some managers named as their big accomplishment completing an OR building project. Among examples:

- completing a \$28 million construction project
- opening 4 state-of-the-art computer-integrated, digital ORs
- opening a new hospital with staff hired for all areas, building volume, and recruiting surgeons
- renovating the day surgery unit for a 3-OR facility in rural Maine.

Personal triumphs

Personal successes made the year especially noteworthy for some.

- A number said they had completed bachelor's or master's degrees.
- The director of a 3-room OR plus other areas was named "clinical director of the year" at her rural hospital in Texas. She also participated in a trial to have a physician removed from the staff and lose all privileges. She said this was the first physician to lose privileges in the history of the organization and set a "huge example" for other physicians and their behavior.
- A director of a 4-room OR redesigned the performance review process from being handwritten to computer assisted. She took responsibility for employee reviews from the 3 clinical managers, which she said resulted in a more consistent process, more time for clinical managers to spend with staff and patients, and more time for the director to spend with each employee. The director uses a peer-review check sheet to record information from coworkers and managers to use in performance reviews. ♦

The year's big challenge—Katrina

By August 2005, Melissa Guidry RN, BSN, MPH, CNOR, had counted among the year's accomplishments filling 3 management positions, merging with a community hospital, and integrating and upgrading a computer system.

Her biggest challenge was still to come—Hurricane Katrina.

Guidry had been director of perioperative services at 250-bed Tulane University Hospital in New Orleans for 8 months when Katrina hit.

"We talked for years about what we would do when the 'big one' hit. I thought we were prepared, but Katrina showed us where we needed to improve our disaster planning," she says.

On the Friday before Katrina's landfall on Monday, Aug 29, 2005, Tulane had the essential personnel it needed to care for 200 patients and run 2 operating rooms.

The team reviewed the disaster plan and decided to be at the hospital by 7 am Sunday with their families and pets if need be.

No one knew the near week-long struggle that lay ahead or that the hospital would not be open again for 6 months. They didn't know many would lose their homes or that many of their families would be scattered to other states.

'A jovial mood'

"All day Sunday, everyone was in a jovial mood. For us, it felt routine," says Guidry. The staff moved supplies, equipment, and instruments from the first-floor central supply to the third-floor ORs just in case of flooding and waited for the storm.

During the storm, damage was minor. The team thought they had fared well.

"We thought we were home free, so we moved the supplies back down to central supply," Guidry says.

'The water started to rise'

On Monday at 10:30 pm, Guidry got a call that the water was rising, and the central sterile area needed to be evacuated again. Within 45 minutes, the staff had moved the supplies back to the OR. They also gathered supplies from the distribution department—IV supplies, bottled water, diapers, and baby formula. They moved essential medications out of the first-floor pharmacy to a secure area on the fourth floor.

Meanwhile, the command center was

“
The staff said
they would
volunteer again.
”

monitoring the rising water and talking with the headquarters of Tulane's parent, HCA Inc, about a plan to evacuate the patients in helicopters. The HCA division president and hospital's administrators were at the hospital during the hurricane.

The hospital did not have a heliport, so the maintenance staff made one on the roof of the parking garage on Monday night.

Guidry says she didn't get to bed until 5 am Tuesday morning. By 7 am, 2 inches of water were on the first floor. Amazingly, she says, the cooks in the cafeteria made pancakes for all the staff.

At 7:30 am, the first helicopter landed to begin evacuating patients. Critical patients were moved first to other HCA facilities. All but 2 were gone when the hospital lost power at 7 pm Tuesday evening.

The decision was made to turn off the emergency generator, located on the first floor, when the water got to a certain point and turn it back on when the water started to go down.

"At that point, we had nothing—no running water, lights, air conditioning, or elevators. You fanned yourself. You fanned the patients. Anything you saw that needed to be done, you did it."

All of Tulane's patients were evacuated by early Thursday morning. The hospital then took patients from the Medical Center of Louisiana. After that, they started transporting staff, families, and pets.

'They were here with us'

Every time HCA sent a helicopter to pick up patients, it was loaded with food and water for those still at the hospital.

Guidry credits Tulane's administrators and HCA Inc with execution of the disaster plan and evacuation of patients and staff.

Administrators met daily with man-

agers, families, and physicians to update them. They set up a Web site the staff could use to find phone numbers and search for family members.

Guidry says she never felt her life was in danger because of the security force, though she was afraid of the fires and explosions that began around the city from fuel and debris in the water.

About 300 staff, family, and pets remained in the parking garage Thursday night because it got too dark for the helicopters to pick them up. At daybreak, the helicopters flew them out.

HCA paid all of its employees their full salaries until the end of the year, Guidry notes. At that time, employees who could were put to work at Tulane's sister community hospital, Lakeside in Metairie, La, or at the downtown location to get the hospital up and running. For those who couldn't come back, their positions were terminated.

Lessons from the storm

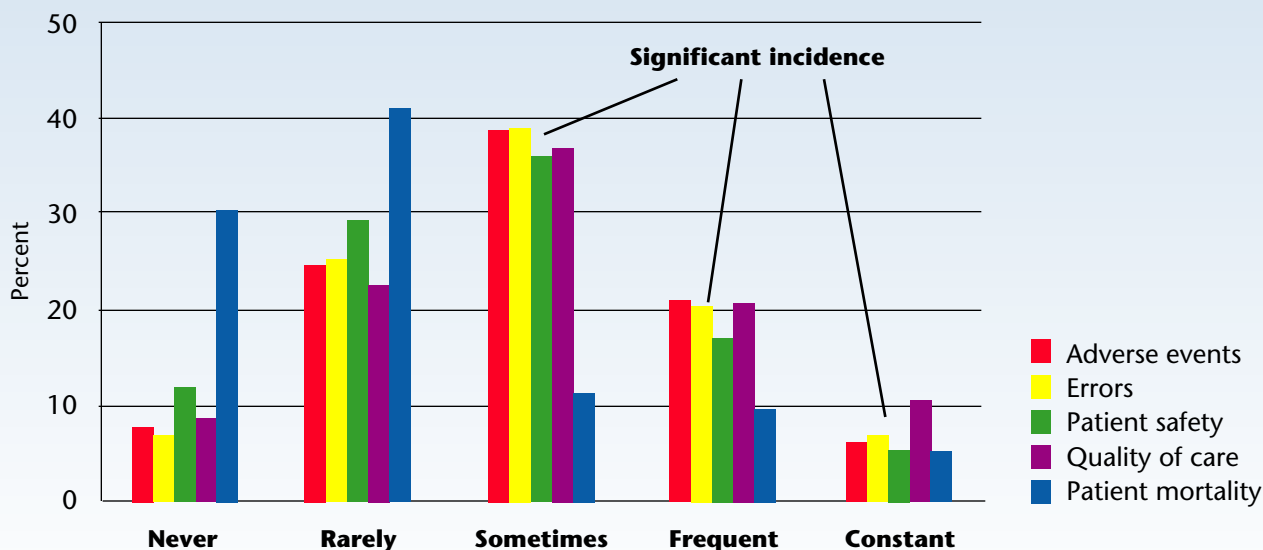
Lessons Guidry passes on to other managers:

- **Communication is number one during a disaster.** Have the staff's cell phone numbers in addition to home and alternate phone numbers, pagers, and addresses. Text messaging also works well. Cell phones won't work if their towers are destroyed. HCA has set up a satellite phone system at Tulane, and key people carry satellite phones.
- **Consider adding to personal disaster kits.** The hospital's disaster plan says each individual who will work during a disaster should bring a change of clothes for at least 2 days, flashlight and batteries, pillow and blanket, water, and nonperishable food. To that list, Guidry has added hand wipes, waterless shampoo and body wash, battery-operated fans, fruit in peel-open plastic cups, and granola bars. She's now asking the staff to gather these items at the beginning of hurricane season and keep them in their lockers or in an office.

Since the hurricane, the hospital has waterproofed generators on the first floor and installed an emergency bullet-proof generator on the second floor of the parking garage with 10,000 gallons of fuel.

Continued on page 19

Managing people



The study asked, "How often do you think there is a link between disruptive behaviors and the following clinical factors?" Reprinted with permission from Rosenstein AH, O'Daniel M. *J Am Coll Surg*. 2006;203:96-105. Copyright © 2006 American College of Surgeons.

Continued from page 1

Rosenstein, MD, MBA, and Michelle O'Daniel, MHA, MSG, of VHA West Coast, Pleasanton, Calif. Building on earlier research, they surveyed 244 surgical team members at a large academic medical center and compared results with their national data from more than 100 hospitals. A report appeared in the July 2006 *Journal of the American College of Surgeons*.

Nearly all of the respondents—94%—said disruptive behavior could potentially affect patient outcomes, and almost half—46%—were aware of such an event that could have stemmed from disruptive behavior.

Countering inappropriate behavior requires a strong commitment from the top of the organization. The study provides data that can be used to convince senior executives that confronting negative behavior is crucial to patient safety and their overall business, the researchers say.

"We don't think you can afford to have this go on any more because bad things happen to patients," Dr Rosenstein told *OR Manager*.

The problem isn't confined to physicians. Nurses also contribute. More than one-fourth (28%) of study participants said they saw RNs display disruptive behavior at least weekly, compared to 37% who saw it weekly in attending surgeons, and 19% who saw it that often in anesthesiologists.

In discussing the findings with the medical center's nurses and physicians in focus groups after the study was completed, Dr Rosenstein and O'Daniel say they were struck by the close tie between disruptive behavior and operational issues. Problems such as case delays, broken or missing equipment, and short staffing raised the level of tension, leading to outbursts.

"The physicians would say, 'We keep bringing this up, and no one ever addresses it,'" Dr Rosenstein says.

Adds O'Daniel, "It's never OK to be disruptive. But it goes back to organizational awareness and commitment. Leaders need to hear these physicians and address the issues."

The researchers outline a program for addressing behavior in a related article on p 21. ❖

Reference

Rosenstein A, O'Daniel M. Disruptive behavior and clinical outcomes: Perceptions of nurses and physicians. *Am J Nurs*. 2005;105:54-64.

Rosenstein A, O'Daniel M. Impact and implications of disruptive behavior in the perioperative arena. *J Am Coll Surg*. 2006;203:96-105.

Survey links disruptive behavior to negative patient outcomes. *OR Manager*. 2005;21 (3):1, 20, 22.

Big challenge—Katrina

Continued from page 18

The long road back

Nearly 3 weeks after Guidry left New Orleans, she returned to help reopen Lakeside and meet with a core group of managers to set a goal for reopening Tulane's downtown campus. She had been staying with relatives in Memphis, where her family had gone before the storm. Her house was a total loss.

In February, the downtown campus reopened with 63 beds, the OR, cath lab, and radiology department. Four ORs are staffed with the goal to have 9 rooms operating by the end of the year. The OR staff is down by 8 FTE RNs and 11 FTE STs, but people are starting to come back to New Orleans, Guidry says.

To help ease the transition, the staff is having luncheon get-togethers, and managers are being flexible with schedules. Many of the staff are still meeting with insurance companies and contractors.

"We make changes as we go along. It is so different than it was before the storm," she says.

One sign that the staff are doing well—when Guidry put out the volunteer list for this hurricane season, staff who were at the hospital during Katrina volunteered again. ❖

—Judith M. Mathias, RN, MA

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A program for ending disruptive behavior

An 11-point program recommended by Alan H. Rosenstein, MD, MBA, and Michelle O'Daniel, MHA, MSG, authors of the new VHA study on disruptive behavior.

Gain organizational commitment

- *Make a commitment to address disruptive behavior both from the top of the organization down and from the bottom up.*

Tying disruptive behavior to patient safety is an effective way to get the attention and support of senior leadership, they advise.

"A lot of times, we've found senior executives aren't looking at the issue from a clinical safety standpoint. They don't see the tie between disruptive behavior and the effect on patients," O'Daniel says. "Once they see that tie, we almost always see a shift in their mindset."

There's also a business case for addressing inappropriate behavior.

"If this is a problem in your organization, your reputation is at stake," Dr Rosenstein says. Disruptive behavior can drive away staff and anesthesia providers. It influences staff satisfaction and turnover. "And it certainly influences the quality of care," he says. There's also the risk of a liability suit for harassment or some other issue—"that's becoming much more prevalent," he says.

"But it all comes down to the culture and making safety a priority."

Raise awareness

- *Conduct a self-assessment to bring the issue to the surface where it can be dealt with.*

"If you do a self-assessment and put your finger on the pulse, you might find out this is much bigger and affects many more people than you might think," he says.

Dr Rosenstein and O'Daniel conduct assessments for hospitals using their research tool, adding the data to their database. Other assessment tools that can be used are staff satisfaction surveys or the Safety Attitude Questionnaire developed at the University of Texas, which

measures perceptions of health care teamwork and safety culture (<http://psnet.ahrq.gov/resource.aspx?resourceID=1439>)

Using the VHA assessment tool, Dr Rosenstein and O'Daniel have compiled a database from 100 hospitals, enabling them to compare one hospital's results with others. The assessment "really goes beyond the data," O'Daniel says. "People need to understand the data, the implications, and how to use it." The assessment is done for both members and nonmembers of VHA.

Organize get-togethers

- *Organize group meetings of physicians, nurses, and other team members to encourage discussion of behavior issues.*

This can be done through a task force, committees, or town hall meetings, Dr Rosenstein suggests.

"A lot of organizations are putting together some sort of nurse-physician liaison committee where they seek input to address these issues," he says.

Develop policies and procedures

- *Set norms for behavior, such as a code of conduct.*

"The policy must be for physicians, nurses, techs, housekeepers—everybody," O'Daniel stresses. "You can't let one person slip through the cracks for any reason, whether it's because they bring in money or whatever."

The policy also must be consistently applied. "You can't have one policy for physicians, one policy for nurses, and one policy for everybody else," she says.

For the medical staff, she and Dr Rosenstein recommend that the policy become part of the medical staff bylaws. Physicians should be required to sign the policy and agree to follow it at the time they request or renew credentials.

Set up a reporting mechanism

- *Make reporting safe and easy. People shy away from reporting bad behavior because they're afraid of retaliation or think nothing will be done about the problem.*

"You need to make reporting safe, easy, with no worries about retaliation, and you need to follow up," Dr Rosenstein says. Staff may not want to write out incident reports, so provide other ways of reporting, such as a suggestion box.

A method that can work well is to have a committee with authority to review complaints and get back to those who filed them.

Teach intervention strategies

- *Help develop intervention strategies to address inappropriate behavior.* Strategies should include:
 - real-time strategies to use when an incident occurs, such as assertiveness training
 - approaches that address communication barriers that arise—cultural, gender, language, personality clashes, and so forth.

For example, how will the organization address barriers that may surface when a 55-year-old male physician from the Middle East is communicating with a 22-year-old female Filipino nurse?

To be effective, there needs to be a broad-based effort to improve sensitivity and communication.

"A lot of organizations know culture and ethnicity are a big issue, but they feel like it's dicey and not politically correct. It is something that has to be acknowledged and addressed," Dr Rosenstein says.

Provide communication tools

- *Give teams communication tools they can use to head off or manage communication problems.*

"We've found it's effective, especially in the OR, to use tools such as SBAR," Dr Rosenstein says. (SBAR stands for Situation, Background, Assessment, Recommendation.)

"We often find physicians and nurses just don't know how to communicate with each other," notes O'Daniel. "For instance, a nurse calls a physician in the middle of the night but doesn't have the appropriate information from the chart. It's never an excuse for a physician to be

Continued on page 25

Please see the ad for
CARDINAL HEALTH
in the OR Manager print version.

Conduct codes address OR behavior

A surgeon says he never wants to see a particular instrument in his kit again and bends it. Nurses talk around each other rather than to each other when having problems with a colleague. A surgeon yells at a nurse during a procedure, shouting that he needs “someone who knows what she’s doing.”

Sound painfully familiar? This inappropriate behavior is becoming less common for some ORs that have implemented codes of conduct for physicians and staff. These range from guidelines for addressing disruptive behavior to contracts staff members must sign to be employed in the OR.

Giving staff the power

Surgical services administrators say their codes of conduct empower staff to take measures they would not have taken before, such as confronting an offensive surgeon.

One OR manager relates how a staff nurse approached a surgeon who spoke inappropriately to her and said, “Perhaps you don’t realize we have a code of conduct now. This is what it says, and this is how we are expected to treat each other in the operating room.”

At Elmhurst Memorial Hospital in Elmhurst, Ill, the code of conduct has all but eliminated triangular communication among nurses—that is, when Nurse A is frustrated with Nurse B and complains to Nurse C rather than discussing concerns with Nurse B.

“Our code of conduct has helped us find effective ways to communicate,” says Annamarie Schalk, RN, BSN, director of surgical services. “We’ve seen a big improvement. Behavior is more productive, leading to increased efficiency. (Excerpts from Elmhurst’s code of conduct are on p 24.)

OR leadership also brought in Michael H. Cohen, author of *The Power of Self-Management: Achieving Success in Your Healthcare Career* (Canoe Press, 1992). Cohen led an in-service session for OR staff on managing conflict. His tips are incorporated into Elmhurst’s code of conduct, which states that the staff should:

- ask for what they want in a direct, honest, and respectful manner

“
**We were at
risk of losing our
top nurses.**
”

- remain cool, calm, and collected and appropriately set limits
- if the conflict cannot be resolved one-to-one, document the offense and seek third-party assistance
- not take things personally.

Keeping top staff

Schalk says Elmhurst’s code has been effective in the past 5 years to retain stellar staff.

“We knew that if we didn’t take action to encourage more productive communications, we were at risk of losing our top nurses,” she says. “Since we implemented the code of conduct, some of our more negative staff have chosen to leave. The result has been a much higher level of overall employee satisfaction.”

Southcoast Hospitals Group (SHG) in New Bedford, Mass, has watched staff, physician, and patient satisfaction scores rise over the decade since it institutionalized its “Southcoast Culture,” which includes behavioral standards such as:

- communicate openly and honestly with all members of the SGH community
- act with trustworthiness and respect for all
- relate to others in a caring, friendly, and professional manner.

Performance measured

Lyn Ames, MS, RN, CNOR, CNAA, BC, director of perioperative services at SHG, says the Southcoast Culture standards are incorporated into job descriptions and employee performance appraisals for nurses and physician employees.

“This is the organizational culture,” she says, adding that 50% of perfor-

mance is measured by an employee’s ability to meet or exceed the behavioral standards in daily activities.

Physicians with privileges who are not employees also are expected to practice the cultural standards and are subject to a formal disciplinary process if they violate them.

“If a physician acts out in the OR, he’ll be visiting me,” Ames says.

Some physicians, such as the surgeon who tried to run Ames over with a gurney with the patient on it while the surgery schedule was stopped for a fire alarm, have been counseled and sent to anger management classes.

At Elmhurst Memorial Hospital, the standards are a part of employee disciplinary action. “It’s pretty sobering when you bring out a document that employees signed, showing they agreed to standards of behavior,” she says.

Schalk says incorporating the code of conduct into disciplinary actions has been part of its staying power.

“This is not another document that went by the wayside in a couple of months. It has established enforceable behavioral expectations, and employees understand that they must abide by them if they want to work here,” she says.

Employee reporting expected

At Massachusetts General Hospital (MGH) in Boston, employees are expected to document disruptive behavior and report the incident immediately after the behavior happens to nurse managers and clinical service coordinators, who will refer the matter to the associate chief nurse for perioperative nursing and OR medical director when necessary.

“First we work with staff to better understand the issues and events, then strategize together how to move forward,” says Marion Freehan, RN, MPA/HA, CNOR, nurse manager of the main operating room.

MGH’s Guidelines for Addressing Disruptive and Inappropriate Behavior in the Perioperative Environment, which apply to both employees and physicians, state that “all individuals working in the perioperative environment are required to treat others with respect, courtesy, and

Continued on page 24

Continued from page 23

dignity and to report immediately conduct that is disruptive or otherwise inappropriate.”

The guidelines also define disruptive behavior and spell out how the incident will be investigated and addressed. The guidelines state that progressive corrective action may include, depending on the findings, suspension or termination of employment or hospital privileges.

Physician champion

Freehan, an OR employee at MGH for 35 years, remembers when physicians could tell nurses they were not paid to think, have nurses removed from their ORs, throw instruments, or refuse to have certain nurses on their cases.

Today, Freehan says 2 factors are critical to the guidelines’ success. First are nurse managers who coach staff to bring issues forward, especially those concerning physicians. Second is a physician champion, Richard Wiklund, MD, anesthesiologist and OR medical director.

“He holds the physicians, regardless of rank and file, to the letter of the law,” Freehan says. “We try to empower the staff to manage disruptive behavior directly with the people involved when it happens, but there are times we need Dr Wiklund’s support. He addresses issues immediately and promptly gets back to me or my staff to discuss his followup.”

Freehan says incident reports still include traditionally inappropriate behavior, such as verbal outbursts but also more subtle forms of misconduct, such as veteran nurses who impede the success of new staff because they have a sense of entitlement to work with a certain group of physicians, or physicians who speak with intimidating body language and tone.

“We have a significant amount of cultural diversity in our hospital, and aggressive eye contact, loud speech, and invading body space are extremely threatening and inappropriate in some cultures,” Freehan says.

High-intensity interactions

Freehan adds that it wasn’t one catalytic event that led to the policy but the need to manage the high-intensity interactions of more than 400 people in a 42-room OR and 10-room same-day surgical unit.

Elmhurst Memorial Hospital code of conduct

The OR employee satisfaction committee at Elmhurst Memorial Hospital, Elmhurst, Ill, developed its code of conduct. By signing it, OR employees agree to adhere to the following positive teamwork behaviors and not engage in negative teamwork behaviors. They include:

Positive teamwork behaviors

- When not currently involved in a case, sets up or helps cases in other rooms without being asked. Helps circulate in another room when his/her room is done.
- Puts supplies/equipment away; keeps halls clear.
- Checks with charge RN when finished with assignment.
- Shows timely follow through on projects, tasks, and requests for information.
- Actively participates on departmental committees.
- Attends departmental meetings and in-services and shows respect for presenters by not talking during presentations.
- Tries to solve problems in most appropriate form, eg, one-on-one, via committees, department meetings.
- Speaks positively about the department, the organization, and the initiatives underway.
- Demonstrates departmental and organizational support by providing timely feedback, constructive criticism, and/or recognition for positive efforts.
- Is attentive during surgery to the needs of the case, such as gives supplies without prompting because he/she is paying attention.
- When given an assignment, maturely and professionally accepts and completes the assignment.
- Works effectively with people he/she dislikes and maintains effective communication.

Negative teamwork behaviors

- Gripping, dumping, gossiping, or

complaining before and after meetings.

- Lodging a complaint about a co-worker and asking for anonymity about the complaint.
- Gossiping and back-biting about co-workers, managers, etc.
- Escalating negative situations by adopting bad behaviors, such as yelling.
- Hiding out in unused OR rooms, locker rooms, and/or staff or MD lounges.
- Leaving the department without informing the charge RN.
- Responding with one of the following when given an assignment: sigh, huff, refusal, asking what others are doing.
- Conducting inappropriate conversations in front of patients, including complaining that the case is too hard, you feel tired or not well, or your co-worker did not do something he or she was supposed to do.
- Making comments that are generally negative.
- Abandoning the OR when someone comes in to help you.
- Intentionally miscommunicating information about lunch requests.
- Criticizing people publicly.
- Demonstrating discourteous and unfriendly behavior to new staff.
- Complaining and/or refusing an assignment.
- Eating in front of patients in the holding area or at the front desk.
- Responding “I don’t know” to an inquiry without offering to find out or help.

Signature

Date

My signature confirms that I have read the Positive Teamwork Behaviors contract and agree to comply with the behaviors and to facilitate the development of a strong, teamwork-oriented, and cooperative team.

Forum

"The OR environment challenges communication tremendously—we wear masks that muffle voices and hide facial features, eyes are riveted on the surgical site, and we speak loudly to be heard over competing noises," she says.

MGH reaffirms its almost 3-year old behavioral guidelines with every employee during annual reviews. Freehan believes the policy is working to address disruptive behavior because nurses know they are supported when they report it. In fact, she is unsure if the number of disruptive incidents has declined, because the number of reports has gone up since nurses have been empowered to make them. ❖

—Leslie Flowers

WEB extra



Sample codes of conduct

Codes of conduct from Elmhurst Memorial Hospital and Massachusetts General Hospital are available in the *OR Manager* Toolbox at www.ormanager.com.

To the Editor:

I was pleased to see the article about OR Briefings in the July issue of *OR Manager*. I believe you captured the work we've done at Johns Hopkins and the spirit and intent of the briefings in an accurate and positive manner. My concern, however, is the box with the sample preoperative briefing on page 13 with William Taggart (University of Texas and SaferHealthcare) listed as the source.

The sample differentiates the surgeon by using his title and last name (Dr Davis) throughout the sample while the other team members are referred to as Julie, Bill and John. This differentiation perpetuates the hierarchy that we have worked so hard to diminish. Flattening the hierarchy promotes safety by creating an environment where team members are more at ease to share concerns. In addition, using a title and last name for the surgeon implies a greater level of respect for this individual over the other team members. We have tried to move

our culture to a place where all team members are respected and valued for their different expertise and contributions to patient care.

I believe the sample briefing in *OR Manager* would have been more instructive and reflective of the true intent of a briefing if the surgeon had been referred to in an equitable manner as the other team members.

—Lisa Rowen, RN, DNSc

Director of Nursing

Department of Surgery

The Johns Hopkins Hospital, Baltimore

Have an idea?

Do you have a topic you'd like to see covered in *OR Manager*? Have you completed a project you think would be of help to others? We'd be glad to consider your suggestions.

Please e-mail Editor Pat Patterson at ppatterson@ormanager.com

Disruptive behavior

Continued from page 21

disruptive, but that type of situation can cause a physician to get cranky."

With SBAR, nurses have a communication tool they can use to get their message out in 1 minute or less. "Then physicians know exactly what's going on, and it helps alleviate the tension," O'Daniel says. (Suggestions for using SBAR in the OR are in the April *OR Manager*.)

Address competency issues

- *Competency issues include technical as well as communication skills.*

"We heard physicians saying, 'I really need to feel comfortable that the person across from me or on the other end of the phone knows what they're doing or talking about,'" Dr Rosenstein says.

The concern is technical as well as communication competency, he says.

"You need to help people with their communication skills," he advises.

"Because when a physician is awakened in the middle of the night by a nurse who doesn't know what's going on with the patient, can't speak English well, and on top of that, it isn't even the physician's patient, but the physician is covering for

someone else—that's a setup for disaster."

Identify clinical champions

- *Recruit clinical leaders, nurses as well as physicians, to give the program credibility and set the tone for behavior.*

"Your clinical champion doesn't have to be the chief of staff," Dr Rosenstein says. "But it needs to be somebody who is a respected clinician and believes in this. We've been finding that it's better to have co-champions, such as a chief medical officer and a chief nursing officer. That tends to work better than a single champion."

Address operational issues

- *Tackle operational issues like surgical scheduling and equipment availability.*

A major complaint from physicians that can cause frustration to boil over is that no one addresses issues that affect them, such as equipment and the flow of cases, the researchers say.

"Physicians would say, 'I yelled at a nurse because the equipment wasn't there.' Then they'd say, 'Isn't the real issue that the equipment should have been there?'" O'Daniel says.

In focus groups she and Dr Rosenstein conducted, "it all came to operational issues. They would say, 'Yeah, this doctor or nurse was disruptive, but the equipment was wrong, or there were throughput issues.' That's what caused the tension.

"If you make these operational adjustments, you might see a lot of this disruptive behavior alleviated," O'Daniel says.

Provide feedback, followup

- *Give feedback to those who report behavior.*

Though these incidents are sensitive and need to be handled confidentially, it's important for those who report the behavior to know it's being addressed, they say.

"Some organizations have a form letter they use when they get a report of a disruptive behavior or something inappropriate," says O'Daniel. The letter might say: "Thank you for your report. We wanted you to know we're following up on it."

"You need something to let them know it's not going into a black hole." ❖

For more information about the VHA study and assessments, contact Alan Rosenstein at arosenst@vha.com.

Please see the ad for
AVANCED STERILIZATION PRODUCTS
in the OR Manager print version.

Sabbatical allows RNs to test OR waters

How would you like a chance to return to nursing school, knowing you already love nursing and feel comfortable with basic nursing care?

That's how an RN at Newton-Wellesley Hospital, Newton, Mass, described her experience in the hospital's nursing sabbatical program. The hospital developed an in-house sabbatical program as a retention strategy in 2002.

"We received feedback from the staff that we were not doing enough to retain nurses and allowing them to grow into other positions," says Susan Duffy Smith, RN, director of perioperative services.

A win-win

For example, if a staff nurse from a specialty such as labor and delivery wanted to transfer to the OR, the nurse would not be considered because OR experience was required. Some staff were leaving because they could not transfer.

"The sabbatical program allows staff to work in another specialty area for 3 months and test the waters without losing their current positions," notes Smith.

Some participants realize how much they like their original positions and return with expanded nursing knowledge. Others like the new specialty better and gain enough experience to apply for a transfer to that department.

For example, a postanesthesia care nurse was awarded a sabbatical in the outpatient minimally invasive gynecology unit last fall. Though the nurse originally thought she wanted to move to a different type of nursing, after the sabbatical, she realized she wanted to stay in the postanesthesia care unit.

Whether nurses gain a renewed enthusiasm and decide to stay in their original specialty or like the new specialty and transfer, it's a win-win for recruitment and retention, says Smith.

The 3-month sabbaticals, which the hospital offers 2 to 3 times a year, are rotated through all the departments. Departments that can free up their educators and have enough preceptors agree to take sabbatical nurses.

The OR benefits if a sabbatical nurse has a good experience and enrolls in a

Senior RNs get to try a new department.

program to prepare for perioperative nursing. The sabbatical also enhances the relationship between the OR and the sabbatical nurse's home department.

Ginny McCabe, RN, an L & D nurse who recently completed an OR sabbatical, says she chose the OR because she wanted to develop a positive working relationship with OR colleagues and learn more about the area.

McCabe says she "is in awe" of the technical abilities and knowledge of perioperative RNs, especially their ability to learn new equipment quickly. McCabe kept a daily journal so she could share the information with her L & D co-workers.

Orienting to the OR

The sabbatical nurse's OR orientation follows the same objectives as that for a newly hired RN. Sabbatical nurses work closely with the educational resource nurse and review policies and procedures, operating room systems, and sterile technique. They are assigned to preceptors and rotate through as many services as possible.

McCabe progressed from observing to assisting the circulating nurse. As the weeks passed, she says her comfort level and independence increased.

OR retention value

Having a sabbatical nurse is a great opportunity for any OR, says Smith. Because most colleges and universities do not prepare nurses for the perioperative setting, and student nurses aren't exposed to the OR environment unless they request it, she says any opportunity to expose nurses to the OR, such as the sabbatical program, is invaluable. ♦

—Judith M. Mathias, RN, MA

In-house sabbatical protocol

At Newton-Wellesley Hospital, nurse sabbaticals are subject to the following terms:

- The hospital will offer sabbatical opportunities annually—each for a 3-month period: 2 opportunities in odd years and 3 opportunities in even years. Opportunities will be posted for 1 week.
- Nurses must fulfill a 1-year work commitment after completing sabbaticals.
- To be eligible, nurses must have at least 2 years' seniority and must be regularly scheduled to work or have worked an average of 24 hours per week over a 6-month period immediately before the sabbatical. Nurses will work the same number of hours as they are regularly scheduled.
- Nurses will be selected by seniority unless a documented performance problem exists.
- Nurses can apply for a second sabbatical if there are no other applications and if the nurses have worked for at least 2 years since the last sabbatical. Two nurses from the same department cannot be selected for successive sabbaticals.
- The hospital will assign preceptor nurses to work with the sabbatical nurses. Sabbatical nurses may be given patient assignments if the preceptors and hospital agree they are competent to do so.
- The hospital will provide classroom orientation if available.
- After completing sabbaticals, nurses will be evaluated on knowledge, experience, and performance. Evaluations will be used when assessing nurses for vacancies in the new department.
- Before starting sabbaticals, nurses will have informational interviews with the department manager to discuss the nurses' expectations and needs of the department.

Implant costs not slowing, hospitals say

Though the number of hip and knee implants is growing—a benefit to patients—relatively flat reimbursement and continued implant price increases are squeezing hospitals even more than in the past.

Medicare payment for a primary joint replacement (DRG 544) for the 2007 federal fiscal year beginning Oct 1 is estimated to be \$10,544, a 4.2% increase over last year. Medicare pays for about two-thirds of the joint replacements in this country.

Meanwhile, hip and knee implant costs per case increased by 7% to \$5,327 between 2004 and 2005 for the Orthopedic Research Network (ORN), a group of 45 hospitals that tracks their implant costs. Implant costs include the metals, plastics, bone cement, bone grafts, and substitutes used for joint replacements. The increase is less than the 9% between 2002 and 2003 or the 8% between 2003 and 2004.

Though many industry sources report slowdowns in implant price increases, this is not apparent in the network. Of 41 hospitals that had sufficient case volume between 2004 and 2005, 4 reported increases of implant costs per case of 20% or higher, and 9 reported increases of 11% to 20%. Another 21 had increases of 1% to 10%, and 7 saw no change or decreases.

The difference in perceptions between industry and hospitals is partly due to a time difference—the hospital data is for the year between 2004 and 2005, while industry reports on the most recent quarter. Also, hospitals report implant costs per case, regardless of the technology used, while the industry reports “upgrades,” such as increases in ceramic-on-ceramic hips at the expense of cemented hips as sales mix changes, rather than price increases.

Hospitals in the ORN have been tracking their implant costs since 1995. They report the data as part of an annual review by *Orthopedic Network News* (ONN).

Trend toward premium hips continues

A shift to more technology-intensive implants plus higher prices explains the increase in implant costs for total hips.

In the ORN, the trend toward premium hip systems continues with acceptance of ceramic-on-ceramic and metal-on-metal hip systems. In 2005, 78% of total hip cases

Hospitals squeezed by flat pay, higher prices.

used “premium” implants, while in 1999, only 39% of such cases were premium.

In other changes related to total hip:

- Coated stems with poly liners increased from 39% of cases in 1999 to 59% in 2005.
- Hybrid hip systems (uncoated stem, head, poly liner, and metal shell) continued to decline, from 55% of total hip cases in 1999 to 19% in 2004.
- The cemented stem/all poly cup construct, prevalent in Europe, now accounts for fewer than 1% of the cases in the US-based ORN.

Changes in premium hip implant costs between 2004 and 2005 reported by the ORN:

- ceramic-on-ceramic total hips increased by 4%, to \$7,785 per case
- metal-on-metal total hips declined by 1% to \$6,351
- coated femur/poly liner constructs increased by 6% to \$6,498
- uncoated femur/poly liner constructs increased by 5% to \$5,522.

Hip resurfacing

Femoral resurfacing has been extensively promoted as an alternative to total hip replacement. In this procedure, the femoral head is removed and replaced with a somewhat shorter femoral component. New ICD-9-CM procedure codes were introduced this year to capture this new procedure. According to ONN's data, the percentage of stems used for femoral resurfacing actually declined between 2004 and 2005, though there were increases in the number of acetabular components classified as resurfacing.

Cross-linked polyethylene acetabular liners account for 66% of liners sold in 2005. Metal liners accounted for 9% and ceramic liners for 7% of the acetabular liners sold in 2005. “Regular” polyethylene accounted for 18%.

Implant price increases

Increases reported between 2004 and 2005 for 41 hospitals.

	Increase	Average price
Total hip	5%	\$6,466
Knee	8%	\$5,109
Partial hip	3%	\$2,991
Revision hip	8%	\$5,823
Revision knee	20%	\$6,538

Source: *Orthopedic Research Network*, *Orthopedic Network News*.

Knee implants

The vast majority of knee implants are performed for patients with osteoarthritis. In 2005, 61% of knee implant patients were over 64 years old.

Knee replacements have favored uncoated femur and tibial combinations, with 74% of procedures using this construct. Hybrid cases (those with a coated femur and an uncoated tibia) accounted for 13% of procedures in 2005, similar to the 12% in 2004. The coated femur/coated tibia accounted for about 5% of knee procedures, while unicondylar procedures accounted for 5%.

The implant cost per procedure in the ORN continued to increase:

- coated systems by 3% to \$6,831
- hybrid systems by 2% to \$5,363
- uncoated systems by 9% to \$5,008.

Use of unicondylar knees in the ORN hasn't increased significantly, although their price surged from \$1,232 in 1999 to \$4,062 in 2005—a 229% increase. The price was up by 14% between 2004 and 2005 alone. Femoral components for unicondylar knees actually were reported to be more expensive than femoral components for bicondylar knees in 2005. ♦

— Stan Mendenhall

Editor, *Orthopedic Network News*
Mendenhall Associates, Ann Arbor, Mich

For more information, go to www.OrthopedicNetworkNews.com.

Ambulatory Surgery Centers

Salary/Career Survey

ASC leaders see bigger salary increases

Leaders of ambulatory surgery centers (ASCs) received bigger raises than their hospital counterparts this year, according to the 2006 annual *OR Manager Salary/Career Survey*. ASC managers averaged a 5% pay boost, while hospital OR managers averaged 4%. Last year the average raise for an ASC manager was 3.9%.

Despite larger increases, ASC leaders earn more than \$10,000 less on average than hospital-based OR leaders. The average ASC manager's salary is \$82,170, while the average OR manager earns \$92,680.

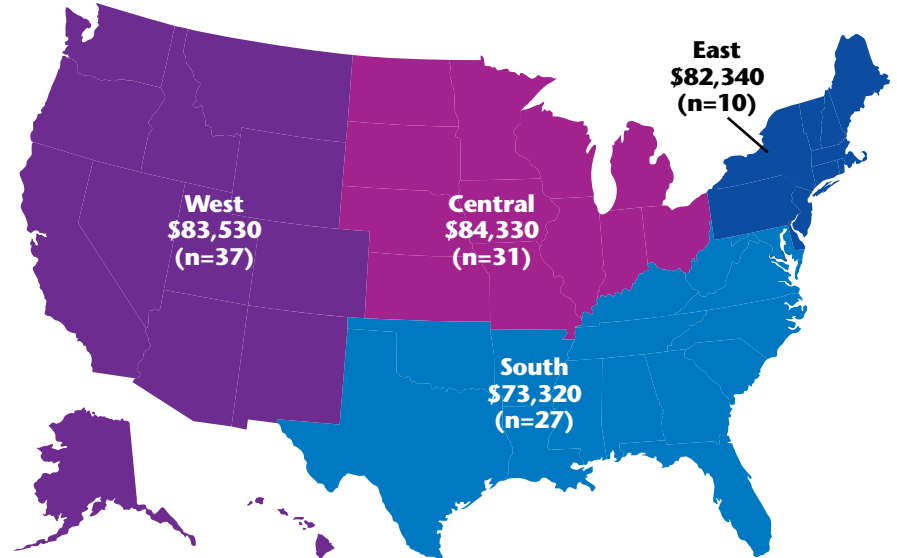
The higher hospital salaries reflect a difference in responsibilities. ASC managers on average manage 21.6 clinical FTEs and 6.4 nonclinical FTEs, whereas hospital OR managers oversee 82.7 clinical FTEs and 21.1 nonclinical FTEs. ASC directors manage an average of 4.2 ORs, compared to hospital-based OR managers and directors, who are responsible for an average of 11 ORs.

The *OR Manager Salary/Career Survey* data is based on surveys mailed to 600 ASCs. In all, 112 ASCs replied, for a 19% response rate.

Salary breakdowns

The highest average salary, \$110,300 (n=3), was reported by managers of corporate-owned ASCs, followed by \$98,500

Average annual ASC salary by region



(n=6) for hospital-owned facilities, \$83,770 (n=47) for joint ventures, and \$75,580 (n=45) for physician-owned ASCs.

Facilities in the Central region of the US pay slightly more on average—\$84,330—than those in the West (\$83,530), East (\$82,340), and South (\$73,320). The highest salary in this year's survey was reported by an ASC

director in the West—\$148,000.

ASC directors at facilities with 5 or more ORs earn \$10,000 more (\$89,020) than directors at facilities with fewer than 5 ORs (\$78,910). Suburban ASCs pay about 10% more than urban centers and 16% more than rural centers.

Bonuses and profit sharing

Despite lower salaries, ASC directors

Continued on page 30

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Salary/Career Survey

Respondents to ASC survey

Region	Distribution	Response
East	12%	9%
South	35%	24%
Central	23%	28%
West	30%	33%
Unknown	-	6%

Continued from page 29

are more likely to be eligible for incentive bonuses and profit sharing than hospital-based OR directors. In all, 64% of ASC directors are eligible for these perks, versus 40% of OR managers and directors in hospitals.

Leaders in corporate-owned (100%, n=4) or joint venture (66%, n=31) ASCs are the most apt to offer incentives. The average incentive amounted to 9.0% of ASC leaders' base salaries.

Benefits

Hospitals and ASCs provide health insurance and paid time off almost

Average annual salary by ownership

Hospital owned	\$98,500
Physician owned	\$75,580
Corporate owned	\$110,300
Joint venture	\$83,770

FTEs in span of control

Clinical FTEs	21.6
Nonclinical FTEs	6.4

equally, but other benefits weigh in the hospitals' favor.

	ASC	Hospitals
Health insurance	97%	99%
Paid time off	95%	99%
Life insurance	76%	97%
Retirement plan	77%	94%
Dental insurance	80%	95%
Tuition reimbursement	51%	91%
Disability insurance	64%	86%
Dependent health insurance	55%	83%
Eye care	60%	77%

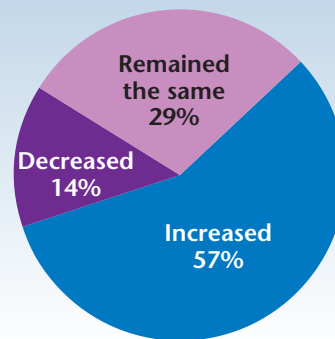
Management role

The most common title for ASC is director (32%) or administrator (32%), followed by nurse manager (24%). A majority of respondents report to the facility's administration (46%), followed by the board of directors (25%), medical director (16%), or corporate office (5%). Half say they manage the ORs only at one ASC, while the other half manages the ORs and other departments at one ASC.

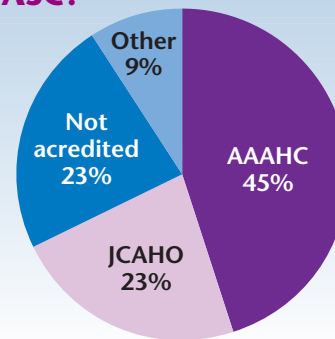
Purchasing influence

More respondents to this year's survey—45%—say they are the primary decision maker in purchasing decisions, compared with 35% in 2005. The remainder are members of a purchasing committee or team (30%) or serve in an advisory capacity (24%). Nearly all (97%)

The ASC's surgical volume has...



Who accredits your ASC?



influence both the selection and purchase of capital equipment and surgical supplies.

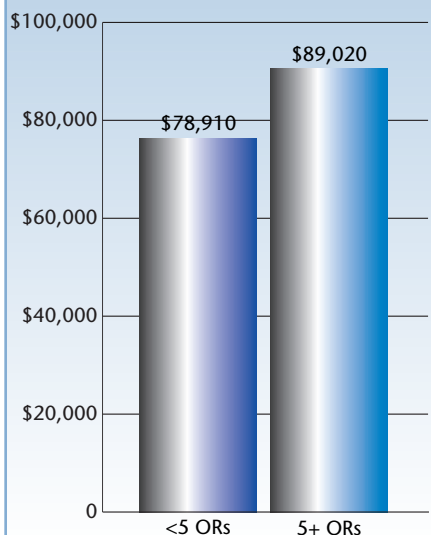
About your ASC

The respondents' ASCs are owned predominantly by physicians (45%) or joint ventures (44%). The largest group is located in the suburbs (46%), followed by urban (33%) or rural (21%) areas.

Most are performing more surgery. More than half—57%—say their surgical volume has increased in the past year, while 29% reported their volume stayed the same, and 14% said it decreased. The average increase in volume is 9%, and the average decrease is 11%.

The average overall annual operating budget for responding ASCs is \$5.7 million. Only 47% (n=53) responded to this question.

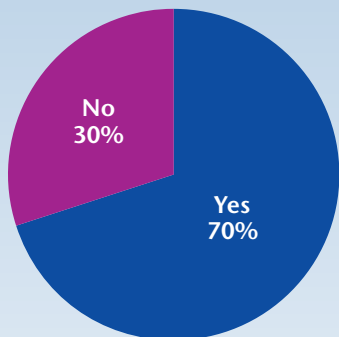
Average annual salary by number of ORs



Salary/Career Survey

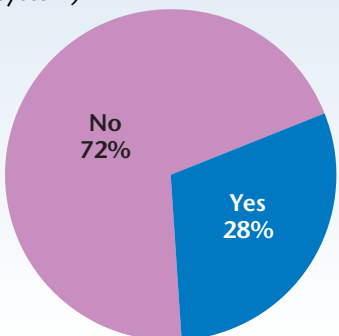
Information systems

Does your ASC have a computerized information system?



Is there a computer in each OR?

(for those with an information system)



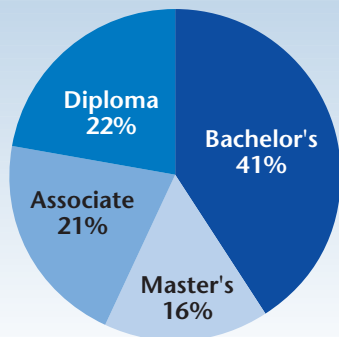
Who accredits ASCs?

The largest group of respondents (45%) says their facility is accredited by the Accreditation Association for Ambulatory Health Care, followed by 23% that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (23%). In all, 23% are not accredited. One facility is accredited by the American Association for Accreditation of Ambulatory Surgery Facilities and the rest, by some other organization.

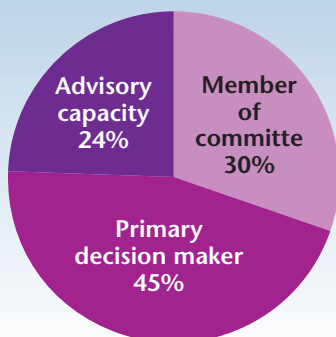
Information systems

Nearly three-fourths of ASCs (70%)

Highest degree completed



Purchasing power



have computerized information systems. Of those, only 28% have computers in each operating room.

About you

The average age of OR directors at ASCs and hospitals inches up each year, reaching 51 (50.6 to be exact) for ASCs and 51.4 for hospitals in 2006. All but 8 of this year's ASC survey respondents are RNs. In all, 12% of ASC leaders are males, compared with 15% of hospital-based managers and directors.

Fewer ASC nursing leaders hold master's degrees than their hospital colleagues. In ASCs, 42% of ASC managers have an associate degree or diploma as their highest degree, while in hospitals, 23% do.

Highest degree held

	Bachelor's	Master's
ASC	41%	16%
Hospital	36%	40%

In all, 41% (n = 45) of respondents say their ASC requires a specific degree for their position. For these, the degree required is a:

Bachelor's	73%	(n=32)
BSN preferred	39%	(n=17)
Master's	16%	(n=7)
MSN preferred	5%	(n=2)

—Leslie Flowers

Ambulatory surgery leaders to identify quality measures

Ambulatory surgery leaders have formed the ASC Quality Collaboration to identify standard quality and surgery measures for ambulatory surgery centers (ASCs).

The group says these measures might be used in discussions on pay-for-performance, for state data collection initiatives, for providing information to consumers and payers, and for guiding quality improvement and benchmarking efforts in ASCs.

The collaboration says it will work with the Centers for Medicare and Medicaid Services to make these quality measures part of the new ASC payment system expected to be in place in January 2008.

The group includes, among others, representatives from FASA Inc, the Accreditation Association for Ambulatory Health Care, HealthSouth, CMS, the American Association of Ambulatory Surgery Centers, the Joint Commission on Accreditation of Healthcare Organizations, the Association of periOperative Registered Nurses, and the American College of Surgeons. ❖

ASCs concerned about details of pay plan

Medicare's proposed new payment system for ambulatory surgery centers (ASCs), slated to take effect Jan 1, 2008, for the first time would link ASC payments to hospital outpatient payments.

The ASC industry generally has supported that approach. But the proposal has important differences that could affect ASC payments, industry leaders are saying.

The proposal was published Aug 23 by the Centers for Medicare and Medicaid Services (CMS). Comments are due by Nov 6.

At first blush, it looks like ASCs would get 62% of what hospital outpatient departments (HOPDs) receive in the first year of the new system.

But there's concern about the details, Kathy Bryant, president of FASA Inc, a trade group for ASCs, said in an Aug 30 audioconference. But she cautioned ASCs to wait to comment until FASA Inc has completed its analysis. She also noted that changes are likely before CMS publishes the final rule.

New concepts

The proposal introduces some new concepts for ASCs. Bryant outlined basics of how the new system is likely to work. Congress ordered the plan to be budget neutral, meaning it is not supposed to cost Medicare more than the current system. That doesn't give CMS much leeway, she explained.

The hospital outpatient department (HOPD) payment system, on which the new ASC system would be based, groups CPT codes into ambulatory patient classifications, or APCs. HOPD payments are determined using 2 basic steps:

- Each APC has a relative weight, which reflects how procedures in that group relate to other APCs for cost and resource use. For example, a cataract procedure might belong to an APC with a relative weight of 24, while a colonoscopy is in an APC with a relative weight of 8. That means the payment for cataracts

**Some limits
apply to ASCs
but not
hospitals.**

would be about 3 times that of a colonoscopy.

- To arrive at the actual payment, the relative weight is multiplied by a conversion factor, which is set each year. Right now, the conversion factor is about \$60.

The ASC industry proposed a simpler method, where Medicare would pay ASCs a straight percentage, say 75%, of what HOPDs receive, Bryant says. But CMS chose a more complex method.

The graph shows how payments for specialties would be affected in 2008 if the proposal is unchanged.

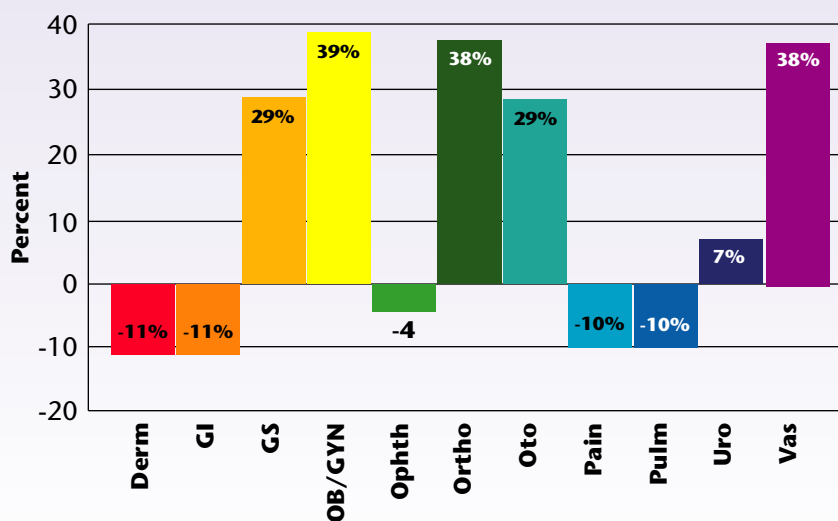
It would be hard for ASCs to predict how their payments would change from year to year. Instead of the 9 current Medicare payment groups, there would be 221 APC rates that could be adjusted up or down.

Big differences for ASCs

There are important differences between the HOPD system and proposed ASC system that could have a big effect on ASCs. Major differences include:

- Relative weights would be adjusted every year. In 2008, the relative weights would be the same for HOPDs and ASCs, but after that relative weights would be adjusted a second time for ASCs.
- Payment rates would be updated annually. But starting in 2010, CMS would use 2 different methods: ASC payments would be updated using the consumer price index for urban consumers (CPI-U), while HOPD rates would be adjusting using the hospital market basket, an inflation factor reflecting resources hospitals use. In recent years, the hospital

Proposed changes in ASC specialty payments in 2008



Source: FASA Inc analysis of proposed changes in Medicare ASC payment system.

market basket has gone up faster than the CPI-U, probably in part because of increases in nurses' salaries.

- Bundles of services covered by the APCs would be different for ASCs and HOPDs.
- Local wage adjustments would be made differently. For HOPDs, about 60% of the payment would be adjusted for local wages, while 34% of the ASC payment would be.

Payment limit for office procedures

Another proposal, which Bryant said could be "incredibly significant," applies to about 500 of the 750 procedures CMS plans to add to the Medicare-approved list of procedures in ASCs. These are procedures performed 50% or more of the time in a physician's office. Essentially, CMS pro-

poses to pay ASCs no more than a physician's practice would get for performing these procedures in the office. (This would not affect how much physicians are paid.)

"This limitation only applies to ASCs—not hospitals," Bryant said. "This is yet another reason why ASCs are not being proposed to be paid 62% of the HOPD rate."

ASC list would expand

In a move long-awaited by ASCs, CMS plans to take a new approach to the Medicare ASC list. Starting in 2008, all surgical procedures would be on the list unless there is a reason to exclude them for safety reasons. But the ASC community might take issue with CMS's criteria for defining safety, Bryant said. CMS proposes to exclude only procedures it says "pose a significant safety risk" or require an overnight

stay. Procedures excluded would be those involving major blood vessels, major or prolonged invasion of body cavities, significant blood loss, or defined as inpatient only by CMS.

But Bryant said this approach is not flexible enough to allow for the future as technology changes. A procedure that CMS defines as unsafe for an ASC today might not be considered unsafe in 10 or 20 years. But once the CMS criteria are set, it is difficult to get them changed. ❖

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New steam sterilization guide from AAMI

A new collection pulls together 5 steam sterilization recommended practices, updated and revised, from the Association for the Advancement of Medical Instrumentation (AAMI).

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At a Glance

Mattress overlays promising for pressure ulcers, lit review shows

Mattress overlays on OR tables are one promising strategy for preventing pressure ulcers, according to a new review of 59 randomized controlled trials.

For the OR, the authors found one well-designed study involving 446 patients, published in 1998. The study found specialized foam mattress overlays on OR tables decreased the incidence of postoperative pressure ulcers (Nixon J McElvenny D, Mason S, et al. *Int J Nurs Stud*. 1998;35:193-203).

In general, the authors found the study methodologies lacking, though recent studies show improvement.

—Reddy M, Gill S, Rochon P A. *JAMA*. Aug 23/30, 2006;296:974-984.

Hospital supply costs to rise by 5%

Hospitals are expecting supply costs to rise an average of 5.1% in fiscal 2006, according to a survey by Moody's Investors Service. In the responses from 82 not-for-profit hospitals, supplies accounted for a median of 18.25% of operating expense in 2005 and 18.05% in 2004. Moody's says it doesn't expect rising supply costs to hurt credit ratings in the short term because most hospitals have invested in supply-chain management technology and engaged physicians in controlling costs. The vast majority of respondents (98%) belong to group purchasing organizations that have gleaned them an average of 4.5% savings on supplies. Moody's clients may access the study.

—www.moody.com

CMS to promote gainsharing pilot

The Centers for Medicare & Medicaid Services (CMS) announced Sept 6 it is conducting a 3-year project to see if giving physicians financial incentives to support better care can improve patient outcomes in hospitals without increasing Medicare costs.

Up to 72 participating hospitals will be paid their usual inpatient rates and will share a portion of the savings with physicians who collaborate in quality improvement and efficiency initiatives.

Incentives would be allowed only for documented, significant improvements.

—www.cms.hhs.gov.

Look under Newsroom.

FDA approves implantable artificial heart

The Food and Drug Administration on Sept 5 announced approval of the first totally implantable artificial heart for patients with advanced heart failure involving both pumping chambers. The device is for patients who are not eligible for a heart transplant and are unlikely to live more than a month without it. The device has been implanted in 14 patients, who all have died, but the longest survivor lived 512 days.

The AbioCor Implantable Replacement Heart from Abiomed, Inc, Danvers, Mass, was given an FDA humanitarian exemption to sell up to 4,000 devices a year.

—www.fda.gov

JCAHO issues alert on planning for power failures

The Joint Commission on Accreditation of Healthcare Organizations in a Sept 7 Sentinel Event Alert urged facilities to assess their risk of a power failure in a disaster and develop contingency plans. JCAHO gives recommendations to keep patients safe if power is lost.

According to the alert, compliance with the minimum National Fire Protection Association (NFPA) codes is not enough to ensure patient safety during an emergency.

Also, for 2007, JCAHO is adding a requirement that facilities test emergency generators at least once every 36 months for a minimum of 4 hours—facilities already test generators 12 times a year for 30 minutes.

—www.jcaho.org. Look under Sentinel Event.

J & J wins suit over bundling minimally invasive instruments

A federal jury in Santa Ana, Calif, rejected claims by Applied Medical Resources Corporation that Johnson & Johnson's Ethicon unit illegally offered discounts on sutures to hospitals that also bought its minimally invasive surgery instruments, *Bloomberg News* reported Aug 30.

Applied Medical claimed Ethicon had blocked competition and taken away sales of trocars.

J & J argued that such bundled contracts were requested by hospitals that sought lower prices and did not unfairly exclude other suppliers. ❖

—www.nytimes.com



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