Even with the stresses of managing surgery departments, the atmosphere in most ORs is upbeat. Nearly all of those responding to this year’s OR Manager Salary/Career Survey report good working relationships with their physicians. And nine out of ten say their staff works together as a cohesive team. This is the first year the survey asked managers and directors about their job satisfaction.

If they were to receive an award for their OR’s achievements this year, most would turn around and give the award to their staffs, crediting them for team spirit, accountability, and willingness to help out when needed.

Salaries top $80,000
Salaries for managers and directors now average over $80,000 a year. The average raise was 4.6%. Raises have outpaced inflation for the past 5 years and compare favorably with those for managers and executives nationally (chart).

The average age of directors has edged above 50, reflecting the aging of the RN population. Five years ago the average age was 47.

Purchasing power increases
Purchasing power jumped this year—with more than two thirds of managers and directors saying they gained influence. That may be because group purchasing reforms are returning more decision making to clinicians.

OR Manager’s 13th annual Salary/Career Survey of hospitals was mailed in May to 1,197 OR Manager subscribers with management titles in hospitals, with a return rate of 37%. The survey has a 95% confidence level with a margin of error of 4.75%. A separate survey was conducted for ambulatory surgery centers.

Raises
The vast majority of managers and directors—87%—received a salary increase this year. Those in medium- and large-sized OR departments were a little more likely to receive a pay boost than those in small ORs:

<table>
<thead>
<tr>
<th>Size of Department</th>
<th>Percent Receiving Raises</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5 ORs</td>
<td>84%</td>
</tr>
<tr>
<td>6 to 9 ORs</td>
<td>88%</td>
</tr>
<tr>
<td>10+ ORs</td>
<td>88%</td>
</tr>
</tbody>
</table>

Rises varied little by region. Those in teaching institutions got slightly higher increases (5.2%) than those in community hospitals (4.4%).

Those titled “director” received raises that were slightly higher (4.7%) than those titled “nurse manager.”

Raises for managers and directors ran even with those for staff nurses of all disciplines. The average staff nurse’s...
Please see the ad for MEDLINE INDUSTRIES in the OR Manager print version.
Managing bariatric surgery risk

What you need to know about the medical-legal risks.

Bargaining with anesthesia groups

The shortage is easing, but negotiating will still be tough. Read advice from experts.

Excuse me, but what are we bypassing?


Surgery and ambulance diversion

What does elective surgery have to do with ambulance diversion? A lot. Some hospitals are taking action.

**Editorial**

As their shift draws to a close, the two nurses meet in the lounge to change from their scrubs into street clothes.

“Boy, today was tough. I hope there aren’t too many like that,” comments Mary.

“Mines wasn’t exactly a piece of cake,” commiserated Susie.

“Say, did you see that show the other night, ‘Nip/Tuck?’ It is about cosmetic surgery, and it is supposed to be funny, but I guess I see enough of that during the day,” Mary added.

“We probably see enough to script a made-for-TV movie,” Susie suggests.

Mary pauses a moment. “I’ve got an idea. What if we had surgeons who do a lot of unnecessary heart surgery on healthy patients because they wanted to make a lot of money. We could use the plot to show people how profit drives the health care system—in the wrong direction—and what can happen when it does.”

Susie quickly gets caught up in the plot. “And of course, we need the whistle blowers—among them a handsome young internist who goes to administration to complain that the cardiac surgeon is doing too many procedures . . . procedures he thinks aren’t necessary. He is told to mind his own business.”

“But, of course, the administration doesn’t pay any attention to the docs who complain because they need to satisfy their investors who want to see growth in cardiac care so they will make more money. And senior officials of the company that owns the hospital keep pressuring the administrators for larger and larger profits,” continues Mary.

“The part about the patients will be pitiful,” muses Susie. “They suffer terribly from the unnecessary surgery. Like Mrs W, who has emergency bypass surgery. She used to go dancing with her husband and now she can no longer write or walk steadily. Her husband had to quit his job to take care of her.”

“That’s so sad.” Susie goes on, “Another patient is told she has severe coronary disease and needs immediate surgery. But after her surgery, her cardiologist reviews her chart and finds no evidence of serious heart problems.”

“We will need a hero!” both exclaim together.

“I’ve got it,” says Mary excitedly.

“Enter a Roman Catholic priest who decided to have a cardiac stress test at the hospital. Although he passes the test, the surgeon suggests a trip to the catheterization lab. While he is still on the table, the surgeon tells him he needs an emergency triple bypass.”

“Leery, the priest consults an accountant friend who persuades him to come to another hospital for the surgery. When he arrives, the cardiologist asks, ‘Excuse me, but what are we bypassing?’”

“What happens next?” asks Susie.

“The priest and the accountant meet with hospital officials, but when the officials don’t seem concerned, the accountant contacts the Federal Bureau of Investigation.”

“And, ta da . . . four months later, federal agents raid the hospital.”

“After all is said and done, the hospital owner agrees to pay $54 million to the government for billing federal health programs for unnecessary care, only slightly less than the $55.7 million in outlier payments it received in 2002.”

“So what do you think?” asks Mary.

“Would that work as a plot?”

“Nah, it’s too weird,” replied Susie. “It could never happen. Nobody would believe it. Besides, you need lots of sex and violence for anything on TV. We would have to make up some steamy OR scenes.”

She slips into her leather jacket, “See you tomorrow. Hope we both have an easier day.”

Sometimes fact is stranger than fiction.*

—Elinor S. Schrader

“Thanks to the New York Times Aug 12 article, “How one hospital benefited on questionable operations,” for the facts about Redding Medical Center in Redding, Calif. Redding Medical Center is owned by Tenet.

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Please see the ad for KIMBERLY-CLARK CORPORATION in the OR Manager print version.
A woman who sees no barriers. A person who brings energy into any room she enters. A leader not only in the hospital but in her community.

That’s how colleagues see Rita Borden, RN, BSN, the 2003 OR Manager of the Year.

Borden was recognized at the Managing Today’s OR Suite conference Sept 17 to 19 in San Diego.

Borden is executive director of surgical services for Sun Health based in Sun City, Ariz, which includes W.O. Boswell and Del E. Webb Memorial Hospitals.

During her tenure, she has overseen surgical services’ growth from five ORs and 13 staff members to 22 ORs and 235 employees. She is responsible for the departments of surgery, postanesthesia care, cardiac care, outpatient surgery, IV therapy, endoscopy, and dialysis in both facilities.

Borden’s nominating letters cited many accomplishments—leading Sun Health’s Heart Center, named as one of the nation’s Top 100 cardiac programs for the second year in a row; increasing surgical volume at Del E. Webb by 20%; lowering costs in orthopedics; and building a career ladder for surgical technologists (STs), among others.

She has worked to address gaps in the surgical schedule that enabled the system to recruit new anesthesiologists during a nationwide shortage.

“We do what we need to do to make our facility attractive to physicians,” Borden commented for a profile in the January 2003 OR Manager.

She has helped create an environment that retains nurses, with a turnover rate lower than the national average. The training program she developed for STs, the only one in the state, draws from the central service department and gives techs a career advancement path.

A family unit

Of all her achievements, she treasures a close relationship with her leaders and staff.

“Rita organizes fun events for her staff and families,” writes Rita Mathis, RN, BSN, a staff nurse in the OR. “She has instilled good rapport among her staff, and we all feel like a family unit and work well together.”

JoAnne M. Andrews, RN, manager of same-day surgery at Boswell adds, “She knows every staff member and their families. She recognizes little and big accomplishments with praise, a hug, and gift certificates.

“I value going to work every day. At the end of the day, I feel I was part of a caring and competent team. Rita is the energy behind all of this.”

Borden is also a leader in her community.

In August 2002, she was recognized with the Health Care Hero Award from the Arizona Business Journal, one of eight honorees selected from 100 nominees.

Along with family members, she is dedicated to causes, including the Cystic Fibrosis Foundation and the Arthritis Foundation. After her 16-year-old granddaughter, Brittany, died of cystic fibrosis last year, Borden and her daughter organized a charity golf tournament that raised $125,000. The money was used to build an outdoor stage at Phoenix Children’s Hospital to honor Brittany’s interest in acting.
Please see the ad for
OLYMPUS ENDOSCOPY
in the OR Manager print version.
The EEOC (www.eeoc.gov) is a federal agency that enforces civil rights laws. 

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
raise nationally was 4.6%, according to the Hospital and Healthcare Compensation Service (www.hhcsinc.com). Staff nurse raises dropped back from last year, when the average was 8.7%.

**Annual salaries**

Average annual salaries for OR managers and directors rose only slightly to $81,694 from $81,655 in 2002.

Those with the title “director” earned an average of $85,165, while those with the title “nurse manager” earned an average of $68,032.

**Who’s making the most?**

Those in the West have the highest salaries, averaging $89,189, almost $8,000 higher than the national average.

The highest pay is earned by those in teaching hospitals, managing 10 or more operating rooms, and having multiax campus responsibilities.

**Manager bonuses and incentives**

The percentage eligible for a bonus, 40%, is similar to last year’s 43% but higher than the 34% reported 5 years ago.

Bonuses are most popular in the West (52%) and least popular in the East (28%). Large- and medium-sized departments are far more likely to offer an incentive than small ones:

<table>
<thead>
<tr>
<th>Those receiving bonuses by size of OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5 ORs</td>
</tr>
<tr>
<td>29%</td>
</tr>
<tr>
<td>6 to 9 ORs</td>
</tr>
<tr>
<td>42%</td>
</tr>
<tr>
<td>10+ ORs</td>
</tr>
<tr>
<td>47%</td>
</tr>
</tbody>
</table>

The average bonus is 8.5% of base salary, with 42% receiving more than 8%. Bonuses are far more common for those with the title “director” (44%) than “nurse manager” (31%). The average bonus for a director is 9.2% of base salary; the average for nurse managers is 6.2%.

**Benefits**

Most benefits have remained stable, with the exception of health insurance. Many respondents wrote in that they had seen an increase in their copays and deductibles this year. This is part of a national trend as many employers trim health benefits in the face of rising premium costs.

A few commented that eye-care benefits had been dropped, while others said eye and dental benefits had been added.

Tuition is one benefit that has improved. With the nursing shortage, more organizations are boosting tuition

**Salary/Career Survey**

**Hospital respondents to survey**

<table>
<thead>
<tr>
<th>Region</th>
<th>Distribution</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>176 (15%)</td>
<td>16%</td>
</tr>
<tr>
<td>South</td>
<td>406 (34%)</td>
<td>26%</td>
</tr>
<tr>
<td>Central</td>
<td>363 (30%)</td>
<td>32%</td>
</tr>
<tr>
<td>West</td>
<td>255 (21%)</td>
<td>21%</td>
</tr>
</tbody>
</table>

**Average annual salary by region**

<table>
<thead>
<tr>
<th>Region</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>$89,189</td>
</tr>
<tr>
<td>Central</td>
<td>$78,199</td>
</tr>
<tr>
<td>South</td>
<td>$80,260</td>
</tr>
<tr>
<td>East</td>
<td>$80,352</td>
</tr>
</tbody>
</table>

**Continued from page 1**

**How OR leaders’ raises compare**

Note: CPI-U is seasonally adjusted for June 2003.

Please see the ad for BOVIE MEDICAL in the *OR Manager* print version.
assistance as part of their strategy to attract and retain nurses.

**Benefits**

- **2003**  **2000**  **1998**
  - Health insurance: 99%  99%  98%
  - Dependent health insurance: 76%  81%  69%
  - Life insurance: 94%  97%  94%
  - Retirement plan: 92%  93%  91%
  - Dental insurance: 93%  94%  89%
  - Disability ins: 81%  86%  83%
  - Paid time off: 99%  — —
  - Tuition reimb: 90%  86%  81%
  - Eye care: 60%  54%  47%

**About your organization**

More than three-quarters of respondents (78%) are from community hospitals, with 20% from teaching institutions and the rest from other types of hospitals.

Respondents are more likely to be employed by a freestanding hospital (54%) than one that is part of a health care system (42%).

**About your role**

**Title and work area.** The most common title for respondents is director (71%), followed by manager or nurse manager (26%).

Most (62%) refer to their work area as “surgical services.” The term “perioperative services” has gradually grown in popularity, with 20% using it this year compared with 12% in 1998. As in past years, this title is more common in the East (25%) than in other regions.

**Reporting structure.** As in past years, respondents are much more likely to report to the nursing administration (73%) than to the hospital administration (21%) or any other entity. Less than 1% (N=2) report to an OR medical director, a percentage that also has remained stable over the years.

**Managing beyond the OR.** Nearly all of the survey respondents (90%) have a role that extends beyond the operating room.

The largest group (79%) manages the OR plus other departments in the same hospital. These managers and directors head an average of:

- five departments—with 4% (N=13) having ten or more units
- 10 ORs
- 72 clinical and 19 nonclinical FTEs.

They are responsible for an average annual budget of $11.3 million.

For 11% (N=51) of respondents, the role extends beyond the hospital to multiple facilities. Those with multi-site responsibilities oversee an average of:

- nine departments
- 16 ORs
- 121 clinical and 27 nonclinical FTEs.

The average budget they manage is $18.7 million.

Compared with 10 years ago, managers and directors are much more likely to have responsibility for the central service area—71% versus 40% in 1993—

Continued from page 8

### Average annual salary

**by number of ORs**

- 1-5 ORs (N=41): $70,074
- 6-9 ORs (N=111): $80,406
- 10+ ORs (N=174): $92,197

**by facility type**

- Community (N=341): $80,195
- Teaching (N=86): $86,114

**by scope of role**

- OR only (N=41): $76,134
- OR+ other depts (N=347): $80,806
- Multiple sites (N=50): $92,256

### To whom do you report?

- Hospital admin 21%
- Nursing admin 73%
- OR medical director <1%
- Other 6%

**Who reports to respondents?**

<table>
<thead>
<tr>
<th>2003</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postanesthesia</td>
<td>88%</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>78%</td>
</tr>
<tr>
<td>Central service</td>
<td>71%</td>
</tr>
<tr>
<td>GI/endoscopy</td>
<td>65%</td>
</tr>
<tr>
<td>Anesthesia support</td>
<td>59%</td>
</tr>
<tr>
<td>Preadmission</td>
<td>55%</td>
</tr>
<tr>
<td>Perfusion services</td>
<td>16%</td>
</tr>
<tr>
<td>Materials management</td>
<td>8%</td>
</tr>
<tr>
<td>Inpatient units</td>
<td>5%</td>
</tr>
<tr>
<td>Cardiac cath lab</td>
<td>4%</td>
</tr>
<tr>
<td>Emergency/trauma</td>
<td>2%</td>
</tr>
<tr>
<td>ICU</td>
<td>2%</td>
</tr>
</tbody>
</table>

Continued on page 12
Please see the ad for SURGICAL INFORMATION SYSTEMS in the OR Manager print version.
and the GI/endoscopy unit—65% versus 44% a decade ago.

More than half (59%) manage anesthesia support functions, and a few have responsibility for inpatient units, the cardiac cath lab, emergency/trauma services, and intensive care units.

Respondents, primarily from small facilities, wrote in that their scope includes a wide variety of other units, ranging from the pain clinic to the dermatology clinic. Also mentioned were obstetrics, infection control, radiology, ambulatory clinics, dialysis, PRN and temporary staff, and employee health.

### Purchasing power

OR managers and directors could be regaining some of their purchasing clout.

More than two thirds—68%—say their purchasing role increased in the past year. That is the largest increase reported since this question was first asked in 1999. It is much higher than the 24% who said their involvement had risen last year.

Also up is the number who say they are the primary decision maker—41% compared with 35% in 1999. Leaders of small ORs (1 to 5 rooms) are most likely to be the primary decision maker (55%). There was little difference by title.

One possible reason for the shift is group purchasing reforms in the past year. As Congress has put more pressure on group purchasing organizations, they are reforming practices such as bundled contracts with unrelated items and sole-source agreements. GPOs say they are increasing the amount of clinician input. (See September OR Manager.)

### About the operating room

#### Number of ORs

Those with the title "director" manage an average of 11 ORs, while those with the title "manager" are responsible for an average of 7 ORs. They report an average annual surgical case volume of 7,695.

#### Surgical volumes

The majority, 55%, saw their surgical volumes rise in the past year; 27% said volumes remained about the same; and 18% reported a decline. The average volume increase was 10%.
**OR budget.** Those with the title “director” manage an average annual budget of $15.9 million. For those with the title “nurse manager,” the average annual budget they oversee is $11.8 million.

**About you**

**Age, gender.** The average age of managers and directors is creeping up. The average age in this year’s survey is 50, compared with 47 in 1998.

Consistent with past years, 88% of respondents are female, and 12% are male. Less than 1% (N=4) are not RNs.

**Education.** The level of education continues to rise. This year, for those with the title “director,” more have a master’s degree than a bachelor’s only. The most common master’s is an MS/MSN (50%), followed by an MBA (38%) or another master’s (12%).

For those with the title “nurse manager,” the most common degree is a bachelor’s, followed by a diploma, associate degree, and master’s.

Most respondents—71% of directors and 54% of managers—say their employer requires a specific degree for their position. For directors, 58% say their position calls for a bachelor’s and 39% for a master’s. When a degree is specified for nurse managers, almost always (92%) it is a bachelor’s; only 3% mandate a master’s.

The OR Manager Salary/Career Survey is coordinated by Billie Fernsebner, RN, MSN.

**Thank you**

OR Manager thanks its subscribers who generously 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.

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**Skill mix in OR remains stable**

**Do surgical techs circulate?**

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes, RN available</th>
<th>Yes, RN in room</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>6% (N=174)</td>
<td>16%</td>
</tr>
<tr>
<td>1998</td>
<td>8% (N=152)</td>
<td>17%</td>
</tr>
</tbody>
</table>

The skill mix in the operating room, at roughly 60:40, continues to see little change.

The ratio of RNs to surgical technologists (STs) has held steady since OR Manager began collecting this data in 1993.

A small number of hospital respondents to this year’s Salary/Career Survey, 6% (N=26), continue to have a staff that is 90% or more RNs. Most (N=21) are small facilities with five or fewer ORs.

Only 1% (N=6) of respondents allow STs to circulate with an RN immediately available, which means outside the operating room but in the immediate area. These were evenly split by size of facility; five were community hospitals, and one was a teaching institution.

**Ambulatory surgery centers.** The skill mix for ASCs is very similar to that of hospitals: 65:35. Like hospitals, most ASCs (86%) do not report STs circulating. A few, 8% (N=12) have STs circulating with an RN in the same room, and 6% (N=8) allow STs to circulate with an RN immediately available.

---

**Ratio of RNs to surgical techs**

<table>
<thead>
<tr>
<th>Year</th>
<th>64:36</th>
<th>62:36</th>
<th>65:35</th>
<th>66:33</th>
<th>69:31</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1997</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>By number of ORs</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1+ ORs</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>6-9 ORs</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td>10+ ORs</td>
<td>37%</td>
<td>63%</td>
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<table>
<thead>
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<td>36%</td>
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<tr>
<td>13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37%</td>
<td></td>
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</tbody>
</table>

*The OR Manager Salary/Career Survey is coordinated by Billie Fernsebner, RN, MSN.*
**Strong teams are reason to celebrate**

Despite constant pressure to save money, improve safety, and respond to staffing challenges, OR managers and directors find much to celebrate.

The Salary/Career Survey asked, “If your OR were to receive the ‘golden scalpel’ award this year for an accomplishment, what would it be for?”

Most often mentioned—a cohesive staff and good results with recruitment and retention despite a shortage of experienced perioperative personnel.

These managers said staff teamwork plus stable staffing enabled them to carry out successful performance improvement and patient safety projects.

**Kudos to hard-working staff**

More than any other thing, managers count a close working relationship with their staffs as their greatest achievement. Here’s a sampling of their comments:

“I have never worked with such a cohesive staff. When a case finishes, they call out, and everyone free actually goes and helps with turnover, and they don’t complain. They are all well versed in their experience, and all have a pleasant personality.”

—Manager who took a new position in a four-room OR in Nevada

“The surgical services teams are what makes these departments work. I don’t know how or why, but the staff in my departments work cohesively and positively together for the benefit of the patient. Their goals are good days where everything clicks, and patients and surgeons are happy.”

—Manager of five-room OR and other departments in rural Iowa

“My staff is cross-trained to work all areas. On any given day, an RN may circulate cases, scrub, work in the PACU, or do preop teaching and help in the same-day surgery area. We are a family and work together and support one another.”

—Manager of five-room OR in Mississippi

“The staff is a great team, accountable for what is needed in our department. They will work through lunch to keep cases going and not complain. When asked, they will always be there to help patients and MDs.”

—Director of four-room OR in rural Florida

“Developed a scheduling committee (staff only) including RNs of various seniority and STs. Rocky start. Director was only involved in providing number of staff needed for each shift. Staff [now] much more willing to cover off shifts with set schedule. Open-heart call decreased by 2 FTEs. Staff now love schedule and will cover even the Sunday shifts. Zero turnover in past year.”

—Manager of 16-room OR in West Virginia

“Sterile processing remodel forced us to process instrument trays in OR substerile areas. That increased positive communication between OR and CS staff.”

—Manager of three-room OR in rural Alaska

**Recruiting, retaining staff**

Many reported their success in attracting and preparing new RNs who did not have previous experience in surgery:

“Our retention of staff is remarkable. In my 10 1/2 years, only one person left because she didn’t like it, and she asked to come back several months later. Being the manager here is easier because of the truly compassionate staff. It is more like a family. Our case load has increased dramatically, and everyone adjusts by helping each other.”

—Manager of four-OR ambulatory surgery center

“We have offered the Periop 101 course [by the Association of periOperative Registered Nurses] through a consortium in the state of Alaska. Twelve hospitals are participating. We were the first to graduate a nurse who had no OR experience. She was up and running in six months taking independent call. We can’t wait for the next opportunity.”

—Manager of three-room OR in rural Alaska

“Community reputation for fair work environment attracts personnel. Serve as site for university BSN senior management students 8 hours per week for 6 weeks. Staff is active toward improving relations with high school shadow program and students on site.”

“We receive a golden scalpel award almost every time we receive a patient (satisfaction) survey. The patients are very complimentary, stating that our staff makes them feel comfortable and at ease; that the staff is caring and kind, friendly, professional, cheerful, informative, organized, and that we work...”

—Manager of 16-room OR in rural Iowa
Nearly half have computers in each OR

Is there a computer in each OR?

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Yes, by size of OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1+ ORs</td>
<td>34%</td>
</tr>
<tr>
<td>6-9 ORs</td>
<td>45%</td>
</tr>
<tr>
<td>10+ ORs</td>
<td>57%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASCs</th>
<th>Yes, by size of ASC</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5 ORs</td>
<td>13% (N=10)</td>
</tr>
<tr>
<td>5+ ORs</td>
<td>10% (N=6)</td>
</tr>
</tbody>
</table>

Computers in each OR are used for:

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>ASC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inventory control</td>
<td>29%</td>
<td>39%</td>
</tr>
<tr>
<td>Patient charges</td>
<td>48%</td>
<td>50%</td>
</tr>
<tr>
<td>Intraop documentation</td>
<td>72%</td>
<td>61%</td>
</tr>
<tr>
<td>Other</td>
<td>32%</td>
<td>39%</td>
</tr>
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</table>

Automation in surgical services has arrived.

All but two respondents in this year’s hospital Salary/Career Survey have a computerized management information system (IS) for their departments. The two that do not are both small facilities with five or fewer ORs.

Also up sharply are those with computers in each operating room, 46% this year compared with 28% in 1998.

Though computers are more widely used, the majority of hospital ORs—53%—don’t have a dedicated information specialist to support their systems.

For the 47% who do, most (75%) have a specialist within their own department rather than in the IS department.

Application of automation extends beyond the usual functions of charges, documentation, and inventory control. Among other uses are digital imaging, laboratory data, order entry, immediate postoperative notes for physicians, and policy and procedure manuals.

Automation use also has taken a big jump in ambulatory surgery centers, with 88% having information systems this year compared with 66% in 1998.

Most haven’t yet extended its use to each operating room, however.

Improving patient safety

With national initiatives, patient safety projects have been high priorities. Examples of what ORs have accomplished:

“Labeling of medications on sterile field, establishing ways to determine correct site, documentation of near misses, and follow-up with staff to discuss ways to correct for near misses.”

—Manager of three-room OR in rural Illinois

“Learning the six safety goals issued by JCAHO. The staff all adjusted very well and handled obstinate physicians with tact and professionalism.”

“We are fully staffed. Our focus has shifted from recruitment and retention to retention and attraction. We have worked with the medical staff to comply with the National Patient Safety Goals. We have increased our volume 16% in the past year. We celebrate often, and the staff are quick to applaud exceptional work. Life is good.”

—Manager of ambulatory surgery center

“This is our tenth year for a summer extern program. Three students in their junior year spend 10 weeks learning basics of OR nursing. The intent is to have three available full-time RNs each year from our school of nursing.

—Director of 15-room OR in Pennsylvania

Future conferences

Future dates for conferences offered by OR Manager, Inc:

Managing Today’s OR Suite
Oct 6 to 8, 2004
Hyatt Regency Chicago

Oct 12 to 14, 2005
Manchester Grand Hyatt San Diego

OR Business Management
May 12 to 14, 2004
Hyatt Regency Downtown Albuquerque, NM
Running a surgical suite is a difficult job but also a satisfying one, judging from responses to the OR Manager Salary/Career Survey.

The overwhelming majority of managers say they are satisfied with their support and communication from senior management. Though in the past, managers have counted among their challenges friction with physicians and staffs who were reluctant to change, in this survey they report a high level of satisfaction with their professional relationships. Nearly all managers say they have a positive relationship with their MDs. And nine out of ten say they have a cohesive staff.

Though budgets for education have been cut in recent years, most feel they have adequate opportunities for continuing education. Satisfaction on this issue was a little lower for ambulatory surgery centers.

Satisfaction dipped in two areas—pay and recognition. A slimmer majority thinks their pay is in line with their responsibilities, and many would like to see more recognition for what they achieve.

OR directors’ satisfaction with pay is on a par with that of chief nurse executives across the country; 60% thought their pay was fair and equitable in a survey by recruiters Witt/Kieffer. This is the first year the survey has asked about managers’ satisfaction.

### How satisfied are you with your position?

**Do you believe...**

<table>
<thead>
<tr>
<th></th>
<th>Hospitals</th>
<th>ASCs</th>
</tr>
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<tbody>
<tr>
<td>you receive adequate</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>support from upper</td>
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<td>No 15%</td>
</tr>
<tr>
<td>management?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>you receive adequate</td>
<td>79%</td>
<td>80%</td>
</tr>
<tr>
<td>communication from</td>
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<td>No 20%</td>
</tr>
<tr>
<td>your administration?</td>
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<td></td>
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<tr>
<td>you have a positive</td>
<td>98%</td>
<td>99%</td>
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<td>relationship with</td>
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<td>No 1%</td>
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<td>your physicians?</td>
<td></td>
<td></td>
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<tr>
<td>your staff works</td>
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<td>93%</td>
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<td>together as a cohesive</td>
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<td>No 7%</td>
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<tr>
<td>team?</td>
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<tr>
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<td>78%</td>
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<td>No 22%</td>
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<tr>
<td>continuing education?</td>
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<td></td>
</tr>
<tr>
<td>your salary structure</td>
<td>56%</td>
<td>61%</td>
</tr>
<tr>
<td>is commensurate with</td>
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<td>No 39%</td>
</tr>
<tr>
<td>your position?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>you receive adequate</td>
<td>62%</td>
<td>67%</td>
</tr>
<tr>
<td>recognition for your</td>
<td>No 38%</td>
<td>No 33%</td>
</tr>
<tr>
<td>achievements?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OR Benchmarks plans study of gastric bypass

With bariatric procedures growing annually, facilities are interested in measuring their costs. OR Benchmarks is conducting a special study of the laparoscopic gastric bypass procedure.

Some 80,000 bariatric procedures were performed last year, and the number is expected to climb to 120,000 this year. The number of people eligible for the procedure is expected to grow by 10% to 12% per year.

Insurance plans are often reluctant to pay for this procedure. Facilities that know their costs will be able to calculate their return on investment and will be in a stronger negotiating position with payers.

OR Benchmarks’s procedure studies include direct costs for supplies, anesthesia, and labor. Case times are included for the procedure as well as for prep, induction, and turnover times. Facilities’ costs will be compared with like facilities. Differences in costs are analyzed to point out opportunities for cost savings.

The fee to participate is $1,500. To register on-line, go to www.orbenchmarks.com or for more information, call Judy Dahle, RN, MS, director of OR Benchmarks, at 877/877-4031.

### Boomers busting for bionics

New vanity procedures for aging baby boomers range from shoulder repairs to knee-cartilage-cell transplants, according to the Aug 22 Wall Street Journal.

Helping spur the movement are new procedures with shorter recovery times, plus the fact that insurance companies pay for many of these procedures. Experts say this helps explain a jump in orthopedic surgery.

Oxford Health Plans reports a 63% rise in arthroscopic shoulder surgeries in middle-aged patients in the past 3 years. Knee replacements doubled in the 38- to 56-year-old age group from 1996 to 2001.

Hospitals and manufacturers are pumping these procedures with TV, print campaigns, and pop-up ads on the web. Lost in much of the advertising, however, is the fact that these procedures may involve painful recoveries, and boomers don’t recover as easily as they did in their 20s.

Please see the ad for TRUMPF MEDICAL INC. in the OR Manager print version.
Big growth forecast for surgery by 2020

The over-65 population will swell by 53% by 2020. Who will perform their surgery?

Not only will perioperative RNs be in short supply. Surgeons could also be scarce.

A new study from UCLA finds the demand for some types of surgery could increase by nearly 50% in the next 20 years.

Cataract procedures will see the biggest growth—47%—followed by cardiothoracic surgery, expected to rise by 42%.

Growth also is forecast for urology (35%), orthopedics, and neurosurgery (both 28%). General surgery will increase by 31%.

The only specialty that won’t keep pace with the population growth is ear, nose, and throat because a large share of those procedures are performed in patients under 15.

Enough surgeons?

“We may wake up and find ourselves without enough surgeons to provide surgical care,” says David A. Etzioni, MD, a general surgeon at UCLA and lead author of the study.

He and his colleagues conducted the study by obtaining government data on age-specific rates of procedures in 1996, calculating the amount of surgical work involved, and combining that with population forecasts to predict the future use of surgical services.

Basically, he says, “We took a snapshot in time to ask what would happen if services are provided at the same rate they are now.”

This approach has some limitations because it assumes the demand for surgery will remain constant. This could change with new technology and more noninvasive therapy, though he notes that hasn’t happened yet.

“There is the misguided notion that medical therapies are going to make the OR a dinosaur,” Dr Etzioni says. “But as a result of increasing technology, we’re seeing more procedures, some of which are minimally invasive.”

But trends in the physician workforce have been notoriously hard to predict. In the 1980s, a report projected there would a surplus of 145,000 physicians. A follow-up report in 1991 conflicted with the earlier findings and forecasted the need would grow in certain areas.

Technology has an influence. Coronary artery bypass surgery has fallen by more than 20% while cardiac stent procedures have doubled.

Predicting need difficult

Any attempt to predict the need for physicians is difficult, Richard Cooper, MD, another labor force researcher at the Medical College of Wisconsin’s Health Policy Institute in Milwaukee, told American Medical News (Aug 25).

“You just can’t extrapolate a lot from surveys that way,” Dr Cooper said. “Who knows what will happen next year, let alone in 10 years? It’s a given an aging population will need more hips and knees and things. You only know they’ll need more, but you don’t know what it will be.”

On the other hand, Dr Etzioni notes that other recent analyses, including one by Dr Cooper, also project a shortage of physicians, particularly specialists, within the next 20 years.

<table>
<thead>
<tr>
<th>Surgeons’ workload could rise by 2020</th>
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</thead>
<tbody>
<tr>
<td>% Increase (relative to 2001)</td>
</tr>
<tr>
<td>US population</td>
</tr>
<tr>
<td>Cardiothoracic</td>
</tr>
<tr>
<td>General surgery*</td>
</tr>
<tr>
<td>Neurosurgery</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Orthopedics</td>
</tr>
<tr>
<td>Otolaryngology</td>
</tr>
<tr>
<td>Urology</td>
</tr>
<tr>
<td>Year</td>
</tr>
<tr>
<td>2001</td>
</tr>
<tr>
<td>2010</td>
</tr>
<tr>
<td>2020</td>
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</table>

*Category includes vascular, breast, hernia, abdominal, gastrointestinal, and pediatric procedures.

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Continued on page 20
Please see the ad for ADVANCED STERILIZATION PRODUCTS in the *OR Manager* print version.
Future of surgery

Continued from page 18

Doing more with fewer surgeons

Assuming demand for surgery rises, an important question will be how to help surgeons get more done.

“I think we’ll see change occurring on several fronts,” Dr. Etzioni told OR Manager.

“One solution is to train more surgeons. But that usually takes a decade. Even if we start when the shortage begins, we’ll be behind.”

Two other possibilities are to ask surgeons to work harder and for surgical facilities to make better use of their time.

Will surgeons work harder?

But will surgeons be inclined to work harder when malpractice premiums are rising and reimbursement is falling? In fact, the opposite seems to be happening, with some surgeons cutting back on their practices or retiring early.

“We didn’t do research on that,” Dr. Etzioni says. “But the implication is that if health care doesn’t treat surgeons well, they will vote with their feet.”

Physicians are leaving states that haven’t taken action to curb malpractice rates, for instance.

“Surgeons will be in demand. It is going to be up to states, hospitals, and health care systems to make them welcome,” he says.

Other possible strategies are relieving the paperwork burden and having ORs function more efficiently.

“Any surgeon and hospital could identify things surgeons don’t have to be doing,” he says. “That doesn’t mean absolving them of all nonprocedural work but making it so they can focus more on procedures.”

Some of the work might be diverted to other providers like physicians’ assistants and advanced practice nurses, he suggests.

“We might be seeing this in care before and after surgery,” he says. “We might also see it in some of the less intense areas. For example, you might have prolonged skin closures performed by nurse practitioners or PAs.”

That, of course, raises the question about whether there will be enough nurses and PAs to take on these roles.

Getting a life

Another trend that could affect the supply of surgeons is younger peoples’ wish for more control over their lives.

Medical students are paying more attention to issues like the amount of call and time for families when they choose a specialty. A new study led by E. Ray Dorsey, MD, MBA, published in JAMA found a strong association between specialties chosen by medical school seniors and controllable lifestyle.

There was a significant shift from 1996 to 2002, with the number of students ranking surgery as their first choice declining from 10.4% to 7.6%. Interest in anesthesiology, which is perceived to have a more controllable lifestyle, rose from 1.2% to 6.4%.

Another report found the percentage of senior students who thought general surgeons “inadequate control over their time” rose from 67% to 92% from 1997 to 2001.

“The students say they don’t want to work the long hours of my generation,” comments Kirby Bland, MD, FACS, of the University of Alabama, Birmingham, who studies the general surgery workforce.

“They see their colleagues in the ER with a 4-year residency without the same number of hours and the guarantee that when they’re off, they’re off.”

New limits in residents’ work hours by the Accreditation Council for Graduate Medical Education, which took effect July 1, have helped a bit. General surgery filled 99% of its residency slots this year, with 83% of those from the US, compared with 75% in 2002.

But medical students are looking far beyond residency to consider what kind of a life they want to live.

References


Call for abstracts: Share your successes

Have you developed a new program to retain perioperative staff or led a successful cost management effort?

Perhaps you have found creative ways to foster leadership in your staff or develop a culture of patient safety.

Or you might have heard a dynamic speaker you think your colleagues would benefit from hearing.

Share your ideas and successes with the planning committee for the Managing Today’s OR Suite 2004 conference. The committee is inviting proposals for the conference to be held Oct 6 to 8, 2004, at the Hyatt Regency Chicago.

Send a proposal of about 500 words describing the session you wish to present.

Provide enough information to give the committee a good understanding of the content.

Sessions are 1 1/2 hours long and focus 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.

The deadline for proposals and suggestions is Nov 1.

OR Business Management Conference

Proposals are also invited for the fifth annual OR Business Management Conference to be held May 12 to 14, 2004, at the Hyatt Regency Downtown in Albuquerque, NM.

Covered are topics such as financial management, materials and technology management, automation, and OR design and construction.

Please fax or e-mail proposals by Nov 1 to Billie Fernsebner, RN, MSN, education specialist, OR Manager, Inc, at 303/442-5960 or bfernsebner@ormanager.com

If you have questions, call her at 303/442-1661.
Please see the ad for CENSIS TECHNOLOGIES INC. in the OR Manager print version.
Self-scheduling an aid to staff retention

Self-scheduling is a strategy OR managers say is making a real difference in recruitment and retention.

Not only does it save management time, but it also provides OR staff the opportunity to be autonomous and control their work schedules.

OR managers and directors find that the accountability and responsibility fostered by self-scheduling lead to improved job satisfaction and professional growth. Unscheduled absences improve job satisfaction and professional growth. Unscheduled absences fostered by self-scheduling lead to the accountability and responsibility.

opportunity to be autonomous and control their work schedules.

Respect for staff needs

Self-scheduling attracts staff and shows respect for needs of staff, says Trish Barber, RN, clinical coordinator at Shands Hospital at the University of Florida, Gainesville.

As evidence, Barber says, the Shands operating room suite is fully staffed and does not have any travelers.

"Self-scheduling makes the employees happy, and happy employees do a better job for me and are more likely to be here every day," says Barber.

Shands has worked hard to get away from rigid policies that expected the staff to accept whatever schedule was given to them.

"The staff have total control over their schedules. They, not me, choose the times and days they will work," says Barber.

"It is impossible for staff to plan their busy lives around rigid schedules. We realize people have a life outside the OR, and they shouldn't have to choose between work and home."

When staff are given the responsibility to schedule their days and call, they learn to respect the needs of others and work together as a team.

The staff make the schedule out for 2 months at a time. They also make their own daily assignments in their specialty teams. Each specialty team has a lead RN and a lead surgical technologist. The teams decide which technologists and which nurses will work with which surgeons each day.

"They work it out however they want. As long as it is covered, it doesn't matter to me," says Barber.

The staff rarely present a schedule to Barber with an empty slot because they know she will have to put someone of her choosing in the slot. They know it is better to work it out among themselves, she says.

A cardiac team self-schedules

The staff's willingness to compromise, backed with a "ding list," is key to a successful self-scheduling program at Inova Fairfax Hospital in Falls Church, Va. The 30-member cardiac team began doing its own scheduling as part of the hospital's effort to promote self-governance by the nursing staff. One member became the scheduling go-to person, which was needed because the team is scheduled using a computer program.

The cardiac team has policies that address how vacations are assigned, when requests are due, and how seniority is used to determine who works at what time.

The cardiac team consists of all RNs with two surgical technologists. Two levels of RN first assistants (RNFAs) also are on the team. The more experienced RNFAs harvest the saphenous vein and radial artery, whereas the other RNFAs suture and assist the surgeon. Both levels must be accounted for in the schedule.

"The trickiest part is in making sure we have the right complement of people," says the scheduling go-to person, Mary Dellinger, RN, CRNFA.

The staffing guideline says the OR will run four rooms at 6 am, and the staffing pattern will consist of a scrub person, a circulator, and two RNFAs, one of whom must be more experienced. Four staff members are on call each night. The schedule must also consider those who work 8-, 10-, or 12-hour shifts.

What works well is for each member to choose a night as his or her call night. The 10- and 12-hour staff are scheduled to be off following their night of call in order not to disrupt the staffing for the next day if they must work all night. Who gets which call night and the day off is determined by seniority. As new people join the team, the call nights might need to be adjusted to maintain the right complement of staff.

"The worst part of self-scheduling is that people get attached to their call nights and don't want to move," says Dellinger. "However, everyone knows we have to have the competency levels and shifts evenly distributed, and we have to assign ourselves, so we work it out."

Three people are allowed to be on vacation at a time. To use their seniority, staff must submit their vacation requests by certain posted dates. After that, requests are taken by date submitted. The staff sign up for the weekends they would prefer to work. Using an alphabetical list, weekends are rotated according to the staff's preferences and to maintain the proper complement.

For holidays, the staff is divided into seven groups, each with the proper complement of staff. The staff take one holiday each year and rotate through the holiday groups; ie, they work on Thanksgiving once every 7 years. Those who worked the holiday the previous year get priority for vacation during that holiday the next year. As staff come and go, the groups are adjusted to maintain the right mix of staff.

When a call night is not filled or someone who is on call is sick, Dellinger uses a rotation list, nicknamed the "ding list." The person at the top of the list gets "dinged" to take the call. That person can take the call or work out a deal with another staff member. Once that person takes the call, he or she goes to the bottom of the list. This saves time in trying to arrange

Continued on page 24
Meeting productivity targets

As part of self-scheduling, the St John staff must meet targets for the number of worked hours per case using the center’s productivity tool. They figure out exactly how many hours they can staff on a given number of cases, maintaining between 95% and 110% productivity.

The staff have learned how to calculate the number of worked hours they can schedule based on volume, which may change every day, says Dendy.

Right now, the target for worked hours per case is 12.12 (includes the nurse anesthetists), based on 22 cases and upward. The OR component needs to stay at 3.45 worked hours per case. “We divide the number of cases by the number of staff to come up with the hours that we actually work per case,” says St John Surgery Center manager Joanna Rabaut, RN.

“It has been a huge buy-in for the staff,” Dendy adds. “They are learning to become more accountable, which helps all of us to be accountable to those targets.”

An inclusive plan

Central DuPage Hospital in Winfield, Ill, formed an OR staffing committee to oversee staff scheduling for its 22 ORs. The committee has five members who are rotated alphabetically every 2 years.

The staffing committee is not exclusive but inclusive, notes Joe Bonura, RN, BSN, past committee member and OR staff educator.

Members include surgical technologists, charge nurses, 12-hour staff, evening shift staff, and perioperative care technicians. All staff are represented, and committee members understand every shift and role, giving everyone a voice.

“It is the whole community setting rules and setting responsibilities for everybody,” says the director of perioperative services, Michelle Chotkowski, RN, BSN, MSHA.

“The system works because people are informed,” adds committee member Lee Barnes, RN. “The staffing committee was formed because the staff felt they needed some representation. It works because people know the rules. They know they have to sign up for call. They know they are responsible for a certain number of hours of call, and everyone has to take their turn.”

The committee has a book in which they keep track of how much paid time off staff members have coming. There also is a request book in which staff write their requests for time off and call requests during a 6-month period.

The committee has determined that five staff members can be off per day. At least the first three or four staff on the list can have the day off; the other two slots are reserved for anyone who may have worked a Saturday and wants a day back, says Julianne Davis, RN, BSN, charge nurse of the neuro service and staffing committee member.

Covering specialty call

Because the OR staff is divided into teams, the staffing committee also has to look at how many staff from a certain team have asked for time off. The team concept also affects call because call is divided into specialty call and first call. For example, if an emergency craniotomy case comes in, the neuro team member on call would be called in to scrub, and the first-call nurse would be called in to circulate.

As the staffing committee gives days off, they also look at the specific services to see if there are, for example, enough orthopedic members scheduled to run the orthopedic rooms for the specific day.

DuPage also has an in-house registry, so if someone needs a day off that can’t be provided for by the OR staff, the person can arrange with a registry nurse to work. It is the staff nurses’ responsibility to find a replacement.

Christmas and Thanksgiving are assigned differently. Call on these days is assigned by seniority in conjunction with a lottery system. Names are drawn, then assigned days off according to seniority so the same persons don’t get the same holidays off every year. Because many of the staff have been in the OR more than 30 years, “someone almost has to expire so the rest of us can move up on the seniority list and get the holidays off,” jokes Bonura.

If a call slot can’t be filled, and no one will volunteer, the committee looks back at the previous month to see who took the least amount of call. That person will be assigned to take the call.

—Judith M. Mathias, RN, MA
Please see the ad for MOLNLYCKE HEALTH CARE INC in the *OR Manager* print version.
California’s nursing schools hampered by state’s budget crisis

Hampered by a state budget crisis, California’s community colleges are having trouble hiring enough faculty for nursing programs. That is keeping the colleges from enrolling more nursing students to help meet demands of the state’s mandatory staffing standards, which take effect in January, the Aug 28 Wall Street Journal reports. In the meantime, hospitals are recruiting nurses from the Philippines, Australia, and New Zealand.

Community colleges prepare almost two thirds of California’s nurses.


Foreign nurses must meet new requirements

Foreign nurses and other health care workers seeking temporary admission to the US will have to comply with new certification requirements in a final rule from the Department of Homeland Security (DHS). Workers entering the US health care system after Sept 23 must present a certificate from an approved independent credentialing organization.

For 1 year after publication of the final rule, DHS will approve applications for change of status or extension of stay for nonimmigrant health care workers to help ensure the rule does not disrupt care.


Health care management still dominated by white males

Despite efforts to promote racial and gender diversity, health care management continues to be an old boys’ network, according to a study by the American College of Healthcare Executives. The survey of 1,621 healthcare executives in 2002 showed the industry actually slid backward in promoting women and minorities compared with previous studies in 1992 and 1997. White females made some gains, with some 40% holding the titles of CEO, COO, or senior vice president—up from 35% in 1997. In 2002, 44% of black males responding were CEOs, COOs, or senior vice presidents—compared with 43% in 1997.


Physician compensation increases slightly or not at all

Physicians’ pay was up slightly in 2002, though some specialties experienced decreases. Primary care physicians had a 2.8% median increase, and specialists had a 4.3% median increase. But invasive and noninvasive cardiologists reported decreases of 6.2% and 3.9%, respectively in a survey by the Medical Group Management Association (MGMA) of Englewood, Colo.

Pay is stagnant or declining though demands on practices are growing. Factors affecting compensation are increasing practice costs, especially labor, drugs, supplies, and malpractice insurance, coupled with cuts in reimbursement.

—www.mgma.com

Please place here the PDF file:

CDROMAd.pdf

included with the OR Manager files from Karen Gerhardt
Raisers for ambulatory surgery center (ASC) managers dropped back this year after outpacing raises for hospital-based OR managers for 2 years.

The average raise was 3.9% this year, compared with 6% in 2002 and 6.5% in 2001. Hospital OR leaders averaged 4.6%.

But more ASC managers received a salary boost this year—86%—compared with 78% last year.

The annual base salary of $73,213 is not as high as the $81,694 average for hospital-based OR directors. But for smaller facilities, the salaries are about the same. An ASC manager overseeing fewer than five ORs earns an average of $69,715, while a hospital-based OR manager responsible for an equivalent-sized department makes $70,074.

The 13th annual OR Manager Salary/Career Survey polled 607 ASC managers of centers performing general surgery. The list included OR Manager subscribers. In all, 150 responses were received, for a return rate of 26%.

What ASC managers earn

Annual salaries. Managers in the East and West had the highest salaries, with those in the South lagging. Pay in joint-venture and hospital-owned centers is higher than that in physician-owned centers.

Raises. The South and Central states were most generous with raises, with 88% of managers in both regions receiving a pay increase. That compares with 84% in the West and 79% in the East. All respondents from hospital-owned centers got a pay boost, compared with 85% of those in joint ventures and 82% in physician-owned facilities.

The biggest raises—4.6%—were reported by leaders from joint-venture facilities. Hospital-owned centers granted an average of 3.1% and physician-owned facilities an average of 3.4%

Incentive bonuses. Surgery center leaders are more likely than their hospital counterparts to be eligible for incentives like profit sharing. More than half—55%—qualify for such a plan, while 40% of hospital OR leaders do.

Incentives are much more common in physician-owned centers (60%) and joint-venture facilities (59%) than in hospital-owned ASCs (36%).

The average bonus paid was 9.7% of base salary, with 30% of managers receiving more than 10%.

Benefits

Benefits packages for ASC leaders have improved substantially in the past 5 years. They are much more likely to receive most kinds of insurance as well as tuition reimbursement. Like many workers, though, several wrote that they have seen their insurance costs rise as employers shift more of the cost of swelling insurance premiums to their employees.

ASC benefits are leaner than what hospitals offer. Except for health insurance, all benefits included in the survey are less common in ASCs. The biggest gap is for tuition reimbursement, offered by 54% of ASCs and 90% of hospitals.

Continued on page 28
Benefits for ASC managers

<table>
<thead>
<tr>
<th>Benefit</th>
<th>2003</th>
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</thead>
<tbody>
<tr>
<td>Health insurance</td>
<td>98%</td>
<td>95%</td>
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<tr>
<td>Dependent health ins</td>
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<td>40%</td>
</tr>
<tr>
<td>Dental insurance</td>
<td>84%</td>
<td>61%</td>
</tr>
<tr>
<td>Life insurance</td>
<td>81%</td>
<td>74%</td>
</tr>
<tr>
<td>Disability insurance</td>
<td>75%</td>
<td>55%</td>
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<tr>
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<tr>
<td>Retirement plan</td>
<td>75%</td>
<td>—</td>
</tr>
<tr>
<td>Eye care</td>
<td>48%</td>
<td>43%</td>
</tr>
</tbody>
</table>

About the ASC

Joint-venture and physician-owned facilities dominated the survey, with 41% and 34% of responses respectively. Hospital-owned centers made up 15% of respondents, with others accounting for 11%.

Most of the hospital-owned centers have five or more operating rooms, while most owned by physicians have fewer than five ORs.

Ownership by number of ORs

<table>
<thead>
<tr>
<th>Ownership Type</th>
<th>&lt;5 ORs</th>
<th>5+ ORs</th>
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<tbody>
<tr>
<td>Hospital</td>
<td>38%</td>
<td>62%</td>
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<tr>
<td>Physician</td>
<td>77%</td>
<td>23%</td>
</tr>
<tr>
<td>Joint venture</td>
<td>47%</td>
<td>53%</td>
</tr>
</tbody>
</table>

About your role

Titles. The most common title held by leaders in this year’s survey is director (38%), followed by administrator (25%), and nurse manager (24%).

The nurse manager title was most common in hospital-based centers, while administrator was more common in physician-owned and joint-venture facilities.

Titles by ownership

<table>
<thead>
<tr>
<th>Title</th>
<th>Hosp</th>
<th>Physician</th>
<th>Jt vent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td>5%</td>
<td>31%</td>
<td>28%</td>
</tr>
<tr>
<td>Director</td>
<td>32%</td>
<td>39%</td>
<td>38%</td>
</tr>
<tr>
<td>Manager</td>
<td>50%</td>
<td>20%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Among other titles mentioned were clinical director of surgical services, OR coordinator, executive director, and surgery supervisor.

Reporting. More than half of respondents (51%) report to the administrator, with 21% reporting to the board of directors. Far fewer report to the medical director (13%), or the corporate office (5%), or some other office (11%).

Scope of role. Nearly all of the participants (94%) manage in a single facility, either overseeing the ORs only (49%) or the ORs and other areas (45%). Of the eight who manage at multiple sites, four are employed by a hospital.
Please see the ad for KARL STORZ ENDOSCOPY-AMERICA in the *OR Manager* print version.
About you
Age and gender. Like RNs in general, the age of ASC managers is creeping up, averaging 48 this year compared with 47 in 2002. Some 41% are over 50.
Most of the managers (87%) are female.
RN status. Nearly all ASC managers are RNs, with just 5% (7) holding other credentials. Six of the seven with another credential are male.
Education. The majority of ASC leaders (59%) hold a bachelor’s degree or higher. An associate degree is held by 25% and a diploma by 16%.
In all, 44% say their ASC requires a specific degree for their position. This is more common in hospital-owned centers (64%) than in those owned by physicians (40%) or joint ventures (46%).
When a degree is required, it is most likely to be a bachelor’s (64%), with fewer (15%) specifying a master’s. Joint ventures were more apt than other types of centers to require a master’s, with 20% asking for that degree.

Lobbying heavy on surgical hospitals

Lobbying on surgical hospitals has been intense as a House and Senate conference committee weighs whether to take steps to curb the growing industry.
The House and Senate passed differing amendments on freestanding surgical hospitals in their versions of the Medicare bill to create a prescription drug benefit.
The House bill simply calls for a study. But the Senate bill includes an amendment from Sen John Breaux (D-La) that would narrow the type of physician investments that would be protected under the Stark law.
The American Surgical Hospital Association has been lobbying against the curbs. Meanwhile, a newly formed Coalition of Full-Service Community Hospitals has hired a Washington law firm to lobby on behalf of acute-care hospitals in 13 states.
It was not clear in mid-September which side will win out.
Caught off guard
“Our Washington sources indicate the Breaux amendment caught many legislators in both House and Senate off guard,” says attorney Lorin Patterson of Shook Hardy & Bacon, Kansas City, adding that both houses have been struggling to understand the complex issues.
Specialty hospitals, which usually have physicians as owners and investors, argue that they provide efficient, cost-effective care both for patients and physicians. Community hospitals maintain these are “boutique hospitals” that siphon off the best paying cases and leave them with less money to support services and patients that are less well insured.
The Stark law in general prohibits physicians from referring Medicare and Medicaid patients to providers in which they have a financial interest. But the Stark law has a “whole hospital exception” that allows physicians who invest in a whole hospital to refer patients to that facility.
The Breaux amendment would exclude hospitals that focus on one specialty such as cardiac care or orthopedics from the whole hospital exception.
A lot of interpretation will be needed if the Breaux amendment passes, Patterson says, because it could give the government a lot of latitude in enforcement.
There also are questions about a “grandfathering” clause that would protect surgical hospitals currently under development from being covered by the amendment.
Meanwhile, state bills to regulate surgical hospitals in Ohio and Indiana have died in committee, Patterson reports.
Please see the ad for INTEGRATED MEDICAL SYSTEMS in the *OR Manager* print version.
Building an ASC team from the ground up

**She helps staff blend work and their personal lives.**

A team that works well together is key to making any surgical facility successful.

Teamwork helps keep cases moving and aids the type of communication that supports good customer service and patient safety.

Teamwork also boosts recruitment and retention. Staff who feel part of a team are more likely to stay, and attracting new employees is easier if a facility has a reputation for high morale.

But what if teamwork isn’t what it should be? How do you go about creating a team-based environment?

Donna Quinn, RN, MBA, CPAN, CAPA, found herself in that position when she became director of the Orthopaedic Surgery Center in Concord, NH.

It’s been a 3-year transition that involved an almost complete turnover of staff and required use of agency personnel for 3 months.

Now, she wrote in response to this year’s Salary/Career Survey: “We have a great staff, and everyone works together.”

In a phone interview, Quinn talked about how she turned the situation around.

**Setting expectations**

When Quinn was hired by the center, she found each of the groups—nurses and physicians—had its own agenda.

There was friction, for example, about nurses staying late for cases that ran past 5 pm. It had been taken for granted that the staff would stay late, no questions asked. The staff was not consulted over who would stay when cases ran over, which caused conflicts with their family and other commitments.

And not everyone was observing common courtesy and decorum with patients and coworkers.

In making the transition, Quinn drew on her 20 years of management experience. Her philosophy combines two basic concepts:

- setting clear expectations
- treating employees as she would want to be treated.

Though some facilities have written codes of conduct that employees are expected to sign and follow, Quinn doesn’t use a formal document.

She relies on professionalism to set the tone.

“It means setting behavioral expectations,” she says. “We are a business, and we need to act accordingly. There also is an expectation that you will work well with your coworkers.”

When employees don’t meet expectations, she attempts to deal with the situation openly and fairly.

“For example, if an employee is calling in sick often, you as a manager have to address that. The other employees are watching.”

She helps staff blend work and their personal lives.

**Hire for fit**

In selecting new employees, Quinn follows a business maxim used by the center’s affiliated hospital: ‘Hire for fit, train for skill.’ That means first seeking candidates who have the right blend of energy and a positive attitude. The technical skills can be taught.

“If people come in with the attitude, ‘It’s just a job,’ they won’t last,” says Quinn. They need to have a willingness to do what it takes to serve the organization and physicians.

She assesses an applicant’s “fit” by asking open-ended questions:

- Tell me about a conflict you’ve had with a coworker and how you resolved it.
- Tell me about a conflict with a physician and how you resolved that.
- How would your previous boss describe you?
- How would your peers describe you, in addition to your clinical skills?
- How would you handle a strong coworker who is opinionated?

“People are amazing in what they will tell you,” she laughs. “When they say in response to the questions on conflict, ‘I was right, and they were wrong,’ or ‘I avoid conflict,’ that tells you something.”

She also relies on her informal network of nurse colleagues for off-the-cuff references. In the small community, most know each other.

**Flexibility builds morale**

Quinn balances firm expectations with the second basic concept—to treat employees as she would want to be treated.

She helps staff blend work and their personal lives.

She also relies on her informal network of nurse colleagues for off-the-cuff references. In the small community, most know each other.

**Continued on page 34**
Please see the ad for MOBILE INSTRUMENTS in the *OR Manager* print version.
Instead, she helps the staff balance their work and personal lives. The typical workweek at the center is four 9-hour shifts, which is considered full time, which enables employees to have long weekends.

Arrangements are made for staff who have family or school needs.

“If an employee can’t get to work until 8:15 because she needs to get her children on the school bus, we will work with that,” she says. “If they need to attend a school function in the middle of the day, we let them.”

On occasion, the surgical schedule is adjusted to accommodate an employee. When one of the surgical technologists couldn’t arrive until 7:30 am because of a day care issue, the schedule was switched to perform a knee arthroscopy case, which requires one tech, before an anterior cruciate ligament repair, which requires two.

This flexibility “in itself is better than any financial reward,” she says, “and a happy staff is more productive.”

A per diem pool helps fill in the staffing gaps. Per diem nurses earn $3 an hour more than base pay and may work at several facilities in the community.

**Bonuses recognize success**

The center has started building in financial incentives to reward staff for meeting objectives. Last year for the first time, employees received a bonus in January in recognition of a successful year. The center is developing a bonus system that will pay bonuses based on quality indicators. The following indicators are tracked and posted each month:

- supply expenses per month
- total operating expenses per month
- turnover time
- patient satisfaction
- physician satisfaction
- physician start time.

How the results will be linked with rewards is still under discussion. But Quinn has found the staff already waits for the new charts to be posted.

When the center needs to recruit staff, it won’t have trouble recruiting.

“I have a list of people waiting to get in,” Quinn says.

Now in its fourth edition, the classic reference, *Core Curriculum for Perioperative Nursing*, has guided the orientation of thousands of OR nurses since it was first published in 1991.

This respected guide has been updated to reflect changing practice.

The book includes basic competencies for expected performance, lesson plans for classroom activities, outlines for clinical focus days, and performance checklists. The extensive references have also been updated.

As hospitals and ambulatory facilities face an increasing shortage of nurses, many are hiring nurses without OR experience and providing on-site training. This book is the perfect guide for such training.

The book can be used for orientation of nurses who are experienced in perioperative nursing as well as those who are new to this specialty.

**Order now from OR Manager**

$48 plus $7.95 shipping and handling

Call 800/442-9918 or order online at www.ormanager.com
Please see the ad for ENCISION, INC in the *OR Manager* print version.
CMS loosens emergency treatment rule

The Centers for Medicare and Medicaid Services (CMS) is revising its controversial emergency treatment rule to make it less onerous for hospitals.

The new regulation for the Emergency Medical Treatment and Labor Act (EMTALA) was published in the Sept 9 Federal Register and is effective Nov 10.

CMS Administrator Tom Scully said the revised regulation “carries out EMTALA in a common sense and effective way to ensure that people who come to hospitals seeking emergency care are promptly screened and stabilized.”

Rule revisions

Among the changes in the reg:
• Hospitals will have discretion in organizing on-call lists for physicians. Physicians will be able to be on call at more than one facility at a time. They also will be able to schedule elective surgery and other procedures during their on-call time. This may make it easier for hospitals to get more physicians to take call. Physicians have resisted call because, despite the EMTALA requirement, they often receive no payment for the many emergency patients who are uninsured. They also say emergency care leaves them open to more lawsuits at a time when malpractice premiums are skyrocketing.
• Off-campus departments will be able to care for emergency patients without moving them to the main campus if that will be best for the patient.
• EMTALA will not apply to off-campus clinics that do not routinely provide emergency services. The rules will apply to off-campus sites only if they are specifically licensed as an emergency facility, are held out to the public as a place that provides emergency care, or if emergency cases accounted for at least one-third of all of their outpatient visits in the past year. The old rule applied to all hospital departments, including those not on the main hospital campus.
• EMTALA does not apply to inpatients, including those who have been admitted through the emergency department.

EMTALA was passed in 1986 to address the issue of hospitals dumping patients who are uninsured. The law requires a hospital to provide medical screening to any person who comes to the hospital emergency department and requests treatment or an exam. If the case is an emergency, the hospital must either stabilize the patient or transfer the patient to another facility.

Hospitals that violate EMTALA can be dropped from the Medicare program and fined up to $50,000 per violation.

The American Hospital Association said it “welcomed the helpful and practical guidance” and supported CMS’s efforts “to remove barriers to the efficient operation of emergency departments.”

But critics said the revisions might make it more difficult for patients to get specialized care when they have an emergency.
Please see the ad for SPECTRUM SURGICAL INSTRUMENTS in the OR Manager print version.
Senators support $50 million for nurse funding

The US Senate voted Sept 10 to add $50 million in funding for the Nurse Reinvestment Act for fiscal 2004. The House previously voted for flat funding—a $0 increase. A House-Senate conference committee will have to resolve the difference.

The original Senate amendment offered by Sen Barbara Mikulski (D-Md) and Sen Susan Collins (R-Me) would have increased funds by $63 million. That would have brought funding for nursing workforce development to $175 million, the amount the American Nurses Association recommends.

—www.capitolupdate.org
—www.hospitalconnect.com

Senate Finance to investigate Tenet

Senate Finance Committee chairman Charles Grassley (R-Iowa) sent a harshly worded letter to Tenet in early September requesting documents.

Among other things, the committee asked for information on allegations of unnecessary heart surgery at Tenet’s Redding Medical Center in California.

“In the annals of corporate fraud, Tenet more than holds its own among the worst corporate wrongdoers,” said the letter, quoted in the Sept 8 Wall Street Journal.

Tenet has been faced with a series of government investigations since last fall. Jeffrey Barbakow, its previously praised CEO, resigned in May. Tenet’s reorganized board in September was considering whom to appoint as a replacement.


Smallpox vaccine compensation rule published

In an interim final rule, the Department of Health and Human Services outlined its policy for paying for injuries from smallpox vaccination. The rule lists the vaccine-related injuries that will be covered and the timeframes for making claims. Comments are due by Oct 27. The notice is in the Aug 27 Federal Register under the Health Resources and Services Administration.


Senate passes measure opposing new overtime rules

The Senate voted Sept 10 to oppose the White House’s plan to revamp overtime pay rules. Opponents say the rules would weaken workers’ rights to overtime pay. The vote was largely along party lines. Since the House endorsed the measure earlier this year, differences will have to be worked out in a conference committee. Ten nursing organizations, including the Association of peri-Operative Registered Nurses, wrote the labor department June 30 asking for the rule’s comment period to be extended.

The proposed rule was in the June 23 Federal Register.

—www.dol.gov/opa/media/press/esa
Please see the ad for DUPONT in the OR Manager print version.
Peaks and valleys in scheduled surgery strain ICUs more than emergencies

Contrary to popular belief, variability in scheduled surgery strains hospital capacity more than the random variation of emergencies, a new study shows. One result is wide swings in demand for ICU beds that in high-capacity hospitals mean patients get shunted to other departments such as the PACU or are refused admission altogether. Smoothing scheduled cases might be a better alternative to increasing hospital capacity than the usual remedies of rationing care or adding more staff and beds, suggest the researchers led by M.L. McManus, MD, of Harvard Medical School.


FDA approves new type of sterilizer

The Food and Drug Administration on Sept 3 authorized marketing in the US of a new ozone sterilizer and chemical indicator made by the Canadian company TSO3.

The company says the new 4.3 cu ft sterilizer is designed for sterilization of instruments that are not heat resistant, particularly those made of polymers. The process uses medical grade oxygen and water with only oxygen and water vapor as byproducts.

The TSO3 sterilizer will be distributed in the US by Skytron.

—www.tso3.com
—www.skytron.us

Medicare to cover lung reduction surgery

The Centers for Medicare and Medicaid Services (CMS) has announced it will pay for lung volume reduction surgery (LVRS) for patients with severe emphysema who meet criteria outlined by the National Emphysema Treatment Trial (NETT).

LVRS is designed to improve lung function by removing diseased portions of the lung to provide space for remaining healthy tissue.

Medicare decided to provide the coverage after the NETT—a 5 year, multicenter, randomized study—provided new evidence of the procedure’s safety, and cost-effectiveness in certain patients. Hospitals need to be accredited for LVRS to receive Medicare reimbursement.

—www.cms.hhs.gov
—www.jcaho.org

Why do CABG patients get readmitted?

The most common causes for readmission to the hospital within 30 days after coronary artery bypass graft (CABG) are postsurgical infection (28%) and heart failure (16%). In all, 13% of patients were readmitted in a study of all patients who had CABG in New York State during 1999. Eleven factors were independently associated with higher readmission rates: older age, female sex, African-American race, greater body surface area, previous myocardial infarction within 1 week, and six comorbidities.

After correcting for these, four provider-related factors also were related to higher readmission rates: annual surgeon CABG volume of less than 100, a hospital with a high mortality rate, discharge to a nursing home or rehab facility, and length of stay during CABG admission of 5 or more days.


Canadian health care system offers cost savings

The US spends three times as much per patient as Canada processing paperwork, a study from Harvard Medical School finds. This partly owes to wrangling over who is going to pay the bill, according to press reports.

The Harvard researchers found savings from a national health-insurance system like Canada's would be enough to provide health insurance for the 41 million Americans who lack coverage.

The study estimated Americans spent $294.3 billion, or more than $1,000 per patient, on health care administration in 1999. That compared with $307 per patient in Canada.

Another opinion, offered by Henry Aaron of the Brookings Institution, noted the US costs cited in the study could be exaggerated by 24%, and the research doesn’t consider labor and other costs, which are higher in the U S.