# Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 30 Years

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## IN THIS ISSUE




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# Outpatient surgery providers examine how to thrive in current economy

*(Editor's note: In this special issue of* Same-Day Surgery, *we explore the impact of the current economy on outpatient surgery. We've included a status report, an economic outlook, an examination of the impact of the Obama administration, and cost-cutting tips.)*

A decline in elective surgeries. Fuel surcharges. Hospitals and surgery centers cutting costs, but some still having to close. The economy is having an impact on outpatient surgery at all types of facilities and at all levels.

"We're all concerned, clearly, about the economy," says **Kathy Bryant**, president of the Ambulatory Surgery Center Association. "Many of our concerns are the same: that people have a means for paying for health care in the future."

Bryant wonders if this is what providers faced in The Great Depression. "I assume most of us think, this is as bad as it's going to get," but the news just keeps getting worse, she adds.

Thirty percent of hospitals have reported a moderate to significant decline in patients seeking elective procedures, according to a report from the American Hospital Association (AHA).[1] Ambulatory surgery visits are down 0.6% for the third quarter of 2008, compared to the third quarter of 2007, according to DATABANK data included in the AHA report. According to *The Wall Street Journal*, knee replacements fell 18.6%

## EXECUTIVE SUMMARY

Outpatient surgery providers are feeling the impact of the economic decline in terms of declining elective procedures, increased charity care, staffing cuts, and decreased purchasing.

- Some providers are moving ahead with investment in bariatric surgery and cosmetic surgery programs.
- Look for areas to cut costs. **(See our list of ideas, p. 4.)**

between March 2007 and March 2008.[2]

Most hospitals are seeing an increase in the proportion of charity care, and the need for subsidized services is increasing, according to the AHA report.

Sixty percent of hospitals that responded to an AHA survey recently indicated they would make cuts or consider reducing administrative costs, while more than half had reduced staff or are considering such reductions.[3]

"Some hospitals are reducing staffing levels on slow days on a day-by-day basis," says **Stephen W. Earnhart**, MS, president and CEO of Earnhart & Associates, an Austin, TX-based ambulatory surgery consulting firm. "Most of the surgery centers having been doing that for some time," he adds.

Managers are more cautious, Bryant says. "So if you were considering adding another person, you might not be adding one," she adds.

There might be repercussions, according to a recent report from The Joint Commission.[4] Staffing shortages lead to increased wait times for surgeries, as well as canceled surgeries, according to information quoted in the report.[5]

And staffing isn't all that has been affected. "Some programs are cutting back on patient transportation, reducing free meals for surgeons and staff, and generally just belt tightening," Earnhart says.

Forty-five percent of hospitals are delaying purchases of clinical technology or equipment, the AHA report said. Even new surgery centers are being cautious, according to **Beverly A. Kirchner**, RN, BSN, CNOR, CASC, president of Genesee Associates in Dallas, which develops, manages, and consults with freestanding surgery centers.

Kirchner is getting ready to open a surgery center. While she is planning to spend $6 million on equipment in the next six months, "we're more cautious about what we buy, and we really negotiated hard to get rock-bottom prices on what we buy," Kirchner reports.

One vendor says manufacturers are starting to reduce their prices. "Surgery centers are getting a lot more cost-effective, cost-efficient, and cost-concerned," says **David Brucker**, marketing development manager for Ethicon Endo-Surgery in Cincinnati. "Vendors are having to cut costs to stay competitive."

Some vendors are more cooperative than others, according to Earnhart. "We are finding that vendors are less willing to offer to let expensive equipment sit in a facility for periods of time — trial periods — without a commitment of purchase," he says. "We are also noticing that vendors are requiring personal guarantees on new surgery centers, even those centers with strong hospital partners."

Some equipment vendors are very concerned, Kirchner says. "Sales reps are panicking; they're afraid hospital systems and surgery center systems will stop buying equipment, and they won't make their numbers," she says. There could be positive and negative impacts, Kirchner says. "They may drop costs for some of those of us who are still developing centers. On the bad side, they won't have enough reps out there to service us."

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So what should you do? "Do not make long-term changes for a short-term problem," Earnhart suggests. "Continue your marketing programs, and implement whatever revenue programs you are or were pursuing in the past."

Do not overreact, he emphasizes. "Health care is the best industry to be working in right now," Earnhart says. "Cut back on expenses that make sense in any economy, and expand programs that would make sense anytime."

Many see the current situation as "doom and gloom," but most of the world's economic changes are due, for the most part, to poor business practices in sectors such as banking, Earnhart reports. "In Texas, we have a saying, 'If you want to make an omelet, you have to break a few eggs.' Well, the eggs are breaking, and the end result will be pleasant," he says. "The financial structure in the next year or two will be a much stronger and stable place to do business."

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## Are you prepared for what is coming?

There is no crystal ball to consult, so how do you know what to expect, in terms of the impact of the economy?

It's difficult to spot trend trends yet, says **Kathy Bryant**, president of the Ambulatory Surgery Center Association. "Interestingly, where I would have expected to cut back — in plastic surgery — people have said not necessarily so," she says. "Some people have money and are spending it."

That thought is echoed by **Stephen W. Earnhart**, MS, president and CEO of Earnhart & Associates, an Austin-based ambulatory surgery consulting firm. ". . . [I]f anything, we are purchasing new equipment and expanding procedures to make additional revenue in programs such as bariatric surgery and more cosmetic procedures such as tattoo removal," he reports.

The aging population should bring increased cases, says **Beverly A. Kirchner**, RN, BSN, CNOR, CASC, president of Genesee Associates in Dallas, which develops, manages, and consults with freestanding surgery centers. "I've read that you'll see up to a 20% increase in surgery in the next five to seven years, due to baby boomers."

However, some sources say that procedures that rely mostly on self-pay, such as bariatric surgery, will be vulnerable. Outpatient surgery providers might start seeing an increase in self-insured and in COBRA coverage, Earnhart predicts. Those thoughts are echoed in a new report from The Joint Commission.[1] Hospitals can expect increases in publicly insured patients and uncompensated care due to an aging population and a continuing decline in employer-sponsored insurance, according to The Joint Commission. "This is expected to create more competition for the fewer patients to whom costs may be shifted," it says.

For hospitals to be economically viable, they must follow certain principles, which include addressing how general acute hospitals and specialty hospitals can both fulfill the social mission for health care delivery, The Joint Commission says.

The American Hospital Association (AHA) is urging congressional assistance for general acute hospitals. The AHA has urged Congress to place moratoria on Medicaid payment cuts to hospital outpatient services.[2]

"Hospitals are not immune to the pressures of a worsening economy," the association said. "Any changes to Medicaid and Medicare payments directly impact the health of our facilities and the patients we serve."

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1. The Joint Commission. Health Care at the Crossroads: Guiding Principles for the Development of the Hospital of the Future. Accessed at www.jointcommission.org/NR/rdonlyres/1C9A7079-7A29-4658-B80D-A7DF8771309B/0/Hosptal_Future.pdf.
2. American Hospital Association. Hospitals, Medicaid programs reeling from recession, AHA tells Congress. *AHA News Now* Nov. 13, 2008. ■

# Will new president mean less reimbursement?

All health care providers, including those in outpatient surgery, might face less reimbursement under health care reforms implemented by President-elect Barack Obama, according to **Kathy Bryant**, president of the Ambulatory Surgery Center (ASC) Association.

"It's difficult to do anything with no money in the federal budget," she says. With Obama promoting policies that would expand access to health insurance, there might be a tendency to cut health care reimbursement to pay for that access, she adds. "Maybe not ASCs specifically, but providers in general, and we'd be part of that," Bryant says.

In addition to health care reform, President-elect Obama faces economic woes, says **Rich Umbdenstock**, president and CEO, American Hospital Association. "The ballooning federal deficit and severely constrained state budgets mean that Washington will have to find ways to trim the federal budget and stem the tide of red ink," he says.

Any changes to the current health care system are likely to be incremental, Bryant predicts. "There will be changes that expand access that will mean the number of uninsured goes down," she says. "But for the most part, the system we already have will be the way we get health insurance."

President-elect Obama showed pragmatism on the campaign trail, which is positive because the "successful path to health care reform will be a phased approach," Umbdenstock says. "Finding and implementing solutions to our health care challenges is a big job, and we believe that doing it in a thoughtful and coordinated manner and getting it right the first time is more important than getting it done first."

In terms of health care reform, Obama is just one person, Bryant says, "and I'm not even sure he's even the most important person." She points to Sen. Edward Kennedy, D-MA, a longtime Senate leader on health care; Sen. Max Baucus, D-MT, chairman of the Senate Finance Committee; and Sen. Ron Wyden, D-OR, a longtime proponent of universal health insurance, as key figures.

The appointment of Senate Majority Leader Tom Daschle, D-SD, to serve as secretary of the Department of Health and Human Services is "interesting," Bryant says. "I don't think Daschle has an incredible amount of experience in health care," she says. However, he's a "quick learner," and has given a significant amount of support to Obama, Bryant says. "He'll have the ear of Obama, given all of his support of him," she adds. "It's good when people are in sync." *(Editor's note: For a full copy of Obama's health care reform plan, go to www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf.)* ■

# Multitude of tips for saving on equipment

*(Editor's note: This is the first part of a two-part series on saving money. This month we cover how to save on equipment and give you information on how adding surgeons results in cost savings. Next month, we'll cover how to stop throwing away money on supplies.)*

To cut costs for your outpatient surgery equipment, establish and enforce protocols for new product entry, advises **Peggy Camp**, RN, BSN, MSN, clinical resource director at HCA Supply Chain, Continental Division, in Denver.

"Control the flow of new technology," she advises.

Set up a purchasing decision-making hierarchy, suggests **Roger Pence**, president of FWI Healthcare, an Edgarton, OH-based consulting firm primarily for ambulatory health care providers. "Let team leaders make decisions on limited-dollar purchases, then supervisors at the next price level, then managers for greater amounts, and so on," Pence says. The lower the decision is made, the greater the probability of nonpurchase, because they'll think, "we really don't need it," he says. "The higher a low-dollar purchase is made, the greater likelihood it will be acquired — 'it's a small amount; buy it.'"

Only buy equipment when it has been justified by the requestor and approved by most or all of the users, he advises.

When you aren't using a piece of equipment, get rid of it, Pence suggests. "I hear all the nurses saying, 'What if the other one breaks?' Right. When was the last time it happened?"

Potential sales outlets include ads with the state surgery center/hospital association's newsletter or web site, fliers to other providers in the area, contacts with the original manufacturer, or an ad on eBay or your web site, he says. Be careful that the ad doesn't imply to patients that their care might have been provided with out-of-date equipment, he

says. "There are also numerous 'refurbished' equipment firms that buy used equipment," Pence says. "Or ask your medical staff," he adds. "They may have a contact that would be interested."

Also, you can give it to an organization that accepts equipment donations to take to third-world countries, which might give you a tax deduction. *(Editor's note: For information on an organization that links donors of medical equipment and supplies with charities, go to www.med-eq.org.)*

Purchase products considered environmentally friendly, Pence advises. The initial price might be higher, but long-term electric, water, and supply use is much less, he says.

Most of Pence's centers use a main medical gas shutoff valve. "If you leave the gas lines open — especially to anesthesia machines — they bleed a lot of gas out overnight and over the weekend," he says. "Installing the main shutoff near the supply tanks — and the last one out at night shuts it off and the first one in turns it on — saves dollars and potentially a delayed start by having an empty tank."

For older facilities that need to replace their heating, ventilating, and air conditioning (HVAC) systems, know that the less efficient/lower purchase price systems use much more energy, Pence says. "The efficient ones tend to be higher priced, but save operating expenses for the rest of their lives," he says. The sales company or installer can help calculate savings, Pence says. **(See another cost-saving story, below.)** ■

## Add new doctors, or lose money

When was the newest surgeon added to your center's staff?

"If it is more than one year, you are losing money now or definitely will be in the near future," says **Roger Pence**, president of FWI Healthcare, an Edgarton, OH-based consulting firm primarily for ambulatory health care providers.

The reason? "New physicians have new skills, new ways of doing procedures, use new equipment that can be faster," Pence says. Doing cases efficiently and faster is better and saves dollars, he adds.

Also, new surgeons bring new ideas, new techniques, and quicker ways to do treatments, he says. "It keeps the 'established' doctors on their toes," Pence says. As the existing practitioners age and eventually retire, you'll have built-in replacements, he says. "By being there, the new physician is developing a desire to use the center and will be ready to buy in as soon as possible," Pence says. "What is easier and less time-consuming: hunting up new doctors in town, or proposing to an existing utilizer the availability of ownership shares?" ■

## Update your disinfection, sterilization in one month

*Take time to study new CDC guidelines*

After a six-year wait, the Centers for Disease Control and Prevention (CDC) has finally released the updated guidelines on disinfection and sterilization. So what's the next step for outpatient surgery managers?

Study and apply them now, says **James T. Lee**, MD, PhD, a member of the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) during assembly of guidelines. Lee is affiliate surgeon, Department of Veteran's Affairs Medical Center, and professor of surgery (retired), University of Minnesota, both in Minneapolis.

"The bacteria that may cause infections in our patients have no way of knowing whether we are in a surgery center or main OR," he says. As a result, "it's my belief: We have to do by the book," he says.

OR staff always are looking for ways to cut corners, he says. "They're not evil; they're trying to save money," Lee says.

It's estimated that 80% of hospitals don't follow

### EXECUTIVE SUMMARY

Revised guidelines on disinfection and sterilization from the Centers for Disease Control and Prevention (CDC) include the following:

- Grossly clean endoscopes before sterilization.
- Laparoscopes, arthroscopes, and other scopes that enter normally sterile tissue should be sterilized before each use. If this is not feasible, they should receive at least high-level disinfection.
- The CDC has a revised list of liquid chemical sterilants and high-level disinfectants that can be used to reprocess heat-sensitive medical devices, such as flexible endoscopes (www.fda.gov/cdrh/ode/germlab.html).

sterilization guidelines, he says. Surgery centers have a reputation for turning over ORs very fast, he says. "That's OK, because a lot are clean cases, but they must mop them down and follow a regimented plan," Lee says.

To ensure your facility is following these new guidelines, have your nurses and central supply examine one of the four chapters every week for a month, he suggests. "Have them discuss them in great detail with management present," he says. Go through the chapters page by page, and highlight items and discuss areas that stand out, Lee advises. "The problem is that if they don't do something like this, if they plop it on the desk of the OR manager or central supply, it's just a large bunch of paper," he says. "It's not going to be assimilated and digested."

The new document took so long to be released because the co-authors reviewed 26 years of literature, Lee says. The end result is very comprehensive guidelines, he says.

"You can take it to the bank in terms of being dependable," he says. In fact, Lee says "it may be the best guidelines ever to come out of the CDC." Additionally, this is a "sensitive" document with cost implications, he says.

One of the most important new sections of the new disinfection and sterilization guidelines from the Centers for Disease Control and Prevention (CDC) points to the need for cleaning endoscopes, says **James T. Lee**, MD, PhD, a member of the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) during assembly of guidelines. Lee is affiliate surgeon, Department of Veteran's Affairs Medical Center, and professor of surgery (retired), University of Minnesota, both in Minneapolis.

Lee says he has found that even trained and experienced professionals sometimes do not appreciate the importance of aggressively cleaning used surgical instruments before the sterilization step. Channeled instruments, which have small diameter openings, are particularly an infection problem, Lee says. "Surgeons are fascinated with small instruments, and you have to make . . . sure they're all sterile," he says.

Also, outpatient surgery managers should understand which instruments require sterilization and which ones require high-level disinfection, he says. Read the section on p. 17 of the guidelines about laparoscopes and arthroscopes, he says. "Those are frequently used, and people tend to cheat," Lee says.

The revised CDC guidelines spell it out: ". . . laparoscopes, arthroscopes, and other scopes that enter normally sterile tissue should be sterilized before each use; if this is not feasible, they should receive at least high-level disinfection."

Lee says, "A lot of people have gotten away with doing it without sterilizing arthroscopes, but the standard should be a sterile arthroscope." **(For updates on lists of disinfectants/sterilants and information on disinfecting surfaces, see stories below and on p. 7. To access the full guidelines, go to www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf.)**

Follow the Spaulding Classification System, which says anything that touches blood needs to be sterilized, suggests **Kay Ball**, RN, CNOR, FAAN, perioperative consultant/educator for

## List of disinfectants, sterilants changed

In its updated sterilization and disinfection guidelines, the Centers for Disease Control and Prevention (CDC) has revised its list of liquid chemical sterilants and high-level disinfectants cleared by the Food and Drug Administration (FDA) that can be used to reprocess heat-sensitive medical devices, such as flexible endoscopes. That list, available at www.fda.gov/cdrh/ode/germlab.html, includes the following:

- ≥ 2.4% glutaraldehyde;
- 0.55% *ortho*-phthalaldehyde (OPA);
- 0.95% glutaraldehyde with 1.64% phenol/phenate;
- 7.35% hydrogen peroxide with 0.23% peracetic acid;
- 1% hydrogen peroxide with 0.08% peracetic acid;
- 7.5% hydrogen peroxide.

The FDA has removed some items from its previous list. ■

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K&D Medical in Lewis Center, OH. "Anything that touches intact mucous membranes needs to be high-level disinfected," she says. Any piece of equipment that touches intact skin needs to be cleaned, Balls adds. "Anything less than these recommendations is unacceptable." ■

## What you need to know about disinfecting surfaces

In terms of cleaning surfaces in the OR, the Centers for Disease Control and Prevention (CDC), in its revised guidelines on disinfection, says, "The effective use of disinfectants is part of a multibarrier strategy to prevent health care-associated infections."

The CDC says if you use reusable cleaning cloths or mops, you should decontaminate them regularly to prevent surface contamination during cleaning, along with the subsequent transfer of organisms from these surfaces to patients or equipment by staff members' hands.

The CDC points out that some hospitals are using a new mopping technique that uses microfiber materials. The microfibers attract dust and are more absorbent than a conventional, cotton-loop mop, according to the CDC. Microfiber materials can be wet with disinfectants, such as quaternary ammonium compounds, it says. Microfiber systems prevent transferring microbes from room to room because a new microfiber pad is used in each room, it adds.

*[Editor's note: A list of methods of sterilization and disinfection is enclosed with the online version of this issue at www.ahcmedia.com. If you need help logging in, e-mail customerservice@ahcmedia.com or call (800) 688-2421.]* ■

### CNE/CME instructions

Physicians and nurses participate in this CNE/ CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

**Same-Day Surgery Manager**

## Steps to prepare for a disaster

By **Stephen W. Earnhart**, MS
CEO
Earnhart & Associates
Austin, TX

As we start a new year, this is a good time to do some internal housekeeping and defensive planning.

If you live in the northern states, you need to deal with blizzards, ice, and snow. The southern states generally must address hurricanes and tornadoes. The Gulf States have the hurricanes. California has its fires, floods, earthquakes, landslides, and general mayhem.

As the recent fires and hurricanes proved, we need to make sure that we are prepared, not only for the influx of patients, but for the potential physical destruction of our hospitals, surgery centers, and surgical suites. Hundreds of facilities were affected this year alone, and according to what we hear from reported experts, it is only going to get worse.

What would you take out of your facility if you only had one hour to prepare? Patient records? Computer hard drives? Employee and pay records? Where would you put them? Do you have boxes available? Who can carry all this? Where would you take it? What authority do you need to even take it out?

Being the "worst-case scenario" person that I am, I lie awake at night thinking about this. Hurricane Ike took our summer home, and we essentially lost everything because we didn't have a plan. It can happen to your facility as well.

Don't let a disaster be a disaster twice by losing more than just your physical plant.

- Determine what you critically need when you leave the facility and how you are going to handle it.
- Make sure your critical computer data are backed up off-site. Consider backing it up hourly online. Check with your IT personnel to see how to automate this process. More companies go out of business after a disaster because they lost their computer data.

• Don't forget payroll info.

• Scopes are expensive. What is the best method for getting your more expensive and portable equipment out. What about those expensive "towers?" They can be wheeled someplace safe.

• Plan! Plan! Plan!

Remember that after the disaster, you are going to need to get back in business as fast as possible. How you plan before it happens will determine how quickly you can get back after the excitement is over. *(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart @earnhart.com. Web: www.earnhart.com.)* ■

## CNE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

1. What should bring increased cases to outpatient surgery, according to Beverly A. Kirchner, RN, BSN, CNOR, CASC?

A. A new administration.
B. The aging population.
C. A turnaround in the economy.
D. None of the above

2. How can you control the flow of new technology, according to Roger Pence?

A. Set up a purchasing decision-making hierarchy.
B. Require those who want new technology to make a presentation that includes a return on investment.
C. Set a spending limit.
D. Establish a budget, and do not deviate from it.

3. What is the revised guidance from the CDC regarding laparoscopes, arthroscopes, and other scopes that enter normally sterile tissue?

A. They should be sterilized before each use; if this is not feasible, they should receive at least high-level disinfection.
B. They do not need sterilization.

4. What does the CDC say regarding a new mopping technique that uses microfiber materials?

A. The microfibers attract dust and are more absorbent than a conventional, cotton-loop mop.
B. Microfiber materials can be wet with disinfectants, such as quaternary ammonium compounds.
C. Microfiber systems prevent transferring microbes from room to room because a new microfiber pad is used in each room.
D. All of the above

**Answers: 1. B; 2. A; 3. A; 4. D.**

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# Recession-proof your job — How to thrive in tough economic times

*SDS Survey results show more received no or small increases*

Outpatient surgery managers are feeling the repercussions of the current difficult economy. With programs often performing fewer surgeries and some facilities being sold, careers seem less certain.

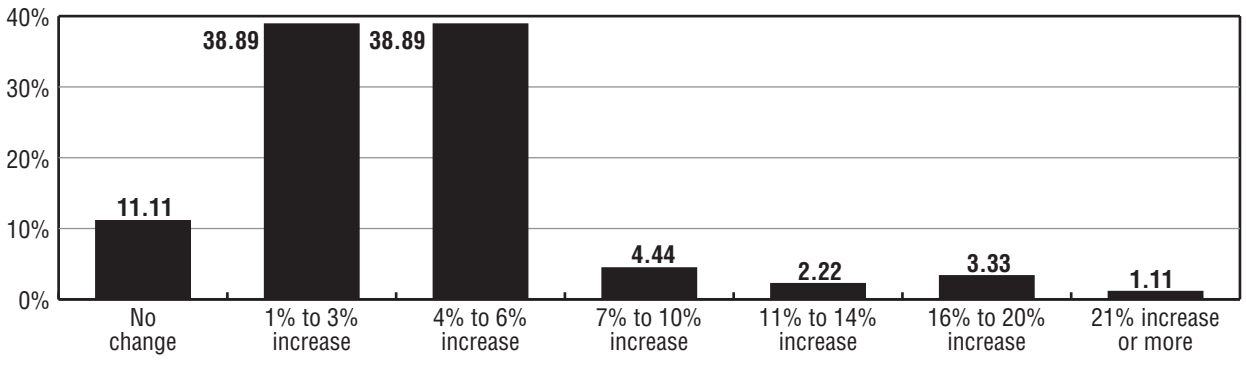
Some managers are even losing their jobs. Usually it's because a management company was brought in, says **Jane Kusler-Jensen**, RN, MBA, CNOR, BSN, director of perioperative services at River Woods and Ozaukee campuses, Columbia St. Mary's, Milwaukee. "They don't think financial margins are not where they should be, or there's been a change in partnership," Kusler-Jensen says. "Lots of times, the management company wants to put their own people in place," she says.

The 2008 *Same-Day Surgery Salary Survey* results indicate more people received no change in their salary (11.11%) than in 2007 (7.5%). Also, more (38.89%) received smaller increases of 1%-3%, compared to 31.25% who received raises of that size in 2007. **(See graphic, below.)**

Two things are happening, Kusler-Jensen says. One is that, depending on where you're located, reimbursement levels have declined, she says. "Margins are tightening up," she says. "Any time that happens, the market starts changing, as far as wages go."

The *SDS Salary Survey* was sent with the July 2008 issue to 581 subscribers. There were 90 responses, for a 15.5% response rate.

## In the Last Year, How Has Your Salary Changed?



Consider these steps to boost your job security:

**• Know what a management organization is looking for, and assess whether current management will stay.**

If a management company is going to come in, "work with them closely," Kusler-Jensen says. "Get an idea of their expectations for performance, both from an individual perspective and an organizational perspective."

**• Sell yourself.**

Be proactive in terms of keeping current in your knowledge of the organization and where in stands in terms of finances and quality, Kusler-Jensen advises.

**Paula Graling**, RN, MSN, CNOR, CNS, clinical nurse specialist of perioperative services, Inova Fairfax Hospital, Falls Church, VA, says, "I think the current managers must showcase their strengths and articulate what they can bring to the unit by having the historical perspective. They must utilize their intellectual capital, especially when it comes to dealing with the physician base." Intellectual capital might be knowledge of surgical procedures, the business, or quality outcomes, for example, she says. "I don't always know what the physician's need to consider, and they don't always know what I need to consider from the nursing aspect, but putting all of our viewpoints on the table and respect each other for their knowledge and opinion goes a long way to making sound decisions," Graling says.

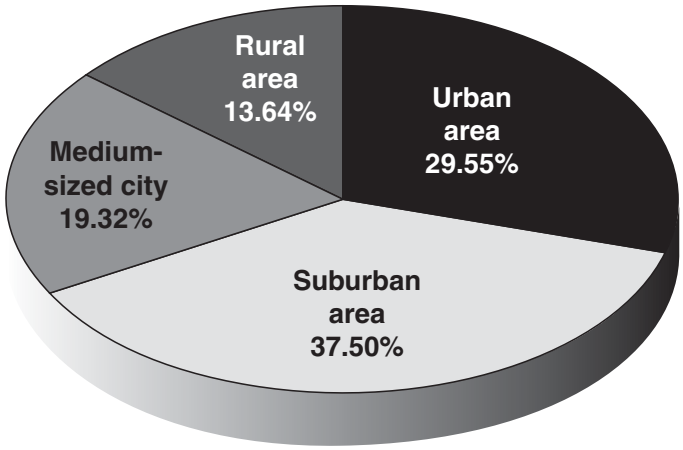
**• Obtain special training, education, and/or certification.**

Surgery center managers should obtain their certified administrator surgery center (CASC) credentials, says Kusler-Jensen, who helped developed some of the coursework for the certification. It shows a commitment to wanting to stay current in your position, she says.

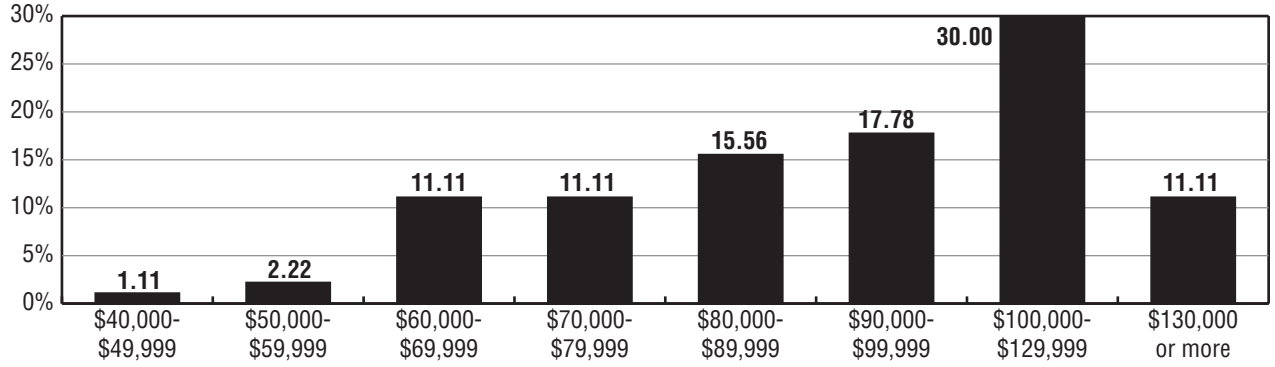
Identify areas for improvement, and get your skills up to speed, Kusler-Jensen says. "Health care is so complex, and so many skill sets are needed," she says. It's difficult to be strong in every area, Kusler-Jensen emphasizes. "Obviously accentuate your strengths, but make sure areas where you are a little weaker are fortified with CE."

For example, consider strengthening your business skills, says **Laurie J. Wensink**, RN, MBA, MSN, clinical director of perioperative services at Luther Midelfort Hospital in Eau Claire, WI. "I'm a firm believe in a master's program of some kind,

## Where is Your Facility Located?




## What is Your Annual Gross Income from Your Primary Health Care Position?



especially on the business side," she says. "I learned a lot by taking those business courses and really understanding the clinical side as well as the fiscal side. A combination is where we should be."

• **Know your options.**

Find out who is looking to fill positions, Kusler-Jensen advises.

"I think just having options keeps you more focused in a positive direction," she says. "The grass isn't always greener, but if a management company comes in and you lose your job, you'll have the ability to still have income coming in." ■

## Should you expect a big increase this year?

Will outpatient surgery managers be receiving large salary increases in 2009?

Probably not, says **Kathy Bryant**, president of the Ambulatory Surgery Center (ASC) Association. "I would expect increases not to be as robust as in previous years, particularly if hospitals are laying off people," she says. "Hospitals in a community often set wages that will be paid."

While the *Same-Day Surgery 2008 Salary Survey* results showed more people getting no raise or a low raise, it also indicates that managers at the high end of the wage scale were increasing:

• 17.78% make $90,000-$99,999, compared to 13.92% in 2007;

• 30% make $100,000-$129,999, compared to 22.78% in 2007;

• 11.11% make $130,000 or more, compared to 7.59% in 2007. **(See graphic, p. 2.)**

The shift might be attributed to the fact that the salary survey responses showed more people have worked 25 or more years in the field (23.6% compared to 17.5% in 2007).**(See graphic, below.)**

"The ambulatory surgery center market has matured," says **Jane Kusler-Jensen**, RN, MBA, CNOR, BSN, director of perioperative services at River Woods and Ozaukee campuses, Columbia St. Mary's, Milwaukee. "We're realizing that clinical expertise in hard-to-run ORs is critical knowledge you need to bring in." ■

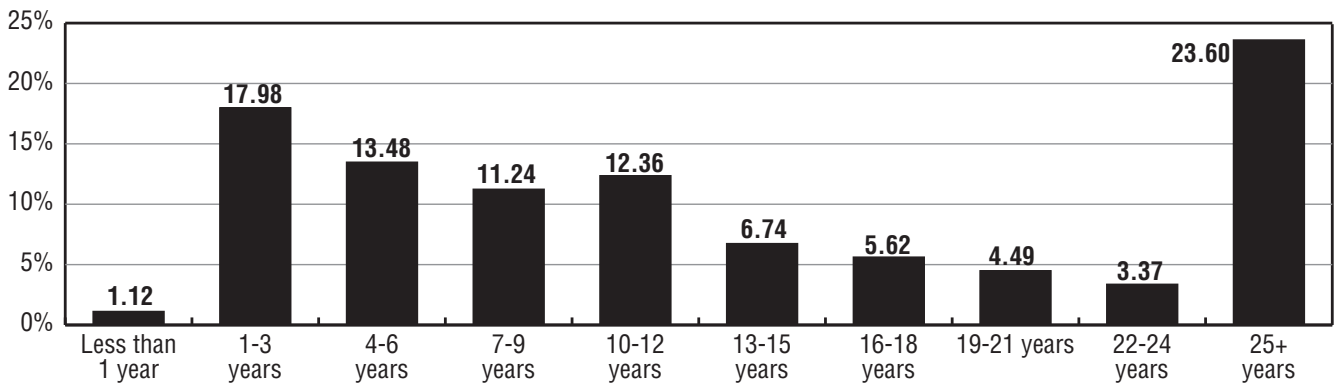
## Manage time with tips that some swear by

Outpatient surgery managers are increasingly facing larger workloads. The 2008 *Same-Day Surgery* Salary Survey results show that more than 92% of survey respondents work more than 40 hours a week. Almost 5% work 65 hours a week or more.

So how can you get it all done? The first key to better time management is to realize that the term actually is misleading, says **Barry Izsak**, a productivity expert in Austin, TX. You can't manage time, but you can manage yourself. "We all have time to accomplish our priorities if we identify them and then manage ourselves," he says.

Planning can be a bugaboo for managers, Izsak says. Planning is good, of course, but he says managers can not do it enough, or they can overdo it. Planning helps you become proactive with your time if it is done correctly, rather than

### How Long Have You Worked in Your Present Field?



simply being reactive running around putting out fires.

"At the end of the day, people should write down, while the day is fresh in their mind, the three big things you want to get done the next day," he says. "There still will be interruptions tomorrow, and maybe you'll only accomplish one or two of those things on your list, but even then you're far ahead of the game, better off than if you just came to work the next morning and started reacting to each new event."

## A better solution

Remember that working longer rarely is the solution when you feel overburdened or behind in your work, Izsak says. Better organization and planning can help you accomplish more than simply staying late at the office, he says. Having specific goals for the day, the week, and the month can help you stay on track and get the important work done, even if you are periodically interrupted and thrown off track.

"When people work 10, 12, and 14 hours a day, they are just spreading their inefficiency over a long-time period," he says. "Focusing on those top things you want to do in the day are really key. Schedule them in your planner just like a doctor's appointment or a meeting with your colleagues. You make those things happen because you schedule them, and so you need to schedule your main goals, too, or they're not going to get done."

Sometimes you must "defend your calendar," says **Pamela Dodd**, PhD, productivity expert in Orlando, FL. That means sticking with your scheduled activities unless absolutely necessary to deviate, she says. That includes your personal and family time, which can be the most difficult to defend.

Dodd also recommends determining your own "peak time," the time of day when you are most efficient. If that is your best time, schedule your day accordingly so that interruptions are minimized. Block out that time for your most important or most challenging tasks.

## Find a way to focus

**Drew Stevens**, PhD, a productivity expert in St. Louis, also emphasizes that a clear focus on the most important goals is key to making progress.

"If you're just staring at this huge pile of work that needs to be done, and the phone's ringing, and three people want your attention, nothing will ever be accomplished. You'll be overwhelmed and just respond to whoever's yelling the loudest at that moment," he says. "It is crucial that you seize control of your time and protect it. Don't make it available to just anyone. Keep your eye on the big picture, and apportion your most precious resource — time — wisely."

Stevens says there are four key steps to managing your time more effectively:

**1. Do not procrastinate.** Sometimes it helps to do the things you hate to do first and get them off of the plate.

**2. Do little things first so that you can get to the large items and focus on them.** It is easy to waste time thinking about the little items that are distracting you from the bigger tasks.

**3. Prioritize your tasks.** Do the things that are most important that day, and do not try to do more than you know is possible. It is better to accomplish your most important tasks than to have done a little bit of work on everything.

**4. Make a "don't-do" list.** These are the things that interrupt or waste your time. The list will vary for each person, but they might include web surfing, listening to the radio, or letting a co-worker sit down to chat.

Organization can help you feel more in control and minimize the time spent tracking down information or trying to remember what you're supposed to be doing. Tickler files can be especially helpful for an overburdened manager, Dodd says. There are things that you have to remember to do at a certain time or projects that you should check on periodically, so a tickler file can be a great way to make sure those things don't fall through the cracks, she says. Any calendar or electronic organizer will provide a way to plug in reminders, so be sure to fully use this option, she says.

Dodd also cautions about an overdependence on "organized piles." Sometimes even organized, neat people can become dependent on placing items in a pile here and another pile there, knowing all the time what the pile contains. But that just invites disaster, she says.

"Sooner or later, you're going to need something important, and you'll have to go tearing through those piles to find it. And you're probably the only one who has any idea what the piles are, so your assistant can't really help," she says. "Take the time to really organize and file things, even if it seems like another burden at the moment. You'll thank yourself later when you have to find that file in a hurry." ■

**Table 1. Methods of sterilization and disinfection.**

| | Sterilization | | Disinfection | | |
|---|---|---|---|---|---|
| | Critical items (will enter tissue or vascular system or blood will flow through them) | | High-level (semicritical items; [except dental] will come in contact with mucous membrane or nonintact skin) | Intermediate-level (some semicritical items[1] and noncritical items) | Low-level (noncritical items; will come in contact with intact skin) |
| Object | Procedure | Exposure time | Procedure (exposure time 12-30 min at ≥20°C)[2,3] | Procedure (exposure time ≥ 1 m)[9] | Procedure (exposure time ≥ 1 m)[9] |
| Smooth, hard Surface[1,4] | A | MR | D | K | K |
| | B | MR | E | L[5] | L |
| | C | MR | F | M | M |
| | D | 10 h at 20-25°C | H | N | N |
| | F | 6 h | I[6] | | O |
| | G | 12 m at 50-56°C | J | | |
| | H | 3-8 h | | | |
| Rubber tubing and catheters[3,4] | A | MR | D | | |
| | B | MR | E | | |
| | C | MR | F | | |
| | D | 10 h at 20-25°C | H | | |
| | F | 6 h | I[6] | | |
| | G | 12 m at 50-56°C | J | | |
| | H | 3-8 h | | | |
| Polyethylene tubing and catheters[3,4,7] | A | MR | D | | |
| | B | MR | E | | |
| | C | MR | F | | |
| | D | 10 h at 20-25°C | H | | |
| | F | 6 h | I[6] | | |
| | G | 12 m at 50-56°C | J | | |
| | H | 3-8 h | | | |
| Lensed instruments[4] | A | MR | D | | |
| | B | MR | E | | |
| | C | MR | F | | |
| | D | 10 h at 20-25°C | H | | |
| | F | 6 h | J | | |
| | G | 12 m at 50-56°C | | | |
| | H | 3-8 h | | | |
| Thermometers (oral and rectal)[8] | | | | | K[8] |
| Hinged instruments[4] | A | MR | D | | |
| | B | MR | E | | |
| | C | MR | F | | |
| | D | 10 h at 20-25°C | H | | |
| | F | 6 h | I[6] | | |
| | G | 12 m at 50-56°C | J | | |
| | H | 3-8 h | | | |

Modified from Rutala and Simmons. [15, 17, 18, 421] The selection and use of disinfectants in the healthcare field is dynamic, and products may become available that are not in existence when this guideline was written. As newer disinfectants become available, persons or committees responsible for selecting disinfectants and sterilization processes should be guided by products cleared by the FDA and the EPA as well as information in the scientific literature.

A, Heat sterilization, including steam or hot air (see manufacturer's recommendations, steam sterilization processing time from 3-30 minutes)
B, Ethylene oxide gas (see manufacturer's recommendations, generally 1-6 hours processing time plus aeration time of 8-12 hours at 50-60°C)
C, Hydrogen peroxide gas plasma (see manufacturer's recommendations for internal diameter and length restrictions, processing time between 45-72 minutes).
D, Glutaraldehyde-based formulations (≥2% glutaraldehyde, caution should be exercised with all glutaraldehyde formulations when further in-use dilution is anticipated); glutaraldehyde (1.12%) and 1.93% phenol/phenate. One glutaraldehyde-based product has a high-level disinfection claim of 5 minutes at 35°C.
E, Ortho-phthalaldehyde (OPA) 0.55%
F, Hydrogen peroxide 7.5% (will corrode copper, zinc, and brass)
G, Peracetic acid, concentration variable but 0.2% or greater is sporicidal. Peracetic acid immersion system operates at 50-56°C.
H, Hydrogen peroxide (7.35%) and 0.23% peracetic acid; hydrogen peroxide 1% and peracetic acid 0.08% (will corrode metal instruments)
I, Wet pasteurization at 70°C for 30 minutes with detergent cleaning
J, Hypochlorite, single use chlorine generated on-site by electrolyzing saline containing >650-675 active free chlorine; (will corrode metal instruments)
K, Ethyl or isopropyl alcohol (70-90%)
L, Sodium hypochlorite (5.25-6.15% household bleach diluted 1:500 provides **>**100 ppm available chlorine)
M, Phenolic germicidal detergent solution (follow product label for use-dilution)
N, Iodophor germicidal detergent solution (follow product label for use-dilution)
O, Quaternary ammonium germicidal detergent solution (follow product label for use-dilution)
MR, Manufacturer's recommendations
NA, Not applicable

[1] See text for discussion of hydrotherapy.
[2] The longer the exposure to a disinfectant, the more likely it is that all microorganisms will be eliminated. Follow the FDA-cleared high-level disinfection claim. Ten-minute exposure is not adequate to disinfect many objects, especially those that are difficult to clean because they have narrow channels or other areas that can harbor organic material and bacteria. Twenty-minute exposure at 20°C is the minimum time needed to reliably kill *M. tuberculosis* and nontuberculous mycobacteria with a 2% glutaraldehyde. Some high-level disinfectants have a reduced exposure time (e.g., ortho-phthalaldehyde at 12 minutes at 20°C) because of their rapid activity against mycobacteria or reduced exposure time due to increased mycobactericidal activity at elevated temperature (e.g., 2.5% glutaraldehyde at 5 minutes at 35°C, 0.55% OPA at 5 min at 25°C in automated endoscope reprocessor).
[3] Tubing must be completely filled for high-level disinfection and liquid chemical sterilization; care must be taken to avoid entrapment of air bubbles during immersion.
[4] Material compatibility should be investigated when appropriate.
[5] A concentration of 1000 ppm available chlorine should be considered where cultures or concentrated preparations of microorganisms have spilled (5.25% to 6.15% household bleach diluted 1:50 provides > 1000 ppm available chlorine). This solution may corrode some surfaces.
[6] Pasteurization (washer-disinfector) of respiratory therapy or anesthesia equipment is a recognized alternative to high-level disinfection. Some data challenge the efficacy of some pasteurization units.
[7] Thermostability should be investigated when appropriate.
[8] Do not mix rectal and oral thermometers at any stage of handling or processing.
[9] By law, all applicable label instructions on EPA-registered products must be followed. If the user selects exposure conditions that differ from those on the EPA-registered products label, the user assumes liability from any injuries resulting from off-label use and is potentially subject to enforcement action under FIFRA.

*Source*: Centers for Disease Control and Prevention. "Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008." Accessed at www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf.