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Should patients with obstructive sleep apnea be handled as outpatients?

Condition often is undiagnosed and may result in cardiopulmonary arrest

A hospital had seven respiratory arrests among its surgery patients in a short time period. A root-cause analysis surprised managers when it determined a common trait in all seven patients: obstructive sleep apnea (OSA).

A recent report in the *Anesthesia Patient Safety Foundation Newsletter* described eight cases of "unexplained" postoperative cardiopulmonary arrests.[1] "All patients received parenteral narcotics and were ultimately diagnosed with OSA," according to **Janet van Vlymen**, MD, FRCPC, assistant professor in the department of anesthesiology, Queen's University, Kingston General Hospital in Ontario, Canada. Van Vlymen participated in a discussion on sleep apnea published by the Park Ridge, IL-based Society of Ambulatory Anesthesia.

There are 19 cases of patients with OSA in the closed claims database of the Park Ridge, IL-based American Society of Anesthesiologists, according to van Vlymen. "In 18 of 19 cases, the patient sustained brain damage or death related to adverse respiratory system events," she wrote.

Some outpatient surgery providers report being "besieged" with patients having the diagnosis of obstructive sleep apnea, which is a sleep-related breathing disorder.[2]

"It's the newest patient syndrome on the horizon," says **Yvonne Mull**, RN, CNOR, former director of nursing at HealthSouth Alaska Surgery Center in Anchorage. Mull has published on the topic of OSA.

And there's even more frightening news. According to published reports, 80% to 95% of the approximately 18 million Americans believed to have OSA arrive for surgery without a diagnosis of OSA.[3-4]

David O. Warner, MD, professor of anesthesiology and vice chair for research at the anesthesia clinical research unit in the department of anesthesiology at the Mayo Clinic in Rochester, MN, says, "It is suspected that the numbers are increasing as average weight of the population increases, but it is equally likely that increased awareness of the syndrome, and improvements in diagnosis and treatment, account for

the fact that it seems we are seeing more of these patients."

Don't expect the number of patients with OSA to diminish soon.

"We do know that the number of patients with OSA is expected to increase five- to tenfold over the next decade," van Vlymen wrote.

What are the symptoms?

How can you recognize whether a patient has OSA? Sources and studies estimate that the percentage of patients with OSA who are obese ranges from 50% to 90%.[5-6] Symptoms of the condition include abnormal breathing during sleep (apnea and/or snoring), frequent arousals (periodic extremity twitching, vocalization, turning, and/or snorting) and daytime somnolence.[7]

Anesthesia may increase the number and duration of sleep apnea episodes and may decrease arterial oxygen saturation, according to the Washington, DC-based American Sleep Apnea Association. "Further, anesthesia inhibits arousals that would occur during sleep," it stated.[8]

Sedative medication, such as anesthesia, suppresses upper airway muscle activity, the association warned.

Grover R. Mims, MD, medical director of the Outpatient Surgical Center at Wake Forest University Baptist Medical Center in Winston Salem, NC, says, "The most important thing is being aware that these patients have problems, and [OSA] can cause problems in the immediate waking up of patients in the early post-op period."

The American Sleep Apnea Association says that given the nature of the disorder, it may be fitting to monitor sleep apnea patients for several hours after the last dose of anesthesia and opioids or other sedatives. The association suggested that possibly the monitoring should continue through one full natural sleep period. "Hence there is concern that same-day surgery . . . may not be appropriate for some sleep apnea surgery patients," the association stated.[8]

Most OSA patients are obese and need various therapies and equipment that aren't normally available in a same-day surgery facility, says **Jonathan L. Benumof**, MD, professor of anesthesiology at the University of California, San Diego Medical Center.

These requirements include specialized airway management equipment such as fiberoptic bronchoscopes, respiratory therapy treatment and equipment such as continuous positive airway pressure (CPAPs) and mechanical ventilator devices, monitoring equipment such as continuous pulse oximetry in the recovery room and elsewhere, and immediate availability of chest X-rays, arterial blood gases, 12-lead EKGs, and arterial and central venous catheters, he maintains.

Additionally, the facility needs to have skilled personnel such as respiratory therapy technicians, X-ray technicians, and EKG technicians who are available to come to the bedside with their equipment, Benumof says. "Often, those are not present in an outpatient facility," he says. Staff also should be skilled in areas such as advanced cardiac life support, he says.

Another reason to consider these patients for

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Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Valerie Loner**, (404) 262-5475, (valerie.loner@thomson.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@thomson.com).
Senior Production Editor: **Ann Duncan**.

Editorial Questions

Questions or comments? Call **Joy Daughtery Dickinson** at (229) 551-9195.

inpatient surgery is that the patient's increased sensitivity to narcotics and sedatives means that ventilation may be depressed, Benumof warns. "The arousal response is even more likely to be depressed, and because the arousal response is depressed, the severity of OSA will increase," he says.

Also, because most of these patients are obese, the chest walls are heavy, the lungs are small and carry less oxygen, and the tracheobronchial tree is small, Benumof says.

Airway resistance is decreased, and these obese patients have higher consumption of oxygen, he says. Additionally, consider the cardiovascular ravages of OSA, he says. "Many of these people have high blood pressure and cardiac enlargement."

When considering outpatient surgery on OSA patients, consider whether factors such as obesity, cardiovascular disease, as well as the OSA itself are mild or severe, he says. "You also have to decide whether the surgery is appropriate for an outpatient setting," he emphasizes.

If all of the factors are mild, and the procedure is appropriate, then an OSA patient can have outpatient surgery, Benumof states. However, if one single factor is severe, then patients should have inpatient surgery, he adds.

"It is absurd to think that we can manage a 5-foot, 8-inch, 440-pound, BMI equal 69, morbidly obese patient with a history consistent with severe OSA for an outpatient knee arthroscopy in the same manner as we do for a non-OSA, normal-weight patient," Benumof wrote in an article. "Nevertheless, this difficult problem is currently being presented to many anesthesiologists daily."[7]

A recent study by Warner and others shined a more positive light on outpatient surgery for OSA patients. This retrospective analysis indicated that the preoperative diagnosis of OSA was not a risk factor for unanticipated hospital admission or for other adverse events among patients undergoing outpatient surgical procedures in a tertiary referral center.[9]

However, van Vlymen says she found several problems with this study. "There was a very high unanticipated admission rate [24%], the controls were obese and not screened for symptoms of OSA, the OSA group was a mixture of treated and untreated, and there was no information about complications for patients who were sent home," she wrote.[2]

Warner says that most procedures that are less invasive enough to be performed as an outpatient in normal circumstances could be performed in many patients with OSA. "Typically, these would be procedures that do not require long-acting opioids for postoperative pain relief," he adds.

Ultimately, each institution needs to develop guidelines for managing these patients, van Vlymen said. "I think it is imperative that patients are screened preoperatively for symptoms of OSA and elective surgery postponed until they can be assessed and treated," she wrote. "Adequately treated OSA patients may be considered for ambulatory surgery if they are having minor surgery with minimal need for postoperative analgesics, are alert and are willing and able to use nCPAP [nasal continuous positive airway pressure] themselves at home for all sleep periods."[2]

Warner encourages more studies. "Most of the discussion and debate regarding these patients is occurring in the absence of good data and is driven by anecdotes of postoperative catastrophes," he says.

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For more information on obstructive sleep apnea, contact:

- **Grover R. Mims**, MD, Medical Director, Outpatient Surgical Center, Wake Forest University Baptist Medical Center, Winston-Salem. E-mail: gmims@wfubmc.edu.
- **Yvonne Mull**, 13320 Floral Lane, Anchorage, AK 99516.
- **David O. Warner**, MD, 200 First St. S.W., Rochester, MN 55905. E-mail: warner.david@mayo.edu.

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Sleep apnea patients require special handling

Because most sleep apnea cases have not been identified, it is not sufficient for same-day surgery providers to simply ask patients if they have sleep apnea, according to the Washington, DC-based American Sleep Apnea Association.[1]

Instead, health care providers must ask proper screening questions of patients, especially those individuals at risk for sleep apnea and those children undergoing a tonsillectomy and adenoidectomy, before making decisions on patient care, according to the association. Obstructive sleep apnea occurs frequently (30% to 40%) in obese children who have enlarged tonsils.[2]

In the preoperative area, routinely ask patients whether they have symptoms, advises **Yvonne Mull**, RN, CNOR, former director of nursing at HealthSouth Alaska Surgery Center in Anchorage.

Ask specifically about whether patients snore or are having problems sleeping at night, advises **Grover R. Mims**, MD, medical director of the Outpatient Surgical Center at Wake Forest University Baptist Medical Center in Winston Salem, NC. "Most of these people are world class snorers." Spouses often volunteer information, he says.

Also look for sleepiness, because these patients often don't sleep well at night, Mims adds.

If they have symptoms, ask if they have been diagnosed with sleep apnea, Mull advises. If they aren't diagnosed, alert the anesthesia provider, she suggests.

Sometimes patients arrive with a continuous positive airway pressure (CPAP) machine, and the staff wasn't aware that the patient used one. "Even if at the last minute, if they have CPAP machine, they were encouraged to use it," beginning the evening of discharge from the facility, Mull says.

According to the American Sleep Apnea Association, monitor the pressure of the CPAP to ensure that it is adequate.[1]

Consider these additional suggestions:

• **Examine use of medications.** "Logic would suggest that shorter-acting drugs would be preferable, although this remains to be proven," says **David O. Warner**, MD, professor of anesthesiology and vice chair for research at the anesthesia clinical research unit in the department of anesthesiology at the Mayo Clinic in Rochester, MN.

If you're going to err with medication, err on the light side, Mims advises. "We give narcotics to these patients very gingerly," he says.

These patients are especially sensitive to morphine, Mims said in a discussion published by the Park Ridge, IL-based Society for Ambulatory Anesthesia.[3]

• **Be particularly cautious with patients having airway surgery.** Patients who have had airway surgery can have problems recovering after surgery, Mims said. "I feel that these patients should be admitted overnight after general anesthesia and airway surgery," he said.[3]

• **Consider keeping all sleep apnea patients overnight.** HealthSouth Alaska Surgery Center keeps all sleep apnea patients overnight, Mull says. If they refuse, the medical director is consulted and the patient can be given the option of leaving against medical advice. The first 24 hours are critical, she says. "They may look like they're sleeping, but their oxygenation can be so low," Mull adds. "They desaturate."

Although the American Sleep Apnea Association stops short of saying all sleep apnea patients should be admitted, the association suggests letting sleep apnea patients remain under medical care until you're certain that their breathing will not be obstructed.[1]

• **Develop and maintain a good working relationship between the nurses, anesthesia providers, and the medical director.** The outpatient surgery staff must be cohesive, Mull says. "They need to be helping each other to identify patients [with sleep apnea] for their safety and well-being, even if they have only a hint of this syndrome," she explains. Ensure that the anesthesia staff realize the important of this issue, Mull suggests. "You need cooperation between anesthesia and nursing to provide these patients with the optimum post-anesthesia recovery," she adds.

• **Develop policies and procedures.** There is a desperate need for policies and procedures on acceptable outpatient surgery candidates that takes into consideration the particular problems and risks of obstructive sleep apnea (OSA) patients, sources say.

"Writing down the acceptable boundaries will necessarily increase medical awareness of the

disease and help to decrease the administration of anesthetics to risky patients in risky environments," said **Jonathan L. Benumof**, MD, professor of anesthesiology at the University of California — San Diego Medical Center, in a published letter to the editor in the *Anesthesia Patient Safety Foundation Newsletter.*[4] **[For a sample policy and procedure on OSA patients, go to www.same-day surgery.com. Your user name is your subscriber number on your mailing label. Your password is sds (lowercase) plus your subscriber number (no spaces). Look for the policy and procedure in the "toolbox" under "policies and procedures."]**

For example, there can be inappropriate scheduling of morbidly obese and/or severe OSA patients for outpatient surgery, Benumof tells *SDS*. "Many outpatient surgery facilities do not have the immediate availability of special equipment and personnel to handle these medically complex and challenging patients," he says. The wrong place equals adverse outcomes, he adds.

"The frequency and severity of adverse outcomes in OSA patients undergoing anesthesia and surgery will likely not decrease until these preoperative evaluation deficiencies, intraoperative airway, postoperative pain management, and outpatient scheduling problems are solved," Benumof wrote.

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Same-Day Surgery Manager

Do you really need that technology? Think first

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

No one — absolutely no one — likes gadgets and electronic toys more than me. Forget food; the fastest way to my heart is by giving me the latest and greatest gizmos. When I can afford it, I will indulge myself in a binge of credit card charges. When I cannot afford it, I pitifully look at that which I cannot have, right now anyway. That should (emphasis on the "should") be the case at our facilities.

Is technology getting to be a bit too much? How many monitors and diodes do we need to do a hernia repair, especially when we are dealing with healthy patients? Is there an end point? Actually there is. It's called "reimbursement."

How do we know when enough is enough? Do we need three 25-inch monitors in the operating room for the typical patient who will be going home in a few hours? Are we going just a bit overboard? When a physician recently was asked what he wanted in the new surgery center in the way of technology, he said that he wanted it to be "at least as good as what the hospital has, if not better." Well, sure, I would agree with that statement, but who is going to pay for all this technology? Certainly Medicare won't. And what is "as good as the hospital?" Is it the people, technology, or the equipment that makes it "good"?

Three goals for any surgical facility (or any business) are:

- patient/customer safety;
- quality of patient/customer experience;
- increasing profitability.

Throwing money after overkill technology does not necessarily add to patient safety.

Is there some sort of yardstick to determine what technology to buy? Depending upon your organizational structure, it might be the physician members of a surgery center, the information technology department of the hospital, the CEO, the physician users, or the staff who determine the spending habits on technology. Whoever it is also needs to determine who pays for it and the criteria for the payback.

Health care costs are beginning to spiral out of control again, just as they did in the early 1990s. We need to regulate ourselves and practice a bit of fiscal control — or someone else will come in and

do it for us. But, you ask, what about those occasional patients who really need this technology because they need the type of intensive monitoring this technology can buy? Don't they deserve it? You know, maybe that patient should be handled in the hospital and not in the surgery center.

We are continuing to do more and more intensive procedures in the ambulatory setting — but how long can we continue if we lose money on each case?

A good rule of thumb: If you think the equipment is excessive or the technology a bit overkill — it is.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 8303 MoPac, Suite C-146. Austin, TX 78759. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

What can be done to boost surgery safety in offices?

While a recently published review of Florida surgeries said that death or injury is 10 times more likely in the physician office setting,[1] another recently published report indicates a high level of safety in physician offices, at least with oral and maxillofacial procedures.[2] **(For more information on the Florida study, see *Same-Day Surgery*, October 2003, "Analysis examines surgery in physician offices," p. 119.)**

Of 34,000 patients who received office-based anesthesia for oral and maxillofacial procedures between January 2001 and December 2001, there were 24,000 patients who received deep sedation or general anesthesia. A surgeon aided by two to three anesthesia assistants, rather than an anesthesiologist, provided anesthesia services for 96% of the patients. Complications were experienced by 13 patients per 1,000 who received deep sedation/general anesthesia. According to the authors, these were minor side effects, such as nausea, that often are associated with anesthesia.

The bottom line, however, is that all same-day surgery programs, whether in an office, surgery center, or hospital, want to reduce the risk of injuries and deaths. Consider these suggestions:

• Become accredited.

Fewer than 10% of physicians offices are accredited by accrediting bodies, estimates **Michael Kulczycki**, executive director of the Ambulatory Care Accreditation Program at the Joint Commission on Accreditation of Healthcare Organizations.

The Florida study said that less than half of office-based practices in that state were accredited.

However, under state regulatory reform of office surgery oversight, that number has now risen to almost 90%, says **Maureen Doherty**, spokeswoman for the Tallahassee-based Florida Board of Medicine. Under new state regulations, the number of deaths has dropped from 13 in a two-year period (April 1, 2000, to April 1, 2002) to three in the past year, Doherty says. Also, the number of injuries has decreased from 93 in the two-year period to 18 in the past year, she says.

The regulatory changes include a rule, implemented in 2002, that anesthesia must be administered by an MD or DO, not a nurse anesthetist or other provider. Also, office-based practices must be inspected and accredited by a national organization, and they face training and risk management requirements.

• Define the scope of your practice, and be prepared for the unexpected.

One of the critical elements of safe office-based practice is selecting the right patient for that setting, says **David Shapiro**, MD, president of the Johnson City, TN-based American Association of Ambulatory Surgery Centers and senior vice president of medical affairs for Surgis, a Nashville, TN-based company that owns and manages ambulatory surgery centers with physicians and hospitals. "That includes the surgeons selecting patients for procedures and making sure the patients are suitable and at a low risk of complications," he says.

Also, a "safety net" of an adequate number of competent and trained ancillary staff and an appropriately equipped facility is critical, he adds.

Referring to the deaths and injuries reported in

EXECUTIVE SUMMARY

In light of recently published studies and growing regulation at the state level, the safety of surgery in physician offices is under increased scrutiny.

- Lack of accreditation has been linked with increased risk of injury or death.
- Physician practices must ensure they have sufficient equipment and trained staff to handle unexpected events.
- Six more states are considering increased regulations of physician offices.

SOURCES

For more information, contact:

- **Michael Kulczycki**, Executive Director, Ambulatory Care Accreditation Program, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL. E-mail: mkulczycki@jcaho.org.
- **David Shapiro**, MD, Surgis, 30 Burton Hills Blvd., Suite 450, Nashville, TN 37215. Telephone: (615) 665-3012.

the Florida study, Shapiro says, "I don't think anything intentionally was done to put patients in harm's way, but from hearing about cases and learning about them through the board of medicine hearings, it was a combination of a lack of real preparation to anticipate and treat any complications arriving from the procedure."

Staff coordination is a key step, he says. "From the preadmission staff to the circulating staff to the recovery area, when that team is working together, that safety net is there for that patient," Shapiro says.

In such an environment, complications can be avoided, or at least recognized, he says. "It requires constant vigilance and constant contact, and that was lacking in some offices [in the Florida study]."

• Provide the same level of care, regardless of setting.

Shapiro and other leaders in outpatient surgery maintain that the patient should receive the same level of care whether he or she is in an office, surgery center, or hospital.

"If you adhere to good medical practices and all the ancillary issues, such as personnel and equipment and precautions, then the patient should be able to get good care in any setting," Shapiro says.

Instead of rewriting state regulations for office-based practices, states should hold practices to the same level of care as surgery centers and hospitals, he says. In the meantime, states do continue to boost their regulation of office-based practices.

Twenty-two states have laws or regulations covering office surgery, according to the Florida study. Many limit the length of surgery or the number of procedures that can be done on a patient at one time.

Six more states are reviewing proposed regulations and may implement new ones in the next six months, Kulczycki says. They are Alabama, Arkansas, Arizona, Georgia, Tennessee, and Washington, he adds.

"One element may be requiring Joint Commission accreditation or accepting that accreditation in lieu of another inspection by the state, Kulczycki says. **[For more on safety in physician offices, see *Same-Day Surgery,* November 2000, "Number of office-based surgeries rivals surgery centers; are they safe?" p. 133, "What led Florida board to pass moratorium?" p. 137, and *SDS*, December 1999, p. 137, "Long arm of regulation reaches out from states and anesthesia society."]**

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If you make it fun, lessons will be remembered

Stuffed animals, prizes work for HIPAA education

[Editor's note: Health Insurance Portability and Accountability Act (HIPAA) regulations require providers to offer ongoing training. As a service for our readers, we're offering information on some unique educational programs that can help managers meet the staff training requirements.]

What do a stuffed hippopotamus and a very cool hippie named Chip have in common? Both are tools used by hospitals and their same-day surgery departments to reinforce patient privacy regulations stipulated by HIPAA.

"We knew we had to think out of the box to find a way to make the dry topic of HIPAA regulations into something that makes sense and keeps employees' attention," says **Kathleen Graham**, JD, LLM, HIPAA privacy officer and director of corporate compliance and privacy for Children's Hospital in Birmingham, AL.

To educate all staff members in the hospital, HIPAA educational sessions were conducted as part of departmental staff meetings, as separate inservice educational sessions, in new employee orientation sessions, and through computerized

EXECUTIVE SUMMARY

Several programs have found that thinking "outside the box" enables them to come up with clever ways to teach employees about the Health Insurance Portability and Accountability Act (HIPAA) and have fun at the same time.

- Pick a suitable mascot for your organization's efforts, such as a HIPAA hippo or Chip, the hippie.
- Use the mascot throughout games, inservices, and publications to carry the message to employees.
- Give employees a point of contact when they have questions or concerns about HIPAA-related issues.

lessons available to all employees, points out Graham. The multidisciplinary team responsible for HIPAA education at Children's knew that it would take more than one or two educational sessions to really get employees to think about privacy on a day-to-day basis, she adds.

"We started educating our department heads and managers about four to five years ago, then introduced the education for all employees in the months preceding introduction of the privacy rule," says **Pam Atkins**, CPHIMS, HIPAA security officer and divisional director of information technology. Now the hospital is incorporating tips related to the security rule into the information.

Betsy Karr, RN, divisional director of surgical/anesthesia services, says, "Because we are a pediatric hospital, we can have fun when communicating with each other without being silly." While the original HIPAA educational session involved one day of inservice for different groups of same-day surgery staff, the education continued with events that reinforced the teaching, she explains.

The fun included a scavenger hunt that consisted of hippo fliers posted around the hospital and same-day surgery areas. Each flier contained one HIPAA-related question that the employee was to answer and return to the marketing department for prizes that included movie passes and hippo beanie babies, Graham explains. "Of the more than 50 fliers we hid, we only received one wrong answer," she adds.

Other fun activities enabled employees to win hippos that ranged in size from Beanie Babies to a 4-foot-tall hippo. These included *Family Feud*-type games in meetings that focused on HIPAA questions, e-mail quizzes that went to all employees, a HIPAA holiday choir that sang a song that praised HIPAA rules, and a HIPAA safari theme for educational sessions. **[See example of quiz questions, p. 129. To see a copy of Children's safari game slide show, go to www.same-daysurgery.com and click on the "toolbox." Your subscriber number on your mailing label is your user name. Your password is sds (lowercase) plus your subscriber number (no spaces.)]**

"We encourage employees to be on the lookout for HIPAA violations and report them immediately to the compliance department," Graham says. "In fact, we call a HIPAA concern a HIPAAspotamus."

Cartoon hippie spreads the word

While Children's Hospital in Birmingham relied upon a hippopotamus to carry their HIPAA message, the staff at Lee Memorial Health System in Cape Coral, FL, learned about HIPAA regulations from Chip, the hippie. "Chip is a cartoon character that carries our 'hip on HIPAA' theme throughout our publications, inservices, videos, and meetings," says **Brad Pollins**, executive director of learning and performance systems.

A multidisciplinary team designed an educational program that would create a cultural transformation in the way staff think about privacy, Pollins says. "The team developed a combination of videos, handbooks, and educational classes to share the information, but we needed something to tie everything together and make it memorable for employees," he adds.

The cartoon character, Chip the hippie, appeared on posters and in a cartoon strip that appeared in the employee newsletter, he says. **[To see a copy of Lee Memorial's "Chip" cartoon, go to www.same-daysurgery.com and click on the "toolbox." Your subscriber number on your mailing label is your user name. Your password is sds (lowercase) plus your subscriber number (no spaces.)]**

SOURCES

For more information, contact:

- **Kathleen Graham**, JD, LLM, HIPAA Privacy Officer, Director of Compliance and Privacy, Children's Hospital of Alabama, 1600 Seventh Ave. S., Birmingham, AL 35233. Telephone: (205) 939-9271. E-mail: kathleen.graham@chsys.org.
- **Brad Pollins**, Executive Director of Learning and Performance Services, Lee Memorial Hospital, 636 Del Prado Blvd., Cape Coral, FL 33990. Telephone: (239) 772-6734. E-mail: brad.pollins@leememorial.org.

HIPAA quizzes test basics

Employees at Children's Hospital in Birmingham, AL, enjoy quick e-mail quizzes that test their knowledge of Health Insurance Portability and Accountability Act (HIPAA) requirements and give them a chance to win hippos.

"While the idea for the e-mail quizzes came from a consultant, we created our own content based upon employee suggestions," says **Kathleen Graham**, JD, LLM, HIPAA privacy officer and director of corporate compliance and privacy for Children's Hospital in Birmingham, AL. Some of the quiz questions included:

Question: Baby Bubba is the son of famous country music singer Big Bubba. Baby Bubba is visiting Children's Health System for a checkup. The media has been attempting to contact you to ask questions about the Bubbas. One local TV station, promoter of the Big Bubba fan club, even wants to stop by to see Baby Bubba. What should you do?

Answer: Stop, think, and clarify the HIPAA consequences. Famous people and their children have HIPAA rights. Talk to Big Bubba to let him know what is happening. Please follow Children's policy and call Media Relations for assistance.

Question: You go to church with the Bubbas. Many people at your church saw patient Baby Bubba and Children's in the news last week. They are asking you questions at the service about Baby Bubba because they know you work at Children's. They would like to pray for the Bubbas, who aren't there that day. How do you respond?

Answer: Tell them that they need to talk with the Bubbas to find out any information. HIPAA applies in the church setting. Sharing confidential patient information — even prayers — can be a breach of confidentiality. Although these people are genuinely concerned and their intent is good, they have no "need to know" confidential patient information because of Baby Bubba's privacy rights.

Question: What should you do if you are talking with a patient/parent in a semiprivate patient area?

Answer: Pull privacy curtains, lower your voice, and be discreet.

Question: What should you do if you are in an elevator and others are discussing a patient?

Answer: Politely remind them to respect patient privacy. ■

"We also found an employee who dresses as Chip for meetings and special employee events," he adds. The HIPAA education program kept the hippie theme going with e-mail quizzes and contests that awarded lava lamps and tie-dyed T-shirts as prizes, he adds.

Pollins' staff also created a HIPAA site on the hospital's internal network that employees can access to find answers to HIPAA questions or concerns they may have, he says. The HIPAA pad, as the site is named, enables employees to submit questions or concerns to the compliance department, he explains. "Chip answers the questions with a note that starts out, "Hey man," then responds to the employee's note," he says.

Employees at Children's Hospital also can use e-mail to report concerns or make suggestions to improve compliance with privacy regulations, says Karr. "Within the surgery areas, staff members suggested locations of whiteboards that would protect privacy, and our post-anesthesia care unit requested curtains for the cubicles," she explains.

An important part of the program at Children's is the clear identification of who to call if you have questions, Karr says. "Because we are dealing with pediatric surgery patients, we have a larger group of family members who want information and are concerned. It's nice to have a compliance officer that can be easily reached when we have a question," she says. ■

Formularies list supplies needed for disasters

The Health Industry Distributors Association (HIDA), the Association for Healthcare Resource & Materials Management (AHRMM), and the Health Industry Group Purchasing Association (HIGPA) have created medical/surgical supply formularies that provide a blueprint for planning and coordinating supplies in the case of a large-scale chemical, biological, radiological, nuclear, explosive, or natural disaster.

"When there's an external disaster, [outpatient surgery providers] are available to the community for supplies and, depending on the situation, personnel," says **Marjorie E. Vincent**, RN, MBA, CNOR, CASC, principal at Woodrum Ambulatory Systems Development, a Los Angeles-based company that operates, develops, and manages ambulatory care centers.

The formularies focus on adult and pediatric patient needs and provide a targeted supply formulary for each of the events. Same-day surgery providers are likely to have most of these supplies on hand, but there are a few exceptions, Vincent says. For example, the Biological Pack

recommendations include a 50 µ mask. "They may not have it, but they would need it, particularly if the disaster was biological," she says.

In the core pack, outpatient surgery providers aren't likely to have arterial line tubing, a central vein cath kit, or a multilumen central cath kit, she says. However, outpatient surgery departments and surgery centers aren't likely to need these specific items in a disaster, Vincent says.

For a copy of the supply formularies, visit www.hidanetwork.com and search for "formulary disaster." Click on "formularies by disaster.xls." ■

Surgical areas to face shortages of 14% to 42%

Most surgical specialties will experience a shortage of surgeons by 2020, a new study predicts.

Ophthalmology was listed as the No. 1 specialty likely to experience a shortage, with a 47% increase in demand projected, according to the study performed by researchers at the University of California, Los Angeles. Other projections for increases in demand by 2020 are:

- cardiothoracic surgery, 42%;
- urology surgeries, 35%;
- general surgery, 31%;
- orthopedics, 28%;
- neurosurgery, 28%;
- otolaryngology, 14%.

A major factor in the predicted increase is an aging population, researchers say.

Strategies such as offering assistance with time-consuming paperwork or making ORs run more efficiently may help surgeons use their time more efficiently, according to the lead author, **David A. Etzioni**, MD. More research needs to be done to identify areas that may help surgeons, he says.

The study developed a work force model using national surveys of medical and surgical services to establish a profile of age-specific rates of surgical use. The study is featured in the August 2003 issue of the *Annals of Surgery.*

For more information, go to www.ucla.edu/. **(For additional information, see "General surgeon shortage expected to reach crisis level in next 5 years," *Same-Day Surgery*, August 2002, p. 97.)** ■

Noncompliant transactions to be accepted by CMS

The Centers for Medicare & Medicaid Services (CMS) has implemented a contingency plan to accept noncompliant electronic transactions. This plan will ensure continued processing of claims from thousands of providers who were not able to meet the deadline and otherwise would have had their Medicare claims rejected.

"Implementing this contingency plan moves us toward the dual goals of achieving HIPAA [Health Insurance Portability and Accountability Act] compliance while not disrupting providers' cash flow and operations, so that beneficiaries can continue to get the health care services they need," says CMS Administrator **Tom Scully**.

CMS made the decision to implement its contingency plan after reviewing statistics showing unacceptably low numbers of compliant claims being submitted. **Tom Grissom**, director of CMS' Center for Medicare Management, says that Medicare is able to process HIPAA-compliant transactions, but CMS needs to work with providers to increase the percentage of claims in production. The contingency plan permits CMS to continue to accept and process claims in the electronic formats now in use, giving providers additional time to complete the testing process. CMS regularly will reassess the readiness of providers to determine how long the contingency plan will remain in effect.

According to CMS representatives, the contingency plan does not change the requirement that all claims be submitted electronically. Institutional providers with 25 or fewer employees and non-institutional providers with 10 or fewer employees are the only providers that can still bill Medicare on paper after Oct. 16, 2003. ■

COMING IN FUTURE MONTHS

- Tips that cut liability, boost safety, accreditation compliance
- Systems that reduce postoperative pain, enhance recovery
- Answers to your most pressing HIPAA questions
- Procedure moves outpatient but is controversial
- Get an underwriter to look at your application

State web sites feature average outpatient charges

To compare your procedure charges with other facilities, look to two state web sites that offer this information for free.

While several states collect hospital outpatient data and some collect surgery center data, Wisconsin and Missouri are unusual in that they post data by county and region with names of facilities and charges for common procedures on their web sites.

Providers can use a web site sponsored by the Madison-based Wisconsin Department of Health and Family Services to look up the average cost for seven ambulatory surgery procedures in that state.

The seven procedures include colonoscopy, carpal tunnel release, ear tube insertion, flexible sigmoidoscopy, laparoscopic cholecystectomy, left heart catheterization, and upper endoscopy.

The web site provides the average statewide facility charge, as well as the average facility charge at individual surgery centers and hospitals across the state. Go to: www.dhfs.state.wi.us/healthcarecosts. Click on "find a facility's average charge for an outpatient procedure."

The Missouri Department of Health and Human Services in Jefferson lists facility charges and number of cases for outpatient procedures at hospitals and freestanding centers.

Go to www. health.state.mo.us. Click on "Data" and then click on "Outpatient Procedure Charges by Hospital," which includes freestanding centers. ■

CE/CME instructions

Physicians and nurses participate in this CE/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 December 2003 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. ■

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PS Form **3526**, September 1999 *(Reverse)*

CE/CME objectives

After reading this issue you will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. (See *"Should patients with obstructive sleep apnea handled as outpatients?"* and *"Good managers are key to retention of experienced nurses,"* in this issue.)
- Describe how those issues affect clinical service delivery or management of a facility. (See *"Sleep apnea patients require special handling."*)
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *"If you make it fun, lessons will be remembered."*)

CE/CME *questions*

If you have any questions about this testing method, please contact customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com.

17. How much is the number of patients with obstructive sleep apnea expected to increase over the next decade, according to Janet van Vlymen, MD, FRCPC, assistant professor in the Department of Anesthesiology, Queen's University, Kingston General Hospital?
    A. 50%
    B. Double
    C. Threefold to fourfold
    D. Fivefold to tenfold

18. How frequently does OSA occur in obese children who have enlarged tonsils, according to the American Academy of Otolaryngology — Head and Neck Surgery Foundation?
    A. 5% to 10%
    B 10% to 20%
    C. 20% to 30%
    D. 30% to 40%

19. According to Betsy Karr, RN, divisional director of surgical/anesthesia services for Children's Hospital, what is the purpose of ongoing e-mail quizzes and contests for education related to the Health Insurance Portability and Accountability Act (HIPAA)?
    A. To enable employees to add to the beanie baby collections
    B. To introduce new ideas for performance improvement
    C. To see how many employees check their e-mail on a regular basis
    D. To reinforce HIPAA education on a day-to-day basis

20. What is the primary reason that traits valued in a manager differ between experienced nurses and new graduate nurses, according to Ann Warner, RN, MS, CCRN, assistant professor at the College of Nursing at McNeese State University?
    A. A difference in generational values
    B. Working nurses see the workplace from a different perspective.
    C. Geographic location
    D. New graduates don't yet know what to expect from a manager.

Answer Key: 17. D; 18. D; 19. D; 20. A

25th Anniversary
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Good managers are key to retention of experienced nurses

Supportive, approachable, and fair are vital traits

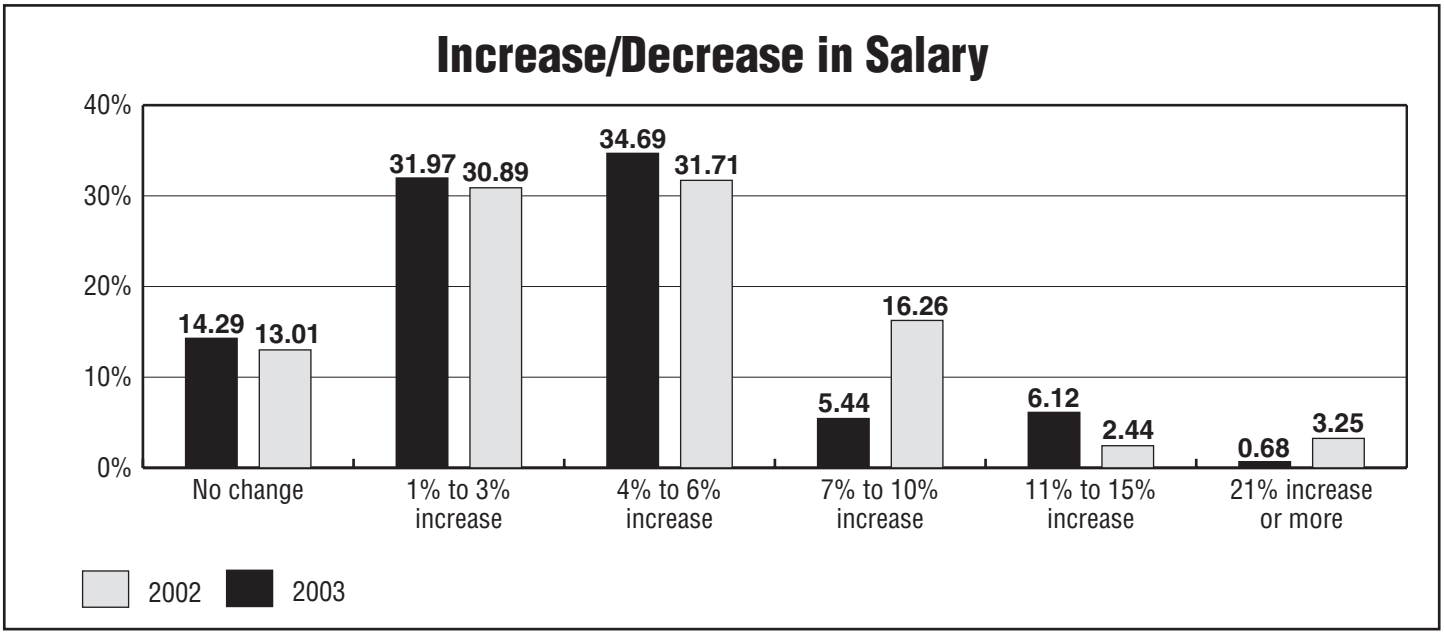
Same-day surgery managers have looked at every aspect of their new employee recruitment program to identify how to best attract good nurses. Partnerships with nursing schools, accreditation as a magnet facility, and a strong benefits package are a few ways to attract new nurses, but how do you keep them satisfied with the job and happy with you as an employer?

Retention is a key issue for respondents to the 2003 *Same-Day Surgery* Salary Survey: Almost 56% of the respondents saw an increase in employees during the past year. **(See chart, p. 2.)**

As same-day surgery programs get busier and staff sizes increase, it is more important than ever to be able to keep good employees because it is too hard to replace them, says **Karen A. Hart**, RN, BSN, senior vice president of the health care division of the Bernard Hodes Group, a human resource communications company in New York City.

The *SDS* salary survey was mailed in June to 1,029 subscribers and had 147 responses, for a response rate of 14.3%.

While salaries and benefits are important to recruitment of new nurses, they are not key reasons that nurses leave their employees, according to a survey recently conducted by Bernard Hodes Group, Hart says. (For a copy of the survey report, go to www.hodes.com/hcrecruiting/, then click on



"Nursing's Pulse" under the research and results section.) The reasons nurses leave include not feeling valued (39%), lack of growth potential (33%), lack of confidence in management (31%), and lack of professional respect (30%), she adds.

"We find that a manager or supervisor is the key to retention of a quality nursing staff," says Hart.

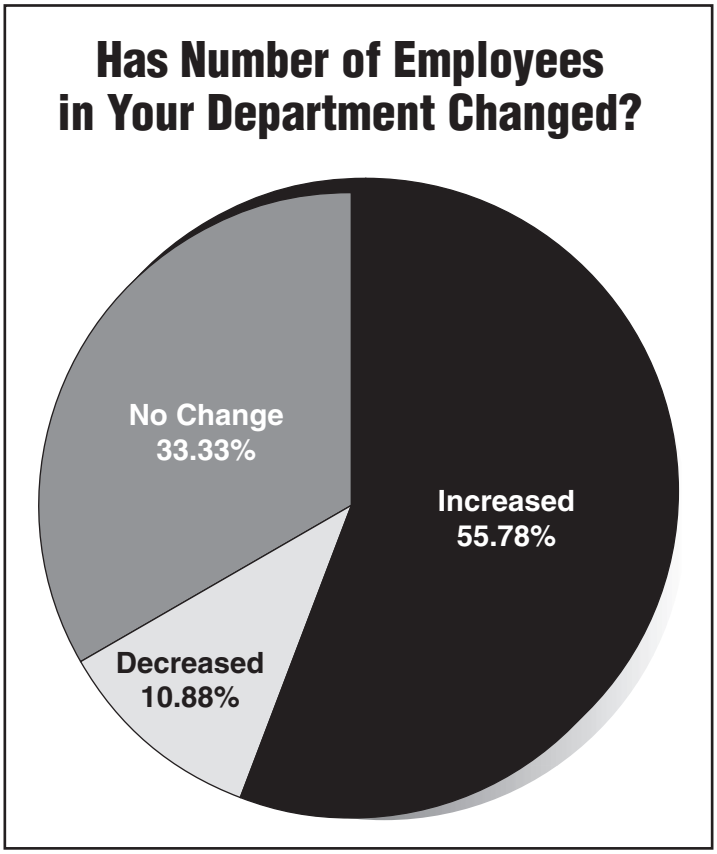
"There are people who are natural managers, and you can see it immediately as they talk with other people and walk around their departments. Other people may need training because they don't instinctively know what is necessary to manage people," she adds.

Traits valued by different age groups

Manager traits that are important to employees can differ according to generational differences, says **Ann Warner**, RN, MS, CCRN, assistant professor in the College of Nursing at McNeese State University in Lake Charles, LA.

"In a study that we conducted to compare the traits nursing students considered important to manager traits that experienced nurses considered important, we found a number of interesting differences,"she says.[1]

"Of the top three traits identified by both groups, only 'team player' and 'receptive to people and ideas' is mentioned as a top 10 trait by both groups," says Warner.



Even with these two traits, the groups ranked them differently, she points out. "Experienced nurses identified 'receptive to people and ideas' as third most important, while students rank it ninth. 'Team player' is ranked first by students, while experienced nurses rank it ninth. Clearly these two groups value different traits," she adds.

Carol Hiatt, RN, nurse administrator of Ocala (FL) Eye Surgery, says, "Staff members want to know that their experience, ideas, and suggestions are appreciated."

One of the reasons Hiatt's same-day surgery program has experienced virtually no turnover in the seven years she has been the administrator is the willingness of the physician owners to listen to the staff, she says.

While she is the administrator, Hiatt points out that she can only reflect the values of the owners when it comes to staff, so the owners also must possess the same traits employees' value in a day-to-day manager, she adds.

A good example of the physician-owners' willingness to listen is related to patient wait times, says Hiatt. "When our nurses noticed that patients were waiting a long time in the preoperative area, they conducted a time study to discover why the waits were occurring," she explains.

"They discovered that although the physicians might say that they want to start the procedure at 8:15 a.m., they were not arriving at the facility until 8:15, then starting 30 minutes later," Hiatt continues.

When that information was presented, the staff suggested that they be allowed to adjust the schedules so that the patients did not arrive so early, she explains. "This suggestion was well-received, and the staff were told to set schedules in whatever way would minimize patient wait times," Hiatt adds.

Managers need to understand generations

The differences in traits valued in a manager are generational, says **Julie Thompson,** RN, MSN, CNOR, administrative research coordinator for the Harris County Hospital District in Houston and co-author of the study.

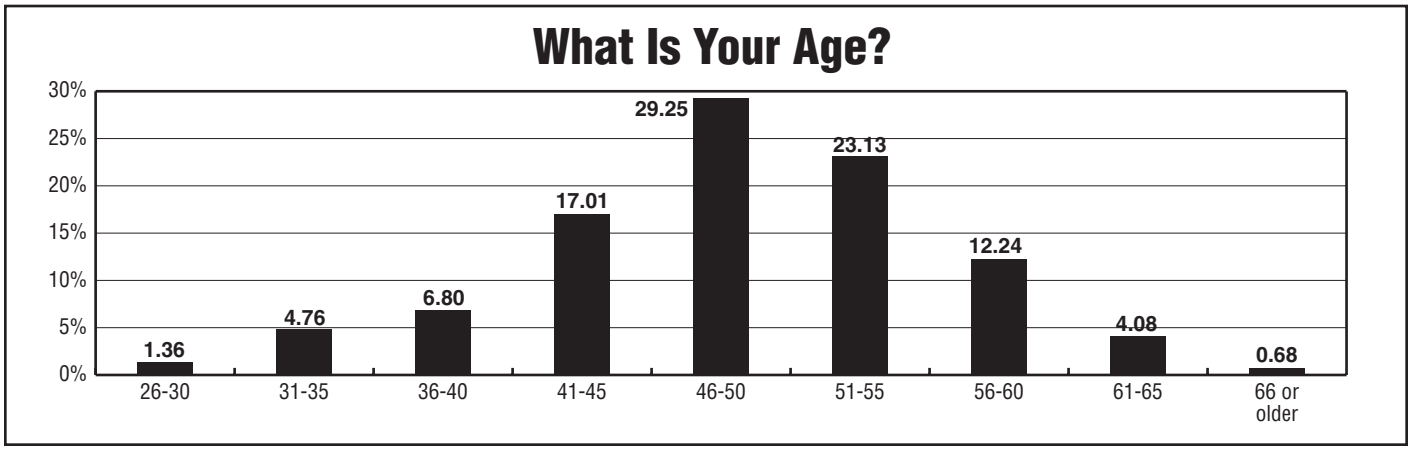
"This is important for same-day surgery managers to understand, because many managers and many entrenched nurses are members of the baby boomer generation who are having to learn how to supervise members of the Generation X. **(For**

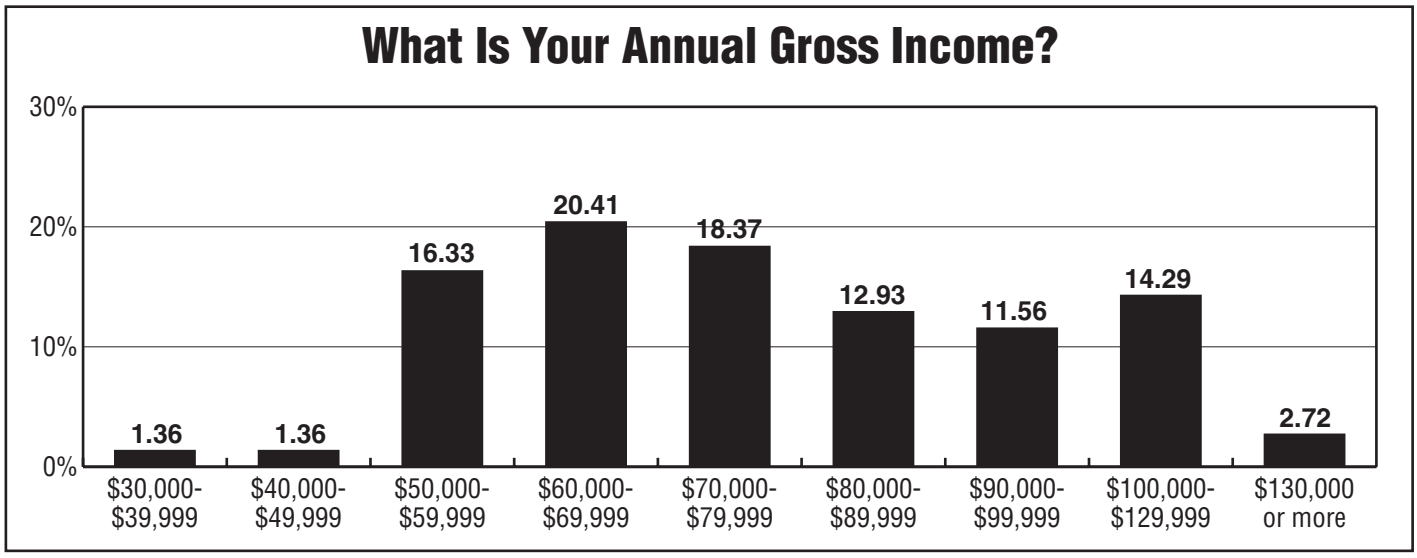
more information on the differences between generations, see "Managing Generation X in same-day surgery," ***Same-Day Surgery,*** **February 2000, p. 16.)**

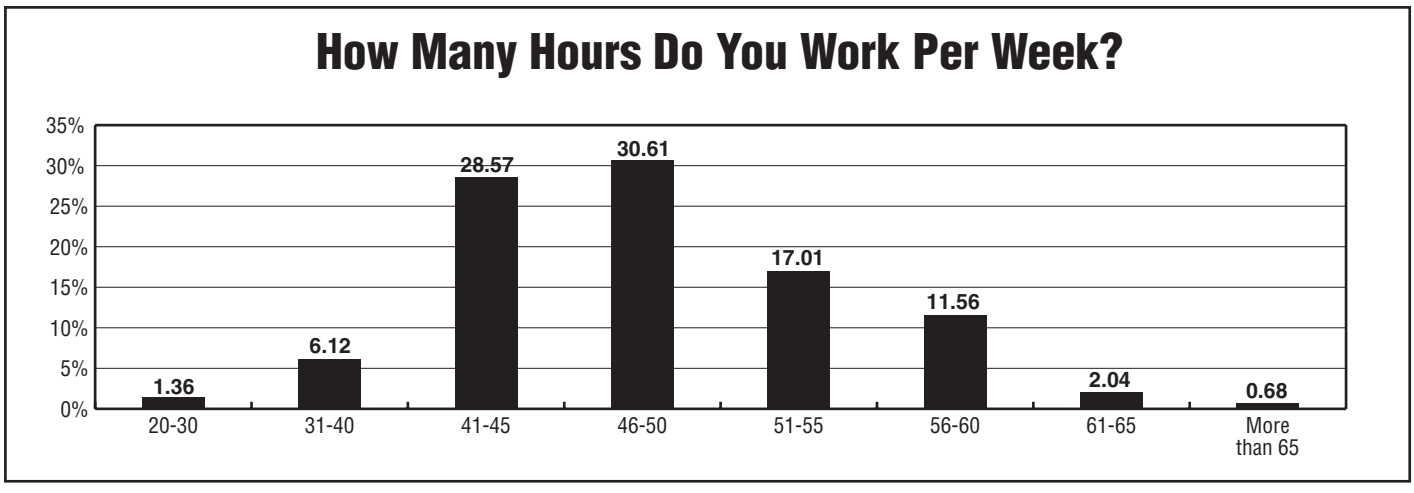
Salary survey respondents are representative of the baby-boomer generation, with more than 69% of respondents born between 1943 and 1961. **(See chart, below.)** Generation X, born between 1960 and 1980, is represented by almost 14% of survey respondents.

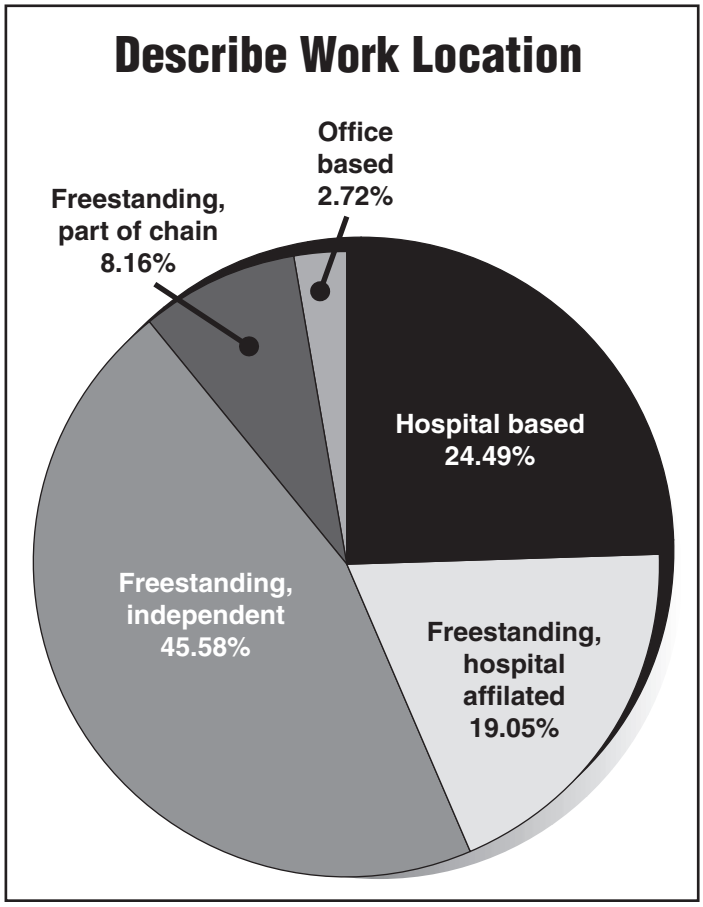
"We believe that the perioperative setting is tailor-made for members of Generation X, because they are self-reliant, technologically oriented, and interested in the flexible scheduling that same-day surgery programs can offer," says Thompson.

"What is necessary, however, is that managers









understand that the emerging work force wants to be appreciated in different ways, such as an e-mail that thanks the employee for doing something above and beyond their responsibility or passing along a compliment from a patient or physician," she points out.

The emerging work force also is focused on outcomes and doesn't want long meetings at which issues are discussed at length, she adds.

"Generation X employees want you to give them a task, then let them do it," Thompson says.

A hard-working profession

"Nurses tend to be workaholics," Hart says, "but there are generational differences, so managers need to understand that while baby boomers will put in long hours, Generation X nurses want to finish the task, then move on to their personal life."

Salary survey respondents also point out that same-day surgery managers are willing to put in longer than normal weeks as well, with slightly more than 90% of the respondents working more than 40 hours each week. **(See chart, p. 3, bottom.)**

With the extra work hours, the good news for survey respondents is that although slightly more than 14% experienced no pay increase in 2003, almost 67% experienced an increase that ranged between 1 and 6%. **(See chart, p. 1.)** Slightly more than 55% of survey respondents earn between $50,000 and $80,000 annually. **(See middle chart, p. 3.)**

With increasing workloads for managers, it is more important than ever that managers be able to prioritize their work, says Hart.

"Being able to prioritize your staff's work is also an important trait for a manager because employees want to know that the manager has them doing the most important work when time is limited," she adds.

If you want to evaluate your own management style, Hart suggests that you think back to all the years of your work experience.

"I always tell managers that it is helpful to think about the manager that made the biggest difference in their careers. What qualities possessed by that manager can you emulate?" she says.

Hart adds, "When you encounter a difficult situation, ask yourself what that manager would have said or done."

Reference

1. Thompson J, Wieck L, Warner A. What perioperative and emerging workforce nurses want in a manager. *AORN Journal* 2001; 78:246-261. ■

SOURCES

For more information on manager traits, contact:

- **Karen A. Hart**, RN, BSN, Senior Vice President, Health Care Division, Bernard Hodes Group, 220 E. 42nd St., 16th Floor, New York, NY 10017. Telephone: (330) 865-5988. Fax: (330) 865-5989. E-mail: khart@ny.hodes.com.
- **Carol Hiatt**, RN, Nurse Administrator, Ocala Eye Surgery, 3330 S.W. 33rd Road, Ocala, FL 34474. Telephone: (352) 873-9311. Fax: (352) 873-9652. E-mail: chiatt@ocalaeye.com.
- **Julie Thompson**, RN, MSN, CNOR, Administrative Research Coordinator, Harris County Hospital District, 1615 Hermann Drive, Suite 2115, Houston, TX 77004. Telephone: (713) 566-6473. E-mail: Julie_Thompson@hchd.tmc.edu.
- **Ann Warner**, RN, MSN, CCRN, Assistant Professor, College of Nursing, McNeese State University, P.O. Box 90415, Lake Charles, LA 70609. E-mail: awarner@mail.mcneese.edu.