

## Health care reform

# For ORs, more pressure to perform

**H**ow health care reform will affect hospitals and other facilities will be unfolding for years. There will be some time to prepare. Under the sweeping reform law passed in March 2010, the major expansion in insurance coverage won't take effect until 2014.

The Congressional Budget Office estimates the reform legislation will reduce the number of uninsured by 32 million in 2019. Many of the newly covered will enroll under Medicaid, while others will be able to purchase coverage through new health insurance exchanges.

For hospitals, the prospects are decidedly mixed. Some say hospitals will be winners, but others think that's too optimistic. Though hospitals agreed to give up \$155 billion in Medicare funding over the next decade as part of the negotiations to pass the legislation, they expect to make up at least \$170 billion by treating fewer uninsured patients, according to Kaiser Health News. But many of the newly insured will be in government programs that don't pay well.

### A few realities

Reform is likely to be an extension of what has been happening for years, at least on the payment side, says Nathan Kaufman of Kaufman Strategic Advisors LLC, San Diego. The government has squeezed Medicare payments for nearly a decade and will continue to do so. Medicaid enrollment has grown during the recession as unemployment has risen, yet 39 states are freezing or cutting Medicaid payments to providers.

A few realities he cites:

- More than half of community hospitals' revenue is from public programs, including Medicare and Medicaid.
- Community hospitals lose 15 cents of every dollar they spend caring for Medicare patients.
- 300 to 500 more baby boomers reach Medicare age every hour.

There are also new realities. Hospitals will see some of their payments put at risk in the coming years through a new value-based purchasing plan and penalties for hospital-acquired conditions and readmissions (related article).

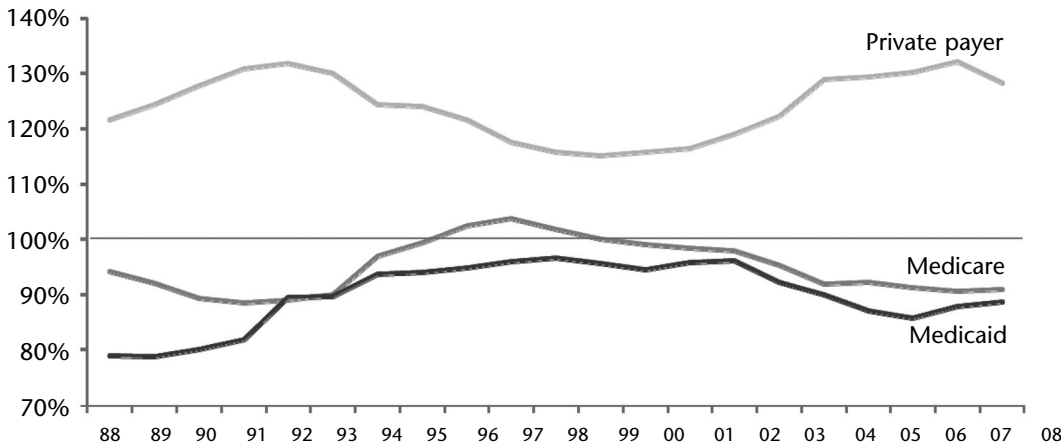
### Pressure for performance

The economic picture will create more pressure than ever for OR performance.

"The pressure exists to improve perioperative performance because that is 65% of a hospital's bottom line," says Jeff Peters, president of Surgical Directions, LLC, a Chicago-based consulting firm. "There is tremendous pressure on hospitals to improve the bottom-line, and they look to the OR to be a major contributor to that."

**Special focus: Health care reform**

**Hospital payment-to-cost ratios, 1988-2008**



Source: American Hospital Association Annual Survey data, 2008, for community hospitals. Medicaid includes Medicaid Disproportionate Share payments.

Also in the forefront—quality and accountability. The reform legislation has initiatives aimed at improving quality while lowering costs.

“OR throughput will be important,” adds Kaufman, “but so will the total cost of the patient episode and patient satisfaction—we may eventually be rewarded or punished based on patient satisfaction scores from Medicare.”

Though the prospects seem daunting, Kaufman says it’s no different from the challenges any industry faces. “You are expected to produce better products at a lower cost at a certain price point—that eventually is what ORs are going to be expected to do.

“The way you do that,” he continues, “is to identify best practice protocols; eliminate variability and waste; use data for developing and monitoring your protocols; and look at your processes to see if there are opportunities to eliminate steps, duplication, and unnecessary use of expensive supplies.”

**A focus on the fundamentals**

Where should perioperative leaders place their efforts? The response from consultants *OR Manager* interviewed was unanimous—focus on the fundamentals. Peters emphasizes these priorities:

1. Reinforce good OR governance.
2. Find ways to grow surgical volume.
3. Increase OR performance so you can expand services with the same resources.
4. Lower costs, particularly for supplies.

(Suggested strategies are in the sidebar, p 8.)

**Reinforce good OR governance**

Better performance starts with a strong governance structure. Three criteria for good governance were outlined by Randy Heiser, president and CEO of Sullivan Healthcare Consulting, Ann Arbor, Michigan:

- physician leadership

**Hospital physician-generated revenue**

Net annual revenue per hospital per physician from referrals, tests, and procedures performed at the hospital.

Neurosurgery	\$2.8 million
General surgery	\$2.1 million
Orthopedic surgery	\$2.1 million
Gastroenterology	\$1.5 million
Urology	\$1.4 million

Source: Merritt Hawkins, 2010. [www.merrithawkins.com](http://www.merrithawkins.com)

- constant communication with the medical staff
  - support for the leadership team that goes all the way to the CEO.
- Physician leadership is an essential element. “I have yet to find an effective governance structure that didn’t have physician leaders,” he says.

Physician leadership is not the same as physician control, Heiser cautions. Physician leadership is being willing to tell a surgeon that doing a particular case at 2 am is not appropriate. In contrast, “being afraid to do the right thing because a physician might react badly is physician control.”

A strong multidisciplinary leadership group can develop surgical scheduling policies that can be reinforced for all members of the surgical team. Regular, consistent communication is needed to convey, explain, and reinforce the scheduling policies and other rules, Heiser adds. And those policies will hold up only if the organization’s senior leadership is willing to stand behind the OR leadership team.

**Beef up the business side**

The principles of good supply and inventory management are well known—keep preference cards updated, strive for standardization, manage custom packs, put every possible product on consignment, capture charges, and so on.

One of the best investments an OR can make is to hire a business manager, a position Heiser calls “a CFO for surgery.”

“This is one of the most cost-effective positions you can create. I would say that in 9 out of 10 clients where we have recommended that position, it has paid for itself in 3 months.”

He suggests that the position is most successful if the business manager is recruited from a related department, such as finance or materials management, so the person is already familiar with the business side of health care.

**Expect to see more employed physicians**

Health care economics are causing a shift in the hospital-physician relationship, with implications for the OR. More physicians are seeking to be employed by hospitals and health systems.

Among forces driving physician employment are uncertainty about the economic climate, declining reimbursement, increasing practice overhead, and in some states, the malpractice environment.

“We are beginning to see more surgeons think of employment as a means to stabilize their incomes,” Kaufman says.

The Medical Group Management Association reports that hospital employment among its physician members rose to 37% in 2009 from 25% in 2003.

Physicians bring hospitals a lot of revenue, with a specialist generating on average \$1.8 million in net revenue a year, according to the recruiting firm Merritt Hawkins (chart).

In another development, many hospitals are looking to buy ambulatory surgery centers (ASCs) from their physician owners and convert them into hospital outpatient departments because hospital-based outpatient surgery provides higher reimbursement than in an ASC, according to *Becker's ASC Review* published by Scott Becker of McGuireWoods. Medicare pays hospitals substantially more than ASCs for the same procedures, and the gap is often greater with commercial payers, Becker says.

### **Pressure to perform**

What should OR directors know about the shifting economic climate for physicians?

“Physicians are coming to realize they need to be more efficient than ever before,” comments Bryan Warren of Accelerio, a consulting firm owned by Zimmer that focuses on management of the orthopedic service line. Warren says he recently talked with a surgeon who said that if he doesn't find a way to perform more joint procedures in less time, he doesn't want to do the surgery anymore because it doesn't pay well enough.

### **Will better alignment ensue?**

Don't assume that because surgeons are employed, closer collaboration with OR leaders will automatically follow, Warren cautions.

“Employment is an alignment strategy,” he says, “but it does not ensure alignment in and of itself. When surgeons walk into the OR, they don't think of themselves as employees. They still have a certain amount of autonomy in the way they function.”

Warren adds: “Strategies that allow the OR to run better to meet the needs of the physicians are probably more important than ever, regardless of whether the physicians are employed or not.”

He echoed the advice about good OR governance, saying that the physicians need to be actively engaged in governance, setting goals, and reinforcing policies.

### **Reaching out**

Warren notes that he does see physicians reaching out to hospitals in a more collaborative manner than in the past, and “We are telling hospitals to take advantage of that.”

Hospitals that employ surgeons should build in administrative responsibilities, he advised so they are required to take an active leadership role.

Physicians who are not employed are sometimes offered incentives in the form of medical director positions or comanagement agreements, in which there is a formal arrangement between the hospital and physician to share management of a service line (related article, p 1).

Warren says his firm is receiving a lot of inquiries about comanagement.

“In some cases it’s a good idea,” he says. “In others, you can accomplish the same thing without all the work it takes to put that together. In our mind, it’s one of a number of solutions.”

### **A greater urgency**

No matter what lies ahead, perioperative leaders will face more urgency in the areas they already focus on: patient safety and quality, throughput, and cost. Take the opportunity to diagnosis your current situation and plan a strategy, suggests Ryan Bengtson of the Huron Consulting Group, Chicago.

Three areas to focus on:

- **Actionable data.** Can your information system produce the reports you need for making decisions?
- **Operational effectiveness.** Do a diagnosis: What is your current OR utilization? How well are you using the OR facilities and staff you have?
- **Reinforce your governance structure.** Strong leadership will be critical.

This is not just an OR committee that meets every month or two, Bengtson advises. He suggests asking: What is your leadership structure for monitoring and measuring systems, providing feedback, and resolving disputes? Do you have the right mix of nurses, surgeons, and anesthesia personnel, and other leaders involved? Are there clear expectations and individual accountability?

OR leaders already know the fundamentals—improving throughout, allocating and managing OR time efficiently, and relentlessly working to improve performance while conserving resources. Success is in the execution. ❖

—Pat Patterson

*Surgical Directions, LLC, will present an all-day seminar, “Transforming Your OR into a Better Performer,” and Jeff Peters will present the closing session, “How Will Health Care Reform Affect the OR?,” at the OR Business Management Conference May 12 to 14, 2010, in San Francisco. Download the brochure and register online at [www.ormanager.com](http://www.ormanager.com)*

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### **References**

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## **Improving OR performance**

Strategies offered by Jeff Peters of Surgical Directions, LLC.

### **Develop a collaborative OR governance structure**

Effective management of the OR schedule and scheduling policies requires a multidisciplinary leadership team that involves surgeon, anesthesia, and nurse leadership. Involving the hospital’s senior leadership, ideally the CEO, ensures that the team has the authority to set and enforce policy.

### **Move to 8-hour blocks**

Aim to provide surgeons with 8-hour blocks and require 75% utilization.

Eight-hour blocks allow surgeons who work at the facility regularly to start in the morning and operate continuously through the day without gaps, which is efficient both for the surgeon and facility.

A related rule: Leave 20% of rooms open each day so surgeons without an 8-hour block have access to OR time.

### **Have patients ready for surgery**

Having patients ready for surgery minimizes delays and cancellations because of clinical issues or missing paperwork.

Refine the preadmission process so that as much as possible, 90% of patients' charts are complete 3 days before surgery, and 95% are complete the day before.

### **Consider specialty teams**

For high-volume specialties, consider specialty teams of nursing personnel. Some facilities include anesthesiologists and nurse anesthetists on the teams. Specialty teams reduce variability because they know the surgeons' routines and setups. Teams can create a balancing act for staffing, however.

### **Tighten up on supply management**

Reinforce basic concepts:

- Do you capitalize surgical supplies as you buy them (ie, consider them an asset), or do you immediately expense them? Converting supplies into an asset can give you a one-time gain of \$50,000 to \$100,000 per OR.
- Make sure that implants and any other eligible supplies are placed on consignment.
- Review par levels to make sure the right supply quantities are available but not overstocked.

### **Review staffing**

Some ORs still use traditional 8-hour shifts when staggered and flexible shifts would be more cost-effective.

If, as in many facilities, more cases are being performed between 5 and 7 pm, stagger staffing through the day so those hours can be covered without paying overtime. Make sure staffing doesn't drop off too rapidly after 3 pm.