Is your OR’s governing structure up to today’s intense demands?

Everyone wants the OR to run smoothly—on-time starts, few delays, a well-managed schedule, and buy-in on quality and safety projects. To make it happen takes strong leadership and collaboration. The traditional OR committee may not be up to the task. Too often, it becomes a complaint forum, with the OR director caught in the middle. Perioperative departments need a strong governance structure to build a bridge between often competing agendas of physicians and the institution. They also need leadership to meet the growing list of patient safety and quality expectations.

“Demands on surgical services today are so different than they were even 10 years ago. Every year, there are more requirements,” notes Linda Slezak, RN, MSN, a former OR director who is now a consultant with the Sullivan Lakier Group. Strong leadership is needed to steer through quality and regulatory expectations, such as the Joint Commission’s Universal Protocol and the Surgical Care Improvement Project.

Perhaps most important, a good governance structure establishes a culture of leadership and continuity, which is increasingly important as perioperative directors and physician leaders begin to retire.

What makes for effective governance? OR Manager spoke with 4 consultants who have long experience with surgical services departments and their leaders.

The governing body should function as the OR’s “board of directors,” says Jerry Ippolito, MBA, MHSA, of Naples, Florida-based consultants, OR Efficiencies (www.orefficiencies.com). “The OR is the most valued business unit of your hospital, so you need to look at it as a business.”

Randy Heiser, MA, of DJ Sullivan Healthcare Consulting, Ann Arbor, Michigan (www.sullivanhc.net), says the most critical aspect is ensuring the key stakeholders, such as the physicians, are at the table and engaged.

“I’m a strong believer that physician leadership has to be in place for the surgical program to be effective,” Heiser says. “Nursing can do a lot, but the best programs are those with strong, proactive, innovative physician leaders.”

Some hospitals rely on the general surgical division meetings to deal with OR issues, Slezak notes, “but it’s harder to get things accomplished.”

They agree an effective structure has these elements:

• An OR “board of directors” with representation from physicians, hospital administration, nursing, and other departments related to surgery. (This group might be called the surgical services steering committee, OR governance committee, or a similar name.)

• A smaller OR “executive committee” that reports to the OR “board of directors.” The executive committee is usually a triad made up of a surgeon, an anesthesiologist, and the director of surgical services. A fourth member may be a senior hospital administrator.

“That is the model we’ve found works best, whether it’s a 4-room operating room or a 40-OR university hospital,” says Heiser. “The difference is in the size and people who are in those 2 groups.”

Who are the members?

Having the right leaders and members for the OR board of directors is critical, Ippolito comments. The chief of surgery and chief of anesthesiology may not always be the right choices. The key is for physicians to be part of the solution for operational issues.
“What you do not want (as chair) is the chief of surgery who barely operates,” Ippolito says. “You want physicians who have a vested interest in the business enterprise because their decisions are going to directly affect their pocketbooks.”

“It is not imperative that the medical staff members be department chairman,” emphasizes Kathleen F. Miller, RN, MSHA, CNOR, senior clinical consultant for perioperative services, Catholic Health Initiatives, Denver, who has also been a perioperative director. “It is imperative that well-respected medical staff ‘champions’ be named to the committee.”

For the “OR executive committee,” in a large hospital, the surgeon and anesthesiologist members may be the medical directors of the OR, Heiser notes. In a smaller facility, they may be the chief of surgery and chief of anesthesiology. These physicians often also serve as chair or cochairs of the OR board of directors.

Who does the governing body report to?

Ippolito describes the OR board of directors as a hybrid between a medical staff committee and an operations committee. The group needs to be empowered to set and enforce policies for the OR.

In Miller’s view, the OR governance committee should be appointed by hospital administration, which should have the authority to replace members who do not demonstrate the necessary commitment.

In Slezak’s experience, the OR board of directors is a medical staff committee with a physician chair that reports to the medical staff department. “In the best of worlds, the OR director has voting privileges on the committee,” she adds.

The group needs an administrative sponsor, which she finds is usually the administrator the surgical services director reports to, such as the chief financial officer and chief medical officer.

What is their role?

The role of the OR board of directors is “unbiased and balanced leadership of the surgical program,” says Ippolito.

Says Miller, “A key point is that the role of the members is to represent their disciplines and not personal gain. Physicians should see themselves as accepting responsibility for maximizing hospital resources.” Sample guidelines are in the sidebar above.

A key role for the director of surgical services is to provide accurate statistics and data analysis because these are essential to good decision making, Miller adds.

A major role of the board is to set policies for surgical services. The OR executive committee carries out the policies and runs surgical services day to day.

Slezak was part of a triad model when she was OR director at Stanford University Hospital in California.

“It worked well because I had physician partners from surgery and anesthesia,” she says. “The 3 of us met briefly every week and more often if necessary. We dealt with some pretty politically charged and dicey issues. It was a well balanced approach to managing the complexities of the operating room.”

How it works

The primary goal of the OR executive committee at least initially, in Miller’s view, is efficiency of the schedule and increasing OR utilization. She suggests giving this smaller group the authority to develop recommendations, which are brought to the larger governance committee.

Consider management of block scheduling, for example. The OR executive committee would draft policies for managing the block schedule, such as how OR time will be allocated, how use of the time will be monitored, and so forth. The policies would be brought to the larger committee for discussion and approval. Once the policies are approved, the executive committee would monitor use of OR time, report data to the board, and make adjustments according to the policies.

In other examples, the OR board of directors would set behavior standards for OR team members. If a physician is disruptive, the OR executive committee has the authority to enforce the standards, knowing it will be backed by the OR board of directors.

At capital budget time, physicians are invited to submit requests, and costs are analyzed by the OR business manager or finance department. The OR executive commit-
tee screens and prioritizes the requests and submits them to the OR board of directors for approval. This preliminary work helps expedite the process and avert conflict, Slezak says.

**Should physician leaders be paid?**

Typically, the OR board of directors members are volunteers, while the OR executive committee physicians are paid, the consultants say.

“I believe these positions have to be paid today,” Slezak remarks. As reimbursement tightens, “any time a physician spends out of the office is a loss of potential revenue.”

She believes the investment is worth it: “It’s necessary to have physician leaders that support the hospital in making changes and to have strong policies and procedures developed.”

Ippolito says the physician leaders are typically paid in larger institutions but may not be paid in smaller organizations.

“Their pay comes from improving efficiencies in the OR so they can better utilize their time,” he says.

Often, notes Heiser, the physicians on the executive committee are also the medical directors of the OR, which are paid positions. He finds most hospitals now have at least one OR medical director. In smaller hospitals, the position may be 25% or 30% of an FTE. Most often, the medical director is an anesthesiologist, and the surgeon member of the executive committee may be the chief of surgery.

Ippolito, who negotiates anesthesia stipends, advises that part of the stipend, usually 25% of a physician’s salary, be assigned to the OR medical director function.

“That way, the hospital is saying to the anesthesia group, ‘Now I’m going to pay you to effectively manage my business. I’m going to hold you accountable for that also,’” he says.

The OR medical director position requires a formal job description and clear delineation of authority and responsibility, the consultants emphasize.

**A culture of leadership**

Developing an OR governance model “is really about instilling a culture of leadership within your organization,” Ippolito says. “The management of the OR program shouldn’t rest on one person, such as the director of surgical services.”

Empowerment for the OR governing body must come from the CEO, Heiser stresses. The CEO must delegate the authority for management of surgical services to the OR board of directors, and physicians must be actively involved.

Then when a physician goes directly to the CEO and says, “If you don’t do this, I’m taking my business elsewhere,” the CEO can refer the physician back to the OR board of directors and say they are the ones who have the authority to resolve the situation, and the CEO will back their decision.

Once a strong, effective governing structure is in place, Heiser says, “suddenly, you have a marketable program, you have no problems recruiting staff, surgeons, or anesthesiologists. Your costs go down, and your efficiency goes up.”

—Pat Patterson

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For more, see “Models for governance of the OR” in the January 2007 OR Manager.
Example of OR governance committee guidelines

The OR governance committee:
• shall be assigned authority by the administration to participate in governance of the operating room
• shall have an agenda and minutes for each meeting
• shall meet on a regular basis to review findings of reports on utilization, late starts, delays, turnover time, and so forth
• shall develop guidelines for scheduling
• shall uphold guidelines as outlined
• shall outline action plans to address problems
• shall draft letters to medical staff when appropriate
• shall review compliance with standards and professional affairs related to patient care (typically standards, rules, and regulations)
• shall communicate with the surgery department regularly
• shall have one vote per member, representative of their disciplines
• shall be committed to the efficiency of the operating room.

The OR governance committee:
• shall not serve as a formal grievance hearing committee
• members shall not represent themselves for personal gain.

Courtesy of Kathleen Miller, RN, MSHA, CNOR.