Economic trends

OR leaders bracing for more cost pressures with economic downturn

With no bailout in sight, health care needs to invent its own version of the hybrid car—become more efficient and cost-effective—to survive the economic downturn, one consultant quips.

The times will challenge OR leaders to do even more to reduce costs and streamline operations.

“We will all need to pitch in and take 10% to 15% of cost out of the system we are managing,” says Nathan Kaufman, of Kaufman Strategic Advisors, San Diego, who consults with hospitals nationally.

“If your department isn’t meeting the best benchmarks on cost and efficiency, you’re hurting your hospital.”

Kaufman painted a sobering picture of economic trends (sidebar).

Though it is early, about a dozen OR leaders told OR Manager in December they are starting to see effects of the economic recession.

A few said surgical volume was below projections, while others were on target or slightly ahead of last year.

The American Hospital Association (AHA) reported in November that more than 30% of 736 hospitals in an October 2008 survey had seen a moderate to significant decline in patients seeking elective procedures. Inpatient surgery was down by 1.4% and ambulatory surgery by 0.6% in the third quarter of 2008 compared to 2007.

Managers are seeing OR staff’s behavior change as they become concerned about their jobs and incomes. Some managers have fewer vacancies and say the staff are asking for more hours—even call. Some are trying to meet financial targets through attrition and hiring freezes.

In the AHA survey, 53% of responding hospitals either were making staff reductions or planned to do so.

Managers are also worried about tightening capital budgets and the need to postpone technology purchases and upgrades.

“I’m concerned that the start of 2009 will be a huge challenge as the holiday bills roll in, utility costs go up, and deductibles start over,” says Jayne Byrd, RN, MSN, associate vice president, surgical services, for Rex Healthcare, Raleigh, North Carolina.

“Elective surgery should be down if people are thinking clearly. I’d be worried that being out of work for 6 to 12 weeks would make me a little more dispensable [as an employee].”

Michigan hard hit

Southeastern Michigan, cradle of the car industry, is particularly hard hit. The area’s unemployment rate, at 8.8% in October, was higher than the nation’s 6.5%, and was expected to rise.

“We’re crossing our fingers on what Congress decides to do about a bailout,” said one OR director in the Detroit suburbs.

“Some of my nurses’ spouses have lost their jobs in the auto industry. They are looking for additional hours, call, and overtime,” said another perioperative director of 9 ORs in the Detroit area. The hospital had laid off some nonclinical staff.

She has been charged with cutting her budget by 4.5%. Capital expenses and raises are on hold, as is tuition reimbursement.

William Beaumont Hospital, a large referral center with a high orthopedic volume in the Detroit suburb of Royal Oak, is seeing patients forgo elective procedures.
Economic downturn's impact on hospitals, patients
American Hospital Association data, October 2008.

Percent of hospitals reconsidering or postponing capital expenditures

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New capacity/renovations</td>
<td>56%</td>
</tr>
<tr>
<td>Clinical technology/equipment</td>
<td>45%</td>
</tr>
<tr>
<td>Information technology</td>
<td>39%</td>
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</tbody>
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Percent change in volume, 3rd quarter 2007 to 3rd quarter 2008

<table>
<thead>
<tr>
<th>Category</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Inpatient surgery</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Emergency visits</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Ambulatory surgery visits</td>
<td>-0.8%</td>
</tr>
</tbody>
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Hospital margins, 3rd quarter 2007 and 3rd quarter 2008

<table>
<thead>
<tr>
<th>Category</th>
<th>Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>3Q 2007</td>
<td>3.9%</td>
</tr>
<tr>
<td>3Q 2008</td>
<td>2.9%</td>
</tr>
<tr>
<td>Operating margins</td>
<td>6.1%</td>
</tr>
<tr>
<td>Total margins</td>
<td>-1.6%</td>
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How hospitals plan to weather economic storm

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Cut administrative costs</td>
<td>59%</td>
</tr>
<tr>
<td>Reduce staff</td>
<td>53%</td>
</tr>
<tr>
<td>Reduce services</td>
<td>27%</td>
</tr>
<tr>
<td>Divest assets</td>
<td>12%</td>
</tr>
<tr>
<td>Consider merger</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>21%</td>
</tr>
</tbody>
</table>

Source: American Hospital Association based on October 2008 survey of 736 hospitals and AHA database.
“We’re also seeing a shift from people with private insurance to those with Medicaid/Medicare coverage, which pays less,” says Susan Nielsen, RN, MSA, CNOR, director of the central processing department.

Beaumont had eliminated 500 of 18,000 positions, 200 through a hiring freeze. Executives and salaried physicians are taking pay cuts to help save another 225 jobs.

Surgical services, with few RN openings, didn’t have to cut nursing staff, but some support positions were affected.

On the other side of Michigan in the small city of Holland, Kathy Shaneberger, RN, MSN, CNOR, director of surgical services at 200-bed Holland Hospital, says she is hearing from surgeons that patients are putting off elective surgery, even more urgent procedures such as shoulder repairs.

“More staff are wanting to work rather than taking low-census time off,” she adds.

More volume, less staff

Massachusetts General Hospital (MGH), the large teaching center in Boston, has had low staff turnover in perioperative services for a long time.

“What we are seeing is staff requesting to increase their hours, and we don’t have the benefited hours to give them on a regular basis,” says Dawn Tenney, RN, MSN, associate chief nurse for perioperative services.

MGH had a 4% across-the-board budget cut for fiscal 2009, meaning about $1.7 million less than last year for perioperative nursing. A number of positions were eliminated at MGH, but any RNs displaced were offered other jobs in the hospital, and none has been laid off from perioperative services.

Surgical volume was steady through the fall. “What we are feeling now is the impact of increased volume with about 10% less staff than last year at this time,” Tenney says.

Shrinking capital dollars

In Seattle, despite a slightly higher surgical volume, the University of Washington is living with tight OR supply and FTE budgets, but so far there have been no layoffs or hiring freezes, says Bill Anton, RRT, business associate for surgical services.

Swedish Medical Center, also in Seattle, hasn’t seen much change in surgical volume.

“Our impact has been in capital monies going away and tightening up on hiring and use of travelers,” says the director of intraoperative services, Renae Battie, RN, MN, CNOR.

The economy could have an unexpected effect on the future supply of OR managers and directors.

With shrinking 401(k)s, “almost everyone who is nearing retirement age (including me) is making statements about having to work further into the future than they originally planned,” Shaneberger says.

—Pat Patterson

What’s ahead for hospitals?

A rundown from Nathan Kaufman of Kaufman Strategic Advisors LLC, San Diego, and the American Hospital Association (AHA):

Medicare, Medicaid margins

Hospital’s margins from the nation’s largest payer continue to slide. Medicare has said it will cut payments by 1% to 2% a year, adjusted for inflation.

“That means if a hospital broke even on Medicare this year, it will lose 2% on Medicare next year, 4% the next year, and so on,” says Kaufman.

As state revenues fall, Medicaid, already severely underfunded, will face even more cutbacks.

Patient volumes

As unemployment rises, patients are likely to put off elective surgery.

“For every 1% increase in unemployment, 2 million more people become uninsured,” he says. “And even people with insurance can’t afford their copays and deductibles. It’s creating a huge problem.”
The majority of hospitals surveyed by AHA had seen an increase in patients who are unable to pay for care. Uncompensated care was up 8% from July to September 2008 compared to the same period in 2007.

Credit crunch
Like other businesses and nonprofits, hospitals are caught in a credit bind. Costs of credit are up, and access to financing is down. Hospitals rely on credit to fill payment gaps and shortfalls.
Kaufman cited a recent study showing 50% of hospitals in the US are insolvent or approaching insolvency.
“That was before the credit crunch. Basically, hospitals that don’t have A-rated credit, which includes most small hospitals in the country, are going to have a heck of a time finding affordable credit.”

More physicians seeking financial support from hospitals
Physicians are facing their own cost and reimbursement pressures. In the AHA survey, 83% of hospitals reported physicians were seeking increased pay for being on call or providing other services, and 69% said physicians were seeking hospital employment.

Lower costs, better contracts
Hospitals’ 2 best options for the short term, says Kaufman:
• reduce costs
• negotiate better managed-care contracts and fine-tune the revenue cycle.
To OR directors, Kaufman’s advice is blunt.
“If you haven’t started re-engineering your processes to take costs out of the system, you’re contributing to the problem,” he said.
Areas to focus on—supply costs, particularly implants, and capturing more volume.
“One thing OR directors can do is to make their ORs so attractive to physicians that they will switch their allegiance from another facility.
“In a time of falling volume and revenue, nothing is better than improving volume.”

No near-term fix from Washington
When Congress tackles health care reform, the first iteration is likely to be universal coverage. Many predict that could cost the country an additional $130 billion, Kaufman notes.
A change in the reimbursement system will only come later, he says, “when costs are totally out of control, and politics become less important.”
Medicare is experimenting with alternatives.
One is the ACE project, short for the Acute Episode of Care demonstration, being conducted in 4 states, Texas, Oklahoma, New Mexico, and Colorado. Basically, Medicare will select 1 qualified hospital in each market that is willing to accept a single hospital-physician payment for certain orthopedic and cardiac surgery. Medicare beneficiaries will be given a financial incentive to encourage them to use these designated hospitals. Depending on how this turns out, Congress could consider more global payments to encourage hospitals and physicians to work together for better coordinated, less costly care.