Flipping, double teaming, running ORs back-to-back. These are a few terms for the practice of providing multiple ORs for particular surgeons.

The practice is widespread. A show of hands during a breakout session at the recent Managing Today’s OR Suite conference in Orlando found nearly everyone used this practice.

Flipping is popular with surgeons. They can perform more cases in less time, which is a major satisfier.

But which surgeons get to flip rooms? Is flipping mainly a response to the “squeaky wheel” who makes the most demands, or does it also make business sense for the hospital?

Strategies for managing flipping were discussed by the session’s presenters, David Wyatt, RN, MPH, MA, CNOR, vice president for perioperative services and the kidney transplant program at Presbyterian/St Luke’s Medical Center, Denver, and Mary Jane Edwards, RN, MHSA, CNOR, FACHE, of Deloitte Consulting, LLP, McLean, Virginia. Wyatt has since taken a new position as administrative director for operative services at Vanderbilt University Medical Center in Nashville, Tennessee.

Their main messages: Flipping should be:

- guided by clear, consistent policies
- viewed as a tactic that is in line with the hospital’s business objectives and strategic plan
- aided by regular communication among the OR management team, medical staff, and senior executives.

**How is flipping defined?**

In establishing policies for flipping, it’s important to be clear about how your organization defines flipping, they advised. Three types are:

- sequential
- overlapping
- simultaneous (illustration, p 7).

**What are the benefits?**

For surgeons, the benefit is clear. Flipping helps them conserve their most critical asset—time. By moving directly from one OR to the next, they can complete more cases in a day, which may enable them to fit another case into the schedule, a win for the surgeon and the hospital, assuming the case has a positive margin.

Surgeons also need to understand the hospital’s objectives, Wyatt noted. Common reasons hospitals agree to flip cases are to:

- increase surgical volume
Three types of flipping

**Sequential:** The surgeon moves from one room to the next without turnover time.

**Overlapping:** The surgeon moves from one room to the next with cases overlapping. The first patient is not out of the OR before the next one enters the next OR.

**Simultaneous:** Two cases are performed at the same time. This option applies only to teaching hospitals where residents perform portions of the cases.

- protect surgical volume in a competitive environment
- carry out promises made when recruiting new surgeons.

“I’m interested in helping surgeons to be more efficient, to do more cases, and be more satisfied,” Wyatt said. “They also need to understand my rationale—to grow volume and protect volume.”

**Establish policies**

Flipping is about allocation of the hospital’s resources and needs to be managed as such, he emphasized. Like the block schedule, flipping needs to be guided by policies administered by the OR’s executive leadership team. Having clear criteria and policies helps avoid charges of favoritism and ensures flipping is consistent with the hospital’s business goals. (Suggested criteria are in the sidebar, p 8.)

Among issues policies should address:

- Who receives the requests?
- How are decisions about flipping made?
- How will senior executives be involved in decisions?

Senior executives need to be informed about the OR’s flipping policy so they can support it.

“Involve the C-suite so you get ahead of the deals that are made,” Wyatt suggested. For example, OR leaders need to be involved in the recruitment of new surgeons so they can communicate the OR’s policies about block time, flipping, and other issues.
• How will OR utilization be measured for flipped rooms?
  Depending on how utilization is measured, results may be different for surgeons with flipped rooms than for others. What is important is to decide in advance how it will be measured, Wyatt said. It’s also important to be open and honest rather than to make adjustments in utilization behind the scenes.

Communicate the policies
  Make sure all surgeons, managers, team coordinators, and staff are aware of the policies and how flipping decisions are made.
  “You can’t do these things in isolation,” Edwards said. “Surgeons are very competitive. If they see the orthopedic surgeons flipping rooms, they may say, ‘I should be able to flip rooms, too.’”
  The leadership team should be able to articulate why certain surgeons are given flipped rooms. For example, a surgeon routinely schedules 6 cases a day that are each performed in under 2 hours. His surgical volume has risen since he was provided with flipped rooms, and overtime has declined.
  It’s also important to inform the staff, Wyatt noted.
  That heads off rumors that a surgeon using multiple rooms “must be threatening to take his cases elsewhere,” or “must not be happy.”

Risks and benefits
  Flipping should be considered in the context of the organization’s quality framework. Presbyterian/St Luke’s uses the Studer Group’s 5 pillars of excellence: people, service, quality, cost, and growth:
• People: Surgeons and patients
• Service: Surgeons and patients
• Quality: A potential issue is surgical site infections. Wyatt and his team considered possible risks from flipping cases, such as increased flash sterilization, to be sure practice standards are maintained.
• Cost and growth: These pillars are considered together. “Labor costs did increase, and that was a risk,” Wyatt said. “But with growth, you hope to increase or at least keep your volume.”

Regulatory issues
  As surgeons move from room to room without the usual turnover time, steps need to be taken to ensure compliance with The Joint Commission’s Universal Protocol for preventing wrong surgery. The protocol requires preoperative verification, surgical site marking, and a timeout before the procedure.
  In planning, the hospital must ensure the flipping process conforms to its Universal Protocol policy—and not the other way around, Wyatt and Edwards stressed.
  “Ensure your policy is maintained and then review how flipping accommodates to the policy,” Wyatt said. No one wants a side or site error, only to learn it occurred because the rules were bent for flipping.
  At Presbyterian/St Luke’s, the policy is that the attending surgeon marks the site. The next patient does not go to the OR until the surgeon has come out of the previous case, met with the patient, and marked the site. Meanwhile, the previous case may be finished by the physician assistant or RN first assistant.
  Another regulatory issue can arise in teaching hospitals where resi-
dent's perform some parts of the procedure. Medicare regulations stipulate that, in order to bill for the procedure, the supervising surgeon must be present for “critical” portions of the procedure. All parties need to be clear about how the hospital’s definition of critical portions of the procedure applies to flipped cases.

**Patient relations**

Patient perceptions need to be managed carefully so patients and families don’t feel care is being rushed. Flipping can lead to embarrassing situations.

At the conference, a member of the audience told of a case in which the circulating nurse called out to the waiting room to let the family know the case had started.

The family responded, “Well, you had better tell the surgeon because he is here in the family waiting room.”

Another recalled being with a patient in the preop area when a nurse manager came through urging her to “get your patient back to the room.”

The patient turned to the nurse and said: “Are you going to be taking care of me today?” The nurse said yes. The patient said: “Good, because I don’t want that hurry-up nurse.”

**Staff productivity**

Though flipping holds the promise of more cases and revenue, it also requires more staff. Staff must be available to start the next case before the previous case is finished and to clean the room after the surgeon has moved on to the next one, affecting the department’s productivity statistics.

Wyatt said he explained that fact to senior executives, pointing out, “The more we flip rooms, the worse our productivity is going to look.”

There’s always the risk that flipping won’t bring in additional cases or revenue to compensate for the additional staffing.

**Has flipping met objectives?**

Flipping should be managed and evaluated with the same rigor as any other business decision, Edwards advised. “Evaluate it every quarter and involve all of the key decision makers.”

Some areas to examine: To what extent has flipping helped the hospital to meet its objectives? Have surgical volume and revenue increased for the surgeons who have flipped rooms? Has flipping improved OR throughput? Have staffing and other costs increased? What is the impact on physician and staff satisfaction? How effective are the policies for managing flipping?

If the OR is starting to consider flipping, Edwards recommended conducting a 3-month pilot and reviewing the results. Did the pilot further the hospital’s strategy? “Flipping is another business decision,” she said. “Have it be a solid business decision and not a political decision.”

—Pat Patterson

**Criteria for flipping**

**Surgeon criteria**

- “Good citizen”: The surgeon is cooperative, treats the staff well, and is a practitioner you want to keep in your organization.
• Provides high quality care. The surgeon meets quality standards, including those for infection rates.

**Case criteria**

• Predictable case type, for example:
  — total joint replacement
  — arthroscopy
  — laparoscopic gastric banding for weight loss.

• Case length of about 2 hours.

**Contribution margin**

• Do surgeons who want to flip rooms perform procedures with a positive contribution margin? (Contribution margin = revenue – variable costs.)

  “We want to allocate resources to cases that produce more margin for the facility and protect the revenue of the hospital,” notes David Wyatt, RN, MPH, MA, CNOR.

  In some cases, the hospital may decide to allow a surgeon to flip cases even though that procedure does not have a positive contribution margin because the surgeon performs enough other cases that do have a positive margin.

**Strategic plan**

How does flipping fit in with the organization’s strategic plan?

• Does the surgeon who wants to flip bring in business the hospital wants to protect?

• Is this physician part of a service line the hospital is interested in, such as cardiac surgery or orthopedics?

_Sources: David Wyatt, RN, MPH, MA, CNOR; Mary Jane Edwards, RN, MHSA, CNOR, FACHE._