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OR performance

Is your OR leadership team up to health care reform challenges?

First in a series on OR performance.

How can you make progress on on-time starts? Are you attracting the right cases to meet your volume and revenue projections? How can you manage block utilization more consistently?

The first answer to these persistent questions is good OR governance and a strong leadership team built on collaboration among nursing, surgery, and anesthesia.

That firm foundation will be critical as the nation moves into health care reform. With tightening Medicare and Medicaid reimbursement and higher stakes for quality reporting and performance, ORs will need to be in top form. Though insurance coverage will expand and bring more paying patients to hospitals, many of those patients will be covered by government programs with low reimbursement. Medicare and Medicaid will also move toward value-based purchasing, or pay for performance, starting in 2013, tying a small part of hospitals' DRG payments to quality and efficiency measures (May 2010 *OR Manager*).

Is the traditional OR Committee up to the task? If the committee meets sporadically, has trouble raising a quorum, and is mainly a forum for complaints, it's time to look at another model.

Two consultants described governance models that can place the OR on a firm foundation to meet the challenges ahead. In related articles, 2 hospitals describe their governance structures and what they believe makes them effective.

OR as asset

Perioperative services are a major asset—a multimillion-dollar business—that needs to be guided by a board of directors, advises Mary Jane Edwards, RN, MHSA, CNOR, FACHE, of Deloitte Consulting, McLean, Virginia.

"The OR contributes 65% of the margin for a hospital—it's your revenue engine," she says, adding that a business of that magnitude needs a structure like that of any successful business.

The 12- to 15-member board is an operation that takes an interest in the whole perioperative enterprise.

"It's like being on the board of a public company," says Edwards, a former OR director who has been consulting with surgical services departments for 15 years. "A director can't just be interested in his or her own division. Directors need to act together to protect the shared asset, perioperative services."

Day-to-day management of the department is carried out by a manage-

ment team that reports to the governing board. The team, which includes a nurse administrator, anesthesiologist, and surgeon, reports to the board and interprets and executes the board's policies.

Who are the members?

The board consists of respected representatives from surgery, anesthesia, nursing, and the administration, with members selected based on criteria, not title.

"What's important is that the surgeons and anesthesiologists on the board really have an understanding and investment in the OR running well," Edwards says.

The hospital administrator directly responsible for perioperative services should be an active participant.

"This can't be just an honorific appointment," she adds. "The administration brings the larger picture and provides support."

What happens to the traditional OR committee?

Some hospitals redirect the OR committee's charge in line with the model described for perioperative governance, says Edwards. Others redirect the committee's charge, perhaps to focus on issues like morbidity and mortality, specific safety issues, and outreach to community physicians and surgeons.

Clear expectations

Expectations for the board of directors need to be clear. The mission should be set forth in the board's charter, Edwards advises. The board should be familiar with the hospital's strategic mission, determine the OR's key performance indicators, ensure resources are available to fulfill the mission, and track performance.

The aim is to set specific targets for improvement, which many hospitals are doing through methods like Lean Six Sigma.

"With perioperative governance, there is no place to hide. You have to achieve the goals," she says. She suggests a set of clear, basic indicators. Examples are:

- OR utilization
- first case on-time starts
- turnover time
- case volume and case hours
- quality and safety measures
- recruitment goals
- length of stay in the postanesthesia care unit.

Active members

The board needs active, participating members. "Make this the one committee that members attend if they can't attend any other," she suggests. That may mean re-evaluating the committee assignments of key physicians.

Regular attendance is expected. Some boards set a rule: Members who are absent 3 times per year or for 3 consecutive meetings are automatically replaced by another member who will be actively engaged.

Regarding compensation, Edwards says that in her experience, physicians have not requested supplemental payment for serving on the perioperative governing body.

"The reason is that this committee is so important," she says. It decides

on the rules for block scheduling, the hours of operation, and other policies that directly affect physicians' practices.

"Rather than a stipend, their payoff is in the creation of a disciplined, effective, and safe environment for their patients, families, and practice."

Surgery executive committee

A similar model that works well for any size of department, whether a 50-OR academic medical center or a 2-OR rural hospital, has 3 components, says Randy Heiser, president and CEO of Sullivan Healthcare Consulting, Ann Arbor, Michigan, which specializes in perioperative consulting:

- A surgery executive committee, typically a duo or triad with a nurse administrator and an anesthesiologist and/or a surgeon. "They run the OR and enforce policy," he says.
- A surgical services committee that acts as a board of directors, with the executive committee members as cochairs. This is an operational committee, not a medical staff committee, and reports to the CEO.
- A broad-based medical staff communication plan to convey information directly from the committee to the medical staff. The plan might include a regular town hall meeting or news bulletin.

In most hospitals where Heiser has consulted, the physician members of the surgery executive committee are paid positions. In a small hospital, the positions might be a part of an FTE, whereas in a large facility, they are generally full-time.

Good of the program

The physician members of the executive committee aren't necessarily the chief of surgery and chief of anesthesia, Heiser points out. The key is whether they are willing to step outside their specialty and make decisions based on the good of the program.

That's in contrast to the traditional OR committee where the members typically have been selected by the medical staff and "felt they owned the OR, and the OR was there as a service to the surgeons. That can create problems with anesthesia, because the traditional OR committee doesn't have anesthesia providers present," he notes.

Clear expectations are established. In a department that is working well, the executive committee might focus on strategic planning and operational and financial performance. In an OR that is implementing new programs, efforts might be directed toward those issues, compliance with policies, and so forth.

"Overall, this committee has to be fully responsible for the daily operations of the perioperative program. How that is defined is up to each hospital," he says.

Direct communication

As part of the plan, Heiser recommends a direct communication route with the OR medical staff. "Leaving it up to the chiefs to communicate with their services doesn't work."

One option is physician forums or town hall meetings, typically held quarterly unless there are pressing issues.

"It's a way for the executives to speak directly to the medical staff and give them an opportunity to have input that isn't filtered through anyone else," he says.

A typical agenda for a town hall meeting might include:

- the latest OR metrics
- issues and changes facing the department
- a "first reading" and feedback on new policies being considered
- new business and concerns.

These governance structures are easier to implement than they were 3 years ago, Heiser observes.

"Surgeons are starting to see in other hospitals that this does work," he says. "They see that with a good governance structure and good physician leadership, the volume of cases goes up, the money available to invest in new equipment and technology goes up, and most surgeons are doing more procedures." Sometimes, physicians who have been the greatest skeptics become the biggest converts.

"They see they are better off with the new model," Heiser says. ❖

—Pat Patterson

OR governance success factors

Support from senior management

Support from the top of the organization is "absolutely the one thing that makes governing bodies more or less effective," says Randy Heiser of Sullivan Healthcare Consulting.

"If the CEO who talks with an angry surgeon says anything other than, 'I will make sure to get you in front of the right committee so you can get this resolved,' it's dead in the water."

Clear responsibilities

Responsibilities and accountability for the OR board of directors and executive committee need to be clearly outlined.

"Once you tell a surgeon you don't know whom to take an issue to, the surgeon will solve it independently, and you will no longer have a governance structure," he says.

The right members

- Are the members able to think about what is best for the program rather than only about what is best for themselves or their own service?
- Is there a balance among surgery, nursing, and anesthesia so all 3 groups participate and have a say?