Unique Challenges from Surgical Services

An Excerpt from *The Healthcare Executive's Guide to Navigating the Surgical Suite*

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Serving as the leader of surgical services within an organization can be a daunting endeavor for a new executive. Unless they have actually worked at an operating room (OR) table as a surgeon or surgical nurse or managed a surgical product line, most new executive leaders lack an operational frame of reference for the unique concerns and challenges present in the contemporary OR's dynamic environment. The dress is different, the language unique and the management nuanced. Operating rooms have their own supply chain, scheduling and billing systems, and procedure codes. What can be touched or where one can safely tread is closely monitored.

Once referred to as "the workshop" of the hospital, with all of its tools and gadgets, the OR has rapidly evolved into a high-tech robotic center. Staying current with the ever-evolving clinical evidence on everything from safe patient positioning to the use of sophisticated technologies requires constant practitioner vigilance. Thousands of pages of federal and state regulations, along with various professional association practice guidelines, govern everything from cleaning protocols to physician preceptorships. Well-educated physician and nurse practitioners, emerging from the finest sites of higher learning, require thousands of additional hours of training to be judged proficient in the surgical arts. The fact

that operating theatres are by necessity isolated from the rest of hospital operations makes it increasingly difficult for an executive to understand and experience this very different world.

In the past, it was not uncommon for surgical service operations to be the bastion of an elite group of physicians who operated behind closed doors, controlled the granting of practice privileges to colleagues and determined everything from professional standards of behavior to who would receive preferential time on the OR schedule.

However, the importance of the operating room to the overall success of a healthcare organization has cast a new light – a very bright spotlight — on operating rooms. It is of critical importance for the new executive to gain an immediate understanding of complex OR operations. While simultaneously providing the greatest contribution of total revenue for the average hospital, the OR represents the location of greatest legal and patient-safety risk and the largest investment in physical assets and materials.

Additionally, the rapidly evolving payment landscape now includes innovative provider models affecting ORs and once unthought-of partnerships. Surgeons can now be competitors and collaborators simultaneously as they develop their own surgical centers. Revolutionary technology is blurring the traditional boundaries of radiology, cardiology and surgery. The new executive may be rapidly immersed in conversations about building or buying ambulatory centers, recruiting a new surgeon in a technology-intense specialty or mediating block scheduling conflicts. Such topics rarely, if ever, emerge in other areas of hospital operations

A Systems Approach

The “operating room” was once the label for actual operating suites and all departmental activities related to the management of ORs, including finance, supply chain, materials management, scheduling and more. Organizations now recognize that effective management of this complex operation requires a systems approach, both to improve the way a patient experiences a surgical procedure and to align practitioners in the creation of effective and efficient processes. Increased payer interest in this most-costly aspect of healthcare also has fueled the new approach.

Industry process improvement efforts have confirmed the benefit of subsystem alignment as a precursor to system optimization. Once separate silos of care must now function in complete synchronicity for care to be safe, cost-effective and efficient. Navigating a patient through a surgical event requires the systemic efficiency of the following processes: scheduling in the physician’s office, preoperative testing and anesthesia assessment, the arrival and check-in processes, pre-procedure holding, the surgical procedure itself, post-anesthesia recovery and discharge and post-procedure follow-up. Optimizing any one of these processes does not necessarily improve the entire experience for either the patient or the provider.

As a result, formerly disparate departments or functions typically are now referred to as perioperative services or surgical services. This name change suggests more than a simple refresh of signage. Driven by contemporary payment structures, optimization of processes and labor across the entire surgical event is required. Additionally, competition is playing a major role. Hospitals are now competing with a growing number of alternate sites for delivery of surgical services, including surgeon offices, ambulatory surgery centers and even clinics in the local mall. Each of these sites advertises the fact that procedures can be performed cheaper, quicker and with great convenience. Customers are responding.

The term "surgical services" is used in this text to refer to the surgical product line and the fully integrated system of surgical care, including sites of care (inpatient and outpatient) and their strategic, operational, management and business processes. When referring to the actual suite where the procedure is performed, the term "operating room" is used.

Surgical Services and the Transformative Changes in Healthcare

The next sections describe four major forces that are transforming healthcare in surgical services and beyond, and the response required of surgical services leadership.

Changing Payment Structures for Surgical Care

Highsted and Peters report that "in a financially healthy hospital, surgery generates up to 65 percent of contribution margin" (2017, para. 2) This suggests that any reluctance to prioritize the efficiency and effectiveness of all aspects of surgical services places the organization and the executive at significant risk. The Centers for Medicare & Medicaid Services (CMS) just released final guidance on mandated episode or bundled payment programs for both joint replacements and cardiac rehabilitation (2017). Despite canceling mandatory participation in the bundles, CMS continues to believe that bundled payments offer opportunities to improve quality and care coordination while lowering spending. CMS is leaving the door open for voluntary efforts by providers to create less expensive models that offer value and accessibility. Although this particular approach to incentive payment has been suspended (possibly temporarily) by the government, it is clear that the payment environment is rapidly moving to a value-based model. Executives must expect payer reimbursement methodologies that incentivize the delivery of care in less expensive settings, and through less expensive means, with significant emphasis on value and outcomes.

Simply put, as the most expensive operation within most organizations, and the one generating the highest contribution to an organization's overall strategic and financial health, surgical services will continue to find itself under the greatest pressure to cut costs. This makes it a target for disruption as payment strategies evolve. Porter and Kaplan (2016) in the Harvard Business Review discuss two likely payment alternatives **in the evolution toward value-based reimbursement:** capitation and bundled payments. Each has significant impact on the provision of surgical services.

With capitation, the organization receives a fixed payment per year per covered life and must meet all care needs of that population, including required surgical procedures. With the bundled payment system, by contrast, providers are paid a set rate for the entire care episode for a certain diagnosis or procedure, such as joint replacement, cardiac surgery or congestive heart failure. Within this payment, the organization must provide all tests, procedures, devices and medications.

The authors do not expect a single payment approach in the short term but do foresee plenty of payer-driven experimentation with unique market and geographic nuances. The impact to surgical services likely will be significant, as the total cost of a surgical procedure and the often-lengthy recovery will consume an inordinate percentage of that payment. This phenomenon is accelerating the development of innovative models in surgical services to efficiently manage the episode of care across the entire system, including preoperative preparation, choice of implantable device and trajectory of postoperative recovery.

The challenge for many legacy hospitals is a lack of agility to make expeditious changes to care models, including development of the most cost-effective venue for care. Disruptive provider models that compete on both cost and convenience threaten expensive, overhead-laden operating rooms. Where community hospitals once competed with other hospitals in town, now surgeon- or investor-owned surgical centers – with considerable ability to provide excellent care at less expense and greater convenience – challenge hospitals to an entirely different scale of operations. In fact, future competition may come from investor-owned facilities or hospitals nationwide or across the globe in the form of domestic or global medical tourism.

The Evolving Market for Surgical Care

As if cost pressures from government and private payers were not challenging enough, traditional market forces governing healthcare are experiencing sea changes as well. The notion that healthcare is local is being challenged from a number of perspectives. Hospitals historically have defined their market based on local demographics. Patient proximity, coupled with aggressive marketing of a skilled team of surgical experts and the most cutting-edge technology, was assumed to be enough to recruit profitable surgical cases to the organization. A stable base of primary care practitioners helped to ensure the pipeline of surgical cases through well-established referral patterns.

While this served hospitals well prior to the advent of value-based shopping for surgical services, Slotkin, Ross, Coleman and Ryu (2017) suggest that the traditional approach for defining a market is now experiencing significant disruption. Tired of raising insurance costs and opaque quality and clinical outcomes data, large employers like Lowe's Walmart, GE, and Boeing are setting the quality criteria for a successful surgical outcome at a price they are willing to pay and are negotiating directly with providers to obtain such surgical care for employees irrespective of provider location. This means that a Boeing

employee living and working in Chicago's corporate office may be directed to a hospital in Ohio or Seattle for a hip replacement or cardiac procedure.

The majority of surgical procedures performed annually are considered elective or semi-elective (clinically necessary but not emergent) and hence, can be "shopped" by employers. Employers nationwide are partnering with payers, payer intermediaries and business coalitions to identify providers of surgical care that meet specific quality and cost standards. In order to be considered for participation in this type of network, surgical care providers will need to demonstrate value in the purest economic terms – which outcomes can be guaranteed at what cost.

For the hospital looking to participate as a destination provider, the implications are significant. Systems and processes must be reengineered, workflows redesigned, best practices implemented across all practitioner groups, and all unnecessary clinical variation removed. The data and analytical requirements will involve significant investment to provide continuous evidence of value. Next-generation scorecards and performance metrics will provide the evidence that care that heretofore was considered aspirational has indeed become "hardwired" into the organization.

Evolving Relationships with Surgeons: Competitor or Collaborator

The growth of ambulatory centers has been meteoric given new payment approaches, advances in technology and biopharmaceuticals, which have radically lessened the need for traditional inpatient surgical care. For the most part, surgeons continue to direct cases to a preferred hospital and a preferred level or location for care, whether inpatient or ambulatory. The emergence of surgeons as business owners should not come as a surprise. Whether surgeons are primary owner-investors or partners with a growing number of ambulatory surgery center (ASC) management companies, acute care hospitals increasingly are finding themselves in the thorny position of competing with their referring surgeons for surgical business.

Reporting in Becker's ASC Review, Dyrda (2013) notes that between 2001 and 2011, the number of ASC operating rooms doubled in the U.S., and by 2011, 60 percent of all hospitals had an ASC within five minutes of the hospital. ASCs are big business. In 2011, Medicare made $3.5 billion in payments to ASCs (Dyrda, 2013). This competitive threat for hospitals will only escalate with the continued evolution of minimally invasive surgical techniques, pain management approaches and non-acute venues for recovery and rehabilitation, including home care and home therapies.

Hospitals were once able to balance the number of highly profitable, less complex cases covered by surgical services with those patients whose multiple comorbidities, lengthy inpatient stays and overall high resource utilization resulted in lower profitability. With the growth of ASCs, profitable surgical cases increasingly are diverted from acute care hospitals to ASCs that can achieve clinical outcomes that rival or exceed hospital surgical programs for much lower cost.

Unique Challenges in the OR

In addition to the disruptive payment, market and competitive forces described here, the new executive faces unique labor challenges with surgical service programs, which threaten the long-term financial health of the organization. While there has been a surge in healthcare hiring, healthcare employees continue to represent a steady 7.3 percent of U.S. workers (Daly, 2016). According to the Bureau of Labor Statistics (BLS), union members across sectors of the economy represent roughly 11 percent of the overall workforce (2017).

The American Federation of State, County and Municipal Employees (AFSCME) — United Nurses of America reported that the issues that typically drive organizing efforts among nurses include mandatory shifts, poorly constructed and implemented overtime and on-call policies, and deteriorating relationships with physicians (Holleran, 2001). All of these triggers are prominent in the operating room. Coupled with the administrative isolation of the department, they represent a potential area of smoldering discontent for surgical services. The union reports that nurses in a number of states are lobbying for legislation to end the practice of mandatory overtime. This practice has increased in operating rooms across the country as hospitals attempt to create more flexible schedules to accommodate surgeons and patients.

Personnel management challenges are on a collision course with the unique demographic threats facing surgical services. A 2013 national study of nurses conducted by AMN Healthcare found that 12 percent of the total nursing workforce is concentrated in the perioperative areas, specifically the operating room and post anesthesia. Patterson, in OR Manager (2012), noted that almost 60 percent of surgical service managers who responded to a survey reported current difficulty filing RN and technician positions. A larger 68 percent predicted significant difficulty during the next five years.

AN or Nursing Shortage Looms

Buerhaus, Staiger, and Auerbach (2000) point to the fact that graduates of nursing diploma programs have concentrated in greatest numbers in the operating room because these programs offered greater exposure and experience in surgical nursing than baccalaureate programs. The shift away from diploma programs mean that younger, college-educated nursing students in the late 1970s and through the 1980s were less likely to have been exposed to operating room experiences than in earlier decades. As a large group of expert OR nurses approaches retirement, surgical departments are facing a precipitous need for new nurses that will require a lengthy amount of time and resources to develop skills and proficiency in the care of surgical patients.

Surgical Services at the Epicenter of Healthcare Disruption

Healthcare is facing disruptive forces beyond any experienced before, and Kaufman (2018) notes that disruption will be faster, bigger, and broader in 2018 and beyond. Creative and well-capitalized industries (such as the technological industry) without a historic presence in healthcare are entering the

business, using their experience to redefine and set the standard for the level of service in a customized, immediate world.

Grube (2018) suggests that numerous parallels exist between the retail industry and healthcare. Both are beset by converging forces, including large-scare disruptive competitors, intense pricing pressures and a need to optimize efficiencies. Healthcare, much like retail, is experiencing a significant decline in revenue as disruptive models from some unlikely sources compete with traditional approaches.

Amid this intense pressure to provide value at lower costs, hospital executives face significant pressure to more effectively and efficiently manage their surgical operations. Labor is scarce and regulatory requirements mounting.

For new executives, the surgical service learning curve is steep, with significant financial and operating risk if they fail to address challenges with thoughtful expedience.

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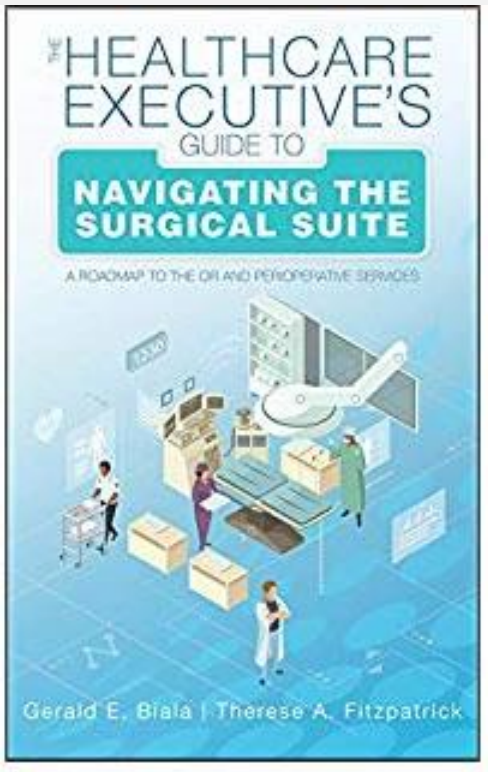

The Healthcare Executive's Guide to Navigating the Surgical Suite is a book released in 2018 by **Gerald Biala** and **Therese Fitzpatrick**. The book covers contemporary market realities, business challenges, labor requirements and clinical and operational complexities as it points leaders toward the most pressing issues in strategic surgical services leadership. **Gerald Biala** is an Executive Vice President of Sullivan Healthcare Consulting.

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