

Theory and Application of OR Management

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No Disclosures

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Learning Objectives

- Why ASC's
- What is OR Management/Leadership
- Application of OR Management: Branches
- OR Scheduling/Utilization
- Relationship building/Conflict Management
"OR Equilibrium"

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- Today there are more than 5,300 ASC's in the US with over 50 million surgeries annually
- Medicare grants approval for ASC's for approximately 3,500 procedures
- 65-70% of all surgeries are performed in Ambulatory centers

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Advantages of ASC's

- Better patient/surgeon satisfaction
- Less psychological stress
- Faster patient recovery
- Decreased DOS cancellations
- Decreased risk of hospital acquired infections
- Decreased hospital waiting list

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The Business Side of ASC's

- ASC's provide care at a Significant Cost Savings
- Currently medicare pays ASC's 58% of the amount paid to a hospital for the same service, thus = tremendous medicare savings
- Also, ASC procedures usually equal less coinsurance

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Cost Savings

- Staffing, supplies and building
- Specialized specific procedures (smaller scale)
- Cross training personnel
- No guarantee of work hours

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OR MANAGEMENT

- The Science of how to run an OR
- Focuses on maximizing operational efficiency
- Maximizing the number of cases that can be done in a given day while minimizing required resources and cost

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Application Management

- Includes best practices, techniques and procedures essential for optimal operation, performance and efficiency
- Strategic objectives must be tangible and measurable
- Standardization of work process

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OR MANAGEMENT (How to best)

- Ensure patient safety and optimal patient outcomes
- Provide surgeons with appropriate access to the OR
- Maximize efficiency of OR utilization, staff and materials
- Decrease patient delays
- Enhance satisfaction among patients, staff and physicians

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OR Leadership/Management

- Leadership sets a direction for change, developing a vision, power and ability to lead people toward this shared goal, inspiring a team
- Leadership includes communication, listening skills, rapport building, conflict resolution and trust building
- Leadership requires intelligence, emotional savvy, flexibility and rapid response for rapidly shifting circumstances
- Management consists of implementing those goals through planning, budgeting and staffing

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Departmental Leadership

- Compartmentalizes each member of a surgical suite team to his/her department (e.g. surgery, anesthesia, nursing)
- The principle behind departmental leadership is the delegation of responsibility
- This interest directly relates to OR utilization and OR productivity

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Branches of Management in the ASC (Team)

- Anesthesiology: Work efficiently and guarantee patient safety, valuable management perspective, same as ASC
- Surgeon: Incomplete vision, conflict of interest
- Nursing: Leadership in the OR Suite

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Anesthesiologists as the OR Manager

- Skills include maximizing the effectiveness, efficiency and integration of delivered healthcare
- Establishing Anesthetic Care Pathways that optimize rapid emergence, room turnover time and expedite PACU discharge, including patient satisfaction
- Affectively reducing perioperative complications and improving outcomes

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Surgical Suite Leadership

- Must be in compliance with several internal and external governing bodies, i.e. JCAHO and CMS
- Universal protocols must be implemented to ensure patient safety, reduce iatrogenic errors and postoperative complications

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Case Scheduling

- In an ASC, cases are elective, therefore the imminent and emergency surgeries are not considered
- Historical approach for scheduling OR time should be used when available
- Limiting this approach is limited number of cases by surgeon and the surgeon's familiarity with the procedure

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Operating Room Utilization

- The measure of the use of an operating room that is properly staffed with people needed to successfully deliver a surgical procedure to a patient

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Block Utilization

- A measure of the use of operating room time by a surgeon or group of surgeons to whom time has been allocated

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Raw Utilization

- Equals total hours of cases performed divided by total hours of OR time allocated

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Assessing OR Efficiency

- Case Cancellations (DOS)
- Staff Unavailability (Call in's), back up plan
- Start time tardiness
- PACU congested
- Turnover times (cleaning time)
- Surgeon Unavailability
- Late or unprepared patient

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Case Cancellation Rate, DOS

- Range from approx 1% for the ASC to 13-18% for VA Medical Centers
- CMS reports approx 1% since 2014 for ASC's

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Start Time Tardiness

- A mean tardiness of start times for elective cases per OR/day
- Reducing the amount of time a patient has to wait for their surgery

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PACU Admission Delays

- Expressed as a % of work days with at least one delay of 10 mins or greater in PACU admission because PACU is full
- Adjust PACU nurse staffing accordingly

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OR Turnover Times

- Time from the exit of one patient until the next patient enters the same OR
- Includes cleanup time and setup time, but not delays
- At best performing OR suites, average < 25 mins

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Surgeon Unavailability

- Habitually late surgeon: Review and assist either collegially or via a discipline policy
- Policy's should be applied fairly and without favorites

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Unprepared Patient

- Access process
- Late patient arrival
- Delayed check-in process
- Delayed preop nursing process/difficult IV access

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Relationship Building

- Build Relationships with EVERYONE
- Ask Opinions from Everyone
- Know the name of Everyone: Nurses, Scrub techs, cleaning people, EVERYONE!
- These are the people you will want to help you - have their backs, seek their opinions...they are the experts in their fields

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Interpersonal Conflict

- Communication errors, conflict and flawed decision making contribute to the majority of accidents
- Communication problems is an overwhelming barrier to OR performance
- This is consistent and can disrupt an OR and distract from OR efficiency
- Personal issues must be acted on quickly and optimized
- Teaching communication skills/simulator training/crises management

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Disruption to the Daily Plan

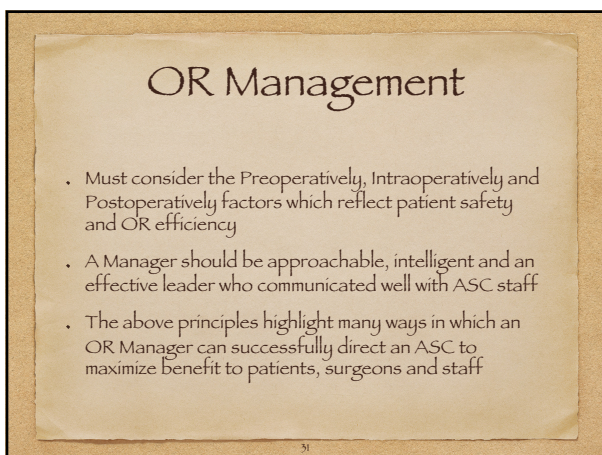
- It Will Happen!
- Never answer emotion with emotion
- Consider the options/alternatives, stick to your principles
- Always keep patient care a priority
- Lead by example and with kindness

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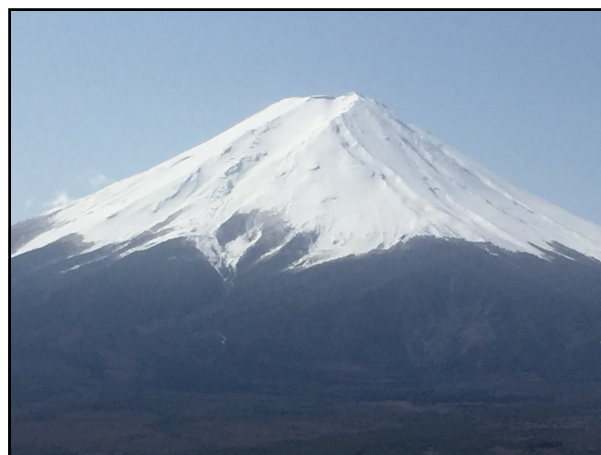
Debrief

- Talk about it: What went right/what didn't/could it go better?
- Debriefing: Keep it short and constructive
- Consider: Reasons situation occurred/future handling

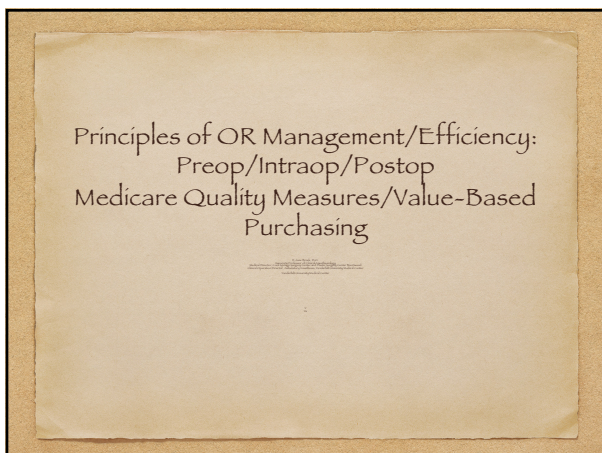
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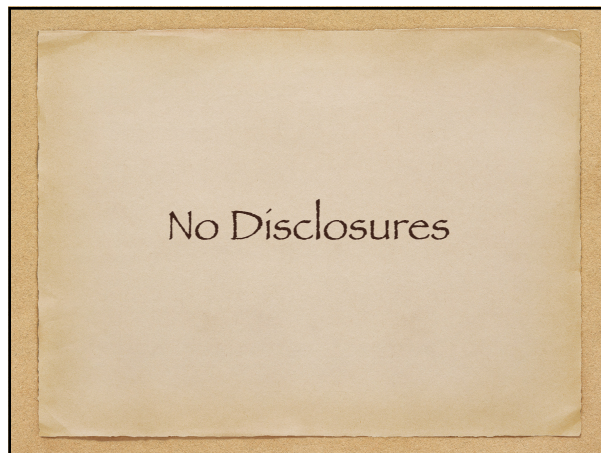
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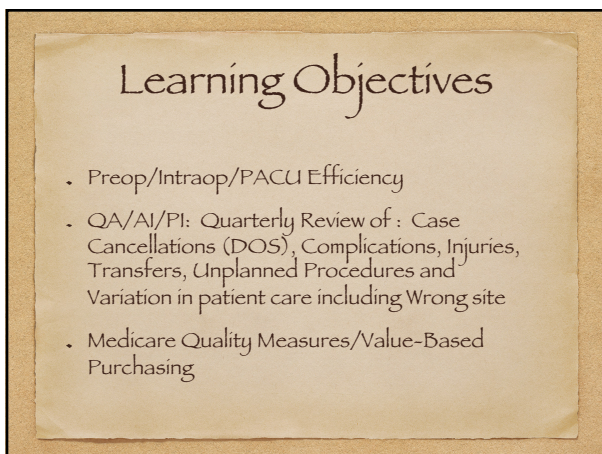
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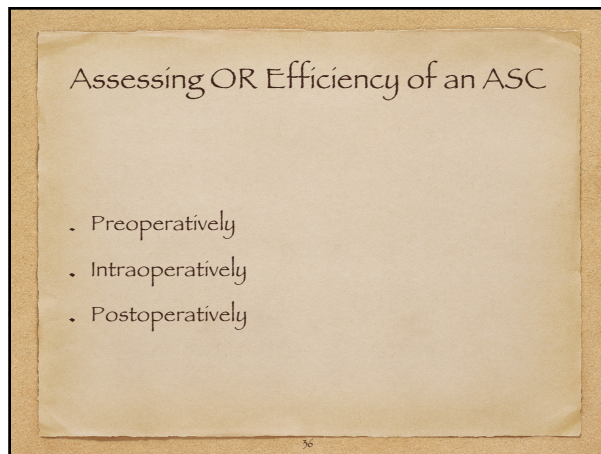
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Preoperatively

- Screening questionnaires/also in pre op
- Preoperative phone calls/evaluations
- Consider procedure first
- Consideration for Anesthetic technique
- Starting IV's, applying BP cuffs/EKG leads (plug and play)

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Patient Selection for an ASC

- Suitable Surgical Procedure: i.e. CMS Ambulatory approved, low risk for blood loss and pain control
- Patients pre op health, ASA Classification
- Proposed Anesthetic Technique
- Suitability of Facility, ie Freestanding
- Caregiver considerations

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Complication Risk Predictors, 72 hr

- High BMI
- COPD
- Previous PCI/Cardiac Surgery
- Hypertension
- TIA/CVA Hx
- Prolonged Operative Time
- Anesthesiology 2013; 119: 1310-21, ASA Monitor, 2014, Joshi

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Common Pre Op Management Issues

- Patient Waiting Time
- Operating Room Scheduling

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Preoperative Waiting Time

- Defined as time from surgical scheduling to check-in for the procedure
- Increases as demand for surgery increases/or operating room availability reduces or fails to grow proportionally to surgical demand

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Three Checkpoints are:

- 1) Preoperative verification of procedure and background information
- 2) Marking of the operative site per surgeon
- 3) An official timeout for an audible confirmation of patient identity and the procedure

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Intraoperatively

- Techniques that expedite the wake up process
- Aim for pain free/nausea free, multimodal techniques/preemptive antiemetics/regional techniques
- These techniques also improve post-op efficiency and room turnover time

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Intraoperative Management Issues (Review)

- Departmental Leadership (Anesthesia, Surgery and Nursing)
- OR Turnover times
- Interpersonal conflict among team members
- Communication systems

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Postoperatively

- Judicious with sedative and narcotic based post-op remedies to expedite recovery
- Quick rescue if PONV/pain to expedite discharge/patient satisfaction
- PACU team on board with efficiency/proper eval systems
- Effective discharge scoring system/PADSS

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Ambulatory Recovery Goals

- PONV adequately controlled
- Pain adequately controlled
- Adequate hydration, normothermia
- No minimum stay required, meet discharge criteria
- Responsible home care

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Post Anesthetic Care in Ambulatory

- ASA Practice Guidelines for Postanesthetic Care, Anesthesiology 2013; 118, No 2
- SAMBA's Consensus Guidelines for Management of PONV, Anes & Analg 2014; 118: 85-113

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PARSAP (Modified Aldrete for Ambulatory Centers)

- Numeric values to the following criteria: Activity, respiration, circulation, consciousness and oxygenation
- Maximum score of 10, with a minimum of 9 acceptable for discharge to home
- Main goals are controlling postoperative pain, N/V and meeting PARSAP score

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Unplanned Admission

- Length of surgery > 1 hr
- ASA status > 3
- Advanced age > 80
- High BMI
- Whipped A. et al, Can J Anaesth 2013; 60: 675-83

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Transfer Protocols

- Protocols to affect a smooth, timely and safe transfer of emergency cases
- Determined by the Anesthesiologists/Surgeon
- Agreement with an accepting hospital

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Internal Risk Management Program (Performance Improvement)

- Minimize risk of injuries, incident, adverse event and unplanned occurrences to patients and staff
- Investigation of adverse events, analysis of frequency
- Includes at least annual Risk Management and Risk Prevention education/training
- Analysis of patient grievances related to patient care and quality of medical services

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Value -Based Care

- Holds health care providers accountable for both cost and quality of care
- Attempts to reduce inappropriate care
- Attempts to identify and reward the best-performing providers
- The "Value" in VBC is derived from measuring health outcomes against the cost of delivering the outcomes

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Benefits of VBC

- Patients spend less money to achieve better health
- Providers achieve efficiencies and greater patient satisfaction
- Payers control costs and reduce risk
- Suppliers align prices with patient outcomes
- Society becomes healthier while reducing overall healthcare spending

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VBC Models

- Patient-Centered Medical Home (PCMH)
- ACO's
- Hospital Value-Based Purchasing Program (VBP)

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- The Medicare Shared Savings Program is the most well-known and standardized example of this model
- Medicare continues to reimburse health systems on a FFS basis, then, at the end of the year, shared savings bonuses are calculated
- If a client did better than the FFS population, they get a piece of the savings

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Key Management Goals to Maximize Reimbursement

- Improve operating cost to deliver care more efficiently (eliminate waste), ie standardize work, decrease/eliminate medical errors/patient injury
- Increase patient volume by improving quality and patient satisfaction
- Understand the shared savings arrangements
- Track quality measures

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Future of VBC

- Moving from a fee-for-service to a fee-for-value system will take time
- Transition has proven more difficult than expected
- Likely will see short-term financial hits before longer-term costs decline

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ASC Quality Reporting CY 2019 Payment Determination

- Patient Burn
- Patient Fall
- Wrong site/patient/procedure/implant
- All Cause Hospital Transfer/Admission
- Influenza Vaccination Coverage among Healthcare Personnel
- Endoscopy/Polyp Surveillance/followup, interval for patients with and w/o history
- Cataracts/vision function w/i 90 days
- Facility 7-Day Risk-Standardized Hospital Visit Rate after OP Colonoscopy

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CY 2017 Measures

- ASC's may voluntarily submit data for CY 2017
- Not subject to a payment reduction during the voluntary reporting period
- 2019 measures with addition of IV Antibiotic Timing, Safe Surgery Checklist Use, ASC Facility Volume Data on Selected ASC Procedures

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Possible New Quality Measures

- Postoperative nausea and vomiting
- Case hospital admission within two days of discharge
- Emergency department visits within two days of discharge

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Patient Experience of Care

- 32-item HCAHPS patient survey (Hospital Consumer Assessment of Healthcare Providers and Systems)
- 2 % of Medicare payments linked to its performance in 2017
- Validity not proven

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Public Reporting Survey Includes

- How well doctors communicate with patients
- How well nurses communicate with patients
- How responsive staff are to patients' needs
- How well staff help patients manage pain
- How well staff communicates with patients about medicines
- Whether key information is provided at checkout

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OR Management/Quality Measures

- An OR Manager must be able to lead and manage from the preop setting to the discharge setting and beyond.
- He or She must be involved in the quality measures required by CMS and other governing bodies
- Protocols must be implemented to ensure patient safety, reduce iatrogenic errors and postoperative complications

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Importance for the Anesthesiologists (OR Manager)

- Involvement in the Performance Improvement Council: Review DOS cancellations, hospital transfers, etc
- Involvement in Medical Advisory Boards: Reporting of PI Council reviews and involved in block scheduling, start time tardiness and identifying consistent outliers
- Make yourself irreplaceable! Involve yourself in protocols, mock codes, MH drills, write your care pathways for expediting patient care.

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