Cost management for ORs moves from minor to the major leagues

If your household had to cut expenses by 7% to 8% and then hold the line for 10 years, how would you adjust? That’s the situation hospitals face as they cope with cuts in Medicare and Medicaid payments and rising numbers of uninsured patients.

The high unemployment rate plus state and federal budget pressures are leaving hospitals with huge budget gaps.

“We still have the same amount of work. We’re just getting paid a whole lot less to do it,” said one hospital CEO.

Hospitals have already seen big cuts in Medicaid and face more cuts from Medicare. The giant health programs, which account for almost 25% of federal spending, are a big target for Congressional deficit cutters. These cuts will come on top of those already scheduled under the 2010 health reform law. That’s a serious hit to hospital revenues—Medicare accounts for 43% of hospitals’ gross revenue on average. The majority of hospitals—6 in 10—already lose money on Medicare, according to the American Hospital Association.

Moving to major leagues

Perioperative leaders are veterans at cost management. But this is like “going from the minor to the major leagues,” says Ken Perez of the management consulting firm, MedeAnalytics, author of a recent white paper on the financial crisis (sidebar).

In the coming issues, OR Manager will report on steps OR directors and their teams are taking to squeeze costs and help keep their organizations afloat. That includes basics like keeping preference cards up to date, scrutinizing custom packs, and clamping down on product acquisition.

But the basics are no longer enough.

“Continual diligence is not the answer any more,” says Terry Wooten, director, clinical supply chain at St Joseph Hospital in Orange, California. St Joseph plans to tackle product conversions and costly physician preference items at the system level through a new Clinical Effectiveness Committee.

The workforce is not exempt. Hospitals, where jobs have been fairly secure, are being forced to address staffing costs through hiring freezes, voluntary separations, and layoffs.

Redoubling efforts

Nailing the basics like preference cards and custom pack management is still a major focus. Packs with unnecessary items are costly and wasteful. Inaccurate preference cards are a drag on efficiency if missing items have to be fetched during a case.

“We are evaluating every avenue to reduce supply costs—revamping preference cards to make sure we only have what is actually going to be used,” says Martha Stratton, MSN, MHSA, RN, CNOR, director of nursing, surgical services for AnMed Health, Anderson, South Carolina.

“We are constantly reviewing our procedure packs to remove items not used at least 90% of the time.”

For the 37 ORs at Abbott Northwestern Hospital in Minneapolis, management of
preference cards and custom packs is hard-wired (sidebar, p 11).

**Revving up throughput**
Like preference cards and packs, boosting OR throughput takes constant attention. Lean management is a theme in many ORs, which are applying this system developed by Toyota to weed out waste and steps that don’t add value.

To help engage physicians, Sinai Hospital of Baltimore has initiated a gain-sharing program with orthopedic surgeons to better manage costs in that specialty. In gain sharing, a hospital enters into a structured plan with physicians in which they agree to share savings without affecting the quality of services.

The arrangement can create a closer alignment with physicians, providing an incentive for both parties to collaborate in becoming more efficient and controlling costs.

**Adding induction rooms**
Another strategy to increase case throughput is a plan to build induction rooms to reduce preoperative prep times, says Jerry Henderson, MBA, BSN, RN, CNOR, CASC, assistant vice president for perioperative services.

The 2 induction rooms will be built in repurposed supply storage areas adjacent to the ORs. The rooms will be used to insert lines and administer nerve blocks.

“We estimate that we will shave off between 15 and 45 minutes of induction time,” Henderson says. "We already move cases back and forth between rooms, but our preop area is at least a 5-minute walk from the ORs. The induction rooms will eliminate this wasted walk time during turnover time."

Jackson Hospital and Clinics in Montgomery, Alabama, is taking a detailed look at turnover time, comparing the usual times with the times for surgeons who are provided with a second OR. In this practice, known as “flipping,” a second OR is set up for the surgeon while his or her previous case is in progress, reducing the down time between cases.

“We have several physicians who always expect to have a second room, so we are monitoring turnover times as well as their volumes closely,” says Deb Cooksey, MBA, MS, RN, CNOR, director of perioperative services.

**Managing staffing costs**
In the Pacific Northwest, Seattle-based Swedish Medical Center announced September 19, 2011, that it was evaluating 300 jobs, or about 3% of its workforce. Because of a “seismic shift” in the national economy, it faces a $19 million budget gap.

“High unemployment in the region means we are seeing more and more Medicaid and charity-care patients and are writing off more cases as ‘bad debt’ due to people being unable to pay their medical bills,” said Swedish’s president and CEO, Rod Hochman, MD.

Providence St Peter Hospital in Olympia, Washington, with a $28 million gap, also has had to turn to a reduction in force. “Inpatient volume is flat, and outpatient surgery is down 12%,” says Lorna Eberle, BSN, RN, CNOR, director of perioperative services.
**Economic realities facing hospitals**

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<th>Medicare margins</th>
<th>Specter of more cuts</th>
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<td>Medicare accounts for 35% to 55% of most hospitals’ revenue.</td>
<td>Congress is debating additional cuts as part of deficit reduction talks:</td>
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<td>Medicare margins for the average hospital are projected to worsen to -7% in 2011.</td>
<td>□ If Congress’s “super committee” fails to agree on a deal by November 23, 2011, to reduce the deficit by at least $1.5 trillion over 10 years, across-the-board cuts would result.</td>
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**Margins are eroding**

- The government is whittling away at Medicare payments. Under the 2010 health reform law:
  - Market basket updates will be adjusted downward in FY 2010 through FY 2019.
  - “Productivity adjustments” are being made for FY 2012 through FY 2020. The FY 2012 adjustment is -1.0%.
  - Other downward adjustments are to make up for what the government says were increased payments to hospitals caused by the phase-in of MS-DRGs.

**What does this mean for a 300-bed hospital?**

- Assuming a 300-bed hospital with $250 million in revenue has no volume growth, and Medicare accounts for 40% of its total revenue, the hospital would need to reduce costs by $2 million in FY 2012 to keep its Medicare margins at the FY 2011 level.

<table>
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<th>More reimbursement at risk</th>
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<td>Under Medicare’s pay-for-performance initiatives, by 2016, 6% of a hospital’s IPPS reimbursement will be at risk, creating more pressure to excel with fewer resources. Initiatives include:</td>
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  - value-based purchasing
  - penalties for health care-associated conditions (HACs)
  - penalties for excess readmissions.

- Congress is debating additional cuts as part of deficit reduction talks:
  - If Congress’s “super committee” fails to agree on a deal by November 23, 2011, to reduce the deficit by at least $1.5 trillion over 10 years, across-the-board cuts would result.
  - Medicare cuts would be capped at 2% and come out of payments to hospitals, physicians, and other providers.

Perioperative services has reduced its 200-employee workforce by 19 FTEs. Most of the reductions were through attrition or early-separation agreements, with 2 layoffs.

**Probing staffing variances**

Staff productivity is under close scrutiny as managers try to hew closely to productivity targets.

Managers at the University of Kansas Hospital (KUH), Kansas City, Kansas, track staffing variances for each pay period and reinforce the staff’s accountability to conform to assigned hours.

Data are reported daily on a spreadsheet from the hospital’s productivity management system, Kronos, notes the department’s business operations manager, Brian Dolan, MHSC, RHIA, CHDA, SSGB, who developed the spreadsheet.

Each pay period, coordinators review staffing, identify variances, and report reasons to the perioperative director. They also reinforce the staff’s accountability not to clock in early or stay late without permission, which has been identified as one cause of variances.

**Tightening product evaluation**

Tightening up on supply management is a major theme. That includes stricter compliance with group purchasing contracts, eliminating duplicate products, and...
Review of procedure cards and custom packs is hardwired for the 37-OR department at Abbott Northwestern Hospital, part of Minneapolis-based Allina Hospitals & Clinics. Resource nurses (team leaders) and staff play a leading role.

A representative from VHA Inc, in a 3-day review, found the hospital’s management of preference cards and pick lists was “probably as good as she’s seen,” says Terry Voigt, CRNA, director of surgical, perioperative, and anesthesia services.

Preference cards are procedure- and surgeon-specific. When developing a new card, resource nurses start with a master card and customize it for the procedure and surgeon.

Resource nurses and staff are watchdogs for preference card accuracy. If a circulating nurse consistently notices unused items on the back table, the nurse will ask the surgeon if these items are still needed.

Nurses note changes on the bottom of the preference card or pick list. Resource nurses make sure changes are made in the computer system.

**Diligence on custom packs**

Packs are widely used at Abbott Northwestern, which with 23,000 cases a year, has high volumes of spine, neurosurgery, and general surgery.

“We’ve worked hard on making sure that if we have a custom pack for a procedure, it fits the majority of surgeons doing those cases,” says Voigt. “What you are trying to gain are efficiency and, hopefully, cost savings.”

As with preference cards, resource nurses and staff play a key role.

The critical elements:

**Constant vigilance**

Resource nurses constantly monitor items that are frequently thrown out or requested to be added.

Pack use is also observed periodically by the surgical pack company, which discusses findings with staff. Kimberly-Clark provides an independent review.

Custom packs are discussed regularly at team meetings. Resource nurses ask for the staff’s input on items considered for deletion.

**Changes based on usage**

When a change is requested, lead time from the pack vendor, American Contract Services (ACS), is about 4 to 5 weeks.

“With other vendors, it was a couple of months before we would see a change,” he says.

**Cost awareness**

What motivates the staff to stay on top of packs and preference cards?

“It’s our ongoing discipline about managing costs for our patients,” Voigt says. “We talk a lot about that. It’s about our financial viability. Something may not cost a lot but if used for 1,000 procedures, it adds up.”

A sample preference card from Abbott Northwestern is in the OR Manager Toolbox at www.ormanager.com.

making sure new product requests comply with a standardized protocol. Physicians are also playing a greater role in product decisions, managers report.

Abbott Northwestern began taking a harder stand a few years ago.

“I’ve been surprised by the surgeons’ acceptance of the process, both in the time to get new products through and their reactions to price comparisons,” says Terry Voigt, CRNA, director of surgical, perioperative, and anesthesia services.

Sinai Hospital of Baltimore has reinforced product selection with its PAM Committee structure, short for Product Acquisition Management (PAM). The perioperative PAM committee includes physicians, periop leadership, front-line staff, and materials management.

“The PAM committees have specific and aggressive goals for reduction in supply costs,” says Henderson.

Requests for new products must be accompanied by evidence to justify the request. “Vendors are not allowed to fill out requests for physicians.”

The requesting physician must attend the PAM meeting to sponsor the request, which must be signed by a physician sponsor, such as the chair of the service, plus
the head of the requesting department. A detailed financial analysis is completed before the committee’s deliberation.

**Do product claims pan out?**

Once a new product is approved, KUH is taking a more structured approach to ensure claimed savings and outcomes are actually achieved.

“We’re taking time with supply chain and finance to identify a protocol to be used at 3 months or 6 months to see if we are actually seeing a cost benefit and a change in utilization or waste patterns,” says Dolan.

A key step is to identify metrics and a data collection method. For example, is there an improved length of stay? Are complications lower?

A recent example is a follow-up for a newly purchased antimicrobial-impregnated neurosurgery catheter. The new catheter was compared with the standard product to see if there was an effect on the infection rate. The infection preventionist tracked infections for 6 months for patients who received each type of catheter.

“We were able to identify that we didn’t have a big problem, and the problem did not decrease as a result of using these (antimicrobial) catheters,” says Dolan.

That triggered a discussion with the surgeons, asking, “Do we need to maintain this product, or can we revert to the previous product line that has the same clinical outcomes?”

The tough environment will call on the ingenuity of the entire perioperative team as they continue their efforts to provide safe, high quality care in a time of economic constraints.

—Pat Patterson