Anesthesiology: An important ally in building better surgical services

Among the challenges facing OR leaders everywhere are declining payment in tandem with rising costs, increased quality and patient satisfaction requirements, and the ongoing struggle to manage relations with surgeons. When it comes to tackling these issues, many OR directors do not realize they have a powerful natural ally—the anesthesiology department.

In most hospitals, nursing and anesthesia operate in distinct silos. Nurse managers and anesthesiologists may come together to run the board, but the 2 groups generally pursue separate agendas. This situation is unfortunate, because the interests of OR nursing and anesthesia are closely aligned.

In well-run surgery departments, nursing and anesthesia collaborate closely to manage daily operations, drive care innovations, and optimize financial performance. In these ORs, anesthesiologists are the enablers who allow nurse leaders to achieve their most important goals.

Developing a positive working relationship with anesthesia should be a strategic priority for any OR director. The first steps are to understand the needs of the anesthesia group and identify ways to work toward shared goals.

Aligned needs
Recent trends in healthcare affect hospital surgery departments and anesthesiology groups alike.

One big issue is declining revenue thanks to the 2% sequestration cuts in Medicare payment coupled with a fall-off in surgery demand. Anesthesiologists are also affected by declining payment, and lower OR volumes mean lower service volumes for anesthesia providers.

Quality requirements are also a shared concern. OR leaders have focused for several years on meeting performance standards established through quality payment initiatives like the Value-Based Purchasing program. Anesthesiologists also are increasingly subject to quality performance expectations. By 2017, all anesthesia groups will be affected by the Medicare value-based payment modifier.

One of the most challenging trends in healthcare is consolidation. Hospital mergers and acquisitions continue to drive change and uncertainty in ORs, but anesthesiology is experiencing its own consolidation phenomenon. The last few years have seen the rise of several national anesthesia groups—efficiently run operations with significant organizational resources. These groups are offering to provide anesthesia coverage with little or no financial support from the hospital. For small anesthesia practices, this competition is a source of significant pressure to improve efficiency and accept a lower stipend.

The opportunity for OR leaders is to forge an alliance with anesthesia based on shared needs to improve efficiency, increase quality, and maintain revenue. There are 4 areas in which OR and anesthesia leaders can collaborate productively (sidebar, p 24).

Frontline management
Efficiency improvements are the foundation of many other performance gains. To start building a productive alliance, OR leaders should invite anesthesiologists to take part in frontline operational leadership.
In many better-performing ORs, anesthesiologists provide medical direction for preadmission testing (PAT). These anesthesia leaders work closely with the surgical specialties to develop preoperative testing protocols based on procedure, surgical invasiveness, and patient comorbidities. They can also help PAT staff implement surgical risk reduction strategies such as preoperative management of anemia, cardiovascular risk assessment (including aspirin management), and delirium risk assessment.

Better PAT processes have a huge impact on OR efficiency. At a North Central academic medical center, anesthesiologists developed a preoperative assessment clinic. Between August 2011 and January 2013, the clinic reduced delays related to incomplete testing by 60% and cut the cancellation rate from 2.6% to 1.3%.

Anesthesia can also add value by leading a daily huddle. Working side by side with nurses and other perioperative stakeholders, anesthesiologists coordinate the review of all cases 24 to 72 hours prior to surgery. Daily huddles are important for ensuring patients are medically cleared on the day of surgery. They also play an important role in efficiency, giving perioperative leaders the chance to optimize scheduling, patient flow, and utilization.

Anesthesiologists can also provide effective management of critical care. Currently, only a small percentage of hospital ICUs are led by an anesthesiologist. In those that are, anesthesia medical direction is key to improving care and reducing costs. Ventilator-associated pneumonia (VAP) represents a major opportunity. According to a recent analysis, VAP increases hospitalization costs by nearly $40,000 per patient. Anesthesiologists are leading efforts to assess new strategies for preventing this costly complication.

**Care innovation**

Growing demands for higher quality are driving the need for innovation in care. Nationwide, anesthesiologists have shown they are effective at implementing new processes and care models that improve outcomes.

**Discharge processes.** Poor handoffs to post-acute care are a major factor in readmissions. In some hospitals, anesthesiologists have developed protocols to ensure all surgery patients are seen by a primary care provider within 24 hours after discharge. This system enables postoperative follow-up of comorbidities identified during the PAT process.

**Pain management.** Pain control is becoming increasingly important as patient expectations rise. OR directors should work with anesthesiologists to reexamine and strengthen pain management protocols. For instance, some ORs have created a block nurse position to facilitate the efficient administration of presurgical regional nerve blocks. The block nurse is a registered nurse who prepares the materials for regional blocks, assists the anesthesiologist or certified registered nurse anesthetist (CRNA)
with the performance of the block, and helps manage block toxicities and complications.

**Surgical home.** We previously noted the success of the University of Southern California’s Keck Medical School surgical home model at reducing mortality rates (see OR Manager January 2014, pp 21-23). This anesthesia-led initiative also had a dramatic impact on performance metrics that reflect hospital costs:

- shorter ICU stay—2.72 days for surgical home patients compared to 4.85 days for patients receiving a conventional care approach
- shorter hospital length of stay—6.87 days (surgical home) versus 10.1 days (conventional)
- lower ICU readmission rate—1.65% (surgical home) versus 15% (conventional).

Surgical home models can also help an OR attract more surgical volume as a result of better outcomes and greater surgeon convenience.

**Cost control**

Anesthesiologists can provide effective support of cost control goals.

**Controlling materials costs.** Because most anesthesiologists work with a wide range of surgeons, they understand variations in supply utilization and the underlying rationale of supply preferences. They can use this knowledge to engage in productive one-on-one discussions with surgeons regarding supply cost outliers. They can also help persuade surgeons to stand with the hospital during pricing negotiations with vendors.

**Reducing anesthesia costs.** Most anesthesia groups receive a financial stipend from their hospital. Improvements in OR utilization can reduce anesthesia revenue shortfalls significantly, enabling many groups to reduce support costs.

In addition, OR directors can often work with anesthesiology to find ways to grow anesthesia revenue organically. For example, they can help their anesthesia group develop a service line providing coverage for colonoscopies. Endoscopy cases are short and offer a significant number of induction units, thereby increasing anesthesia revenue significantly.

Management improvements can also increase anesthesia profitability. For instance, many anesthesia groups pay CRNAs an hourly rate. Depending on the situation, an annual salary for a CRNA can be more cost-effective, especially as regards overtime and call pay. A salary-based cost structure also allows the anesthesia group to budget more effectively.

**Bridge to surgeons**

Anesthesiologists can also help nursing leaders by mediating between the needs of the OR and the needs of surgeons.

One major opportunity is block time. In many surgery departments that have successfully reformed the block schedule system, anesthesiologists have played a key role in building consensus on new principles and rules. A large public hospital system in the Southeast recently worked to restructure OR block lengths, block release standards, and utilization requirements. An anesthesiologist took the lead in disseminating these changes to surgeons; he and the nurse manager visited each surgeon’s office to explain the changes and win support. Even though all surgeons were required to reapply for block time, anesthesia-led outreach laid the groundwork for widespread acceptance among the surgical staff.

Anesthesiologists can contribute to strategic planning by helping to identify specialties with realistic growth potential. They can also advocate for strategic change with hospital administration. Most important, anesthesiologists are essential for creating differentiation within strategically targeted service lines.
For example, OR leaders at an East Coast academic medical center recently developed a strategy for growing orthopedic surgery. One weakness in the plan was poor service for joint replacement procedures. The average turnover time for total joint replacements was 48 minutes. Lengthy turnover time and other inefficiencies made surgeons reluctant to bring additional case volume to the hospital.

The anesthesiology department worked with nursing leadership and other stakeholders to address this issue. Using parallel processes and other interventions, they were able to reduce joint procedure turnover to 18 minutes. Faster turnover enabled surgeons to perform 1 additional case per day—generally speaking, a revenue increase of 33%. Not only were orthopedic surgeons more satisfied, the additional surgical volume increased OR revenue while improving its cost structure.

The big question
Will anesthesiologists get behind initiatives like these? In our experience, most anesthesia groups are very open to exploring how they can improve the OR.

They are more than eager to improve the clinical environment. And they understand that their active leadership will not only drive better OR performance, it will improve their financial outcomes and solidify their group’s relationship with the hospital.

This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow revenue, control costs, and increase department profitability.

References