Tracking tool streamlines scheduling, enhances communication with surgeons’ offices

Sacred Heart Medical Center RiverBend in Springfield, Oregon, began OR optimization efforts soon after moving to a new facility in August 2008. Because of the US economic downturn around that same time, the hospital launched several initiatives to make the most of available resources, including a Lean process to improve turnover times.

But an underlying problem was holding back progress on turnover time and other improvement fronts: Scheduling between surgeons’ offices and the OR staff wasn’t standardized, often leading to missing information, errors, and delays.

“The schedule is your roadmap for the day. We did other initiatives, but because we recognized the importance of an accurate schedule, we were always prepping in the background, looking at options to address scheduling,” says Barbara A. Faust, MN, RN, CNOR, director of quality, safety, and standards for surgical services. Sacred Heart is part of the PeaceHealth system, which operates 9 hospitals in Alaska, Washington, and Oregon and has a strong commitment to patient quality and safety.

Surgeons’ offices were scheduling via phone or fax, using a variety of different forms. Problems with this process included incorrect transcription of patients’ names and procedures because of not hearing correctly or difficulty in reading handwriting, missing information because of lack of a standardized form, and missing documentation, such as orders, for the day of surgery because of unreliable fax transmission. Cases were sometimes delayed while nurses hunted for information.

“There was a lot of finger-pointing. It was difficult to track the source of problems because there was no trail,” Faust says.

With the go-ahead from the executive leadership but with a limited budget, work on the tool began in November 2011.

A full-time job
Sacred Heart has 25 ORs and 4 procedure rooms where 18,000 procedures per year are performed. Early on, it became clear that overhauling the scheduling system would require a full-time staff person’s efforts. Because resources wouldn’t allow for a dedicated IT team, this individual had to be multitalented, Faust says.

“This person needed to be computer-savvy and work well with people. We were going to be asking the offices to do their work differently, so we had to sell this project. This individual had to have the time to make improvements and do the communication.”

As it turned out, that person was already on staff. Julie Womack had been a staffing coordinator for surgical services, with a track record of facilitating scheduling there. As the newly appointed surgical data and business analyst, Womack began investigating software options for electronic transmission of information between the offices and the OR.

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### Performance improvement

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the OR’s own scheduling software, PICIS, into the surgeons’ offices turned out to be technically unfeasible. A secure email system was considered, but what they really needed was a system similar to Microsoft’s Sharepoint that would allow multiple users access to the same database.

Because of the tight budget and lack of a dedicated IT project team, Womack turned to a home-grown software tool already in use as an “issue tracker” that allowed multiple users access to address particular problems.

“We researched what we could do with our capabilities and virtually no money,” Faust notes.

The issue tracker was renamed “Data Exchange Scheduling Tool,” and a PeaceHealth business analyst showed Womack the different features of the application. Then she began configuring it to address the unique requirements of scheduling. Within the tool, she designed electronic forms for each surgical specialty. All the forms contain the same required fields, including the patient’s name, birthdate, pre-operative diagnosis, name of procedure, CPT and ICD-9 codes, primary language, and phone number, all in the same order.

Under the previous system, faxes arrived with the information listed in random order. Having the information listed uniformly makes it much easier for the OR schedulers to type or copy and paste it into PICIS. “The form flows exactly the same way every time,” Womack notes. (Unfortunately, they weren’t able to get the tool to automatically populate into PICIS and data must be entered manually, but at least now all the information is being received electronically and in a standardized way.)

Next, Womack created customized drop-down lists of instrumentation for each surgical specialty, with each list containing all the equipment available on-site. If a procedure requires special instrumentation, that order is typed into a separate box.

In order to comply with HIPAA (Health Insurance Portability and Accountability Act) regulations, a part of the tool called an “issue set” allows it to be sliced so that the OR schedulers can see the incoming forms from all surgeons’ offices, but each office only sees the forms for their own patients.

Another feature, called a “diary note,” allows the office schedulers to send a message signaling any special requests or changes, such as the date of surgery. The OR schedulers then respond and confirm the request or change.

Documents such as consent forms and order sets are attached to the tool either directly from the office’s electronic health record or by scanning the paper forms.

Womack set up checklists of all the necessary forms so that OR schedulers can easily see which documents are attached and which are missing. That way, they have time to locate missing forms prior to the day of surgery.

“If you can’t see the orders, H&P, and consent in the data exchange, we don’t have them. They’re not sitting on a fax machine,” Faust notes.

A key feature, Faust points out, is that the tool eliminates finger-pointing. “Everyone who touches the data leaves a time trail. If a case is scheduled incorrectly, we can go back and see which side the error came from.”

Taking it to the offices

Once the pilot tool was developed, secure connectivity had to be established to exchange information between the OR and surgeons’ offices. The practices affiliated with PeaceHealth were already connected to the secure server, but the outside offices needed to be brought in. Forms had to be filled out to obtain the appropriate licenses, for which there was a small fee.

Faust and Womack began rolling out the tool in February 2012, beginning with a PeaceHealth-affiliated bariatric surgery practice, followed shortly by an orthopedic surgeon’s office that was also part of the PeaceHealth system.
After visiting each office and giving an initial presentation on the tool, Womack trained the scheduling staff of each office one by one, making sure the software was properly set up and taking the schedulers through practice cases. “I would stay there as long as they needed me, and I’d come back as many times as they needed. We really wanted this system to work, and we really wanted to partner with them,” Womack explains. “The tool turned out to be very intuitive and easy to use, and many offices did not need extra assistance,” Faust adds.

Once the offices were fully functioning with the new scheduling tool, Faust and Womack invited office schedulers and office managers into the OR to see the patient pathway on the day of surgery. They met their scheduling counterparts on the OR side as well as the charge nurses for the specialty of each of their practices. Included in this tour was a stop in sterile processing, along with the implant and loaner room. “This really opened their eyes to the reason we need specific information in a timely manner in order to prepare for the patient and surgeon,” says Womack.

“We gave the schedulers a chance to meet our schedulers, and then the office managers could meet the surgery directors and really build those relationships,” Faust says.

**Evolving every day**

Since bringing the last of the practices on board in November 2012, Faust and Womack have received very positive feedback on the tool from users on both ends, as well as suggestions for further tweaks. “We interview all the office staff during the tour. It was surprising to us that even the most reluctant adopters were very positive about the new tool; they said, ‘this is one of the best things that has been done to improve communication between the office and surgery.’”

PeaceHealth facilities in Oregon, Alaska, and Washington are in various stages of developing a similar system.

Other parts of the hospital have also begun using the tool. The financial services department now obtains CPT and ICD-9 codes from it, whereas before they often struggled to get that information from the offices. This has helped reduce the number of cancellations of surgery caused by lack of preauthorization and has improved communication between patient financial services and surgeons’ offices, Womack says.

Internally, the utilization review team is also using the tool to make sure offices are entering the correct admission status for patients in order to be reimbursed for the surgery.

“We didn’t know we’d be using it beyond scheduling, but then realized it could do so much more,” Womack explains. Faust adds, “The tool is honestly evolving every day. It has taken on a life of its own.”

Faust advises other OR teams interested in developing such a tool to research what they have on-site because many hospitals already have an issue tracking system or other platform that can be similarly reconfigured. “You may have something within your system that you can use at a lower cost, instead of looking outside,” she notes.

Faust and Womack are working to collect data on how well the system has performed in streamlining their OR practice. They will present “Improving Patient Safety and OR Efficiency Through Scheduling and Communication” during the 27th OR Manager Annual Conference, September 17-19, in Long Beach, California.

*Miriam E. Tucker is a medical journalist in Bethesda, Maryland.*