Affordable Care Act prompts OR leaders to push the efficiency envelope

As implementation of the Affordable Care Act (ACA) continues, OR leaders are looking ahead and finding the view murky.

“I think every organization is struggling because our crystal ball is not very clear as to what is coming,” says Donna Doyle, MS, RN, NE-BC, CNOR, administrative director for surgery and anesthesia at Grant Medical Center, a level 1 trauma center that’s part of the OhioHealth system in Columbus. The medical center has 30 ORs in two locations, with an annual volume of more than 20,000 cases.

The 24th annual OR Manager Salary/Career Survey (cover) found that the ACA is on OR leaders’ minds (sidebar, p 12). Survey results and interviews with perioperative services experts reveal that the top concern is cost management.

Discourage outliers

Good cost management starts with knowing existing costs. “You absolutely have to know in finite detail what it costs for every single physician to do every single procedure,” says Marian McCann, MBA, BSN, RN, CNOR, a healthcare consultant and director of the OR at Memorial Health Care in Long Beach, California. Once McCann has cost-per-case data, she works with the medical staff to address outliers. Often, it’s simply a matter of meeting with the surgeon to point out variations.

“Physicians are fairly competitive,” she says. “Most don’t like being the outlier, so they will sit up and take notice.”

Kevin Behrns, MD, chair of surgery at the University of Florida (UF) Health in Gainesville, agrees: “Once surgeons see they are an outlier, they will often fix that themselves. If not, we meet with them.” UF uses standardized order sets and preoperative conferences to address potential problems before a patient arrives in the OR.

Make wise decisions

Hospitals are getting creative in their efforts to cut costs. Doyle says that at OhioHealth, a surgery peer group meets monthly to share best practices and successes.

“We have a multidisciplinary committee, with both clinical and nonclinical members, that identifies where we can take cost out of the system without affecting quality of care,” she says. Ideas can be as simple as the choice of cleaning products, which can save almost a million dollars in the first year. “It’s a way to be proactive.”

Doyle adds that standardizing supplies and equipment and using evidence-based practices also play a role in keeping costs down. “We use Lean and Six Sigma to identify variation in processes,” she says.

Colleen Becker, MSN, RN, CCRN, director of perioperative services at Barnes-Jewish Hospital in St Louis, Missouri, agrees with Doyle that cost management has to occur at a higher level. More than 41,000 cases a year are performed in 62 ORs at Becker’s hospital. “We now manage value analysis from the system level,” she says.

Surgeons and their teams are included in discussions about supply chain and management. “We have worked closely with the surgeons to determine current usage of product, what is the best value for the patient, and what is the best value for the organization,” Becker says. “Decisions are based on the available data and information. The surgeons
are actively engaged in the process so that we can be as minimally disruptive as possible to their practice. A big change for them is that this involves more of their time.”

Value analysis committees now require a fuller evaluation that includes return on investment on any product a surgeon wants to introduce into the OR. “We don’t just look at costs; we also look at what will be replaced,” Becker says.

“We know that in the future, readmissions are probably not going to be covered (by insurance),” Doyle says. Like many hospitals, Grant is trying to reduce readmissions, notably by focusing on healthcare-acquired infections. “For example,” Doyle says, “we’re struggling to maintain compliance with CHG [chlorhexidine gluconate] bathing and not have that affect our on-time starts when a patient who hasn’t bathed comes in.”

It’s also important to track length of stay and outcomes data. McCann advises OR directors to work closely with the hospital’s quality and infection control departments to ensure they have what they need. “You have to create and maintain those relationships.”

### Maximize efficiency

To stay competitive in the ACA environment, hospitals must increase volume and efficiency. Doyle notes that Grant is competing not only with other hospitals, but also with freestanding ambulatory surgery centers because she believes that ultimately reimbursement will be the same for both.

Doyle says the OR provides two rooms for high-volume surgeons, so they can easily work back and forth between the two. “We staff up those rooms, and turnover time is about 16.25 minutes. If surgeons have both inpatients and outpatients, we want to make it so efficient that they will want to do both patients in the same location instead of traveling somewhere else to do outpatients.”

No matter what the volume, efficiency is essential to keep costs down, starting with on-time first case starts. “It’s hard to have a great day in the OR if you don’t get off to a great start,” says Dr Behrns. “Before we can have an on-time start, all of our processes need to be standardized.”
Dr Behrns says he and Diane Skorupski, MS, RN, NE-BC, CNOR, assistant vice president for perioperative services at UF, review daily reports on start times so they can follow up as needed.

“We look at variances by behavior, supplies, and practice,” Skorupski says. Behavior variation related to the preoperative briefing is captured with an audit tool that someone (usually an RN not participating in the procedure) uses to observe the interaction. Managers coach staff with deficiencies in behavior, and a value analysis committee addresses supply issues. Education plays a key role in reducing practice variation, and Skorupski notes that simulation training is particularly helpful.

“The effort in the OR is on improving efficiency, reducing waste, and building capacity,” says Judy Pins, MBA, BSN, RN, vice president of Pins Productions, LLC, in Chicago. To build capacity, ORs are rethinking their schedule, adding more evening and weekend hours, and adapting as hospitals close and consolidate.

“ORs are under extreme pressure to run as lean and efficiently as they can,” Pins says, which puts pressure on OR leaders to make smart decisions. “One hospital had 32 different spine vendors, but decided to take crackers and peanut butter out of the doctor and nurse lounges (the cafeteria was not open after hours),” she says. “It that really going to get them where they need to go when it comes to managing costs?”

She says many OR managers need to think more strategically. “If I were an OR director now, I’d want to know the major trends affecting my business” (sidebar). “Put together a business plan, and go to your boss and say, ‘We can do better with our capacity.’ Be proactive; that’s what CEOs are looking for,” Pins says.

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