How do we get to high-value health care—care that strikes the right balance between quality and cost? It’s a question leaders will be facing as health care reform is implemented.

What might that high value be like in surgical services?

One place to look is Minnesota-based HealthPartners, a nonprofit integrated health system. Costs in the system’s clinics are 9% below the Minnesota average and 38% lower than the national average. The system also rates high on quality. Examples are a 500% improvement over 5 years in the number of patients receiving optimal diabetes care and reaching 100% in the optimal care of heart attack patients in 2009.

Regions Hospital in St Paul, one of HealthPartners’s 3 hospitals, in 2009 for the second year in a row was rated as one of the nation’s 45 “high-value” hospitals by the Leapfrog Group for its performance on complex high-risk procedures such as heart bypass surgery and its efficiency in bypass surgery, angioplasty, and other services. A Level 1 trauma center, Regions has 17 ORs and an ambulatory surgery center with a surgical volume of 18,000 to 19,000 cases a year.

The director of surgical services, Dana Langness, RN, BSN, MA, talked with OR Manager about how her department contributes to HealthPartners’s quality and cost results.

Like HealthPartners as a whole, she says, surgical services is guided by the Triple Aim, an initiative of the Institute for Healthcare Improvement (IHI) that seeks to simultaneously improve:
• the patient’s experience with care
• the health of the population
• the cost of care.

The Triple Aim is reflected in OR leaders’ approach to governance, patient safety, operational performance, and cost-effectiveness.

OR governance

An effective governance structure is needed to set and reinforce policies for surgical scheduling and other efforts to make good use of surgical services’ primary resource—OR time.

“Our surgical structure is very strong,” says Langness, who is in a leadership triad with the medical director of anesthesia, Matt Layman, MD, and the surgeon lead, David Dries, MD.

“We say to the staff that we cannot keep our patients safe or deliver cost-effective care if we are not in total partnership with our colleagues,” she says. “Gone are the days when we can keep our patients safe by ourselves, even though that’s the way we were taught.”

About 80% of physicians who operate at Regions belong to the HealthPartners medical group.
To reinforce the department’s culture of safety, the 3 disciplines hold joint quarterly in-services attended by surgeons, anesthesia providers, OR personnel, and preop and postop staff as available.

“Most of our sessions are about safety and quality,” Langness says. “That way, all of our staff hear the same thing. We are getting much more innovation and dialog with this approach.”

**OR throughput**

The department is “constantly looking for ways to improve safety and efficiency,” Langness says.

The block schedule was revamped using Lean management methods in preparation for opening a new ambulatory surgery center in 2007 and a new main surgical suite in September 2009. The new schedule, in addition to considering the needs of the specialties, also started the process of smoothing the flow of inpatient cases through the week to even out demand for inpatient beds. Research has shown that peaks and valleys in the elective surgical schedule are one factor that can cause capacity crunches in inpatient units and the emergency department.

Another innovation was to provide “swing rooms” for certain high-volume procedures, such as total joint replacements, to provide those surgeons with 2 rooms a day so they can complete more cases.

Langness runs OR utilization and block utilization reports monthly for the multidisciplinary OR committee, which is chaired by a surgeon. “We try to stay at about 70% to 75% utilization in the main OR, which promotes growth in volume,” she says.

**Safer scheduling**

Langness says leaders continue to seek ways to make scheduling safer.

“Our goal is to never have a ‘good catch’ again because the surgery schedule didn’t match what is actually being done on the day of surgery,” she says.

A current project is to create a “master file” that includes the key documents used for patient verification and orders. The OR is working with the clinics to ensure use of consistent terminology when scheduling into the OR’s scheduling system, Epic’s Optime, which in turn ensures that the correct preference lists are generated.

**Patient safety**

Patient safety is woven into all of the department’s activities.

Reports of OR safety projects are shared with the HealthPartners 5 Million Lives Committee led by the CEO, Mary Brainerd. Sponsored by IHI, the 5 Million Lives Campaign aims to save patients’ lives by encouraging organizations to adopt proven practices.

To advance safety in the OR, leaders, with support of administration, agreed to abide by a limited set of “red rules”—clear, simple rules accepted by the whole organization.

The point is not to discipline people who do not follow the red rules, Langness explains. Instead, the rules provide a way for clinicians to call out in a safe, respectful way things they feel are not being done appropriately during a case. Examples are a time-out that isn’t carried out completely or a water basin for fire safety that is not in the correct place.

In 2009, the ORs celebrated a year with no OR fires, retained foreign objects, or wrong-site surgery.
Being transparent

Being open about errors and near misses is part of the safety culture.

“We are totally transparent,” Langness says. “If we have a good catch, we bring those to the staff.”

To further learning, in-services typically start with a story about an event or close call, whether at Regions or another hospital. “Those stories are really powerful,” she notes.

To reinforce the message about speaking up if something seems amiss, a certified registered nurse anesthetist (CRNA) at Regions was recently awarded the Minnesota Hospital Association’s Speak Up for Safety Award.

The CRNA was recognized for speaking up during a time-out and preventing a wrong event. The CRNA had noticed a discrepancy between the OR schedule and the surgeon’s statement about the procedure to be performed. The case involved a vulnerable patient and a guardian who didn’t understand the situation.

“The CRNA said the case could not move forward. The surgeon listened, and the situation was resolved before there was harm to the patient,” says Langness. “I think that’s an example of how our hard work is changing the culture.”

The OR has also been recognized by Health Partners for its “time-out towel,” placed over the Mayo stand to remind the team to conduct the time-out before surgery.

Cost management

To help make cost-effective decisions about supplies and equipment, a surgical services value analysis team guides requests. The team is led by Langness and the director of materials management, with surgeon representation.

“We never want a supply in the OR that hasn’t gone through this process,” Langness says. “We are very tight on the trials we will conduct.”

Requests are submitted by the service line leader and physician lead for the service, using a standard form. The value analysis team examines the impact of the request on current services and costs.

The surgical services business manager supports the value analysis team and works with the service line leaders when new procedures are proposed to assess profitability and impact on OR staffing and operations.

“There is a fine line between managing the process and not being so tight that you are not going to consider new technology,” Langness says. “Because we’re growing, we want new physicians. We’re also a teaching facility.”

A continuing challenge, not unique to Regions, is finding a way to manage the rising cost of implants, an issue that challenges most if not all surgical services departments.

Savings in ambulatory surgery

In a recent cost management project, Regions ambulatory surgery center saved by reviewing costs service line by service line, starting with the ones that were least profitable.

“We asked for surgeon leadership to standardize the procedures and only use the supplies that were needed,” Langness says.
Reimbursement specialists also worked with payers to present the center’s costs and negotiate for better payments for some procedures.