Six strategies for boosting outcomes as Medicare/Medicaid pay tightens

The message coming out of Washington is clear: Do more with less. Under Medicare’s hospital inpatient value-based purchasing (VBP) program launched July 1, 2011, DRG payments will be tied to performance on quality and patient satisfaction metrics. This is part of the government’s plan to link payment more closely with improved quality. The program is budget neutral. Hospitals will essentially have to work harder for the same reimbursement.

At the same time, the government is looking for new ways to reduce Medicare and Medicaid payments. Congress is debating plans to reduce the federal deficit, and entitlement programs are on the table. Medicare makes up 43% of hospitals’ revenue on average. The cuts would be on top of the $400 billion reduction already built into the Patient Protection and Affordable Care Act.

What does all this mean for OR directors? As expectations rise and resources tighten, directors will be evaluated on their ability to improve surgical outcomes while reducing costs and boosting efficiency. Here are 6 opportunities to focus on.

1. Use PAT to improve quality
Ensuring quality and avoiding complications will be the keys to qualifying for VBP incentive payments. Avoiding wasteful care also will be essential for succeeding under new bundled payment systems, including accountable care organizations (ACOs). One of the most powerful tools for impacting these issues is preadmission testing (PAT).

The first priority is to create standardized protocols for preoperative testing based on procedure, surgical invasiveness, comorbid conditions, and other factors. Work with the departments of surgery, anesthesia, and medicine to build consensus around testing algorithms.

As part of this effort, collaborate with anesthesia providers to develop a standard preop risk assessment tool to flag potentially high-risk patients.

Once protocols are in place, develop scheduling processes that ensure elective surgery patients are evaluated at least 3 to 5 business days prior to their procedure. Better-performing ORs have a phone screening process for triaging patients to either a normal preop timeline or additional testing.

An effective PAT process can dramatically improve patient outcomes, helping to minimize complications that lead to unreimbursed care. Well-designed protocols also reduce costs from unnecessary testing. And optimizing patients presurgically lowers costs associated with same-day cancellations and case delays.

2. Hold a daily huddle
Another way to optimize OR performance is to anticipate scheduling issues. In better-performing ORs, leaders hold a “daily huddle” every morning to review cases for the next 3 days and resolve scheduling concerns before they become problems.

The huddle should be attended by the anesthesia medical director, the OR nursing manager, the PAT manager, and a representative from central sterile processing. Critical issues include:

• Do any patients have medical problems that could delay the case or lead to a...
cancellation? For example, a patient on Coumadin (warafin) should not be scheduled as the first case of the day because INR [international normalized ratio] labs might be required before clearance.

• Do any cases present unusual supply needs? If the schedule includes patients receiving an implant, a manager should verify that the correct implants are on site.

• Are there ways to improve the schedule logistically? For instance, when looking at an orthopedic block, try to make sure same-side shoulder surgeries are scheduled sequentially. Alternating between right-shoulder and left-shoulder cases will lead to excessive positioning time.

A strong daily huddle process can reduce cancellations and first-time delays and help minimize complications.

3. Use the WHO checklist to improve processes and outcomes

Initially, the VBP program will be based primarily on process measures, but it is likely to expand to cover outcome measures as well. Clinical directors can help ensure good processes and improve outcomes by leading the adoption of a checklist, such as the World Health Organization (WHO) Surgical Safety Checklist.

Research shows that the WHO checklist can significantly reduce postsurgical complications and mortality (A B Haynes et al. *N Engl J Med.* 2009; 360:491-499). This is important, because one long-term goal of all health care reform initiatives is to shift emphasis to actual patient outcomes.

The WHO checklist will support compliance with VBP measures such as Surgical Care Improvement Project (SCIP) protocols for antibiotic prophylaxis.

Another Medicare initiative penalizes hospitals that have certain hospital-acquired conditions (HACS). One HAC is retained foreign objects. The WHO checklist prompts the team to ask at the end of the case whether instrument, sponge, and needle counts are correct, helping to ensure counts are conducted. The checklist can also improve performance on new quality-reporting measures related to deep vein thrombosis, respiratory failure, and other postoperative complications.

4. Control labor costs

Given the growing demand for payment cuts, clinical directors will increasingly be held accountable for the OR’s overall cost performance. Labor costs are a major portion of department overhead, and managers will need to keep worked hours per OR minute at or below the appropriate benchmarks. As a point of reference, a West Coast health system consisting mainly of community hospitals uses a labor benchmark of 0.13 nursing hours per OR minute. This is calculated by dividing total nursing hours (including nurses and surgical technologists) by total OR minutes.

OR management teams can use a variety of tools to address nursing costs:

Flexible staffing

A flexible staffing matrix can reduce nursing labor costs by more closely matching worked hours to case volume. Periodically review volumes by day of the week and hour of the day and adjust the schedule appropriately.

Specialty teams

Specialty nursing teams can function more efficiently and allow for better skill allocation. Consider creating a dedicated nursing team for key services such as cardiovascular surgery, neurosurgery, obstetrics, and orthopedics. Specialty teams also improve surgeon satisfaction, an important factor in maintaining OR revenue. A recent study from the Netherlands found that fixed OR teams who worked together on con-

Process efficiency
In general, efforts to improve process efficiency will help reduce labor costs. For example, improving preadmission testing (as discussed above) can enable OR management to reduce nursing FTEs and transfer tasks from nurses to more cost-efficient clerical assistants. For example, the task of scheduling calls between patients and PAT nurses could be given to a clerical assistant, reducing the hours nurses spend on nonclinical work.

To avoid disruption, it is advisable to adjust nursing staff changes over a 1-year period. Managing a staff decrease through attrition is a realistic expectation for most ORs.

5. Reduce supply costs by targeting waste
Most ORs have a product evaluation committee to help control spending on supplies and equipment. These committees can help keep overpriced products out of the department, but they have little impact on actual utilization or supply management. Clinical directors who aim to improve an OR’s cost structure need to address the high expenses that result from supply waste and poor inventory practices.

Surgical supply packs are a major opportunity for better cost management. Significant numbers of items in a pack can go unused during a procedure, which can represent 10% or more of an OR’s total supply expenses.

Clinical directors can reduce waste significantly by improving the department’s supply pack systems:
- First, work with the surgical staff to update surgeon preference cards and keep them current. Outdated cards are a leading source of waste.
- Lay out on a table all the items from a surgeon’s preference card and ask the surgeon which items can be deleted. Do this annually for each surgeon.
- Analyze actual waste patterns to identify items that can trimmed from supply packs.

Reducing the total number of supply packs allows for better management of pack contents.

Better inventory practices will also help control costs. To the extent possible, the OR should hold high-cost implants on consignment. Better-performing ORs have converted 90% of their implant inventory to a consignment basis.

ORs can also do a better job of controlling expenses on high-cost capital equipment. Create a policy requiring every proposed equipment purchase above a threshold (for example, $100,000) to be accompanied by a formal business plan that projects utilization, reimbursement, operational costs, and expected return. The plan should be signed by the clinical director and surgeons advocating the purchase. Review equipment business plans annually to verify actual performance against projections.

6. Increase OR utilization
One of the most effective ways to improve cost efficiency in the OR is to reduce wasted OR time. Clinical directors can help their OR adjust to lower payments by bringing utilization as close as possible to the benchmark rate of 85%. Several initiatives are key:

* Adopt a more efficient OR scheduling model*
Many hospital ORs assign time to surgeons in 4-hour blocks. Better-performing ORs have proven that 8-hour blocks promote better time utilization with less waste.

**Set utilization standards**
Allocate block time to surgeons based on their utilization (not seniority) and make retention of a block conditional on maintaining target utilization thresholds.

**Create open rooms**
An OR schedule needs to be flexible enough to accommodate late add-on cases and make room for independent surgeons. Approximately 20% of rooms should be held open for add-on scheduling.

**Balance the drawdown**
Surgeons now need to spend more time in the office to generate cases, so there is a growing demand for late afternoon OR time. Reconsider the department’s current drawdown policy to ensure adequate staffed rooms after 3 pm.

**Free up unscheduled time**
Most ORs do not have strong policies for reclaiming unscheduled block time from surgeons. Create an automatic block release timetable that meets the needs of the various specialties while providing management with ample opportunity to fill up OR time.

**New core competency**
Clinical directors who successfully implement these initiatives will also be addressing the challenges facing anesthesiologists. Improving OR utilization will enable anesthesiologists to increase their revenue while minimizing downtime between cases. Emphasizing safety and efficiency also will give anesthesiologists greater opportunity to demonstrate their value in driving surgical performance. Anesthesiologists can play a major role in leading PAT initiatives and implementing safety protocols. As these efforts bear fruit in fewer complications, improved surgical outcomes, and improved revenue, the pressure from the hospital administration to reduce anesthesia stipends will likely diminish. In addition, as anesthesia providers help the OR achieve full VBP payments, control costs, and maintain profitability, the administration will likely ease calls to reduce anesthesia stipends. The key to all these outcomes is the ability to lead quality improvement within an environment of cost control and efficiency. To serve effectively in the coming years, OR clinical directors will need to master the art of doing more with less.

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**How are you adjusting to financial challenges?**

How is your OR coping with the economic challenges? Have you made major inroads on improving quality or saving money through OR logistics, supply management, or staffing?

Share your progress with our readers. Contact Pat Patterson, editor, for a possible interview at ppatterson@accessintel.com.

Next month: OR leaders share strategies for meeting economic challenges.