Clinical management

Making the case for specialty teams

Teams have long been discussed by OR managers as a way to improve physician and staff satisfaction. It makes sense to have teams of the same staff working with surgeons in the same specialty consistently. But a variety of management issues arise. How do you balance the need for specialist and generalist staff? How do you manage call? Will team members expect additional pay and other perks? How much will it cost to implement teams, and will the costs be offset by the ability to perform more cases and generate more revenue? How can an OR manager determine the return on investment, if there is one, and make the business case for teams in the OR?

St John’s Regional Health Center, an 866-bed referral and trauma center in Springfield, Missouri, with an annual surgical volume of about 30,000 cases, embarked on this journey in early 2000. Starting with the heart team, St John’s then moved the team concept into neurosurgery, orthopedics, and gynecology. A plan is underway to include all specialties, individually or in clusters, over the next year.

Benefits so far

So far, teams have shown a benefit. The current teams have demonstrated reduced setup and turnover times, shorter case times, and cost containment. With teams, despite rising costs, St John’s has been able to keep volume-adjusted cost increases in surgery to 5% per year for the past 2 years, compared with cost increases of 17.6% before the orthopedic and neurosurgery teams were implemented. In neurosurgery, enough time was saved in a year to accommodate 200 additional cases in the same amount of time (graph). Gynecology teams recommended an instrument change that saved $733 per case for laparoscopically assisted vaginal hysterectomy. Revenues for surgery also increased, but multiple factors are involved.

This article is an overview of issues St John’s considered as it developed teams. A discussion of the business case is in the sidebar on p 12.

Team composition

Not all staff should be on a team. A generalist pool is also necessary. In fact, many staff have no desire to “pigeon-hole” themselves and enjoy performing different cases every day.

Not all staff on a case need to be on a team. In some instances, only one person may need to be the specialist. This may be the scrubbed person (surgical technologist or nurse) or the circulator. Often, the surgeons can specify who and how many experts are needed for their cases.

Creating teams by service allows team members to work with all surgeons in that service and is generally more cost-effective than creating teams by surgeon. Also, not all services need teams. This is an organizational decision driven by the volume of cases in a specialty, the intensity of resources and labor required, and the savings and revenue potential a team would provide.

Team membership

Team members must be the specialists within their service. They should also be exemplary employees with few absences who function well in a team environment.

Team members should undergo a rigorous application and interview process.
The interview panel should include surgeons within the service, the OR manager, and one or more existing team members.

**Team compensation**

Another important decision is whether to pay a differential for staff who belong to a team. St John’s decided to pay team members a differential of $2 an hour. Call pay is the same for all staff. The differential was paid first to the open-heart team and then adopted for other teams.

The decision to pay a differential is organization specific, depending on the recruitment and retention issues in each market. Some organizations may be able to implement teams without paying a differential.

Occasionally, a generalist staff member has asked, "Why do I have to help the ortho team when they get additional pay?" The managers’ response is that team members are required to meet additional requirements for education, attendance, and call. Everyone has an opportunity to apply for a team, and members are selected based on their qualifications and willingness to accept the rules of engagement.

**Rules of engagement**

Rules for each team should be developed by the team, including surgeons, staff, and management. OR leadership can provide overall guidelines, with individual teams making many of their own decisions, which provides ownership, authority, and accountability—building blocks for a successful team.

Among issues the rules should address:

- Admission to the team, including the minimum education and years of service required.
- Scheduling, including how team members schedule themselves and how call is handled.
- Attendance. If a team member calls in sick for work or for call, what happens?
- Leaving the team. Does the person leaving return to the general staff? Does an
Building a business case for teams

Drivers of the business plan for teams include team composition, compensation, current and proposed instrument and equipment repair costs, surgical case and turnover times, recruitment and retention issues, and revenue and market share projections.

Analysis of these drivers will provide information for making a decision that can be justified. For neurosurgery, for example, St John’s OR leaders were able to show the team saved an average of 24 minutes per case, which over a year enabled the OR to accommodate 200 more cases in the same amount of time. Of course, this depends on the hospital’s ability to attract more cases.

Cost of teams

There is a cost to developing teams. If the labor market is competitive, teams may either help or hurt recruitment. If the cost savings and revenue opportunity of teams are compelling, but it is difficult to recruit staff without an increase in compensation, the organization must consider an increase in pay. The increase should be the least amount necessary to staff the team with the needed expertise to achieve the cost savings and revenue opportunities identified.

Before teams are developed, the OR manager must determine the number of team members necessary. The number is determined by analyzing the volume for the specialty combined with the number of experts needed per case and their benefit time.

The decision to pay a differential to team members depends on the local labor market. St John’s elected to pay a differential of $2 to team members. Call pay is the same for all staff.

The staffing should be assessed regularly to identify changes in volume that would necessitate a change in the number of team members. In St John’s case, the number varied by team: The heart team includes 2 scrub persons and a circulator on call, while the orthopedics team has a scrub person with a backup and no circulator on call.

Call requirements for specific specialty cases must also be considered. The number of personnel and their skill mix for both primetime and on-call cases should be analyzed to determine staffing costs for the team.

This required an intense evaluation of the number of team members needed, skill mix, and call responsibilities prior to each team implementation. Call responsibilities for the teams were established for each team, with the surgeons providing information about the expertise they needed for specific cases.

Benefits of teams

Specialty teams have a number of benefits:

• Providing consistent staff for a particular surgeon or service reduces case time and turnover time and provides an opportunity for supply and equipment standardization.
• Reducing case time allows for shorter anesthesia time for patients, lowering the risk of complications such as hypothermia.
• Shorter turnover times may allow more cases to be done during prime time hours.
• Staff who work with the same physician or service are able to anticipate supply or equipment needs. This often translates into less waste.
• Synergy between surgeons and staff provides for better quality and patient safety.
• Other intangible benefits include patient, staff, and physician satisfaction; improved staff retention and recruitment; and marketing opportunities.

Cost savings

Some of the cost savings teams may enable:

• Supply standardization is more accepted when high-volume, resource-intensive specialty cases are staffed consistently by the same OR personnel. Resulting cost savings could be redirected to buy equipment requested for the team.
• Preference cards are more easily monitored, and the team must accept the responsibility for maintaining these.
• Team care of equipment yields potential savings. Repair costs have been shown to decrease with consistent staff, and the savings should be reflected in the business plan. The teams are also able to help identify items that can be standardized, moved to the “hold, don’t open” category, and take better care of specialty instruments than generalists would. In one type of case, laparoscopically assisted vaginal hysterectomy, St John’s was able to achieve a $733 reduction in instrumentation, yielding a potential savings of $174,454 per year.

Revenue enhancement

Reducing case time and turnover time may increase capacity for more surgical volume, allowing more cases to be performed during prime time hours. Time savings may also help reduce overtime hours.

The hospital’s market should be evaluated to determine the potential to increase surgical volume or increase market share for a strategic service line. Potential revenue associated with the increase in volume should be addressed in the business plan (chart).

At St John’s, the neurosurgery physician group lost a physician, but because the team made activities more efficient and predictable for the remaining surgeons, the same volume could be managed by the remaining neurosurgeons without an increase in overtime.
opening have to be available before a person can leave the team? What happens in the case of disciplinary action?

• What cases require a team member? For example, does the orthopedic team need to be available for a closed reduction? What about the complicated trauma case with an open fracture at 2 am?

• Maintaining basic competency. Team members and generalists should all maintain basic competencies as defined by the hospital policy. St John’s decided team members must work outside their specialty when needed and maintain competency to function with assistance or as second scrub in all basic-competency cases outside their service areas.

Education and mentoring
Continuing education is crucial to keep team members’ expertise up to date and to build team cohesiveness. A minimum number of service-specific continuing education hours or courses should be determined and monitored for each team member.

St John’s team members must complete 15 CEUs per year in subjects relating to their service areas. Involving the surgeons in this education helps build team cohesiveness while providing team members with up-to-date, relevant education.

Mentoring of new team members and generalists helping the team in cases should be an expectation for team members.

Team implementation
At St John’s, each team was implemented as a 3-month trial. The trial was billed as “no harm, no foul”; that is, although the application and interview process was clearly defined and followed, no penalty was assessed if, during the trial, staff members changed their mind about being part of the team. In addition, during the trial, data was collected on repair costs, labor costs, and staff and physician satisfaction. This data was analyzed at the completion of the trial and shared with staff, surgeons, and administration, and a decision was made about the team’s viability.

Surgeons were encouraged to share experiences, good and bad, in writing with the team and management. Good experiences were shared in letters to the staff involved, which were placed in their files and shared in team meetings. Opportunities for improvement were shared with the team for learning and team development.

Management was quick to address issues and admit mistakes. Rules and policies were changed as the environment changed, always including staff and physicians.

Pitfalls
Fear of the unknown is a common issue when teams are considered. The staff is often afraid they will take more call or be called in more often. Sometimes they are afraid they will lose basic competency skills if they join a team. These fears are often put to rest when the team is able to determine some or all of the rules of engagement.

Regarding call, it’s important to share data with teams about how often they may be called in. At St John’s, the OR leaders ran reports showing, for example, how many orthopedics cases in the past year would have required the orthopedic team to be called in. That gives the staff concrete information to use making an informed decision on whether to apply for a team. Call time did increase. But because call was specialty specific, staff were not called in as often. Also, the surgeons understood that if they “abused” the teams by calling the team in for cases that did not require their expertise or for cases that clearly were not emergent or urgent, they risked losing the team. As a result, the surgeons began to be good team members, too.

Arrogance is a pitfall for some teams. Team members may see themselves as more valuable to the organization than other staff, and members may perceive themselves as above helping outside of their service area. This issue is addressed by requiring team members to maintain basic competency skills and to work outside the service area on occasion. This also addresses some team members’ concerns about losing some skill sets.
An overarching concept

The team concept is an overarching one. Teams are most likely to be effective if they are modeled by the collaborative teamwork between the hospital and physicians. If the hospital and physicians model team behavior and build a business case, teams can benefit both physicians and the organization. ✦

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