What does it take for an OR to get to the top of the chart in physician satisfaction? Baptist Medical Center Beaches, a 146-bed hospital serving the coastal communities of Jacksonville, Florida, scored in the 99th percentile for physician measures in a Press Ganey survey, one of the highest scores the survey firm has seen.

Nationally, Press Ganey found surgeons are among hospitals’ least happy physicians (related article).

“If we had been measured 2½ to 3 years ago, we probably would have been in the tank,” says the hospital’s administrator, Mark Slyter, FACHE, who has been in the position about 3 years.

At that time, surgeons were dissatisfied with late starts and inconsistent turnover times. Only about 1% of first cases of the day were starting on time, and cases were being lost to surgery centers that offered predictable block schedules.

Today, things are different. The incision is made promptly at 7:30 am for 81% of first cases of the day, and 79% of turnover times are within 15 minutes, up from only 42% previously.

Says Slyter, “I have physicians coming into my office saying, ‘I’m done at noon or 1 pm instead of 3 or 5 pm before.’ They are thrilled.”

He credits the surgeons, anesthesiologists, and nurses with leading the change.

“Some of the physicians had been working in surgery centers that were performing better and more consistently. They felt we could do a better job,” he says, adding, “This is a tight-knit community, and we have a medical staff that truly cares about the hospital.”

About 50 surgeons use the facility, which has 7 main ORs and 2 OB-GYN ORs. The hospital performs about 6,500 procedures a year and is served by one anesthesia group. The payer mix is about 45% managed care and 40% Medicare, with the rest self-pay, Medicaid, and other coverage.

**Block committee**

A key step was setting up a “block committee” separate from the OR Committee that established policies and agreed to enforce them. Block committee members include 2 orthopedic surgeons, a general surgeon, an OB-GYN physician, the lead anesthesiologist, and Slyter.

The hospital also brought in consultants from GE Healthcare Performance Solutions, who gathered and analyzed data and helped set up policies.

The biggest improvements were:

- establishing a block schedule
- setting consistent start times with clear definitions—start time is defined as the incision, and any start after 7:30 am is considered late
- achieving more consistent turnover times.

**Block policies**

These are some of policies the block committee developed:

- Blocks are allocated by individual surgeon, not groups. A surgeon may allow a partner to use the block, but the hospital didn’t want to have to police who uses a block.
- Policies are clear about release of unused block time. Release times are set by specialty. For example, orthopedics has a voluntary release time of 5 days prior to the day of surgery with an automatic release time of 48 hours. For most other special-
ties, voluntary release time is 10 days, and automatic release is 5 days. (Voluntary release means unused time doesn’t count against the surgeon’s block utilization.)

- Surgeons must maintain 70% utilization of their blocks. If utilization falls below 70% for 3 consecutive months, some block time can be removed.
- Surgeons are monitored on 2 data points:
  - block utilization above 70%
  - on-time arrival for cases.

**Reviewing use of blocks**

Every month, the block committee reviews use of block time, OR utilization, turnover times, and start times and sends each surgeon a letter. If the surgeon’s block utilization meets the 70% target, the letter is a thank you. If utilization falls below that level, the letter reminds the surgeon of the 70% target and says he or she could lose some block time if that is not maintained. The letters are signed by the chair of the block committee and Slyter.

Surgeons who don’t meet the criteria consistently can lose the ability to schedule for the first hour of the day, something the committee so far has not had to do, Slyter says.

**Tightening up on turnovers**

To better manage time between cases, a turnover improvement team examined each part of the case process, from the time the patient arrives in the facility until the patient arrives in the OR. They set up a data collection sheet to track each time element, aided by the GE consultants.

The data is collected daily for each case on paper. On the sheet, the staff records times for each phase of the case, for example, when the patient arrives, surgeon arrives, patient assessment is complete, and so forth. If there is a delay, they must indicate a reason.

“We ask the surgeons to be here by 7:10 am and have the patient ready to go to the OR by 7:15,” explains Donna Bowen, RN, BSN, C-NE, director of surgical services.

If the surgeon arrives late, the staff circles “surgeon late” on the sheet. If the patient isn’t on the way to the OR by 7:15, a reason must be recorded, such as the surgeon wanted more time to talk to the family, or the anesthesia block was not complete. If the patient arrives late in the OR, and no reason is marked, the staff is held accountable for the delay.

“At no point do we want to rush a patient or a doctor,” Bowen stresses. “But we need to have a reason why a case is late.”

To help avoid missing preop paperwork, physician offices now fax documents to the hospital via computer. That way, if the printed copy is missing, the staff can simply print a new copy.

Bowen compiles the data each day and enters it into an Excel spreadsheet for tracking and analysis. Turnover times are reported weekly.

**Keeping up the momentum**

Results have been sustained for about 1 year.

The first 6 months after the consultants left were a control phase. A committee of lead nurses and physicians met weekly with Slyter to help cement the changes.

“We would bring up snags, such as not having enough equipment,” he says. “Then we could make decisions on the fly to fix the problem.”

Regular reporting of data and enforcement of scheduling policies by physician peers keep up the momentum.

Start-time reports are posted in the department with reasons for late starts and names of those involved.

“As long as the numbers stay up, we just report the results and give accolades—‘You were here at 7:10. That’s great!’” Bowen says. “When we have an issue, the staff will suggest ideas for how to address it.

“This is becoming a way of life,” Bowen adds. “We are always going to be looking at it. Now it is becoming hard wired.”