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SURGICAL DIRECTIONS

5 Must Reads for Optimizing Your OR

A compilation of essential, industry informing articles from Becker's Healthcare

BECKER'S HEALTHCARE

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3 areas of focus to create a more productive operating room

Written by Heather Punke

It has never been more prudent of a time for hospitals to look into improving the efficiency of their operating rooms. This is due to a number of factors, like reimbursement linked to patient satisfaction scores and the overall demand to do more with less. Improving efficiency in the OR can move the needle on all of those issues and more.

For instance, a more productive OR can result in a significant amount of savings.

"Having a room empty during primetime use is costing hospitals money," says Alecia Torrance, RN, the senior vice president of clinical operations for Surgical Directions – and a significant amount of money at that. When a hospital OR is open and does not have a procedure in progress, every minute is costly. Estimates of cost per minute of an unused OR range from $20 (based on research from Stanford University School of Medicine) to $69 (according to UCSF Health System research).

Secondly, patient satisfaction can be boosted with a more efficient OR. "When patients are not operated on during the time they expect, and they have to wait, it affects their satisfaction," Ms. Torrance explains – so eliminating that problem can make for happier patients and higher HCAHPS scores.

Additionally, surgeons want to work in an OR that runs like a well-oiled machine. "Surgeons, who are your customers, are not going to want to utilize a facility if it's not run efficiently," Ms. Torrance says. If a hospital's OR is notorious for inefficiency, surgeons take their cases elsewhere.

Even though it's hugely beneficial to run an efficient OR, it isn't easy to achieve. Several aspects must change to transform an OR into a productive entity with satisfied customers, patients and staff. Highlighted below are three areas hospitals should hone in on and what they can do to make change.

1 On-time starts

According to Ms. Torrance, the No. 1 reason recorded in EMRs for a late start to an operation is that the surgeon did not show up on time.

To fix this problem, hospitals need to dive deeper into the issue of why surgeons are not prompt. For instance, surgeons often point out that even if they do show up on time, their patient isn't optimized for surgery, so it can't start on time anyways.

"It's a culture of apathy…they're trained to [show up late] because no one is every ready for them," Ms. Torrance says of surgeons. "They get there early to just sit around and do nothing."

To combat this issue, hospitals should do the following:

Put together a daily huddle. One good step toward eliminating these issues is instituting a daily huddle with OR staff. In the huddle, staff members should run down the equipment and supplies they will need for the next day's surgeries. The surgeon's preference card is pulled and verified, and instrumentations are prepared prior to the day of surgery. Staff can also check that every patient's lab work is up-to-date and patients are optimized for surgery. Planning ahead can help put an end to surprises or conflicts that stall procedures from starting on time.

Make sure staff members arrive on time. Ms. Torrance compares OR start times to airplane takeoffs – if the first flight doesn't take off on time, it can back everything up across the country. Similarly, if the day's first surgery is delayed, subsequent surgeries in that OR will also be delayed.

After those changes are made, "then we need to start holding the surgeons accountable for getting there on time," Ms. Torrance says. These two simple steps will eliminate the common reasons or excuses they previously had to arrive later than scheduled.

2 Improve turnover time

Another area ripe for improvement when it comes to OR efficiency is cutting down on time in between cases. This is easier said than done, according to Thomas Blasco, MD, medical director of Surgical Directions.

"The hardest thing to do in an OR is improve room turnover time," he says, "because the incentives in an OR are directly conflicting with the need for quick turnovers." For instance, nurses are often not incentivized for speeding up room turnovers. Therefore, open communication with the nursing and anesthesia staff is paramount to truly make a dent in turnover times.

Combined with open and honest communication, Surgical Directions recommends and helps hospitals with two solutions to this issue:

Record actual turnovers. It can be beneficial for hospitals to pull out a camera and actually videotape turnovers, Ms. Torrance says. If leaders are simply asking frontline staff what a turnover entails, they "tell you what their perception is" instead of what might actually be happening. "You have to observe the current process of turnovers," Ms. Torrance urges. "When you tape it, you can see all kinds of things to improve."

Institute parallel processing. Another good practice when it comes to speeding up turnover times is implementing parallel processing. "Most often, everything occurs sequentially," Ms. Torrance says, "but it could occur in parallel and can shorten the duration of turnover time."

3 Revamp the scheduling system

One of the last strategies for improving productivity in the OR is to have a hospital change how it schedules time with surgeons. "Surgeons are going to work wherever they have the greatest access," Ms. Torrance says. Generally, they are looking for a block schedule, where they have an OR reserved unless they release the time.

While implementing a block schedule is a good start, scheduling must be efficient and

organized, and that task should come down to a new committee: the surgical services executive committee. This group would include surgeons, anesthesia representatives, senior hospital leaders and nurses.

After it is formed, the surgical services executive committee would work with the surgeons who use the OR to make sure the block schedule is run as smoothly as possible. For instance, if a surgeon knows he or she is going to be on vacation, they should be encouraged to let the committee know ahead of time so it can free up that block of time for use by another surgeon.

Results

Surgical Directions has the results to prove that this multitier approach to boosting productivity in the OR works. One OR, for instance, went from having 57 percent of first cases start on time to 98 percent of first cases beginning promptly by working with Surgical Directions. Ms. Torrance has also seen turnover time decrease from 47 minutes to 26 minutes and seen same-day surgery cancellations fall from 6 percent to less than 1 percent.

The figures are encouraging and inspiring, and the change behind them is comprehensive and methodical. Hospitals shouldn't just pick and choose strategies to implement if they really want to make change in the OR, according to Ms. Torrance.

"I can't stress this enough. If you don't do the whole package – the governance, block redesign, performance improvement with frontline staff and behavior and expectation changes – it won't work."

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–Alecia Torrance, RN, Senior Vice President, Clinical Operations, Surgical Directions

How improving sterile supply management in the OR can reduce infections and readmissions

Written by Shannon Barnet

"Compliance failures in any one of these three areas significantly increase the risk of infection and readmission for patients."

–Barbara McClenathan, RN, BSN, MBA, CNOR, Senior Nurse Specialist, Perioperative Consulting, Surgical Directions

Improving sterile supply management is one way hospitals can reduce the risk of infections and infection-related readmissions for their patients.

Hospitals and other healthcare facilities may have hundreds or thousands of different kinds of sterile products and implants in inventory– such as total joint implants, laparoscopic and open stapler devices, intraocular lens implants, disposable endomechanical devices, dressing, suture, needles, syringes, biological products and multiple other disposables – at any given time. Ensuring the integrity of these products is vital to preventing infections in patients and reducing readmissions.

Barbara McClenathan, RN, BSN, MBA, CNOR senior nurse specialist for perioperative consulting firm Surgical Directions, highlighted key concerns of ensuring product sterility: bioburden, product integrity, expiration, dust, debris, temperature and humidity.

"Bioburden is living, microbial load that may be a result of cross contamination or aerosolization and that may reside on the exterior of sterile disposable products," said Ms. McClenathan. "Managing sterile supplies to prevent bioburden contamination is extremely important to preventing infections."

There are three areas of supply management that hospitals and other healthcare facilities must focus on to ensure products remain sterile and free of contaminates, according to Ms. McClenathan. They include:

1. Manufacturer defined product sterility. There are two ways product sterility can be compromised, including:

- Event-related sterility. Product integrity can be compromised due to some specific event (i.e. it was exposed to moisture, had its packaging torn, crushed, etc.); or
- Expiration date. The product has passed its manufacturer-designated expiration date. Workers should be sure to check product expiration dates and the integrity of the packaging before using them on patients. Products should also be rotated so that the oldest products that have not yet expired are used before newer products.

2. Product storage. If a product is not stored appropriately, it may no longer be considered sterile. For instance, sterile products storage

must follow manufacturer and regulatory agency recommendations. This includes being stored in a place at the right temperature, right humidity level, appropriate air flow direction and number of air exchanges per hour. Traffic should be limited and workers should be wearing the appropriate attire to be in sterile storage areas near supplies.

Ensuring appropriate sterile product shelving is also crucial. Shelves shouldn't be near windows, doors, sinks, vents or pipes, and bottom shelves should be covered to keep out dirt and dust. Additionally, sterile products should be immediately removed from outside shipping boxes that may be contaminated with debris, insects, fungi or bacteria.

3. Cross-contamination in the OR. In the OR, products should be kept in a closed container during a surgical procedure and transported while covered to prevent aerosolized bioburden contamination. Nurses and OR staff should also be sure to check whether products can be dropped on the sterile field or must be opened by a circulating nurse and handed directly to the scrub technician.

"Compliance failures in any one of these three areas significantly increase the risk of infection and readmission for patients," said Ms. McClenathan.

Improving sterile supply management is a goal that staff at any level of the hospital can achieve.

For instance, hospital executives can:

- Support capital needs for providing an appropriate environment to house supplies
- Endorse supply procurement and purchasing initiatives such as Kanban or perpetual ordering systems, to increase product turns and support product integrity
- Back the continuous improvement work of the infection control director and OR director

Surgeons can:

- Maintain cost awareness among other staff members
- Use up all existing product stock before switching to a new brand and eliminate the mindset of keeping old or obsolete sterile products around "just in case"
- Find a surgeon champion who can collaborate with other surgeons to standardize the types of products used, decreasing inventory that can potentially be contaminated

OR staff members can:

- Work to reduce the handling of products, often referred to as "touch-points" by updating preference cards at a minimum annually, and even bi-annually if possible, and removing products from preference cards than haven't been used during the past twelve months or an agreed upon span of time
- Make sure products are always covered and contained interoperatively
- Bring as few products in the OR as possible and transition from the mindset of picking products that may be needed "just in case" to the mindset of leaving products that can be picked, if needed, "just in time"

Implementing tactics like the ones above takes time and is always challenging. It may be more difficult in smaller, stand-alone hospitals that are not part of a larger system, where surgeons or clinicians may threaten to leave if they find the rules disagreeable. In larger health systems there tends to be more tolerance of these necessary processes, according to Ms. McClenathan. Still, the goal of improving sterile supply management is an important one for all hospitals looking to reduce infections and readmission.

How can changes made in the OR positively affect patient satisfaction?

Written by Shannon Barnet

At every patient care touchpoint, healthcare providers have an opportunity to improve the patient experience and boost satisfaction. This is especially true for surgical patients, who may be particularly nervous and in need of extra assurance from those who will be in the operating room.

Caring for patients is always providers No. 1 priority, but as the industry shifts from a volume-based to a value-based reimbursement model, caring for patients encompasses a whole lot more than healing wounds and treating illness.

"Creating a positive experience and making sure patients leave the hospital satisfied is becoming increasingly important," says Robert M. Dahl, senior vice president and COO for national perioperative consulting firm Surgical Directions. "Throughout the perioperative process, there are countless opportunities for providers to improve care, put patients at ease and make a good overall impression."

According to Mr. Dahl, there are four major perioperative steps along any patient's journey: Pre-surgical evaluation, the surgical procedure, post-surgical care and discharge. The care team, including care coordinators, nurses, technicians, surgeons and anesthesia providers, is carefully orchestrated to optimize each of these respective steps.

"Every player involved in perioperative surgical care can make a difference for patients," says Mr. Dahl.

Following the patient journey, Mr. Dahl highlighted who is involved in each step and what improvements can be made to boost patient satisfaction.

Pre-surgery

Even before the patient's surgery, there are a lot of people and moving parts involved in ensuring that the surgery and clinical outcomes are optimized within the perioperative process. Key players involved in the pre-surgery process include the hospital or ambulatory surgical center staff within pre-admission or pre-anesthesia testing, the surgeon, surgeon's staff, hospitalist, OR director, anesthesiologist, CRNAs, nurses, and staff members in patient financial services and admissions.

"More often than not, the prospect of surgery can be a bit stressful for patients," says Mr. Dahl. "Orchestrating and streamlining all areas within the hospital that require patient information and patient dialogue prior to surgery is key to reducing anxiety, setting expectations for the day of surgery, improving clinical outcomes and improving patient satisfaction."

All areas of pre-surgery should be coordinated through a streamlined process, and the triggering of each pre-surgical event should be tied to the scheduling process when the patient is identified as a candidate for surgery. For instance, the PAT department can ensure all pre-admission testing and clearances have been completed and evaluated prior to surgery. When a patient is scheduled for surgery, a PAT call or visit can be scheduled with the patient along with a brief explanation of the service that will be performed. Full patient preparation reduces delays and cancellations. It also has the potential to reduce complications that require additional care that can lead to hospital readmissions and increased length of stay.

PAT is the critical component to manage patients' comorbidities and risk factors prior to surgery.

The PAT team can also work with the OR director to make sure adjustments to the OR staff, supplies and equipment have been made to cater to the specific procedure needs. Hospitalists and other advanced practice professionals can assist the clinic with patient and chart evaluations to ensure each patient is "touched" either through a phone triage screening or in-person evaluation. Anesthesia personnel typically oversee this function.

Patient financial services and admissions can be tethered to the PAT process by being addressed at the conclusion of the PAT call or visit. The purpose of this interaction with the patient is to go over insurance matters, set expectations for billing and payment and to outline the day of surgery payment at point of service for the procedure in terms of deductibles and co-pays for the technical and professional components of the hospital or ASC.

Finally, the hospital or ambulatory surgical center staff can contact the patient at specific time intervals – three days and the day prior to the procedure – to inform the patient of the procedure day and time, outline the required preparation, including which medications to stop taking, ensure the patient has appropriate transportation, remind the patient of the co-pay and deductible requirements and answer any questions the patient may have.

Day of surgery

The day of a patient's surgery is likely when the patient's anxiety is highest, but those involved in the perioperative process can help alleviate stress through patient contact and staged interaction. Key players involved in the day-of-surgery process that interact with the patient frequently include admissions, the pre-operative nurse or medical assistant, transport, circulating nurse, certified registered nurse anesthetist, anesthesiologist and the surgeon.

Right off the bat, hospitals and surgery centers can improve satisfaction by providing patients with clear wayward signage and instructions – from the parking lot or entrance to the check-in desk. Some organizations even go so far as to have a volunteer, pre-operative nurse or medical assistant meet surgical patients at the entrance to escort them to registration or their patient room.

"When patients have extended wait times greater than the times that were specified, hospitals run the risk of receiving lower satisfaction scores," says Mr. Dahl. "The times that are conveyed to the patient pre-surgically set expectations for the day of surgery. If times are delayed, it is imperative that the caregiver immediately explain the situation to the patient and family members and recalibrate the expected times for the revised surgical day. Consistent and staged communication is critical to improving patient satisfaction scores. That said, if there is a wait, patients should be alerted via pager, buzzer or text when a room does become available."

The "staged" communication can be as simple as employing the Studer Group's AIDET patient interaction strategy coupled with the AIDET interaction assessment.

Once patients arrive in their room and change into their surgical gowns, the certified registered nurse anesthetist, anesthesiologist and surgeon typically carry out their interviews and pre-surgical evaluation and checklists. This process can also be stressful and confusing for patients, according to Mr. Dahl, but if these healthcare workers interact either in unison or in a sequenced manner with minimal duplication to confirm the information gathered, it can make the process go much more smoothly.

According to Mr. Dahl, keeping patients' family members or loved ones updated before, during and after surgery can also boost satisfaction the day of surgery.

Post-surgical care

The patient journey does not simply end upon completion of a surgery; patients still have to recover and prepare to navigate the discharge and recovery process. Key players involved in this step of care include the surgeon, anesthesiologist, certified nurse anesthetist, nurses, medical assistants and care management. Patient financial services or patient advocates also play a critical

role at this point.

Once the patient is awake and stable, surgeons can create a sense of comfort by explaining to both the patient and their family members or caregivers what exactly was performed and what the patient can expect going forward, along with the timeframe for the next patient follow-up visit or call. While the patient heals, both the nurses and the anesthesia providers should monitor the patient's symptoms and pain level, and inform the surgeon if pain medication or other intervention is required.

"Patients don't remember their surgery but they do remember how comfortable they felt afterward, so monitoring symptoms and pain is crucial to making sure they feel comfortable to improve satisfaction scores," says Mr. Dahl.

Another basic step that hospitals and ASCs should take is letting the patient know about both the billing expectations and recovery process. The best care can be administered, but if there are surprises in the billing process, all good will achieved through up to that point is lost. According to Mr. Dahl, this small gesture is frequently overlooked and, by consistently communicating these two aspects, hospitals can ease patients' anxiety and boost satisfaction.

Following the surgery, the patient will eventually receive their bill (or, more often, bills) including those from the hospital and those for professional fees and ancillary charges. Billing can really make or break satisfaction scores as it can leave the patient coming away feeling totally overwhelmed and confused. Why am I receiving a pathologist bill for laboratory tests? Why is there a separate radiologist and anesthesiologist bill? These types of questions, if left unresolved, can damage satisfaction scores.

"Without the help of patient financial services integrated within the process, issues can arise and days in accounts receivable can be protracted. Patient advocacy is important to make the process as painless as possible. Dealing with billing can be daunting for patients," said Mr. Dahl.

Discharge and beyond

Once patients have begun healing and received their post-surgery care instructions, many hospitals have a nurse navigator help patients ensure compliance with recovery instructions. Post-surgical communication with a patient's family, skilled nursing facilities and the patient him or herself is a critical component of patient satisfaction scores.

As more reimbursement is tied to value- or performance-based contracts with insurers, hospitals and ASCs alike have to pay more attention on post-discharge care to ensure patient satisfaction and treatment adherence and, ultimately, to prevent readmissions, reduce length of stay and reduce surgical site infections.

Balancing the value-based equation will take all stakeholders' involvement. Already, organizations have begun experimenting and implementing different post-discharge care models – some of which are automated whereas others require key players such as nurses, care managers or office staff to follow-up with patients. Specific models, such as perioperative or surgical home models, focus caretakers' attention on performance objectives to reduce surgical site infections, length of stay and hospital readmissions. Bundled payments mandate oversight of the entire continuum of care to optimize patient outcomes.

"The post-surgical communication is critical to how patients may respond to satisfaction surveys," says Mr. Dahl." Post-surgical calls to the patient the following day should include asking how they are feeling, if there are any symptoms, answering any questions that they may have and providing support and/or a referral if needed."

"What matters most is the choreography of care that is consistently provided throughout the care continuum," he says. "A true market disrupter and point of differentiation that can create meaningful change in both patient satisfaction scores and market share is defining the patient experience from each department and service line, and devoting resources and tools to implement the patient care strategy."

Preparing for Success Under the Comprehensive Care for Joint Replacement Model - Before, During and After Surgery

Written by Tamara Rosin

HHS declared lofty goals in January when it announced a historic overhaul to shift reimbursements from a fee-for-service to a value-based care model.

By the end of 2016, HHS aims to tie 30 percent of traditional fee-for-service Medicare payments to quality or value through alternative payment models, such as accountable care organizations or bundled payment arrangements. By 2018, this percentage will rise to 50 percent.

CMS showed it is serious about holding providers and hospitals more accountable for the quality and cost of care when it announced the Comprehensive Care for Joint Replacement Model in July, effective Jan. 1, 2016. CMS said the model will test bundled payment and quality measurement for an episode of care associated with hip and knee replacements, and is designed to incentivize hospitals, physicians and post-acute care providers to work together to improve quality and coordination from the initial hospitalization through recovery.

About the CCJR Model

The agency would implement the proposed model in 75 geographic areas, defined by metropolitan statistical areas – counties associated with a core urban area and a population of at least 50,000. The CCJR model has immediately higher stakes than past bundled payment models, which were voluntary, because hospitals in the 75 areas would be required to participate.

"There is a movement nationally toward value-based payment," says Jeff Peters, president of Chicago-based Surgical Directions. "The Comprehensive Care for Joint Replacement Model is a very loud and clear message that this is how CMS is looking to tie 50 percent of reimbursement to value. It's a test case for hospitals."

Under the CCJR model, participating hospitals would be held financially accountable for the quality and cost of an episode of care for hip and knee replacements, also called lower extremity joint replacements. The episode would include the 90-day period following discharge.

All providers and suppliers would be paid under Medicare's usual payment system rules and procedures for episode services throughout the year. At the end of the performance year, each hospital's actual spending for the episode would be retroactively compared to Medicare's episode price for the responsible hospital, which is based on a blend of hospital- and region-specific costs. Depending on the hospital's quality and spending, the hospital could receive additional reimbursement from Medicare, or it could be required to repay Medicare for a portion of the episode spending.

According to Mr. Peters, joint replacement surgery is a good procedure to test bundled payments on because of its high frequency, relative standard process and variable cost.

Indeed, hip and knee replacements are two of the most common surgeries among Medicare beneficiaries. According to the latest CMS data, in 2013, there were more than 400,000 inpatient primary procedures for Medicare beneficiaries, incurring more than $7 billion in hospitalization

costs alone.

Outcomes and costs for these surgeries are vastly different across providers. Rates of complications, such as infections and implant failures post-surgery, could be up to three-times higher at some facilities than others, and the average cost to Medicare for surgery, hospitalization and recovery can range from $16,500 to $33,000 across geographic areas. Additionally, complications can result in hospital readmissions, extended rehabilitative care and pain, which contribute to negative patient experiences and unfavorable HCAHPS scores.

How can hospitals prepare to succeed under the CCJR Model?

The program includes three quality measures: 30-day readmission rate, risk-standardized complication rate and the patient experience. Since payment to participating hospitals is retroactively adjusted, hospital executives and clinical leaders must take the necessary steps to optimize costs, reduce complications and readmissions and ensure a positive patient experience, according to Mr. Peters.

"The fact that this program is not voluntary makes it more challenging for hospitals," says Mr. Peters. "Before you had the ability to prepare and get ready on your time. Now CMS is saying, 'This is what we're going to do.'"

Mr. Peters suggests the following strategies to develop improved clinical management pathways.

Develop a surgical home and a governance structure to bring the whole care team together
The first step to prepare for the CCJR model is to evaluate and restructure the governance model to ensure it will bring together the surgeons, anesthesia, nurses and case coordinators to develop a coordinated model to care for CCJR patients. The care model should extend from the point of scheduling through pre-surgical optimization, surgery, hospital recovery and the 30-day discharge period.

The team ensures there is organizational buy-in for best practices, standardization of clinical pathways, workflows and order sets. A common organizational model for this is a surgical home, which is responsible for the continuum of a patient's care and ensures cost, quality and patient satisfaction metrics are achieved.

Use information dashboards to encourage improvement
Surgeons may vary greatly in their expenditure and clinical outcomes. However, it is hard to communicate the urgent need for surgeons to change without providing them and other OR staff with concrete information regarding their personal performance, according to Mr. Peters.

"The only way to change behavior is to show individuals their performance levels," says Mr. Peters. "To address this, we suggest developing dashboards so surgeons can see how their performance compares to the national benchmark, as well as their peers in the same facility."

Cost-per-case dashboard reports that show surgeons exactly how their costs compare with reimbursement and to their peers can have a significant influence on their supply choices and surgery time, the latter of which is highly associated with their rates of deep vein thrombosis, surgical site infections and 30-day readmissions.

These quality outcomes will have a direct influence on CMS' retrospective payment adjustment at the end of each performance year under the CCJR model, so it is in hospitals' best interest to work with individual surgeons and OR teams to take the necessary steps to prevent surgical and post-op complications, and keep surgical costs as low as possible.

These dashboards can also be used to educate nurses and other clinical staff about the cost of common supplies, which reinforces the focus on reducing waste.

Expand and enhance pre-admission testing
Pre-admission testing is one of the most impactful factors that will contribute to hospitals' success under the CCJR model, according to Mr. Peters.

"There are numerous comorbidities that affect clinical outcomes, so you want to identify them

to reduce risk," says Mr. Peters, "We know what contributes to bad outcomes: people who are smokers, people who have high BMIs, diabetics and those with cardiac disease."

The goal is to manage these patient populations preoperatively. While hospitals typically aim to control these comorbidities for a short period immediately ahead of surgery, Mr. Peters suggests extending that time period farther ahead of the scheduled surgery date can lead to better outcomes. Mitigating risks such as these will likely require interventions by the patient's care team, such as helping patients who are smokers find smoking cessation programs, discussing the benefits of bariatric surgery with obese patients and close monitoring of glucose levels for diabetics.

Thorough pre-admission testing and identification of risks helps the surgery team address patients' individual needs and prepare for potential complications with their hip and knee procedures. The better prepared the surgery team is, the less likely it is for the patient to have a long length of stay, early readmission and costly post-acute care.

Prepare for post-operative care
Hospitals participating in the CCJR model will aim to reduce patients' length of stay as a means of cost reduction. However, post-acute care admission to rehabilitation centers is among the highest costs associated with hip and knee joint replacement procedures. Annually, $6 billion is spent on post-acute care for joint replacement patients. Sometimes you can justify an extra day in the hospital if it will reduce the need for a patient to go to a rehabilitation facility, according to Mr. Peters.

To reduce the need to send patients to inpatient rehabilitation centers, surgeons and nurses must carefully prepare for discharge prior to surgery. Nurses or care managers should visit certain categories of patients in their homes to assess the environment they will be discharged to. The patients assessed would be those that have the potential to avoid admission to a post-surgery rehabilitation facility.

"When looking at a patient's home, you should be looking for ways to make it easier for the patient to function there, as opposed to needing to go to a rehab facility," says Mr. Peters. "Maybe it's providing equipment to help him or her ambulate, such as a walker or assisted toilet seat."

Patients will need continued support once they are discharged from the hospital. Nurses can pre-empt post-op complications or injuries by visiting patients in their home and ensuring they are complying with their medications. Regular communication – via phone calls and/or email – is vital during this stage, for if problems arise, patients will likely go to the emergency room if no one answers their questions promptly.

"It's essential to convey the message that, 'Just because we've discharged you doesn't mean we don't care about you anymore and that we're not willing to help you,'" says Mr. Peters.

Case study: Hospital for Joint Disease at NYU Langone Medical Center
The Hospital for Joint Diseases at New York City-based NYU Langone Medical Center was an early adapter to the government's voluntary bundled payment initiative. HJD's success under the Bundled Payment for Care Improvement initiative and its specialization as a joint facility makes it a prime example for other hospitals under the CCJR model.

How Can Hospitals Prepare to Succeed Under the CCJR Model?

- *Develop a surgical home and a governance structure to bring the whole care team together*
- *Use information dashboards to encourage improvement*
- *Expand and enhance pre-admission testing*
- *Prepare for post-operative care*

HJD's results under bundled payment

To bolster coordination among surgeons, nurses, anesthesia and other OR staff, HJD created the Total Joint Episode Management Group. This new governance structure ensured the respective staff worked together under established best practices for clinical and management pathways from the moment surgery was scheduled, through pre-admissions testing, surgery, discharge and recovery.

At the end of its first year under the bundled payment initiative, HJD decreased average length of stay to 3.58 days from 4.27 days, with a median of three days. Discharge to inpatient facilities after discharge decreased on average from 63 percent to 44 percent.

Overall, the hospital saw significant reduction in inpatient costs, and it achieved positive margins compared to CMS' target price. HJD's hospital cost per case decreased between $7,000 and $6,300 under the bundle.

HJD realized 17 percent savings on MS-DRG 470 – major joint replacement or reattachment of lower extremity without major complications or comorbidities – and 8.1 percent savings on MS-DRG 469 – major joint replacement or reattachment of lower extremity with major complications or comorbidities.

HJD decreased average length of stay to 3.58 days from 4.27 days, with a median of three days. Discharge to inpatient facilities after discharge decreased on average from 63 percent to 44 percent.

HJD's keys to success

The hospital achieved a high degree of success in its first year under BPCI because it was committed to improving its clinical management workflow, according to Mr. Peters. After building the Total Joint Episode Management Group, the hospital had an authoritative body to oversee the full spectrum of care provided to joint replacement patients. Central to this was improving communication with attending physicians, residents, fellows, social workers, nurse practitioners and clinical care coordinators.

In its new inpatient workflow, the hospital zeroed in on length of stay as a top area for improvement, and set clear expectations that lengths of stays should be between two and three days. If it needed to be longer, the patient's admission was reviewed by the care team.

HJD also initiated an aggressive approach to pain management, to ensure patients could ambulate early and often after surgery. This is important for reducing complications such as DVTs and cardiac events, and helps patients return to their normal lives sooner.

The hospital focused heavily on the post-acute care period. Clinical care coordinators checked in with patients regularly for the 30-day period following discharge to monitor their progress and ensure patients complied with their medication regimens.

Home nurses greet patients identified as high-risk for post-op difficulties at their homes after they are discharged to ensure they are fully oriented and understand how to take their medications. Additionally, HJD implemented targeted medical follow-ups by internists for high-risk patients.

HJD's progress in one year under bundled payments shows hospitals can achieve significant savings if they invest in the necessary cultural, clinical and workflow changes. The proposed CCJR model opens the door to new challenges for hospitals, given it is mandatory, but it also presents a great opportunity for hospitals to achieve substantial improvements in both quality and cost reduction.

Creating Change That Sticks: Lessons Learned From Years of Improving ORs

Written by Molly Gamble

"We say, 'We're going to get that benchmark to 90 percent.' Then we open it up to the team to ask: 'But do do that, what must you change about your work? What will this change look like in your OR?'"

–Lee Hedman, Senior Vice President, Surgical Directions

The fact that change has become more frequent in healthcare does not mean it's easier.

People are creatures of habit, and professionals in any field know it's extremely challenging to adopt and maintain new ways of working. In a field as regimented as medicine, many healthcare professionals experience discomfort when abandoning the routines, habits or points of view to which they've grown accustomed over time.

Leaders are tasked to not only see their people through unease, but to ensure change is sustained in the long-term. This is not impossible. In fact, most people support change if they believe it makes a real and positive difference to patients.

In the operating room, patients are exposed to several – even hundreds – of decisions, actions and relationships that can immediately help or harm them. The nontechnical skills and behaviors of a care team directly affect patient outcomes, and ORs rife with teamwork, harmonious relationships between management and staff, collegial familiarity, coordination and stress management are safer than their counterparts. These are also the ORs in which surgeons, anesthesiologists and nurses most want to work.

Infusing these skills and behaviors in the OR, however, takes deliberate effort.
Most hospital ORs struggle with problems related to efficiency, behaviors, cost and physician satisfaction. Over time, these problems cascade. They lead to more cancellations, low patient satisfaction, high costs, and ultimately poor financial outcomes since the operating room is one of the most expensive areas in an acute care hospital. Sixty percent of the high-performing hospital's margin derives from perioperative services.

Over the years, Surgical Directions has collaboratively transformed OR cultures for hundreds of clients – from rural to urban facilities, from community-based hospitals to large academic medical centers. The process takes an average of six months, and Surgical Directions is most proud of what occurs after that: Change that sticks.

What does Surgical Directions do to make change stick in the OR?

Tap into team cognition

When working toward lasting change, leaders cannot underestimate the importance of interpersonal relationships and emotion. Oftentimes, change is unleashed upon

employees rather than being a goal they work toward together. This puts the horse before the cart. Initiatives that focus first on people — before workflow and processes — are those that gain momentum and ultimately stick.
Oftentimes, the glue holding 'change that sticks' is team cognition. This is a group's collective knowledge about their roles, responsibilities and capabilities. When team members understand how one role affects another, they have greater self-awareness about their own duties and more accurately anticipate their colleagues' needs. To grasp how you fit into the big picture is eye-opening. To grasp how your colleague fits into the big picture is just as important.

Regardless of technical skill, a disjointed team will struggle with any attempt at cultural transformation. When surgeons, anesthesiologists, nurses and other personnel are unfamiliar with one another, their responsibilities and day to day challenges, it is unreasonable to assume they are capable of sustaining meaningful change that will benefit patients.

"A lot of times, members of the same surgical team have different ideas about how to get through their day," says Lee Hedman, senior vice president of Surgical Directions. "It's critical to align motivations and bring people onto the same page to work as a coordinated team toward the same goals."

Surgical Directions addresses team cognition head-on through multidisciplinary performance improvement sessions. Individuals from other areas of the hospital meet with the OR team and participate in roundtable discussions about workflow, efficiency, morale and culture. Sometimes these sessions bring colleagues face-to-face for the very first time, even though their jobs and responsibilities have affected one another for months and years.

Ms. Hedman says the strategic performance improvement sessions are remarkable for many reasons. Aside from team members finally meeting and getting to know one another, the sessions also serve as something similar to a town hall gathering. Each stakeholder has a chance to express his or her dissatisfaction about OR processes or culture, and this peer-to-peer dialogue is precisely what gets things off the ground.
"For many people, learning about a teammate's pain points sparks a total shift in mindset," says Ms. Hedman. "When a member of your organization tells you how your work or attitude affects them, that's a wake-up call. It sparks an internal drive for improvement, and people walk out of the session wanting to do better."

Paint a vivid picture of improvement efforts

While team cognition is a critical piece of the cultural improvement process, individualization is just as key. Once team members understand one another's roles, needs and frustrations — as well as the greater need for cultural change — Surgical Directions digs into data to target improvement efforts. Surgical Directions analyzes numerous metrics and functions, including same-day cancellation rates, direct costs of supplies and labor, case volumes, primetime utilization, block length and scheduling.

One other metric analyzed, which Ms. Hedman uses as an example, is the rate of on-time surgical starts. Delays in first case starts present problems for organizations and contribute to problems further down the line. When the first case does not start on time, the delay cascades throughout the day and can trigger overtime costs and dissatisfaction among patients and staff. What's more, the cause of a delayed first case can change from day to day.

Surgical Directions' performance improvement team benchmarks the OR against the best practice metrics of comparable ORs. In a healthy and efficient OR, 90 percent or more of surgical cases begin within 5 to 7 minutes of the start time. In many hospitals, only 60 to 65 percent of cases start in that timeframe.

Surgical Directions makes these metrics visible so the OR team can see just how far they are from the best practice metric. The disparity is especially powerful given the competitive nature

of many physicians and medical professionals, who are wired to outperform and usually despise mediocrity.

But as any medical professional will tell you, numbers without context are meaningless. To craft a comprehensive and meaningful improvement plan, members of the Surgical Directions team sit down with the OR team for a more detailed discussion.

"We say, 'We're going to get that benchmark to 90 percent," says Ms. Hedman. "Then we open it up to the team ask: 'But to do that, what must you change about your work? What will this change look like in your OR?'"

This is where individualization comes in. When it comes to improving first case start times, numerous stakeholders must readjust their workflow. Perhaps the patient's history and physical needs to be completed earlier. Maybe the pre-operative process needs to be standardized, with surgeons arriving and consulting with the patient earlier than 30 minutes before the scheduled start. Perhaps the entire surgical team will huddle post-surgery for a debrief, allowing for an opportunity to address delayed first case starts and further analyze how to prevent them.

Specific conversations force surgeons, anesthesiologists and nurses out of the abstract. Team members must vividly describe their roles in achieving the shared goal, and understand how their behaviors and decisions will help or hinder their team's progress. Such specificity calls for individuals to take responsibility for the outcome and own up to the "small" changes they must make in their daily lives to support the "big" organizational change at hand.

These conversations also strengthen team members' understanding about what the change means for them personally. This is the predominant concern of every member in an organizational transformation. Some roles face a greater intensity of change than others, and people are more empowered when they have an upfront understanding of the degree to which their routines will change.

"It's always easy to go back to the way it was rather than keep it the way it should be," says Ms. Hedman. "Detail is incredibly important when you are trying to distance yourself from the 'old way.' To do that successfully, you need a vivid picture of your new reality."

"For many people, learning about a teammate's pain points sparks a total shift in mindset. When a member of your organization tells you how your work or attitude affects them, that's a wake-up call. It sparks an internal drive for improvement, and people walk out of the session wanting to do better."

–Lee Hedman, Senior Vice President, Surgical Directions

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Becker's Hospital Review features up-to-date business and legal news and analysis relating to hospitals and health systems. Content is geared toward high-level hospital leaders (CEOs, CFOs, COOs, CMOs, CIOs, etc.), and we work to provide valuable content, including hospital and health system news, best practices and legal guidance specifically for these decision-makers.

SURGICAL DIRECTIONS

Surgical Directions LLC is a national consulting firm based in Chicago that assists hospitals in improving the operational, financial, and market performance of perioperative and anesthesia services. Our consulting team is led by nationally-recognized, practicing anesthesiologists, surgeons, and surgical service professionals experienced in organizational design, block time, surgical scheduling, patient throughput, materials, staffing, strategic planning, and physician relations. Team members have successfully helped over 500 hospitals nationally increase surgical volume, improve clinical outcomes, improve surgeon satisfaction, improve anesthesia satisfaction, and enhance overall perioperative performance.