Transforming Surgical Services

SURGICAL DIRECTIONS

Presented by

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Better Performing Perioperative Services

- Drive hospital financial performance
- Collaborative management between anesthesia, surgeon, nursing and administration
- Strong physician leadership
- Effective surgical services executive committee

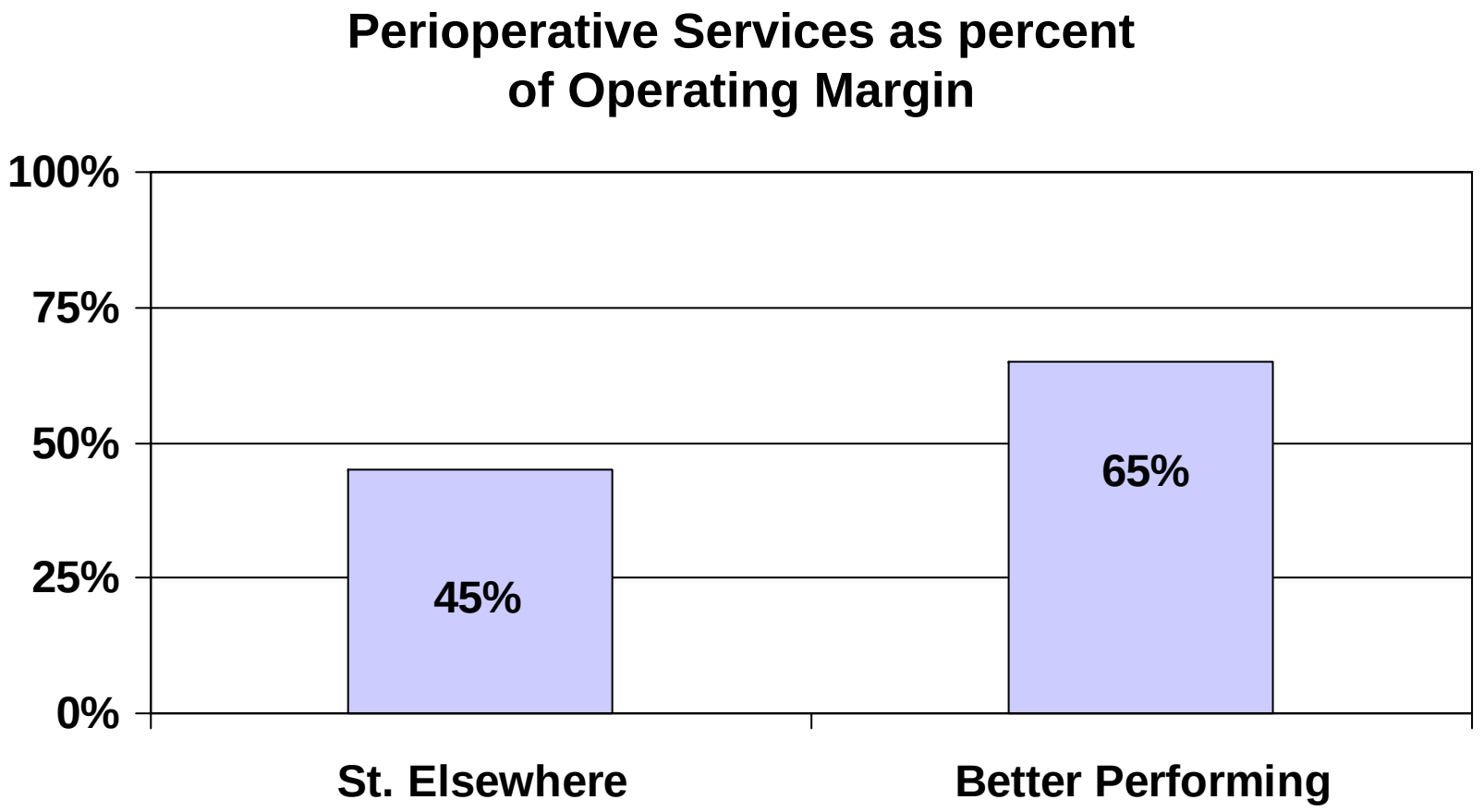
SURGICAL DIRECTIONS

Better Performing Perioperative Services

- Effective operating system
  - Pre operative evaluation
  - Scheduling
  - Block
- Exceed surgeon expectations

SURGICAL DIRECTIONS

Perioperative Services Drive Hospital Profitability



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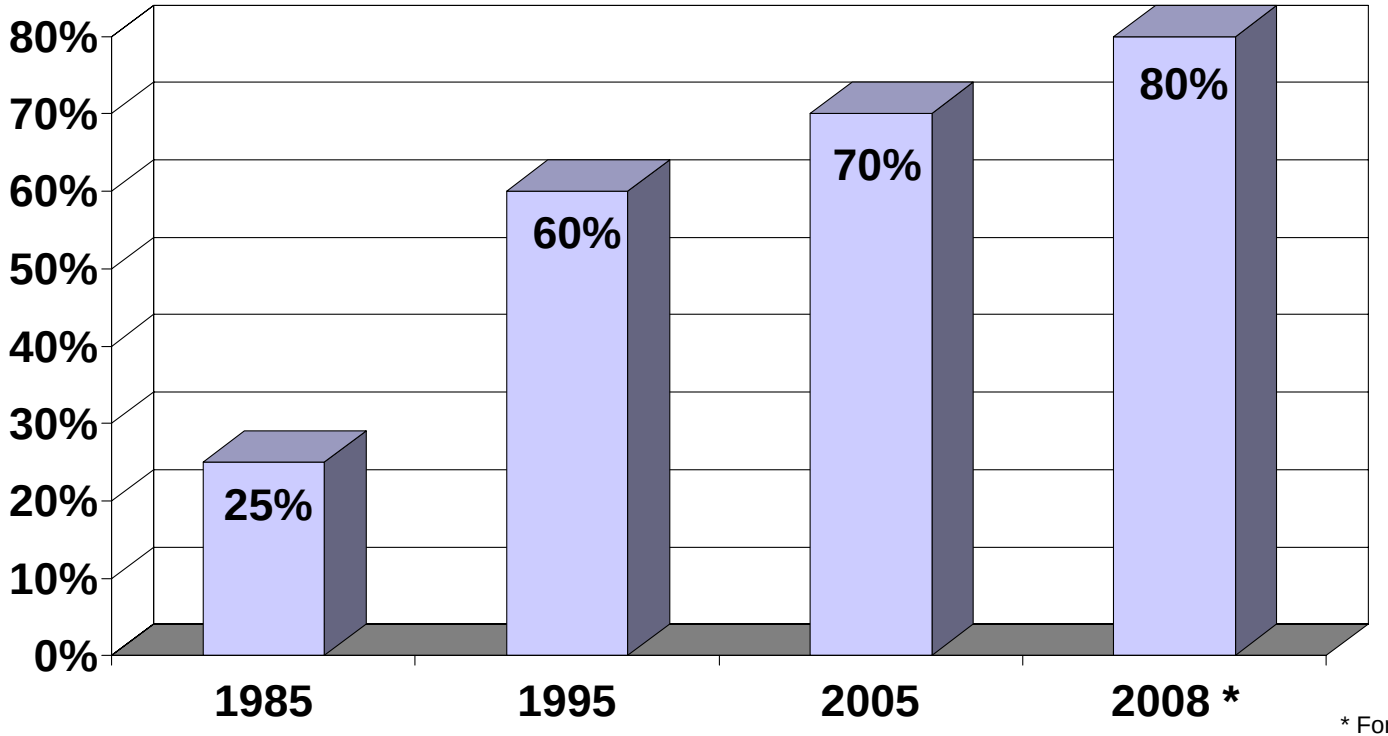
Profitability Driven by Outpatient Surgery

- Outpatient surgery will account for more than 80% of all procedures.



* Forecast HCAB

Percent of Surgical Cases Performed/Projected in an Outpatient Setting

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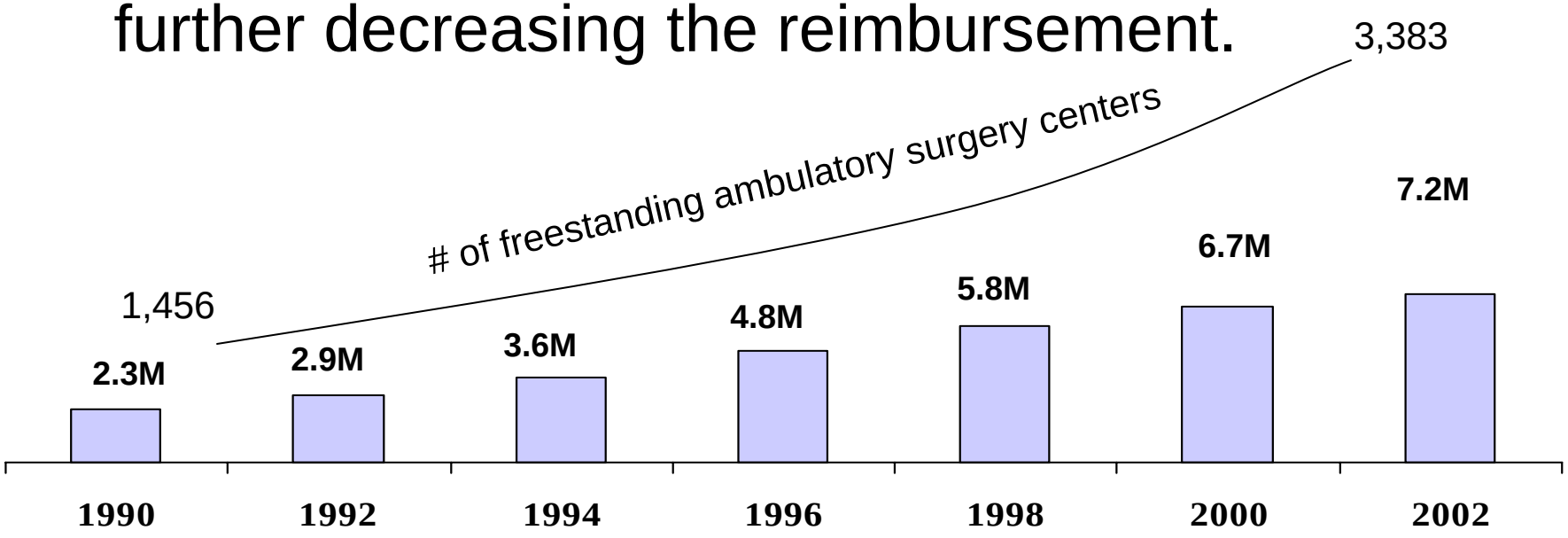
Competition

- The movement of ASC will increase the severity of hospital surgical patients while further decreasing the reimbursement.



Total Annual Cases Performed in Freestanding Ambulatory Surgery Centers

Source: Schubert A. Eckhout G. Cooperider T., et al: "Evidence of a Current and Lasting National Anesthesia Personnel Shortfall: Scope and Implications"; May Clinic Proceedings 2001; 76:995.

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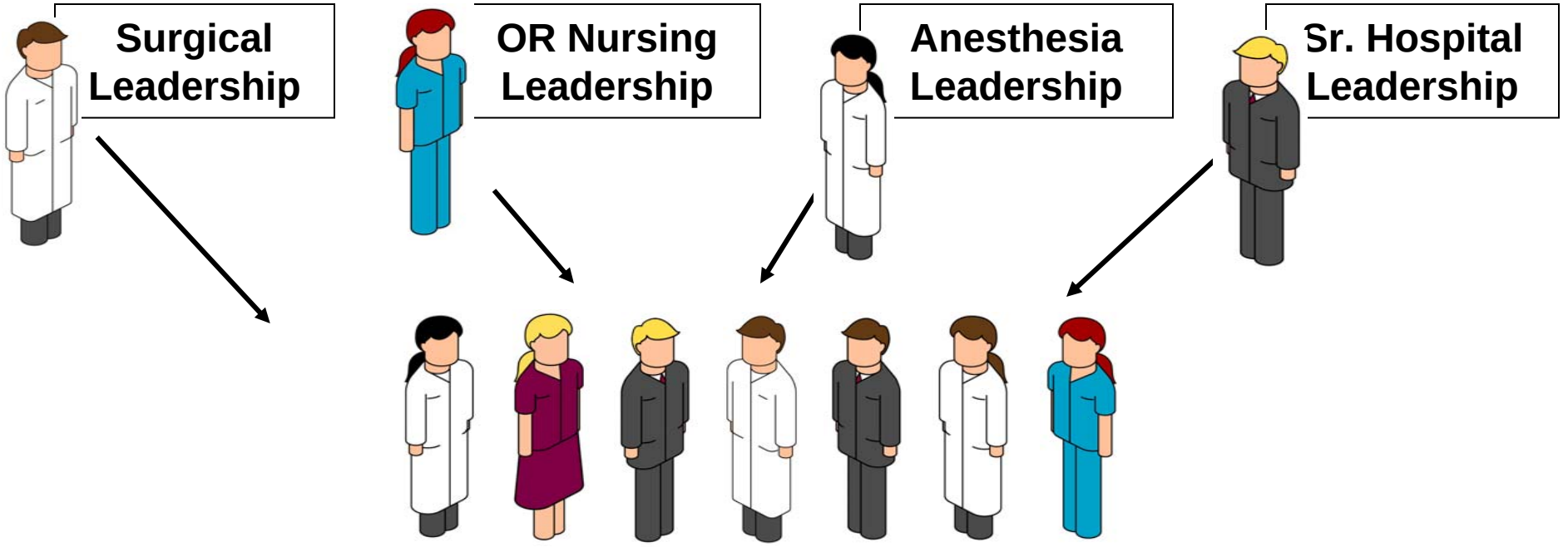
Collaborative Management

- Surgical Services Executive Committee
- Organization
- Medical Director

Governance: Collaborative Management



Surgical Services Executive Committee (SSEC) Chaired by Medical Director

- Administration-sponsored Surgery BOD
- Controls access and operations of OR
- **Sponsors and directs team activity**

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Surgical Services Executive Committee

- Responsibilities
  - Participate in developing a strategic plan for surgical services
  - Oversee the redesign of patient throughput: from pre-op scheduling to fast tracking in PACU
  - Design a modified block time scheduling system that will improve access as well as utilization
  - Monitor and provide guidance to hospital and anesthesia on number of ORs to be staffed

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Surgical Services Executive Committee

- Committee's agenda and activity must be given strong sponsorship (and representation), by hospital administration
- Committee's chief mission will be to grow surgical services and improve perioperative processes

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Surgical Services Executive Committee

- Executive Committee Recommended Membership
  - Medical Director(s) of the OR
  - Director of Surgical Services
  - Hospital's COO/VP
  - Clinically active and motivated members of the Departments of Surgery
  - Representative of Anesthesia (key)

Organization

Organization

Perioperative services typically managed by the Director of Nursing for surgical services

- Nursing, versus business-oriented background
- Sometimes, little post graduate management education
- Responsible for clinical and business functions
- Reports to CNO

Absence of daily direct physician involvement in management

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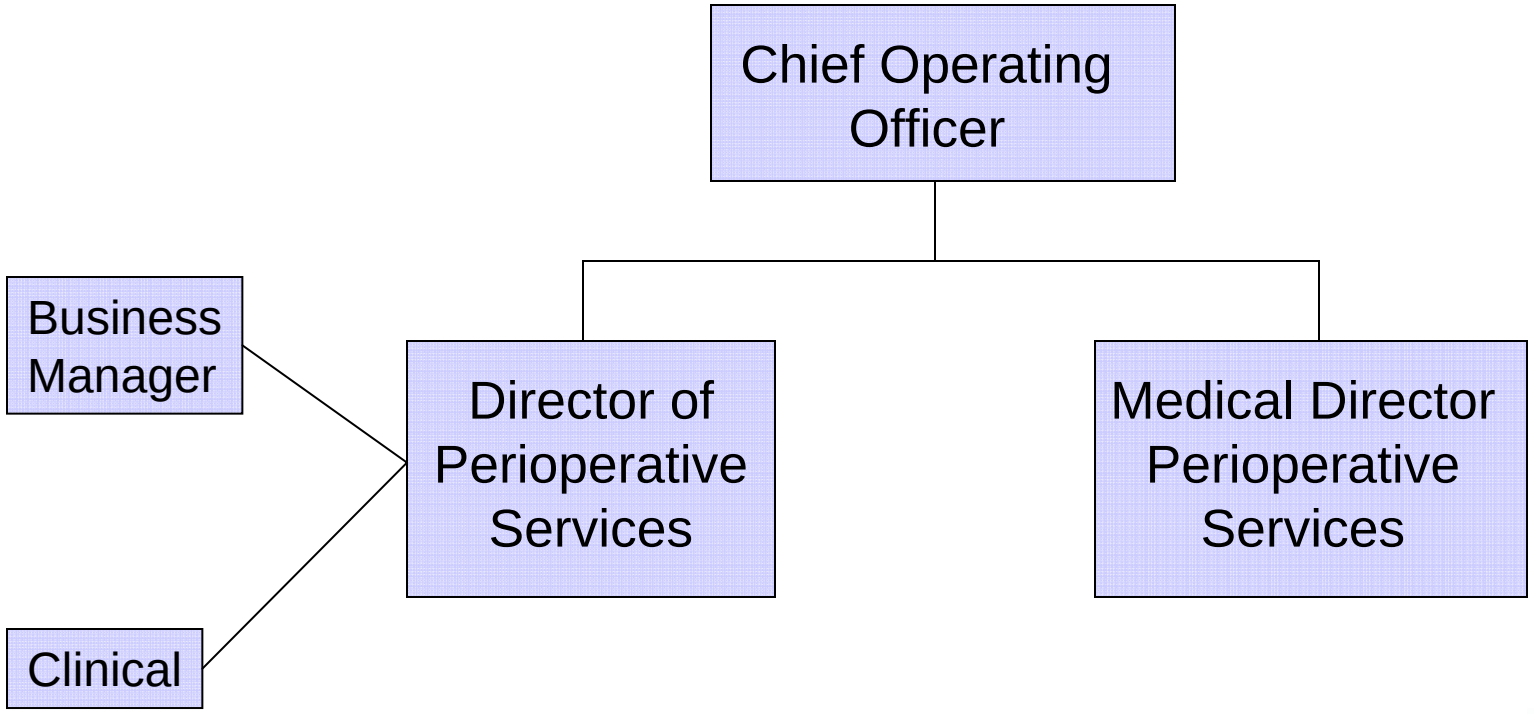
Organization

Management of Perioperative Services Requires Strong Nursing and Physician Leadership



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Organization

- Business managers are required for busy ORs
  - Budgeting
  - Block time utilization reporting
  - Surgeon recruitment

Medical Director Perioperative Services

Medical Director Role

- Co-manages the OR jointly with Director of Perioperative services
- Address physician issues impacting perioperative performance
- Daily operational authority over:
  - Pre, intra, and post-op policies
  - Anesthesia deployment
  - Scheduling (daily and long-term) in conjunction with Director of Perioperative Services
  - Block utilization

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Case Study 1

Situation

- Community hospital in attractive market experiencing out-migration
- High staff turnover
- Surgeon dissatisfaction
- Inefficient OR schedule

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Case Study 1

Intervention

- Appointment of Medical Director
- Establish SSEC
- Block time offered

Case Study 1

Outcome

- Surgical volume increased 20% in 6 months
- Staff turnover dropped
- Surgeon satisfaction increased

Case Study 2

Situation

- Tertiary hospital in south not meeting budget
- ORs closed due to anesthesia shortage
- Autocratic Chair of Anesthesia

Case Study 2

Intervention

- Change in anesthesia leadership

Outcome

- All anesthesia positions filled
- Anesthesia turnover reduced
- OR volume grew 19% in 24 months

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Operational Systems

- Operational Targets
- Block time
  - Allocation %
  - Utilization
  - Release time
- Urgent / emergent room
- Pre-surgical evaluation

Key Targets

The key measures of OR efficiency

- Cases per OR
- Same Day Cancellations
- On Time First Starts

- not turnover time.

Efficiency - Targets

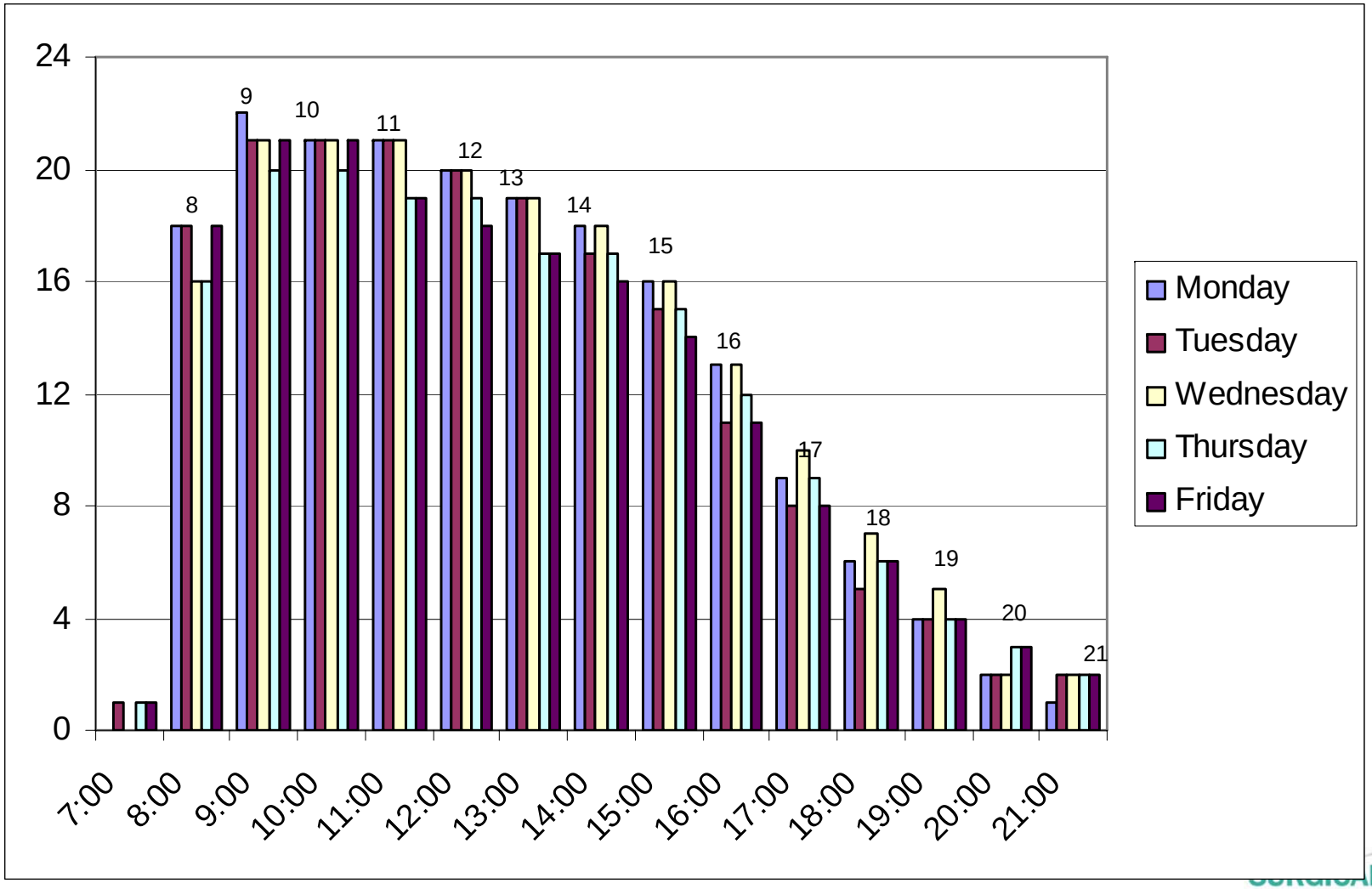
	IP	OP
Academic	800	1,000
Non-academic	1,000	1,500

In cases per OR

Operating Targets

- Same day cancellations: 1% or less
- On-time first case starts: 90%

Efficiency: Excess OR capacity typically exists in the early morning and in the afternoon



Block Time

The goal of block time is to ensure efficient utilization during “prime time” and promote surgeon satisfaction.

Block vs. Open Guidelines

- "Never" > 80% block
  - "Always" have at least 2 open rooms
- Full day blocks better than shorter blocks
  - No difference between 7 and 8 hour block
  - Short mid-day blocks problematic
- Variable release times will help increase OR availability for those without block time

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Block Time Utilization Recommendations

- Set target usage of 80%
- Measure utilization on a monthly basis
- Inform surgeons on a monthly basis of their utilization
- Report utilization to Surgery Committee monthly
- Set criteria for extricating block time based on utilization, i.e. 3 months consecutively below 80%
- Measure profitability by block time category
- Consider minimum level of profitability for maintaining block time

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Suggested Release Times

Burn service (inpatient)	1 day	Orthopedic (joint)	14 day
Cardiac	1 day	Orthopedic (spine)	3 day
General surgery	7 day	Pediatrics	7 day
Gynecology	7 day	Plastic (cosmetic)	14 day
Head and Neck	7 day	Radiology	3 day
Neurosurgery	4 day	Vascular surgery	2 day
Ophthalmology	7 day	Thoracic	3 day

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Handling of Urgent Cases

- Urgent Room
  - Held open until 48 hours prior to surgery
  - Anyone may use between 48 and 24 hours
  - Reassigned if no cases booked
- Emergency/Trauma Room
  - Required for Level 1 trauma service
  - Definitely needed if occurrence > once a month, not needed if occurrence < once a year

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Case Study – Efficiency Workflow Redesign

Problem

- Academic hospital ORs cannot accommodate surgeons' requests for time.
- Hospital is becoming a medical hospital with negative impact on financial performance.

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Efficiency
Case Study: Workflow Redesign

- Patient and staff processes are inefficient and contribute to long turnover time and longer case time
  - Anesthesiologist, circulating nurse and surgical technologist leave OR multiple times during turnover to accomplish assigned work and personal tasks.
  - Circulating nurse required to make multiple trips to transport specimens, retrieve printed OR records from control desk, deliver record to PACU, check in next patient, locate missing equipment/supplies.

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Efficiency
Case Study: Workflow Redesign

Intervention

- Redesign the workflow
  - Reduce case length by creating incentives to finish cases and turn rooms
  - Develop improved preoperative readiness and timeliness to add more cases per day
  - Create tracking of on time first starts

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Efficiency
Case Study: Workflow Redesign

- Intervention
- Minimize out of OR time for anesthesiologist, scrub tech and circulating nurse
- Reschedule non turnover tasks to non turnover periods
- Create better utilization processes of support staff

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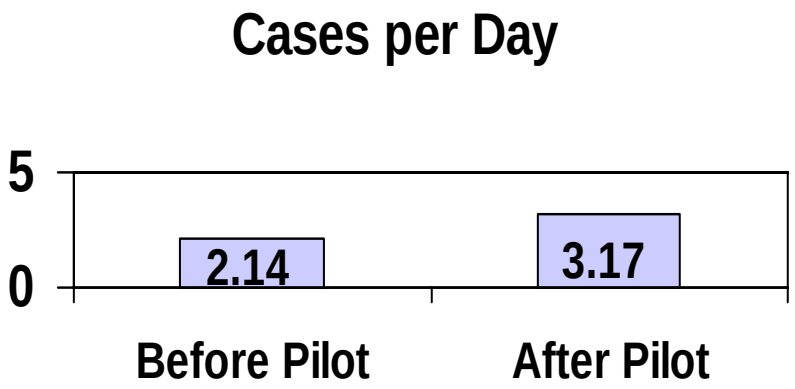
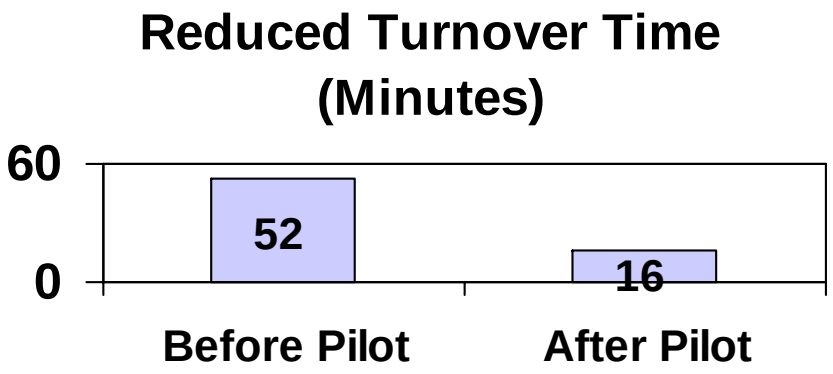
Case Study: Workflow Redesign

Workflow redesign pilot studies have resulted in increased cases per room per day and decreased turnover time





Source: Drs. Cendan and Good's study Univ. of FL, Gainesville, FL

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Pre-Surgical Evaluation

Effective pre-surgical evaluation is the key to:

- Reducing same day cancellations
- Reducing late / delayed case starts
- Reducing unnecessary diagnostic testing
- Reducing surgical morbidity / mortality

Case Study – Cleveland Clinic

Situation

- Same day surgical cancellations 9%
- High Number of Delays

** Disclosure: An Affiliate of Surgical Directions has a financial Relationship with CCF. This discussion is not intended To promote CCF's pre-surgical evaluation process

Case Study – Cleveland Clinic

Intervention

- Establishment of pre-surgical evaluation protocol
  - Standardized 140 question evaluation using branch chain logic
  - Organization wide acceptance of protocols

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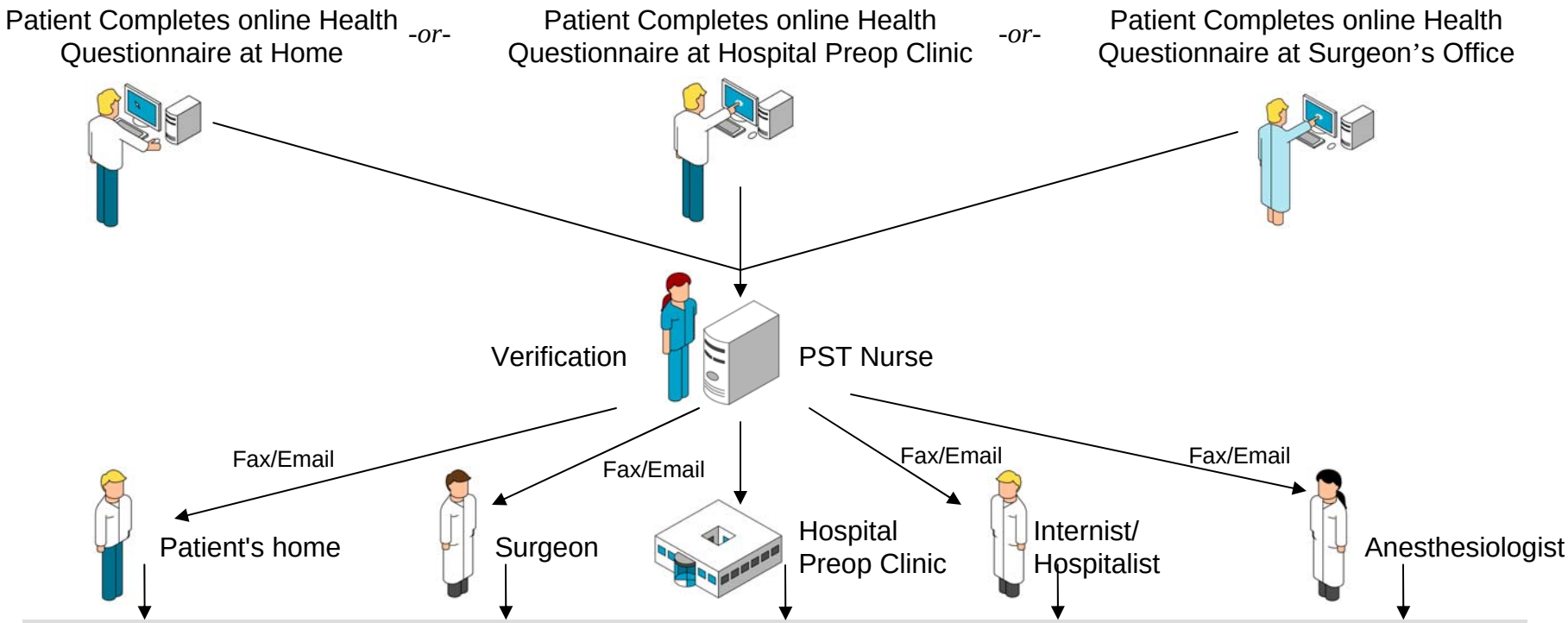
Case Study – Cleveland Clinic

Intervention

- Pre-surgical assessment initiated at time of surgical decision.
- Protocol driven assessment
  - Questions
  - Tests
  - Requirement for physician evaluation

Information Technology will transform preoperative process



Case Study - Cleveland Clinic

Outcome

- Same day cancellations for medical reason decreased from over 5% to 1%.
- First case delays decreased 50%.

Financial Impact

- For most hospitals, improvements in Perioperative process and volumes will significantly impact financial operations

Additional Annual Cases	Increase in Contribution Margin
1,000	$3.8 to $4.5m
1,500	$5.7 to $6.7m
2,000	$7.6 to $8.9m

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Open Discussion