Effective Perioperative Leadership: The Driving Force in Creating a High Performing OR

Case Study: *How Anesthesia Leadership Turned Around the OR;* The Brooklyn Hospital Center, NY Presbyterian Health System

**Does Your OR Have a Leader?**

If the OR is the engine that drives the hospital, anesthesia is the engine that drives the OR – but who is at the wheel? On average, the operating room accounts for up to 70% of hospital revenue; if the OR doesn’t succeed as a business, neither does the hospital. You have likely designated a team and set goals for recruiting surgeons and increasing surgical volume. More than that, you’ve made sure the correct team members are in place and have empowered them to drive the process they are responsible for. However, many hospitals have not taken those same basic steps to ensure the success of their OR suite.

When an OR is underperforming, it is rarely because members of the surgical team aren’t up to their jobs. What’s missing is almost always OR leadership; a competent individual with the tools, experience and authority to drive success. “Leadership” means an accountable point person who manages roles and responsibilities, understands the greater goals of the hospital, and creates a culture that thrives on change/improvement. Historically, successful perioperative directors have come from a variety of disciplines including; nursing, operations and anesthesia. Regardless of the individuals particular path of ascension, there are common themes in excellence that have been uncovered which will be discussed in the following whitepaper.

**Best Practices in Perioperative Leadership**

*Slow room turnover between cases, high complication rates, wasted disposables, growing day-of case cancellations, low first case on-time start rates, high staff turnover, climbing dissatisfaction among surgeons and patients....*

For the most part, these kinds of indicators are symptoms of a larger problem: poor leadership. Poor leadership can be defined as the inability to coordinate and capitalize on the specific surgical assets available, to develop additional assets as needed, or to create a supportive and responsive work environment.
where everyone is treated with respect and expected to contribute to team goals.

In a study of surgical team performance written for Health Care Management Review, Leach et al conclude that coordination through leadership can contribute to a successful surgical result, improve the overall process, including error reduction, and enhance knowledge creation and dissemination. The study further talks about a need to integrate the technical aspects of surgery with social processes, that is, behaviors and attitudes. They describe a number of skills required to achieve this integration, which, they point out, is complicated by the fact that many if not most surgical teams are ad-hoc in nature and simply don’t have the time to develop stable, interactive dynamics built on trust. The leadership skills highlighted include resource management, coping well with pressure and fatigue, assessment of risks, mental readiness, decision making, flexibility, and workload distribution.

In addition, an effective perioperative director should be an excellent communicator with a deep knowledge of OR management. To succeed, they must continually seek improvement and have at their disposal, resources in the following areas:

- best practices in OR management
- hospital goals and the role of the Operating Room in meeting them
- communications tactics to deal with colleagues, competitors, and superiors
- processes to cut through red tape to fix problems quickly
- knowledge of effective load management techniques
- proficiency in performance measurement and analysis
- best practices in scheduling
- understanding of revenue drivers
- understanding of surgeons’ priorities and concerns
- ability to identify and mentor prospective leaders
- utilization of national and regional databases
- familiarity with acknowledged leaders in the field
- utilization of peer connections on local, state, and regional levels

**Putting Leadership into Action**

Effective OR Leadership can help increase hospital revenues in a number of direct and indirect ways that will vary depending on the specific organization and its needs. In order to help a hospital meet its OR efficiency goals, an effective Perioperative Leader could use the following process to assess and prioritize potential areas for improvement:

**Step 1. Conduct a Three Part Situation Assessment**

*Interview all members of the surgical team,* including the surgeons, anesthesia, and nursing / perioperative staff, to ascertain their concerns, their opinions, and their ideas. The different groups can be interviewed together, but each individual should have a chance to provide input privately, as well.

*Gather and report accurate and timely performance data* on individual staff and

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The importance of data should not be overlooked. By gathering, analyzing and managing against data, you can remove the speculative nature of your situation assessment and base it on actual, empirical, results. The more granular your measurements, the more targeted your solutions can be. It is important to report not just to executive leadership but to the staff themselves, who can be expected to respond to variances that are presented scientifically and attached to corrective action plans.

Observe processes and workflows to identify redundancies, inefficiencies, logjams, and conflicts.

Targets might include:

- patient flow and throughput, specifically in PACU and discharge from PACU to floor
- patient preparation (does the patient have all appropriate medical clearances in place prior to the day of surgery)
- case time effectiveness (time-sensitive steps: patient in holding area/induction area, induction to incision, incision to closure, closure to patient out of room, room turnover)
- materials management (inventory control, materials distribution, physician preferences, standardization, vendor relationships, storage and locator system)
- management structure and staffing (case coverage, skill sets, scheduling, reporting structure, assignment of responsibilities)
- governance (medical leadership, surgeon relations: development and enforcement of policies and procedures; credentialing; quality monitoring; introduction of new technologies)
- surgeon relations

Step 2. Analyze & Benchmark

What does it mean that post-operative nausea and vomiting (PONV) rates are 7%? Is this higher or lower than the rate of a year ago? Is it more or less than other hospitals are experiencing? Is it all associated with one anesthesiologist or several? What are the causes and how can these be eliminated?

Measuring and benchmarking team performance against organizational, local, regional, and national standards is most effective when you are comparing apples with apples, that is, looking most closely at indicators from hospitals with similar types of procedure and case mixes. You should also investigate the precise definitions of your benchmark data, is your definition of case state the same as your benchmarks?

The importance of quality data comes to the forefront of your process at this point. You must be certain that the information you are compiling is accurate and interpreted according to consistent parameters. Keep in mind the old axiom “Garbage In = Garbage Out”.

Metrics are a critical component to managing a hospital’s business - you can’t improve what is not being measured.

The Perioperative Director should involve the physicians and nursing staff in the identification and prioritization of key operational strategies that drive the change process.
Step 3. Set Goals in Sync with Hospital Needs

The goals of the Perioperative Director and their management of the Operating Room should always reflect the larger priorities of the hospital as a whole and the realities of both operating and capital budgets. Some of the most common goals include:

- **Expansion of services to cover additional surgical volume** – The Perioperative Director should take responsibility for procedural areas outside the “4 walls” of the OR Suite as well as managing surgical demands for additional OR capacity. As the areas of the hospital being utilized to deliver care expand, the need to provide proper and efficient perioperative oversight also grows. The Perioperative Director should be prepared to address scheduling and staffing concerns of nursing and anesthesia while concurrently balancing the desires of the hospital's surgical staff. Working with nursing and anesthesia to create a more efficient scheduling and staffing model can help to cost effectively cover increased surgical volume inside and outside of the OR and provide the flexibility that these important constituents need. Flexibility also must be addressed. An efficient staffing model can flex to accommodate additional case volume and provide enhanced patient care.

- **Quality assurance program** – Devise a robust program that enables tracking and trending of both facility and individual clinician performance relative to clinical outcomes. Hospitals want detailed reports available for real-time review and presented on a quarterly basis to prove results and drive improvement. Again, the utilization of data can take a discussion based on conjecture and turn it to one based on actual outcomes and results.

- **Customer Service** – The Perioperative Director must recognize the needs of his or her most important customers – the surgeons and patients.

Several factors which drive surgical satisfaction are:

- On time first case starts
- Speedy room turnover time
- Readily available and properly functioning supplies and equipment
- A friendly and efficient environment

In order to increase patient satisfaction, the Perioperative Director should:

- Provide a patient centric experience that clearly communicates to all that the patients safety and comfort are the top priority of the organization
- Ensure the hospital's Pre Surgical Testing program is working correctly – leading to a reduction in day-of-case cancellation rates
- Facilitating communication between the patient, the OR staff and the patient’s family to insure all parties are informed as to the patients status during surgery
Step 4. Develop an Action Plan

Input from surgeons and staff, performance measurements and the list of priorities provide ample data to develop a plan of action that will create a clear operational infrastructure that engages all parties. This plan must:

1. Be realistic
2. Win the support of department and hospital leadership
3. Introduce best practices

Each project should include specific performance goals, tactics to achieve goals, project assignments, budgets, and timelines.

Step 5. Implement Your Action Plan

Leadership is especially important during plan implementation. Change is almost always resisted at first. Consistent and transparent communication is essential during the transition. A culture that is unable to constantly change and adapt will never foster high performance; this inability to change is one of the top reasons ORs fail.

Step 6. Monitor Progress and Reassess

A true leader is never satisfied with the status quo, but is constantly watching to see that gains are not lost over time and seeking to identify where further improvements can be made.

The perioperative leader may not handle each of these tasks personally in their entirety, but he or she will be accountable. The leader sets each step in motion and determines when it has been accomplished satisfactorily, identifies and engages the right team members in the appropriate parts of the process, and is always available to inspire, consult, help, and, as necessary, reset course.

Leadership means an accountable point person who manages roles and responsibilities, understands the greater goals of the hospital, and creates a culture that thrives on change/improvement.
The Virtuous Cycle

Perioperative leadership and the anesthesia department’s ability to fuel top perioperative performance are at the center of a healthy hospital. It has been proven that an engaged and effective anesthesia leader, working in concert with the hospital’s nursing, perioperative and surgical staff can help create a cycle of positive outcomes which is self sustaining.

At the start of this cycle is Superior Patient Care, the core function of any hospital. If every other point of the cycle is executed consistently, the final point is accomplished – Greater Hospital Revenue. This increase of revenue allows the hospital and its staff to invest in additional competencies that again lead to an increase in patient care.

At the center of this cycle is the Anesthesia & Perioperative Alliance which drives OR performance. That performance supports surgeons to improve outcomes, increase patient and surgeon satisfaction, enhance the hospital reputation, improve surgeon recruitment, increase case volume, etc. While the OR, is not the only part of the hospital working on developing these initiatives, it is the keystone, and its leader must be constantly striving to improve performance and become more efficient.
Today’s OR Needs Require Next Generation Anesthesia Solutions

One of the challenges many hospitals face is that the typical anesthesia group, which in many instances has been in place for many years, if not decades, is set up for failure in this new era of reform. While it is usually staffed by excellent physicians, they lack the management expertise and infrastructure to provide effective anesthesia stewardship. According to the American Society of Anesthesiologists, nearly 70% of these groups have just 1-25 physicians. They often lack internal expertise including scheduling, recruiting, billing, collections and contracting. If they have a QA program at all, it includes minimal data and is often solely dependent upon the data the hospital is providing them. They can’t develop continuing training programs, tested policies and procedures, or a nationwide network of peers for problem solving.

Smaller groups lack the infrastructure that is required to participate in many hospital initiatives and many are using inefficient staffing models that no longer meet the hospital’s current goals, structure, and patient mix. In a survey of hospital administrators conducted by the Tarrance Group for the American Society of Anesthesiologists less than a decade ago, nearly half of the respondents said they had reduced or redirected OR procedures due to anesthesia staffing issues. Among hospitals reporting shortages, 75 percent had experienced an increase in surgery wait times and 66 percent had had to limit access to the OR as a result.

These common results are unacceptable for hospitals and health systems facing massive challenges and changes to how they do business including:

- The expected surge in patient volume as 30 million additional Americans enter the public insurance roles
- The shift in emphasis to outpatient care
- The increased use of other surgical procedure areas within the hospital such as catheterization labs, interventional radiology and GI suites
- The continued competition for surgical cases from independent ambulatory surgery centers (ASCs)
- The requirements set out in PPACA, such as Accountable Care and Shared Savings Models.

Regardless of its makeup, an anesthesia group of a dozen or two dozen clinicians is simply not in a position to drive clinical or business efficiencies the way a large regional or national group can.

As a result, a growing trend of consolidation has emerged as these small groups are increasingly joining larger organizations so they can continue to serve the hospital and community they have invested themselves in -- but now with the management infrastructure the anesthesia department needs to succeed.

The larger anesthesia group can:

- Take advantage of economies of scale, which means its costs are going to be lower
- Devote specialized resources to the business -- to billing, collections, contracting -- resulting in improved results and allowing clinicians to devote their time to patient care
- Build a comprehensive QA program with seasoned, up-to-date QA
experts
- Collect, analyze and utilize data to assess the effectiveness of individual clinicians against their peers and the larger entity. This function also allows integration with a local RHIO and/or ACO
- Drive the development of non-clinical competencies among its leadership physicians through involvement on committees such as Risk Management, QA, Equipment and others
- Allow the operations of the practice to be run by dedicated experts and alleviate some of the management burden that the clinicians in a small practice face.

All of these advantages give the hospital an edge when it comes to recruiting and retaining top surgeons, who are needed to expand surgical capacity in and beyond the OR and to bring in more patients to fill the complete range of facilities.

The OR is the engine that drives the hospital, and anesthesia is the fuel that powers the OR.

By combining effective perioperative and anesthesia leadership, hospitals are provided the tools required to successfully compete in today’s new post reform reality.

About North American Partners in Anesthesia

Founded in 1986, North American Partners in Anesthesia (NAPA) is the largest Single Specialty anesthesia management company in the U.S. With over 700 clinicians nationwide, the company is known for having the most respected clinical staff, management leadership, and evidence-based quality initiatives in the industry – resulting in maximized OR performance, reduced costs and consistent surgeon & patient satisfaction.

www.NAPAanesthesia.com
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**Hospital Overview:**
- Member NY Presbyterian Health System
- 9000 admissions/year
- 12,000 surgical operations/year
- 15 ORs/anesthetizing locations

**Situation:** Hospital was experiencing declining OR performance which lead to declining revenues from surgical procedures. At the same time, its costs to run the OR were increasing as an inefficient and expensive anesthesia staffing model was in place.

**Reason for Issue:** Lacked anesthesia leadership and management infrastructure

**Solution:** Develop a new anesthesia staffing model to ensure optimal coverage and designate an OR leader responsible for maintaining OR performance, efficiency and satisfaction from all constituents including patients, surgeons and hospital leadership.

**Implemented Solution:**

1. **Fix Staffing:** A fast and thorough situation assessment revealed a need for a MD/CRNA staffing model consisting of 14 MDs and 6 CRNAs. This decision was based on the department’s ability to:
   a. cover all anesthetizing locations
   b. cover vacation demands
   c. cover call schedule
   d. provide capacity for service expansion for labor epidurals, GI cases, acute and chronic pain service

2. **Provide OR Performance Measurement:** the hospital did not have an OR/anesthesia specific quality assurance program to measure and manage performance. The new program:
   a. Tracks 31 different indicators of OR performance
   b. Measures results against peers and national (ABG) benchmarks
   c. Results analyzed by NAPA and presented to hospital management on a quarterly basis

3. **Designate an OR Leader:** There was no person in the OR designated to function as a perioperative leader. NAPA, and its anesthesia chief, took on the responsibility and immediately implemented:
   a. A refined Pre-surgical testing process
   b. Communication and coordination with nursing and surgeons
   c. Integration with hospital committees and management
   d. Build a strong relationship with surgical staff

4. **Improve Revenue:** there were no set procedures to make sure every case was billed and collected. New procedures and by implementing NAPA’s well developed management protocols, department revenue was improved by:
   a. Reducing days in A/R to under 35 days (top quartile of MGMA results)
   b. Working all charges to an ultimate resolution of 99.6% of collectable dollars
   c. Ensuring that each case and procedure were captured and subsequently billed
   d. Implementing correct and up-to-date case coding
Results in 2010:
1. Surgical Volume increased 7%, to 12,000 cases a year
2. Anesthesia Subsidy decreased 50%
3. OR Utilization improved 6%
4. 99.6% of allowable claims resolved
5. Days in A/R reduced to under 35 days