Better Operating Rooms

High-performing ORs lead to improved care, lower readmissions, reduced costs

By John Di Capua M.D. | Issue: September 9, 2013

The majority of hospitals in the U.S. are struggling to transition from fee-for-service to capitated reimbursement directly tied to results. The best way to bridge that chasm is to transform the highest profile and most expensive component of most hospitals—the operating room.

Hospitals need to understand that the operating room is the nexus where quality, costs, outcomes and earnings meet. Its improvement will lead to higher-quality care, better outcomes that lower readmissions, and smarter ways to reduce costs that support rather than detract from quality.

It starts by creating real incentives for those involved in patient care in the operating room to be part of solutions. It is as much a cultural shift as it is procedural, so buy-in and training are key.

Here’s a six-part road map that hospitals can use to plot their own course to a high-performing OR based on my organization’s experience at 46 hospitals across the U.S.

First, recognize that anesthesia care is at the center of creating a high-performing OR. Other disciplines, such as radiology and gastroenterology, perform important roles but are narrower in scope. Only anesthesia is—or should be—omnipresent throughout the entire perioperative spectrum of care.

Second, hospitals need a champion to bring healthcare specialists and administrators together across the perioperative spectrum. Anesthesiologists touch every area involved in surgery. Thus, it makes sense for an anesthesiologist from the hospital team to lead the entire perioperative process.

For example, for years doctors would take surgical patients off anticoagulants for fear of extensive bleeding during surgery. This practice led to a 20% spike in acute cardiac events and surgery cancellations. However, heart surgeons perform open-heart surgery all the time while patients are on anticoagulants.

Clearly, one segment of the surgical community knew something that most other surgeons did not. So when a patient is on an anticoagulant, we now send a letter to the patient and surgeon, encouraging them to discuss options for surgery. As a result, we saw intra-operative and post-operative cardiac events plummet.

Third, hospitals need to create a comprehensive system and culture of ongoing quality improvement that drive better outcomes. To be grounded in reality, quality improvement has to be thoroughly data-driven, capturing performance data across disciplines with the hospital, creating and maintaining a robust data warehouse, mining data, analyzing it for best practices and risks, and putting it into action across a well-aligned and comprehensive system.
For instance, data reveal patients are at a higher risk of morbidity when a surgery patient is transported from the OR to the recovery room. So we added a monitor and oxygen tank to every stretcher, and watched unexpected post-op morbidity drop significantly.

Fourth, hospitals are struggling with significant reporting requirements including Surgical Care Improvement Project scores, the Inpatient Quality Reporting Program to the National Committee for Quality Assurance and reporting to insurers. This increased transparency is sparking competition and creating an empowered army of patient consumers willing and able to make informed decisions about where and how their healthcare is delivered.

Consequently, hospitals need the structures and processes in place for constant quality improvement, data capture and analytics. On a macro level, the challenge is that many hospital records are still paper-based, making the aggregation and dissemination of well-organized information nearly impossible in an age when hospitals are paid based on highly specific quality measures (antibiotics, patient temperature, etc.).

Hospitals need to commit to an in-house or outsourced IT infrastructure that delivers quarterly reports that lead to better care decisions and reporting, lower administrative costs and stronger reimbursements. These reports must be usable for hospital staff so they can understand their performance, how they impact overall outcomes and how they can improve.

Fifth, healthcare reform has tied hospital compensation to quality outcomes. If a hospital wants to function in an incentive-driven environment, there needs to be a data-powered dashboard of quality measures that holds individuals accountable for the patient experience every step of the way.

Finally, if hospitals really want to pursue quality and make it part of their cultural fiber, they need to motivate staff (both clinical and administrative) to be thought leaders. It should become a part of their core job responsibilities and they should be compensated for it. Hospital staff should teach, do research, and serve on local, state, regional and national professional boards and committees. Having an army of motivated thought leaders in the community delivers tangible and intangible benefits to the hospital.

The development of accountable care organizations make these changes mandatory. The ACOs will redistribute hospital priorities and investment from traditional fee-for-service activities to prevention, evidence-based medicine and outcomes for a defined population. As the host in the patients’ surgical home, the perioperative leader should triage patients by using data to identify the right solution in the hospital (the main or non-main OR, for instance) or in another more suitable setting (an ambulatory surgical center perhaps).

Effective ACOs will lead to the migration of care from acute to outpatient settings, which if done well can improve outcomes, improve reimbursement rates and lower the cost of care. By going through these steps, the pieces of the puzzle—quality, sustainable outcomes, cost, reimbursements and overall financial performance—will all fit together and everybody wins.

Dr. John Di Capua is CEO and interim managing partner at North American Partners in Anesthesia in Melville, N.Y.