Your Presenters

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Overview

An efficient surgical department requires management of a complex ecosystem of multiple processes, people and communication pathways.

How your institution handles the preoperative preparation of the surgical patient is an important part of this ecosystem and one that increasingly drives your operational and financial success.

Failures to adequately collect, communicate, coordinate and act on pertinent patient and surgical procedure information can lead to suboptimal care including: decreases in patient safety, operating efficiencies, and ultimately in the satisfaction of patients, staff and surgeons.

We will review basic strategies that boost O.R. efficiency and case throughput, reduce cancellations and delays in the surgery schedule, and ultimately enhance patient safety, metrics and surgeon satisfaction.
Key themes of this presentation

There is tremendous variation in how patients are prepared for surgery, even within a given hospital or surgery center.

Even facilities with an existing planned process have variation in patient preparation based on surgical specialty, surgeon, anesthesia clinician, nursing and even primary care preferences.

Lack of a coordinated approach to patient preparation leads to case cancellations and delays, decreased satisfaction of patients, medical and nursing staffs, increased costs and even potential decreases in patient safety.

Using tools and skills that you likely already possess can make significant improvements in your preparing your patients for their surgical procedure.
Overview of the problem

Current pre-admission processes typically

- Driven by patient registration and “required” lab testing needs [not assessment and intervention]
- Reactive instead of anticipatory
- Constrained by traditional roles and responsibilities
- View the surgical experience as a series of siloed, sequential steps - with the patient treated like inventory moving down an assembly line with minimal communication
Overview of the problem

This leads to

- Variability in patient preparation and surgical experience
- Mismatch in resources requested and needed (e.g., labs ordered and needed)
- Mismatch in personnel
- Communication and information gaps
- And ultimately an inefficient, costly and suboptimal surgical experience
Goals of Preoperative Preparation

- Optimize patient’s surgical outcomes through standardization
- Optimize value creation through better resource utilization
- Provide all participants what they need (information, intervention, etc.) where they need it and when they need it to do their jobs
- Drive higher satisfaction of patients, families and clinicians
Overview of the approach

Assess the current state

- Data, data, data (throughput metrics, cancellation rates, etc.)
- Involve (listen) to representatives from all areas of the continuum including patients, surgeons, their staff members and even primary care clinicians and office staff
- Identify barriers and constraints

Develop an action plan using common tools (lean, constraint theory, project and change management techniques, etc.)

Implement and measure
The Perioperative Continuum: an exercise in clinical care delivery as supply chain management

Perioperative medicine: The discipline dedicated to creating value as the surgical patient flows through an integrative surgical experience.
Quality and value in perioperative medicine

Perioperative Medicine

Clinical Care
- Care Delivered
  - SCIP
  - Clinical indicators
  - Airway
  - Block adequacy

Service
- Satisfaction
  - Patients
  - Surgeons
  - Staff
  - Anesthesia Personnel

Operations
- Throughput
  - Case cancellations
  - 1st case delays
  - Room Turnover
  - % Pts seen in clinic

Cost
- Total Fixed & Variable
  - Facility
  - Professional
  - Ancillary
  - “Rework” or complications
Strategic Review and Implementation
What seems to be the problem?

- Hospitals may or may not have a designated pre-admission procedure and/or screening process.
- Of those hospitals that do have a pre-admission process in place, only 50% of patients are pre-admitting.
- Only 50% are pre-admitting.
- Very few patients are getting pre-anesthesia optimization.
- Patients who are not pre-admitting and pre-screened make up the majority of cancelled cases.
Barriers to improvement

- Resistance to change (primary care, surgeon, anesthesiology, nursing, etc.)
- Medical community environment
- Fear of penalization/retribution; punitive use of data
- Work flow constraints
- Poor design of measurement instruments
- Manual processes
Barriers to improvement

- Technology (EMR)
- Educational deficiencies including lack of ongoing training
- Lack of use of common definitions and guidelines
- Nursing staff turnover
- Employees and policies from multiple institutions involved in the process
- Lack of administrative support
**Evaluate your current pre-op process**

- How do the patients currently get scheduled for surgery? Who does the scheduling? What information is collected?
- What information is the surgeon’s office giving the patient?
- Preregistration process? When are benefits verified?
- Is there a nurse interview for clinical information?
- How far out are you in your throughput?
Evaluate your current pre-op process

Surgical cases

# of cases annually?

Block time?

# cancelled within 24 hours of start time / same day? Cost per case cancelled?

# delayed or rescheduled? Overtime cost?

Post surgical

Post surgical complications, length of stay and readmissions within 30 days of discharge
Model 2020

ASA 1 and 2: patients go to pre-admit

ASA 3 and 4: patient goes to pre-anesthesia clinic
Keys to success

Patients who are well prepared for surgery have better outcomes.

Implementing a PAT clinic model significantly improves efficiency and the perioperative experience for all stakeholders.

The perioperative surgical home concept is not new. Bringing all the necessary players to the table is the key to success.
Keys to success

- PAT Medical Director
- Surgeon Champion
- OR Scheduler
- PAT Nursing Staff
- Director of Clinical Services/OR Manager
- Hospitalist
- Anesthesia Provider
- C-Suite
- PCP
- Specialist Support Team
- Discharge Planning
- Insurance Verification
- Registration
- Coding and Billing
- Marketing
- Pharmacy
Keys to success

Commit to providing:

- Anesthesia Director
- Project Manager
- Well-trained PAT Staff
- IT Support
- Robust PAT EMR
When the PAT Clinic is done right!

- Model allows for improved performance and revenue
- Reduction of cancellations and delays
- Better patient care and satisfaction
- Reduction in overall expenses to hospital
- Quality analysis and best practices reporting measures
- Surgeon/anesthesia/hospitalist/PCP/patient satisfaction
- Better patient care and satisfaction
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When the PAT Clinic is done right!

- Revenue for not cancelling surgeries
- Revenue generated through the PAT clinic
- Expense savings for patient, insurance company and hospital
- Increased O.R. utilization
Facility has performed 30 day, post-operative follow-ups on a total of 106,000 patients.

37,000 of these patients were admitted from the emergency department.

69,000 were elective and came through Pre-Op (they target 100% of elective O.R. patients).

Evidence shows the patient population has grown sicker (# of co-morbidities) over study period.

33,000 were before software go-live.

34,000 were after software go-live.
Post Implementation Results

34,000 patients reviewed, 30-day post-op follow-up:

- 18% reduction in patient death
- 15% reduction in MI's
- 12% reduction in blood transfusions
- 3 O.R. cancellations in 2012, N=6000 cases (0.05% of OR's)

 Patients seen up to 1 month before O.R.
 Median seen 4 days before O.R.
Post Implementation Results

Dictation (and associated costs, estimated $60,000/year) eliminated

ED Admissions
- No statistical difference in patient outcomes over study period

Provides evidence the improved pre-op outcomes were not caused by other hospital process changes
Thank you!

“The best way to predict the future is to create it.”