If your OR wants to improve on-time first-case starts and turnover time—focus on everything else. That’s the advice of Integris Southwest Medical Center in Oklahoma City, recently recognized as a “leading performer” for OR first-case on-time starts by VHA, Inc. Its strong performance is the outgrowth of a 4-year focus on Lean management, plus a locally developed surgical logistics system.

<table>
<thead>
<tr>
<th>Integris’s OR performance</th>
<th>Integris (average)</th>
<th>Proprietary database (top quartile)</th>
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</thead>
<tbody>
<tr>
<td>First-case on-time starts</td>
<td>73.6%</td>
<td>58.0%</td>
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<tr>
<td>Turnover time*</td>
<td>18.8 min</td>
<td>21 min</td>
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*Patient out to patient in.

**Byproduct of periop process**

On-time starts and turnover time “are a byproduct of the entire perioperative process. You cannot focus on that, or you will underperform in the other areas,” says Keley John Booth, MD, chairman of anesthesiology at Integris Southwest and president of Advanced Perioperative Services, PC, who built the logistics systems from the ground up.

Here is his logic. A patient having a routine procedure like a laparoscopic cholecystectomy typically is in and out of the hospital in 4 to 5 hours, or about 300 minutes at most.

“If your turnover time is 30 minutes, that is only 10% of that time. I think you get a lot more bang for the buck by focusing on the 90%,” he says.

Integris Southwest was recognized by VHA, Inc, for first-case on-time starts averaging 73.6% over 12 months. (On time is defined as the patient in the room no later than the scheduled time.) Its turnover time for patient out to patient in, averaging 18 minutes for 12 months, is on a par with top performers. Meanwhile, OR staffing costs were reduced by 18.5% on a per-minute basis, and surgical volume rose by 7.95%.

**Untangling the process**

Before launching its Lean effort in 2006, Integris Southwest faced the same frustration as many ORs. “We were making hundreds of phone calls,” says Marva Harrison, MBA, RN, assistant vice president for perioperative/ancillary services for the 10-OR department. “We would pick up the phone on the day of surgery and ask, ‘Did this patient
Dr. Booth recalls realizing during an early Lean event how tangled the process was. “We decided to ask a simple question, ‘If Dr. S has an 8 am surgery, where is the patient?’ It hit me that the problem was not that we didn’t have enough people,” he says. “It was that we didn’t have fluid communication among the departments.”

The first solution was a rudimentary shared spreadsheet that caregivers could use to communicate about patients’ status (OR Manager, May 2009, p 16-17, 20).

Technology for communication

From that starting point, Dr. Booth, a technology buff, went on to develop the sophisticated logistics software with displays throughout perioperative services. The system can also send messages and alerts to any smart phone with a browser, meaning physicians can access their schedule and any changes from their home or office. The software is owned by his anesthesia group.

Patient status and changes are displayed in real time. For example, if a lap chole is changed from OR 4 to OR 9 or if a surgeon is running late, the change is displayed where everyone can see it. No phone calls are needed. Nurses can enter status updates easily using touch screens. The software also sends alerts. If there’s a delay in preparing a patient for surgery, for instance, the system sends an alert.
“We are in real time able to communicate with our physicians, our day surgery department, and our PACU,” says Harrison, referring to the postanesthesia care unit. “We know where the patient is at all times and whether the patient is ready for surgery.”

The software can also produce reports that aid in accurate case scheduling and staffing.

**On-time starts**

Having instant access to information is a boon in starting cases on time, as are other improvements Integris Southwest has made.

The preadmission process has been fine-tuned. About 80% to 90% of patients have a preadmission evaluation before the day of surgery. That way, charts are complete when patients arrive for their procedures.

Before a case is scheduled, specific information is required from the physician’s office, including patient demographics, the diagnosis, planned procedures, and predicted case length to help in preparing the patient and the schedule prior to the surgery date.

Harrison also changed how staff are assigned in the preop unit. Before, nurses took the chart of whichever patient came up next. Now preop nurses are assigned to patients for a block of ORs, just as the circulating nurses are.

“That way, they are more attuned to how those rooms are running,” she says. “They know whether a room is running late and when the patient needs to be ready.” If a patient isn’t ready, they realize they will be identified as one of the responsible parties.

**Saving on staffing**

Staffing costs have gone down as performance has gone up. Harrison achieved those results by better matching staffing to when cases are actually performed. For example, on Mondays, there is a big influx of patients at 7 am, the pace slows at noon, and then picks up later in the day.

She found when she compared the staffing pattern to that, it was the opposite. “Our staffing didn’t follow the bulk of patients,” she says. “I might not have had enough staff in the morning. Then a bunch came in at noon to cover for lunches, and many went home at 3, just when physicians were returning from their offices to perform more cases.”

Reports from the logistics system helps her see when more or fewer staff are needed to match the cases.

**Hiring for improvement**

Technology alone won’t improve performance. The entire organization, from administrators to front-line staff, have to adopt a culture of relentless improvement, Dr Booth and Harrison emphasize.

That extends to hiring.

“When you want to move your organization forward, you have to hire and train the type of person who is going to fit with your organization,” Harrison says.

“We want people who will fit into our culture of continuous improvement. We will
never get to the point where our efficiency is where we want it to be—we can always do better.”

How do you hire the “right person”? There is no magic, she notes. “We look for people who are excited about the job and don’t see it just as an 8-hour workday. Our managers have embraced our culture. They know what we need, and they look for those characteristics.”

In interviews, managers ask questions to elicit a candidate’s attitude toward performance improvement (PI), such as “What are your ideas for the OR? What can we learn from you?” They watch for signals that the person is not focused mainly on how many hours he or she will work.

Hand-in-hand

The logistics software and continuous improvement philosophy go hand-in-hand. “You cannot get the successes we have without putting all of the puzzle pieces in place,” Harrison says. “There are 50 things behind every process we have changed.

“It doesn’t work to take one piece of the puzzle, like turnover time. You have to constantly change and work on every process you have.”

A hospital doesn’t have to adopt Lean management—any performance improvement method can be effective as long as you stick with it, Dr Booth notes.

Adds Harrison, “I’m glad we have Lean at Integris, but we could have picked any tool. As long as you have the attitude that you are going to improve, you can use any tool available.”

The physicians are on board.

“It really is the physicians’ ideas we work on,” she says. “They don’t come to me with problems any more—’My case didn’t start on time; you delayed me.’ They come to me with projects they want to look at.”

With the logistics software and the consistent focus on PI, Harrison says, “our cases being on time and our turnover times are among the best in the country. I would put us up against any surgery center.

“And we didn’t do it by adding staff or more ORs. We did it with our efficiency.”

—Pat Patterson