Finding Time: Spotlight on Ways to Maximize Capacity in your Operating Rooms

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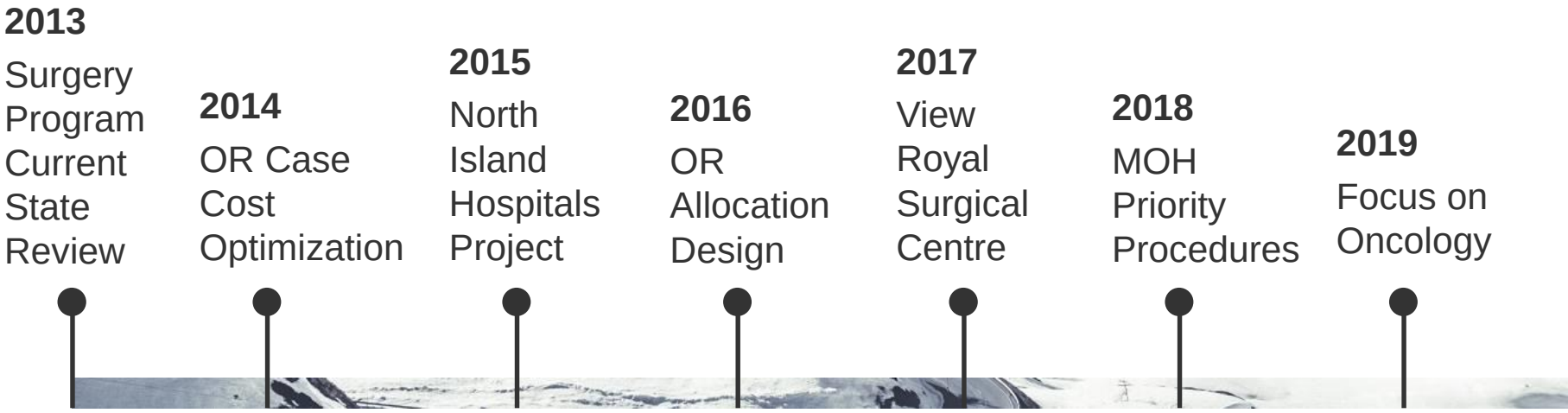
Disclosure

Overview

- Since 2013, we've been on a journey to maximize OR capacity **to better meet patient need**
- Today, we plan on **sharing some of our lessons learned**



Acknowledgments

- Many people have shown great leadership and willingness to participate

  Island Health Leadership Team

  Surgery Program Leadership Team

  Site-Level Leadership

  Surgery Program Analysis Steering Committee

  Physician Stakeholders

  AnalysisWorks Team

  …

Example Initiatives

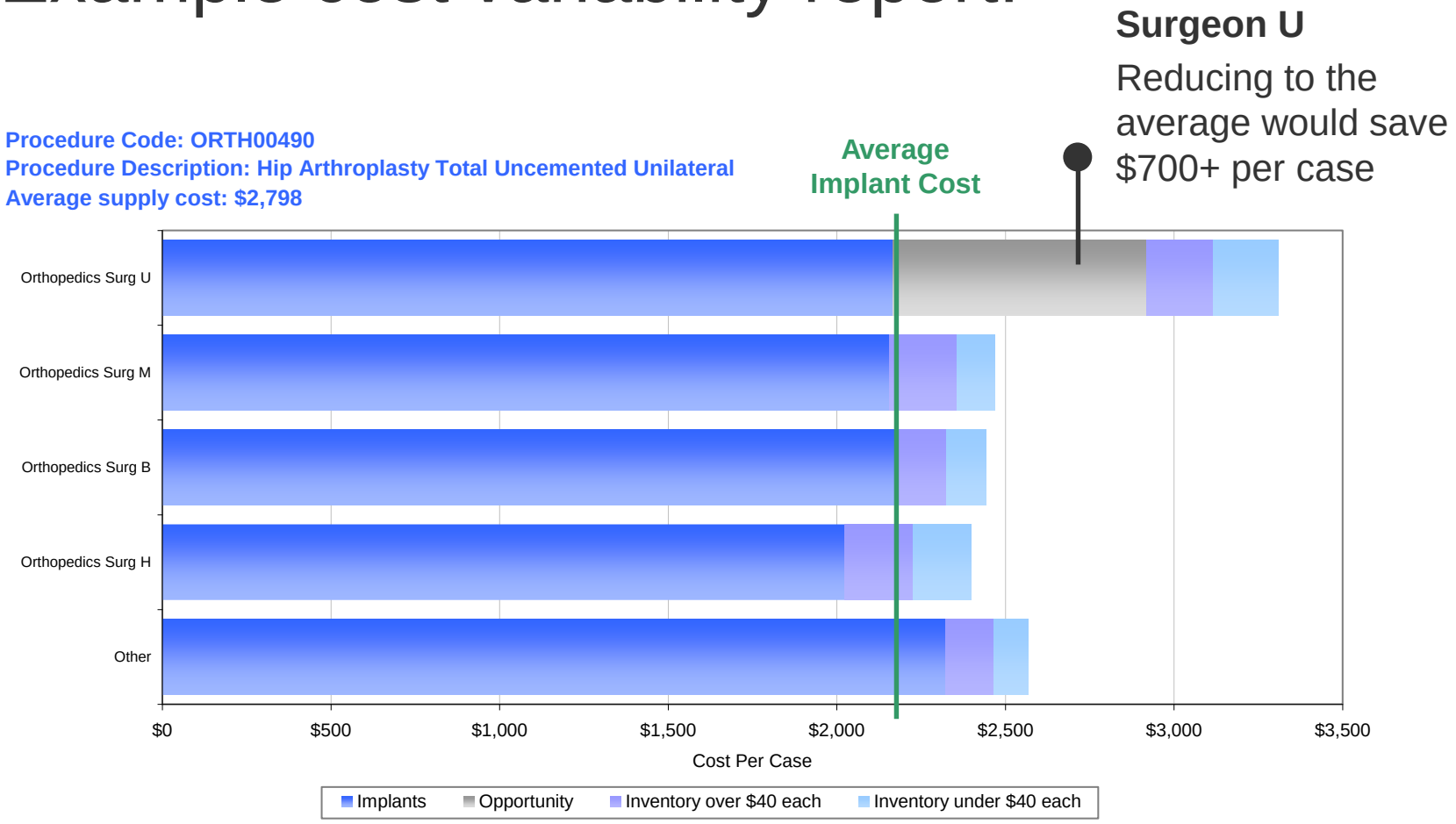
- Making **cost savings** in the OR
- Improving **OR efficiency**
- Shifting activity to **private centres**
- Building the **business case** for increased funding
- **Strategic allocation** of OR time

Cost Savings in the OR

- Focus on **variability between surgeons**
- Empowered **division heads to engage with their group**
- **Rewarded** cost savings (a proportion reinvested in the division)
- Fiscal period reporting to ensure timely access to up-to-date data

Cost Savings in the OR (Example)

- Example cost variability report:



Source: LightHouse (Total Hips performed at one site only)

Cost Savings in the OR (Example)

Cost per case reduction from $6,041 to $5,383

Total Hips

$630k

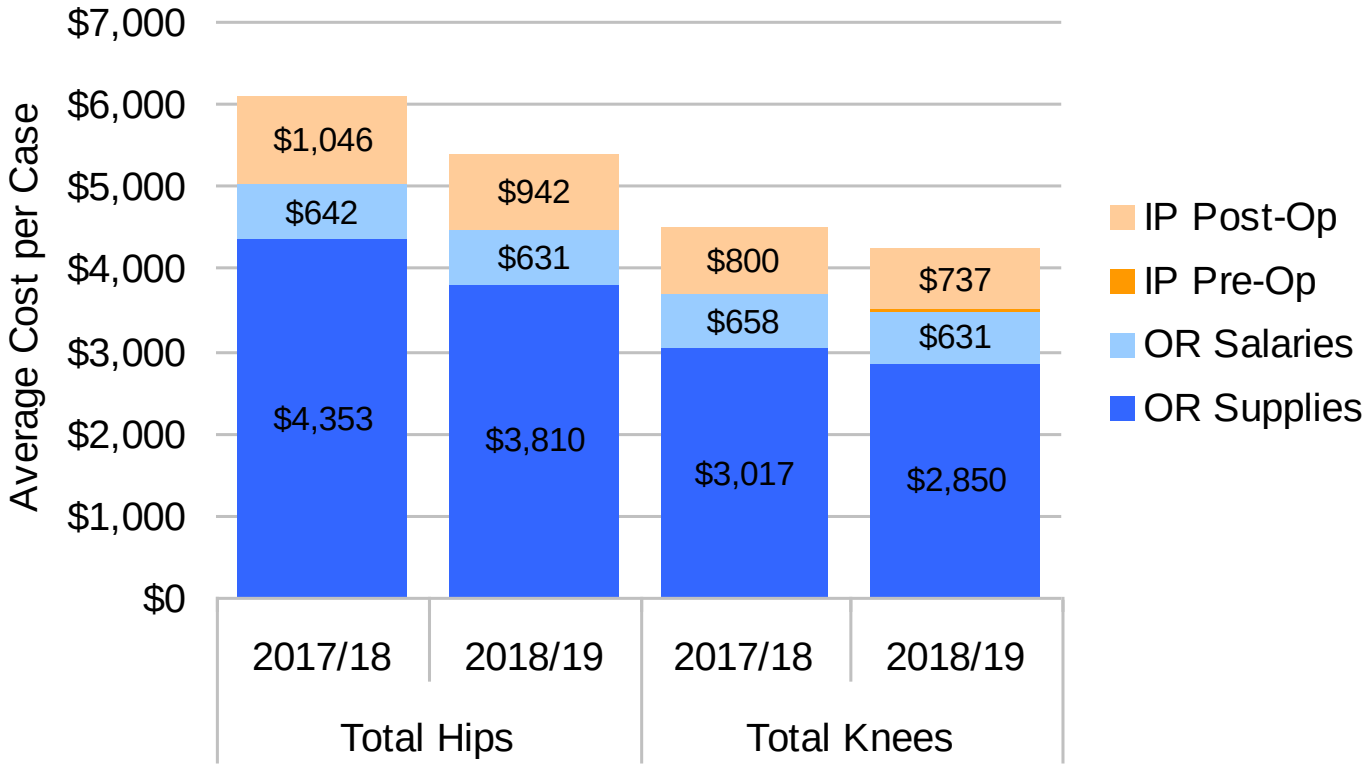
annual saving

Total Knees

$300k

annual saving

Cost per case reduction from $4,475 to $4,218



Source: LightHouse (excludes revisions and bilateral procedures)

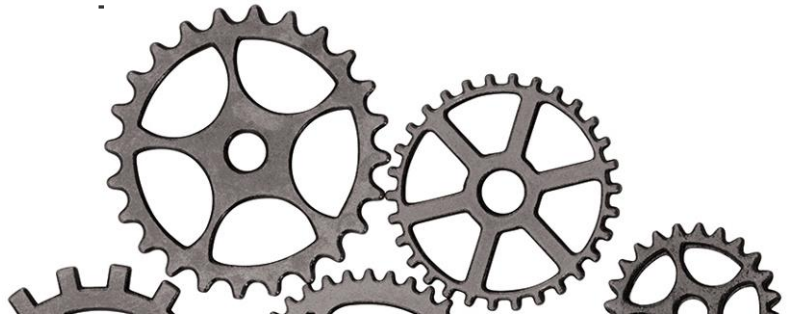
Improved OR Efficiency

Early days …

- Focus on **variability between sites** for late starts, turnaround times and early finishes
- **Annual report** to clinical and operational leaders

Now …

- Focus on **achievable opportunity** to perform more cases
- Interactive trending reports to clinical and operational leaders **every fiscal period**



Improved OR Efficiency (Example)

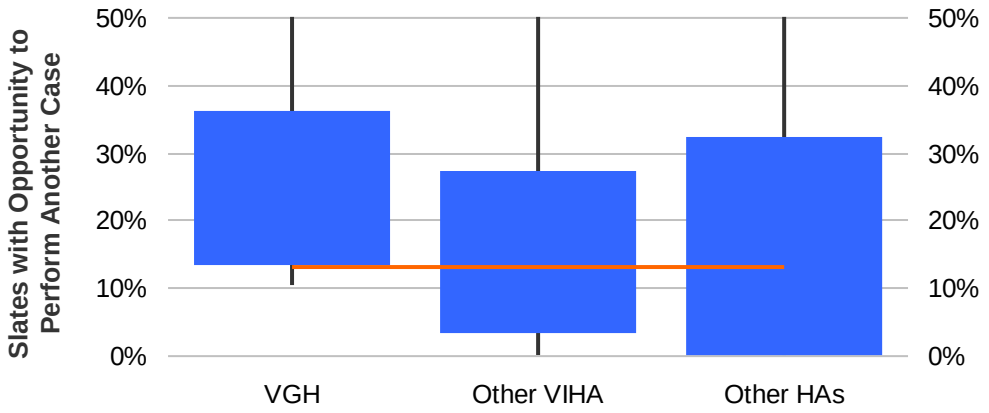
Ranges from 10% to 55%

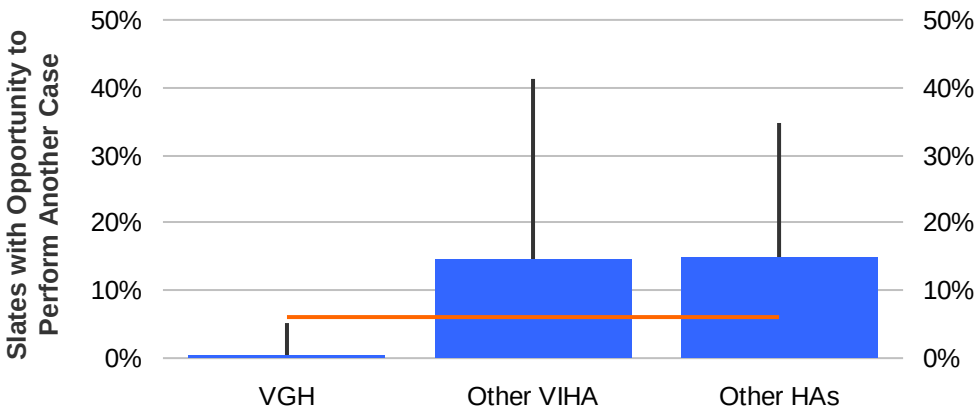
Most physicians above Provincial median

Division A

31%

slates with opportunity to perform another case





Division B

2%

slates with opportunity to perform another case

Ranges from 0% to 5%

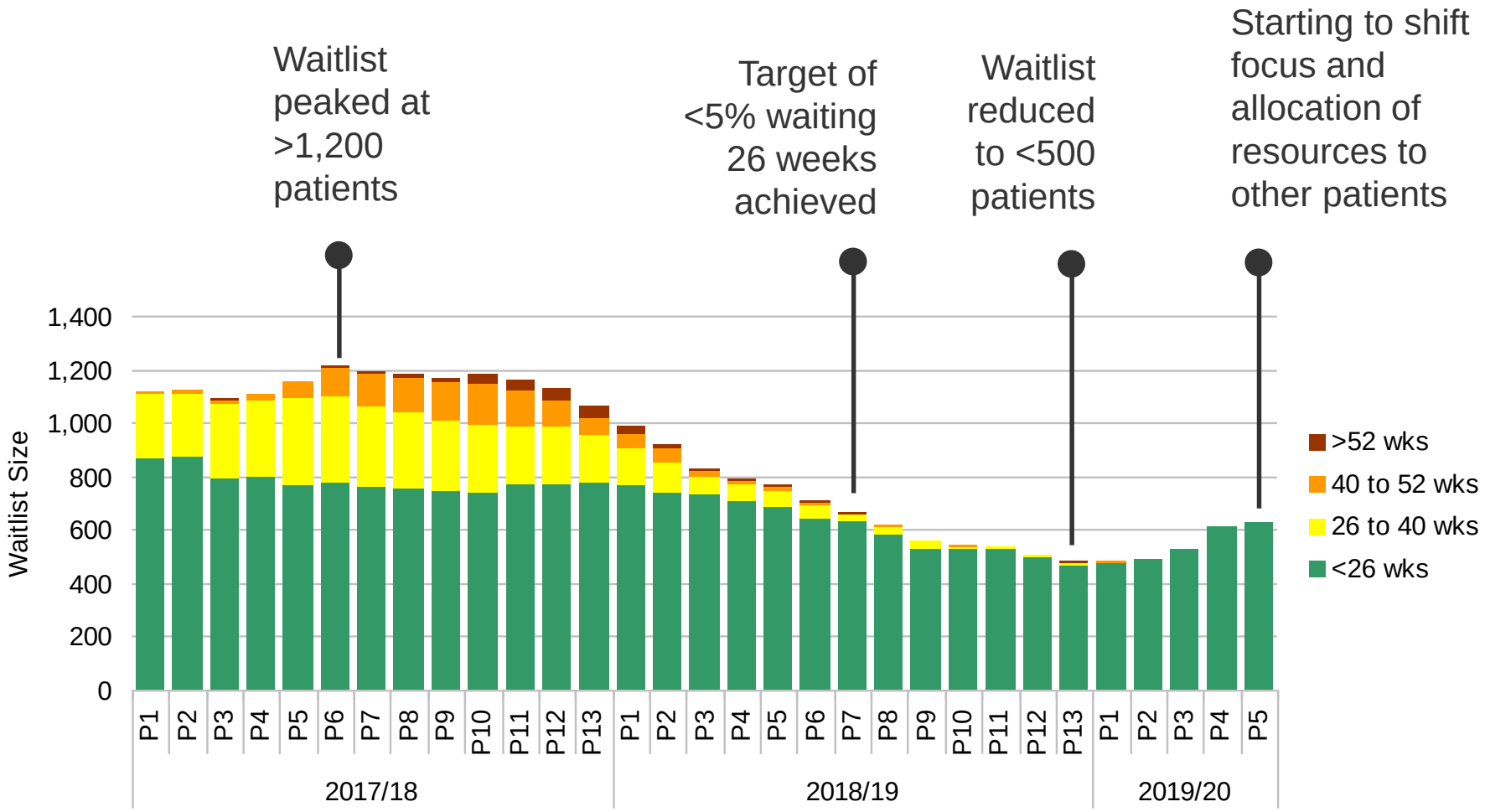
Most physicians below Provincial median

Source: LightHouse (includes weekday daytime slates during FY2019/20 P1 to P5)

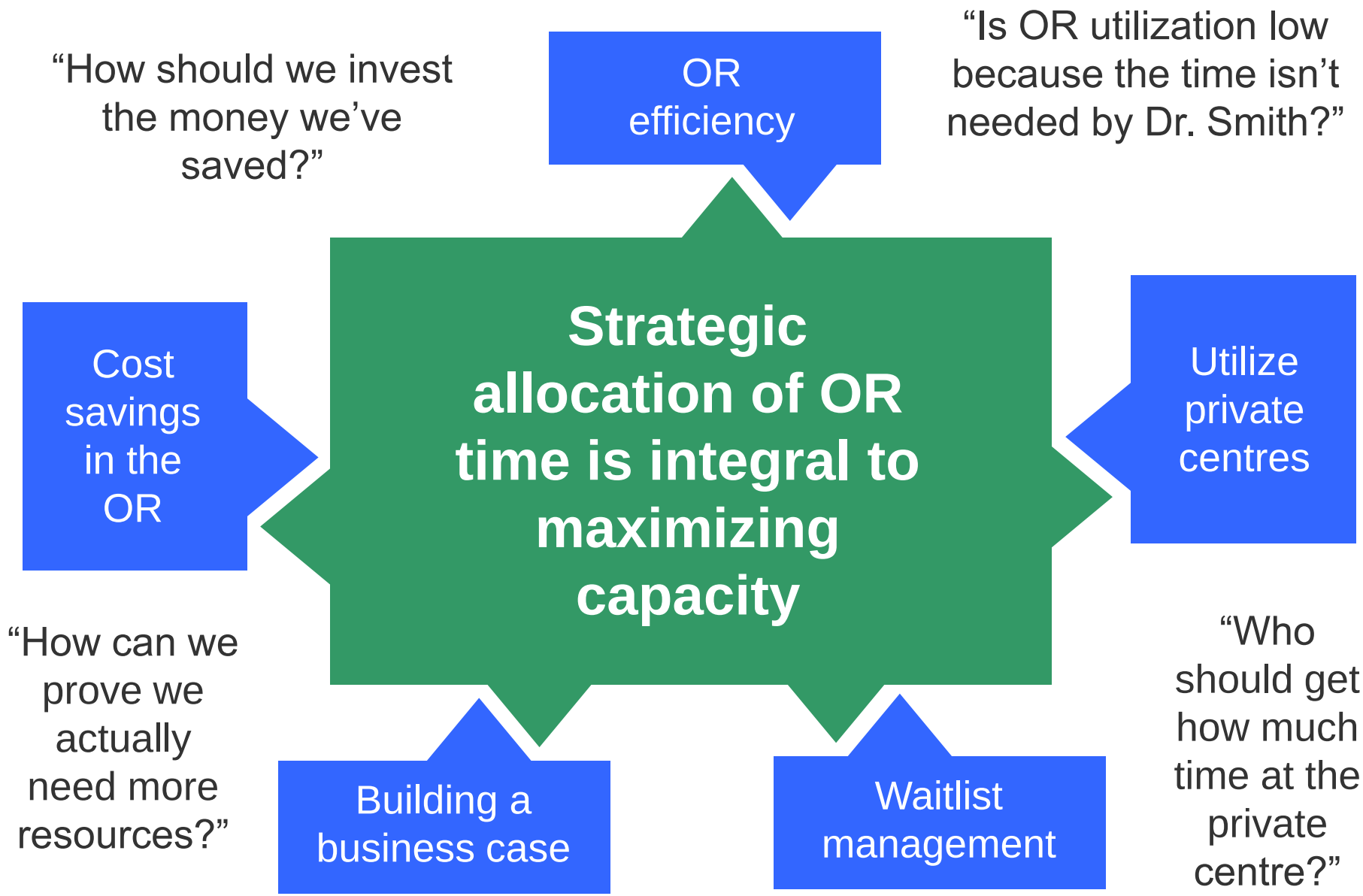
Ramping Up Capacity

- Prove that we're **making the most of existing** resources (e.g. OR costs, efficiency)
- Build a capacity model around **realistic planning assumptions**
- **Attach strings** to funding (i.e. central intake, prioritization of long-waiters)
- Monitor progress and **prove ROI**

Ramping Up Capacity (Example)



Source: LightHouse (includes all MOH priority Total Joint procedure codes)


"How should we invest the money we've saved?"
OR efficiency
"Is OR utilization low because the time isn't needed by Dr. Smith?"
Cost savings in the OR
Strategic allocation of OR time is integral to maximizing capacity
Utilize private centres
"How can we prove we actually need more resources?"
"Who should get how much time at the private centre?"
Building a business case
Waitlist management
"Is our 'need' inflated through poor waitlist processes?"

Strategic Allocation of OR Time

How far along are we?

- **Robust methodology** applicable to all sites and services
- **Making ongoing decisions** around resource allocation
- Some **sites/services further along** when it comes to making change

Model inputs …

- ✓ Waitlist backlog
- ✓ Net arrivals rate
- ✓ FIFO performance
- ✓ Unscheduled/urgent access rate
- ✓ Population growth
- ✓ …

Strategic Allocation of OR Time

Example business questions …

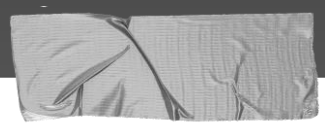
- How much capacity is needed by **division X to meet target Y?**
- How much **dedicated unscheduled/ urgent** OR capacity should we set aside?
- How do we ensure **‘relatively equal’ access** within available capacity?
- How many **new ORs** should we build?

What are the largest hurdles you've had to overcome to reassign OR time?

Here are a few of our lessons learned …

1) Principles Before Methodology

- What are you trying to achieve?
- What do you need to take account of?
- Who needs to be engaged?

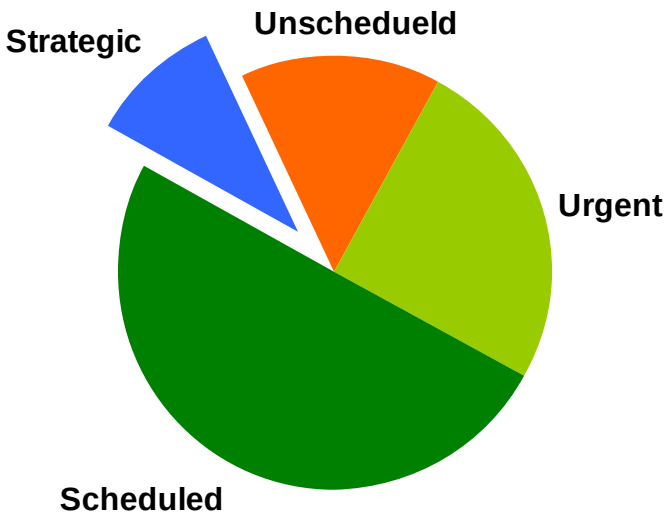


Our principles …

- **Patient focused** (i.e. primary goal is to improve patient access)
- **Fair and transparent** (i.e. data driven and easily explainable)
- **Sustainable** (i.e. as best as possible work within everyone's constraints, e.g. physicians, physical resources, administrative priorities)
- **Flexible** (i.e. ability to adjust for site-level nuances)

2) Set Aside Strategic Capacity

- It's **easier to give time** than take it away
- Recommend **at least 10%** of your capacity
- **Never permanently allocate** net new capacity to a specific service/surgeon … set it aside as 'Strategic Time'
- **Monitor closely** that time used as intended



3) Focus and Commit

- Choose a **‘Top Priority’**
- Create a burning platform
- Improving access ‘usually’ requires **significant investment**
- Keep your eye on things even when it looks like the job is done

What is left to do?

- Lots …
- Continue to work towards **MOH targets**
- Creating capacity for **patient populations most in need** (e.g. oncology)
- **Increase uptake** of the framework in other parts of the Island

Takeaway Message

Maximizing OR capacity is a challenge …

But, there are opportunities for us all to be more **strategic with how we allocate our precious resources**