Seeking a cure for ASCs’ block schedule gridlock

The Christiana SurgiCenter, a 7-OR ambulatory surgery center (ASC) was losing volume. Although its ORs were staffed 8 hours a day, surgeons were saying they couldn’t get their cases scheduled.

The problem turned out to be the block schedule. It was like a patchwork quilt.

“Our blocks were small and impossible to manage in an efficient way,” says Kenneth Silverstein, MD, medical director, perioperative services and chairman of the Department of Anesthesiology for the center’s parent, the Christiana Care Health System, Wilmington, Delaware.

Surgeons had blocks for as little as a half-day a month.

“Nobody used 100% of their block,” he says, “leaving gaps that were hard to fill.” On average, only 32 of the 48 staffed hours, including turnover time, were used on a given day. Some surgeons who wanted to perform more cases couldn’t because they would run into the following block.

The surgery center had seen its volume slip to about 6,500 procedures a year from 10,000.

The solution was radical—wipe the slate clean and start over.

Five months into the new scheduling model, volume is up 7.5%, and productivity per OR has risen by 23%. Surgeons are bringing more cases to the center, and the staff is happier.

Trying to fix block schedule

The center’s leaders had tried previously to optimize the block schedule in various ways, including adjusting the release times for blocks. Though the policy was for the surgeons to maintain 75% block utilization, it was difficult to enforce. Surgeons often had a reason why their utilization had dropped.

“Some cases were clear-cut. Others hovered in the 60% to 70% range,” Dr Silverstein says.

With competition from nearby ASCs, there was concern about enforcing the policy too aggressively.

Building the ‘ideal OR’

After much deliberation, the decision was made to start over. The goal: Build the “ideal OR schedule.”

Under the new plan, OR time is allocated to specialties based on their historical utilization of the ASC for the past 2 years. For example, 45% of the center’s caseload is gynecologic surgery, so 45% of the schedule is committed to the GYN surgeons.

“It’s an open-access system,” Dr Silverstein notes. “It takes away all of the individual blocks and allocates time to the specialties based on how they use the center.”

The new schedule, introduced in March 2011, started with 5 rooms allocated and staffed for 8 hours a day, equaling 40 hours per week. Of this, 45% was allocated to the GYN service.
“It doesn’t come out to be a round number, but if you do the modeling, you can work it out,” he says. On Fridays, for instance, 60% of cases are GYN, so 3 of the 5 rooms on that day are allocated to the GYN surgeons.

A 6th room is staffed for 8 hours but left for open access. Originally, the plan was to cut back on staffing this room after 3 to 6 months.

“We thought the 6th room would wither. But that was wrong,” he says. “We have filled the 6th room and are getting ready to open a 7th to accommodate the volume.”

**Key role for schedulers**

Schedulers have a key role in the new system. They are able to adjust OR time on the fly. For example, if the ENT surgeons aren’t using their time, and the schedulers get a call from a GYN surgeon asking for time, then GYN time is booked. The schedulers know they can schedule the case into the ENT time.

“Basically, we accommodated the business coming through the door,” Dr Silverstein says. “That says to the surgeons, ‘If you have a case tomorrow, call us, and we’ll put it on.’”

That has proved to be a major benefit of the new scheduling model. It also gives the center’s management more control over how cases are booked.

**Managing the transition**

Moving away from block scheduling caused the predictable turmoil. Close and frequent communication with surgeons and their offices was needed to manage the change.

The main message was, “We’re not taking away your block time; we’re improving access.” Still, for some it was a tough sell.

Dr Silverstein and Judy Townsley, MSN, RN, CPAN, the vice president for perioperative services, met with individual surgeons and their staffs at their offices to inform them about the new arrangement and how their cases could be grouped to use the new schedule most effectively.

For the offices, one of the big changes was to encourage surgeons to schedule their cases further ahead and to group them so they could be performed in sequence on the same day. Using that approach, a GYN surgeon can often perform 4 or 5 cases on the same day.

Cases can be scheduled so surgeons can follow themselves and “are not scattered all over the OR schedule like they were before,” Dr Silverstein notes.

“A key was to work with the scheduling team and give them room to maneuver and negotiate with the offices,” he says.

**Managing the data**

The historical data used in managing the schedule is captured by the perioperative nursing documentation system and stored in a data warehouse, where it is updated every night.

Dr Silverstein manages the schedule personally. He accesses the data using a program he describes as “like a pivot table on steroids.”

“I can put the data in Excel, and do the modeling myself. I don’t have to wait for a data analyst and 3-month-old data. I can tell you what we did yesterday.”

He watches actual utilization and adjusts the schedule accordingly. For example, if the GYN caseload grows to 55% of the volume, the center will allocate more time to that specialty.
Results
The new plan has been in effect since mid-March 2011.
“We are witnessing essentially a 23% increase in cases,” compared to the same period in 2010, he says. The average caseload has gone from about 25 cases to 30 cases a day. Financially, some trends have been reversed from unfavorable to favorable, including revenue and contribution margin. Labor expenses are on budget. Productivity is up from 3.8 cases per room in 2010 to 5 cases per room in 2011.
Staffing has not changed. The 6th room is staffed even if the room isn’t filled.
“That allows some operational efficiency on the day of surgery,” says Townsley. For example, the room can be used for certain surgeons to flip cases; that is, move from one OR directly to the next.
“All of the block holders are managing to get their cases done,” notes Dr Silverstein.
A surgeon who previously could do only 3 cases in her block is able to get a 4th one on. “We have surgeons who are doing 5 to 6 cases in a row,” he says. “We no longer have blocks that are keeping us from scheduling cases. Our schedule is filling up 6 weeks down the line.”
With the new scheduling model in place, attention is turning to improving patient flow for the larger volume. That includes rethinking logistics for the preoperative process, on-time starts, and turnover time.
Says Townsley, “The block schedule truly is for the convenience of the surgeons, but it was destroying us fiscally as a hospital operation.”
Though the center’s leaders had tried working with the physicians’ offices to better manage the block schedule, “none of it made any difference,” she says. “This has made a difference.”

—Pat Patterson