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**OR performance**

# Benchmarking labor productivity: How is your OR being compared?

Productivity monitoring and management are near the top of the priority list for every perioperative nursing director. With 50% to 80% of a hospital's costs in labor, staffing dollars are a big target for cost management.

Some experts say hospitals and health systems will face budget cuts of 20% to 25% over the next 5 years as the nation tries to cope with health care costs and an aging population. With cuts that steep, labor isn't immune.


As the hospital's greatest cost and revenue center, the OR won't escape scrutiny.

With about 60% to 65% of a hospital's profitability coming from surgery, "a well-run program can make or break perioperative services and your hospital's profitability," says Patrick Voight, BSN, MSA, RN, CNOR, of Deloitte Consulting.

Perioperative directors typically receive a regular labor productivity report showing how their FTEs compare with a target or a benchmark. Understanding these reports is essential to managing and justifying the FTE count.

## Managing to a benchmark

Managers and directors often are expected to meet a labor productivity benchmark. The hospital may subscribe to an outside benchmarking service or be part of a network that benchmarks internally.

Regardless of the source, it's important to realize what benchmarking can and can't do, Voight advises.

Benchmarking can give you a sense of how your OR compares to a peer group. But benchmarking doesn't show exactly where you might have problems if you are off the target.

For example, the report might show that your staffing for a reporting period is 5 to 10 FTEs over the benchmark. But "it doesn't tell you which positions those are," he says. That requires an internal analysis to learn why your labor numbers are higher and a performance improvement project to identify and address what is driving labor costs (sidebar).

## What is needed for benchmarking?

ORs often benchmark their labor productivity both internally, such as comparing their own performance month to month, and externally with a peer group.

## Key principles

A few key principles:

- Benchmarking generally focuses on worked hours rather than paid hours because management has more control over worked hours. Paid hours include worked hours plus paid leave, such as sick time and vacation. Typically, paid hours are 24% to 32% higher than worked hours, depending on the region of the country, Voight notes.
- In benchmarking, worked hours generally include straight time, overtime, call-back hours (usually calculated as overtime), orientation, and education.

## Unit of service

The unit of service for labor productivity in the OR typically is either worked hours/OR case or worked hours/OR minute. Voight says he prefers worked hours/OR minute adjusted to worked hours/100 OR minutes, a more workable number.

OR minutes give a more accurate picture of labor productivity than cases, he says, because they better capture the complexity of service. For example, a facility performing 5,000 orthopedic cases a year will require more labor than one performing 5,000 cataract cases.

A caveat: Be clear about which database your OR minutes are drawn from when comparing yourself to an external peer group. That could make a big difference in the productivity numbers, Voight advises.

For example, if OR minutes are drawn from the hospital's financial system, and the system rounds case time up to the nearest 15 minutes for billing purposes, the total minutes will be higher than the minutes captured by the OR information system, which documents actual minutes patients are in the room (wheels in to wheels out).

Assume a patient is in the OR for 31 minutes, for instance. The financial system may round up to 45 minutes when the actual worked time is 31 minutes. In this case, if 45 minutes is used in the unit of service (OR minutes), productivity will look better than it actually is.

## Data needed

To establish initial benchmarks for your department, you will need 1 year of data; that is, hours worked (or paid):

- payroll data including paid hours and worked hours
- unit of service by department (cases, OR minutes, visits, etc)
- the organization's financial and operational characteristics.

## External benchmarking

Elements needed for forming an external peer group:

- a defined peer group of similar departments in similar hospitals
- data for specific departmental benchmarks consistent with what the benchmarking service uses
- a department description similar to that used by the benchmarking service.

## Comparing apples to apples

To get a true picture of where you stand in benchmarking, make sure you're being compared appropriately with facilities you're measured against.

You can often find out which organizations your facility is being benchmarked against through the benchmarking service to which the hospital subscribes.

Here are a few pointers for understanding how labor productivity is compared.

### *Understand your peer group*

If you're being compared with a peer group, make sure those hospitals have characteristics similar to yours. These criteria are often used in determining peer groups:

- whether the hospital is part of a system
- bed size
- case mix index
- inpatient-outpatient mix
- number of discharges

## What's driving your labor costs?

**Does your OR's labor productivity consistently exceed the benchmark? Check your OR against these characteristics of top-performing departments.**

| | |
|---|---|
| **Perioperative governance** | |
| ■ | The surgical enterprise is led by a perioperative governing body that functions like a board of directors to manage department resources. |
| **Preoperative preparation** | |
| ■ | Patients are consistently cleared 48 to 72 hours before the day of surgery:<br>—Patients are financially cleared.<br>—Anesthesia assessment is completed.<br>—Diagnostic testing results are complete and on the chart. |
| ■ | Elective patients are removed from the schedule at 48 hours until all preoperative components are complete. |
| **Case scheduling accuracy and predictability** | |
| ■ | Cases are scheduled using historical data from the OR information system. |
| **Block schedule management** | |
| ■ | Block time is released by specialty so unused time can be filled in advance of the day of surgery. |
| ■ | Roughly 80% of time is blocked and 20% is open, depending on the strategic needs of the facility. (Ambulatory surgery centers typically have a high percentage of blocked rooms because of a predictable schedule.) |
| ■ | Block times are preferably 8 hours and not less than 4 hours. |
| **OR availability** | |
| ■ | The number of staffed rooms matches the daily schedule. |
| **On-time starts** | |
| ■ | The target is for 95% of first cases to start on time, with no grace period. |
| **Flipping rooms** | |
| ■ | It is recognized that when surgeons flip rooms (that is, surgeons are assigned to 2 ORs or move from one case directly to the next), labor productivity may be affected because of potential down time in one of the rooms. The criterion for flipping should be that a surgeon's cases proceed sequentially with no down time. |
| **Delays and cancellations** | |
| ■ | The OR strives to minimize delays and cancellations. Cancellations are 4% or less. |
| **Add-on cases** | |
| ■ | Add-on cases are kept to 10% or less. Add-ons not only affect efficiency but also safety because patients may not be adequately prepared for surgery. |
| **OR utilization** | |
| ■ | Prime-time utilization for hospital-based ORs is 75% (wheels in to wheels out) without turnover time (setup/cleanup time) or 85% with turnover time (setup/cleanup time). |
| **Turnover time** | |
| ■ | Turnover time does not exceed 25 minutes on average. |
| ■ | OR personnel use parallel processing for turnover activities (that is, perform some setup and cleanup activities while the patient is in the room both pre- and postprocedure). |

*Source: Patrick Voight, BSN, MSA, RN, CNOR, Deloitte Consulting, and other sources.*

- urban or rural location
- region
- teaching status.

A rule of thumb is to select about 4 criteria and strive for a peer group size of at least 20 hospitals.

"The more criteria you select, the smaller your peer group will become," Voight notes. That might not provide sufficient data for comparison.

### *Peer group criteria*

Particularly useful criteria:

- **Case mix index.** This is an average DRG weight for the hospital's Medicare vol-

ume. Voight says he thinks this is an important criterion because it should reflect the complexity of the hospital's services, which may reflect the type of cases performed.
- **Bed size.** This criterion ensures the hospitals are similar in the scope of their operations.
- **Region of country.** It's helpful to compare within the same region because of geographical differences in staffing and practice patterns. Some parts of the country, such as California, are more aggressive in managing staffing than other regions.
- **Teaching status.** Teaching hospitals typically have higher staffing requirements than community hospitals because of their educational mission.

### *Select the correct department description*

For the comparison to be accurate, the description of your department should match what the benchmarking service uses. The description your hospital selected for your department should be reviewed and agreed upon by the OR director.

Using similar department descriptions "gets you closer to an apples-to-apples comparison," Voight says.

The description should specify what personnel are included in the OR's productivity numbers. Here's a sample description of an OR:

*Includes: All operating room services, intraoperative patient care, perfusion services, inpatient and/or outpatient services, and operating room support system.*

*Does not include: Postanesthesia care unit, anesthesia functions, preop holding area, and/or central sterile functions.*

### *'Normalize' your OR's data*

If your department description does not match that of the benchmarking service, your data needs to be "normalized" for a more accurate comparison.

For example, environmental services personnel typically are not included in the OR department description. If your OR FTEs do include environmental services, you will want to move their hours out of the OR staffing numbers for benchmarking purposes, Voight advises.

Other personnel who may not be included in the OR description are:
- inpatient transporters
- admissions personnel
- phlebotomists in the presurgical testing area
- nurse managers.

Nurse managers may or may not be included. They are often benchmarked separately under a department description called "OR administration."

### *See how you compare*

Benchmarking reports generally show how the peer group is performing at the 25th percentile, 50th percentile, and so forth. The 25th percentile represents the best performers for labor productivity in your peer group, while the 50th percentile is average, he says.

A note of caution: "Achieving the 25th percentile doesn't mean you are running a leading practice department," Voight says. "You are only comparing your OR with others in the peer group, who may not be top performers."

### *Reach out to your peers*

Once the peer group is selected and the FTE data has been normalized, you still may find you are over the benchmark.

In addition to conducting an internal analysis, you may want to contact high-performing peer group members to discuss how they are meeting the target. Your

finance department should be able to provide a list of hospitals in your peer group. Then you can reach out and compare notes.

### Who's accountable?

Labor productivity is one measure of an OR's cost-effectiveness, but it can't be viewed in isolation. The worked hours/unit of service are directly affected by the surgical schedule and how well it is managed.

An OR with big gaps between cases because of unused block time and frequent elective add-ons during the day will not use staff as efficiently as an OR with a predictable schedule and a minimum of gaps, delays, and add-ons.

An efficiently managed surgical schedule requires interdisciplinary leadership.

"If you're expected to manage labor productivity to a benchmark, and you have an ineffective OR committee that doesn't manage the schedule well, you will have a hard time meeting the benchmark," Voight notes.

ORs with leading performance typically have an effective perioperative governing body that acts like a board of directors for surgical services, he says. The governing body sets and enforces policies for scheduling, block time, add-on cases, and related issues.

Accountability for labor productivity should extend beyond nursing to the entire perioperative leadership.

"Variances in labor productivity aren't just about turning the rooms around quickly," Voight says.

"It's about scheduling, scheduling management, and having effective perioperative governance to start eliminating gaps and managing overtime." ❖

*—Pat Patterson*

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*To learn more about calculating and managing worked hours/unit of service, listen to the webinar, Managing Labor Productivity in the OR, available for purchase at www.ormanager.com.*