The right strategies can help increase OR utilization

How do you improve an OR’s financial performance? Last month’s column focused on two key strategies: using data to identify improvement opportunities and rallying support for organizational change. These strategies can be used to overcome a major challenge in OR management—increasing utilization.

Any OR with a utilization rate below 75% has room for improvement. If your department’s utilization is below 65%, you are likely experiencing moderate-to-severe problems in costs, profitability, and organizational effectiveness.

Low utilization means an OR is operating more rooms than it needs. Overcapacity leads to high costs, mostly for labor, but also for anesthesia coverage.

To improve utilization rates, you need to identify the underlying causes of low utilization and work with physicians to design effective solutions.

Inefficiencies
Many hospital administrators see low OR utilization as a marketing problem. There is an insufficient case volume because patients or their surgeons are choosing competing facilities. While such decisions can contribute to low utilization, the main culprit may be an inefficient block schedule system.

One common problem is that surgeon blocks are too short. Many ORs assign block time in 4-hour increments, which leads to several inefficiencies. For example, often the block accommodates only two 90-minute cases, leaving 60 minutes of OR time unused. In addition, a case that runs long in Surgeon A’s morning block will delay Surgeon B’s afternoon start time. Shorter blocks also require more frequent room changeovers between specialties. Tearing down a room for urology and setting it up for spine surgery, for example, requires additional time that eats into utilization.

Another common problem is that block rules are too loose. Many hospitals set low utilization requirements for maintaining blocks. Surgeons may be allowed to release block time shortly before the day of surgery, with no utilization penalty. These short-notice releases prevent the OR from backfilling the schedule.

Overall, poor block design leads to wasted capacity and low department revenue.

Efficient block systems
Designing a strong block schedule is not difficult. Efficient block systems are based on 6 strategies that promote utilization and improve surgeon satisfaction.

1. Set the minimum block length at 8 hours. Better-performing ORs allocate block time in increments of 8 to 10 hours. One long block will accommodate more cases than 2 short blocks combined. Whole-day blocks also minimize downtime caused by specialty changeover.

2. Establish a utilization threshold of 75% to 85%. OR time is a valuable commodity, and surgeons should be held accountable for how they use it. Well-run ORs
adopt a version of the old mess hall slogan: “Take all you can eat, but eat all you take.”

A utilization threshold of 75% is appropriate for most ORs. Departments with a challenging payer mix should aim higher. (Utilization above 85% creates its own problems—a tight schedule leads to significant delays in end-of-day cases.)

3. Assign blocks to surgeons, not specialties. The individual assignment of block time creates a sense of ownership that encourages surgeons to maintain and optimize utilization. Utilization can be 10 to 15 percentage points higher for individual blocks than for group blocks.

4. Release block time according to specialty. The OR must be able to fill unscheduled time. To do this, set up a staggered block release schedule that is sensitive to specialty needs. Specialties that treat many emergent cases should retain block time until shortly before the schedule day. Specialties with longer presentation times can auto-release farther out. (See chart for a suggested release system.) Surgeons who consistently maintain greater than 85% utilization are exempt from auto-release.

5. Create flexibility through open rooms. Reserve approximately 20% of rooms for urgent and emergent cases. In many ORs, this translates into 2 rooms per shift. This unblocked capacity gives flexibility to the entire schedule and makes it easier for less-tenured surgeons to access the OR.

6. Develop a structure for enforcing rules. Without the ability to enforce the rules, even the best block system will fail. To make the system work, OR management must have the backing of a physician leadership group. Last month’s column introduced the idea of the multidisciplinary Surgical Services Executive Committee (SSEC). A strong SSEC is vital to leading block schedule reform and ensuring compliance (see illustrations of poorly designed vs efficiently designed schedules).

**Overhaul schedules**

Work closely with the SSEC to lead an open, consultative approach to developing and implementing a new block system. Lay the groundwork by calculating your department’s adjusted utilization rate. (Adjusted utilization is total in-block case minutes plus total turnover minutes, divided by total block minutes.) In addition, analyze provider data to determine surgeons’ individual case volumes and utilization rates.

Begin by working with an SSEC subcommittee to review current block guidelines and systems. Develop recommendations based on the above design principles. Next, propose rule changes to the full SSEC and gain agreement on the new system. Meet again with the subcommittee to craft a detailed block time reallocation based on surgeon volume and utilization.

To introduce surgeons to the new system, organize an open meeting for all procedural staff. During the meeting, SSEC members should explain the importance of reforming the block system, the rationale for the new design, and the expected impact on surgeons. Use feedback garnered during the meeting to revise the schedule.
an implementation date that allows surgeons time to prepare for the new system. Present the final plan during an all-surgeon meeting, and follow up as needed with surgeons’ office managers.

The SSEC plays a critical role in monitoring and managing the new schedule. The committee has the ultimate authority to enforce policies by reassigning block time when necessary. As much as possible, the SSEC should make decisions based upon actual data, reviewing utilization on a monthly basis and reporting back to surgeons quarterly. Surgeons who fall short of their utilization threshold should be allowed 3 months’ “probation” to improve their utilization.

When you need to reassign block time, reduce surgeon time by entire blocks. Do not shorten existing blocks. For instance, a thoracic surgeon who cannot fully utilize a weekly block could be transitioned to 3 blocks per month.

**Leverage utilization gains**
Greater efficiency makes the schedule easier for surgeons to access, and performing more cases within the same time frame increases surgeon revenue. Longer blocks also facilitate the management of specialty nursing teams. In addition, surgeons appreciate a schedule that their peers administer according to clear and transparent rules.

A better block time system helps make the nursing schedule more predictable, which can improve nurse satisfaction and retention. Reduced schedule variability also improves anesthesiologist satisfaction because higher utilization rates allow anesthesiologists to increase their income by attending more cases per day.

Higher utilization also enables OR leaders to reduce costs by balancing capacity with demand. An efficiently utilized surgical suite can accommodate 900 inpatient cases or 1,400 outpatient cases per year. Suppose you have a volume of 22,000 cases per year and a 40/60 blend of inpatient and outpatient procedures. You can easily calculate your ideal per-room capacity and total room requirements for a given department (chart).

Improving overall utilization will likely enable you to close one or more rooms. Analyze case volume data by day of the week, and adjust your room plan to accommodate typical volume peaks.

Then create an efficient step-down schedule. Most surgery departments close rooms through the afternoon and evening as case activity diminishes. Drawing down capacity too quickly creates bottlenecks that extend surgery times, but reducing capacity too slowly creates waste.

To design the most efficient step-down schedule, begin by calculating the depart-
ment’s average number of cases per hour. For each hour, calculate the standard deviation (using an Excel spreadsheet or engineering calculator). You can use these calculations to shape a step-down curve that accommodates case volume while minimizing variable costs.

A large medical center in the Midwest recently used utilization improvements to reduce OR capacity from 27 to 22 rooms. This historically understaffed organization reduced its OR staff by 5 RN FTEs and 5 OR technician FTEs, and the anesthesia department cut positions for 1 physician and 5 certified registered nurse anesthetists. The cost savings increased overall profitability.

**Coming up**

Once a hospital strengthens OR profitability, it can grow revenue by increasing total case volume. The next “OR Business Performance” will show how to design and execute an effective service line strategy that drives volume growth. Learn how to use data to identify the best strategic opportunities and create a provider-centered organization that wins strong surgeon loyalty.

*This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow revenue, control costs, and increase department profitability.*