Firm policies and the right procedures tip the cost-benefit balance toward flip rooms

We spoke recently with surgery department leaders at an academic medical center in the Midwest. One of their biggest concerns was a challenge faced by many ORs today: “Flip rooms are just killing us.”

Most surgeons prefer the efficiency and revenue potential of a flip room schedule. But for hospitals, flip rooms are becoming increasingly expensive. Room flipping can create long gaps between cases when not effectively managed, driving down utilization and eroding profitability.

Yet OR directors and managers at some hospitals have achieved a balance between the costs and the potential benefits of a flip room system. In our experience, the key to managing flip rooms effectively is to establish clear standards for awarding them, strong processes for managing them, and a robust decision-making structure that minimizes flip room costs while maximizing potential gains.

A management challenge
The main drawback of room flipping is that it increases unproductive time. Utilization in a flip room can be 30% to 40% lower than a fully scheduled operating room under a single-room system. Considering that OR time costs between $20 and $65 per minute, low utilization makes room flipping a very expensive service. Flip rooms can also create problems for anesthesiologists, as low room utilization translates directly into low anesthesia productivity. In addition, providing flip rooms to some surgeons can create a “2 room” expectation among the rest of the surgical staff.

But refusing to provide flip rooms can be risky for a hospital surgery department. Flip room schedules are standard in ambulatory surgery centers and specialty hospitals. To recruit and retain key surgeon specialists within this competitive environment, surgical services directors must offer flip rooms. Taking a hard line is “penny wise and pound foolish.” A hospital that loses just 1 orthopedic surgeon over the flip room issue can easily forfeit hundreds of high-revenue cases.

Room flipping does have an upside. Leading hospitals across the country have demonstrated that a well-constructed flip room plan can drive OR growth. We recently worked with a hospital that had a clear potential to increase orthopedic surgery volume by 15% to 20% by properly structuring its flip room system.

The key to success is careful management. Room flipping will never be as efficient as single-room scheduling. But with the proper policies and controls, OR leaders can limit the costs of a flip room system and use it to improve the overall profitability of the department (sidebar, p 20).

Basic criteria
The first step to creating a strong flip room system is to establish clear requirements and standards for obtaining and retaining a flip room. Effective systems have requirements in 5 areas:

• Adequate volume. The purpose of a flip room is to accommodate busy surgeons, so it is important to establish thresholds that define high volume. First, a surgeon should be awarded a flip room only if he or she is using OR time very efficiently.
Current block time utilization should be a minimum of 75% to 80%. Second, the surgeon should be able to schedule at least 6 to 7 cases per 8-hour block. In addition, it can make sense to establish an annual volume threshold. Some hospitals provide flip room time only to surgeons who bring 250 or more cases to the OR per year.

- **Appropriate procedures.** Not all operations are suited to a flip room schedule. To maximize efficiency, restrict flipping to shorter cases with predictable case times. Operative times should average 1 hour maximum. In addition, focus on procedures for which a physician assistant (PA) or registered nurse first assistant (RNFA) can close, allowing the surgeon to leave 1 room early and begin in the next room promptly. There should always be a back-up surgeon immediately available to assist if needed in the room where the PA or RNFA is closing.

  Many orthopedic procedures provide an excellent opportunity for room flipping. Some spine procedures and robotic cases also qualify. The ideal case is a short operation with a complicated setup, such as a hip arthroplasty that requires extensive preparation but only regional anesthesia. These cases can be flipped very efficiently, as operative time and turnover time come close to matching.

- **Reasonable economics.** Flip rooms are expensive, so they are sustainable only for cases with a strong economic foundation. Some specialties and procedures are important to the healthcare mission of the hospital, but creating flip rooms for these cases can endanger that mission. Provide flip rooms for case volume that supports the economic viability of the OR.

- **Exemplary behavior.** Flip rooms should be seen as the culmination of a positive, mutually beneficial relationship between the hospital and a surgeon. Surgeons with a pattern of disruptive behavior should not be considered for flip room time. Once a surgeon receives a flip room, he or she should continue to demonstrate efficiency and conscientious use of resources (no leaving the OR during flip blocks).

- **Good citizenship.** Surgeons who receive a flip room should reciprocate by serving on hospital committees and task forces. Given the cost of flip room time, a hospital is within its rights to expect a reasonable quid pro quo.

**Timing**

In addition to establishing strong flip room rules, OR directors should create processes and management systems that maximize flip room efficiency and minimize problems.

For a flip room system to be successful, the second patient of the day must be brought to the OR before the first case is complete. But this makes it difficult for the surgeon to visit the second patient immediately prior to in-room time. The solution is to set an early surgeon arrival time, allowing the surgeon to complete H&P attestation and site marking for the first patient and the second patient before the start of the schedule. Following the first case, the surgeon should visit the third and the fourth patients for preop attestation and marking. This process is repeated as the schedule progresses.

Remember to weave family communication into the process. Coordinate with waiting area staff to make sure families are readily available to meet with the surgeon. Family meetings can often take place while the patient is being closed by an assistant.

Flip rooms create an even greater need for perioperative orchestration, so nursing specialty teams are critical. Specialty teams for orthopedics, neurosurgery, cardiovascular surgery, and other types of procedures help ensure surgeons can move from case to case smoothly and with minimal hiccups.

Consider allowing only same-side procedures within a flip room block on a given
day. Not only does this decrease the chance of a wrong-site surgery, it greatly reduces staff workload with regard to repositioning equipment (such as the C-arm) or the OR table.

**Communication and flexibility**

A strong daily huddle process is crucial to making a flip room system work. Daily huddles improve overall efficiency by ensuring patients are fully prepared for their procedures on the day of surgery (see p 24). A daily huddle can support flip room efficiency by identifying potential problems that can derail schedule flow. For example, huddle participants might identify patients with known anesthesia problems who are at risk of a longer operative time.

Huddle participants should also scrutinize the schedule for special equipment requirements that will be problematic within a flipping schedule. Vendor participation must be carefully coordinated to ensure proper timing and an adequate quantity of loaner trays. Manage supply needs carefully to prevent unnecessary slowdowns. In addition, work with central sterile processing to ensure quick turnaround on key instruments.

Consider requiring surgeons to facilitate an end-of-day team debriefing to review successes and problems during the preceding flip room block. This will help prevent recurrence of problems and facilitate standardization of best practices.

Ongoing attention is essential. Once a flip room schedule is done for the day, frontline leaders should look for opportunities to fill up remaining time with any elective or add-on cases. Whenever possible, flipping should be an option for eligible surgeons on the day of surgery. For example, Dr Smith may be scheduled for a long day in a single room. If another room becomes available in the afternoon, frontline managers should juggle the schedule to allow Dr Smith to flip remaining cases into the extra room. This is a great way to improve surgeon satisfaction, and it can help an OR control costs by keeping the schedule as vertical as possible.

Although anesthesiology staff may not initially see the benefits of flipping cases, the overall concept does offer some important advantages. Flipping rooms when possible as the day is coming to an end will shorten anesthesia’s cumulative time in the OR, especially after hours. That gets them out of the OR sooner and can reduce overhead costs for the anesthesia department. Flip rooms also benefit on-call anesthesia providers by allowing them to finish elective cases earlier rather than extending these procedures into the urgent and emergent schedule.

**Full transparency**

Successful flip room management also requires attention to the political dimension of a flip room policy. Even with a clear set of rules, flip rooms create a potential for

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### Single room vs flip rooms

The scenarios below illustrate typical schedule flows for a single-room block versus a flip room system. (Orange indicates operative time, and grey denotes turnover time.) Single rooms increase utilization and decrease variable costs, but flip rooms produce higher net revenue and contribution margin.

#### Single room schedule

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- **Utilization**: 78%
- **Net revenue**: $39,520
- **Variable costs**: $14,400
- **Contribution margin**: $25,120

#### Flip room schedule

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- **Utilization**: 58%
- **Net revenue**: $59,280
- **Variable costs**: $28,800
- **Contribution margin**: $30,480
conflict between the hospital and surgeons and within the surgical staff.

Ultimately, success hinges upon how flip room decisions are made and who makes them. In some hospitals, the surgery department chair decides which physicians are awarded a flip room. But even when decisions are based on utilization and other objective factors, “one-man rule” can create misunderstanding and resistance.

The solution is to create a shared decision-making process that is completely transparent. The best way to do this is to place the flip room system in the hands of a physician-led Surgical Services Executive Committee (SSEC). In many cases, physician governance of the OR all but dispels surgical staff conflicts (see OR Manager, April 2013, p 21). Broad physician representation allows an SSEC to create flip room rules that are seen as balanced and fair by the medical staff. Just as important, members of the committee become strong advocates for the system among their surgeon colleagues.

SSECs should evaluate all flip room requests based on agreed-upon guidelines and relevant data. Key data points include the surgeon’s utilization rate and the cost per procedure and contribution margin of the proposed flip cases. The committee should also review outcomes data for the surgeon’s patient population. Regular monitoring of outcomes is important for ensuring that quality is not suffering at the hands of efficiency.

A fair exchange
Clear rules and effective controls help OR leaders achieve an acceptable trade-off between the costs and benefits of a flip room system. When flip rooms are managed properly, they will decrease utilization but increase revenue and contribution margin. That opens the opportunity for an OR to build revenue-generating case volume and realize greater overall profitability.

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.

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