Questions managers ask about blocks

An OR director who also consults on OR management responds to frequently asked questions on managing the block schedule. M. Tammy Tenerowicz, RN, BSN, MPA, CNOR, is interim OR director at Robert Wood Johnson University Hospital, New Brunswick, NJ, and senior management consultant with Sullivan Healthcare Consulting, Ann Arbor, Mich.

**Q**: How should block utilization be calculated? Is turnover time included in the calculation?

**Tenerowicz**: I’ve seen utilization calculated both with and without turnover time. The most important thing is to clearly define whether turnover time is included or not and, if so, how you calculated the turnover time.

The definitions for both utilization and turnover time need to be agreed upon up front by all involved.

Including turnover time in utilization is tricky because there are many factors that affect turnover time. These factors are not always in control of the surgeon, and block time is the surgeon’s time.

Another issue is what figure do you use for turnover time? Do you use the actual turnover time for the period you are looking at, or do you use an average?

You must be able to say to the surgeons and administrators who receive the utilization data that you’ve used a turnover time number consistently and that everyone receives the same fair share.

The keys are:
- defining utilization and turnover time
- sharing that information up front
- making sure everyone is comfortable with the definitions.

I find surgeons will not push back if you have good data, consistently used.

The best approach is to have a couple of key surgeons work with you when you are developing the utilization reports for the first time or when you are revising them. That makes the approach more defensible when the surgeons question it—and they will question it.

It also matters whether the surgical information system you’re using is perceived to be reliable. Some of the old information systems are not reliable. If your physicians have been able to poke holes in your data produced by your system before, you will have a hard time trying to do new reports with that same system.

**Q**: Do you recommend using standard definitions, such as those developed by the American Association of Clinical Directors (AACD)?

**Tenerowicz**: We recommend that a key group in your organization agree to the definitions your organization will use. Until nursing, anesthesia, and surgery agree to the definitions, you will not make progress.

I haven’t found success in saying, “We will use this set of definitions because they were published, or we will use the definitions from the last hospital I was at.” It has to be a set of definitions your hospital agrees upon.

(The AACD definitions are at www.aacdhq.org/Glossary.htm.)

**Q**: Should block time be allocated by individual surgeon, specialty, or group?

**Tenerowicz**: That is determined by the culture of the organization. You find more service blocks in academic centers and more individual blocks in ambulatory sur-
gery centers. You find group practice blocks in organizations where there are larger-sized groups. In practice, I see a combination.

I do see more organizations moving away from service blocks to a combination of individual and group practice blocks. That takes away some of the politics that can happen with service blocks. For example, the chief of the service may insist on making the block-time decisions for the specialty block, and they may or may not be equitable.

**Q** How much time in an OR schedule should be open versus blocked time?

_Tenerowicz:_ This depends on the needs of the institution. In an ambulatory surgery center, you typically see 90% to 100% of the time blocked. That’s because the surgery is 100%, and the more time you block, the more efficient you can be.

In an OR that does both inpatient and outpatient surgery, has a lot of trauma, and is seeing an influx of new physicians and changing practice patterns, you will likely see a 70:30 split between blocked and open time.

The ideal we shoot for is 80% blocked and 20% open time, but that is not always doable.

Another decision is whether you want the open time to be first-come, first-served or whether you want to reserve some of the open time, say, for orthopedic trauma or other urgent or emergent cases.

One organization I was in recently had a pattern of a high urgent and emergent caseload on Mondays and Fridays. After examining their data, they decided to set aside 10 hours of the first-come, first-served time on Monday and Friday for urgent cases. They will look at the utilization in 3 months to see if this approach is warranted. Setting aside time is a tough decision because there will be times when it isn’t used. In this day and age, OR leaders have to be fiscally responsible about any unused minutes.

**Q** New physicians say they can’t get on the schedule. How do you manage that?

_Tenerowicz:_ Again, this depends on the organization. One organization I’m familiar with decided to reserve 8 hours per week for a “new physician block.” This might be a good strategy if you are trying to attract new physicians. It’s better than the usual custom of relegating new physicians to starting, for example, at 4 pm on Friday afternoon. It gives them the opportunity to build case volume and a history so you have data for assigning an appropriate block later.

Sometimes, OR directors get blindsided by a new physician’s request. Senior administrators who are trying to recruit a new surgeon may say, “Of course, we’ll make the OR available to you.” But the OR director doesn’t find out until 2 months later that this new surgeon has been promised block time. Then the director has to figure out where to find the time. I give credit to the organization that planned proactively with the “new physician block.”

**Q** What should be the release time for unused block time? Should release time be set by specialty?

_Tenerowicz:_ You would be surprised how many places stick with a straightforward 7-day release time. But it makes sense that release time should be set by services because some specialties can schedule further in advance than others. As with the other issues, this decision needs to be made by each organization.

OR leaders need to have a discussion with the physicians to agree on realistic release times. Physicians tend to want to hold on to their time just in case a patient comes in at the last minute. A lot of education is needed to remind them that block time is for elective cases, and urgent and emergent cases fall under different definitions and scheduling practices.

If you set release times by specialty, you may have orthopedic surgeons, for example, who get upset when you want them to have a 7- or 10-day release time. But if you show them their actual practice patterns, they may realize it actually takes
that much time to prepare orthopedic patients for surgery. You need to take the time to have those conversations.

**Q** How often should block time allocations be readjusted?

**Tenerowicz:** Generally, 3 to 6 months is a good time frame. You need to work with the physicians to let them know what the time frame and policies are.

Three months tends to be too short, mainly because of seasonal variation. That's particularly true in states like Florida and New York where some of the population migrates in the winter and summer.

Also, let’s say you decide to introduce a new plan on March 1 to adjust the block schedule every 3 months. Many practices book their procedures 4 to 6 weeks ahead of time, which would be the middle of April. You would be readjusting the blocks on June 1, the end of the 3-month period. I don’t think that gives you enough history to know whether the surgeons are using blocks well.

I think 6 months is more reasonable. A year is too long. Too many things happen in a year—physicians retire, groups change, practice patterns change, and so forth. You can have a waiting list of unhappy physicians who are requesting time or changes in their times.

Also, because this issue is so fraught with politics, if you only do it yearly, it’s easy to put it off and not deal with it. I think that is a setup for failure.

**Q** What block time utilization should surgeons be expected to maintain?

**Tenerowicz:** Ideally, we shoot for 80%. If you’re in an ambulatory surgery center doing straightforward cases, you can push that up to 90%.

I have seen organizations accept block utilization as low as 60%. In one case, that was because they thought their surgical information system was inaccurate. When surgeons said they had released their time, the information system did not give them accurate data to demonstrate that the time had not been held against them.

Again, you need to have an upfront discussion and clear policies stating that you expect surgeons to release their time, and if they do, the time will not be held against them. That policy needs to be applied and documented consistently.

In one organization, the surgery scheduler keeps a separate calendar on release times. When surgeons call to release their time, the scheduler documents that on the calendar in addition to recording it in the computer. Then she can review the calendar when there is a question about whether a surgeon released time.

Tammy Tenerowicz will speak on Block Scheduling: Political Pitfalls and Administrative Milestones at the OR Business Management Conference May 10 to 12 in Austin, Tex.