

OR throughput

Fine-tuning the block schedule? Now could be the right time

If you want to fine-tune the block schedule, now may be the time. A silver lining of the recession is that surgeons and staff may be more accepting of changes to the schedule than they might be otherwise.

With the decline in elective surgery from the economic downturn, surgeons are less able to leverage one hospital against another.

In all, by the end of March 2009, 59% of hospitals were seeing a moderate or significant decrease in elective procedures, the American Hospital Association reports.

"This is allowing hospitals to make changes that are more politically challenging," observes William Mazzei, MD, medical director of perioperative services and clinical professor of anesthesiology at the University of California, San Diego.

"What is important to surgeons is good use of their time at one facility rather than playing one facility against another. They don't have the business to do that any more."

Facilities may be able to enforce stricter rules to improve OR utilization, he says. With more OR time available, they may be able to encourage surgeons to stay at the facility longer than they might have in ordinary times.

For example, if the OR has allowed some surgeons to have half-day blocks, which is not optimal for utilization, it may be easier to make these full-day blocks.

If the surgeons object, the facility might respond by saying it will convert these blocks to open time into which anyone can schedule cases. In this environment, most surgeons will accept the change, says Dr Mazzei, who is also with Surgical Directions LLC, Chicago-based consultants.

It may also be easier to match staffing more closely to the surgical schedule, he notes. In a down economy, staff may be more accepting of scheduling changes.

The business of blocks

With fewer cases, ORs need to pay close attention to how surgeons' block time is affecting their business, comments Jerry Ippolito, MBA, MHSA, of consultants OR Efficiencies LLC, Naples, Florida.

When a surgeon asks for block time, he suggests the question should be: "What are you going to bring us?" How will the surgeon's cases benefit the hospital? He advises posing the same question to surgeons who already have block time.

The block time analysis should include not only how much of their block time surgeons are using but also the contribution margin of their cases. (Contribution margin = revenue - variable costs, such as implants and specialty staffing). The contribution margin should be calculated before indirect costs are allocated and should include revenue and expenses for the sur-

geon's patients hospitalwide, not just for the OR, he adds.

The literature includes a number of studies on OR time allocation, including use of contribution margin (related article, p 11).

Good governance

Nothing is more important to effective block scheduling than strong, active leadership, these experts say. The block scheduling system must be governed by policies and procedures endorsed by the medical staff and enforced by the OR's governing body. Policies must be transparent.

"The system must be scrupulously fair. If there is any favoritism, the surgeons will sniff it out, and it will never work," stresses Tom Blasco, MD, MS, an anesthesiologist and intensivist at Advocate Lutheran General Hospital, Park Ridge, Illinois, and a consultant with Surgical Directions LLC.

The OR governing body must be committed to ongoing measurement and evaluation, Ippolito adds. "Many organizations allocate block time to a surgeon and never look at it again, whether the surgeon uses it or not."

When blocks are poorly managed, surgeons have bad experiences and may end up rejecting block scheduling all together. (For more on OR governance, see the July 2008 *OR Manager*.)

Communication is a corollary

Communicating with surgeons about their blocks is essential in managing the block schedule, says Stephanie Davis, RN, MS, CNOR, assistant vice president, surgical services for the HCA Clinical Services Group of HCA Inc, the national health care company based in Nashville, Tennessee.

The surgeon's office often schedules the cases. The office may be scheduling some cases outside the block because these other times are more convenient, she notes.

"If we are not transparent with surgeons about their utilization, they may not know they are not meeting the target. They may volunteer on their own to adjust their block," she says.

Open communication is also part of customer service.

"If you have a good relationship with your surgeons, they will trust you to manage blocks fairly," says Davis, who has assembled a block scheduling toolkit for HCA Inc's 165 hospitals (related article, p 9).

Starting a conversation

Good relationships make it easier to start a conversation if a surgeon's block utilization is not what is expected. Davis says that when she was a perioperative director, she talked to the surgeons about low utilization as soon as she found out.

She might say, for example, "Dr Smith, I hope you got your letter about block utilization. Did you realize you were only running about 35%? Do you want to move your block to a different day? What can I do to help you get your utilization where it needs to be?"

Efforts to manage the block schedule can be worth it because everyone benefits, Dr Mazzei observes.

"The workday is more enjoyable for physicians and staff alike in hospitals that have completely full blocks, do lots of cases during the day, and have limited overtime and limited nights and weekends," he says. "They find this is a win-win situation." That may not be obvious to people in sys-

tems that have had the same underutilized block times for 20 years, he adds. Today's environment may create the opportunity to change that situation. ❖

—Pat Patterson

Stephanie Davis will speak on block scheduling at the Managing Today's OR Suite Conference Oct 7 to 9 in Las Vegas.

References

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